PET

Fertility • Genomics • Clarity

Fertility Problems: Assessment and Treatment

PET comments were submitted (in response to a NICE consultation) on 17 October 2025
NICE responded publicly to PET comments on 31 March 2026

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1. PET comment on Recommendation 1.1.5

Draft update of the Fertility Guideline, p5, line 25

Recommendation 1.1.5 says: *'Inform people who experience fertility problems that they may find it helpful to contact a peer group or other relevant organisation for support.'*

Please can the wording *'peer group or other relevant organisation for support'* be amended to *'relevant support group*'.

A growing number of individuals and organisations now offer peer support for a fee, and are liable to exploit the proposed wording for promotional purposes.

NICE response to PET comment

Based on stakeholder feedback, the Committee agreed to remove *'peer group'* from the Recommendation, only referring to *'relevant organisation for support'*.

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2. PET comment on Recommendation 1.2.4

Draft update of the Fertility Guideline, p8, Table 2

In **Table 2** of **Recommendation 1.2.4**, we note that data from the **Human Fertilisation and Embryology Authority** concerning intrauterine insemination (IUI) is from 2015-2019. Furthermore, we note that *'data from 2019 is preliminary'*.

Is there more recent and more robust data that could be used?

NICE response to PET comment

Table 2, which your comment refers to, has been updated in terms of cumulative probability of clinical pregnancy through 6/12 cycles of IUI based on more up-to-date data from HFEA dashboard (data from 1991 to 2023, however, data from 2020 to 2023 is preliminary).

3. PET comment on Recommendation 1.2.17

Draft update of the Fertility Guideline, p10, line 16

Recommendation 1.2.17 says: *'Advise women, trans men and nonbinary people with female reproductive organs who have a BMI of less than 18.5 kg/m² and who have irregular menstruation or are not menstruating that increasing body weight is likely to improve their chance of conception.'*

When a specific body mass index (BMI) is presented as a threshold beneath which patients should be advised to increase their body weight, if menstruation is irregular or absent, this is appropriate only in the context of additional consideration and support.

Specifically, it should be considered that there may be another underlying cause for the irregular or absent menstruation (and that this may warrant investigation), and that the patient may need specialist support in order to help them gain weight.

NICE response to PET comment

We don't disagree with your comment, but this would be outside of the remit of this *Guideline* to address. However, we expect healthcare professionals to use their clinical and professional judgment in their practice to consider potentially underlying causes or other considerations relevant to the clinical scenario.

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4. PET comment on Recommendation 1.2.28

Draft update of the Fertility Guideline, p12, line 9

Recommendation 1.2.28 says: *'If a woman, trans man or nonbinary person with female reproductive organs is using artificial insemination to conceive, offer further clinical assessment and investigation if they have not conceived after six cycles of insemination, in the absence of any suspected or known clinical cause of infertility. Where this is using partner sperm, the referral for clinical assessment and investigation should include her partner.'*

This Recommendation is predicated on the assumption that people will self-fund treatment in a licensed clinic. However, many people do not take this course of action, but instead use sperm donors whom they meet online.

These sperm donors will not have been screened for sexually transmitted infections, and will not have had their family history taken by a medical professional. Sometimes, people who choose this route find that the donor demands sexual intercourse.

If women have to self-fund IUI, they should nonetheless receive NHS-funded care – for example tests, drugs and advice – which will optimise their chances of success. They should also be given advice about how to stay safe when seeking IUI.

NICE response to PET comment

The Committee acknowledged that due to the costs of donor insemination and people needing to self-fund, people may end up using unregulated donor insemination which can be unsafe. Therefore, they made a Recommendation to advise people who are thinking about using donor sperm to conceive to have treatment in a licensed fertility clinic to ensure clinical safety and legal parenthood. See **Recommendation 1.1.4** and associated short explanation of why the Committee made the 2026 Recommendation and how it might affect practice.

