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Scrutiny Committee

Agenda

Date:	**Thursday, 26th June, 2025**
Time:	**10.30 am**
Venue:	**Council Chamber, Municipal Buildings, Earle Street, Crewe CW1 2BJ**

The agenda is divided into 2 parts. Part 1 is taken in the presence of the public and press. Part 2 items will be considered in the absence of the public and press for the reasons indicated on the agenda and in the report.

It should be noted that Part 1 items of Cheshire East Council decision-making meetings are audio recorded and the recordings are uploaded to the Council's website.

PART 1 – MATTERS TO BE CONSIDERED WITH THE PUBLIC AND PRESS PRESENT

1. **Apologies for Absence**

   To note any apologies for absence.

2. **Declarations of Interest**

   To provide an opportunity for Members and Officers to declare any disclosable pecuniary interests, other registerable interests, and non-registerable interests in any item on the agenda.

3. **Minutes of Previous Meeting** (Pages 3 - 6)

   To approve as a correct record the minutes of the previous meeting held on 13 March 2025.

4. **Public Speaking/Open Session**

   There is no facility to allow questions by members of the public at meetings of the Scrutiny Committee. However, a period of 10 minutes will be provided at the beginning of such meetings to allow members of the public to make a statement on any matter that falls within the remit of the committee, subject to individual speakers being restricted to 3 minutes.

Contact: Jennifer Ashley
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5. **Appointments to Sub-Committees, Working Groups, Panels, Boards and Joint Committees** (Pages 7 - 12)

   To consider a report to nominate members to the body referred to in the report.

6. **Early Release from Prison**

   To receive information on the Early Release Scheme.

7. **Cheshire and Merseyside NHS Proposals for harmonised Fertility Treatment Policy** (Pages 13 - 140)

   To consider whether proposals would constitute being a Substantial Development of Variation of Service (SDV).

8. **Review of Prevent and Channel Guidance - Statutory Duties** (Pages 141 - 150)

   To receive an update on the implementation of the national Prevent and Channel Guidance.

9. **Domestic Homicide Review** (Pages 151 - 160)

   To consider the attached report.

10. **Work Programme** (Pages 161 - 162)

    To consider the Work Programme and determine any required amendments.

Membership: Councillors S Adams, L Anderson, D Brown, C Bulman (Vice Chair), S Corcoran, N Cook, B Drake, J Pearson VR, H Seddon, M Sewart, M Simon, J Smith, L Wardlaw (Chair)

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Scrutiny Committee**
held on Thursday, 13th March, 2025 in The Capesthorne Room - Town Hall, Macclesfield SK10 1EA

PRESENT

Councillor L Wardlaw (Chair)
Councillor R Vernon (Vice-Chair)

Councillors S Adams, D Brown, H Seddon, M Sewart, J Snowball, L Anderson, G Marshall, M Brooks, L Braithwaite and T Dean

OFFICERS IN ATTENDANCE

Cheshire East – Lead Local Flood Authority
Domenic De'Bechi – Head of Highways
Guy Metcalfe - Flood Risk Manager
Sarah Hemmings - Street Lighting and Drainage Manager

Environment Agency
David Brown, Senior Advisor, Flood Risk Management
Katy Holt, Team Leader, Flood Risk Management

United Utilities
Emma Birch, Area Engagement Lead for Cheshire
Craig Connor – Wastewater Drainage Area Manager

Cheshire Fire Authority
Matt Barlow, Service Delivery Manager

Brian Reed, Head of Democratic Services
Jennifer Ashley, Democratic Services Officer

33 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillors Craig Browne, Nicola Cook, Sam Corcoran, Brian Drake, Margaret Simon and John Smith.

Councillors Lata Anderson, Liz Braithwaite, Mary Brooks, Tony Dean and Garnett Marshall attended as subsitutes.

34 **DECLARATIONS OF INTEREST**

In the interest of openness and transparency, Councillor Tony Dean declared a non-pecuniary interest in item 5 in that he formerly worked for the Environment Agency.

35 **MINUTES OF PREVIOUS MEETING**

RESOLVED:

That the minutes of the meeting held on 12 December 2024 be approved as a correct record.

36 **PUBLIC SPEAKING/OPEN SESSION**

There were no registered public speakers.

37 **UPDATE ON FLOOD RISK MANAGEMENT**

The Committee received presentations on flood risk management from key colleagues representing Cheshire East Highways (Lead Local Flood Authority), Cheshire Fire Authority, United Utilities and the Environment Agency. Representatives updated Committee Members on the role of their organisations in the event of flooding and how partners worked together.

Cheshire East Highways highlighted to the committee that flood risk and drainage management is a growing concern with reoccurring incidents that are contributed to from a range of factors including third party ownership of drainage infrastructure, increased level of development, climate change and more frequent extreme weather events with persistent heavy rainfall.

Localised issues were bringing challenges in terms of applying for funding as it is difficult to demonstrate positive impacts for high numbers of residents which is a consideration when producing business cases for funding allocations. In addition, levels of development across the borough is adding to the challenges of providing sufficient management of water and drainage issues.

The committee noted that the team had responded to an unprecedented number of emergency calls over the New Year period with 230 calls requesting assistance with flood related incidents. The impact of this lasted a number of weeks with several teams involved in the clean-up operation. As a result of this, it was confirmed that gully cleansing operations have been increased. In addition, funding is being sought to improve drainage systems to make them more efficient and sustainable.

Representatives from United Utilities presented information to the Committee regarding their improvement plan that had recently been approved by OFWAT as the industry regulator. The plan detailed where funding would be spent to improve services and increase education, as the leading reason for flooding was blockages in sewers.

The Environment Agency provided details of their ‘Cows to Coast’ and ‘Environment Lands Management’ schemes which were natural flood risk management initiatives. In addition, flood risk mapping details had been

improved, along with a better understanding of the data available which in turn has resulted in better preparation for flooding incidents.

Cheshire Fire Authority informed the Committee that as a category 1 responder, the role of Cheshire Fire was to be prepared to respond to a range of emergency situations and increasingly, to incidents of flooding. The service had reviewed its ability to respond to events of this nature and staff have been appropriately trained and suitable equipment available to support incidents of flooding.

Following a review of the Community Risk Management Plan, locations of crews and appropriate vehicles has been improved and has allowed response times across the borough to be reduced. Overall, the service is better placed to respond to the range of emergencies they are now seeing.

The Committee asked a number of questions to all partner agencies to which it was agreed a written response would be provided.
The questions included;
Cheshire East Highways

- How many 'dig-ups' were outstanding?

Environment Agency

- What is the Northwest budget, and budget specifically for flood prevention?
- How are pollution rates measured, and what levels are there in Cheshire East?
- What impact has enforcement had, has there been any successful cases?

United Utilities

- In relation to monitoring of blockages, from the data available can you identify how many blockages were in the Cheshire East area?
- New Treatment Works – where are they to be located and when will they be operational? How are current ones functioning, are there plans to upgraded systems?
- Permits around water treatment levels for rivers, what are these and what level is required to be deemed 'safe'?

On behalf of the Committee, the Chair thanked all partners for their attendance and ongoing collaborative working.

RESOLVED:

That the presentations be noted.

38 **WORK PROGRAMME**

RESOLVED:

That the Work Programme be noted and that the Chair and Democratic Services will agree the appropriate timeframes for items to be presented.

The meeting commenced at 10.30 am and concluded at 1.30 pm

Councillor L Wardlaw (Chair)

Agenda Item 5

OPEN

Scrutiny Committee

Date: 26 June 2025

Appointments to the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee

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Report of: Janet Witkowski, Acting Governance, Compliance and Monitoring Officer

Report Reference No: SC/01/25-26

Ward(s) Affected: N/A

For Decision

Purpose of Report

1 This report seeks approval from the Scrutiny Committee to nominate members to the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee.

2 This report contributes to the council's objective of being an effective and enabling organisation – effective and responsive governance, compliance and evidence-based decision-making.

Executive Summary

3 This report concerns those bodies which fall to be nominated by the Scrutiny Committee. Where political proportionality is applicable, the agreed conventions and methods of calculation have been applied.

RECOMMENDATIONS

That the Scrutiny Committee

1. Nominate to the membership of the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee for 2025-26, as set out within this report.

2. Where appropriate, agree to submit member nominations to the Head of Democratic Services.

Background

4 Bodies which the Scrutiny Committee is required to appoint to:

Body	Purpose	Membership 2024-25	Proposed Membership 2025-26
Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee	The Joint Health Scrutiny Committee meets when it is deemed that a proposal is a "substantial development or variation (SDV)". The Joint Committee is made up of 18 elected members from 9 local authorities, hosted by Knowsley Council. The role of the Joint Committee and its functions, including the SVD process are set out within the Joint Health Scrutiny Protocol. **Political balance of the committee is reviewed by the Host Authority.*	Councillors L Wardlaw and R Vernon ***(2 seats: 1 Lab, 1 Cons)***	**Councillors L Wardlaw and C Bulman** ***(2 seats: 1 Lab, 1 Cons)***

Consultation and Engagement

5 There has been consultation with Group Leaders and Administrators in relation to the political representation of the body set out within this report**.**

Reasons for Recommendations

6 In accordance with the Constitution, the Scrutiny Committee is responsible for agreeing nominations to the body referred to in this report.

Other Options Considered

7

Option	Impact	Risk
Do nothing	The Council's Constitution requires this body to be appointed in line with the legislation referenced in this report. Not nominating members to this body would negatively affect the ability to make decisions in an open and transparent manner.	Failure to comply with the Council's Constitution and the legislation referenced in this report could leave the Council open to legal challenge.

Implications and Comments

Monitoring Officer/Legal/Governance

8 The Scrutiny Committee has power to nominate members to this body. In line with the arrangements agreed by the constituent local authorities, the host authority calculated the political make-up of the body, and this is in line with the Council's expectations.

Section 151 Officer/Finance

9 There are no financial implications that require an amendment to the Medium-Term Financial Strategy.

Human Resources

10 There are no HR implications.

Risk Management

11 Failure to comply with the Act and Regulations when appointing its committee memberships would leave the Council open to legal challenge.

Impact on other Committees

12 There are no implications on other committees.

Policy

13 There are no direct policy implications.

Commitment 3: An effective and enabling organisation Effective and responsive governance, compliance and evidence-based decision-making.

Equality, Diversity and Inclusion

14 There are no equality, diversity and inclusion implications.

Other Implications

15 There are no other implications.

Consultation

Name of Consultee	**Post held**	**Date sent**	**Date returned**
Statutory Officer (or deputy) :			
Sal Khan	Deputy S151 Officer	03/06/25	04/06/25
Janet Witkowski	Acting Monitoring Officer	03/06/25	04/06/25
Legal and Finance			
Julie Gregory Steve Reading	Head of Legal Services Finance Manager	13/05/25	15/05/25
Other Consultees:	None		

Access to Information	
Contact Officer:	Brian Reed, Head of Democratic Services Brian.reed@cheshireeast.gov.uk
Appendices:	NA
Background Papers:	NA

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Agenda Item 7

Scrutiny Committee

26 June 2025

Consultation on Proposed Changes to Fertility Treatment Policies Across Cheshire and Merseyside

Report of: NHS Cheshire and Merseyside Integrated Care Board

Report Reference No: SC/05/25-26

Ward(s) Affected: All

For Decision or Scrutiny: Decision

1. Purpose of Report

1.1 Proposals by NHS Cheshire and Merseyside ICB to harmonise the existing 10 Fertility Policies in place across the nine Local Authority Place areas in Cheshire and Merseyside into a single policy for Cheshire would result in some changes to existing access for patients registered with a GP Practice within Cheshire East.

2. Executive Summary

2.1 The purpose of this report is to inform the Committee that the Board of NHS Cheshire and Merseyside Integrated Care Board (ICB), at its meeting on 29 May 2025,[1] approved the recommendation that the ICB commences a period of public consultation regarding the proposal to implement a single Cheshire and Merseyside fertility policy which looks to harmonise access to sub-fertility services for patients registered with a GP Practice across Cheshire and Merseyside. Proposals incorporate changes to:

- the number of NHS funded IVF cycles available to patients
- changes to eligibility with regards Body Mass Index and Smoking
- changes to definition of childlessness
- changes to Intra Uterine Insemination commissioning
- wording on the lower and upper ages for fertility treatment.

2.2 The six week public consultation went live on 03 June 2025 and is due to finish on 15 July 2025. Following a period of conscious consideration of the findings of the

[1] https://www.cheshireandmerseyside.nhs.uk/get-involved/meeting-and-event-archive/nhs-cheshire-and-merseyside-integrated-care-board/2025/29-may-2025/

consultation, it is intended that recommendations for approval regarding the single Fertility Policy for Cheshire and Merseyside will be presented to the ICB Board at its meeting on **25 September 2025**.

Recommendations:

The Committee is asked to:

- **confirm** whether they believe the proposal represents a substantial development or variation (SDV) to local NHS services
- **confirm** whether they believe the ICB should formally consult with the Committee.
- if the Committee confirms both of the above, and in line with the Cheshire and Merseyside Joint Scrutiny Protocol, **identify** and **confirm** which Councillors to be the representatives of the Cheshire East Scrutiny function who will form part of the membership of a Joint Health Scrutiny Committee to formally consider the proposals, in the event that at least one other Local Authority Health Scrutiny Committee also consider the proposals to be an SDV.

2.3 The ICB has a duty to engage with Local Authority Health and Overview Scrutiny Committees (HOSC) to seek confirmation as to whether the HOSC considers this proposal is a substantial development or variation (SDV) to NHS services. If this is confirmed by HOSC then this triggers the requirement for the ICB to formally consult with the HOSC, in line with the s.244 Regulations[2] of the NHS Act 2006 (as amended by the Health and Care Act 2022).

3. Background

3.1 The NHS faces significant financial challenges, necessitating careful balancing of population needs, clinical risk and commissioning decisions to address health inequalities. This paper is written in the context of ensuring commissioning decisions prioritise the most pressing needs of the population, recognising the potential for increased demand in areas like mental health, urgent care and community services, whilst addressing unwarranted variation and the need for a consistent offer.

3.2 On formation of ICB on 01 July 2022, 10 fertility policies were inherited from the nine predecessor CCGs which covered patients registered with a GP Practice within the geographic areas of the nine Cheshire and Merseyside local authority area places. These policies were not harmonised which has meant that patients had different access to services and care, based on their postcode/where they were registered with a GP Practice. The ICBs Reducing Unwarranted Variation programme set out to harmonise this approach to ensure we work to address health inequalities and provide a consistent offer across Cheshire and Merseyside.

3.3 The patient population in scope of this single Cheshire and Merseyside Fertility policy is for patients with health-related fertility issues, who are struggling to have a live birth and require fertility treatments. The proposed Cheshire and Merseyside single policy has been reviewed in line with the latest evidence base and National Institute for Health and Care Excellence (NICE) guideline CG156. It is important to note that this will be an interim policy until new NICE guidance is published when a broader review of subfertility and assisted conception will be undertaken.

3.4 The main area of variation within the existing 10 policies is the number of In vitro fertilisation (IVF) cycles offered which ranges from 1 to 3 cycles depending on

geographic area. The proposal out to consultation predominantly focuses on the options to harmonise the number of IVF cycles offered so that in the future people have the same level of access to NHS fertility treatment wherever they live in our area.

3.5 IVF is a type of fertility treatment that can help people who have difficulty getting pregnant. It involves an egg being fertilised by sperm outside of the body in a laboratory to create an embryo, which is then transferred into a uterus to achieve a pregnancy. NICE defines a 'full cycle' of IVF treatment as involving each of the following steps:

- **Ovarian stimulation:** Using medications to stimulate the ovaries to produce multiple eggs
- **Egg and sperm retrieval:** Mature eggs are collected from the ovaries
- **Fertilisation**: Eggs are fertilised with sperm in a laboratory setting which then develop into embryos
- **Embryo transfer:** One or more embryos are transferred into the uterus 4
- **Embryo freezing**: Any additional good quality embryos created in the cycle will be frozen and stored for use at a later date.

3.6 A full cycle of IVF treatment only ends when either every viable embryo has been transferred, or one results in a pregnancy. NICE Health Economics analysis describes the effectiveness of each cycle with regard to cumulative live birth rate and shows that whilst the chances of having a live birth increase with each cycle, the effectiveness and cost effectiveness of each cycle is reduced. For example in the case of an average 34-year-old, the 1st cycle is c 30% effective, the 2nd cycle is c 15% and the 3rd cycle is less than 10% effective

3.7 Currently, depending on where the patient is registered with, will determine the number of IVF cycles that they are eligible for. Table One outlines by Local Authority Place geography the number of NHS funded IVF cycles currently offered to people who are 39 or younger and the criteria for treatment.

Table One

Local Authority / Legacy CCG area	Cycles
Liverpool	2 cycles (additional cycle available via an IFR)
St Helens	2 cycles
Warrington	3 cycles
Southport & Formby	3 cycles
South Sefton	3 cycles
Halton	3 cycles
Knowsley	3 cycles
Wirral	2 cycles
Cheshire East	1 cycle
Cheshire West	2 cycles (Unless IUI has been undertaken, then 1 cycle)

3.8 People aged 40 and up to 42 are currently offered one cycle in all of the above areas.

3.9 Currently, around 734 people in Cheshire and Merseyside access NHS IVF each year. This figure is based on the number of first cycles that take place. Treatment is provided by The Hewitt Fertility Centre at Liverpool Women's Hospital, which is part of NHS University Hospitals of Liverpool Group, and has facilities based in both Cheshire and in Merseyside. Previously and until September 2023, Care Fertility provided fertility treatment for some of our Cheshire based patients at the Countess of Chester Hospital. Historic activity data from both sites has been used to model the proposal.

3.10 To determine the average number of cycles and frozen embryo transfers (FET) each patient receives, historical data from Care Fertility and Liverpool Women's Hospital has been used. This data along with outcome information and Tariff detail (as described in Table Two) has been used to model the options with validation undertaken by Liverpool Women's Hospital operational and finance teams.

3.11 An IVF cycle is deemed complete when all quality embryos have been transferred. The IVF cycle tariff allows for one fresh and one frozen embryo transfer, with any remaining required FET being charged at the subsequent FET tariff.

Table Two

	IVF cycles	Subsequent FETs
Number (average)	1.36	1.88 (All frozen transfers)
Tariff	£4,862.34	£1,210.80

3.12 Based on the 2024/25 actuals and forecast, data has been extrapolated from those Cheshire and Merseyside areas already providing 3 cycles to enable options to be modelled across all Cheshire and Merseyside area based on %s of activity for each cycle:

- percentage of patients receiving 1 cycle: 64%
- percentage of patients receiving 2 cycles: 23%
- percentage of patients receiving 3 cycles: 13%.

3.13 Nationally there is variation in the number of IVF rounds funded by ICBs. Table Three shows the number of ICBs offering 1, 2 or 3 cycles funded by the NHS, excluding Cheshire and Merseyside.

Table Three

CYCLES	No. ICBs	%
1	27	66%
2	7	17%
3	3	7%
Currently unharmonised position under review	4	10%

3.14 It is important to note that the majority of neighbouring ICBs offer one NHS funded IVF cycle, with the only exception Greater Manchester. Following a similar review undertaken, Greater Manchester are also undertaking a Public Consultation regarding the number of IVF cycles offered. The current picture is:

- Lancashire and South Cumbria offer one IVF cycle.

- Greater Manchester is currently varies from one to three. Out to consult on harmonizing to one cycle.
- West Yorkshire offer one IVF cycle.
- Staffordshire and Stoke-on-Trent offer one IVF cycle.

3.15 It is also of note that other aspects within the proposed single Cheshire and Merseyside policy are proposals around harmonisation in accordance with the latest available NICE guidance and local clinical and operational knowledge. In summary, these incorporate:

- changes to eligibility on Body Mass Index (BMI) (Wirral only)
- change to eligibility based on smoking status (Halton, Knowsley, Liverpool, Sefton and St Helens)
- changes to definition of childlessness (Cheshire East and Cheshire West only)
- change to commissioning of Intra Uterine Insemination (Wirral only)
- wording on the lower and upper ages for fertility treatment (all areas).

Proposals out to consultation

3.16 **IVF.** We are proposing that in the new single policy, everyone in Cheshire and Merseyside who is eligible for IVF would have **one** cycle paid for by the NHS. This cycle would include one fresh and one frozen embryo transfer, followed by the transfer of all good quality frozen embryos until there is a successful live birth. There would be no change for people aged between 40 and up to 42, as they are already offered one cycle in all of our areas.

3.17 If the change went ahead, once they had received a first cycle, people would no longer be able to have any additional cycles funded by the NHS. **This would mean that there would be no change for people registered with a GP practice in Cheshire East.**

3.18 **Change to eligibility on BMI (body mass index).** At the moment, nine out of ten Cheshire and Merseyside policies state that women need to have a BMI of between 19 and 29.9 in order to begin NHS fertility treatment. This is in line with national NICE guidelines, which recommend this weight range for the best chance of successful treatment. However, the current Wirral fertility policy is the only one that says that a male partner should also meet this BMI in order for a couple to be eligible. We are proposing that:

- the new Cheshire and Merseyside policy would state that women intending to carry a pregnancy need a BMI of between 19 and 29.9 for fertility treatment to begin
- men with a BMI of more than 30 would be advised to lose weight to improve their changes of conceiving, but this would not necessarily be a barrier to the couple accessing NHS fertility treatment.

3.19 If the new single policy was introduced, **it would mean that there is <u>NO</u> change for people registered with a GP practice in Cheshire East with regards access to fertility treatment based on BMI.**

3.20 **Change to eligibility on smoking.** NICE guidelines state that maternal and paternal smoking can adversely affect the success of fertility treatment. This includes passive smoking. However, our current fertility policies for Halton, Knowsley, Liverpool, Sefton and St Helens only make reference to the female

partner needing to be a non-smoker. We are proposing that the new Cheshire and Merseyside policy will say:

- that both partners will need to be non-smokers in order to be eligible for NHS fertility treatment. This would include any form of smoking, including the use of e-cigarettes and vapes. This is because of the impact of on treatment outcomes, and the increased risk of complications in pregnancy.

3.21 This update to would **result in no change for people registered with a GP Practice in Cheshire East**.

3.22 **Change to the definition of 'childlessness' in Cheshire East and Cheshire West**. In the majority of areas in Cheshire and Merseyside, IVF will only be made available on the NHS where a couple has no living birth children or adopted children, either from a current or any previous relationship. This is consistent with the majority of other areas across England too. This means that if someone had a baby through IVF, they would not be eligible for any further NHS funded IVF cycles either.

3.23 However, the current policies for patients registered with a GP practice in Cheshire East and Cheshire West state that where a patient has started a cycle of IVF treatment, they can have further embryo transfers to complete their current cycle, even if they achieve a pregnancy leading to a live birth or adopt a child during the cycle. **We are proposing that the new policy would not include this wording, meaning that funding would only be made available where a couple have no living children. This would be a change to patients registered with a GP Practice in Cheshire East**.

3.24 **Change to IUI commissioning.** Intra uterine insemination (IUI), also sometimes known as artificial insemination, is a fertility treatment where sperm is put directly into the womb when a female is ovulating. Female same-sex couples are often asked to self-fund IUI before they can access NHS funded fertility treatment as a means to prove their infertility.

3.25 Currently in most areas of Cheshire and Merseyside, in line with NICE guidance, the use of NHS funded IUI is also permitted for treating each of the following groups:

- people who are unable, or would find it difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psycho-sexual problem, who are using partner or donor sperm
- people with conditions that require specific consideration in relation to methods of conception (for example, after sperm washing where the man is HIV positive)
- people in same sex relationships.

3.26 However, the Wirral policy currently states that IUI is not routinely commissioned, and this does not reflect NICE recommendations nor is it consistent with neighbouring areas. In practice, NHS funded IUI is not carried out very often – for example Cheshire and Merseyside data shows that a total of just 56 NHS funded IUIs have been provided at Liverpool Women's Hospital over the past six years, which is an average of just nine per year.

3.27 We are therefore proposing that the single Cheshire and Merseyside policy would

allow NHS funded IUI in the groups listed above, across all areas. **This would not be a change to patients registered with a GP Practice in Cheshire East**.

3.28 **Wording on the lower and upper ages for fertility treatment.** We are also proposing that the new policy includes clearer wording around the upper and lower ages for fertility treatment. This is because our ten current policies all say that NHS IVF treatment should be available to those from 23 years old up to 42 years of age in Cheshire and Merseyside. However, we are proposing that the new policy doesn't state a lower age limit, which would bring it in line with current NICE guidance. We are also proposing to use clearer wording around the upper age limit, to make it clear that people are eligible until their 43rd birthday. We don't believe that amending the wording for the upper and lower age limits will have a significant impact on the number of people accessing treatment, but it will bring our local approach in line with current NICE guidelines, and make sure there aren't different ways to interpret what the policy says.

Other Options Considered

3.29 In undertaking this work, a number of other options regarding IVF cycles were considered and which are outlined in Table Four. The Pros and Cons of each option are also outlined in Table Five. Appendix One to this report provides the full options appraisal document. Contained within Appendix One there are a number of equality Impact and Quality Impact Assessments for the options considering if the ICB was to offer one or two cycles of NHS funded IVF. Further detail around our other proposed changes that would be incorporated into the single Cheshire and Merseyside policy can be seen in Appendix Two.

Table Four Options for Consideration - IVF

Option	Description	Outcome	EIA feedback	QIA feedback	Financial impact
1	Do nothing. • ***Discounted option***	This is not a viable option as this would leave the ICB and its patients with an unharmonised position and therefore unwarranted variation in access to fertility services.	Not completed	Not completed	**£5,043,081 per year**
2	NHS C&M offers patients 1 round of IVF treatment. • ***Executive Committee preferred option***	This option would disadvantage a cohort of patients who require additional cycles to have a live birth, as the average number of cycles that our patients have is 1.36. Clinically this is not supported due to the benefits in being able to take the learnings from an unsuccessful first cycle to improve chances of success in a second cycle. Whilst this option will reduce the cost of this service to the ICB, it is not supportive of NICE	The number of cycles does not affect protected characteristics. This option will affect those patients and families who are on a low income, if the patient does not have a successful live birth following a single round of IVF, they would have to self-fund to try again. This may mean they cannot have a biological child. Appendix One covers the full policy EIA.	There would be a negative impact for patients who are currently eligible for either 2 or 3 cycles. Without additional attempts at subsequent IVF cycles, there is a risk that patients would be detrimentally impacted and may not be able to have a biological child if they cannot afford to privately fund. Data shows the average number of IVF cycles that our patients have is 1.36. Therefore, there is a risk that if those	This would result in an estimated cost of **£3,728,347 per year.** Comparing this to the current position, this would result in estimated **savings of £1,315,732 per year.** (This cost includes the modelled cost of additional FETs – on average patients have an additional 1.88 FETs)

Option	Description	Outcome	EIA feedback	QIA feedback	Financial impact
		recommendation and would attract negative publicity. A public consultation exercise would be required in 8 Places.		patients are not successful in the first IVF round, they would be disadvantaged by not being able to try a different approach in the second cycle. Knowledge is gained from the first cycle such as optimum dose of stimulation and best methods used for fertilisation. These are then implemented for subsequent attempts. **Overall risk rating: 16 (High)**	
3	NHS C&M offer patients 2 rounds of IVF treatment. • ***Clinical Working Group Preferred Option***	This option is the preferred clinical option and is supported by the data that patients are having an average of 1.36 IVF cycles. Knowledge is gained from the first cycle such as optimum dose of stimulation and best methods used for fertilisation. These are then implemented for subsequent attempts.	The number of cycles does not affect protected characteristics. Appendix One covers the full policy EIA.	According to the data analysis allowing 2 cycles of IVF would benefit the majority of patients, with the average number of IVF cycles being 1.36. Because the estimated number of 2nd IVF cycles for Cheshire East is equal to the existing number of 3rd cycles in Sefton,	This would result in an estimated cost of **£5,084,437.** Comparing this to the current position, this would result in an estimated **cost increase of £40,357 per year.** (This cost includes the modelled cost of additional FETs – on

Option	Description	Outcome	EIA feedback	QIA feedback	Financial impact
		A public consultation would be required in 4 Places.		Knowsley, Warrington and Halton, the number of FETs is assumed to be the same based on this average. Once harmonised, this will mean that there is a consistent equitable offer for patients accessing subfertility treatments. **Overall risk rating: 4 (Moderate)**	average patients have an additional 1.88 FETs)
4	NHS C&M offer patients 3 rounds of IVF treatment. • ***Unsupported option***	This option is not supported because data suggests that the average number of IVF rounds is 1.36. Also, this option would require additional funding of over c.£734k pa and therefore does not support the ICB to meet its financial objectives.	The number of cycles does not affect protected characteristics.	Not completed as not supported.	This would result in an estimated cost of **£5,778,295.** Comparing this to the current position, this would result in an estimated **cost increase of £734,217 per year.**

Table Five Pros and Cons of each option

Option 1: Do nothing (Option discounted)

Pros	Cons
• There would be no change in the ICB financial position.	• This would leave NHS C&M with an unharmonised position, patients would continue to have unequal access to IVF rounds. • There is an increased risk of challenge by Equalities and Human Rights commission re inequality in service access.

Option 2: Offer patients 1 cycle of IVF

Pros	Cons
• This offer is in line with most of our neighbouring ICBs offer. • Offering 1 cycle provides the greatest financial savings opportunity. • 66% of ICBs across the country offer 1 cycle.	Data shows that the average number of cycles patients require is 1.36. Therefore offering 1 cycle would disadvantage patients who require an additional cycle. If the first cycle is not successful, observation and learnings are used to inform the second cycle in order to increase the potential for a successful live birth. This is especially relevant as patients are becoming more complex, are older, have comorbidities which affect their fertility or are under time pressure (e.g. fertility preservation). Although it is of note that patients could choose to fund this privately. • Risk of negative publicity for the ICB in those places that currently offer 2 or 3 cycles - patients will be generally dissatisfied, and this may result in an increase of complaints, therefore more time will need to be allocated to respond to these. • Patients on low income in 8 Places could be disadvantaged as they either receive 2 or 3 cycles currently, and if they fail to have a live birth in the first cycle, they would be required to self-fund which may not be financially possible. • A public consultation exercise would need to be held which would impact the time taken to implement and could be costly. • Does not match current NICE guidance of three cycles. • There is a sustained decline in birth rates across Cheshire and Merseyside. The OECD identifies a replacement fertility rate of 2.1 children per woman as necessary to maintain population levels. ONS

Pros	Cons
	data shows that the total fertility rate in C&M has been in consistence decline since 2021, falling to 1.49 in 2022. This trend presents significant long-term risks to the region's workforce and the sustainability of health and social services. Therefore, a reduction in cycles will undermine efforts to support population health and long-term system planning. • There is a risk on the mental health impact that childlessness has on couples, research shows that this is coupled with grief, depression and emotional stress which can impact on quality of life, this can be expected to increase. • Reducing NHS IVF cycles will potentially increase cost elsewhere as more patients will turn to cheaper IVF options in other countries with less regulation and potentially increasing the rates of multiple pregnancies, leading to maternal and neonatal morbidity and placing a greater financial and clinical burden on the NHS services downstream. • Data shows that 1 cycle of treatment (with subsequent FET's) gives a 56% chance of a live birth whereas with 2 cycles couples have a cumulative 68% chance of a live birth.

