Appendix A Equality analysis of consultation feedback by protected characteristics.

Introduction scope and change

The consultation explored five proposed changes to the fertility treatment policy in Cheshire and Merseyside:

- Change to the number of IVF cycles funded
- Change to eligibility on BMI (body mass index) in Wirral
- Change to eligibility on smoking
- Change to the definition of ‘childlessness’ in Cheshire East and Cheshire West.
- Change to intrauterine insemination (IUI) commissioning in Wirral.

Additional clarifications were also proposed regarding age limits for treatment eligibility.

Proposed changes

On the next page is a summary of the proposed interim changes.

Proposed change	Current situation	Proposed policy	Impact on patients	Reason for change
Standardisation of NHS-funded IVF cycles	Varies by area: Between 1 and 3 cycles for under 40s; 1 cycle for 40–42	1 full cycle for all eligible patients (including fresh and frozen transfers)	Reduction in funded cycles for all areas except Cheshire East; no change for 40–42 age group	Financial sustainability and equitable access
Alignment of BMI eligibility criteria	Wirral requires both partners to meet BMI criteria – others only require this of female partner	Only the female partner must have BMI between 19–29.9; male partners with a BMI over 30 advised to lose weight, but this would not be a barrier to treatment	Removal of potential barrier to access for couples in Wirral, and alignment with the rest of Cheshire and Merseyside	Align with NICE guidance and ensure there is equal access across Cheshire and Merseyside
Inclusion of smoking status for both partners	In some areas, only female partner must be a non-smoker	Both partners must be non-smokers (includes vaping/e-cigarettes)	Stricter criteria in Halton, Knowsley, Liverpool, Sefton, St Helens	Improve treatment outcomes and align with NICE guidance, and ensure equal access across Cheshire and Merseyside
Revision of definition of childlessness	In most areas of Cheshire and Merseyside, IVF is only made available on the NHS where a couple has no living birth children or adopted children, either from a current or previous relationship. However, Cheshire East and West allow continued embryo transfers even after a live birth or adoption during cycle	No further transfers once a live birth or adoption occurs	Stricter eligibility in Cheshire East and West	Standardise definition to ensure equal access across Cheshire and Merseyside
Commissioning of IUI in Wirral	IUI not routinely commissioned in Wirral	IUI to be funded in Wirral for specific groups (e.g., same-sex couples, physical psychosexual issues, HIV considerations).	More equitable access in Wirral	Align with NICE guidance and ensure consistency of access across Cheshire and Merseyside
Additional clarification: Age limits	IVF available from age 23 to 42	No lower age limit: upper limit clarified as up to 43rd birthday	Minimal impact; clearer eligibility	Align with NICE guidance and reduce ambiguity

Legitimate aim

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

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

This would be an interim policy as NICE have begun their initial consultation on updated fertility treatment guidance. This updated guidance is expected to be published in March 2026. Once this is available, the ICB will review and consider any required changes to the policy where necessary.

Proposed change to the number of IVF cycles that are funded

The proposed change

If the new single policy was introduced it would mean everyone in Cheshire and Merseyside who is eligible for IVF would have one cycle paid for by the NHS. This would mean that the number of cycles funded 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 eligible people aged between 40 and up to 42, as they are already offered one cycle in all areas of Cheshire and Merseyside.

Respondents were asked **"To what extent do you agree/disagree with the proposed change to the number of IVF cycles that are funded?"** The results were as follows:

Answer choices	Responses	
Strongly agree	6%	114
Agree	5%	85
Neither agree nor disagree	2%	33
Disagree	9%	166
Strongly disagree	77%	1,366
	Answered	**1,764**

Respondents who disagree or strongly disagree

86% of 1764 respondents answered 'disagree' or 'strongly disagree' to the proposed change to the number of IVF cycles that are funded.

Of the respondents who answered 'disagree' or 'strongly disagree', 65% indicated they were either 'someone who has accessed (or is accessing) NHS fertility treatment, either personally or as a partner/spouse' or 'a relative/friend of a patient who has accessed (or is accessing) NHS fertility treatment.'

1,291 respondents provided further explanation of why they selected 'disagree' or 'strongly disagree' with the proposal, with the following themes identified:

Mental/emotional impact - respondents highlighted the psychological and emotional toll of infertility and IVF treatment. With many describing how hard it is trying to maintain hope and keep a positive mental attitude whilst trying to conceive.

> *"Reducing access to further attempts can cause significant emotional distress."*

> *"This change will strip so many people of the chance to get pregnant. IVF and infertility are hard enough."*

Success rates and medical rationale - many respondents cited reasons that supported their view that IVF often requires multiple cycles.

> *"The first round is very often treated as a test round to test the efficacy of the treatment plan and often fails."*

NHS funding concerns - respondents questioned the financial logic of reducing IVF cycles, in the context of the estimated financial impact.

> *"The additional £40,000 cost is small when considered in the context of the total budget for local health care."*

> *"Reducing to one cycle will widen inequalities in access to care between those who can afford additional private cycles and those who cannot."*

Equity and fairness - respondents criticised the policy as short-sighted and poorly justified**.** Respondents shared their own personal IVF journeys about fairness and equal access to care.

> *"Reducing everyone to one cycle to make it the same doesn't seem fair."*

> *"I had to pay privately for my IVF, and this is something that not everyone can do."*

Societal impact -some respondents pointed to broader consequences like declining birth rates.

> *"Fertility treatment is an investment in the future stability of our community."*

Women's health -respondents reported a gender bias in healthcare decisions.

> *"Women's health is always targeted; first changing smear tests... now taking away the hopes from women."*

Regional differences - respondents expressed frustration that Cheshire and Merseyside going to one IVF cycle meant it would fall into line with other regions in England.

> *"Just because other areas of the country only offer 1 cycle of IVF doesn't mean we should follow suit."*

Impact on relationships - some respondents noted the strain the proposed change would have on relationships.

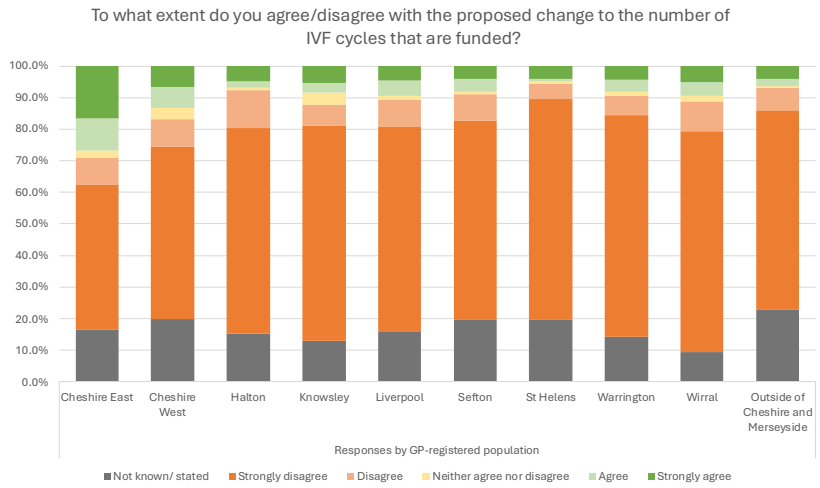
> *"This change would impact mental health and relationships."*

Equality Analysis: Proposed Reduction to One IVF Cycle in Cheshire and Merseyside

Public Sector Equality Duty (PSED) – Section 149 Equality Act 2010

The proposed reduction to one funded IVF cycle raises several key equality concerns:

