Scientific and Clinical Advances Advisory Committee (SCAAC) – Minutes

Wednesday 6th June 2026, 10:00am – 2:35pm

Virtual Meeting: Microsoft Teams

Authority members	Present	Tim Child (Chair) Christine Watson Zeynep Gurtin Frances Flinter
	Apologies	Stephen Troup (Deputy Chair) Geeta Nargund
External advisers	Present	Anthony Perry Scott Nelson Peter Rugg-Gunn Veronique Berman Ying Cheong Sarah Martins Da Silva Laura Shallcross
	Apologies	Alison Campbell Asif Muneer
Executive	Present	Julia Chain (Chair of Authority) Clare Ettinghausen (Director of Strategy and Corporate Affairs) Rachel Cutting (Director of Compliance and Information) Dina Halai (Head of Policy, Scientific) Rebecca Taylor (Scientific Policy Manager) Mina Mincheva (Policy Manager, Scientific) Dharmi Deugi (Scientific Policy Officer; Committee Secretariat)
	Apologies	Peter Thompson (Chief Executive)
Observers	Present	Several HFEA staff observed the meeting as relevant to their role or induction into the organisation.

1. Welcome, apologies, declarations of interest

1.1. The Chair welcomed the Committee and reminded members of the advisory role of the SCAAC, highlighting that members should advise the HFEA on any significant implications for licensing and regulation arising out of scientific and clinical developments in assisted conception, embryo research and related areas.

1.2. Declarations of interest were made by:

- Sarah Martins Da Silva (Clinical Reader at the University of Dundee, clinical lead for NHS Tayside fertility services and Person Responsible for Ninewells Assisted Conception Unit) – Involved in research investigating the female reproductive tract microbiome and impact on sperm.

1.3. No further conflicts of interest were declared.

2. Matters arising

2.1. The Executive updated the Committee on the matters arising as laid out in the matters arising for this meeting.

2.2. No further comments were made.

3. Chair's business

3.1. The Chair provided an update from the May 2026 Authority meeting where a paper on embryo testing was presented.

3.2. The Chair informed the Committee that following a query from a clinic regarding a non-invasive ploidy testing technology, the SCAAC chair and members with expertise in embryo testing met separately to consider which licensed activity non-invasive ploidy testing would fall within. The Chair reminded the Committee of Licence Condition T91 which states that 'Clinics may use non-invasive procedures, for example metabolomics, to test and select for the viability of embryos. However, clinics must not use these procedures to test for a specific gene, chromosome, or mitochondrion abnormality without prior authorisation from the Authority'. Members agreed that any clinic wishing to offer testing that derives genetic information about the embryo, including non-invasive methods, would require a HFEA licence for embryo testing, furthermore the SCAAC would need to authorise the use of such non-invasive methods as new authorised processes before they can be used.

3.3. The Chair noted that the Executive are planning the HFEA's Annual Horizon Scanning Meeting, to be held in London during the 42nd Annual Meeting of the European Society of Human Reproduction and Embryology (ESHRE). The meeting is used as an opportunity to discuss scientific developments on the horizon with international experts and regulators.

3.3.1. Topics for discussion at the meeting include:

- Oocyte Rejuvenation: Emerging Interventions to Enhance Egg Quality
  - Speaker: Dr Agata Zielinska, OvoLabs, Germany

- Advances in Oocyte In Vitro Maturation (IVM) – Protocol Evolution and Clinical Practice Implications
  - Speaker: Dr Tuong Manh Ho, MyDuc Hospital, Vietnam
- Non-invasive Ploidy Assessment – Cell Free DNA Genomics and AI Approaches for Embryo Prioritisation
  - Speaker: Dr Christian Ottolini, GenEthyx/UCL, UK
- The Fertility Exposome: Environmental Determinants of Fertility and Clinical Implications
  - Speaker: Professor Paul Fowler, University of Aberdeen, UK

3.4. The HFEA is also holding a session as part of the ESHRE annual meeting main programme. The session, "Past, present, and future: Regulating a changing fertility sector", will examine the changing regulatory environment of the UK fertility sector. The session will be chaired by HFEA Chair Julia Chain and speakers include HFEA Chief Executive, Peter Thompson (past) and SCAAC members, Ying Cheong (present) and Peter Rugg Gunn (future).

