Human Fertilisation & Embryology Authority

Authority meeting

Date: 5 November – 11am – 1.00pm

Venue: Teams

Agenda item	Time
1. Welcome, apologies and declarations of interest (5)	11.00am
2. Choose a Fertility Clinic (CaFC) – full publication 2025 For decision	11.05am
3. Any other business (verbal) (5)	
4. Close	

Choose a Fertility Clinic – full publication 2025

Details about this paper

Area(s) of strategy this paper relates to:	Regulating a changing environment / Supporting scientific and medical innovation
Meeting:	Authority
Agenda item:	2
Meeting date:	5 November 2025
Author:	Clare Ettinghausen, Director of Strategy & Corporate Affairs; Rachel Cutting, Director of Compliance & Information; Ruby Relton, Social Research Manager; Danielle Hall, Senior External Communications Manager, Kathleen Sarsfield Watson, Communications Manager
Annexes	Annex A Summary of consultation responses Annex B Text of focused consultation Annex C The changing fertility sector Annex D Information on CaFC detailed statistics

Output from this paper

For information or decision?	For decision
Recommendation:	The Authority is asked: • To decide the main profile page statistics to be published for the full CaFC publication and what they should include; • To agree what data, if any, is shown for those clinics who will not meet the full CaFC publication deadline this year; • To agree that we do not reinstate a symbol to signify 'in line with national average' at the top of each clinic page; • To establish a sub-group of Authority members to decide on methodological questions.
Resource implications:	To be resourced by HFEA staff
Implementation date:	Winter 2025
Communication(s):	As set out in section 8

Organisational risk:	Low/Medium

1. Background

1.1. The Authority last discussed Choose a Fertility Clinic (CaFC) in **May 2025** and **July 2025**.

1. At the May meeting the background to CaFC was set out including that the Authority has a statutory duty provide information, and the CaFC function provides verified information on all UK licensed clinics.
2. Following the migration of the HFEA's register data to a new database and the introduction of the new data submission system, PRISM, CaFC has not been updated for some time and the Authority had previously agreed that a suitable caveat should accompany the data.
3. The 'Interim' CaFC will be based on publishing three headline rates (the 'composite' headline rate, the 'fresh only' headline rate and the multiple birth rate). This will also include caveats that various practices can affect success rates such as the proportion of donor egg treatments or PGT-A cycles carried out by clinics. In addition, for clinics where the number of donor egg treatments and/or PGT-A cycles is above the national average, a note will be added advising patients that this can make it more difficult to compare that clinic's rate against the UK average and those of other individual clinics.
4. Revisions to the main profile page statistics (data) which were then published as an **'interim CaFC' in May 2025**.
5. The Authority noted in May that by the end of 2025, CaFC will be updated with data to the end of 2023 (births) and 2024 (pregnancies) and the metrics used in this publication would be decided following a focused consultation involving clinic staff, stakeholder groups and the patient engagement forum on the most appropriate metrics for the upcoming 'full' CaFC publication.
6. It was also noted in the May 2025 meeting that following the publication of the full CaFC at the end of 2025, the information programme that begun with PRISM will be complete.
7. The Authority agreed that following the publication of the full CaFC later in 2025, we should review the different information sources held on the HFEA website and consider whether they can be brought together in a more unified or different way. This is planned for during the current strategic period of 2025-2028.

1.2. At the July meeting, the Authority agreed that a focused consultation should take place over the summer to gather the views of clinic staff and patients on the clinic's main profile page statistics. The Authority agreed that:

8. a focused consultation is published over the summer with a read out of the responses coming to Authority in Autumn 2025 for discussion and decision over the full CaFC publication.
9. the HFEA should seek views on the four metrics set out at paragraph 4.3 of the paper before the Authority, noting that the inclusion of "procedure" within some of the metrics might help aid understanding of the questions being asked.
10. the metric on reporting multiple births should be retained as currently presented and therefore there was no requirement to consult on this metric.

1.3. Following the July Authority meeting, the focused consultation was drafted, user testing took place and was launched on 18 August 2025 for six weeks, closing on 30 September 2025. Further details of the survey design and analysis of the results can be found in **Annex A** of this paper. This is a draft of a report on the consultation that will also be published separately on the website in due course.

1.4. A summary of the options of different possible clinic main profile page statistics can be found in **Annex B**.

1.5. This paper sets out findings from the consultation and outlines the decisions for Authority in relation to the full CaFC publication later this year. The focused consultation was undertaken to inform the Authority's consideration of the metrics for full CaFC publication; it should not be viewed as a 'vote' on any particular option that the Authority are bound by.

1.6. Section 2 looks at the wider context for this discussion; sections 3 and 4 look at the focused consultation; section 5 sets out some relevant considerations; section 6 lists some further questions relating to publication; section 7 lists some methodological queries. Lastly, section 8 sets out proposed and next steps and in section 9, the Authority are asked for decision on the full CaFC publication.

2. Wider context

2.1. The HFEA CaFC information is the only place where patients and the wider public can see all information from the UK wide regulator on a clinic by clinic basis. This includes inspection reports, other licensing decisions (e.g. relating to decisions on PGT-M applications), verified data on success rates and information uploaded by the clinic such as donor waiting times.

2.2. The most recent **HFEA patient survey** found that success rates was the second most important factor when considering the choice of fertility clinics. For self-funded patients, this has increased from 44% when we first carried out the survey in 2018 to 59% in the most recent survey.

2.3. The CaFC landing page on the HFEA website has had over 991,350 views in the last 12 months and over 2 million views in the last 3 years. In total, the clinic individual homepages had 659,468 views over the last year.

2.4. There are other clinic comparison websites that use HFEA data as the basis for their pages. We also receive requests to publish information in league table or excel formats for different comparisons to be made.

2.5. Following previous discussions with the Authority, it was agreed that because of the different patient groups that clinics may treat, all data should be available through CaFC webpages and not via other publications. As noted in the introduction above, we have said that we will look at publication of our data during the current HFEA strategy.

2.6. In looking at what we publish as main profile page statistics, it may be worth considering how data is published elsewhere. For example, in Australia, multiple data points **https://yourivfsuccess.com.au/national-statistics** are published and in the United States **SART** publish several different rates. Although a full comparison of other sites has not been made, it is important to acknowledge that there is no consensus on the most useful way of presenting outcome data and that the various methods employed all demonstrate a tension between showing something straightforward and understandable versus publishing lots of detailed statistics. One way that the HFEA has approached this in the past is to have some information as the main profile page statistic for each clinic with more detailed information (with further statistics) on the 'detailed statistics' page for each clinic.

2.7. Whichever profile page statistic is chosen, we hope to make some improvements to the CaFC landing page in line with the full CaFC publication later this year. There will also be some technical refinements to the detailed statistics information, for example, updating terminology in relation to genetic testing. Updates will be published for the sector in Clinic Focus.

3. Focused CaFC consultation background

3.1. The focused consultation aimed to gather views from patients, individuals sharing their professional views, professional and patient organisations on the statistics shown on the clinic's main profile page that they would find most useful. There was also an option for members of the public outside of these categories to submit responses.

3.2. The focused consultation was designed to be lay friendly with information provided to enable people without detailed knowledge to engage with the questions.

3.3. The views expressed in the focused consultation are not a representative sample of the public, clinic staff or patient groups, but the views of respondents.

3.4. Further details on the methodology used to develop the consultation is provided in Annex A. A the full text of the consultation is in **Annex B**.

4. Summary of responses

4.1. A total of 273 responses were included in the analysis. Respondents could respond to the consultation in one of four groups (Table 1). These groups are used throughout to look at any differences in views.

Table 1. Number of responses by group

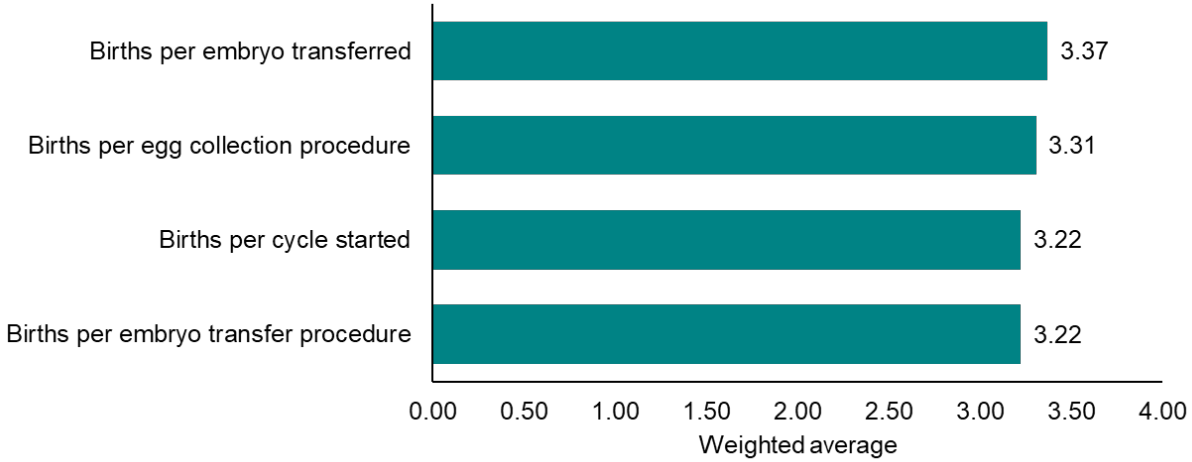
Response group	Number of responses	Percentage
Prospective, current, or past patient	85	31%
Interested member of the public	12	4%
Individual sharing professional view	121	44%
On behalf of an organisation	55	20%
Total	**273**	**100%**

Q: ***In what capacity are you responding to this consultation (please select only ONE option)*** (N=273).

Respondents were asked to rank the options presented in order of preference from one to four (one being most preferred, four being least preferred). In cases where they would not choose any statistic, they could select "Would not choose" and this would be ranked as one. From this, weighted averages for each way of presenting the main profile page statistic were calculated.

4.2. Differences between the preferences expressed for the four options was minimal. The most preferred statistic out of the four options presented was births per embryo transferred (3.37, see Figure 1), followed by births per egg collection procedure (3.31). The least preferred were births per cycle started and births per embryo transfer procedure (both 3.22). Further detail on the distribution of responses is included in **Annex A**.

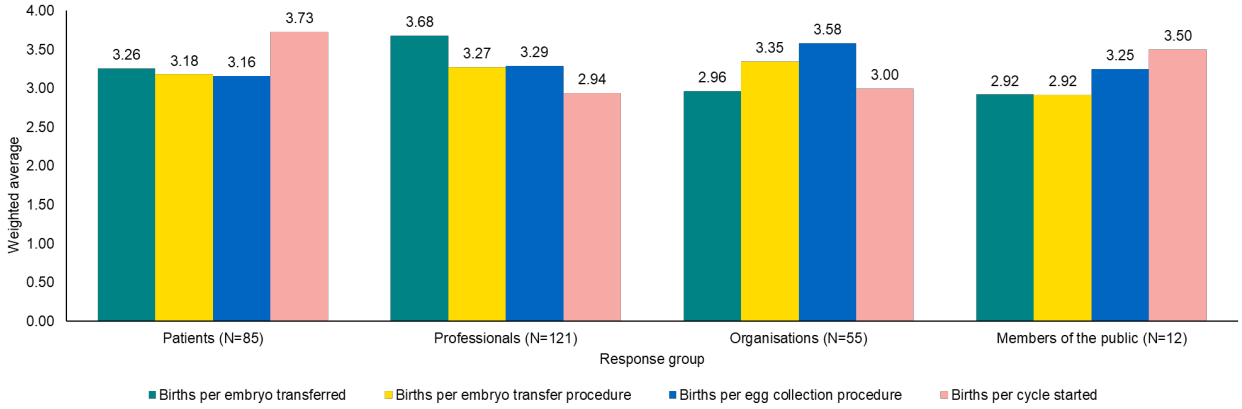
Figure 1. Preference for clinic's main profile page statistic



Q: ***Which of these options do you think should be a clinic's main profile page statistic?*** Please place the below options in order of preference from one to four (one being most preferred, four being least preferred option) by writing the number (1, 2, 3, or 4) in the corresponding box. If you would not choose one, or any, of these options please put a cross (X) in the box (N=273).

4.3. Differences in preferences on a clinic's main profile page statistic were seen between groups (Figure 2). Both patients and members of the public's most preferred method was births per cycle started (3.73 and 3.50, respectively) whereas organisations' was births per egg collection procedure (3.58) and professionals was births per embryo transferred (3.68).

Figure 2. Preference of clinic's main profile page statistic by response group



Q: Which of these options do you think should be a clinic's main profile page statistic? Please place the below options in order of preference from one to four (one being most preferred, four being least preferred option) by writing the number (1, 2, 3, or 4) in the corresponding box. If you would not choose one, or any, of these options please put a cross (X) in the box (N=273).

Combined statistic

4.4. Respondents were then asked their preferences were on whether a clinic's main profile page statistic should be presented as a combined statistic (including all different types of IVF treatment such as fresh and frozen transfers and treatments using donor eggs or PGT-A). Overall, most respondents (77%, 209/270) did not think that there should be one combined statistic presented.

4.5. When looking at this by response group, most patients (72%, 61/85), professionals (84%, 100/119) and organisations (76%, 41/54) and 58% (7/12) of members of the public did not think

a clinic's main profile page statistic should be displayed as a combined statistic (as defined above, Figure 3).