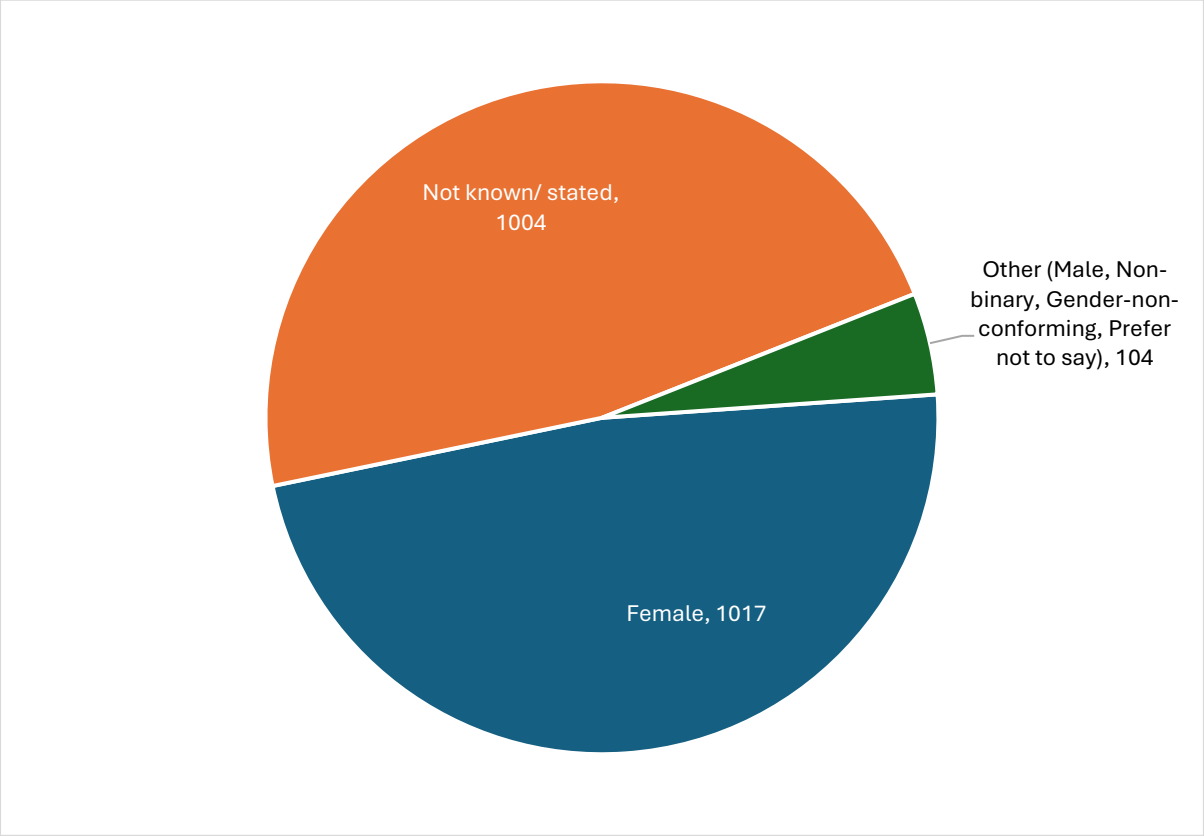
Responses by area



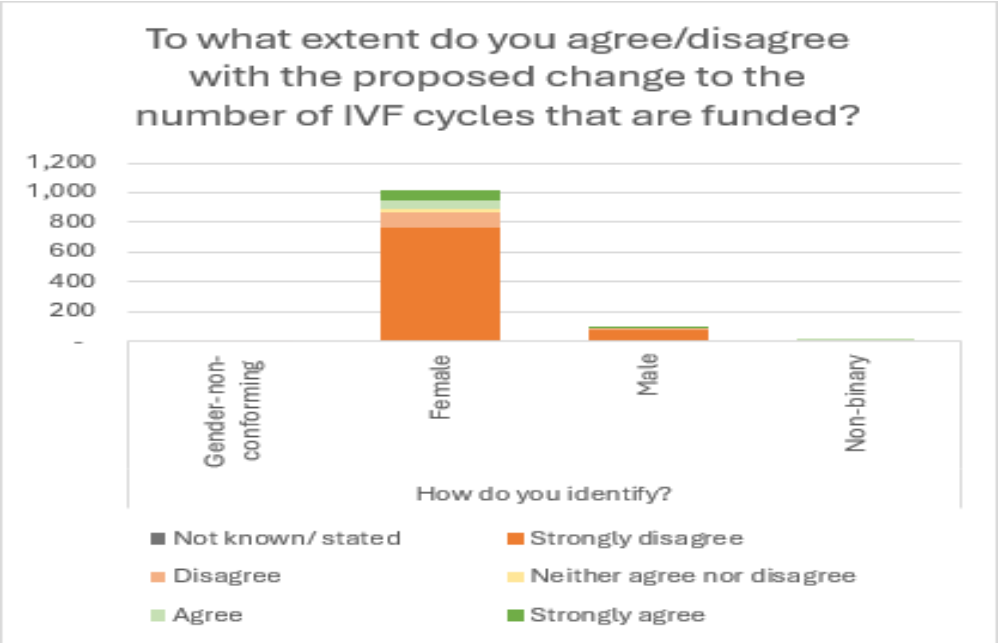
Overall there is overwhelming numbers across Places who disagree or strongly disagree.

In East Cheshire the opposition to the proposal in slightly lower.. Currently people in this area are already offered a single IVF cycle.

Sex/ gender



Reduction in cycle



Both males and females strongly disagree or disagree with the proposal.

Women's Views on the Disadvantages of Reducing IVF Cycles

1. Emotional Devastation and Mental Health Impact

· Woman, 35-44, Liverpool:

"I would only be eligible for one cycle of IVF... now that hope has been stripped from me and the prospect of having a baby is getting smaller and smaller."

· Woman, 35-44, St Helens:

"I feel this proposed change will take my hope away and send me into a deep depression... This change would have a devastating impact on my life, mental health, relationship and my employment."

· Woman, 25-34, Sefton:

"If I was to only have one round of ivf and it was unsuccessful this would be a heartbreaking experience and can cause alot of unnecessary pain and emotional distress."

2. Financial Hardship and Creating a Two-Tier System

· Woman, 35-44, St Helens:

"Given one cycle is likely not going to work we will not be able to afford £10k+ to try again. You are basically forcing us to not have children, taking away our only choice."

· Woman, 25-34, Knowsley:

"Myself and my husband both work for the NHS and have done for 10 years. Our salaries barely cover essentials, and paying for IVF would not be an option for us. By removing one of these cycles... our local NHS is taking away what could potentially be one of our only two chances of becoming parents."

· Woman, 35-44, Liverpool:

"My financial resources should not dictate my opportunity to have a child."

3. Unfairness and Impact on Women's Life Choices

· Woman, 25-34, Cheshire West:

"By giving women less opportunity to have a child by IVF it increases gender inequality. Women will feel less secure waiting until late twenties/ thirties to establish a career, finish education etc before having children as if they want a family they will feel more pressure to do so during their ‘most fertile’ years."

4. Clinical Ineffectiveness & reduced Chances of Success

· Woman, 45-54, St Helens:

"Often the first round of IVF is unsuccessful due to tayloring medications and treatment to the individual. If unsuccessful then much will have been learned from the first round to feed into a possible 2nd round. The stress of knowing you have one and only chance is huge..."

· Woman, 35-44, St Helens (Health Professional):

"From experience the first round of fertility treatment isn't usually successful... You wouldn't just give someone 1 dose of cancer treatment."

5. Impact on Family Vision and Siblings

· Woman, 26, St Helens:

"As a 26 year old woman, my worries of not being able to access IVF treatment at an affordable rate causes immense stress, as a life goal to become a mother of 2 could potentially become tricky and expensive due to these changes."

· Woman, 35-44, Sefton:

"If this wasn't the case for me and I'd had one cycle of IVF already my child would not be able to have siblings."

Summary of Key Disadvantages Highlighted by Women:

· Psychological: The policy is described as "heartbreaking," "devastating," and a primary cause of depression and despair, stripping away hope.

· It creates a system where only the wealthy can afford multiple chances at parenthood, while those reliant on the NHS have a single, high-stakes attempt.

· Women feel specifically targeted and penalised for life choices like pursuing careers, and see the policy as a setback for gender equality.

·The first cycle is widely understood to be partially diagnostic; limiting treatment to one cycle ignores clinical reality and reduces the overall chance of a successful live birth.

Contextualising Women's Strong Opposition - A Disproportionate Disadvantage

To understand their opposition is to understand the fundamental inequality inherent in the experience of infertility and its treatment:

1. The Physical Burden is Borne by Women

IVF is a Medical Marathon for Women: For a woman, a single cycle of IVF involves weeks of daily hormone injections, frequent internal scans and blood tests, and an invasive surgical procedure (egg retrieval) under sedation. The physical side effects can be significant, including bloating, pain, and the risk of Ovarian Hyperstimulation Syndrome (OHSS).

· The Male Role is Limited: In contrast, the physical role for a male partner in IVF is typically a single, non-invasive sperm sample. The policy change equates one cycle for him with one cycle for her, but the physical experiences are in no way equivalent.

2. The Biological Clock is a Female Reality

· The Tyranny of Time: A woman's fertility has a non-negotiable biological deadline. The stress of a single cycle is magnified exponentially by the knowledge that if it fails, her remaining window of opportunity is rapidly closing. This creates immense pressure that men do not face in the same way.

· Compounded by Delays: As highlighted in the consultation, long waiting lists for NHS treatment directly consume a woman's limited fertile years, making the "one chance" nature of the policy even more devastating.

3. The Emotional and Psychological Impact is Gendered

Women often face intense societal pressure to become mothers. Infertility can trigger profound grief, shame, and a crisis of identity. When the NHS then limits treatment, many women feel their pain and their fundamental desire to parent is being invalidated and de-prioritised.

4. The Policy Creates a Gendered Financial Disadvantage

This creates a two-tier system where a woman's chance of motherhood becomes a function of her or her partner's wealth. This financial burden and the anxiety it causes fall disproportionately on women, who are the ones who must undergo further physical treatment.

PSED considerations

- Indirect discrimination – A provision criteria or practice that appears neutral (proposed one cycle) puts persons of a particular protected characteristics (puts persons of a particular sex (women) at particular disadvantage, compared with persons from another sex (men).
- Advancing equality of opportunity – not taking into account the specific needs of women.

Women/ disability-Context and background

Equality Impact Assessment Summary: IVF Effectiveness and Women's Health
This assessment considers how specific health conditions and disabilities may disproportionately affect women undergoing a single cycle of IVF, particularly in the context of NHS-funded fertility treatment.

Key Health Conditions Impacting IVF Success summary

• Cancer – there will be a range of medical interventions that result in decreased fertility.
• Mental health - For people with mental health issues, reducing the number of cycles may have a higher impact.
• Disability - Evidence suggests that around a third of all disabled adults of working age are in low-income households. This is twice the rate of that for non-disabled adults. This could impact upon disabled resident's ability to pay for IVF treatment privately. those with certain medical conditions, this meant IVF was their only option of having children.
• Women with certain disabilities are more likely to have adverse birth outcomes and experience pregnancy complications, because some medications interact negatively with pregnancy. Those with learning disabilities and those living with long term health conditions are often restricted from making choices about their health and childbearing.
Physical disabilities can impact fertility in various ways, depending on the nature of the condition. Some disabilities may affect reproductive organs directly, while others may influence hormonal balance, mobility, or overall health, making conception more challenging.
Examples include:

• Spinal Cord Injuries: These can affect nerve signals related to sexual function and fertility, particularly in men, leading to difficulties with ejaculation or erectile dysfunction.
• Musculoskeletal Disorders: Conditions like cerebral palsy or muscular dystrophy may not directly impact fertility but can make sexual activity or pregnancy more physically demanding.
Examples include:

