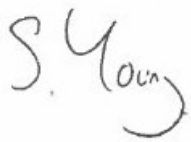
Public Document Pack

Health and Social Care Policy and Performance Board

Tuesday, 24 June 2025 at 6.30 p.m.
Council Chamber, Runcorn Town Hall



Chief Executive

BOARD MEMBERSHIP

Councillor Eddie Dourley (Chair)	Labour
Councillor Sandra Baker (Vice-Chair)	Labour
Councillor Sian Davidson	Reform UK
Councillor Louise Goodall	Labour
Councillor Stan Hill	Labour
Councillor Colin Hughes	Labour
Councillor Alan Lowe	Labour
Councillor Katy McDonough	Labour
Councillor Norman Plumpton Walsh	Labour
Councillor Aimee Skinner	Labour
Councillor Tom Stretch	Labour
David Wilson	Healthwatch Co-optee

Please contact Kim Butler on 0151 511 7496 or e-mail kim.butler@halton.gov.uk for further information.

The next meeting of the Board is on Tuesday, 23 September 2025

ITEMS TO BE DEALT WITH
IN THE PRESENCE OF THE PRESS AND PUBLIC

Part I

In accordance with the Health and Safety at Work Act the Council is required to notify those attending meetings of the fire evacuation procedures. A copy has previously been circulated to Members and instructions are located in all rooms within the Civic block.

HEALTH POLICY AND PERFORMANCE BOARD

At a meeting of the Health Policy and Performance Board held on Tuesday, 11 February 2025 at the Council Chamber, Runcorn Town Hall

Present: Councillors Dourley (Chair), Baker (Vice-Chair), Begg, Fry, Garner, Goodall, C. Loftus, L. Nolan and Thornton and Healthwatch Co-optee D. Wilson

Apologies for Absence: Councillors Davidson and Stretch

Absence declared on Council business: None

Officers present: A. Jones, D. Nolan, H. Moir, D. O'Connor and S. Griffiths

Also in attendance: T. Leo – Halton Place, NHS Cheshire & Merseyside and two members of the public

ITEMS DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HEA27 MINUTES

The Minutes of the meeting held on 26 November 2024 were signed as a correct record.

HEA28 PUBLIC QUESTION TIME

The following question was received:

Question:

Appendix 1 - the Quality Assurance Framework was approved and published in October 2024 to meet the Council's obligations under the Care Act 2014. Although the obligations under the care Act has been in place since April 2015.

What Quality Assurance Framework did the Council's quality assurance team use to mitigate risks that led to the Council's (the providers) failure to protect its residents across its own internal care homes prior to October 2024 (specifically from 2022-2024)? No Audits performed from 2022.

The Quality Assurance Team employs 2 part time quality

assurance officers - one of which has been off long term sick since 2021. The nominated person over all of the Council care homes had overall responsibility to protect services users from avoidable harm, and overall governance of the services owned by the Council.

I'd really appreciate if my response to my question, was in the public domain in the next minutes of the PBB. I feel it's in the public interest to know the failings that are occurring in our care Homes in Halton.

Response:

The question was received the day before the meeting at 1141 hours, so a response would be prepared following the meeting and sent to the member of the public. — Executive Director of Adult Services

HEA29 HEALTH AND WELLBEING MINUTES

The minutes from the Health and Wellbeing Board meeting held on 9 October 2024, were submitted to the Board for information.

HEA30 EMPLOYER STANDARDS HEALTH CHECK SURVEY 2024

The Board received a report which presented the results from the Employer Standards Health Check Survey 2024. The survey was conducted at a national level between 16 February and 22 March 2024. The summary report was attached at appendix 1.

It was noted that the health check was conducted on an annual basis and this was the fourth year that it had been run nationally by the LGA, where Halton had taken part each time. Some key points were outlined for Members in the officers report, taken from the summary.

Members welcomed the results of the survey and that required standards were being met. It was noted that staff employed by the Council were preferred over agency staff, as this offered clients consistency and reassurance.

RESOLVED: That the report and appendix be noted.

HEA31 ADULTS PRINCIPAL SOCIAL WORKER ANNUAL REPORT

The Board considered a report from the Executive Director – Adult Social Care, which provided an annual

progress report from the Adults Principal Social Worker (APSW) showing how the role of social work supported the Council to meeting its priorities and objectives.

It was reported that the APSW was a statutory requirement under the Care Act 2014. The national guidance on the role and responsibilities had evolved and been updated and clarified over recent years. It was noted that the Principal Social Worker played a key role in representing and promoting the social work profession; the report listed some of the responsibilities that came with the role.

The report also outlined details of the strengths based approaches and practice training, which had been carried out over the past 12 months. Included were details of specialist training such as e-learning for all staff and webinars, in conjunction with the Learning Disability and Autism Programme.

Information on: present and future workforce development; the mental health 'Think Ahead' Programme; the LGA's Standards for Employers of Social Workers; the organisational health check and quality assurance, was also presented in the report.

In response to Councillor Fry's question on apprenticeships, it was announced that updated guidance had been issued in relation to apprenticeships eligibility criteria, which is encouraging for the Social Worker profession.

RESOLVED: That the report is noted.

HEA32 ADULTS PRINCIPAL OCCUPATIONAL THERAPIST ANNUAL REPORT

The Board received a report from the Executive Director – Adult Social Care, which presented the Principal Occupational Therapist's (POT) Annual Report.

Although the Adults Principal Social Worker (APSW) role was a statutory requirement under the Care Act 2014, at present there was no requirement in place for local authorities to have a POT, however Halton had one in post since January 2024. It was acknowledged by the ADASS (Association of Directors of Adult Social Services) that having a POT to work alongside the APSW added diverse leadership within adult social care and had a positive impact on local populations.

The report outlined the role of occupational therapy, referral numbers, challenges faced, and culture and practice of the service and the current workforce. Members were referred to the appendix, which presented an anonymised case study for information.

Members agreed that the addition of the POT's post was a benefit to the service and welcomed the appointment.

The consensus of the Board was that the adaptation of homes, where possible, was preferable to people being admitted to hospital. It was commented that the Occupational Therapy Team was a stable workforce, and staff members had been employed at Halton for a long time. Although a challenging area to work in, they were creative and motivated and had the support of a good leadership team.

RESOLVED: That the report and appendix be noted.

HEA33 QUALITY ASSURANCE FRAMEWORK FOR USE BY THE QUALITY ASSURANCE TEAM

The Board was presented with the Quality Assurance Framework that is used by the Quality Assurance Team; this was appended to the report.

This document brought together the process, methods and tools that the Quality Assurance Team (QAT) used to gather evidence and intelligence about Adult Social Care services that were commissioned for Halton. It was noted that these quality assurance activities supported the delivery of social care commissioned services, in meeting and exceeding contractual, regulatory and quality standards.

A summary of the purpose of the Framework and the services supported were provided. This included the role of Elected Members in the quality assurance process, through Councillor visits to care homes (Section 4.27).

RESOLVED: That the report is noted.

HEA34 HOUSING ADAPTATIONS FOR DISABLED PEOPLE POLICY AND HOME ASSISTANCE POLICY

The Board received a report from the Executive Director of Adult Services, which presented the *Home Adaptations for Disable People Policy* and the *Home Assistance Policy.*

The Board was advised that the Home Adaptations for Disabled People Policy was the internal policy for staff for determining eligibility, approval and management of both minor and major housing adaptions requests. The Home Assistance Policy was the corresponding public facing document, required to be in place as per the Regulatory Reform (Housing Assistance) Order (RRO) 2002.

The report provided Members with details of a recent review of the policies, using Government guidance published in March 2022 – *Disabled Facilities Grant (DFG) Delivery: Guidance for Local Authorities in England*.

Following Members discussion and scrutiny of the policies, the following additional information was provided:

- It was disappointing that the review had not included proposals for an increase on the £30k maximum DFG (Disabilities Facilities Grant) award for housing adaptations – a review was supposed to have taken place last year, but this was cancelled by Government;
- Concerns were raised that £30k does not go as far as it did when it was set years ago, so for some people this may not be enough to cover required adaptions and therefore push them into care homes;
- The fast track process for a DFG application took approximately 6 months from when the grant application is made;
- It was noted that only the Motor Neurone Disease (MND) Association had responded to the consultation, despite two reminders being sent. Members were curious as to why other charities had not responded;
- Top up loans were available to clients in certain circumstances;
- Discretionary support loans may be available for owner occupiers to cover contributions to adaptations or to cover a shortfall in funding. These charges were then placed against the property and recouped if the property was sold or transferred within 10 years;
- Housing associations do fund housing adaptations and were signed up to fund 50% of costs; and
- In the case of a private landlord not agreeing to adaptations to their property, the client would be supported to consider a house move.

RESOLVED: That the report is noted.

HEA35 PROPOSED CHANGES TO NHS FUNDED GLUTEN FREE PRESCRIBING

The Board considered a report from the Integrated Care Board (ICB) Place Director for Halton, which informed of the proposals to commence consultation on the cessation of NHS Funded Gluten Free Prescribing across Cheshire and Merseyside.

It was noted that the ICB had a duty to engage with Local Authority Health and Overview Scrutiny Boards, so that confirmation could be sought as to whether the Scrutiny Boards believed that the proposal was a substantial development or variation (SDV) to NHS services. If this was confirmed by the Board, then the requirement for the ICB to formally consult with the Board would be triggered.

Members were referred to Appendices one and two – *Gluten Free prescribing paper to the Board of NHS Cheshire and Merseyside ICS* (28 November 2024); and *Cheshire and Merseyside Protocol for the establishment of Joint Health Scrutiny Arrangements in Cheshire and Merseyside.*

Members discussed the proposals and after taking into consideration the fact that Halton was a deprived Borough; 141 patients were accessing the prescriptions; the demographics of this group of patients was unknown; and coeliac disease was a medical condition; it was agreed that the proposal to cease NHS funded gluten free prescribing represented a substantial variation.

The Healthwatch Co-optee requested the consultation to be available in other formats other than online, this would be addressed. It was also noted that all stakeholders that wished to be included in the consultation would be.

RESOLVED: That the Board confirms that the proposal to cease NHS funded gluten free prescribing represents a substantial development or variation.

Executive Director of Adult Services

HEA36 SCRUTINY TOPIC 24/25 OUTCOME AND PLANNED TOPIC 25/26

The Board received the summary of evidence, Member conclusions and recommendations, relating to the Scrutiny Committee Review of NHS (Non GP) Community Services.

This topic was agreed by the Board in June 2024 and

between July and December, a scrutiny group met monthly to receive evidence from several contributors. Details of the membership, contributions and summary evidence was presented in appendix 1 – Scrutiny Recommendations Report. The recommendations proposed were also outlined in the report in paragraph 3.5.

The Board agreed that the findings and recommendations of the Scrutiny Review of NHS (Non GP) Community Services be approved.

Members had proposed two options for potential areas for security in 2025, as follows:

Mental Health Support – looking at how existing provision was meeting current demand and responding to predicted demand, and equality of access to services for marginalised or minority groups, covering both Adults and Children and Young People's services; and

Access to Health Care – looking at equality of access, experience and outcomes across specific health care provisions for marginalised or minority groups (specific provisions to be identified, but including mental health and dentistry).

After discussion and consideration of a further suggested topic, oral health and dentistry, Members voted for the Mental Health Support topic group. A full topic brief would be developed and shared with Members at the next meeting. It was noted that an update on dentistry in the Borough would be requested for the next meeting.

RESOLVED: That

Executive Director of Adult Services

1) the findings and recommendations of the Scrutiny Review of NHS (Non GP) Community Services be approved; and

2) the Board agrees that Mental Health Support is the scrutiny topic for 2025.

HEA37 COUNCILWIDE SPENDING AS AT 30 NOVEMBER 2024

The Board received a report from the Director of Finance, which gave the Council's overall revenue and capital spending position as at 30 November 2024, together with the latest 2024-25 outturn forecast.

On 16 January 2025, Executive Board received the

attached report and appendices, which presented details of Councilwide revenue and capital spending by each department and outlined the reasons for key variances from budget.

Executive Board has requested that a copy of the report be shared with each Policy and Performance Board for information. This was to ensure that all Members had a full appreciation of the Councilwide financial position, in addition to their specific areas of responsibility.

RESOLVED: That the Councilwide financial position as outlined in the report be noted.

Meeting ended at 8.00 p.m.

REPORT TO: Health & Social Care Policy & Performance Board

DATE: 24 June 2025

REPORTING OFFICER: Chief Executive

SUBJECT: Public Question Time

WARD(S) Boroughwide

1.0 **PURPOSE OF THE REPORT**

1.1 To consider any questions submitted by the Public in accordance with Standing Order 34(9).

1.2 Details of any questions received will be circulated at the meeting.

2.0 **RECOMMENDATION: That any questions received be dealt with.**

3.0 **SUPPORTING INFORMATION**

3.1 Standing Order 34(9) states that Public Questions shall be dealt with as follows:-

(i) A total of 30 minutes will be allocated for dealing with questions from members of the public who are residents of the Borough, to ask questions at meetings of the Policy and Performance Boards.

(ii) Members of the public can ask questions on any matter relating to the agenda.

(iii) Members of the public can ask questions. Written notice of questions must be given by 4.00 pm on the working day prior to the date of the meeting to the Committee Services Manager. At any one meeting no person/organisation may submit more than one question.

(iv) One supplementary question (relating to the original question) may be asked by the questioner, which may or may not be answered at the meeting.

(v) The Chair or proper officer may reject a question if it:-

- Is not about a matter for which the local authority has a responsibility or which affects the Borough;
- Is defamatory, frivolous, offensive, abusive or racist;
- Is substantially the same as a question which has been put at a meeting of the Council in the past six months; or

- Requires the disclosure of confidential or exempt information.

(vi) In the interests of natural justice, public questions cannot relate to a planning or licensing application or to any matter which is not dealt with in the public part of a meeting.

(vii) The Chair will ask for people to indicate that they wish to ask a question.

(viii) **PLEASE NOTE** that the maximum amount of time each questioner will be allowed is 3 minutes.

(ix) If you do not receive a response at the meeting, a Council Officer will ask for your name and address and make sure that you receive a written response.

Please bear in mind that public question time lasts for a maximum of 30 minutes. To help in making the most of this opportunity to speak:-

- Please keep your questions as concise as possible.
- Please do not repeat or make statements on earlier questions as this reduces the time available for other issues to be raised.
- Please note public question time is not intended for debate – issues raised will be responded to either at the meeting or in writing at a later date.

4.0 **POLICY IMPLICATIONS**

4.1 None identified.

5.0 **FINANCIAL IMPLICATIONS**

5.1 None identified.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Improving Health, Promoting Wellbeing and Supporting Greater Independence**

None identified.

6.2 **Building a Strong, Sustainable Local Economy**

None identified.

6.3 **Supporting Children, Young People and Families**

None identified.

6.4 **Tackling Inequality and Helping Those Who Are Most In Need**

None identified.

6.5 **Working Towards a Greener Future**

None identified.

6.6 **Valuing and Appreciating Halton and Our Community**

None identified.

7.0 **RISK ANALYSIS**

7.1 None.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified.

9.0 **CLIMATE CHANGE IMPLICATIONS**

9.1 None identified.

10.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

10.1 None under the meaning of the Act.

REPORT TO: Health Policy and Performance Board

DATE: 24 June 2025

REPORTING OFFICER: Chief Executive

SUBJECT: Health and Wellbeing Minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes from the Health and Wellbeing Board's meeting held on 12 March 2025 are attached at Appendix 1 for information.

2.0 RECOMMENDATION: That the Minutes be noted.

3.0 POLICY IMPLICATIONS

3.1 None.

4.0 OTHER IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Improving Health, Promoting Wellbeing and Supporting Greater Independence**

None

5.2 **Building a Strong, Sustainable Local Economy**

None

5.3 **Supporting Children, Young People and Families**

None

5.4 **Tackling Inequality and Helping Those Who Are Most In Need**

None

5.5 **Working Towards a Greener Future**

None

5.6 **Valuing and Appreciating Halton and Our Community**

None

6.0 RISK ANALYSIS

6.1 None.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

8.0 CLIMATE CHANGE IMPLICATIONS

8.1 None identified.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

9.1 There are no background papers under the meaning of the Act.

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 12 March 2025 at Karalius Suite, Halton Stadium, Widnes

Present: *Councillor Wright (Chair)*
Councillor Ball
Councillor T. McInerney
Councillor Woolfall
K. Butler, Democratic Services
D. Nolan, Adult Social Care
I. Onyia, Public Health
L. Gardner, Warrington & Halton Teaching Hospitals
S. Griffiths, Adult Social Care
D. Haddock, Cheshire Constabulary
L. Hughes, Healthwatch Halton
A. Leo, Integrated Commissioning Board
W. Longshaw, St. Helens & Knowsley Hospitals
T. McPhee, Mersey Care NHS Foundation Trust
L. Mogg, Public Health
A. Moore, Cheshire Constabulary
D. O'Connor, Adult Social Care
H. Patel, Citizens Advice Bureau
S. Patel, Local Pharmaceutical Committee
K. Stratford, Public Health
F. Watson, Public Health
L. Windle, Halton Housing
S. Yeoman, Halton & St Helens VCA

Action

HWB22 APOLOGIES FOR ABSENCE

Apologies had been received from H. Crampton – Cheshire Fire & Rescue Services, M. Charman – Bridgewater Community Health Care NHS Foundation Trust, W. Rourke – Halton Borough Council and J. Wallis - Bridgewater Community Health Care NHS Foundation Trust.

HWB23 MINUTES OF LAST MEETING

The Minutes of the meeting held on 15 January 2025, having been circulated, were signed as a correct record.

HWB24 TOBACCO

Members of the Board received a report and accompanying presentation from the Director of Public Health which provided an update on the Tobacco Programme.

Smoking was still the main preventable cause of death, disability and ill health in England, despite a decline in prevalence over recent years. Smoking was the cause of around 75,000 deaths, 1 in 4 of cancer deaths and killed up to two thirds of long-term users.

The smoking prevalence of Halton was estimated to be around 13.7% of adults which was slightly above the national average of 12.4%. It was estimated that it costs Halton around £89M in productivity, £5M in healthcare and £45M in social care. In addition, there was an estimated loss of £102M due to premature deaths from smoking in Halton.

In 2014, Halton Council signed the Local Government Declaration on Tobacco Control, which was a statement of a commitment to ensure tobacco control was part of mainstream public health work and committed councils to take comprehensive action to address the harm from smoking. Halton's local tobacco alliance was paused due to the pandemic, however, it was reformed in 2024 as part of the "Live Well" Programme within One Halton and local partners rejoined. Their aim was to reduce prevalence of smoking in Halton to 5% or less by 2030.

The Board noted and discussed the information presented and in response to questions raised, the following additional information was noted:

- a piece of work was being done nationally about young people vaping; the major concern was what was in the vapes and the effects on those using them; and
- Trading Standards conduct test purchases with appropriate young people at premises to ensure they comply with the law in respect of age restricted products, and this work was supported by the Police. However, Board Members were advised that anyone who had any concerns about tobacco/vapes being sold illegally or to those underage, could contact Crimestoppers.

RESOLVED: That the Board:

1) note the report; and

2) support ongoing activity in local and regional plans.

HWB25 HEALTH INEQUALITIES DASHBOARD

Members of the Board received a report and accompanying presentation from the Director of Integration, Mersey and West Lancashire Hospitals, which set out the Trust's Health Inequalities Dashboard.

Mersey and West Lancashire Hospital Trust provided care for around 50% of Halton's population, with a particular focus around Widnes. Board Members were informed that a recent Kings Fund Health Inequalities paper sited a number of statistics which included:

- People in the most deprived areas were twice as likely to die prematurely from cardiovascular disease than people in the least deprived areas;
- People in the most deprived parts of England were more than twice as likely to wait over a year for elective care than people in the most affluent areas in 2022; and
- The difference in life expectancy for people living in the most deprived areas of England compared with the least deprived areas is 9.7 years for males and 7.9 years for women.

The Trust was committed to reducing health inequalities and therefore had developed a dashboard that used near live data to support the journey. The next steps in the development of the dashboard would be to complete the activity undertaken within the wide Trust's footprint to include Sefton and West Lancashire. The Trust was in dialogue with Warrington and Halton Hospitals Trust to explore the possibility of providing this system to their Trust as this would give a complete picture of Acute Care in Halton.

The dashboard held demographic data of local boroughs as well as elective and non-elective activity across the Trust. The data from the dashboard, along with insights from Public Health, should lead to changes in service provision and lead to a reduction in health inequalities.

The Board noted and discussed the information presented and suggested that there needed to be more of an understanding about why some people do not attend appointments. A question was raised about "did not attend" rates for children and young people and whether it would make a difference if this was changed to "was not brought" (by parents). It was noted that this approach was being considered by Alder Hey.

Further work was needed from a) a quantitative perspective and whether patients were showing up in the hospital system somewhere else and b) from a qualitative perspective, patients should be asked why they are not turning up. This should provide a clearer picture to change the system and help prevent those on the waiting list ending up in A&E.

RESOLVED: That the Board:

1) note the establishment of the Health Inequalities Dashboard; and

2) endorse the collaboration with Warrington and Halton Hospitals Foundation Trust so that a complete picture of Acute Care across Halton is available.

HWB26 SOCIAL NEED SUPPORT FOR SECONDARY CARE MENTAL HEALTH PATIENTS

The Board received a report and accompanying presentation which provided an update on the integrated offer between Mersey Care and Voluntary Community Faith and Social Enterprise (VCFSE) sector. The report addressed the social needs of secondary care mental health patients to support delivery of the One Halton Living Well Strategic priorities.

The service was funded from NHS England via Community Mental Health Transformation monies and a three year contract was in place, with the option to extend for a further two. The funding was intended to support the interface between primary and secondary mental health care, to transform delivery of care for adults with severe mental illness and those with complex needs.

The service in Halton was run by a team which included two Mental Health Navigators; this was managed by Halton & St. Helens CVA but was embedded in the secondary care community teams and mental health in-patients units. The service:

- Acts as a connector/sign-poster between health care professionals, VCFSE groups and local people; and
- Facilitates a voluntary sector mental health forum and builds an alliance of local VCFSE sector providers that support engagement between mental health professionals and the sector.

The core outcomes and benefits of the service were outlined in the report which also highlighted the Mental Health Care Navigator Team achievements, performance and activity reports and identified some challenges. In addition, some examples of service user stories and feedback were provided for noting.

RESOLVED: That the report be noted.

HWB27 ADULTS PRINCIPAL SOCIAL WORKER - ANNUAL REPORT (OCTOBER 2024)

The Board received an annual report from the Adults Principal Social Worker (APSW) which outlined how the role of social work supported the One Halton Based Partnership in order to meet its priorities and objectives.

It was reported that the APSW was a statutory requirement under the Care Act 2014. The national guidance on the role and responsibilities had evolved and been updated and clarified over recent years. It was noted that the Principal Social Worker played a key role in representing and promoting the social work profession; the report listed some of the responsibilities that came with the role.

The report also outlined details of the strengths based approaches and practice training, which had been carried out over the past 12 months. Included were details of specialist training such as e-learning for all staff and webinars, in conjunction with the Learning Disability and Autism Programme.

Information on: present and future workforce development; the mental health 'Think Ahead' Programme; the LGA's Standards for Employers of Social Workers; the organisational health check and quality assurance, was also presented in the report.

It was acknowledged that there were some challenges in hospitals due to vacancies in social care. However, it was anticipated that apprenticeship appointments in the discharge teams and intermediate care teams would help address some of the issues.

RESOLVED: That the report be noted.

HWB28 PRINCIPAL OCCUPATIONAL THERAPIST - ANNUAL REPORT

The Board received a report from the Executive Director – Adult Social Care, which presented the Principal Occupational Therapist's (POT) Annual Report.

The Adults Principal Social Worker (APSW) role was a statutory requirement under the Care Act 2014. Although there was no current requirement in place for local authorities to have a POT, Halton had had one in post since January 2024. It was acknowledged by the ADASS (Association of Directors of Adult Social Services) that having a POT to work alongside the APSW added diverse leadership within adult social care and had a positive impact on local populations.

The report outlined the role of occupational therapy, referral numbers, challenges faced, and culture and practice of the service and the current workforce. Members were referred to the appendix, which presented an anonymised case study for information.

It was agreed that the Public Health Improvement Team would liaise with the POT regarding health and wellbeing.

RESOLVED: That the report and appendix be noted.

Director of Public Health

HWB29 BETTER CARE FUND PLAN 2024/25 - QUARTER 2 UPDATE

The Board received a report from the Executive Director – Adult Services, which provided an update on the Quarter 2 Better Care Fund (BCF) Plan 2024/25, following its submission to the National Better Care Fund Team in June 2024.

In line with the national requirements, the quarter 2 report focussed on reporting on the spend and activity funded via the discharge funding allocated to the local authority and NHS Cheshire and Merseyside (Halton Place).

As at the end of quarter 2, there were no areas of concern to advise the Board of. Spend and activity would continue to be monitored via the Better Care Commissioning Advisory Group, as part of the joint working arrangements.

RESOLVED: The Board note the report.

HWB30 BETTER CARE FUND PLAN 2024/25 - QUARTER 3 UPDATE

The Board received a report from the Executive Director – Adult Services, which provided an update on the quarter 3 Better Care Fund (BCF) Plan 2024/25, following its submission to the National Better Care Fund Team in June 2024.

In line with the national requirements, the quarter 3 report focussed on reporting on the spend and activity funded via the discharge funding allocated to the local authority and NHS Cheshire and Merseyside (Halton Place).

Spend and activity would continue to be monitored via the Better Care Commissioning Advisory Group, as part of the joint working arrangements.

RESOLVED: The Board note the report.

HWB31 2023/24 ANNUAL REPORT OF THE PAN CHESHIRE CHILD DEATH OVERVIEW PANEL

The Annual Report of the Pan Cheshire Child Death Overview Panel 2023/24 had been added to the agenda for the Board to note.

A copy of the report had previously been circulated to members of the Board for their information.

Meeting ended at 3.45 p.m.

REPORT TO:	Health and Social Care Policy and Performance Board
DATE:	24th June 2025
REPORTING OFFICER:	Executive Director, Adults
PORTFOLIO:	Adult Social Care Health & Wellbeing
SUBJECT:	Health Policy and Performance Board Annual Report: 2024/25
WARD(S):	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Health Policy and Performance Board's (PPB's) Annual Report for April 2024 - March 2025.

2.0 **RECOMMENDATION: That the Board:-**

i) note the contents of the report and associated Annual Report (Appendix 1).

3.0 **SUPPORTING INFORMATION**

3.1 During 2024-25, the Health Policy and Performance Board has examined in detail many of Halton's Health and Social Care priorities. Details of the work undertaken by the Board are outlined in the appended Annual Report.

4.0 **POLICY IMPLICATIONS**

4.1 There are no policy implications arising directly from the Annual Report. Any policy implications arising from issues included within the Annual Report will have been identified and addressed throughout the year via the relevant reporting process.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 As with the policy implications, there are no other implications arising directly from the report. Any finance implications arising from issues included within it would have been identified and addressed throughout the year via the relevant reporting process.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Improving Health, Promoting Wellbeing and Supporting Greater Independence**
The remit of the Health Policy and Performance Board is directly linked to this priority.

6.2 **Building a Strong, Sustainable Local Economy**
Not Applicable.

6.3 **Supporting Children, Young People and Families**
There are no specific implications as a direct result of this report, however the health needs of children and young people are an integral part of the Health priority.

6.4 **Tackling Inequality and Helping Those Who Are Most In Need**
Not Applicable.

6.5 **Working Towards a Greener Future**
Not Applicable.

6.6 **Valuing and Appreciating Halton and Our Community**
Not Applicable.

7.0 **RISK ANALYSIS**

7.1 None associated with this report.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None associated with this report.

9.0 **CLIMATE CHANGE IMPLICATIONS**

9.1 There are no environmental or climate implications as a result of this report.

10.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

10.1 None under the meaning of the Act.

Health Policy and Performance Board

Annual Report

April 2024 - March 2025

Colleagues, in my capacity as Chair, I am pleased to report on the work of the Health Policy & Performance Board during 2024/25.

As you would expect, the Board continues to take its scrutiny responsibilities very seriously and during the last 12 months, the Board has taken the opportunity to scrutinise and comment on numerous health and care services as outlined in this report.

Given the well documented and long standing pressure's experienced by Health & Care Services, I believe the Board has performed it duties in a fair and robust manner to ensure the people of Halton receive the best services available.