Option 3: Offer patients 2 cycles of IVF

Pros	Cons
• The average number of cycles patients currently have is 1.36, therefore the proposal of 2 cycles of IVF would support these findings and would enable learning to be taken from the first cycle and a different approach to be used for the second cycle with an aim to improving success. • Offering 2 cycles would be a positive for Cheshire East patients, as currently they are eligible for 1 cycle.	• Patients in the 4 Places who offer 3 cycles, particularly if on low income, may feel they are disadvantaged by a reduction in the IVF cycle offer and this may generate negative publicity for the ICB. • A public consultation exercise would need to be held which would impact the time taken to implement. • Does not match current NICE guidance of three cycles, (NICE data shows that whilst the effectiveness of each cycle with regard to cumulative live birth rate increases with each cycle the effectiveness of each cycle is

Pros	Cons
• This option is supported by all clinicians including the Obs & Gynae clinical network and LWH Finance and Operational teams who will deliver the service.	reduced). Our data modelling showing the average number of cycles per patient is 1.36. • This offer is higher than the national average (66% offering 1 cycle), our neighbouring ICB Cumbria and Lancashire offer patients 1 cycle of IVF. (Greater Manchester are in the process of harmonising their cycles offer). This would mean there is continued variation in access to subfertility services within the Northwest region and surrounding areas.

Option 4: Offer patients 3 cycles of IVF (Option discounted)

Pros	Cons
• Often if the first cycles are not successful, learnings are taken from this, and a different approach is used for the second and third cycles with an aim to improving success. • Offering 3 cycles would be a positive for Cheshire East, Cheshire West, Liverpool, St Helens and Wirral patients, currently they are eligible for 1 or 2 cycles. • A public involvement exercise could be a light touch communication approach. • Meets current NICE guidance, NICE data shows that whilst the effectiveness of each cycle with regard to cumulative live birth rate increases with each cycle, the effectiveness of each cycle is reduced.	• This offer is higher than our neighbouring ICB, NHS Cumbria and Lancashire who offer 1 cycle. (NHS Greater Manchester are in the process of harmonising their cycles offer). • This offer is higher than the country average, with 66% of ICBs offering 1 cycle. • This results in estimated additional cost to the ICB of £734k pa • The average number of cycles patients currently have is 1.36, therefore this option does not support data findings.

4. Consultation and Engagement

4.1 NHS Cheshire and Merseyside began a 6-week public consultation period on 03 June 2025, with the closing date being the 15 July 2025. The objectives of the consultation are:

- to inform patients, carers/family members, key stakeholders, and the public of proposed changes to gluten free prescribing.
- to engage with people who currently are undergoing fertility treatment as well as those who may be in scope of the policy, organisations which support them (where applicable), their carers/family members, and the wider public, to gather people's views about the proposed changes, including how individuals might be impacted.
- to use these responses to inform final decision-making around the proposal.

4.2 A clear consultation communication plan has been approved by the ICB Board (Appendix Three). The public-facing information about the proposal details who is likely to be impacted and how, setting out the background to the issue and explaining why NHS Cheshire and Merseyside is proposing to make changes. A summary booklet has been produced to support this (Appendix Four). This information is accompanied by a questionnaire[2] containing both qualitative and quantitative questions, designed to gather people's views and perspectives on the proposals. Both the information and questionnaire will be available in Easy Read format upon request. All materials have been made available on the NHS Cheshire and Merseyside website at https://www.cheshireandmerseyside.nhs.uk/get-involved/current-consultations-and-engagements/share-your-views-on-proposed-changes-to-fertility-treatment-policies-in-cheshire-and-merseyside/ with printed versions and alternative formats/languages available on request (via email or telephone). People who are unable to complete the questionnaire will be able to provide their feedback over the telephone.

4.3 The consultation will be promoted across NHS Cheshire and Merseyside's internal and external communication channels. Wider partners and stakeholders, including providers of NHS services (hospitals, community and mental health providers and primary care), local authorities, Healthwatch, and voluntary, community, faith and social enterprise (VCFSE) organisations, will be asked to share information using their own channels, utilising a toolkit produced for this purpose.

4.4 While specific standalone events will not be organised as part of the consultation, if individual groups/networks request further information, NHS Cheshire and Merseyside will offer to attend meetings to provide additional briefings if required/appropriate.

4.5 NHS Cheshire and Merseyside recognise that it is important to understand the effectiveness of different routes for reaching people, so that this can be utilised for future activity, and the questionnaire will ask people to state

[2] https://www.surveymonkey.com/r/9CKB7BH

where they heard about the engagement. We will summarise this information – along with other measures such as number of enquiries received and visits to the website page – in the final consultation report.

4.6 When the consultation closes, the findings will be analysed and compiled into a report. The feedback report will be used to inform final decision-making about the proposal and will therefore be received by the Board of NHS Cheshire and Merseyside at its meeting on 25 September 2025. The outcome of this will be communicated using the same routes used to promote the consultation.

4.7 Any formal response to the proposal/consultation by Local Authority HOSC would be requested to be provided prior to 12 September 2025 so as to help inform in a timely manner the final report to the Board of NHS Cheshire and Merseyside.

5. Reasons for Recommendations

5.1 For NHS Cheshire and Merseyside to understand better and plan accordingly how to inform and/or consult Local Authority HOSC across Cheshire and Merseyside, a decision is required by each Local Authority regarding whether:

- they determine that the proposals are to be classed as a substantial development or variation, and
- whether this triggers the need to establish a Joint HOSC in line with the Cheshire and Merseyside protocol.

6.0 FINANCIAL IMPLICATIONS

6.1 There are no financial implications to Cheshire East Council in relation to the proposal.

6.2 Due to the financial constraints of the ICB and the need to prioritise commissioning decisions and funding against the most critical needs, it is important that all options are considered which may not always result in adherence to guidance including NICE recommendations.

6.3 NICE recommends offering patients with infertility three cycles of IVF. The cost of this would equate to a total spend for the ICB of £5.78m. (The current spend is £5.043m so there would be an additional annual spend of circa £734k if the ICB offered three rounds of NHS funded IVF treatment across all of Cheshire and Merseyside).

6.4 If the ICB was to implement the proposed fertility policy where only one round of NHS funded IVF treatment was provided then this would result in an estimated cost of **£3,728,347 per year.** Comparing this to the current position, this would result in estimated **savings to the ICB of £1,315,732 per year.**

6.5 Table Six provides month 7 activity for Cheshire and Merseyside and the forecast outturn for 2024/25 activity. The reason for using this data set is

because the month 7 position will be used as the basis for the 2025/26 forecast and activity plan for Liverpool Women's Hospital.

Table Six

		Based on LWH's Month 7 2024/25 actual position, forecasted to year-end using agreed					
	IVF		FET		Total		
Sub ICB Location	Actvity	Spend	Activity	Spend	Activity	Spend	
Southport & Formby	48	£ 231,494	5	£ 6,227	53	£	237,721
South Sefton	87	£ 415,617	9	£ 10,378	96	£	425,995
Liverpool	322	£ 1,559,470	56	£ 68,497	378	£	1,627,967
Knowsley	72	£ 350,088	14	£ 16,605	86	£	366,694
Halton	39	£ 189,913	9	£ 10,378	48	£	200,291
St Helens	46	£ 225,057	8	£ 10,378	54	£	235,435
Warrington	51	£ 242,471	12	£ 14,530	63	£	257,001
Cheshire E	101	£ 492,606	27	£ 32,185	128	£	524,792
Cheshire W	115	£ 555,761	30	£ 36,311	145	£	592,073
Wirral	117	£ 566,810	7	£ 8,303	124	£	575,113
TOTAL	**998**	**£ 4,829,289**	**177**	**£ 213,793**	**1175**	**£**	**5,043,081**

7.0 LEGAL IMPLICATIONS

7.1 The ICB has a duty to engage with Local Authority Health and Overview Scrutiny Committees (HOSC) to seek confirmation as to whether the HOSC believes this proposal is a substantial development or variation to local NHS funded services. If this is confirmed by a HOSC then this triggers the requirement for the ICB to formally consult with the HOSC, in line with the s.244 Regulations of the NHS Act 2006 (as amended by the Health and Care Act 2022).

7.2 A substantial development or variation is not defined in legislation. Guidance has suggested that the key feature is that it should involve a major impact on the services experienced by patients and/or future patients. Paragraph 5.2.3 of the Cheshire and Merseyside Protocol outlines the following criteria that Local Authorities should consider to help them with their determination:

- ***Changes in accessibility of services:*** any proposal which involves the withdrawal or change of patient or diagnostic facilities for one or more speciality from the same location.

- ***Impact on the wider community and other services:*** this could include economic impact, transport, regeneration issues.

- ***Patients affected*** changes may affect the whole population, or a small group. If changes affect a small group, the proposal may still be regarded as substantial, particularly if patients need to continue accessing that service for many years.

- ***Methods of service delivery****:* altering the way a service is delivered may be a substantial change, for example moving a particular service into community settings rather than being entirely hospital based.

- ***Potential level of public interest****:* proposals that are likely to generate a significant level of public interest in view of their likely impact

7.3 In considering substantial development or variation proposals local authorities need to recognise the resource envelope within which the NHS operates and should therefore take into account the effect of the proposals on the sustainability of NHS services, as well as on their quality and safety.

7.4 Where a substantial development or variation impacts on the residents within one local authority area boundary, only the relevant local authority health scrutiny function shall be consulted on the proposal. Where a proposal impacts on residents across more than one local authority boundary, the NHS body/health service provider is obliged to consult all those authorities whose residents are affected by the proposals in order to determine whether the proposal represents a substantial development or variation.

7.5 Those authorities that agree that any such proposal does constitute a substantial development or variation are obliged (under the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013) to form a joint HOSC for the purpose of formal consultation by the proposer of the development or variation. Whilst each local authority must decide individually whether a proposal represents a substantial development/variation, it is only the statutory joint health scrutiny committee which can formally comment on the proposals if more than one authority agrees that the proposed change is "substantial".

7.6 Determining that a proposal is not a substantial development/variation removes the ability of an individual local authority to comment formally on the proposal. Once such decisions are made, the ongoing obligation on the proposer to consult formally on a proposal relates only to those authorities that have deemed the proposed change to be "substantial" and this must be done through the vehicle of the joint committee. Furthermore, the proposer will not be obliged to provide updates or report back on proposals to individual authorities that have not deemed them to be "substantial".

7.7 Committee members are also reminded that from 31 January 2024, new rules[4] came into place in respect of the aspect of health scrutiny that relates to substantial development or substantial variation of local health services. The new rules mean that from this date, local HOSCs or JOSCs are no longer able to formally refer matters to the Secretary of State for Health and Social Care where they relate to these substantial developments / variations. Instead, the Secretary of State themselves will have a broad power to intervene in local services – HOSCs will have the right to be formally consulted on how the Secretary of State uses their powers to "call in" proposals to make reconfigurations to local health services.

7.8 Instead of the referral power, HOSCs/JOSCs and other interested parties can write to request (via a call-in request form) that the Secretary of State consider calling in a proposal. It is expected that requests are only to be used in exceptional situations where local resolution has not been reached.

7.9 Other aspects of health scrutiny remain unchanged – the power to require representatives of NHS bodies to attend formal meetings, the power to get information from NHS bodies and the power to require NHS bodies to have regard to scrutiny's recommendations.

8.0 EQUALITY IMPACT ASSESSMENT

8.1 Equality Impact Assessments and Quality Impact assessments have been prepared to support this consultation and are available within the documents in Appendix One. This outlines the possible impacts on protected characteristic groups, as well as mitigations.

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APPENDICES

Appendix One:	Options Appraisal for the harmonisation of In vitro fertilisation (IVF) cycles
Appendix Two:	Additional proposals to changes to Fertility Policies across Cheshire and Merseyside
Appendix Three:	Communication Plan for Single Cheshire and Merseyside Fertility Policy Consultation
Appendix Four:	Cheshire and Merseyside Fertility Policy Consultation Summary Booklet
Appendix Five:	Protocol for the establishment of of Joint Health Scrutiny Arrangements

BACKGROUND PAPERS
References:

1. Papers for the May 2025 meeting of the Board of NHS Cheshire and Merseyside ICB https://www.cheshireandmerseyside.nhs.uk/get-involved/meeting-and-event-archive/nhs-cheshire-and-merseyside-integrated-care-board/2025/29-may-2025/
2. National Health Service Act 2006, Section 244 https://www.legislation.gov.uk/ukpga/2006/41/section/244
3. Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, https://www.legislation.gov.uk/uksi/2013/218/contents/made
4. Rule changes reflect amendments to the local authority scrutiny function following the introduction of the Health and Care Act 2022 ('the 2022 Act'), which inserted schedule 10A into the National Health Service Act 2006 ('the NHS Act 2006'). Further detail at https://www.gov.uk/government/publications/advice-to-local-authorities-on-scrutinising-health-services/local-authority-health-scrutiny

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NHS
Cheshire and Merseyside

Appendix One

Subfertility Clinical Policy

Options Appraisal for harmonisation of

In vitro fertilisation (IVF) cycles

Glossary

Term	Definition
In vitro fertilisation (IVF)	A full cycle of IVF (with or without ICSI) is defined as one episode of ovarian stimulation and the transfer of all resultant fresh and/or frozen embryo(s). If there are any remaining frozen embryos, the cycle is only deemed to have ended when all these embryos have been used up or if a pregnancy leading to a live birth occurs or the patient adopts a child (i.e. in accordance with the ICB's policy on "Childlessness").
Embryo	A fertilised egg.
Egg collection	As part of the IVF cycle, eggs are collected from the womb. The collection involves attempts to retrieve all eggs within the stimulated follicles in the ovary.
Embryo transfer	After egg collection, the embryos are transferred into the womb. The best quality embryo available is transferred.
Frozen embryo transfer (FET)	Treatment involves freezing and storing embryos, the embryo(s) is warmed and transferred into the womb.
Intra-cytoplasmic sperm injections (ICSI)	Intra-cytoplasmic sperm injection. A common treatment for sperm-related male infertility. It is performed as part of IVF and involves the sperm being injected directly into the egg.
Intrauterine insemination (IUI)	Sperm is put directly into the womb when the female is ovulating. This can also be called artificial insemination.

1. Background

On formation of the Integrated Care Board (ICB), clinical policies were inherited from across the 9 places. This meant that patients had different access to services and care, based on their postcode. The Reducing Unwarranted Variation programme set out to harmonise this approach to ensure we work to address health inequalities and provide a consistent offer across Cheshire and Merseyside.

The NHS faces significant financial challenges, necessitating careful balancing of population needs, clinical risk, and commissioning decisions to address health inequalities. This paper is written in the context of ensuring commissioning decisions prioritise the most pressing needs of the population, recognising the potential for increased demand in areas like mental health, urgent care and community services, whilst addressing unwarranted variation and the need for a consistent offer.

At present each Place within NHS Cheshire and Merseyside (C&M) ICB has a separate unharmonised fertility policy and therefore unwarranted variation in access to these services exists.

The main area of variation within the policies is the number of In vitro fertilisation (IVF) cycles offered which ranges from 1 to 3 cycles. This document focuses on the options to harmonise IVF cycles. It is of note that other aspects within the policy are proposed to be harmonised in accordance with the latest available NICE guidance and local clinical and operational knowledge.

The scope of this policy is for patients with health-related fertility issues, who are struggling to have a live birth and require fertility treatments. This policy has been reviewed in line with the latest evidence base and NICE guideline CG156; it is important to note that this will be an interim policy until the new NICE guidance is published when a broader review of subfertility and assisted conception will be undertaken.

NICE recommends offering patients with infertility 3 cycles of IVF. The cost of this would equate to a total spend for the ICB of £5.78m. (The current spend is £5.043m so there would be an additional annual spend of circa £734k).

Due to the financial constraints of the ICB and the need to prioritise commissioning decisions and funding against the most critical needs, it is important that all options are considered which may not always result in adherence to guidance including NICE recommendations.

1.1 National Policy Position:

Nationally there is variation in the number of IVF rounds offered.

The table below shows the number of ICBs offering 1, 2 or 3 cycles excluding C&M:

CYCLES	No. ICBs	%
1	27	66%
2	7	17%
3	3	7%
Currently unharmonised position under review	4	10%

Source: ICB websites (March 2025)

It is important to note that the majority of neighbouring ICBs offer 1 IVF cycle, with the only exception Greater Manchester. Following a similar review undertaken, colleagues in GM are working up a proposal and plan for Public Consultation following discussion planned at their Board meeting in May.

- Lancashire and South Cumbria offer 1 IVF cycle.
- Greater Manchester is currently under review - varies from 1 to 3.
- West Yorkshire offer 1 IVF cycle.
- Staffordshire and Stoke-on-Trent offer 1 IVF cycle.

1.2 Current C&M Position

There are currently 10 subfertility policies across C&M. Depending on where the patient lives, will determine the number of IVF cycles that they are eligible for, the number of cycles range from 1 – 3. Below is the current offer:

Place / Legacy CCG	Offer
Liverpool	2 cycles (additional cycle available via an IFR)
St Helens	2 cycles
Warrington	3 cycles
Southport & Formby	3 cycles

South Sefton	3 cycles
Halton	3 cycles
Knowsley	3 cycles
Wirral	2 cycles
Cheshire East	1 cycle
Cheshire West	2 cycles (Unless IUI has been undertaken, then 1 cycle)*

*This document discusses IVF cycles; it does not include IUI cycles as activity is minimal.

Within Cheshire and Merseyside, we only have one provider for IVF, The Hewitt Fertility Centre at Liverpool Women's Hospital. Previously and until September 2023, Care Fertility provided fertility treatment for some of our Cheshire based patients at the Countess of Chester Hospital. Historic activity data from both sites has been used to model the proposal.

1.3 Current activity levels with cost to NHS C&M

This table below shows the month 7 activity and the forecast outturn for 2024/2025 activity.

		Based on LWH's Month 7 2024/25 actual position, forecasted to year-end using agreed					
	IVF		FET		Total		
Sub ICB Location	Actvity	Spend	Activity	Spend	Activity	Spend	
Southport & Formby	48	£ 231,494	5	£ 6,227	53	£ 237,721	
South Sefton	87	£ 415,617	9	£ 10,378	96	£ 425,995	
Liverpool	322	£ 1,559,470	56	£ 68,497	378	£ 1,627,967	
Knowsley	72	£ 350,088	14	£ 16,605	86	£ 366,694	
Halton	39	£ 189,913	9	£ 10,378	48	£ 200,291	
St Helens	46	£ 225,057	8	£ 10,378	54	£ 235,435	
Warrington	51	£ 242,471	12	£ 14,530	63	£ 257,001	
Cheshire E	101	£ 492,606	27	£ 32,185	128	£ 524,792	
Cheshire W	115	£ 555,761	30	£ 36,311	145	£ 592,073	
Wirral	117	£ 566,810	7	£ 8,303	124	£ 575,113	
TOTAL	**998**	**£ 4,829,289**	**177**	**£ 213,793**	**1175**	**£ 5,043,081**	

(Please note BI data still represents former CCG allocations and therefore Cheshire data is not split out into Cheshire East and Cheshire West. In the above table this split has been modelled based on previous years' activity as provided by LWH and Care Fertility).

2. Approach

As part of the CPH programme, a subfertility working group was convened to review the current policies and support the harmonisation. This multi-disciplinary working group included Secondary care local fertility specialists, GPs, health watch colleagues, commissioners, Equality & Diversity colleague and policy development specialists. The group reviewed each of the policy positions within the current policies and made recommendations in line with evidence base to shape the proposed policy, the policy has also been reviewed by the Clinical Network and feedback has been considered. A summary of these and the changes can be found in **Appendix 1.1**.

The data used is the 2024/25-month 7 activity reported by SLAM and the remainder of the year forecast outturn. The reason for using this data set is because the month 7 position will be used as the basis for the 2025/26 forecast and activity plan for LWH. The data provided is non patient identifiable, therefore, modelling has been carried out by C&M BI Team to determine the current allocation of first, and where applicable second and third cycles with the support and validation from operational and finance staff at LWH. The data modelling is available upon request by the Board.

Based on the data modelling an options appraisal process considered a do-nothing option, 1 cycle, 2 cycle and 3 cycle options. A do-nothing option was not supported by the group, this is because this would leave C&M in an unharmonised position and unwarranted variation would remain.

A 3-cycle option was also not supported by the group, this is because our data shows that 2 cycles would support majority of patients, and harmonising to 2 cycles would enable equity of access whilst maintaining current activity levels; a 3-cycle option would increase activity levels and which would impact LWH capacity to deliver and increase the annual cost of funding this service.

An Equality Impact Assessment and Quality Impact Assessment have been completed for the recommended option of 2 cycles and a 1 cycle option. This is to consider the impact on patients with protected characteristics and patient safety and experience.

2.1 Clinical effectiveness of IVF cycles

NICE Health Economics analysis describes the effectiveness of each cycle with regard to cumulative live birth rate and shows that whilst the chances of having a live birth increase with each cycle, the effectiveness and cost effectiveness of each cycle is reduced.

For example, in the case of an average 34-year-old, the 1st cycle is c 30% effective, the 2nd cycle is c 15% and the 3rd cycle is less than 10% effective.

2.2 Activity data and options modelling

To determine the average number of cycles and frozen embryo transfers (FET) each patient receives, historical data from Care Fertility and LWH has been used. This data along with outcome information and Tariff detail (as described in the table below) has been used to model the options with validation undertaken by LWH operational and finance teams.

An IVF cycle is deemed complete when all quality embryos have been transferred. The IVF cycle tariff allows for one fresh and one frozen embryo transfer, with any remaining required FET being charged at the subsequent FET tariff.

	IVF cycles	Subsequent FETs
Number (average)	1.36	1.88 (All frozen transfers)
Tariff	£4,862.34	£1,210.80

Based on the 2024/25 actuals and forecast, data has been extrapolated from those Places already providing 3 cycles to enable options to be modelled across all C&M Places based on %s of activity for each cycle:

- Percentage of patients receiving 1 cycle: 64%
- Percentage of patients receiving 2 cycles: 23%
- Percentage of patients receiving 3 cycles: 13%

2.3 Modelling of IVF cycles and FETs

Baseline – current unharmonised position

Sub ICB Location	1 cycle		2 cycle		3 cycle		Total	
	IVF	FET	IVF	FET	IVF	FET	IVF	FET
Southport & Formby	31	3	11	1	6	1	48	5
South Sefton	56	6	21	2	11	1	88	9
Liverpool	236	41	86	15	0	0	322	57
Knowsley	46	9	17	3	9	2	72	14
Halton	25	6	9	2	5	1	39	9
St Helens	34	6	12	2	0	0	46	8
Warrington	33	8	12	3	6	1	51	12
Cheshire E	101	27	0	0	0	0	101	27
Cheshire W	84	22	31	8	0	0	115	30
Wirral	85	5	31	2	0	0	116	7
TOTAL	**731**	**133**	**230**	**38**	**37**	**6**	**998**	**178**

1 cycle

The table below shows the modelled activity data if NHS C&M were to offer 1 cycle of IVF.

Sub ICB Location	1 Cycle		2 cycle		3 Cycle		Total	
	IVF	FET	IVF	FET	IVF	FET	IVF	FET
Southport & Formby	31	3	0	0	0	0	31	3
South Sefton	56	6	0	0	0	0	56	6
Liverpool	236	41	0	0	0	0	236	41
Knowsley	46	9	0	0	0	0	46	9
Halton	25	6	0	0	0	0	25	6
St Helens	34	6	0	0	0	0	34	6
Warrington	33	8	0	0	0	0	33	8
Cheshire E	101	27	0	0	0	0	101	27
Cheshire W	84	22	0	0	0	0	84	22
Wirral	85	5	0	0	0	0	85	5
TOTAL	**731**	**132**	**0**	**0**	**0**	**0**	**731**	**132**
Difference in activity (to baseline)							**-267**	**-46**

2 cycles

The table below shows the modelled activity data if NHS C&M were to offer 2 cycles of IVF.

Sub ICB Location	1 Cycle		2 cycle		3 Cycle		Total	
	IVF	FET	IVF	FET	IVF	FET	IVF	FET
Southport & Formby	31	3	11	2	0	0	42	5
South Sefton	56	6	21	2	0	0	77	8
Liverpool	236	41	86	16	0	0	322	57
Knowsley	46	9	17	3	0	0	63	12
Halton	25	6	10	2	0	0	35	8
St Helens	34	6	12	3	0	0	46	9
Warrington	33	8	12	3	0	0	45	11
Cheshire E	101	27	37	9	0	0	138	36
Cheshire W	84	22	31	8	0	0	115	30
Wirral	85	5	32	2	0	0	117	7
TOTAL	**731**	**132**	**269**	**50**	**0**	**0**	**1000**	**182**
Difference in activity (to baseline)							**2**	**4**

3 cycles

The table below shows the modelled activity data if NHS C&M were to offer 3 cycles of IVF.

	1 Cycle		2 cycle		3 Cycle		Total	
Sub ICB Location	**IVF**	**FET**	**IVF**	**FET**	**IVF**	**FET**	**IVF**	**FET**
Southport & Formby	31	3	11	2	6	0	48	5
South Sefton	56	6	21	2	10	1	87	9
Liverpool	236	41	86	16	44	7	366	64
Knowsley	46	9	17	3	9	2	72	14
Halton	25	6	10	2	4	1	39	9
St Helens	34	6	12	3	7	1	53	10
Warrington	33	8	12	3	6	1	51	12
Cheshire E	101	27	37	9	19	5	157	41
Cheshire W	84	22	31	8	15	4	130	34
Wirral	85	5	32	2	15	1	132	8
TOTAL	**731**	**132**	**269**	**50**	**135**	**23**	**1135**	**205**
Difference in activity (to baseline)							**137**	**27**

2.4 Guiding Principles

- To reduce unwarranted variation and harmonise access to services across Cheshire and Merseyside.
- Use the latest evidence base to develop harmonised policies.
- Consider sustainability of Cheshire and Merseyside ICB in context of financial requirements.

2.5 Strategic Context

The harmonisation of the policies and in particular IVF cycles meets the “Tackling health inequality, improving outcomes and access to services” and ‘Enhancing productivity and value for money’ strategic objectives:

Objective 1	
Objective	Tackling health inequality, improving outcomes and access to services
Current Arrangement	Inequity in the number of IVF cycles offered across C&M. Places currently offer either 1, 2 or 3 cycles and therefore there is unwarranted variation. There is a reputational risk, as we are one organisation, but patients are not being treated equitably, which is a risk to quality.
Gap/Business Needs	To harmonise the IVF rounds offered within the NHS C&M subfertility policy.

Objective 2	
Objective	Enhancing Productivity and Value for Money
Current Arrangement	Inequity in the number of IVF cycles offered across C&M. Places currently offer either 1, 2 or 3 cycles and therefore there is unwarranted variation.
Gap/Business Needs	To harmonise the IVF rounds offered within the NHS C&M subfertility policy whilst maintaining existing levels of activity and cost to support our Providers to continue to deliver against their operational plans.

3 Options and considerations:

Option	Description	Outcome	EIA feedback	QIA feedback	Financial impact
1	Do nothing • ***Discounted option***	This is not a viable option as this would leave the ICB and its patients with an unharmonised position and therefore unwarranted variation in access to fertility services.	Not completed	Not completed	**£5,043,081 per year**
2	NHS C&M offer patients 1 round of IVF treatment. • ***Executive Committee preferred option***	This option would disadvantage a cohort of patients who require additional cycles to have a live birth, as the average number of cycles that our patients have is 1.36. Clinically this is not supported due to the benefits in being able to take the learnings from an unsuccessful first cycle to improve chances of success in a second cycle. Whilst this option will reduce the cost of this service to the ICB, it is not supportive of NICE recommendation and would attract negative publicity. A public consultation exercise would be required in 8 Places.	The number of cycles does not affect protected characteristics. This option will affect those patients and families who are on a low income, if the patient does not have a successful live birth following a single round of IVF, they would have to self-fund to try again. This may mean they cannot have a biological child. **See Appendix 1.1 for EIA.**	There would be a negative impact for patients who are currently eligible for either 2 or 3 cycles. Without additional attempts at subsequent IVF cycles, there is a risk that patients would be detrimentally impacted and may not be able to have a biological child if they cannot afford to privately fund. Data shows the average number of IVF cycles that our patients are having is 1.36. Therefore, there is a risk that if those patients are not successful in the first IVF round, they would be disadvantaged by not being able to try a different approach in the second cycle. Knowledge is gained from the first cycle such as optimum dose of stimulation and best methods used for fertilisation. These are then implemented for subsequent attempts. **See Appendix 1.2 for QIA** **Overall risk rating: 16 (High)**	This would result in an estimated cost of **£3,728,347 per year.** Comparing this to the current position, this would result in estimated **savings of £1,315,732 per year.** (This cost includes the modelled cost of additional FETs – on average patients have an additional 1.88 FETs)

3	NHS C&M offer patients 2 rounds of IVF treatment. • ***Clinical Working Group Preferred Option***	This option is the preferred clinical option and is supported by the data that patients are having an average of 1.36 IVF cycles. Knowledge is gained from the first cycle such as optimum dose of stimulation and best methods used for fertilisation. These are then implemented for subsequent attempts. A public consultation would be required in 4 Places.	The number of cycles does not affect protected characteristics. **See Appendix 1.3 for EIA.**	According to the data analysis allowing 2 cycles of IVF would benefit the majority of patients, with the average number of IVF cycles being 1.36. Because the estimated number of 2nd IVF cycles for Cheshire East is equal to the existing number of 3rd cycles in Sefton, Knowsley, Warrington and Halton, the number of FETs is assumed to be the same based on this average. Once harmonised, this will mean that there is a consistent equitable offer for patients accessing subfertility treatments. See **Appendix 1.4** for QIA **Overall risk rating: 4 (Moderate)**	This would result in an estimated cost of **£5,084,437.** Comparing this to the current position, this would result in an estimated **cost increase of £40,357 per year.** (This cost includes the modelled cost of additional FETs – on average patients have an additional 1.88 FETs)
4	NHS C&M offer patients 3 rounds of IVF treatment. • ***Unsupported option***	This option is not supported because data suggests that the average number of IVF rounds is 1.36. Also, this option would require additional funding of over c.£734k pa and therefore does not support the ICB to meet its financial objectives.	The number of cycles does not affect protected characteristics.	Not completed as not supported.	This would result in an estimated cost of **£5,778,295.** Comparing this to the current position, this would result in an estimated **cost increase of £734,217 per year.**

3.4 Risks, Constraints & Dependencies

The following risks, constraints and dependencies have been highlighted as part of the development of the case for change.

