Appendix 7 – Survey and face-to-face comments in full

Comments on proposal to restrict access to fertility treatment:

Q. Please tell us any thoughts you have on our proposal to restrict access to NHS-funded fertility treatment. In particular whether you think we are considering the right criteria changes, and if not, what you think we should be considering.

Please note that comments are categorised by key themes, but have been transcribed exactly as received.

Comments which appeared to be in favour of the proposal:

For Proposal

- I totally agree with the proposals.
- I think these are the right changes. There are many couples who wish to have children and cannot, but there is not a shortage of children available. If people are desperate enough, they will prioritise getting their weight to the correct level.
- I feel these are the right criteria for the present position in the NHS. Limited finances make these changes necessary.
- I agree with your thinking on this.
- Although fertility issues can be difficult for people, they are not strictly a health issue. As an older woman in an 'infertile partnership' I have been able to life a full and happy life. I don't think scarce NHS funds should be used in this area as a first priority, i.e. other chronic and poverty/age-related conditions should be prioritised.
- This is very difficult, but I strongly believe that the NHS is for illness not for infertility. I recognise though that this may cause mental health issues. But prior to infertility treatment, people just accepted they could not have children. There is adoption if you want to have children.
- I think it's not great but I understand the reasons for it.
- I don’t think fertility treatment should be available at all on the NHS.
- Infertility is neither a terminal nor life-threatening condition and given that cuts need to be made, IVF treatment is an obvious candidate. The money saved can be far better used to help those suffering from genuine illness and disease.
- I think the criteria changes are reasonable considering the financial constraints of the NHS. Being able to conceive is not a right and much could be done to improve education in general health which would increase natural fertility
- Correct criteria.
- Unless a couple has a physical problem that can be corrected I believe if they want a family they should fund it themselves.
- Yes I think that it makes sense to set criteria that are attainable.
- Another criteria - the number of children the couple/individual already has. Also the ability to support the new born - financially and emotionally.
- These seem the right sort of criteria.

- I agree with your proposals, if a couple are genuinely eager to have a child they will adopt a healthy lifestyle to help with their chances. Those who take it for granted, as it's a free service, aren't doing it for the right reasons.
- Smoking should have ceased for 6 months and alcohol intake be within recommended limits
- I agree with it.
- Absolutely the right thing to do - we have limited, finite resources and these need to be targeted appropriately. Having a child is a privilege, not a tax- payer funded right.
- Having children is not a 'right' however help should be given ONCE to young fit healthy adults.
- Focus should be on keeping risk as low as possible.
- I agree with your suggestions.
- I completely agree with new proposals.
- A good idea.
- Agree with changes.
- Agree, it's not an 'illness' per se. Should come alongside a BIG push for doctors in the BANES area to take women's health care significantly more seriously, though.
- Although I think you should set up criteria whereby there are guides in decision making, I do think that there may be circumstance in some cases that further thought is necessary for the right decision. Each case should be considered carefully bearing in mind that the subject matter has the utmost importance.
- I think there is no choice as the health service is so underfunded.
- Infertility is not an illness and there are plenty of babies available for adoption.
- Generally support. I don't think it is a God-given or State-given right
- NHS funding for fertility treatment should be cut by a large amount. It's personal choice, not a medical requirement and funding should be utilised elsewhere.
- We cannot take care of the people who are already alive, &, environmentally, it is irresponsible to increase the number of people, infertility is a natural way of curbing the numbers. Contraception should not be cut or restricted.
- The restrictions seem reasonable.
- I agree with proposed changes.
- There is no absolute right to have children and at the same time, there are many children waiting to be adopted. The latter is, perhaps, a minor matter but non-NHS funded treatment is available and scarce resources should be directed towards those members of the public who are genuinely ill and need treatment.
- Agree to the extent that it may be too easily available and lessen possibilities to the more select groups - without penalising. I think it is a well thought out approach.
- You shouldn't be restricting it.
- Personally I'm not sure this treatment should be offered on the NHS.
- I think you have picked the right criteria.
- These seem to consider the right criteria.
- I agree and there should be a consistent approach across the NHS.
- I think you are entirely right. Infertility must be very hard but it is not an illness. If hard choices have to be made, this is right.

- It's tough but choices have to be made. I had to go private for IVF as I was older than 35. Restriction to one cycle is ok as well
- In straitened times, I believe that we should be restricting access to certain services, including fertility services. I am saying this as someone who has struggled with fertility, and though made use of the NHS service, I would have paid if not available. If a decision has to be made between essential services and non-essential, then I feel fertility services falls into the latter category ad wholeheartedly support the new approach.
- Fertility treatment is not a right. These appear to be evidence based criteria
- I believe you are. I'm sure some couples could be directed towards adoption options prior.
- I think this feels about the right balance under difficult circumstances, particularly given overpopulation and risks and successes of IVF.
- Criteria are appropriate
- The UK is hugely overpopulated; any measures which reduce our population are to be welcomed.
- Fertility treatment is not a right, and in times of restricted budget and ever increasing demand for essential services it should be curtailed in favour of spending on serious medical conditions.
- Yes, right criteria.
- Should not fund fertility treatment on NHS except for medical reasons.
- I would consider lower ages for women and make the male and female ages the same.
- The criteria should be more restrictive than currently proposed. Fertility treatment isn't live-threatening and that is where resources should be directly.
- Cost savings must be made for non-essential treatment.
- Proposals are fair and reasonable. Applicants for treatment should not have unlimited and uncontrolled access to such treatment at other council tax payers expense and there should be clearly defined criteria for those most suitable for treatment with the highest chance of success.
- In times of increasing need, funding should be focussed on illness.
- I think that not having a baby is not an illness and as such should not be treated like one.
- I would restrict all free access. It's not essential to health, more of a lifestyle choice. The people involved should self-fund if required. Although a different topic, dental care is graded in various ways and many treatments like dentures have to be paid for or means tested.
- Very good proposal.
- Fertility may be wanted but is not a right, in my view. So restricting access to NHS support for this is OK as there are much more important things to do, primary health care in particular.
- I agree with reducing the access to free IVF treatment on the NHS, and would reduce the maximum age for males to 40.
- Yes, good idea.
- I agree to the proposed criteria.
- Agree with the proposals.
- One couple felt that there were more important things to spend NHS money on and that adoption should be more widely encouraged.
- General feeling that this should be introduced.

- This facility should be withdrawn completely. It is not a RIGHT to have a child. It is a matter of nature one way or another. IVF is very expensive in financial, psychological and failure terms. There are many children waiting for fostering or adoption and would-be parents should be steered in that direction.
- One man shared that everyone he knows who has had IVF has paid for it.
- One man felt that people who live around Bath have money and shared that his friend's mum went to Spain for IVF treatment.
- One woman felt that the adoption regulations should be relaxed.
- One younger woman shared that she didn't want children at all, but understood that some people would find these criteria very difficult
- I agree that changes should be introduced due to lack of funding available. Perhaps another criteria could be income, i.e., make it means-tested after the first or second round of treatment.
- One person felt it was reasonable
- There are alternatives, such as adoption
- One woman said: restrict child birth - there are too many kids. She would not be affected by the proposal. Her sister couldn't conceive

Agree with age criteria:

- There may be health complications if a woman has children when she is older.
- One woman highlighted the potential complications of having children at an older age (e.g. increased risk of having a baby with a congenital abnormality).

Agree with BMI criteria:

- I think that the BMI of the partner should apply to both male and women - that is for both hetero and homosexual relationships. Also I think there should be some exceptions made for women with polycystic ovaries and their weight.
- Felt that women need to prep their body for giving birth and parenthood.
- Felt that men need to prep their body for parenthood (which is a decision).
- One woman had strong views that people should not be very overweight when they are trying for children.
- One man felt that it depends, as some people can't help that they are overweight.
- Women should be educated to understand that it is better not to delay having babies for too long, and that obesity is a thing to address before trying for a baby they need to know why it seems that it is acceptable to be morbidly obese now most people have no idea of how this affects the internal organs and skeleton. I always tell people who are morbidly obese that each extra 4 stones of weight they carry is equal to a large sack of potatoes and imagine carrying one or two sacks of potatoes around all day (I was obese in my early years but lost my weight in the 1970's). I have run slimming clubs informally and formally in the years since then I would be very happy to educate people for free in the most effective way that I have found in the 45 years that I have maintained a healthy weight it works for me and it is no gimmick it is healthy basic foods similar to the GI diet. I think this is a very difficult thing to do I know of several people who had their first child using IVF treatment who were not that young they are perfect parents they have families who support them who am I to judge them who are you to judge them I think they are far more responsible that the people who don't take contraception seriously and breed children knowing that the state will care for them resulting in so many children who never know what a caring family is.

Perhaps after 35 is too old but with good education perhaps there would be fewer people needing IVF. There are easier ways to save money in the NHS. Our government can find money for TRIVIA yet OUR NHS is at breaking point whilst private companies are making money out of our ill health to hand out to their shareholders. See what I put in my reply to your survey on vasectomies

- Help & support for women who need to lose weight
- Both female and males need to be at the correct BMI in order to get most success.
- Woman has polycystic ovaries and was asked to reduce BMI - she lost 2 stone in 2-3 months. She still had complications with her pregnancy and agrees that it's important to be healthy for pregnancy.

Agree with duration of infertility criteria:

- Should be about the timescale (of trying) not the age range.
- Two women felt most people try for a while anyway.
- Two years is reasonable.

Comments in disagreement with the proposal

Disagreement in totality/discriminatory:

- You should not be considering these restrictions.
- As someone who is currently undergoing fertility treatment, I feel very strongly about the proposed changes. My husband and I have been trying to conceive for around three years. My mental health, along with my husband's has been affected tremendously, and this is without the proposed changes in place. I feel that fertility treatment is extremely 'urgent'. I would love to start a family now. I decided to look at starting a family in my late 20s - some people do not want to start until a little later on, and restricting the age further I feel is disgusting and cruel! As for the weight, why should someone be restricted because of this? Has eating disorders, polycystic ovary syndrome been thought about? Losing weight in these cases is extremely difficult! Why would you prevent these people from fertility treatment due to conditions out of their control? I think these changes would cause further upset and stress to those who only want to bring a child into this world, to love and cherish for life!
- Change to upper age limit is unfair. Change to BMI rating for women without regard for pre-existing medical conditions is unfair. Changes and the criteria are not inclusive or clear for lesbian or bisexual women in a same sex relationship. Two years wait in combination of reduced female upper age limit is grossly unfair.
- divisive and discriminatory
- It is discriminating against many couples unable to have children naturally
- I think it’s unfair
- I assume this exercise is about cost cutting only as no other justification is given. I think it is reasonable that any female seeing to achieve a first child up to the end of her 40th year (at least) should be entitled to fertility treatment. I can understand that people need to be encouraged to lose weight, but I question whether apparent discrimination against women with polycystic ovaries would be legal - or lead to potential costly legal challenges. I think an age limit on male partners may

be justified but that 55 is too low. I do not see the relevance of a male partner being 1 point above a new criteria level. I anticipate that trying to conceive for a year may be appropriate as criteria, but if so any age criteria should be extended by that amount. Children and family are essential to society and the happiness of couples who wish to have children - cruel cost cutting measures at the cost of couples having difficulty in having a first child cannot in my view be justified (I could not justify the state allowing my wife and I treatment as we could afford to pay. I therefore wonder whether there is any room to consider means testing). I think cost cutting here may cost in other ways including marriage breakdown and mental health issues or necessary treatment arising from breakdown and from depression as a result of inability to have children.

- Anything that involves a postcode lottery is inherently unfair in a NATIONAL Health Service (the caps are intentional). Women today are tending to have a career and then perhaps have children. These measures militate against that and make it more difficult. It also seems to be a short-sighted measure in the light of the UK demographic position especially post-Brexit with a distinct possibility of a reduction in the breeding population. Though of course, the cynic in me might point out that the CCG's other proposals to no longer fund vasectomies/sterilisation may work in the opposite direction. The difference being that the extra pregnancies will be at best unplanned and at worst unwanted leading rather than the exact opposite for IVF.
- Restrictions like these are truly appalling and chips away at the fundamental principles of the NHS in the worst possible way
- You are picking on vulnerable people who desperately need this treatment. You should hang your heads in shame and feel a fraud to call yourselves healthcare professionals.
- One person felt it was not fair.
- There should not be any restrict access to NHS funded fertility treatment. It is a medical problem & all patients need our help
- Infertility is a disease of the reproductive system; by proposing to deny IVF treatment to certain groups of women you are cruelly targeting those that are desperate for a baby. Given that research shows that more and more women and couples are struggling to conceive, your proposals should be to increase funding rather than cutting it. The proposed money you will save is such a meagre amount and given the emotional trauma that women experience infertility go through, I have no doubt that more would be forced to seek help for their mental health as a result of being denied treatment. It is cruel and unnecessarily targets women that are desperate to start a family.
- What happens to patients who need fertility treatment who have had cancer treatment and are over the age of 35...? Restricting a family to couples is the worst thing you could possibly do. This is heart-breaking for so many women, think about how you might feel before reducing your current restrictions
- For someone that IVF and was unsuccessful this is very upsetting news if I tried now under your new idea I wouldn’t be eligible
- Please don't restrict this, especially as the mental health services are already limited, this is already emotionally exhausting
- Criteria too rigid.
- I am very concerned to hear that BANES CCG is proposing to stop funding male and female sterilisation on the NHS. This will disproportionately disadvantage the

most vulnerable women in BANES. Comprehensive reproductive health is a cornerstone of preventative medicine, and it has long been established that this works best when men and women have access to all contraceptive options.

- General comment: it shouldn't be a postcode lottery re. Number of IVF cycles offered.
- What right do you have to put restrictions and control when someone wants a family? As long as the couple have been trying for a fair amount of time they should be entitled to fertility treatment. I don't see why having a family when you decide you want one regardless of your size suddenly became a privilege for the wealthy.
- Feel that the policy unfairly discriminates against people who cannot have children and it is not their fault. People who pay taxes should be supported to have a child if they choose
- No analysis has been done of how these policies interact. The net effect of these combined policies could be to reduce the chance of IVF succeeding – and impair the cost effectiveness of CCG spending. The BMI-related policies would have the effect of effectively delaying treatment for couples – which the consultation paper itself acknowledges is likely to lead to reductions in fertility for both partners. No analysis has been presented to demonstrate that, for example, the improvement in a man's fertility as a result of weight loss would necessarily compensate for the loss in a woman's fertility over the period of that weight loss – or to demonstrate what the impact might be on IVF succeeding. There is a serious risk of unintended consequences – with the combined effect of these proposed policies reducing the chance of IVF being successful – and reducing the cost effectiveness of the CCG's spending. The paper is also incomplete. Involuntary childlessness has been found to put significant pressure on relationships and on couples' long-term wellbeing. The paper makes no analysis of this impact on couples' relationships, mental health or wellbeing following from these proposed policies – all of which are likely to be negatively affected as a result of the proposed policies – and all of which may incur extra costs to the CCG and to wider society in the longer-term. The BMI limit outlined on the website is arbitrary – and seems purely designed to cut cost It is ironic that B&NES CCG is putting forward proposals that would mean that more than 70% of Bath Rugby Club's forwards would not be able to access IVF with their partners should they need to. BMI is a blunt instrument and does not automatically do proper justice to men's health, weight or fertility. The proposals will also have a very wide-ranging impact. The Health Survey for England estimated that in 2015 around 24% of men in the South West had a BMI of over 30. Critically, no evidence has been presented that this measure would improve the chance of IVF succeeding or the cost effectiveness of CCG spending – only that it affects non-IVF fertility. Other exclusion criteria and methods have also not been evaluated – for example measuring the quality of sperm and the likelihood of success before proceeding with IVF. Setting a weight management criterion for men when local weight management services are failing to reach and engage men – is unfair and unreasonable. Even though men are consistently more likely to be overweight and obese than women across the UK at every age, the way local services are designed in Bath & North East Somerset means that local men are less than a quarter of those using them. In a 2017 FOI request by the Men's Health Forum, Bath & North East Somerset Council reported that, in 2016/17, approximately 16% of 632 participants in public health sponsored weight management

programmes with Slimming World and Weight Watchers were men. In 2015/16, 25% of the 130 people referred to their GP Counterweight programme were men - with a similar proportion reported for 2016/17. Finally, the core thinking behind the proposals – namely restricting access to IVF people who are more likely to have fertility problems – is illogical and unethical. The purpose of IVF is to achieve pregnancy and help those who are infertile. The new criteria seem to be designed to arbitrarily exclude some couples with infertility that IVF is intended to remedy, rather than to exclude on evidence that treatment could not be effective.

- The criteria are discriminatory- a heavy set lady is just as eligible as a slender one.
- It is a very stressful time for couples without all sorts of criteria to fill and couples are waiting for a longer time to start families because they want to be more financially stable to bring children into the world which is a responsible attitude to have rather than have children early on and run the risk of splitting up due to financial pressure and to then maybe have to rely on the government to help provide for their children I find it totally unfair on these people who are being responsible members of society
- Everyone has the right to be a parent irrespective of their age or body mass index. This is completely unfair.
- Are these cuts the tip of the iceberg? Will many other cuts to 'non urgent ' NHS treatment follow. These cuts are a way of rationing NHS care and take away the rights of those who are seeking fertility treatment. None of us can control our life circumstances and having access to fertility services should be a matter of choice not an immediate cut off when we reach 35.
- Do not restrict access to IVF treatment for childless couples.
- To have this service as open ended as possible is essential to those that have fertility problems. Too many people I know need this service and I see the pain of not being able to have a baby. I can’t imagine what they would be like if they were ever restricted.
- Woman is sad about proposal to restrict access to fertility treatment (in any way). We've come a long way since Louise Brown was born (first baby born from IVF).
- Unhappy with this.
- Felt it should be up to the person.

Disagrees with age criteria:

- Women often start families later in life nowadays and to reduce the age to 35 and make them wait and there is always a waiting list, they may miss the opportunity. The age limit for women should not be reduced.
- Didn't think 35 should be the cut-off age.
- The changes proposed unfairly impact on women aged 35 and over who for various reasons may not have yet had a family. For instance, waiting to try to conceive until financially able to support a child, ensuring in a stable relationship, having to overcome irregular cycles or needing therapy to overcome sexual difficulties for example. For women who are now aged over 35 and would qualify under existing rules, it should not be estimated the ongoing impact these proposals have on their mental health and on their relationships. Having experienced pregnancy loss at 35 and only now experiencing fertility issues, I feel unsupported and ignored.

- The average age of women when they choose to start trying to conceive is increasing. I didn't start to try until I was 36 despite being in a long term relationship. This decision was made due to my career. We should not restrict access to 35 as this will affect career choice/ progression for women.
- Think women should be able to access until age 40 or age 42 if started trying before 40. Agree male age limit. Agree BMI for men and women.
- Reducing the age for fertility treatment for women is unfair. Many women aren't in the right relationship, do not have financial security and are not ready to have children until they are in their 30's so lowering the age is just unfair. Lowering the age to 25 means women will have to be trying for a baby from the age of 23 if they have to have been trying to fall pregnant for 2 years. It is unrealistic and unfair. The BMI requirement is also unrealistic; some women are really healthy and fit and still have a higher BMI than the requirement why should they be excluded from fertility treatment. I think weight & health should be considered on an individual basis. Every woman should have the right to fertility treatment - the proposed changes are discriminatory and just plain unfair.
- I believe that the age of the woman should be kept at 40. If you are expecting couples to have been trying for two years to conceive before being eligible to have funded fertility treatment I feel that this would result in more women being aged between 35 and 40. You also have not indicated why the age '55' has been selected for men. Is this evidence based as a correlation to men's fertility and therefore chances of success with IVF as you have indicated it is for women?
- One person felt that the age criteria should stay as it is, as up to age 40 years gives women the chance for a better life balance.
- One woman felt it was a bit harsh and shared that her daughters had children late.
- Women face career pressures so this criteria is very unfair
- Age criteria should be at least 40+, as one woman shared she has friends who tried to get pregnant for years
- 38 would be better, as some women wait until they're older to try for children.
- The age limit of 35 for women is harmful and restrictive; it is a well-known fact that due to financial pressures and changes in lifestyle in the 21st century that women are choosing to have babies after the age of 30. I do agree a couple should try to conceive naturally for two years to avoid putting themselves potentially unnecessary strain but, the age of limit of 40 should therefore remain in place to give all women a fair chance.
- It takes years for females to be diagnosed with fertility issues, many will try for years before discovering issues by which stage they have surpassed the 35 years threshold. This is a medical condition and should not be treated differently than any other condition by withholding vital treatment. Couples who work hard, pay tax and are generally healthy should not be penalised by restricting their right to fertility treatment, for a condition not of their making. This is a very unfair policy to save a few pounds. Treatment is life changing for couples.
- This change in the age undermines women's rights and access to employment and a career. For women who attend university and then undertake a masters will not be starting their careers until late twenties. They are then expected to be making a decision about having a family and settling with a partner. We advocate for people to make informed decisions about parenthood and committing to long term relationships, yet this undermines this. Counting backwards- a woman

needs to be starting IVF by 35th birthday, one year on a waiting list, takes us to 34, two years of trying takes us to 32 (if they have notified the GP otherwise possibly 31), so they must be making a decision re a family at 30/31. The average age for 1st child is currently 32. These proposed changes do not align with the changing role of women in society and take us backwards. If the age is to be changed it should be the other end with the younger age bracket (23-28) in special circumstances. We've worked hard for women's rights and equal access to employment- this will be a massive step backwards. In terms of fairness- this is also targeting hard working women and men who work hard and have contributed a lot

- Reducing the age limit to 35 will exclude a large number of patients, personally I did not find out I needed IVF until I was 35.
- I think reducing the age limit for women to 35 does not reflect the fact that most people now rely on two incomes to have a stable home and to start a family, and so are forced to wait longer to start a family. With a 2 year period where people need to try to conceive naturally, plus a period for any tests, this means women must have started trying for a baby before they are 32 to have any hope if funded fertility treatment. This is not realistic for many women. The chances of success of IVF are still good for many women aged 35-40 and the CQC recommends 3 funded IVF cycles for women under 40. These restrictions are neither appropriate nor in line with the NHS' own guidelines. It is morally indefensible that only rich people have the ability to access treatment to start a family.
- I have a concern that restricting the age from 40 years would deny women a service. Women may not look to have a child or realise there is a fertility problem until after 35 years old
- I think it is very unfair to suddenly reduce the age of woman to be able to access fertility treatment by 5 years. Some women in their mid-late 30s may have otherwise starting trying for a baby earlier if they had been aware fertility treatment would no longer be available to them. It is discriminatory on the basis of age of the woman. The majority of women who are not able to conceive in 1 year will not conceive in 2 years- effectively decreasing the age of eligibility by a further year. This would mean that women would need to be trying for a baby by 33 years old in order to be eligible for fertility treatment if they run into difficulties, which seems very young considering the average age of first time mothers in the UK is 29 years old. Many women are not ready to have a family either due to finances or careers at an earlier age.
- Upper age limit is too low. Most couples can’t afford to start a family until they are in their mid-thirties. Would then be too late for IVF.
- Setting the female age limit at 35 is arbitrary and cruel. It discourages women from establishing their careers first.
- I think the age of women you are proposing is unfair especially if you are expecting couple to have tried for at least two years. Normal NHS guidelines say you should visit your go after a year so this does not tally up. Also most people do now not start trying for children until their 30s so this could discriminate against a lot of woman
- No age limit on fertility treatment, no woman should be made to feel like they should be trying to conceive before the age of 35.
- Age is 35 is too low! Regarding the other factors, every case should be assessed individually.

- The option of having fertility treatment with a reduced female age limit of 35 is too young it should at least stay at 40yrs old - this should not be a postcode lottery! 40 is not too old to be given the chance of a child!!!
- I feel that the proposal is discriminatory. I do not agree that the age of the female should be lowered; women are more likely to be older before they realise they have a problem, with the current financial environment. A lower age would only be appropriate with greater publicity about the benefits of having a family at a younger age, together with changes in employment policies and some sort of financial benefit. Instead I think the main focus of saving money should be on reducing unnecessary layers of management and bureaucracy
- Most couples these days are waiting to have children until they are in a financial position to do so. With my friendship group this has meant starting to try for children after the age of 39. With house prices and other living expenses so high this seems reasonable and responsible. However by these new criteria, by the time most couples realise they require fertility treatment they will be past the age of restriction, and then face a decision of getting into huge debt or not having a family at all. It will also vastly separate people in different economic circumstances with a message of the wealthy being entitled to a family, and those who are not are not. People in a better financial position can both potentially afford the fertility treatment, but also be able to afford to start trying for children earlier, so will end up being able to meet the criteria.
- Unfair & unrealistic in today's society to reduce the female age limit from 40 to 35yrs, it should stay at 40 and up to 3 cycles should be offered
- I am a 34 year old career woman who is only just starting to seriously consider having children. 35 is too young nowadays.
- Firstly I am confused because the proposed criteria document states that the BMI of the male has to be 35 or less, however the question above states it has to be 30 or less. This is a huge difference in weight and couples reading the proposed criteria will have more heartbreak when it is confirmed that in fact what you are proposing is BMI of 30 or less. I do understand the restrictions on women as they have to go through the pregnancy but do not understand why there is now a male weight limit other than purely to make cuts. I do not agree with the upper age limit although this does not affect me because many women now are having children later in life and ARE able to carry a child when over 35.
- I think that lowering the age where women are eligible is closing the gap too much. Not many women in their early twenties will discover their infertility. Especially if you are introducing the 2 year 'trying' period, which may push some women over the age group. I am currently undergoing IVF at the age of 36, coming up to 37, and I cannot imagine being told at 36 I was too old to be eligible. Once my partner and I were in a stable position and had purchased our own home, we started trying; two years later we discovered that we could not have children. Our sense of responsibility would mean that under new changes we wouldn't have been eligible.
- I would have thought the age would be better at 30-40 as these are the most likely to be trying and struggling and have been trying longer
- Female age should be at least up to 40 years old for funded NHS fertility treatment, proposed 35 years old is too low
- I think restricting the age of the women to a maximum of 35 is unreasonable bearing in mind the odds of success at this point with IVF are still quite high.

Keeping the mac age at 40 seems the fairest middle ground. I can see more the rational for saying that a couple should have been trying to conceive for one or two years as this means all other options had been looked into and given time to work. My only question is when does this time start from? If it's when a couple first presents at their doctor than 1 year would seem a sensible maximum as that gives time to try other treatments. If it's from when a couple start trying then 2 years would seem reasonable as this would mean 1 year after a couple first seek help from their doctor as a couple should wait one year before seeking this help if under 35.

- Due to society changes people are ‘settling’ down much later due to having to pay back massive university debts and then struggling to save to get on the property ladder. I myself have been down this path and having only met my husband when I was 34, I was 35 by the time we started trying for a baby, 18 months and a miscarriage later, under these new guidelines we would not be eligible for NHS funded fertility treatment. After having struggled with said university debts, buying our first house and paying for our own wedding has meant that we have no savings left and therefore would not be able to access private IVF.
- I think restricting the age puts added pressure on the couple to conceive. This pressure could be detrimental to treatment.
- Proposed Female age limit too low
- Female fertility age should not be reduced to 35 years old; in today's world some women want a career first before settling down. Increasing trying/ infertility time to 2years is over the top, 1year would perhaps be more acceptable
- Restricting to women of age 35 is not acceptable; it eliminates the category of women most in need of IVF purely because of age. This is effectively penalizing many who are still fertile for simply aging and not due to biological reasoning
- 3 cycles should be offered not just proposed 1 and female age limit should be 40 years old not reduced to the proposed 35 years old. The proposed trying to conceive for at least 2 years is also too long, should be no more than 1 year.
- Restricting the age for female partner to less than 35 is far too young. I agree with restrictions based on BMI
- I think it is important that couples with underlying medical conditions are eligible up to the age of 40. However, agree that that if the reason for not conceiving naturally is purely due to age then it may be appropriate to cap the age limit for women to age 35.
- One member raised concerns that the restricted age requirement for women would discriminate against women who choose to have children when they are older.
- Women can/do have babies into their 40s, so issue with career and gender equality.
- It feels like being punished financially twice over. We tried to do the right thing and wait until we could afford to care for a child - which is very challenging when rent/ property costs mean we are reliant on two incomes. I was 33 when we started trying for a baby. It seemed a little late but not wildly out of step with our peers. I am now 36 and about to start IVF treatment after a frankly sad and demoralising few years. I feel so sad for the people who will be following just behind us and probably won't have the chance for a family, or will have to take on crippling debt to try for their dream.

- If you must lower it, you should offer everyone over 28 a free fertility health check, and clear information that if they fail to start trying to conceive before the woman is 33 they will not be eligible for any NHS support should they have fertility problems. These messages should be actively promoted. Sounds pretty crass doesn't it? When you spell it out like that? This approach is yet another way in which women's opportunities are closed down and their bodies controlled, their choices not valued. We are simply not an investment priority.
- It is unfair and cruel to deny people the chance to have a child. Please keep the age limit unchanged.
- As a 38 year old female living in Bristol, I have had NHS funded IVF treatment this year. I don't consider myself too old to start a family and believe that women over 35 should be entitled to the same treatment.
- I feel that the age restrictions are limiting the chances for people who should be given the opportunity to start a family
- To limit the age to 35 years old would mean that females have to start trying to get pregnant very early in life before realising something is wrong and needing help. Why should females (and females only) be discriminated and having to start a family at early age to have one to get help before the age of 35? IVF is a last resort to get a child and it takes a long time before coming to that stage
- I disagree as I think some couples have children later for accepted reasons
- I don't believe restricting the age of a free cycle of IVF to 35 is in the best interest of the public. Women are waiting until later in life to have children because they want to make sure they are with the right partner and are more financially secure when becoming a mother. This restriction would just add to the whole "running out of time" worry. If a change to the age must be made, the lower age limit should be amended as this would then not restrict people who wanted to children, they would just need to wait a bit longer until they reached the required age.
- Age limit should not be decreased
- I think that this would be devastating for many couples currently trying for children. Reducing the age for women to 35 is unfair to a large number of women. Women should be able to try for fertility treatment as long as they are still able to, not given restrictions due to age.
- If financial pressures make it necessary to narrow the band width of age for the female partner then I think the younger age limit should be raised rather than the older limit lowered. I.e. Age range of 28 to 40. Not least because women in this age group are more likely to be mentally and financially equipped to be parents.
- Age should never be a limiting factor
- Reducing the age is a terrible plan. I am in my mid-30s and looking to conceive over the next few years once I have finished my qualifications. I would hate to think if I me fed help I couldn’t get it because the NHS are trying to save money. Look at other areas, people claiming cosmetic surgery because they are depressed about their boobs!! Heavy smokers taking up beds because they have no will power! Why should I suffer because of these people!!!
- I think restricting based on BMI is sensible as it will lead to healthier pregnancies. I think limiting access to under 35 only is extreme - lots of women are leaving it later to have children but this also means a more supportive and stable environment for a family so often important - especially in a time where many people struggle to get on the property ladder etc. I agree with restricting over 40 though as chances of success are much lower.