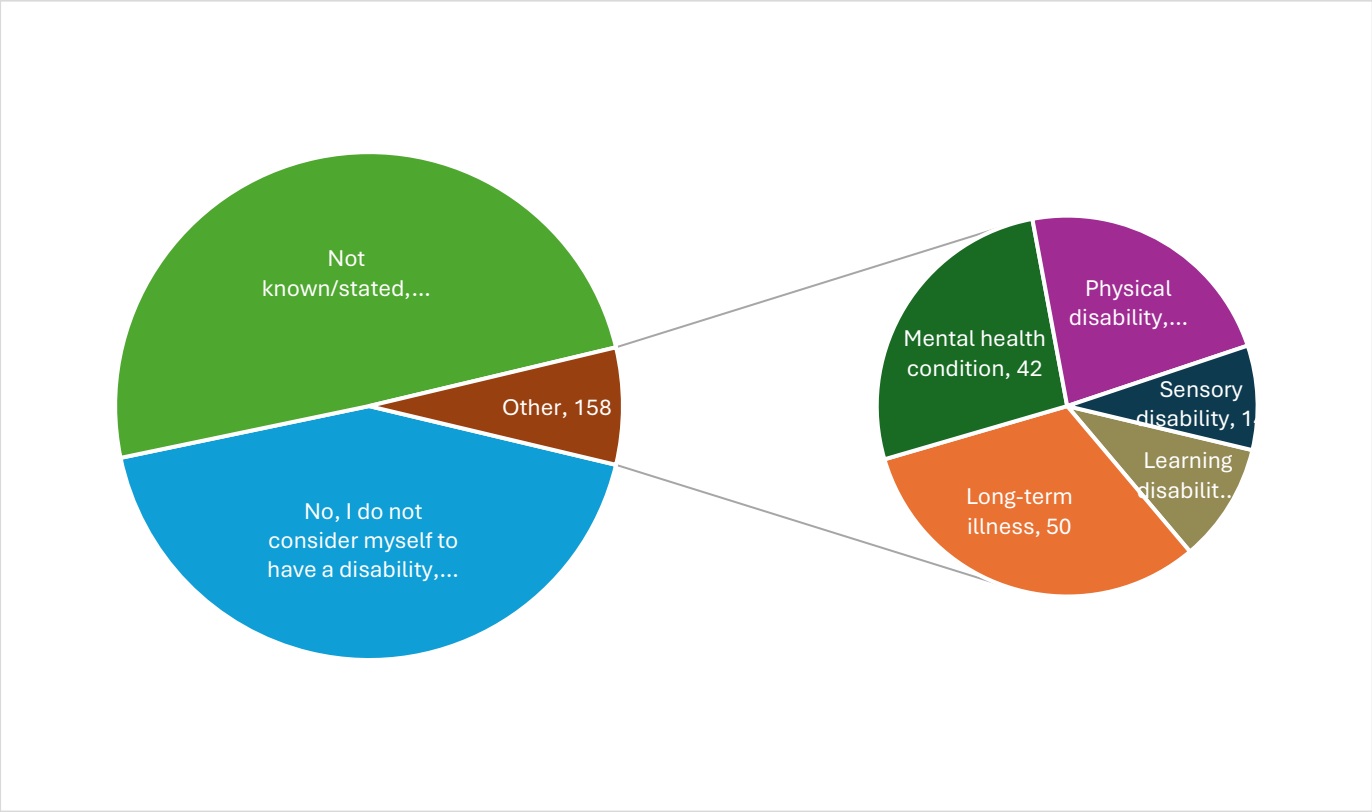
• Rheumatoid Arthritis (RA) – An autoimmune condition that can affect reproductive health, particularly due to inflammation and medication side effects.
• Lupus – Another autoimmune disorder that can impact fertility and pregnancy outcomes, requiring careful management.
• Endocrine Disorders: Some disabilities involve hormonal imbalances, which can affect ovulation and sperm production.
• Diabetes – A condition where the body struggles to regulate blood sugar due to insulin issues.
• Haemophilia: While it primarily affects blood clotting, it can also influence reproductive health, particularly in women who experience heavy menstrual bleeding.

Disability-Related Barriers

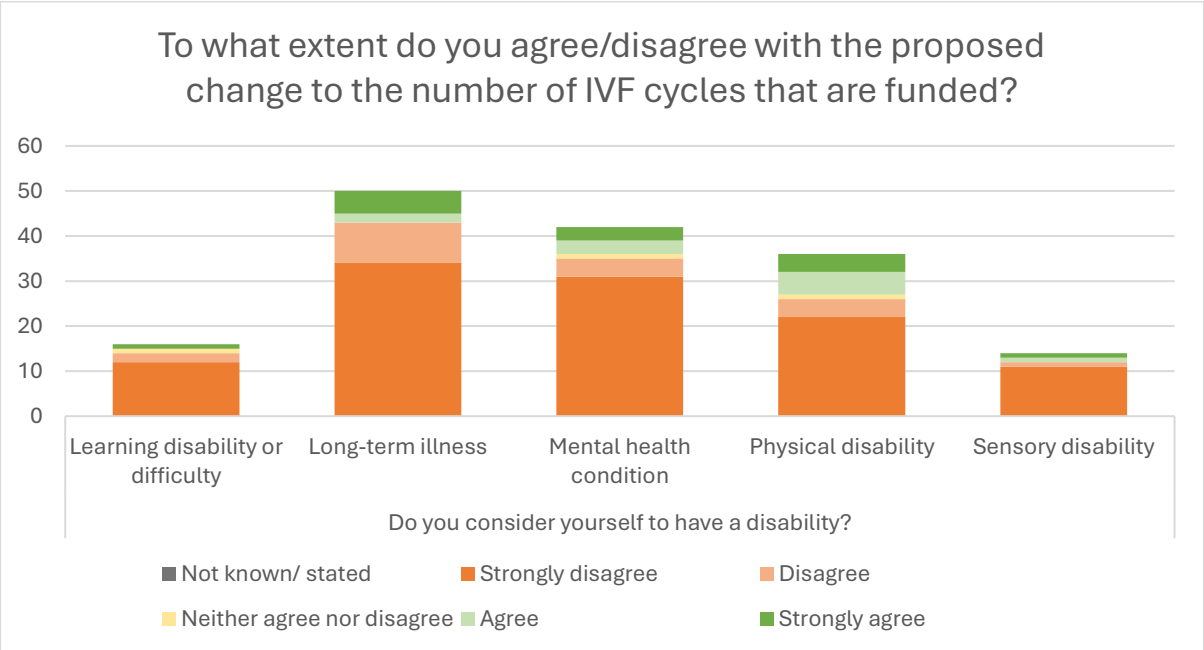
Disability Type	Potential Impact
Sensory impairments	May not directly affect fertility but can hinder access to care and communication.
Cognitive disabilities	Challenges in understanding treatment protocols and navigating services.
Mobility impairments	Physical access to clinics and procedures may be limited.
Mental health conditions	Depression and anxiety can affect hormonal balance and adherence to treatment.

Condition	Impact on IVF Effectiveness
Polycystic Ovary Syndrome (PCOS)	Irregular ovulation, poor egg quality, increased risk of ovarian hyperstimulation.
Endometriosis	Inflammation and scarring reduce implantation and embryo quality.
Uterine abnormalities (e.g., fibroids)	Impaired implantation and increased miscarriage risk.
Autoimmune disorders (e.g., lupus, thyroiditis)	Can interfere with embryo implantation and increase pregnancy loss.
Obesity or underweight	Hormonal imbalance affects egg quality and uterine receptivity.
Diabetes and hypertension	Increased risk of complications and reduced implantation success.
Advanced maternal age (40+)	Lower egg quality and higher rates of chromosomal abnormalities.

Consultation analysis



158 people declared their disability, 1053 consultees not known was stated.



All disabilities and impairments consultees strongly disagree or disagree with the proposal.

Representative Quotes from disabled consultees

- “This change would have a devastating impact on my life, mental health, relationship and employment. It is not my fault that I am infertile.”

- “I feel like you’re telling women who have fertility struggles that you have one shot to become a mother and if it isn’t successful then I’m afraid there is nothing we can do.”

- “The psychological impact on couples and the pressure of just one cycle is huge. The additional costs in therapy would way outstrip any savings.”

- “As someone with multiple rare health conditions, the chances of the first round being successful are slim. You are ruining our chance at becoming biological parents.”

- “Reducing to one cycle will widen inequalities in access to care between those who can afford private IVF and those who cannot.”

Respondent with Epilepsy (Long-term illness):

"If I was to only have one round of ivf and it was unsuccessful this would be a heartbreaking experience and can cause alot of unnecessary pain and emotional distress"

Respondent with Anxiety, Depression, ADHD

"If I did not get a good egg collection on cycle 1, it would mean I would not be able to have a child. There is no way for me to get pregnant naturally as my eggs can't get to my womb... I feel is proposed change will take my hope away and send me into a deep depression... This change would have a devastating impact on my life, mental health, relationship and my employment."

Respondent with ASD and ADHD:

"I do not have any tubes. My eggs can't get to the womb by themselves (following 2 ectopic pregnancies). If I was only funded for 1 cycle of IVF if I did not get any viable embryos from the cycle, it would mean that I would not be able to have a child... Having already had my fertility take away from me, this would result in a significant impact to my mental health and would likely push me into a deep depression... It is well documented that the first round of IVF is unsuccessful. This change would affect my whole life and would result in me having to access other treatment i.e for mental health via the NHS therefore not actually saving any money." Respondent with a Long-term Illness (Limited a little):

"It would impact negatively finacially, stress which could impact on being able to be relaxed to fall pregnant with one round of IVF. Depression."

These comments consistently highlight profound negative impacts, including severe emotional distress, deepened depression, the removal of hope, financial strain, and the *specific challenges posed by their existing health conditions/ disability/ impairment in conjunction with the fertility treatment process and its negative clinical impact.*

Discrimination and Disadvantage for Disabled Women

1. Women with disabilities or long-term health conditions face additional barriers to conception.

Reducing to one cycle disproportionately impacts these women and potentially constitutes indirect discrimination.

2. Impact on Mental Health and Wellbeing

- The emotional toll of infertility is exacerbated by the stress of having only one funded cycle.
- Disabled women may experience increased mental health challenges, undermining equitable access to care.

3. Socioeconomic Inequality and Access to Treatment

- Disabled women are more likely to face financial hardship, making private IVF unaffordable.

- The policy risks creating a two-tier system and widening health inequalities.

4. Departure from NICE Guidelines and clinical advice (see QIA)

- NICE recommends up to three IVF cycles for eligible women under 40.

- Reducing to one cycle may be seen as non-compliant with clinical best practice.

- NICE Guidelines: Recommend tailored support for women with disabilities and complex health needs.

5. Lack of Reasonable Adjustments

- The Equality Act requires reasonable adjustments for disabled people.

- A blanket policy fails to accommodate individual medical circumstances and its impact.

Age

By nature this service is accessed by women, most often (but not exclusively) by heterosexual
couples. Engagement may identify issues that need to be considered during the broader review of C&M Assisted Conception Policy.
Desktop research indicates the total fertility rate (TFR) decreased to 1.49 children per woman in 2022 from 1.55 in 2021; the TFR has been decreasing since 2010 (Office of National Statistics (ONS) data). The ONS data also showed that women are tending to have children later: the fertility rate was highest among women aged 30-34, whereas before 2002 it was higher in the 25-29 age group[1].