Risks

The following risks have been identified:

Risk	Mitigating actions
Option 2: There is a risk of challenge during the public consultation from those patients in Knowsley, Halton, Warrington, Southport & Formby and South Sefton where currently 3 cycles are offered, and Liverpool, Wirral, Cheshire West and St Helens where currently 2 cycles are offered. If we reduce the number of cycles to 1, patients living in these Places may feel disadvantaged	There is an option to submit an Individual Funding Request if the patient could demonstrate clinical exceptionality. It should be noted however, that Liverpool Place have a policy of 2 cycles and 3 if clinical exceptionality is evidenced and there have been no instances of a 3rd IVF round approved. Whilst not a mitigation for these patients, reducing the IVF offer to 1 cycle would support the ICB to deliver savings in support of the financial challenge, and ensure that we can continue to provide this treatment across the whole of Cheshire and Merseyside
Option 2: If C&M ICB offers patients 1 cycle of IVF there is a risk that LWH would not receive enough income and therefore would not be sustainable as a Provider	This option would reduce LWH income by between £1m - £1.5m. A small element of this may be mitigated by planned productivity initiatives but would leave a deficit.
Option 3: There is a risk of challenge during the public consultation from those patients in Knowsley, Halton, Warrington, Southport & Formby and South Sefton where currently 3 cycles are offered, If we reduce the number of cycles to 2, patients living in these Places may feel disadvantaged.	C&M data shows that the average number of cycles patients have is 1.36, so the option to move to 2 cycles would support the majority of our patients. There is an option to submit an Individual Funding Request if the patient could demonstrate clinical exceptionality. It should be noted however, that Liverpool Place have a policy of 2 cycles and 3 if clinical exceptionality is evidenced and there have been no instances of a 3rd IVF round approved.
Option 3: There is a risk that unknown activity in non C&M Providers may mean that there is a significant number of CE patients having treatment out of area, due to geographical location.	Because of historic data reporting, we know that under £70,000 was spent in Cheshire with Greater Manchester providers. Assuming all of these are Cheshire E patients, there would be an estimated number of 4 patients requiring a 2nd cycle – Which would cost around £20k.
Option 3: If C&M ICB offers patients 2 IVF cycles, there is a risk that there will be increased activity levels for our provider Liverpool Women's Hospital. This increase will come from patients in Cheshire East who currently are eligible to 1 cycle. This would potentially increase waiting lists for treatment and will have a negative effect on women aged 40 and over, who are eligible for 1 cycle and may miss out on treatment due to a longer wait.	Offering 2 cycles of IVF for C&M patients will mean reducing the offer in Warrington, Halton, Sefton and Knowsley where patients are currently eligible for 3 cycles. Our data shows that the number of patients having 3 cycles per year and the estimated number of Cheshire East patients having a second cycle would result in minimal change to the activity levels and therefore minimal risk of introducing patient waiting lists. Patients in Cheshire East will sometimes choose to have their treatment in one of the Greater Manchester Trusts due to locality, so it is not expected that all of the estimated increased activity fall wholly on LWH.
All Options: Data from our providers has been used to inform the recommendations regarding the number of IVF cycles. There is a risk that this data may not be accurate as it is not patient identifiable – and is therefore based on averages.	To make for a richer data set, data has been collated and validated with LWH and Care Fertility. This will give a more accurate understanding of both Cheshire patients and Mersey patients. The options have been modelled using month 7 actuals with forecast end of year outturn for 2024/25 using SLAM data and verified by LWH finance and operational team.

Constraints

- The review is being undertaken in context of the reducing unwarranted variation recovery programme and the current financial climate.
- Due to the significance of the change, a public consultation exercise would be required in Cheshire and Merseyside to support either proposal to harmonise to one or two IVF cycles. In addition, it would be necessary to engage and consult with the Health Oversight and Scrutiny Committees in all affected Places for them to determine if this proposal is a significant development or variation. If so, a joint OSC would need to be formed. The availability and timing would largely be dictated by the Local Authorities, this would impact the timing of benefits delivery.
- Engagement/communication would also be required with local MPs.
- Consideration is needed regarding any delays to benefits delivery caused by the potential for 'call in' to the Secretary of State for Health & Care of any proposed service change – members of the public or organisations can write to the Secretary of State at any stage of the process.

Dependencies

- NHS C&M's communications and engagement team are currently focused on a number of pieces of public involvement work. Any public involvement requirements around IVF cycles will need to be considered alongside existing work plans.

4 Options Appraisal

For completeness, a range of options have been considered as part of the case for change, a brief description of the options, including subsequent actions required for Options 2, 3 or 4 is below:

Option 1: Do nothing (Option discounted)

Pros	Cons
• There would be no change in the ICB financial position.	• This would leave NHS C&M with an unharmonised position, patients would continue to have unequal access to IVF rounds. • There is an increased risk of challenge by Equalities and Human Rights commission re inequality in service access.

Option 2: Offer patients 1 cycle of IVF

Pros	Cons
• This offer is in line with most of our neighbouring ICBs offer. • Offering 1 cycle provides the greatest financial savings opportunity. • 661% of ICBs across the country offer 1 cycle.	• Data shows that the average number of cycles patients require is 1.36. Therefore offering 1 cycle would disadvantage patients who require an additional cycle. If the first cycle is not successful, observation and learnings are used to inform the second cycle in order to increase the potential for a successful live birth. This is especially relevant as patients are becoming more complex, are older, have comorbidities which affect their fertility or are under time pressure (e.g. fertility preservation). Although it is of note that patients could choose to fund this privately.

	• Risk of negative publicity for the ICB in those places that currently offer 2 or 3 cycles - patients will be generally dissatisfied, and this may result in an increase of complaints, therefore more time will need to be allocated to respond to these. • Patients on low income in 8 Places could be disadvantaged as they either receive 2 or 3 cycles currently, and if they fail to have a live birth in the first cycle, they would be required to self-fund which may not be financially possible. • A public consultation exercise would need to be held within 8 Places which would impact the time taken to implement and could be costly. • Does not match current NICE guidance of three cycles. • There is a sustained decline in birth rates across Cheshire and Merseyside. The OECD identifies a replacement fertility rate of 2.1 children per woman as necessary to maintain population levels. ONS data shows that the total fertility rate in C&M has been in consistence decline since 2021, falling to 1.49 in 2022. This trend presents significant long-term risks to the region's workforce and the sustainability of health and social services. Therefore, a reduction in cycles will undermine efforts to support population health and long-term system planning. • There is a risk on the mental health impact that childlessness has on couples, research shows that this is coupled with grief, depression and emotional stress which can impact on quality of life, this can be expected to increase. • Reducing NHS IVF cycles will potentially increase cost elsewhere as more patients will turn to cheaper IVF options in other countries with less regulation and potentially increasing the rates of multiple pregnancies, leading to maternal and neonatal morbidity and placing a greater financial and clinical burden on the NHS services downstream. • Data shows that 1 cycle of treatment (with subsequent FET's) gives a 56% chance of a live birth whereas with 2 cycles couples have a cumulative 68% chance of a live birth.

Option 3: Offer patients 2 cycles of IVF

Pros	Cons
• The average number of cycles patients currently have is 1.36, therefore the proposal of 2 cycles of IVF would support these findings and would enable learning to be taken from the first cycle and a different approach to be used for the second cycle with an aim to improving success. • Offering 2 cycles would be a positive for Cheshire East patients, as currently they are eligible for 1 cycle. • This option is supported by all clinicians including the Obs & Gynae clinical network and LWH Finance and Operational teams who will deliver the service.	• Patients in the 4 Places who offer 3 cycles, particularly if on low income, may feel they are disadvantaged by a reduction in the IVF cycle offer and this may generate negative publicity for the ICB. • A public consultation exercise would need to be held within 4 Places which would impact the time taken to implement. • Does not match current NICE guidance of three cycles, (NICE data shows that whilst the effectiveness of each cycle with regard to cumulative live birth rate increases with each cycle the effectiveness of each cycle is reduced). Our data modelling showing the average number of cycles per patient is 1.36. • This offer is higher than the national average (71% offering 1 cycle), our neighbouring ICB Cumbria and Lancashire offer patients 1 cycle of IVF. (Greater Manchester are in the process of harmonising their cycles offer). This would mean there is continued variation in access to subfertility services within the Northwest region and surrounding areas.

Option 4: Offer patients 3 cycles of IVF (Option discounted)

Pros	Cons
• Often if the first cycles are not successful, learnings are taken from this, and a different approach is used for the second and third cycles with an aim to improving success. • Offering 3 cycles would be a positive for Cheshire East, Cheshire West, Liverpool, St Helens and Wirral patients, currently they are eligible for 1 or 2 cycles. • A public involvement exercise could be a light touch communication approach. • Meets current NICE guidance, NICE data shows that whilst the effectiveness of each cycle with regard to cumulative live birth rate increases with each cycle, the effectiveness of each cycle is reduced.	• This offer is higher than our neighbouring ICB, Cumbria and Lancashire who offer 1 cycle. (Greater Manchester are in the process of harmonising their cycles offer). • This offer is higher than the country average, with 71% of ICBs offering 1 cycle. • This results in estimated additional cost to the ICB of £734k pa • The average number of cycles patients currently have is 1.36, therefore this option does not support data findings.

5.1 Financial Case

Options	Description (*Committed costs)	Recurrent cost annual	Comments
Option 1: Do nothing – Variation would remain in the number of IVF cycles offered across C&M	£5,043,081	£5,043,081	
Option 2: Offer patients 1 cycle of IVF across C&M	N/A	£3,728,347	This would result in estimated savings of £1,315,732 per year.
Option 3: Offer patients 2 cycles of IVF across C&M	N/A	£5,084,437	This would result in an estimated cost increase of £40,357 per year**.**
Option 3: Offer patients 3 cycles of IVF across C&M	N/A	£5,778,295	This would result in an estimated cost increase of £734,217 per year.

Annexes

Annex 1.1 **EIA for 1 IVF Cycle option**
Annex 1.2 **QIA for 1 IVF Cycle option (post panel review)**
Annex 1.3 **EIA for 2 IVF Cycles option**
Annex 1.5 **QIA for 2 Cycles option**

NHS
Cheshire and Merseyside

ANNEX 1.1

Equality Analysis Report

Pre-Consultation *(Use the same form but delete as applicable. If it is post-consultation it needs to include consultation feedback and results)*

C&M Wide

Start Date:	19/08/24	
Equality and Inclusion Service Signature and Date:	Nicky Griffiths	
Sign off should be in line with the relevant ICB's Operational Scheme of Delegation (*amend below as appropriate)		
***Place/ ICB Officer Signature and Date:**		
***Finish Date:**		
***Senior Manager Sign Off Signature and Date**		
***Committee Date:**		

1. Details of service / function:
Guidance Notes: Clearly identify the function & give details of relevant service provision and or commissioning milestones (review, specification change, consultation, procurement) and timescales.
This change concerns the number of IVF cycles within a harmonised sub-fertility policy. There is currently disparity across Cheshire and Merseyside on the number of IVF cycles offered as part of the sub-fertility policies: 1 cycle - Cheshire East 2 cycles – Liverpool, St Helens, Wirral, Cheshire West 3 cycles – Warrington, Southport & Formby, South Sefton, Halton, Knowsley The clinical policy harmonisation programme undertook an exercise to harmonise the number of cycles, and a working group set up to work through this. The working group proposed 1 or 2 cycles. Our data shows that the average number of cycles patients are currently having is 1.36. Following creation of the recovery programme, the review had to consider costing up both 1 and 2 cycles. This EIA considers the impact of a 1 IVF cycle policy.
What is the **legitimate aim** of the service change / redesign For example • Demographic needs and changing patient needs are changing because of an ageing population. • To increase choice of patients • Value for Money-more efficient service • Public feedback/ Consultation shows need/ no need for a service • Outside commissioning remit of ICB/NHS

- To ensure a harmonised approach across Cheshire and Merseyside for the number of IVF cycles offered within the sub-fertility policy.
- To ensure the ICB have had the opportunity to consider the risk and impact of reducing the number of IVF cycles to 1 across Cheshire and Merseyside in light of the current financial challenge.

2. Change to service.

To harmonise the number of IVF cycles across C&M – see above for current.

This EIA considers reducing to 1 cycle as there is a potential financial saving of @£1.2m

In addition, there are a number of other changes proposed to the policy to bring it in line with the latest evidence base including:

- The minimum age (23 years) has been removed as NICE no longer supports this.
- "Before the woman's 42nd birthday" has been changed to "before the woman's 43rd birthday" because this is consistent with NICE. NICE withdrew the recommendation for minimum age (23 years) in 2004, together with the increase of the upper age limit to forty-three.
- Some narrative has been changed to improve clarity and accuracy.
- The definition of childness confirms that any biological or adopted child would mean ineligibility for the policy.
- The right to a family has been confirmed to mean that once the patient has a successful live birth (baby has reached 12 months) they are no longer eligible for further treatment. This is only a change to E&W Cheshire whose current policy implies the patient can continue using the frozen embryos.
- BMI recommendations based on NICE guidance for women. Female partners will be required to achieve a BMI of 19-29.9 kg/m² before subfertility treatment begins. Women outside this range can still undergo investigations, but subfertility treatment will not commence until their BMI is within this range.
- Female and Male Smoking Status – The proposal is that both partners (i.e. female and/or male) should be confirmed non-smokers to access any subfertility treatment and must continue to be non-smoking throughout treatment. Providers should seek evidence from referrers and confirmation from patients. Providers should also include this undertaking on the consent form and ask patients to acknowledge that smoking could result in cessation of treatment. *Smoking increases the risk of infertility in women and men. Nicotine alone is known to affect development of the foetus and long-term safety data on e-cigarettes are unknown. Because of these concerns and issues, all forms of smoking (which includes cigarettes, e-cigarettes or NRT) are not permitted. Both partners are now included in the smoking restriction, and this is consistent with NICE guidance. The change to specify both partners and to include Nicotine Replacements could potentially result in a small number of patients being refused treatment. The change regarding Nicotine replacement is in relation to East and West Cheshire. Guidance states that all smoking and NRT can be harmful, including secondary smoking. This is **a change** in policy.
- Female and Male Drugs & Alcohol intake – Proposal: Male and female partners will be asked to give an assurance that their alcohol intake is within Department of Health guidelines, and they are not using recreational drugs. Any evidence to the contrary may trigger a pause in treatment with possible referral for a welfare of the child assessment and/or further information sought from the GP. The current Mersey policy applies to the person who is receiving treatment only whereas the other policies apply

to all partners whether they are receiving treatment or not. In addition, the evidence-based policy has been expanded to included situations where the clinician might have concerns about a potential alcohol/drug misuser and if this could have implications for the welfare of the child. This means that there is **some change**.

- Intra-uterine Insemination (IUI) / Donor Insemination (DI) – the position in Mersey policies will be introduced to Cheshire (change to number of cycles required before IVF) and Wirral (not routinely commissioned).
- Overseas Visitors eligibility for NHS- funded IVF treatment – a new section has been added to confirm the position for those patients applying for treatment if they are not ordinarily resident in the UK. The policy states that where a non-resident wishes to access IVF, they should be charged 150% of the National NHS tariff (or locally agreed price where applicable). IVF treatment charges should be made in advance of any treatment being given.
  If care is deemed an emergency by the Fertility Consultant, the provider and ICB can enter a risk share scheme and split 50% of the costs each. This is **a change** as is it an addition to the proposed policy but not a change to patient access as it reflects the existing process.

3. Barriers relevant to the protected characteristics

Guidance note: describe where there are potential disadvantages.

[ENTER RESPONSE HERE]

[COMPLETE DIFFERENTIAL MATRIX]

Protected Characteristic	Issue	Remedy/Mitigation
Age	• The minimum age (23 years) has been removed as NICE no longer supports this. • "Before the woman's 42nd birthday" has been changed to "before the woman's 43rd birthday" because this is consistent with NICE. NICE withdrew the recommendation for minimum age (23 years) in 2004, together with the increase of the upper age limit to forty-three. • Some narrative has been changed to improve clarity and accuracy**.** • Overall, this will result in a positive impact due to clarity and NICE evidence-based age guidelines, including the removal of the minimum age of twenty-three requirement, therefore widening access. *All age guidance is based on the evidence of successful fertility treatment. The changes proposed will mean a positive impact.	No action as this brings the policy in line with NICE guidance. This is a positive impact for patients and will increase the eligibility criteria for those patients under 23 and those over 42.

Protected Characteristic	Issue	Remedy/Mitigation
Disability (you may need to discern types)	The policy will have a positive impact on people who may have a disability as defined in the PSED / Equality Act 2010. This is because the policy has been designed so that fertility treatment is made available to those who have a medical condition and, or undergoing treatment that impacts on fertility. Treatment for cancer or other procedures which affect fertility are considered thoroughly within the policy. Cryopreservation of embryos, oocytes or semen is routinely commissioned before treatments or procedure (e.g. for cancer or other medically essential interventions such as a surgical procedure and/or administration of medication) which are known to affect fertility. This will be performed in accordance with the Human Fertilisation and Embryology Authority (HFEA) regulations and NICE guideline CG 156. Patients must satisfy the prevalent subfertility criteria when the time comes to use this stored material, and they must have been informed of this requirement before commencing cryopreservation. The cryopreserved material may be stored for 10 years or up to the female partner's 43rd birthday, whichever comes sooner. The ICB will ensure that communication needs are considered and factored into the Engagement and Consultation work.	No action
Gender reassignment	Eligibility for this treatment is that the patient must have a clinical reason for sub-fertility. Therefore, the policy is not inclusive for people who are proposing to undergo, or who are undergoing, or who have undergone gender reassignment. The policy is not clear, for example, where a male partner who has undergone gender realignment would be required to evidence subfertility if requesting fertility treatment (sperm donation) with a female partner. The policy needs to make clear the organisations position so that patients and staff have clear guidance. The proposed policy is an	This is an interim policy in order to harmonise the number of IVF rounds. Revised guidance is expected 2025 so the wider issues within the policy will be reviewed in a separate project.

Protected Characteristic	Issue	Remedy/Mitigation
	interim position because there is an expectation that NICE guidance will be reviewed and potentially could impact the stance the ICB propose on wider eligibility.	
Marriage and Civil Partnership	This group received protection under the Equality Act with regards to the main Equality Duty and it does not extend to service provision. The policy does not discriminate between marriage of either the opposite or same sex or Civil Partnerships. The policy does not have any criteria related to marital status and therefore this group is not a specific target for the Engagement and Consultation plan.	No action
Pregnancy and maternity	Key factors in the proposed policy regarding pregnancy and maternity include the storage periods and discontinuation of treatment after a live birth and the definition of childlessness. The Engagement and Consultation plan proposes to work with a range of groups including the Hewitt Fertility Centre. The HFC have also been represented on the working group.	Public consultation will take place once the ICB have approved an option, and comms will be provided to articulate the changes to the policy a part of this process.
Race	The working group considered the higher rates of Infant Mortality within the Black, Asian and other Ethnic groups. This factor was considered when agreeing that the proposed timescales for storage after a live birth would be 12 months. This is a positive impact. The policy proposal is - In accordance with the policy on “Childlessness”, the ICB will not fund storage of embryos and/or gametes following a live birth (or adoption of a child). However, the ICB will fund up to 12 months’ storage following the birth or adoption of a child to give the patient enough time to	The ICB will ensure that cultural sensitivities and language needs are considered and factored into the Engagement and Consultation work.

Protected Characteristic	Issue	Remedy/Mitigation
	decide whether they wish to self-fund, donate the stored material or consent to having any remaining gametes or embryos destroyed. However, the policy on “storage following a live birth” (above) also applies following a live birth (or adoption) and the patient is then permitted the 12 months’ period, beyond which NHS funding is no longer available.	
Religion and belief	Whilst there is a neutral impact in relation to the policy proposed, the ICB will ensure that religious and cultural sensitivities are considered and factored into the Engagement and Consultation work.	
Sex	The revision and harmonisation of the policy will result in a fairer, consistent, and clearer Subfertility policy across Cheshire and Merseyside. This will mean that couples accessing Fertility services will no longer be faced with disparity across the region. The policy has in the main been brought up to date with the best and latest guidance, NICE guidance CG 156. The harmonisation of the policy may mean that in some areas the number of cycles is increased, whilst in other areas they are reduced. This is unavoidable in ensuring equity. Both male and female patients will benefit from the clarity of position within the new policy. IVF Definition & Number of Cycles - The four policies are very similar but differ in terms of the number of cycles permitted. The definition of “IVF cycle” has been reviewed and is now more in line with NICE. The upper age limit has	Public engagement / consultation will take place once the ICB have approved progression of an option, and comms will be provided to articulate the changes to the policy a part of this process. This is an interim policy in order to harmonise the number of IVF rounds. Revised guidance is expected 2025 so the wider issues within the policy will be reviewed in a separate project.

Protected Characteristic	Issue	Remedy/Mitigation
	been increased to forty-three and the lower age limit of twenty-three has been removed. However, the ICB will need to agree its policy on the maximum number of permitted cycles which currently ranges from 1 to 3 cycles according to Place. For women aged <40, this option considers the maximum permitted cycles to be 1. The working group agreed that 1 or 2 cycles is appropriate. For information, over 90% of ICBs in England only permit two cycles (71% allow only one cycle). With regard to weight, the proposed policy now includes a statement that male partners with a BMI of over 30 should be informed that they are likely to have reduced fertility and should be encouraged to lose weight as this will improve their chances of a successful conception. Because this policy is the interim sub-fertility policy and eligibility is based on a clinical reason for sub-fertility, there is no change to provision for single sex couples therefore it may be that the policy disadvantages these patients as they have to self-fund some or all of the procedure.	
Sexual orientation	Because this policy is the interim sub-fertility policy and eligibility is based on a clinical reason for sub-fertility, there is no change to provision for single sex couples therefore it may be that the policy disadvantages these patients as they have to self-fund some or all of the procedure.	Public engagement / consultation will take place once the ICB have approved progression of an option, and comms will be provided to articulate the changes to the policy a part of this process
Whilst currently out of scope of Equality legislation it is also important to consider issues relating to socioeconomic status to ensure that any change proposal does not widen health inequalities. Socioeconomic status includes factors such as social exclusion and deprivation, including those associated with geographical distinctions (e.g. the North/South divide, urban versus rural). *Examples of groups to consider include:*		

Protected Characteristic	Issue	Remedy/Mitigation
refugees and asylum seekers, migrant, unaccompanied child asylum seekers, looked-after children/ care leavers, homeless people, prisoners and young offenders, veterans, people who live in deprived areas, People living in remote, and rural locations. *Health inclusion groups* *https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/inclusion-health-groups/* *For a more in-depth assessment of health inequalities please use the HEAT toolkit* https://www.gov.uk/government/publications/health-equity-assessment-tool-heat		
Refugees and asylum seekers	No impact	
Looked after children and care leavers	No impact	
Homelessness	No impact	
Worklessness	No impact	
People who live in deprived areas	No impact	
Carers	No impact	
Young carers	No impact	
People living in remote, rural and island locations	No impact	
People with poor literacy or health Literacy	No impact	
People involved in the criminal justice system: offenders in prison/on probation, ex-offenders.	No impact	
Sex workers	No impact	
People or families on a low income	If the patient does not have a successful live birth following a single IVF round, they would have to self-fund to try again. This may disadvantage those on a low income if they could not afford to self-fund as this may mean they cannot have a biological child.	Public engagement / consultation will take place once the ICB have approved progression of an option, and comms will be provided to articulate the changes to the policy a part of this process.
People with addictions and/or substance misuse issues	The proposed policy states that patients must demonstrate that their alcohol limits are within department of health guidelines and that they don't use recreational drugs. This is in line with	Public engagement / consultation will take place once the ICB have approved progression of an option, and comms will be provided to

Protected Characteristic	Issue	Remedy/Mitigation
	both the existing Mersey policy and NICE guidance. Technically those patients who have addictions could be disadvantaged by this clause, however, there is a safeguarding aspect to children in this environment.	articulate the changes to the policy a part of this process.
SEND / LD	No impact	
Digital exclusion	No impact	

4. What data sources have you used and considered in developing the assessment?

There has been extensive research carried out in the development of this policy. The Communication and Engagement plan will further inform the policy development. The policy has been written by a Public Health professional in conjunction with the Policy Harmonisation Steering Group and an Assisted Conception Working Group.

Key evidence includes the following:

- The main objectives of the Policy Harmonisation Group were to harmonise the policy positions across the region and to maintain consistency with the current NICE clinical guideline (CG 156) on fertility. The working group are aware that NICE are revising CG 156 which is due for publication in 2025. Because this represents a major revision, the ICB will review its policy again following publication of the revised CG 156.
  This policy has drawn on guidance issued by the Department of Health, Infertility Network UK and the NICE guidance (CG156) first published in February 2013 (updated in September 2017).
- https://fertilitynetworkuk.org/ & https://www.nice.org.uk/guidance/cg156/evidence/full-guideline-pdf-188539453https://www.nice.org.uk/guidance/cg156
- https://www.nice.org.uk/guidance/cg156/evidence/full-guideline-pdf-188539453 https://www.gov.uk/government/policies/reducing-drugs-misuse-and-dependence
- https://www.gov.uk/government/policies/reducing-harmful-drinking https://www.hfea.gov.uk/about-us/our-campaign-to-reduce-multiple-births/
- http://www.oneatatime.org.uk
- http://www.hfea.gov.uk/6195.html
- http://www.sexualhealthnetwork.co.uk/media/documents/HIV
- NHS cost recovery - overseas visitors - GOV.UK (www.gov.uk)

5. Involvement: consultation/ engagement

Guidance note: How have the groups and individuals been consulted with? What level of engagement took place? (If you have a consultation plan insert link or cut/paste highlights)

Once the options appraisal has been considered and a decision made on the number of IVF cycles, a public engagement / consultation exercise will be undertaken.

6. Have you identified any key gaps in service or potential risks that need to be mitigated

Guidance note: Ensure you have action for who will monitor progress.

Ensure smart action plan embeds recommendations and actions in Consultation, review, specification, inform provider, procurement activity, future consultation activity, inform other relevant organisations (NHS England, Local Authority).
This is an interim subfertility policy which aims to harmonise the C&M policies in line with NICE guidance and to harmonise the number of IVF cycles. There are other areas which are currently harmonised across C&M, and in line with guidance that haven't been addressed e.g. single sex assisted conception. Revised NICE guidance is expected in 2025 and the aim is to carry out a wider review at this time.

Risk	Required Action	By Who/ When
If the option of 1 IVF cycle round is approved, there is a risk of adverse publicity and a reputational risk for the ICB due to the reduction in access. This change impacts 8 of the 9 Places so negative feedback is likely.	A public engagement exercise will be carried out and messaging will be particularly important. It is worth noting that our neighbouring ICBs in the main offer 1 cycle.	Project Team supported by Comms
If option of 1 IVF cycle is accepted, patients who rely on that second cycle of IVF to have a biological baby will not be eligible. Therefore, we would be disadvantaging these patients. Patients in all Places except Cheshire East would be impacted by this option.	A public engagement exercise will be carried out and messaging will be particularly important. It is worth noting that our neighbouring ICBs in the main offer 1 cycle.	Project Team supported by Comms
Planned activity data from 2024/2025 for Liverpool Women's Hospital (LWH) has been used to model the financial impact on the number of cycles offered, there is a risk that the data may not be 100% accurate as it is not patient identifiable – therefore is based on assumptions and averages.	This planned activity data has been modelled up to predict the number of IVF cycles and fertility treatments that LWH should complete in 2024/25.	Project Team

7. Is there evidence that the Public Sector Equality Duties will be met (give details) Section 149: Public Sector Equality Duty (review all objectives and relevant sub sections)
PSED Objective 1: Eliminate discrimination, victimisation, harassment and any unlawful conduct that is prohibited under this act: (check specifically sections 19, 20 and 29)
PSED Objective 2: Advance Equality of opportunity. (check Objective 2 subsection 3 below and consider section 4)
Analysis post consultation
PSED Objective 2: Section 3. sub-section a) remove or minimise disadvantages suffered by people who share a relevant protected characteristic that are connected to that characteristic.
Analysis post consultation
PSED Objective 2: Section 3. sub-section b) take steps to meet the needs of people who share a relevant protected characteristic that are different from the needs of people who do not share it
Analysis post consultation
PSED Objective 2: Section 3. sub-section c) encourage people who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such people is disproportionately low.
Analysis post consultation
PSED Objective 3: Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. (consider whether this is engaged. If engaged consider how the project tackles prejudice and promotes understanding -between the protected characteristics)
Analysis post consultation
Health Inequalities: Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.14T);
[ENTER RESPONSE HERE]
PSED Section 2: Consider and make recommendation regards implementing PSED in to the commissioning process and service specification to any potential bidder/service provider (private/ public/charity sector)
Analysis post consultation
8. Recommendation to Board
Guidance Note: will PSED be met?
[ENTER RESPONSE HERE]
9. Actions that need to be taken
[ENTER RESPONSE HERE]

Annex 1.2 Quality Impact Assessment

NHS Cheshire and Merseyside

QUALITY IMPACT ASSESSMENT			
Project/Proposal Name	Unwarranted Variation Recovery Programme – Subfertility policy option 1 IVF round	Date of completion	06/05/2025
Programme Manager	Katie Bromley	Clinical Lead	Rowan Pritchard Jones

Background and overview of the proposals (can be copied from PID on Verto or from National/Regional commissioning guidance)

The Subfertility policy was included in the scope of the Clinical Policy Harmonisation programme, as currently each Place has its own policy and there is variation in access to these services across Cheshire and Merseyside. The Clinical Policy Harmonisation programme used an evidence-based approach to develop harmonised policies. There is currently disparity across Cheshire and Merseyside on the number of IVF rounds offered as part of the sub-fertility policies:
1 cycle - Cheshire East
2 cycles – Liverpool, St Helens, Wirral, Cheshire West
3 cycles – Warrington, Southport & Formby, South Sefton, Halton, Knowsley
The clinical policy harmonisation programme undertook an exercise to harmonise the number of cycles and a working group was set up to work through this. The working group proposed 1 or 2 cycles, an options appraisal is being undertaken to explore offering patients either 1 or 2 cycles of IVF.

Whilst NICE specifies 3 cycles should be offered, their Health Economics analysis describes the effectiveness of each cycle with regard to cumulative live birth rates and shows that whilst the chances of having a live birth increase with each cycle, the effectiveness and cost effectiveness of each cycle is reduced. For a woman aged 34, the birth rates for each cycle are estimated: 1 cycle: 30%, 2 cycles: 15%, 3 cycles 10%.
In addition, research shows that 73% of those ICBs that have already harmonised their position will fund only 1 cycle and 19% currently fund 2 cycles with <10% funding the full 3 cycles as recommended by NICE.

It is worth noting that our neighbouring ICBs offer the following:

- Lancashire and South Cumbria offer 1 IVF cycle.
- Greater Manchester currently under review.
- West Yorkshire offer 1 IVF cycle.
- Staffordshire and Stoke-on-Trent offer 1 IVF cycle.