3.5. The Committee were informed that the HFEA held a PR (person responsible) Event in April 2026 which included sessions on the changing fertility landscape, HFEA inspections, HFEA fees and incorporating AI into fertility treatment.

3.6. A member reflected on the AI discussion at the PR Event and highlighted the importance of robust regulatory oversight, governance, and data security arrangements for AI technologies used in fertility treatment. The separation of AI from automation and robotics was noted highlighting that while automation may offer operational benefits, AI systems require careful evaluation due to the potential for errors, bias, and unintended consequences in clinical decision-making.

3.7. The Chair informed the Committee that his term as an Authority member, and therefore Chair of the SCAAC, will end in January 2027, and the Department for Health and Social Care were advertising for two new Authority members.

4. Relevant public health developments and research findings

4.1. The Chair informed the Committee that this item provides members with the opportunity to highlight research relevant to the interests and role of the SCAAC, including those relevant to the horizon scanning topics that SCAAC have prioritised, the 'watching brief' topics (February 2025 horizon scanning paper), and for treatment add-ons ratings.

4.2. The Committee considered the following research papers and made the following comments:

- "Add-ons" in medically assisted reproduction treatments | Freepub

4.2.1. The Committee noted that the HFEA is mentioned in the report including reference to the treatment add-ons rating system. The recommendations in the report align with our add-ons rating (where they exist) and/or with relevant professional body guidance.

- Automated oocyte retrieval, denudation, sperm preparation, and ICSI in the IVF laboratory: a proof-of-concept study and report of the first live births | Human Reproduction | Oxford Academic

4.2.2. A member commented that the study provided an excellent example of the level of validation required for proof-of-concept technologies of this nature with the authors describing, where

appropriate, significant pre-clinical validation of the new technologies using a number of animal models before progressing to human studies.

4.2.3. The member further highlighted the large number of declarations within the Conflicts of Interest section. It was recognised that such declarations may become increasingly common in a field with significant commercial potential.

4.2.4. It was noted that this work has generated considerable interest within the field. The research group's previous publication of the first live-birth using a digitally controlled, remotely operated ICSI system has been awarded the RBMO Robert G. Edwards Prize Paper Award for 2025.

- The first Australian evidence-based guidelines on male infertility - Katz - 2025 - Medical Journal of Australia - Wiley Online Library

4.2.5. The Committee noted the study.

- Sperm storage causes sperm senescence in human and non-human animals | Proceedings B | The Royal Society

4.2.6. The Committee noted the study.

- Overview | Fertility problems: assessment and treatment | Guidance | NICE

4.2.7. The Committee noted the study.

- Per- and polyfluoroalkyl substances exposure from preconception to lactation: implications for female fertility, pregnancy complications, and birth outcomes: a narrative review - F&S Reviews

4.2.8. The Committee noted the study.

- Outcomes and efficiency of embryo donation: an 8-year retrospective analysis from a Belgian ART centre | Journal of Assisted Reproduction and Genetics | Springer Nature Link

4.2.9. The Committee noted the study.

- PGT-A is associated with reduced live birth rates in routine practice: evidence from the UK National ART register - ScienceDirect

4.2.10. A member welcomed the publication of research using HFEA data and asked how such research is promoted. The Executive noted that ongoing and completed research projects using HFEA data are published on the data research webpage and also shared through the data research newsletter.

4.2.11. A member commented that the study covered treatment cycles undertaken between 2012 and 2018 and suggested that more recent data would be valuable. The member also highlighted that the study was observational in nature.

4.2.12. It was noted that for some women, PGT-A may reduce the likelihood of pregnancy by excluding embryos that may have been viable, resulting in fewer embryos available for transfer and potentially leading to additional treatment cycles and increased financial costs. It was further noted that the evidence supporting the use of PGT-A for many women remains limited.

4.2.13. Members observed that only a small proportion of participants included in the study were women aged over 40 years. It was therefore noted that the findings may be of limited applicability to an older patient group who are most likely to experience chromosomal abnormalities.

4.2.14. A member raised concerns regarding embryo biopsy and sampling methodologies, noting that chromosomal abnormalities detected in sampled trophectoderm cells may not necessarily be present within the inner cell mass. As a result, some embryos classified as abnormal could be capable of resulting in a viable pregnancy.

4.2.15. An increase in discussion on PGT-A on social media was also highlighted, including claims that access to the technology is being restricted. Members noted the importance of ensuring that patients have access to clear, evidence-based information to support informed decision-making and to counter potential misconceptions.