[1] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthsummarytablesenglandandwales/2024refreshedpopulations#:~:text=The%20total%20fertility%20rate%20(TFR)%20for%20England%20and%20Wales%20has,of%20six%20occurring%20since%202011

Context

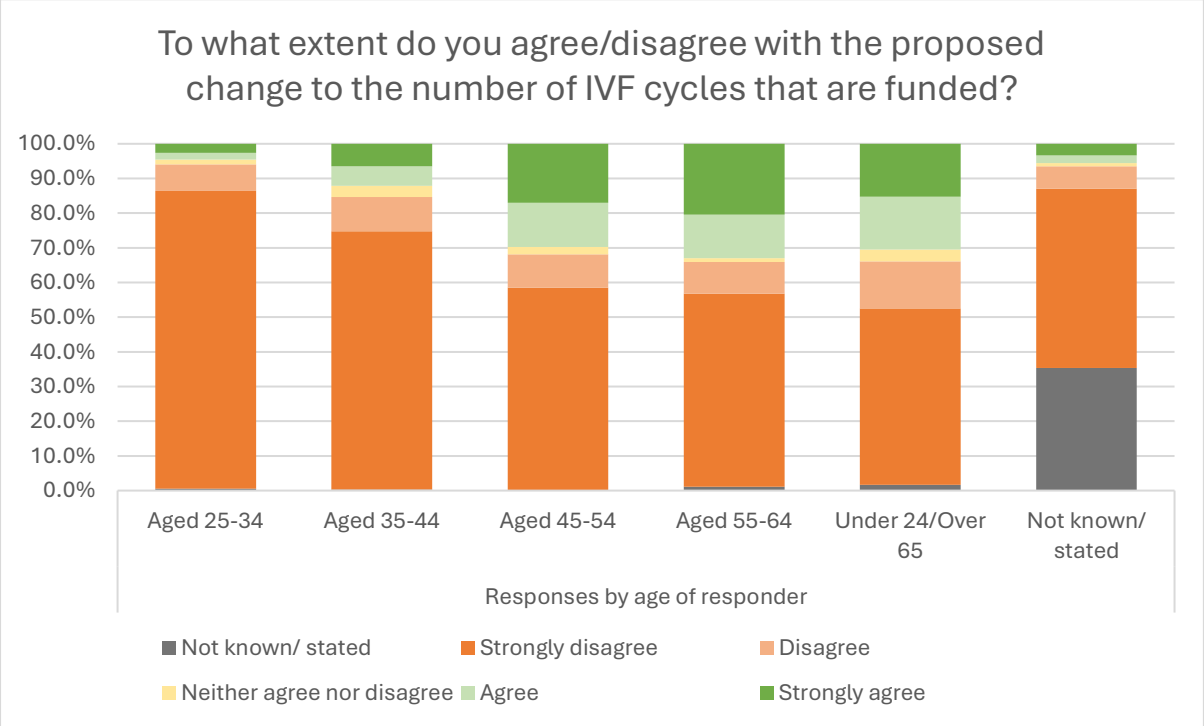
The fact that there is an age cut off means there is a limited amount of time that couples / women are eligible for NHS funded care. Most seek support having undergone 2 years of regular unprotected sex without conceiving and their pathway of investigations and treatment prior to IVF can take some time. Engagement identified delays in accessing treatments, but these delays must be happening in other parts of the system as data shows that the waiting list for IVF treatment from the Hewitt Centre is minimal. The IVF proposal is considering reducing the number of cycles to one, but there are no proposed changes to the age cut off so the total time available to access the NHS offer remains the same. The working group considered waiting times as part of the review, because the longer these are the older women will be when they access IVF. National information from the Human Fertilisation and Embryology Authority (HFEA) shows that women are tending to access IVF later in life.
May 2024:
• 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 fertility decreases
• Moving from initial NHS funded IVF treatment and then onto self-funded NHS and HFEA Guidance Highlights

• NHS IVF Criteria: Women aged 40–42 are typically offered one cycle due to reduced success rates.

• HFEA Data: Success rates drop significantly after age 35; birth rates for women aged 40–42 are around 10% per embryo transferred.

• NICE Guidelines: Recommend tailored support for women with disabilities and complex health needs.

Consultation analysis



Selection of Feedback on Disadvantages by Age Range

Age 25-34

· Impact on Family Planning & Siblings:

"As a 26 year old woman, my worries of not being able to access IVF treatment at an affordable rate causes immense stress, as a life goal to become a mother of 2 could potentially become tricky and expensive due to these changes... I believe giving aspiring parents the option to conceive 2 children through IVF will fulfill so many families..." (St Helens)

· Financial Barrier and Lost Hope:

"Given one cycle is likely not going to work we will not be able to afford £10k+ to try again. You are basically forcing us to not have children, taking away our only choice." (St Helens)

· Impact on Future Generations:

"I, and numerous friends, have grown up in a generation where we were encouraged to prioritise education and establishing a career before beginning a family... to remove ivf cycle options now means that many women, myself included, may not be able to have a family..." (Cheshire West)

· Mental Health and Pressure:

"As a woman with thyroid issues and PCOS, being unable to maintain a pregnancy, for me, I have been advised that for me my next option is IVF... Having the current 2 rounds of IVF in my current area gives me that hope that should the first round of IVF fail... there would be a final option... it feels like you're telling women who have fertility struggles that you have 1 shot to become a mother..." (St Helens)

Age 35-44

· Devastation and Lack of Alternatives:

"One of the only benefits to living in Merseyside is the entitlement to 3 cycles... I would only be eligible for one cycle of IVF... now that hope has been stripped from me and the prospect of having a baby is getting smaller and smaller." (Liverpool)

· First Cycle as a Learning Process:

"Often the first round of IVF is unsuccessful due to tayloring medications and treatment to the individual. If unsuccessful then much will have been learned from the first round to feed into a possible 2nd round. The stress of knowing you have one and only chance is huge..." (St Helens)

· Compounding Existing Health Struggles:

"We will be going from 2 rounds to 1 round so losing a round of IVF. As someone with multiple rare health conditions, the chances of the first round being successful are slim. You are ruining our chance at becoming biological parents" (St Helens)

· Unfairness and Deprivation:

"Liverpool is one of the most deprived areas in the UK. Reducing to 1 cycle would remove the chance for a number of women who cannot afford private treatment to have the opportunity to be a parent." (Knowsley)

Age 18-24

Comments on IVF for Women Later in Life and Reduced Success Chances

1. From a 25-34 year old in Cheshire West, highlighting gender inequality and pressure:

"By giving women less opportunity to have a child by IVF it increases gender inequality. Women will feel less secure waiting until late twenties/ thirties to establish a career, finish education etc before having children as if they want a family they will feel more pressure to do so during their 'most fertile' years."

2. From a 35-44 year old in St Helens, on the critical importance of multiple cycles for older women:

"I feel like the country-wide standard should be to increase other areas, not reduce this one... There is no guarantee that a single round of IVF will yield a viable embryo and with the cost of living at an all time high, only wealthier people will be able to continue to have further rounds and therefore have children..."

3. From a 35-44 year old in Liverpool, explicitly linking age and success rates:

"I strongly disagree with changing to one cycle of IVF... The reduction to a single cycle of IVF will widen inequalities in access to care between those who can afford additional private cycles and those who cannot."

4. From a health professional (age 35-44,), on the clinical reality for older women:

"From experience the first round of fertility treatment isn't usually successful... I think it's a great shame that those with medical conditions that prevent pregnancy are not going to be given an optimum chance to achieve this."

· While not explicitly stating "age," this comment from a professional underscores that the first cycle often fails, which is a critical factor for women with declining ovarian reserve who have less time to waste.

5. From a 25-34 year old , on the pressure and time lost to waiting lists:

"I've waited 8 months from my initial referral to then be seen by a consultant, and am now 8 months older and have been told that there's now no other option for me apart from IVF. Ongoing waiting lists have caused me to wait this long... now that hope has been stripped from me and the prospect of having a baby is getting smaller and smaller."

Comments on IVF for Women Later in Life and Reduced Success Chances

1. From a 25-34 year old in Cheshire West, highlighting gender inequality and pressure:

"By giving women less opportunity to have a child by IVF it increases gender inequality. Women will feel less secure waiting until late twenties/ thirties to establish a career, finish education etc before having children as if they want a family they will feel more pressure to do so during their 'most fertile' years."

2. From a 35-44 year old in Liverpool, explicitly linking age and success rates:

"I strongly disagree with changing to one cycle of IVF... The reduction to a single cycle of IVF will widen inequalities in access to care between those who can afford additional private cycles and those who cannot."

Summary of Key Disadvantages Mentioned Across Age Groups:

- Impact of women seeking treatment at a later age as re ONS data suggests, means time and chances of success will be reduced.
- Financial Hardship: Inability to afford private treatment, making one unsuccessful cycle the end of the road.
- Mental Health Crisis: Descriptions of immense stress, heartbreak, devastation, depression, and removal of hope.
- Unfair "Postcode Lottery": Anger that their area's more supportive policy is being taken away.
- Impact on Family Vision: Specifically the inability to have more than one child (siblings).

Compounding Existing Inequalities: The change disproportionately affects people in deprived areas who cannot go private.

Public Sector Equality Duty (PSED) Considerations

- Emotional wellbeing: Increased mental health risks due to reduced chances.

- Equality of opportunity: Disproportionate impact on younger and older women with limited financial means.

- Indirect discrimination: Policy may disadvantage women based on age and socioeconomic status.

- Clinical fairness: Departure from NICE guidelines undermines equitable access to effective treatment.