- Some consideration for female 35-40 when specific/adequate reason for delay e.g. oncology treatment
- Restricting the female age to 35 wipes out a HUGE amount of women that could need fertility help
- To keep the age limit up to 40 years for females
- I disagree in lowering the age of females. Many women chose to start a family in their 30's to ensure an established career and a financial safety net for their family.
- The function of IVF is to help couples conceive when the odds are against them. It's fair enough to restrict access where there is something that people can change about themselves e.g. BMI. It is not fair to restrict on age. To say that there is less chance of the IVF being successful in older age misses the point of the service.
- Unsure why you would lower the age group for those eligible for fertility treatment as it is well known fact that you are less fertile within age.
- Having used services myself, restricting the age to 35yrs for one free treatment is unrealistic, many couples start families later in life or would have only just started trying around that age. If they then have to try for a further two years this would mean they would not be eligible. I was fortunate enough to have the finances to try two further treatments at over 5k ago to have my son. Many couples are not in this position and can only have the one shot. Someone doesn't choose to have difficulties conceiving and this does feel like another barrier when the emotional side of not being able to have a child naturally is hard. This is unfair and should not be passed.
- I think that it is a shame that services have to be restricted due to funding, especially those that affect fertility services. I do agree with the criteria you are setting as they establish healthy guidelines, but the female age restrictions should be increased to 40.
- My sister had IVF, she was late 30s before she had exhausted other options, 35 is too young for a cut off.
- I'm 42 and have had 2 healthy children since I was 40. I didn't meet my husband until I was 39, and would miss out on this chance to have children.
- I believe the upper age limit should not be restricted to 35. As per the proposal to change the BNSSG age limit, this was not upheld. I believe all couples should be offered the same criteria in every area. In this day and age there are a lot of women who would like to have a career to enable them to support a child. Forcing couples to have treatment before they are ready will not only affect their lives but also government funds if they are then not able to pay for a child at that time.
- Need to take into account age of woman when she starts trying to get pregnant. Many women have to leave this until later for financial reasons. Unfair to penalise couples where man is older if the problem is with the woman.
- Don't put a time/age limit for women to receive IVF on NHS. This is not fair. 35 years is too young.
- In a country that needs to address its aging population this is a massively short sighted suggestion. In addition is does not reflect the needs of the residents / demographic of Bath. Aside from the higher than average cost of living and housing in Bath, which forces women to focus on their careers first before starting a family. We should also consider the employment market in Bath. There is a

high proportion of small businesses and self-employed here. Unlike bigger city with bigger employers offering job security and maternity benefits. So for many young women in Bath, starting a family age under 35yrs is simply not an option. And this proposal will limit the options for all but the rich. Everyone pays their taxes, it shouldn't be a two tier system, and changes should properly reflect the needs of the end users.

- As a lady who at the age of 37, being told I had gone through the menopause was devastating.
- With the trend to have children later in life/ less financial security/ leaving home later, 32 seems young for the cut off to have started trying for children.
- The drop in the mother's maximum age is cruel. Often, this is a last resort, and they will, by definition, be older women. Don't make the pain of infertility worse for people already suffering
- Only providing women with the opportunity to receive fertility treatment between the ages of 23-35 is completely unrealistic and does not take into account the times we live in. Most people in this age bracket are not even financially stable enough to buy a house at the moment, let alone have children. It would also directly contribute to the gender pay gap as maternity leave is the biggest contributor to this, telling women they are only able to have a baby during this time frame (when they are likely to be climbing the career ladder), is not going to do anything for pay equality. It's going to make it worse.
- Some of the criteria I would have expected to be in place anyway, i.e. being a healthy weight. The huge issue I have is with there being a cut off for women who are over 35. It is women who are over 35 who are most likely to need to access fertility help as it can often take this long to find the right partner, realise you have a problem, or to even become broody in the first place. Coupled with having to try for two years and you have a recipe for disaster. You're effectively cutting off women from the age of 33. The fear of the biological clock ticking can have a real impact on a woman's mental health and compounding this anxiety by adding an unnecessarily low NHS imposed cut off is extremely cruel. I believe that any money saved from restricting access to fertility treatment for over 35s may need to be spent on dealing with women's mental health, stress, anxiety and depression which may arise as a result of the pressure put on women who fear they have missed their chance to have children. I also think having a men's cut off at 55 and woman's at 35 is profoundly sexist and I don't understand how this can be justified.
- I think limiting women to fertility treatment before the age of 40 is unjust.
- I absolutely believe that 35 is too young to restrict the giving of one cycle of fertility treatment on the NHS. This is commonly an age when people are trying to conceive, and the data is not that strong to suggest their success rates are too low. I believe this is extreme, and especially in an area where women are highly educated and have developed careers, you will be alienating a large group of people. Do consider other lifestyle changes to restrict people by - such as weight, smoking, alcohol and drug use etc.
- I think the age of the woman should not matter
- I think that aged 35 is very restrictive, lots of people don't start trying for a family until they are 35
- Due to ongoing inequality in the vast majority of workplaces many women don’t consider having children until their early 30’s. With this in mind, the expectation

that women will be penalised as a result by disallowing access to IVF treatment if women are over 35 or have been trying to conceive for less than 2 year seems extremely unfair

- Aged 35 cut off for a female partner is too severe, particularly if combined with the restriction of trying for at least 2 years, as some women may not start trying until they are 34yrs old, then find out they have difficulty conceiving and are outside the age limit if they have to show they have been trying for 2 years.
- They should not be changed. 35 is way too young an age limit I have just turned 35 struggles to get pregnant and lost my daughter at 18wks so I may IVF to have my own child but your ideas means this won't be possible for me. BUT in a sexist twist old men will be eligible for help?!?
- Women are increasingly forced to wait later to start families, you are disproportionately targeting women, rather than men in these cuts and ignoring the evidence that male partners are increasingly likely to face problems with fertility too. Research has shown this starts increasing significantly at about 44. If you want to cut fertility treatment how about making the ages more comparable rather than further penalising women of child bearing age? A system that penalises all obese women regardless of their medical status is going to be even more unfair if women who are coming up to the age limit cannot then access treatment until their weight is down. This is ageist and disablest as many women with higher weight may have other health issues affecting it that also increase their risk of infertility. Equally insisting on a male partner having a BMI under 30 seems to be designed to cut the provision of IVF since you provide no evidence of any scientific reason to make this claim. Again, while you intend to cut the age limit for women, having to wait for a partner to lose weight when there is such a short window to access treatment for women disproportionately affects their chances of accessing treatment. This is sexist. Two years to conceive is unfair if it is a blanket provision regardless of people's medical status, whether they have conditions which affect their fertility and with such a short window. It effectively means no woman over 33 can access treatment?
- It is essential for equality in the workplace for women to have the ability to get support for having children later in life
- I think 35 is ridiculous, there are many women who don't even think about having children until they 35 or older, to find out they couldn't conceive naturally would be awful then not to have the option of IVF would devastating.
- I think the drop in age proposal to age 35 for females is wrong when some women wait until the right time in their life, e.g. for financial or career reasons, only to find they then have trouble conceiving. To reduce the age limit to 35 then means they need to have been trying since age 33 but then still might not get help to have a family to meet the 2 year criteria and the 35 years old maximum. I think they should leave it to age 40. I have one child (which took 12 months to fall pregnant with) and now have been trying for our 2nd child for 22 months and just getting a referral to a fertility clinic. When we started for our 1st baby I had just turned 30 and felt it right career and financially right to start our family. Now I am 35, have a beautiful little girl but long for a sibling but having fertility issues. If you cut the age to 35 I am verging on not getting the help I really need. It just isn't seem fair to make these changes and funding cuts when we work hard and pay our taxes but need some help to have a baby. Please don't make these changes!
- This is particularly unfair as it usually take s along process for a couple to get to the route of IVF. For example, the go will only usually consider seeing if there are

any issues and run test after a couple have been trying for year. Most couples who have careers may not consider children until their mid-30s.

- I think lowering the age limit to 35 is awful. I'm 31 and currently pregnant via IVF. Living in BANES it's bad enough you only get one free cycle of IVF without lowering the age limit to 35 and ensuring couples have been trying for over 2 years
- I do not agree with this. It is not fair for people like me who have waited to find the right partner and so now am being penalised for doing so in being in a stable marriage but unfortunately cannot conceive without help through the IVF. I feel that age 40 is still the better age to restrict access as there is well known evidence that over that age the quality of the eggs etc. have reduced
- Male fertility age should be brought down further in line to woman. You can say female over 35 cannot have treatment but men can, which could be seen as discriminate towards woman.
- Women above the age of 35.
- Limiting or lowering the age limit to 35 is shocking and disgusting. In modem times women do not find out until much later in life that they may require help to conceive... I feel sick at this change. The others are understandable
- I think the restriction on female age and duration of infertility is wrong as it will effectively mean that women will have had to have met, and settled down with, the person they want to have children with by the age of 32. For many women this simply hasn't happened and so you are penalising them for not having met a partner soon enough. I would support the 2 year duration of infertility restriction if the upper age limit was kept at 40 as this is a more realistic time-frame for most women in the modern world.
- I had funded treatment last year age 39 which worked first time. Often problems are more likely later in life and people may not meet their life partner early on.
- I accessed the services when I was 36. I think it's extremely unfair reducing the age limit. Services are restricted enough as it is. It took me 17 years to finally have a child and through BANES funded IVF I now have a 3 month old daughter at 37 years of age. We are both fit and healthy!
- I think it is unfair to penalise women aged 35-40, given the average age to have a baby is 30 and couples may only be able to get treatment after 2 years of trying to conceive. This will disproportionately affect women who have spent more time in education.
- For some couples who know that they have issues with starting a family, trying for two years could restrict their ability to access fertility services. I have only recently been diagnosed with PCOS and am 33. If I had to wait two years then I would be too old to qualify for fertility treatment. I equally do not feel that 35 is a fair age to stop offering treatment. Due to many constraints on couples, they don't always have a chance at starting a family until their later 30's. To take their ability/right to having a family appears, to me, unjust.
- Women should be offered treatment up to age 40. By not doing so will cause mental health issues and depression. The main purpose of life is to reproduce and by limiting the age range will cause a lot of misery to many in the 35 to 40 age group. Money will then need to be diverted to mental health, which is already overloaded.
- Woman over 35 are most likely to need fertility treatment. The age limit for women should not be lowered.

- I find it alarming that IVF for females aged 35-40 would be cut, particularly considering the two year 'trying' period before consideration. Should a woman start trying at age 32, which is a perfectly logical age to want to start a family, then spend two years trying, she is then grasping frantically at a one year timeframe. Meanwhile, her male partner can be up to 55 years old. I understand biology but that discrepancy is huge and unfairly disadvantages females trying to conceive. I suggest females kept to 40 and men 50, should you need to make any adjustments.
- Cut off ages for male and female are not equitable. There is a 20 year difference between the two ages. I think this needs to be reviewed, I suggest leave 40 years as is currently the cut off age for females and reduce the age for males to 40 / 45 years.
- People become ready for a family at different ages and it is unfair on those who decide a bit later to have a family and then find that they are infertile. Many young people these days have had to delay getting a mortgage and therefore feeling ready to start a family, so please don't discriminate against them further. Age should not be criteria for ruling people out. There should be other ways of ruling people out other than age such as if they already have children, or their BMI. Each case should be considered individually. Please don't deny young people over 35 out of hand.
- Setting an age limit of 35 years is ridiculous. I am turning 30 soon and like many of my friends are not even in a relationship looking to have children yet. However, reducing the age limit by 5 years is huge and makes me wonder how many of us will feel anxious and worried about our future.
- Upper limit for women should remain at 40. Many women do not meet the partner they want to have a family with until later. Undecided about trying for 2 years - would this include access to Clomid or would that be offered before 2 years? BMI limits seem relatively fair. Glad there will be no change go offering provision - 1 is better than none, which I know is an option and one that is being taken by many other areas. We had NHS IVF in banes in 2016, with a happy result but a very difficult time. I am very glad the provision will remain open.
- I don't feel age should be a criteria. What age people are when they discover they cannot conceive children is irrelevant. Likewise, how long someone has been trying to conceive should not be a barrier. The emotional impact of multiple miscarriages can be felt within a few months. Age and length of time trying to conceive should not be the difference between whether someone has an opportunity to have children or not.
- I think a restriction on the age of 35 is a huge blow. Woman can easily reach 35 before children are in the pipeline. At school you're encouraged to get good grades, go to uni, and get a good job. All of which can take years. After uni and working your way to a successful position - of which u have worked so hard towards, could easily take a woman into her mid 30's easily. Being penalised for trying to better yourself and get yourself into a stable financial situation should not go against everything you work for. There are so many young girls getting pregnant and taking every handout and benefit they can as it's so easily offered now a days that woman who are trying to better themselves could then be penalised for it. It's just so demoralising for any woman who has strived to better themselves.
- I think the age restriction for women is unfair. Given that many women are delaying starting a family due to university and career it seems making 35 the

upper limit misguided. Fertility declines after 35 which means you are cutting off access to a service when it might be needed most. If you consider the two years of trying a women will need to start considering a family before her 33rd birthday, I had only been married a year at this stage of my life and only just thinking of starting a family. As it was I needed fertility treatment due to unexplained infertility and had my daughter just after my 36th birthday. I do not consider this old to be having my first child but your criteria suggests it is. The cause of infertility is often not as a result of the lifestyle of the mother or father, unlike many medical and health issues the NHS service in BANES does fund.

- I am 41 and embarked on our IVF journey when I was 38. Under your proposal I would not have been considered! I now have the most amazing 2 year old boy that would not be possible without intervention. My husband had to have a PESA to retrieve his sperm then I had to have IVF with ICSI. How can you determine who can have a family? I would not have mine under your new ruling! You need to look at cases individually! The fact that I can only have one child! Although this is the only way I can have one! My desire for Theo to have a brother or sister never goes away! We are so blessed to have Theo in our lives and I'm not sure I would have ever got over not having him! Think about the mental illness related to this subject! Think about someone ripping your heart out when you're told you might never have children. I could go on!
- I think the combination of female age limit and two years trying to conceive is too restrictive. With women often leaving it later to marry and start a family I think too many couples would no longer be eligible. BANES already has more restricted criteria than NICE recommend, this takes those restrictions too far.
- I think the age limit should be higher than 35; if a woman has been trying to conceive for a long time it could easily put her into an age category above that. It also seems unfair to penalize someone who may have been trying for a while or only met her partner when she was slightly older only to then discover she cannot conceive naturally.
- I feel somewhat divided, scenario is a little discriminatory, should be national policy, not enough money so has to be priority. It's unfair to couples who don't start trying for baby till mid 30's hence they miss the boat of being treated as they don't find out fertility problems till too late. On "GP" level we should still be able to refer routinely to the fertility clinic as lots of assessment/investigation/treatment is not "IVF". Fertility clinic should be the ones advising couples and applying for funding if needed. NOT another form/hoop etc. for GP's.
- Myself and my partner are early 30's. We like so many others waited until we had stable well paid carers and had a comfortable home big enough for a family. We tried to conceive for 9 months and knew something must be wrong. Blood tests confirmed my 29yr old wife to be perimenopausal with a low egg reserve. We are now pregnant with a miracle after having been given less than 10% chance of success and retrieving 2 eggs after 20 days on 300ml Menopur. Had we have had to wait 2 more years for treatment we may never have got those eggs.
- I don't believe that funding should be based purely on age. My wife and I paid for our treatment and had two sons after many years of trying. We were both fit, healthy, had successful careers (my wife was even a trained and registered midwife) but we didn't qualify for any funding for IVF after 6 miscarriages. This issue is far too important to base a decision on funding purely on age.
- I would suggest that the lower age limit is increased - 23 is too young. I would also suggest that if there is a known cause for lack of conception (dreadful semen

analysis or blocked tubes) couples should not have to wait two years to try (by which time they may be above the upper age limit to access treatment)

- These changes are terrible. In particular, the age limit combined with requirement to have tried to conceive for two years means that to be eligible for treatment you would have to have started trying for a baby at 33; this is incompatible with modern life in many circumstances.
- Women face career pressures so this criteria is very unfair
- 33 (the age at which a woman would have to start trying) is very young. This age requirement discriminates women.
- A lot of people get married/start families when they are older and it may too late by the time they realise they are infertile.
- Re. the IVF success rate, some of the group felt the fact there is still a chance is a positive to share and that the cut-off criteria could be destructive.
- The group felt that introducing this, as well as the age range criteria, would leave people with a limited amount of time/window to try for a baby/find out they are infertile.
- One man disagreed with age restriction because he felt that many women may get to 35 and not be able to have children.
- One woman shared that some women can have children up to aged 40, and she had a child aged 41.
- Women under pressure to start trying for a family earlier.
- Male support worker raised the issue of gender equality and felt this wouldn't be fair. He added that he appreciates the biological reasoning.
- Might not meet partner until later in life (this applies to first criterion too).
- Criteria 1 and 4 (re. age): people with learning disabilities often have limited opportunities to meet people, so may meet a partner later in life. Dimensions run a relationships group for this reason.
- People with learning disabilities may access education and information about sex later on, so may be informed/aware at a later stage than others.
- I wish to register my objection to the proposal to restrict access to fertility treatment for vasectomies and female sterilisation and the withdrawal of IVF treatment for female patients over 35.
- I know this is a time of significant financial challenge, but I would not like to see the funding removed for these crucial services
- The Clinical Commission needs to put pressure on the government to continue to provide funding, so that these services are not withdrawn
- I will also contact my MP to express my views and concerns
- I would disagree with the upper age limit of 35, especially given the need to demonstrate trying to conceive for 2 years minimum. With the current social and labour markets meaning people settle down later, I think this should be 40.
- People may want to start families later. Not fair - if they want one, should have one.
- What about women who go through the menopause early?
- I feel that everybody should have a chance at conception if wanted, and while I understand why a lower age limit is being set women are tending to start their families at a later age these days, therefore access to fertility treatment should reflect this

- I think that a 35 year old cut off for women is too young, especially if they need to have been trying to conceive since age 33. This is not realistic for working women who are trying to establish their finances and career in their twenties.
- I am luckily happily married with two children at nearly 35. However I have lots of friends over 35 who have not been so lucky. Those who have not found a partner before 35 should not have their opportunity to have children restricted. I have been a neonatal nurse for 8 years and know very well the possible health implications that can come having babies in later life. I however feel that we do not see a higher number of older mothers. The age restriction would be removing a woman's right to bear a child if they wish. I also have a BMI of 31. I am not massively overweight I a built a certain way. I eat healthy and exercise. In my pregnancies I did not gain lots of weight and had my health and weight monitored throughout by health in pregnancy practitioners. I gave birth naturally.
- IVF success rates can still be very good over 35- I was given a 60% chance of success at age 36. Sometimes circumstances dictate that you don't try for a baby until your 30s; therefore you could well be over 35 once you have tried to conceive e naturally for a few years and gone through numerous tests.
- I disagree that the age limit is dropped to 35. I was 38 when I had my daughter on my 2nd round of IVF. If you are asking people to try for 2 years that means they would need to be 33 or younger when starting to try for a child which I don't think is realistic. Not all women are lucky enough to be in a position at 33 to try for a child. Life doesn't work like that.
- I do not agree with the change to ages. As a 37 year old new mother who had a completely healthy pregnancy I do not agree with capping at 35. I didn't feel ready to have children earlier and at 37 am far more mature, capable and financially secure to raise a child. Also if people have to be under 35 and trying for 2 years it then it pushes forward the age where women would need to try to circa. 31/32 which I would not have felt ready at nor was I so career / financially secure.
- Women who work can find themselves trying for children over 35. The NHS website says it can be used till 42. Restricting the limit to 35, it hugely unfair to women who are trying to be secure financially before having children
- The combination of 2 years trying to conceive and then an age limit of 35 for the female partner means that couples who may have fertility issues must know this by the time the female partner is 33 years old. I think it would be acceptable for the female partner to be 35 and trying to conceive for 2 years which would make the upper age limit for the female partner 37 years of age and with less impact upon likelihood of successful pregnancy than if the female partner was 40 years old as per current criteria.
- Considering a lot of women are now waiting until their 30s to start having a family, personally I am already 30 and haven't yet got to the point of being ready for a family, these proposals would make me feel rushed to start trying for a family earlier than I am ready to so that I can access fertility treatment should I need to. I worry that if I want to wait another 12-24 months before starting to try for a baby, that will put me right on the brink of being 35 by the time we have "tried" for two years, and as such potentially be approaching not being able to access fertility treatment should we need it.
- Age of women shouldn't change. Many don't meet their partner until 33+ due to careers and then with 2 years trying they would not be eligible.

- I accept that the criteria must become more restrictive but I do not think that the upper age limit for women should be set at 35
- 23 is very young for a woman, could it not be 28-40 for example. Women are deciding to have children when they are older and therefore not finding out till they are older that they have issues with fertility
- that the age limit for a woman is reduced to 35 when many women are now following good careers and may not have found a partner until they were in their mid-30's and I feel the age should possibly go to 38 rather than 35.
- I think females should be eligible until 40 years of age. Both partners should be mentally stable and free of drug and drink addiction. I am sure you already consider this. However desperate people are to have children, they must accept that nature may not intend this. I agree that there must be restrictions as the population of the UK is increasing - not to our eventual benefit; so why boost it artificially?
- Restriction on age of the female is discrimination. It should be available until menopause age. Any less is cruel.
- I think 35 for women is too young. Lots of 35 year old women haven't even met a partner by then. What you are proposing is in humane. BMI is also a very crude measurement and scientifically proved to be incorrect. The idea that fat people cannot be good parents is ludicrous. Look at amalgamating and getting rid of managers.
- I agree however I think 35 is too young to restrict women ; should stay 40
- Age restriction is too low. If age has to be reduced, I suggest 37 as that is still a higher percentage success rate than 37-40. The combination of having to try for two years and a reduced age means people have to start trying by 33, which is still very young these days.
- I think the female age limit should be up to 40 because women are still naturally conceiving at this age. I also think more than one cycle should be offered to those who don't have the funding
- I actually would restrict the age at the younger end as they have much longer to ‘try’, I would keep the upper age at 40 as the reality is people are marrying later. as for putting a 2 year trying limit on this, can’t see the purpose as there is no way to police it and you’ll just catch out the honest ones
- I appreciate that funds are restricted. My issue is that often couples will have avoided seeking services for some years trying to conceive naturally. Cutting off the age limit at 35yrs I understand could be sensible from the point of view of chances of success but this if implemented should be phased over a period of years to establish a new norm. This is otherwise grossly unfair on couples who will have been trying and following all the right guidelines on health BMI etc. but then are restricted on age arbitrarily. Equally having a 2yrs trying rule should not be applied across the board. It would depend on the age of the female. For example a female starts trying for a family aged 34 she automatically is now excluded from this treatment. I think it needs to be guidance and phased in gradually. The community should be aware of the changes coming over a period of time so they are not in a group who are then caught out. BMI is topical at 30 whilst I agree it can reduce fertility this might exclude a lot of people unfairly. I am mainly opposed to the age cut off I think this needs a more subtle and phased approach with good communication.

- We consider that the reduction of the age limit from 40 to 35 seems very short sighted as most women and families wait until their thirties to start a family. This action would be restricting a large constituency of women and men who may lose out on their only opportunity to conceive. This action has wide ranging impact on the happiness of couples who cannot pay for treatment and will have a less enriched life as a result of this short term measure.
- I somewhat agree, albeit women's age should be to 43
- In agreement with changes regarding BMI due to impact of weight on risk during pregnancy. However very much disagree with 35 as cut off - will discriminate against career focussed individuals who contribute to society through employment and pay taxes. Many career focussed women leave pregnancy later due to career goals. Should these driven ambitious women be penalised? What message is this sending to young girls?
- Life is tough with cost of housing, job insecurity and low wages. People have to delay having children because of lack of security. It would be unethical to restrict fertility treatment to 35 max in women! it would mean a drop in birth rate in women who cannot afford IVF
- Change the age parameters to 25-42 for women. Times have changed, economically and socially. Couples are getting married later in life, or are in second marriages. Many couples face financial challenges, struggling to get employment and housing, so many couple delay parenthood wanting to prepare responsibly. The health of the couple, notably the women should be taken into account beyond age and weight. A smoker aged 27 should not get priority over a healthy 41 year old.
- Making people wait longer increases the chance of infertility due to age. To then also reduce the age at which someone can get treatment feels like you are penalizing those who need it the most.
- I think the male age should be lowered also. With women working now I think the age for women should be raised to 38 or 39.
- I think the minimum age could be higher than 25.
- I think it makes more sense to help women that are over 35 that below it. I do not see the point in considering the BMI of the man.
- The age limits are all wrong. Every woman has a right to bring a baby into this world when she chooses to do it. Not when dictated to. I am 34, getting married this year and I want a baby within a marriage and not before. I won't be eligible to even contact NHS for help until I'm almost 37 if we start trying immediately after we marry. It's all wrong. Very wrong.
- Instead of wines age 23-35 would it not be better 27-40 give the Person longer to try when they are more fertile. The BMI index cannot be put in all cases. Look at rugby players they are all over the BMI index but would be considered fit and healthy people. Some of the BMI goals are unrealistic to achieve. Would non-smokers and fit an active be a better way of surveying?
- I think restricting the age is wrong. I'm 37 and managed to conceive when I was 33, however it took 18 months to conceive. I left having children until later in life so I would be financially stable, I could have had them at a young age but I would be benefits and I didn't want that. These changes need to be stopped; it's completely unfair especially if you are struggling to conceive. I was one of the lucky ones but there are others that have been trying for several years.

- The age of people trying for a baby is getting older so I definitely think the age of 35 is far too young to stop free treatment.
- The average age of first time mothers has risen to 28.6 in 2015. I think the top age bracket needs to be reviewed regularly as first time mothers age increases.
- Lowering the age from 40 to 35 discriminates women in higher managerial, administrative and professional occupations, who are an average older at birth according to the ONS (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthsbyparentscharacteristicsinenglandandwales/2015#mothers-tend-to-be-younger-in-households-employed-in-intermediate-and-routine-occupations)
- 35 years old is FAR too young to deny women fertility treatment. Most young women nowadays pursue a career and often don't even think about starting a family until their mid-30s. With your proposals someone discovering a problem preventing them from conceiving at this young age will already be denied support. The only women who would qualify are those who forego a career entirely and are determined to start a family from a very young age, like most women used to until a few decades ago. This is a backward and conservative proposal that has no place in our society in the 21st century.
- I believe the age restriction should be higher. I didn't meet my husband until I was 35 and therefore if we struggled with fertility issues we would be ruled out based on female age. I believe this should be 40.
- I don't necessarily think there should be an upper age limit for the female partner. This could limit some people to becoming parents even though they may have been trying for several years. If they can't afford to go privately, then they don't have another option
- Age shouldn't be lowered it should be looked at on an individual basis as every case is different
- The fact that I'm general more women are waiting until later in life to even consider trying for a family, this is partly made viable by the fact that people are generally living longer. So maybe the upper age limit for women should be increased....
- You are considering the correct changes but women's lifestyles have had to change so it is harder for women to have families younger without needed lots of government support.
- Strongly disagree with the age changes as nowadays women are also pursuing a career. They don't exist to just have children, so shortening the age criteria would disadvantage many women. The fertility treatment is so expensive which means that 80% of the population would not be able to afford the necessary treatment on their salary.
- In this day and age, couples give their careers significant attention before settling down and thinking about having a family. These people largely are financially secure and have the life experience to be great parents. It's statistically less likely that they will conceive when the female carrying the child is aged 40+, so in my opinion you should raise the lower age limit to 29 and increase the upper age limit to 45.
- I don't think there should be a restriction on age for women; the criteria should be based on the extent of their fertility issues. Age should not be restricted, because

you may not have met your partner until later and then realise you have these issues.

- Women are leaving trying for babies until later so 35 as an age limit is too young.
- I believe the service should be extended to women between 25 and 42. 35 years of age us far too young a cut off. I know first time mums who are excellent, energetic care givers at age 41.
- People are working longer before deciding to start families due to excessive costs of living. Penalising them for waiting until they are settled and financially secure should be rewarded with support no penalised.
- Concerned about the impact on mental health that restricting fertility treatments might have on older women, in what I'm sure is already a very stressful period, and might just push women to have a child earlier than they are ready.
- A recent study has identified that adulthood doesn't begin until 25. Your proposed fertility treatment changes must comply with modern day society. 35 is far too young to restrict fertility treatment. This should be at least 45 for women. And what about equality? If you're proposing 35 for women, then it should be age 35 for men too! Sound ridiculous? That's because it is!! Raise the age for both male and female to 45!
- Women are trying to conceive later in life. The average age of for mothers giving birth for the first time is now 30 .3. The restriction to the age of 35 is not helpful societally for these women. NICE guidance is supportive of offering 3 full cycles of treatment to women up to the age of 40 and one full cycle to women over the age of 4o. Technology and laboratory practices have improved pregnancy rates so the CCG would be getting value for money from treating this age group. Where a couple have a clear diagnosis of infertility e.g. blocked fallopian tubes, waiting for two years will not change the diagnosis or the recommended treatment. PCO patients can find it extremely difficult to achieve a BMI of less than 30.
- I think the female age range should continue to be 40. If they have to have been trying to conceive for 2 years prior to treatment, this would mean that they have to start trying to conceive at around 31 to 32. I don't think this is a fair reflection on women and when they decide to try for a family.
- I think it nonsensical to restrict the age limit for treatment given those who are older are more likely to be the ones needing it. It is hardly unusual, especially in BANES for couples to delay having children until post 35. This will only prevent women from being able to make a stable career which they can return to after having children and therefore this policy does not aid equality for men and women. Similarly, 55 is hardly uncommon for a man to have a child. I also think that in general, instead of looking for cuts to services, the CCG should be campaigning to stop cuts to funding.
- Placing limits on the upper age of women is unfair; refer to the Dutch (https://www.statista.com/statistics/520290/average-age-mother-at-the-first-birth-in-the-netherlands/) You should leave the max age at 40.
- I think if you are younger and been together two years or more you are able to save up over time as time is on your side, however I personally would like to see the older people get more help if they have previously not managed to have a child naturally, IVF clinics except women up to the age of 50 but I believe IVF puts a lot of strain due to the prices for IVF itself when you pay for it. I personally would like to see the pricing brought down to a more affordable cost to give

people more hope in achieving a child and especially for older people. This is what I would like to see across the country Bath, Cardiff, Manchester and other places.