In addition to the regular scrutiny meetings, the Board has also undertaken another specific scrutiny topic during 2024/25 exploring NHS Community Health Services, which has required the Board to hold an additional 6 meetings through the course of the past 12 months. In addition to the meetings, as part of the scrutiny topic, we also conducted site visits to the North West Ambulance Service (NWAS) and the Widnes Urgent Treatment Centre. The visit to NWAS in particular highlighted the difficulties being experienced by front line NHS services.

In addition to thanking all members of the Board, I would particularly like to thank my Vice Chair, Sandra Baker, who has provided valuable support to me over the past 12 months, along with acknowledging the work of Damian Nolan, Director - Commissioning & Provision and his colleagues from the Adults Directorate, Louise Wilson, Denise Taylor and Emma Bragger, for all the help and support they have given to myself and the Board over the past year as well.

Finally, I would just like to take this opportunity to pass the Board's sincere thanks onto all the dedicated staff and volunteers we have working across the health and social care system in Halton, both from the statutory and non-statutory sector. Without this level of dedication and the continued hard work of our staff and volunteers, we certainly would not be able to continue to deliver quality services and care to the residents of Halton. Thankyou!!!

I look forward to 2025/26 and the continued challenge of ensuring the quality of health and social care services within Halton are of the highest standard.

Cllr Eddie Dourley, Chair

Health Policy and Performance Board Membership and Responsibility

The Board:

Councillor Eddie Dourley (Chair)
Councillor Sandra Baker (Vice-Chair)
Councillor Victoria Begg
Councillor Sian Davidson
Councillor Mike Fry
Councillor Emma Garner
Councillor Louise Goodall
Councillor Chris Loftus
Councillor Louise Nolan
Councillor Tom Stretch
Councillor Sharon Thornton

During 2024/25, David Wilson was Halton Healthwatch's co-opted representation on the Board and we would like to thank David for his valuable contribution.

The Lead Officer for the Board is Damian Nolan, Director, Commissioning & Provision.

Responsibility:

The primary responsibility of the Board is to focus on the work of the Council and its Partners, in seeking to improve health in the Borough. This is achieved by scrutinising progress against the aims and objectives outlined in the Council's Corporate Plan in relation to the Health priority.

The Board have met four times in 2024/25. Minutes of the meetings can be found on the Halton Borough Council website. It should also be noted that the Board, at each of their meetings, receive and scrutinise the minutes from Halton's Health and Wellbeing Board and monitors work/progress within this area.

This report summarises some of the key pieces of work the Board have been involved in during 2024/25.

GOVERNMENT POLICY- NHS AND SOCIAL CARE

One Halton Place Based Partnership

The One Halton Partnership Board is the vehicle for the delivery of national priorities, local priorities and Halton's Joint Health and Wellbeing Strategy. Achieving One Halton's ambitions is the responsibility of all partners working together to achieve a set of shared strategic objectives for Halton Place: Wider determinants of Health, Starting Well, Living Well and Ageing Well.

The report that was presented to the Board in November outlined the current One Halton Partnership activities, which built on previous activities reported to the Board and specifically focused on how NHS Cheshire & Merseyside (Halton Place) were contributing to these activities.

SERVICES

Dental Services

In September, the Board received an update on dental services within Halton. Information was shared in relation to progress made against the local dental improvement plan, along with an update in respect to the national dental recovery plan.

Dental care remains one of the key priorities for NHS Cheshire & Merseyside. The Board heard how there had been an increase in access across the region since 2023/24 and this had led to a number of providers now offering urgent care. Additionally, a new pathway was created for looked after children and vulnerable patients such as those receiving cancer treatment.

NHS Funded Gluten Free Prescribing

The Board considered a report from NHS Cheshire & Merseyside, which informed Members of the proposals to commence consultation on the cessation of NHS Funded Gluten Free Prescribing across Cheshire and Merseyside.

Members discussed the proposals and after taking into consideration a number of factors, it was agreed that the proposal to cease this represented a substantial variation to NHS Services locally and therefore if other local authority areas agreed the same, then the proposals would be subject to Joint Scrutiny arrangements, in line with the Cheshire and Merseyside Protocol for the establishment of Joint Health Scrutiny Arrangements.

Mental Health – Bed Services

The Board received details on the availability and utilisation of mental health beds by Halton residents. Details were shared on the type and number of adult mental health inpatient commissioned beds and the utilisation of those and any out of area placements, along with details of services in place to support patients to safely remain in the community, reducing avoidable admissions, providing better quality and outcomes for local people and the challenges faced in ensuring local people were able to access inpatient mental health beds locally, when they needed them.

The Board heard how NHS Cheshire and Merseyside was implementing a Mental Health System Flow Programme in 2024/25 which was intended to reduce the numbers of patients waiting in a community setting for admission to a hospital bed,

reduce the numbers of patients waiting in acute hospital emergency departments for discharge into the community or to a mental health inpatient bed and reduce the number of patients who were clinically ready for discharge in mental health in-patient settings.

Integration – Warrington & Halton Teaching Hospitals NHS Foundation Trust (NHSFT) and Bridgewater Community Healthcare NHSFT
The Board received an update on the integration between Warrington and Halton Teaching Hospitals NHSFT and Bridgewater Community Healthcare NHSFT.

Members were advised about the significant opportunities which had been identified to improve both patient services and staff experiences working at the front line, and were launching a programme of work to deliver integrated and collaborative models of care between both Trusts.

The Board will continue to monitor and receive updates as work progresses.

Carers
The Board received details of the new All Age Carers Strategy which had been agreed under the One Halton governance framework. This Strategy arose from a review of the previous Strategy, engagement with carers and the wider partnership, and incorporated changes to national guidance where this had occurred. Halton worked with partners in the independent, voluntary and statutory sectors, to ensure a wide range of factors, engagement and types of provision that could be supported.

The Board also welcomed Mr Carl Harris, Manager of Halton Carers Centre, who presented details of activities being undertaken at the Centre and the support being provided to carers in Halton.

Housing Solutions
In November, the Board received a report which provided an update on the homelessness service provision administered by the Housing Solutions Team.

The report provided details on homelessness performance, services being commissioned, S21 Notice's seeking possession or eviction, future challenges and contributing factors affecting the service delivery, as well as funding information. It was reported that a recent survey had found that Halton had the lowest number of rough sleepers and hotel occupancy in comparison with its neighbouring authorities.

Adults Principal Social Worker (PSW) & Principal Occupational Therapist (POT) Annual Reports
At the February Board, Members received the annual reports which provided details about the two roles and how they play a key role in representing and promoting the social work and occupational therapy profession. The reports also provided details of key developments and challenges over the past 12 months.

The Board heard how having a POT working alongside the PSW adds diverse leadership within adult social care and has a positive impact on local populations.

Also at the February Board, as part of the PSW Annual report and included as a separate Board report, Members received the results of Employer Standards Health Check Survey 2024 (Adult Social Care), which outlines that the required standards were being met.

POLICY

Adult Social Care Prevention Strategy 2023-2027

In June, the Board received details of the Adult Social Care Prevention Strategy which sets out the vision and focus for Adult Social Care's role in Prevention in Halton over the next four years. The Board heard how the Strategy has been closely aligned to the Council's Adult Social Care Vision of improving the health and wellbeing of local people, so that they lived longer, healthier and happy lives.

Property Pool Plus Policy

The Board received a report recommending several amendments be made to the Property Pool Plus (PPP) Policy. The Board considered the recommended changes and rationale for these, including changes to qualification criteria and amendments to the discretion criteria. It was reported that to further ensure that the Policy was compliant with new legislation and to seek views on the recommendations, a 12-week formal consultation process would begin; the Board endorsed that the consultation process would move forward.

Public Health Annual Report (PHAR) 2023/24

In September, the Board received the PHAR for 2023-24 'Healthy Start, Healthy Future', which focused on Children and Young People. The PHAR highlighted some of the key health challenges as well as some of the ways that the healthy schools programme tackled these. Members were referred to numerous case studies with some of Halton's schools and the different areas of focus such as obesity, vaping, intergenerational initiatives, young health champions and wellbeing.

Members also heard about the impact of empowered young people who had embraced key messages from the Personal, Social and Health Education curriculum, and who were inspired to promote change within their school communities.

The report was commended along with the work being undertaken by Public Health in the Borough.

Halton Safeguarding Adults Board (HSAB) Annual Report 2023/24

Under the Care Act 2014, Safeguarding Adults Boards (SAB) are responsible for producing an annual report setting out their achievements and highlighting priorities for the following year.

The Report that was presented having been developed in conjunction with HSAB partners to ensure the report encompassed a multi-agency approach. The report included performance data and comparisons between years, achievements in the year and highlighted areas of good practice regarding safeguarding in the Borough.

The Board discussed the reporting of safeguarding incidents in the Borough and the facts and figures presented to them. It was noted that it was important that people knew when to report something, which may start as a concern initially.

Research & Practice Development Care Partnership
In November, the Board welcomed members of the Research and Practice Development Care Partnership. The Partnership is a joint venture between Halton Borough Council's Adult Social Care Directorate, the University of Chester, Age UK Mid Mersey and the Caja Group. The Partnership aims to improve experiences of care by forging closer links between social care professionals and researchers and the Board heard about the work it had been undertaking and it's benefits.

Joint Health Scrutiny Arrangements – Cheshire & Merseyside
In September, the Board received a report proposing changes to the Joint Health Scrutiny Arrangements which were first developed 10 years ago. The arrangements were developed as an operating framework for joint health scrutiny arrangements across the Cheshire and Merseyside Local Authorities.

Proposed changes were being proposed in light of recent legislative changes. The Board endorsed the changes and recommended approval of the revised arrangements to Council.

Quality Assurance Framework – Quality Assurance Team
Members were provided with details of the Framework which brought together the process, methods and tools used by the Quality Assurance Team to gather evidence and intelligence about Adult Social Care services that were commissioned in Halton. The Board noted that these quality assurance activities supported the delivery of social care commissioned services, in meeting and exceeding contractual, regulatory and quality standards.

Housing Adaptations for Disabled People Policy and Home Assistance Policy
In February, the Board received details of the two policies to scrutinise.

They were advised that the Home Adaptations for Disabled People Policy was the internal policy used by staff for determining eligibility, approval and management of both minor and major housing adaptions requests, whilst the Home Assistance Policy was the corresponding public facing document, required to be in place as per the Regulatory Reform (Housing Assistance) Order (RRO) 2002.

Following the policies being presented discussions at the Board focused on level of grants available and the length of time applications took.

SCRUTINY REVIEWS

At the Board's meeting in February 2024, it was agreed that the 2024/25 work topic would examine Community NHS Health (Non-GP) Services, specifically;

- Non-Urgent Services
    - NHS Community Nursing
    - Podiatry
    - Therapy
    - Musculoskeletal services

- Urgent Services

- Urgent Treatment Centres (Widnes & Runcorn)
- Northwest Ambulance Service
- Urgent care responses

Community health services play a key role in the NHS. They keep people well, often with complex needs, at home and in community settings close to home and support people to live independently. These services often involve collaboration across health and social care teams, including professionals like community nurses, therapists, and social care workers.

At the time of writing this report, the outcome from the scrutiny review is due to be presented to the Council's Executive Board.

PERFORMANCE

The Health Policy and Performance Board has a key role in monitoring and scrutinising the performance of the Council in delivering outcomes against its key health priorities. Therefore, in line with the Council's performance framework, during the year the Board has been provided with thematic reports which have included information on progress against key performance indicators, milestones and targets relating to Health.

INFORMATION BRIEFING

During 2024/25, the Board continued to receive an Information Briefing Bulletin in advance of each of the Board meetings.

The Information Briefing is a way of trying to manage the size of the agendas of the Board meetings better. Including information on topics which were previously presented to Board as reports only for the Board's information now into the Information Briefing bulletin allows the Board to focus more on areas where decisions etc. are needed.

Example of areas that have been included in the Information Briefing over the last 12 months have included: -

- North West Association of Directors of Adult Social Services (NW ADASS): Annual Report 2023-2024
- Healthwatch Halton Annual Report 2023-2024
- NW ADASS & NW Employers: Delivering Great Social Care in the North West

WORK TOPICS FOR 2025/26:

At the meeting of the Board in February 2025, it was agreed that the focus of Scrutiny topic for 2025/26 would be on Mental Health Support. Specifically looking at how existing provision was meeting current demand and responding to predicted demand, and equality of access to services for marginalised or minority groups, covering both Adults and Children and Young People's services.

At the time of writing this report, a topic brief is currently being developed to outline the scope of this work.

Report prepared by Louise Wilson, Commissioning & Development Manager, Adults Directorate
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REPORT TO:	Health & Social Care Policy and Performance Board
DATE:	24th June 2025
REPORTING OFFICER:	ICB Place Director (Halton)
PORTFOLIO:	Health & Wellbeing
SUBJECT:	Consultation on Proposed Changes to Fertility Treatment Policies Across Cheshire and Merseyside
WARD(S):	Borough wide

1.0 PURPOSE OF THE 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 Halton.

1.2 The ICB has 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 (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

2.0 RECOMMENDATION: That the Board:

1) confirm whether they believe the proposal represents a substantial development or variation (SDV) to local NHS services; and

2) confirm that they agree that the proposals represent an SDV in health services impacting on the patients and residents of Halton then the ICB will need to formally consult with the Committee. Subject to the decision of the HOSCs of each of the other eight Local Authorities within Cheshire and Merseyside this may need to be achieved by the formation of a Joint Overview and Scrutiny Committee as per the Cheshire and Merseyside protocol.

3.0 SUPPORTING INFORMATION

3.1 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.

3.2 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 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.**

3.3 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).

4.0 BACKGROUND

4.1 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.

4.2 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

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

we work to address health inequalities and provide a consistent offer across Cheshire and Merseyside.

4.3 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.

4.4 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.

4.5 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
- **Embryo freezing**: Any additional good quality embryos created in the cycle will be frozen and stored for use at a later date.

4.6 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.

4.7 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)

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

4.10 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.

4.11 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

4.12 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%.

4.13 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%

4.14 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 no 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.
- West Yorkshire offer one IVF cycle.
- Staffordshire and Stoke-on-Trent offer one IVF cycle.

4.15 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

4.16 **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.

4.17 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 in the future people registered with a GP practice in Halton would have access to one funded cycle of IVF, a reduction from the three cycles that are currently funded by the NHS.**

4.18 **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.

4.19 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 Halton with regards access to fertility treatment based on BMI.**

4.20 **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.

4.21 This update to would **result in a change for people registered with a GP Practice in Halton**.

4.22 **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.

4.23 However, the current policies for patients registered with a 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.

4.24 **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.

4.25 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.

4.26 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.

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

4.28 **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

4.29 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 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	This would result in an estimated cost **£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.		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. A public consultation would be required in 4 Places.	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, 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)**	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)

Option	Description	Outcome	EIA feedback	QIA feedback	Financial impact
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.	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

Pros	Cons
• 66% of ICBs across the country offer 1 cycle.	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 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 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 (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	• 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.

reduced.	

5.0 COMMUNICATION AND ENGAGEMENT

5.1 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.

5.2 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.

5.3 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.

5.4 While specific standalone events will not be organised as part of the consultation, if individual groups/networks request further

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

information, NHS Cheshire and Merseyside will offer to attend meetings to provide additional briefings if required/appropriate.

5.5 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 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.

5.6 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.

5.7 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.

6.0 POLICY IMPLICATIONS

6.1 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).

6.2 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.

6.3 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.

6.4 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.

6.5 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”.

6.6 Determining that a proposal is not a substantial development / or 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.”

6.6 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.

6.7 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.

6.8 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.

7.0 FINANCIAL IMPLICATIONS

7.1 There are no financial implications to Halton Council in relation to the proposal.

7.2 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.

7.3 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).

7.4 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.**

7.5 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**

8.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES *(click here for list of priorities)*

Not applicable'

9.0 RISK ANALYSIS

None identified.

10.0 EQUALITY AND DIVERSITY ISSUES

10.1 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.

11.0 CLIMATE CHANGE IMPLICATIONS

None identified.

12.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

12.1 **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

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

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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						
	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
Will the project or proposal impact on the workforce or system delivery?						

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

NHS
Cheshire and Merseyside

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

		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

NHS
Cheshire and Merseyside

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

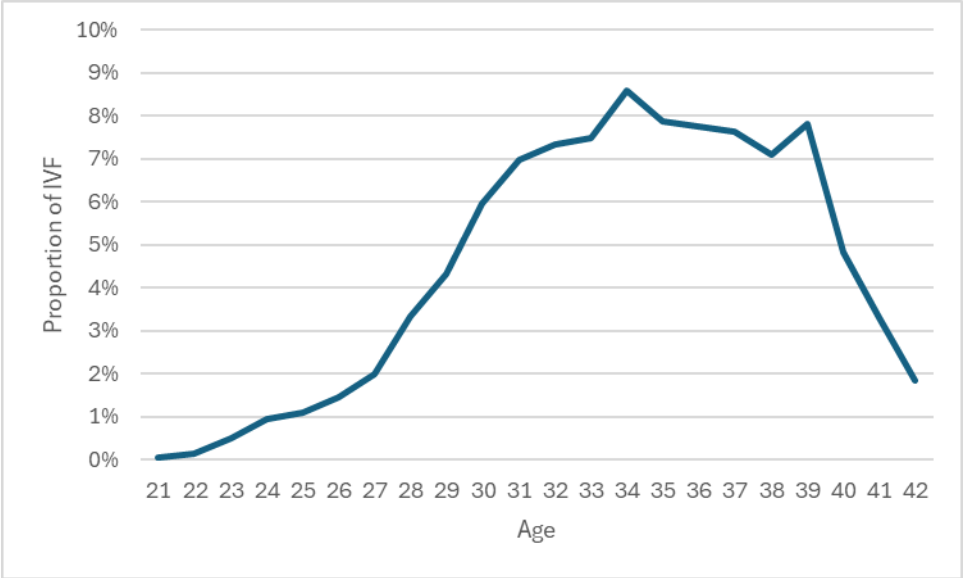
Section	Current CCG policies	Evidence-based policy suggestion & proposed policy section	Major changes and Rationale	Impact
	11.3 Donor insemination (with IUI) will be funded where clinically indicated. 11.4 Stimulated IUI will be funded where clinically indicated, due concern must be given to the risk 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

REPORT TO: Health and Social Care Policy and Performance Board

DATE: 24th June 2025

REPORTING OFFICER: Executive Director - Adults

PORTFOLIO: Adult Social Care

SUBJECT: HPPB Scrutiny Review Topic Brief 2025/26

WARD(S): Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Topic Brief for the 2025/26 Health Policy & Performance Board (HPPB) Scrutiny Review.

2.0 **RECOMMENDATION: That**

(1) The report be noted; and
(2) The Board approves the Topic Brief.

3.0 **SUPPORTING INFORMATION**

3.1 Annually, as part of the HPPB remit, there is a duty on Members to scrutinise a specific area of focus within health and social care and make recommendations to Executive Board.

3.2 At the February 2025 HPPB meeting it was agreed that the following topic would be the focus of the 2025/26 Scrutiny Review:

Mental Health Support – *looking at how existing provision is meeting current demand and responding to predicted demand, and equality of access to services for marginalised or minority groups, covering both Adults and Children and Young People services.*

3.3 The Topic Brief attached at **Appendix 1** sets out the remit and areas of focus that will be considered as part of the Scrutiny Review. The predominant focus will be on mental health support services delivered by Mersey Care NHS Foundation Trust for adults and children and young people.

3.4 Members of the scrutiny topic group will be nominated by the Chair of the HPPB at the June 2025 HPPB meeting, with the first meeting of the group taking place in July 2025.

3.5 Prior to the first meeting, Members will be issued with a background paper to provide context to the topic area.

3.6 Meetings will take place monthly and provide opportunity for Members to be presented with information relating to the areas covered in the Topic Brief and scrutinise service delivery, emerging issues and opportunities in order to develop a set of recommendations for presentation at the February 2026 HPPB meeting. These recommendations, once approved by HPPB, will be presented to Executive Board.

4.0 POLICY IMPLICATIONS

4.1 Any policy implications arising from the recommendations of the Scrutiny Topic Group will be presented to HPPB and Executive Board and considered in line with existing process.

5.0 FINANCIAL IMPLICATIONS

5.1 Any financial implications arising from the recommendations of the Scrutiny Topic Group will be presented to HPPB and Executive Board and considered in line with existing process.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Improving Health, Promoting Wellbeing and Supporting Greater Independence**
Please see Topic Brief attached.

6.2 **Building a Strong, Sustainable Local Economy**
None.

6.3 **Tackling Inequality and Helping Those Who Are Most In Need**
None.

6.4 **Working Towards a Greener Future**
None.

6.5 **Valuing and Appreciating Halton and Our Community**
None.

7.0 RISK ANALYSIS

7.1 No specific risks identified.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 An Equality Impact Assessment (EIA) is not required for this report.

9.0 CLIMATE CHANGE IMPLICATIONS

9.1 None identified.

10.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

10.1 Health Policy and Performance Board Scrutiny Report February 2025, in which reference to the proposed 2025/26 Scrutiny Topic Brief was made.

Appendix 1

Health Policy & Performance Board (HPPB) Scrutiny Review 2025/26

Topic Brief

Topic Title: Mental Health Support

Officer Lead: Helen Moir, Head of Service – Independent Living Services & Mental Health

Planned Start Date: July 2025

Target PPB Meeting: February 2026

Topic Description and Scope:

The 2025/26 scrutiny review for the Health Policy & Performance Board will look at Mental Health Support, specifically how existing provision is meeting current demand and responding to predicted demand, and equality of access to services for marginalised or minority groups, covering both Adults and Children and Young People Services.

This will include:

- The range and type of support and services for mental health available in Halton.
- Access to mental health support via primary care and during times of crisis.
- Assessment, diagnosis and treatment of mental health conditions.
- Community based mental health services.
- Inpatient mental health services and alternatives to hospital admission.
- The mental health crisis response.

Please note that services to support those with dementia, a learning disability and/ or autism are out of scope of this scrutiny topic.

The main focus of the topic will be on health services delivered by Mersey Care NHS Foundation Trust. Predominantly this will be looking at services for adults but the topic will also consider Child and Young People's Mental Health Services (CAMHS).

Through evidence presented at the scrutiny meetings, and/or site visits to services, the scrutiny group will develop an oversight of the key duties of each service, as well as the referral pathways, key operational practices and interface with other services. Through considering current performance, outcomes and service user feedback for each service area, the group will make recommendations on how services can further improve service user experience, outcomes and maximise performance.

Why this topic was chosen:

"Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our

individual and collective abilities to make decisions, build relationships and shape the world we live in. Mental health is a basic human right."

(World Health Organization, 2022)

According to NHS England, one in four adults and one in 10 children experience mental illness. The NHS Long Term Plan makes a renewed commitment to improve and widen access to care for children and adults needing mental health support.

Mental health has a direct impact on an individual's overall wellbeing and quality of life and is interlinked with physical health. It is essential that people have access to support at the earliest opportunity when they are experiencing difficulties with their mental health. It is also important for those with mental health conditions to be able to access appropriate treatment and ongoing support.

It is important for Health PPB Members to gain an understanding of the local services that are in place to support the mental health needs of the local community in order to ensure that Halton residents have access to the right support at the right time.

Key outputs and outcomes sought:

- Understand who uses the services and why.
- Understand how the service ensures equality of access and outcomes for all sections of the community, including minority or marginalised groups.
- Understand referral/access pathways, including any barriers.
- Understand key performance indicators, outcomes and service user experience.
- Understand how each of the services interact with the wider health and social care landscape.
- Understand the level of capacity and demand within the services and highlight emerging issues through trend analysis.
- Understand how the service is meeting current demand and what it predicts future demand will look like and how it will meet that demand.
- Understand any opportunities, challenges or emerging issues faced by the services.
- Highlight any innovative work taking place to improve performance, outcomes and service user experience.
- Make recommendations as to how services can further improve performance, outcomes and service user experience.

Which of Halton's strategic priorities this topic addresses and the key objectives and improvement targets it will help to achieve:

Priority One: Improving Health, Promoting Wellbeing and Supporting Greater Independence

Encouraging good quality health, wellbeing and social care, by involving everyone in our community. To support the people of Halton to feel safe, be active, happy and lead their best lives.

Appendix 1

This scrutiny topic will contribute to the following objectives from the Corporate Plan 2024-2029:

- Offer easily accessible and integrated health care, advice and services from birth.
- Encourage preventative care and healthy lifestyles for the people of Halton throughout their lives.
- Support mental health services and tackle elderly isolation in Halton.

Nature of expected/desired PPB input:

This Member-led scrutiny review of Mental Health Support Services in Halton will be undertaken through a series of six monthly meetings at which Members will receive evidence presentations by the service areas identified. Service site visits will be arranged as applicable/requested. Members will make recommendations for inclusion in the Scrutiny Topic report to be presented to Health PPB and Executive Board.

The Children, Young People and Families Policy and Performance Board will be invited to attend the CAMHS session due to the overlap with their remit.

Preferred mode of operation:

- Meetings with/presentations from relevant officers from each of the services identified.
- Visit to services where applicable/requested.

Agreed and signed by:

Role	**Signature**	**Date**
HPPB Chair *(Cllr Eddie Dourley)*		
Lead Officer *(Helen Moir, Head of Service)*		

REPORT TO: Health and Social Care Policy and Performance Board

DATE: 24th June 2025

REPORTING OFFICER: Executive Director, Adults

PORTFOLIO: Adult Social Care

SUBJECT: Minor and Major Adaptations Performance Update

WARD(S): Borough wide

1.0 **PURPOSE OF THE REPORT**

1.1 The purpose of this report is to provide an update on performance relating to Minor and Major Adaptations funded through Halton Borough Council's Disabled Facilities Grant (DFG).

2.0 **RECOMMENDED: That the Board**

1) **Note the contents of the report.**

3.0 **SUPPORTING INFORMATION**

3.1 **Background**

3.1.1 Minor adaptations (which may include grab rails, hand rails, steps and banister rails) as well as major adaptations (which include stair lifts, level access shower area and ground floor extensions) are assessed for by the Occupational Therapy (OT) team within the Prevention and Wellbeing Service (PWS).

3.1.2 A minor adaptations contract is in place for people in owner occupied or private rentals. This contract is currently awarded to Upholland Property Services (UPS). Minor adaptations required for people living in Registered Social Landlord (RSL) properties are processed in 2 ways. Many minor adaptations can be arranged via a self-referral to the RSL directly. Recommendations may also be made via the OT service.

3.1.3 Major adaptations requiring a Disabled Facilities Grant are managed through Halton's Home Improvement Agency (HIA). RSLs utilising the joint funding agreement are mostly managed by the RSL, who will then invoice Halton Borough Council via the HIA.

3.2 **Performance**

3.2.1 There are 4 key stages of delivering a home adaptation.
Average for cases completed April 2024 to March 2025

Stage 1	No of days from referral to HIA to return of agency agreement	20
Stage 2	No of days from referral to valid grant	140
Stage 3	No of days from grant application to grant approval (legislative framework set by government is 6 months)	20
Stage 4	No of days from work ordered to work signed off by OT	101

3.2.2 Stage 2 of the process is the most complex hence the larger timescales presented. The steps involved include proof of ownership, agency agreement sent and returned, survey stage, design stage, landlord consent, planning permission, building regs approval, tender, scrutiny of documentation etc.

3.2.3

Minor adaptations completed (UPS)	1515
DFG completed	35 (44 cancelled)
RSL DFG completed (50/50)	110
Stairlifts completed	9 (20 cancelled)

3.2.4 In the financial year 2024-25 UPS completed minor adaptations at 995 owner occupied/privately rented properties (NB. Multiple adaptations may have been completed at each address, and on some occasions the adaptation will be benefitting more than 1 person, e.g. husband and wife).

3.3 **Current challenges within the provision of minor and major adaptations**

3.3.1 **Staffing**

There are currently vacancies sat within the HIA. It has historically been difficult to recruit to the position of Surveyor and we are currently working with a company to support. Within the OT service although it has been difficult to recruit Occupational Therapists, by utilising apprenticeships and a grown your own approach the service is fully recruited to.

3.3.2 **Disabled Facilities Grant (DFG) paperwork**

There is a lot of paperwork involved in the administration of DFGs, and requirements for physical signatures which adds time to the process. The tender process for DFGs is also paper based and therefore we are working with procurement to identify options to streamline the process.

3.3.3 **DFG funding**

The DFG limit is set at £30,000 per application. There has been an increase in the complexity of adaptations required in the borough and as a result more adaptations are breaching this limit. There has also been a sharp increase in cost of materials since Covid. When this happens the most common top up route is via the Discretionary Support Loan (DSL). This can put financial pressure on individuals and adds more time and staff resource to the overall process.