5. Emerging technologies in embryo and gamete testing

5.1. A summary of the paper highlighting key developments in genetic testing of sperm, AI driven sperm selection, oocyte selection and testing, non-invasive ploidy analysis for embryos, metabolomic profiling and PGT-P was presented. The research developments summarised include those published between May 2024 and April 2026.

5.2. The Committee made the following comments and recommendations:

5.2.1. A member noted that AI-assisted sperm selection technologies are intended to support identification of sperm and streamline laboratory workflows by reducing the embryologist time required for sperm selection.

5.2.2. There is increasing interest in the use of microfluidics for sperm selection with a range of approaches being developed to support the selection of morphologically normal sperm and many laboratories have a commercial interest in the development and use of microfluidic devices.

5.2.3. Members discussed the potential advantages of microfluidic sperm preparation for ICSI (intracytoplasmic sperm injection), including improved sperm selection and reduced sample debris. However, it was clarified that these systems do not replace conventional sperm preparation, as sperm must still be separated from seminal plasma and other contaminants before use in IVF or ICSI.

5.2.4. Concerns were raised about the use of microfluidic sperm selection encouraging a shift from conventional IVF towards ICSI despite limited evidence. Members flagged that this may have financial implications for patients where additional charges are applied for such technology.

5.2.5. It was noted that uptake of microfluidic sperm selection remains relatively limited, partly due to the cost of the devices compared with conventional density gradient preparation.

5.2.6. The Chair commented that microfluidic sperm selection could be considered for future assessment under the treatment add-ons system, noting similarities with other sperm selection technologies, such as PICSI (physiological intracytoplasmic sperm injection), that have previously been rated.

5.2.7. Members acknowledged the competing pressures faced by clinics and patients. While clinics operate within commercial constraints, some patients actively seek access to specific technologies despite limited evidence of clinical benefit. Members emphasised the importance of maintaining appropriate oversight to ensure that new technologies are introduced only where they

are supported by sufficient evidence of safety and effectiveness, and that patients receive clear information to support informed decision-making.

5.2.8. A member raised that some sperm selection technologies are approved for specific clinical indications and may be appropriately incorporated into treatment costs where clinically justified. It was emphasised that it is important to distinguish between the appropriate use of approved technologies in selected patients and the wider adoption of interventions where the evidence base remains uncertain.

5.2.9. Concerns were also flagged in relation to the marketing of AI-based technologies and the potential for AI-assisted sperm selection tools to be promoted despite limited evidence.

5.2.10. A member commented that research investigating follicular fluid biomarkers should continue to be monitored.

5.2.11. It was noted that oocyte quality assessment technologies can be costly for patients, particularly where AI-based morphological assessment is incorporated, and that the value of such approaches is likely to be highly patient-specific. A member further noted that the potential value of these technologies may be greater in countries where legislation restricts the number of oocytes that can be fertilised, whereas such restrictions do not apply in the UK.

5.2.12. In relation to non-invasive embryo testing and AI-assisted embryo assessment, a member flagged that the current evidence base is largely derived from retrospective and cohort studies, with a lack of randomised controlled trials.

5.2.13. There is a lack of prospective, long-term studies assessing safety and effectiveness. It was suggested that consideration be given to mechanisms for encouraging the collection of longer-term follow-up data, particularly where interventions during early embryo development may have effects later in life.

5.2.14. Members discussed whether the HFEA could restrict clinics from charging patients for tests or interventions that have been identified as treatment add-ons with uncertain benefit. The Executive clarified that the HFEA does not have a regulatory remit over treatment costs, although it can set expectations regarding the provision of clear patient information and the use of appropriate practices.

5.2.15. The Executive highlighted the consensus statement on the responsible use of treatment add-ons in fertility services which discourages charging patients for experimental treatments.

5.3. Recommendation: The Executive to issue a Clinic Focus article reminding clinics of the treatment add-ons consensus statement.

5.3.1. A member highlighted the importance of distinguishing between biological effects and technical variation in relation to non-invasive methods for embryo testing. It was noted that differences in laboratory practices between clinics may influence outcomes, even where procedures appear similar, and that these factors are not always fully described in published methodologies.

5.3.2. It was further noted that technical variation between clinics could affect interpretation and reproducibility, emphasising the need for greater standardisation and transparency in reporting methodologies.