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5. PET comment on Recommendation 1.2.29

Draft update of the Fertility Guideline, p12, line 13

Recommendation 1.2.29 says: *'If a miscarriage occurred during the one year of unprotected vaginal sexual intercourse or during the six cycles of insemination, still offer further clinical assessment and investigation after the initial one year of unprotected intercourse or six cycles of insemination. Do not wait for a further one year of unprotected intercourse or expect six more cycles of insemination following the miscarriage.'*

The addition of this Recommendation is welcome, as some commissioners have been restarting the clock each time there is a miscarriage, which then delays investigation of possible infertility.

We hope that this change will prevent that bad practice.

NICE response to PET comment

Thank you for this comment.

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6. PET comment on Recommendation 1.3.10

Draft update of the Fertility Guideline, p14, line 27

Recommendation 1.3.10 says: *'Consider testing for karyotype abnormalities in men, trans women and nonbinary people with male reproductive organs who have a very low sperm count.'*

For clarity, please include a definition of what constitutes *'a very low sperm count'*.

NICE response to PET comment

The Committee agreed to amend the Recommendation and now it refers to people who have a persistent sperm concentration of less than 5 million per ml.

7. PET comment on Recommendation 1.7.2

Draft update of the Fertility Guideline, p29, line 18

Recommendation 1.7.2 says: *'Offer six cycles of unstimulated IUI (providing there are no contraindications) for people who have not conceived after six cycles of donor insemination before considering IVF.'*

It is not necessarily good medical practice to offer six cycles of IUI when six rounds of donor insemination have failed. This may not be what a medical professional would advise, particularly when the patient's age is taken into consideration.

There is a cost attached to the use of donor sperm, and donor sperm is not in plentiful supply. In light of these facts, it may not make sense to continue using donor sperm without an investigation.

NICE response to PET comment

This Recommendation has been clarified that a further six cycles of unstimulated donor IUI should be offered (after the initial six cycles) if there are no contraindications and no suspected or known clinical cause of infertility.

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8. PET comment on Recommendation 1.9.5

Draft update of the Fertility Guideline, p31, line 28

Recommendation 1.9.5 says that *'If a person is under 40 years and has not conceived after three full cycles of 24 IVF treatment'*, then commissioners and providers should *'consider up to three further full cycles of IVF treatment'*.

The wording *'consider up to three further full cycles of IVF treatment'* is bitterly disappointing. Our charity, the **Progress Educational Trust** (**PET**), has campaigned for many years to improve access to NHS-funded fertility treatment. We were looking forward to a long overdue increase in the number of full cycles of NHS-funded treatment recommended by NICE.

Asking Integrated Care Boards (ICBs) to *'consider'* offering a further three cycles is risible. Since NICE published the first version of its *Fertility Guideline* in 2004, the majority of commissioning bodies have not implemented the Recommendation to fund three full cycles of IVF. Since the majority of ICBs are already flaunting the NICE *Guideline*, there is zero reason to believe that they would be moved by something framed as a matter for mere consideration.

Furthermore, other than specifying that the patient should be under 40 years of age, there is no guidance as to circumstances in which ICBs should *'consider up to three further full cycles of IVF treatment'*.

NICE response to PET comment

NICE produces recommendations on the best available clinical and cost-effectiveness evidence. As per the previous NICE *Guideline* it is recommended that three cycles are offered. The Committee considered that the evidence for this Recommendation was even better supported this time.

However, a weaker Recommendation was made to consider an additional three cycles of IVF in those who have not achieved a live birth in previous attempts. This reflected that the evidence for cost-effectiveness evidence supporting these additional cycles was subject to greater uncertainty.

This is explained in the *Guideline*.

> *The analysis suggested that up to six cycles could be cost effective using a threshold of £20,000 per QALY; however, there were some uncertainties in the evidence, particularly for cycles four to six. These uncertainties related to concerns about increasing selection bias in the datasets informing the prediction models and the very small numbers of women in these datasets having four or more cycles, resulting in considerable sampling uncertainty around the point estimates for predicted live birth rates for these higher order IVF cycles. The Committee agreed that the evidence was not sufficiently robust to justify increasing the number of cycles initially being offered, because of its potentially significant resource impact, but agreed that further cycles, beyond the initial three, could be considered.*

We additionally refer you to the wording of recommendations in the NICE *Guidelines Manual*. See **Section 9.3**.