3.3.4 **DFG budget allocation**

Due to the increased in complexity of referrals for adaptations, this adds additional pressure to the overall budget allocation for the financial year.

More RSLs are choosing to ask tenants to utilise a DFG application rather than using the joint funding process because of their own financial concerns. This in turn impacts on the DFG allocation.

3.3.5 **Managing expectations**
Sometimes expectations of what can be provided via the DFG are not realistic. There has been a slight increase in people disputing the agreed adaptations when work is on site, even when they have been discussed, plans shown, agreed and signed. This can cause delays at the start or mid adaptation work.

3.3.6 **Availability of building contractors**
Some adaptations have been delayed in starting as the contractor who has won the tender has a backlog of work, or experiences unforeseen circumstances.

3.3.7 **Minor adaptations**
The limit for a minor adaptation is set at £1000, and the increase in cost of materials has impacted on the scope of minor adaptations that can be provided within this allocation.

3.3.8 **Behaviours that challenge**
There has been an increase in referrals for children and adults with behaviours that challenge who require adaptations to support their safety at home for example padded walls and specialist lighting.

4.0 POLICY IMPLICATIONS

4.1 None identified.

5.0 FINANCIAL IMPLICATIONS

5.1 None identified.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Improving Health, Promoting Wellbeing and Supporting Greater Independence**
Occupational Therapy delivered by the Local Authority is key in the delivery of the Prevention agenda as set out in the Care Act 2014. Occupational Therapists are vital in promoting wellbeing and maximising independence, and this is core to their role in social care.

6.2 **Building a Strong, Sustainable Local Economy**
None identified.

6.3 **Supporting Children, Young People and Families**
None identified.

6.4 **Tackling Inequality and Helping Those Who Are Most In Need**
None identified.

6.5 **Working Towards a Greener Future**
None identified.

6.6 **Valuing and Appreciating Halton and Our Community**
None identified.

7.0 **RISK ANALYSIS**

7.1 None identified.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified.

9.0 **CLIMATE CHANGE IMPLICATIONS**

9.1 None identified.

10.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

10.1 None under the meaning of the Act.

REPORT TO:	Health and Social Care Policy and Performance Board
DATE:	24 June 2025
REPORTING OFFICER:	Director Commissioning and Provision
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Performance Management Reports, Quarter 4 2024/25
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 This Report introduces, through the submission of a structured thematic performance report, the progress of key performance indicators, milestones and targets relating to Health in Quarter 4 of 2024/25. This includes a description of factors which are affecting the service.

2.0 **RECOMMENDATION:**

i) Receive the Quarter 4 Priority Based report

ii) Consider the progress and performance information and raise any questions or points for clarification

iii) Highlight any areas of interest or concern for reporting at future meetings of the Board

3.0 **SUPPORTING INFORMATION**

3.1 The Policy and Performance Board has a key role in monitoring and scrutinising the performance of the Council in delivering outcomes against its key health priorities. Therefore, in line with the Council's performance framework, the Board has been provided with a thematic report which identifies the key issues in performance arising in Quarter 4, 2024/25.

4.0 **POLICY IMPLICATIONS**

4.1 There are no policy implications associated with this report.

5.0 **FINANCIAL IMPLICATIONS**

5.1 There are no policy implications associated with this report.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Improving Health, Promoting Wellbeing and Supporting Greater Independence**
The indicators presented in the thematic report relate specifically to the delivery of health outcomes in Halton.

6.2 **Building a Strong, Sustainable Local Economy**
None identified.

6.3 **Supporting Children, Young People and Families**
None identified.

6.4 **Tackling Inequality and Helping Those Who Are Most In Need**
The indicators presented in the thematic report relate specifically to the delivery of health outcomes in Halton.

6.5 **Working Towards a Greener Future**
None identified.

6.6 **Valuing and Appreciating Halton and Our Community**
None identified.

7.0 **RISK ANALYSIS**

7.1 None identified.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 An Equality Impact Assessment (EIA) is not required for this report

9.0 **CLIMATE CHANGE IMPLICATIONS**

9.1 None identified.

10.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

None under the meaning of the Act.

Health Policy & Performance Board Priority Based Report

Reporting Period: Quarter 4 – Period 1st January – 31 March 2025

1.0 Introduction

This report provides an overview of issues and progress against key service area objectives and milestones and performance targets, during the fourth quarter of 2024/25 for service areas within the remit of the Health Policy and Performance Board. These areas include:

- Adult Social Care (including housing operational areas)
- Public Health

2.0 Key Developments

2.1 There have been a number of developments within the Directorate during the fourth quarter which include:

Adult Social Care

Establishing the Debt Recovery Officer Roles within the ASC Review Team. The aim is to support people who are in significant debt to HBC, to maximise their benefits and establish repayment plans. Immediate success is in place.

Homelessness Strategy

A review of the homelessness strategy is underway, consultation with service users and providers being undertaken.

Youth Protocol / Strategy

Joint review of youth protocol being undertaken with Children's Services to develop clear pathway plan for young people when presenting as homeless.

The youth strategy is being reviewed, and youth event was held April 2025, with final strategy document completed by June 2025

Public Health

There have been lots of developments and progress across all public health areas over the last quarter. Key developments include:

- A proposal for the Health Improvement team to use healthcare data to identify and contact residents at risk of fuel poverty due to their health conditions was agreed. This will be done in partnership with local general practices. This is the first non-NHS application in C&M to use this data for this type of project and the principles established from this may open doors for similar future projects.

- The new contract for the 0-19 (+25 SEN) Healthy Child Programme was awarded to Bridgewater which went live on the 1st of April. The Healthy Child Programme is the national evidence based universal programme for children aged 0-19 and for children with Special Education Needs (SEN) up to age 25 to support giving every child the best start in life. The programme is led by health visitors and school nurses who work in partnership with a range of professionals and agencies to support children and families.

- New government funding for supervised toothbrushing has been announced for this year. Halton has already restarted a supervised toothbrushing programme and is a 'trail blazer' for a regional programme. The funding is only for this year but it is hoped that further funding will be announced at the Government Spending Review due in June as this was a manifesto commitment.

3.0 Emerging Issues

3.1 A number of emerging issues have been identified during the ? quarter that will impact upon the work of the Directorate including:

Adult Social Care

Asylum / Refugee Homelessness

The Housing Solutions team are seeing a vast increase in presentations from asylum seekers receiving positive refugee decisions. Many clients do not meet the homelessness criteria, resulting in an increase in rough sleeping within the Borough and further legal challenges, which can prove costly to the Local Authority. It is anticipated that there will continue to be an increase across this cohort

Public Health

NHS reorganisation

We await further announcements regarding the proposed changes to the NHS and Department of Health. This will include changes to the ICB as well as the disbandment of NHS England. We work closely with our colleagues in the NHS and will need to understand the potential impact to our work and residents.

4.0 Risk Control Measures

Risk control forms an integral part of the Council's Business Planning and performance monitoring arrangements. As such Directorate Risk Registers were updated in tandem with the development of the suite of 2018/19 Directorate Business Plans.

As a result, monitoring of all relevant 'high' risks will be undertaken and progress reported against the application of the risk treatment measures in Quarters 2 and 4.

5.0 Progress against high priority equality actions

There have been no high priority equality actions identified in the quarter.

6.0 Performance Overview

The following information provides a synopsis of progress for both milestones and performance indicators across the key business areas that have been identified by the Directorate. It should be noted that given the significant and unrelenting downward financial pressures faced by the Council there is a requirement for Departments to make continuous in-year adjustments to the allocation of resources in order to ensure that the Council maintains a balanced budget. Whilst every effort continues to be made to minimise any negative impact of such arrangements upon service delivery they may inevitably result in a delay in the delivery of some of the objectives and targets contained within this report. The way in which the Red, Amber and Green, (RAG), symbols have been used to reflect progress to date is explained at the end of this report.

Commissioning and Complex Care Services

Adult Social Care

Key Objectives / milestones

Ref	Milestones	Q4 Progress
1A	Monitor the Local Dementia Strategy Action Plan, to ensure effective services are in place.	✓
1B	The Homelessness strategy be kept under annual review to determine if any changes or updates are required.	✓
1C	Monitor the effectiveness of the Better Care Fund pooled budget ensuring that budget comes out on target**.**	✓
1D	Integration of Health and social care in line with one Halton priorities.	✓
1E	Monitor the Care Management Strategy to reflect the provision of integrated frontline services for adults**.**	✓
1F	Continue to establish effective arrangements across the whole of adult social care to deliver personalised quality services through self-directed support and personal budgets.	✓

Supporting Commentary

1A
Dementia Delivery Group meeting in again (Feb 2025) to progress the delivery plan.

Plans being progressed to introduce a 'Dementia Inform' programme for One Halton staff (around services and support along the dementia pathway), standardised dementia messaging (signposting and myth busting) across One Halton orgs comms public channels, gathering PWD/Carer insight.

1B
Homelessness Forum consultation with providers as completed, with additional consultation underway with service users. The review of the strategy will be completed and submitted for approval April 2025.

1C
Budget balanced.

1D
The NHS has published new guidance on locality working. The ICB and HBC continue to work together to develop this in Halton.

1E
The Prevention & Well-Being Service have dedicated Carers Assessors and are responding to carers referrals in a timely manner. The carers assessors are spending 1 day a week at the Carers Centre, this allows assessments and support to take place without the carer having to complete a referral.

1F
A Complex Care Forum takes place on a weekly basis, Chaired by Head of Service to Quality Assure, Person Centred Support Plans, ensuring best value, adherence to legislation and safety, whilst remaining creative and complimenting a person's own assets. A Direct Payment Forum is in place to promote the recruitment and retention of Personal Assistants, to support flexibility for individuals with a personal budget.

Key Performance Indicators

Older People:						
Ref	**Measure**	**23/24 Actual**	**24/25 Target**	**Q4**	**Current Progress**	**Direction of travel**
ASC 01	Permanent Admissions to residential and nursing care homes per 100,000 population 65+ ***Better Care Fund performance metric***	616.3	600	769.3	✓	TBC
ASC 02	Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population. ***Better Care Fund performance metric***	Dec 23 to Jan 24 = 4,283	No plan set			
ASC 03	Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (ASCOF 2B) ***Better Care Fund performance metric***	96.4%	85%	NA	NA	NA
Adults with Learning and/or Physical Disabilities:						
ASC 04	Percentage of items of	96%	97%	97.5%	✓	NA

	equipment and adaptations delivered within 7 working days (VI/DRC/HMS)					
ASC 06	Proportion of people in receipt of SDS (ASCOF 1C – people in receipt of long term support) (Part 2) DP	40.9%	45%	44.2%		
ASC 07	Proportion of adults with learning disabilities who live in their own home or with their family (ASCOF 1G)	92.8%	89%	92%		
ASC 08	Proportion of adults with learning disabilities who are in Employment (ASCOF 1E)	7%	7.5%	TBC	TBC	TBC
Homelessness:						
ASC 09	Homeless presentations made to the Local Authority for assistance In accordance with Homelessness Act 2017. Relief Prevention Homeless Advice	756	3500	882 246 213 140 382		
ASC 10	LA Accepted a statutory duty to homeless	121	800	140		

	households in accordance with homelessness Act 2002					
ASC 11	Number of households living in Temporary Accommodation Hostel Bed & Breakfast	148 38 30 Singles 8 Families	800	171 108 Singles 40 Families 15 Families 6 Singles	✓	NA
NEW The proportion of section 42 safeguarding enquiries where a risk was identified, and the reported outcome was that this risk was reduced or removed (ASCOF 4b)	NA	NA	92%	TBC	NA	
ASC 12	Percentage of individuals involved in Section 42 Safeguarding Enquiries	34%	30%	40.9%	✓	↑
ASC 13	Percentage of existing HBC Adult Social Care staff that have received Adult Safeguarding Training, including e-	76%	85%	80%	✓	↑

	learning, in the last 3-years (Previously PA6 [13/14] change denominator to front line staff only.					
ASC 15	Proportion of Carers in receipt of Direct payment	99%	99%	98%		

Published Data 2023/24 – Adult Social Care Outcomes Framework:

1A Quality of life of people who use services:

Halton	Peer Neighbours	North West	England
18.9	19.2	19.1	19.1

1C Carer reported quality of life:

Halton	Peer Neighbours	North West	England
7.0	7.3	7.3	7.3

1D Overall satisfaction of people who use services with the care and support:

Halton	Peer Neighbours	North West	England
68.7	65.7	66.8	65.4

1E Overall satisfaction of carers with social care:

Halton	Peer Neighbours	North West	England
44.4	44.6	37.3	36.7

2A Outcome of short-term services: sequel to service:

Halton	Peer Neighbours	North West	England
69.0	80.0	80.6	79.4

2B Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,00 population (*lower is better*)

Halton	Peer Neighbours	North West	England
7.8	16.8	16.5	15.2

2C Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population (*lower is better*)

Halton	Peer Neighbours	North West	England
616.3	693.5	636.8	566.0

2D1 Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reabalement / rehabilitation services

Halton	Peer Neighbours	North West	England
96.4	81.2	86.1	83.8

2D2 proportion of older people (aged 65 and over) offered reablement services following discharge from hospital

Halton	Peer Neighbours	North West	England
3.2	2.5	2.7	3.0

2E Proportion of adults with Learning Disabilities who live in their own homes or with their family

Halton	Peer Neighbours	North West	England
92.8	89.2	88.9	81.6

3A Proportion of people who use services who report having control over their daily life

Halton	Peer Neighbours	North West	England
72.9	79.0	78.6	77.6

3B Proportion of carer who report that they have been included or consulted in discussion about the person they care for

Halton	Peer Neighbours	North West	England
75.2	70.1	65.5	66.4

3C1 Proportion of people who use services who find it easy to find information about services

Halton	Peer Neighbours	North West	England
70.2	70.1	69.5	67.9

3C2 Proportion of carers who find it easy to find information about services

Halton	Peer Neighbours	North West	England
66.2	66.6	58.7	59.1

3D1A Proportion of people who use services who receive self-directed support

Halton	Peer Neighbours	North West	England
76.3	95.6	82.0	92.2

3D1B Proportion of carers who receive self-directed support

Halton	Peer Neighbours	North West	England

97.9	98.7	88.0	89.7

3D2A Proportion of people using services who receive direct payments

Halton	Peer Neighbours	North West	England
40.9	26.1	24.2	25.5

3D2B Proportion of carers who receive Direct Payments

Halton	Peer Neighbours	North West	England
97.9	85.0	80.3	77.4

4A Proportion of people who use services who feel safe

Halton	Peer Neighbours	North West	England
69.6	72.3	70.9	71.1

51A Proportion of people who use services who report that they had as much social contact as they would like

Halton	Peer Neighbours	North West	England
49.2	48.3	46.4	45.6

51B Proportion of carer who report that they had as much social contact as they would like

Halton	Peer Neighbours	North West	England
28.1	31.6	30.4	30.0

Halton performed well in most areas during 2023/24, where figures were below the regional or national average, these have bee been investigated and plans are in place, e.g.

- 4A – Proportion of people who use services who feel safe; we have looked at the people who say they do not feel safe as to why this is, people report they do not feel safe in the area they live or are scared of falling, it is not because of the care they receive; additional support is being provided to address these issues.
- 51B Proportion of cares who report that they had as much social contact as they would like; we have dedicated carers assessors within our Carers Centre to look at service provision and referral for assessment to look at support available to unpaid carers.

Supporting Commentary

Older People:

ASC 01 Figures are subject to change due to data cleansing. We have had a change in system recording and statutory reporting in this financial year, we are, therefore continuing to analysis the data to ensure its accuracy. We do however expect to see an increase from previous years due to the increase in an aging population.

ASC 02 NHS Midlands and Lancashire Commissioning Support Unit until around 6 weeks following the end of the month.

ASC 03 Figures are subject to change due to data cleansing. We have had a change in system recording and statutory reporting in this financial year, we are, therefore continuing to analysis the data to ensure its accuracy. This measure is collated annually, and data is currently being processed; figures will be updated as soon as they are available.

Adults with Learning and/or Physical Disabilities:

ASC 04 Figures are subject to change due to data cleansing. We have had a change in system recording and statutory reporting in this financial year, we are, therefore continuing to analysis the data to ensure its accuracy. Due to limited resources within the team, we have been unable to provide this information for Q4, however figures do tend to remain stable in this area.

ASC 05 Figures are subject to change due to data cleansing. We have had a change in system recording and statutory reporting in this financial year, we are, therefore continuing to analysis the data to ensure its accuracy.

ASC 06 Figures are subject to change due to data cleansing. We have had a change in system recording and statutory reporting in this financial year, we are, therefore continuing to analysis the data to ensure its accuracy. At the end of 2023/24, Halton did not achieve their target of 45 per cent, however we achieved the highest percentage across the Northwest, England and Peer Neighbours. At Q3 2024/25 the percentage had increased by 3.3 per cent from year-end 2023/24.

ASC 07 (a) This measure has been split into 2 parts to include people who receive support and live in the own homes and people who have a learning disability who live in their own homes or with their family.

ASC 07 (b) This measure has been split into 2 parts to include people who receive support and live in the own homes and people who have a learning disability who live in their own homes or with their family.

Homelessness:

ASC 09 There continues to be an increase in homelessness nationally.
Halton has seen an increase in family presentations, due to no fault S21 notice seeking possessions, placing additional pressure upon temporary accommodation providers.

The main emphasis is placed upon prevention, and many clients are prevented from homelessness after the officers have provided advice and assistance and prevention incentives available to resolve the identified issues.

ASC 10 There has been an increase in the homelessness acceptance duty. This is partly due to the increase in no fault eviction notices and affordability, whereby,

the rents charged are far greater than the awarded local housing allowance. Accommodation continues to be a barrier, especially for families.

ASC 11 Due to the increase in homelessness this has placed additional pressure upon temporary accommodation providers, resulting in many clients being placed temporarily in hotels.
There continues to be an increase in families presenting as homeless, for the above stated reasons, resulting in many families being placed in hotel accommodation. The service has a robust process in place to transfer families from hotels into commissioned services as quickly as possible.

Safeguarding:

ASC 12 We have a dedicated team who triage safeguarding concerns as they are received to ensure the appropriateness of these referrals.

ASC 13 Although the target has not been met there is a 4 per cent increase on the same position last year.

ASC 14 This is a new ASCOF measure for 2024/25. We will continue to monitor this new measure to inform future performance

Carers:

ASC 15 We continue to support unpaid carers flexibly via direct payments to enable them to have choice and control over their breaks.

Public Health

Key Objectives / milestones

Ref	**Objective 1: Child Health**	
	Milestones	**Q4 Progress**
PH 01	Working with partner organisations to improve the development, health and wellbeing of children in Halton and to tackle the health inequalities affecting that population.	✓
Ref	**Objective 2: Adult weight and physical activity**	
	Milestone	**Q4 Progress**
PH 02	Reduce levels of adult excess weight (overweight and obese) and adult physical inactivity	✓
Ref	**Objective 3: NHS Health Checks**	

	Milestone	Q4 Progress
PH 03	Ensure local delivery of the NHS Health Checks programme in line with the nationally set achievement targets and locally set target population groups.	✓
Ref	**Objective 4: Smoking**	
	Milestone	
PH 04	Reduce smoking prevalence overall and amongst routine/manual and workless groups and reduce the gap between these two groups.	✓
Ref	**Objective 5: Suicide reduction**	**Q4 Progress**
	Milestone	
PH 05	Work towards a reduction in suicide rate.	✓
Ref 05	**Objective 6: Older People**	
	Milestone	**Q4 Progress**
PH 06	Contribute to the reduction of falls of people aged 65 and over and reduction in levels of social isolation and loneliness.	✓
Ref	**Objective 7: Poverty**	
	Milestone	**Q4 Progress**
PH 07	To increase awareness of fuel poverty and drive change to tackle the issue through better understanding of services available across Halton (staff and clients).	✓
Ref	**Objective 8: Sexual health**	
	Milestone	**Q4 Progress**
PH 08	To continue to provide an easily accessible and high quality local sexual health service, ensuring adequate access to GUM and contraceptive provision across the Borough, whilst reducing the rate of sexually transmitted infections and unwanted pregnancies.	✓
Ref	**Objective 9: Drugs and alcohol**	
	Milestone	**Q4 Progress**
PH 09	Work in partnership to reduce drug and alcohol related hospital admissions.	✓

PH 01 **Supporting commentary**

Regular contract performance meetings take place every quarter with the 0-19 (+ SEND) (0-19 HCP) service. The 0-19 HCP service are supporting the development of the Family Hubs model, starting well strategy, leading on infant parent mental health and attachment, the Local Offer, and the SEND priority action plan. Bridgewater Community Health Care Trust (Bridgewater) continue to deliver the 0-19 HCP from four teams in four localities across Halton. Bridgewater are a key partner in the delivery of the Family hubs and starting well strategy, leading on infant parent mental health and attachment. Working in collaboration with all our partner agencies including Halton BABs, which launched on 19th November 2024 Halton BABS (Building Attachment & Bonds Service) - Halton Safeguarding Children Partnership The 0-19 HCP continues to offer a comprehensive health and wellbeing service to children and young people within the Borough. Some discrete elements of the service include, but not limited to, Health Visitor Service for 0 - 5 years, Family Nurse Partnership (First time pregnancy in teenagers), School Nursing Services for 5 - 19 years, SEND up to 25 years, support service users to give children the 'best start in life' based on current evidence of 1001 Critical Days, Reception Age Hearing and Vision Screening, National Child Measurement Programme Services and Immunisation Services for children and young people aged 5 – 19 years (this element is commissioned separately by NHS England but forms an integral part of the service). The infographic below (using Q1 2024/25 performance data) gives an overview of the 0-19 HCP service and tracking the progress and impact of areas where the service is improving health outcomes for children and young people. These include maternity and first year of life, early years and school age and transition.

Public Health report to direct award to Bridgewater using the Provider Selection Regime went to the Executive Board in October and was approved. This report was to seek executive board approval to proceed with a procurement process to grant a direct award to Bridgewater Community Healthcare NHS Foundation Trust (Bridgewater) for the delivery of 0-19 (+25 SEND) Healthy Child Programme (0-19 HCP) for the period 1st April 2025 – 31st March 2030, with the option of 2 x plus 1-year, pre-determined extension periods up to 31st March 2032.

PH 02 **Supporting commentary**

The infant feeding offer continues to offer weekly drop-in support groups, in addition to home visits and telephone support in the postnatal period, plus antenatal workshops and engagement at community health visiting and midwifery clinics. HIT work closely with the Infant Feeding Specialist from Halton 0-19 team to offer a joined-up universal and specialist service.

HENRY is facilitated jointly by HIT and 0-19 staff. Outcome data reports demonstrate consistent improvements in parenting confidence score and lifestyle scores by those completing courses.

Triple P: Two cohorts completed this quarter with 18 parents completing fully and 6 partially completing course.

RSPH Award for Young Health Champions Two cohorts completed this quarter, with 13 young people completing – both at Ashley SEN School.

Healthy Schools and Healthy Early Years 43 schools (64%) have signed up so far in 2024/25. HIT have delivered 44 workshops this quarter to over 1,000 pupils, including alcohol awareness, tobacco & vaping, healthy eating, sleep & screens. HIT delivered a screen time and wellbeing workshop at the Crucial Crew multi-agency safety event for Year 5 pupils from a number of Halton schools.
Supervised Toothbrushing Programme has launched, with the first Early Years settings being trained this quarter, ready to implement the scheme in the coming months.

Teen Lifestyle Programme 35 young people completed the Teen Lifestyle and Leisure Programme. This programme is for eligible 13-19 year olds, aligned with Core20Plus5 priorities.

PH 03 **Supporting commentary**

Through the Fresh Start program the Adult Weight Management Service continues to offer an in-depth curriculum of advice and exercise that supports local people to manage their weight and positively impact their lifestyles. In the current climate, more focus has been emphasised within the service to increase support of weight management for target population groups such as low-income households by embedding key skills such as shopping on a budget, meal planning for 1 and supporting resilience.

Over the fourth quarter, Fresh Start has 721 referrals to the service from Halton residents. So far 246 have started on the face-to-face service and 130 started via the digital App version of Fresh Start. Towards the end of Q4 we were informed that the coaching platform for our digital offer would be closing down. Therefore the number of clients starting on the app is reduced this quarter.

PH 04/05 **Supporting commentary**

Halton continues to support physical activity through the ‘exercise on prescription’ program. Exercise on Prescription is a free service, which supports people with health conditions to become more physically active and is part of their treatment to improve their condition management. Some of the common health conditions that clients come for support with include cardiovascular conditions, pulmonary & respiratory conditions, mental health conditions, falls prevention and back and joint

conditions. All clients in service receive brief intervention and advice around their health condition and guided support by an exercise specialist who is trained to deliver activity to people with health conditions.

Throughout quarter 4, **331 referrals** have been made so far into this service and, **(196) 59%** of clients engaging with physical activity so far.

PH 06 **Supporting commentary**

The Health Improvement Team continues to offer NHS Health Checks in workplaces, working alongside the GP Practices and in the community. Each year 20% of the total eligible population should be invited for an NHS Health Check. In Halton the target for 2024/25 is 7,254 per year; this equates to 1,815 invites per quarter. In Q4 2024/25 up to now, 1,944 NHS Health Check Invites were sent, which is 107% of the quarterly invite target.

National targets are set that NHS Health Check services should aim to have a completion rate of around 80%. In Halton of those invited, so far in Q4 2024/25, 888 patients have received a Health Check, which is a 45.7% uptake rate. This is a decrease on quarter 3 performance in which 906 Health Checks were completed, with an 86% uptake rate. This large range of completion percentages across quarters can be explained by invite volumes changing over each quarter.
Following an NHS Health Check, Halton have a target that 30% of patients should be referred onto wider support services. In Q4 2024/25 473 referrals have been completed. This is 53% of NHS Health Checks completed. This is an increase on Q3's referral rate of 22%. Halton have prioritised tackling health inequalities within the service to which some key milestones have been achieved this year to date. These include:

- In Q3 2024/25, 100% of ethnic minorities who are eligible for an NHSHC have received an invitation.

Halton was highlighted at the Northwest NHS Health Check steering group as we have gone from ranked 92nd in the country for the uptake of NHS Health Checks in 2022/23 to 18th in the country year to date 2024/25. This is a significant improvement in the ranking of Halton's NHS Health Check service in comparison to other areas. In addition to this, Halton now represent Cheshire and Merseyside on the local implementor nation forum for the subregion. We now play a leadership role to feedback to the national time the progress and barriers for the subregion and to support the subregion with development from the national team.

PH 07 **Supporting commentary**
Overall **569/992** clients setting a quit date this year (2024/25) are from routine/manual and workless groups. This equates to **57%** majority.

Overall **285/532** clients quitting this year (2024-2025) are from routine/manual and workless groups. This equates to **54%** majority

PH 08, 09 **Supporting commentary**

We continue to work closely with partners and Champs on the Zero Suicide Agenda and consistently drive Halton's action plan to contribute to reduction in suicides. Dual diagnosis standard operating procedure has been agreed by all relevant partners but still awaiting internal sign off by Merseycare. Merseycare, task and finish group exploring how the mental health of those with COPD accessing support from rapid respiratory response team can be improved has agreed key mental health info to be provided to this cohort and referral pathway to talking therapies, self-harm data capture form is being updated to ensure it meets the needs of education settings helping the most accurate data to be captured, Mental Health crisis number has now been replaced with NHS 111 option mental health, self harm booklets for staff working with CYP now available and being shared. Real Time Surveillance for Q4 2024/2025 are 50% lower than Q4 for 2023/2024 but variation could be naturally occurring due to small numbers.

PH10, PH11 The Exercise on Prescription Programme which includes falls prevention has been rolled out in some GP practices to target common health conditions such as hypertension and falls. In Q4 there have been 37 clients attend a consultation and engage in the service who are active fallers, or at risk of falls. These service users have been supported with advice and a strength and stability class. There are some ongoing issues with the data from the Sure Start to Later Life service, due to the transition from Care First to Eclipse data systems by Adult Social Care Services.

Data for Q4 shows 71 referrals into service with 56 assessments and 61 review appointments being completed. Of those clients reviewed in Q4, and answered questions regarding loneliness, 63% reported that they feel less socially isolated as a result of the intervention from the service. During Q4 72 local people attended Get Together events aimed at reducing loneliness and social isolation.