Data from our provider Liverpool Women's Hospital shows that the average number of cycles that patients are currently having is 1.36 cycles (this was based on reviewing patient outcomes for patients receiving 2 and 3 IVF cycles over a 5 year period who did not have a live birth after the first cycle), therefore offering patients 2 cycles of IVF would enable the majority of our patients to achieve a successful outcome.

However, there is a requirement for the ICB to review its costs and use of resources, and therefore the option of reducing the offer to 1 cycle has been modelled and offers a potential saving of £1.3m.

To develop a harmonised policy, a decision needs to be made on the number of IVF cycles that patients are offered. An options appraisal is being undertaken to explore offering patients either 1 or 2 cycles. This QIA considers the impact of a 1 IVF cycle policy.

There are a number of other changes that have been made to bring the policy in line with NICE guidance e.g. minimum age, smoking status, weight requirements, definition of childness and right to a family definitions, which are documented in the corresponding EIA but where appropriate are called out in this document.

Reason For Change/Proposal
Currently C&M ICB has an unharmonised position with regard to the number of IVF cycles offered. A 2-cycle option is clinically recommended; however, a 1 cycle approach has been modelled due to our current financial situation and this reduction would offer savings. This option would mean reducing the offer in 8 Places, who all currently offer either 2 or 3 cycles. Only Cheshire East patients would not be affected by this option as they are already entitled to 1 cycle, this option would result in estimated savings of £1.3m per year.

Who is likely to be Impacted?	Public	X	Patients	X	Workforce		Other parts of the system	X
Please provide additional details, including scale	671 per year (2019 data)							
Who has been consulted with as part of the QIA development	There has been no formal consultation, a request to Board in May 25 is being made to request permission to progress a public consultation, however, the Obs & Gynae Clinical Network and Liverpool Women's Hospital Clinical, Operational and Finance Teams have all be involved in reviewing the options, proposed policy and supporting with activity and finance modelling.							
Financial Considerations	Current Costs		£5,043,081 per year		Proposed Costs		£3,727,350 per year	

Place/Local Sign off:						
Sign off group	Stage 2 QIA Panel	Date of meeting	12/05/25	Post mitigation risk score *(Likelihood x Consequence)*	Safety	3
					Effectiveness	12
					Experience	16
					Workforce/system	15

Annex 1.2 Quality Impact Assessment

NHS Cheshire and Merseyside

Has an EIA been completed?	Y	Has a DPIA been completed?	Y – full DPIA not required	Have identified risks been added to risk register?	N

Risk scores above 12 in any area of quality, including patient safety, clinical effectiveness or experience will be taken to QIA panel and must be included within the corporate risk register.

Patient safety						
Will the project or proposal impact on patient safety?	Positive impact Improved patient safety, such as reducing the risk of adverse events is anticipated	Neutral Impact May have an adverse impact on patient safety. Mitigation is in place or planned to mitigate this impact to acceptable levels	Negative impact Increased risk to patient safety. Further mitigation needs to be put in place to manage risk to acceptable level	Pre-mitigation Identified Risk Score (Prior to Mitigations)		
				L	C	Total L x C
Please consider… • Will this impact on the organisation's duty to protect children, young people and adults? • Impact on patient safety? • Impact on preventable harm? • Will it affect the reliability of safety systems? N/A • How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections to patients is reduced? N/A	There is no additional impact on adults and children at risk, however, the inclusion of males in the smoking and drug and alcohol intake criteria for Merseyside patients would have a positive impact on the child. If non-compliance evidence is found this could trigger a pause in treatment with possible referral for a welfare of the child assessment and/or further information sought from the GP. This is a positive impact on all patients including welfare of the child. The proposed policy is that both partners should be confirmed non-smokers due to the harmful impact nicotine	The proposals regarding the number of IVF cycles doesn't impact the risk of harm. If implemented the policy would impact patients positively as it would eliminate inequity across C&M.	For those patients who currently receive 2 or 3 cycles there may be an impact on their mental health if they were relying on NHS funded cycles to have a family, but aren't successful during the first cycle.	3	1	3

	has on fertility and foetal development. Likewise, the proposed policy on drug and alcohol intake applies to both partners as in the current Cheshire policy not just the partner undergoing treatment as in the current Mersey policy. This is a positive impact on all patients including welfare of the child.					

Mitigations					
Action	**Owner**	**Expected date of completion**	**Date completed**		
No specific mitigating actions identified for this section					
A comms and engagement approach would be developed to explain the rationale for the decision.	Katie Bromley	tbc			
		Post Mitigation Risk Score	3	1	3

Clinical Effectiveness	
Please confirm how the project uses the best, knowledge based, research	The proposed interim subfertility policy has, where possible, been developed using the latest NG156 NICE guidance and input from local expertise and knowledge. With regard to IVF cycles, it should be noted that NICE guidance (NG156) suggests 3 IVF cycles, however, this has been in place for over 10 years and processes are much improved. NICE Health Economics analysis describes the effectiveness of each cycle with regard to cumulative live birth rates and shows that whilst the chances of having a live birth increase with each cycle, the

	effectiveness and cost effectiveness of each cycle is reduced. For a woman aged 34, the birth rates for each cycle are estimated: 1 cycle: 30%, 2 cycles: 15%, 3 cycles 10%. The Working Group who helped develop the harmonised policy comprised fertility & GP clinicians who supported the review of number of IVF rounds based on this, however, 1 cycle is not an option that is supported clinically. C&M data shows that the average number of cycles is 1.36, with an average of 1.88 subsequent Frozen embryo transfers. For those patients who do not have a successful pregnancy after the first IVF round, there is an opportunity to learn from this and change the approach for the 2nd to increase the risks of success. If the ICB were to offer 1 cycle of IVF, this would remove this opportunity for those patients.					
Will the project or proposal impact on Clinical effectiveness?	**Positive impact** Clinical effectiveness will be improved resulting in better outcomes anticipated for patients	**Neutral Impact** May have an adverse impact on clinical effectiveness. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	**Negative impact** Significant reduction in clinical effectiveness. Further mitigation needs to be put in place to manage risk to acceptable level	Identified Risk Score (Prior to Mitigations)		
				L	C	Total L x C
Please consider… • How does it impact on implementation of evidence based practice? • How will it impact on clinical leadership N/A • Does it reduce/impact on variation in care provision? • Does it affect supporting people to stay well? N/A • Does it promote self-care for people with long term conditions? N/A • Does it impact on ensuring that care is delivered in the most clinically and cost effecting setting? N/A • Does it eliminate inefficiency and waste by design? N/A • Does it lead to improvements in care pathways? N/A	Where possible, the harmonised policy has been brought in line with NICE guidance. The harmonisation of policy in regard to childlessness, weight, smoking and drugs and alcohol intake and approach to Intra-Uterine Insemination (IUI) and ovarian reserve testing should support more patients to be successful in treatment. Outcomes will be monitored in the same way as they are now.	There would be no change to number of cycles for Cheshire East patients. There is a risk that for those patients are not successful in the first IVF cycle, would be disadvantaged by not being able to try a different approach in the second cycle.	The C&M Clinical Network do not support a 1 cycle option. The clinically supported option would be to offer 2 cycles of IVF; however, this QIA considers the impact of 1 cycle. NICE guidance NG156 advises that 3 cycles should be offered. However, C&M data suggests that the numbers of patients requiring 3 cycles is minimal with the average number of cycles being 1.36. Therefore a 1 cycle option is difficult to provide a clinical evidence base for, however, this proposal	3	4	12

	The subfertility policy has been developed with a MDT working group that consisted of Local Fertility Specialists, GPs, Healthwatch, Commissioners who helped to shape the policy. The working group recommended 1 or 2 cycles of IVF. The policy has been shared with the relevant clinical networks who were supportive of the alignment to NICE guidance across the whole of C&M and supported the "interim" approach whilst waiting for revised NICE guidance to ensure new policy positions are developed using all evidence.		would bring NHS C&M in line with over 70% of the ICBs who have already harmonised their policies (4 others have yet to do so). NICE health economics analysis describes that the effectiveness of each cycle with regard to cumulative live birth rate is reduced with each cycle (although there is still a greater chance of a live birth). For an average 34 year old, the 1st cycle is c 30% effective, the 2nd cycle is c 15% and the 3rd cycle is less than 10%.			

Mitigations					
Action	**Owner**	**Expected date of completion**	**Date completed**		
There are no mitigating actions specific to this criteria					
		Post Mitigation Risk Score	3	4	12

Patient Experience				
	Positive impact	Neutral Impact	Negative impact	Identified Risk Score (Prior to Mitigations)

Annex 1.2 Quality Impact Assessment

NHS
Cheshire and Merseyside

Will the project or proposal impact on patient experience?	Improved patient and carer experience anticipated	May have an adverse impact on patient and carer experience. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Significant reduction in patient and carer experience. Further mitigation needs to be put in place to manage risk to acceptable levels	L	C	Total L x C
Please consider… • What is the impact on protected characteristics, such as race, gender, age, disability, sexual orientation, religion and belief for individual and community health, access to services and experience? • What impact is it likely to have on self-reported experience of patients and service users? (Responses to national/local surveys/complaints/PALS/incidents) • How will it impact on the choice agenda? N/A • How will it impact on the compassionate and personalised care agenda? N/A • How might it impact on access to care or treatment? N/A	The proposed harmonised policy will ensure that patients have equal access to subfertility treatments in Cheshire and Merseyside. It will remove the current variation in the number of IVF cycles offered. The proposed harmonised policy would have a positive impact on patients younger than 23 years who want to start treatment as this minimum age has been removed as per NICE guidance. Women aged 42 are included in the policy in line with NICE guidance – previously the cut off was up to 42nd birthday. The current Mersey position on IUI / Donor Insemination (DI) has been introduced to Cheshire (clarification to number of cycles required before IVF) and Wirral (not routinely commissioned) however, activity for these treatments is minimal.	With regard to IVF cycles, a 1 cycle approach would have a neutral impact on Cheshire East patients as their offer would be in line with all other Places. Definitions of childlessness and right to a family have been clarified, however, this doesn't change the policy position except in Cheshire where previously patients were able to continue to use any remaining eggs following a live birth. The Department of Health (DoH) position on Overseas Visitors is now included in the proposed policy statement, however, this is not a change to process as it reflects the existing rules.	With regard to IVF cycles, a 1 cycle approach would negatively impact those patients who would have had a second or third attempt at IVF. They will have a worsened patient experience if they are unsuccessful in their first cycle particularly if they are unable to self-fund further cycles, they will be unable to have a biological family. • Patients in Knowsley, Halton, South Sefton, Southport & Formby & Warrington who currently are eligible for 3 cycles. • Patients in Liverpool, St Helens, Cheshire West and Wirral currently eligible for 2 cycles. The likelihood of PALS and complaints are expected to increase in these Places if the offer is reduced.	4	4	16

			With regard to the definition of childlessness, the current Cheshire policy implies that even if a patient had a live birth or adopted a child, they could continue with using all frozen embryos. This was not aligned across C&M and is not usual practice, so this has been removed, therefore these patients could feel disadvantaged. Because the status of male partners with regard to smoking & alcohol and drug use has an impact on eligibility in the proposed policy, treatment will only be provided if both partners comply with the requirements. This cohort could feel disadvantaged by this revised approach; however, the smoking requirement follows NICE CG156: “smoking can adversely affect fertility and the success rates of assisted reproductive techniques (in both men and women).” And the drugs and alcohol are based on evidence that			

			alcohol and recreational drugs reduce the chance of conception in both men and women.			

Mitigations					
Action	**Owner**	**Expected date of completion**	**Date completed**		
A comms and engagement approach would be developed to explain the rationale for the decision.	K Bromley / Olivia Billington	Tbc			
		Post Mitigation Risk Score	4	4	16

Workforce/System						
Will the project or proposal impact on the workforce or system delivery?	Positive impact Improved patient and carer experience anticipated	Neutral Impact May have an adverse impact on patient and carer experience. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Negative impact Significant reduction in patient and carer experience. Further mitigation needs to be put in place to manage risk to acceptable levels	Identified Risk Score (Prior to Mitigations)		
				L	C	Total L x C

Please consider… • Capacity and demand on services • Changes in roles N/A • Training requirements • Staff experience & morale • Redundancies N/A • Opportunities (including staff development) N/A • Impact on other parts of the system, including changes in pathways or access N/A • Increased demand • Financial stability • Safety N/A	The relaunch of the revised policy would require strong communications with the provider in order to ensure any new elements were understood and implemented correctly.	The move to 1 cycle would negatively impact demand at our provider Liverpool Women's (LWH) as their current plans contain greater activity than is needed to deliver activity for 1 cycle.	It is likely that moving to 1 cycle will have a negative impact on staff experience and morale for those working in our Provider organisation as they were supportive of the 2 cycle option. LWH have confirmed that reducing to 1 cycle would have a detrimental financial impact of between £1m and £1.5m and whilst they can identify some productivity improvements, it won't mitigate this financial loss.	5	3	15

Mitigations					
Action	**Owner**	**Expected date of completion**	**Date completed**		
Discussions will be had with LWH to advise of the proposal	Katie Bromley	12/05/25			
		Post Mitigation Risk Score	5	3	15

Annex 1.2 Quality Impact Assessment

NHS Cheshire and Merseyside

Summary

Decision made	Pre Mitigated Score	Mitigated score	Impact
Progress	16	16	Catastrophic
Not progress	6	4	Moderate
Score summary (add to front page)			
Negligible and Low risk	Moderate risk	Major risk	Catastrophic risk
1-3	4 - 7	8 - 12	13 - 25

- The 'progressed' risk scores are applicable if the 1 cycle option is approved. The 'not progressed' risk scores are applicable if the 2 cycle option is approved. In line with the ICB Risk Management Strategy, an ICB wide risk score for a risk-in-common should mirror that of the highest domain risk score.

Risk Impact Score Guidance

LEVEL	DESCRIPTOR	DESCRIPTION – ICB LEVEL
5	Catastrophic (>75%)	**Safety** - multiple deaths due to fault of ICB OR multiple permanent injuries or irreversible health effects OR an event affecting >50 people. **Quality** – totally unacceptable quality of clinical care OR gross failure to meet national standards. **Health Outcomes & Inequalities** – major reduction in health outcomes and/or life expectancy OR major increase in health inequality gap in deprived areas or socially excluded groups **Finance** – major financial loss - >1% of ICB budget OR 5% of delegated place budget **Reputation** – special measures, sustained adverse national media (3 days+), significant adverse public reaction / loss of public confidence major impact on trust and confidence of stakeholders
4	Major (50% > 75%)	**Safety** - individual death / permanent injury/ disability due to fault of ICB OR 14 days off work OR an event affecting 16 – 50 people. **Quality** – major effect on quality of clinical care OR non-compliance with national standards posing significant risk to patients.

		Health Outcomes & Inequalities – significant reduction in health outcomes and/or life expectancy OR significant increase in health inequality gap in deprived areas or socially excluded groups **Finance** - significant financial loss of 0.5-1% of ICB budget OR 2.5-5% of delegated place budget **Reputation** - criticism or intervention by NHSE/I, litigation, adverse national media, adverse public significant impact on trust and confidence of stakeholders
3	**Moderate (25% > - 50%)**	**Safety** - moderate injury or illness, requiring medical treatment e.g., fracture due to fault of ICB. RIDDOR/Agency reportable incident (4-14 days lost). **Quality** – significant effect on quality of clinical care OR repeated failure to meet standards **Health Outcomes & Inequalities** – moderate reduction in health outcomes and/or life expectancy OR moderate increase in health inequality gap in deprived areas or socially excluded groups **Finance** - moderate financial loss - less than 0.5% of ICB budget OR less than 2.5% of delegated place budget **Reputation** - conditions imposed by NHSE/I, litigation, local media coverage, patient and partner complaints & dissatisfaction moderate impact on trust and confidence of stakeholders
2	**Minor (<25%)**	**Safety** - minor injury or illness requiring first aid treatment **Quality** – noticeable effect on quality of clinical care OR single failure to meet standards **Health Outcomes & Inequalities** – minor reduction in health outcomes and/or life expectancy OR minor increase in health inequality gap in deprived areas or socially excluded groups **Finance** - minor financial loss less than 0.2% of ICB budget OR less than 1% of delegated place budget **Reputation** - some criticism slight possibility of complaint or litigation but minimum impact on ICB minor impact on trust and confidence of stakeholders
1	**Negligible (<5%)**	**Safety** - none or insignificant injury due to fault of ICB **Quality** – negligible effect on quality of clinical care **Health Outcomes & Inequalities** – marginal reduction in health outcomes and/or life expectancy OR marginal increase in health inequality gap in deprived areas or socially excluded groups

	Finance - no financial or very minor loss **Reputation** - no impact or loss of external reputation

The likelihood of the risk occurring must then be measured. Table 2 below should be used to assess the likelihood and obtain a likelihood score. When assessing the likelihood, it is important to take into consideration the existing controls (i.e. mitigating factors that may prevent the risk occurring) already in place.

Table 2 - Risk Likelihood Score Guidance

1	2	3	4	5
Rare The event could only occur in exceptional circumstances (<5%)	**Unlikely** The event could occur at some time (<25%)	**Possible** The event may well occur at some time (25%> -50%)	**Likely** The event will occur in most circumstances (50% > 75%)	**Almost certain** The event is almost certain to occur (>75%)

The impact and likelihood scores must then be multiplied and plotted on table 3 to establish the overall level of risk and necessary action.

Table 3 - Risk Assessment Matrix (level of risk)

LIKELIHOOD of risk being realised	**IMPACT (severity)** of risk being realised				
	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Almost Certain (5)	5	10	15	20	25

Low Risk	Moderate Risk	High Risk	Extreme Risk	Critical Risk

Risk Proximity
A further element to be considered in the risk assessment process is risk proximity. Risk proximity provides an estimate of the timescale as to when the risk is likely to materialise. It supports the ability to prioritise risks and informs the appropriate response in the monitoring of controls and development of actions.

A pragmatic approach to the use of risk proximity which supports leadership, decision making and reporting is used and is therefore determined to be applied to all Risks.

The proximity scale used is below:

Proximity and timescale for dealing with the risk	Within the current quarter	Within the financial year	Beyond the financial year
Rating	**A**	**B**	**C**

Likelihood, impact and proximity are dynamic elements and consequently all three must be reviewed and reassessed frequently in order to prioritise the response.

Sign off process			
Name	Role	Signature	Date
Olivia Billington	Project lead	Olivia Billington	06/05/25
Rowan Pritchard Jones	Clinical lead		
Katie Bromley	Programme manager	Katie Bromley	06/05/25
	PMO lead		
Once signed off by all above, then the QIA is submitted via qia@cheshireandmerseyside.nhs.uk **to QIA review group**			

PMO receipt					
Verto/PMO reference	N/A	Date QIA reviewed PMO		Reviewed by	

Annex 1.2 Quality Impact Assessment

NHS Cheshire and Merseyside

This section to be completed following review at the QIA review group				
Meeting Chair	Date of Meeting	Approved	Rejected	Comments/feedback
Chris Douglas	12.05.2025	14.05.25		Recommendations made for amendments to QIA for panel to be reconsidered at a later date: 1) Psychological impact to the patient to be articulated in patient safety domain 2) Negative impact on clinical effectiveness is to be reworded and centred on evidence 3) Further work to be undertaken on the system/workforce domain 4) Clarification of scores across all domains required

NHS
Cheshire and Merseyside

Annex 1.3

Equality Analysis Report
(Equality Impact Assessment)

Pre-Consultation *(Use the same form but delete as applicable. If it is post-consultation it needs to include consultation feedback and results)*

C&M Wide

Start Date:	21/08/2024	
Equality and Inclusion Service Signature and Date:		
Sign off should be in line with the relevant ICB's Operational Scheme of Delegation (*amend below as appropriate)		
***Place/ ICB Officer Signature and Date:**		
***Finish Date:**		
***Senior Manager Sign Off Signature and Date**		
***Committee Date:**		

1. Details of current service, function or policy:
Guidance Notes: Clearly identify the function & give details of relevant service provision and or commissioning milestones (review, specification change, consultation, procurement) and timescales.
This change concerns the number of IVF cycles within a harmonised subfertility policy. There is currently disparity across Cheshire and Merseyside on the number of IVF cycles offered as part of the subfertility policies: 1 cycle - Cheshire East 2 cycles – Liverpool, St Helens, Wirral, Cheshire West 3 cycles – Warrington, Southport & Formby, South Sefton, Halton, Knowsley. The clinical policy harmonisation programme undertook an exercise to harmonise the number of cycles, and a working group set up to work through this. The working group proposed either 1 or 2 cycles. Our data shows that the average number of cycles patients are currently having is 1.36 cycles. Following creation of the recovery programme, the review had to consider costing up both 1 and 2 cycles. This EIA considers the impact of 2 IVF cycles.
What is the **legitimate aim** of the service change / redesign For example • Demographic needs and changing patient needs are changing because of an ageing population. • To increase choice of patients • Value for Money-more efficient service

• Public feedback/ Consultation shows need/ no need for a service • Outside commissioning remit of ICB/NHS
• To ensure a harmonised approach across Cheshire and Merseyside for the number of IVF cycles offered within the subfertility policy. • To ensure the ICB have had the opportunity to consider the risk and impact of reducing the number of IVF cycles to 2 across Cheshire and Merseyside, as currently some Places offer 3 cycles.
2. Proposed change service, function or policy
Guidance Note: Describe the proposed changes. (New service, change to service specification or service delivery, change to policy / practice).
To harmonise the number of IVF cycles across C&M – see above for current offer. This EIA considers allowing for patients to have 2 cycles of IVF. Other policy positions have been updated to reflect NICE guidance to bring the policy in line with the latest evidence base, this has been covered in the EIA for 1 IVF cycle.
3. Barriers relevant to the protected characteristics
Guidance note: describe where there are potential disadvantages.
[ENTER RESPONSE HERE]
[COMPLETE DIFFERENTIAL MATRIX]

Protected Characteristic	Issue	Remedy/Mitigation
Age	• The minimum age (23 years) has been removed as NICE no longer supports this. • "Before the woman's 42nd birthday" has been changed to "before the woman's 43rd birthday" because this is consistent with NICE. NICE withdrew the recommendation for minimum age (23 years) in 2004, together with the increase of the upper age limit to forty-three. • Some narrative has been changed to improve clarity and accuracy. • Overall, this will result in a positive impact due to clarity and NICE evidence-based age guidelines, including the removal of the minimum age of twenty-three requirement, therefore widening access. *All age guidance is based on the evidence of successful fertility treatment.	No action as this brings the policy in line with NICE guidance. This is a positive impact for patients and will increase the eligibility criteria for those patients under 23 and those over 42.

Protected Characteristic	Issue	Remedy/Mitigation
	The changes proposed will mean a positive impact.	
Disability (you may need to discern types)	The policy will have a positive impact on people who may have a disability as defined in the PSED / Equality Act 2010. This is because the policy has been designed so that fertility treatment is made available to those who have a medical condition and or undergoing treatment that impacts on fertility. Treatment for cancer or other procedures which affect fertility are considered thoroughly within the policy. Cryopreservation of embryos, oocytes or semen is routinely commissioned before treatments or procedure (e.g. for cancer or other medically essential interventions such as a surgical procedure and/or administration of medication) which are known to affect fertility. This will be performed in accordance with the Human Fertilisation and Embryology Authority (HFEA) regulations and NICE guideline CG 156. Patients must satisfy the prevalent subfertility criteria when the time comes to use this stored material, and they must have been informed of this requirement before commencing cryopreservation. The cryopreserved material may be stored for 10 years or up to the female partner's 43rd birthday, whichever comes sooner. The ICB will ensure that communication needs are considered and factored into the Engagement and Consultation work.	No action
Gender reassignment	Eligibility for this treatment is that the patient must have a clinical reason for sub-fertility. Therefore, the policy is not inclusive for people who are proposing to undergo, or who are undergoing, or who have undergone gender reassignment. The policy is not clear, for example, where a male partner who has undergone gender realignment would be required to evidence subfertility if requesting fertility treatment (sperm donation) with a female partner. The	This is an interim policy in order to harmonise the number of IVF rounds. Revised guidance is expected in 2025 so the wider issues within the policy will be reviewed in a separate project.

Protected Characteristic	Issue	Remedy/Mitigation
	policy needs to make clear the organisations position so that patients and staff have clear guidance. The proposed policy is an interim position because there is an expectation that NICE guidance will be reviewed and potentially could impact the stance the ICB propose on wider eligibility.	
Marriage and Civil Partnership	This group received protection under the Equality Act with regards to the main Equality Duty and it does not extend to service provision. The policy does not discriminate between marriage of either the opposite or same sex or Civil Partnerships. The policy does not have any criteria related to marital status and therefore this group is not a specific target for the Engagement and Consultation plan.	No action
Pregnancy and maternity	Key factors in the proposed policy regarding pregnancy and maternity include the storage periods and discontinuation of treatment after a live birth and the definition of childlessness. The Engagement and Consultation plan proposes to work with a range of groups including the Hewitt Fertility Centre (HFC). The HFC have also been represented on the working group.	Public engagement / consultation will take place once the ICB have approved an option, and comms will be provided to articulate the changes to the policy a part of this process.
Race	The working group considered the higher rates of Infant Mortality within the Black, Asian and other Ethnic groups. This factor was considered when agreeing that the proposed timescales for storage after a live birth would be 12 months. This is a positive impact. The policy proposal is - In accordance with the policy on “Childlessness”, the ICB will not fund storage of embryos and/or gametes following a live birth (or adoption of a child). However, the ICB	The ICB will ensure that cultural sensitivities and language needs are considered and factored into the Engagement and Consultation work.

Protected Characteristic	Issue	Remedy/Mitigation
	will fund up to 12 months' storage following the birth or adoption of a child to give the patient enough time to decide whether they wish to self-fund, donate the stored material or consent to having any remaining gametes or embryos destroyed. However, the policy on "storage following a live birth" (above) also applies following a live birth (or adoption) and the patient is then permitted the 12 months' period, beyond which NHS funding is no longer available.	
Religion and belief	Whilst there is a neutral impact in relation to the policy proposed, the ICB will ensure that religious and cultural sensitivities are considered and factored into the Engagement and Consultation work.	
Sex	The revision and harmonisation of the policy will result in a fairer, consistent, and clearer subfertility policy across Cheshire and Merseyside. This will mean that couples accessing fertility services will no longer be faced with disparity across Cheshire and Merseyside. The policy has in the main been brought up to date with the best and latest guidance, NICE guidance CG 156. The harmonisation of the policy may mean that in some areas the number of cycles is increased, whilst in other areas they are reduced. This is unavoidable in ensuring equity. Both male and female patients will benefit from the clarity of position within the new policy. IVF Definition & Number of Cycles - The four policies are very similar but differ in terms of the number of cycles permitted. The definition of "IVF cycle" has been reviewed and is now more in line with NICE. The upper age limit has been increased to forty-three and the lower age limit of twenty-three has been removed. However, the ICB will need to agree its policy on the maximum number	Public engagement / consultation will take place once the ICB have approved an option, and comms will be provided to articulate the changes to the policy a part of this process. This is an interim policy in order to harmonise the number of IVF rounds. Revised guidance is expected 2025 so the wider issues within the policy will be reviewed in a separate project.

Protected Characteristic	Issue	Remedy/Mitigation
	of permitted cycles which currently ranges from 1 to 3 cycles according to Place. For women aged <40, this option considers the maximum permitted cycles to be 1. The working group agreed that 1 or 2 cycles is appropriate. For information, over 90% of ICBs in England only permit two cycles (71% allow only one cycle). With regard to weight, the proposed policy now includes a statement that male partners with a BMI of over 30 should be informed that they are likely to have reduced fertility and should be encouraged to lose weight as this will improve their chances of a successful conception. Because this policy is the interim sub-fertility policy and eligibility is based on a clinical reason for sub-fertility, there is no change to provision for single sex couples therefore it may be that the policy disadvantages these patients as they have to self-fund some or all of the procedure.	
Sexual orientation	Because this policy is the interim sub-fertility policy and eligibility is based on a clinical reason for sub-fertility, there is no change to provision for single sex couples therefore it may be that the policy disadvantages these patients as they have to self-fund some or all of the procedure.	Public engagement / consultation will take place once the ICB has approved an option, and a communication will be provided to articulate the changes to the policy a part of this process.

Whilst currently out of scope of Equality legislation it is also important to consider issues relating to socioeconomic status to ensure that any change proposal does not widen health inequalities. Socioeconomic status includes factors such as social exclusion and deprivation, including those associated with geographical distinctions (e.g. North/South divide, urban versus rural). *Examples of groups to consider include:*
refugees and asylum seekers, migrants, armed forces community, unaccompanied child asylum seekers, looked-after children, homeless people, prisoners and young offenders.

The Health Equity Assessment Tool (HEAT) can also be used as a tool to systematically address health inequalities to a programme of work and identify what action can be taken to reduce health inequalities.
https://www.gov.uk/government/publications/health-equity-assessment-tool-heat

Protected Characteristic	Issue	Remedy/Mitigation
Refugees and asylum seekers	No impact	
Looked after children and care leavers	No impact	
Homelessness	No impact	
Worklessness	No impact	
People who live in deprived areas	No impact	
Carers	No impact	
Young carers	No impact	
People living in remote, rural and island locations	No impact	
People with poor literacy or health Literacy	No impact	
People involved in the criminal justice system: offenders in prison/on probation, ex-offenders.	No impact	
Sex workers	No impact	
People or families on a low income	An option of 2 cycles is more inclusive to those patients on low income. If the patient does not have a successful live birth following the first IVF round, they would have a second chance under a 2-cycle policy. C&M data shows that the average number of cycles needed is 1.36 so this option would be not disadvantage those on a low income.	Public engagement / consultation will take place once the ICB has approved an option, and communications will be provided to articulate the changes to the policy a part of this process.
People with addictions and/or substance misuse issues	The proposed policy states that patients must demonstrate that their alcohol limits are within department of health guidelines and that they don't use recreational drugs. This is in line with both the existing Mersey policy and NICE guidance. Technically those patients who have addictions could be disadvantaged by this clause, however, there is a safeguarding aspect to children in this environment.	Public engagement / consultation will take place once the ICB have approved an option, and communications will be provided to articulate the changes to the policy a part of this process.
SEND / LD	No impact	
Digital exclusion	No impact	

NHS
Cheshire and Merseyside

4. What data sources have you used and considered in developing the assessment?
There has been extensive research carried out in the development of this policy. The communication and engagement plan will further inform the policy development. The policy has been written by a Public Health professional in conjunction with the clinical policy harmonisation steering group and an assisted conception working group. Key evidence includes the following: • The main objectives of the policy harmonisation group were to harmonise the policy positions across the region and to maintain consistency with the current NICE clinical guideline (CG 156) on fertility. The working group are aware that NICE are revising CG 156 which is due for publication in 2025. Because this represents a major revision, the ICB will review its policy again following publication of the revised CG 156. This policy has drawn on guidance issued by the Department of Health, Infertility Network UK and the NICE guidance (CG156) first published in February 2013 (updated in September 2017). • https://fertilitynetworkuk.org/ & https://www.nice.org.uk/guidance/cg156/evidence/full-guideline-pdf-188539453https://www.nice.org.uk/guidance/cg156 • https://www.nice.org.uk/guidance/cg156/evidence/full-guideline-pdf-188539453 https://www.gov.uk/government/policies/reducing-drugs-misuse-and-dependence • https://www.gov.uk/government/policies/reducing-harmful-drinking https://www.hfea.gov.uk/about-us/our-campaign-to-reduce-multiple-births/ • http://www.oneatatime.org.uk • http://www.hfea.gov.uk/6195.html • http://www.sexualhealthnetwork.co.uk/media/documents/HIV • NHS cost recovery - overseas visitors - GOV.UK (www.gov.uk)
5. Engagement / Consultation
Guidance note: How have the groups and individuals been engaged or consulted with? What level of engagement took place? (If you have a consultation plan insert link or cut/paste highlights)
Once the options appraisal has been considered and a decision made on the number of IVF cycles, a public engagement / consultation exercise will be undertaken.
6. Have you identified any key gaps in service or potential risks that need to be mitigated
Guidance note: Ensure you have action for who will monitor progress. Ensure smart action plan embeds recommendations and actions in Consultation, review, specification, inform provider, procurement activity, future consultation activity, inform other relevant organisations (NHS England, Local Authority).
This is an interim subfertility policy which aims to harmonise the C&M policies in line with NICE guidance and to harmonise the number of IVF rounds. There are other areas which are currently harmonised across C&M, and in line with guidance that haven't been addressed e.g. single sex assisted conception. Revised NICE guidance is expected in 2025 and the aim is to carry out a wider review at this time.