> ***Reflect the strength of the Recommendation***
>
> *In 'strong' recommendations (see the section on strength of recommendations) for actions that should (or should not) be offered, use directive language such as 'offer' (or 'do not offer'), 'advise', or 'ask about'. In keeping with the principles of shared decision making, people may choose whether or not to accept what they are offered or advised.*
>
> *If there is a closer balance between benefits and harms (activities or interventions that could be used), use 'consider' reflecting that the Recommendation is 'weak'.*

The *Guideline* developers did not want to provide prescriptive criteria for what is a weaker *'consider'* Recommendation.

However, the Recommendation to consider a further three full cycles of IVF, also states that any consideration of further cycles should include a discussion of *'the probability of success and the implications of further treatment'*.

9. PET comment on Recommendation 1.9.6

Draft update of the Fertility Guideline, p32, line 2

Recommendation 1.9.6 says: *'For those under 40 years, any previous full IVF cycle, whether self- or NHS-funded, should count towards the total number of full cycles that should be offered by the NHS.'*

The wording of this Recommendation is very unclear.

Is it intended to mean that if a patient has previously received a self- or NHS-funded cycle of IVF, then that cycle would be deducted from the amount of NHS-funded IVF that an ICB would provide? If so, then given that most ICBs only offer one cycle of NHS-funded IVF, this would preclude most people from accessing NHS treatment.

Furthermore, how is this Recommendation to be interpreted where an ICB funds – or has previously funded – only a partial cycle (for example, one round of stimulation and one fresh and one frozen transfer)?

NICE response to PET comment

The wording of this Recommendation has been revised to make it clearer although your interpretation in the comment is correct.

Based on the best available clinical and cost-effectiveness evidence NICE recommends that three cycles of IVF be offered.

We recognise that ICBs have to make difficult decisions and NICE cannot enforce implementation of its guidance or ensure that recommendations are interpreted as intended.

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10. PET comment on Recommendation 1.9.6

Draft update of the Fertility Guideline, p32, line 3

Recommendation 1.9.6 goes on to say: *'Previous self-funded IVF treatment should not preclude NHS-funded IVF treatment.'*

Previously self-funded cycles of IVF should not be counted *at all* when a patient is being considered for NHS-funded treatment. This is wrong on general principle, and also because it could result in a perverse incentive for patients to lie about treatment they have received in the private sector. This in turn could obscure parts of their medical history that might be relevant to their current treatment.

People often resort to self-funded treatment either because they cannot access NHS-funded treatment at all, or because they cannot access NHS-funded treatment in a timely way. If their local ICB were to change its policy, thereby enabling them to access NHS-funded treatment, why should they be penalised for having previously had to resort to self-funded treatment?

NICE response to PET comment

In this *Guideline*, previous cycles, irrespective of how they are funded, are counted as they are a prognostic marker. The prediction model used to inform the economic analysis suggested that previous unsuccessful IVF cycles were associated with a lower probability of success (even after allowing for the possibility of selection bias). Such a 'depletion of susceptibles' effect would be expected unless a successful IVF outcome was completely random. So, for example, the ovarian reserve in a population who had not had successful live birth from previous IVF cycles would on average be lower than a treatment naive population.

Therefore, clinical and cost-effectiveness depend on previous cycles of IVF.

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11. PET comment on Recommendation 1.9.7

Draft update of the Fertility Guideline, p32, line 5

Recommendation 1.9.7 says: *'If a person is 40 or 41 years, meets the criteria in Recommendation 1.9.3 5 and has not had IVF treatment before, offer one full cycle of IVF treatment.'*

This is a lamentable reduction in NHS-funded provision.

It is disappointing that the use of donor eggs has not been recommended, or seemingly even considered, for these patients. If egg donation were to be recommended, then the age limit would not need to be lowered. Egg donation is a safe and cost-effective way to treat many women aged 40 or older.