PH12 In Q4 we were successful in taking an application to access patient identifiable data from the CIPHA fuel poverty dashboard to the Data Access and Governance Committee. We are the first Public Health department in the area to be granted access to the dashboard. This opens up the option for us to be proactive in offering emergency support and help with accessing home improvement grants before winter. We have continued along the path to accessing this data with the support of both PCNs in the area. We will begin this project in September, focusing on those at greatest risk from fuel poverty due to severe respiratory conditions. We will be working with the Business Intelligence team in Cheshire and Merseyside to assess the impact the intervention has on the cohort supported, compared to a control cohort. We hope to provide an evidence base that can shape the way we approach fuel poverty and health conditions in the future.

PH13, PH14 The sexual health service continues to be delivered by Axess and provides free contraception and sexual health services across the borough, including dedicated Young People's clinics. It has been agreed to utilise the 'plus one' and extend the contract duration with Warrington for an additional year until Autumn 2026.

Work is ongoing at a local and regional level around Women's Health Hubs (WHH), where Halton have been identified as a priority area. The specifics of the funding allocation are still under discussion. The initial focus of developing WHH will be to increase access to LARC (IUD/IUS contraception and non-contraceptive) through enhanced training, inter-practice referrals and collaborative working between ICB, Local Authority, Primary Care, pharmacies and the sexual health service

PH15, PH16 The first plus one for the contract extension with Change Grow Live has now been finalised, there is flexibility for another plus one for 2026/2027 if required. Commissioners in the North West have agreed to collaboratively fund a post to be employed by North West Ambulance Service (NWAS) initially over 2 years. The post will support strategic planning to ensure targeted and tailored support is provided following a non-fatal opiate overdose. This means that every opiate non-fatal overdose is automatically referred to the local drug and alcohol service, with or without patient consent.

The role is unique to England and is expected to make a significant contribution to improved responses to non-fatal overdoses in the North West and contributing to a reduction in drug-related deaths in the region. The expected outcomes include:
• Increase in referrals into drug and alcohol treatment services;
• Contribution towards a reduction in drug-related deaths.

Health Check Officers completed **888** Audit C's in **Q4.**
Lifestyle Advisors completed **91** Audit C's in **Q4**
Stop Smoking Service completed **157** Audit C's in **Q4** so combined total for H.I.T delivering Audit C screenings in **Q4** is **1,136**

Key Performance Indicators

Ref	Measure	23/24 Actual	24/25 Target	Q4	Current Progress	Direction of travel
PH 01a	Healthy life expectancy at birth: females (years)	58.6 (2020-22)	58.8 (2019-21)	56.8 (2021-23)	✗	↓
PH 01b	Healthy life expectancy at	58.6 (2020-22)	58.8 (2019-21)	56.6 (2021-23)	✗	↓

	birth: males (years)					
PH 02	A good level of child development (% of eligible children achieving a good level of development at the end of reception)	62.2% (2022/23)	62.5% (2023/24)	61.2% (2023/24)	✗	↓
PH 03	Health Visitor new births visits (% of new births receiving a face to face visit by a Health Visitor within 14 days)	83.9% (2023/24)	90% (standing target)	89.5% (Q1-3 2024/25)	U	↑
PH 04	Prevalence of adult excess weight (% of adults estimated to be overweight or obese)	72.7% (2022/23)	72.0% (2023/24)	73.6% (2023/24)	✗	↓
PH 05	Percentage of physically active adults	62.8% (2022/23)	62.8% (2023/24)	63.2% (2023/24)	✓	↑
PH 06	Uptake of NHS Health Check (% of NHS Health Checks offered which were taken up in the quarter)	44% (2023/24)	60% (2024/25)	61% (Q1-3 2024/25)	✓	↑
PH 07	Smoking prevalence (% of adults who currently smoke)	13.3% (2022)	13.0% (2023)	14.6% (2023)	✗	↓
PH 08	Deaths from suicide (directly standardised rate per 100,000 population)	9.3 (2020-22)	9.9 (2021-23)	13.2 (2021-23)	✗	↓

PH 09	Self-harm hospital admissions (Emergency admissions, all ages, directly standardised rate per 100,000 population)	261.6 (2022/23)	259.2 (2023/24)	224.4 (2023/24)	✓	↑
PH 10	Emergency admissions due to injuries resulting from falls in the over 65s (Directly Standardised Rate, per 100,000 population; PHOF definition)	2,206 (2022/23)	2,195 (2023/24)	2,144 (2023/24)	✓	↑
PH 11	Social Isolation: percentage of adult social care users who have as much social contact as they would like (age 18+)	32.7% (2021/22)	40% (2022/23)	36.2% (2022/23)	✗	↑
PH 12	Fuel poverty (low income, low energy efficiency methodology)	12.4% (2021)	12.0% (2023)	10.7% (2023)	✓	↑
PH 13	New sexually transmitted infections (STI) diagnoses per 100,000 (excluding chlamydia under 25)	407 (2023)	399 (2024)	n/a	u	n/a
PH 14	Long acting reversible contraception (LARC) prescribed as a	49.2% (2023/24)	50% (2024/25)	51.4% (Q2 2024/25)	✓	↑

	proportion of all contraceptives					
PH 15	Admission episodes for alcohol-specific conditions (Directly Standardised Rate per 100,000 population)	857 (2022/23)	848 (2023/24)	922 (2023/24)		
PH 16	Successful completion of drug treatment (non opiate)	19.1% (2023/24)	19.5% (2024/25)	24.8% (Q1-3 2024/25)		

Supporting Commentary

PH 01a - 2021-23 data showed a significant drop since 2020-22 of almost 2 years in healthy life expectancy. This will have been largely the result of the Covid-19 pandemic but also the cost of living crisis.

PH 01b - 2021-23 data showed a significant drop since 2020-22 of 2 years in healthy life expectancy. This will have been largely the result of the Covid-19 pandemic but also the cost of living crisis.

PH 02 - Despite the percentage rising in 2022/23, it decreased in 2023/24. Halton performs below the England average. Data is released annually.

PH 03 - The Q1-3 2024/25 data has seen an increase from 2023/24, and is close to the target of 90%.

PH 04 - Adult excess weight increased each year since 2020/21 and did not meet the target in 2023/24. Data is published annually by OHID.

PH 05 – Adult physical activity increased slightly in 2023/24, but is below the England average of 67.4%. Data is published annually by OHID.

PH 06 - Q1-3 2024/25 data has seen an increase in uptake.

PH 07 – Smoking levels increased in 2023 and did not meet the target. Data is published annually.

PH 08 - The suicide rate increased during 2021-23 and did not meet the target. However the rate is statistically similar to the England average. Data is published annually over a three year period.

PH 09 - Published 2023/24 data shows the rate of self-harm admissions has reduced since 2019/20, and met the target. Data is available annually.

PH 10 - There has been a reduction in falls injuries in 2023/24 and the rate has met the target. Halton's rate is now statistically similar to the England average. Data is available annually.

PH 11 - The proportion of adult social care users having as much social contact as they would like increased in 2022/23 but did not meet the target. Data is available annually.

PH 12 – Fuel poverty has improved in Halton since 2020 and is slightly below the England average. Data is published annually.

PH 13 – New STI rates increased slightly in 2023. However, rates are consistently better than the England. Data is published annually.

PH 14 – Data for Q1-3 2024/25 shows a slight improvement on the 2023/24 annual figure and is on track to meet the target.

PH 15 – The alcohol-specific admissions rate has increased during 2023/24 (as it did across England as a whole) and has not met the target.

PH 16 - Data does fluctuate year on year but in 2022/23 and 2023/24, the Halton proportion of successful completions was worse than the England average. However, the figure has increased in so far in 2024/25 and is on track to meet the target.

Appendix 1 – Financial Statements

COMPLEX CARE POOL BUDGET

Revenue Budget as at 31st March 2025

	Annual Budget	Actual Spend	Variance (Overspend)
	£'000	£'000	£'000
Expenditure			
Intermediate Care Services	5,298	5,393	(95)
Oakmeadow	1,936	1,941	(5)
Community Home Care First	2,088	1,807	281
Joint Equipment Store	535	564	(29)
Development Fund	27	0	27
Contracts & SLA's	3,247	3,243	4
Inglenook	134	108	26
HICafs	3,703	3,373	330
Carers Breaks	554	455	99
Carers centre	357	357	0
Residential Care	6,952	7,552	(600)
Domiciliary Care & Supported Living	4,227	4,227	0
Pathway 3/Discharge Access	391	416	(25)
HBC Contracts	72	78	(6)
Total Expenditure	**29,521**	**29,514**	**7**
Income			
BCF	-13,484	-13,484	0
CCG Contribution to Pool	-2,959	-2,959	0
Oakmeadow Income	-19	-13	(6)
ASC Discharge Grant Income	-1,631	-1,631	0
ICB Discharge Grant Income	-1,282	-1,282	0
Other Income	-80	-80	0
Total Income	**-19,455**	**-19,449**	**(6)**
ICB Contribution Share of Surplus		1	(1)
Net Operational Expenditure	**10,066**	**10,066**	**0**

Comments on the above figures:

The pool has achieved a small underspend of £987 at the end of the financial year 2024/25.

The £0.095m overspend on Intermediate Care Services is primarily due to the use of agency staff in the Reablement team. In the previous financial year this area was underspent, and it is higher staffing costs and the absence of the LAUEC Grant this year which has caused to such a change from last financial year.

The underspend on HICafs is due to a reduction in value of both the Warrington and Bridgewater contracts

The Community Home Care First is a demand led service and the underspend of £0.281m is due to costs being lower than anticipated.

Expenditure on Carer's Breaks is £0.099m less than expected, as demand for services is still lower than pre-pandemic levels.

The BCF funding was underspent by £0.600m which was shared equally between the Council and The ICB to cover pressures in the Health & Social Care Budget. The councils share of £0.300m was allocated to Residential Care.

A balance of £987.21 has been carried forward into the new financial year.

The pool budget is balanced at the end of the year and as previously mentioned, funds have been diverted to cover Health and Community Care pressures. These pressures continue to rise but it cannot be guaranteed that we can rely on Pool underspends in the future to help cover the shortfall.

COMMUNITY CARE

Revenue Budget as at 31st March 2025

	Annual Budget £'000	Actual Spend £'000	Variance (Overspend) £'000
Expenditure			
Residential & Nursing	14,942	18,415	(3,473)
Domicilary Care & Supported living	13,332	14,436	(1,104)
Direct Payments	14,291	14,194	97
Day Care	648	617	31
Total Expenditure	**43,213**	**47,662**	**(4,449)**
Income			
Residential & Nursing Income	-13,794	-13,836	42
Community Care Income	-2,670	-2,715	45
Direct Payments Income	-1,154	-1,157	3
Income from other CCGs	-587	-587	0
Market sustainability & Improvement Grant	-2,796	-2,796	0
Adult Social Care Support Grant	-5,167	-5,167	0
War Pension Disregard Grant	-67	-55	(12)
Total Income	**-26,235**	**-26,313**	**78**
Net Operational Expenditure before year end adjustments	**16,978**	**21,349**	**(4,371)**
Additional Non-Recurrent Funding Identified			
Capitalised salaries (DFG)	994	0	994
Capitalised equipment (DFG)	0	-326	326
Pool budget contribution	0	-300	300
ASC contribution	100	0	100
Total additional Non-Recurrent Funding	**1,094**	**-626**	**1,720**
Net Operational Expenditure after adjustments	**18,072**	**20,723**	**(2,651)**

Comments on the above figures:

At the end of the 2024/25 financial year expenditure on Community Care services before year end adjustments was overspent against budget by £4.371m. This is an increase of £0.844m from the previous position reported at the end of January 2025.

Residential and nursing net forecast spend increase over the period was £0.861m. Supplementary invoices over the period amounted to £0.290m. Various other factors contributed to the overspend and are included in the further analysis.

Domiciliary and Supported Living net forecast spend increase over the period was £0.466m. New packages of care amounted to £0.188m and increases in current packages of care (including 2:1 care) amounted to £0.107m. Small changes to packages of care resulted in a decrease of £0.006m. Supplementary invoices paid amounted to £0.177m. These invoices relate to service users not included on the Master Service Return as no financial assessments has yet been completed. This results in a delay in these service users being captured in the year end forecast.

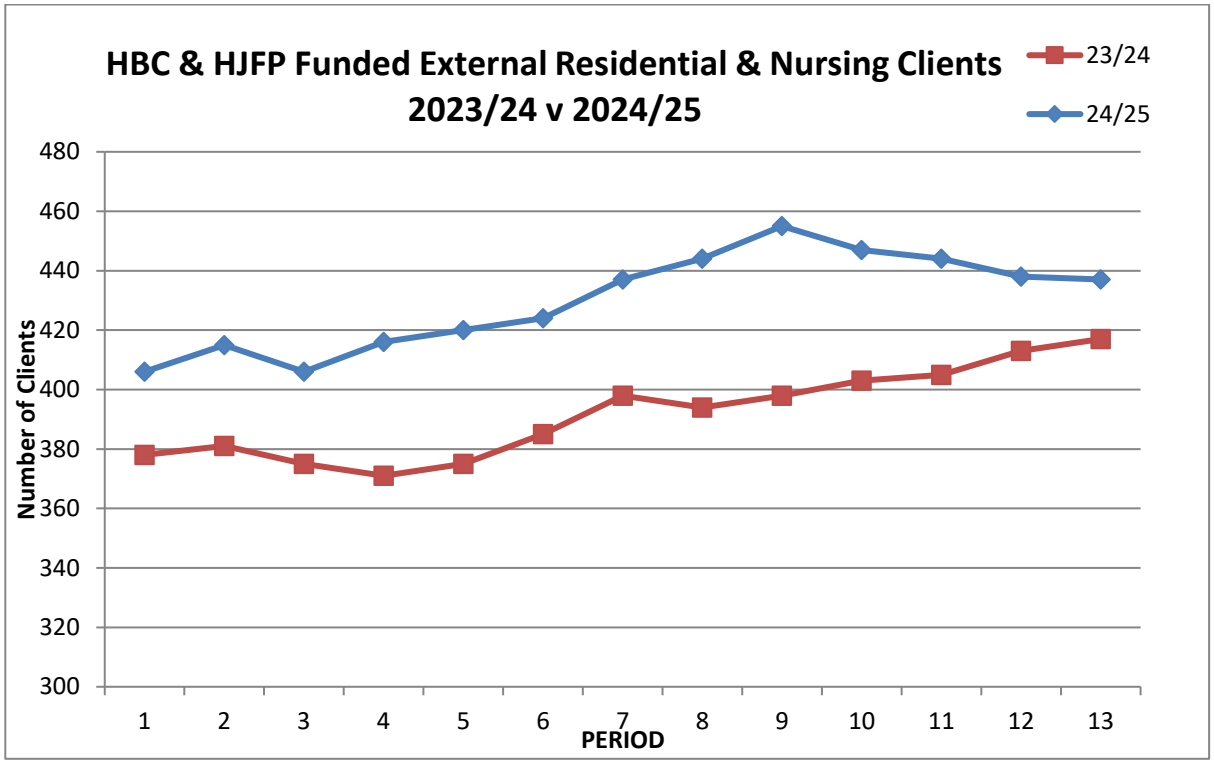
Direct Payments net expenditure decreased by £0.383m. The primary reason for this was reimbursements of £0.333m, the remaining £0.050m being a reduction of service users and reductions to packages of care.

Further analysis of individual service budgets is provided below.

Residential & Nursing Care

There are currently 437 residents in permanent external residential/nursing care as at the end of March 2025 compared to 406 in April 24, an increase of 7.6%. Compared to the 2023/24 average of 391 this is an increase of 11.8%. The average cost of a package of care in the current year for the same period has increased from £866.47 to £915.08 an increase of 5.6%. Supplementary invoice payments amounted to £1.2m for the year.

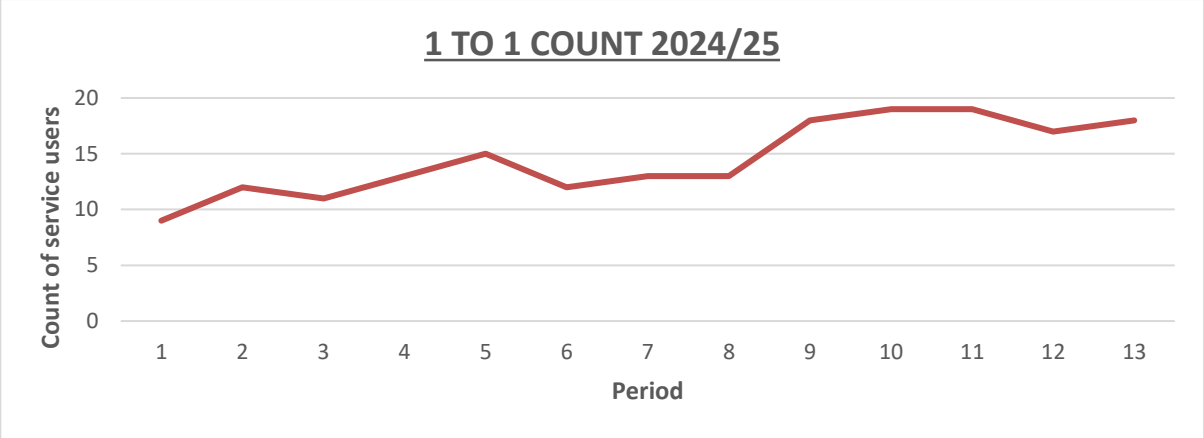
The graph below illustrates the demand for permanent placements.



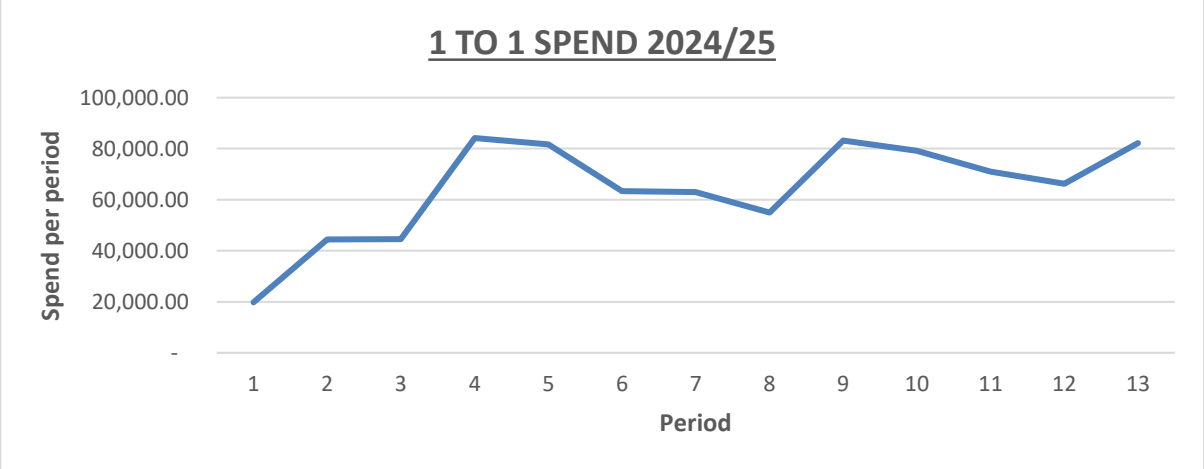
1 to 1 SUPPORT IN CARE HOMES

Providers are increasingly requesting payment for 1 to 1 support, especially on discharge from hospital. This is generally to mitigate the risk from falls. The full year cost is £0.838m with £0.219m spent in the final 3 months. This is exerting pressure on the budget.

The graph below shows 1 to 1 count of service users by period and demonstrates that numbers have doubled since the start of the year.



The graph below shows the spend on 1 to 1 by period. This clearly shows that the monthly spend has increased from £19,800.20 in April to £82,169.68 at the end of the financial year.
This is an increase of 314%.



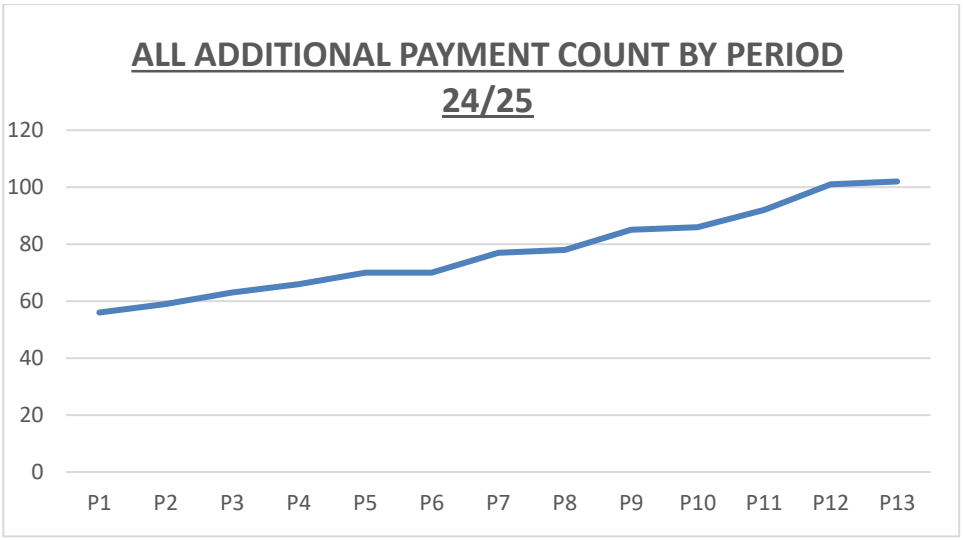
ADDITIONAL PAYMENTS 2024/25

Additional payments to care homes are rising, both in and out of the borough. These are where the care home charges an additional amount on top of the contracted bed rate. There does not appear to be any consistency in these extra charges even within the same care home.

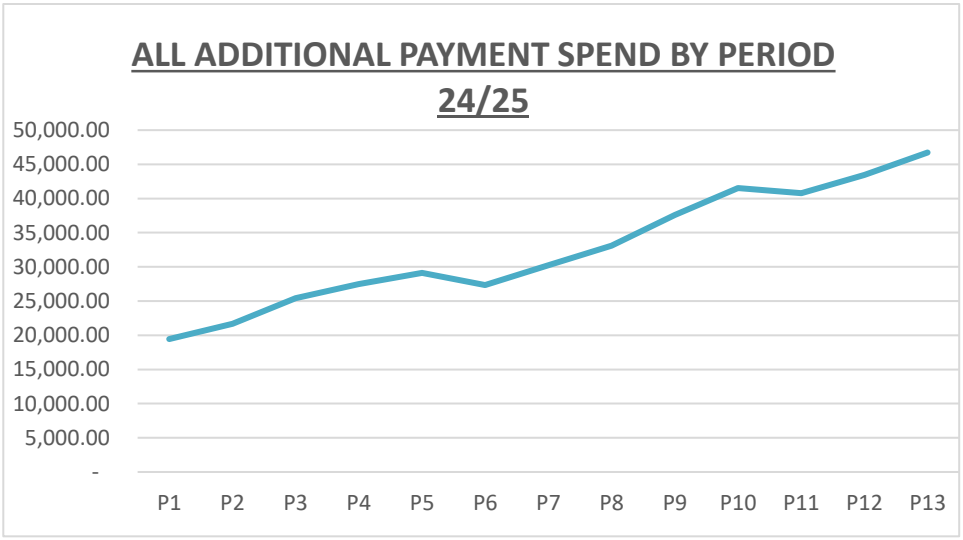
The risk, if the Council don't pay these extra charges, could be that care homes do not accept service users. This could result in even more people being placed out of borough at even higher rates.

The cost of this for 2024/25 is £0.424m. £0.131m of this occurred in the final 3 months. The average additional payment was £112.48 per week with the lowest being £12.50 week and the highest £748 per week.

The graph below illustrates the count of service users with an additional payment by period.
This clearly shows a steady increase in numbers.



The graph below illustrates the cost of additional payments by period. This clearly shows a steady increase in costs.



The number of Permanent external packages over £1k per week are illustrated below:

Weekly Cost	No of Permanent PoCs											
£	P 1	P2	P 3	P4	P5	P6	P7	P8	P9	P10	P11	P12
1000-1999	52	53	53	53	54	53	56	57	59	59	59	57
2000-2999	18	18	16	17	17	17	18	20	21	21	21	22
3000-3999	5	5	5	5	5	5	5	5	5	5	5	5
4000-4999	7	8	8	8	9	8	8	7	7	8	6	8
5000-5999	3	2	2	2	3	3	4	3	4	4	2	3
6000-6999	1	2	1	2	2	2	2	2	3	3	3	2
7000-7999		1	1	1	1	1	1	1	1	1	1	1
8000-8999												1
>10,000	1	1	1	1	1	1	1	1	1	1	1	
Total	87	90	87	89	92	90	95	96	101	102	98	99
Over £1,000 Out of Borough	60	62	60	62	63	62	66	67	74	73	74	72
Over £1,000 Joint Funded	41	43	42	43	46	46	48	46	48	50	48	47

Since the beginning of the financial year the number of permanent packages over £1k has increased from 87 to 99 (13.7%).

Out of borough over £1k has increased from 60 to 72 (20%).

Joint funded over £1k has increased from 41 to 47 (14.6%).

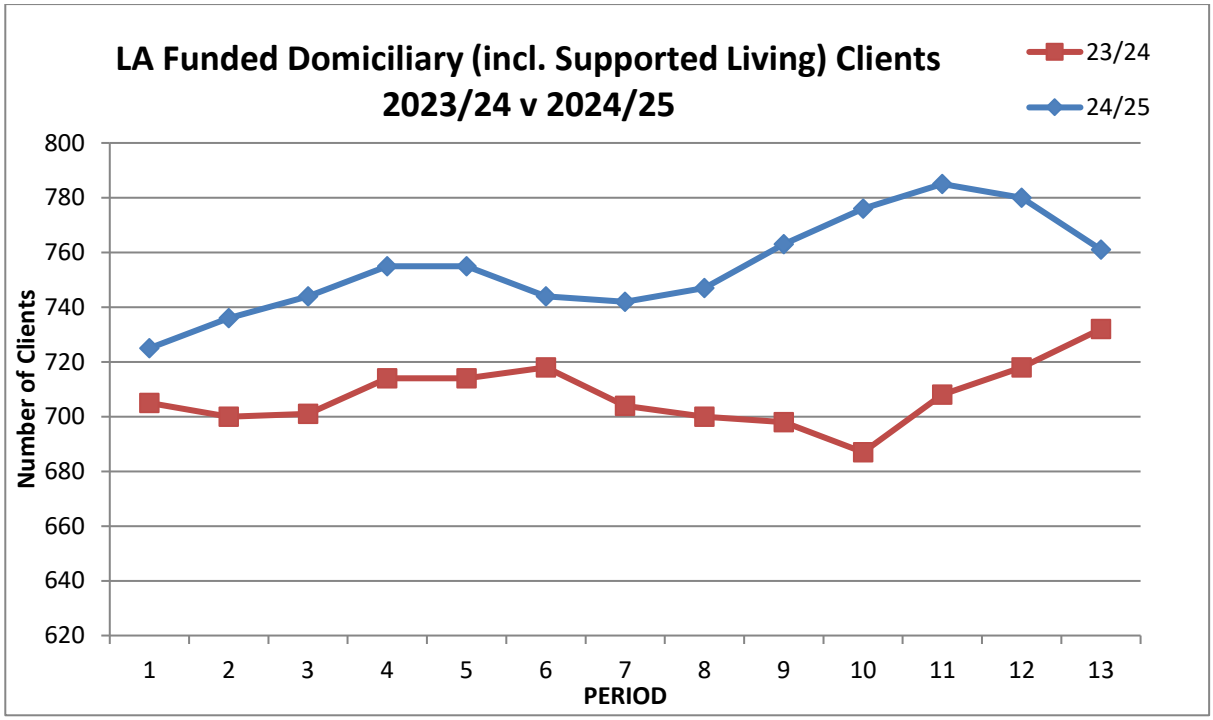
Domiciliary Care & Supported Living

There are currently 781 service users receiving a package of care at home compared to 776 in January an increase of 4 (0.6%). However, the average number of service users during 2023/24 was 707, so there has been an increase of 10.4% demonstrating that demand for the service has increased this financial year.

The average cost of a package of care has increased since January by 5.24% from £475.14 to £500.04.

The average cost over the full financial year has increased from £425.47 to £500.04, an increase of 17.52%. This suggests packages are more complex.

The graph below illustrates the demand for the service from April 2023 to date.