- Personally I would rather taxes were increased in order to pay for NHS services. However, in the current climate I think it is (regrettably) right that further restrictions apply. However, I think the upper limit for women should remain at 40!
- These days many couples are leaving it later to try for children. I think the cut off should be left at 40 years for females.
- To meet the proposed criteria, female patients will have had to start trying for a family by the age of 32 so that they can spend 2 years trying to conceive and 6 months (at least) going through funding application process. Considering the average age of marriage for females in the UK is 30.8 years old, this proposal is outdated, is considered discriminatory and not reflective of current societal norms. Most importantly, the proposal is rationing fertility treatment and continuing the worrying trend of postcode lottery healthcare despite clear NICE guidance to the contrary. B&NES have a moral and legal responsibility to provide access to 3 full cycles of IVF treatment to women aged under 40 who have failed to get pregnant after 2 years of trying, and 1 full cycle for some women aged 40-42, which complies with NICE guidance.
- I take issue with the age limit of the female being decreased to 35. Society is changing. Women are increasingly waiting to start a family until later in life. Whether that is because of a career (developing financial stability for their family) or wanting to find the right partner (for a happy stable home for their child), the number of woman waiting to conceive until their 30's is on the increase. I myself didn't start my family until I was 36 and have conceived 2 children naturally in my "geriatric" state. I find it incredibly unfair that woman such as myself whole were unable to start a family earlier should suffer from this life changing decision when so much money is wasted elsewhere - for example how much is spent on those extremely expensive and unnecessary 'break and swab' things used to sterilize my arm before a blood test is taken!?
- Considering the average age for women to have their first child has just tipped over into the 30s for the first time, and then (agreeable) asking couples to wait two years before treatment, limiting the age of women from 40 to 35 seems very unfair. This is a three year window to seek professional help for which for some people it would take a while to be brave enough to get here. I strongly disagree with lowering the age limit from 40 to 35.
- I think restricting fertility treatment to couples based under these age ranges is a disgrace - why should people older than your proposed she's be discriminated against? Couples are getting together later and later in age, and should have access to the same treatment as younger people
- The restrictions on women's age is concerning. I think the age restrictions would be better increasing the minimum age as couples would be more stable and mature. The ages for women should be 27-40 years
- I strongly disagree with the lowered age for women.... This is a bizarre decision given that we are now living longer, working longer and healthier for longer....
- I think the female age restriction is too low as I just had IVF treatment at 36 and I'm pregnant with my first child. I'm perfectly healthy to get pregnant. It was my husband's sperm that was the issue. Please consider

- Whether a couple already have children should be strong criteria as I think if you are already blessed with children then you may not need treatment. Women are working until a later age, paid into the system and then when they are older and may need help to conceive, in a better place to raise a child, not getting fertility help when it is most needed. People should be married too.
- It concerns me that the female max age is down to 35. I am also concerned about the BMI for people with conditions such as PCOS.
- I don't agree with restricting access to the proposed age ranges. Most women over 35 are the ones struggling to conceive, so it makes little sense to restrict IVF to them
- I was 36 when I had IVF on NHS in London
- Average age of mothers is increasing due to careers and getting on to property ladder. Then would need 2 years before eligible. This would disadvantage many women. Need to consider
- If you are asking women to wait 2 years before treatment, then 35 is too young for cut off. It takes time to investigate infertility and workup to IVF
- I think to restrict the upper age limit for women to 35 when the upper limit fir men is 55 is to deny a lot of women a chance to have a baby. Some women will need IVF treatment due to male fertility issues. So to deny a woman who is 36 an opportunity to try for a baby because her partner who may be older or younger has fertility issues and she does not, is not fair. Also to start the funding at age 25 would deny younger women with diagnosed fertility issues an opportunity to access funding until they were older which does not make sense.
- 40 too old.
- Woman had fertility treatment aged 37 years old and it was successful (after two months of injections). Disagrees with proposal, as women are having children later. She decided she wanted children in her early 30s, but didn't have a partner/wasn't in a position to start a family. She has polycystic ovaries, so knew she would have difficulties.
- Councillor suggested age cap should be 37.
- One woman felt this is too low, as a lot of people don't find out they have fertility problems until later. She felt that the fact fertility dips after 35 means people need the support more after this point. She felt the minimum age should be increased and the cap should be higher. She had fertility treatment (injections) for one of her children and it took 3.5 years for it to be successful (she said there were long gaps between seeing consultants)
- Felt unfair (and only five years difference to keep it at 40).
- Unfair, as women start families later now.

Disagrees with BMI criteria:

- I disagree with the BMI.
- BMI is misleading, what if you are muscular and fit. People can conceive younger than 23yrs and over 35 yrs.
- Agree people should not be grossly overweight, however BMI doesn't necessarily account for muscle weight?? Don't understand why women have to be 35 or under; my mother was 38 when she conceived my brother, using Clomid. Women should have same age range as men.
- BMI has limitations and so should not be used so stringently. As in NHS information: The limitations of the BMI Your BMI can tell you if you're carrying too

much weight but it can't tell if you're carrying too much fat. The BMI can't tell the difference between excess fat, muscle, or bone. The adult BMI does not take into account age, gender or muscle mass. This means that: very muscular adults and athletes may be classed "overweight" or "obese" even though their body fat is low adults who lose muscle as they get older may fall in the "healthy weight" range even though they may be carrying excess fat

- These treatments should not be restricted on age or weight grounds
- One woman disagreed because she knows several overweight men who have got women pregnant.
- One man felt this was discriminatory as being overweight is often linked to low income.
- BMI is not a full proof measure. Is waist measurement also used as a check?
- Are there other syndromes which cause weight gain, which could therefore be taken into account as 'exclusion criteria'?
- Men's Health Forum condemns proposals to cut reproductive health services for men and women by Banes CCG - particularly cutting access to IVF for couples where the man has a BMI >30
- Overweight people or those who have been trying to conceive for less than 2 years should not be penalised by being denied the service. Is this fair just because some people has a health issue or would like to have babies sooner but the council does not consider the feelings of some cases who would be harmed by such a decision that was solely taken for financial reasons.
- In my opinion the focus should also be on diet/lifestyle factors. BMI is an inaccurate measure of health. Nutritionists should be advising people on proper nutrition and vitamins (not Pregnacare!) to help with fertility. Drinking coffee for instance is not good for fertility. I think you are right to limit funding to couple who have tried to conceive for at least 2 years. I do not think that fertility treatment should be limited to 23-35 year old women. I actually think women in their late 20's upwards struggle more than women in their early 20's.
- BMI is a deeply flawed system that fails to take a lot into account, including genetics. There is lots of research that people with an "overweight " BMI are healthier in multiple ways than people with "normal" scores, including the ability to carry children
- Your policy on having strict BMI criteria is going to cause massive mental health issues for women who are not only suffering because they cannot conceive, but because they have a condition that they have not inflicted on themselves. It is a chicken and egg situation with PCOS as to which came first, but often it is a problem that shows its self with established puberty and a high BMI was not present before this point. To then stop them having IVF because of a money saving criteria could push them over the edge. The strain to your services will then be compounded by mental health costs of treating these women who feel that they are being punished as failures. I do not see you restricting IVF to people who smoke, drink, or use recreational drugs. Evidence might suggest that the chance of conception may be lower for someone with a higher BMI, but this should be a decision for the patient and consultant to make, and not a figure written on a piece of paper. It should never be suggested that the NHS will only spend the money on you if you're worth it and fit their picture of what perfect is. A woman who is overweight but follows a healthy diet with no other health issues, does not smoke, drink or take any drugs should be as able to have treatment as

someone who is within weight guidelines, but has a poor diet, binge drinks and smoke recreationally. To be honest the costs long term to the NHS are likely to be lower for the overweight parent and child than the one that meets your criteria. If that overweight woman who tries to do everything right, but is over your threshold because she has PCOS you then say I am sorry but we cannot offer you treatment, you are setting her up as a failure for the rest of her life. What might occur because of this one decision could be eating disorders, depression, drink problems…….etc. Do you want to foot the bill for that? The other thing to look at is the long term costs of that pregnancy to the NHS. I have PCOS and I have a BMI above your criteria. I conceived at 29 naturally, 34 on Metformin and 38 on metformin. My pregnancies where totally normal. I gave birth to a 9lb baby within 12 hours, a 10lb baby in 5 hours and a 9lb baby induced and everything from induction to leaving hospital within 6 hours. Why would I be denied IVF as a cost cutting exercise? Allocate 1 treatment per patient but let it be a decision made by that patient and their consultant.

- BMI should not be a factor in considering funding for women/couples who want to have funding
- One woman shared that she has an underactive thyroid, so is overweight.
- 1. One woman thinks female BMI criteria should stay the same.

Disagree re. Polycystic ovaries:

- I feel the proposed age reduction for females is unfair, and the removal of the higher BMI for those with polycystic ovaries is potentially discriminatory, as they may not have the means and capabilities of achieving the new BMI target range. However I do agree that couples should be asked to try naturally for a certain time, and that men should be held to a BMI target, I am not sure I agree that 30 is a reasonable upper limit, maybe 35
- I am 35 years old and have polycystic ovaries. I have been with my partner 18 months and we have just made the decision to try for a baby knowing that the extent of my polycystic ovaries is bad and I will struggle to conceive. Under your proposed plans I will not be able to have IVF and we don't have the funds available to pay for it ourselves as we are trying to move out of our rented flat and purchase a house for our family. Along with government cuts in helping first time buyers all that is happening is we are paying into a system which no longer helps us when we need it. I barely use the NHS however I will need to with a situation like this and it's almost saying if you're older and have not long met someone you want to be in a long term relationship with them then you can't have children as we won't help. I understand there needs to be limits and the service needs to be means rated but to reduce it from 40 doesn't make sense bless you want to prevent more people from having children.
- Polycystic ovaries can cause weight gain and it's a medical condition. Other conditions are treated (even those that are 'lifestyle' related) so why are women being penalised?
- I have PCOS and had been trying to conceive for years without luck. I was past 35 when I found out that I had this condition after years of trying and would not have been eligible for the treatment which I could not afford privately. Many women are trying to get a degree of stability with a career before trying for children and so a reduction in age is indirectly a method of preventing the working classes from having children.

- I can understand the reason and think the majority of things being put forward are reasonable. I disagree with the change to BMI for women with polycystic ovaries as it's not their fault. The CCG should think again about this.
- My BMI is over 30. I have been trying to conceive for 4 years. I have PCOS and Prolactinoma. Weight loss has been extremely difficult with very little help from my GP and NHS. I was offered weight loss vouchers for weight watchers without my medical history being taken into account, as if to say try harder. Sometimes weight loss should not be the driving factor behind these decisions. I am healthy, exercise regularly, but still struggle to get my BMI to 30. I have privately paid for my own gastric band procedure. My BMI has remained at 33. I was still not meeting the criteria and feel that the weight restrictions prolong what is already an extremely difficult process.
- Disagree with proposed changes to restrict women dealing with polycystic ovaries. Typically they struggle to lose weight, meaning reaching a BMI of 19-30 would be difficult.
- I find it unfair to penalise women with polycystic ovaries and unfair to demand different BMI and age criteria for men and women. Male fertility is strongly affected by age and BMI! I see no provision here for women with a health condition (damaged fallopian tubes) that can prevent conception. For this reason the 2 year wait period is inappropriate as a blanket change.
- Are we able to get some more information on the criteria for being given IVF? I'll be honest; I do have a personal interest in this as well as it being brought to me by a resident. I am 29, not married or in a long term relationship, and I have polycystic ovary syndrome. These cuts are actually something that worries me and my friends. The resident who emailed me regarding this makes some really valid points. I admit I did not pick this up before, but in an age where we are striving for gender equality, removing the only free option for male contraception seems a backward step. A woman at least has access to free contraception using the pill, but Ms Adams makes a valid point. Do we have a justification on why we are one of the only CCGs who have taken this decision to make these cuts? Is there a wider issue in BATHNES regarding contraception that has led to this decision?
- Should not apply to women with polycystic ovaries. There should be some requirement, but it should be about promoting the benefits of losing weight and persuading - rather than forcing - people to make changes. Enforcing this would only eliminate people from being able to access the treatment.
- You need to try for two years which may take you over the age of 35! Is a slightly higher BMI going to make a big difference! It's an outdated method! You take no account of other health or how women hold body mass! Such has muscle mass, breast size etc.!
- Woman has polycystic ovaries and was asked to reduce BMI - she lost 2 stone in 2-3 months. She still had complications with her pregnancy and agrees that it's important to be healthy for pregnancy.

Disagrees with male age criteria:

- One woman disagreed because she feels there are older men who have not had a chance to have children until later in life, should have the opportunity.
- What is wrong with men over 55? Depending on the gynaecology knowledge of the past for the mother, maybe two years is too long before envisaging to help

her! (Ex. if she already has symptoms that alert to possible infertility). Should we propose a solution for BMI of men and women around 30 that will make them healthier and may be in good condition for having babies?

- I think it should be a question of thing being equal between men and women.
- There was a feeling that 55 is too old (as a cut-off). There was a discussion and general feeling that younger parenthood is beneficial.
- 55 is still too old. Should make the age cut-off 45.
- I think the male partner should be aged 40 or under. Older parents may not be as able to care for their children as they grow.
- why the disparity between ages of female and male partners 55 too old to father first child
- The male partner should have the same age and BMI restrictions as their female partner
- Male partner age 55 too high. This means when a child reaches teenage year the father is nearly 70. Should we be funding IVF for same sex couples? I know this is very controversial but recently read RUH article about triplets born to female couple after IVF. Louise Brown recently wrote about the abuse she has had during her 40 years and this would be 100 times worse if also have 2 mums.
- Male age should be the same as female. This is a difficult decision but decisions should be made on factors that increase success.
- The differing male and female ages are worrying. If you're going to put a cap on when people can conceive prior to female menopause, it should apply to both equally. Additionally it's much less likely a woman would be in the financial situation to have a child by 35 than a man, given projected salary expectations. This disproportionality on the caps for women in the new measures means a woman has a hard cap on when she is able to potentially conceive with no such consideration for men with issues such as low sperm mobility in their 50s (so long as their partner is under 35). It's gross.
- I think that male age range should be 45 or younger, not 55. Male BMI should be same as female. Age range for females should be up to 45. 35 is extremely young. Couple have tried to conceive for at least two years or have had 3 consecutive miscarriages in a 12 month period. Should also be available for single women who wish to have children.
- Age limit for men should be the same as for women.
- One woman felt that 55 is too old and that male age requirement should be a bit older than it is foe women (but not this much).

Disagree with duration of infertility criteria:

- I do not believe you should have to have been trying for 2 years, we went through tests in Hampshire and had to wait 1 year and this felt like a life time, I do however agree with the other proposed requirements, this seem reasonable.
- Delaying referral for 2 years is a long time. 1 year is reasonable. Even if referred after 2 years, you may not conceive for years once treatment has begun. Also delaying may not be optimal for the couple who may be on the older spectrum
- How are couples measured on 'time trying to conceive"
- I was made to wait two years before being given fertility treatment as was told that was I criteria by my Doctor when I had a medical condition that had

caused me to go into premature menopause so when I was finally passed through to the fertility clinic 2 years later my AMH had dropped again and I was unable to use my own eggs (IVF still hadn't worked for me). I was failed by my Doctors surgery who kept fobbing me off and made me miss my chance of having a biological child as they would even pass me through to the fertility specialist before two years! Now I find out they were wrong and I can't do anything to change the outcome. I don't want others to go through what I have so feel the two years is out of order if the person has a medical condition or the doctors do an AMH test and it comes back to low. Maybe introduce a 2years or AMH lower than 6 clause. Mine was 4.2 and they couldn't get any eggs.

- *1 year duration would be better.
- Some felt that contraception is out of your system quicker than this, so why a two year wait.
- One female support worker felt that two years is too long and one year is more reasonable/long enough.
- One man felt this is too long, as he hasn't had a relationship longer than 13 months.
- Concern that the 'duration of infertility of at least 2 years' is the most selective of the criteria, and how will this be documented? DC explained that evidence suggests that over 80 per cent of women aged under 40 years will conceive naturally within the first year of trying, and about half of those who do not, will conceive during the second year. The two year duration of infertility being proposed will allow sufficient opportunity for a couple to conceive naturally, without the need for fertility treatment. GPs will have to check with patients how long they have been trying for – it will be about a trusting conversation, rather than record-keeping
- This is a very badly designed response box. Restricting the age of women's access to receive free treatment is an example of structural gender-based inequality against women. Women aged 35-39 in couples trying to conceive have a 90% chance after 2 years, down from 98% in the 19-26 year old age bracket. There is no fertility "cliff edge" in this age range. The decision to restrict access to the under-35s therefore is an example of a structural decision that punishes women for not putting careers and other life experience before relationships and child-bearing. This does not apply to men; they need only be under 55.
- Having had fertility treatment, (donor sperm insemination, not on the NHS although investigations to establish the cause of the infertility and my suitability for treatment were) my concerns are these. Requiring people to try for 2 years when 1 year is sufficient to raise concerns, affect relationships and impact mental health, seems counterproductive. Surely people should seek help as early as possible. Fertility investigations and sourcing donor sperm / eggs if required can take many months and for many people trying to conceive without treatment when there are medical reasons that they can't conceive is futile. The 35 cut off may also push people to access invasive treatment as a first resort due to fear of missing the age criteria. If we had been subject to these new rules we may have felt pressured to go for IVF straight away at increased cost to the CCG.
- Trying for 2 years is not useful when you have a specific problem that is causing fertility - for example blocked fertility tubes. Even trying for two years

would not make any difference and could in fact put a woman in danger of an ectopic pregnancy. There should be exceptions for specific fertility problems.

- I feel the new imposed age restriction for a woman to be under the age of 35, along with the minimum of two years previously trying to conceive is unfair as a lot of women are settling down later in life. I'm lucky that I have managed to conceive my two boys naturally (albeit at 25 and 27 years of age), but when I attended my NCT course all the other women were in either their 30's or 40's. I feel 40, would be a better age cut off, I know too many women worry about finding someone to settle down with and have kids, and this feels like it would be added pressure for them. Maybe an earning cap, would be more appropriate? I agree with the weight and time restrictions though
- I think a couple should have been trying to conceive for at least a year or two before they have IVF. Cheaper options such as Clomid could be available after a shorter time. I do not know how BMI affects fertility but if a high BMI reduces the chance of conception that should count against someone getting free treatment.
- I believe it's fair to request that each person be healthy and within the recommended BMI and that the age limits seem reasonable however the time restriction on trying would have the most impact on my personal situation, as someone with an older partner we want to be able to know after a year of trying whether there's something wrong with either us. That extra year makes the difference to us in being able to have children or not really.
- 2 years of infertility before treatment is much too long, especially when you take into account the time between referral and seeing a doctor. Making the BMI requirements for women the same across the board punishes women with PCOS, considering this is a condition which negatively impacts fertility it seems that they're being penalised for something they can't altogether avoid.
- The proposals seem quite harsh, and some of them very hard to prove. How will you know if someone has been trying for two years to get pregnant? That's very hard to prove. Also, yes BMI might have an effect on conceiving but as a female with a higher BMI and an excellent pregnancy I'm not sure why these restrictions would be so put in place.
- 2 year wait is not applicable if known factor affecting fertility e.g. tubal block, severe Male factor. Investigation should occur at 12 months trying and decision then made based on clinical evidence. 2year wait is acceptable for unexplained infertility.
- I think the proposed changes make sense but agree least with the duration of trying to conceive as time isn't always a luxury people have particularly if they are at the upper age limit.
- One woman felt 2 years is too long and it should be 1 year.
- Felt this is too long.

Adhere to NICE Guidelines:

- NICE guidelines should be followed
- I think the only fair and right way to proceed is to follow the clinical guidance already suggested by NICE
- The minimum trying period of 2 years is arbitrary. What if a couple meet at age 33 for the woman. They are immediately disqualified from receiving any support. It takes at least 2 years to get a referral in most cases and if you

have to add another 2 years on top of that your discounting a lot of potential families. It amounts to age discrimination. The cap of 35 is too low. Nice guidelines say clinically suitable women should be able to access fertility treatment up to the age of 40. The fact that you already only offer 1 partial cycle is bad enough.

- NICE guidance on Fertility provides commissioners with an evidence-based set of recommendations to support funding of fertility treatment. The criteria changes proposed are contrary to NICE guidance, and it is not clear whether they are fair and equitable or merely arbitrary from the documents provided. The female age restriction to 35 is discriminatory against women over 35 who have excellent chances of having a baby through treatment, and do not take into account ovarian reserve. The male age and BMI restrictions are also discriminatory without sufficient clinical evidence to back them up.
- I think it is a terrible idea, I am very against it. I am very angry about it. Infertility is an illness. NHS should be for EVERYONE including FERTILITY FAIRNESS, this should not be a postcode lottery. NHS everywhere should follow the NICE recommendations for 3 free rounds of IVF.
- I understand that the CCG has a finite resource which it has to manage as equitably as possible. Women today are much more likely to delay having a family because of career choices and pressures. For this reason the cut off at 40 years (as per the NICE guidelines) seems fair and reasonable. I don't understand the point of having National Guidelines if each CCG then makes its own arbitrary decision. There should be NO postcode lottery for ANY NHS treatment.
- These are too restrictive , you should comply with NICE guidelines .It is discriminatory to have a cut-off point which is based purely on age and not on likely clinical outcome
- I have undertaken fertility. You might not meet your partner then have tried for a couple of years; we didn't expect to have trouble. We couldn't have achieved this by the age of 35years. You are increasing the pressure on couples, it is stressful enough. We had traumatic miscarriage prior to be told at 35 you’re too old. I lost weight for IVF again slowly is the most successful, again give them time. You are rushing the whole process. Going against NICE guidelines. Though when care isn't individualised then medical care quote NICE guideline. As professionals advised to work in accordance to NICE guidelines.
- The age range cap of 35, fertility problems are not immediately apparent and there are good success rates for woman <38. Where’s the evidence on male BMI? Appears to be a made up restriction. Again the evidence on female BMI is not apparent and clinics treat up to 35 privately. Another way not to meet the NICE guidelines
- The NICE guidelines recommend 3 attempts for all; the postcode lottery is extremely unfair!
- NICE recommends women under 40 have access to three IVF cycles; therefore the age of women should be no less than 40 years old. Also, this is not happening in neighbouring counties such as BNSSG
- You should be implementing the recommendations from NICE. That is 3 funding cycles per couple, anything less is a failure to those patients and frankly immoral. Patients choose to have fertility problems as much as they choose to have cancer - burdening them with the cost of treatment goes

against all principles of the NHS and you should be ashamed. You have not provided any details on the number of patients this would affect, or the proposed savings this would lead too. You have also not accounted for the increase in mental health treatment costs that result from untreated fertility problems. Finally, your consultation has not requested comments on reducing the number of funded cycles from two to one. The consultation is therefore flawed in its implementation. Finally, you have failed to compare your guidelines against the recommended NICE guidelines that all CCGs should be looking to adopt.

- People having children too early/young/when they're not ready is not good.
- I find it really concerning that this is not a nationwide cut, and in fact there are a number of CCGs across the country who offer the recommended 3 cycles of IVF for women under 40, and one cycle for women between 40-42. Cutting access to vasectomies will remove the only real option men have available for contributing to a couple's reproductive health, and once again puts all that pressure back on women. [What is your position on this, and do you have plans to speak out against these plans?]
- By offering only 1 round of IVF, you are already falling below the NICE guidelines of providing 3 rounds of IVF, which is known to greatly increases the chances of a live birth to 45-53% vs 20-35% with 1 round. Reducing the age limit from 40 to 35 would see Bath and North East Somerset fall further bellow the NICE guidelines. Outside of the NICE guidelines, and from a mental health perspective, 2 years is a long time to expect those suffering with infertility to wait without treatment, and should be considered carefully. Will additional psychological well-being support be provided to patients suffering from infertility while they wait for, and undergo treatment?
- I feel really concerned that this is going to further limit access to fertility treatment to those who are able to pay. My understanding is that NICE guidelines suggest women under 40 should be offered 3 full cycles of IVF in order to maximise the benefit and opportunity to conceive. I think that our current offering in B&NES already falls short of this and I fear that these proposals will widen the gap still further. I do appreciate that funds are limited and that it is not possible to pay for everything that people would benefit from all at once. However, I dislike the idea of determining who is eligible for treatment based on judgements about their lifestyle (when they decide to start a family, whether or not they have difficulty maintaining a healthy weight etc.) rather than what is medically possible and appropriate. My worry is that this has wider implications for our society and community - by framing the questions in this way, you are inviting us to make judgements about each other about who is more 'deserving'. It may start with fertility treatments, but it opens the way for other judgements to be made and means that unless we are careful we will have different groups set against each other for funding for their health needs. In my view, part of the role of the CCG should be to be responsible for the complete health and well-being of our community and to help us to appreciate that when everyone's needs are met we are a happier, healthy and more cohesive society. That may involve explaining to us that money is limited, but this should not restrict access to treatment and services that are known to be beneficial (even though IVF is more successful for younger women, it still offers a reasonable chance of a live birth for women under 30) - if anything, the money issue may mean that people need to wait

slightly longer to be seen, but everyone should be referred and offered treatment based on individual need as and when they seek help. In addition, my feelings on fertility are that it can cause huge psychological stress and unhappiness, and that this needs to be recognised too. It may be too easy to dismiss having children and starting a family as a 'lifestyle choice' but this ignores the sense of longing and isolation that people experiencing infertility live with day to day. Also, it suggests that being parents and creating a loving family is something that we do in isolation, and overlooks the wider benefits to society that it would bring. Parenting and family life should be something that we are all concerned with. I feel really uncomfortable with the idea that these proposals could support the idea that it is an acceptable view that being a parent is something that is determined by how much money you have.

- I feel very strongly against the proposed changes to the criterion. I think the age restriction of 35 for women is unrealistic given that many women are not in a position to be thinking about children until their early thirties which means they would have little or no time to discover they had fertility problems before the cut off time. I think it is very short sighted and will result in other costs to the NHS as such restriction will undoubtedly lead to an increase in depression and mental health issues for those concerned. Suffering from infertility problems can be extremely isolating and this set of proposals would send a very damaging message to those involved and impacting on their feelings of being alone with no help available. Presenting the criterion as this proposal does suggest that having children with the help of IVF should only be available to those who deserve it. Those who have managed to keep slim, find a partner in their twenties and immediately start trying for a family, oh and make sure you fall in love with someone in the right age bracket. It removes people experiencing fertility problems from the rest of society who have none of these value judgements to deal with and further isolates them. The last thing you need in this situation is to feel guilty for wanting what most other people want and to feel undeserving of a chance to have children. People who have to live with the sadness of not being able to have children at least should be able to feel that as a community they were supported through that process and given all the help outlined in the NICE guidelines. Obviously those with more money can carry on with IVF cycles and given that most successful outcomes need 3 cycles they will be more likely to experience a happy ending to their struggles, this sends out a clear message that this society values the children of richer people more than poorer and we are a poorer society if we allow this to happen. Having suffered from infertility myself and deciding to become a family through adoption I feel more could be done to introduce the possibility of adoption and fostering as very fulfilling alternative ways of becoming parents. I know that this would not suit many people and you would not want to inflict such parents on children in care but for some it may be a great way to move forward. Obviously as a result money could be saved but of course this should not be the motivation and the needs of the child should be foremost. I just think it is an area that could be looked into.
- The Bath CCG only offers 1 round of funded IVF. NICE guidance is that couples should be offered 3 rounds of fertility treatment on the NHS. The fertility treatment in this area is already limiting enough without adding additional criteria. In particular the criteria to make all couples try to conceive

for 2 years before being able to access treatment is short sighted. Some couples know they have a very low chance of success through natural conception due to known health problems, for example - polycystic ovarian syndrome, but under these new rules will still have to wait 2 years. This is just delaying the inevitable and seems a pointless exercise to save money in the short term.

- You should give three free cycles to all couples without restriction. These proposals are immoral and unfair
- Whilst I appreciate the funding pressures you are under, the NICE guidelines still state that the best chance of conception is from three IVF cycles which is what should be provided by all authorities. The World Health Organisation also classes infertility as a disease yet you are restricting access to treatment for a disease. Would you consider restricting access to people needing treatment for heart disease? Liver disease?

Cycles of IVF:

- Number of cycles for IVF?
- Are you offering one, two or three cycles? Certainly one cycle of IVF at least.