4.6. Respondents were then asked to indicate their preference for treatments to include in a clinic's main profile page statistic, if it was not presented as a combined rate. Those who would prefer a combined statistic (as defined above) were excluded from the analysis below (N=44).

Fresh and frozen embryo transfer cycles

4.7. Most respondents (80%, 178/223) were in favour of including a combination of both fresh and frozen embryo transfer cycles in the main profile page statistic compared to only 15% (34/223) who would prefer for it to include fresh embryo transfer cycles only.

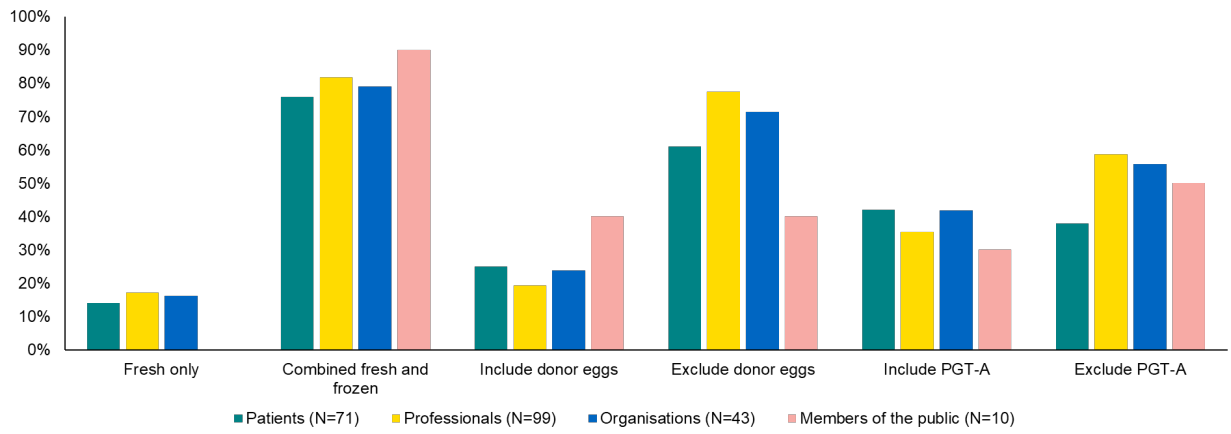
Treatments with donor eggs

4.8. Almost 70% (69%, 153/221) of respondents were in favour of excluding treatments using donor eggs in a clinic's main profile page statistic while 23% (51/221) were in favour of including treatments using donor eggs. However, differences were seen between response groups when asked for their preferences on the inclusion or exclusion of treatments involving donor eggs in the main profile page statistics. Over 70% of both professionals (78%, 76/98) and organisations (71%, 30/42) were in favour of excluding treatments using donor eggs in a clinic's main profile page statistic. Although a high proportion of patients were in favour of excluding donor eggs (61%, 43/71), a quarter were in favour of including treatments using donor eggs (25%, 18/71). Equal proportions of members of the public were both in favour of including and excluding treatments using donor eggs in a clinic's main profile page statistic (40%, 4/10). Further detail on those who ticked Don't know/Not sure are included in **Annex A**.

Treatments with PGT-A

4.9. Half (51%, 113/221) of respondents were in favour of excluding treatments using PGT-A from a clinic's main profile page statistic. 38% (85/221) were in favour of including treatments using PGT-A. When looking at this by response group, a slightly higher proportion of patients were in favour of including treatment using PGT-A in a main profile page statistic (42%, 39/69 vs 38%, 26/69 exclude treatments using PGT-A). While a higher proportion of professionals (59%, 58/99), organisations (56%, 24/43) and members of the public (50%, 5/10) were in favour of excluding treatments using PGT-A from the main profile page statistic. Further detail on those who ticked Don't know/Not sure are included in **Annex A**.

Figure 3. Views on including treatments using fresh and frozen cycles, donor eggs and PGT-A in the main profile page statistic by response group



Q: Which of the following would be your preference if births per embryo transfer procedure or births per embryo transferred was chosen as a clinic's main profile page statistic? AND Should

treatments using donor eggs be included or excluded from a clinic's main profile page statistics? AND Should treatments using PGT-A be included or excluded from a clinic's main profile page statistics? Percentages are calculated on the total number of respondents to the question, rather than total respondents to consultation overall. Respondents who answered yes to presenting the profile page statistic as a combined rate were excluded from this question. Respondents who ticked don't know/Note sure are not included in this graph. Please see figures in full summary support for further details on the number of respondents who skipped these questions (N=223).

4.10. Finally, there was a 'free text' box giving respondents the opportunity to add any other comments. 88 free text responses were submitted, which have been summarised in **Annex A**. Many responses provided further reasoning or context to why they had made specific choices for a clinic's main profile page statistic and the inclusion/exclusion of any treatments.

4.11. Additionally, some respondents also provided their views on the ways statistics should/could be displayed to increase clarity for patients and the public, or stated additional information they feel would add value to CaFC. While outside the scope of this consultation, these responses should form part of future work undertaken by the Authority to review how information on clinics and the outcomes of treatments are presented to patients.

4.12. The above findings of the focused consultation have been summarised in Table 2.

Table 2. Summary of consultation findings per response group

	Births per cycle started	Births per egg collection procedure	Births per embryo transfer procedure	Births per embryo transferred	Combined rate	Include fresh & frozen	Include donor eggs	Include PGT-A
Patients (N=85)	1	4	3	2	x	✓	x	-
Professionals (N=121)	4	2	3	1	x	✓	x	x
Organisations (N=55)	3	1	2	4	x	✓	x	x
Public (N=12)	1	2	3	3	x	✓	-	x

Note: Respondents who answered that yes to presenting a clinic's main profile page statistic as a combined rate were excluded from analysis of questions asking for preferences on the inclusion/exclusion of fresh and frozen cycles and treatments using donor eggs, PGT-A. A response group was deemed as being in favour of including/excluding a treatment when over 50% of the respondents within that group were in agreement. A "–" has been used to highlight cases where no clear preference was found. Further information on key findings is summarised in **Annex A**.

5. Relevant considerations

5.1. It is important to note that the aim of providing information on CaFC is to enable patients to look at a clinic's data and compare it with others, ensuring that a fair comparison is possible.

5.2. The current CaFC clinic homepage has three 'slots' available to show a clinic's main profile page statistics, as well as the more detailed statistics shown on subsequent pages and set out at **Annex D**. Any change to the three 'slots' would require complex and/or time consuming website development work which is not recommended at this stage, given the ambition to look more broadly at the way our data is presented on our website during this strategic period.

5.3. The Authority agreed in July 2025 that whatever profile page statistics are shown, the clinic's individual multiple birth rate should continue to be displayed and so there are two 'slots' left that can be used to show a clinic's main profile page statistics.

5.4. Previously in the CaFC data published prior to PRISM launch the main profile page statistics were birth per egg collection and birth per embryo transferred from fresh stimulated transfers using own eggs.[1]

5.5. While the view from the focused consultation show very little difference in preferences between the four profile page statistics, it *may* be helpful to have two contrasting profile page statistics such as births per cycle started (which is shown as a cumulative rate) and births per embryo transferred. This would reflect the preferred first choice expressed in the focused consultation for patients and professional respondents.

5.6. The Authority previously noted in the May 2025 meeting that the use of PGT-A in the UK is increasing and, when combined with a technique known as 'batching cycles' (where the patient undergoes several cycles before an embryo is transferred), this is likely to distort the reliability of birth per embryo transferred as a fair measure of clinic performance as it does not reflect patients who may start a cycle of treatment, undergo PGT-A, and don't have an embryo to transfer. Therefore, if PGT-A cycles are included in the births per embryo transferred calculation, clinics that undertake more PGT-A may show an inflated success rate, which could make comparisons across clinics more difficult.

5.7. Extending this argument, it might be helpful to avoid having two similar statistics; for example, births per embryo transfer procedure and births per embryo transferred might not be helpful to users.

5.8. For context, we previously displayed births per cycle started as a main profile page statistic but moved away from this as part of the broad policy move to encourage single embryo transfer.

5.9. As set out in **Annex C**, because of the increase in the number of frozen cycles taking place, it would make sense to include *both* fresh and frozen cycles in whichever profile page statistic is chosen. The consultation responses indicate that this would be an option most groups would be in favour of.

5.10. The Authority will need to discuss whether to include or exclude cycles with donor eggs and cycles with PGT-A in the profile page statistics. To note, that both of these are shown in the in the detailed statistics as set out in Annex D.

[1] The interim CaFC published in May 2025 shows 'births per embryo transferred – average of all types of treatment' and 'births per embryo transferred – fresh stimulated transfers using own eggs'

6. Publication questions

Clinics that will not have updated data ready for publication

6.1. The Authority is asked to note that at the most recent AGC meeting in October 2025, it was noted that there are currently four clinics who are unlikely to make the full CaFC publication deadline.

6.2. AGC discussed this and what data, if any, should be displayed for them. The committee considered what is in the best interest of patients noting as a national regulator it is necessary and appropriate for the HFEA to publish up-to-date data on the website as quickly as possible pursuant to its statutory duty under s.8(1)(c) of the Human Fertilisation and Embryology Act 2008. The committee felt it would not be in the best interest of patients to continue displaying 2018 data for those clinics as it would be misleading for patients.

6.3. AGC recommended to the Authority that for those clinics who are unlikely to make the full CaFC publication, no data should be displayed.

6.1. It should be noted that the approach adopted in the recent Interim CaFC was to allow clinics that chose not to sign off their data to still display their existing headline data which dates from 2018.

6.2. If no data displayed then patients have no alternative but to use any information provided on other websites including the clinic's own.

6.3. The Authority is now asked to consider this and decide whether, for those clinics not making the publication deadline later in 2025, there should be no data available to view on these clinic's CaFC pages. If this is the case, then a note will be added to the relevant clinic's CaFC page to say why there is no data available.

National averages appearing on CaFC profile pages

6.4. The current clinic CaFC profile page (for the Interim CaFC) has at the top of the page under IVF Birth Rate, the text: *view birth statistics*. Previously this had symbols to show if the clinic was in line with the national average. Assuming that the Authority chooses <u>two different</u> statistics it is suggested that we do not reinstate a symbol to signify 'in line with national average' as this could change depending on the statistic.

7. Methodological questions

7.1. Arising from the verification process with clinics, we will provide a clarification glossary on certain terms to be included as an appendix to any communication on success rate methodology. The Authority is asked to agree to establishing a sub-group of Authority members to meet with the Executive to discuss the issues set out below. Recommendations from the sub-group will be circulated to the Authority for information.

7.2. These decisions will be documented and published on the Clinic Portal.

7.3. This is still being constructed but will include for example:

- Definition of a clinical pregnancy
- How to record when more than 1 type of genetic testing is done following biopsy (for example, when PGT-A is carried out alongside PGT-M)
- Exact definition of 'donor eggs'
- Definition of egg collections and cycles started
- Calculations for egg collections and cycle started in 2022

7.4. When we publish the full CaFC, we will also update the large amount of data behind the detailed statistics for each clinic. Whilst we are not changing the data structure there may be

some minor changes as a consequence of the Authority decision that will need to be discussed by the sub-group, for example, relating to language used or choices on 'drop down' menus.

7.5. The CaFC methodology statement will be updated before we share calculation results with clinics and we publish data. This will be published on the Clinic Portal as well as shared with clinics.

8. Next steps

8.1. Once the Authority has decided the main profile page statistic(s) for the full CaFC publication, we will:

- Simplify the CaFC front page and where possible any explanation of statistics
- Meet with the Authority sub-group to agree the methodological issues set out above
- Publish information for the sector in Clinic Focus, in public facing social media posts, and on our website once the new CaFC data is updated. If this is towards the very end of the calendar year, then we will follow this up in early 2026 using the same communication channels.

9. For decision

9.1. The Authority is asked to consider the merits of the options below. Members may wish to consider both the findings of the focused consultation, the target audience for CaFC and the primary reasons for its use, namely to enable users to compare effectively between clinics:

1. To decide which main profile page statistics (**one or two** from below) are published - with the multiple birth rate - for the full CaFC publication later in 2025

From these choices:

   a. Births per cycle started
   b. Birth per egg collection procedure
   c. Births per embryo transfer procedure
   d. Births per embryo transferred

2. From these choices should the main profile page statistic include:
   a. Fresh *and* frozen cycles or not
   b. Donor egg cycles
   c. PGT-A cycles
   d. Or be a combined rate

3. To agree what data, if any, is shown for those clinics who will not meet the full CaFC publication deadline this year.
4. To agree that we do not reinstate a symbol to signify 'in line with national average' at the top of each clinic page.
5. To establish a sub-group of Authority members to decide on methodological questions as set out in section 7.

Annex A - Summary of consultation responses

10. Introduction

10.1. The HFEA provides information to patients and the wider public in many ways, including through the **Choose a Fertility Clinic** (CaFC) function on our website, which has information about UK licensed fertility clinics. Information on CaFC is not designed to predict an individual patient's chance of having a baby but rather it shows clinic level information such as data about outcomes for patients treated at a clinic over a specific period of time.

10.2. Fertility treatment has changed significantly since CaFC was last reviewed by the HFEA in 2016-17. The HFEA ran a focused consultation from August to September 2025 to gather views from clinic staff, patients, professionals and organisations on the main profile page statistics they would find most useful to be on CaFC to help inform Authority about the full CaFC publication later in 2025.