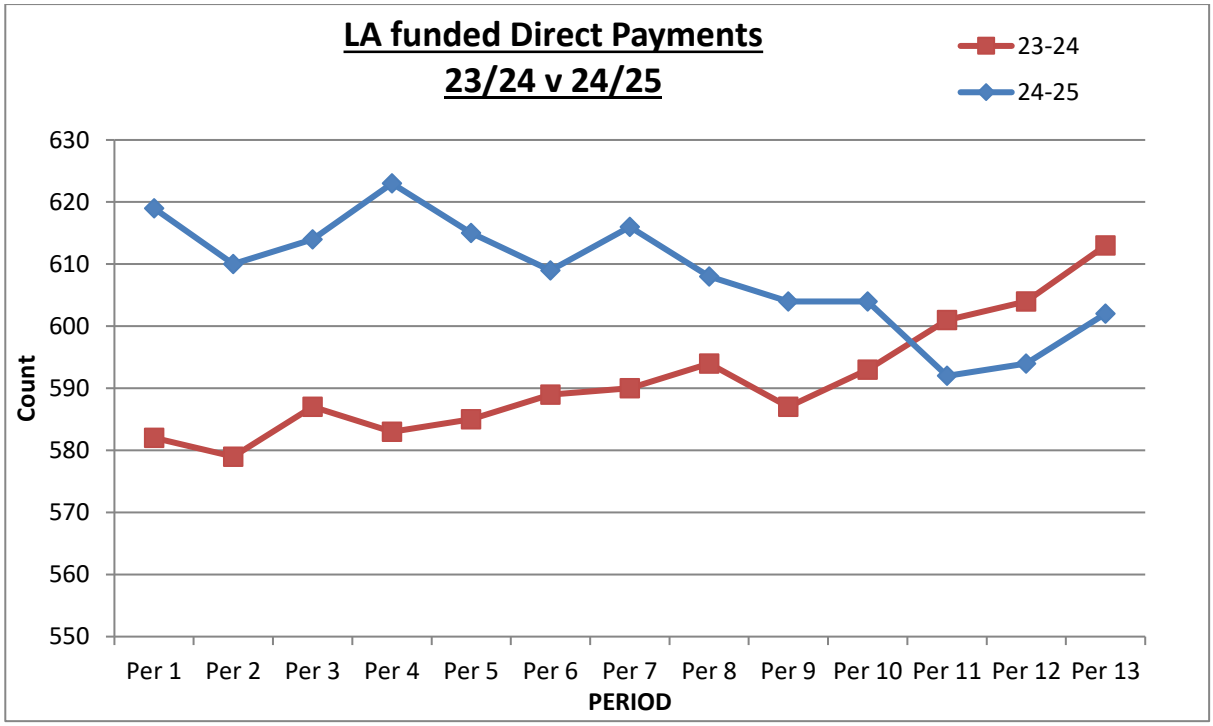
Direct Payments

The average number of clients who received a Direct Payment (DP) in 2024/25 was 608 compared with 591 in 2023/24, an increase of 2.8%.

The average cost of a package of care in 2024/25 was £486.65 compared with £488.68 in 2023/24, a decrease of 0.4%.

An amount of £1.6m has been recovered from service users following audits to seek assurance the DP is spent in line with their care and support needs.

The graph below shows movement throughout the year.



The Community Care budget as a whole is very volatile by nature as it is demand driven, with many influential factors. It will continue to be closely monitored and scrutinised in the next financial year to quantify pressures on the financial performance. The Community Care budget recovery group continues to meet to identify savings to try to mitigate the risk of overspends against this budget. At year end they have realised savings to date circa £2.5m.

Additional Non-Recurrent Funding

In helping to mitigate the overall net spend against the department, a number of adjustments have been made at year-end, including:

Salary and supply costs of £1.320m being capitalised and charged to a surplus of Disabled Facilities Grant funding (DFG). This is considered to be a one-off gain and unlikely to be achieved in future years due to diminishing levels of DFG.

A contribution of £0.300m from the surplus of the Pool budget, overall Pool budget surplus shared equally with ICB.

Pooled Budget Capital Projects as at 31st March 2025

	2024/25 Revised Allocation £000	Actual Spend to 31 March 2025 £000	Allocation remaining £000
Adults Directorate			
Halton Carers Centre Refurbishment	0.0	0.0	0.0
Grants - Disabled Facilities	2,461.8	2,461.8	0.0
Stair Lifts	250.0	304.2	(54.2)
Joint Funding RSL Adaptations	250.0	317.9	(67.9)
Telehealthcare Digital Switchover	135.0	60.0	75.0
Oakmeadow & Peelhouse Network Improvements	40.0	0.0	40.0
Madeline McKenna Refurbishment	120.0	90.8	29.2
Millbrow Refurbishment	50.0	54.9	(4.9)
St Lukes Care Home	120.0	159.8	(39.8)
St Patricks Care Home	150.0	120.8	29.2
Adults Directorate Total	**3,576.8**	**3,570.2**	**6.6**

Comments on the above figures:

There are a number of capital schemes where spend for the year exceeds the revised budget as reported to Executive Board on 13 March 2025. Where this is the case funding for overspend against allocation will come from external grant.

The £0.400m Telehealthcare Digital Switchover scheme was approved by Executive Board on 15 July 2021. Significant capital investment is required to ensure a functional Telehealthcare IT system is in place prior to the switch off of existing copper cable based systems. Procurement commenced in 2022/23 with an initial purchase to the value of £0.100m. It is anticipated that the scheme will be completed early in the new financial year, fully funded from the residual capital allocation of £0.075m.

On 16th June 2022 Executive Board approved a £4.2M refurbishment programme in respect of the four Council owned care homes, initially to be completed withing a three year timescale. Spend to 31 March 2024 amounted to £947,000, leaving available funding of £3.253M at the start of the current financial year.

At present, detailed costing proposals are in development, with further revisions to the capital allocations to be submitted at a later date.

The 2024-25 capital allocations against each home therefore just reflect ongoing minor refurbishment costs.

Care Homes Division

Revenue Budget 24-25 Outturn

	Annual Budget	Actual Spend	Variance (Overspend)
	£'000	£'000	£'000
Expenditure			
Madeline Mckenna			
Employees	698	674	24
Agency - covering vacancies	0	112	(112)
Other Premises	101	104	(3)
Supplies & Services	20	30	(10)
Food Provison	48	49	(1)
Total Madeline Mckenna Expenditure	**867**	**969**	**(102)**
Millbrow			
Employees	2,057	1,244	813
Agency - covering vacancies	3	1,071	(1,068)
Other Premises	129	169	(40)
Supplies & Services	61	104	(43)
Food Provison	78	80	(2)
Total Millbrow Expenditure	**2,328**	**2,668**	**(340)**
St Luke's			
Employees	2,884	2,158	726
Agency - covering vacancies	551	1,653	(1,102)
Other Premises	172	273	(101)
Supplies & Services	59	156	(97)
Reimbursements & other Grant Income	-325	-318	(7)
Private Client Income 1:1	-81	-81	0
Food Provison	120	143	(23)
Total St Luke's Expenditure	**3,380**	**3,984**	**(604)**
St Patrick's			
Employees	1,839	1,217	622
Agency - covering vacancies	91	1,067	(976)
Other Premises	157	156	1
Supplies & Services	63	12	51
Food Provison	122	114	8
Reimbursements & other Grant Income	-45	-45	0
Total St Patrick's Expenditure	**2,227**	**2,521**	**(294)**
Care Homes Divison Management			
Employees	305	244	61
Supplies & Services		4	(4)
Care Home Divison Management	**305**	**248**	**57**
Net Operational Expenditure	**9,107**	**10,390**	**(1,283)**
Recharges			
Premises Support	264	264	0
Transport Support	0	0	0
Central Support	683	683	0
Asset Rental Support	318	318	0
Recharge Income	0	0	0
Net Total Recharges	**1,265**	**1,265**	**0**
Net Departmental Expenditure	**10,372**	**11,655**	**(1,283)**

Comments on the above figures

Financial Position

The care home division is made up of the following cost centres, Divisional Management Care Homes, Madeline Mckenna, Millbrow, St Luke's and St Patrick's.

The net departmental expenditure across the division is over budget for 2024-25 financial year by £1.283m.

Employee Related expenditure

Employee related expenditure was over budget at the end of the financial year by £0.953m.

The 2024-25 pay award offer of £1,290 was accepted, and included in the November pay award with backpay to April 2024.This resulted in an over budget spend of £0.188m across the Care Home Division for the full financial year.

It should be noted therefore that whilst the overspend for the current financial year is broadly comparable to the previous financial year figure of £0.846m, the previous year had employees spend offset by £0.245M of the market sustainability and workforce improvement grant (no grant received in current year), and did not include unbudgeted pay award costs.

Recruitment of staff is a continued pressure across the care homes. There remains a high number of staff vacancies across the care homes.

Due to pressures with recruitment and retention in the sector, heavy reliance is being placed on overtime and expensive agency staff to support the care homes. At the end of the financial year total agency spend across the care homes reached £3.815m, the cost of this has partially been offset by staff vacancies.

Throughout the year a number of residents within the care homes were identified as needing 1:1 care in addition to the support the care homes provide on a day to day basis. The staffing budget has been revised to take this into consideration. The revised budget helped support agency spend:

In-Year Revised Agency Budget

Millbrow	£3,168
St Luke's	£550,075
St Patrick's	£90,820
Total	£644,063

Premises Related Expenditure

At the end of financial year 2024-25 premises costs were over budget by £0.143m.

Premises related expenditure covers both repairs, maintenance and utilities. The budget was increased significantly for utilities in the previous 2023-24 financial year due to increases in costs in previous years, therefore the spend above budget relates to repairs and maintenance. This remains a budget pressure across all homes.

Supplies and Services Expenditure

Supplies and Services expenditure is over budget at the end of 2024-25 financial year by £0.057m.

Food Provision Expenditure

Food Provision expenditure is over budget at the end of 2024-25 financial year by £0.017m.

Approved 2024-25 Savings

There were no approved savings for the care home division in financial year 2024-25

Risks/Opportunities

Recruitment and retention of care and nursing staff within care homes remains the significant risk to the budget.

Adult Social Care

Revenue Operational Budget as at 31st March 2025

	Annual Budget	Actual Spend	Variance (Overspend)
	£'000	£'000	£'000
Expenditure			
Employees	17,409	16,377	1,032
Agency- Covering Vacancies	0	1,173	(1,173)
Premises	492	501	(9)
Supplies & Services	1,120	1,352	(232)
Aids & Adaptations	37	43	(6)
Transport	242	437	(195)
Food & Drink Provisions	213	197	16
Supported Accommodation and Services	1,385	1,153	232
Emergency Duty Team	115	104	11
Transfer To Reserves	75	75	0
Contracts & SLAs	1,090	1,149	(59)
Housing Solutions Grant Funded Schemes			
Homelessness Prevention	563	554	9
Rough Sleepers Initiative	137	135	2
Total Expenditure	**22,878**	**23,250**	**(372)**
Income			
Fees & Charges	-921	-938	17
Sales & Rents Income	-480	-495	15
Reimbursements & Grant Income	-1,933	-1,964	31
Capital Salaries	-1,115	-1,115	0
Transfer from Reserves	-49	-49	0
Housing Schemes Income	-995	-994	(1)
Total Income	**-5,493**	**-5,555**	**62**
Net Operational Expenditure	**17,385**	**17,695**	**(310)**
Recharges			
Premises Support	529	529	0
Transport Support	582	818	(236)
Central Support	3,465	3,465	0
Asset Rental Support	360	360	0
Recharge Income	-112	-112	0
Net Total Recharges	**4,824**	**5,060**	**(236)**
Net Departmental Expenditure	**22,209**	**22,755**	**(546)**

Comments on the above figures

The above information relates to Adult Social Care, excluding Community Care and Care Homes.

Net Department Expenditure

Net spend for the year is £0.546m above the approved budget, this is an increase of £0.079m from period 10 reporting.

Employee Related Spend

The backdated pay award was paid in November 2024 and is shown within the expenditure above. The full-year cost above full-year budget is £0.141m.

Agency expenditure across the division as a whole at the end of March 2025 stood at £1.173m. The unbudgeted agency costs are in respect of covering vacant posts, particularly in terms of front-line Care Management and Mental Health Team posts.

Supplies and Services related spend

The full-year spend of £0.232m above approved budget relates to an increased volume of caseload in respect of Deprivation Of Liberty Standards (DoLs) assessments. Spend to the end of the financial year on DoLs was £0.229m.

Transport related spend

Transport and transport recharge costs were substantially above budget both in this financial year and the previous financial year. Full-year spend above budget was £0.195m in respect of direct transport costs, and £0.236m in respect of internally recharged costs.

Following a review of the way the transport recharges are calculated, from April 2025, the average cost per trip is to be calculated and used for the recharge each month, ensuring a more accurate recharge for transport used.

Housing Strategy related spend

Housing Strategy initiatives included in the report above include the Rough Sleeping Initiative and Homelessness Prevention Scheme. The Homelessness Prevention scheme is an amalgamation of the previous Flexible Homelessness Support and Homelessness Reduction schemes, and is wholly grant funded. It is assumed that unspent funding is carried forward to the following financial year.

Income

Income for the Department as a whole is broadly to budget for the year, the income shortfall from Community Meals fees and charges being met from over-achievements in other areas.

Further information

Whilst some of the 2024/25 approved savings have been achieved, work is still ongoing on a number of items. The above projections account for the currently projected delayed or partially achieved items.

A list of 2024/25 and 2025/26 saving items approved in February 2023 is included at Appendix A.

Progress Against Agreed Savings

	Service Area	Net Budget £'000	Description of Saving Proposal	Savings Value		Current Progress	Comments
				24/25 £'000	25/26 £'000		
ASC1	Housing Solutions	474	Remodel the current service based on good practice evidence from other areas.	0	125	✓	Anticipated to be achieved, currently under review.
ASC2	Telehealthcare	680	Explore alternative funding streams such as Health funding or Disabled Facilities Grants.	170	0	U	Currently Under Review
			Increase charges / review income.	170	0	✓	Increased 2024/25 income target achieved
			Cease the key safe installation service.	15	0	✗	Service still being provided
ASC17/18	Quality Assurance Team	395	Review the activities of the Quality Assurance Team, given there are fewer providers for domiciliary care and the transfer of four care homes into the Council.	0	0	✓	Saving implemented
			Merge the service with the Safeguarding Unit.	50	0	✓	
ASC16	Shared Lives (Adult Placement Service)	115	Engage with an external agency currently operating Shared Lives to take over the running of this service. It is anticipated that this would provide an improved service.	58	0	U	Service currently still provided in-house, although a balanced budget will be attained for 2024/25 as a result of current temporary savings, and work is ongoing to ensure the 2025/6 structure can

							achieve the permanent savings target
ASC19	Voluntary Sector Support	N/A	Review the support provided by Adult Social Care and all other Council Departments, to voluntary sector organisations. This would include assisting them to secure alternative funding in order to reduce their dependence upon Council funding. A target saving phased over two years has been estimated.	200	100	✓	Anticipated to be achieved
ASC4	Positive Behaviour Support Service	349	Increase income generated in order to ensure full cost recovery, through increased service contract charges to other councils. Review the Integrated Care Board contribution for Adults, to ensure the full recovery of related costs.	100 150	0 0	✓ ✗	Contracts being re-costed on renewal, saving anticipated to be achieved Increased contribution from ICB not agreed.
ASC15	Learning Disability Nursing Team	424	Cease provision of this service. The service is a Health related function rather than Adult Social Care, but this is a historical arrangement. The Integrated Care Board would need to consider	424	0	✓	Costs now recharged to the ICB

			how they want to provide this function.				
ASC14	Care Management Community Care Budget	18,982	Attract £500k investment from the pooled budget (BCF) from 2024/25. Undertake work in years 1 and 2 to reduce reliance upon contracted services from 2025/26. Services are currently in the process of being redesigned on a "Strengths Based Approach" ie. focused upon prevention.	500	1,000	U	Contribution of £0.400m received from 2024.25 Pool Budget. One-off contribution only. Uncertainty if this will be achieved in 2025.26
Total Adult Social Care Department				**1,837**	**1,225**		

PUBLIC HEALTH & PUBLIC PROTECTION DEPARTMENT

Revenue Budget as at 31 March 2025

	Annual Budget	Actual Spend	Variance (Overspend)
	£'000	£'000	£'000
Expenditure			
Employees	4,799	4,796	3
Other Premises	6	0	6
Supplies & Services	354	287	67
Contracts & SLA's	7,741	7,704	37
Transport	4	2	1
Transfer to Reserves	1,281	1,281	0
Other Agency	24	24	(0)
Total Expenditure	**14,208**	**14,095**	**113**
Income			
Fees & Charges	-148	-147	(0)
Reimbursements & Grant Income	-714	-714	0
Transfer from Reserves	-1,714	-1,714	0
Government Grant Income	-12,231	-12,231	0
Total Income	**-14,807**	**-14,806**	**(0)**
Net Operational Expenditure	**-598**	**-711**	**113**
Recharges			
Premises Support	150	150	(0)
Transport Support	22	24	(3)
Central Support	2,387	2,399	(12)
Asset Rental Support			0
Recharge Income	-669	-669	0
Net Total Recharges	**1,890**	**1,904**	**(15)**
Net Departmental Expenditure	**1,291**	**1,193**	**98**

Comments on the above figures

Financial Position

The net Department spend for the year ending 31st March 2025 is £0.098m under the available budget.

Employee costs have achieved a very small underspend. Additional income has been received from the public health grant recharge to support the sure start to later life team. Staff savings targets for 24/25 have been achieved.

Expenditure on supplies and services was kept to essential items only throughout the year and has achieved an underspend of £0.067m.

There is a small underspend on Contracts & SLA's of £0.037m, however, budget pressures to be aware of are a number of contracts are due for renewal in the current financial climate and are likely to increase significantly in the next financial year.

APPENDIX 2 – Explanation of Symbols

Symbols are used in the following manner:

Progress		Objective	*Performance Indicator*
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	*Indicates that the annual target is on course to be achieved.*
Amber		Indicates that it is uncertain or too early to say at this stage, whether the milestone/objective will be achieved within the appropriate timeframe.	*Indicates that it is uncertain or too early to say at this stage whether the annual target is on course to be achieved.*
Red		Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	*Indicates that the target will not be achieved unless there is an intervention or remedial action taken.*

Direction of Travel Indicator

Where possible performance measures will also identify a direction of travel using the following convention

Green		*Indicates that* **performance is better** *as compared to the same period last year.*
Amber		*Indicates that* **performance is the same** *as compared to the same period last year.*
Red		*Indicates that* **performance is worse** *as compared to the same period last year.*
N/A		*Indicates that the measure cannot be compared to the same period last year.*

REPORT TO: Health & Social Care Policy & Performance Board

DATE: 24 June 2025

REPORTING OFFICER: Finance Director

PORTFOLIO: Corporate Services

SUBJECT: Councilwide Spending as at 31 January 2025

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To report the Council's overall revenue and capital spending position as at 31 January 2025, together with the latest 2024/25 outturn forecast.

2.0 RECOMMENDED: That;

(i) The Council's overall financial position as at 31 January 2025 as outlined in the Appendix, be noted.

3.0 SUPPORTING INFORMATION

3.1 On 13 March 2025 the Executive Board received the report shown in the Appendix. This presented details of Councilwide revenue and capital spending by each Department as at 31 January 2025 along with forecasts to year-end, and outlines the reasons for key variances from budget.

3.2 Given the scale of the Council's current financial challenges, Executive Board requested that a copy of the report be shared with each Policy and Performance Board for information. This is to ensure that all Members have a full appreciation of the Councilwide financial position, in addition to their specific areas of responsibility.

3.3 The report is presented to Executive Board every two months and the attached report covers the period 1 April 2024 to 31 January 2025. It includes details of spending to date by each Department against both the revenue budget and capital programme.

3.4 Within the report Appendix 1 provides a Councilwide summary of revenue spending, while Appendix 2 presents details relating to each Department. The latest forecast of revenue spending to year-end compared to budget is also provided.

3.5 Appendix 3 presents spending to date against the Capital Programme. Appendix 4 indicates progress with implementation of previously approved budget savings for 2024/25 and 2025/26.

4.0 POLICY IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Improving Health, Promoting Wellbeing and Supporting Greater Independence**

5.2 **Building a Strong, Sustainable Local Economy**

5.3 **Supporting Children, Young People and Families**

5.4 **Tackling Inequality and Helping Those Who Are Most In Need**

5.5 **Working Towards a Greener Future**

5.6 **Valuing and Appreciating Halton and Our Community**

There are no direct implications, however, the revenue budget and capital programme support the delivery and achievement of all the Council's priorities.

6.0 RISK ANALYSIS

6.1 There are a number of financial risks within the budget. However, the Council has internal controls and processes in place to ensure that spending remains in line with budget as far as possible.

6.2 A budget risk register of significant financial risks is maintained and is included at Appendix 5 of the attached report.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

8.0 CLIMATE CHANGE IMPLICATIONS

8.1 None

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1072

9.1 There are no background papers under the meaning of the Act

APPENDIX

REPORT TO: Executive Board

DATE: 13 March 2025

REPORTING OFFICER: Finance Director

PORTFOLIO: Corporate Services

SUBJECT: 2024/25 Spending as at 31 January 2025

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.2 To report the Council's overall revenue net spend position as at 31 January 2025 together with a 2024/25 forecast outturn position.

3.0 RECOMMENDED: That;

(ii) Executive Directors continue to identify areas where they can further reduce their directorate's spending or generate income, in order to reduce the councilwide forecast outturn overspend position;

(iii) Executive Directors continue to implement the approved savings proposals for 2024/25 and 2025/26 as detailed in Appendix 4;

(iv) Council be asked to approve the revisions to the capital programme set-out in paragraph 3.22 and incorporated within Appendix 3;

(v) This report be shared with each Policy and Performance Board, in order to ensure they have a full appreciation of the councilwide financial position, in addition to their specific areas of responsibility.

3.0 SUPPORTING INFORMATION

Revenue Spending

3.1 Appendix 1 presents a summary of spending against the operational revenue budget up to 31 January 2025 and Appendix 2 provides detailed figures for each individual Department. In overall terms, net Council spending as at 31 January 2025 is £15.487m over budget. The outturn forecast for the year estimates that net spending will be over budget by £18.906m if no corrective action is taken.

3.2 The forecast outturn overspend has improved by £1.851m from the amount reported on 16 January 2025. Whilst the financial position for the

year remains deeply concerning the forecast outturn is a significant improvement. The improvement largely relates to reduced net spend estimates across Children Services. Further information regarding significant departmental variances is included within the report and departmental figures are included in Appendices 1 and 2.

3.3 Over the two month period since the last reported position, financial focus workshops led by the Chief Executive have taken place with each Directorate's senior leadership team on a monthly basis. These workshops are looking for urgent ways to reduce or stop spending, or generate income. The aim is that initiatives identified in these workshops will help reduce the overall forecast overspend position for the year.

3.4 Ordinarily, where net spend is exceeding available resources for the year, the Council would have used reserves to achieve a balanced position. Due to decreasing levels, the Council are not in a position to cover the forecast overspend for the year. Therefore, on 04 December 2024 Council approved an application to the Ministry of Housing, Communities & Local Government (MHCLG) for Exceptional Financial Support (EFS). The Government's EFS arrangement provides councils with exceptional permission to capitalise annual revenue costs and fund them from long term borrowing (over 20 years) from the Public Works Loans Board (PWLB). EFS provides permission to borrow and does not provide grant funding. On 20 February 2025 MHCLG confirmed the Deputy Prime Minister is minded to approve a capitalisation direction of a total not exceeding £52.8 million over the period 2024/25 and 2025/26. The position will only be confirmed following an external assurance review to be undertaken in the summer of 2025.

3.5 The Council's available useable reserves (general and earmarked) total £11.484m. This is well below that required to help provide a balanced budget position given the forecast outturn overspend. Further detail on reserves is provided at paragraph 3.19.

3.6 The forecast outturn figures reflect a prudent yet realistic view of spend and income levels through to the end of the year. Work will continue to update the financial position as more information becomes available. Included within the forecast position is the 2024/25 pay award which was paid in November 2024.

3.7 The largest pressure on the Council's budget continues to be within the Children & Families Department and the Adults Directorate. Against Children & Families net spend for the year is forecast to be £6.817m (16.2%) above 2023/24 actual spend. Against the Adults Directorate net spend for the year is forecast to be £4.557m (7.5%) higher than 2023/245 actual spend.

3.8 On 24 October 2024 the Board approved additional revenue funding of £4.2m per year, to help develop a programme around the stabilisation and redesign of Children's Social Care, following the Ofsted review. This investment is focused upon proactive early intervention and prevention systems. It is envisaged that this investment will help control and reduce

costs within Children's Social Care over the next few years, and these cost reductions will be built into future year budget targets.

3.9 The use and cost of agency staff continues to be one of the main contributing factors to the overspend position for the year. This is mostly evident within the Children & Families Department and the Council's in-house Care Homes. Initiatives and support from the Transformation Programme are ongoing to reduce reliance upon agency staff.

3.10 Analysis of agency spend for the year, together with comparative analysis of 2023/24 costs, is included in the table below. Note information for Q4 only includes data for one months, January.

	2024/25						2023/24
	Q1	Q2	Q3	Q4 to Date	Total		Total
	£'000	£'000	£'000	£'000	£'000		£'000
Adult Social Care	1,341	1,656	1,210	1,241	5,448		5,927
Chief Executives Delivery Unit	132	179	239	82	632		0
Children & Family Services	1,283	1,432	1,321	400	4,436		6,157
Community & Greenspace	116	129	104	33	382		336
Economy, Enterprise & Property	86	105	110	38	339		343
Education, Inclusion & Provision	99	78	53	14	244		393
Finance	14	42	31	8	95		56
Legal & Democratic Services	253	274	212	41	780		814
Planning & Transportation	94	85	19	3	201		206
Public Health & Public Protection	11	10	1	0	22		21
Total	**3,429**	**3,990**	**3,300**	**1,860**	**12,579**		**14,253**

3.11 Within the approved budget for the year is a £4m savings target against the Transformation Programme. To date budget savings of £0.129m have been identified against this target. In addition, the Transformation Delivery Unit (TDU) have identified cost reductions and cost avoidance measures, although these will not lead to an overall reduction in the budgeted target. Progress against transformation savings is reported monthly to the Transformation Programme Board.

3.12 The forecast overspend is significantly above that which has been recorded in recent years. Whilst the current year net budget for the Council has increased by £7.7m (5.45%), this is well below the forecast increase in net costs, currently estimated as an increase of £20.997m (14.1%).

Revenue - Operational Spending

3.13 Operational net spending for the first ten months of the year is higher than the budget to date by £15.487m Based on current forecasts it is estimated net spend will be over budget for the year by £18.906m if no further corrective action is taken.

3.14 Within the overall budget forecast position for the quarter, the key budget variances are as follows;

(i) **Children and Families Department**

The overall estimated forecast overspend position at the end of 2024/25 has reduced by £1.616m since last reported at 30 November 2024.

Significant investment as part of a Children's Social Care improvement plan has helped to reduce the forecast overspend position as well as reductions in agency and placement costs.

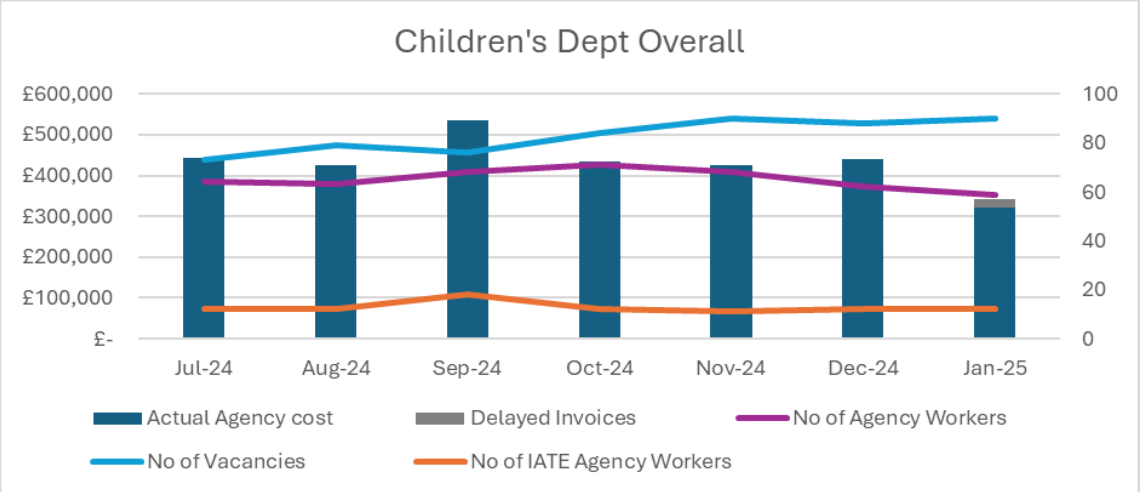
Although that there is a reduction in estimated forecast overspend across the Children's and Families department the overspend is still an area of serious concern and the issues remain the same. The difficulty in the recruitment of social workers and the subsequent extortionate agency costs, along with the spiralling costs of residential placements. This has been an ongoing problem for a number of years.