Risk	Required Action	By Who/ When
If the option of 1 cycle of IVF is approved, there is a risk of adverse publicity and a reputational risk for the ICB due to a reduction in access. This would impact 8 of the 9 places, so negative feedback is likely.	A public engagement exercise will be carried out and messaging will be particularly important. It is worth noting that our neighbouring ICBs in the main offer 1 cycle.	Project team supported by Comms
If the ICB reduces the number of IVF cycles to 2, patients who rely on that third cycle of IVF to have a baby will not be eligible. This will affect patients in Knowsley, Halton, Warrington, Southport & Formby and South Sefton. Therefore, we would be disadvantaging these patients.	A public engagement exercise will be carried out and messaging will be particularly important. It is worth noting that our neighbouring ICBs in the main offer 1 cycle.	Project team supported by Comms
Planned activity data from 2024/2025 for Liverpool Women's Hospital (LWH) has been used to model the financial impact of the number of cycles offered, there is a risk that the data may not be 100% accurate as it is not patient identifiable – therefore is based on assumptions and averages.	This planned activity data has been modelled up to predict the number of IVF cycles and fertility treatments that LWH should complete in 2024/25.	Project team

NHS
Cheshire and Merseyside

7. Is there evidence that the Public Sector Equality Duties will be met (give details) Section 149: Public Sector Equality Duty (review all objectives and relevant sub sections)
PSED Objective 1: Eliminate discrimination, victimisation, harassment and any unlawful conduct that is prohibited under this act: (check specifically sections 19, 20 and 29)
Analysis post consultation
PSED Objective 2: Advance Equality of opportunity. (check Objective 2 subsection 3 below and consider section 4)
Analysis post consultation
PSED Objective 2: Section 3. sub-section a) remove or minimise disadvantages suffered by people who share a relevant protected characteristic that are connected to that characteristic.
Analysis post consultation
PSED Objective 2: Section 3. sub-section b) take steps to meet the needs of people who share a relevant protected characteristic that are different from the needs of people who do not share it
Analysis post consultation
PSED Objective 2: Section 3. sub-section c) encourage people who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such people is disproportionately low.
Analysis post consultation
PSED Objective 3: Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. (consider whether this is engaged. If engaged consider how the project tackles prejudice and promotes understanding -between the protected characteristics)
Analysis post consultation
PSED Section 2: Consider and make recommendation regards implementing PSED in to the commissioning process and service specification to any potential bidder/service provider (private/ public/charity sector)
Analysis post consultation
Health Inequalities: Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.14T);
[ENTER RESPONSE HERE]
8. Recommendation to Board
Guidance Note: will PSED be met?
[ENTER RESPONSE HERE]
9. Actions that need to be taken
[ENTER RESPONSE HERE]

Annex 1.4 Quality Impact Assessment

NHS Cheshire and Merseyside

QUALITY IMPACT ASSESSMENT			
Project/Proposal Name	Reducing Unwarranted Clinical Variation – Subfertility policy option (2 IVF cycles)	Date of completion	14/05/2025
Programme Manager	Katie Bromley	Clinical Lead	Rowan Pritchard Jones

Background and overview of the proposals (can be copied from PID on Verto or from National/Regional commissioning guidance)

The Subfertility policy was included in the scope of the Clinical Policy Harmonisation programme, as currently each Place has its own policy and there is variation in access to these services across Cheshire and Merseyside. The Clinical Policy Harmonisation programme used an evidence-based approach to develop harmonised policies. There is currently disparity across Cheshire and Merseyside on the number of IVF rounds offered as part of the sub-fertility policies:
1 cycle - Cheshire East
2 cycles – Liverpool, St Helens, Wirral, Cheshire West
3 cycles – Warrington, Southport & Formby, South Sefton, Halton, Knowsley
The clinical policy harmonisation programme undertook an exercise to harmonise the number of cycles and a working group was set up to work through this. The working group proposed 1 or 2 cycles, an options appraisal is being undertaken to explore offering patients either 1 or 2 cycles of IVF.

Whilst NICE specifies 3 cycles should be offered, their Health Economics analysis describes the effectiveness of each cycle with regard to cumulative live birth rates and shows that whilst the chances of having a live birth increase with each cycle, the effectiveness and cost effectiveness of each cycle is reduced. For a woman aged 34, the birth rates for each cycle are estimated: 1 cycle: 30%, 2 cycles: 15%, 3 cycles 10%.
In addition, research shows that 73% of those ICBs that have already harmonised their position will fund only 1 cycle and 19% currently fund 2 cycles with <10% funding the full 3 cycles as recommended by NICE.

It is worth noting that our neighbouring ICBs offer the following:

- Lancashire and South Cumbria offer 1 IVF cycle.
- Greater Manchester currently under review.
- West Yorkshire offer 1 IVF cycle.
- Staffordshire and Stoke-on-Trent offer 1 IVF cycle.

Data from our provider Liverpool Women's Hospital shows that the average number of cycles that patients are currently having is 1.36 cycles (this was based on reviewing patient outcomes for patients receiving 2 and 3 IVF cycles over a 5 year period who did not have a live birth after the first cycle), therefore offering patients 2 cycles of IVF would enable the majority of our patients to achieve a successful outcome.

However, there is a requirement for the ICB to review its costs and use of resources, and this option would result in a cost increase of £40k per year. So a 1 cycle option has also been modelled, which would make an estimated £1.3m savings each year.

To develop a harmonised policy, a decision needs to be made on the number of IVF cycles that patients are offered. An options appraisal is being undertaken to explore offering patients either 1 or 2 cycles. This QIA considers the impact of a 2 IVF cycle policy.

There are a number of other changes that have been made to bring the policy in line with NICE guidance e.g. minimum age, smoking status, weight requirements, definition of childness and right to a family definitions, which are documented in the corresponding EIA but where appropriate are called out in this document.

Reason For Change/Proposal

Currently C&M ICB has an unharmonised position with regard to the number of IVF cycles offered. A 2-cycle option is clinically recommended; however, a 1 cycle approach has been modelled due to our current financial situation and this reduction would offer savings.

A 2 cycle option would mean reducing the offer in 4 Places and increasing the offer in 1 Place, who all currently offer either 1 or 3 cycles. Those patients in Liverpool, St Helens, Cheshire West and Knowsley would not be affected.

Who is likely to be Impacted?	Public	X	Patients	X	Workforce	X	Other parts of the system	X
Please provide additional details, including scale	671 per year (2019 data)							
Who has been consulted with as part of the QIA development	There has been no formal consultation, a request to Board in May 25 is being made to request permission to progress a public consultation, however, the Obs & Gynae Clinical Network and Liverpool Women's Hospital Clinical, Operational and Finance Teams have all be involved in reviewing the options, proposed policy and supporting with activity and finance modelling.)							
Financial Considerations	Current Costs		£5,043,081 per year		Proposed Costs		£5,083,438 per year	

Place/Local Sign off:						
Sign off group	Not required	Date of meeting		Post mitigation risk score *(Likelihood x Consequence)*	Safety	1
					Effectiveness	4
					Experience	4
					Workforce/system	1
Has an EIA been completed?	Y	Has a DPIA been completed?	Y – full DPIA not required	Have identified risks been added to risk register?	N	

Annex 1.4 Quality Impact Assessment

NHS Cheshire and Merseyside

Risk scores above 12 in any area of quality, including patient safety, clinical effectiveness or experience will be taken to QIA panel and must be included within the corporate risk register.

Patient safety						
Will the project or proposal impact on patient safety?	Positive impact Improved patient safety, such as reducing the risk of adverse events is anticipated	Neutral Impact May have an adverse impact on patient safety. Mitigation is in place or planned to mitigate this impact to acceptable levels	Negative impact Increased risk to patient safety. Further mitigation needs to be put in place to manage risk to acceptable level	Pre-mitigation Identified Risk Score (Prior to Mitigations)		
				L	C	Total L x C
Please consider… • Will this impact on the organisation's duty to protect children, young people and adults? • Impact on patient safety? • Impact on preventable harm? • Will it affect the reliability of safety systems? • How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections to patients is reduced?	The proposed policy is that both partners should be confirmed non-smokers due to the harmful impact nicotine has on fertility and foetal development. Likewise, the proposed policy on drug and alcohol intake applies to both partners as in the current Cheshire policy not just the partner undergoing treatment as in the current Mersey policy. This is a positive impact on all patients including welfare of the child. There is no additional impact on adults and children at risk, however, the inclusion of males in the smoking and drug and alcohol intake criteria for Merseyside patients would have a positive impact on the child. If	The proposals regarding the number of IVF cycles doesn't impact the risk of harm, if implemented the policy would impact patients positively as it would eliminate inequity across C&M.	For those patients who currently receive 3 cycles there may be an impact on their mental health if they were relying on NHS funded cycles to have a family, but aren't successful during the first or second cycle.	2	1	2

	non-compliance evidence is found this could trigger a pause in treatment with possible referral for a welfare of the child assessment and/or further information sought from the GP. This is a positive impact on all patients including welfare of the child.					

Mitigations					
Action	**Owner**	**Expected date of completion**	**Date completed**		
Our modelling shows that patients have on average 1.36 cycles and a 2 cycle option is clinically supported.	Katie Bromley		Complete		
A comms and engagement approach would be developed to explain the rationale for the decision.			Tbc		
		Post Mitigation Risk Score	1	1	1

Clinical Effectiveness	
Please confirm how the project uses the best, knowledge based, research	The proposed interim sub-fertility policy has, where possible, been developed using the latest NG156 NICE guidance and input from local expertise and knowledge. It should be noted that NICE suggests 3 IVF cycles, however this guidance has been in place for over 10 years and fertility processes are much improved.

Annex 1.4 Quality Impact Assessment

NHS Cheshire and Merseyside

	C&M data shows that the average number of cycles is 1.36, with an average of 1.88 subsequent Frozen embryo transfers. For those patients who do not have a successful pregnancy after the first IVF round, there is an opportunity to learn from this and change the approach for the 2nd cycle to increase success.					
Will the project or proposal impact on Clinical effectiveness?	Positive impact Clinical effectiveness will be improved resulting in better outcomes anticipated for patients	Neutral Impact May have an adverse impact on clinical effectiveness. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Negative impact Significant reduction in clinical effectiveness. Further mitigation needs to be put in place to manage risk to acceptable level	Identified Risk Score (Prior to Mitigations)		
				L	C	Total L x C
Please consider… • How does it impact on implementation of evidence based practice? • How will it impact on clinical leadership • Does it reduce/impact on variation in care provision? • Does it affect supporting people to stay well? • Does it promote self-care for people with long term conditions? • Does it impact on ensuring that care is delivered in the most clinically and cost effecting setting? • Does it eliminate inefficiency and waste by design? • Does it lead to improvements in care pathways?	Where possible, the harmonised policy has been brought in line with NICE guidance. For Cheshire East patients this will be positive, as patients will be eligible for an additional IVF cycle. Outcomes will be monitored the same way as they are currently. The harmonisation of policy in regard to childlessness, weight, smoking and drugs and alcohol intake and approach to Intra-uterine insemination and ovarian reserve testing should support more patients to be successful in treatment. Outcomes will be monitored in the same way as they are now.	For Liverpool, St Helens, Cheshire West and Wirral patients the number of IVF cycles eligible will remain at 2. For patients in Knowsley, Halton, S Sefton, Southport & Formby & Warrington patients this will have a negative impact as we are reducing the number of cycles from 3 to 2. Outcomes will be monitored in the same way as they are now.	This proposal is a higher offer than other ICB areas, with over 70% of the ICBs who have already harmonised their policies only offering 1 cycle (4 others have yet to do so). NICE guidance NG156 advises that 3 cycles should be offered. However, C&M data suggests that the numbers of patients requiring 3 cycles is minimal with the average number of cycles being 1.36. NICE health economics analysis describes that the effectiveness of each cycle with regard to cumulative live birth rate is reduced with each cycle (although there is still a greater chance of a live birth). For	2	3	6

	The subfertility policy has been developed with a MDT working group that consisted of Local Fertility Specialists, GPs, Healthwatch, Commissioners who helped to shape the policy. The working group recommended 1 or 2 cycles of IVF. The policy has been shared with the relevant clinical networks who also support the proposed policy including the 2-cycle option. The policy has been shared with the relevant clinical networks who were supportive of the alignment to NICE guidance across the whole of C&M and supported the "interim" approach whilst waiting for revised NICE guidance to ensure new policy positions are developed using all evidence.		an average 34 year old, the 1st cycle is c 30% effective, the 2nd cycle is c 15% and the 3rd cycle is less than 10%.			

Mitigations			
Action	**Owner**	**Expected date of completion**	**Date completed**
Our modelling shows that patients have on average 1.36 cycles and a 2 cycle option is clinically supported.	Katie Bromley		Complete
A comms and engagement approach would be developed to explain the rationale for the decision.			Tbc

Annex 1.4 Quality Impact Assessment

NHS Cheshire and Merseyside

		Post Mitigation Risk Score	2	2	4

Patient Experience						
Will the project or proposal impact on patient experience?	Positive impact Improved patient and carer experience anticipated	Neutral Impact May have an adverse impact on patient and carer experience. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Negative impact Significant reduction in patient and carer experience. Further mitigation needs to be put in place to manage risk to acceptable levels	Identified Risk Score (Prior to Mitigations)		
				L	C	Total L x C
Please consider… • What is the impact on protected characteristics, such as race, gender, age, disability, sexual orientation, religion and belief for individual and community health, access to services and experience? • What impact is it likely to have on self-reported experience of patients and service users? (Responses to national/local surveys/complaints/PALS/incidents)? • How will it impact on the choice agenda? • How will it impact on the compassionate and personalised care agenda? • How might it impact on access to care or treatment?	The proposed harmonised policy will ensure that patients have equal access to subfertility treatments in Cheshire and Merseyside. It will remove the current variation in the number of IVF cycles offered. For patients in Cheshire East, they will be offered an additional cycle. Positive impact on patients younger than 23 years who want to start treatment as this minimum age has been removed as per NICE guidance. Women aged 42 are included in the policy in line with NICE guidance – previously the cut off was up to 42nd birthday. The current Mersey position on Intra-uterine	Patients in Knowsley, Halton, South Sefton, Southport & Formby & Warrington who currently are eligible to 3 cycles will be impacted neutrally, as data shows the average number of cycles to be 1.36 cycles – so the likelihood is that minimal patients would be having the cycles. For patients in Liverpool, St Helens, Cheshire West and Wirral it will have a neutral impact as these patients are currently eligible to 2 cycles – so there will be no change. Definitions of childlessness and right to a family have been clarified, however, this	The current Cheshire policy implies that even if a patient had a live birth or adopted a child, they could progress with using all frozen embryos. This was not aligned across C&M and is not usual practice, so this has been removed, therefore these patients could feel disadvantaged. Because the status of male partners with regard to smoking & alcohol and drug use has an impact on eligibility in the proposed policy, treatment will only be provided if both partners comply with the requirements. This cohort may feel disadvantaged by this revised approach, however, the smoking	2	3	6

	Insemination (IUI) / Donor Insemination (DI) has been introduced to Cheshire (clarification on the number of cycles required before IVF) and Wirral (not routinely commissioned)	doesn't change the policy position except in Cheshire where previously they were able to continue to use any remaining eggs. The DoH position on eligibility of Overseas Visitors is now included in the proposed policy statement, however, this is not a change to process as it reflects the existing rules.	requirement follows NICE CG156: "smoking can adversely affect fertility and the success rates of assisted reproductive techniques (in both men and women)." And the drugs and alcohol is based on evidence that alcohol and recreational drugs reduce the chance of conception in both men and women.			

Mitigations					
Action	**Owner**	**Expected date of completion**	**Date completed**		
Our modelling shows that patients have on average 1.36 cycles and a 2-cycle option is clinically supported.	Katie Bromley		Complete		
A comms and engagement approach would be developed to explain the rationale for the decision.			Tbc		
		Post Mitigation Risk Score	2	2	4

Workforce/System				
	Positive impact	Neutral Impact	Negative impact	Identified Risk Score (Prior to Mitigations)

Annex 1.4 Quality Impact Assessment

NHS Cheshire and Merseyside

Will the project or proposal impact on the workforce or system delivery?	Improved patient and carer experience anticipated	May have an adverse impact on patient and carer experience. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Significant reduction in patient and carer experience. Further mitigation needs to be put in place to manage risk to acceptable levels	L	C	Total L x C
Please consider… • Capacity and demand on services • Changes in roles • Training requirements • Staff experience & morale • Redundancies • Opportunities (including staff development) • Impact on other parts of the system, including changes in pathways or access • Increased demand • Financial stability • Safety	The relaunch of the revised policy would require strong communications with the provider in order to ensure any new elements were understood and implemented correctly. It is likely that moving to 2 cycles would have a positive impact on staff experience and morale for those working in our Provider organisation as they were supportive of offering 2 cycles.			1	1	1

Mitigations

Action	Owner	Expected date of completion	Date completed		
There are no mitigating actions					
		Post Mitigation Risk Score	1	1	1

Annex 1.4 Quality Impact Assessment

NHS Cheshire and Merseyside

Summary

Decision made	Pre Mitigated Score	Mitigated score	Impact
Progress	6	4	Moderate
Not progress	16	16	Catastrophic
Score summary (add to front page)			
Negligible and Low risk	Moderate risk	Major risk	Catastrophic risk
1-3	4 - 7	8 - 12	13 - 25

- The ‘progressed’ risk scores are applicable if the 2-cycle option is approved. The ‘not progressed’ risk scores are applicable if the 1-cycle option is approved. In line with the ICB Risk Management Strategy, an ICB wide risk score for a risk-in-common should mirror that of the highest domain risk score.

Annex 1.4 Quality Impact Assessment

NHS Cheshire and Merseyside

Risk Impact Score Guidance

LEVEL	DESCRIPTOR	DESCRIPTION – ICB LEVEL
5	Catastrophic (>75%)	**Safety** - multiple deaths due to fault of ICB OR multiple permanent injuries or irreversible health effects OR an event affecting >50 people. **Quality** – totally unacceptable quality of clinical care OR gross failure to meet national standards. **Health Outcomes & Inequalities** – major reduction in health outcomes and/or life expectancy OR major increase in health inequality gap in deprived areas or socially excluded groups **Finance** – major financial loss - >1% of ICB budget OR 5% of delegated place budget **Reputation** – special measures, sustained adverse national media (3 days+), significant adverse public reaction / loss of public confidence major impact on trust and confidence of stakeholders
4	Major (50% > 75%)	**Safety** - individual death / permanent injury/ disability due to fault of ICB OR 14 days off work OR an event affecting 16 – 50 people. **Quality** – major effect on quality of clinical care OR non-compliance with national standards posing significant risk to patients. **Health Outcomes & Inequalities** – significant reduction in health outcomes and/or life expectancy OR significant increase in health inequality gap in deprived areas or socially excluded groups **Finance** - significant financial loss of 0.5-1% of ICB budget OR 2.5-5% of delegated place budget **Reputation** - criticism or intervention by NHSE/I, litigation, adverse national media, adverse public significant impact on trust and confidence of stakeholders
3	Moderate (25% > - 50%)	**Safety** - moderate injury or illness, requiring medical treatment e.g., fracture due to fault of ICB. RIDDOR/Agency reportable incident (4-14 days lost). **Quality** – significant effect on quality of clinical care OR repeated failure to meet standards **Health Outcomes & Inequalities** – moderate reduction in health outcomes and/or life expectancy OR moderate increase in health inequality gap in deprived areas or socially excluded groups **Finance** - moderate financial loss - less than 0.5% of ICB budget OR less than 2.5% of delegated place budget

		Reputation - conditions imposed by NHSE/I, litigation, local media coverage, patient and partner complaints & dissatisfaction moderate impact on trust and confidence of stakeholders
2	**Minor (<25%)**	**Safety** - minor injury or illness requiring first aid treatment **Quality** – noticeable effect on quality of clinical care OR single failure to meet standards **Health Outcomes & Inequalities** – minor reduction in health outcomes and/or life expectancy OR minor increase in health inequality gap in deprived areas or socially excluded groups **Finance** - minor financial loss less than 0.2% of ICB budget OR less than 1% of delegated place budget **Reputation** - some criticism slight possibility of complaint or litigation but minimum impact on ICB minor impact on trust and confidence of stakeholders
1	**Negligible (<5%)**	**Safety** - none or insignificant injury due to fault of ICB **Quality** – negligible effect on quality of clinical care **Health Outcomes & Inequalities** – marginal reduction in health outcomes and/or life expectancy OR marginal increase in health inequality gap in deprived areas or socially excluded groups **Finance** - no financial or very minor loss **Reputation** - no impact or loss of external reputation

The likelihood of the risk occurring must then be measured. Table 2 below should be used to assess the likelihood and obtain a likelihood score. When assessing the likelihood, it is important to take into consideration the existing controls (i.e. mitigating factors that may prevent the risk occurring) already in place.

Table 2 - Risk Likelihood Score Guidance

1	2	3	4	5
Rare The event could only occur in exceptional circumstances (<5%)	**Unlikely** The event could occur at some time (<25%)	**Possible** The event may well occur at some time (25%> -50%)	**Likely** The event will occur in most circumstances (50% > 75%)	**Almost certain** The event is almost certain to occur (>75%)

Annex 1.4 Quality Impact Assessment

NHS Cheshire and Merseyside

The impact and likelihood scores must then be multiplied and plotted on table 3 to establish the overall level of risk and necessary action.

Table 3 - Risk Assessment Matrix (level of risk)

LIKELIHOOD of risk being realised	**IMPACT (severity)** of risk being realised				
	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Almost Certain (5)	5	10	15	20	25

Low Risk	Moderate Risk	High Risk	Extreme Risk	Critical Risk

Risk Proximity

A further element to be considered in the risk assessment process is risk proximity. Risk proximity provides an estimate of the timescale as to when the risk is likely to materialise. It supports the ability to prioritise risks and informs the appropriate response in the monitoring of controls and development of actions.

A pragmatic approach to the use of risk proximity which supports leadership, decision making and reporting is used and is therefore determined to be applied to all Risks.

The proximity scale used is below:

Proximity and timescale for dealing with the risk	Within the current quarter	Within the financial year	Beyond the financial year
Rating	A	B	C

Likelihood, impact and proximity are dynamic elements and consequently all three must be reviewed and reassessed frequently in order to prioritise the response.

Annex 1.4 Quality Impact Assessment

NHS Cheshire and Merseyside

Sign off process			
Name	Role	Signature	Date
	Project lead		
	Clinical lead		
	Programme manager		
	PMO lead		
Once signed off by all above, then the QIA is submitted via qia@cheshireandmerseyside.nhs.uk **to QIA review group**			

PMO receipt					
Verto/PMO reference		Date QIA reviewed PMO		Reviewed by	

This section to be completed following review at the QIA review group				
Meeting Chair	Date of Meeting	Approved	Rejected	Comments/feedback

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Appendix Two

Subfertility Clinical Policy

Other proposed changes to NHS C&M Subfertility policies

Section	Current CCG policies	Evidence-based policy suggestion & proposed policy section	Major changes and Rationale	Impact
3. Definition of Subfertility, Timing of Access to Treatment & Age Range	3.1 Fertility problems are common in the UK, and it is estimated that they affect one in seven couples. 84% of couples in the general population will conceive within one year if they do not use contraception and have regular sexual intercourse. Of those who do not conceive in the first year, about half will do so in the second year (cumulative pregnancy rate 92%). In 25% of infertility cases the cause cannot be identified. 3.2 Where a woman is of reproductive age and having regular unprotected vaginal intercourse two to three times per week, failure to conceive within twelve months should be taken as an indication for further assessment and possible treatment. In the following circumstances an earlier assessment should be considered: • If the woman is aged 36 or over, then such assessment should be considered after 6 months of unprotected regular intercourse since her chances of successful conception are lower and the window of opportunity for intervention is less. • If there is a known clinical cause of infertility or a history of predisposing factors for infertility. 3.3 Women should be offered access to investigations if they have subfertility of at least 1 year duration (6 months for women aged 36 and over) and offered IVF if they have had subfertility of at least 2 years duration (12 months for women aged 36 and over) Additional criteria apply for IVF in women aged 40 – 42 (see paragraph 12.4). 3.4 If, as a result of investigations, a cause for the infertility is found, the patient should be referred for appropriate treatment without further delay.	4.1 Fertility problems are common in the UK and it is estimated that they affect one in seven couples. Eighty four percent of women in the general population will conceive within one year if they have regular, unprotected sexual intercourse. Of those who do not conceive in the first year, about half will do so in the second year (cumulative pregnancy rate 92%). In 25% of infertility cases the cause cannot be identified. 4.2 Where a woman is of reproductive age and having regular unprotected vaginal intercourse two to three times per week, failure to conceive within twelve months should be taken as an indication for further assessment and possible treatment. 4.3 In the following circumstances an earlier assessment should be considered: • If the woman is aged 36 or over, then such assessment should be considered after 6 months of unprotected regular intercourse since her chances of successful conception are lower and the window of opportunity for intervention is less. • If there is a known clinical cause of infertility or a history of predisposing factors for infertility. 4.4 Women should be offered MAR treatments if they have had subfertility of at least 2 years duration (12 months for women aged 36 and over) – this includes the initial 12-month period before the initial assessment. Additional criteria apply for IVF in women aged 40–42 (see paragraph 12.6). 4.5 This policy adopts NICE guidance that access to high level treatments including IVF should be offered to women up to the age of 42 years. First treatment cycles must be commenced before the woman's 43rd birthday. 4.6 Women will be offered treatment provided their hormonal profile is satisfactory i.e. in line with NICE CG156.	1. The minimum age (23 years) has been removed as this is no longer supported by NICE. 2. "Before the woman's 42nd birthday" has been changed to "before the woman's 43rd birthday" because this is consistent with NICE. 3. Additional Mersey paragraph (in green) has been deleted – the statements are not supported by the cited references. However, this topic is covered later in section 11. 4. Paragraph 3.3 rewritten to improve clarity/accuracy.	1. NICE withdrew the recommendation for minimum age (23 years) in 2004. 2. Together with the "increase" in upper age from before the woman's 42nd birthday to 43rd birthday, these changes in age limits are unlikely to have a significant impact. 3. The impact on additional costs with increasing this upper age limit has been detailed below **

Section	Current CCG policies	Evidence-based policy suggestion & proposed policy section	Major changes and Rationale	Impact
	Additional text in Mersey only The CCG will offer access to intra-uterine insemination (IUI) or donor insemination-(DI) services where appropriate after subfertility of at least 12 months duration. See Section 11. NICE guidance recommendations 117 – 119. P223 http://www.nice.org.uk/guidance/cg156/resources/cg156-fertility-full-guideline3 Fertility | Guidance and guidelines | NICE section 1.91 p31 This policy adopts NICE guidance that access to high level treatments including IVF should be offered to women between the ages of 23 – 42 years. First treatment cycles must be commenced before the woman's 42nd birthday (See section 12.4 for further details). Women will be offered treatment provided their hormonal profile is satisfactory i.e. in line with NICE CG156 section 6.3 guidance recommendations.	https://www.nice.org.uk/guidance/cg156 https://www.nice.org.uk/guidance/cg156/evidence/full-guideline-pdf-188539453		

Section	Current CCG policies	Evidence-based policy suggestion & proposed policy section	Major changes and Rationale	Impact
4. Definition of Childlessness	4.1 Funding will be made available where a couple have no living children from a current or any previous relationship i.e. if previous living child from current or previous relationship then excluded from subfertility treatment. 4.2 A child adopted by a patient or adopted in a previous relationship is considered to have the same status as a biological child. 4.3 Once a patient is accepted for subfertility treatment they will no longer be eligible for further treatment if a pregnancy leading to a live birth occurs or the patient adopts a child. Alternative text in E & W Cheshire only 4.3 Where a patient has started a cycle of IVF treatment and they have a pregnancy leading to a live birth, or the patient adopts a child, they can continue to complete this cycle but would not be eligible to start a further new cycle. (E Cheshire / W Cheshire)	7.1 Funding will be made available where a couple have no living children from a current or any previous relationship i.e. if there is a previous living child from a current or previous relationship, then patients are excluded from subfertility treatment. 7.2 A child adopted by a patient or adopted in a previous relationship is considered to have the same status as a biological child. 7.3 Once a patient is accepted for subfertility treatment, they will no longer be eligible for any other MAR treatment or procedures if a pregnancy leading to a live birth has occurred or the patient has adopted a child.	1. Around 75% of ICBs in England and 87% of the former CCGs concur with the evidence-based policy definition of childlessness related to living/adopted children. This definition is not covered by NICE because (presumably) this is a "non-clinical" factor. 2. All 4 current policies carry this same definition in 4.1 & 4.2 and thus are "harmonised". 3. The E & W Cheshire's modified version of paragraph 4.3 suggests that once a pregnancy occurs, the patient can continue using the frozen embryos from the existing cycle. This is unusual, and most policies state that once a woman is pregnant (or adopts a child), the NHS is no longer liable for further treatment. It is also inequitable that some women may receive treatment for more than one child, whereas others are ineligible for any NHS treatment at all.	1. The current and evidence-based policies are in broad agreement with each other and are consistent with the rest of the country. 2. There is unlikely to be a significant impact with regard to the cost to this policy. This will result in reduced activity and therefore a small financial saving. 3. The subject of storage of any remaining embryos following a live birth is covered in section 16.
8. Female and Male Body Mass Index (BMI)	8.1 Women Male and female partners will be required to achieve a BMI of 19-29.9 before subfertility treatment begins. Women outside this range can still undergo investigations, but subfertility treatment will not commence until their BMI is within this range. Alternative text in Wirral only Additional text in green. N.B. Although Wirral is the only CCG which specifies *male and female* patients , E & W Cheshire and Mersey CCGs cite women only in their statements. However, it has to be emphasised that the title in the Cheshire policies is "Female and Male BMI". This could leave the reader in some confusion as to whether the policy applies to men or women.	8.1 The woman intending to carry the pregnancy, will be required to achieve a BMI of 19-29.9 kg/m² before subfertility treatment begins. Women outside this range can still undergo investigations, but subfertility treatment will not commence until their BMI is within this range. 8.2 Men who have a BMI of 30 or over should be informed that they are likely to have reduced fertility, and they should be strongly encouraged to lose weight as this will improve their chances of a successful conception.	1. According to NICE, a BMI which is >30 in females has a negative impact on fertility. The chance of a live birth following IVF treatment falls with a female BMI outside the range 19-30. 2. Therefore, it is not unreasonable to withhold treatment until the female BMI is <30. 3. In men, a high BMI may become a consideration especially if male factor infertility is a problem. 4. NICE recommendation of "informing" men that their obesity is likely to have an impact on their fertility was based on the best available evidence at that time (2013).	1. It could be argued that the current CCG policies are so ambiguous that readers will be uncertain whether the BMI restrictions apply to both men and women. Therefore, the proposed policy brings greater clarity.