10.3. We received a range of responses from organisations, professionals working in the sector, prospective, current, or future patients (including partners and/or family members), and interested members of the public.

10.4. The views expressed in this focused consultation are not a representative sample of the public, clinic staff or patient groups, but the views of respondents to this consultation only. Additionally, across both the professional and organisational response groups there was a high number of responses from two individual organisations (17% and 20%, respectively). Further details are included in the limitations section of this report.

10.5. The HFEA would like to thank every individual and organisation who took the time to respond to our consultation. Each response has been read in detail and used to help inform discussions on the CaFC update.

11. Overview of response groups

11.1. A total of 273 complete, submitted responses were included in the analysis (Table 1). The methodology for data collection and analysis can be found in the Methodology section of this report.

11.2. Respondents were able to share/respond to the consultation in one of the following capacities:

- A prospective, current or past fertility patient sharing personal views (this can include partners and family members)
- An interested member of the public sharing their personal views
- An individual sharing their professional views (for example a member of clinic staff, other relevant healthcare professional or clinical researcher)
- On behalf of an organisation (for example, professional bodies/patient organisations/charities, HFEA licensed clinics and others)

11.3. The above groups are used throughout the report to look at differences in views and we have presented the results by the following four response groups in this report:

- Patients
- Members of the public
- Professionals
- Organisations

11.4. Just over 35% (97) of responses came from individuals sharing their personal views or experiences, either as a patient (31%, 85) or as a member of the public (4%, 12). Apart from

the question asking for respondents to specify the capacity in which they were responding to the consultation and their preference for a clinic's main profile page statistic, all questions were optional. Where respondents have skipped a question or not provided a response, this has been highlighted in the accompanying figure note.

11.5. Just under half (44%, 121) of responses came from professionals and 20% (55) of responses were submitted on behalf of organisations. These respondents were asked to provide details about the name of the organisation they are working with or responding on behalf of, contact details (to verify their responses) and to provide some information about the organisation where they worked. A list of the organisations that responded to the consultation is available in Section 17.

Table 1. Number of responses by group

Response group	Number of responses	Percentage
Prospective, current, or past patient	85	31%
Interested member of the public	12	4%
Individual sharing professional view	121	44%
On behalf of an organisation	55	20%
Total	**273**	**100%**

Q: ***In what capacity are you responding to this consultation (please select only ONE option)*** (N=273).

11.6. Most professionals worked at HFEA-licensed clinics (86%). Over half (64%) of those were working at private clinics compared to 27% at NHS clinics. A large proportion of the responses submitted by organisations came from those working at HFEA-licensed clinics (70%) whereas 13% were submitted on behalf of a professional body or organisation and 15% were submitted by a UK group, organisation or charity that represented patients. Some organisational and professional responses were submitted by multiple members of individual organisations which have been included in the report. Further details are provided in the Methodology section.

12. Profile page statistic: which was the chosen rate?

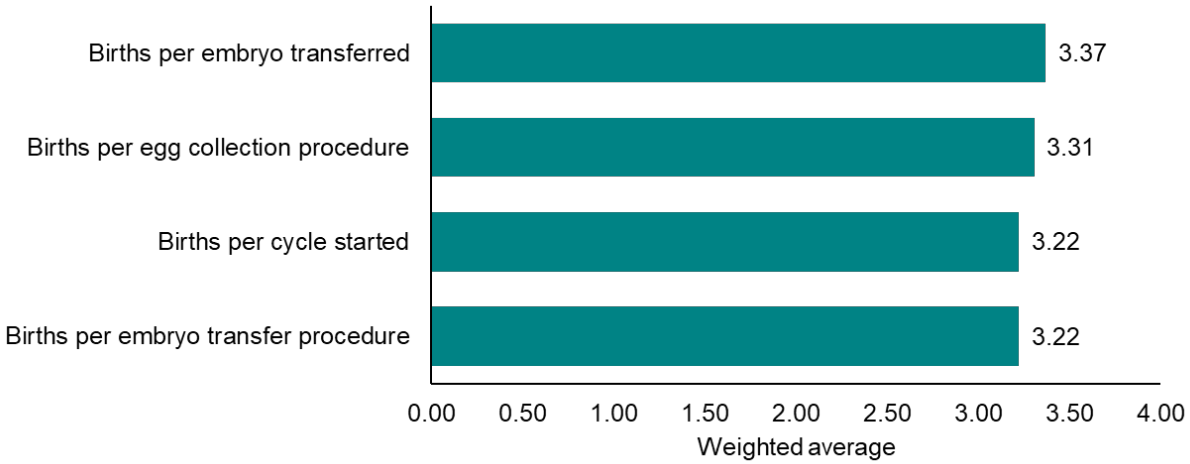
12.1. The first section sets out information on the different ways of presenting statistics (see Annex B). Respondents were able to rank options in order of preference from one to four (one being most preferred, four being least preferred). These were assigned weights from 5 to 2. In cases where they would not choose any statistic, they were able to select “Would not choose” and this would be ranked as 1. From this, weighted averages for each way of presenting a clinic’s main profile page statistic were calculated for all those completing the consultation and by response group.

12.2. Differences between the preferences expressed for the four options were small. However, overall, the consultation found that the most preferred statistic out of the four options presented would be births per embryo transferred (3.37), followed by births per egg collection procedure (3.31, Figure 1). The least preferred metrics were births per cycle started and births per embryo transfer procedure (both 3.22).

12.3. Both births per embryo transferred and births per cycle started had the highest proportion of respondents who ranked this value as their most preferred statistic (33%, 91/273 and 32%, 87/273, respectively). However they also had the highest proportion of respondents who ranked these values as their least preferred statistic (23%, 64/273 and 26%, 71/273, respectively).

Most respondents ranked births per egg collection procedure (56%, 154/273) and births per embryo transfer procedure (63%, 173/273) as either their second or third most preferred statistic. Similar proportions of respondents reported that they "would not choose" each proposed statistic as their chosen statistic (12-14%) although this was highest in births per embryo transfer procedure (14%, 38/273) and births per egg collection procedure (14% 39/273).

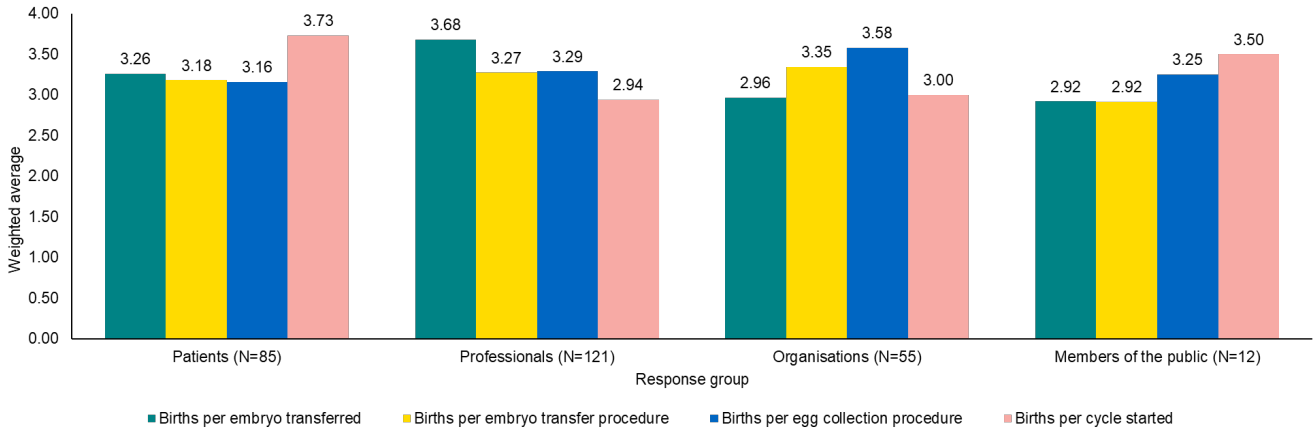
Figure 1. Preference of a clinic's main profile page statistic



Q: ***Which of these options do you think should be a clinic's main profile page statistic?*** Please place the below options in order of preference from one to four (one being most preferred, four being least preferred option) by writing the number (1, 2, 3, or 4) in the corresponding box. If you would not choose one, or any, of these options please put a cross (X) in the box (N=273).

12.4. However, differences in preference were seen between response groups (Figure 2). The most preferred method of presenting statistics on a clinic's main profile page for patients was using births per cycle started (3.73), followed by births per embryo transferred (3.26). Patients least preferred method was births per egg collection procedure (3.16). Professionals most preferred method was births per embryo transferred (3.68) and least was births per cycle started (2.94). Organisations most preferred method of presenting statistics on a clinic's main profile page was births per egg collection procedure (3.58) and least preferred was births per cycle started (3.00).

Figure 2. Preference for presenting a clinic's main profile page statistic by response group



Q: ***Which of these options do you think should be a clinic's main profile page statistic?*** Please place the below options in order of preference from one to four (one being most preferred, four being least preferred option) by writing

the number (1, 2, 3, or 4) in the corresponding box. If you would not choose one, or any, of these options please put a cross (×) in the box (N=273).

12.5. Free text responses received from professionals and organisations often provided further context as to why they had ranked different statistics in a particular order or, conversely, why another way of presenting the main profile page statistic would not be suitable. The quotes provided by respondents throughout this report were chosen to give an indication of some of the views expressed.

12.6. Some professionals and organisational responses felt births per cycle started would be a suitable profile page statistic as it "accurately reflects the patient journey from the very start of treatment" and represents differences in laboratory performance. While some voiced concerns that this may lead to clinics deliberately taking on fewer poor prognosis patients (as this would affect their overall main profile page statistic) or may "penalise patient-friendly strategies such as minimal stimulation, cancelled cycles, or multiple egg collections". Births per embryo transferred was preferred by organisations and professionals as it takes into account the quality of embryo transferred and encourages single embryo transfer Conversely, some others felt it does not include cycles which do not reach embryo transfer and therefore may not provide a full picture for patients. Similar sentiments were mentioned about birth per egg collection procedure and births per embryo transfer procedure, although fewer respondents mentioned these statistics specifically.

"There are positives and negatives for each option of how to present the data and if presented in isolation as only one option, then we run the risk of some clinics and patients not being fairly represented. As a clinic we feel that per cycle started is the fairest option, and allows laboratory standard to be taken into account - ie if fertilisation rates or good quality blastocyst rate is poor then lower rate of freezing and therefore per cycle started/cumulative success will be lower. This also captures those clinics who may not freeze many embryos/opt to go straight to a further egg collection. However, may penalise those clinics who freeze 'average' embryos to offer a (smaller) chance to patients with limited NHS funding" Anonymous, on behalf of an organisation.

12.7. A small number of responses from organisations and professionals proposed different ways of presenting a clinic's main profile page statistic, such as live birth per new patient over a defined period or live births after a euploid embryo transfer.

12.8. While patients did not comment on specific benefits or drawbacks to the particular rate chosen, those that did were in favour a statistic that would show the portion of cycles which resulted in a baby from the start of treatment. Patients also often referred to additional information which they think they would like to see alongside any statistic.

"What is key to me as a patient is to understand how successful I am likely to be with a specific clinic, so it is key that the option of seeing success per cycle started is included. This is important because birth per embryo transfer or embryo transferred obscures the situations where the treatment doesn't yield any eggs or any viable embryos - from patient's perspective this is just as bad if an outcome as transferring an embryo and not resulting in success" A prospective, current or past fertility patient sharing personal views.

12.9. Many responses across different groups stressed that regardless of whatever method of presenting outcomes of treatment cycles at clinics, there was a need to ensure that statistics were presented clearly using plain language. There were also suggestions to include things such as visual aids, text to summarise any differences between metrics, the associated benefits and drawbacks of any metric chosen. Reasoning behind this was to improve understanding and reduce the risk of misinterpretation.

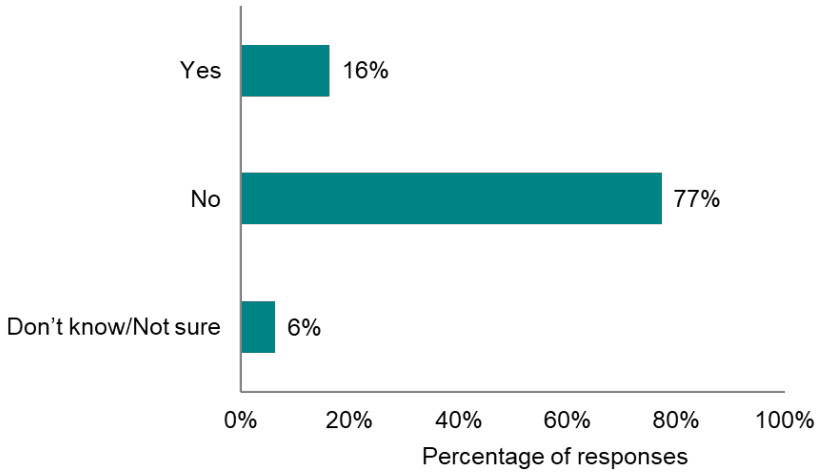
"…We also strongly recommend that statistics are presented with clear explanatory notes, plain-language definitions, and reliability ranges, so that patients understand both the meaning and the limitations of the figures. Patients frequently report feeling confused or distressed when interpreting success rates, and additional context helps prevent misinterpretation" Organisational response from British Infertility Counselling Association.