NICE response to PET comment

NICE produces recommendations on the best available clinical and cost-effectiveness. The economic analysis reported in full in Appendix I of Evidence Review J did not find good evidence that IVF was cost-effective in those aged 42 years. Recommendations for IVF provision for those aged 40-41 years is unchanged from the previous *Guideline*.

Evidence on IVF using donor eggs was not reviewed for this *Guideline* update and has not been commented on. Please note, NICE welcomes topic suggestions from stakeholders which will be considered for NICE topic prioritisation process.

12. PET comment on Recommendation 1.10.24

Draft update of the Fertility Guideline, p36, line 8

Recommendation 1.10.24 says: *'Do not offer preimplantation genetic testing for aneuploidy (PGT-A) as part of fertility treatment.'*

This blanket statement is not aligned with information about IVF add-ons from the statutory regulator of fertility treatment, the **Human Fertilisation and Embryology Authority** (**HFEA**).

On its webpage about PGT-A, the HFEA says that PGT-A is *'Rated green for reducing the chances of miscarriage for most fertility patients'*, and says that '*findings from high quality evidence shows this add-on is effective at reducing the chances of miscarriage for most fertility patients'*.

Given the contrast between this statement from the regulator and the wording employed here by NICE, how are commissioners and patients supposed to understand whether or not this is a treatment they should pay for?

NICE response to PET comment

While the HFEA gave PGT-A a green rating for reducing the chances of miscarriage for most fertility patients, they also stated that reducing the chance of miscarriage still might not translate to an increased chance of having a baby due to the evidence showing no benefit of PGT-A for live birth rates as well as the potential risks associated with PGT-A, as noted in Evidence Review N and on the HFEA's website. An additional risk of PGT-A is that it often reduces the number of embryos with the potential to result in a healthy live birth available for transfer, therefore lowering the likelihood of a fertility patient undergoing embryo transfer at all, as well as their chances of having a baby.

Additionally, although the point estimate reported in the studies considered by the HFEA favoured PGT-A in terms of reducing miscarriage, the 95% confidence intervals all crossed the line of no effect, which would usually (according to standard NICE methodology) be interpreted as showing no important difference between interventions for the outcome miscarriage rates. The Cochrane Review also concluded that it is uncertain whether PGT-A with blastocyst-stage biopsy improves miscarriage rate. The Committee agreed that the available evidence showed uncertainty regarding PGT-A's effect on miscarriage rates, but were aware of emerging evidence that was published too recently to be included in either of the considered reviews which could show a benefit of PGT-A in terms of reducing miscarriage rates. The Recommendation on PGT-A has therefore been amended to the following.

> *Do not offer preimplantation genetic testing for aneuploidy (PGT-A) as part of fertility treatment to improve live birth rates.*

This reflects the fact that the evidence does not show effectiveness of PGT-A in terms of improving live birth rates, while leaving room for other clinical reasons PGT-A might be considered.

13. General comment by PET

Draft update of the Fertility Guideline

Although reference is made in the draft update of the *Fertility Guideline* to *'trans men'* and to *'nonbinary people with female reproductive organs'*, and although certain parts of the draft update are potentially relevant to same-sex female couples and to single people, there is no reference in the draft update to same-sex male couples or to surrogacy.

A decision was clearly made at the outset to exclude certain patient groups and treatment scenarios from the scope of the *Guideline*, and this decision was wrong. Are same-sex male couples not as worthy of being served by the *Fertility Guideline* as everyone else? This failure makes the *Guideline* out of date before it has even been published.

NICE response to PET comment

The scope of the *Guideline*, consulted on and published in 2022, defined the *Guideline*'s population remit.

> ***Groups that will be covered in the update***
>
> - *People with health-related fertility problems.*
> - *People who may require interventions to preserve fertility because of high risk of fertility problems due to clinical conditions or medical or surgical interventions.*
>
> *In this Guideline, people with health-related fertility problems are those who have a known health-related impediment to fertility, or those who do not achieve a pregnancy:*
>
> - *after 12 months of regular unprotected sexual intercourse or*
> - *after six cycles of artificial insemination.*
>
> *The Guideline will be applicable to all people seeking assessment and treatment of health-related fertility problems who meet these criteria, irrespective of their sexual orientation, partnership status or gender reassignment. This includes single people, people in heterosexual relationships, people in same sex relationships, people who are non-binary, undergoing or have undergone gender transition and people using a surrogate.*

The scope also defined the topic areas to be updated and you're correct that not all treatment scenarios were included.