Race

Background and context

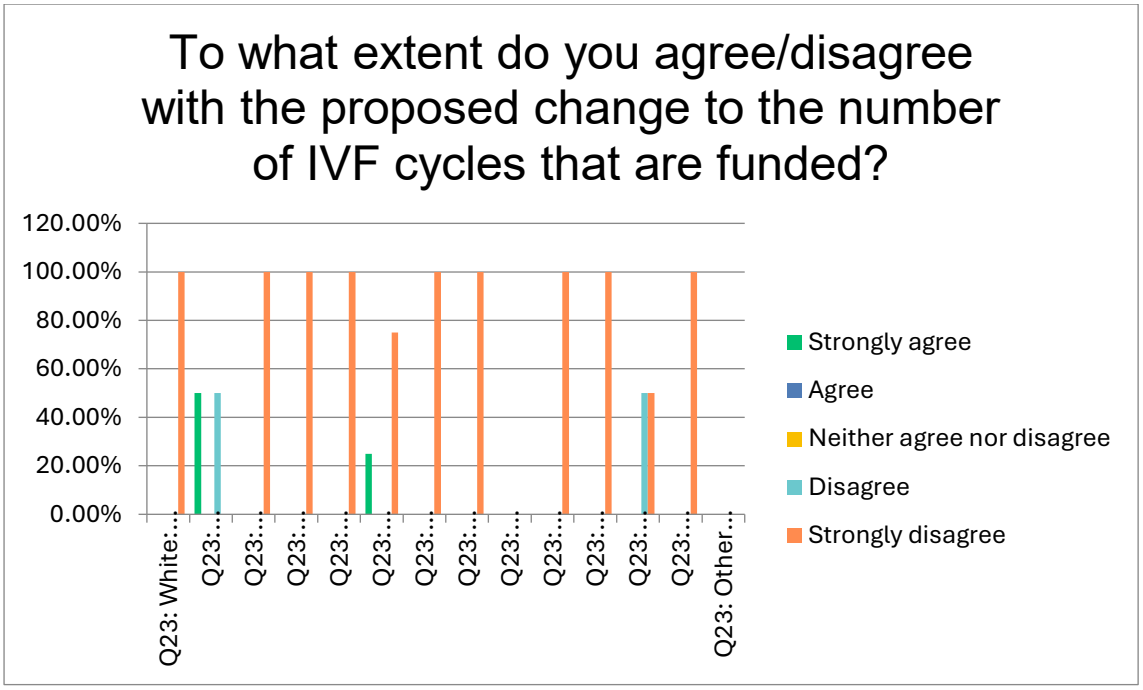
• Evidence indicates that members of Black, Asian and minority ethnic communities are more likely to live in areas of high deprivation and suffer disproportionate levels of health inequalities.
• HFEA's report "Ethnic diversity in fertility treatment 2021" provides us with key information to consider:
• Black people started fertility treatment later than other ethnic groups.
• People from ethnic minority backgrounds undergoing fertility treatment are less likely to have a baby, with Black patients having the lowest chances of successful treatment. Whilst overall birth rates from fertility treatment have increased and are highest in patients under 35, Black patients aged 30-34 have an average birth rate of 23%, compared to 30% for Mixed and White patients.
• It also highlights that 31% of Black fertility patients have fertility problems related to issues with their fallopian tubes, compared to only 18% of patients overall, with Black

patients also starting IVF almost two years later (36.4 years old) compared to the average patient at 34.6 years old.
• The report also shows that Black patients experienced higher than average multiple births from double embryo transfers, at around 14% from 2014-2018.
• The higher the age of Black IVF patients, the higher prevalence of heart conditions in the Black population means that it is particularly important that risks should be seriously considered prior to using double embryo transfers, as multiple births represent the single biggest risk to both mother and babies. While disparities for Black patients are the most notable, other ethnic groups also have worse outcomes when going through fertility treatment.
• Asian patients, who represent a larger proportion of IVF users at 14% whilst comprising 7% of the UK population may struggle to access donor eggs if needed. The report shows that 89% of egg donors are White, followed by 4% Asian, 3% Mixed and 3% Black, resulting in the use of White eggs in 52% of IVF cycles with an Asian patient.
• Some ethnic groups may be less likely to seek/access clinical care for IVF because of past experiences or community perceptions. Black African and Caribbean communities are high in this cohort.
• Some ethnic groups may be less likely to get culturally competent care when they do seek clinician care. This includes Black African and Caribbean and Asian groups and Gypsy, Traveller and Roma (GTR) communities but will extend to other ethnicities where there are language or cultural barriers or misunderstandings.
• Some ethnicities may experience higher levels of community and familiar pressure and consequential infertility distress. This will include some Asian, African and GTR communities (particularly women). This may also be compounded by religion or belief.
• Some people may experience language and cultural barriers related to their ethnicity or disability regardless of whether they are in the above cohorts (e.g. Deaf people and those of Chinese ethnicity).

Consultation analysis

	White	Not stated	Other
Ethnicity	1,098	1,001	26
	51.7%	47.1%	1.2%

Please note that 47.1% of consultees did not state their ethnicity.



Overall, there is opposition to the proposal.

Feedback

- Mixed/Multiple ethnic groups: White and Black African and Funding

‘ I believe it is essential to consider where NHS savings could be made without harming patients or jeopardising the future of our communities. Significant sums are spent on non-clinical staff and management within the NHS, and reviewing these administrative costs could identify opportunities for efficiencies without cutting essential fertility treatments. Investing in fertility care supports families who want to have children, which is critical for the long-term health of our communities and the sustainability of our economy. Reducing IVF access risks undermining the next generation and could contribute to long-term demographic and economic challenges, which in turn will massively exacerbate the NHS' funding issues. I urge the commit.

- Asian/Asian British: Bangladeshi

‘You won’t ever understand the mental, financial and physical stress this will have unless you have been through it’.

- Asian/Asian British: Indian

‘I am currently 33 and am currently waiting for treatment for a cyst on my ovary i have been on a waiting list for 18 months and still waiting I anticipate I will need fertility treatment at some time in the future’.

May negatively impact my ability to have kids in the future

- English/ French

‘Only offering a single IVF cycle may increase the level of risk a couple would be prepared to take. Increased risk increases cost of recovering from the consequences. £40,000 saving prediction could soon be exceeded by the resulting extra costs’.

- Asian/Asian British: Indian

Equal treatment

- Asian/Asian: Pakistani

‘Overall I feel like this chance would negatively impact the area as a whole, we are so fortunate to have access to the wonderful NHS in this country and for this ICB to place limitations on what patients can and cannot access is extremely upsetting. For example patients with any other health condition (except dentistry) are eligible to have free healthcare regardless of the severity of their disease. For some people may not believe that infertility is a disease, and it may not be however it is something which requires treatment & to have to pay for something which in the eyes of biology should come naturally is something which hits very close my heart. Having had multiple friends, and family patients require IVF treatment and the numerous cycles they have required, without that it would mean they would not have the families they do today and the joy and completion that these children bring to this world’. ‘By reducing the number of cycles to you are limiting the chance for patients to access the fundamental and vital funding they need to have a child. Furthermore regardless of the number of patients who do achieve success with one cycle, there are many couples who can't afford a second cycle and therefore will remain childless. I therefore do no believe it is fair to remove this chance of becoming parents’.

‘As someone who has had many family access IVF via NHS funded, this would crush their dreams of becoming parents, which is something that brings so much joy and happiness into people's lives. Secondly as someone who works in the fertility field, it would reduce the number of patients who require treatment in essence reducing work load and in the future may result in the reduction of staff. Losing a job at a young age especially after having worked and studied for so long to become qualified is unimaginable’.

- Mixed/Multiple ethnic groups: White and Black African

‘Think is is absolutely shocking you expect people to become pregnant after 1 cycle, it is very rare this happens, Fertilty treament is Emotional each cycle involves a demanding physical process, emotional highs and lows, and a period of anxious waiting, this now being limited to one cycle is just going to incase this’.

‘It would cause emetional and financial strain’.

- Black/African/Caribbean/Black British: African

‘’I strongly disagree because removing the second funded IVF cycle would unfairly disadvantage people like me who cannot afford to self-fund treatment. After an unsuccessful first round with no embryos frozen or transferred, the second cycle offers a medically informed and more hopeful chance at success. Taking that away worsens health inequality, especially in regions like Merseyside where socioeconomic disparities are already significant’.

‘In closing, I urge decision-makers to carefully consider the human cost of these proposed changes. For patients like me, who are navigating infertility with limited financial means, the

removal of a second funded IVF cycle and a restrictive definition of childlessness would not only reduce our chances of success — it would effectively shut the door on the possibility of building the families we long for. These proposals risk reinforcing fertility inequality along lines of income, race, and geography, particularly in areas like Merseyside where health and socioeconomic disparities already run deep. True fairness in healthcare means levelling up access, not bringing everyone down to the most restrictive standard. Policies should reflect the realities of medical treatment, the diversity of family dreams, and the principle that the chance to become a parent should not be a privilege reserved for the wealthy'.

- Asian/Asian British: Pakistani

'I think the current postcode lottery is unfair and SHOULD be changed. However dropping to a 1 round system will prove to be unreliable and unfair. The first round is often where the doctors learn about how a woman's body reacts to medication and often is the first chance they get to look at the eggs. This is often refined resulting in the second round having better outcomes than the first. If there is a drop in funding, there would need to be many more invasive done before they went ahead with the round of IVF in a "throw the kitchen sink at it" approach otherwise you will have wasted someone's chances at an otherwise often unaffordable process. This will especially be unfair for those who have low AMH and may only gain 1 or 2 eggs from a retrieval'

'As someone who has low AMH for a 29 year old. I only had 5 eggs from retrieval and from that only 2 viable embryos. This in comparison to those who managed to get upwards of 20 eggs and embryos means it would put me at a severe disadvantage and reduce my chances of having children. IVF isn't a definite and there needs to be nuance and space to adapt the treatment based on each persons specific physiology'

- Black/African/Caribbean/Black British: Caribbean

'I think 2 rounds is good within the Liverpool area however this should depend on the kind or underlying issues either parties has which may not be enough to have a successful outcome'

'This will be insignificant because a first round is usually done without much tests - it is used to then assess what could have been the problem so this is not useful but cause a stress to the patient'

- Mixed/Multiple ethnic groups: White and Asian

'I understand there is disparity in the availability of fertility treatment across the country, however there are hundreds, if not thousands of women and men, who are desperate to be parents and simply because of money they're not able to. It would be an injustice to cut it to down to one cycle, it is discriminatory and the NHS need to make it a priority in looking after people who have both medical and emotional conditions that need help to conceive. The impact of reducing the number of cycles will cause further mental health, relationship, and work pressures notwithstanding the inability to afford to pay for IVF, and getting into debt. Many couples require more than one treatment cycle to achieve a successful live birth. One cycle does not fit all & limiting IVF cycles to one will disproportionately impact women as some women need multiple attempts to succeed and they will be excluded. This proposal is damaging and will exacerbate existing inequalities in access to healthcare with women. While IUI is an option it is not a guaranteed solution for fertility as success rates can vary. Streamlining criteria's is something to be considered and I don't disagree. My daughter &

husband have already put themselves through a lot, physically & emotionally to even reach this point and to take away what was their three approved cycles would be criminal. A new policy should be designed to minimise disruptions and ensure a transition that allows'
'fertility is highly valued in most cultures & the wish for a child is one of the most basic of all human motivations and when attempts have the potential to fail it can be an emotionally devastating experience without having the worry of cycles being withdrawn. To reduce or cut the promised cycles the NHS needs to understand the psychological implications it will have on my daughter and many others that have already started this process with clear views of agreed cycles. To cut my daughter's IVF cycles would have devastating implications to her wellbeing as the first cycle has highlighted the pitfalls & challenges of fertility which relates to procedures and treatments, and as such the correct information isn't always imparted as it's an unknown but has impactive effects. The first round of fertility treatments have highlighted the potential risks & drawbacks. The first cycle feels like it's a trail and error exercise, getting the right medication dosages, monitoring the patient as each individual is different. Through no fault of my daughters a single-cycle approach could fail and this would be through no fault of her own but moreover to common errors by the clinic which undermines the the trails ability to measure the desired outcomes accurately before settling on the right course of treatment. In view of this, it causes heightened psychological distress. My daughter's observations are largely based on her own experiences & my observations through her experiences.'