"The statistics need to [be] clearly understandable by lay public and also meaningful. It's that we understand what the chances are of having a baby with the treatment type we choose. We don't want to be bamboozled by births per embryo transferred or per cycle etc, we need to know what are our chances of having a successful live birth." A prospective, current or past fertility patient sharing personal views.

13. Presenting a combined rate

13.1. In total 270 responses were received for this section, which asked respondents whether the clinic's main profile statistic should be presented as a combined statistic to include all different types of IVF treatment such as fresh and frozen transfers and treatments using donor eggs or PGT-A. Most participants (77%, N=209/270) did not think that there should be one combined statistic presented (Figure 3).

Figure 3. Views on presenting the main profile page statistic as a combined statistic



Q: ***Do you think there should be one combined statistic that includes all different types of IVF treatment (fresh and frozen embryo cycles, donor eggs and PGT-A cycles)?*** Percentages are calculated on the total number of respondents to the question, rather than total respondents to consultation overall. A total of 3 respondents skipped this question (N=270).

13.2. This trend was seen across response groups with over 70% of patients, professional and organisations in agreement. Whilst a high proportion of public respondents were unsure (25%, 3/12), the majority (58%, 7/12) did not think that the clinic's main profile statistic should be presented as one combined statistic.

13.3. Overall, fewer responses specifically commented on presenting profile page statistics as a combined rate. When mentioning presenting data as a combined rate, very few highlighted the potential benefits of a combined rate. One response from an organisation highlighted that, in their opinion, a combined rate would promote innovative practices to get patients pregnant on the first try. Another understood it may be beneficial to report a "simpler" overall statistic.

13.4. Comparatively, more respondents provided further context to why they felt a combined rate was inappropriate. Common reasons presented by professionals and organisations against a combined rate were a reduction in the "meaning" of the statistics presented (as different

treatments may be used for different reasons/conditions) and the distortion of outcomes, particularly for treatments which have the potential to "manipulate" reporting outcomes and lead to a statistic that may mislead patients and the public. One patient echoed this point of view.

"If the HFEA is genuinely committed to protecting the public from misuse and misleading practices related to add-ons, then maximum effort should be made to ensure that data is presented as homogeneously and transparently as possible. Allowing clinics to mix outcomes from donor egg cycles, PGTA, and freeze-all strategies without clear separation introduces a high risk of inflating success rates and misinforming the public.… "An individual sharing their professional views.

14. Inclusion of different treatment types

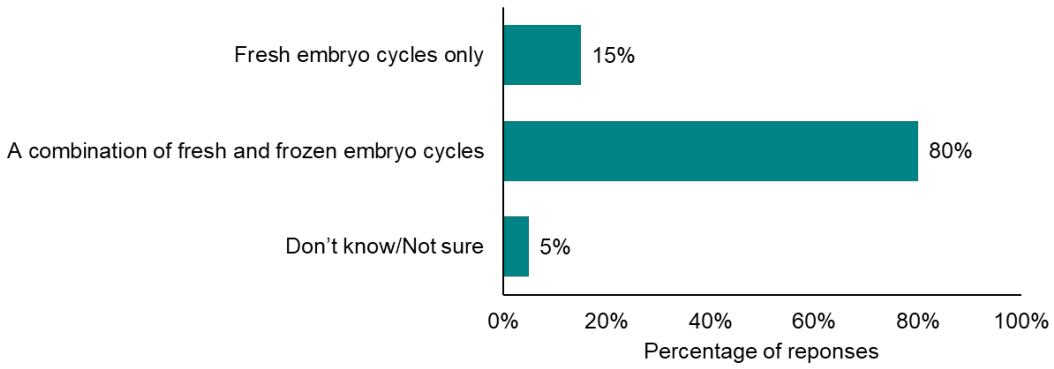
14.1. Respondents were then asked to indicate their preference for treatments to include in a clinic's main profile page statistic, if it was not presented as a combined rate. Those who would prefer a combined statistic (including fresh and frozen embryo cycles, donor eggs and PGT-A cycles), were excluded from the below analysis (N=44).

Fresh/frozen embryo transfer

14.2. In total 223 respondents answered this question, which asked them to indicate what their preference would be on the inclusion of frozen embryo cycles, should births per embryo transfer procedure or births per embryo transferred be chosen as a clinic's main profile page statistic.

14.3. Most respondents (80%, 178/223) were in favour of including a combination of both fresh and frozen embryo transfer cycles in the main profile page statistic compared to only 15% (34/223) who would prefer for it to include fresh embryo transfer cycles only (Figure 5). Just 5% (11/223) were unsure.

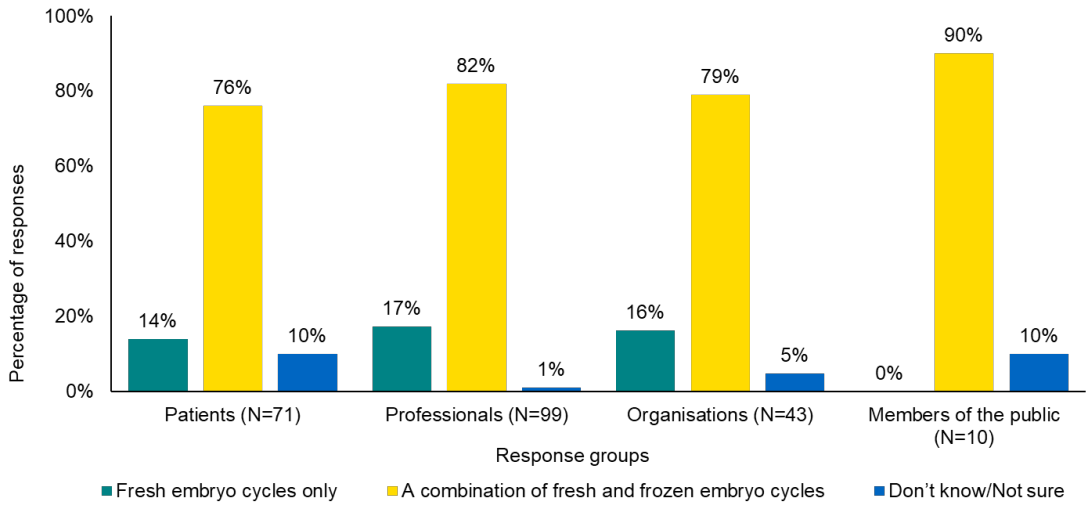
Figure 5. Views on including fresh and/or frozen embryo cycles in a clinic's main profile page statistic



Q: ***Which of the following would be your preference if births per embryo transfer procedure or births per embryo transferred was chosen as a clinic's main profile page statistic?*** Percentages are calculated on the total number of respondents to the question, rather than total respondents to consultation overall. Respondents who answered that yes to presenting the profile page statistic as a combined rate were excluded from this question. A total of 3 respondents skipped this question (N=223).

14.4. When looking at this by response group, over 70% of all response groups preferred for the statistic to include a combination of both fresh and frozen embryo transfers (Figure 6). However, around 10% of both patients (7/71) and members of the public (1/10) were unsure.

Figure 6. Views on including fresh and/or frozen embryo cycles in a clinic's main profile page statistic by response group



Q: ***Which of the following would be your preference if births per embryo transfer procedure or births per embryo transferred was chosen as a clinic's main profile page statistic?*** Percentages in the above figure are calculated on the total number of respondents to the question, rather than total respondents to consultation overall. Respondents who answered that yes to presenting the profile page statistic as a combined rate were excluded from this question. A total of three professionals skipped this question (N=223).

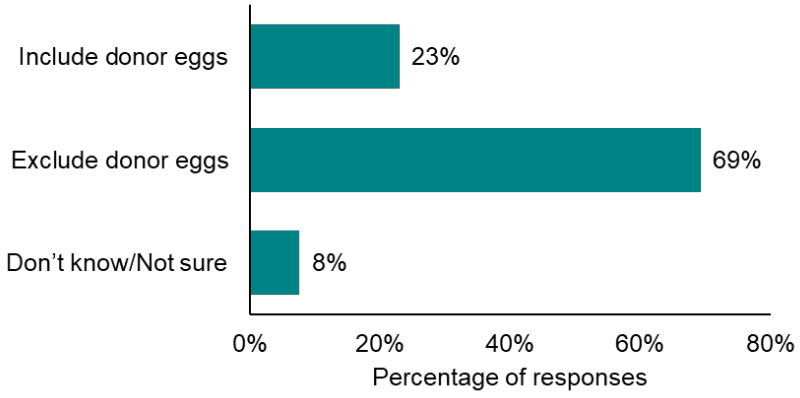
14.5. Many of the free text responses which specifically mentioned whether fresh or frozen embryo cycles should be included from a clinic's main profile page statistic were from professionals and organisations, who provided further emphasis or context on their answers. Views were mainly from those stating that fresh and frozen embryo transfer cycles should both be reported on but separately, rather than combined. Some provided further context as to what information was needed to ensure proper interpretation if fresh and frozen embryo transfer cycles were combined such as including providing the ratio of fresh and frozen cycles or by the age of the at which egg collection occurred. Only one patient provided a free text response on this topic, who was in favour of presenting outcomes from fresh and frozen cycles separately in the "View detailed statistics" section of the CaFC tool.

Donor egg treatments

14.6. In total 221 respondents answered this question, which asked whether treatments with donor eggs should be included or excluded from a clinic's main profile page statistics.

14.7. Over 69% (153/221) of respondents were in favour of excluding treatments using donor eggs in a clinic's main profile page statistic while 23% (51/221) were in favour of including treatments using donor eggs (Figure 7).

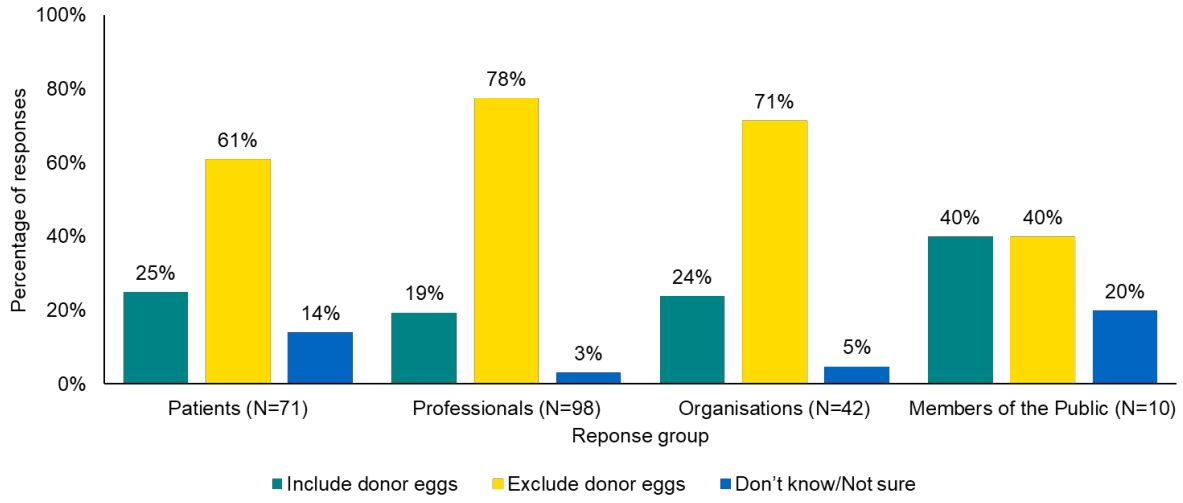
Figure 7. Views on including treatments using donor eggs in a clinic's main profile page statistic



Q: ***Should treatments using donor eggs be included or excluded from a clinic's main profile page statistics?***
Percentages in the above figure are calculated on the total number of respondents to the question, rather than total respondents to consultation overall. Respondents who answered that yes to presenting the profile page statistic as a combined rate were excluded from this question. A total of 5 respondents skipped this question (N=221).

14.8. Over 70% of both professionals (78%, 76/98) and organisations (71%, 30/42) were in favour of excluding treatments using donor eggs in a clinics main profile page statistic (Figure 8). Although a high proportion of patients were also in favour of excluding donor eggs (61%, 43/71), a quarter were in favour including treatments using donor eggs (25%, 18/71). Equal proportions of members of the public were both in favour of including and excluding treatments using donor eggs in a clinic's main profile page statistic (40%, 4/10). The proportions of both patients (14%, 10/71) and members of the public (20%, 2/10) who were unsure about whether treatments using donor eggs should be included or excluded was higher than professionals (3%, 3/98) or organisations (5%, 2/43).

Figure 8. Views on including treatments using donor eggs in a clinic's main profile page statistic by response group



Q: ***Should treatments using donor eggs be included or excluded from a clinic's main profile page statistics?***
Percentages are calculated on the total number of respondents to the question, rather than total respondents to consultation overall. Respondents who answered that yes to presenting the profile page statistic as a combined rate were excluded from this question. A total of four professionals and one organisation skipped this question (N=221).

14.9. Similar to the above section on fresh and frozen embryo cycles, most respondents provided further reasoning behind their decision to exclude donor eggs from a clinic's profile page statistic. Responses from organisations and professionals mainly centred around the fact that, in their view, combining treatments using own and donor eggs may be confusing or misleading to patients due to the impact of age on fertility and its subsequent effect on outcomes of treatment. A few respondents clarified that they would wish to see outcomes from donor eggs reported on, but separately.

14.10. A small number of patients provided free text responses which highlighted their views on the inclusion/exclusion of donor eggs. Most felt these should be separated out as they are "distinctive" and would make it "nearly impossible" to choose a clinic. However, there were comments from patients who felt that while it was important to separate these out, it would not be appropriate to exclude these cycles from statistics overall.

