Renewal Inspection Report

Infertility Unit Craigavon Area Hospital

Centre 0294

Date of Inspection: 25 February 2009

Date of Licence Committee: 22 June 2009

Centre Details

Person Responsible	Mr Richard Noel Heasley
Centre name	Infertility Unit Craigavon Area Hospital
Centre number	Centre 0294
Centre address	Infertility Unit Craigavon Area Hospital 68 Lurgan Road Portadown Craigavon BT63 5QQ
Type of inspection	Renewal
Inspector(s)	Mrs Gill Walsh Dr Andrew Leonard
Fee paid	Yes
Licence number	E0294-1-a
Licence expiry date	31 August 2009
NHS/ Private/ Both	NHS/Private

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About the Inspection:

This inspection visit was carried out on 25 February 2009 and lasted for 7 hours.

The purpose of the inspection is to ensure that centres are providing a quality service for patients in compliance with the HF&E Act 1990, Code of Practice and to ensure that centres are working towards compliance with the EU Tissue and Cells Directive 2004/23/EC. Inspections are always carried out when a licence is due for renewal although other visits can be made in between.

The report summarises the findings of the licence renewal inspection highlighting areas of good practice, as well as areas where further improvement is required to improve patient services and meet regulatory requirements. It is primarily written for the Licence Committee who make the decision about the centre's licence renewal application. The report is also available to patients and the public following the Licence Committee meeting.

At the visit the inspection team assesses the effectiveness of the centre through five topics. These are:
How well the centre is organised
The quality of the service for patients and donors
The premises and equipment
Information provided to patients and to the HFEA
The clinical and laboratory processes and competence of staff.

An evaluation is given at the end of each topic and for the overall effectiveness of the centre:
No Improvements Required – given to centres where there are no Code of Practice, legal requirements or conditions that need to be imposed.
Some Improvements Required – given to centres that are generally satisfactory but with areas that need attention. Recommendations will usually be made to help Persons Responsible to improve the service.
Significant Improvements Required – given to centres that have considerable scope for improvement and have unacceptable outcomes in at least one area, causing concern sufficient to necessitate an immediate action plan or conditions put on the Licence.

Where recommendations are made the HFEA will provide details of <u>what</u> needs to be addressed but not <u>how</u> they should be carried out as this is the responsibility of the Person Responsible.

The report includes a response form for the Person Responsible to complete following the inspection.

The HFEA welcomes comments from patients and donors, past and present, on the quality of the service received. A questionnaire for patients can be found on the HFEA website <u>www.hfea.gov.uk</u> .

Brief Description of the Centre and Person Responsible

This centre is set within the general gynaecology service of Craigavon Area Hospital, Co. Armagh, Northern Ireland and is part of the Southern Health and Social Care Trust. The centre shares resources with the general gynaecology and maternity outpatient department with two rooms being 'ring-fenced' specifically for the centre's use.

The centre provides services for the investigation and diagnosis of sub fertility and treatment for couples who may benefit from stimulated and unstimulated cycles of partner sperm intra uterine insemination. The centre operates Monday to Friday from 7:30 to 13:00 hours for licensed treatments with medical cover available via on call arrangements in place at all other times.

The Person Responsible (PR) is registered with the General Medical Council, is a Consultant Gynaecologist at the Infirmary with a special interest in fertility. The PR has also successfully submitted her Person Responsible Entry Programme to the HFEA.

This centre has been licensed with the HFEA since June 2007 and had one previous visit by the HFEA in August 2007. The purpose of that visit was advisory and was arranged as HFEA inspectors were scheduled to be visiting other licensed centres in Northern Ireland at that time.

Activities of the Centre[1] for the time period from 5 July 08 to 31 December 08

Intra uterine insemination (IUI) cycles initiated	112

Summary for Licence Committee

This was the first inspection visit to this centre, during the course of which the centre team were able to demonstrate good practice and a pro active approach to the improvement of their service to users in a number of areas including internal audit and seeking service user feedback. Patient feedback submitted to the HFEA was entirely positive about the centre and treatment provided and were comments were made, they were highly complementary about the staff and the care given by them..

No improvement is required in relation to the centres information. A number of areas for improvement were noted during the inspection and recommendations have been made accordingly.

Some small improvement is required in the following areas:

[1] This data is supplied to the HFEA by individual clinics who are responsible for its accuracy and for verifying it. The data published by the HFEA is a snapshot of the state of the Register at a particular time. The data in the Register may be subject to change as errors are notified to us by clinics, or picked up through our quality management systems.

Organisation

- One third party agreement with the Trust procurement department remains outstanding.

Quality of service

- Key quality objectives relative to the centre's licensed activity should be established
- A quality review has not been conducted.

Premises and equipment

- Background air quality falls below grade D
- Key equipment and processes require validation

Laboratory and clinical practice

- Laboratory procedures and processes require validation

The executive requests that licence committee supports the recommendations proposed by the executive and that the centre informs the lead inspector of progress in accordance with the time scales proposed.

The executive supports the renewal of this centre's licence for five years without condition.