Section	Current CCG policies	Evidence-based policy suggestion & proposed policy section	Major changes and Rationale	Impact
9. Female and Male Smoking[1] Status	9.1 Patients (Male and female partners) should be confirmed non-smokers in order to access any subfertility treatment and must continue to be non-smoking throughout treatment. Providers should seek evidence from referrers and confirmation from patients. Providers should also include this undertaking on the consent form and ask patients to acknowledge that smoking could result in cessation of treatment. 9.2 It is preferable that couples are not using any nicotine products but if nicotine replacement therapy or e-cigarettes are being used by either person in the couple, this would not exclude fertility treatment. (Wirral, E Cheshire and W Cheshire) Alternative text in Mersey only Additional text in green. Additional paragraph in E & W Cheshire only Text in blue Mersey and Wirral contain paragraph 9.1 only.	**Female and Male Smoking * Status** 9.1 Both partners (i.e. female and/or male) should be confirmed non-smokers in order to access any subfertility treatment and must continue to be non-smoking throughout treatment. Providers should seek evidence from referrers and confirmation from patients. Providers should also include this undertaking on the consent form and ask patients to acknowledge that smoking could result in cessation of treatment. *Smoking increases the risk of infertility in women and men. Nicotine alone is known to affect development of the foetus and long-term safety data on e-cigarettes are unknown. Because of these concerns and issues, all forms of smoking (which includes cigarettes, e-cigarettes or NRT) are not permitted.	1. The Mersey policy refers to "patients" (as opposed to *male and female partners*) which suggests that smoking restrictions apply only to the person receiving treatment i.e. the "patient". This ignores the impact of second-hand smoke on the on the offspring and if the partner is also a smoker, the impact of smoking on their fertility. 2. Paragraph 9.2 (in blue) appears in E & W Cheshire policies only and this exempts couples using e-cigarettes and/or nicotine therapy. 3. According to NICE CG156, smoking can adversely affect fertility and the success rates of assisted reproductive techniques (in both men and women). 4. There are significant associations between maternal cigarette smoking in pregnancy and increased risks of small-for-gestational-age infants, stillbirth and infant mortality. 5. Nicotine-containing products (which include e-cigarettes) are not considered to be safe in pregnancy. 6. Whilst current evidence on e-cigarettes suggests these may be less toxic than smoking, long term safety data in the general population are lacking. 7. There is even less data on the impact and safety of e-cigarettes on fertility and on the developing foetus and beyond. 8. In addition, there is increasing concern about the propellants used in e-cigarettes which may be responsible for a number of reported deaths. 9. Because of these safety concerns on the growing foetus and offspring, paragraph 9.2 has been removed.	1. Both partners are now included in the smoking restriction, and this is consistent with NICE guidance. 2. Practically, the rewritten paragraph 9.1 is unlikely to have an impact on activity. 3. Removal of paragraph 9.2 could potentially result in a small number of patients being refused treatment albeit temporarily. However, it remains to be seen whether, in practice, Providers follow this policy for Cheshire patients.

Section	Current CCG policies	Evidence-based policy suggestion & proposed policy section	Major changes and Rationale	Impact
10. Female and Male Drugs & Alcohol intake	10.1 Patients Male and female partners will be asked to give an assurance that their alcohol intake is within Department of Health guidelines, and they are not using recreational drugs. Any evidence to the contrary will result in the cessation of treatment https://www.gov.uk/government/policies/reducing-drugs-misuse-and-dependence https://www.gov.uk/government/policies/reducing-harmful-drinking **Alternative text in Mersey only** Additional text in green.	10.1 Both partners (i.e. female and/or male) partners will be asked to give an assurance that their alcohol intake is within Department of Health guidelines, and they are not using recreational drugs. Any evidence to the contrary may trigger a pause in treatment with possible referral for a welfare of the child assessment and/or further information sought from the GP. https://www.gov.uk/government/policies/reducing-drugs-misuse-and-dependence https://www.gov.uk/government/policies/reducing-harmful-drinking	1. The Mersey policy applies to the person who is receiving treatment only whereas the other policies apply to all partners whether they are receiving treatment or not. 2. There is evidence that alcohol and recreational drugs reduce the chance of conception in both men and women. Also, there are the well-recognised adverse effects of alcohol on the growing foetus. 3. Required assurances on alcohol/recreational drug intake should, therefore, apply to both partners irrespective of which one is receiving treatment. 4. In addition, the evidence-based policy has been expanded to included situations where the clinician might have concerns about a potential alcohol/drug misuser and if this could have implications for the welfare of the child.	1. Practically, changing the requirement to include both partners in Mersey is unlikely to have an appreciable impact. 2. Providers will be able to confirm that the need for a welfare of the child assessment has always been standard practice.
11. Intra-uterine Insemination (IUI)/Donor Insemination (DI) & Intracytoplasmic Sperm Injection (ICSI)	11.1 In advance of IVF treatment Consider unstimulated intrauterine insemination (to a maximum of 6 cycles) as a treatment option in the following groups as an alternative to vaginal sexual intercourse: • People who are unable to, or would find it very difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or-psychosexual problem who are using partner or donor sperm; • People with conditions that require specific consideration in relation to methods of conception (for example, after sperm washing where the man is HIV positive); • People in same sex relationships. 11.2 For people with unexplained infertility, mild endometriosis or 'mild male factor infertility', who are having regular unprotected sexual intercourse, do not routinely offer intrauterine insemination, either with or without ovarian stimulation. Advise them to try to conceive for a total period of time as per section 3.3 before IVF will be considered.	11.1 Unstimulated intrauterine insemination is a treatment option in the following groups as an alternative to vaginal sexual intercourse: • People who are unable to, or would find it very difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or-psychosexual problem who are using partner or donor sperm; • People with conditions that require specific consideration in relation to methods of conception (for example, after sperm washing where the man is HIV positive); • People in same sex relationships (please see section 5 regarding eligibility and the need for the first 6 cycles to be self-funded). 11.2 For people in 11.1 above who have not conceived after 6 cycles of donor or partner insemination, despite evidence of normal ovulation, tubal patency and semen analysis, should be offered a further 6 cycles of unstimulated intrauterine insemination before IVF is considered.	1. Policies in Mersey, E & W West Cheshire are very similar with minor differences in wording. 2. The main difference is that paragraph 11.5 is missing in the Cheshire policies. This details the number of IUI cycles required before treatment and is consistent with NICE. 3. Paragraphs 11.1, 11.2 are closely aligned to current NICE recommendations. 4. The Wirral “no commission” policy is of grave concern as it contradicts current NICE guidance and is open to legal challenge. 5. Overall, the best representation of the NICE guideline is provided by the Mersey policy. The evidence-based policy, therefore, is largely based on this and has been expanded to include more appropriate recommendations from NICE. 6. For example, the new paragraph 11.4 on donor insemination are all NICE recommendations. 7. For same sex couples and single women (in 11.1), reference is made to section 5	1. With the exception of Wirral’s “not routinely commissioned” stance, the evidence-based policy is based on the Mersey/Cheshire policies and has been revised to improve clarity and include some additional NICE recommendations. 2. There is unlikely to be an appreciable change in access. 3. Only Providers can confirm whether they have rigidly adhered to the Wirral policy in the past. If they have there will be a number of patients who will now be

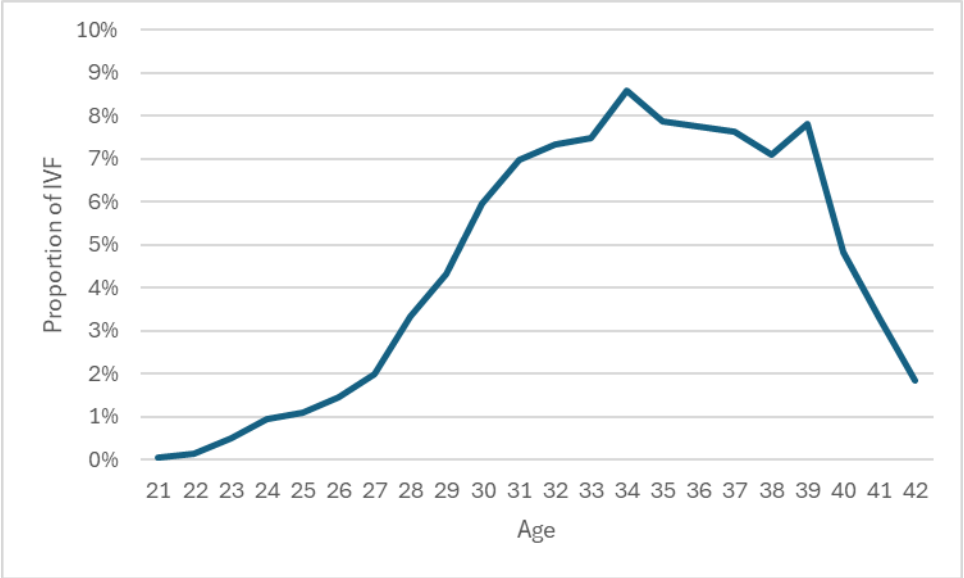
Section	Current CCG policies	Evidence-based policy suggestion & proposed policy section	Major changes and Rationale	Impact
	11.3 Donor insemination (with IUI) will be funded where clinically indicated. 11.4 Stimulated IUI will be funded where clinically indicated, due concern must be given to the risk of multiple births in this situation and insemination abandoned if this is felt to be a possibility. 11.5 Patients who are receiving IUI who have not conceived after 6 cycles of donor or partner insemination, despite evidence of normal ovulation, tubal patency and semen analysis, should be offered a further 6 cycles of unstimulated intrauterine insemination before IVF is considered. (NB this paragraph has been deleted in the Cheshire policies) 11.6 Patients who fail to achieve a pregnancy using IUI/DI will be considered for IVF. Alternative text in E & W Cheshire 1. Additional text in green. 2. Also note that paragraph 11.5 has been deleted in both Cheshire policies. **Section 11 Wirral only** **NB** Policy statement is "not routinely commissioned" for **ALL** of the above.	11.3 For people with unexplained infertility, mild endometriosis or 'mild male factor infertility', who are having regular unprotected sexual intercourse, do not routinely offer intrauterine insemination, either with or without ovarian stimulation. Advise them to try to conceive for a total of 2 years (or 12 months for women aged 36 and over) as per section 4 before IVF will be considered. 11.4 Donor insemination (with IUI) may be funded for the following indications:- • obstructive azoospermia • non-obstructive azoospermia • severe deficits in semen quality in couples who do not wish to undergo intracytoplasmic sperm injection (ICSI). • high risk of transmitting a genetic disorder to the offspring • high risk of transmitting infectious disease to the offspring or woman from the man • severe rhesus isoimmunisation 11.5 Stimulated IUI will be funded where clinically indicated, due concern must be given to the risk of multiple births in this situation and insemination abandoned if this is felt to be a possibility. 11.6 Patients who fail to achieve a pregnancy using IUI/DI will be considered for IVF. 11.7 For the sake of clarity, according to CG 156, 12 months of unprotected vaginal intercourse is considered to be equivalent to 6 cycles of artificial insemination. Further, the usual requirements for women aged ≥ 36 years are halved (in comparison to women aged <36 years) i.e. they may be required to experience a period of "watchful waiting" of 6 months (as opposed to 12 months in younger women) and/or to undergo 3 cycles of artificial insemination (as opposed to 6 cycles in younger women). 11.8 Intracytoplasmic Sperm Injection (ICSI) is routinely funded for:- • severe deficits in semen quality or • obstructive azoospermia or • non-obstructive azoospermia.	which specifies the need for self-funding of the first 6 cycles of artificial insemination. 8. The need for self-funding is discussed in more detail in section 5 above.	eligible for this treatment. However, our data shows that this will be minimal. Liverpool Women's Hospital data shows 56 cycles for 19 patients over a period of 6 years were completed. Care Fertility reported 0 IUI's over this same period.

Section	Current CCG policies	Evidence-based policy suggestion & proposed policy section	Major changes and Rationale	Impact
Overseas Visitors eligibility for NHS-funded IVF treatment	This is a new section and does not appear in any of the existing CCG policies.	6.1 An individual ordinarily resident in the UK is eligible for NHS funded fertility treatment. 6.2 Overseas visitors coming to, or remaining in, the UK for six months or more are usually required to pay the immigration health charge (referred to as the health surcharge, or IHS) unless an exemption from paying the surcharge applies or the charge is waived. 6.3 IVF is excluded from the list of NHS treatments overseas visitors can access, even if the above surcharge is paid. 6.4 Where a non-resident wishes to access IVF, they should be charged 150% of the National NHS tariff (or locally agreed price where applicable). IVF treatment charges should be made in advance of any treatment being given. 6.5 If care is deemed an emergency by the Fertility Consultant, the provider and ICB can enter a risk share scheme and split 50% of the costs each. 6.6 Current Guidance on Overseas Visitors and Eligibility can be found using the following link https://www.gov.uk/government/publications/nhs-cost-recovery-overseas-visitors.	1. This is a new section which has been written in conjunction with Liverpool Women's Hospital Overseas Visitors Team.	1. Although this section is new, the guidance on overseas visitor's access to fertility treatment is the same as the current position, it is just not called out in the policies.
16. Storage and cryopreservation of embryos, oocytes (eggs) and semen	19.1 Embryo, egg and sperm storage will be funded for patients who are undergoing NHS subfertility treatment in line with The Human Fertilisation and Embryology Authority guidance. The storage standard period for sperm, egg and embryo storage is normally ten years (subject to 4.3) **Additional text for E & W Cheshire** Additional text in green **Section 22: Cryopreservation** 22.1 Cryopreservation services in line with the relevant principals outlined in NICE IPG 156 Section 1.16 will be offered to: Women with premature ovarian failure under the age of 40 (see previous definition - see section 17).	17.1 Storage of embryos, oocytes or semen is routinely commissioned for eligible patients who are undergoing NHS subfertility treatment. Readers are required to interpret this section in conjunction with the ICB policy on "Childlessness". **Fertility Preservation before treatment for cancer (or other procedures which affect fertility)** 17.2 Cryopreservation of embryos, oocytes or semen is routinely commissioned before treatments or procedure (e.g. for cancer or other medically essential interventions such as a surgical procedure and/or administration of medication) which are known to affect fertility. This will be performed in accordance with the Human Fertilisation and Embryology Authority (HFEA) regulations and NICE guideline CG 156.	1. This section has been completely redrafted and combines sections 19 & 22. 2. It more accurately reflects the recommendations from NICE on this topic. 3. Strictly speaking, CG 156 recommends cryopreservation for patients about to receive treatment for cancer. However, reading the full guideline version, it is clearly apparent that the intention of the guideline committee was to provide cryopreservation for any treatment which could affect fertility. 4. Thus, paragraph 19.2 specifies cancer but also treatment for "other medically necessary interventions"	1.There is unlikely to be any cost implications for cryopreservation as this storage limit hasn't changed. 2. LWH finance colleagues have confirmed they are comfortable with all proposed changes and there is no significant financial impact.

Section	Current CCG policies	Evidence-based policy suggestion & proposed policy section	Major changes and Rationale	Impact
	Men and women with cancer, or other illnesses which may impact on fertility, may access tertiary care services to discuss fertility preservation (egg, embryo or sperm storage). Other illnesses are not defined in this policy but will be considered on an individual basis via an Individual Funding Request. Storage will be in-line with section 19. 22.2 The eligibility criteria set out in this policy do not apply to cryopreservation but do apply to the use of the stored material. 22.3 Storage of ovarian tissue will not be funded.	17.3 Patients must satisfy the prevalent subfertility criteria when the time comes to use this stored material and they must have been informed of this requirement before commencing cryopreservation. 17.4 The cryopreserved material may be stored for 10 years or up to the female partner's 43rd birthday, whichever comes sooner. **Following a live birth** 17.5 The ICB will fund up to 12 months' storage following the birth or adoption of a child (i.e. a "grace" period) to give the patient enough time to decide whether they wish to self-fund, donate the stored material or consent to having any remaining gametes or embryos destroyed. 17.6 This is in accordance with the ICB's policy on "Childlessness" and beyond the "grace" period, funding for storage will no longer be available. **18 Storage of Ovarian Tissue** 18.1 Storage of ovarian tissue is not routinely funded.	which is more in keeping with CG 156. 5. Patients will need to be confirmed as sub-fertile when the stored material is being used according to CG156 (recommendation 1.16.1.6) 6. The Working Group discussed the length of storage for a number of situations. 7. For cryopreservation, a period of 10 years was agreed, and this is consistent with the existing policy. 8. Section 17.5 'Following a live birth' was added to the policy at the request of the fertility experts on the working group. 9. The group were advised that a 6 – 12 months' storage period is standard for this situation.	

** Definition of Subfertility, Timing of Access to Treatment & Age Range - Impact

The graph below shows the IVF split over the past five years. It suggests that women aged 42 make up about 2% of all IVF activity at LWH. There's a clear pattern where the uptake increases from 29 onwards, peaking at age 34. It then starts to drop-off again gradually to 41, when it falls of steeply at age 42. Therefore, the impact of increasing this upper age limit by a year will have minimal impact on activity and costs.



NHS
Cheshire and Merseyside

Share your views on changes to fertility treatment policies in Cheshire and Merseyside

Share your views on changes to fertility treatment policies in Cheshire and Merseyside

What is happening?

NHS Cheshire and Merseyside Integrated Care Board (ICB) is responsible for planning local health care services.

Currently, we have ten separate policies covering NHS fertility treatments for people in Cheshire and Merseyside who are having problems getting pregnant. Because there are some variations in these policies, it means that people's access to fertility treatments depends on where they live.

We're proposing a new, single policy for the whole of Cheshire and Merseyside, which would mean that everyone would get equal access to treatment in our area.

Our new policy would include a number of changes based on the latest national guidance, but we are also proposing to make some changes for financial reasons. This includes reducing the number of in vitro fertilisation (IVF) cycles the NHS funds (pays for).

Between **3 June - 15 July 2025**, we are holding a six-week public consultation, so that people can find out more, and share their views. We will use the feedback we receive to make a final decision.

We are expecting new national guidance on fertility treatments to come out from The National Institute for Health and Care Excellence (NICE) later this year, so our new policy would be an interim one.

When this new guidance comes out, we will review it again to make sure our policy is up-to-date with the latest medical evidence.

The current situation

Cheshire and Merseyside includes nine different local authority areas (sometimes called ‘places’).

In the past, a number of smaller NHS organisations called clinical commissioning groups (CCGs) were responsible for setting local health policies across these areas.

NHS Cheshire and Merseyside took over the responsibilities of our local CCGs, when it was set up in 2022. Although CCGs no longer exist, we are still using some of their policies, including the ten separate ones which cover IVF, called ‘NHS Funded Treatment for Subfertility’ policies.

You can view the ten NHS Funded Treatment for Subfertility policies for Cheshire and Merseyside at: https://www.cheshireandmerseyside.nhs.uk/your-health/clinical-policies/. Simply scroll to the map at the end of the page and click on the area you want to see the policy for.

(**Note**: there are ten policies because Sefton has two separate policies – one from South Sefton CCG and one from Southport and Formby CCG).

What are we are proposing?

NHS Cheshire and Merseyside is proposing to replace its ten separate fertility policies with one single policy, so that in the future people have the same level of access to NHS fertility treatment wherever they live in our area.

Because our current policies have some differences, moving to a single policy would mean some changes.

Over the next few pages, we describe each of the changes we are looking to make, what they would mean for patients, and why we want to make them.

The table below gives an overview of the things we're looking at:

PROPOSED CHANGE 1: Change to the number of IVF cycles funded

In vitro fertilisation (IVF) is a type of fertility treatment that can help people who have difficulty getting pregnant. It involves an egg being fertilised by sperm outside of the body in a laboratory to create an embryo, which is then transferred into a uterus to achieve a pregnancy.

The National Institute for Health and Care Excellence (NICE) defines a 'full cycle' of IVF treatment as involving each of the following steps:

- **Ovarian stimulation:** Using medications to stimulate the ovaries to produce multiple eggs
- **Egg and sperm retrieval:** Mature eggs are collected from the ovaries
- **Fertilisation:** Eggs are fertilised with sperm in a laboratory setting which then develop into embryos
- **Embryo transfer:** One or more embryos are transferred into the uterus

- **Embryo freezing:** Any additional good quality embryos created in the cycle will be frozen and stored for use at a later date

A full cycle of IVF treatment only ends when either every viable embryo has been transferred, or one results in a pregnancy.

What happens at the moment?

Currently, around 734 people in Cheshire and Merseyside access NHS IVF each year. This figure is based on the number of first cycles that take place.

Treatment is provided by The Hewitt Fertility Centre at Liverpool Women's Hospital, which is part of NHS University Hospitals of Liverpool Group, and has facilities based in both Cheshire and Merseyside.

At the moment, people living in different parts of Cheshire and Merseyside have different numbers of IVF cycles paid for by the NHS, depending on where they live.

The table below shows how many cycles of IVF the NHS offers to people who are 39 or younger and meet the criteria for treatment:

Place	**Number of IVF cycles**
Cheshire East	1 cycle
Cheshire West	2 cycles - or 1 if Intrauterine insemination (IUI), has already been undertaken
Halton	3 cycles
Knowsley	3 cycles
Liverpool	2 cycles - although 3 may be considered in exceptional clinical cases
Southport and Formby	3 cycles
South Sefton	3 cycles
St Helens	2 cycles
Warrington	3 cycles
Wirral	2 cycles

People aged 40 and up to 42 are currently offered one cycle in all of the above areas.

NICE published clinical guidelines for assessing and treating fertility problems in 2013 which recommend that women aged under 40 years should be offered three full cycles of NHS funded IVF. You can read this at: www.nice.org.uk

Updates to this guidance were expected during 2024, with a focus on providing clearer and more equitable access to fertility treatment, but are now expected to be published later in 2025.

However, across England, 66% of Integrated Care Boards (ICBs), the organisations which make decisions about local NHS treatment policies, only provide one funded cycle of IVF.

What are we proposing to change?

We are proposing that in the new policy, everyone in Cheshire and Merseyside who is eligible for IVF would have one cycle paid for by the NHS.

This cycle would include one fresh and one frozen embryo transfer, followed by the transfer of all good quality frozen embryos until there is a successful live birth.

What would this change mean for patients?

If the change went ahead, it would mean that the number of cycles of IVF paid for by the NHS would reduce for people aged up to 39 in all areas of Cheshire and Merseyside, except in Cheshire East, where it would stay the same as it is now.

There would be no change for people aged between 40 and up to 42, as they are already offered one cycle in all of our areas.

If the change went ahead, once they had received a first cycle, people would no longer be able to have any additional cycles funded by the NHS.

Why are we proposing this?

Financial pressures

Across the country, the NHS is facing a serious financial challenge. ICBs like NHS Cheshire and Merseyside are given a fixed amount of money by NHS England each year to spend on local health care.

With demand for NHS services increasing, and the cost of providing care rising, we are facing some difficult decisions about how we spend this money.

Unfortunately, this means we might no longer be able to fund some of the things that we have in the past, and that for some areas of treatment, such as IVF, we are looking at reducing the overall costs of this care, so that we can continue providing it.

We need to decide how we best use our budget to have the biggest impact on the health and wellbeing of our local population. This is not an easy task, as it involves finding a balance between different priorities and the needs of different groups of people.

We know that some people will be concerned about the proposal to change the number of IVF cycles, and we understand that this is a sensitive issue for many.

However, we believe that moving to a single IVF cycle across our area is the best way to continue providing this treatment, while making sure that it remains affordable for the NHS.

Consistent care

We also want to ensure that people are offered the same number of NHS funded IVF cycles, wherever in Cheshire and Merseyside they live or are treated, which isn't the case at the moment.

Making this change would mean that the same level of NHS treatment was available to all eligible people living in our area.

What else did we look at before proposing changes to the number of IVF cycles?

1. **Making no changes**

NHS Cheshire and Merseyside is not considering keeping things as they currently are, because this would mean continuing with a situation where the number of NHS funded IVF cycles offered, and who has access to those cycles, varies depending on where people live. Whatever decision we take, we want to make sure that we have a more consistent approach in the future.

Also, if we keep things as they are now, we would not be able to reduce the cost, which is something we need to do.

2. **Two cycles**

We did consider whether we could provide two cycles of IVF to everyone who is eligible, and this was the option that local NHS fertility specialists supported. However, it is estimated that to do this would cost around £40,000 extra each year, compared to what is currently spent on IVF.

Because the NHS is facing such a serious financial situation, we do not believe this would be the best way to spend our limited resources. We need to look at options which would reduce the amount we spend on IVF cycles, not increase it.

3. **Three cycles**

We also looked at the impact of providing three cycles to everyone who was eligible, but it is estimated that this would cost around £734,000

extra each year. Again, for financial reasons we do not believe this would be the right approach.

Current costs and potential savings

Currently, NHS Cheshire and Merseyside spends more than £5 million each year funding IVF cycles. These costs (based on 2024/25) are broken down below by area:

Place	**Cost (annual)**
Cheshire East	£524,792
Cheshire West	£592,073
Halton	£200,291
Knowsley	£366,694
Liverpool	£1,627,967
Sefton	£663,716
St Helens	£235,435
Warrington	£257,001
Wirral	£575,113

The table below shows the estimated financial impact for the NHS, depending on whether one, two or three cycles of IVF were offered across Cheshire and Merseyside in the future:

Number of cycles	**Approximate cost each year to the NHS in Cheshire and Merseyside**
Offering 1 cycle across the whole of Cheshire and Merseyside	Would **save** £1.3 million per year
Offering 2 cycles across the whole of Cheshire and Merseyside	Would **cost an extra** £40,000 per year
Offering 3 cycles across the whole of Cheshire and Merseyside	Would **cost an extra** £734,000 per year

PROPOSED CHANGE 2: Change to eligibility on BMI (body mass index) in Wirral

BMI (body mass index) is a measure of whether you are a healthy weight for your height.

At the moment, nine out of ten Cheshire and Merseyside policies state that women need to have a BMI of between 19 and 29.9 in order to begin NHS fertility treatment. This is in line with national NICE guidelines, which recommend this weight range for the best chance of successful treatment.

However, the current Wirral policy says that a male partner should also meet this BMI in order for a couple to be eligible.

We are proposing that the new Cheshire and Merseyside policy would state that women intending to carry a pregnancy need a BMI of between 19 and 29.9 for fertility treatment to begin.

Men with a BMI of more than 30 would be advised to lose weight to improve their changes of conceiving, but this would not necessarily be a barrier to the couple accessing NHS fertility treatment.

What would this mean for patients?

If the new single policy was introduced, it would mean that in the future people living in Wirral would have the same access to fertility treatment based on BMI as people in other parts of Cheshire and Merseyside.

Why are we proposing this?

To bring our local approach in line with national NICE guidance, and to make it clearer that only a female partner's BMI would be considered when deciding on eligibility. It would also mean that the same approach is taken for everyone across Cheshire and Merseyside.

PROPOSED CHANGE 3: Change to eligibility on smoking

NICE guidelines state that maternal and paternal smoking can adversely affect the success of fertility treatment. This includes passive smoking.

However, our current policies for Halton, Knowsley, Liverpool, Sefton and St Helens only make reference to the female partner needing to be a non-smoker.

We are proposing that the new Cheshire and Merseyside policy will say that both partners will need to be non-smokers in order to be eligible for NHS fertility treatment. This would include any form of smoking, including the use of e-cigarettes and vapes.

This is because of the impact of on treatment outcomes, and the increased risk of complications in pregnancy.

What would this mean for patients?

If the new single policy were introduced, it would mean that in future people in Halton, Knowsley, Liverpool, Sefton and St Helens would not be eligible for NHS funded fertility treatment if either partner was a current smoker.

This wouldn’t be a change for people in Cheshire East, Cheshire West, Wirral or Warrington, because the policies for these areas already say this.

Why are we proposing this?

To bring our local approach in line with national NICE guidance, and to ensure that the same approach is taken for everyone across Cheshire and Merseyside.

PROPOSED CHANGE 4: Change to the definition of ‘childlessness’ in Cheshire East and Cheshire West

In the majority of areas in Cheshire and Merseyside, IVF will only be made available on the NHS where a couple has no living birth children or adopted children, either from a current or any previous relationship. This is consistent with the majority of other areas across England too.

This means that if someone had a baby through IVF, they would not be eligible for any further funded IVF cycles either.

However, the current policies for Cheshire East and Cheshire West state that where a patient has started a cycle of IVF treatment, they can have further embryo transfers to complete their current cycle, even if they achieve a pregnancy leading to a live birth or adopt a child during the cycle.

We are proposing that the new policy would not include this wording, meaning that funding would only be made available where a couple have no living children.

What would this mean for patients?

If this change went ahead, it would mean that people in Cheshire East and Cheshire West would no longer be offered more embryo transfers once they have become a parent.

Why are we proposing this?

To ensure that the same approach is taken for everyone across Cheshire and Merseyside.

PROPOSED CHANGE 5: Change to IUI commissioning in Wirral[1]

Intra uterine insemination (IUI), also sometimes known as artificial insemination, is a fertility treatment where sperm is put directly into the womb when a female is ovulating.

Female same-sex couples are often asked to self-fund IUI before they can access NHS funded fertility treatment as a means to prove their infertility.