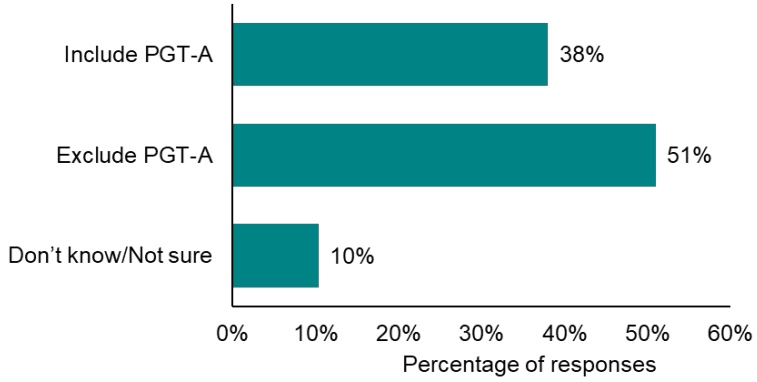
"To mix egg donation statistics would change the data completely as it might indicate a clinics success treating a 43-year-old but it makes a huge difference if they are not her eggs. Transparency is key" A prospective, current or past fertility patient sharing personal views.

Pre-implantation genetic testing for aneuploidy (PGT-A)

14.11. In total 221 respondents answered this question, which asked whether treatments with PGT-A should be included or excluded from a clinic's main profile page statistic.

14.12. Half (51%, 113/221) of respondents were in favour of treatments using PGT-A being excluded from a clinic's main profile page statistic. However, 38% (85/221) were in favour of including treatments using PGT-A in a clinic's main profile page statistic (Figure 9).

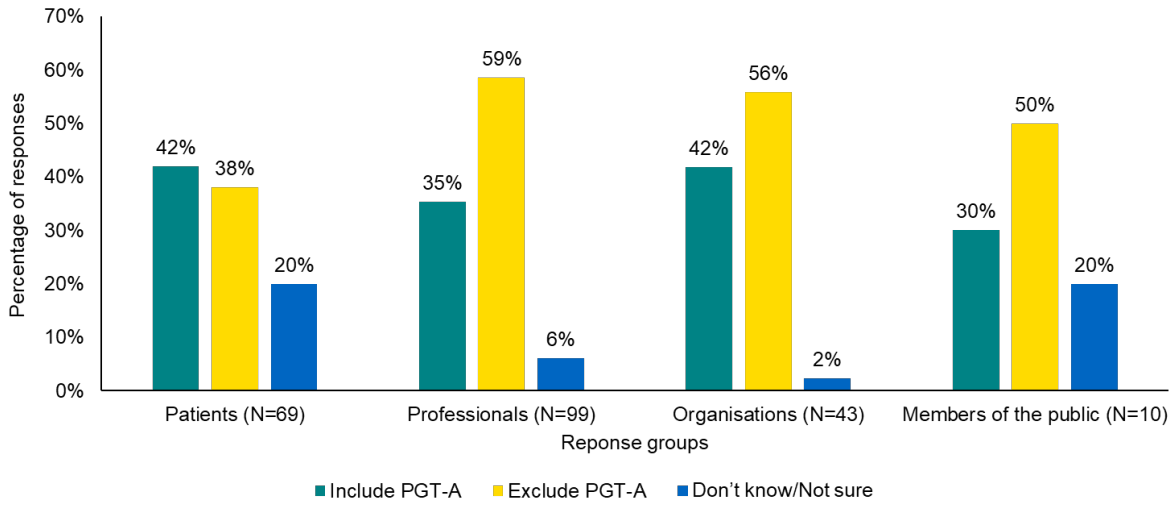
Figure 9. Views on including treatments using PGT-A in a clinic's main profile page statistic



Q: ***Should treatments using PGT-A be included or excluded from a clinic's main profile page statistics?***
Percentages in the above figure are calculated on the total number of respondents to the question, rather than total respondents to consultation overall. Respondents who answered that yes to presenting the profile page statistic as a combined rate were excluded from this question. A total of 5 respondents skipped this question (N=221).

14.13. Differences were seen between response groups (Figure 10). A slightly higher proportion of patients were in favour of including treatment using PGT-A in a clinic's main profile page statistic (42%, 39/69 vs 38%, 26/69 exclude treatments using PGT-A). While a higher proportion of professionals (59%, 58/99), organisations (56%, 24/43) and members of the public (50%, 5/10) were in favour of excluding treatments using PGT-A from the profile page statistic .The proportions of patients (20%, 14/69) and members of the public (20%, 2/10) who were unsure about whether to include PGT-A treatments was higher than professionals (6%, 6/99) or organisations (2%, 1/43).

Figure 10. Views on including treatments using PGT-A in a clinic's main profile page statistic by response group



Q: ***Should treatments using PGT-A be included or excluded from a clinic's main profile page statistics?*** Percentages are calculated on the total number of respondents to the question, rather than total respondents to consultation overall. Respondents who answered that yes to presenting the profile page statistic as a combined rate were excluded from this question. A total of two patients and three professionals skipped this question (N=221).

14.14. Most responses provided either further specified their choices in the consultation or provided additional context as to their thoughts on the inclusion or exclusion of PGT-A cycles in the profile page statistics.

14.15. Patients who mentioned PGT-A in their responses wanted to see the outcomes of cycles with PGT-A separately, so as not to "confuse statistics". Most responses from professionals and organisations also stated that outcomes of treatments using PGT-A should be reported separately for the same reasons. Additionally, some responses from professionals and organisations voiced concerns that, by including PGT-A in the profile page statistics, this may mislead patients about the "actual effect of PGT-A", particularly given it's inclusion on the HFEA's treatment add-ons list for having limited evidence of it's effectiveness.

"If the HFEA is genuinely committed to protecting the public from misuse and misleading practices related to add-ons, then maximum effort should be made to ensure that data is presented as homogeneously and transparently as possible. Allowing clinics to mix outcomes from donor egg cycles, PGTA, and freeze-all strategies without clear separation introduces a high risk of inflating success rates and misinforming the public. This loophole benefits clinics that intentionally adopt such strategies to manipulate reporting outcomes…" An individual sharing their professional views.

"…PGT-A reporting: Results of PGT-A cycles should be reported separately, to avoid misleading patients about the actual effect of PGT-A, as outlined in the consultation document. Presentation on Choose a Clinic website: The way PGT-A is presented should be carefully considered, to avoid creating the impression of endorsement of a technique currently rated red for its effectiveness in increasing success rates." An individual sharing their professional views.

14.16. Conversely, a small number of responses from organisations/professionals were in favour of including PGT-A in a clinic's main profile page statistic. These responses were provided alongside either detailed information of the other benefits that they have seen from PGT-A use in their clinic or several different options of how it could be presented on the page.

15. Considerations for the HFEA

15.1. Many of the responses to the consultation highlighted additional considerations for the HFEA to take into account when thinking about how information is presented on CaFC to increase clarity and transparency for patients and the public. Several suggestions were made for additional information to be included (such as more demographic breakdowns like more granular age categories or patient ethnicity) or links to additional verified data sources. Many of the suggested additional statistics mentioned (such as number of egg collections, number embryo transfers and outcomes by treatment type) are already available in the "View detailed statistics" section of CaFC (see **Annex D**). Suggestions were also provided on how additional tools, such as visual aids or infographics, and plain language could be used to increase clarity and transparency for those using the CaFC tool.

15.2. Many comments also outlined future developments they would like to see to the CaFC tool to make it easier for patients and the public to find reliable information about outcomes at HFEA-licensed clinics. While outside the scope of this consultation, these responses should form part of future work undertaken by the Authority to review how information clinics and the outcomes of treatments is presented to patients.

16. Methodology

Consultation development

16.1. The focused consultation was designed to be as lay friendly as possible with information provided to enable people without detailed knowledge to engage with the questions. Where possible, jargon, technical terms, or complex language has been avoided. Visual aids such as images and tables were also used to support understanding.

16.2. Following the July Authority meeting, a draft survey was developed with input from internal staff and Authority members with expertise in social research and survey design, clinical and scientific knowledge, public involvement and data analysis. A webpage was also drafted to provide further background information to the consultation, which was the 'landing page' for the consultation.

16.3. Once a draft consultation was agreed, it was piloted with a range stakeholders, including members of our Professional Stakeholder Group (PSG) and Patient Engagement Forum (PEF). Feedback was reviewed by the consultation working group and, after amendments were made, a second round of user testing was run. This was carried out to ensure that the consultation functioned as planned in the platform, was clinically accurate and was accessible to a range of audiences, particularly patients.

16.4. A third-party software, built by SurveyMonkey, was used to host this consultation, information on accessibility of this software is available on the SurveyMonkey **website**. The HFEA also provided the option for respondents to request the survey in an alternative, accessible format in cases where the survey was unable to meet user requirements.

Format and fieldwork period

16.5. The consultation ran for six weeks from 18 August 2025 to 30 September 2025. It was publicised widely across HFEA social media channels on Facebook, Twitter, Instagram and LinkedIn and shared via the Clinic Focus newsletter. It was also promoted on the HFEA website, shared directly with clinic PR's by email and via partner organisations and stakeholders. Respondents could respond via an online survey or email using the questionnaire in an accessible Word document. It was restricted to only those over the age of 18 and when

using the online questionnaire, and was only possible to take the survey once from the same browser.

16.6. Monitoring of the survey responses took place on a bi-weekly basis with follow-ups with groups and re-posts on social media during the period that the consultation was open.

Data cleaning

16.7. We received 486 responses to this consultation. A total of 213 responses were excluded due to being incomplete, abandoned or not meeting eligibility criteria. Of those 213, 83% (177) respondents did not provide an answer to the required question asking for their preference on a clinic's main profile page statistic. The remaining 17% (36 responses) were not submitted by respondents despite clear direction given in the consultation text. It was therefore assumed these respondents no longer wished to participate.

16.8. In total, 273 complete, submitted responses were included in the final analysis. Free text responses which did not directly relate to the topic consulted on asked were beyond the scope of this consultation are summarised at the end of this report but will form part of further, more detailed work.

Analysis

16.9. Apart from the question on ranking preferences for the way in which a clinic's main profile page statistic would be presented, all questions in the main body of the consultation were optional. Individual respondent groups refer to responses from the professional, professional/patient, patient, and member of the public response groups.

16.10. Percentages provided in figures have been calculated from the total number of responses received for that specific question, rather than the total number of responses to the consultation. Respondents who did not respond to a question were excluded from the summary analysis where relevant and corresponding N numbers are included in the figures and figure notes directly below.

16.11. 88 free text responses were received to the consultation. These were analysed using a coding framework developed by labelling of overarching themes, updating as necessary to ensure flexibility and reliability. The framework allowed key themes and issues to be summarised across the responses. Further, more detailed analysis of themes which fell outside the scope of this consultation is planned.

16.12. The selection of quotes provided by respondents throughout this report were chosen to represent key themes drawn from the coding framework. Suspected spelling errors in quotes have been corrected and denoted with square brackets within the text of the quote. Explanations of abbreviations in quotes have also been added for clarity.

16.13. Prior to publication, a number of quality checks were undertaken to ensure data accuracy. This included manual validation of consultation responses, structural checks to underlying data, consensus coding and a thorough check of all figures listed in the consultation (not by the author of this summary report) and signed off by a third member of the team. The summary report was also reviewed by several members of staff internally to ensure accuracy of data and messages.

Generalisability

16.14. Responses received are only representative of those who took part in the consultation and should not be interpreted as being representative of UK public opinion. Demographic information such as age or ethnicity was not collected. This was agreed by the Authority to adhere to the principle of data minimisation, and it was decided early on that a full analysis by demographic background would not be possible during the timeframe.

Strengths

16.15. The consultation received engagement from a range of stakeholders i.e., professionals, organisations and prospective, current or future patients. Due to the complex nature of the topics covered, the consultation text was user tested with several different stakeholder groups (including patients and professionals). In addition to this, visual aids were also developed and user tested to ensure that the consultation was as accessible as possible to a wide audience. Instead of asking respondents to choose one rate, this consultation allowed respondents to rank rates in order of preference and/or to choose none. This allowed us to gather as wide a perspective of views across different groups as possible. Respondents also had the opportunity to provide any additional comments they had on the topics addressed in the consultation to allow for the Authority to gain further context into the choices made.

Limitations and mitigations

16.16. When reviewing responses submitted on behalf of an organisation to the consultation, there were five organisations where more than one response was submitted on behalf of an organisation. Due to this, 12 individual responses submitted were determined to have incorrectly classified themselves under the "respondent type" question and should instead be regarded as "individuals sharing their professional view". This is based on our assumption that a an organisational response would be a single, unified response sharing the views of the organisation as whole. Where possible, those who provided an email address were contacted to verify whether their response was submitted correctly.

16.17. Due the minimal impact overall, poor engagement when clarifying responses and the need to share findings with the Authority to ensure that deadlines to update CaFC were met, responses were not reclassified. If there was no email address associated with the response, we were unable to validate these responses. In cases where there was only one response provided by an organisation or one response associated with contact details, these responses were not verified.

16.18. Additionally, across both the professional and organisational response groups there were a high number of responses from two individual organisations (17% and 20%, respectively). A large proportion of these respondents provided the same or very similar responses and may reflect standard practice at those clinics. As it is known that clinics differ in the treatments offered, caution is advised when extrapolating these findings to the rest of the sector. This was a known risk of the consultation and the HFEA used every opportunity to share the consultation text with stakeholders across the sector.