Right to family:

- Everyone should be given the chance to become a biological parent irrespective of their age, BMI or how long they have been "trying"
- People who can't get pregnant are heartbroken. No matter the age or area everyone deserves to become a parent.
- I am very unhappy that fertility treatment is identified as an 'easy' target for cuts. Buying into existing public prejudice that couples 'do not have a right' to have children. Each couple will have individual histories which need to be discussed with clinicians who are best placed to understand if certain criteria should apply or with discretion can be waived. One round of treatment is often not sufficient - then what criteria? Socially - women are having children later - may not have a partner until early thirties - may have had cancer or another illness. Difficulty with making criteria outside of knowing the couple is that many people will be disadvantaged. Stability of relationship is important.
- Having children is it a right

Discriminatory against those who have a low income:

- It seems unfair to place an additional financial burden on IVF which would restrict its usage to higher income families who can afford to undertake longer term fertility treatments
- Some will not be able to afford to go private
- It is an imposition on the freedom of tax payers to access services made from a narrow moralising point of view. It will adversely affect those already most deprived.
- This consultation fails to provide information to the public about the cost of IVF treatment in the private sector which is prohibitively expensive. Tinkering at the edges of universal healthcare is a gateway to broader reductions in universal healthcare. Please, stop this cut.
- I have completed your online survey so will not repeat what I have already said there, but I found the survey did not allow me to express how painful and

emotional I find it watching fertility treatment become something only rich people can access.

- One of the support workers shared their friend spent £60,000 trying to have a baby.
- People may have money issues and need to wait until they're ready.
- She also asked how much IVF costs, acknowledging it is expensive.
- At a time when real destitution is returning to Britain, when food banks have become a familiar backdrop to our daily lives, when homelessness has increased 134% in the last decade, when childhood poverty rates are escalating sharply, it is absolutely the wrong time to choose to save money by limiting access to reproductive health services for the most vulnerable. This would set us back decades. If the poverty the NHS has been left in by the bail-out of the banks requires the withdrawal of services, and the rationing of those which remain, reproductive health services should be among the last services to have funding withdrawn. Sanitation, sewage management, clean water, reproductive health services, childhood immunisation, and female education: these are the established first steps to the health of a community. Have we regressed so far that even these most basic pillars of population health are under threat? Contraceptive services work best when men and women can chose from the whole range of options available. To limit options on the basis of ability to pay is discriminatory
- I'm strongly against these cuts which will limit access to important health services for people who cannot afford them.
- Cutting vasectomies and sterilisation is counterproductive as surely an unwanted child will end up costing the NHS far more than the cost of a sterilisation or vasectomy. Cutting a chance of a couple having a baby, via a free round of IVF from the NHS service, is hugely discriminatory in terms of wealth. Also, restricting IVF to women under 36 seems is unreasonable as it is often girls in their late thirties, who have spent years training then establishing worthwhile careers, ones that benefit us all, who then discover they can't conceive as they have left it too late.
- Two men felt families deserve choice and said they could 'no way' afford treatment.
- One woman has Endometriosis, so would potentially be affected by proposal. She couldn't afford to self-fund and feels people shouldn't have to save.

Savings are too small:

- Do not believe these cuts will save sufficient money for the CCG.
- One member queried the administrative costs of ensuring that patients are compliant with the criteria.
- I think the limited savings this will give BANES NHS alongside the comparative joy and life-changing opportunities IVF and fertility services offer BANES' residents does not sufficiently justify this proposal.

NHS should be properly funded:

- I feel strongly that the NHS is about health and wellbeing and these services are not optional extras.
- I’m outraged that the government has driven the NHS to this parlous position.
- NHS should be properly funded for everything

- It's time for the NHS to get the funding from extra tax not letting the NHS slowly die as this government is doing.
- cuts to non-urgent services but non urgent services may still be vital services
- I feel strongly that the NHS is about health and wellbeing and these services are not optional extras. I'm outraged that the government has driven the NHS to this parlous position.
- These proposed cuts are completely untenable. They would have an adverse effect on aspects of health care which contradicts the meaning of a National Health Service, and would have disproportionate consequences for women and the poorer section of the population. Rather than cravenly accepting further budget cuts, a responsible CCG would just simply refuse, and demand that the service is funded adequately (we now spend about 2% less GDP than other European nations).
- I write to express my shock and dismay that BANES CCG is considering withdrawing funding for male and female sterilisation. Access to reproductive health services is a cornerstone of preventative medicine of which we hear so much. The first category in The World Health Organisation document 'Monitoring human rights in contraceptive services and programmes' (2017) is 'Ensuring Access for All'. If funding for sterilisation is withdrawn, then access to the full range of contraceptive options is denied to the most vulnerable members of our community

Alternatives:

- Your proposal to restrict services is entirely misconceived, and is the product of the high tariff price you have with your current provider. Based on your published treatment numbers and annual budget, you are currently paying around 40-50% more than is the correct amount for assisted conception services. As a member of national campaigns on NHS IVF funding and part of NHS England's IVF Pricing Framework Group, it is clear that there is a lack of knowledge at CCG level about the true cost of IVF. If competitive tender were sought, it is likely that the CCG would save considerably without any need to ration services. Alternatively, moving to an 'Any Qualified Provider' model would facilitate the setting of a more fair and sustainable price and patient choice. The restrictions are entirely unnecessary and will look heavy handed when other CCGs across the UK are availing themselves of providers at the true cost of IVF, which is considerably lower than your current tariff.
- I think consideration should be given to whether the applicants have children already.
- I think some of the criteria changes make sense however shouldn't reduce funding to make NHS funded fertility treatment less accessible for those who can't conceive naturally. there are many other NHS funded operations that should be reviewed before this in terms of less spend i.e. obesity, drug addiction
- What about restricting access to people who smoke? Also, what about people who already have children?
- Criteria should be similar for that for adoption
- I would guess that there were other areas that I would look to make savings before fertility treatment.
- Perhaps not to consider any woman who already has a child?

Concerns over process:

- The impression I gained at the AGM where the audience were asked about their reactions to certain cuts is that areas for cuts were being made by gauging what other CCGs were doing and what the gut reaction of the general public would be. This seems a worrying way to develop policy. It might be better to seriously analyse consequences and real value for money of certain treatments. Fertility treatment seems an easy target as no one dies. So it is difficult to measure a positive benefit of happiness at having children. The inevitable consequence of reduced IVF treatments on the NHS would be more people going abroad for this. The practises of many private clinics in UK have been questioned as they have changed their treatments in order to enhance statistics. Treatment in various European countries may not be the same as would be done here. This could well result in more multiple births or less 'viable' embryos being used. The consequences may be an enormous expense for the NHS which would quickly wipe out any savings made. There are many cancer treatments which are purely palliative and probably have limited extension of life but which are costly and seem to be given just so that something is being done.
- Should there not be some mention of how many courses of treatment are allowable per individual/couple? Are there any circumstances when a female/female couple would be considered?
- PROPOSALS NOT CLEAR. ANY REASONABLE APPLICATION SHOULD BE SERIOUSLY CONSIDERED
- Not really sure I understand
- Concern that infertility is not deemed important by certain people and concern that the CCG is not consulting with specific groups. The National Childbirth Trust was suggested as an organisation to engage with. DP confirmed that a work-in-progress equality impact assessment (EIA) is being used to direct public engagement and will be informed by feedback that is received.
- Concern that the decision has already been made (to introduce the proposals). TC reassured members that the CCG will genuinely listen to public feedback and explained that, following the consultation, all feedback will be summarised in one report, which will be presented to the B&NES Joint Commissioning Committee (JCC) and the BaNES CCG Board for a final decision to be made
- One member said that it needs to be clear that these would not be efficiency savings, but cuts to services. DP reassured members that the CCG has been very open and transparent with the public about this throughout the consultation.

Other/Questions:

- Men need to help themselves.
- One young man asked if people could freeze eggs and we explained that people could but this would not be NHS-funded.
- Some in the group felt that the success rate for IVF (including 20.8% stat) is quite high and should be shared with people more proactively, so they are informed and can make a choice about when they start trying for a baby.
- One 26 year old man shared that he has been trying to have a child for years and is worried he may be infertile (due to smoking marijuana for 12 years, as he is aware this affects sperm count). He has had multiple partners (longest relationship has been 13 months) and tried with two partners for six months each

time - several of his partners have apparently gone on to get pregnant by other partners. He doesn't want to find out, as worries that if he has fertility problems, it will worsen his mental health. We had a discussion about cumulative pregnancy rate re. 1/2 years with the same partner. He says he may give up if he has not had a child by the time he is 30. He doesn't think he will live past 64.

- One woman shared that she had two children and got pregnant within one month of trying (for both).
- One young woman showed Daisy the 38 degrees petition on limiting access to contraceptive services
- Group asked - what if a person/couple already have children?
- One young woman asked how this impacts LGBT+ couples
- Question about eligibility and whether health/mental health will be assessed.
- "Please could you provide me with information about the scope, scale, methods and detail of the consultation process regarding the proposed restriction of access to fertility treatment, vasectomies and female sterilisations in Bath and North East Somerset?

  What other activities, apart from the consultation, have been carried out or are planned under the following?

  1) Which specialist interest groups, community organisations or service user groups across BNSSG area have been asked to submit a formal response to the proposed changes?

  2) Has the CCG held open consultation meetings across the area, for different constituencies, such as Patient Participation Groups or for the general public to attend?

  3) Which social media networks have been utilised to disseminate information about the proposed changes and the consultation process?

  4) With who in the Local Authority have you had detailed discussions about these proposals?

  5) Which of the health care professional associations and trade unions have been invited to contribute their views?

  6) Which categories of clinical health staff have been consulted?
- I have already completed and returned the questionnaire on this subject as I am a member of my local patient Participation Group (PPG). However, on reading the page covering this matter in the BANES Council magazine ""together"" - Winter 2018 (sic) edition, I was confused by the statement:

  ""However, to fulfil our duty to live within the budget we've been given for BANES, we now have to consider other ways we could save money.....""
- Please can you explain to me:

  1) Who is it that has given the CCG its budget?

  2) How long is the Budget period?

  3) What happens if the CCG exceeds its Budget expenditure? I look forward to hearing from you in due course.
- I would also be interested in knowing who the providers of these services are expected to be in future and whether there are any conflicts of interest with the CCG and/or its members.
- How many IVF treatments were given, how many resulted in live births and what proportion of babies had learning difficulties/ abnormalities compared to 'normal' fertilization? What is the cost per IVF treatment?

- Fertility: Would these changes have any effect on treatment following egg/sperm freezing because of treatments that might destroy fertility?
- While BNSSG just withdrawn proposals to limit IVF treatment after listening to patients / campaigners
- I think there should be some individual criteria.
- Prefer you to stop supporting drug addicts self-inflicted issues and lazy foreigners who don't work and get every handout going
- Definitely not considering the right changes.
- Smoking and substance misuser exclusions
- Councillor asked if over the counter fertility checkers could be developed. Felt research into whether this is possible would be helpful for people earlier on/when they start thinking about having children.
- One woman's dad was 50 when she was born
- One man felt he couldn't comment on this as he's a man.
- Councillor felt this is a challenging question - optimum time for career development for women, but this age window makes sense to her (as time to be trying).
- Councillor noted possibility that more people using services privately may put a strain on this system...
- Questioned if fair on child to have older parent, but felt should be fair for all (to choose).
- 4. One man felt it should be a personal choice (he would not be affected by the proposal).
- 1. If they really want children and know the risks, should be up to them.

Q. Would you be affected by these changes?

Proposal to restrict access to fertility treatment:

- Two women shared would not be affected by the proposal.
- One woman shared she couldn't afford the treatment.
- One woman could see it from both sides. She would not be affected.
- Woman with polycystic ovaries wouldn't be affected herself, but her daughter might be (as condition hereditary)
- One woman with Endometriosis was told she wouldn't ever naturally conceive and had her first child (of three) when she was 27
- One woman was told she would never conceive again and did. She would not be affected the proposal.
- Councillor represents Southdown, so noted that a lot of her residents would be likely to be affected. She noted social determinants of health - people more likely to have higher BMIs in areas of deprivation. She suggested the CCG engage with people 'at the other end of the scale' too e.g. Federation of Bath Residents Association. She asked how long a round of IVF is.
- Emotionally affected about what is happening to the NHS. I am already pissed off that some people with a different postcode to me have 3 chances at IVF and I will only have one- IF I AM LUCKY
- I am 68 so this does not directly affect me; however it does affect all citizens. Would be parents unable to access help for example are more likely to then require NHS expenditure on their mental health - we need some joined up

thinking on these issue please. Restriction has knock on consequences and costs.

- As missed our chance failed at first chance, though NICE guidelines recommend 3 chances. As over stimulated.
- Currently needing IVF treatment!
- I am aged 30 and should not feel pressure to conceive in the next few years, based on a proposed cut off of 35 years
- The reduction of funding cycles from 2 to 1 significantly affects us our first cycle was not successful. There is a significant body of evidence that shows couples have a significantly higher success rate on their 2nd cycle, so these proposals would deny significant numbers of couples from starting families.
- Now would excluded
- That I may require this service if infertile despite being healthy BMI not always representing this appropriately.
- Wife has polycystic overuse and struggles to lose weight even with medication.
- About to receive funded IVF treatment
- Potentially, as I am 34 and would like to start a family soon. If we have difficulty conceiving I would've been eligible under the old criteria but not the new criteria
- We are currently undergoing our first round of IVF treatment. These changes will mean we don't get a second chance because I'm 37.
- Through the age restriction, I want to make sure I have an adequate career before having children to make sure I can provide. However, with the age restriction, I feel like I am being made to choose between being able to provide or having children. Feels a bit 1950s!!!
- Luckily but if these changes were in place already then I would be childless as my child was born through IVF
- Not personally, but from the possible impact on people around me. A possible even further reduction in birth rates impacts on all of us in UK society
- I'm 34 female, and only just starting to seriously trying to have a baby
- Proposed reduced female age limit would mean no longer eligible
- Potentially. I am currently in the early stages of fertility treatment having been trying for just over 1.5 years. I will be 35 next year. There will be a very small window where I meet the two year trying to conceive and under 35 criteria and bearing in mind how long all the paperwork takes and decision making I could just get pushed out. As someone who entered the system under one set of rules, then suddenly changing midway would be devastating and seem unfair. One thing for the CCG to consider is whether the new rules should only apply to new people (not those already in the fertility system) and alongside this having transparent comms about the changes so people not in the system yet can make informed choices. This would seem to at least instil an element of fairness
- See previous question
- My wife and I have been trying for 3 years. She is 36. After extensive testing we have learnt that IVF is the only way we are likely to conceive due to an issue on my (the man's) side arising from complications in an operation earlier in life.
- age limit
- My wife would have a very limited time within which she would remain eligible. The changes would severely impact our chances of starting a family.
- NA

- I'm 38 and have very few eggs left. Without hormone treatment and IVF me and my husband will never be able to start a family. We who have waited to be financially stable and have tried for so many years and only have this last resort will not get help whilst people who still have years to try and make it work will get help. Such a slap in the face!
- But it is wrong and should be spoken against.
- Family planning
- Possibly
- If it moved to Bristol I would be
- Cuts have already happened in Bristol and I was under the understanding I would be referenced to bath but I am over the age of 35.
- It could affect me. At age nearly 33 and considering IVF.
- Changing this ruling would disadvantage women like me who have not even had the opportunity to start a family.
- over 35
- I am a woman in my late twenties; I am nowhere near financially or professionally ready to consider having children and won't be in the next 5 years. If I am unable to get pregnant in my thirties and don't have access to IVF, I will have been prevented from having children for wanting to put my career first. Also, please stop referring to NHS funded services as free, we pay for them through taxes, they are not free.
- I am 35 and having ICSI at Bath fertility clinic.
- I am 36 years old, and have been with my partner a year and we have just started trying for a baby.
- I'm currently 34 and we've been trying to conceive for 9 months, so if we are unsuccessful we would consider IVF if needed and these changes would take this opportunity away from us.
- I'm 35 and struggling to get pregnant and have a healthy child
- Using the proposed criteria I would now be doubly ineligible for IVF. I have complex health needs which have prevented me from being able to safely conceive until recently. I am now over 35 and in a position where I could risk pregnancy, but two years of trying to conceive would take me even further beyond the age limit. Why should couples have to wait two years if there are known problems with conception and this lowers the chances of a successful pregnancy and birth? It's counter-intuitive to claim women can't be allowed kids over 35 and then try and push them to be as old as possible before they can use the service? This is completely unfair on couples with the most complex problems. It is clearly simply about reducing costs and not about the health or wellbeing of couples.
- I am 35 now, been trying for 22 months and just been referred to fertility clinic and awaiting an appointment. I do have a daughter who took 12 months to fall pregnant with naturally but now need some help with our 2nd child. I waited till I was 30 to have a family, so we were financially secure, and these changes just aren't fair. Please don't make the age change to females it should remain at 40
- I am 37
- I'm potentially wanting a 2nd baby via IVF and this may mean I won't be able to access the help I need
- I am nearly 37 and yes will be affected. My husband and I having been trying for more than 2 years and to now be told that my chances of ever having my own

child may never happen this will really bring me great misery, incredible pressure to our relationship and will have to find money we don't have to fund this

- I already have used my finding with negative results... however I would be effected should I only now brave enough to ask for help
- I am about to turn 32, have polycystic ovaries and have not started trying for children. These proposals would mean that I would have to start trying for children now just in case my polycystic ovaries did cause a problem in order to know that I could still have IVF. I am not ready to have children now but if I want them and have any concerns that there might be problems I would have no choice but to start trying in order to meet the criteria, or decide that I would not have children at all.
- FET not funded
- Services already accessed
- I am aged 33 and newly married, if these changes are approved and I have trouble conceiving naturally I will receive no support.
- I may out of the age bracket to qualify treatment. It is also well known that famines can take up to three cycles of IVF to be successful. If not even one round of IVF if available then families will not be able to afford to start a family. This may lead to emotional difficulties for couples, mental health issues which in turn will put a different financial burden on the NHS and work environments with time off sick.
- Just miss the 35 cut off point
- As a female Bath resident, I would like to feel assured that should I struggle to conceive after the age of 30 (bearing in mind 30 in the average female marriage age) that I wouldn't be wouldn't be racing a postcode lottery NHS clock to find support in conception and pregnancy.
- Possibly in the future
- Indirectly - friend with PCOS looking to undertake IVF in 2018 if BMI is acceptable
- Having had fertility treatment myself, after multiple miscarriages, an ectopic pregnancy and emergency surgery, I still may not have qualified under these new criteria if that hadn't happened over at least 2 years before the age of 35.
- I'm currently 35 and after finishing uni and working hard to be in a stable financial position along with finding the right partner to marry and settle down with has taken me into my mid 30's. So by bettering myself and working hard, paying all my taxes I could then be penalised for not deciding to try for child sooner. Despite not being able to afford it or be in a stable relationship to bring a child into a happy loving family.
- But I would have been
- We may need further treatment for a second child and losing banes IVF will increase the price in nearby private clinics
- I am 35 and been trying for two years I also have a BMI of 31.5!
- Because I am currently receiving treatment, but I may be if I want another child, should I be successful this time round.
- Possibly - is that relevant?
- I am about to turn 33 and about to get on the housing ladder in the hope of having a family. Now if I have to try for years before addressing your services, I will be already too old to have those services. I prefer to have a house before

becoming pregnant, I live in a studio and my income is small. So if I try not to have a child I might need housing services after this?

- Because you would erode the service provided in the area to the point that centres of excellence that even private users use would no longer be viable.
- IVF is an option that I am currently giving to think about. If it was limited, this not something that I could afford.
- A family member needs help
- Friends and relatives will be forced to seek loans and donations from our family. Not to mention, the pain of watching friends go through the difficulties of IVF amplified with major cost implications in such an extraordinarily expensive town. This kind of cut will force many millennials into difficult decisions between life goals that their parents didn't face and in the long-run this will break down the solidarity that underpins a tax base to pay for more acute care - mostly consumed by elderly citizens
- I cannot tell if I will or won't.
- However my husband and I did have access to the Bath Fertility Clinic in 2009 after suffering three miscarriages. This was greatly appreciated.
- As other councils will make same decisions please don't.
- May struggle to conceive in future, my parents did
- If the changes are made I would be instantly too old
- In the future
- I don't know yet
- May require this treatment in future
- Currently trying to conceive, so far unsuccessfully. These changes would remove IVF as an option for us and mean that we were unable to have children at all.

Proposal to stop funding vasectomies and sterilisations:

- Patient outrage and exceptional circumstances form writing, increased workload
- Reduction in funding as the provider of this work. If activity levels drop this service will not be viable to provide. GPSI need to be able to carry out at least 40 vasectomies per year to be competent. Practices that host this service will lose a funding stream for rent and use of HCA and reception. GPSI are a key part of workforce retention and recruitment for new GPs considering working in B&NES.
- Possibly, because as an IUD/IUS fitter there would probably be more of these required.
- But irrelevant because I care about the math not the few.
- Within the next 18m my husband plans on requesting male sterilisation, it's always been our long term contraception option.
- More work about female contraception
- I would consider vasectomy in the future
- It is the 'Start'...we will all be affected.
- daughter with special needs
- Planning on having a vasectomy myself but would be happy to pay for the services as it is not related to health problems.
- We are looking into vasectomies as we have decided we don't want any more children and if we couldn't have access to the operation, then we could become a burden on the government

- My husband is considering having this procedure done.
- Reduces my future choice
- It would limit my families future contraceptive choices based on gender
- Potentially - I am 45 & can't use hormonal contraception. My partner does not want children; nor do I. A vasectomy should be available as a free option.
- I may, someday, want a vasectomy.
- It would mean that me or my partner would no longer have the choice of being sterilised or having a vasectomy, because we would never be able to afford it privately.
- Currently, our long-term plan for contraception after having a family is for my partner to have a vasectomy, as I have struggled with hormonal contraception and do not want a copper coil long-term. This will remove our opportunity to have our first choice of family planning method.
- It could help other CCGs like mine
- In my day to day work seeing patients
- I do plan on getting 'the snip'
- I am a member of the public who may one day seek long term contraception
- I was hoping my husband would get a vasectomy.
- My husband is planning a vasectomy and we are both over 40 with a complete family
- My husband would not be eligible for a vasectomy once our family is complete and we would not be able to pay for one privately, so I would personally be forced to continue using contraception which I would rather not do when there is a one-off alternative that costs very little to the NHS in the grand scheme of things.
- My husband plans to have a vasectomy after the birth of our second child.
- Refusing patients access to NHS treatment
- It would make my already difficult job as a GP in BANES so much harder
- I am childfree and have not yet been sterilised.
- To the extent that they will further increase the costs to my local CCG, rather than decrease them
- I am a BaNES resident and therefore my healthcare is affected by the capacity of the BANES NHS service in this area. If BANES must provide health services for 20 years following an unplanned pregnancy, then this raises costs that potentially strain the BANES resources. See 8.
- my partner is applying for a vasectomy and we would have to pay privately to have this
- Should my husband and I had already decided that it is likely that after our second child he would have a vasectomy, which after a 15 year relationship would mean that I as the woman would no longer be responsible for accessing contraception. Should these changes come into play, with two children to support and associated costs e.g. childcare, it's unlikely we would be able to justify financially having the procedure privately, therefore would have to resort to available contraception methods
- We were considering vasectomy in the future
- I would have been affected if I was younger.
- Husband is planning a vasectomy when our family is complete
- Potentially in future

- You're attacking a permanent form of contraception, of course I'm affected, If this went though I would have to have to take contraception until menopause
- As a woman who suffered birth complications and cannot be on hormonal contraceptives or the coil, I find it terrible that couples like me and my partner will have that choice taken away. By taking away this option you are simply adding to the NHS crisis, many women will go onto have more children which costs the NHS money and more birth or post birth complications will further cost the NHS money. Look at the bigger picture!
- But not directly. Unless we, as taxpayers, are required to support unwanted children. People who need these operations for health & well-being should be funded.
- More distressing physical and mental health issues for patients
- Personally I would have been as I have three children and my husband has had a vasectomy. At the point of the vasectomy we would have not been able to pay for it privately but also probably wouldn't have reached a threshold for funding. Professionally I work within the management team in the RUH and would foresee a big increase in our work in the contraception and advise service which as we are on a block contract would be very difficult to sustain.
- As a GP my consultation rate for contraception is likely to increase
- I am a GP and will have to pick up the additional work load that this proposal will cause with no additional resources.
- would likely consider long term sterilisation after completing my family
- I am a GP so trying to find the best method for my patients.
- When our family is complete, vasectomy or sterilisation may be an option for us.
- I plan to have a vasectomy in the coming years after the birth of my second child. I also would like other men to be able to shoulder the burden of family planning, balancing the roles taken for pregnancy prevention
- the population would continue to grow at an unsustainable rate
- I may want to choose to have a vasectomy in the future.
- All of society will be affected by the costs of unwanted children.
- Well, I don't know. I'm not planning to use them now, but it's conceivable that I may in future.
- In that I may in the future consider a vasectomy
- I would be unable to have a vasectomy.
- Possibly
- People dealing with the emotional, social and economic consequences of unwanted pregnancies is enormous and that money comes from public funds to which I contribute as a tax payer.
- I have PCOS and cannot take other forms of contraception due to side effects.
- Yes, I am potential user of this service, as is my partner.
- That should not be a question. Plenty of people would not be affected by services I need, that doesn't mean other people should influence my rights to health!
- Not personally, but through the effects on the society I live in, and the possible impact on people I know
- I do not have a crystal ball, neither do you? You can cut costs in numerous other areas without making profit from a simple and needed procedure.

- Denied the option of being sterilised after 3 children.
- I am someone who would consider vasectomy
- This is something I may want in the future. Additionally if more babies are born within BANES as a result of these cuts we'll all be affected.
- I may, in future, require a vasectomy
- Relatives of mine.
- Would have to reconsider family planning options
- It may be something my husband would consider
- I am a male. Therefore I have only one choice of contraception which is condoms. Yet you are planning to take away a key form of contraception from me and the 150+men who accessed the service last year. Now what if you were proposing to stop funding IUDs for women? There would be an outcry, but women would still have several contraception options. That isn't the case for men. Your proposal will breach my human rights, and guidance on contraceptive care set out by the FSRH, MedFASH, BHIVA, RCGP and RCOG.
- I plan to have a sterilisation
- I may be in the future, not sure yet.
- We have 3 children and my husband wants a vasectomy but as he's a manual worker and self-employed we are having to plan for when he would able to take time off. If we leave it too much longer we may to pay.
- We are currently considering a vasectomy as we have a family
- We would not be able to afford this and we can't have any more children.
- My husband is thinking of having a vasectomy
- My partner will be looking to get a vasectomy sometime in the future.
- If I chose to have a vasectomy in the future I would need to fund this myself. This may not be easy to justify for some people!
- I don't wish to have children and am currently looking into being sterilised.
- Considering having a vasectomy
- Choice for my patients
- We would not be entitled to make the informed and responsible decision to permanently control the size of our family on the NHS
- See answer no9
- My mother had cancer in her late 30's
- If my husband was reluctant to pay
- We have a child who is disabled and we are both near 40 and no longer want to have children and my husband is thinking about having a vasectomy, if this happened we couldn't afford to pay privately
- Your taking away choices from my older family
- Inability to refer patients to these services in future. Difficulties for those who cannot afford to go privately.
- I have been told I am too young to be considered for sterilisation. By the time I am old enough, you will have already stopped allowing people to access this service.
- I would want to have a vasectomy as soon as I have the number of children that I believe I can properly prepare for the world...
- We did get a much needed vasectomy
- Yes, but minimally compared to families on lower incomes.

- One day my husband plans to have a vasectomy and if private we couldn't afford it. If we had an unwanted pregnancy the NHS would have to pay for an abortion (whether due to health or choice).
- We are considering my husband having a vasectomy, as we have four children.
- My husband would like to get this done.
- I am in the cohort whereby I may consider vasectomy as a potential method of contraception
- As I have finished having children my husband and I may in the future want to consider long term contraception, although we are not currently considering this.
- Who knows what the future holds!
- I'm a woman, you take away women's choices and you affect us all
- Not anymore but I would have been
- These procedures may be of interest once our family is complete.
- Want vasectomy
- Considering vasectomy - needing to rush the choice to get it free as couldn't afford to pay or have more children
- My husband plans to get a vasectomy in the next few years

Q. Do you have any suggestions or thoughts on ways that the CCG can make financial savings over the coming years?

- Incentivise the workforce to spot inefficiencies and empower them to act and change processes
- No
- Reduce middle and top management roles attracting over 50k a year salaries. Look at way to make services more efficient through technology and lean process reviews. Get your house in order before taking away vital services for people.
- We recognise that the funding situation is restrictive. However, it is not fair that the burden of lack of funding should automatically fall on fertility treatment. What other options has the CCG considered and how was the decision made to reduce funding for fertility, rather than any other services? We can only advise on how fertility services may be made more cost-effective, for instance, by adopting standardised referral pathways and proformas between primary and secondary care, so that investigations are not repeated or carried out unnecessarily. The CCG could also engage with NHS England's efforts to develop a benchmark price for IVF to ensure it gets value for money.
- No. I am not a financial expert.
- Streamline health and social care to ensure more appropriate spending on care for the elderly. Pay nurses more; treat them with respect to ensure more stay in post after training, thus reducing the excessive amounts spent on agency staff. Reverse Brexit? Might mean we could hang on to our most valuable European health service workers!
- The CCG should challenge the funding allocation instead of meekly following government directives.
- Review medications, often we prescribe the more expensive brands, providing analgesia on NHS. Quantities of meds provided. Communication between primary care and secondary care. Repeating of appt as unsure what is required,

or if they just did the BT while there- Improve patient care and save appt and money.