Employee Expenditure

Employee costs are forecast to be over budget profile at the end of financial year 2024/25 by £1.994m this is a reduction of £0.624m based on information available at 31 January 2025.

The reduction mainly relates to an agreed investment within children's services which has resulted in the establishment of new roles across the department. Agency staff that were previously in addition to the establishment (IATE) are no longer considered as IATE. Additional in-year budget of £0.501m (funded from contingency) has been provided for some of the newly established posts which has helped reduce the overspend position.

The chart below demonstrates agency cost that cover the month of April to January based on the period that was worked, the number of agency members of staff that the Council have received an invoice for within each period, the number of vacancies across the department and the number of staff that are currently in addition to the establishment (IATE).

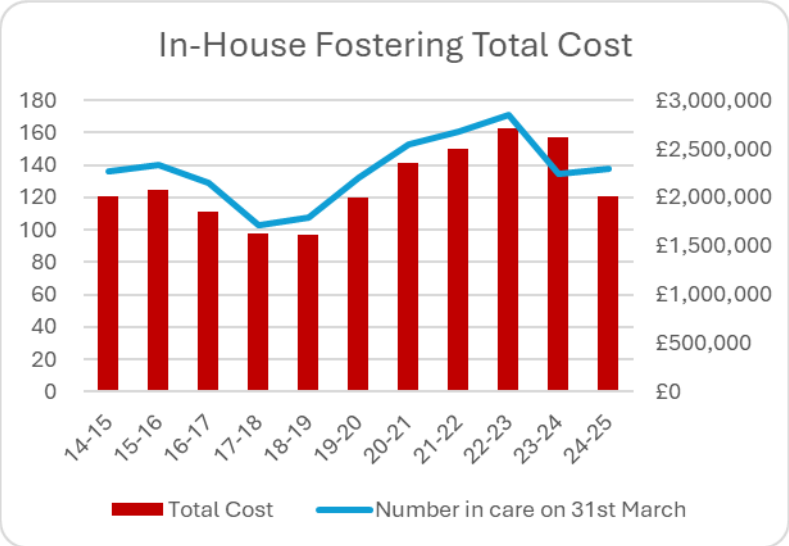


Various workstreams are in place to target the difficulties in recruitment, including a recruitment work group, social work academy and market supplements for applicable posts.

The chart above shows the level of agency has consistently reduced since October this is due to a number of agency converting to vacant positions and external recruitment which has resulted agency staff being stepped down.

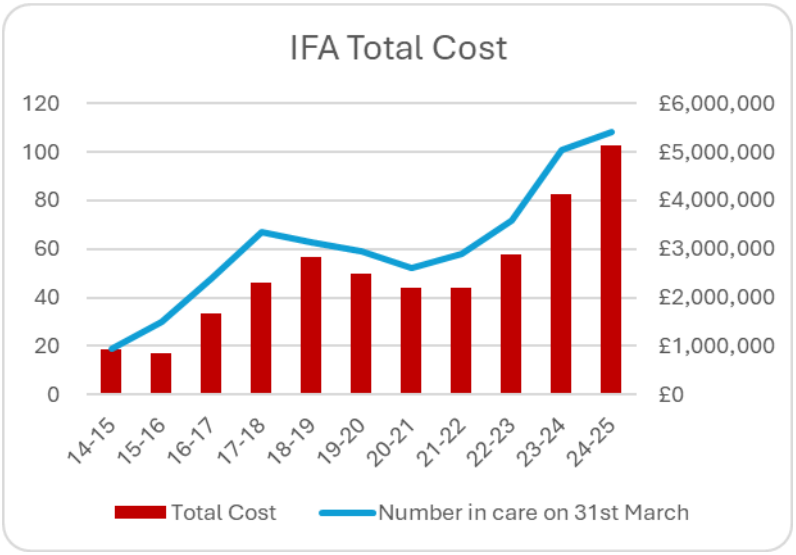
Fostering

Inhouse fostering placements is estimated to be £0.348m under budget profile for financial year 2024/25. Inhouse fostering budgets were increased to support the budget pressure in this area.



Work continues to recruit and retain Halton's In-house foster carers, along with training to develop carers enabling them to accommodate more specialist placements. This therefore means that costs could increase. However, the ability to accommodate young people within in-house provision provides a substantial saving in comparison to Independent Fostering Agency (IFA) or residential care.

Increasing numbers of children in care and insufficient in-house fostering provision has meant increased reliance on IFA. Higher numbers of children placed within IFA provision and increased IFA rates has resulted in an estimated forecast overspend for the end of 2024/25 as £0.886m.



Residential Care

Out of Borough Residential Care continues to be the main budget pressure for the Children and Families Department as the costs of residential care have continued to rise year on year. The numbers of young people in residential placements remains high and the cost of placements is rising significantly year-on year.

		31-Jan-25		30-Nov-24	
Provision	**Weekly Costs**	**No. Placed**	**Estimated cost for the year**	**No. Placed**	**Estimated cost for the year**
Residential	£1000 - £3000	4	488,662	4	476,360
Residential	£3001 - £5000	27	5,108,252	25	4,956,870
Residential	£5001 - £7000	26	6,737,694	26	7,413,389
Residential	£7001 - £15982	16	9,452,930	17	9,291,964
Secure	£6397 - £8137				
Leaving Care	£443 - £7175	11	2,134,843	14	2,341,056
Parent & Child	£2000 - £5500	7	774,025	7	913,562
Total:		**91**	**24,696,405**	**93**	**25,393,201**

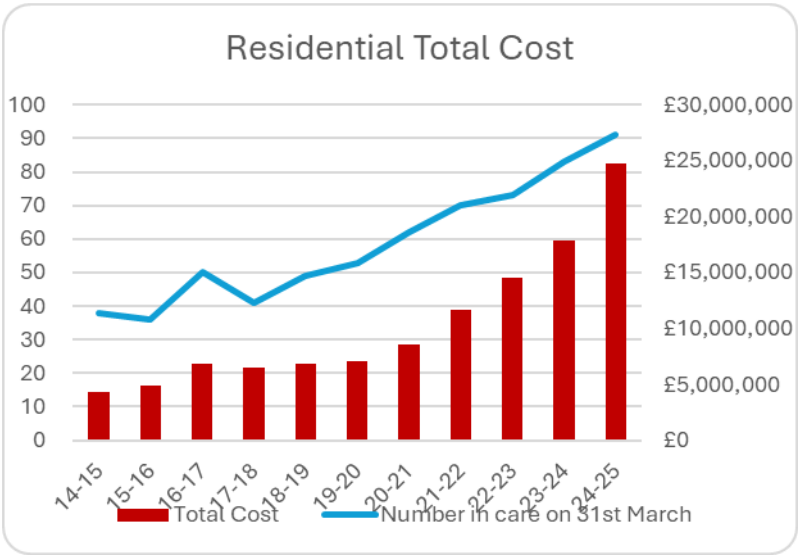
At the end of financial year 24/25 the estimated overspend is £6.410M over budget for residential placements this has reduced by £0.784m since last reported.

Overall cost of packages are increasing due to the complexity of support the young people require as well as standard package cost increases. This is a national issue and market factors such as low supply and high demand have resulted in the costs of residential care packages rising significantly over the last year, meaning that the level of spend is unsustainable at the current rate.

A number of initiatives are taking place to try and address the issue including a High Cost Placement Panel where high cost packages are individually scrutinized to ensure the placement is

right for the young person and at the best available cost for the placement.

The graph below illustrates the rising costs of residential care, for consistency this does not include the costs of Unaccompanied Asylum-Seeking Children (UASC) as these costs were not included previous years.



(ii) **Adult Social Care Directorate**

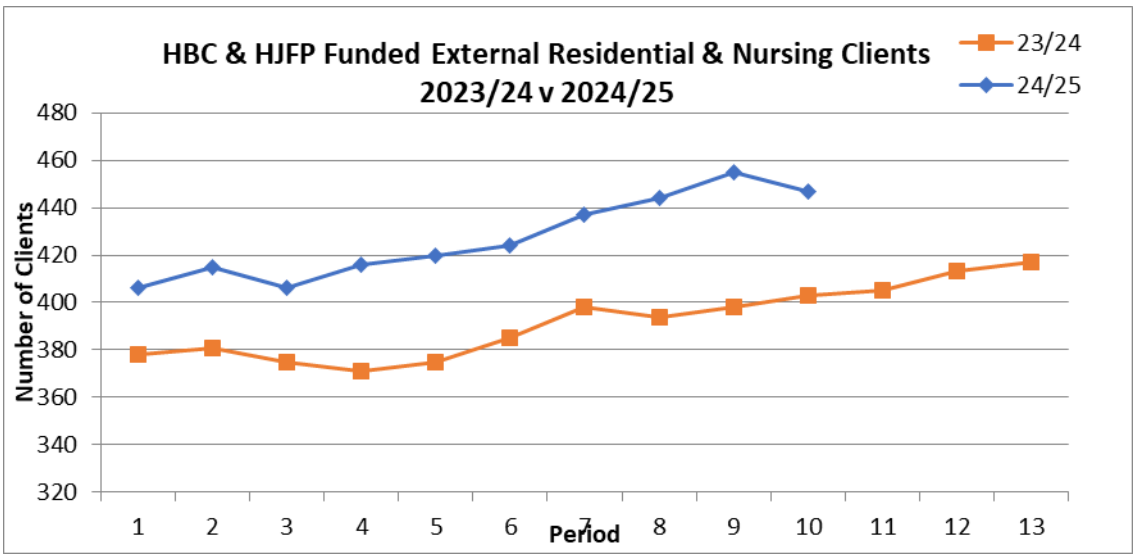
Community Care

At the end of January 2025 expenditure on Community Care services is over budget profile by £2.679m. It is anticipated that at the end of the financial year it will be overspent by £3.527m. This is an increase of £0.585m from the previous position reported at the end of November 2024.

Residential & Nursing Care

There are currently 447 residents in permanent external residential/nursing care as at the end of January 2025 compared to 444 in November, an increase of 0.6%. Compared to the 2023/24 average of 391 this is an increase of 14.3%. The average cost of a package of care in the current year for the same period has increased from £873.48 to £902.99 an increase of 3.3%. Based on this average cost, the 3 additional service users from November to January will cost approximately £0.032m to year end. In addition there is an increase in supplementary invoices during this period, amounting to £0.223m.

The graph below illustrates the demand for permanent placements.



Additional 1:1 hours in care homes currently cost the Council £0.023m per week. Spend to date is £0.596m for 30 individuals (27,432hrs), the forecast to year end is circa £0.803m.

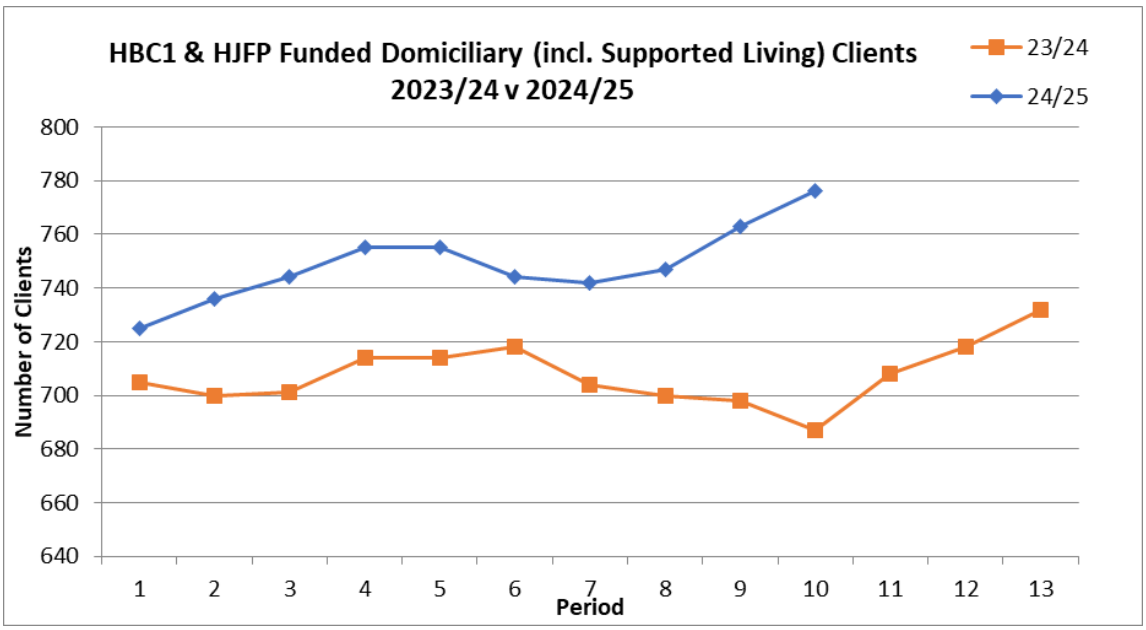
There are 76 care homes charging an additional payment over and above the contracted framework bed price. The current cost of additional payments is £0.012m per week, circa £0.610m per annum.

Domiciliary Care & Supported Living

There are currently 776 service users receiving a package of care at home compared to 747 in November, an increase of 29 (3.8%). However, the average number of service users during 2023/24 was 707, so there has been an increase of 9.8% demonstrating that demand for the service has increased this financial year.

The average cost of a package of care has increased by 5.3% from £450.89 to £475.14.

The graph below illustrates the demand for the service from April 2023 to date.

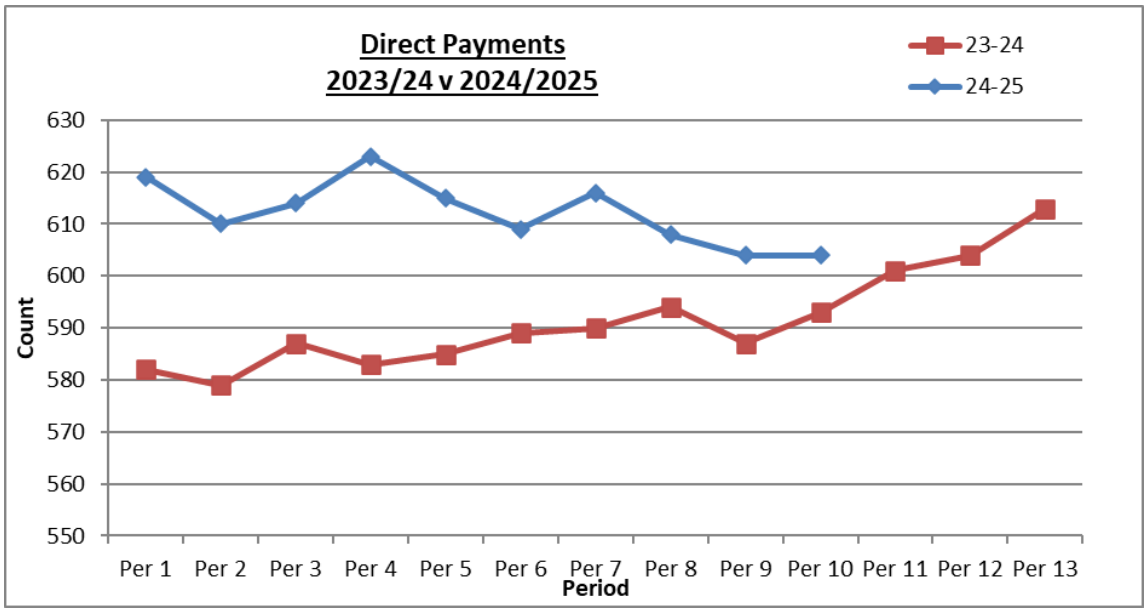


Direct Payments

In January 604 clients received a Direct Payment (DP) compared with 608 in November, a decrease of 0.6%. However, the average number of DP's in 2023/24 was 591, therefore there has been an increase of 2.2% on last year's average.

The average cost of a package of care has decreased since November from £471.94 to £438.54 in January, a reduction of 7.1%.

The forecast position for Direct Payments assumes an amount of £1.6m will be recovered from service users following an audit to seek assurance the DP is spent in line with their care and support needs. Variations to the amount recovered will directly affect the forecast.



Care Homes

The spend to 31 January 2025 across the Division is over budget profile by £1.020m. The forecast for the end of 2024/25 financial year is an estimated outturn position of £1.159m over budget. This is assuming the level of agency staffing continues at a similar rate and includes higher spend assumptions later in the financial year due to winter pressures surrounding staffing and utilities.

Recruitment of staff is a continued pressure across the care homes, where there remains a high number of staff vacancies. A proactive rolling recruitment exercise is ongoing, supported by HR.

Due to pressures with recruitment and retention in the sector, heavy reliance is being placed on overtime and expensive agency staff to support the care homes. At the end of January 2025 total agency spend across the care homes reached £3.034m, the cost of which has partially been offset by staff vacancies.

(iii) **Education, Inclusion and Provision**

Schools Transport is the main budget pressure for the Education, Inclusion and Provision Department. The Council has a statutory responsibility to provide Special Educational Needs (SEN) pupils with transport. This is split into two main areas of SEN pupils attending In-Borough and Out-of-Borough Schools.

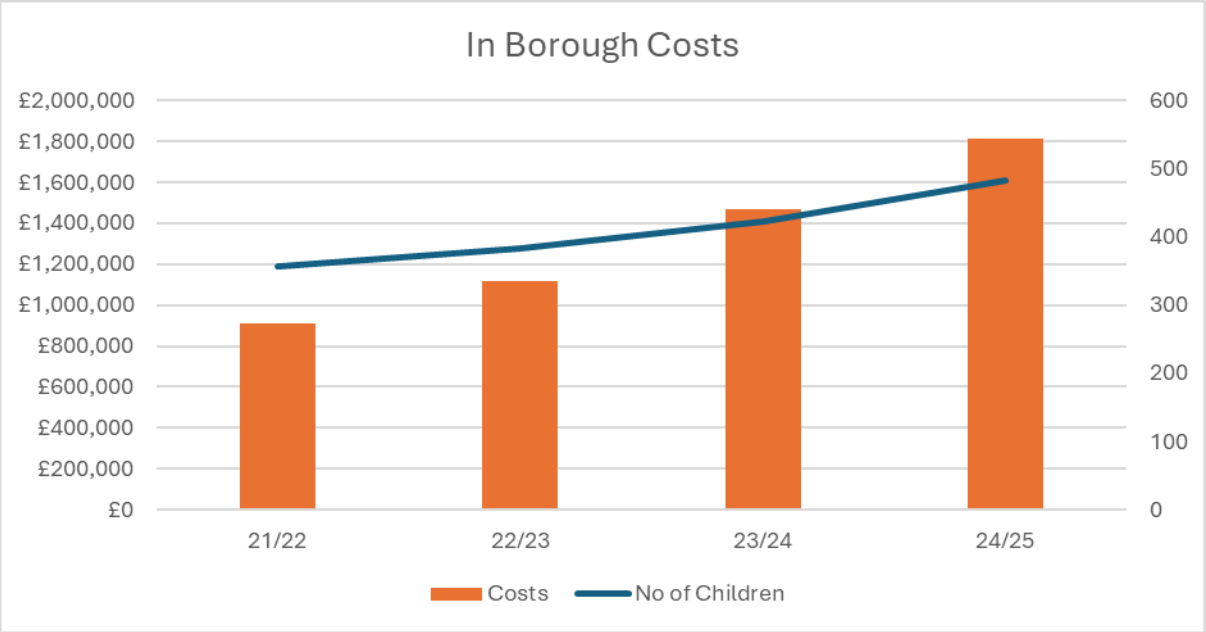
The table below illustrates the split between the two areas, and how each areas spend compares to the budget.

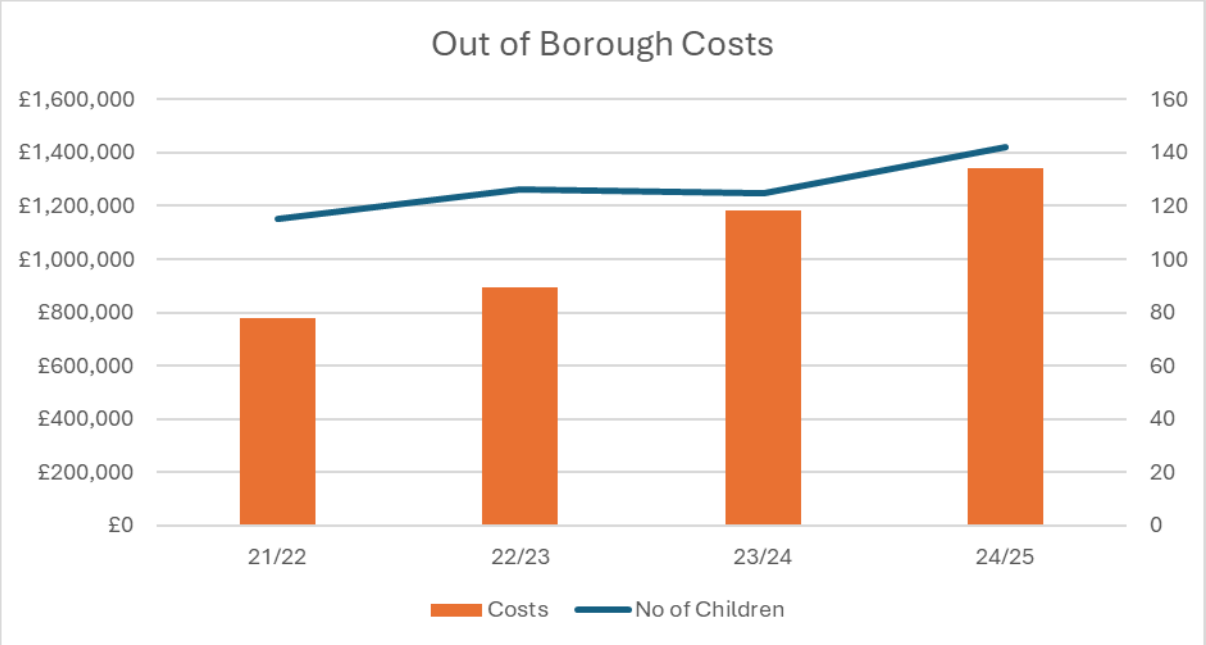
2024-25 as at Jan-25					
Area	**Number of Users**	**Budget £000**	**Projected Spend £000**	**Variance £000**	**Average Cost per User**
In Borough	482	1826	1812	14	£3,759.16
Out of Borough	142	491	1343	(852)	£9,459.70
Total	**624**	**2317**	**3155**	**(838)**	

The current records show 624 service users, the majority of which attend schools within the Borough. The Out of Borough overspend has increased from the previous reporting period from £0.797m to £0.852m.

During the current Academic year, it is anticipated that these figures will continue to rise, based upon historic information. The demand for the School Transport Service continues to increase in line with the increasing number of pupils with SEN within the Borough.

The graphs below show the trend in the number of SEN children using this service and the associated costs.





A further pressure on the departmental budget for the year relates to Psychology and SEN Assessment services provided to schools. For a number of years these costs have been funded by the Dedicated Schools Grant (DSG). The Department for Education have recently advised that these costs cannot be DSG funded as

they are outside of scope in meeting the grant conditions. It is therefore currently assumed this cost will fall upon the Council's budget at a cost of £0.860m, until at such time other sources of funding are found.

Income figures have changed compared to previous reports due to a review of departmental earmarked reserves and £0.420m being released to the General Fund.

(iv) **ICT Department**

At the end of the 2024/25 financial year it is forecasted that the ICT and Administration Department will be over the approved budget profile by £0.596m.

The main pressures faced by the ICT and Administration Department is in relation to the IT infrastructure, with the move to Microsoft 365, staff have been able to utilise much more efficient hardware. However, the software utilised by the new hardware is at a premium and will be a continuous pressure the Council will need to react to as prices fluctuate.

(v) **Community and Greenspaces Department**

The net departmental expenditure is forecast to be £0.819m under budget at the end of the 2024/25 financial year. This is an improved position from the expected £0.616m forecasted at the end of November 2024.

The largest contributor to the underspend is in relation to spend on Employees, which is currently forecast to be £0.951m under the approved budget profile by the end of the financial year. There are several restructures taking place across the Department, therefore, in order to facilitate these a number of posts are currently being held vacant until the new structure is implemented. The most notable of these being the new structure being implemented when the new Halton Leisure Centre opens.

Collection Fund

3.15 The council tax collection rate through to the end of January 2025 is 89.01% which is 0.08% lower than the collection rate at the same point last year.

Debt relating to previous years continues to be collected, and the Council utilises powers through charging orders and attachment to earnings/benefits to secure debts. £2.205m (12.52%) has so far been collected this year in relation to previous years' debt.

3.16 Business rate collection through to the end of November 2024 is 92.70% which is 3.21% higher than the collection rate at the same point last year.

£2.057m has so far been collected this year in relation to previous years' debt.

Review of Reserves

3.17 As at 31 January 2025 the Council's General Reserve is unchanged from the previous period at £5.149m, which represents 3.44% of the Council's 2024/25 net budget. This is considered to be a minimum level.

3.18 There is a regular review of earmarked reserves undertaken to determine whether they can be released in part or in full to assist with funding the Council's current financial challenges, recognising that this only provides one-year funding solutions.

Reserves Summary

3.19 A summary breakdown of the Council's reserves is presented in the table below, showing the balance of reserves as at 31 January 2025.

Summary of General and Earmarked Reserves	
Reserve	**Reserve Value £m**
Corporate:	
General Fund	5.149
Transformation Fund	6.355
Capital Reserve	0.499
Insurance Reserve	1.000
Specific Projects:	
Adult Social Care	0.507
Fleet Replacement	0.454
Highways Feasibility Costs	0.102
Local Development Framework	0.494
Community & Environment	0.253
Mersey Valley Golf Club	0.483
Mersey Gateway	27.222
Various Other	0.554
Grants:	
Building Schools for the Future	6.529
Public Health	0.232
Supporting Families Performance Payments	0.114
Children's & Education	0.741
Domestic Abuse	1.186
Enterprise & Employment	0.112
Various Other	0.767
Total Earmarked Reserves	**52.753**

3.20 Held within the Transformation Reserve is £6.355m, set aside to help fund future balanced budgets, fund overspends, and meet a range of

potential spending commitments in future years associated with delivering the Transformation Programme.

3.21 The above table shows the diminishing level of reserves available to assist with funding any future budget overspends and balancing future budgets. Only the £11.484m of the General Fund and Transformation Reserve could now be used for these purposes, as all remaining reserves are committed for specific purposes. Use of these reserves will help contribute towards reducing the Council's overall forecast overspend position and mitigate against the level of Exceptional Financial Support required.

Capital Spending

3.22 Council approved the 2024/25 Capital Programme on 6 March 2024. Since then the capital programme has been revised to reflect a number of changes in spending profiles and funding as schemes have developed. Included in the list below is a number of schemes which have been revised where profiles have been moved forward to 2025/26. Appendix 3 brings all the separate elements together and report on the Council's total planned capital programme expenditure over the next three years. The schemes which have been revised within the programme are as follows:

I. Basic Need Projects
II. SEND capital allocation
III. SCA unallocated
IV. Childcare Expansion
V. Stair Lifts
VI. Joint Funding RSL Adaptations
VII. Madeline McKenna Refurbishment
VIII. St Lukes Care Home
IX. St Patricks Care Home
X. Foundary Lane Residential Area
XI. Sci-tech Daresbury Project Violet
XII. Port of Weston
XIII. Street Lighting - Structural Maintenance
XIV. Street Lighting – Upgrades
XV. Risk Management
XVI. Fleet Replacements
XVII. Mersey Gateway Handback Land
XVIII. Halton Smart Microgrid

3.23 Capital spending at 31 January 2025 totalled £33.9m, which represents 66.9% of the total revised Capital Programme of £50.7m (which assumes a 20% slippage between years).

Approved Savings

3.24 On 02 February 2023, Council approved savings proposals against the budget for the three year period 01 April 2023 to 31 March 2026. Appendix 4 lists those savings covering 2024/25 and 2025/26, together

with RAG rated information on progress to date with developing and implementing the target savings.

