

Proposal: Introduction of a Single Interim Subfertility Policy for Cheshire and Merseyside

1. Introduction and Proposal Summary

NHS Cheshire and Merseyside ICB proposes to replace ten existing local subfertility policies with a single, interim policy to standardise access across to fertility services across the region. The primary driver is to ensure equitable access, while also achieving essential financial savings to stabilise the local health system.

The key proposed changes are:

1. Standardise NHS-funded IVF cycles to one full cycle for all eligible patients (a reduction for most areas).
2. Align BMI eligibility criteria in Wirral with the rest of the region (removing the requirement for male partners to meet BMI criteria).
3. Standardise smoking eligibility so both partners must be non-smokers across all areas (a new requirement in five areas).
4. Revise the definition of 'childlessness' in Cheshire East and West to exclude those who have had a live birth or adopted a child from further embryo transfers.
5. Commission IUI in Wirral for specific groups, aligning with NICE guidance and other areas.

This EIA has been revised in light of the extensive feedback from the public consultation (3 June – 15 July 2025), which received 2,124 responses. The EIA draws on the data provided by those who shared their demographic details, please note not all respondents answered these questions. (The skip rate on these questions, were between 995 and 1013).

2. Summary of Consultation Findings Relevant to Equality

The strength of opposition across all protected groups, particularly women, disabled people, and those from lower socio-economic backgrounds, underscores the disproportionate impact of the proposed policy. The consultation responses provide compelling evidence of lived experience, emotional distress, and systemic disadvantage. This feedback is a critical source of equality intelligence that must inform decision-making.

The consultation revealed profound concerns regarding the equitable impact of the proposals, particularly the reduction in IVF cycles.

- **Overwhelming Opposition:** 86% of respondents (1,532 people) disagreed or strongly disagreed with the reduction to one IVF cycle. All protected groups consistently opposed the proposal.
- **Lived Experience:** 72% of respondents had direct personal experience with subfertility treatment (as patients, partners, or close relatives), lending significant weight to the feedback.

Key Equality Themes (see Appendix A- consultation equality analysis). Respondents highlighted potential for:

- **Indirect Discrimination:** Against women, people with disabilities, racially minoritised and those from lower socio-economic backgrounds.
- **Widening Inequalities:** Creating a two-tier system where only those who can afford private treatment have a realistic chance of conceiving.

- Adverse Mental Health Impacts: The emotional toll of subfertility would be exacerbated by the pressure of a single cycle.
- Lack of Reasonable Adjustment: A blanket one-cycle policy fails to account for individual circumstances.

3. The Financial and Legal Context: Proportionality and Due Regard

The Financial Imperative -

The ICB is operating under significant financial pressures. The proposal to offer a single cycle of IVF is based on a legitimate objective: achieving necessary financial savings. Given the current financial constraints, the ICB must prioritise commissioning decisions and allocate funding to the most critical areas to ensure the long-term financial sustainability of the local NHS.

The Public Sector Equality Duty (PSED) in a Financial Crisis -

The PSED under Section 149 of the Equality Act 2010 is a continuous duty and is not suspended during a financial emergency. The duty to have "due regard" to the need to eliminate discrimination, advance equality of opportunity, and foster good relations is at its most critical when making difficult decisions that cause harm. While saving money is a legitimate aim, it cannot be the only consideration.

Decision-makers must:

1. Properly understand the equality impacts. (Appendix A -Consultation Equality Analysis)
2. Consider all possible mitigations to reduce those impacts.
3. Consciously weigh the equality impacts against the financial imperative in a proportionate way.

4. Detailed Equality Analysis and Consideration of Mitigations

The following analysis applies a structured equality lens to each protected characteristic, identifying potential negative impacts, potential mitigations, and proportionality considerations. It is important to note that many impacts intersect—particularly those related to sex, disability, race, and socio-economic status. These intersections compound disadvantage and must be considered holistically, not in isolation.

This analysis assesses the impact of the proposal against the three aims of the PSED and documents the consideration of mitigations.

Protected characteristic	Potential Negative Impact & Evidence	Potential Mitigation & Actions	Points of consideration for decision makers
Age	Severe negative impact for women under 40. Feedback stressed that IVF success often requires multiple cycles. The pressure of a single cycle could cause	Strengthen signposting to mental health support. Commit to a full review once new NICE guidance is published.	The severe impact is acknowledged. The interim nature as a partial mitigation. The financial and equity imperatives are deemed as a legitimate aim.