- Yes by continuing to fund IVF and the one embryo at a time rather than people accessing cheaper IVF abroad with a risk of multiple birth. The financial impact of this would be considerable. Also OTC meds fit people not on benefits should not be prescribed. Same with gluten free products.
- Money is spent on alcoholics & type 2 diabetics when their issues are predominantly self-inflicted. Most fertility struggles are not self-inflicted.
- Bulk order for GP surgeries and distribute stock accordingly?
- Reduce/delay treatment options for those ailments caused by 'lifestyle' choices - including smoking and obesity. Also, dissolve the CCG and merge with adjacent groups. Having a significant number of CCGs is an inefficiency and unnecessary. Ultimately, the CCG should be implementing the NICE guidelines across all treatments in full. If the budget doesn't stretch, then you need to play politics - overspend until the government is forced to act and increase your funding. Continually cutting services to meet unrealistic budget expectations imposed by government results in significant harm to your most vulnerable patients. These are the people YOU are supposed to be protecting, and YOU are failing them. The patients are your first priority. Hitting unrealistic central government budgets is not your job, so have some courage, act in your patients' best interest and implement the NICE guidelines in full across all treatments.
- Look at options for paying for TOPs on NHS. Not to pay for repeat TOPs.
- Charge people for missed appointments - providing they've had the text reminder, a small nominal fee perhaps of £5 and they would only forget once!
- I think people should have some responsibility for their life choices and the health consequences these may have. Why penalise a couple who, through no fault of their own can conceive but yet provide bariatric surgery to those who are overweight, treatment for smoking related disease and alcohol abuse...it is not fair
- I may have several suggestions of how savings might be made if I had some idea of which services or cost areas the CCG would like to review.
- No but one round of IVF is unfair 2 should be offered you don't understand the mental illness infertility causes. It's a medical condition. I think 2 cycles for people with confirmed reasons of infertility/low AMH/early menopause/illnesses and unexplained should only be one round as I know a lot of people who got pregnant on first round with unexplained infertility and then fell naturally with second. Another option would be a grant you could apply for towards a second round to help pay for it so the CCG isn't paying the whole bill but will give you a set amount towards the costs depending on the treatment required.
- Stop changing management structure. Stop making people redundant at huge costs and them re-employing them.
- Stopping all OTC meds on prescription - especially Carpool/brufen for children for all patients
- No
- Stop spending money on OTC prescription items
- Ring-fence the money for IVF/ICSI.
- Stop wasting time and money trying to fix what isn't broken! Help people properly the first time and there won't be repeat issues.

- No because I don't know how the CCG is spending the rest of the budget and this isn't widely advertised.
- No
- CCG is not explained on this form. A very thorough search of the form reveals Clinical Commissioning Group written under the NHS logo on the front page. With no explanation of the scope of the CCG having been provided, this question cannot be answered in a meaningful way.
- I think other areas of the provision need to be considered such as drug abuse, alcohol abuse and the amount of money spent on national obesity. It seems the funding for fertility issues is seen as less important yet it is debilitating in a number of ways that can lead to other social and health problems.
- Stop employing temporary agency staff. Look at what is given under prescriptions and be sensible about prescribing. Treat conditions holistically and through joint up services to prevent conditions becoming chronic. Continue to campaign for sufficient funding from the government.
- I agree with the BMI changes, maybe include smoking as well, but move the age bracket the other end for IVF
- Ensure efficient running of current services.
- No
- Investment in social care to keep older people out of hospital. Continue to empower and upskill nurses, who deliver excellent care and great value for money.
- Give a financial fine for people who regularly miss medical appointments.
- Have couples make a means-tested contribution towards treatment. This approach could be applied in many areas of healthcare.
- I think that less emphasis should be put on the age of women and more should be placed on the Medical outcome. I.e. if you are too high risk or likely to have a poor outcome, this should be taken more into account. Ruling out women on age seems very unfair especially in an age when women have starting family's later
- Charge patients for not attending appointments/ scans etc.
- Maybe look into other ways of raising funds charity crowd funding?
- Yes - see my responses above. Reduce layers of management and bureaucracy
- Investing in high quality physical and mental health care to include preventative and early intervention work as a means of saving longer term. Healthier citizens contribute more to the economy and will be less of a drain ultimately on resources. Don't shift the costs of healthcare onto social care and vice versa.
- Charge for missed GP appointments and stop offering the pointless six sessions of counselling - either people need way more or they can get help in one session. Six is rubbish.
- Prescription drugs are free for someone who has a thyroid problem, and probably many other problems. Why is this not only free for prescriptions relating to the illness/problem? For example, if someone with an overactive/underactive thyroid has a bad back, why are the prescription painkillers free when this is not direct cause of the thyroid problem?
- working with the healthy lifestyle service on preconception preventative health including ensuring couples are getting lots of fresh air, a healthy diet and lots of exercise and having a positive emotional health /mental state and not smoking prior to age 30 when considering a family seems to be key.
- Use email rather than posting costly letters

- Paying less to agencies for staff to cover staffing gaps by recruiting actual staff to fill those gaps. If there aren't applicants then campaigning to government to up the nurse and doctors supplement to universities or bursaries to get them?
- http://www.bbc.co.uk/news/health-33071066
- No, I don't know enough about your services
- Digital appointment system using email and text also hospital records as paper trail can get lost, saves costs on paper & postage fees.
- Restrict services for treatments based on lifestyle choices (e.g. smoking, drugs) rather than those that would take away opportunities for unfortunate couples to start a family
- I think there should be more restrictions on access to procedures and the morbidly obese rather than restrict relatively healthy people from accessing IVF, gluten free food etc.
- No.
- Reviewing the provision of other services
- Work more efficiently. You're still stuck in the 90's and are just wasting resources. Look at other countries, the Scandinavian countries for example and learn how to be more efficient. Don't punish the people who need help!
- Make sure medicines are used, cut costs in certain drugs
- As above.
- Cut back in other areas
- No
- Encourage the public to take responsibility for their own health. Provide an annual fact sheet with a breakdown of what each patient has cost the NHS each year. Include a supplementary document with costs for life saving treatments/surgery. Also stop providing free surgery for people who "lose" objects up their backsides
- To do more research and stop limiting women's decisions
- Already stated in previous answer
- Reducing missed appointments - we had 10 in our surgery just this Friday, never mind the number of hospital appointments that are missed. Restricting procedures and making us do extra admin work is time consuming and not always successful - it leads to a lot of patient distressed and therefore many more appointments at the GP.
- not paying for tattoo removal, cosmetic treatments except if for trauma caused by accidents or medical interventions
- NA
- Stop supplying paracetamol and over the counter medications for free from the hospitals.
- Fund prevention and lifestyle interventions
- start charging people who do not attend appointments in both primary and secondary care
- Make it easier for couples to find treatments in the future with part funded opportunities, rather than a full free treatment. For example to pay £1000 towards first if over 35yrs, or couples pay for medication and any specialist treatment outside of OFF or ICSI.
- No

- Cut down on the number of prescriptions. Charge over 60s for prescriptions if they pay tax. Suggest to central government that working over 60s should continue to pay NI.
- Charge for people who go to A&E with trivial complaints.
- Better education of people about services available and when to access them to save waste.
- Change culture, become more efficient and bring salaries of senior officers in line with commercial salaries - stop over paying people.
- It is a disgrace that you are even considering this.
- enable online booking at Dr surgeries, availability of triage to better use resources
- Pay senior managers of the CCG less than a combined salary £810-880,000 per year. Clearly if they're being paid that much they would never consider what it must be like for people that could not afford IVF.
- Reduce the age that men can access fertility treatment so that it is in line with the women's age. Carry out more research on male infertility to avoid the reliance on IVF/ICSI in future.
- Perhaps you need to develop criteria in another way, rather than age or BMI, look at income of couple, perhaps consider services in the area and what "real" alternatives couples have it they are unable to afford treatment.
- Medication reviews yearly - stop providing people with medications they don't take or use, or need anymore. Provide more Nurse Specialist roles, who can prescribe and review patients by telephone instead of Consultant clinic time.
- Invest in preventative care to reduce longer term costs, assess eligibility for non-essential treatments on lifestyle choices, e.g. smokers, obese patients etc.
- Why limit the women's age. There must be other ways this can be achieved
- A change of government to one that funds the NHS properly? A focus on earlier prevention and staying healthy so that late stage costs are reduced. This question is beside the point though. The NHS is supposed to treat people free and regardless of age, sex or illness. It's not pick and choose because someone decides some conditions are 'less important'. As usual this exercise disproportionately affects the poorest who have no option to buy in extra care.
- Lobby central government for more funding. We have the money we just aren't spending it in the right places nationwide.
- No
- Manager cuts. Too many layers. Free batteries for people with hearing aids (can't believe this is even happening!). Cut funding for families with 4 or more children. Single parent family allowance again reduce this for the number of unwanted kids they have
- Some prescriptions could be done every other month instead of monthly on regular medication. Prevention is a key element for future. Like educate residents on how to look after themselves. NHS 111 service needs a major overhaul as people who need to see a doctor cannot access especially between 7am to 8am.
- I believe limiting the BMI of patients and also the male being treated the same as a female. I also believe the time of trying is correct
- Work with care homes to enable convalescence or even open a convalescence home as this is cheaper than people remaining in hospital beds when they no longer need to but are not well enough to return home
- Donate other eggs to qualify for free IVF, encourage more home births

- Fewer locum doctors and managers with high salaries. Invest to save projects e.g. Pharmacists in GP surgeries
- Better education for families on dental health and general health/fitness. Carried out by health visitors and GPs to reduce admissions to extractions of teeth and obesity management. The cost of theatre slots and stays in hospital costs thousands each year. Prevention strategies rather than fixing it once it's done.
- Stop supplying free hearing aid batteries. Cut down on management staffing. Ensure NHS facilities only available to those entitled to use it. Chase debts from health tourists.
- Certain prescriptions could be means tested.
- Will need to think further with regard to this question.
- Pay GPs less
- Reduce follow up checks for routine appointments and give the patient choice to contact you when needed.
- Sadly, no
- Having experienced infertility and everything that is involved with years of loss, investigation and treatment, this can cause much greater emotional strain that the financial savings will only shift the financial strain to other areas of health such as mental health.
- Making more effort to check the eligibility of non-British patients to receive treatment and recouping the cost of it from the EU country or making people pay up front. Whilst I appreciate this may delay treatment, there are those that happily exploit the NHS.
- Less layers of bureaucracy/red tape, but this can only be addressed by government/CQC. Harder negotiation with secondary care.
- Stop using private contractors for everything. Stop prescriptions for small drugs like paracetamol. Take back control of hospital car parks so the hospital receives the parking income. Lease your own ambulances instead of subbing out to the likes of Bristol ambulance ems. Find private sector procurement specialists to source the cheapest available supplies. The list is endless before you cut services, who knows the next IVF baby could find the cure for cancer
- Yes, if you would like to invite me to comment formally I would be glad to, but through a survey doesn't impart the message I wish to communicate on the subject which affected my wife and I over the earlier part of our respective lives.
- Ask the government to properly fund the NHS.
- Stop wattage i.e. £250,000 clock at the new Southmead Hospital which no one could read, spend the budget on things that will improve health outcomes. Don't let people with airy fairy ideas spend as though there is no limit to recourses. Patients should value OUR NHS and pay if they miss appointments dentist manage to do this and it is very effective. Reward people who manage budgets well by saving wastage and more efficiency who save money who get results and sack without bonuses or pensions those who are useless.
- Same sex Couple get access straight away, this isn't fair as they are aware of limitations in not being able to conceive, people should not be punished for being a little over weight! I mean I was turned down as I was as slightly overweight! I don't see the big issue with being 1stone over weight! I am a fit person wanting to have a child!
- Stop gastric band surgeries (for people with a BMI over 30), breast augmentation (cosmetic only)

- The priority of the NHS should never be to scrimp on funding but to provide a service. Money never seems to go where it needs to but seems to end up financing big companies or individuals who are simply out to make money.
- Please make clinicians accountable for their Practices and by all means ask them to make a case/or not. Stop offering abortion as a means of contraception. Lobby government for funding fertility treatment and stress the importance of this service for women. In all other areas of medicine, when research improves the quality of life, why should advances in fertility treatment not equally be considered but instead restricted to those who can afford it. Unjust. Medicine used to be practiced on a basis of individual need assessed by the appropriate clinician, not a 'tick box'. This paper exercise must have been very costly, yet few people will respond or be aware of this complexity of health care - why can't the CCG members advocate for their patients instead of cutting services.
- Cutting back on 'non-urgent' services. Breast reductions/enlargements, for example, due to people being 'upset/stressed' etc. Cut back salaries of those right at the top, but don't do much work! Cutting back on fertility treatment is not right!
- I think these days women are trying and should have the chance to go to university and to have a career. A lot of 23 year-olds are still living with their parents. A woman of this age still has time to decide if they want or do not want children. They are healthier as well. I think the age category should be more around 28 to 40. I know a lot of women who are around 40 and are trying to have children. A young woman of 23 years old is more likely to not have a job or not saving money thinking of this kind of future for herself and her little ones.
- ensure tourists pay total cost of NHS access
- Pay chief executives less money!
- No
- Is there any room for means-testing of non-essential procedures?
- Improve staff retention and seriously reduce the use of agency staff. Be more obviously active in convincing central government that the NHS is seriously unfunded.
- The wrong question - lobby hard, dare to be political, and if any services fail have the gumption to highlight the failings of our government through policies of austerity. Never restrict services like this as a matter of principal!
- Remove layers of management, use the purchasing power afforded by uniting with other CCG's procurement, and reduce senior management salaries. Pay nurses more with the savings you would make from not using agency staff, don't cut funding but have the guts to stand up for the people you serve and lobby for more funding.
- No
- Foreigners who are not eligible for NHS treatment to pay up front.
- reduce top managers' and clinician's salaries cut wasteful committees encourage greater co-operative ness at delivery level
- What a terrible question - push back to the DoH.
- Do this!
- No other suggestions as retired and feel it is up to the younger people now to decide.
- We need to encourage people to take more care of themselves - diet, weight etc.

- Focus on chronic conditions. Make use of allied health professionals. Smart use of IT. Focus on health promotion/illness prevention. Better access to primary care to ease the burden on emergency services.
- Sorry, no!
- Consider restricting antibiotics unless there is a serious health problem. I am in favour of the NHS not funding prescriptions for drugs such as paracetamol and ibuprofen which can be bought cheaply in a supermarket. This is draining NHS budgets and enriching drug companies. The NHS should hold health seminars for the public where they offer education on common health issues and how to tackle them using common sense.
- Spend less money on tech and more on staff
- If people are ignoring medical advice by smoking, over eating or drinking, then they should contribute to their own healthcare.
- To be much tougher on whether plastic surgery is required for ‘medical’ reasons. I.e. just because someone is ‘unhappy with their body’ is not enough. I have no idea of what types of surgery are performed and cost - perhaps it would help if you disclosed a list and then people can comment.
- See my earlier answer. Treatments such as fertility treatment are a luxury not a necessity, and the CCG should consider this carefully when thinking about which services to restrict or cut.
- Control RUH overspends and high executive pay
- Continue to reduce fertility treatment services and also ensure all health "tourists" are made to pay for the full cost of any NHS services they may receive.
- You need to provide more detail on how the total budget is spent. How much is the Trust spending on locums? How much is it spending on non-UK residents? How much of this is it failing to recover? How much is it paying out to settle compensation claims each year? How much has this changed over recent years?
- Work efficiently and productively and cut down bureaucracy.
- It is unclear what is in the CCG budget as opposed to the wider NHS budget but fewer letters sent by post, no chaplains and not treatments not backed by research
- Focusing on preventative, emergency and lift-threatening interventions
- Non-essential treatments shouldn't be covered by the NHS.
- No
- Buy drugs from the cheapest source and not pay for things like breast reduction and enlargement or gender change.
- Charging for meals in hospital, charging for missed appointments, charging for prescription drugs, charging for the overnight cost of a hospital stay - all assuming some means testing can be applied to protect the vulnerable.
- Restrict other very expensive services which help a small number of people, and focus on the mass of cheaper care. Don't let some consultants enthusiasms for their specific work determine what the mass of basic things people want. There is no point in spending £1000s on someone when others can’t even see a GP.
- Reduce wastage such as use of agency nurses instead of using local nurses on a reasonable overtime salary which is much less than agency nurses who provide the necessary numbers but not the necessary workload
- stop wasting money on us oldies, I hear of all sorts of mad procedures on 90 year olds etc. who might live an extra week - makes no sense
- Not that I can think of right now

- Not from cutting financial help for fertility treatment. Having a child is a human right for everyone. Also for the people who needs the NHS help & do not have extra money to pay for a private fertility treatment
- Stop spending money on management consultants hired to draw up plans to slash treatment. Demand that the Government adequately funds our NHS.
- I believe the government is not providing sufficient funding to the CCG's. Therefore the CCG's will not be able to provide services with current financial constraints.
- Charing people £10 for missed appointments
- Stricter guidance on use of Community Hospitals. As a nurse on an elderly care ward patients/relatives still assume they have a right to "convalesce" in a Community Bed. These should be for people who have REAL potential for rehab, not respite or a wait for a nursing home! Would it not be more cost effective to have more rehab beds in Care Homes - more homely and similar environment/obstacles to a house rather than the expanse of a hospital ward?
- Increase beds at St Martins i.e. rehab beds for elderly people to facilitate faster discharge from the RUH so to release beds for acute care. Improve liaison and care for elderly so they can stay at home as much as possible.
- Means-testing
- Stop giving treatment to people who are not from this country!
- By not giving to people that do things of their own fault!
- As stated, it is clear that the CCG does not have the knowledge of the true cost of IVF, and is significantly overpaying for services compared with other CCG. I would be happy to share true costs with the CCG, so that it is able to make a better informed choice as to whether it prefers to avail itself of significant savings without placing restrictions on assisted conception. A new procurement would likely achieve the financial savings outcome without the need to affect patients, and should be preferred to restricting services in the first instance. I am currently working with other CCGs to lower costs and increase the quality of outcomes.
- I don't know, but please don't take it away from mental health
- I think the CCG is in a much better position to consider cost savings in an informed way than I am as I do not have the financial or medical information to make these decisions. I would like to see the CCG initiating policy and justifying their decisions in a reasoned way.
- Medically? Not sure if free of charge ops for breast augmentation, anything to change a person's looks (other than dealing with something caused at birth or as a result of accident, injury or disease.
- Reduce the RUH spend there are savings internally that they could do
- Too many patients are given the option of general anaesthesia for simple dental extractions- make it LA unless there are exonerating reasons. Stop prescribing paracetamol etc. that can be bought cheaply at the pharmacy.
- IMPOSE A CHARGE/EXCESS ON SUCH TREATMENT
- Stop funding unnecessary medications
- No
- Sorry what is CCG? Less waste from the top, trying to implement systems and processes that don't work or haven't been thought through
- Apart from the above, perhaps no repeat prescriptions without review, or charge for repeat prescriptions unless reviewed. I know loads of people who never take

their medication because it was inappropriately prescribed initially, but GPs feel pressured.

- No
- Focus on prevention and less on treating problems. Stop prescribing other drugs that end up not used - repeat prescriptions,
- No
- Stop prescribing Paracetamol it's cheap to purchase, charge a minimum for a Doctor's appointment.
- Minimise the number of unnecessary tests that are currently carried out. Although this is unrelated to fertility, I recently had an infection (BV) that was misdiagnosed; I was sent for numerous urological tests, all of which must have been expensive and all of which were unnecessary. The problem - and the expense - could easily have been avoided if a GP had simply examined my body from the very first visit. I realise that diagnosis isn't always straightforward, and that it's best to be on the safe side, but too many doctors reach instantly for technology when a simple inspection would do the trick.
- Increased demands require increased funding.
- No
- To ensure everyone is eligible for the treatments they're receiving, rather than over-using the system. To ensure prescriptions are not wasted when patients don't collect them/or already have them available. To print surveys in black and white on cheaper paper.
- Ask the LA to tell its government to stop imposing senseless cuts on the most disadvantaged in society
- Stop employing managers and not health care workers, nurses and doctors. The NHS needs people working with patients not paper pushers and bean counters. How much has this survey cost? You'll do what you want regardless of the outcome anyway so what a waste of money. These services you're cutting fertility and gluten free food only affect the minority so you know majority won't care and will probably side with you. Caring Britain - haha!
- Develop community preventative services
- mmm
- Encourage people to help pay for prescriptions where possible
- Charge patients who miss appointments either at hospital or at their GP surgery and stop giving out free prescriptions to working people who are diabetic or who need thyroid medicines
- Cut funded exercise and slimming class, stop giving out free paracetamol ibuprofen etc.
- Promote help and support via pharmacies, wealth of knowledge and probably underutilised.
- Review and update nursing procedures at hospital
- Cuts to management and less glossy magazines and surveys
- Print clinic appointment letters whilst patient is at the hospital - not post them - worked well in the past.
- I would not be eligible
- Weight range would exclude me.
- I'm 21 and have just had a baby however I had a c section so there are changes my fertility can be affected by this. This means if I wish to expand my family I may have to wait where as anyone else gets access to treatment straight away. That

means not only a long drawn out process but it also stops me moving on with my life as if I knew there was no chance I would start looking into adoption. This is something that many other families also have to think about

- I am already 34 and I am not in place yet to try for children. Yet I would like to in the next years. What if I need IVF, Why would I go private while I pay all my taxes? It is so expensive and I can't afford it
- Potentially when I am older?!
- No, although l have been affected previously based on BMI 30 and age over 41! Having paid taxes all my working life and not really used the NHS, l feel that the NHS has failed me when l need it most.
- I used the fertility clinic a few years ago; I wouldn't have been able to with these new changes due to being over 35 at the time.
- See previous comments. I am already 30 and not planning on "trying" to conceive yet but feel pressured to do so, so that I can ensure I have two years, as per your other restriction.
- I could be as we are currently trying for our first baby
- PCOS sufferer waiting for fertility to return after being on the depo injection
- aged 34, have older partner and have had fertility concerns in the past
- I am a woman living with endometriosis and am currently unsure whether I would be able to conceive on my own in the future.
- Possibly. My daughters are 32 and 34 and do not have children yet and haven't started trying for families. My two step daughters are the same. What if they are unable to have children just because they been forging out careers for themselves?
- I am undergoing infertility treatment
- I'm in my mid 30s and considering starting a family. If I found out I was infertile I would have no NHS help
- We have been trying to conceive for over a year and have recently been diagnosed with PCOS and are now on the waiting list for a fertility clinic referral. The new criteria would mean we have to wait nearly another year for treatment, despite being told we need a referral by our GP.
- I have been trying to conceive for less than 2 years now with no luck.
- My wife and I would be unable to get help (we do live outside BANEs so less relevant but as a GP I feel strongly about this)
- My daughter has polycystic ovaries and has gained so much weight, why should she be denied the opportunity to become a mother?
- Potentially if I do not have children in the next 2 and a half years. As an NHS doctor who has studied for over ten years and worked for NHS for 5 years in and around Bath I feel BANES would be failing me should I ever need fertility treatment. The rising cost of housing in BANES means many people are not able to get on the housing ladder and during their early 30's may be saving for a deposit - to then have to save for IVF. Or should young professionals have to choose between having a home and having a child?
- I’m 35 and have been unwell with ME. Due to sheer length of time to be qualified in my field and amount of volunteering, and my health, I have had to delay having children. It turns out we have fertility problems in family. this means I would not be able to afford or get help with IVF
- Would no longer be eligible for IVF due to change in age restriction

- I have been through several rounds of IVF and this is another nail in our fertility coffin
- My granddaughter is struggling to become pregnant. She is only 27.
- My partner is over the proposed age for women
- Age limit
- Weight and age.
- If I struggled to conceive when/if I come to have children.
- If I decide to have another child and cannot conceive I will be nearing 40 and couldn't afford IVF.
- I am 33 and about to start trying for a family, so if this is not possible I will be out of the age criteria for free support which would be devastating.
- I may be affected by lowering the age eligibility for women
- I am about to turn 34 and am not close to being able to afford a family.
- Male BMI limit
- I am planning on having a baby in the next year & may need fertility support.
- I am 40, I have one child but we are struggling to conceive again after a miscarriage 16 months ago. We can't afford IVF privately so our only choice is to rely on Mother Nature.
- I am 37 and unaware if I may have fertility issues and not had children yet. If these restrictions are put in place this may affect me.
- 2 year wait
- I would be if my current IVF cycle is unsuccessful as I am 37 years old and have blocked tubes
- No longer, but my feelings were the same when I was of that age.
- I am 33 and not ready to start a family. If I decide to start a family in 5 years, I'll be 38 and I may have problems conceiving which may not be associated with age. I would not be eligible for NHS fertility treatment under the proposed changes which is not fair.
- My daughter will not be treated
- Restricting the BMI to under 30 for people with PCOS. It is well known from research into the syndrome that people with PCOS often have a higher BMI, due to the way the body processes insulin and sugar. There is no treatment for PCOS. It is incredibly difficult to work on losing the weight needed for a minimum of 6 months, when you are already stressed and potentially depressed by the situation of needing IVF to conceive.
- If only one chance of IVF was available could be a few years before we could afford to pay ourselves by which time we could be too old.
- Possibly, hard to say right now!
- I am 33 and having problems conceiving but would have to wait two years and then I would be too old!
- No because I've just got IVF treatment but I could have as I had my treatment at 36
- Age as I am 35
- I'm 35 this year. Been trying for children for 1 year and worried that me and my husband won't get help.
- I am 30 and not yet with a partner, I also have PCOS and I understand I may struggle to conceive naturally. The lowering of the age to 35 doesn't give me much chance to find a partner and then try for 2 years before I am hitting 35.

- I would no longer be eligible for treatment on the NHS as I am 36. My partner is 42 and is the one with the fertility issues not me. ICSI could help us to conceive and help with his speed issues- low count, low motility etc. All tests with me are normal but I would be penalised for being 36 rather than 35.
- BMI has no leeway or flexibility. Provision should remain at BMI 19-33 for women with other medical conditions that directly affect fertility i.e. Prolactinoma/PCOS.

Comments on proposal to stop funding male vasectomies and female sterilisations in all but exceptional circumstances:

For Proposal:

- This is money well spent to help the NHS future.
- I think this is one way to ease the financial situation in the health service. We can then concentrate more on prevention and treating sick people!
- I think birth control is up to the individual, but people who have mental health/disability problems should be treated as 'special' cases.
- NHS is right to consider restricting vasectomies and sterilisations, but also the administration in all departments should be reviewed.
- I think this is right.
- Fertility is not an illness so why is the NHS treating it?
- I feel you are considering the right things.
- I think it's fine.
- Contraception is free anyway so this type of unnecessary op should be funded privately.
- I think it is a reasonable proposal but as I am over 70 and not sexually active it does not really affect me.
- Yes you are considering the right things. There are other methods of contraception available.
- It's not life or death but a lifestyle choice so to take it off the NHS table is correct
- Agree - tough choices need to be made
- I think it is right to restrict sterilisations and vasectomies as there are cheaper and proper control to prevent unwanted pregnancies.
- You are considering the right things. Might need to consider procedures that are cosmetic?
- You are considering the right things. There are many alternatives - LARCS and those who won't use them are being a bit precious.
- You need to make some cost savings and this may be the choice if we are to live within our means. There are newer choices for contraception for women that are safe .
- The CCG needs to look at all aspects of healthcare - I understand why this is being done. I hope the decisions aren't taken lightly and that full medical histories will be taken. Other problems e.g. social problems may come up, which needs to be thought about.
- Correct approach
- As a retired GP, (I used to work in North Somerset), I think that your proposals are fine providing you provide an easily accessible, cheap, non-profit making vasectomy and female sterilization service that works seamlessly with the NHS.

Private consultants can charge very high fees for vasectomies, yet I have seen it done for much cheaper fees by interested GPs.

- This is the right decision. Reliable contraception is widely and freely available, and whilst sterilisation may be more convenient it is not essential to the wellbeing and health of anyone except the most vulnerable (see above). Terminations should remain available, however, for the rare occasions when contraception has failed.
- I agree with this proposal.
- It needs to be considered but you should be doing more to get necessary funding from central government.
- I think the proposal is right but it is one size fit all
- Contraception is relatively cheap nowadays and a lot more widely available than it was before. Vasectomies and sterilisation is not as needed as it was before and with a lot more adults now having more than one long term relationship then go to have another child.
- I think you are considering the right things
- There are other forms of contraception that could be used instead of using up surgical services
- Cuts have to be made.
- I think this is possibly s good way to save money, however I do hope that men and women are still given the support and information they need of they are considering this procedure and need to be aware of how much it would cost them to go private.
- One member shared that they agree with the proposals
- Feeling that married couples with children/families in a more financially stable position, so able to afford to pay for the procedure.
- View from some in the group that pregnancies can be prevented in other ways and that condoms are just as effective as a vasectomy.
- Agreed that male responsibility important (if women don't get on with contraception, for example), but there is still a choice (i.e. to pay for the procedure) and other options.
- One man shared that he would pay towards the service (happy to make a contribution).
- One man shared that he had funded his own and thought that’s what everyone did (but his was a long time ago).
- One person said they thought there were enough alternatives available for women, and men (condoms).
- If it is a personal/lifestyle choice, one man agreed with proposal.
- There's a choice of alternative contraceptives available
- Encourage the development of safe and affordable paid for services
- Right thing
- I agree
- Easily accessible contraceptive information
- Without knowing the cost to the NHS or cost to patients if they went private, it's hard to comment fully. I understand the NHS need to make cuts and I'm fully supportive. But my opinion could change if I ever needed the services which had been cut. It's tricky.
- A good idea

- Now that birth control is readily available with choice of method, I do not think vasectomies and sterilisations are really necessary.
- Considering correct things
- It's the right thing to do; money should be spent on fixing people. Condoms can always be used...
- Don't have much opening on this. If NHS has to save money somewhere I guess this could be considered as a viable option
- Its right to restrict these treatments as contraceptives are available. I think that cosmetic surgery should not be provided by the NHS.
- I actually was under the impression that vasectomies were privately done anyway but I think how you are considering the proposal seems fair
- I do not think you are considering the right things. There must be other places you can save e.g. consultation follow ups - too many and too highly qualified staff. Car parking should be paid for people visiting but NHS should profit from
- I agree with proposals
- . It helps elsewhere - not essential.
- £400 is affordable. Would not be affected.
- Vasectomy cost is reasonable amount to pay.

Proposal is wrong:

- I do not think this is a good idea
- Human rights
- Carry on as before
- In my experience, people do not choose to have these procedures without considerable thought. Therefore, clinical and social need should take precedence over financial considerations. Decisions about health should not be driven solely by finance. Take a more rounded and long term view PLEASE.
- Just please don't, I think this is going to damage communities. Sterilisation isn't an easy choice but its right for some people.
- I think this is an essential service for reasons that aren't medical, and this already a strict enough service for getting approval, so why restrict further? If I am not well enough to carry a baby to term and hormonal birth control is not an option for me, I shouldn't just be restricted to condoms for my whole life when this option is available.
- these services should be freely available
- You should be upholding the principle that all NHS services are free at the point of delivery
- People should be encouraged to not have children that they don't want
- I feel that there should be an impact assessment regarding the effects on the social make-up of the community. I feel these restrictions could be regarded as social engineering
- Most stupid idea I have ever heard. Next you will be restricting contraception
- Individuals make these decisions based on their own personal circumstances, whether it be social, financial or otherwise. Restricting this could result in personal hardship and suffering. Having a child should be a choice, and the health service should be available to support that choice and the individual for their own physical and mental wellbeing, which should be the concern and priority of the government.
- Disgusting.