4.0 CONCLUSIONS

4.1 As at 31 January 2025, net revenue spend is forecast to be £18.906m over the budget for the year.

4.2 It is clear that Council reserves alone will not be sufficient to fund this pressure. As a result of this position and future budget challenges, the Council has successfully applied to Government for Exceptional Financial Support (EFS).

4.3 Departments should continue to ensure that all spending continues to be restricted throughout the remainder of the year, to ensure that the forecast outturn overspend is minimised as far as possible and future spending is brought in line with budget. This will assist with minimising the ongoing cost of EFS borrowing.

5.0 POLICY IMPLICATIONS

5.1 None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Improving Health, Promoting Wellbeing and Supporting Greater Independence**

6.2 **Building a Strong, Sustainable Local Economy**

6.3 **Supporting Children, Young People and Families**

6.4 **Tackling Inequality and Helping Those Who Are Most In Need**

6.5 **Working Towards a Greener Future**

6.6 **Valuing and Appreciating Halton and Our Community**

There are no direct implications, however, the revenue budget and capital programme support the delivery and achievement of all the Council's priorities above.

7.0 RISK ANALYSIS

7.1 There are a number of financial risks within the budget. However, the Council has internal controls and processes in place to ensure that spending remains in line with budget as far as possible.

7.2 A budget risk register of significant financial risks has been prepared and is included at Appendix 5.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None.

9.0 CLIMATE CHANGE IMPLICATIONS

9.1 None

10.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1072

10.1 There are no background papers under the meaning of the Act

Summary of Revenue Spending to 31 January 2025 **APPENDIX 1**

Directorate / Department	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance (Overspend) £'000	**January 2025 Forecast Outturn (o'spend) £'000**		**November 2024 Forecast Outturn (o'spend) £'000**
Adult Social Care	22,925	19,355	19,734	(379)	(467)		(456)
Care Homes`	9,989	8,332	9,352	(1,020)	(1,159)		(1,245)
Community Care	16,460	15,255	17,934	(2,679)	(3,527)		(2,951)
Complex Care Pool	10,706	5,191	4,843	348	189		234
Adults Directorate	**60,080**	**48,133**	**51,863**	**(3,730)**	**(4,964)**		**(4,418)**
Finance	5,030	5,143	4,958	185	95		(162)
Legal & Democratic Services	-621	-482	492	(974)	(1,101)		(1,137)
ICT & Support Services	2,278	981	1,475	(494)	(596)		(657)
Chief Executives Delivery Unit	1,169	845	924	(79)	(90)		(14)
Chief Executives Directorate	**7,856**	**6,487**	**7,849**	**(1,362)**	**(1,692)**		**(1,970)**
Children & Families	38,866	28,142	36,665	(8,523)	(10,087)		(11,702)
Education, Inclusion & Provision	9,771	6,924	7,932	(1,008)	(1,240)		(1,598)
Children's Directorate	**48,637**	**35,066**	**44,597**	**(9,531)**	**-11,327**		**(13,300)**
Community & Greenspace	25,369	18,364	17,865	499	819		616
Economy, Enterprise & Property	2,335	1,031	944	87	116		123
Planning & Transportation	8,405	5,519	5,026	493	336		528
Environment & Regeneration Directorate	**36,109**	**24,914**	**23,835**	**1,079**	**1,271**		**1,267**
Corporate & Democracy	-4,477	-4,657	-2,649	(2,008)	(2,272)		(2,418)
Public Health Directorate	1,291	-962	-1,032	70	82		82
Total Operational Net Spend	**149,496**	**108,981**	**124,463**	**(15,482)**	**(18,902)**		**(20,757)**

Adult Social Care

APPENDIX 2

	Annual Budget	Budget to Date	Actual Spend	Variance (Overspend)	Forecast Outturn
	£'000	£'000	£'000	£'000	£'000
Expenditure					
Employees	17,595	14,633	13,695	938	1,127
Agency- Covering Vacancies	4	3	1,066	(1,063)	(1,275)
Premises	482	435	401	34	41
Supplies & Services	769	673	864	(191)	(229)
Aids & Adaptations	37	30	37	(7)	(9)
Transport	242	201	328	(127)	(149)
Food & Drink Provisions	214	178	166	12	14
Supported Accommodation and Services	1,385	1,154	979	175	210
Emergency Duty Team	115	36	36	0	0
Transfer To Reserves	210	0	0	0	0
Contracts & SLAs	1,090	910	906	4	6
Housing Solutions Grant Funded Schemes					
Homelessness Prevention	502	418	407	11	0
Rough Sleepers Initiative	167	75	67	8	0
Trailblazer	72	43	43	0	0
Total Expenditure	**22,884**	**18,789**	**18,995**	**(206)**	**(264)**
Income					
Fees & Charges	-910	-754	-732	(22)	(27)
Sales & Rents Income	-480	-423	-456	33	39
Reimbursements & Grant Income	-2,058	-1,051	-1,072	21	25
Capital Salaries	-121	-91	-91	0	0
Transfer from Reseres	-164	-164	-164	0	0
Housing Schemes Income	-703	-661	-666	5	0
Total Income	**-4,436**	**-3,144**	**-3,181**	**37**	**37**
Net Operational Expenditure	**18,448**	**15,645**	**15,814**	**(169)**	**(227)**
Recharges					
Premises Support	529	441	441	0	0
Transport Support	582	475	685	(210)	(240)
Central Support	3,465	2,887	2,887	0	0
Asset Rental Support	13	0	0	0	0
Recharge Income	-112	-93	-93	0	0
Net Total Recharges	**4,477**	**3,710**	**3,920**	**(210)**	**(240)**
Net Departmental Expenditure	**22,925**	**19,355**	**19,734**	**(379)**	**(467)**

Care Homes

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Madeline Mckenna					
Employees	698	582	553	29	30
Agency - covering vacancies	0	0	99	(99)	(119)
Other Premises	101	77	81	(4)	0
Supplies & Services	20	13	19	(6)	(6)
Food Provison	48	36	41	(5)	(1)
Total Madeline Mckenna Expenditure	**867**	**708**	**793**	**(85)**	**(96)**
Millbrow					
Employees	2,057	1,744	1,099	645	665
Agency - covering vacancies	3	3	846	(843)	(952)
Other Premises	129	100	128	(28)	(33)
Supplies & Services	61	45	75	(30)	(31)
Food Provison	78	33	39	(6)	1
Total Millbrow Expenditure	**2,328**	**1,925**	**2,187**	**(262)**	**(350)**
St Luke's					
Employees	2,883	2,451	1,920	531	685
Agency - covering vacancies	433	433	1,257	(824)	(999)
Other Premises	172	132	214	(82)	(89)
Supplies & Services	60	41	82	(41)	(42)
Reimbursements & other Grant Income	-248	-226	-226	0	0
Private Client Income 1:1	-81	-81	-81	0	0
Food Provison	120	100	117	(17)	(17)
Total St Luke's Expenditure	**3,339**	**2,850**	**3,283**	**(433)**	**(462)**
St Patrick's					
Employees	1,838	1,531	1,030	501	608
Agency - covering vacancies	42	42	832	(790)	(944)
Other Premises	157	121	122	(1)	(3)
Supplies & Services	64	47	42	5	8
Food Provison	122	102	92	10	11
Reimbursements & other Grant Income	-21	-21	-21	0	0
Total St Patrick's Expenditure	**2,202**	**1,822**	**2,097**	**(275)**	**(320)**
Care Homes Divison Management					
Employees	306	254	215	39	73
Supplies & Services	0	0	4	(4)	(4)
Care Home Divison Management	**306**	**254**	**219**	**35**	**69**
Net Operational Expenditure	**9,042**	**7,559**	**8,579**	**(1,020)**	**(1,159)**
Recharges					
Premises Support	264	220	220	0	0
Transport Support	0	0	0	0	0
Central Support	683	553	553	0	0
Asset Rental Support	0	0	0	0	0
Recharge Income	0	0	0	0	0
Net Total Recharges	**947**	**773**	**773**	**0**	**0**
Net Departmental Expenditure	**9,989**	**8,332**	**9,352**	**(1,020)**	**(1,159)**

Community Care

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Residential & Nursing	13,715	11,929	14,050	(2,121)	(2,758)
Domicilary Care & Supported living	12,890	10,130	10,610	(480)	(624)
Direct Payments	14,125	13,063	13,289	(226)	(293)
Day Care	648	497	484	13	22
Total Expenditure	**41,378**	**35,619**	**38,433**	**(2,814)**	**(3,653)**
Income					
Residential & Nursing Income	-13,138	-10,345	-10,412	67	87
Community Care Income	-2,270	-2,000	-2,027	27	40
Direct Payments Income	-1,014	-882	-888	6	10
Income from other CCGs	-466	-446	-481	35	0
Market sustainability & Improvement Grant	-2,796	-2,330	-2,330	0	0
Adult Social Care Support Grant	-5,167	-4,306	-4,306	0	0
War Pension Disregard Grant	-67	-55	-55	0	(11)
Total Income	**-24,918**	**-20,364**	**-20,499**	**135**	**126**
Net Operational Expenditure	**16,460**	**15,255**	**17,934**	**(2,679)**	**(3,527)**

Complex Care Pool

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Intermediate Care Services	5,225	4,089	4,174	(85)	(103)
Oakmeadow	1,831	1,476	1,584	(108)	(129)
Community Home Care First	2,088	1,507	1,402	105	126
Joint Equipment Store	871	715	707	8	9
Development Fund	174	97	0	97	116
Contracts & SLA's	3,255	1,620	1,620	0	0
Inglenook	134	107	83	24	29
HICafs	3,703	2,468	2,275	193	231
Carers Breaks	554	436	332	104	126
Carers centre	371	361	342	19	23
Residential Care	7,265	5,435	5,435	0	0
Domiciliary Care & Supported Living	4,227	3,170	3,170	0	0
Pathway 3/Discharge Access	391	0	0	0	(41)
HBC Contracts	72	73	78	(5)	(6)
Total Expenditure	**30,161**	**21,554**	**21,202**	**352**	**381**
Income					
BCF	-13,484	-11,237	-11,237	0	0
CCG Contribution to Pool	-2,959	-2,387	-2,387	0	0
Oakmeadow Income	-19	-17	-13	(4)	(4)
ASC Discharge Grant Income	-1,631	-1,360	-1,360	0	0
ICB Discharge Grant Income	-1,282	-1,282	-1,282	0	0
Other Income	-80	-80	-80	0	0
Total Income	**-19,455**	**-16,363**	**-16,359**	**(4)**	**(4)**
ICB Contribution Share of Surplus					(188)
Net Operational Expenditure	**10,706**	**5,191**	**4,843**	**348**	**189**

Finance Department

	Annual Budget	Budget to Date	Actual Spend	Variance (Overspend)	Forecast Outturn
	£'000	£'000	£'000	£'000	£'000
Expenditure					
Employees	6,989	5,829	5,713	116	140
Insurances	975	859	685	174	209
Supplies & Services	417	406	479	(73)	(87)
Rent Allowances	35,500	29,583	29,583	0	0
Concessionary Travel	1,748	1,270	1,383	(113)	(136)
LCR Levy	1,748	0	0	0	0
Bad Debt Provision	77	0	0	0	(145)
Non HRA Rent Rebates	70	43	39	4	4
Discretionary Social Fund	106	90	12	78	94
Discretionary Housing Payments	300	199	186	13	16
Household Support Fund Expenditure	2,613	2,371	2,371	0	0
Total Expenditure	**50,543**	**40,650**	**40,451**	**199**	**95**
Income					
Fees & Charges	-335	-252	-254	2	2
Burdens Grant	-60	-62	-85	23	26
Dedicated schools Grant	-144	-16	0	(16)	(19)
Council Tax Liability Order	-581	-507	-604	97	116
Business Rates Admin Grant	-157	0	0	0	0
Schools SLAs	-312	-312	-307	(5)	(5)
LCR Reimbursement	-1,748	0	0	0	0
HB Overpayment Debt Recovery	-400	-325	-201	(124)	(149)
Rent Allowances	-34,700	-28,917	-28,717	(200)	(221)
Non HRA Rent Rebate	-70	-59	-61	2	0
Discretionary Housing Payment Grant	-300	-300	-277	(23)	(23)
Housing Benefits Admin Grant	-498	-415	-407	(8)	(9)
Housing Benefits Award Accuracy	0	-2	-12	10	12
Universal Credits	-5	-4	0	(4)	(5)
Household Support Fund Grant	-2,613	-1,303	-1,303	0	0
VEP Grant	0	0	-7	7	7
CCG McMillan Reimbursement	-87	-65	-70	5	5
Reimbursements & Grant Income	-185	-220	-440	220	263
Transfer from Reserves	-7	-7	-7	0	0
Total Income	**-42,202**	**-32,766**	**-32,752**	**(14)**	**0**
Net Operational Expenditure	**8,341**	**7,884**	**7,699**	**185**	**95**
Recharges					
Premises Support	377	314	314	0	0
Transport Support	0	0	0	0	0
Central Support	2,365	1,971	1,971	0	0
Asset Rental Support	0	0	0	0	0
Recharge Income	-6,053	-5,026	-5,026	0	0
Net Total Recharges	**-3,311**	**-2,741**	**-2,741**	**0**	**0**
Net Departmental Expenditure	**5,030**	**5,143**	**4,958**	**185**	**95**

Legal Services

	Annual Budget	Budget to Date	Actual Spend	Variance (Overspend)	Forecast Outturn
	£'000	£'000	£'000	£'000	£'000
Expenditure					
Employees	1,511	1,321	1,326	(5)	(7)
Agency Related Expenditure	0	0	780	(780)	(871)
Supplies & Services	388	345	306	39	46
Civic Catering & Functions	23	14	4	10	12
Legal Expenses	218	166	365	(199)	(240)
Transport Related Expenditure	11	11	7	4	6
Other Expenditure	0	3	3	0	0
Total Expenditure	**2,151**	**1,860**	**2,791**	**(931)**	**(1,054)**
Income					
School SLA's	-98	-95	-77	(18)	(20)
Licence Income	-304	-230	-228	(2)	(2)
Government Grant	-42	-42	-42	0	0
Reimbursement & Other Grants	-164	-164	-164	0	0
Fees & Charges Income	-74	-65	-44	(21)	(25)
Transfer from Reserves	-27	-27	-27	0	0
Total Income	**-709**	**-623**	**-582**	**(41)**	**(47)**
Net Operational Expenditure	**1,442**	**1,237**	**2,209**	**(972)**	**(1,101)**
Recharges					
Premises Support	53	44	44	0	0
Transport Recharges	0	0	0	0	0
Central Support Recharges	275	229	231	(2)	0
Asset Rental Support Costs	0	0	0	0	0
Support Recharge Income	-2,391	-1,992	-1,992	0	0
Net Total Recharges	**-2,063**	**-1,719**	**-1,717**	**(2)**	**0**
Net Departmental Expenditure	**-621**	**-482**	**492**	**(974)**	**(1,101)**

ICT & Support Services Department

	Annual Budget	Budget to Date	Actual Spend	Variance (Overspend)	Forecast Outturn
	£'000	£'000	£'000	£'000	£'000
Expenditure					
Employees	5,596	4,660	4,444	216	259
Supplies & Services	921	763	1,112	(349)	(420)
Capital Finance	100	84	43	41	49
Computer Repairs & Software	1,724	1,542	1,834	(292)	(350)
Communication Costs	13	0	123	(123)	(147)
Premises	159	130	108	22	27
Transport	3	2	2	0	0
Total Expenditure	**8,516**	**7,181**	**7,666**	**-485**	**-582**
Income					
Fees & Charges	-1,056	-533	-589	56	68
Schools SLA Income	-646	-622	-571	(51)	(62)
Reimbursements & Grant Income	0	3	20	(17)	(20)
Transfer from Reserves	-148	-148	-148	0	0
Total Income	**-1,850**	**-1,300**	**-1,288**	**(12)**	**(14)**
Net Operational Expenditure	**6,666**	**5,881**	**6,378**	**(497)**	**(596)**
Recharges					
Premises Support	550	458	458	0	0
Transport Support	19	18	18	0	0
Central Support	2,380	1,983	1,983	0	0
Asset Rental Support	1,494	0	0	0	0
Support Costs Income	-8,831	-7,359	-7,362	3	0
Net Total Recharges	**-4,388**	**-4,900**	**-4,903**	**3**	**0**
Net Departmental Expenditure	**2,278**	**981**	**1,475**	**(494)**	**(596)**

Chief Executives Delivery Unit

	Annual Budget	Budget to Date	Actual Spend	Variance (Overspend)	Forecast Outturn
	£'000	£'000	£'000	£'000	£'000
Expenditure					
Employees	3,304	2,689	2,776	(87)	(103)
Employees Training	99	82	65	17	21
Apprenticeship Levy	300	242	265	(23)	(27)
Supplies & Services	391	366	312	54	65
Total Expenditure	**4,094**	**3,379**	**3,418**	**-39**	**-44**
Income					
Fees & Charges	-223	-150	-142	(8)	(8)
Schools SLA Income	-565	-559	-522	(37)	(43)
Transfer from Reserves	0	0	-5	5	5
Total Income	**-788**	**-709**	**-669**	**(40)**	**(46)**
Net Operational Expenditure	**3,306**	**2,670**	**2,749**	**(79)**	**(90)**
Recharges					
Premises Support	174	145	145	0	0
Transport	0	0	0	0	0
Central Support	1,209	1,008	1,008	0	0
Asset Rental Support	53	0	0	0	0
HBC Support Costs Income	-3,573	-2,978	-2,978	0	0
Net Total Recharges	**-2,137**	**-1,825**	**-1,825**	**0**	**0**
Net Departmental Expenditure	**1,169**	**845**	**924**	**(79)**	**(90)**

Children & Families

	Annual Budget	Budget to Date	Actual Spend	Variance (Overspend)	Forecast Outturn
	£'000	£'000	£'000	£'000	£'000
Expenditure					
Employees	15,708	12,970	14,646	(1,676)	(1,994)
Other Premises	415	267	277	(10)	(14)
Supplies & Services	1,726	1,966	2,417	(451)	(571)
Transport	360	252	224	28	27
Direct Payments	1,097	822	1,053	(231)	(277)
Commissioned services to Vol Orgs	224	168	168	0	0
Residential Care	18,620	14,049	19,391	(5,342)	(6,410)
Out of Borough Adoption	96	0	0	0	96
Out of Borough Fostering	4,363	3,154	3,930	(776)	(886)
In House Adoption	548	380	272	108	131
Special Guardianship Order	2,510	1,960	1,993	(33)	(39)
In House Foster Carer Placements	2,739	2,150	1,859	291	348
Lavender House Contract Costs	234	176	164	12	15
Home Support & Respite	340	258	270	(12)	(13)
Care Leavers	277	251	378	(127)	(151)
Family Support	53	36	43	(7)	(9)
Contracted services	3	3	3	0	0
Early Years	0	0	0	0	0
Emergency Duty	132	38	72	(34)	(42)
Youth Offending Services	321	129	169	(40)	(47)
Transfer to Reserves	8	0	0	0	0
Total Expenditure	**49,774**	**39,029**	**47,329**	**(8,300)**	**(9,836)**
Income					
Fees & Charges	-33	-13	0	(13)	(14)
Sales Income	-4	-3	0	(3)	(4)
Rents	-81	-70	-70	0	0
Reimbursement & other Grant Income	-832	-904	-766	(138)	(167)
Transfer from reserve	-82	-82	-82	0	20
Dedicated Schools Grant	-50	0	0	0	0
Government Grants	-11,559	-11,260	-11,191	(69)	(86)
Total Income	**-12,641**	**-12,332**	**-12,109**	**(223)**	**(251)**
Net Operational Expenditure	**37,133**	**26,697**	**35,220**	**(8,523)**	**(10,087)**
Recharges					
Premises Support	2,274	1,895	1,895	0	0
Transport	398	332	332	0	0
Central Support Recharges	16	14	14	0	0
Asset Rental Support	0	0	0	0	0
Internal Recharge Income	-955	-796	-796	0	0
Net Total Recharges	**1,733**	**1,445**	**1,445**	**0**	**0**
Net Departmental Expenditure	**38,866**	**28,142**	**36,665**	**(8,523)**	**(10,087)**

Education, Inclusion & Provision

	Annual Budget	Budget to Date	Actual Spend	Variance (Overspend)	Forecast Outturn
	£'000	£'000	£'000	£'000	£'000
Expenditure					
Employees	7,390	6,158	6,318	(160)	(215)
Agency - covering vacancies	0	0	230	(230)	(290)
Agency - addition to establishment	72	60	14	46	58
Premises	14	12	11	1	3
Supplies & Services	4,597	3,041	3,069	(28)	(33)
Independent School Fees	10,201	8,743	8,743	0	0
Schools Contingency	295	295	295	0	0
Transport	43	33	41	(8)	(10)
Schools Transport	2,341	1,433	2,130	(697)	(837)
Early Years Payments	11,419	9,696	9,696	0	0
Early Years Pupil Premium	132	102	102	0	0
Commissioned Services	1,879	1,431	1,525	(94)	(111)
Inter Authority Special Needs	1,164	973	973	0	0
Grants to Voluntary Organisations	110	25	75	(50)	(60)
Capital Financing	4,661	3,507	3,506	1	1
Total Expenditure	**44,318**	**35,509**	**36,728**	**(1,219)**	**(1,494)**
Income					
Fees & Charges Income	-556	-530	-527	(3)	(4)
Government Grant Income	-8,339	-6,838	-6,838	0	0
Dedicated Schools Grant	-25,530	-21,275	-21,275	0	0
Inter Authority Income	-274	-274	-274	0	0
Reimbursements & Other Grant Income	-1,785	-1,343	-1,343	0	0
Schools SLA Income	-436	-374	-396	22	27
Transfers from Reserves	-119	0	-350	350	420
Total Income	**-37,039**	**-30,635**	**-31,003**	**368**	**443**
Net Operational Expenditure	**7,279**	**4,874**	**5,725**	**(851)**	**(1,051)**
Recharges					
Premises Support	344	287	287	0	0
Transport Support	528	427	582	(155)	(186)
Central Support	1,603	1,336	1,338	(2)	(3)
Asset Rental Support	17	0	0	0	0
Recharge Income	0	0	0	0	0
Net Total Recharges	**2,492**	**2,050**	**2,207**	**(157)**	**(189)**
Net Departmental Expenditure	**9,771**	**6,924**	**7,932**	**(1,008)**	**(1,240)**

Community & Greenspaces

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Employees	17,435	14,211	13,419	792	951
Agency - covering vacancies	0	0	182	(182)	(218)
Agency - in addition to establishment	0	0	200	(200)	(240)
Premises	3,455	2,466	2,532	(66)	(78)
Supplies & Services	2,243	1,622	1,748	(126)	(151)
Hired & Contracted Services	854	854	854	0	0
Book Fund	128	111	111	0	0
Food Provisions	388	334	304	30	36
School Meals Food	1,960	1,087	1,192	(105)	(126)
Transport	117	62	100	(38)	(45)
Other Agency Costs	429	425	425	0	0
Other Expenditure	0	0	67	(67)	(67)
Waste Disposal Contracts	7,002	3,562	3,326	236	284
Grants to Voluntary Organisations	64	50	24	26	30
Grants to Norton Priory	174	174	174	0	0
Total Expenditure	**34,249**	**24,958**	**24,658**	**300**	**376**
Income					
Sales Income	-1,373	-1,218	-1,209	(9)	(10)
Fees & Charges Income	-5,490	-4,623	-4,775	152	183
Rental Income	-235	-193	-241	48	57
Markets Income	-910	-738	-716	(22)	(26)
Government Grant Income	-1,628	-1,628	-1,628	0	0
Reimbursements & Other Grant Income	-703	-687	-687	0	0
School SLA Income	-1,313	-563	-563	0	0
School Meals Income	-3,598	-2,127	-2,210	83	100
Internal Fees Income	-322	-214	-293	79	95
Capital Salaries	-173	-129	-58	(71)	(85)
Transfers From Reserves	-15	-15	-15	0	202
Total Income	**-15,760**	**-12,135**	**-12,395**	**260**	**516**
Net Operational Expenditure	**18,489**	**12,823**	**12,263**	**560**	**892**
Recharges					
Premises Support	1,675	1,396	1,396	0	0
Transport	2,257	1,855	1,916	(61)	(73)
Central Support	3,897	3,247	3,247	0	0
Asset Rental Support	199	0	0	0	0
HBC Support Costs Income	-1,148	-957	-957	0	0
Net Total Recharges	**6,880**	**5,541**	**5,602**	**(61)**	**(73)**
Net Departmental Expenditure	**25,369**	**18,364**	**17,865**	**499**	**819**

Economy, Enterprise & Property

	Annual Budget	Budget to Date	Actual Spend	Variance (Overspend)	Forecast Outturn
	£'000	£'000	£'000	£'000	£'000
Expenditure					
Employees	5,075	4,438	3,991	447	536
Agency - covering vacancies	0	0	349	(349)	(407)
Repairs & Mainenance	1,706	1,478	1,560	(82)	(98)
Premises	136	120	120	0	0
Energy & Water Costs	1,248	920	830	90	108
NNDR	690	684	659	25	30
Rents	173	133	128	5	6
Economic Regeneration Activities	21	16	16	0	0
Security	544	417	473	(56)	(67)
Supplies & Services	506	305	335	(30)	(36)
Supplies & Services - Grant	2,090	812	812	0	0
Grants to Voluntary Organisations	75	107	107	0	0
Capital Finance	0	0	0	0	0
Transfer to Reserves	185	186	185	1	1
Total Expenditure	**12,449**	**9,616**	**9,565**	**51**	**73**
Income					
Fees & Charges Income	-987	-711	-771	60	72
Rent - Commercial Properties	-872	-758	-758	0	0
Rent - Investment Properties	-38	-32	-33	1	1
Government Grant	-2,510	-1,714	-1,714	0	0
Reimbursements & Other Grant Income	-193	-510	-492	(18)	(22)
Schools SLA Income	-227	-223	-210	(13)	(15)
Recharges to Capital	-295	-239	-243	4	5
Transfer from Reserves	-1,120	-1,165	-1,167	2	2
Total Income	**-6,242**	**-5,352**	**-5,388**	**36**	**43**
Net Operational Expenditure	**6,207**	**4,264**	**4,177**	**87**	**116**
Recharges					
Premises Support	2,074	1,728	1,728	0	0
Transport Support	30	22	22	0	0
Central Support	1,947	1,623	1,623	0	0
Asset Rental Support	4	0	0	0	0
Recharge Income	-7,927	-6,606	-6,606	0	0
Net Total Recharges	**-3,872**	**-3,233**	**-3,233**	**0**	**0**
Net Departmental Expenditure	**2,335**	**1,031**	**944**	**87**	**116**

Planning & Transportation Department

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Employees	5,814	4,831	4,440	391	469
Agency - covering vacancies	110	53	120	(67)	(81)
Agency - in addition to establishment	24	2	75	(73)	(88)
Efficiency Savings	-150	-125	0	(125)	(150)
Premises	193	169	127	42	51
Hired & Contracted Services	59	0	208	(208)	(166)
Planning Appeal Decision	0	0	0	0	(300)
Supplies & Services	144	178	340	(162)	(195)
Street Lighting	1,662	862	884	(22)	(25)
Highways Maintenance - Routine & Reactive	1,772	1,215	1,411	(196)	(235)
Highways Maintenance - Programmed Works	1,908	1,028	738	290	349
Fleet Transport	1,455	1,202	1,184	18	21
Bus Support - Halton Hopper Tickets	23	22	15	7	8
Bus Support	498	746	746	0	0
Agency Related Expenditure	8	8	49	(41)	(41)
Grants to Voluntary Organisations	31	31	31	0	0
NRA Levy	74	74	73	1	2
LCR Levy	1,059	794	794	0	0
Contribution to Reserves	359	359	359	0	0
Total Expenditure	**15,043**	**11,449**	**11,594**	**(145)**	**(381)**
Income					
Sales & Rents Income	-97	-80	-148	68	82
Planning Fees	-826	-691	-442	(249)	(299)
Building Control Fees	-245	-204	-190	(14)	(17)
Other Fees & Charges	-908	-760	-1,169	409	491
Grants & Reimbursements	-206	-131	-131	0	0
Government Grant Income	-240	-243	-253	10	0
Halton Hopper Income	-24	-20	-8	(12)	(15)
Recharge to Capital	-562	-91	-91	0	(36)
LCR Levy Reimbursement	-1,059	-1,036	-1,036	0	0
Contribution from Reserves	-1,036	-794	-794	0	0
Total Income	**-5,203**	**-4,050**	**-4,262**	**212**	**206**
Net Operational Expenditure	**9,840**	**7,399**	**7,332**	**67**	**(175)**
Recharges					
Premises Recharges	560	467	467	0	0
Transport Recharges	749	634	648	(14)	(17)
Central Recharges	1,534	1,278	1,278	0	0
Asset Charges	851	0	0	0	0
HBC Support Costs Income	-5,129	-4,259	-4,699	440	528
Net Total Recharges	**-1,435**	**-1,880**	**-2,306**	**426**	**511**
Net Departmental Expenditure	**8,405**	**5,519**	**5,026**	**493**	**336**