	significant psychological distress. Women's most fertile period coincides with the crucial period for becoming established in a career. As a result, many women delay childbearing then some may suffer consequences in struggling to conceive as subfertility decreases Waiting lists or other operational issues might reduce the time available for multiple attempts.	Consider: maintaining two cycles for all patients. For the full policy review, work with our provider to understand delays and waiting lists.	Decision makers to consider maintaining two cycles and weight the harm with its duty to make system wide financial savings Consider mitigations in light of consultation findings.
Disability	Negative impact. Respondents with conditions like PCOS, endometriosis highlighted that BMI criteria can create a significant barrier Disabled people are more likely to have low incomes and therefore are less likely to self-fund. Overall disabled people and people with impairments strongly opposed the proposal for one cycle.	Strengthen signposting to weight management support services Ensure access to appropriate gynaecological services If there was clinical exceptionality around patients with disabilities, the IFR process would be in place.	Decision makers to note the negative impact for disabled people.
Sex	Significant and disproportionate negative impact on women. Women bear the physical and emotional burden of treatment. The cycle reduction disproportionately targets women's healthcare. Significant opposition to the proposal from	Acknowledge the disproportionate impact in communications. Ensure support services are tailored to women's needs.	The severe disproportionate impact is acknowledged. The service is, by nature, disproportionately accessed by women. The mitigations of clear communication and tailored support are accepted. The aim of creating a single, equitable regional policy is

	both women and men. (Appendix A)		considered a legitimate and proportionate counterweight, despite the negative impact. Decision makers to consider mitigations in light of the findings.
Race	Substantial risk of adverse impact. HFEA data shows Black patients start treatment later (avg. 36.4 yrs) and have the lowest success rates (e.g., 23% live birth rate for Black patients aged 30-34 vs. 30% for White patients). A single cycle policy limits the opportunity to overcome these systemic disparities. Cultural, linguistic, and trust barriers can also delay presentation, reducing the window for successful treatment. The proposals risk undermining trust between minority communities and the NHS.	Mitigating action - Work with community partners to ensure clear, accessible communications about the policy and pathways to care. Mitigating action – The working group reviewed data on child mortality in BAME groups to help develop the storage periods in the interim policy. Aim to ensure a targeted involvement model supports the future review of the policy. Work with the provider to understand what data they are collecting around ethnicity to support the future review. Mitigating action - Ensure communication is transparent.	The risk of exacerbating existing health inequalities and disproportionate impact is acknowledged and should be taken into consideration by decision makers.
Sexual orientation	Significant negative impact from the	Consider specific mitigations for	The discrimination is acknowledged. The

	continued requirement for same-sex couples to self-fund IUI. This was widely perceived as systemically discriminatory factor and falls outside of the current scope of the consultation.	same-sex couples as per the Women's Health Strategy. This issue is currently outside the financial and scope parameters of this harmonisation specific review.	commitment to a priority review of this specific issue is a critical mitigation, making the interim policy a proportionate stepping stone to a fairer system.
Religion and belief	Religion or Belief - potential for conflict and distress. While no specific consultation insight was raised, some religious positions (e.g., Catholicism) may morally object to IVF, while others (e.g., Judaism) may strongly encourage it. The policy may cause internal conflict for some, and the reduction in cycles may be particularly distressing for those from communities where there is high cultural or religious pressure to have children. The potential for indirect impact via community pressure is acknowledged. The mitigation of culturally competent care is a proportionate and necessary measure to ensure respect for all patients.	Ensure patient care is sensitive to diverse religious and belief systems. Support clinical staff to have sensitive conversations with patients about their beliefs in the context of treatment. The policy is neutral in its application to religion or belief.	The policy is neutral in its application to religion or belief. The potential for indirect impact via community pressure is acknowledged. The mitigation of culturally competent care is a proportionate and necessary measure to ensure respect for all patients.
Marriage and civil partnership	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	Mitigating action: Communicate the rationale (equity and resource prioritisation)	Consider the negative impact on those in Cheshire East and West who have remaining embryos in storage, following a live birth. The policy is deemed proportionate as it

	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. The 'childlessness' definition means a partner with a child from a previous relationship would make the couple ineligible. This specific issue is not in scope, however some respondents felt this was unfair for blended families.		consistently applies the principle of prioritising NHS resources for those without any children, which is a legitimate aim for equitable resource allocation.
Transgender / gender reassignment	Risk of lack of access and inclusive care. No specific negative impacts were raised in the consultation, but this may indicate a lack of visibility or engagement with this	Mitigating action: Ensure all patient-facing communications, intake forms, and staff training are inclusive of transgender and	Gender Reassignment The risk of indirect exclusion is acknowledged. The mandated mitigations of inclusive communications and