- This limits choice for men and women to control their reproductive healthcare. Absolutely unacceptable.
- I think that these are important services that could in reality save money in other areas themselves, and it should be explored whether this impacts different areas of society differently
- You are wrong to restrict access to NHS-funded vasectomies and sterilisations!
- I strongly believe these services are a right and should be free on the NHS. You argue that you need to "restrict these services is that the population of (B&NES) is growing". The whole point of these practices is to limit population growth! As for funding we know that there is a lot of uncollected tax money, particularly amongst the super-rich. We all need to put more pressure on the government to chase this more vigorously.
- This is a terrible idea
- Keep the same
- I don't think restricting sterilisation is the right thing to do.
- To not fund the last resort is harsh.
- Bizarre thing to cut.
- It is a last resort, so should be the last thing you cut.
- There should be a focus on prevention.
- Another person felt it is a choice and people have the right to have it.
- I feel female sterilisation should remain free as required
- I know money needs saving but this is very short termism
- I think this is disproportionately punishing those who seek to address a pressing issue both economically, politically, and culturally. We should be making accessible these treatments as they are considered choices which often have a positive effect on already over-burdened services.
- Vasectomy is labelled the "gold standard" for contraception in completed families, scandalous to deny the option. Female sterilisation should be a last resort, criteria based access.
- Absolutely not - this is a terrible idea and the fact you felt the need to ask your residents the question is laughable. Perhaps you should look to invest a little less in highly paid business consultants and more in common sense.
- No restrictions to anybody. It is a very significant choice to those who wish to limit their families and to avoid unwanted pregnancies.
- Stop restricting services.
- You should not be restricting contraceptive choices as part of savings needing to be delivered
- I do not think that this is the right thing to do. You should be considering improving the service not cutting it.
- I think it should be free and cannot see any reasonable argument that there should be a charge.
- Simpler for man - should be available. Tried everything else, three children, was an older mum had miscarriage after. She/they would not be able to afford treatment.
- Important for men to 'man up' and take some responsibility for contraception.
- Allows men to take control.

Unintended/more expensive consequences:

- Wouldn't it be cheaper to fund these than free contraception or dealing with the results of unwanted children neglected, in care, social services input?
- The main drive to restrict access to the procedures is to save money. I am confident that this restriction will not show a cost saving after even a year if the costs of terminations of pregnancy are taken into account. There may be some men who can afford to pay for a private procedure but an element of means-testing would result in a fairer situation
- The seriously negative affect to mental health of childfree individuals who are unable to obtain sterilisation is a major concern - especially for men who have no option to abort an unwanted pregnancy. I know of many men who abstain from sex simply because the consequences of a contraceptive failure are too awful for them to consider.
- I experienced severe postnatal depression after the birth of my second child, I was 42 years old. The terror of another child was enormous. I thank God every day that the NHS existed and I could be sterilised. I am proud the NHS exists and it not only saved my life, but also the lives of my children. If I had known it was possible to be sterilised on the NHS I would have done it before I fell pregnant, I had never wanted children (although I love them dearly now they are here) I have not been able to work again because of my mental health problems. Before my daughter was born I was beginning an interesting and fulfilling career. Instead of that I have been a burden on the state for the past 22 years. I believe that there should be a big advertising campaign promoting the option of sterilisation. Every person is an individual and you cannot say one woman's need for sterilisation on the NHS is greater than another's. If a woman asks to be sterilised then there must be exceptional circumstances for her to take that decision. There are too many unplanned children in this world as it is. Many women, myself included could not countenance a termination, but desperately want to ensure they do not fall pregnant again. In fact, rather than restricting this service I feel it should be advertised and encouraged. It is a fact that the more educated a woman is the less children she will have. It is hard for those on a low income to manage with an unplanned pregnancy and the cost to the parents and the public purse is enormous.
- I think these proposals are short sighted and do not take into account the costs involved to both physical and mental health of adults and children when such services are denied - unwanted children, abortions, mental health effects all will cost additional funding, as well as causing misery to those denied access to these treatments.
- This proposal will not save money. An unplanned unwanted pregnancy will increase the population will put more strain on the finances
- Restricting vasectomies could cost more in the longer term. It is a relatively small amount of money that will be saved and will impact most on poorer families. Have you done a cost benefit analysis?
- As I said before it surely costs more to look after a pregnant woman and then a baby than to sterilise.
- As previously stated. The repercussions of unwanted pregnancies are massive. As someone who has worked with young women who have become pregnant at a young age I know how traumatic this can be. Older women too may know that a pregnancy would cause all kinds of issues. Women are expected to take /use

contraception for many years. Chemicals constantly used and other less effective methods. This is a dreadful proposal

- I strongly disagree with getting rid of this service. I think sterilisation and vasectomy are a vital form of contraception for some people and by removing this you are potentially allowing children to enter the world who are not wanted or cannot be supported financially or emotionally, creating more problems within the welfare system
- I would think that the NHS saves the cost of these contraceptive solutions by avoiding further births.
- The cost of abortions for unwanted pregnancies
- I understand you want to save money because "the population of (B&NES) is growing and changing and this is having an unprecedented impact on the local NHS budget". These procedures reduce unwanted pregnancies & births. Taking them away from the poorest, who have most need of them, will add to unwanted children, who are likely to be a particular burden on local health and social care. Your other measures - not providing free gluten-free foods or scrips for OTC medicines - are sensible and reasonable (esp. now that gluten-free foods are so widely available and not over-priced). This one seems bizarrely irrational.
- I understand the need for cut backs however feel this is short sighted and will have a financial implication in the future due to resulting in unwanted pregnancies
- I think this is the wrong cut to make - appreciate you need to make cut backs, but the ramifications of stopping this service could cost more in the long term. Men and Women do not opt for these procedures on a whim, they could have no alternative contraception and the implications of an unwanted pregnancy would surely be much more of a financial burden to the NHS than had these procedures been allowed.
- Definitely should not be restricting vasectomies/ sterilisations as the decision to have this procedure is not taken lightly by the patient in the first place. By restricting these procedures you will have an increase in unwanted pregnancies, which in turn costs the NHS and also causes the patient unnecessary stress.
- as above
- The effects of restricting access to these services means that there could be more unplanned pregnancies with the results of greater pressure on maternity services and on termination of pregnancy services. This would only shift the cost pressure to other areas.
- There will be more unwanted births due to cuts which will cost the health service a lot more in the long run.
- Your proposals will not save money or anguish. The result will be more unwanted pregnancies, terminations and greater demand on other parts of the service. Not all women are able to use hormone based contraception, not all women are able to use an IUD; often a vasectomy is the safest and most reliable option for a couple. Failure to provide would make the responsibility fall on the women alone, and failure of the contraception would again leave them (literally) holding the baby.
- An unplanned pregnancy surely has higher cost implications than a once off payment for a sterilisation procedure, which a responsible choice is generally made where people feel their families are complete. Has research been done on costs of abortions (financially and in terms of physical /emotional impact) where this has been done before? By stopping make vasectomies too, once again the

woman becomes the most likely party responsible for contraception and often at the mercy of methods with side effects or costs involved. The likelihood is that again this will separate people by economic circumstances which surely are discriminatory - less well of people will not be able to access these procedures privately.

- I strongly believe that everyone has the right to choose their preferred method of family planning, without financial reasons influencing their choice. It is especially important to retain vasectomy services as men have very limited choice of family planning services, and by cutting this service, puts the burden back onto women. This would be a huge setback in gender relations. Vasectomy is a popular option in the UK and we cannot deny men this right and (reproductive) responsibility. If men and women have to pay for sterilisations, there is no doubt uptake will be much lower. The consequences for families and the NHS will be much more costly than maintaining free services on NHS.
- Restrictions might increase unplanned pregnancies
- Unplanned pregnancies, abortion, lifetime healthcare for any resulting children will cost the NHS more than it saves
- It is far cheaper to fund vasectomy and sterilisations than it is for society to fund to support children that aren't wanted. I think we have a moral duty to allow people to undergo these procedures
- Various contraception does not always suit people and to limit what is available will cause problems, including unwanted pregnancies, and side effects to contraception that people do not want and which costs the NHS money.
- More babies will be born; surely a person costs the NHS more than one procedure. This is terrible long term thinking.
- Anticipate that unplanned pregnancies will cost far more than this would save. Not everyone gets on with LARC and vasectomy is a sensible male alternative.
- No this needs to remain free to all the service is important to stop unwanted babies
- No, surely a pregnancy, the pre-natal care and post-natal care plus the years pregnancy exemptions card costs the NHS more money than a vasectomy, which the NHS don't exactly hand out like hot cakes anyway. Maybe look at the year free prescription you give mothers.
- If people are minded to stop unwanted pregnancies they should be supported to do this. This proposal may save money in the NHS (but not necessarily if the pregnancy that could have been avoided has to then be supported via midwives, GPs, consultants and possibly a C Section, not to mention subsequent health care costs of the new child throughout its life), but could cost other Government departments a lot more in terms of extra benefits, extra community support needed etc.
- Please refer to my previous comment
- Not sure what you should be considering, all sectors are important. I'd rather fund vasectomies than fund unwanted or unloved children
- I think vasectomies and sterilisations will reduce council spending over time. If more children are born, they will require healthcare, housing and schooling and other council funded services. The plan to stop funding these services is short-sighted.
- I think unwanted children, or more abortions, are greater strain on society. Short termist approach to budget.

- The impact on the future of unwanted pregnancies, for both the child and the community.
- Does the cost of life-long contraception actually outweigh the cost of sterilisation? Including the risks of contraception, such as DVT, infection, and error resulting in unwanted pregnancy and abortion? I don't agree at all. More children, a population increase that you cannot afford to house or school? Honestly I really think these are short-sighted options I'm afraid.
- If these are restricted you end up with more unwanted pregnancies and terminations.
- You may end up spending more on terminations
- I think the proposals are likely to lead to an increase in unwanted pregnancies, terminations and higher birth rates and the subsequent emotional and psychological distress this entails. I cannot foresee that this will lead to any financial savings in the system as a whole.
- Male vasectomies: excellent way to prevent unwanted pregnancies therefore very short-sighted to restrict access as likely to result in healthcare burden from pregnancies/terminations. Female sterilisations: not a great form of contraception and other options often available for their indications
- Fewer sterilisations are surely likely to lead to a higher contraception workload and more unplanned pregnancies and sterilisations? Is there research to support this proposal?
- I think that this proposal won't represent and actual saving. As far as I am aware, a local anaesthetic vasectomy is not that expensive. Removing this is likely to cause an increased number of unwanted pregnancies which will incur costs whether someone has a termination or carries pregnancy to term. There will also be additional costs in terms of providing other contraception to patients both in terms of GP time, cost of contraception and also potentially placing women at risk by continuing on hormonal contraception. I am more supportive of limiting female sterilisation as this is more expensive but do think limiting vasectomy is short sighted. This proposal is also likely to place even further strain on already stretched general practices.
- I am concerned that stopping funding for long term contraception is short sighted - there will be an increase in costs for short term contraceptives and possibly an increase in unplanned pregnancy as a result
- Are you going to have to perform more terminations?
- Ill thought out and unlikely to be cost-effective.
- I think it will create unwanted pregnancies
- See above - it's really not going to save that much money in relation to the problems it might cause.
- I wonder how fully the costs of the implications of this proposal have been considered. Costs of caring for women with unwanted pregnancies, either in the cases where they want to terminate those pregnancies or when the babies are carried to term. What are the costs of other long term contraception?
- I fully understand the challenges facing the NHS, however, restricting vasectomies, sterilisations or any measures which impact on people's ability to limit the size of their families may save money on the cost of sterilisations/vasectomies, but may add costs elsewhere in the NHS system, e.g. through additional abortions or unwanted pregnancies

- I feel this is false economy. Such action will result in more unwanted pregnancies which it turn will lead to more abortions and unwanted children being brought into the world. This in the long term is likely to cost the NHS far more than sterilisation, and could cause much suffering to children born in these circumstances.
- It will increase the likelihood of unwanted and unplanned pregnancies. I would not start from the position of cutting services which is meant to be free at the point of delivery.
- Vasectomies and sterilisations prevent pregnancies and child care which cost the NHS much more money than the cost of these treatments.
- no artificial interference to restrict fertility or its consequences is rationally acceptable
- Your introduction refers to your concern at the population increase in BaNES yet this policy risks even larger population increases along with higher costs to health and social services. Neither joined-up nor long-term thinking.
- This is a short-term saving that will inevitably cause more problems with unwanted pregnancies.
- BANES CCG describe Vasectomy as “non-urgent” but ignore the significant savings to the NHS, public services and families achieved through prevention of unintended pregnancies amongst families who choose not to have more children. The decision will also force women to shoulder an even greater burden of responsibility for preventing unintended pregnancy and undermine one of the few contraceptive options available to men. Vasectomy is a popular option for families who are happy with their family size. There will be major economic impact of the cut to vasectomy services to families and the public sector. The costs of an unintended pregnancy far outweigh the savings to the NHS of cutting vasectomy services. Vasectomy cost on the private sector probably will force most families to choose not to use vasectomy. Gender inequality will be increased by the cut to vasectomy services. This is a major backward step. We’ve seen elsewhere in Britain declines in vasectomy uptake in areas where free services have been cut
- The UK is hugely over populated and any measures taken to reduce that over population are to be welcomed and should be expanded rather than cut back.
- I think tax-payers should be entitled to vasectomies or sterilisations if they want them. For those who no longer want to reproduce, they can be given peace of mind. There will be a saving for the NHS as there will be less accidental pregnancies and all the extra costs associated with child-birth or terminations. Those having these procedures are likely to be older when pregnancies can have more medical complications and dangers. I think those who want reverse vasectomies should have to pay privately though.
- This is a bad proposal. A smaller population is essential to a strong economy.
- The birth of a child due to the non-funding of vasectomies & sterilisations would cost the NHS more during the lifetime of the child. The control of cholesterol by diet instead of medication would save the NHS money
- The systemic costs need to be taken into account. That is: abortion of unwanted pregnancies; child support services and adoption and fostering of unwanted children; extra child benefit costs; women's ill health through unwanted pregnancies. No doubt many more costs I can't think of at the moment.
- It is a lifestyle choice. Paying for a vasectomy is cheaper than having a baby!!

- Presumably the cost of unwanted children will significantly outweigh the 'savings' from this plan, not only in monetary terms. It's a short-term cost saving that doubtless will cost far more in the medium-term, as usual.
- Vasectomies are the most fool proof, cost effective and safest form of contraception there is. All the alternatives are more expensive, riskier for pregnancy and damaging to health e.g. Long term use of the Pill for women. Restricting access to vasectomies will give rise to more wanted pregnancies and quite possibly family breakdowns. If anything vasectomies should be far more widely publicised and encouraged. It would be very short sighted and indeed complete madness to restrict access to vasectomies for these reasons.
- It's a short-sighted proposal that won't save money in the long run.
- You talk about sustainability and living within means, while simultaneously removing a set of relatively inexpensive procedures that help people to do exactly that by preventing accidental pregnancies.
- This is not an area for cuts. Effective contraception is essential. If you cut this costs in other areas will rise significantly
- It should be available to all men for whom this is suitable. It surely is the cheapest form of contraception with the least side effects. How short sighted to restrict it. It will only lead to a higher demand for contraception by women and possibly to unwanted pregnancies. Both are much more expensive than a simple snip.
- There should be no restriction. The emotional and physical cost of unwanted pregnancies to the adults and resulting child is enormous, the cost to society of other forms of contraception, providing for health problems resulting and the maintaining children who are the result of unintended pregnancies is far more than the cost of sterilisation of people acting responsibly.
- Vasectomy and sterilisation should be available to as many people as possible and far from restricting it; we should be enhancing the recommended categories of people who should have one. We live in a grossly over crowded planet and large numbers of children, particularly from families having more than, say 4, children. We are building up unmanageable populations who will require various kinds of health and social service intervention in the future and thus increase the costs and bills even further.
- Members asked about the cost of other types of contraceptive e.g. the coil compared with costs of vasectomies/sterilisations
- What if more children result from this cut? Who will look after them? Far greater costs associated than vasectomy?
- This is just passing the responsibility to the local authority
- Cost of abortion/pregnancy/funding for alternative contraceptive methods needs to be taken into account.
- Cost implication of health risks, including impact on mental health, as a result of unwanted pregnancies/miscarriages/abortions (costs NHS more)
- Does a vasectomy cost more than contraception?
- How much does sterilisation cost?
- One man said he didn't understand the rationale for the proposal, as there are too many people (on the planet) and sterilisation/vasectomy prevent unwanted pregnancies and terminations (they are not cosmetic procedures). He said there are huge anti-natal/maternity costs etc. which the NHS has to pay for.

- One man felt this was a harder issue and that women requesting sterilisation should be cared for by the NHS. He thinks it saves unnecessary pregnancies, costs of other issues such as big families, children in second/third marriages.
- View that cheaper for a man to have a vasectomy than for woman to take the pill long-term.
- View from one support worker that not saving money in the long-run, due to more unwanted pregnancies, children being taken into care etc.
- In the long run this will cost more money. The cost of sterilisation and especially vasectomy is a drop in the ocean compared to the cost to the NHS of terminations or all the health care a baby would need throughout its life. If only 1 baby was born to 100 vasectomies it would still be a greater cost over its lifetime. This is an ill thought out, short sighted suggestion.
- No I don't agree. The risk of unwanted pregnancies and therefore abortion could be higher.
- As before, you mention a growing population yet are stopping services to help combat that.
- People should be able to choose to permanently prevent pregnancy reducing costs of abortion and birth control
- Please take into account the severe psychological effect a restriction to this service could have on some patients and their wider families of not having the surgery. Are you able to give guidance on how much a privately funded procedure would cost patients and make recommendations regarding suitable alternative providers of this service, so people can make a more informed choice about this proposed change in service provision.
- It seems that you'll have to spend more money on maternity, child birth and paediatric care for pregnancies which would have been prevented by sterilisation than you will save with this measure. The people most likely to want this service are also the least likely to be able to have it done privately, which seems discriminatory.
- No and in the long run you will spend more on unwanted pregnancies and contraception
- Restricting vasectomies puts all of the responsibility back on the female if she doesn’t want to get pregnant again. It is unhealthy for women to have to use hormonal methods of contraception long term. More money would be saved providing this service than unwanted pregnancies.
- I think I’m wanted pregnancies will lead to more cost in the long run
- I think the cost of unwanted pregnancy would go up
- I think it is short sighted. People generally will be using as a permanent contraception, trying to be responsible. It will also reduce the cost of supplying female contraceptive for couple where sterilisation/vasectomies have been provided. Surely responsible treatment will stop a greater number of unplanned pregnancies that people may decide to take forward meaning more pressure on the country’s economy.
- Contraception via pill and coil etc. do not suit everyone and long term costs of maternity care (if there were unplanned pregnancies) would far outweigh costs of vasectomies.
- I think that these procedures will save money on contraceptive prescriptions and ongoing care for unwanted pregnancies and is therefore a short sighted money-saving venture. It will cost far more in the long run.

- What will the economic cost of unwanted pregnancies be both to families, the ongoing cost to the NHS, or the possible costs of termination of unwanted pregnancy?
- Will this lead to more cost pressures due to unwanted pregnancies?
- I think this will just make NHS resources even more tight because it will increase the number of children being born and so more people needed in NHS care
- If people are taking responsibility for contraception and stopping unwanted pregnancy it should be encouraged. My husband has a vasectomy 18 months ago. I take enough medication as it is for a condition and he was not happy for me to Take the pill or have the hormonal coil. Vasectomy was the sensible option; it would be taken away for couple like us. This is not fair. Stopping unwanted pregnancies is far more cost effective than assisting pregnancy. A child is a privilege not a right.
- There are long term savings in the form of other now redundant forms of contraceptives which we previously free, also how much does a hospital delivery cost? People voluntarily having sterilisation procedure must surely be an on average saving for the NHS which should be more widely advertised for their safety and convenience, not pushed into the private sector. I think this proposal is short sighted and doesn't look at the wider picture, unwanted pregnancies and more so unwanted children are a massive cost to the NHS surely the cost of one procedure must be much smaller?!
- A person making the decision to be sterilised may seem like a high cost on the face of it, but I believe in the long term would reduce the costs involved with unwanted pregnancies, unwanted children and the cost of contraceptive products. Also, these restrictions will affect the poorer more, who may not have the funds required to pay for it themselves.
- Bad idea - you need to think carefully. These are effective, safe cheap long term contraceptive measures which do not rely on patient compliance
- Feels like it might end up costing the system more in future with unwanted pregnancies but I understand why it's being looked at. Would also consider small wins such as hearing aid batteries and low cost medication
- If you restrict these services, there'll likely be an increase in unwanted pregnancies, leading to unnecessary abortions or unwanted babies. Ultimately this will be far more costly, particularly considering the risks associated with other forms of contraceptive (e.g. DVT and mental health problems with the contraceptive pill)
- No, I believe you are NOT considering the right things. There are many children in social care& many families struggling financially to support their children. Stopping NHS funded sterilisation will mean many more unwanted pregnancies as other forms of birth control are not 100% effective (many girls become pregnant due to being sick& then their pills not working etc.). Many people with young families are struggling financially and will be unable to fund their own operations. There are many operations carried out by the NHS that should be funded privately rather than this. I.e. sex changes etc. Please think again before you stop this vital service.
- I think by making sterilisation impossible for the poor that more unwanted pregnancies, terminations, pregnancy related conditions, babies born with FAS/drug related issues, I think it will cost the health service MORE in the long run

- The restrictions of access to permanent birth control for qualifying parties appears to be short sighted given the rising need to control population increase in the UK. My husband and I are going through the process at this time. For personal and health reasons, I am unable to use other methods of contraception and do not believe in abortion. We have no desire to expand our family anymore and these proposed restrictions would affect people like ourselves who already contribute to the national health and pay the highest level of tax. Restricted access to valid and sensible methods of permanent birth control while our taxes go towards supporting families with multiple (3+) children on benefits seems ludicrous
- Vasectomy is the most cost-effective method of long term contraception. Closely followed by tubal ligation. I have been looking for your cost benefit analysis that takes account of the cost of on-going reversible contraception for those who cannot access surgical contraception. Have you considered the cost of unwanted pregnancies that might result as a result of the loss of this service? This is an argument that was settled in the 1960's and 70's and has been well established since then. This is from Wikipedia...Family planning is among the most cost-effective of all health interventions. [1] Costs of contraceptives include method costs (including supplies, office visits, training), cost of method failure (ectopic pregnancy, spontaneous abortion, induced abortion, birth, child care expenses) and cost of side effects.[2] Contraception saves money by reducing unintended pregnancies and reducing transmission of sexually transmitted infections. By comparison, in the US, method related costs vary from nothing to about $1,000 for a year or more of reversible contraception. During the initial five years, vasectomy is comparable in cost to the IUD. Vasectomy is much less expensive and safer than tubal ligation. Since ecological breastfeeding and fertility awareness are behavioural they cost nothing or a small amount upfront for a thermometer and / or training. Fertility awareness based methods can be used throughout a woman's reproductive lifetime. Not using contraceptives is the most expensive option. While in that case there are no method related costs, it has the highest failure rate, and thus the highest failure related costs. Even if one only considers medical costs relating to preconception care and birth, any method of contraception saves money compared to using no method. The most effective and the most cost-effective methods are long-acting methods. Unfortunately these methods often have significant up-front costs, requiring the user to pay a portion of these costs prevents some from using more effective methods.[3] Contraception saves money for the public health system and insurers.
- This is a bad idea. Surely unplanned pregnancies and abortions are more costly to the NHS than this preventative procedure.
- I think it is short sighted to restrict them as it will cost more in contraception, abortions and unplanned pregnancies
- I believe that assisting people who don’t want kids to be sterilised is a good thing as unwanted children is not in anyone’s interest. I understand that they could use alternative contraception but this all comes at a cost too and is less effective. I understand the need to cut costs but I think this will be false economy in the end
- The biggest issue with the planet and on all services is the amount of people that are needing them, reduce the population, solve the problem
- I think that vasectomies and sterilisations should be prioritised. In the long run, unwanted pregnancies and the care the care needed for those extra children will

cause greater expense than these procedures. I believe everyone should have access to these procedures.

- Stopping vasectomies is a short sighted measure that would result in further population growth, and result in women having to shoulder the burden again on taking contraceptives and the risks this poses them with long-term use.
- These procedures are important to prevent producing unwanted children in an overpopulated world. If you want to save money, restrict IVF treatments.
- This seems like false economy. You may save money here but more would be spent on accidental births and child health costs. It seems short sighted.
- These policies are unbelievably short sighted, and will cause immense suffering as well as future expense.
- I think this is a terrible idea. If your main issue is the growing population you should be making as sure as possible that no unwanted children are added.
- The consequences of failing to offer sterilisation or vasectomy could result in unwanted pregnancy as many can't use contraception
- How does the cost of sterilisation compare with contraception and any unwanted pregnancies should it fail?
- If you do restrict these you are asking for more unwanted children.
- Right to consider but worry it may increase abortions or pregnancies.
- Fewer funded vasectomies and sterilisations will ultimately lead to more births, probably to lower income families who can little afford another dependent. The NHS will ultimately come under more strain.
- It is ridiculous to charge for male vasectomies as they will just increase the risk of more unwanted pregnancies and babies and as a result more pressure on local resources and benefits for the children born in poorer areas.
- I think people who for a number of reasons should stop having children, might then end up having more children either at an older/more high risk age, or when they are unable to support and care for more children. It might affect some relationships if people are worried about the contraception being effective enough. Contraception also costs money and is an extra thing for people to think about.
- If restrictions are made on vasectomies and sterilisations people won't have them increasing unwanted pregnancies which means more terminations and further pressure on other parts of the NHS
- Overall vasectomies and sterilisations save money, surely?
- I think that everyone should have the right to these procedures if they have decided it is the best option for them. As not everyone has the ability to pay to have this done privately the NHS should provide. Has there been an impact assessment on unwanted pregnancies and terminations?
- "There are two main issues: 1, can the saving be made, and 2. what are the wider implications? The methodology assumes that by stopping the service men will pay from their own funds for vasectomy. However there is no evidence presented that enables us to assume this will be the case. There is no analysis of the 160 men who had the process last year. So there is no way of us clearing knowing that if the service had been cut before if ALL of these 160 would have been able to 1. Afford to pay and 2. Choose to go ahead with the procedure knowing they have to pay. The assumption seems to be that all men would be able to afford to pay, and would chose to go ahead with this procedure • we cannot be sure of either of these factors. How do we know that men can afford to

pay for the procedure – likely to cost £400-£500 at current prices. We need to look at the 150ish men who had the procedure last year, and analyse their age, their employment status (if available), their residence (to give an indication of LSOA/ward so we can understand what areas of BaNES they live in; therefore understand the cohort in terms of any socio-economic inequality by where they live for e.g. in the absence of better data, we might assume young men (under 30) living in Twerton West or Foxhill North or Writhlington will have considerably less income than older men (over 35) living in Sowey Sutton or Bathampton) If we don't have this information, we cannot assume all men can afford the procedure in future • Subsequently, if all men cannot afford the procedure in future, we need to understand how that affects their decision to choose to go ahead with the procedure. At a cost of £400-£500 per procedure this could be a significant impediment to men choose to go ahead with the procedure. If they don't what then happens? There are only condoms as another means of male contraception which we know from evidence are not consistently used. So if men decide not to go ahead, and don't use condoms consistently there is a risk of their partners getting pregnant. Unplanned pregnancy has enormous financial costs to both the CCG, Council and wider services – a ToP costs the CCG around £500-600 in terms of the procedure along; factoring in time with GP, consultation and pre-op support this can easily be close to £1000 per unplanned pregnancy. If BaNES wants to save £41,000 on vasectomy, it only takes 25% of the 160 (41 men) not to have a vas for zero savings to be made due to a corresponding increase in ToP costs to the CCG! • There will be an impact on costs to other organisations even if the CCG does save some money. Increased ToPs might lead to small increases in family pressures and possible breakdowns, possibly increased violence, and individual stress to the woman who requires support post-ToP. These financial costs will be transferred away from the CCG and to other organisations, such as social care, public health etc. • If funding for both male and female sterilisations is restricted so that funding is provided for "exceptional cases only" how will an exceptional case be defined? Who will it include and exclude, and for what reasons? This is not detailed in the paper and needs to be so. •The report says "Initial engagement with the main community provider – BEMS+ - suggests that it is likely that the male sterilisation service would become unsustainable for BEMS+ to run if NHS funding is restricted as proposed". An alternative provider would need to be commissioned for the small number of cases that were eligible for funding. There will be a financial cost to the CCG in doing this in terms of: redesign of service specification, advertising of tender, commencement and conclusion of tender process and issuing of contract. It also assumes there are providers in the market prepared to pick up this small activity. If it's unsustainable for BEMS+ then it is likely to be unsustainable for any other potential provider. If no local provider is identified in the tender process, patients will have to go to OOA/OOBaNES providers, which will incur more costs to the CCG than if a local provider was in place • £41K does not seem like a very large sum of money from the overall amount required to save. Can other options be looked at to save this money such as: other services outside of sterilisation be reviewed, renegotiation of the contract for sterilisation services to deliver a lower tariff price, different models of delivery for sterilisation e.g. GP delivered or pooled budgets and one services across a range of different CCG areas (for example like ToP is currently delivered across BaNES and Wilts), or pooled budget and one service across the STP area? • Overall I do not

consider there is enough evidence to declare the saving will be made as proposed. What are the implications to patients of the decision? • By cutting this service, you are restricting 50% of the total contraceptive choice available to men. I believe this creates an unfair and potentially discriminatory situation to one gender. Might there be implications to the CCG in breaching the Equality Act 2010? Also just consider the discussions we would be having right now if we were looking to cut 50% of the total and free contraceptive choice to women for e.g. no pills and one LARC method stopped. Personal opinion – men are possibly a soft target and its sexual health so because of the stigma you won't get men protesting saying "Save our Snips!" We can assume this will likely lead to some increase in ToPs. There is a considerable non-financial cost to the women in terms of having to undergo this procedure – the impact on her mental health, stress etc. • A crude calculation shows a cost of £41K for 150(ish) men equating to £273 per procedure. Rates at private providers are significantly higher meaning it will core more to men – almost double at some providers – in terms of actual costs than what it would cost the CCG. How is it fair that men will be charged almost double the current rate? This is a significant inequality that the cohort will have to bear. Can the CCG guarantee that men will pay the same prices for the procedure as the CCG has done historically to ensure the price is not so much of a barrier? • I believe that by cutting this service, the CCG is not acting in line with the specifications of the Health and Social Care Act 2012, which split commissioning responsibilities for sexual health care between local Councils, NHSE and CCGs. The Act explicitly states that CCGs have commissioning responsibility for vasectomy and female sterilisation. No other partners are removing themselves from this responsibility with the exception of the CCG. • Finally contraception provision is cost-saving. For every £1 spent on contraception, £11 is saved in other healthcare costs. • Overall I feel that consideration of these wider implications of the decision will adversely affect patients in BaNES and possibly lead to increased health inequalities."