Timelines and punctuality

16.19. The fieldwork period of the consultation began in August 2025 and lasted six weeks. Analysis and report writing began on 01 October 2025 and was completed on 16 October 2025. A short analysis period was necessary to ensure that results of the consultation were available for Authority members to review in November 2025, prior to the scheduled CaFC update.

17. Organisations responding to the consultation

The organisations whose representative views were provided for this consultation and who consented for the attribution and publication of their comments are set out below. 23 responses provided on behalf of an organisation but did not name the organisation they were responding on behalf of. Of those who named an organisation, 14 respondents preferred for their comments to be anonymised. In 5 cases there was more than one response from an individual organisation.

1. Association of Reproductive and Clinical Scientists (ARCS)

2. Avenues
3. Beginnings assisted conception unit Epsom & St Helier
4. Bourn Hall Clinic (Norwich)
5. Bourn Hall Clinic (Cambridge)
6. Bourn Hall (Wickford)
7. British Fertility Society
8. British Infertility Counselling Association
9. Care Fertility
10. “Create Health” / or “Create Fertility”
11. CRGH
12. Gateshead Fertility
13. Progress Educational Trust
14. Sarah Banks Coaching/TTC Support UK
15. The Fertility Alliance

Annex B – Text of focussed consultation

Summary

The Human Fertilisation and Embryology Authority (HFEA) is seeking views on the main profile page statistics shown on each licensed clinic's Choose a Fertility Clinic profile page.

This consultation closes on 30 September 2025 at 05:00 PM (BST).

Introduction

The HFEA provides information to patients and the wider public in many ways, including through the Choose a Fertility Clinic (CaFC) function on our website, which has information about UK licensed fertility clinics.

The CaFC information is not a tool to predict an individual patient's chance of having a baby but rather it shows data about outcomes for patients treated at a clinic and other information for each UK licensed clinic.

There are different ways to calculate fertility treatment success rates, depending on what point in the process we count from or what statistics we use. Different approaches have their own benefits and drawbacks.

Purpose of consultation

Fertility treatment has changed significantly since CaFC was last reviewed by the HFEA in 2016-17. We are running this consultation to get views on which statistics are most helpful for the public and best represent fertility treatment today, to support the HFEA in deciding what statistics should be shown on a clinic's main profile page to give a broad overview of that clinic's success rates.

We have provided relevant information before each question and on a **webpage**, which you may find useful to read or refer to while responding.

We would recommend completing this consultation on a laptop or tablet if possible.

This is a focused consultation asking for views on only **one part** of CaFC: **the clinic's main profile page statistics (image below)**.

We are not consulting on the "Inspection rating" or "Patient rating" parts of a clinic's CaFC page. More detailed statistics regarding clinic performance will continue to be available in the "View detailed statistics" section.

The consultation should take around **30 minutes** to complete. If you cannot use the online consultation, or need the consultation in an accessible format, please email: enquiriesteam@hfea.gov.uk.

Your participation

Completing this consultation will not affect your treatment, your research, or your clinic. If you use the free text boxes provided, please do not include any information that could identify you if you are responding as an individual in a personal capacity (for example, as a patient). In these cases, any personal data submitted will be removed.

Any information, comments, or views you provide may be used in reports or documents we produce that are likely to be published online. If you are responding on behalf of an organisation or in a professional capacity, you can provide the name of the organisation, which may be associated with the response provided, and an email address, which may be used to verify your response after submission.

The personal information you supply will be processed in accordance with the UK GDPR and the Data Protection Act 2018. To find out more about how the HFEA manages personal information, please view our **Privacy Policy**.

Participation in this consultation is **voluntary**, and you can **withdraw at any time before completing the consultation** by closing the browser. However, due to design, it may not be possible for us to withdraw your data once you have submitted your response.

Any question marked with a red asterisk (*) is a required question, if you do not answer you will be unable to complete the consultation.

* **In order to complete this consultation, you must be aged 18 or over.**

☐ Yes, I am aged 18 or over

☐ No, I am not yet 18 (ineligible to participate)

* **By continuing, you confirm that you have read and understood the information provided, and you give your consent for your responses to be shared with the HFEA.**

☐ I consent.

About you

1. * **In what capacity are you responding to this consultation (please select only ONE option):**

☐ A prospective, current or past fertility patient sharing personal views (this can include partners and family members)

☐ An interested member of the public sharing my personal views

☐ An individual sharing my professional views (for example a member of clinic staff, other relevant healthcare professional or clinical researcher)

☐ On behalf of an organisation (for example, professional bodies/patient organisations/charities, HFEA licensed clinics and others)

If you are responding as a prospective, current or past fertility patient sharing personal views (this can include partners and family members) or an interested member of the public sharing my personal views, please move on to question 6.

If you are responding as an individual sharing professional views, or on behalf of an organisation, please complete questions 2-5:

2. **What is the name of your organisation? (optional):**

3. **Please provide your organisational email address (optional):**

4. **Which of the following best describes your organisation/where you work? (please select only ONE option):**

☐ HFEA licensed clinic

☐ A UK professional body or organisation

☐ A UK research group or organisation

☐ A UK academic group or organisation

☐ A UK group, organisation, or charity representing patients or others

☐ Other (including organisations or professional bodies outside the UK), please specify:

5. **If you are responding as a member of clinic staff, which of the following best describes the HFEA-licensed clinic that you work at?**

☐ NHS

☐ Private

☐ Not sure/Prefer not to say

6. * **Before providing any further information, please confirm whether you are happy for your responses to be attributed to your organisation in any reports or documents we produce and publish online.**

☐ I consent to the publication and attribution of my quotes.

☐ I prefer my comments to be anonymised.

Should you change your mind after completing the consultation, you can withdraw your consent by contacting **enquiriesteam@hfea.gov.uk**.

A clinic's main profile page statistic

The following questions will ask for your choice for a clinic's main profile page statistic. Below each option is a short explanation of the statistic. **All of these would be split by age.**

Statistics on twin and triplet pregnancies (multiple birth rate) will continue to appear on a clinic's CaFC profile page.

Please read the information below on the different options **before** answering the question. You may also find it useful to refer to the table and infographics below.

This consultation refers to babies born or pregnancies from all types of IVF treatment. These statistics do not include information on outcomes from donor insemination (DI) treatment or intrauterine insemination (IUI).

Births per cycle started

Births per cycle started shows the percentage of **all IVF treatment cycles** that led to a birth.

What does it include?

This includes all cycles from the start of using stimulatory drugs in a fresh embryo cycle or, in a frozen embryo cycle, when embryo(s) are thawed.

It shows the percentage of births from the start of an IVF cycle because all cycles are counted. This includes cycles that do not get to the point of egg collection in fresh cycles or embryo transfer in frozen cycles.

The statistic does not count how many embryos are transferred (unlike births per embryo transferred).

Births per cycle started can also be used to show outcomes over more than one IVF cycle (known as a cumulative success rate).

How is it calculated?

Births per cycle started is calculated using the number of "birth events" (meaning twin or triplet births would only be counted once) divided by the number of treatment cycles, shown as a percentage. This is calculated using cycles started over a 12-month period and includes any outcomes of those cycles over a period of two years.

Because of the way births per cycle started is calculated, **it includes both fresh and frozen embryo transfers from the same egg collection**.

Births per egg collection procedure

Births per egg collection procedure shows the percentage of **egg collection procedures** that led to a birth.

What does it include?

This includes all egg collection procedures. It also includes births from any following frozen embryo cycles from that same egg collection procedure, starting at the point the embryo(s) are thawed.

Births per egg collection procedure does not include any cycles that do not get to egg collection stage and so does not show the percentage of births from the start of an IVF cycle. This statistic does not count how many embryos are transferred (unlike births per embryo transferred).

Births per egg collection procedure can be used to show outcomes over more than one IVF cycle (known as a cumulative success rate).

How is it calculated?

Births per egg collection procedure is calculated by using the number of "birth events" (meaning twin or triplet births would only be counted once) divided by the number of egg collection procedures, shown as a percentage. This is calculated using all the egg collection procedures that took place in a clinic over a 12-month period and includes any births from those egg collection procedures over a period of two years.

Because of the way births per egg collection procedure is calculated, **it includes both fresh and frozen embryo transfers from the same egg collection**.

Births per embryo transfer procedure

Births per embryo transfer procedure shows the percentage of **embryo transfer procedures** that led to a birth.

What does it include?

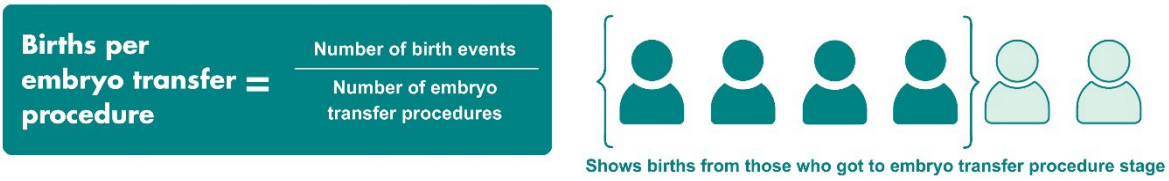
This includes all embryo transfer procedures. This can include fresh or frozen embryo transfers separately or both.

This does not include any cycles that may have been cancelled before the embryo transfer procedure and so does not show the percentage of births from the start of an IVF cycle. This statistic does not count how many embryos are transferred (unlike births per embryo transferred).

This statistic is not usually used to show outcomes over more than one IVF cycle, (known as a cumulative success rate) because it counts an embryo transfer procedure as a single event.

How is it calculated?

Births per embryo transfer procedure is calculated using the number of "birth events" (meaning twin or triplet births would only be counted once) divided by the number of embryo transfer procedures, shown as a percentage, for cycles started in a clinic over a 12-month period.



Births per embryo transferred

Births per embryo transferred is different to 'Births per embryo transfer procedure' in that it shows the percentage of **the total number of embryos transferred** that led to a birth.

What does it include?

This includes outcomes from embryos transferred. This can include fresh or frozen embryo transfers separately or both.

Births per embryo transferred accounts for cases where multiple embryos are transferred in the same procedure. This does not include any cycles that may have been cancelled before embryo transfer and so does not show the percentage of births from the start of an IVF cycle. This statistic counts each individual embryo that is transferred and, therefore, supports the use of single embryo transfer. Single embryo transfer is associated with avoiding the increased health risks for patients and their babies from twin and triplet pregnancies (multiple births).

This statistic is not usually used to show outcomes over more than one IVF cycle (known as a cumulative success rate) because it counts embryo(s) transferred as a single event.

How is it calculated?

Births per embryo transferred is calculated using the number of "birth events" (meaning twin or triplet births would only be counted once) divided by the number of embryos transferred, shown as a percentage, in a clinic over a 12-month period.

A clinic's main profile page statistic

The information above has been summarised below:

	Births per cycle started	Births per egg collection procedure	Births per embryo transfer procedure	Births per embryo transferred
Includes ovulatory stimulation stage*	✓	x	x	x
Includes egg collection stage*	✓	✓	x	x
Includes embryo transfer stage	✓	✓	✓	✓
Accounts for cases where multiple embryos are transferred in the same procedure	x	x	x	✓
Includes multiple cycles, both fresh and frozen transfers from the same egg collection (known as cumulative success rate)	✓	✓	x	x

**For frozen embryo transfers, this instead refers to when embryos are thawed*

7. Which of these options do you think should be a clinic's main profile page statistic? *

*Please place the below options in order of preference from one to four (**one** being **most preferred**, **four** being **least preferred** option) by writing the number (1, 2, 3, or 4) in the corresponding box. If you would not choose one, or any, of these options please put a cross (X) in the box.*

- ☐ Births per cycle started
- ☐ Births per egg collection procedure
- ☐ Births per embryo transfer procedure
- ☐ Births per embryo transferred

Summarised below are the different treatment types that could be included in your preferred main profile page statistic. Please read the information below for a further explanation of each **before** answering the next questions.

Fresh and frozen embryo cycles

Fresh cycles with a patient's own eggs was one of the main ways of comparing one clinic with another. But the decrease in the number and proportion of fresh embryo cycles means that if only fresh embryo cycles are included, this statistic may not accurately reflect a clinic's overall performance.

Typically, an IVF patient today will have a single fresh embryo transferred in their first cycle, and any additional suitable embryos frozen for later use. There are now more frozen embryo cycles compared to previous years. However, this differs between clinics, with some clinics doing more frozen embryo transfers than others.

Combining fresh and frozen embryo cycles reflects treatment as it is increasingly offered today. If both fresh and frozen embryo cycles are included, it could mean that the reliability of the data in each clinic could be increased due to the inclusion of more cycles.

Usually, births per cycle started and births per egg collection would include a combination of both fresh and frozen embryo cycles. If these were chosen as the main profile page statistic, they would be shown as a combined rate. However, if births per embryo transfer procedure or births per embryo transferred was chosen as the main profile page statistic, this could be shown either as fresh or frozen embryo transfers separately or as a combination of both.

Donor eggs

Donor eggs tend to be used for patients who are older, have a low ovarian reserve or have gone through menopause early. The chance of having a baby with IVF using donor eggs is generally higher compared to IVF using a patient's own eggs. This is because egg donors are typically younger than the IVF patients using them and are unlikely to have fertility issues. The reasons why a patient may use donor eggs, sperm, or embryos may differ. The statistic used on a clinic's main profile page would not be split by donor and partner sperm because, compared to the age of an egg donor, the age of a sperm donor will have a much smaller impact on live birth rates from treatment. Information on national success rates by sperm source (donor or partner) is included in the **HFEA dashboard**.