The key issue to bear in mind is that the *Guideline* only covers assessment and treatment for health-related fertility problems and as such does not exclude people based on their sexual orientation or relationship status and the *Guideline*'s recommendations do not determine treatments based on the person's sexual orientation or relationship status.

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14. General comment by PET

Draft update of the Fertility Guideline

Why was so much time and attention focused on IVF add-ons, in communications and publicity concerning the draft update of the *Fertility Guideline* and the accompanying consultation?

Our understanding is that IVF add-ons are very seldom used in the NHS, and so the opinion of NICE on these add-ons was of limited relevance to this *Guideline* and its usefulness.

NICE response to PET comment

NICE is aware of growing usage of IVF add-on treatments whereby patients are increasingly self-funding these interventions that do not have explicit NICE guidance on their use. When the scope of the *Guideline* update was developed and consulted on in 2022, it was agreed that it was important to review the evidence for their effectiveness in order to make evidence-based recommendations, so patient users of this *Guideline* as well as clinicians can make informed decisions.

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15. General comment by PET

Draft update of the Fertility Guideline

The term *'spontaneous'* and variations thereof are used 24 times in the draft update of the *Fertility Guideline*, usually in relation to *'spontaneous conception'*. We question the appropriateness of this, and think that it may cause confusion and be lead to misinterpretation.

In some instances, the term *'natural conception'* would be more appropriate – for example, where the draft update states: *'However, the chances of a live birth both by spontaneous conception and by using assisted reproductive technology decline with advancing age because of decreasing ovarian reserve'* (p47, line 12).

In other instances – such as where the *Guideline* states *'they have not spontaneously conceived after 12 cycles of artificial insemination'* (p31, line 18) – the word *'spontaneously'* can simply be removed altogether.

NICE response to PET comment

The *Guideline* Committee discussed the terms *'spontaneous'* and *'natural'* and other options but agreed that spontaneous conception or pregnancy was their preferred term for this *Guideline*. The Committee did not want to use the term *'natural'* because it would imply other ways of conceiving would be 'unnatural'.

We have removed the word *'spontaneous'* from the Recommendation where it was referring to artificial insemination, this was an error.

The term 'spontaneous conception' has been added to the Terms used in this *Guideline*.

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16. General comment by PET

Press release concerning the draft update of the Fertility Guideline

The press release which was issued by NICE to launch this consultation undermined the guidance in advance in the most appalling way.

Professor Jonathan Benger, Chief Medical Officer and Interim Director of the Centre for Guidelines at NICE, was quoted in the press release saying: *'We recognise the NHS faces significant financial challenges, and ICBs must weigh up local priorities when determining how many IVF cycles to fund.'*

This provides commissioners with the perfect excuse to ignore the *Guideline* once it has been finalised and published by NICE. It has been more than 20 years since NICE published the first version of its *Fertility Guideline*, during which time the *Guideline* has never been implemented in full in England. In the past, NICE has issued robust statements to try to ameliorate this situation. By contrast, Professor Benger's statement actually has the potential to make the access to NHS-funded fertility worse for patients, rather than improving it.

When NICE publishes the final version of its updated *Guideline*, it should take this point into consideration. Please be more positive and assertive in your general communications, and in your dealings with ICBs. This is the least that fertility patients should be able to expect of an organisation with the phrase *'Health and Care Excellence'* in its name.

NICE response to PET comment

While NICE makes recommendations based on the best available evidence on cost-effectiveness, we acknowledge that decisions about commissioning and funding are made at the local level. The Recommendation about offering initial three cycles is based on evidence that showed it to be cost-effective. In fact, we state in the *Guideline* that the evidence for this Recommendation is now stronger than before. However, the evidence on any further cycles is more uncertain and this is reflected in the Recommendation to 'consider' these.