- It is important to consider the detrimental effect unwanted pregnancies and childbirth have long term both on the individual child and on society.
- Both procedures contribute towards responsible birth control without ongoing costs or risks. The alternatives are not as effective, carry degrees of risk to health or of failure and cost money
- You should also consider the cost of terminating an unwanted pregnancy, the psychological impact to a patient having a termination; the costs of GP times in repeated contraceptive services.
- I suspect that unwanted pregnancies will cost more overall to the NHS and Society than providing a safe sterilisation service for both men and women locally. Pregnancy is high risk to women's overall well-being and welfare. For those who have completed their families, sterilisation is the best form of contraception.
- I don't think you should be restricting funding of any services as it just shifts the problem onto the remaining services. I cannot see how that can be beneficial or a cost saving in the long term when you take the whole of NHS and care services into account. I also think that there is no need to cut services and instead efforts should be concentrated on lobbying government to change their policies and provide sufficient funding for the NHS.
- I think restricting vasectomies and sterilisations is silly quite frankly. There are too many people in this world for a start. Secondly, unwanted pregnancies can cause

a lot of grief for all concerned (not least the child). They can also lead to more expense - social services etc.

- If the man is unable to use other means of contraception e.g. if condoms cause erectile dysfunction. The general idea of society aiming to prevent unintended pregnancies.
- I think this is a short sighted action
- It is counter intuitive, the cost of dealing with unwanted pregnancies is surely much higher, and many women have serious side effects from other forms of contraception. There is also a mental health issue here with regards to women having less access to choice and the effects that it has when they have no options.
- Contraception is free and so are abortions, surely that's the consequence the alternative to on offer and in my experience consultants talk women out of sterilisation if they possibly can. What's the cost of an unplanned child? Some people won't abort, how much does maternity care cost?
- This seems a short sighted approach. The costs of unwanted pregnancies and issues relating to hormone based contraception surely outweigh any potential savings.
- Cost of unwanted pregnancies
- It's disgraceful to consider restricting access to these services. It will negatively affect people's lives and only add to the burden of other NHS services further down the line as a result. What next? Restrictions on abortions? I strongly urge you to reconsider these proposals.
- I think the cost of children is far higher - tax credits/benefits/people staying at home to look after children/funding extra places in schools and nurseries. All other contraception is more unreliable (and many are free on NHS with exemption card and surely cost more in the long run with long term use)
- The restriction seems very short-sighted. Whilst this will reduce the burden on budgets in the short to medium terms the cost are minimal vs the impact of children (especially 'unwanted' children) on long term budgets
- This wouldn't cut costs, as impact on maternity services.
- Huge risk in unwanted children and children going into care. Funding strains felt elsewhere. Is there evidence of how well children do who have been in care/costs to other agencies? Are terminations more or less expensive? Need more information about consequences.

Discriminatory against women:

- Inequitable for women to have access to contraception but not men. Increased pressure on women to have to contend with being responsible for contraceptive choice. Has this shown to be cost effective??
- 1. Why are some forms of contraception going to be free and others not? 2. Risk of sex discrimination and legal challenge as is only secure from of contraception for a man 3. Very effective contraception this proposal forces people to sue less safe/effective forms of contraception 4. Risk of increased unwanted pregnancies 5. Cost of LARC over time may increase which will limit the savings made 6. Cost of IFR process to administrate exceptions may be more than the savings made
- I think vasectomies are very good value for money, and it is only fair that men should be enabled to do take responsibility for contraception. Not all women want to have other forms of contraception.

- This will disadvantage women particularly and widen the gap between rich and poor.
- I'm really shocked by this, as a woman I feel frustrated that contraception really is MY responsibility if we want a reliable method of not getting pregnant, after trying many options I have a Mirena, I don't like what it does to me emotionally or physically and want it out. The deal I made with my husband is that when it is due for removal (2019) he will apply for a vasectomy, we will be close to our 40's with a 10y and 8y by then. I already have pressure from my in laws to be sterilised instead as he is the main bread winner and shouldn't be out at risk, if we had to go private the pressure would be more so
- Hormonal contraception is not appropriate for all women with physical and mental health implications. In those instances what long term options are there for women who are confident that they do not wish to have a / another Baby? The copper coil is not 100% reliable.
- I think limiting vasectomy is not right; the burden of contraception should not rest with females entirely.
- Your proposal places an unacceptable and unfair burden on women, as they are the ones most affected by an unplanned pregnancy. Requesting sterilisation/vasectomy makes it clear that further children are not wanted, which means the pregnant woman would have to have an NHS abortion and face the emotional and physical risks inherent in that. Sterilisation and vasectomy should be available on request, on the proviso that the NHS will not fund reversal in the future.
- It is short termist and sexist. Vasectomy is the only long term family planning option for men, so it burdens more women and takes away any choice for men.
- One woman shared that she was sterilised two years ago. Her husband refused to have a vasectomy as he was concerned it would affect his manhood/sex drive. She said she would pay for the procedure if she had to.
- Man taking responsibility (for contraception) is a good thing.
- One woman shared that she wants her husband to have a vasectomy and he refuses to.
- I think reproductive health is absolutely essential to women's health, regardless of income.
- One man shared he had a vasectomy on the NHS and might have put it off if he knew he had to pay for it. He said; "That doesn't seem fair on the wife to have to be responsible for contraception."
- I do not agree with restricting vasectomies. So much of contraceptive becomes the responsibility of the females amen this procedure enables many couples to no longer need to use contraceptives from NHS as well as helps with unwanted births.
- Vasectomies are a quick easy way to prevent pregnancy. The onus is so often on a woman to ensure she doesn't get pregnant, often needing to take pills which affect her hormones, or use coils which are invasive, don't always work and again play around with a woman's body. Condoms are fine but they're throw away and produce waste. A vasectomy procedure, once done, is done!
- One woman's husband had a vasectomy - some people can't stop having children. Alternative contraceptives not good for hormones (side effects). They couldn't have afforded this.
- Her son wouldn't have it if too expensive - unfair.

- Responsibility different for men.
- Wishes her son had had it done and needs access to it.
- One way to save, money. Had one in 1981/82 and wouldn't have been able to afford it.
- One woman considered getting sterilised herself, but felt too final (as tried really hard to have children). Feels, if woman's only option, should be entitled (avoid unwanted consequences).

Women unable to use contraception:

- See my comment above. I am sickened by this proposal. It would leave so very many people unable to access crucial procedures that enable them to take responsible decisions about their lives. For many women sterilisation is a rational and sensible option saving them years of dealing with fertility issues including exposure to unwanted hormone treatment (i.e. the pill).
- I understand the need to reduce some costs, and that in some circumstances; cheaper methods (e.g. copper coil) may be as appropriate and with as little risk of health consequences. However, having suffered a negative impact on my health from taking the contraceptive pill, I do not think it is appropriate to a) reduce women's access to alternative, non-hormonal and longer-term contraception or b) remove the one real option for male long-term contraception.
- One person said that the procedures are good from a birth control point of view and are better than hormones (i.e. certain types of contraception).
- Need to consider the side-effects of contraception that many women experience
- I think that contraception in all its forms is a vital aspect of health care in that it allows us to control our fertility to a large degree. There are some people who are unable to use non-surgical forms of contraception and for these people it is crucial that they should be able to access vasectomy or sterilisation through the NHS. It is vital to our society that we manage our population in a responsible way and these procedures are part of that. Equity of care requires that the NHS provides vasectomy or sterilisation to those unable to use non-surgical contraception effectively.
- Some women can’t use contraception and have had their families
- I have tried many forms of contraception e.g. 2 different types of pill and 2 different types of injections neither of which suited due to side effects or weight gain. Now after 4 children I am looking for something long term and considering sterilisation as am now running out of options

Discriminatory against men:

- Someone said this is the only permanent choice for men, therefore it removes their choice
- GP said that we may assume it's all older men who have completed their family who want a vasectomy, but there are also young men (e.g. 28 year old she has seen) who just can't cope with more children and their partners won't/can't use contraception
- Responsibility different for men.
- Wishes her son had had it done and needs access to it.
- Wouldn't pay for vasectomy. Takes away freedom.

Low income:

- As above - ability to pay
- I'm appalled that this is even a consideration but if it does happen you MUST consider financially challenged people in all cases, people who may have mental health issues. But for me, finance is a huge factor, maybe means test the lower limit of wages/unemployed?
- I am appalled. The working poor can't even get benefits for a 3rd child - unless it's a child of rape (!). I can't use hormonal contraception, for example - sterilisation & vasectomy are important - and £-saving - options. This is appalling discrimination (and will only further increase the onus on women to take family planning responsibility). I am gob-smacked that you would consider this.
- No it not right may be ask the people who are not on benefits and are working to pay for this kind of treatment
- Restricting access is discriminatory affecting the poorest in society
- I don't think vasectomy or female sterilisation should be restricted to what the CCG may consider exceptional circumstances, which were not specified as far as I could see. Male and female sterilisation are a cost effective method of contraception which as well as helping couples avoid unwanted pregnancies have benefits to women through avoiding hormonal contraception, which may not be as reliable in various circumstances as well as having risks for some women. In Public Health terms, vasectomy and female sterilisation are a worthwhile investment. Putting the barrier of needing to pay in the way of couples and individuals who are contemplating vasectomy or sterilisation is grossly unfair at a time when many people's income has reduced in real terms over the last few years.
- Where someone literally cannot afford to pay
- Seems to penalise low income people and will cause problems for small number of people least able to afford help and will only lead to small savings.
- I think it is a mistake to treat this sort of treatment as though it is some sort of lifestyle choice. Fine if people are well off and can afford to pay for this treatment, but what about women in difficult relationships who can't afford to have any more children and can't afford to pay? Contraception needs to be freely available to those who need it. Restricting access may result in higher costs if it increases the number of babies born into dysfunctional situations. Seems both unfair to those less advantaged and unwise, as the availability of this treatment reduces future NHS costs. I think you should be seeking to invest more in preventative measures not less in order to save more in the future.
- I suppose I think that free sterilisations might very well reduce the costs/strain on the maternity system, and that charging penalises the poorest families most (those most likely to financially suffer if unexpected kids show up). I suspect that binge drinking, smoking and poor diet all end up costing more than doing these procedures, and I doubt that any child costs the health service less than ‘the snip’. Maybe it would be better to tackle ongoing, self-harming behaviours before a healthy decision to opt out of unnecessary reproduction.
- Some families struggle with contraception and a sure solution should be provided where they can’t afford more children.
- You should consider how these changes will target the working class families and family planning choices.

- Poor people will not be able to pay for the treatment. So many unwanted children
- Access to reproductive health services is a cornerstone of preventative medicine of which we hear so much. If funding for sterilisation is withdrawn, then access to the full range of contraceptive options is denied to the most vulnerable members of our community. At a time of food banks etc. this would set us back decades. Sanitation, sewage management, clean water, reproductive health services childhood immunisation, female education are the established first steps to the health of a community. Contraceptive services work best when men and women can choose from the whole range of options available. To limit options on the basis of ability to pay is discriminatory.
- One person made the point that people have different incomes and there needs to be a balance
- Is a vasectomy something every couple can afford? Doesn't this penalise those people who don't have much money.
- One man felt that it should depend on income (i.e. be means tested). He also shared that he thinks it's a choice and there are some people who can't even have children.
- I'm particularly concerned if the full range of family planning options only becomes available to families who are better off and can afford to go privately. These proposals will disproportionately affect people on low incomes – contrary to NHS principles of comprehensiveness, universality and mutuality and contrary to the requirements of the GP contract. Access should be based on equity, fairness, clinical effectiveness and cost-effectiveness. The amount saved overall is low (£40k), but the likely cost for those who go private is significant (£450-£900 – considerably more than NHS costs). The proposals also do not evaluate other knock-on costs – both to the NHS and to wider society – arising from an increase in unplanned pregnancies – or compared to the ongoing costs of other options.
- Those on low income that cannot afford for further children are always the most vulnerable when cuts are made.
- I disagree with this proposal because it restricts these options and choices to those who can afford to pay. I believe that contraception and the right to choose to have a family or not, should not be based on the ability to pay. If someone is seeking a vasectomy or sterilisation I suspect they have thought carefully about what is right for them and their family. Apart from this, I imagine that the implications of an unplanned pregnancy are greater than the cost of the procedure.
- The patients that need it the most are the poorer residents who will not pay privately for this. This will increase unwanted pregnancies and result in increases to child protection needs. More children also living in poverty or feeling unwanted.
- It will restrict who can be eligible and on a personal wealth basis.
- I believe that everyone should have access to these services regardless of their financial situation. People who cannot afford to pay for these will also not be able to afford babies.
- I think vasectomies and sterilisations should be free to people who cannot afford to pay for them. This is another tax on the poor
- I think this proposal in inherently unfair. And targets lower income families/people. Funding should be sought from the government to provide a comprehensive service through taxes. Commensurate with people's earnings.

- This proposal seems incredibly short sighted - taking into consideration the cost of pre-natal, childbirth, postnatal and early care for children (i.e. vaccinations, health visitors, midwives etc. etc.). By removing these procedures on the NHS, those unable to afford to pay privately will seek less reliable / permanent forms of contraception.
- Her son wouldn't have it if too expensive - unfair.
- Responsibility different for men.
- Wishes her son had had it done and needs access to it.
- One way to save, money. Had one in 1981/82 and wouldn't have been able to afford it.
- One woman considered getting sterilised herself, but felt too final (as tried really hard to have children). Feels, if woman's only option, should be entitled (avoid unwanted consequences).
- Down to couple. Especially if have had 3/4 children and contraception not good for you. Man said he could potentially be affected by proposal.
- Shouldn't have to pay for anything.
- This wouldn't cut costs, as impact on maternity services.
- Huge risk in unwanted children and children going into care. Funding strains felt elsewhere. Is there evidence of how well children do who have been in care/costs to other agencies? Are terminations more or less expensive? Need more information about consequences.
- Man said he could pay, but would have to save.
- Going that way for all medical treatment - hard question. He had major heart treatment and he would have paid if he'd had to. NHS worked pretty well when it was formed, but this is a basic problem of overloading the system.
- Instead of criteria, introduce income threshold rather than exceptional (extreme) circumstances. People have to apply for IFR and may be put off due to pride. People often don't claim when they should. Woman would be in a position to pay privately, but lots, arguably more affected, wouldn't be able to.
- Means one thing for one person and something else for another. Socio-economic circumstances can change, mental health issues can be changeable, support networks around people vary. Are there drugs-based sterilisation options? Councillor wouldn't be personally affected, but residents could be.
- If people can afford it, ok, but if you can't, you can't. Depends on circumstances. She was going to be sterilised after having had three children, but complications with blood pressure and had to have clamps put in after birth. Her sister's husband had a vasectomy before Christmas. She would be affected by the proposals. Couldn't afford treatment immediately, but could over time possibly.

Savings too small:

- Drop in the ocean in terms of money that will be saved.
- I feel deeply uncomfortable about the restriction of male vasectomies. I feel that that the potential small financial gain does not offset the potentially detrimental effects of limiting a man's ability to access the only form of long acting contraception available to a man; with potential financial burden and psychological distress accrued from unwanted pregnancies/termination of.
- This proposal estimates a saving of £40,000 per year. If we take the figures quoted for the number of people accessing this service last year (approx. 165), what do you estimate the cost to be if this number of people per year are denied

sterilisation services and continue to have more children? People who choose sterilisation generally do so because hormonal or barrier methods of contraception are ineffective for them. You state that the need to make savings is partly due to increasing population, yet suggest cutting funding to a service that would help limit population growth. This does not make any sense.

- My sense is that it probably doesn't account for a great deal of the budget and will serve to grab "restriction" headlines
- As a GP in BANES I have seen info that this will only save £200,000. Those patients we really want to have vasectomies are those most likely not to be able to afford them if there is a fee to have the procedure. I can see this lead to an increase in the use of contraception in their partners or unwanted pregnancies which has both an emotional and financial cost. Many men seek a vasectomy because their partners have difficulties with contraception and as a one off cost I think it is reasonable to allow free access to these methods of contraception. The CCG could save money by not publishing the magazine we get every so often that is never read by any member in the Practice.
- Preventing people controlling their fertility results in very bad long term outcomes for very small savings
- Someone said that the savings would be tiny as such small numbers use the service
- Contraception is an essential element of public health. This will save very little money but impact most heavily on the most vulnerable people in our community. I don't think there are non-essential services in the NHS. It needs to be made clearer to residents of BANES that funding no longer covers NHS services and services are therefore being privatised.
- If you want to save lots of money why are you choosing a procedure that you say isn't used by many people. £80-£100k doesn't seem much of a saving. Also, surely if people have these procedures then the CCG would save money on prescribing contraceptives? As an aside, you would probably save more money by ceasing to fund abortions, however politically that would be unpopular, even though sterilisation is as much about giving women a choice, without the need to harm a child in the womb. Either way, it seems a relatively trivial sum which will then be spent on funding contraceptives for those who aren't able to use these withdrawn services.
- I do not think short term savings are a good idea.
- Is there a significant cost saving to be made by restricting vasectomies and sterilisation? Compared to the cost of, say IVF, I would have thought the cost of vasectomies is relatively small. Also, what about unintended consequences? Restricting vasectomies could increase costs to NHs of other forms of contraception
- This is the wrong thing to be considering. Money saved on sterilisation will be spent very quickly on maternity services and the costs associated with childbirth and subsequently care for the resulting children.
- This is false economy.

Restrict/don't cut altogether:

- I agree with you thoroughly on these two things. I see vasectomy as a social thing. Sterilisation is different, but it would have to be decided whether it was social or medical i.e. mentally impaired or life-saving.

- I know means testing is divisive but so is inability to decide your own future because of finance.
- I think you could make more steps to it- to ensure that people truly do want it. Or at a certain age. As a 44 year old woman, with a 19 year old, I know I don't want any more children.
- Vasectomies should be available on the NHS only to protect women who are in medical danger should they become pregnant
- I strongly disagree with a blanket ban, but would support tightening of criteria to save some funds. After all, costs of increased pregnancies/ births/child care (possibly with disabilities) would be a greater cost than the initial sterilization! Certainly reversals should not be available on NHS.
- Vasectomy and female sterilisation shouldn't be considered together as they're such different procedures involving cost disparity and different levels of invasiveness to the patient. Permanent contraception in the form of vasectomies should always be an option since they're (relatively) so cheap, so un-invasive, so reliable and are also the only proper method available to men. Your proposals insist on women taking all the responsibility for contraception, which is discriminatory in itself.
- I benefited from a free vasectomy some years ago, and wouldn't wish to deny the opportunity to the present generation. I suggest that a small charge for doctors' appointments, say £5, would deter frivolous visits and no shows.
- "To cut this service (vasectomy) would be to build up problems for the future of many different types, a substantial quantity of which would end up costing the tax payer money. People should be given credit for knowing their own minds and not be subjected to a load of unwanted and expensive counselling. The procedure can be done efficiently and cheaply in minor ops in primary care.
- Much the same applies with female sterilisation. The country already has for too many children who are unwanted or uncared for and we should not be preventing people from restricting their fertility. Counselling needs to be the same as above - not too much. Reducing fertility could be a life enhancing experience for many women and would certainly benefit the nation. It would be more to the point to potentially increase the options for vasectomy and sterilisation by making it obligatory for health workers to suggest it to families after the birth of the TX child and off appropriate fact sheets. "
- Introduce tighter eligibility e.g. physical/mental health risks of not having it done or means test it
- Is there currently a criteria for female sterilisations?
- One person suggested that people should be asked to pay half (e.g. £250) and the NHS pays the other half
- One person queried why they should pay for someone who is overweight etc. (and not access this service for free).
- If it is medically necessary, they think it should be available on the NHS. Shouldn't be means tested either, as the 'jewel in the crown' principle of the NHS will be betrayed.
- Needs to be discussed with those who have mental health problems and learning disabilities. Eligibility criteria shouldn't be blanket across the board. People with learning disabilities may not have children, but this shouldn't be assumed.
- If you are considering restrictions they should be around age of being too young
- Those at risk of sexual violence/rape were flagged as needing protection.

- I think there should be more stringent criteria to qualify for a vasectomy on the NHS, for example over a certain age or had children
- Limiting the number of these procedures carried out is understandable however exceptional circumstances rules out many people who may want this done as a means to improve their life, therefore it should be clear what those circumstances are and cases should be judged on their own not with one overarching rule.
- Should add to criteria re partner - explore vasectomy before sterilisation (greater success rate, lower risk etc.) this should be considered as an option.
- I think male sterilisation should be available to all, female sterilization should be on case by case
- Instead of criteria, introduce income threshold rather than exceptional (extreme) circumstances. People have to apply for IFR and may be put off due to pride. People often don't claim when they should. Woman would be in a position to pay privately, but lots, arguably more affected, wouldn't be able to.
- Means one thing for one person and something else for another. Socio-economic circumstances can change, mental health issues can be changeable, support networks around people vary. Are there drugs-based sterilisation options? Councillor wouldn't be personally affected, but residents could be.
- If people can afford it, ok, but if you can't, you can't. Depends on circumstances. She was going to be sterilised after having had three children, but complications with blood pressure and had to have clamps put in after birth. Her sister's husband had a vasectomy before Christmas. She would be affected by the proposals. Couldn't afford treatment immediately, but could over time possibly.
- One woman felt exceptional circumstances should be mental health issues, if not having it would harm someone's health.

Look elsewhere:

- You are definitely not considering the right things. Cosmetic procedures would be a better focus
- Cut treatment for obese to fund free birth control.
- Hospitality
- See 6 above. Also you should be considering not performing breast enhancement. Routine repeat prescriptions without review.
- The NHS should be properly funded. You would know better than I do what is inessential. But I imagine those things were removed long ago. I would rather see people fighting for more money for the NHS - we can afford it if we want to.
- I believe this proposal is not targeting the root of the issue, in fact it may even compound the problems by increasing the numbers of unplanned pregnancies and the resultant costs of these events. As ever, those that will be hardest hit by such a cut would be those most severely affected by the consequences. I believe that a more preventative approach should be taken to health care provision, which I know Bath CCG is working hard to implement, but more could be done. Reducing prescribing of antibiotics is one area where significant savings could be made in a short time. Public education around this subject could be strengthened locally so that people understand why they are not being prescribed antibiotics. As a lactation consultant I strongly believe that a whole lot more could be done in primary care to support breastfeeding in Bath where the rates of drop off are significant beyond the first two weeks. The evidence for costs savings by supporting longer term breastfeeding and therefore avoiding hospital admissions

for otitis media and gastro intestinal infections and are very persuasive. (https://www.nhs.uk/news/pregnancy-and-child/more-breastfeeding-would-save-nhs-millions/) How many GPs locally direct mothers to stop breastfeeding if they develop mastitis or if they need to be prescribed a certain drug which BNF says is not recommended for breastfeeding mothers? How many local GPs are using the GPIFN website resource? (https://gpifn.org.uk) Or know where to signpost mothers to when they are experiencing difficulties with breastfeeding (other than their HV)? How many surgeries have any public information in their waiting rooms about breastfeeding or how families can support their daughters, sisters, and partners with breastfeeding? It's a simple action which could make a big difference. (https://www.youtube.com/watch?v=03yQs9tAe3c)

- I think it's ludicrous and you could make savings elsewhere.
- I'm unsure in see idea relating to fertility should be restricted. Are services to unhealthy individuals restricted? Such as gastric band or gastric bypass. I do not think these should be available so freely on the bus.
- The NHS should be spending money on doctors and nurses and services, not on the big wig managers at the top of the chain. Get rid of their salaries and you could save the required money
- I understand these are non-urgent procedures. Only if they are linked to a serious health concern should they be treated that way. I feel that the money would be better spent improving the midwifery services in the area...and the health visiting service which is just appalling
- I don't feel this is the right service to cut as it is not something that most families can afford or go into the decision lightly. GPs make sure that families have the right information & discuss the procedure before referring you for this. I think it was right to stop the prescriptions for food for people with celiac as gluten free foods are now widely available. Perhaps look at these types of services for people with other food intolerances/allergies. Possibly milk for children after a certain age who have a dairy allergy as you can now buy a variety of milk that is dairy free especially as children are advised to move to milk not formula after 1 year old. Not giving out paracetamol on prescription as it's cheap enough to buy it in the shops.
- I feel if we need to save money then this is an area that is not crucial to maintain the general health and wellbeing of the population.
- You should consider charging for missed appointments, anyone who self-discharges and gets readmitted for the same reason has to pay.
- It would be interesting to see a list of other non-emergency services and what they cost
- Transport should be restricted. Prescriptions reviewed.
- You should consider saving money elsewhere.
- I think this not a service that should be restricted. I understand your need to reduce services in some manner due to funding restrictions due to the current government, but fundamentally disagree with these so-called "efficiency savings". By restricting peoples' access to fertility services, you are preventing people from being empowered to make their own decisions about a very important healthcare topic.
- Two suggestions. (1) Stop using qualified nurses at all NHS day clinics and replace them at lower cost with far fewer reception staff, but only where it is impractical to design and progressively implement a lower cost self-service

system with the support of digital and other technology. (2) Stop the multi-tier referrals, especially for diagnoses, to unqualified or support professions spread over a year or more, before the patient actually meets the consultant or his/her senior house doctor - and the patient finally gets a conclusive result and clear action. In the first place, save waste and unnecessary disappointment by ensuring GPs are entirely satisfied that a consultant referral is necessary. Save substantial sums by disbanding all the staff teams running these cumbersome and frustrating delay-services which increase anxiety and reduce confidence in the NHS. Spend some of the savings on more consultants who have the capacity to be decisive with a diagnosis and the treatment required. Back, hip and groin pain diagnosis is one example of this wasteful tiering.

- Is this really just a way of saving money - in which case why not address some more fundamental issues.
- Human overpopulation is the number one problem facing the planet. I would prefer you find savings elsewhere
- no, restrict more medications that can be bought over the counter
- I think you should be checking the cheapest ways to obtain supplies of goods: medicines, plasters, equipment etc.
- You have got the wrong one here and this not be considered at all pressure on families is intense and this will only make it worse.
- Limiting surgery for obese and smokers. In fertility, consider asking patients to contribute to the cost of treatment
- I don't understand why you would restrict vasectomies and sterilisations but continue to fund IVF treatment, surely IVF treatment is less important
- Consultants pay
- I do not support this proposal at all. Given the CCG is looking to restrict services, I think should be looking at restricting procedures for smokers, alcoholics and the morbidly obese - all self-inflicted and with significant cost to the NHS.
- Vasectomies and sterilisations are a valid and convenient method of population control. You should be focussing on stopping or severely reducing IVF
- Hugh amount of wastage in the NHS expensive nail clippers are used once on patients then thrown away. Absurd H&S rules facilitate this.
- Charges for the thousands of missed appointments. Our population should realise how valuable "OUR NHS" is and pay for missed appointments, say £20.00 each time. You will say this can't be implemented, but dentists do it. I was late once and was horrified to have to pay for £38.00 for my missed dental hygienist appointment - I will never do it again. That was a lot of money to come out of my meagreness state pension. Also so much mismanagement happens, like the £250.00 clock at the new Southmead Hospital, which was unreadable. Wastage is terrible. Would you like me to offer free advice on how to use common sense to save thousands? I had to learn how to manage my budget and I manage very well 70 years of sensible thrift.
- Without a wider presentation of your patterns of spending it is hard to identify alternative saving plans. I would observe that the ability to prevent ill health and extend the years people can remain independent is likely to deliver greater savings than the relatively small savings associated with individual moves like this. But acknowledge it is all elements can contribute and funding is hugely challenging for trusts at present
- Maybe charge people who miss appointments

- We should be looking to renegotiate with the provider, not make cuts.
- I think these are a good idea but also restricting medication that could be bought over the counter
- I understand why the CCG would look to make these restrictions, but are these the right procedures to be looking at? Should the CG another maybe focus on the astronomical amount of Laparoscopic Cholecystectomies currently on the waiting list for elective surgery? Also Hernias (which I know are subject to INNF funding approval, but I don't think any ever get turned down. Some of these patients should be hitting some kind of criteria before being listed / approved.
- Stop other unnecessary surgery such as sex changes. There is evidence that it doesn't improve the mental state of those who have the procedure and is excessively expensive. Should be limited to private options only.
- Stop giving cosmetic surgery to weight loss, stop giving obese people gastric banding
- Wastage in purchasing
- Targeting the wrong category. More consideration should be given to the amount of prescriptions given out. I have been in an unfortunate position of having to return unopened and in date medication to pharmacy only to be destroyed. This should be unacceptable practice
- I don't think it's right to consider sterilisation completely apart from all other contraceptive methods.
- Could also consider assisted conception services.
- Bariatric surgery shouldn't be free without self-help first. I strongly believe free prescriptions should only be for the medicine needed for the ailment which renders the scripts free, and NOT for any other prescriptions. This would save the NHS a huge amount!!
- These procedures should continue to be available to all. Stop treating alcohol related injuries in A&E. Charge people for missed appointments.