In 2023, 6% of all IVF treatment cycles used donor eggs, though in some clinics up to 31% of their IVF treatment cycles were with donor eggs. Further information is available **here**.

Taking out donor egg treatments could make comparison between clinics clearer. This is because if donor eggs are included in the rate along with treatments with a patient's own eggs, clinics that undertake more donor treatment than the national average may show an inflated success rate, which makes fair comparisons across clinics more difficult. However, where clinics carried out above average numbers of donor egg cycles, removing treatments using donor eggs might reduce the reliability of the clinic's data.

Pre-implantation genetic testing for aneuploidy (PGT-A)

PGT-A is classified as a treatment **add-on** by the HFEA, as evidence shows that for most patients, PGT-A does not increase the chances of having a baby.

PGT-A involves checking embryos for abnormalities in the number of chromosomes, as embryos that appear to have missing or extra chromosomes have less chance of developing into a baby. PGT-A is done on fresh embryos and while tests are being done, the embryos are frozen for transfer later once results are ready. Patients having embryos transferred with a normal chromosome number may, therefore, have a higher chance of having a baby from that particular embryo, as it may reduce the chance of a miscarriage. However, PGT-A often reduces the number of embryos available for transfer and may mean that there are no embryos to transfer.

This means, while the chance of a baby per embryo transferred may be higher, if we look at the chance of having a baby for each cycle of treatment started, it may be lower. The inclusion of PGT-A cycles would not include any cycles started that did not reach a stage of embryos being created.

In 2023, almost 3% of all IVF treatment cycles were PGT-A, though for a minority of clinics almost half of their IVF treatment cycles used PGT-A. Further information on this is available **here**.

Taking out cycles with PGT-A could make comparison between clinics clearer. This is because it does not reflect the many patients who may start a cycle of treatment, undergo PGT-A and don't have an embryo to be replaced as they are classed not suitable for transfer. Therefore, if PGT-A cycles are included in the births per embryo transferred calculation, clinics that undertake more PGT-A than the national average may show an inflated success rate. However, where clinics carried out above average numbers of PGT-A, excluding cycles where PGT-A has been used, might reduce the statistical reliability of the clinic's data.

A combined statistic

There are lots of different treatment types that could be included in your preferred main profile page statistic.

One way would be showing a single statistic for each clinic that includes **all different IVF treatment types** (including fresh and frozen embryo cycles, donor eggs and PGT-A cycles) carried out at a clinic over a period of time, **split by age**.

A single statistic would show the outcome for all different types of IVF treatment performed at a clinic combined. However, it could make it harder to compare between clinics because each clinic does different types of treatment and treats a mix of different patients.

8. **Do you think there should be one combined statistic that includes all different types of IVF treatment (fresh and frozen embryo cycles, donor eggs and PGT-A cycles)?**

☐ Yes

☐ No

☐ Don't know/Not sure

If you would prefer a combined statistic (including fresh and frozen embryo cycles, donor eggs and PGT-A cycles), you do not need to answer the below questions and can continue to the next

page. However, if you still complete the questions below, your responses will be taken out of the analysis because you answered yes there should be one combined statistic.

Breaking down by different types of IVF treatment

Below are the different treatment types that could potentially be included or removed from a clinic's main profile page statistic.

Please note, even if these treatments are not included in the main profile page statistic, these statistics will still appear on the "more detailed statistics" section of a clinic's CaFC page.

Information on each of these is included in the previous page - you can navigate between pages using the "Previous" and "Next" buttons below to read through the descriptions provided as many times as needed.

Additional information is also provided on the **website**.

9. Which of the following would be your preference if births per embryo transfer procedure or births per embryo transferred was chosen as a clinic's main profile page statistic?

☐ Fresh embryo cycles only

☐ A combination of fresh and frozen embryo cycles

☐ Don't know/Not sure

10. Should treatments using donor eggs be included or excluded from a clinic's main profile page statistics?

☐ Include treatments using donor eggs

☐ Exclude treatments using donor eggs

☐ Don't know/Not sure

11. Should treatments using PGT-A be included or excluded from a clinic's main profile page statistics?

☐ Include treatments using PGT-A

☐ Exclude treatments using PGT-A

☐ Don't know/Not sure

12. If you have any additional comments or suggestions you would like to make on the clinic's main profile page statistics, please use the box below.

You are about to submit your response. If you no longer wish to participate, close your browser. After you click SUBMIT, you will no longer be able to go back and change any of your answers.

Annex C -the changing fertility sector

The Human Fertilisation and Embryology Authority (HFEA) is seeking views on the main profile page statistics on each licensed clinic's Choose a Fertility Clinic profile page.

The consultation closes on 30 September 2025 at 05:00PM BST

To complete the consultation, please click here.

Introduction

The HFEA provides information to patients and the wider public in many ways, including through the Choose a Fertility Clinic (CaFC) function on our website, which has information about UK licensed fertility clinics.

The CaFC information is not a tool to predict an individual patient's chance of having a baby but shows data about treatment outcomes and other information for each UK licensed clinic.

How can we measure success from IVF?

There are different ways to measure success in fertility treatments and each of these have different benefits and drawbacks.

Although there is no agreed single statistic, there are some things that are helpful for people looking for information from clinics:

- There should be as few headline statistics as possible
- Any statistic should be easy to understand
- Statistics should allow for clear comparison across clinics
- Statistics should be representative of most treatments provided in any clinic.

Why consult on the clinic profile statistics

Choose a Fertility Clinic (CaFC) was last reviewed in 2016-17 after consultation and testing. The clinic profile page statistics agreed then were:

- **Birth per embryo transferred** shows the percentage of the total number of embryos transferred that led to a birth. This can include fresh or frozen embryo transfers separately or both.

  Births per embryo transferred is calculated using the number of "birth events" (meaning twin or triplet births would only be counted once) divided by the number of embryos transferred, shown as a percentage, in a clinic over a 12-month period.

- **Births per egg collection** shows the percentage of egg collection procedures that led to a birth. Because of the way births per egg collection procedure is calculated, it includes both fresh and frozen embryo transfers from the same egg collection procedure.

  Births per egg collection procedure is calculated by using the number of "birth events" (meaning twin or triplet births would only be counted once) divided by the number of egg collection procedures, shown as a percentage. This is calculated using all the egg collection procedures that took place in a clinic over a 12-month period and includes any births from those egg collection procedures over a period of two years.

- **Multiple births (e.g. twins or triplets)** –the total number of multiple birth events divided by the total number of birth events.

The fertility sector has changed significantly since these statistics were published and so it is a good time to ask what the most useful clinic profile page statistics are to use moving forward.

In **May 2025** we published three interim statistics:

- Live birth rate per embryo transferred – the “combined rate” taking account of all IVF treatment split under and over aged 38.
- Live birth rate per embryo transferred – the “fresh rate” comprising only fresh, stimulated IVF using own eggs split under and over aged 38.
- Multiple birth rates split under and over aged 38.

The changes in the UK fertility sector since 2016-17:

The balance of fresh and frozen embryo cycles has changed

Typically, an IVF patient today will have a single fresh embryo transferred in their first cycle, and any additional suitable embryos frozen for later use. There are now more frozen embryo cycles compared to previous years (Fertility treatment 2023: trends and figures). However, this differs between clinics, with some clinics doing more frozen embryo transfers than others.

The continuing importance of patient age and the use of donor eggs

One factor that has remained largely constant since 2016-17 is the importance of patient age on the chance of having a baby.

Figure 1. Average fresh embryo transfer IVF birth rate per embryo transferred using patient eggs by age group, 1991-2023

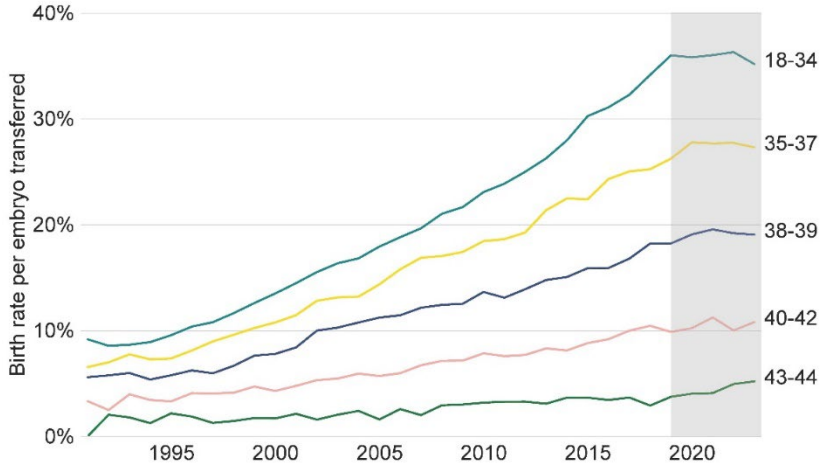


Figure 1 source: Fertility treatment 2023: trends and figures

Although the proportion of IVF cycles using donor eggs remained consistent between 2016 and 2023 (around 6%), in 2023 some clinics performed up to 31% of IVF treatment cycles using donor eggs.

The chance of having a baby with IVF using donor eggs is generally higher compared to IVF using a patient’s own eggs. This is because egg donors are typically younger than the IVF patients using them and are unlikely to have fertility issues.

If donor eggs are included in the rate along with treatments with a patient’s own eggs, clinics that undertake more donor treatment than the national average may show an inflated success rate, which makes fair comparisons across clinics more difficult.

The growth in cycles that use PGT-A in some clinics

PGT-A involves checking embryos for abnormalities in the number of chromosomes, as embryos that appear to have missing or extra chromosomes have less chance of developing into a baby. PGT-A is done on fresh embryos and, while tests are being done, the embryos are frozen for transfer later once results are ready. Patients having embryos transferred with a normal chromosome number may, therefore, have a higher chance of having a baby from that particular embryo, as it may reduce the chance of a miscarriage. However, PGT-A often reduces the number of embryos available for transfer and may mean that there are no embryos to transfer.

PGT-A is classified as a treatment add-on by the HFEA as evidence shows that, for most patients, PGT-A does not improve the chances of having a baby.

In 2016, 1% of IVF treatment cycles involved PGT-A. In 2023, almost 3% of all IVF treatment cycles were PGT-A, though in a minority of clinics almost half of their IVF treatment cycles use PGT-A.

The use of PGT-A in the UK is increasing and, when combined with a technique known as 'batching cycles' (where the patient undergoes several cycles before an embryo is transferred), this is likely to distort the reliability of birth per embryo transferred as a fair measure of clinic performance as it does not reflect patients who may start a cycle of treatment, undergo PGT-A, and don't have an embryo to transfer. Therefore, if PGT-A cycles are included in the births per embryo transferred calculation, clinics that undertake more PGT-A may show an inflated success rate, which could make comparisons across clinics more difficult.

Multiple births have decreased

In 2016-17, 11% of cycles in clinics led to a multiple birth (twins and triplet pregnancies). In 2023, the multiple birth rate was under 4% (Fertility treatment 2023: trends and figures). However, there are still a small number of clinics with significantly higher multiple birth rates and statistics on twin and triplet pregnancies will continue to appear on a clinic's CaFC profile page.

Figure 2. IVF multiple birth rate reduced further to 3.4% in 2023

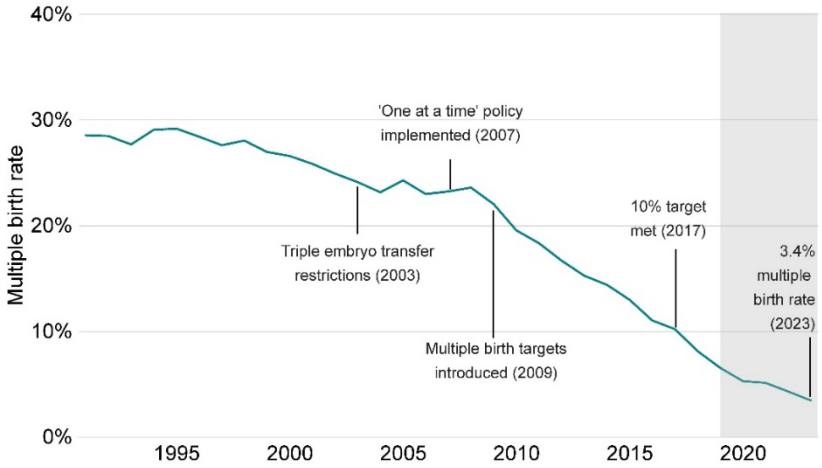


Figure 2 source: Fertility treatment 2023: trends and figures

A clinic's main profile page statistic

There are lots of different ways of showing a clinic's main profile page statistics. Different statistics include different stages of the treatment journey, these are summarised below:

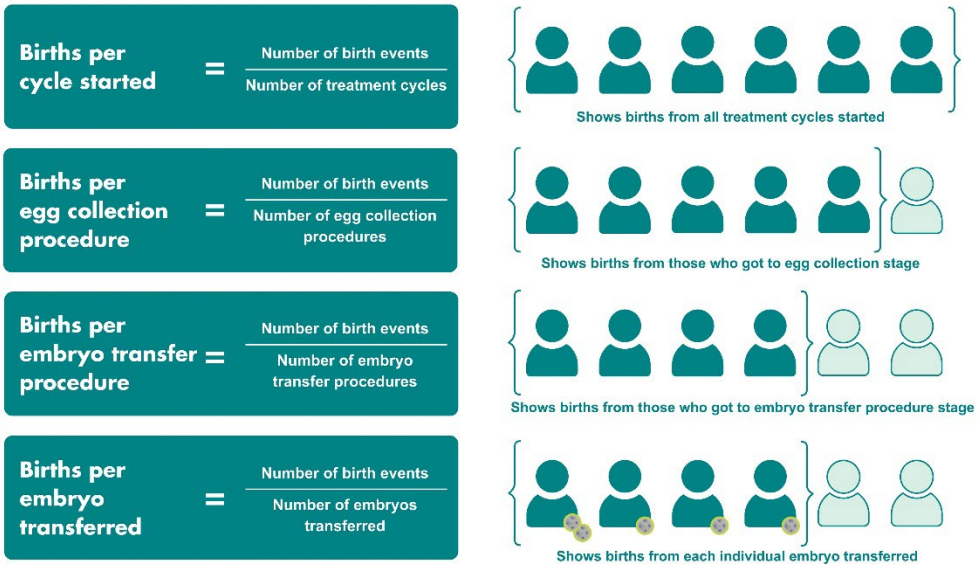
	Births per cycle started	**Births per egg collection procedure**	**Births per embryo transfer procedure**	**Births per embryo transferred**
Includes ovulatory stimulation stage*	✓	x	x	x
Includes egg collection stage*	✓	✓	x	x
Includes embryo transfer stage	✓	✓	✓	✓
Accounts for cases where multiple embryos are transferred in the same procedure	x	x	x	✓

Includes multiple cycles, both fresh and frozen embryo transfers from the same egg collection (known as cumulative success rate)	✓	✓	x	x

**For frozen embryo transfers, this instead refers to when embryos are thawed*

Different statistics start counting from different points in an IVF treatment cycle. This is illustrated in the figure below:

Figure 3. Calculations of a clinic's main profile page statistic



**This figure is for illustrative purposes only and is not meant to reflect actual proportions.*

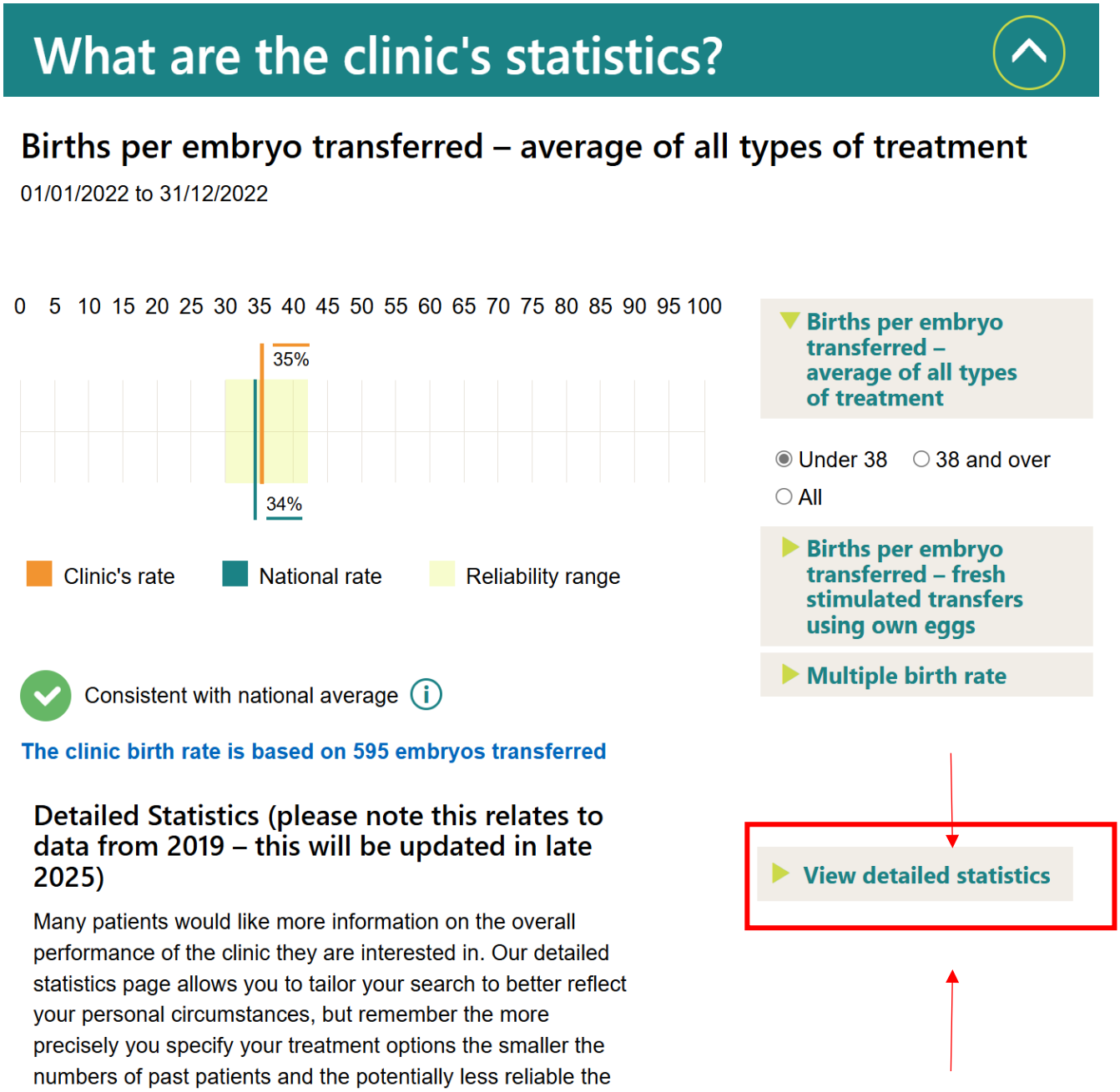
Further information

The data used in this page and the Fertility treatment 2023: trends and figures report is from the Register as of 1 May 2025. Further information on data quality as well as the methods used to create it can be found in our **Quality and Methodology report**.

Annex D - Detailed statistics screenshots

Once on a clinic's main profile page, there is an option to access 'detailed statistics'

Accessing detailed statistics from a clinic's main profile page, first navigate to "What are clinic's statistics" (below) and ensure the arrow is clicked to open the dropdown. Then navigate to:



The **drop-down menus** under detailed statistics allow users to select the data they'd like to view.

Please note, the list below is exhaustive but the options available to the user are dependent on what has been selected by them for the prior step(s); for example, some are only available to view if 'Donor Insemination' or 'IVF and ICSI' are chosen for step 2 etc.

Step 1

- Births (January 2016 - December 2016)
- Births (January 2017 - December 2017)

- Births (January 2018 - December 2018)
- Pregnancies (January 2019 - December 2019_
- Births over 3 years (January 2016 - December 2018)

Step 2

- Donor Insemination
- ISC
- IVF
- IVF and ISCI
- Natural IVF (no stimulation)
- Preimplantation genetic screening

Step 3

- 35-37
- 38-39
- 40-42
- 43-44
- All ages
- Under 35
- Over 44

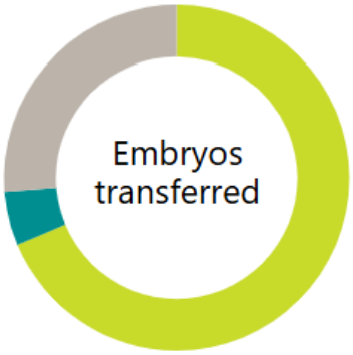
Step 4

- All cycles
- Stimulated cycles
- Unstimulated cycles
- Fresh embryos, donated eggs
- Fresh embryos, patients' eggs
- Frozen embryos, donor eggs
- Frozen embryos, patients' eggs

Example screenshots of what this data looks like are shown on the pages below.

At a glance

Number of cycles started	Number of cycles reaching egg collection stage	Number of cycles reaching embryo transfer stage
672	617	579



Average number of embryos transferred during all cycles
1.26

- **68%** Proportion single embryo transfers (elective)
- **5%** Proportion of single embryo transfers (non elective)
- **26%** Proportion of two embryo transfers
- **0%** Proportion of three embryo transfers

Cycle details

Number of cycles cancelled before eggs were collected

Patient had not produced enough eggs to collect after taking fertility drugs	42
Patient had an adverse reaction to fertility drugs – unsafe to continue cycle	0
Other	11
Reason not supplied	2

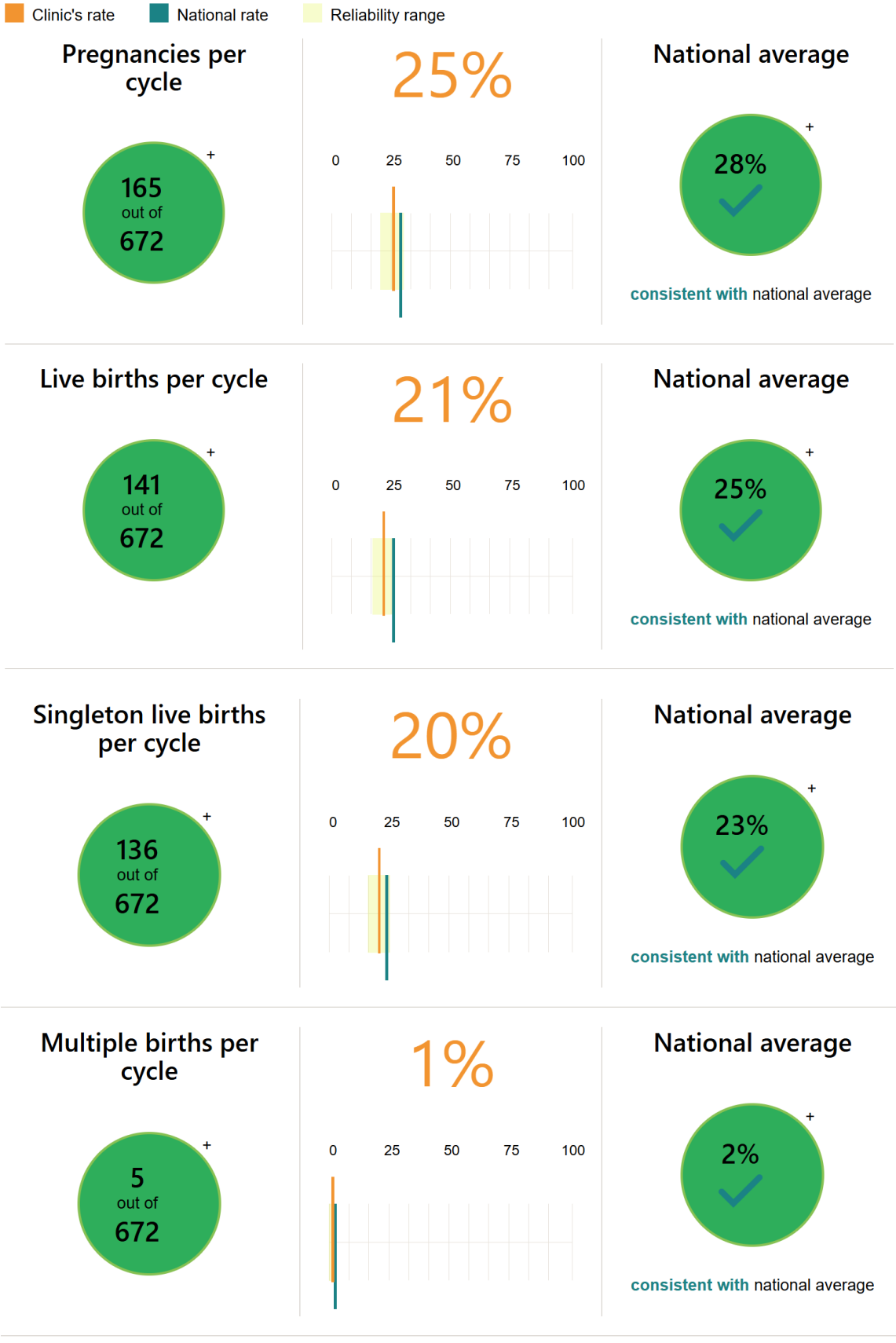
Number of cycles cancelled between egg collection and embryo transfer

Over response (Patient has produced too many eggs after taking fertility drugs and it would not be safe to continue the cycle)	0
Embryos did not develop normally	7
Embryos did not thaw properly (when cycle was using frozen embryos)	0
Embryos tested positive for a genetic test	0
Other	0
No embryos developed	31
Reason not supplied	0

Number of embryos transferred

Total number of embryos transferred during all cycles	732
Proportion of all embryos transfers that were blastocysts	46%

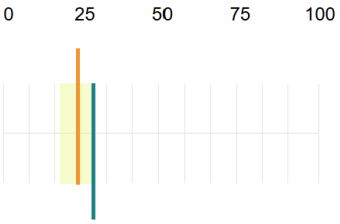
Pregnancies and births per treatment cycle



Live births per egg collection

141 out of 617

23%



National average

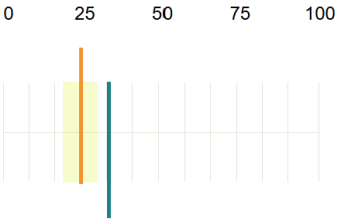
28%

consistent with national average

Live births per embryo transfer

141 out of 579

24%



National average

33%

consistent with national average