Currently in most areas of Cheshire and Merseyside, in line with NICE guidance, the use of NHS funded IUI is also permitted for treating each of the following groups:

- People who are unable, or would find it difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psycho-sexual problem, who are using partner or donor sperm

- People with conditions that require specific consideration in relation to methods of conception (for example, after sperm washing where the man is HIV positive)

- People in same sex relationships

However, the Wirral policy currently states that IUI is not routinely commissioned, and this does not reflect NICE recommendations nor is it consistent with neighbouring areas.

In practice, NHS funded IUI is not carried out very often – Cheshire and Merseyside data shows that a total of just 56 NHS funded IUIs have been provided at Liverpool Women's Hospital over the past six years, which is an average of just nine per year.

We are therefore proposing that the single Cheshire and Merseyside policy would allow NHS funded IUI in the groups listed above, across all areas.

This change would not impact on the current requirement for self-funded IUI for same sex couples.

[1] Please note, this title was amended on 06/06/25 – the previous version was incorrect and did not reflect the change being proposed

What would this mean for patients?

This would mean NHS funded IUI is only offered to those patients who meet the above criteria, in line with NICE guidance. However, with such low numbers of patients accessing IUI, we believe that there would be minimal impact on people if this change went ahead.

Why are we proposing this?

It would mean a more consistent approach across Cheshire and Merseyside, and it would also bring our local policy in line with NICE guidance.

Wording on the lower and upper ages

In addition to the five changes listed above, we are also proposing that the new policy includes clearer wording around the upper and lower ages for fertility treatment.

This is because our ten current policies all say that NHS IVF treatment should be available to those from 23 years old up to 42 years of age in Cheshire and Merseyside.

However, we are proposing that the new policy doesn't state a lower age limit, which would bring it in line with current NICE guidance.

We are also proposing to use clearer wording around the upper age limit, to make it clear that people are eligible until their 43rd birthday.

We don't believe that amending the wording for the upper and lower age limits will have a significant impact on the number of people accessing treatment, but it will bring our local approach in line with current NICE guidelines, and make sure there aren't different ways to interpret what the policy says.

How to share your views

Before we make a final decision, we want to hear what people think, which is why we are holding this public consultation.

To share your views on the proposed changes to the policy, including the number of NHS funded IVF cycles offered to people in Cheshire and Merseyside, you can complete a short questionnaire. You can do this online at www.surveymonkey.com/r/9C72THS

The consultation closes on **15 July 2025** – so please make sure you've submitted your views by then.

If you're part of a community group or network, and you'd like us to come along to a meeting or event to talk about the proposal, or to share views on behalf of a group, charity or organisation, then please email us at: engagement@cheshireandmerseyside.nhs.uk

Need extra help?

If you would like some help to complete the questionnaire, or you need to request a printed version or an alternative format or language, please contact us using the details below.

If you would prefer, we're also happy for you to call us to share your questionnaire responses with us over the phone.

Phone: 0151 295 3052

Email: engagement@cheshireandmerseyside.nhs.uk

Post: Engagement Team, NHS Cheshire & Merseyside, No 1 Lakeside, 920 Centre Park Square, Warrington, WA1 1QY

Next steps

After the consultation period ends, we will analyse the findings and compile them into a report.

This report will be used to develop a final proposal for a single subfertility policy, which will then be put to the Board of NHS Cheshire and Merseyside, so that it can make a decision. This is likely to happen in late summer or early autumn 2025.

When a decision has been made, we will share information about the outcome, and what this means for people who use fertility services.

Until then, our current policies will apply, so people can continue to access treatments as they do now.

Stay updated

If you would like to stay in touch you can **sign up to receive monthly NHS Cheshire and Merseyside email updates at:**

www.cheshireandmerseyside.nhs.uk/latest/sign-up-for-updates/

You can **join our Community Voices group** to be invited to share your views on other health issues that matter to you at: www.cheshireandmerseyside.nhs.uk/get-involved/community-voices/

Glossary

Term	Definition
In vitro fertilisation (IVF)	A full cycle of IVF is defined as one episode of ovarian stimulation and the transfer of all resultant fresh and/or frozen embryo(s). If there are any remaining frozen embryos, the cycle is only deemed to have ended when all these embryos have been used up or if a pregnancy leads to a live birth.
Embryo	A fertilised egg.
Egg collection	As part of the IVF cycle, eggs are collected from the womb. The collection involves attempts to retrieve all eggs within the stimulated follicles in the ovary.
Embryo transfer	After egg collection, the best quality embryo(s) available are transferred into the womb. Often more than one embryo will be transferred at a time.
Embryo storage	This involves freezing and storing any embryos for a later transfer.
Fresh embryo transfer	This is when an embryo(s) is transferred fresh from collection, without being frozen and stored for later use.
Frozen embryo transfer (FET)	This is when a frozen embryo is warmed and transferred into the womb.
Intra-cytoplasmic sperm injections (ICSI)	Intra-cytoplasmic sperm injection. A common treatment for sperm-related male infertility. It is performed as part of IVF and involves the sperm being injected directly into the egg.
Intrauterine insemination (IUI), or artificial insemination	Sperm is put directly into the womb when the female is ovulating.

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Appendix Four

Subfertility Clinical Policy

Consultation Communications Plan Outline

Plan for public consultation

Changes to fertility treatment policies in Cheshire and Merseyside

Introduction

NHS Cheshire and Merseyside Integrated Care Board (ICB) has been reviewing its subfertility policies.

Currently, there are ten separate policies covering NHS fertility treatments for people in Cheshire and Merseyside. These are called NHS Funded Treatment for Subfertility policies.

NHS Cheshire and Merseyside is proposing a new single policy for the whole of Cheshire and Merseyside.

The new policy would include a number of changes based on the latest national guidance, but we are also proposing to make some changes for financial reasons. This includes the number of in vitro fertilisation (IVF) cycles.

Subject to Board approval, we are planning to hold a six-week public consultation between 3 June and 15 July 2025, so that people can find out more, and share their views. We will use the feedback we receive to make a final decision.

This document outlines the plan for public consultation. It should be read alongside the Board paper Sub Fertility Clinical Policy Status and Options for consideration, which contains additional background information about the proposal. The plan has been developed by NHS Cheshire and Merseyside's Communications and Engagement team, and will be presented to the Board of NHS Cheshire and Merseyside for approval ahead of public consultation launching.

Objectives

The public consultation objectives are:

- To inform patients and the public, carers/family members, and key stakeholders about the proposal to have a single subfertility policy for Cheshire and Merseyside, and explain what changes this would mean.

- To gather feedback on the proposal, including from people who are currently accessing or have accessed fertility services, organisations who support them (where applicable), their carers/family members, and the wider public, to understand views, including how people might be impacted if changes were to go ahead.

- To understand where there might be differences in responses between different groups/communities, including those with protected characteristics, in line with equalities duties.

- To use public consultation feedback to inform final decision-making around the proposal.

Consultation mechanisms and materials

Feedback will be gathered using a questionnaire containing a series of qualitative and quantitative questions, available online, or in a printed/alternative format or alternative language on request. Respondents will be able to contact NHS Cheshire and Merseyside's

communications and engagement team for help completing the questionnaire, including providing their feedback over the phone if required.

A consultation document will be made available, setting out supporting information about the proposed change. This will also be available in an Easy Read version, with alternative languages and formats available on request.

Both the questionnaire and supporting information will be hosted on a dedicated page in the 'Get involved' section of the NHS Cheshire and Merseyside website.

As part of the consultation, NHS Cheshire and Merseyside will offer to attend meetings of existing groups and networks to provide information about the proposal.

Members of the public will be directed to contact engagement@cheshireandmerseyside.nhs.uk or 0151 295 3052 with any enquiries about the consultation. NHS Cheshire and Merseyside's Patient Experience Team will be briefed on the engagement so that any enquiries that come through central routes can be directed appropriately.

Stakeholder enquires will be directed to communications@cheshireandmerseyside.nhs.uk

Analysis and reporting

Responses to the consultation will be analysed and compiled into a feedback report by NHS Cheshire and Merseyside's communications and engagement team.

The NHS Cheshire and Merseyside programme team which has been reviewing subfertility policies will use the consultation findings to produce a paper for the NHS Cheshire and Merseyside Board, so that they can make a final decision on the proposal. The feedback report will be appended to this paper, which will be presented to a meeting of the Board. It is expected that this will take place in public, in late summer/early autumn 2025.

Communications and promotion

NHS Cheshire and Merseyside will promote the opportunity to take part in the consultation across its own channels, including website, social media and in regular newsletters and briefings.

A toolkit for promoting the consultation – including social media assets and short and long form copy for newsletters and websites – will be shared with partners and wider networks for use on their own internal and external channels. This will include local authorities, hospital trusts, GP practices, Healthwatch organisations, the VCFSE (voluntary, community, faith and social enterprise) sector, and other relevant groups, including those which support people experiencing fertility issues.

To ensure that those who would be most impacted by any potential change have an opportunity to share their views, we will also work with colleagues at Liverpool Women's Hospital (NHS University Hospitals of Liverpool Group) to utilise existing patient communication routes, where possible.

Audiences and methods of communication and engagement

The table below provides an overview of key stakeholder groups, and details of how we intend to communicate with them during the public consultation. This is not exhaustive – during the consultation period we will continue to actively identify opportunities to reach different groups and communities to encourage them to take part, including those highlighted in the equality impact assessment (EIA).

The intention will be to issue an initial stakeholder briefing at the point the NHS Cheshire and Merseyside Board papers are published on 22 May 2025, followed by a second update on 3 June 2025 to launch the consultation (subject to Board approval).

Audience	**Proposed channel/method of communication and engagement**
Internal	
NHS Cheshire and Merseyside Integrated Care Board (ICB)	• General covering email with stakeholder briefing.
NHS C&M Staff	• Information in weekly staff brief.
NHS CM exec team and: • Ads of Quality and Improvement • Place directors. • Place clinical directors. • AD Place transformation leads	• Covering email with stakeholder briefing.
GP practice staff LMC and LPC	• Tailored email with stakeholder briefing. • GP Practice Bulletin – information and link to communications toolkit.
UK Health Security Agency – North West	• Covering email with stakeholder briefing.
HCP Partnership Board	• General covering email with stakeholder briefing.
Hewitt Fertility Centre Liverpool Women's Hospital (University Hospital Liverpool Group)	• Share stakeholder briefing
NHS trust communications teams – to share with COO / deputy / chair / CEO / medical directors	• Covering email with stakeholder briefing and comms toolkit for use on their channels.
NHS England NW Communications Team	• General covering email with stakeholder briefing.
Assisted Conception Working Group, Reducing Unwarranted Variation Steering Group and the Obs & Gynae Clinical Network	• Tailored covering email with link to stakeholder briefing to clinical networks and other groups.
External	
Current/previous patients	• Hewitt Fertility Centre to share information about consultation across existing patient communication channels, including utilising patient portal, patient participation group, patient support group and Facebook

	page. Wider Liverpool Women's communications channels will also be utilised.
General public across Cheshire and Merseyside	• Promotion across existing NHS Cheshire and Merseyside and partner channels, including social media and website, utilising toolkit.
Democratic services / committee clerks for OSC / HWBs	• Stakeholder briefing shared with OSC Chairs across C&M via democratic services teams in each local authority.
LA leaders / councillors / LA chief execs / Directors of Public Health/ LA comms team	• Tailored covering email to communications teams with stakeholder briefing for onward sharing, and communications toolkit for using on their channels. • Monthly stakeholder bulletin – copy with link to stakeholder briefing.
CHAMPS	• General covering email with stakeholder briefing and communications toolkit.
MPs	• General covering email with link to stakeholder briefing. • MP Briefing (distributed bi-monthly after Board meeting,)
Local voluntary, community, faith and social enterprise organisations (VCFSEs) and CVS organisations	• Tailored covering email with stakeholder briefing and communications toolkit for their channels.
Place communications and engagement collaboratives	• Share communications toolkit and request that they utilise information across their channels and networks.
Local Healthwatch organisations	• Tailored covering email with stakeholder briefing and comms toolkit for their channels • Stakeholder bulletin – copy with link to stakeholder briefing. • Discuss at quarterly communications and engagement meeting.
The media	• Press release to be issued at point Board papers are published, then (subject to Board approval) at point public consultation gets underway.
Community Voices	• Email to be sent to panel members.
Wider groups and networks	• Stakeholder briefing and communications toolkit to be shared with wider groups and networks, including those which represent people experiencing fertility issues.

Legal and statutory context

The main duties on NHS bodies to make arrangements to involve the public are set out in the National Health Service Act 2006, as amended by the Health and Care Act 2022 (section 14Z45 for integrated care boards and section 242(1B) for NHS trusts and NHS foundation trusts). As part of our legal duties, we are required to involve people when we are considering and developing proposals for change which would have an impact on the way in which services are delivered.

Involvement also has links with separate duties around equalities and health inequalities (section 149 of The Equality Act 2010 and section 14Z35 of the National Health Service Act 2006). As part of our work, we need to involve people with protected characteristics, social inclusion groups and those who experience health inequalities.

Local authority scrutiny

NHS commissioners must consult local authorities when considering any proposal for a substantial development or variation of the health service. Subject to the Board's approval of this plan, NHS Cheshire and Merseyside will commence discussions with each of the relevant local authorities.

Evaluation

It's important that we understand the effectiveness of different routes for reaching people, so that we can utilise this for future activity, and the questionnaire will ask people to state where they heard about the engagement. We will summarise this information – along with other measures such as number of enquiries received and visits to the website page – in the final consultation report.

ENDS

PROTOCOL FOR THE ESTABLISHMENT OF JOINT HEALTH SCRUTINY ARRANGEMENTS IN CHESHIRE AND MERSEYSIDE

1. INTRODUCTION

1.1 This protocol has been developed as a framework for the operation of joint health scrutiny arrangements across the local authorities of Cheshire and Merseyside. It allows for:

- scrutiny of substantial developments and variations of the health service; and,

- discretionary scrutiny of local health services.

1.2 The protocol provides a framework for health scrutiny arrangements which operate on a joint basis only. Each constituent local authority should have its own local arrangements in place for carrying out health scrutiny activity individually.

2. BACKGROUND

2.1 The relevant legislation regarding health scrutiny is:

- Health and Social Care Act 2012,

- The Local Authority (Public Health, Health and Wellbeing Boards and

- Health Scrutiny) Regulations 2013; and

- The Health and Care Act 2022.

This is supplemented by relevant guidance:

- Local Authority Health Scrutiny (DHSC, updated 2024)

- Statutory guidance: “Reconfiguring NHS services – ministerial intervention powers” (DHSC, 2024).

2.2 In summary, the statutory framework authorises local authorities individually and collectively to:

- review and scrutinise any matter relating to the planning, provision and operation of the health service; and,

- consider consultations by a relevant NHS commissioning body or provider of NHS-funded services on any proposal for a substantial development or variation to the health service in the local authority's area.

2.3 Ultimately the regulations place a requirement on relevant scrutiny arrangements to reach a view on whether they are satisfied that any proposal that is deemed to be a substantial development or variation is in the interests of the health service in that area. In instances where a proposal impacts on the residents of one local authority area exclusively, this responsibility lays with that authority's health scrutiny arrangements

alone.

2.4 Where such proposals impact on more than one local authority area, each authority's health scrutiny arrangements must consider whether the proposals constitute a substantial development or variation or not.

The regulations place a requirement on those local authorities that agree that a proposal is substantial to establish, in each instance, a joint overview and scrutiny committee for the purposes of considering it. This protocol deals with the proposed operation of such arrangements for the local authorities of Cheshire and Merseyside.

2.5 Whilst it is recognised that the previous power of a health scrutiny committee or joint health scrutiny committee to refer a service change proposal to the Secretary of State for Health and Social Care has been removed, such committees will now possess the ability to request formally that the Secretary of State "call-in" a service change proposal. The ability to "call-in" a proposal should only be used in exceptional circumstances where all efforts to resolve issues locally have been exhausted.

3. PURPOSE OF THE PROTOCOL

3.1 This protocol sets out the framework for the operation of joint scrutiny arrangements where:

a) an NHS commissioning body or health service provider consults with more than one local authority on any proposal it has under consideration, for a substantial development/variation of the health service;

b) joint scrutiny activity is being carried out on a discretionary basis into the planning, provision and operation of the health service.

3.2 The protocol covers the local authorities of Cheshire and Merseyside including:

- Cheshire East Council
- Cheshire West and Chester Council
- Halton Borough Council
- Knowsley Council
- Liverpool City Council
- St. Helens Metropolitan Borough Council
- Sefton Council
- Warrington Borough Council
- Wirral Borough Council

3.3 Whilst this protocol deals with arrangements within the boundaries of Cheshire and Merseyside, it is recognised that there may be occasions when consultations/discretionary activity may affect adjoining regions/ areas. Arrangements to deal with such circumstances would have to be determined and agreed separately, as and when appropriate.

4. PRINCIPLES FOR JOINT HEALTH SCRUTINY

4.1 The fundamental principle underpinning joint health scrutiny will be cooperation and partnership with a mutual understanding of the following aims:

- To improve the health of local people and to tackle health inequalities (outcome-focussed);
- To ensure that scrutiny activity adopts an appropriate balance between a focus on future service delivery and a focus on responding to immediate concerns/ issues (balanced)
- To represent the views of local people and ensure that these views are identified and integrated into local health service plans, services and commissioning (inclusive);
- To scrutinise whether all parts of the community are able to access health services and whether the outcomes of health services are equally good for all sections of the community (evidence-informed); and,
- To work with NHS bodies and local health providers to ensure that their health services are planned and provided in the best interests of the communities they serve, taking into account any potential impact on health service staff (collaborative).

5. SUBSTANTIAL DEVELOPMENT OF /VARIATION TO SERVICES

5.1 Requirements to consult

5.1.1 All relevant NHS bodies and providers of NHS-funded services (1) are required to consult local authorities when they have a proposal for a substantial development or substantial variation to the health service.

5.1.2 A substantial development or variation is not defined in legislation. Guidance has suggested that the key feature is that it should involve a major impact on the services experienced by patients and/or future patients.

(1) This includes NHS England and any body commissioning services to the residents of Cheshire and Merseyside, plus providers such as NHS Trusts, NHS Foundation Trust and any other relevant provider of NHS funded services which provides health services to those residents, including public health.

5.1.3 Where a substantial development or variation impacts on the residents within one local authority area boundary, only the relevant local authority health scrutiny function shall be consulted on the proposal.

5.1.4 Where a proposal impacts on residents across more than one local authority boundary, the NHS body/health service provider is obliged to consult all those authorities whose residents are affected by the proposals in order to determine whether the proposal represents a substantial development or variation.

5.1.5 Those authorities that agree that any such proposal does constitute a substantial development or variation are obliged to form a joint health overview and scrutiny committee for the purpose of formal consultation by the proposer of the development or variation.

5.1.6 Whilst each local authority must decide individually whether a proposal represents a substantial development/variation, it is only the statutory joint health scrutiny committee which can formally comment on the proposals if more than one authority agrees that the proposed change is “substantial”.

5.1.7 Determining that a proposal is not a substantial development/variation removes the ability of an individual local authority to comment formally on the proposal.. Once such decisions are made, the ongoing obligation on the proposer to consult formally on a proposal relates only to those authorities that have deemed the proposed change to be “substantial” and this must be done through the vehicle of the joint committee. Furthermore the proposer will not be obliged to provide updates or report back on proposals to individual authorities that have not deemed them to be “substantial”.

5.1.8 For the avoidance of doubt, if only one authority amongst a number being consulted on a proposal deem it to be a substantial change, the ongoing process of

consultation on the proposal between the proposer and the remaining authority falls outside the provisions of this protocol.

5.2 Process for considering proposals for a substantial development/variation

5.2.1 In consulting with the local authority in the first instance to determine whether the change is considered substantial, the relevant NHS commissioning body / provider of NHS-funded services is required to:

- Provide the proposed date by which it requires comments on the proposals

- Provide the proposed date by which it intends to make a final decision as to whether to implement the proposal- ublish the dates specified above

- Inform the local authority if the dates change (2)

5.2.2 NHS commissioning bodies and local health service providers are not required to consult with local authorities where certain 'emergency' decisions have been taken. All exemptions to consult are set out within regulations. (3)

(2) Section 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

(3) Section 24 ibid

5.2.3 In considering whether a proposal is substantial, all local authorities are encouraged to consider the following criteria:

- Changes in accessibility of services: any proposal which involves the withdrawal or change of patient or diagnostic facilities for one or more speciality from the same location.
- Impact on the wider community and other services: This could include economic impact, transport, regeneration issues.
- Patients affected: changes may affect the whole population, or a small group. If changes affect a small group, the proposal may still be regarded as substantial, particularly if patients need to continue accessing that service for many years.
- Methods of service delivery: altering the way a service is delivered may be a substantial change, for example moving a particular service into community settings rather than being entirely hospital based.
- Potential level of public interest: proposals that are likely to generate a significant level of public interest in view of their likely impact.

5.2.4 These criteria will assist in ensuring that there is a consistent approach applied by each authority in making their respective decisions on whether a proposal is

"substantial" or not. In making the decision, each authority will focus on how the proposals impacts on its own area/ residents.

6. OPERATION OF A STATUTORY JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

6.1 General

6.1.1 A joint health overview and scrutiny committee will be made up of each of the constituent local authorities that deem a proposal to be a substantial development or variation. This joint committee will be formally consulted on the proposal and, in exceptional circumstances, formally request that the Secretary of State to "call-in" a proposal, where local consultation has failed to resolve significant outstanding issues.

6.1.2 A decision as to whether the proposal is deemed substantial shall be taken within a reasonable timeframe and in accordance with any deadline set by the lead local authority (see section 6.6), following consultation with the other participating authorities.

6.2 Powers

6.2.1 In dealing with substantial development/variations, any statutory joint health overview and scrutiny committee that is established can:

- require relevant NHS bodies and health service providers to provide information to and attend before meetings of the committee to answer questions

- make comments on the subject proposal by a date provided by the NHS body/local health service provider

- make reports and recommendations to relevant NHS bodies/local health providers

- require relevant NHS bodies/local health service providers to respond within a fixed timescale to reports or recommendations

- carry out further negotiations with the relevant NHS body where it is proposing not to agree to a substantial variation proposal.

6.2.2 A joint health overview and scrutiny committee has the ability to request the Secretary of State to "call-in" a service change proposal where it has not been possible to resolve significant outstanding issues during the course of local consultation. The ability to request the "call-in" of a proposal should only be exercised in exceptional circumstances where all possible efforts to resolve the matter locally have been exhausted, as outlined in 6.2.3 and 6.2.4 below.

6.2.3 Where a committee has made a recommendation to a NHS commissioning body/local health service provider regarding a proposal and the NHS body/provider

disagrees with the recommendation, the local health service provider/NHS body is required to inform the joint committee and attempt to enter into negotiation to try and reach an agreement.

6.2.4 In any circumstance where a committee disagrees with a proposal for a substantial variation, there will be an expectation that negotiations will be entered into with the NHS commissioning body/local health service provider in order to attempt to reach agreement.

6.2.5 Where local authorities have agreed that the proposals represent substantial developments or variations to services and agreed to enter into joint arrangements, it is only the joint health overview and scrutiny committee which may exercise these powers.

6.2.5 An ad-hoc statutory joint health overview and scrutiny committee established under the terms of this protocol may only exercise the powers set out in 6.2.1 to 6.2.4 above in relation to the statutory consultation for which it was originally established. Its existence is time limited to the course of the specified consultation and it may not otherwise carry out any other activity.

6.3 Membership

6.3.1 The participating local authorities must ensure that those Councillors nominated to a joint health overview and scrutiny committee produce a membership that reflects the overall political balance across the participating local authorities. However, political balance requirements for each joint committee established may be waived with the agreement of all participating local authorities, should time and respective approval processes permit.

6.3.2 A joint committee will be composed of Councillors from each of the participating authorities within Cheshire and Merseyside in the following ways:

- where 4 or more local authorities deem the proposed change to be substantial, each authority will nominate 2 elected members

- where 3 or less local authorities deem the proposed change to be substantial, then each participating authority will nominate 3 elected members.

(Note: In making their nominations, each participating authority will be asked to ensure that their representatives have the experience and expertise to contribute effectively to a health scrutiny process)

Local authorities who consider change to be 'substantial'	**No' of elected members to be nominated from each authority**
4 or more	2 members

3 or less	3 members

6.3.3 Each local authority will be obliged to nominate elected members through their own relevant internal processes and provide notification of those members to the lead local authority at the earliest opportunity.

6.3.4 To avoid inordinate delays in the establishment of a relevant joint committee, it is suggested that constituent authorities either arrange for delegated decision-making arrangements to be put in place to deal with such nominations at the earliest opportunity, or to nominate potential representatives annually as part of annual meeting processes to cover all potential seat allocations.

6.5 Quorum

6.5.1 The quorum of the meetings of a joint committee shall be one third of the full membership of any Joint Committee, subject to the quorum being, in each instance, no less than 3.

6.5.2 There will be an expectation for there to be representation from each authority at a meeting of any joint committee established. The lead local authority will attempt to ensure that this representation is achieved.

6.6 Identifying a lead local authority

6.6.1 A lead local authority should be identified from one of the participating authorities to take the lead in terms of administering and organising a joint committee in relation to a specific proposal.

6.6.2 Selection of a lead authority should, where possible, be chosen by mutual agreement by the participating authorities and take into account both capacity to service a joint health scrutiny committee and available resources. The application of the following criteria should also guide determination of the lead authority:

- The local authority within whose area the service being changed is

based; or

- The local authority within whose area the lead commissioner or provider leading the consultation is based.

6.6.3 Lead local authority support should include a specific contact point for communication regarding the administration of the joint committee. There will be an obligation on the key lead authority officer to liaise appropriately with officers from each participating authority to ensure the smooth running of the joint committee.

6.6.4 Each participating local authority will have the discretion to provide whatever support it may deem appropriate to their own representative(s) to allow them to make a full contribution to the work of a joint committee.

6.7 Nomination of Chair/ Vice-Chair

The chair/ vice-chair of the joint health overview and scrutiny committee will be nominated and agreed at the committee's first meeting.

6.8 Meetings of a Joint Committee

6.8.1 At the first meeting of any joint committee established to consider a proposal for a substantial development or variation, the committee will also consider and agree:

- The joint committee's terms of reference;

- The procedural rules for the operation of the joint committee;

- The process/ timeline for dealing formally with the consultation,

including:

- the number of sessions required to consider the proposal;

and,

- the date by which the joint committee aims to reach its final conclusion on the proposal – which should be in advance of the proposed date by which the NHS commissioning body/service provider intends to make its final decision on it.
-

6.8.2 All other meetings of the joint committee will be determined in line with the proposed approach for dealing with the consultation. Different approaches may be taken for each consultation and could include gathering evidence from:

- NHS commissioning bodies and local service providers;

- patients and the public;

- voluntary sector and community organisations; and

- NHS regulatory bodies.

6.9 Reports of a Joint Committee

6.9.1 A joint committee is entitled to produce a written report which may include recommendations. As a minimum, the report will include:

- An explanation of why the matter was reviewed or scrutinised.

- A summary of the evidence considered.

- A list of the participants involved in the review.

- An explanation of any recommendations on the matter reviewed or scrutinised.

The lead authority will be responsible for the drafting of a report for consideration by the joint committee.

6.9.2 Reports shall be agreed by the majority of members of a joint committee and submitted to the relevant NHS commissioning body/health service provider.

6.9.3 Where a member of a joint health scrutiny committee does not agree with the content of the committee's report, they may produce a report setting out their findings and recommendations which will be attached as an appendix to the joint health scrutiny committee's main report.

7. DISCRETIONARY HEALTH SCRUTINY

7.1 More generally, the Health and Social Care Act 2012 and the 2013 Health Scrutiny Regulations provide for local authority health scrutiny arrangements to scrutinise the planning, provision and operation of health services.

7.2 In this respect, two or more local authorities may appoint a joint committee for the purposes of scrutinising the planning, provision and operation of health services which impact on a wider footprint than that of an individual authority's area.

7.3 Any such committee will have the power to:

- require relevant NHS commissioning bodies and health service providers to provide information to and attend before meetings of the committee to answer questions.

- make reports and recommendations to relevant NHS commissioning bodies/local health providers.

- require relevant NHS commissioning bodies/local health service providers to respond within a fixed timescale to reports or recommendations.

7.4 Ordinarily, a discretionary joint committee would not have the ability to request the Secretary of State for Health and Social Care “call-in” a service change proposal. However, please note section 8.3 below.

7.5 In establishing a joint committee for the purposes of discretionary joint scrutiny activity, the constituent local authorities should determine the committee’s role and remit. This should include consideration as to whether the committee operates as a standing arrangement for the purposes of considering all of the planning, provision and operation of health services within a particular area or whether it is being established for the purposes of considering the operation of one particular health service with a view to making recommendations for its improvement. In the case of the latter, the committee must disband once its specific scrutiny activity is complete.

7.6 In administering any such committee, the proposed approach identified in sections 6.3 – 6.9 of this protocol should be followed, as appropriate.

8. SCRUTINY OF CHESHIRE AND MERSEYSIDE INTERGRATED CARE SYSTEM

8.1 Further to this protocol and in particular section 7 above, the nine local authorities have agreed to establish a discretionary standing joint health scrutiny committee in response to the establishment of the Cheshire and Merseyside Integrated Care System.

8.2 A separate Joint Scrutiny Committee Arrangements document has been produced in line with the provisions of this protocol to outline how the standing joint committee will operate.

8.3 In summary, the “Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee” has the following responsibilities:

- To scrutinise the work of the Integrated Care System in relation to any matter regarding the planning, provision and operation of the health service at footprint level only; and

- To consider the merits of any service change proposals that have been deemed to be a substantial variation in services by all nine authorities.

9. CONCLUSION

9.1 The local authorities of Cheshire and Merseyside have adopted this protocol as a means of governing the operation of joint health scrutiny arrangements both mandatory and discretionary. The protocol is intended to support effective consultation with NHS commissioning bodies or local health service providers on any proposal for a substantial development of or variation in health services. The

protocol also supports the establishment of a joint health overview and scrutiny committee where discretionary health scrutiny activity is deemed appropriate.

9.2 The protocol will be reviewed regularly, and at least on an annual basis to ensure that it complies with all current legislation and any guidance published by the Department of Health and Social Care.

Agenda Item 8

Cheshire East Council

Scrutiny Committee

26 June 2025

Prevent and Channel Panel Statutory Responsibilities

Report of: Jill Broomhall, Director of Adult social Care Operations

Report Reference No: SC/04/2025-26

Ward(s) Affected: All Wards

For Scrutiny

Purpose of Report

1 The purpose of this report is to afford the Scrutiny Committee the opportunity to scrutinise the changing landscape and statutory responsibilities in relation to PREVENT.