- Black/African/Caribbean/Black British: African

'here is it's of data to shows that one cycle of IVf does not have a high enough success rate and this would be cruel to limit proper to one cycle especially as we know that many people will struggle to self fund further cycles. Also with a grow in f rate of secondary infertility and low rates of child birth in the Uk this is mealy a cost saving exercise with Jo consideration for the true human experience, politicians ca save money elsewhere'

'My husband and I have just stared TTc however we both have underlaying medical conditions which could make it difficult or impossible without services like IVf. I have friends and colleagues who have struggled with infertility and as a doctor I also understand the impact this has on families'

- White: Gypsy or Irish Traveller

'I have already had to pay thousands of pounds privately to get to the IVF stage due to endometriosis, as waiting lists for surgery where years and pain got too much for me to live a normal life. Now my self and my husband could end up spending thousands to actually conceive? This is absolutely heart breaking. All we want is to be parents, but now it seems if you don't have the money then that life choice is taken away from us'!

the first round did not work, we would not be able to afford to pay for more. This meaning the opportunity of being parents would be taken away from us, yet we still continue to pay our taxes and national insurance to fund for NHS, now we are told what we can and can't have?

- Black/African/Caribbean/Black British: African

'This change will unfairly impact those who cannot afford private IVF treatment. Fertility issues affect people across all income levels, but this policy will disproportionately harm lower-income individuals and families, effectively making fertility treatment a privilege for the wealthy. True equality is about ensuring everyone has a fair chance of success, not just the same starting point. Additionally, infertility is a profoundly distressing experience. Being offered only one attempt can feel like an institutional dismissal of people's hopes to start a

family. It places undue pressure and emotional stress on individuals and couples, potentially affecting mental health and wellbeing. A more compassionate policy would acknowledge the emotional burden and support multiple attempts, as recommended. While I agree that equal access is important, standardising by reducing access is not a fair or ethical solution. Equality should be achieved by raising the standard, not by cutting care to the lowest common level. Rather than reducing provision in most areas, the ICB should aim to increase provision in those currently underserved'.

'IVF is often a last resort after months or even years of trying to conceive. Being told that I would only have one funded chance puts an immense amount of pressure on that cycle to succeed—something no one can control. The reality is that IVF does not always work the first time, and success often comes after two or three attempts. Reducing funding to one cycle feels like giving hope with one hand and taking it away with the other. This change would also create a financial barrier that many of us simply cannot overcome. Private IVF is unaffordable for many people. If I need another cycle after the first fails (which is likely, based on national success rates), I might have no choice but to give up on having a family—not because of my health, but because of cost. That's an unfair and heartbreaking situation to be in. In addition to the emotional and mental toll that infertility already causes, limiting NHS support to one IVF cycle adds even more distress, anxiety, and hopelessness. It feels like the system is not really supporting people to become parents—it's just ticking a box and moving on. If equity is truly the goal, then access should be levelled up—not cut down. This proposed change would make things harder, not fairer'.

- Asian/Asian British: Any other Asian background

'As a previous user who has been very lucky to have received fertility treatment and being in such an unknown space, I think this change would badly affect someone's journey and their mental health. 2 funding cycles is appropriate. Also, there will be a lot of cases such as mine, where we have been very lucky to require only one cycle, so some funding should be returned and made back in that way or reallocated to other families'.

- Black/African/Caribbean/Black British:

''Please review the statistics on how many women gets pregnant on their second cycle. This proposal will significantly reduce couples chances on having a child as a lot of people such has myself and my partner got no chance of paying it privately'.

'Iam still waiting to be called to discuss my options but for what I've heard it would reduced by one cycle'

'I believe that the NHS values patients by placing them at the center of its priorities. While I understand that the NHS is currently facing a severe financial crisis, I firmly believe that patients should still come first. The impact of changes to IVF cycles on couples' mental health will be significant. As someone who is about to start this process, I can't emphasize enough how much these proposals have already triggered anxiety in the entire fertility community. I agree that IVF cycle opportunities should be equitable across Cheshire and Merseyside, but reducing the number of cycles to just one is not a fair approach. I have read that statistics show couples dealing with infertility have only a 20% chance of success on their first cycle. For those who cannot afford a second cycle, this reduction could leave them without hope and without the possibility of having a child. This situation is simply not fair'.

- Mixed/Multiple ethnic groups: White and Black Caribbean

‘My partner is quadriplegic and we can not have children without IVF’.

‘We would not be able to have children’

Equality Issues and PSED Implications from Minority Ethnic IVF Consultation Feedback

Key Equality Issues and Themes

- Disproportionate Impact on Minority Ethnic Communities: Reduced IVF access disproportionately affects lower-income households, which are overrepresented in some ethnic groups, exacerbating existing inequalities.

- Financial Barriers and Fertility Inequality: Private IVF is unaffordable for many, making fertility treatment a privilege for the wealthy and creating barriers to parenthood.

- Mental Health and Emotional Wellbeing: The emotional toll of infertility is worsened by limited treatment options, with psychological distress highlighted by consultees.

- Cultural Significance of Fertility: Fertility is deeply valued across cultures, and restricted access is seen as a cultural and personal loss.

- Perceived Discrimination and Inequity: The proposals are viewed as discriminatory and unfair compared to other healthcare services.

- Intersectionality: Individuals facing multiple disadvantages (e.g., race and disability) are especially impacted by reduced access.

PSED considerations

- The proposal may result in indirect discrimination

- Systemic inequalities

-Low Representation

-The proposals risk undermining trust between minority communities and the NHS.

Religion and belief

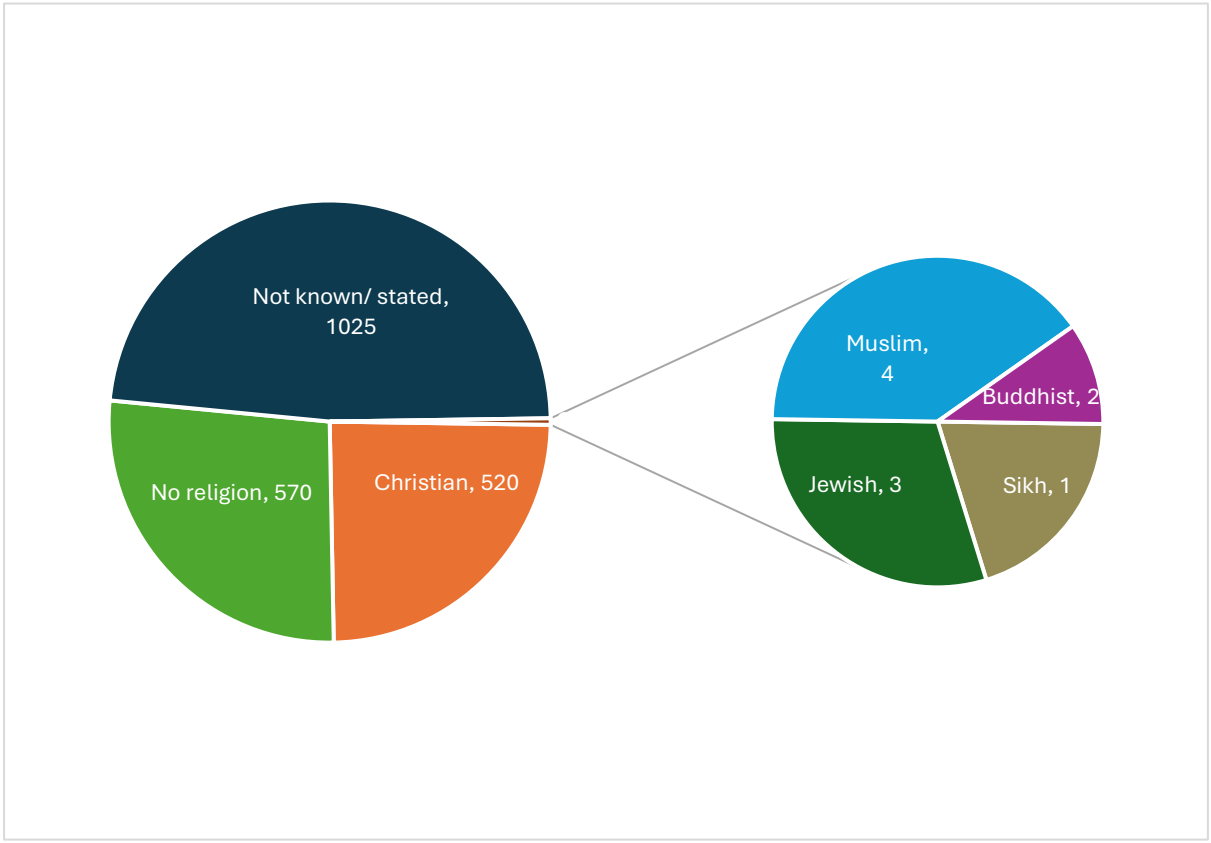
Context

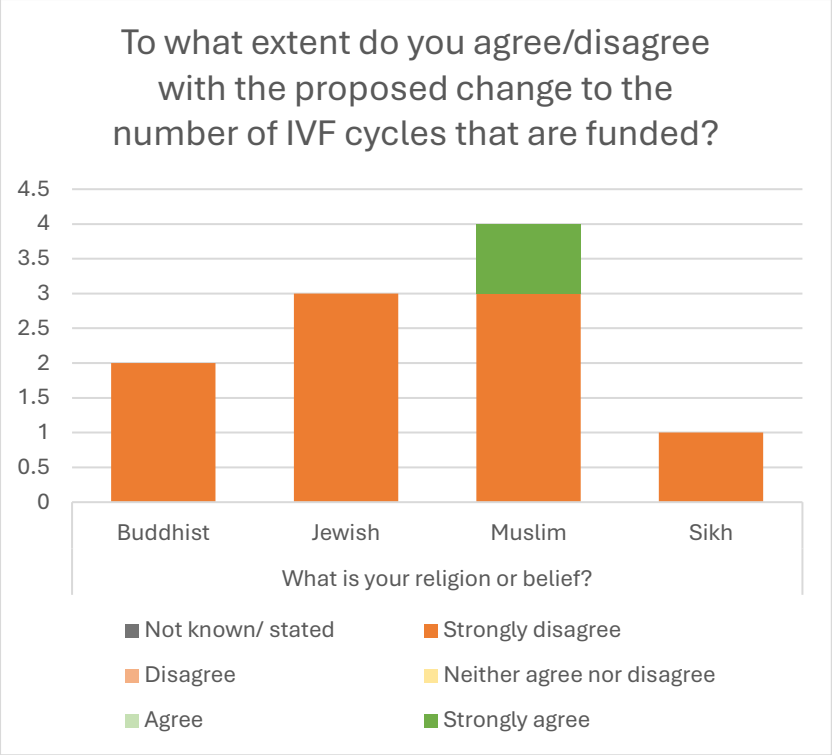
IVF is acceptable in Islam, provided that it is for a married couple and both the egg and sperm come from this couple. Some religious organisations take formal positions associated with IVF. For example:

• The Catechism of the Catholic Church states that IVF is “morally unacceptable” due to the destruction of embryonic life, the assault on the meaning of the conjugal act and the treatment of the child as a product not a gift IVF.

• For Judaism one of the first commandments of the Torah is to be fruitful and multiply, so generally IVF is supported, and by some quarters strongly encouraged, although there is debate around the morality of certain procedures.

Consultation analysis





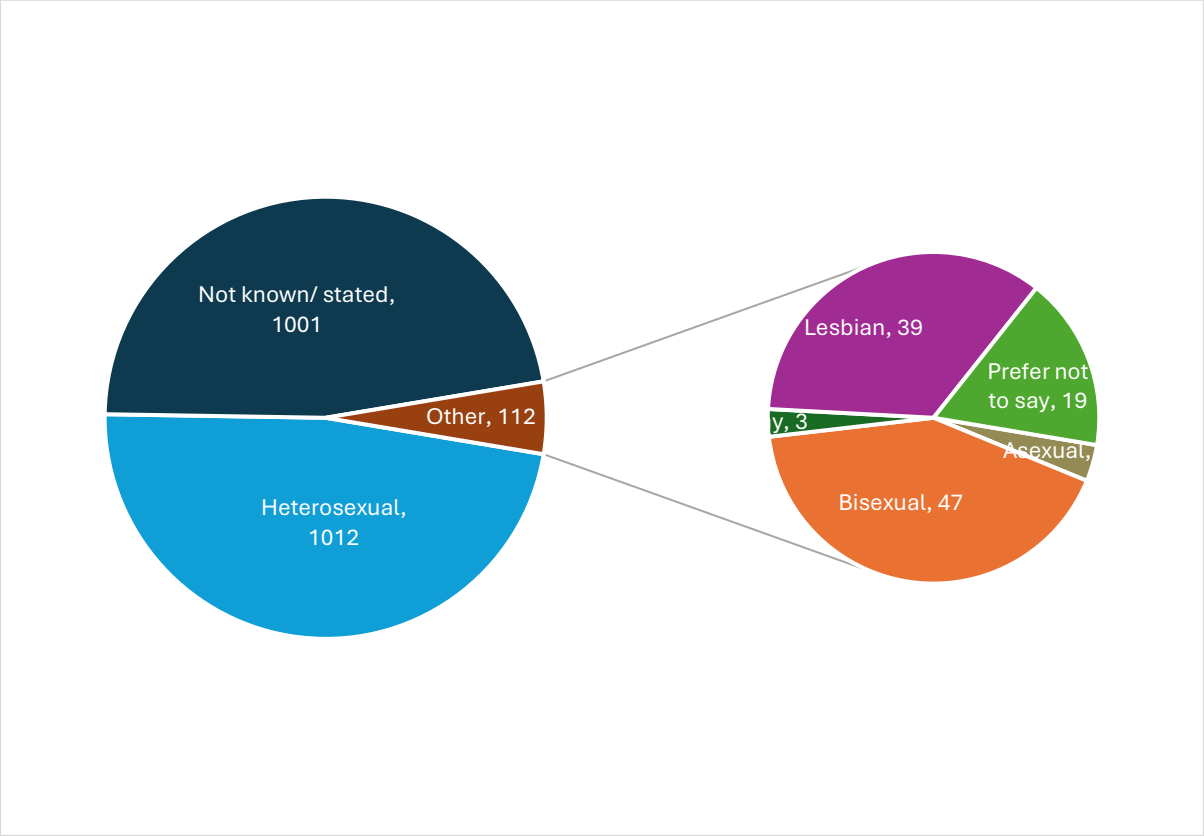
Strong disagreement against the proposal

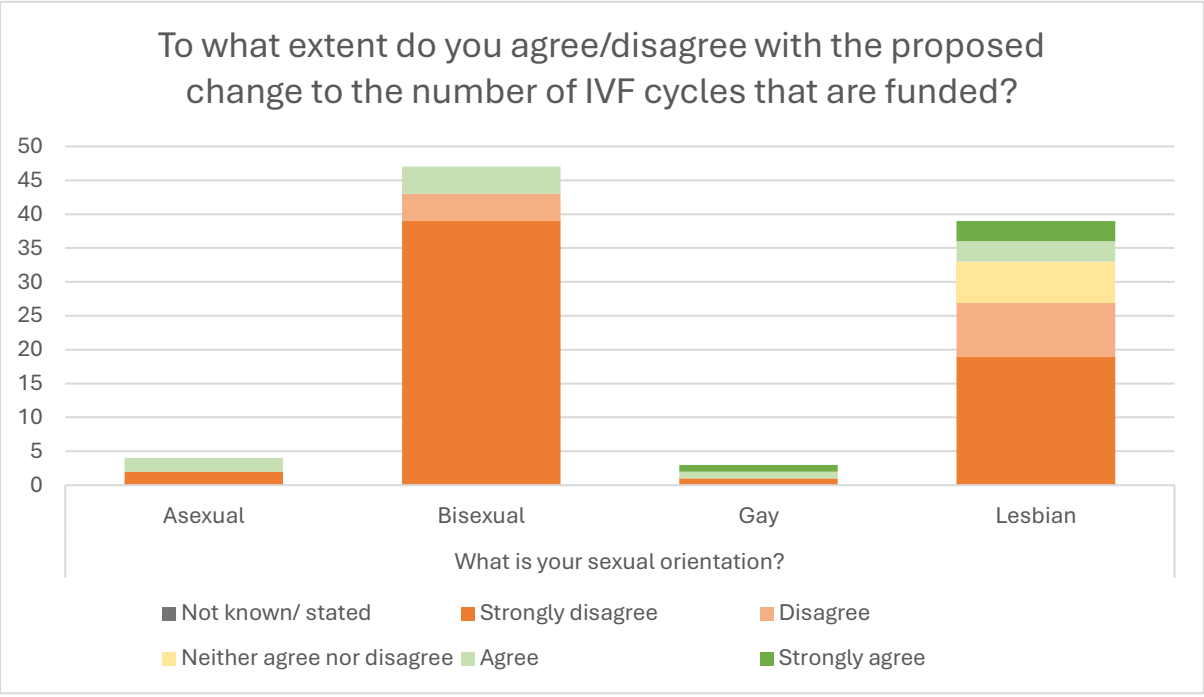
It is important to note that the number of respondents from minority religious groups in this dataset is very small. The predominant groups are "No religion" and "Christian"

Limited Data: The dataset contains no substantive commentary from minority religious groups on the disadvantages or impacts of the policy changes.

- PSED considerations
- Representation is low.

Sexual orientation – context





Bisexual and lesbian women strongly disagreed or disagreed with the proposal on reduction to one cycle.

Please note an update was made to the consultation information and questionnaire on 6 June 2025. A previous version of the consultation information and questionnaire referred to

proposed changes to the requirement for IUI before IVF treatment in Cheshire East, Cheshire West and Wirral. This was an error – the actual proposed change was for the new policy to allow NHS-funded IUI for a number of specific groups across Cheshire and Merseyside, when currently it is not routinely commissioned in Wirral. Analysis of comments indicates that this change made little or no difference to the responses received.

Currently in most areas of Cheshire and Merseyside, in line with NICE guidance, the use of NHS funded IUI is 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.

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.

Respondents were asked **"To what extent do you agree/disagree with the proposed change to IUI commissioning in Wirral?"** The results were as follows:

Answer choices	Responses	
Strongly agree	19%	239
Agree	23%	292
Neither agree nor disagree	37%	469
Disagree	7%	85
Strongly disagree	14%	179
	Answered	**1,264**

Not all respondents who answered this question chose to leave a comment to explain more about why they agreed or disagreed with the proposed policy change, and fewer again left a comment to describe the impact of the proposed policy change.

Themes raised by respondents included:

Fairness and equality - fairness in access to fertility treatment was a recurring concern. Respondents emphasised that policies should not discriminate based on relationship type, geography, or personal circumstances.

"Everyone needs a fair chance"

Access / discrimination for same-sex couples - many respondents, regardless of stance, highlighted the perceived inequality in requiring same-sex couples to self-fund IUI, calling for NHS-funded cycles for all.

"IUI should be free for same sex couples"

Consistency across regions - there was strong support for aligning policies to eliminate postcode-based disparities.

“Consistent criteria across the ICB”

IUI as a less invasive and cost-effective option - IUI was frequently described by respondents as a gentler and more affordable alternative to IVF, with many advocating for its use as a first-line treatment.

“IUI is often the first and less invasive treatment option... more physically and emotionally manageable than IVF.”

Alignment with NICE guidelines - respondents supported aligning local policies with national NICE guidelines to ensure best practice and fairness, though some expressed confusion about selective adherence.

“You should not pick and choose which NICE guidelines to follow.”

Impact

In response to the question ‘Please use this space to let us know how the proposed change to IUI commissioning in Wirral would impact you.’ many comments repeated the themes above however, several responses highlighted specific concerns for medical conditions (e.g., Klinefelter syndrome, endometriosis, PCOS) that complicate fertility and increase reliance on assisted reproduction.