NHS should be properly funded:

- Maintain the current free service and put pressure on central government to provide the funding.
- No services or jobs should be cut. Central government are evidently pushing the NHS to breaking point and CCGs should be explaining this in clear terms to people so that we are informed in our political choices.
- You are, in my opinion, misinterpreting "your duty". You it is your duty to operate within the budget set by government; your duty instead is to stand up to this corrupt government, to be a voice for the people, for the good of our shared society. There is no shortage of cash! It is, however, stored in tax havens. Government acting for society (for civilised society) would collar that cash and direct it to where it is needed. For example EE recorded sales of 6.3 billion but paid zero corporation tax. That's where the missing funds are. Government must end tax avoidance and then end this needless austerity programme. If you want more info about the awesome scale of tax avoidance UK I can supply it! So: you have a clear duty: to refuse to play along with the NHS privatisation. 84% surveyed by YouGov said they wanted NHS to remain publicly owned. Government is ignoring the will of the people.
- I think you should refuse to cut NHS services but making a stand against the erosion of this public service. The austerity drive is a political option for the

government but there are other options open to them. This is the wrong option. We risk death (of the NHS) by a thousand cuts.

- These proposed cuts are completely untenable. They would have an adverse effect on aspects of health care which contradicts the meaning of a National Health Service, and would have disproportionate consequences for women and the poorer section of the population. Rather than cravenly accepting further budget cuts, a responsible CCG would just simply refuse, and demand that the service is funded adequately (we now spend about 2% less GDP than other European nations)
- Countries such as France and Germany spend twice what the UK spends on health services. Concern that the health service is being destroyed
- Members asked what the consequences of not balancing the books would be. TC explained that the CCG would be classed as inadequate or potentially put into 'special measures', whereby the Board would be subject to external control and a 'Turnaround Director' would be brought in to make, what are likely to be, draconian cuts.
- One woman felt that the services be offered for free on the NHS (as that is what the service is there for).
- NHS cuts to non-urgent services, but non-urgent services may still be vital services
- This current body of health commissioners are not doing the best for PATIENTS, patient care or even doing more than paying lip service to patient groups across the UK. That is because they are merely the puppets of current Conservative policy that is only focused on cuts. This is not what the people of the UK want or pay taxes for. The corruption is huge and patients are suffering. We need to save EVERY current NHS building and local service we have, until this government is out of power and we can have rational debate about how to fundraise for NHS, in future. At the moment all cuts and closures are purely ideological, in order to bring about private health insurance. Nightmare. We in Bath are losing the Royal National Mineral hospital, a beautiful, historic building with several wards, for rehabilitation, and instead they will waste millions on building a new tiny outpatient clinic building. Thus, they spend millions to lose 3 wards.....SAVE OUR NHS. And even though the building is worth close to £100, million, there is a local campaign supported by Santander bank to 'raise £2 million' for the new build!' where is the sale money from the building going? Presumably on CEO's of NHS England's bonuses or pensions?!!
- I think that you should not be salami slicing the NHS by the death of a thousand cuts and restricting life-altering treatments to those who have enough income to afford them. This sounds like a return to the iniquitous health system that existed before WWII. I remember my mother telling me of how the poor suffered awful disease and bad health because of lack of free provision. The NHS should remain as one of the jewels in this country's crown.
- The NHS - as with any public service - needs to be free at the point of need. If it ceases to be free at the point at which people need it, it opens a much wider debate about whether people are willing to fund it on a universal basis. On the basis that it will be there for me and my family I am very happy to pay high levels of NI and Income Tax to pay for it. If it ceases to be available to me or my family I may be less willing to pay for it. I would much rather see charges for people making frivolous use of GP services and out of hours services for things like a common cold or a virus than a cut in funding for surgical procedures - withdrawal

of the latter will have a far greater impact on the wellbeing of individuals and their families

- One person felt that the NHS should be free (across the board) I
- think it's just another step towards privatisation of our NHS,
- Authorities/Trusts must so more to share how underfunding the NHS through government policy is ensuring NHS services are slowly no longer free at the point of use.
- Nothing you do should undermine core principles of the NHS like this. By doing so you are complicit in a political change towards privatisation on the NHS and you need to have the leadership as a trust to push back hard against austerity before the people of BANES lost all faith in the trust
- I feel very concerned about the proposed restrictions and feel with are entering an environment where value judgements on people's lives rather than what is medically feasible and appropriate is playing a part in decision making. This stems from having a poorly funded health service and you should be considering presenting the real costs to the public and encouraging the public to see the worth in a properly funded health service.
- The NHS should be funded adequately. Vasectomies should continue to be available for all as with alternative contraception.
- You should be considering how to get the funding for these services rather than cutting back. People will pay a bit more tax for a better service.
- No you are not considering the right things. Try stopping employing meridian to do time in motion studies. Try not privatizing the NHS. Try cutting layers of management. Try funding the NHS properly. The people are willing to pay to keep the NHS.
- This is a really difficult decision to make and one that local CCGs should not have to make. National pressure has created this situation and I feel a national policy decision should be taken which doesn't disadvantage patients in different areas. I was dismayed when I first heard the proposals but over time I have felt that the proposals, amongst other difficult decisions, are necessary to maintain other urgent healthcare services. These selections set a very real benchmark for what the CCG will be willing to fund in future, if agreed.

Concerns over process:

- YOU HAVE NOT OUTLINED YOUR REASONS AT ALL CLEARLY
- Male attendee asked if he is able to have the contraceptive injection and support worker explained that this hasn't been developed for men and only options are condoms or a vasectomy.
- NHS communication with people with learning disabilities is poor and people end up in hospital for days, which could be avoided if support workers were listened to. They said they use health passports, but there is a lack of awareness of people with learning disabilities' needs. The Learning Disabilities Liaison Nurse at the RUH doesn't work at weekends, and they felt this should be a full-time role.

Comments/Questions:

- One woman felt that people with severe mental illness/paedophiles should be sterilised. She also shared views on how the planet is overpopulated and she thinks that people should only have children in their native country and those choosing to immigrate should be sterilised. She gave an example of the 'two-child

policy' in China causing people to leave the country and have more children elsewhere.

- Certainly these but also gender reassignment
- Unsure but this is targeting a specific age group against a backdrop of an increasingly aged population.
- I am a GP with letters of competence in intrauterine contraception and subdermal implants. Laparoscopic sterilisation is less effective than other LARC methods and more invasive. I agree that funding for this should be restricted. However, male vasectomy is an effective method, and the only “male method” of LARC. It is a relatively inexpensive method as it only involves a minor operation under local anaesthetic. Compared to unwanted pregnancy, the cost of vasectomy would seem to me to be fairly low. I have not looked into detail of this however and would be interested to hear your financial case for it.
- One member asked if people who have learning disabilities would be able to access vasectomies/sterilisations in ‘exceptional circumstances’? DC said this is a possibility and it would depend on the patient.
- Someone asked whether we are the first place to suggest this.
- I'm a GP; I work in Wiltshire but live with my husband and 2 daughters in Bath. I am a member of the Faculty for Sexual and Reproductive Health and am a qualified coil and contraceptive implant fitter. I have filled in your survey to raise my concerns about removing funding for vasectomy in BANES. I feel that grouping vasectomy and laparoscopic tubal ligation together is mistaken: the latter is less effective than other long acting reversible contraceptive methods and involves abdominal surgery with its associated risks. I therefore never recommend it to my patients. However, vasectomy is effective and (although I couldn't find any specific cost-benefit analysis) must be relatively cost effective, as it can be delivered as minor surgery in a primary care setting. I would be interested to hear:
- C-Card scheme should be available more widely. Hard to get
- Condoms should be cheaper.
- One woman has been on the waiting list for sterilisation for five years (she has nine children and mental health problems)
- Women in the group have had differing experiences with contraception. One woman has had a positive experience of being on the pill. Another woman had to have the coil removed (at the Riverside Clinic), was pregnant and miscarried (she would have had an abortion if she had not had a miscarriage).
- One homeless man shared that people living in poverty/who are homeless don't know where to go to access services.
- One man shared he had a vasectomy in his 40s (he paid to have it done privately), due to NHS waiting list.
- Three of the women in the group have the contraceptive injection and one woman has the implant (she tried the injection, but didn't like the needle/having to have it every 6-8 weeks). One of the support workers asked one of the women who has the injection if she understand what this is for and she confirmed that she does. Support workers explained that the contraceptive injection is often the method used out of convenience for support staff (it's easier to manage)
- People with learning disabilities get bypassed in terms of sex education. There is an assumption that they won't have sex/children

- No, it would be better to stop unwanted children from possible neglect etc. and to stop extra costs on the council
- I don't believe that individuals opt for these procedures without thought, consideration and weighing up pros and cons. Counselling on the long term effects of these procedures is provided. If comparable data is available regarding male and female sterilisation procedures it would be interesting to see which is dominant. There are, I imagine, many forms of contraception available for females that can be invasive, mood changing, weight changing etc. I'm unclear if it is the same for male contraception. If plastic surgery procedures are funded such as types of breast surgery, should we not fund a procedure that shows an individual is being responsible over a procedure where the individual has a perceived negative body image
- Concerned that those people without mental capacity will not be able to access a reliable form of contraception
- As a resident it is hard for me to make an assessment here because you haven't provided me with enough information: what is the cost of this service and how often is it used in the area? How much do you stand to benefit and how many people might be impacted?
- Other forms of contraception are not 100% effective 100% of the time. I think that the permanent option of a vasectomy or sterilisation should be available on the NHS. Especially in cases where people are unsuitable to be parents, it's unfair for a child to be brought into a family that cannot care for them.
- I am not as concerned about IVF treatments
- My husband's vasectomy was performed in Bath. He found it painful and uncomfortable it was nice to be able to get home quickly. We would have travelled into Bristol if required.
- I think this is the thin end of the wedge and that if you go ahead with these restrictions you will then try and introduce more.
- I am not suitable qualified or informed to respond to this question.
- Down to couple. Especially if have had 3/4 children and contraception not good for you. Man said he could potentially be affected by proposal.
- Shouldn't have to pay for anything.
- This wouldn't cut costs, as impact on maternity services.
- Huge risk in unwanted children and children going into care. Funding strains felt elsewhere. Is there evidence of how well children do who have been in care/costs to other agencies? Are terminations more or less expensive? Need more information about consequences.
- Man said he could pay, but would have to save.
- Going that way for all medical treatment - hard question. He had major heart treatment and he would have paid if he'd had to. NHS worked pretty well when it was formed, but this is a basic problem of overloading the system.

Q. Would you be affected by these changes? If yes, how?

Sterilisation:

- Limit male procedure cutbacks to reversal procedures which have less clinical basis
- We already work with the CCG on a number of initiatives that save money.
- Restrict treatment for smokers and those with high BMI.

- Assisted suicide options for those in elderly care, where they see no meaningful recovery. Having experienced two grandparents with dementia drain their financial resources within a short period to pay for their care (excellent level) and then having to return to state funded care (horrendous) I know they both would have planned Assisted Suicide if such option was available. I know the financial savings are needed, but their care levels dropped significantly, it was heart-breaking for all of us to see.
- Invest in preventative health projects e.g. breastfeeding support services which focus on helping mums with positioning and attachment etc. can reduce the amount of prescribed formula and Gaviscon that the CCG fund. Adequate care pathways for GPs mean that they can better identify an issue that can be dealt with by better supporting mum with feeding rather than prescribing something. Breastfeeding has a positive impact on oral health, childhood obesity levels and emotional well-being.
- Campaign against government cuts.
- Demand more money from the government/cut some top salaries
- Make it available for those who can contribute at the time of treatment to do so discretely. It won't be popular but the time has come! I have worked 35 years in the NHS.
- None (as retired!)
- When new medication prescribed by GP, just one or two weeks given as some people do not tolerate new tablets and many returned to pharmacies to be binned.
- Refer the way patients are notified of appointments. We found there are too many letters sent incorrectly or duplicated. There is also confusion very often when one is required to ring the hospital regarding treatment and appointments.
- Stop funding fertility treatment totally. It's a luxury health service and the money would be better spent on heart/cancer or life threatening problems.
- Fewer people using ambulances as taxis.
- No
- Charge for missed appointments, telephone or internet appointments with GP for some problems; charge pensioners a small amount for medicines.
- Stop funding cosmetic and IVF ops, money should only be used for necessary procedures and treatment.
- I wish I could
- No
- Refuse to treat smokers if they don't change their ways
- Training the public to look after themselves properly.
- Ensure patients can see a GP in a timely manner without having to take time off work to do so.
- Not allow paracetamol and cheaper over the counter medication on prescription.
- Make RUH more efficient and accountable
- It's a very difficult and contentious issue, but I suspect that considerable sums are spent on keeping alive some of the elderly whose life is such that they would rather not be kept alive.
- A tighter rein could be kept on the pilfering in hospitals which occurs at all levels, and the return of unused and unopened medicines from patients who have been over prescribed or no longer require them, whilst they are still in date.

- Something that can prevent people needlessly visiting their GP or hospital for inadequate reasons. Self-cure (such as bed rest) should be promoted more
- Better primary care triage. More restrictive times for non-emergency care and more penalties for non-attendance. Be braver on end of life care and focus on quality of life and not length of life.
- More use of pharmacies as 111 for triage
- Income means based funding for small scale non-essential local anaesthetic procedures.
- Spend money on prevention of unhealthy aging. Generally promoting exercise more, working more closely with educational partners.
- Make sure that social services provide support to people that need support rather than them using up hospital services as proper support was not available at home.
- Talk to clinicians and listen to them. Stop the airy fairy WIA talk. Stop making sweeping changes that cost huge amounts of money with no perceived benefits. Charge £5 to visit GP with the exception of elderly, children and people on benefits. Stop services going out to tender as they are enormously costly exercises in time and admin with often no benefit or savings.
- I think this is difficult, clearly cuts need to be made but at what cost to the residents of BANES? It seems that looking more closely at self-care and how those in the community can manage their health in a better way so that there is less impact on the healthcare system. Giving involved with local communities and working out the best ways to do this would be a step forward but also being clear to residents about the reality of the situation and giving local people a chance to have their say and input into what will clearly be some major decisions for the people of BANES.
- Have long term strategies with good agreement by all. Establish cross party agreement for general NHS policies rather than new governments scrapping policies. For vasectomies have GPSI in performing them fund the training to upskill the GP workforce in this area
- Cut Executive jobs.
- Social / hospitality functions
- It is essential to take the Long View. Both the stopping of vasectomies and sterilisation save absolutely nothing in the long term when complications of pregnancy, disabled children born to older mothers, unwanted babies going straight into homes where it is acknowledged the children have fewer life chances and therefore may never earn a living wage and will always be a drain on social services. The world is drowning - a stitch in time saves a colossal amount of human suffering and COST. I don't know how you can even suggest this.
- Ask patients to make a voluntary contribution to any stay in hospital, if they can afford to, to help fund your services. Ask people to pay for A&E services if they can afford to. Help people to realise that the NHS is insufficiently funded.
- See above. (9)
- Look at different options that don't have a major impact on people's lives!!
- No
- Start at the top of the chain with the big wigs
- Prioritising treatments. I would rather my money spent on saving a child’s life than on someone deciding they can’t be bothered with birth control!
- See question 9

- Stop funding for prescriptions that can be bought in supermarkets or chemists
- Encourage and educate the local population to 'take care' of the NHS by using its services appropriately
- Run AF clinics and educate re. opportunistic times medical staff can test for AF and start anticoagulants to prevent massive strokes, which cost the health service enormous amounts of money and dramatically affect people's lives.
- Review admin top staff
- Restrict treatment to those who continue to smoke/refuse to change lifestyle
- Alternative arrangements for mental health care as an alternative to going to A&E when in crisis. A&E is not really a suitable place for dealing with mental health crises, but I have attended for this reason recently because there was nowhere else for me to go. I would suggest instead you could work with voluntary organisation e.g. Mind to develop a community "safe place" for people in crisis with psychiatric nurses and a psychiatrist, in addition to counsellors and voluntary staff, to safely guide people towards recovery when presenting with acute mental health issues.
- Please see 9 above, if that's within the remit of the CCG. Presumably the productivity and costs of different parts of the operations of service providers are measured, compared and used to make the case for reducing costs. Rather than just rely on total costs. For example evaluation across service providers of Nursing numbers and the mix of pay grades, against patient numbers and outcomes may also identify areas where savings are possible.
- Stop patients missing appointments - e.g. 3 strikes and you are out!
- No
- No, sorry but it is a false economy to cut back on the above services when child costs, including benefits are so much higher than the savings you wish to make.
- Cut senior management and those that due jobs that only generate a paper trail
- Become more efficient, fine people for not turning up to and not cancelling appointments, stop wasting money paying for expensive private care when you just need to sort out some more beds in your own wards, stop paying for expensive agency staff, make NHS staff work all day rather than leaving early, deal with the fake sickness culture among staff
- Consultants pay
- If the CCG wants to restrict services, I think restrictions on smokers, alcoholics and the morbidly obese should be brought in. These activities cause much ill health which is largely self-inflicted and it costs the NHS a huge amount of money treating people who do not do their utmost to look after their health. People wanting sterilisations do not cause the CCG a significant amount of money and are being targeted as an 'easy' target as a large proportion of the BaNES population will not want a sterilisation procedure. Presumably the CCG is choosing this route (despite it not saving large amounts) to reduce negative media attention about service cuts. It is wrong to punish a small proportion of the population.
- Stop translating documents into foreign languages - if they can't speak English and are resident here they should not be eligible for treatment. See other page for money saving tips.
- Thousands doctors should be caring for their patients as what I have seen they are not expert in managing budgets people who are should be employed and if they can't make changes for the good they should be dismissed without huge

hand outs and pensions. Having people who are accountable and held to account and rewarded if they actually turn things round and save huge amounts of taxpayers money should be rewarded with decent wages, not given huge wages without any incentive to turn things around. This is probably government stuff, but get rid of 111 call centres who send everyone to A and E bring back doctors who work so that when they have time off there is always a duty doctor 24/7 to cover for them or have a GP surgery in every A and E. The government should train doctors and nurses free on a contract where they have to work in the NHS for enough years to cover their training (not part time NHS part time private, or agency nursing). Everyone should think of ways to cut expenses from patients to staff. I have noticed that many office staff let down the medical staff which wastes vital medical time. I love the staff at RUH, they are undervalued they often work too many hours and I have seen people screaming out for bed pans and only one nurse is caring for too many people, resulting in the patient messing the bed so the expense of laundry, loss of dignity for the patient and the worse horror of watching the small nurse rushing round then forgetting to wash her hands before she rushes to the next patient.

- Less locum/bank nurses - the cost for these nurses is huge - they very unfairly earn far more than an equal/sometimes higher qualified person on the same shift. Don't waste money on services that would be better served in-house instead of going to Virgin Care. More Indians and less chiefs!
- You haven't set out any info here about that, so this is a weak and invalid question (I'm a consultation specialist).
- Make people who are working pay to go in to a and e on Friday and Saturday
- Presumably there are savings in the prescribing budget if the campaign to reduce antibiotic use is successful, perhaps these savings could be used to subsidise the sterilisation services. Large amounts appear to be spent on administration and salaries from your annual report. Maybe these costs could be reviewed.
- More preventative investment notice a lot of strip lighting in the RUH - maybe consider more energy efficient solutions to lighting (LEDs). Possibly a charge for missed appointments, to deter time wasters, though not if the person calls to cancel. And I wonder if all those posters on healthy lifestyle choices are really worth it/should be the NHS's remit. Perhaps the onus could be put on the government so unwilling to fund you to provide such messaging, and leave the patient care to you.
- No
- False economy to do this.
- certainly make people more aware of other options, as for some the choice of non-permanent methods may be preferable, however it seems unfair to remove the option of permanent contraception
- Vote for a political party that actually believes in and supports the NHS and find it properly. Protest instead of kowtowing.
- Stop translation services
- Not hand out unnecessary items
- More streamlining of purchasing process, as well as consultation budgets.
- More practical support
- Being more discriminatory about the number & type of diagnostic imaging requests made. The type of information required should be weighed against the usefulness of the test to provide that information.

- Put more funding into health improvement, health trainers, breastfeeding support, encouraging exercise, helping improve mental health with outdoor activity groups
- I have no suggestions as I no longer work in the NHS, but I am very disappointed with the way we are heading.
- REQUEST AN 'EXCESS' OR CONTRIBUTION TO GO TOWARDS SUCH PROCEDURES
- Reduce the number of non-medically trained managers
- Attempting to introduce criteria based treatment such as this is morally wrong and undermines the core principles of the NHS. If the leadership of the trust does not have the will to fight bark hard and publicly against the failed policies of austerity that have led to this point then I suggest new leadership is needed
- Abolish the internal market and cut down on management.
- Publicly lobby central government for increased funding
- DON'T MAKE SAVINGS - DEMAND MORE FUNDS!
- Invest more in health creation in communities.
- A small charge against broken doctor appointments. Cut down wastage on prescriptions.
- I would prefer small charges for some things as in New Zealand except for those in poverty or with long term conditions
- stop paying for homeopathy treatments, send multiple reminders of an appointment- like a week out, 1 day before and then that morning- to try to reduce missed appointments.
- Employ occupational therapists as part of the primary care team
- Reduce costs of inter-departmental charges in RUH - one dept. charging other ridiculous fees for changing lightbulbs etc. Costs of having to use NHS suppliers when B&Q etc. is cheaper (e.g. drawers/ tables etc.) Might also be cheaper to employ craftsmen to make more items bespoke? Our new computer trolleys cost £1000 each - crazy!!
- Look at savings to do with waste of medicines, old and inefficient contracts with trusts and providers, re-tender services to make sure you've got the best deals, stop offering free prescriptions to women in their first year after having a baby (unless they're eligible for other reasons)
- See above.
- Not cutting access to services that prevent unwanted pregnancies like sterilisation and vasectomies. Unwanted pregnancies are more costly to individuals' psychological wellbeing and cost of providing abortions. Savings can be made by having better screening methods for conditions such as diabetes outside of having to go to GP surgery, early detection and less appointments are positive savings.
- Improve access to healthy living
- Stop publishing the magazine. Look at some of the very high cost items that it spends on and see if these could be reduced.
- Lobby central government to increase funding
- No free tattoo removal, breast enlargement (other than post mastectomies) reduction following enlargement surgery, cosmetic treatments other than following accidental or medical trauma/damage
- Focus and investment in primary prevention/lifestyle factors and encourage people to take more responsibility for their own health

- We should be lobbying central government for adequate funding. Accepting defeat over this matter will lead to greater and greater cuts, to the point that truly essential services are unsustainable.
- Streamline health and social care for the elderly. This is surely the biggest winner if someone can get it right? Bed-blocking costs millions. Also, let's pay our nurses more and get them to stay on post training, and reduce the amount of money spent on agency staff. Buy every GP one of those desk-top testing kits which shows the patient if the illness they have is bacterial or viral, thus allowing the GP with firm conviction to send patients away appropriately without antibiotic prescriptions.
- Fine those who regularly don't turn up to medical appointments
- The CCG should challenge the funding allocation from the government that is making these cuts necessary instead of meekly following every dictat.
- Are you using all the best methods to fully utilise appointments, theatre time etc. Do you pick up on best practice elsewhere? My recent podiatry appointment at St Martins was a shambles. I was 5 minutes late as I could not park anywhere. I could not book in on the screen (I was told by other patients that they never work) and could find no labelled door to ask at for Podiatry. I could not get hold of anyone on the phone appointment line. The hospital receptionist could not help. I eventually found the person I should be seeing by asking a Physio. By this time 20 minutes into appointment. I think this is contracted out to Virgin care Rubbish.
- Think about wages which the top staff are on. Fight to save the NHS. Look at bureaucracy.
- Saving could be made via better efficiencies of procuring contracts that are cost effective. Through better procurement and contract management NHS funds could be better managed without the need to reduce services to the existent which is being suggested in this survey.
- Get people out of hospital beds as soon as they are able to leave. The number of times that people stay an extra night because the ward round was fairly late on and the paperwork wasn't processed fast enough.
- I would suggest restricting fertility treatments even further than your proposals; taking more active measures to discourage people who go to the GP when it is pointless, such as when they have a cold or flu - the GPs can identify the 'frequent flyers' as they call them, and surely have some ideas on how to address this problem; look at a scheme for charging people who wind up in A&E due to drunkenness; making sure that foreign nationals pay for A&E visits after treatment in the way we would have to do in their country - this isn't always done.
- Reduce red tape/ highly paid management. Reduce about of resources wasted. Long term planning. Thinking about the knock on consequences to other services/funding streams
- Without being aware of the full extent on offer I'm not sure. I've been sterilised through the NHS and am aware this procedure is not funded through private insurance. This is an service I feel should
- You have not at all explained the scope of the CCG - which I assume stands for Clinical Commissioning group? Therefore this question cannot be meaningfully answered. The only place on this form that says anything which might correspond to the CCG is under the logo on the front page, top right corner!

- Overseas visitors should have to pay for non-urgent treatment. I have worked in primary care and health tourism is a big issue. Over the counter drugs should not be available on prescription.
- Think of more ways to make money rather than cut back. Put on charity events, crowd funding, get people on the street raising money.
- Since Dr Shipman was discovered bumping off his patients there has been a great deal more keeping the very old and frail, and those with catastrophic injuries, from birth or accident alive. I have worked in health and social care for my whole career and have seen many changes. When I started the elderly were allowed to die when the time came, now they endure aggressive treatment. (Major Surgery into their 90s antibiotics for yet another chest infection, aggressive treatment for devastating strokes etc. Even when Advance Notices have been written.) All of us working in the system said "Please don't let anyone do that to me". Death is not optional, and there is such thing as a good death. If we don't want to be kept alive with little quality of life it is up to us to make our feelings known. Perhaps a campaign to makes us all make our wishes known would be a +ve step. The authority must spend a great deal on long term health and social care on patients who no longer wish to be there.
- Put a stop to medication and surgery for people with body dysmorphia and give hem counselling instead. End of life care pathways instead of keeping alive at any cost.
- This is a matter for government and legislation to provide more money for the growing and changing needs of Bath.
- Charge people for cancelled appointments
- Stop funding IVF completely.
- Less management, less meetings, less paperwork,
- High up bosses should take a pay cut, don't make those of us who pay for these services suffer while your boss's can afford every private and live off a wonderful wage!
- Band staff wages fairly and stop using extortionate pay scales to Management and above
- I don't know what you've tried already.
- Put more money into preventative healthcare
- Perhaps if there was a financial report available that I could easily access and understand, I would be able to answer this question in a more informed way.
- Less managers, more efficient systems
- Look at your purchasing, for example wound dressings, try to bulk buy from specific companies
- I think there are more savings to be made in funding of prescriptions; whilst pregnant I could have afforded to pay for them. Working more closely with the local providers around gain shares to incentive the trust to work hard to make savings that aren't then just passed straight on to commissioners. I do recognise that this is a difficult decision and savings have to be made somewhere I just feel that these restrictions will affect our most vulnerable groups and will ultimately lead to more costs later on (approximately 9 months).
- Rationalise prescribing
- Change pharmacy contracts so that they work as part of general practice would significantly reduce over ordering. Fine patients for nonattendance of

appointments. Work on getting coding correct for hospital admissions and thus correct tariff.

- improve social care to reduce need for hospital admissions
- Improve access to community beds to reduce over-stay at RUH in more expensive acute beds
- no
- Perhaps there could be some savings in prescribing budgets by using the cheapest and only prescribing what is essential for patients and what they are taking (e.g. my parents and some of our friend - not B&NES residents - manage to stockpile or 'bin' quite a lot of their medication. My friends all say their parents don't take all of their prescribed medication. Look at medication for pain management too. Would there be benefits in increasing social prescribing as a means of reducing the pressure on CCG and primary care; and could social media support people to self-care and use GPs/NHS less
- Not being party to the costs of these procedures, difficult to say. Having recently spent several weeks in hospital, I could see much waste of resources caused by rigid outdated practices.
- I would rather that the CCG was rather less supine than it appears to be and makes more obvious efforts to ensure that the NHS is properly funded.
- As above
- Close down unnecessary committees and slash managerial salaries
- Charge for fertilisation services which I think it is reasonable to cut back. Consider a means test of potential charges for sterilisation - with a few steps up in charges rather than “free” to “full charge”.
- Trial more task sharing in vasectomy and sterilisation services. It is absolutely unnecessary to use a consultant urologist - see the WHO’s guidelines on task sharing in MNCH services
- Ensure that all health "tourists" are compelled to pay in full for any NHS service s they may receive, services funded by the UK tax payer.
- Look to improve the management at Bath RUH.
- Reduce bureaucracy, unwieldy management structures and admin roles.
- See answer to question 9
- More preventative measures will reduce the costs of curative measures. For example: health education; promoting healthy diets (get rid of the confectionery vending machines in the RUH); better organisation of district nurse visits. Look at medical service provision systemically.
- Ensure those accessing your services have a right to do so and charge those who do not PRIOR ago treatment as is the case in ALL a private hospitals.
- Difficult. I don't think they should have to, more funding should be available. I don't know enough about it to make suggestions, but I'd like to see how this suggestion would be a net benefit in anything but the very short-term.
- The CCG is completely failing to address the alarming rise in obesity in the general community. If more money and effort can be expended on that, saving will result because fewer obesity-related illnesses and disabilities will arise.
- Unpopular opinion time, bet this one won't get published! I would suggest paying your executives a little less and trimming away some of the unnecessary staff at the CCG level. (Not at service-level, though, staff are already thin on the ground enough as it is right now.)

- Still lots of waste in the system. Failed appointments. Lack of care of prescriptions. Poor checking of entitlement to services.
- Do MORE sterilizations and vasectomies!
- Employ staff on proper contracts rather than paying agencies, stop paying private companies for operations and other treatments and long term bring all NHS back into public hands.
- Treat people quicker so there are less ongoing complications. Provide better mental health and elective surgery facilities to avoid exacerbating (and therefore adding costs) conditions to the point where they become emergencies (very expensive). Listen to what people want and give it to them rather than putting in place esoteric systems and functions which are not of benefit. Sort out the computer system in health care and penalise the programme writers and software companies who do not fulfil the requirements - too much money is wasted on totally inadequate software.