5.3.3. A member commented that, although epigenetic testing is technically feasible, its current clinical utility is limited by the lack of understanding of normal epigenetic variation and its relationship to clinical outcomes. It was highlighted that this is likely to become increasingly important with the development of in vitro gametogenesis, which will require robust reference datasets to assess the epigenetic profiles of in vitro-derived gametes and embryos.

6. Impact of the microbiome on fertility and fertility treatment outcomes

6.1. The paper presents further studies on research related to both the male and female reproductive tract microbiome and infertility, alongside relevant research on the gut and oral microbiome, as well as interventions targeted to improve fertility treatment outcomes. The research developments summarised include those published between May 2025 and April 2026.

6.2. The Committee made the following comments and recommendations:

6.2.1. Members discussed the increasing use of microbiome testing and raised concerns regarding lack of standardisation in testing methodologies and reporting. It was noted that result reports can vary significantly in format, including differences in bacterial classification, quantification methods, and units of measurement, which may limit their clinical interpretability.

6.2.2. It was further highlighted that sampling and analytical methods, as well interpretation of results, are highly variable and can significantly influence outcomes. The microbiome is dynamic and may vary over time, particularly in relation to the menstrual or treatment cycle. This further raises questions regarding standardisation and clinical relevance of sampling and interpretation.

6.2.3. Members raised concerns regarding the current clinical utility of microbiome testing, noting that the evidence base remains limited and that its use is currently more research focused.

6.2.4. Increasing interest in microbiome testing could be influenced by social media and direct-to-consumer (DTC) marketing rather than established clinical evidence. Members noted that patients increasingly present with microbiome test results obtained through DTC testing and that such results are often difficult to interpret. Members highlighted tension between evidence-based clinical advice and persuasive non-clinical messaging, which can make it challenging for clinicians to communicate uncertainty to patients already exposed to commercial claims.

6.2.5. Members expressed concern regarding DTC microbiome testing services and the nature of claims being made in relation to fertility or fertility treatment outcomes.

6.2.6. Members discussed regulatory oversight, highlighting that such products fall under the remit of the Medicines and Healthcare products Regulatory Agency (MHRA) as medical devices, including the role of other bodies such as the Advertising Standards Authority (ASA) and the Competition and Markets Authority (CMA).

6.2.7. The Executive noted that the ASA acts on a complaints-led basis. Where concerns are raised regarding advertising claims, the ASA may investigate and take action as appropriate.

6.2.8. The Executive clarified that the HFEA regulates licensed clinics and the treatments and services provided within those settings. Activities occurring outside of licensed clinics, including DTC testing or products purchased independently, fall outside the HFEA's regulatory remit.

6.2.9. A member flagged potential broader implications of microbiome testing, including the risk of unnecessary antibiotic exposure and contribution to antimicrobial resistance. Antibiotic use may have unintended downstream effects, including disruption of normal microbiota and subsequent infections.

6.2.10. Members also considered uncertainties regarding the influence of host determinants on the vaginal and endometrial microbiome, including potential genetic, hormonal, and immunological factors. It was noted that factors such as, cyclical hormonal variation may influence microbial composition, and that intra-individual variation over time is likely significant.

6.2.11. It was highlighted that the biological mechanisms underpinning microbiome composition and its relationship to reproductive outcomes remain poorly understood. A member commented that both superficial and deeper tissue colonisation may occur, including potential bacterial persistence within epithelial layers, although the clinical significance of these observations is unclear.

7. Rating review for treatment add-ons: Microbiome testing

7.1. The Chair welcomed expert Statistician, Zipporah Iheozor-Ejiofor.

7.2. The following comments and recommendations were made:

7.2.1. The expert Statistician noted that although some studies may suggest a potential association between microbiome interventions and improved outcomes, the evidence is predominantly derived from non-randomised studies of poor quality. Members acknowledged the lack of good quality studies.

7.2.2. It was noted that microbiome testing is increasingly being undertaken outside licensed fertility clinics and agreed that clear information on the website would help support informed patient decision-making.

7.2.3. The need for further high-quality research in this area was discussed with a member suggesting that research priorities identified through SCAAC discussions could be highlighted to researchers eg on the HFEA website, which could support future funding applications and evidence generation.

7.3. **Recommendation:** The Executive to consider how research priorities could be highlighted.