2 Local Authorities, alongside partner agencies listed in the Counter Terrorism and Security Act 2015, have a statutory responsibility to comply with the Prevent Duties as laid out in Prevent duty guidance: for England and Wales (accessible) - GOV.UK

3 The Local Authority is also responsible for delivering the multi-agency Channel Panel Programme as laid out in Channel duty guidance: Channel duty guidance: protecting people susceptible to radicalisation (accessible) - GOV.UK

4 Following the tragic incident in Southport, in 2024, the Home Office published a Learning Review and made recommendations and changes to the remit of PREVENT Policing and Channel Panel. This report will provide a summary of the learning, outline the changes and risks, include an update on our current working arrangements and ensure that the Local Authority is cognisant of its corporate duty to protect those who are susceptible to radicalisation.

Executive Summary

5 The overarching framework governing for tackling Terrorism is called CONTEST. The first CONTEST strategy was published in 2003. Its aim is to reduce the threat of Terrorism to the UK so that people can live their lives safely and freely. The strategy enables government departments, local authorities, and intelligence agencies to work together to combat Terrorism, and is supported by a framework based on the four pillars - Prepare, Prevent, Protect and Pursue.

6 The latest version of CONTEST was published in July 2023. (Counter-terrorism strategy (CONTEST) 2023 - GOV.UK) The landscape is constantly changing, becoming more diverse and complex. It includes domestic threats which can be less predictable and harder to detect and investigate, persistent and evolving threats from Islamist terrorist groups overseas and advances in technology providing opportunities for online exploitation/radicalisation.

7 At the time of writing this report, the current official threat level to the UK remains as “Substantial” This means an attack is “likely” according to the government’s definitions. Raising it to critical would mean that intelligence and security services regard an attack as “highly likely in the UK.

8 PREVENT is one of the main vehicles for reducing the threat of Terrorism in the UK and sit alongside the other pillars:

9 PURSUE: to stop terrorist attacks

10 PROTECT: to strengthen our protection against a terrorist attack

11 PREPARE: to mitigate the impact of a terrorist attack

12 The objectives of PREVENT, as set out in the duty guidance 2023 are to: tackle the ideological causes of terrorism, intervene early to support people susceptible to radicalisation and enable people who have already engaged in terrorism to disengage and rehabilitate.

13 Anyone who is worried that someone is being targeted and is susceptible to radicalisation, can make a referral to Counter Terrorism Policing. Families can seek advice by the ACT Early Website. The Police conduct the initial screening and risk assessment. They then consider whether the case should be managed by themselves, or whether a person would benefit from a multi-disciplinary approach. If it is the latter, the Police make a referral to the local Channel Panel.

14 Every Local Authority must have robust Channel Panel arrangements in place. The Chair and Deputy must be named Senior and Experienced Officers employed by the Local Authority. The multi-agency panel meets monthly, reviews new cases and offers tailored support to subjects who consent to accept support from Channel. This is a voluntary process. People will remain involved with Channel until the panel is satisfied that the person has been provided with enough information, 1:1 intervention and wrap around services which reduce the risk of further radicalisation. Some cases will be escalated back to the Police, where Terrorism risks have increased. Cases are reviewed at least every 6 and 12 months after they have exited Channel.

15 The Home Office do not permit us to share the numbers of PREVENT/CHANNEL referrals to Cheshire East. However, we can say that most referrals concern people aged 11 – 17. Often people with additional health, social and educational needs, who have experienced trauma and are seeking an identity. Most referrals come from education settings.

16 The Home Office have a Quality Assurance Process in place which assesses each Local Authority regarding their PREVENT and Channel duties annually. Cheshire East completed its Benchmarking Assessment with the Home Office this year on 19th March 2025. To date Cheshire East has met all the necessary benchmarks for its delivery. The Home Office will confirm Cheshire East Benchmarking scores in a letter which will be sent to the Chief Executive of the Council in May or June 2025.

17 In addition, there are robust Governance arrangements in place in Cheshire East, with quarterly reports being presented to the Safer Cheshire East Partnership, the production of a Channel Panel Annual Reports and update presentations to the Scrutiny Committee. The Cheshire East Constitution was updated several years ago to reflect the work and risks associated with PREVENT.

18 Counter Terrorism Policing produce a Counter Terrorism Local Plan each year. A Risk Assessment is produced by each PREVENT Board, based on local threats and risks. The Action Plan captures activity undertaken by partner agencies and includes actions to address training, communication and engagement and working to reduce the risk of permissive environments via venue hire agreements. The Chair of the PREVENT Board is the Director of Adult Social Care, who also represents Cheshire East at the local CONTEST BOARD.

RECOMMENDATIONS

The Scrutiny Committee is recommended to:

1. Scrutinise and note the changing landscape and statutory responsibilities in relation PREVENT.

Background

19 The Home Office published an Independent Review into the Southport incident on 5th February 2025. The Prevent Learning Review was commissioned to examine the Prevent involvement with Axel Muganwa Rudakubana (AMR) prior to the tragic attack which led to the loss of three young lives, which AMR is alleged to have committed, on 29 July 2024 in Southport. It was done with the aim of identifying effective practice, organisational learning opportunities and any further areas for development. At the commencement of the review, prosecution had commenced but not finalised. Prevent learning review: Axel Muganwa Rudakubana (accessible) - GOV.UK

20 AMR was referred to Prevent three times. The **first referral** was received from AMR's teacher on 5 December 2019. The teacher reported several concerns regarding behaviours which included being excluded from his previous school for carrying a knife and searching for mass school shootings

on the internet using his school account. After a discussion with Prevent officers (CTCOs) in which AMR accounted for his internet searches, the case was closed on the Prevent system on 31 January 2020. Acknowledgement is made that AMR is extremely vulnerable but there is no CT/DE concerns and appropriate agencies are already in place to support him.

21 A **second referral** was received from AMR's previous school on 01 February 2021. It was reported that a pupil had showed them [social media] posts by AMR which they were concerned about and felt AMR was being radicalised. The CTCO acknowledged the previous referral, however considered the [social media] posts to be not CT/DE relevant and the case was closed on 17 February 2021.

22 A **third referral** was received from AMR's teacher on 26 April 2021. It reported that AMR had been observed with internet tabs open during a lesson showing a search for London Bomb and seemed to have a passionate interest in Israel/Palestine conflict, MI5 and the IRA. The CTCO acknowledged the previous two referrals but considered that AMR's needs were currently met outside of Prevent and there was no CT/DE concerns to address. The case was closed on 10 May 2021.

23 Overall, the Reviewer considered there to have been a high level of compliance by the Prevent officers with process timescales, assessment completion and adherence to policy that were in place at the time. However, although processes and polices have been largely followed, it is the subjective decisions that have come into focus and AMR should have been referred to Channel. The Review identifies several areas for learning to strengthen risk assessments, particularly around understanding indicators of radicalisation where a coherent ideology is not present and recognising the potential risk from repeat referrals. Several recommendations have been identified through this review. These include strengthening training and guidance, changes to terminology used within Prevent, and improving assurance processes.

24 The independent reviewer identified several factors that may have impacted decision making: The weight put upon the assessments and opinions made in the initial intelligence screening process:

- A focus on the absence of a distinct ideology.
- Potentially incomplete lines of enquiry.
- Under-exploration of the significance of repeat referrals.
- An over-adherence to some aspects of policy where discretion was allowed, which may have influenced decisions taken.
- More broadly a lack of independent business assurance

25 Since January 2025 the Home Office have instigated several measures to address the findings of the Learning Review and to look at PREVENT

legislation and procedures. An Independent PREVENT Commissioner, Lord Anderson, has been appointed to oversee this.

26 20/1/25 The Prime Minister and Home Secretary made public statements about the Southport tragedy and announced the launch of a Public Inquiry, the appointment of the Independent Commissioner and measures to address the sale of knives.

27 27/1/25 The Home Office widened the Roots of Intervention, including Channel to be open to those individuals who are under over Counter Terrorism investigation. (Supporting tools sent to Channel Chairs on 24/1/25)

28 12/2/25 The Home Office published the learning review following the death of Sir David Amess MP who was murdered on 15 October 2021 whilst conducting a regular constituency surgery at Belfair's Methodist Church Hall in Leigh-on-Sea, Essex.

29 20//2/25 The Home Office share a Report regarding the prevalence of autism in the Channel cohort. Key findings indicated that an estimated 14% of Channel cases had diagnosed ASC, plus an additional 12% of cases where ASC was suspected but not formally diagnosed. The research involved qualitative interviews with Local Authority Channel practitioners and IPs.

30 6/3/25 The Home Office introduced changes to the Review Form used when a case is closed and at 6- and 12-month intervals.

31 10/3/25 The Home Office new the Multiple Referral (Repeats) Policy went live.

32 13//3/25 The Home Office updated the Prevent Case Management Ideology Categories to be used by Counter Terrorism Police

33 13/3/25 The Home Office made an addendum to the Channel Duty Guidance for local Policing to be alerted when a case is not adopted by Channel Panel or exits Channel Panel where a person has been categorised as "having a fascination with extreme violence or mass casualty attacks.

34 24/3/25 The Home Office the remit of Channel Panels to include Fascination with extreme violence/mass casualty attacks went live. **To note** that cohorts categorised as 'fascination with extreme violence or mass casualty attacks' have been relevant for Prevent since 2019, although analysis has shown there to be significant inconsistency with how such referrals are progressed through the system.

35 25/3/25 The Home Office issued Guidance to Channel Panels on how to use the PREVENT ASSESSMENT FRAMEWORK more effectively. This is the assessment produced by Counter Terrorism Policing based on information gathering from all agencies and includes details of susceptibility, intent, capability, engagement and risks.

36 7/4/25 The Channel Panel Duty Guidance was updated and published.

Consultation and Engagement

37 No consultation is necessary for this report.

Reasons for Recommendations

38 This report sets out the statutory duties of the Local Authority in relation to PREVENT.

Other Options Considered

39 No further options have ben considered as this is a legal duty placed upon the Authority.

Option	Impact	Risk
The Authority has a legal duty to comply with the responsibilities and duties in relation to PREVENT	Should an incident occur here, in the same manner as the Southport one, the impact for individuals, families, communities and the Council would be immense	It should be recognised that whilst we have robust policies, procedures and partnerships in place, which are quality assured by the Home Office annually, we cannot mitigate or predict all “lone wolf” extremist activity in Cheshire East, which may be emerging behind closed doors.

Implications and Comments

Monitoring Officer/Legal/Governance

40 The aim of Prevent is to stop people from becoming terrorists or supporting terrorism.

41 The objectives of Prevent are to:

- tackle the ideological causes of terrorism
- intervene early to support people susceptible to radicalisation
- enable people who have already engaged in terrorism to disengage and rehabilitate

42 In fulfilling the prevent duty in Section 26 of the Counter – Terrorism and Security Act 2015 (‘CTSA 2015’) all specified authorities are expected to participate fully in work to prevent the risk of people becoming terrorists or supporting terrorism. The Prevent duty statutory guidance: England and

Wales was issued on the 7 September 2023 under Section 29 CTSA 2015 and came into force on 31 December 2023 replacing guidance which came into force in July 2015.

43 Sections 36 to 41 of CTSA 2015 sets out the duty on local authorities and partners of local panels to provide support for people vulnerable to being drawn into any form of terrorism. The Channel duty guidance: Protecting People susceptible to radicalisation has been issued under sections 36(7) and 38(6) of the CTSA2015 to support panel members and partners of local panels. Further guidance has been issued Prevent Multi – Agency Panel Duty guidance: protecting people vulnerable to being drawn into terrorism and a Policy Addendum.

Section 151 Officer/Finance

44 There are no financial implications requiring changes to the MTFS as a result of the recommendations in this report.

45 Cheshire East is an “unfunded” local authority and receives no additional government funding for the work of PREVENT. It should be noted that the responsibility for this has been undertaken by adult social care for seven years.

46 To meet the expectations of the Home Office and to effectively deliver our statutory duties, additional funding and/or capacity may be required. This would support the Administration and Training Requirements. If additional funding is required then it would either need to be funded by additional income from partners or grants, or alternatively the service could include this in the MTFS from 26/27.

Human Resources

47 All Cheshire East Staff should be informed about PREVENT within their Corporate Induction, including Elected Members.

48 Frontline staff and managers should complete additional training depending on their specific responsibilities and interactions with PREVENT and CHANNEL. The Home Office introduced a new Training Portal in April 2025. There is an expectation that Frontline Practitioners across the Council, not only Adults and Children’s Social Care will be provided with this training. At the time of writing this report, we are considering who could deliver this and numbers of staff impacted.

49 Staff will require additional support when managing high risk and complex cases. This should be provided by 1:1 supervision and access to senior management advice.

50 Therefore, the risk surrounding the PREVENT work should be a Cheshire East Corporate responsibility, shared by the Corporate Leadership Team.

Risk Management

51 The Home Office categorise the national risk level dependent on current and emerging risks, and it remains at a Substantial Risk. Counter Terrorism Policing produce an annual Counter Terrorism Local Profile which is available via Resilience Direct. Thereafter Local PREVENT Boards produce a situational risk assessment which is updated and shared at quarterly Board Meetings.

52 It should be recognised that whilst we have robust policies, procedures and partnerships in place, which are quality assured by the Home Office annually, we cannot mitigate or predict all “lone wolf” extremist activity in Cheshire East, which may be emerging behind closed doors. Should an incident occur here, in the same manner as the Southport one, the impact for individuals, families, communities and the Council would be immense.

Impact on other Committees

Policy

53 The Home Office have updated PREVENT and CHANNEL Policy and Procedures this year which all Local Authorities are duty bound to implement. Local documentation has been updated and can be evidenced in the PREVENT Action Plan. Cheshire East and West have updated their Joint PREVENT Strategy to reflect the changes.

54 These statutory duties underpin Cheshire East’s ambition to protects children, adults and families from abuse, neglect and exploitation.

55

Commitment 1: Unlocking prosperity for all	**Commitment 2: Improving health and wellbeing**	**Commitment 3: An effective and enabling council**

Equality, Diversity and Inclusion

56 All areas of Cheshire East are equally impacted by PREVENT and CHANNEL.

57 The Home Office is responsible for the PREVENT and CHANNEL statutory guidance. It is hoped that the recent changes and updates have included a national Equality Impact Assessment on all population groups.

Other Implications

Rural Communities

58 All rural and urban communities are equally impacted by PREVENT.

Children and Young People including Cared for Children, care leavers and Children with special educational needs and disabilities (SEND)

59 Whilst anyone can be susceptible to radicalization, the national and local date tells us that young people between 11 and 17 are more susceptible, including those with autism spectrum disorder.

60 A recommendation is that the ownership and management of PREVENT should be shared equally between Adult and Childrens Social Care with named Senior Management participation.

Public Health

61 It should be noted that some people who are susceptible to radicalization may have experienced trauma and be impacted by where they live in terms of deprivation and access to services.

62 Anyone who is being drawn into terrorist activity and thinking will be impacted in a negative way and their health and wellbeing will be affected.

Climate Change

63 There are no foreseeable impacts on Climate Change.

Consultation

Name of Consultee	**Post held**	**Date sent**	**Date returned**
Statutory Officer (or deputy) :			
Ashley Hughes	S151 Officer		
Janet Witkowski	Acting Monitoring Officer		
Legal and Finance			
Roisin Beressi	Principal Lawyer	13/06/25	13/06/25
Nikki Wood-Hill	Finance Manager	13/06/25	13/06/25

Other Consultees: *Executive Directors/Directors*			
Helen Charlesworth-May	Executive Director Adults, Health and Integration	02/06/25	03/06/25

Access to Information	
Contact Officer:	Sandra Murphy Head of Adult Safeguarding Sandra.murphy@cheshireeast.gov.uk
Appendices:	Prevent learning review: Southport attack - GOV.UK https://www.gov.uk/government/publications/prevent-learning-review-sir-david-amess-attack
Background Papers:	Prevent duty guidance: England and Wales (2023) - GOV.UK https://www.communitycvs.org.uk/wp-content/uploads/2018/09/Prevent-Duty-Toolkit-for-Local-Authorities.pdf Channel duty guidance: protecting people susceptible to radicalisation (accessible) - GOV.UK

Agenda Item 9

OPEN

BRIEFING REPORT

Scrutiny Committee

26 June 2025

Domestic Homicide Review - Mr and Mrs S

Report of: Helen CHARLESWORTH-MAY, Executive Director, Adults Health and Integration

Report Reference No: SC/02/25-26

Purpose of Report

1 The purpose of this briefing report is to inform the Corporate Leadership Team and Committee Members, about the Domestic Homicide Review following the murder and suicide of Mr and Mrs S who both died in March 2021. The Review was commissioned by the Safer Cheshire East Partnership in 2021, signed off by SCEP on 27/4/23 and approved by the Home Office on 3/4/25. The Report is now ready to be published on the Councils Website.

2 The purpose of a Domestic Homicide Review is to:

3 Establish what lessons are to be learned from the domestic homicide, regarding the way in which local professionals and organisations work individually and together to safeguard victims.

4 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

5 Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate. prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a

co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

6 Contribute to a better understanding of the nature of domestic violence and abuse; and highlight good practice.

7 A DHR is not an inquiry into who is culpable, this is for the court or coroner to decide.

8 One of the objectives of the Councils Corporate Plan is for Cheshire East to be a place where a “Everyone feels safe and secure, difference is celebrated, and abuse and exploitation not tolerated”. Therefore, it is important to look in depth at the circumstances leading to this tragedy and the lessons learned and what has been implemented since the Review.

Executive Summary

9 The full Domestic Homicide Review Report is found in the supporting documentation. It will be published on the Safer Cheshire East Website and should be read in conjunction with this Briefing Paper.

10 Mrs S was 81 when she died and had been diagnosed with Dementia in 2016. Mr S was 83 and was his wife’s full time Carer. They had been married for 60 years and prior to moving to Cheshire East, Mr W had been a Farmer. They have 4 adult children who contributed to the DHR. In March 2021 Police attended the house to find both deceased. Margaret had been murdered by her husband, who then committed suicide. They died during the COVID pandemic.

11 Statutory Guidance produced in 2013 defines the criteria for undertaking a Domestic Homicide Review as follows:

12 Under section 9(1) of the 2004 Act, domestic homicide review means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by— (a) a person to whom he2 was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death. Where the definition set out in this paragraph has been met, then a Domestic Homicide Review should be undertaken.

13 To note that the scope and definitions relating to DHRs is currently under review and will become known as Domestic Abuse Related Death Reviews. This is due to the high numbers of cases involving suicide, where a person has been subject to Domestic Abuse and has taken their own lives because of the abuse. In the case of Mr and Mrs S the original criteria were in situ at the time of their death.

14 Mr and Mrs S were known to statutory services in both Staffordshire and Cheshire East. It is important to hear the voice of family members who contributed to the Review and said:

15 “Our Mum was an extremely creative person. As a young Mum she sewed beautiful clothes for her children. Mum was a skilled cook and loved hosting dinner parties. She also found time to attend College to develop her cooking skills.

16 Mum was busy in the community; she was an active member of the WI and an active member of a bowling club. She was a member of an Art Club for many years and was an accomplished artist in watercolour, pastels and acrylics

17 In her working career Mum was ahead of our time in her work rehabilitating people with mental health issues, where she passed on her skills of cooking and homemaking to vulnerable people

18 Mums main work in life, apart from bringing up four children, was to support Dad in his business. She was self-taught in bookkeeping and accounts and managed all the finances of the business.”

The concluding comments were agreed by all four siblings:

19 Dad was totally devoted to Mrs S. He was her principal carer and thought that he could look after her best of all.

20 Mrs S had numerous health issues and Dad found it increasingly frustrating to get a doctor’s appointment which was exacerbated by the Covid epidemic

21 We believe that in the last week of dad’s life he had come to the realisation that he couldn’t care for Mrs S much longer and that she would have to go into a home. He couldn’t bear to be separated from her

22 His actions on the day of the incident were completely out of character for our father who was caring, loyal and devoted

23 We all agree that the Covid pandemic greatly affected our Parents’ social life as many of their elderly visitors did stop visiting for many months

24 We felt that Dad was possibly taken advantage of by a health care system that if he was willing to carry on, then they didn’t need to help.”

25 The DHR Review panel met 8 times to consider how Agencies worked with Mr and Mrs S. The Review made 7 recommendations which will be

highlighted later, together with the actions that have been completed since the conclusion of the Review.

Background and Context

26 Key findings from the Home Office analysis of domestic homicide reviews: September 2021 to October 2022 Key findings from analysis of domestic homicide reviews: September 2021 to October 2022 (accessible) - GOV.UK considered 129 completed DHR's referred to the Home Office Quality Assurance Panel, involving 132 victims.

27 In the 129 DHRs reviewed there were 132 victims: 24% had a familial relationship with the perpetrator(s), for 50% the relationship with the perpetrator was partner or ex-partner. Twenty-six per cent were victims who died by suicide.

28 The average age of familial abuse victims was 55 years, older than the average age of familial perpetrators which was 35 years. Intimate partner victims were on average younger (38 years) and younger than preparators (43 years). The average age of victims who died by suicide was 36 years.

29 Where victims were in an intimate partner relationship or who had died by suicide, 86% and 88% respectively were female. This was different where there was a familial relationship where 53% of the victims were female.

30 Considering nationality, 69% of familial victims were British; 80% of intimate partner victims were British and where the victims died by suicide 91% were British.

31 Of the 132 cases eleven per cent of victims had been identified as being carers. There is a variation between the types of victims: 22% of familial victims were carers, whilst 11% of those in an intimate partner relationship were carers. None of the victims who died by suicide were identified as carers.

32 Of the seven victims who were carers, three of the seven familial victims and one (of the seven) intimate partner victims had received a carer's assessment.

33 The DHR panel for Mr and Mrs S also considered research relating to incidents occurring when people are over 60 published by Professor Benbow at Chester University and relevant themes.

34 How does age relate to the risk of domestic homicide? The analysis suggested that there is insufficient evidence to conclude that ageing, per se, is a significant risk factor. The significant factor that emerges

from their analysis is the role of assumptions and stereotypes about older age which influence risk assessments and the management of potentially abusive situations.

35 The role of stereotypes and myths about dementia The research conducted by Professor Benbow noted that Dementia featured in six of the homicides they reviewed. They noted that there are myths expressed about dementia in relation to DHRs, in particular an assumption that people with dementia are aggressive and violent towards others and that, as a result, more domestic homicides are likely in future since the population of people with dementia is projected to increase.

36 The researchers did note that there is also an opposing myth, that people with dementia are not capable of predetermined acts of violence and this area needs further research.

37 The role of caring The research team led by Professor Benbow suggested that being cared for may be as stressful as doing the caring. In addition, a caring situation changes power dynamics between the individuals involved and involves dependency and loss of autonomy. Sometimes the situation is complex as both people involved are caring for one another, or a person might identify as a carer but the person they care for might dispute this. All these factors affect the relationship.

Briefing Information

38 The key themes which emerged from Mr and Mrs S mirror those highlighted in the research above. However, each set of circumstances are unique and the impact on families and friends and professionals cannot be underestimated.

39 Mr and Mrs S moved to Cheshire East in 2016 to be closer to family members. They lived at their previous address for over 30 years and received daily support from a Care Agency, which enabled Mr S to continue work. But this changed when they moved as Mr S wanted to care for his wife and subsequently, soon experienced a sense of isolation, which was exacerbated by Mrs S's deteriorating Dementia and the impact of COVID. They had one phone and no internet facilities, which indicates the pitfalls of Digital Exclusion. In Mr S's Carers Self-Assessment said, "Mrs S was ashamed of her illness and will not socialise".

40 Mr S rarely left his wife, and the impact of caring affected his health and well being and contact with friends. Following a visit to see a Care Home he did tell his daughter that should his wife go into a Care Home, the impact would be greater for him, thereby indicating the pain, guilt and loss associated with a relative moving into full time care – (like having children removed/placed in care.)

41 There is evidence that Statutory Services did provide advice and made offers of support to Mr and Mrs S, including Occupational Therapists and Dementia Reablement Services. However, Mr S often declined to accept formal support, preferring to make private arrangements, and giving the false impression to Professionals that he was coping. As a "Self-Funder", Mr and Mrs S did not have access to regular Adult Social Care Reviews, thereby missing out on checks and monitoring about how he was coping/changes in need.

42 Whilst the Panel sought confirmation from the General Practices who were responsible for her care, and they confirmed that – certainly from a medicines management perspective – Mrs S received care in accordance with the relevant NICE guidance. The family of Mr S and Mrs S noted that caring for someone with dementia requires more than medication and felt that the fundamental elements of care – for example the relatively simple task of 'sitting with' Mrs S – were missing from her case and from her care.

43 Mr and Mrs S's family felt that services had left their dad to carry on alone, and the DHR Review highlighted the need for a more assertive approach.

44 Any Carer Stress that was identified was in the context of the move to new accommodation and was not sufficiently explored. Neither was the risk associated with Self Harm or Suicide.

45 Professionals did not seek the views of Mrs S, due to her Dementia Diagnosis, and relied on Mr S's reports instead. There were missed opportunities to complete Mental Capacity Assessments and consider Best Interest Decisions and deploy an Advocate for Mrs S.

46 All case records need to be accurate, robust and completed in a timely way.

47 <u>Recommendations:</u> The DHR did include areas of good practice and projects that were initiated during and post COVID. The Review also made several multi agency recommendations which can be seen at the end of the full Report and in the 7-minute briefing. These include the following.

48 Carers identification and recording by all agencies

49 Completion of Carers Assessments

50 Dementia Awareness Training

51 Legal literacy – particularly using the Mental Capacity Act

52 Suicide Awareness – including its impact

53 Assertive interventions by Professionals, rather than leaving people alone

54 Recognition of Domestic Abuse in the context of Dementia or other longer term conditions vs Carer Stress

55 Actions: The Safer Cheshire East Partnership seeks assurances from Partner Agencies about their responses to the learning from DHRs and oversees Action Plans. Whilst the Home Office approved the publication of this DHR in April 2025, the following actions have already been put into place.

56 The development of the Risk Identification Checklist for Older People

57 Guidance, Toolkits and Training on safeguarding and domestic abuse – Approved by the SAB – including bespoke Training during Adult Safeguarding Week November 2023.

58 Improved support provided for carers within Cheshire East – All Age Carers Strategy/Training/Carers Hub

59 The development of a programme of intelligence gathering, learning and professional development concerning domestic violence, suicide, suicidality, and mental health

60 Referral pathways between the Mental Health café and the Domestic Abuse Hub

61 Mental Capacity Act Training and Resources

62 CEC contributed to the LGA Guide - Carers and Safeguarding – A briefing for those who work with Carers

63 CEC - Suicide Prevention/Strategy including Training, Resources and Awareness raising.

64 Care Act Refresher Training

65 Briefings and Training to Practice Managers/Practitioners based on Mr and Mrs S

66 The Dementia Strategy is being refreshed.

67 The Panel and Cheshire East wishes to record its condolences to the family of Mr S and Mrs S for their loss.

68 Dementia – of all types – is becoming a critically important issue, in terms of both the high personal and social costs related to the disease, and the wider impact on the health and care system.

69 The Department of Health report, published in 2009, suggested that demographic changes within the UK will drive significant growth in the number of people with dementia. This will occur even though the percentage of older people developing some types of dementia (particularly vascular dementia) may decline as a result of reductions in hypertension and other dementia related risk factors[1].

70 Research suggests that approximately one in four patients in acute hospitals have dementia – and that these needs are not currently well responded to. Additionally, the cost of dementia will rise by 61 per cent to £24 billion by 2026 (at 2007 prices), with most of this cost being met by social care and by individuals and families rather than the NHS.

Implications

Monitoring Officer/Legal

71 There are no legal implications for this Report

Section 151 Officer/Finance

72 There are no financial implications for this Report.

Policy

73 There are no Policy implications for this Report

74 These statutory duties underpin Cheshire East's ambition to protects children, adults and families from abuse, neglect and exploitation.

Commitment 1: Unlocking prosperity for all	**Commitment 2: Improving health and wellbeing**	**Commitment 3: An effective and enabling council**

Equality, Diversity and Inclusion

75 The learning from this report is relevant to all.

Human Resources

76 There are no HR Resource implications to this report. However, it should be noted that the findings should be accepted by Cheshire East Council and Best Practice principles will be applied to our work with Carers, whether independent or as family members.

Risk Management

77 There are no implications for Risk Management in this report.

Rural Communities

78 There are no specific implications for rural communities. However, the report highlights the impact of isolation when caring for a relative with a long-term condition, particularly if living in a rural setting and without internet access.

Children and Young People including Cared for Children, care leavers and Children with special educational needs and disabilities (SEND)

79 There are no implications for Children or Young People in this report.

Public Health

80 The impact of long-term caring can have a negative impact on health and wellbeing. The learning from this Report is relevant to Cheshire East's Suicide Prevention Strategy.

Access to Information	
Contact Officer:	Sandra Murphy – Head of Adult Safeguarding Sandra.murphy@cheshireeast.gov.uk
Appendices:	7-minute briefing  7 minute briefing - Mr and Mrs S 1.docx DHR Overview Report

	DHR for Mrs S Final March 2023.docx
Background Papers:	Key findings from analysis of domestic homicide reviews: September 2021 to October 2022 (accessible) - GOV.UK Adult social care and safeguarding during COVID-19: a large-scale mixed methods study COVID-19 adult safeguarding insight project - third report (December 2021) | Local Government Association Click to edit Master title Support for carers of adults Carers and safeguarding: a briefing for people who work with carers | Local Government Association

Scrutiny Committee Work Programme 2025/2026

Report Reference	Scrutiny Committee	Title	Purpose of Report	Lead Officer	Consultation	Equality Impact Assessment	Cheshire East Plan Commitment	Part of Budget and Policy Framework	Exempt Item
SC/10/24-25	04/09/25	Primary Care / Community Services	To receive an update on the Primary Care Estates Programme from East Cheshire NHS Trust and potential changes to community services across the borough	TBC	No	No	Improving health and wellbeing	No	No
SC/16/24-25	04/09/25	Cheshire & Merseyside Health Partnership	Following the setting of a number of objectives, how is the partnership meeting the 2 objectives of 'improving population health and health care', and 'tackling health inequalities', – have they been achieved, and what is being done to achieve them?	TBC	N/A	TBC	Improving health and wellbeing	No	No

Scrutiny Committee Work Programme 2025/2026

SC/19/24-25	04/09/25	Suicide Prevention	To scrutinise the support available.	KILMINSTER, Guy	N/A	TBC	Improving health and wellbeing	No	Yes
SC/07/25-26	04/09/25	Domestic Homicide Report	To share with the committee learning from the review into the case of Emma	BROOMHALL, Jill	N/A	No	Improving health and wellbeing	No	No
SC/17/24-25	11/12/25	Domestic Abuse Related Deaths and Inquests at Coroners Courts	The committee to scrutinise why it can take a significant amount of time for an inquest to be undertaken.	BROOMHALL, Jill	N/A	TBC	Improving health and wellbeing	No	No
SC/14/24-25	TBC	Right Care, Right Person	Following its implementation, review a year on, the impact it has had on residents and policing across the Cheshire East area.	BROOMHALL, Jill	N/A	TBC	Improving health and wellbeing	No	No