	patient group. Transgender individuals may have complex subfertility preservation and treatment need that require sensitive, informed care.	non-binary people. Consider issues raised in Appendix A, in full future review.	training are considered essential to prevent discrimination and are a proportionate step to ensure equitable access within the constraints of the policy.
Pregnancy and maternity	Pregnancy and Maternity Neutral/Negative. This characteristic relates to those who are already pregnant or on maternity leave. The policy itself does not directly impact them. However, the distress of secondary subfertility (inability to conceive a second child) is a significant issue, and the 'childlessness' criteria explicitly excludes this group from treatment.	Action: Ensure clear public communication that the policy for secondary subfertility is standardised across the region, even though it is restrictive. Signpost to support services for those experiencing secondary subfertility.	The policy does not adversely impact those who are pregnant or on maternity leave. The negative impact on those experiencing secondary subfertility. This is a direct consequence of the 'childlessness' criteria, which is considered a proportionate means of prioritising limited resources.
Socio economic disadvantage	Socio-Economic disadvantage - The most significant and cross-cutting impact. The policy changes risks creating a two-tier system, making biological parenthood for those who require subfertility treatment a potential privilege of wealth and systematically reducing opportunity for those on low incomes. This intersects with disability and race. Consultation feedback across all protected groups raised this issue consistently. (appendix A).	The primary mitigation is the provision of any funded NHS cycle, which remains a valuable service for those who cannot afford private care. Consultation feedback suggested means-testing or offering more cycles to low-income groups. However, this would be contrary to the NHS constitution.	This is the most significant equality trade-off. The ICB recognises the profound impact. The decision is that providing one universal, standardised cycle rather than having a fragmented or means-tested approach. Decision makers to consciously consider feedback against the legitimate aims of financial challenges and eradicating a postcode lottery approach.

5. Public Sector Equality Duty (PSED) and Health Inequalities Act 2012: Comprehensive Analysis

The policy's blanket approach fails to account for differential need and structural barriers. A one-cycle policy, while administratively simple, risks entrenching disparities. The duty to advance equality of opportunity requires commissioners to go beyond formal equality and consider substantive equity—tailoring provision to meet different needs where justified.

A. Rigorous Application of the Public Sector Equality Duty (PSED - s149, Equality Act 2010)

The PSED is a continuous, proactive duty that requires the ICB to have "due regard" to the need to achieve the three aims. This decision has been tested against each objective.

1. **Eliminate Discrimination, Harassment, Victimisation**

- Direct Discrimination: The policy is neutral in its wording and does not directly discriminate against any group.
- Indirect Discrimination: The evidence in this EIA is unequivocal. The one-cycle policy constitutes indirect discrimination against:
 - Women: As the primary users of the service, they bear the disproportionate physical, emotional, and life-impact of the restriction.
 - Disabled people
 - People from Ethnic Minorities: Specifically Black patients who, due to systemic barriers, start treatment later and have lower success rates, making them disproportionately disadvantaged by a one-cycle limit.
 - People from Lower Socio-Economic Backgrounds: indirectly discriminating on the grounds of socio-economic status, which intersects with multiple protected characteristics.

"Due regard" has been demonstrated by this detailed EIA, undertaking a comprehensive public consultation, and explicitly acknowledging these discriminatory impacts in this document.

2. **Advance Equality of Opportunity**

This aim requires the ICB to consider the need to:

- Remove or minimise disadvantages suffered by people due to their protected characteristics.
- Take steps to meet the needs of people from protected groups where these are different from the needs of others.
- Encourage persons with protected characteristics to participate in public life or in any other activity in which participation by such persons is disproportionately low.

The proposed policy actively works against this aim. It:

- Institutionalises disadvantage for the groups listed above
- Fails to meet different needs.
- The perception of an unfair and discriminatory system may deter future engagement from these communities with NHS services more broadly, damaging trust and participation.

3. Foster Good Relations

This aim involves tackling prejudice and promoting understanding between groups. The consultation feedback indicates that implementing this policy could damage good relations. The overwhelming opposition (86% against the cycle reduction) and the powerful, emotional testimony highlight a sense of injustice and a perception that the NHS is abandoning women and the most vulnerable. These risks fostering alienation and mistrust, rather than understanding.

B. Compliance with the Health and Social Care Act 2012 (Health Inequalities Duty)

In addition to the PSED, the ICB has a legal duty under Section 14G of the Health and Social Care Act 2012 to have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved.

This duty is central to the ICB's core purpose. The analysis reveals that the proposed policy presents a direct conflict with this obligation:

- Inequalities in Access: The policy standardises nominal access (one cycle for all). It fails to address the existing inequalities in access faced by ethnic minority groups and those in deprived areas.
- Inequalities in Outcomes: The policy changes could lead to a widening of outcomes.

C. The Balancing Test: Proportionality in the Face of Competing Duties

The ICB is faced with a direct conflict between its duties:

- The PSED and Health Inequalities Duty point towards the need for a more nuanced, clinically responsive, and equitable subfertility policy.
- The fiduciary and strategic duty to ensure the financial sustainability of the entire local health system points towards the need for significant savings.

Having rigorously applied "due regard" by identifying, evidencing, and acknowledging these severe impacts, the ICB must now make a conscious, reasoned judgement on proportionality.

The interim nature of the policy, the commitments to future review, and the specific mitigations are integral to the final decision the ICB must make.

This report was reviewed and discussed by the ICB QEIA panel and will be subject to further review and discussion at our ICB Board meeting.

Recommendation:

To reach a decision, the Board must formally review and acknowledge this EIA, including its identified disproportionate impacts and the key mitigation measures.

End