7.3.1. Members considered the potential public health implications of empirical antibiotic use following microbiome testing, particularly the risk of antimicrobial resistance associated with repeated or unnecessary antibiotic treatment.

7.3.2. While some members suggested that these safety considerations should be reflected as a red rating, others noted that antibiotics may be clinically indicated in certain circumstances. Members agreed that a red rating would not be appropriate on this basis alone.

7.3.3. The Committee agreed with the Executives suggestion that information on the potential risks associated with inappropriate antibiotic use should be incorporated into the accompanying explanatory text under the safety section on the treatment add-on webpage.

7.3.4. It was clarified that antibiotics are routinely included in culture media to minimise the risk of contamination during culture which is distinct from the systemic use of antibiotics following microbiome testing.

7.3.5. Members discussed the presentation of the add-on ratings for microbiome testing and agreed that the ratings should be separated to improve clarity and accessibility for patients.

7.3.6. A member flagged that chronic endometritis testing is frequently promoted in the context of recurrent pregnancy loss. Following discussion, it was agreed that outcomes relating to miscarriage and recurrent pregnancy loss should be clearly referenced in the accompanying explanatory text.

7.3.7. Members discussed whether emerging evidence relating to chronic endometritis and recurrent pregnancy loss should be reflected in the evidence ratings. The Chronic Endometritis and Recurrent Miscarriage (CERM) trial was referenced; however, the full study data is not yet available for review.

7.3.8. The Chair highlighted that evidence ratings should be based on published and fully available evidence only. While unpublished findings may be of interest, they should not influence the current assessment until they have undergone appropriate publication and peer-review.

7.3.9. It was noted that, should robust evidence from a large, well-conducted randomised controlled trial become available, the evidence ratings would be reviewed and updated as appropriate.

7.3.10. Overall, the Committee agreed with the proposed ratings, noting that the current evidence base is insufficient to demonstrate that microbiome testing and subsequent interventions improve fertility treatment outcomes.

7.4. Recommendation: The Committee agreed the following ratings for microbiome testing:

- GREY for live birth rate for most of the fertility patient population (probiotics, probiotics with antibiotics, and antibiotics).
- GREY for live birth rate for patients with recurrent implantation failure (probiotics, probiotics with antibiotics, and antibiotics).
- GREY for live birth rate for patients diagnosed with chronic endometritis (antibiotics and antibiotics with probiotics).

8. Rating review for treatment add-ons: Sperm DNA fragmentation testing

8.1. The Chair welcomed expert Statistician, Arun Kumar.

8.2. The Committee made the following comments and recommendations:

8.2.1. It was noted that several recent randomised controlled trials evaluating antioxidant treatments have not demonstrated improvements in fertility outcomes. A member highlighted that these findings are reflected in the NICE evidence review.

8.2.2. Overall, the NICE fertility guidelines conclude that the evidence relating to sperm DNA fragmentation testing and subsequent interventions remains limited, inconsistent and of insufficient quality to support routine use.

8.2.3. Interventions following sperm DNA fragmentation testing vary in their invasiveness, risk profile, and evidence base and therefore grouping all interventions together may not adequately reflect these differences.

8.2.4. The Committee agreed that the ratings for sperm DNA fragmentation testing should be separated according to the interventions. It was noted that patients may be particularly interested in specific interventions, such as antioxidant supplementation, and that separate ratings would better reflect the evidence available for each approach.

8.2.5. A member highlighted that sperm DNA fragmentation testing may occasionally be undertaken as part of investigations into recurrent pregnancy loss or to provide patients with additional information regarding possible causes of infertility, rather than with the expectation of improving treatment outcomes. However, it was agreed that this is not sufficient justification for recommending a test in the absence of evidence demonstrating clinical benefit.

8.2.6. It was noted that the ESHRE good practice recommendations on add-ons, has distinguished between the use of sperm DNA fragmentation testing for diagnostic purposes and its use to improve treatment outcomes.

8.2.7. Members considered the relationship between sperm DNA damage and reproductive outcomes, noting that oocytes have some capacity to repair sperm DNA damage following fertilisation. It was suggested that the impact of sperm DNA fragmentation may therefore depend on a range of factors, including oocyte quality.

8.2.8. The Statistician commented that the evidence relating to sperm DNA fragmentation testing and subsequent interventions remains inconclusive. While one large, high-quality randomised controlled trial involving over 2,000 participants was identified, it did not demonstrate a benefit for improving fertility treatment outcomes.