Corporate & Democracy

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Employees	412	343	293	50	17
Contracted Services	39	32	35	(3)	0
Supplies & Services	119	108	110	(2)	(23)
Premises Expenditure	5	5	7	(2)	0
Transport Costs	1	1	8	(7)	(9)
Members Allowances	983	819	823	(4)	0
Interest Payable - Treasury Management	1,341	1,118	1,826	(708)	(849)
Interest Payable - Other	115	96	179	(83)	(100)
Bank Charges	132	99	203	(104)	(100)
Audit Fees	348	261	27	234	0
Contingency	538	538	0	538	667
Capital Financing	2,409	2	2	0	301
Debt Management Expenses	20	17	4	13	0
Precepts & Levies	240	200	175	25	30
Transformation Efficiency Savings	-4,000	-3,333	0	(3,333)	(3,871)
Total Expenditure	**2,702**	**306**	**3,692**	**(3,386)**	**(3,937)**
Income					
Interest Receivable - Treasury Management	-4,152	-3,460	-4,358	898	1,078
Interest Receivable - Other	-19	-16	-16	0	0
Other Fees & Charges	-158	-128	-85	(43)	(61)
Grants & Reimbursements	-255	-85	-418	333	333
Government Grant Income	-377	-314	-504	190	315
Total Income	**-4,961**	**-4,003**	**-5,381**	**1,378**	**1,665**
Net Operational Expenditure	**-2,259**	**-3,697**	**-1,689**	**(2,008)**	**(2,272)**
Recharges					
Premises Support	21	17	17	0	0
Transport	0	0	0	0	0
Central Support	1,016	889	889	0	0
Asset Rental Support	0	0	0	0	0
HBC Support Costs Income	-3,026	-1,866	-1,866	0	0
Net Total Recharges	**-1,989**	**-960**	**-960**	**0**	**0**
Net Departmental Expenditure	**-4,248**	**-4,657**	**-2,649**	**(2,008)**	**(2,272)**

Public Health

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Employees	5,419	3,914	3,913	1	1
Agency - covering vacancies	0	0	0	0	0
Other Premises	6	0	0	0	0
Supplies & Services	388	283	248	35	42
Contracts & SLA's	8,112	6,218	6,188	30	36
Transport	4	3	2	1	1
Transfer to Reserves	19	19	19	0	0
Other Agency	24	24	24	0	0
Total Expenditure	**13,970**	**10,461**	**10,394**	**67**	**80**
Income					
Fees & Charges	-88	-116	-116	0	0
Reimbursements & Grant Income	-574	-559	-559	0	0
Transfer from Reserves	-1,714	-1,714	-1,714	0	0
Government Grant Income	-12,193	-11,984	-11,984	0	0
Total Income	**-14,569**	**-14,373**	**-14,373**	**0**	**0**
Net Operational Expenditure	**-599**	**-3,912**	**-3,979**	**67**	**80**
Recharges					
Premises Support	149	125	125	0	0
Transport Support	22	18	20	(2)	(2)
Central Support	2,387	1,990	1,990	0	0
Asset Rental Support	0	0	0	0	0
Recharge Income	-669	-557	-557	0	0
Net Total Recharges	**1,889**	**1,575**	**1,577**	**(2)**	**(2)**
Net Departmental Expenditure	**1,291**	**-2,337**	**-2,402**	**65**	**78**

Capital Programme as at 31 January 2025 **Appendix 3**

Scheme Detail	2024/25 Original Allocation £000	2024/25 Revised Allocation £000	Q1 Spend £000	Q2 Spend £000	Q3 Spend £000	Q4 Spend £000	Total Spend £000	Allocation remaining £000	2025/26 Allocation £000	2026/27 Allocation £000
Childrens Directorate										
Capital Repairs	749.0	749.0	151.0	531.0	50.0	1.0	733.0	16.0	550.0	
Basic Need Projects	600.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	600.8	
SEND capital allocation	3,355.2	1,529.2	178.0	519.0	356.0	65.0	1,118.0	411.2	1,781.0	
SCA unallocated	255.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	448.0	
Family Hubs & Start for Life	53.2	110.4	1.3	54.1	10.0	27.7	93.1	17.4		
Childcare Expansion	314.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	314.8	
Childrens Directorate Total	**5,328.6**	**2,388.6**	**330.3**	**1,104.1**	**416.0**	**93.7**	**1,944.1**	**444.6**	**3,694.6**	**0.0**
Adults Directorate										
Halton Carers Centre Refurbishment	199.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Grants - Disabled Facilities	600.0	1,050.0	353.0	227.0	157.0	147.0	884.0	166.0	600.0	600.0
Stair Lifts	270.0	250.0	66.0	23.0	62.0	50.0	201.0	49.0	270.0	270.0
Joint Funding RSL Adaptations	270.0	250.0	53.0	24.0	81.0	49.0	207.0	43.0	270.0	270.0
Telehealthcare Digital Switchover	0.0	135.0	60.0	0.0	20.0	-20.0	60.0	75.0		
Oakmeadow & Peelhouse Network Improvements	0.0	40.0	0.0	0.0	0.0	0.0	0.0	40.0		
Madeline McKenna Refurbishment	0.0	120.0	9.0	73.0	2.0	7.0	91.0	29.0		
Millbrow Refurbishment	0.0	50.0	26.0	8.0	0.0	12.0	46.0	4.0		
St Lukes Care Home	0.0	120.0	10.0	14.0	7.0	74.0	105.0	15.0		
St Patricks Care Home	1,200.0	150.0	14.0	16.0	-1.0	86.0	115.0	35.0		
Adults Directorate Total	**2,539.0**	**2,165.0**	**591.0**	**385.0**	**328.0**	**405.0**	**1,709.0**	**456.0**	**1,140.0**	**1,140.0**

Capital Programme as at 31 January 2025 continued

Scheme Detail	2024/25 Original Allocation	2024/25 Revised Allocation	Q1 Spend	Q2 Spend	Q3 Spend	Q4 Spend	Total Spend	Allocation remaining	2025/26 Allocation	2026/27 Allocation
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Environment & Regeneration Directorate										
Stadium Minor Works	30.0	30.0	7.9	7.7	0.0	22.2	37.8	-7.8	30.0	30.0
Halton Leisure Centre	8,997.0	8,997.0	2,030.0	3,045.4	3,229.2	469.0	8,773.6	223.4		
Children's Playground Equipment	67.8	67.8	1.0	1.0	40.0	0.0	42.0	25.8	65.0	65.0
Landfill Tax Credit Schemes	340.0	340.0	0.0	0.0	0.0	0.0	0.0	340.0	340.0	340.0
Upton Improvements	13.0	13.0	0.0	0.0	0.0	0.0	0.0	13.0		
Crow Wood Park Play Area	12.0	12.0	0.0	0.0	0.0	0.0	0.0	12.0		
Open Spaces Schemes	600.0	600.0	130.0	154.4	135.0	-11.0	408.4	191.6	600.0	600.0
Runcorn Town Park	468.6	468.6	0.0	6.8	0.0	3.0	9.8	458.8	280.0	280.0
Spike Island / Wigg Island	1,933.5	1,933.5	2.4	4.4	38.0	0.0	44.8	1,888.7		
Pickerings Pasture Cafe	503.0	503.0	9.7	1.2	1.1	0.0	12.0	491.0		
Replacement Cremator Widnes	308.0	308.0	0.0	77.3	7.0	0.0	84.3	223.7		
Litter Bins	20.0	20.0	0.0	0.0	0.0	0.0	0.0	20.0	20.0	20.0
3MG	134.5	134.5	0.0	0.0	0.0	0.0	0.0	134.5		
Murdishaw redevelopment	21.2	21.2	5.4	0.0	0.0	0.0	5.4	15.8		
Equality Act Improvement Works	293.2	93.2	8.7	17.6	59.6	3.8	89.7	3.5	300.0	300.0
Foundary Lane Residential Area	1,160.0	1,240.0	1.8	464.8	2.3	11.0	479.9	760.1		
Town Deal	11,352.9	11,552.9	174.9	261.8	940.0	588.0	1,964.7	9,588.2	7,190.4	
Property Improvements	360.2	460.5	4.3	131.1	286.6	136.3	558.3	-97.8	200.0	200.0
Runcorn Station Quarter	484.7	76.0	0.0	60.5	15.5	0.0	76.0	0.0		
Waterloo Building	0.0	75.0	0.0	0.0	0.0	1.3	1.3	73.7		
UK Shared Prosperity Fund	178.2	178.2	0.0	0.0	12.2	152.0	164.2	14.0		
Runcorn Waterfront Residential Development	484.7	268.7	8.6	122.9	61.5	0.2	193.2	75.5		
Changing Places	24.1	24.1	2.5	0.1	1.6	0.0	4.2	19.9		
Sci-tech Daresbury Project Violet	2,200.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2,200.0	
Port of Weston	0.0	20.0	0.0	1.3	1.7	0.0	3.0	17.0	3,940.0	
Kingsway Leisure Centre Demolition	0.0	750.0	0.0	30.7	0.0	0.9	31.6	718.4		

Capital Programme as at 31 January 2025 continued

Scheme Detail	2024/25 Original Allocation	2024/25 Revised Allocation	Q1 Spend	Q2 Spend	Q3 Spend	Q4 Spend	Total Spend	Allocation remaining	2025/26 Allocation	2026/27 Allocation
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Bridge and Highway Maintenance	0.0	2,265.6	280.8	313.0	20.0	114.0	727.8	1,537.8		
Runcorn Busway	0.0	0.0	227.4	80.0	371.0	237.0	915.4	-915.4		
ATF3 Murdishaw to Whitehouse	0.0	3,000.0	175.3	363.0	497.0	194.0	1,229.3	1,770.7		
ATF4 Widnes Town Centre Accessibility	0.0	114.5	0.0	0.0	0.0	0.0	0.0	114.5		
A56 Reconstruction (Delph Lane)	0.0	943.7	351.1	0.0	10.0	2.0	363.1	580.6		
Dukesfield ATL (Waterloo Bridge)	0.0	0.0	1.1	0.0	0.0	0.0	1.1	-1.1		
LCWIP Phase 2 Daresbury	0.0	3,861.7	629.3	56.0	15.0	1.0	701.3	3,160.4		
Additional Pothole Funding	0.0	429.1	0.0	0.0	0.0	0.0	0.0	429.1		
CRSTS	5,819.4	5,288.6	1,656.0	884.0	2,184.0	305.0	5,029.0	259.6		
Street Lighting - Structural Maintenance	1,025.6	250.0	0.0	37.0	94.0	21.0	152.0	98.0	975.6	200.0
Street Lighting - Upgrades	969.4	100.0	0.0	0.0	0.0	0.0	0.0	100.0	869.4	
East Runcorn Connectivity	5,851.7	5,851.7	452.5	207.0	810.0	1,670.0	3,139.5	2,712.1	5,851.7	5,851.7
Risk Management	597.8	50.0	4.9	0.0	0.0	0.0	4.9	45.1	667.8	120.0
Fleet Replacements	4,927.4	2,500.0	1,081.8	455.0	256.0	76.0	1,868.8	631.2	3,850.7	
Environment & Regeneration Directorate Total	**49,390.3**	**53,054.5**	**7,247.4**	**6,800.4**	**9,187.5**	**4,085.1**	**27,320.4**	**25,734.1**	**27,380.6**	**8,006.7**
Chief Executives Directorate										
IT Rolling Programme	1,026.9	1,026.9	27.7	668.2	20.0	24.0	739.9	287.0	700.0	700.0
Halton Smart Microgrid	11,000.0	1,000.0	0.0	0.0	128.0	0.0	128.0	872.0	10,000.0	
Transformation Programme	3,740.0	3,740.0	435.0	624.0	712.0	201.0	1,972.0	1,768.0	1,000.0	
Chief Executives Directorate Total	**15,766.9**	**5,766.9**	**462.7**	**1,292.2**	**860.0**	**225.0**	**2,839.9**	**2,927.0**	**11,700.0**	**700.0**
Grand Total	**73,024.8**	**63,375.0**	**8,631.4**	**9,581.7**	**10,791.5**	**4,808.8**	**33,813.4**	**29,561.6**	**43,915.2**	**9,846.7**

Progress Against Agreed Savings

Appendix 4

Adult Social Care

	Service Area	Net Budget £'000	Description of Saving Proposal	Savings Value 24/25 £'000	Savings Value 25/26 £'000	Current Progress	Comments
ASC1	Housing Solutions	474	Remodel the current service based on good practice evidence from other areas.	0	125	✓	Anticipated to be achieved, currently under review.
ASC2	Telehealthcare	680	Explore alternative funding streams such as Health funding or Disabled Facilities Grants.	170	0	U	Currently Under Review
			Increase charges / review income.	170	0	✓	Charges were increased by 40% w.e.f. April 2024, so this should be achieved
			Cease the key safe installation service.	15	0	✗	Service still being provided
ASC17/18	Quality Assurance Team	395	Review the activities of the Quality Assurance Team, given there are fewer providers for domiciliary care and the transfer of four care homes into the Council.	0	0	✓	Saving implemented
			Merge the service with the Safeguarding Unit.	50	0	✓	

ASC16	Shared Lives (Adult Placement Service)	115	Engage with an external agency currently operating Shared Lives to take over the running of this service. It is anticipated that this would provide an improved service.	58	0	U	Service currently still provided in-house, although a balanced budget will be attained for 2024/25 as a result of current temporary savings, and work is ongoing to ensure the 2025/6 structure can achieve the permanent savings target
ASC19	Voluntary Sector Support	N/A	Review the support provided by Adult Social Care and all other Council Departments, to voluntary sector organisations. This would include assisting them to secure alternative funding in order to reduce their dependence upon Council funding. A target saving phased over two years has been estimated.	200	100	✓	Anticipated to be achieved
ASC4	Positive Behaviour Support Service	349	Increase income generated in order to ensure full cost recovery, through increased service contract charges to other councils. Review the Integrated Care Board contribution for Adults, to ensure	100 150	0 0	✓ U	Contracts being re-costed on renewal, saving anticipated to be achieved ICB funding not secured, although a balanced budget will be attained for 2024/25 as a result of current temporary savings, and work is ongoing to ensure the 2025/6 structure can

			the full recovery of related costs.				achieve the permanent savings target
ASC15	Learning Disability Nursing Team	424	Cease provision of this service. The service is a Health related function rather than Adult Social Care, but this is a historical arrangement. The Integrated Care Board would need to consider how they want to provide this function.	424	0	✓	Costs now recharged to the ICB
ASC14	Care Management Community Care Budget	18,982	Attract £500k investment from the pooled budget (BCF) from 2024/25. Undertake work in years 1 and 2 to reduce reliance upon contracted services from 2025/26. Services are currently in the process of being redesigned on a "Strengths Based Approach" ie. focused upon prevention.	500	1,000	U	Position currently being reviewed.

Total Adult Social Care Department	**1,837**	**1,225**		

Finance

Ref.	Service Area	Net Budget £'000	Description of Saving Proposal	Savings Value		Current Progress	Comments
				24/25 £'000	25/26 £'000		
F9	Internal Audit	300	Restructure in light of potential retirements over the next two years within the Internal Audit Team.	0	50	U	No official changes made yet
F13	Discretionary Support Scheme	221	Review the roles, procedures and structure of the team.	25	0	✓	On track
F17	Council Tax	84	Increase the charges applied when a court summons is issued by 30% (£23), to achieve full cost recovery over the three year period.	40	40	✓	On track
Total Finance Department				**65**	**90**		

Legal and Democratic Services

Ref.	Service Area	Net Budget £'000	Description of Saving Proposal	Savings Value		Current Progress	Comments
				24/25 £'000	25/26 £'000		
L4	Marketing, Design and Communications	45	Review the frequency of production of Inside Halton, as part of the wider consideration of the Council's communications strategy required for the Transformation Programme	15		✓	Budget adjusted inline with the savings in the ICT department
Total Legal Services Department				**15**	**0**		

Children and Families

Ref.	Service Area	Net Budget £'000	Description of Saving Proposal	Savings Value		Current Progress	Comments
				24/25 £'000	25/26 £'000		
C1	Ditton and Warrington Road Daycare Centres	52	Closure of Ditton and Warrington Road daycare centres, given the significant on-going net losses at both centres. Sufficient alternative provision exists nearby, as well as in the adjoining nursery schools.	26	0	✓	Early Years has now closed and budget for 24/25 has been removed
C2	Children's Centres	1,293	Review the operation of Windmill Hill Children's Centre, where there is the potential to save on premises and staffing costs.	0	22	U	This is subject to further review as external factors are changing the original review parameters. Potential alternative funding also to be reviewed.
C3	Children with Disabilities and Inglefield	858	Explore the potential for selling Inglefield and then purchase two bungalows within the community to provide a more appropriate setting.	112	0	✗	Amount was removed at budget setting as will not be achieved
Total Children & Families Department				**138**	**22**		

Education, Inclusion and Provision

Ref	Service Area	Net Budget £'000	Description of Saving Proposal	Savings Value		Current Progress	Comments
				24/25 £'000	25/26 £'000		
EIP1	Education Psychology Service	339	There is excess demand from schools for the Education Psychology Service. The service is valued and there is opportunity to expand our offer and generate additional income.	52	0	✓	
EIP2	SEN Assessment Team	82	Consideration will be given to funding the full service costs from the High Needs Block of the Dedicated Schools Grant.	80	0	✗	DSG funding removed as does not comply with grant conditions.
EIP5	Commissioning	148	Review with Health colleagues how the Emotional Health and Wellbeing Service for Children in Care, Care Leavers and Carers could instead be provided by Child and Adolescent Mental Health Services (CAMHS) as they are commissioned by the Integrated Care Board.	148	0	U	To be reviewed.
Total Education, Inclusion and Provision Department				**280**	**0**		

Community and Greenspace

Ref.	Service Area	Net Budget £'000	Description of Saving Proposal	Savings Value		Current Progress	Comments
				24/25 £'000	25/26 £'000		
COMM3	Sport & Recreation	471	Restructuring the roles and responsibilities of the Sports Development Team	36	0	✓	Restructure is currently underway
COMM5	Stadium & Catering Services – School Meals	12	Cease to deliver the school meals service, which has made significant losses of over £200,000 for a number of years and is forecast to make a similar loss by year-end. Work would be undertaken with schools over the next two years to support them to secure an alternative means of delivery, whether in-house or via an external provider.	0	12	✓	The cessation of the service is underway with the majority of schools ending their contracts by the end of the calendar year.
Total Community & Greenspace Department				**36**	**12**		

Economy, Enterprise and Property

Ref.	Service Area	Net Budget £'000	Description of Saving Proposal	Savings Value		Current Progress	Comments
				24/25 £'000	25/26 £'000		
EEP4	Cleaning Services – Council Buildings	580	Review cleaning arrangements, with a focus on only emptying bins and cleaning toilets daily.	100	0	U	A review of the cleaning service is underway with some positions removed from the structure. The full savings will not be achieved until the accommodation review is complete.
EEP2	Caretaking & Security Services	641	A review and restructuring of caretaking arrangements.	52	0	U	The restructure can now take place following the retirement of a member of staff. The full saving will not be made until financial year 25/26
Total Economy, Enterprise & Property Department				**152**	**0**		

Policy, Planning and Transportation

Ref.	Service Area	Net Budget £'000	Description of Saving Proposal	Savings Value		Current Progress	Comments
				24/25 £'000	25/26 £'000		
PPT6	Traffic	N/A	Consider introducing civil traffic enforcement for traffic violations. Employ private sector civil enforcement officers to issue fines and generate income. It would take 12 months to apply for powers from the DFT and put the scheme in place. The Environment & Urban Renewal Policy & Performance Board will consider this via a Topic Group.	150	0		Not currently viable, therefore no income will be generated in the current year as the traffic enforcement will not be carried out.
Total Policy, Planning & Transportation Department				**150**	**0**		

Symbol	Objective
	Indicates that the objective is on course to be achieved within the appropriate timeframe.
	Indicates that it is uncertain or too early to say at this stage whether the milestone/objective will be achieved within the appropriate timeframe.
	Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.

2024/25 Budget Risk Register as at 31 January 2025 **Appendix 5**

Risk No	Risk Identified	Impact	Likelihood	Risk Score	Risk Control Measures	Assessment of Residual Risk with Control Measures Implemented			Responsible Person	Timescale for Review	Progress Comments	Date Updated
						Impact	Likelihood	Risk Score				
1	**Pay costs** • Pay award • Staff Turnover Saving Target • Agency, casuals and overtime • National Living Wage • Pension Costs	4	4	16	• Budget based upon individual staff members/vacancies • Budget monitoring • Contingency • Balances • Medium Term Forecast • Engage with Cheshire Pension Scheme and pension actuary • Recruitment and retention scheme children social care workers. • Social Care Academy for children social care workers • Connect to Halton	3	3	9	ED/SB/Executive Directors	Monthly	2024/25 pay offer accepted and implemented November 2024. •£1290 on all pay points from 1st April •Equivalent to 5.77% on point 2 and 2.5% on point 43 •2.5% on all pay points above 43 and below chief officer level Estimated 4% 2024.25 budget uplift will cover cost of pay award. Connect to Halton scheme went live September 2024, agency and casual appointments to be covered by the scheme.	31/01/25

2	**Redundancy and Early Retirements**	3	3	9	• Benefits Tracking Process • Future savings to take into account cost of redundancy and early retirements. • Seek Government approval to use capital receipts to fund transformation costs. • Transformation Reserve	2	3	6	ED/SB	Quarterly	Tracker created to monitor redundancy costs in current year. Transformation reserve created to cover costs but limited reserves will impact use of this. Look to capitalise compulsory costs where possible where evidence exists it creates in a longer term saving.	31/01/25
3	**Savings not achieved**	4	3	12	• Budget monitoring • Contingency • Reserves / Provisions • Rigorous process in approving savings. • Review of savings at departmental and directorate level • Monthly budget monitoring • Medium Term Financial	4	2	8	RR/ED/SB	Monthly	Savings for 2024/25 have been written into Directorate budgets. Budget savings monitored closely and if necessary offsetting savings sought. Transformation Programme Board meeting on monthly basis to discuss progress against programme.	31/01/25

					Forecast • 2023/24 to 2025/26 savings agreed February 2023. • RAG monitoring of savings included in quarterly monitoring reports. • Transformation saving targets reported monthly through Transformation Programme Board.							
4	**Price inflation**	3	3	9	• Prudent budget provision • Latest forecast information used eg. utilities • Budget monitoring • Contingency • Balances • CPI/RPI monitoring	3	3	9	ED/SB	Monthly	CPI for January 2025 is 3.0% and RPI is 3.6%. Office of Budget Responsibility (OBR) forecast inflation to be 2.6% in 2025 and 2.1% through to 2027. Rates are higher than forecast in September 2024 and remain above	31/01/25

					• MTFS						Governments 2% target.	
5	**Review of LG Finance** • Business rates retention – 100% Pilot and Review • Fair Funding Review • National Public Spending Plans • Social Care Green Paper	4	4	16	• MPs • SIGOMA / LG Futures • Liverpool City Region & Merseyside Treasurers Group • Medium Term Financial Strategy • Member of business rate retention pilot region • Dialogue with DCLG	3	3	9	ED/SB/NS/MW/MG	Weekly/ Monthly	Business rate retention pilot continues through to March 2026. Government are committed to providing more certainty on LG Finances through multi year settlements. Final settlement announced 03 February 2025, funding is higher than within financial forecast.	31/01/25
6	**Treasury Management** • Borrowing • Investment	2	3	6	• Treasury Management Strategy • Link Asset Services advice • Treasury Management planning and monitoring	1	3	3	ED/SB/MG	Daily / Quarterly	Investment rates continue to be high relative to last decade. BoE base rate reduced to 4.5%, Impact of Exceptional Financial Support request to be	31/01/25

					• Attendance at Networking and Benchmarking Groups • Officer Training						assessed with regards to timing of future borrowing.	
7	**Demand led budgets** • Children in Care • Out of borough fostering • Community Care	4	4	16	• Budget monitoring • Contingency • Balances • Review service demand • Directorate recovery groups • Monthly budget monitoring	4	4	16	ED/SB/NS/MW	Monthly	Children in care, numbers and costs continue to exceed budget. Numbers of children in care and with protection plans reviewed on a weekly basis. Community care costs and numbers on increase, reviewed on a regular basis. Investment in Children Services following OFSTED inspection to be monitored with regard to control and reduction of future costs.	31/01/25

8	**Mersey Gateway Costs** • Costs • Toll Income • Funding • Accounting treatment	4	2	8	• Regular monitoring with Crossing Board • Capital reserve • Government Grant • Liquidity Fund	2	1	2	ED/SB/MG	Quarterly	Arrangements in place to monitor spend and availability of liquidity fund.	31/01/25
9	**Council Tax Collection**	3	3	9	• Council tax monitoring on monthly basis • Review of Collection Rate • Collection Fund Balance • Provision for bad debts • Review recovery procedures • Benchmarking	3	2	6	ED/PG/SB/PD/BH/MG	Monthly	Collection rate to 31 January 2025 was 89.01% which is marginally lower than the rate of 89.09% at the same point last year. To 31 January 2025 £2.205m was collected in relation to old year debt.	31/01/25
10	**Business Rates Retention Scheme**	3	3	9	• Review and monitoring of latest business rates income to baseline and estimate for year. • Prudent allowance for	3	1	3	ED/SB/LB/MG	Monthly	Collection rate to 31 January 2025 was 92.7% which is 3.21% higher than the rate at the same point last year. To 31 January 2025	31/01/25

					losses in collection • Prudent provision set aside for losses from valuation appeals • Regular monitoring of annual yield and baseline / budget position • Benchmarking Groups • Review recovery procedures						£2.057m was collected in relation to old year debt.	
11	**Income recovery** • Uncertainty to economy following Brexit, cost of living and high inflation	3	3	9	• Corporate charging policy • Budget monitoring • Contingency • Balances • Income benchmarking	3	2	6	ED/MM/SB	Monthly	Income shortfalls identified and cause of increased concern in certain areas are being closely monitored. Cost of living crisis adds to uncertainty over collection.	31/01/25
13	**Capital Programme** • Costs • Funding • Key Major Projects	4	3	12	• Project Management • Regular monitoring • Detailed financial analysis of new schemes to ensure they	3	2	6	Project Managers/ED /SB/LH	Quarterly	Capital receipts have been fully committed therefore new capital schemes need to bring own funding.	31/01/25

	• Clawback of Grant • Availability and timing of capital receipts • Cashflow • Contractors				are affordable • Targets monitored to minimise clawback of grant. • Contractor due diligence • Dialogue with Government departments.							
14	**Academy Schools** • Impact of transfer upon Council budget • Loss of income to Council Services	2	4	8	• Early identification of school decisions • DfE Regulations • Prudent consideration of financial transactions to facilitate transfer • Services continue to be offered to academies • Transfer Protocol	1	3	3	ED/SB/NS	Monthly	Consideration given in MTFS for loss of funding.	31/01/25
15	**Reserves** • Diminishing reserves, used to balance budget, fund overspend positions.	3	4	12	• Monitored on a quarterly basis, reported to Management Team and Exec Board • Benchmarking	3	3	9	ED/SB	Quarterly	Monitored and reported on a regular basis. Council reserves at historic low levels. Reserves will need to be replenished within future	31/01/25

					• Financial Forecast • Programme to replenish reserves.						budgets	
16	**Budget Balancing** • Council has struggled to achieve a balanced budget position for a number of years. • Forecast for current year is an overspend position of £19m. • Reserves insufficient to balance current year budget. • Before transformation targets, there is a forecast budget gap of £68.5m through to 2028/29.	4	4	16	• Current year budgets monitored on a regular basis. • Forward forecasting through to March 2029 reported on a prudent basis. • Regular conversations with DHLUC re Council's financial position. • LGA to undertake a financial assurance review. • Transformation programme in place.	4	4	16	ED/SB	Ongoing	Updated benchmarking to be reported to better inform Transformation Programme targets.	31/01/25