PSED implications

Please note

NICE Guidance and NHS Policy on Same-Sex Couples and IUI self-funding to evidence sub fertility.

The NICE guidelines (CG156) do not explicitly justify the requirement for same-sex couples to self-fund IUI. Historically, NHS commissioners interpreted the guidelines to mean that same-sex couples must demonstrate infertility—often defined as failure to conceive after 6–12 cycles of donor insemination, which were typically self-funded. This created a financial barrier, as heterosexual couples could access NHS-funded treatment after 2 years of unsuccessful natural conception, while same-sex couples had to pay for multiple IUI cycles to 'prove' infertility.

NICE acknowledges this issue in the scope document for the CG156 update, stating: 'There are known complexities around access and funding in this area – in particular where some people may have had to self-fund initial treatments to demonstrate a health-related fertility problem in order to access further care.' However, NICE also clarifies that it will not make recommendations on funding arrangements.

The Department of Health and Social Care addressed this gap in the Women's Health Strategy for England (2022), stating: 'We will relieve those additional burdens, so that there is no requirement for self-funding and the NHS treatment pathway for female same-sex couples will start with 6 cycles of artificial insemination, prior to accessing IVF services if necessary.'

In summary, NICE does not justify self-funding for same-sex couples— as they do not address funding within the guidance. This position is currently harmonised in the policies.

The Women's Health Strategy now explicitly rejects this requirement, promoting equitable access to NHS-funded IUI.

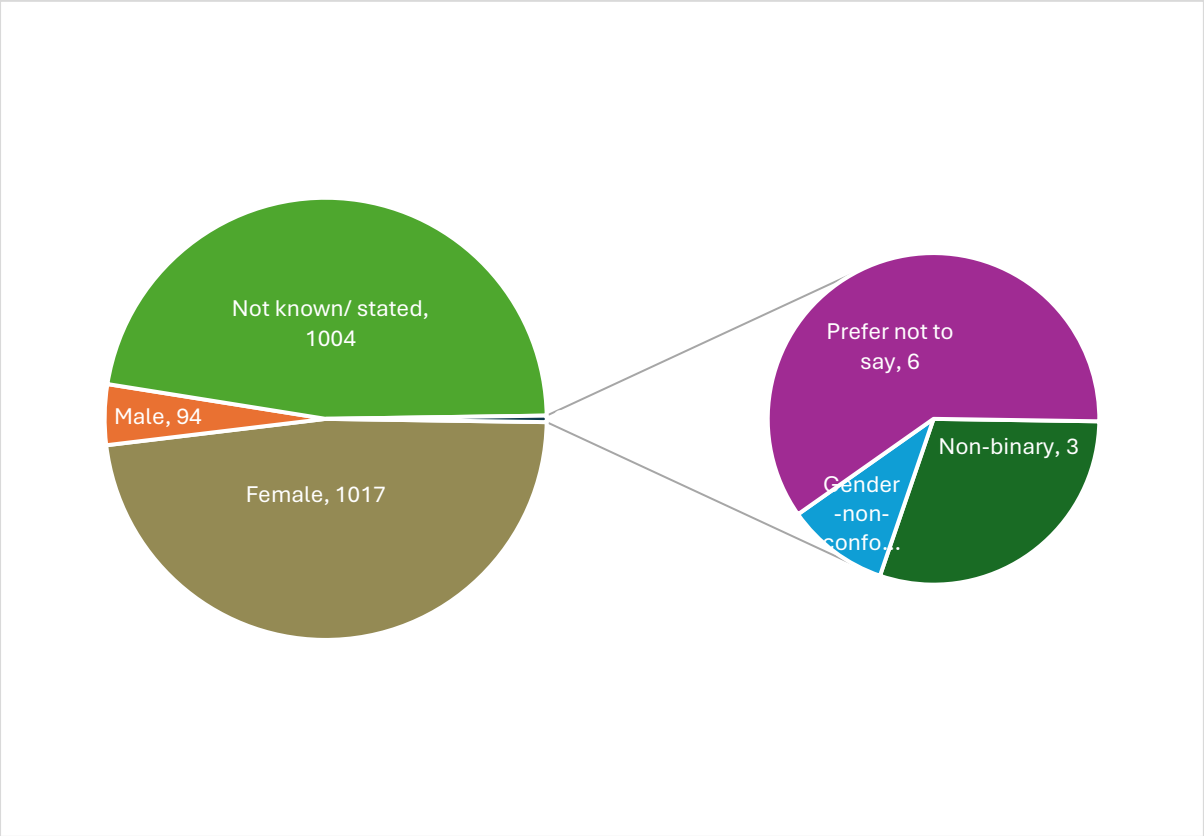
PSED considerations.

- Consideration of this issue IUI funding must form part of the future C&M review.
- Intersectional Financial and Mental Health Impact
- The Core Issue: The cost of private IUI cycles (often thousands of pounds) creates a profound socio-economic barrier. This intersects with the emotional distress of fertility treatment, adding financial anxiety to an already stressful journey.
- The Impact: This effectively creates a two-tier system where parenthood is easier for wealthy same-sex couples, and can cause significant mental health strain and delay treatment.

Transgender

The implications for transgender individuals are not merely about a reduction in cycles, but about how the entire policy framework interacts with the specific and often irreversible nature of their fertility journeys. The "one cycle" policy is not a limitation of attempts, but a limitation on the use of a finite, irreplaceable biological resource preserved at a critical life moment. When combined with eligibility criteria that do not account for the side-effects of essential hormone therapy and definitions of family that may not reflect their lives, the policy creates a series of interconnected barriers. These barriers can ultimately deny transgender people a fair and equitable opportunity to form a biological family, simply because their path to parenthood does not align with a cis-normative model. Ensuring equity requires proactive, inclusive design of policies and pathways, not just the neutral application of rules that have a disproportionately exclusionary effect.

Consultation analysis



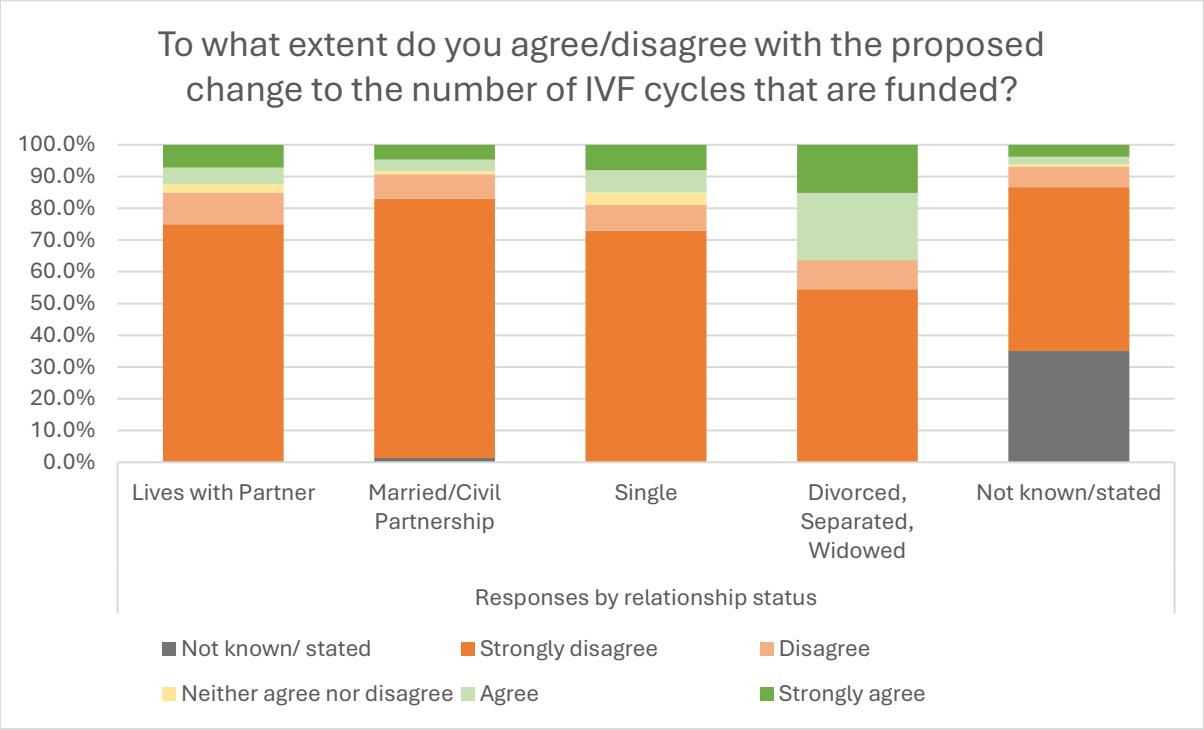
PSED considerations

- Low representation
- Systemic inequalities
- Inclusive design

No specific insight highlighted any issues. No free text narrative or insight gained.

Marriage and civil partnerships

Consultation analysis



There is broad consensus that people living with a partner, in marriage or civil partnership and single women strongly disagree with the proposal.

Health inequalities

The Proposed Fertility Policy and the Perpetuation of Health Inequalities

The proposed shift to a single, standardised IVF policy across Cheshire and Merseyside, while aimed at ending the "postcode lottery," risks institutionalising and exacerbating deep-seated health inequalities. The policy does not create these inequalities, but it interacts with them in a way that will systematically and disproportionately deny the opportunity of biological parenthood to the most disadvantaged groups in our society. This is not an unintended consequence; it is a predictable outcome of applying a blunt, one-size-fits-all solution to a deeply complex and unequal health landscape.

The Policy Locks in Pre-Existing Outcome Disparities

Clinical success in IVF is not distributed equally. We have clear evidence from the Human Fertilisation and Embryology Authority (HFEA) and our own engagement that reveals stark disparities:

· Ethnicity: Black women start fertility treatment later and have significantly lower success rates per cycle (e.g., a 23% live birth rate for Black patients aged 30-34 compared to 30% for

White patients). A policy of one cycle does not compensate for this disparity; it codifies it. It tells a Black woman that the NHS will offer her one attempt, knowing that systemic barriers and biological factors mean her chance of success is statistically and significantly lower than that of her white neighbour. This is the very definition of an inequitable outcome.

The most profound inequality created by this policy is economic. By limiting all couples to one NHS cycle, the policy creates a definitive, two-tier system:

End

Please see Main Full EIA document.