8.2.9. The biological rationale underpinning sperm DNA fragmentation testing and the use of antioxidant therapies was discussed. Oxidative stress during sperm maturation may contribute to DNA damage and that antioxidant treatment has been proposed as a means of reducing this damage in subsequently produced sperm.

8.2.10. Members discussed the evidence relating to antioxidant treatment following sperm DNA fragmentation testing. It was noted that additional published evidence may need to be reviewed before a final rating is agreed for this intervention. The Committee agreed that this should be considered further outside the meeting before finalising the rating.

8.2.11. The Committee agreed that sperm selection techniques, including ICSI and other sperm selection approaches, should retain a grey rating due to limited and inconclusive evidence supporting their use following sperm DNA fragmentation testing.

8.2.12. A member suggested that the testicular sperm retrieval including TESA (testicular sperm aspiration) intervention may warrant a red rating due to the invasive nature of the procedure and associated risks.

8.2.13. Testicular sperm retrieval (including TESA) as an intervention following sperm DNA fragmentation testing was further discussed with members noting that, in addition to the invasiveness and potential risk, there is a lack of evidence demonstrating benefit. Members agreed that due to safety considerations, this intervention should be assigned a red rating.

8.2.14. Members agreed that the evidence relating to sperm DNA fragmentation testing in recurrent implantation failure is limited and that a grey rating remained appropriate.

8.3. **Recommendation:** The Committee agreed the following ratings for sperm DNA fragmentation testing:

- The rating for live birth rate for patients undergoing treatment due to male factor infertility (antioxidant therapy) will be agreed once further published evidence is reviewed.
- GREY for live birth rate for patients undergoing treatment due to male factor infertility (different sperm selection techniques).
- RED for live birth rate for patients undergoing treatment due to male factor infertility (testicular sperm retrieval including TESA).
- GREY for live birth rate for patients with recurrent pregnancy loss.

9. Review of authorised use of In Vitro Maturation (IVM) for oocytes

9.1. The Executive highlighted that the authorised use of IVM for oocytes in fertility treatment is being brought to the attention of the SCAAC to confirm whether the current inclusion of IVM on the authorised processes list includes its use on fresh immature oocytes from ovarian tissues.

9.2. The Committee made the following comments and recommendations:

9.2.1. The Committee discussed the distinction between established clinical IVM procedures which involve the maturation of immature oocytes retrieved from antral or pre-ovulatory follicles and the proposed approach which involves the retrieval and maturation of oocytes obtained from ovarian tissue.

9.2.2. Members discussed the potential application of this approach in patients for whom re-transplantation of ovarian tissue may not be appropriate due to concerns regarding the reintroduction of malignant cells.

9.2.3. It was noted that the current authorised process for IVM was developed in the context of established clinical IVM techniques using aspiration to retrieve immature oocytes from antral or pre-ovulatory follicles and was not intended to encompass the maturation of oocytes derived from ovarian tissue. Members agreed that the proposed approach differs sufficiently from the existing authorised use of IVM for oocytes.

9.2.4. Members expressed the limited evidence currently available and highlighted the importance of reviewing appropriate pre-clinical and clinical safety data before the use of embryos derived from such oocytes in treatment.

9.2.5. The Executive clarified that should the SCAAC decide that the current inclusion of IVM for oocytes on the authorised processes list does not include its use for the maturation of oocytes obtained from ovarian tissue, then clinics wishing to undertake such a procedure would be required to submit a new process application form for consideration by the Committee.

9.3. **Decision:** The Committee confirmed that:

- The current inclusion of IVM for oocytes on the authorised processes list does not include its use for the maturation of oocytes obtained from ovarian tissue and clinics should therefore not use it for this purpose.
- A new process application for the use of IVM for oocytes obtained from ovarian tissue would need to be submitted for SCAAC's consideration and approval.

10. Any other business

10.1. The Chair highlighted that no members are due to complete their terms of office this year.

11. Meeting summary and close

11.1. The Chair closed the meeting by thanking the Executive for drafting the papers and the expert Statisticians for their contributions.

11.2. The next SCAAC meeting will be held in-person on Wednesday 7th October 2026.

12. Chair's signature

I confirm this is a true and accurate record of the meeting.

Chair: Tim Child

Date: Monday 3rd August 2026