Evaluations from the inspection

Topic	**No Improvements required**	**Some Improvement required**	**Significant Improvement required**
1. Organisation		✓	
2. Quality of the service		✓	
3. Premises and Equipment		✓	
4. Information	✓		
5. Laboratory and clinical processes		✓	

Breaches of the Act, Standard Licence Conditions or Code of Practice:
The table below sets out matters which the Inspection Team considers may constitute breaches of the Act, Standard Licence Conditions and/or the Code of Practice, and their recommended improvement actions and timescales. The weight to be attached to any breach of the Act, Standard Licence Conditions or Code of Practice is a matter for the Licence Committee;-

Breach	**Action required**	**Time scale**
A review of the quality management system has not been conducted	A review of the Quality Management System should be conducted and include, but not be limited to, consideration of changes in the volume and scope of work, personnel, premises, and the performance of third parties (suppliers) that could affect the Quality Management System or the service provided to users and the results of the ongoing evaluation and improvement activities. (S.4.2.8 / 9 & S.9	July 09

One third party agreement is still outstanding with the Trust procurement department.	The centre shall establish documented agreements with third parties where activities take place or goods and services are supplied which may influence the quality or safety of the gametes procured or processed. S.4.2.10 A.5	June 09
Key equipment and processes, including those for air quality monitoring have not been validated.	It is recommended that a plan for validation is drawn up. The plan should take into account the particular needs of the unit and prioritise the validation of those processes/equipment considered to be most likely to impact on the quality of service. Procedures should be validated in accordance with professional guidelines and should be based on previously published studies, or retrospective evaluation of the Centre's own data. Records of all validations should be kept. A.10.13 and A.11.11	Sept 09
The most recent air particle count conducted in march 2008 showed that the background air quality in the laboratory had fallen below the required Grade D.	The processing of gametes while exposed to the environment must take place in an environment with specified air quality and cleanliness in order to minimise the risk of contamination. To achieve this, such gametes and embryos must be processed in an environment of at least grade C, with a background of at least grade D as defined in GMP Annex 1 and Directive 2003/94/EC. The effectiveness of these measures must be annotated and monitored. The centre should monitor air quality as a matter of urgency and document measures to be implemented to ensure that the critical parameters are maintained within acceptable limits at all times and relevant corrective actions in compliance with S.6.4.2.	June 09

Non-Compliance

Area for improvement	Action required	Time scale

Recommendations

Area for improvement	Action required	Time scale

Changes/ improvements since last inspection

Recommendations	Action Taken
No previous inspection.	

Additional licence conditions and actions taken by centre since last inspection

The previous licence was issued without additional conditions.

Report of inspection findings

1.Organisation

Desired Outcome: The centre is well-organised and managed and complies with the requirements of the HFE Act.

Summary of the findings from the inspection of the following areas of practice:

- Leadership and management
- Organisation of the centre
- Resource management
- Clinical governance
- Risk management
- Incident management
- Alert management
- Complaints management
- Contingency arrangements

- Establishment of third party agreements
- Meetings / dissemination of information
- Payment of licence/treatment fees

Areas of firm compliance
The centre's activities are lead by the Person Responsible (PR) Mr Noel Heasley who is supported by a small clinical and administrative team. An organisational chart is in place which demonstrates clear reporting lines and responsibilities. The centre participates in the Trust wide clinical governance agenda. Examples of risk assessments conducted were submitted to the HFEA prior to inspection, including most recently a risk assessment signed off by the PR, of the area in which patients deliver semen samples for analysis or processing for IUI, following building work in this area. A policy is in place for incident management which was seen to be compliant. Staff asked were able to accurately describe the reporting requirements for incidents and adverse events to the HFEA and were able to describe how incidents are investigated and outcomes discussed at team meetings. Staff were also able to describe the HFEA Alert system and how, when relative to their practice, the information is disseminated. The centre adheres to the Trust complaints management policy which was seen to be compliant. The centre staff were able to demonstrate contingency arrangements in the event of disruption to service at a number of levels. Staff stated that the department is supported by the hospital wide emergency power supply. Staff were also able to provide evidence of some replacement equipment in the event of failure. As this is a consultant lead service, treatment is suspended in the significant absence of the PR. No incidents or complaints have been submitted to the HFEA since the initial licence was granted. A policy for the management of ovarian hyperstimulation syndrome was seen to be in line with Royal College of Obstetricians and Gynaecologists Green-top guideline No: 5 ' Management of OHSS' and the centre also has a policy for the emergency referral of a patient requiring admission to hospital. It was noted that the centre has a third party agreement with the haematology department of Craigavon Area Hospital for andrology laboratory services. Meetings were seen to be regularly held, minutes for which were available for review. Staff members stated that attendance at such meetings was encouraged and staff attended according to availability. No incidents or complaints have been submitted to the HFEA since the initial licence was granted. Policies for the management of complaints and incidents were seen to be in place

and considered to be compliant. The registry department of the HFEA report prompt submission of treatment data from this centre and the finance department of the HFEA report prompt payment of fees to date. The finance department of the HFEA report prompt payment of fees to date.
Areas for improvement
One third party agreement remains outstanding with the Trust's procurement department.
Areas for consideration
None
Executive recommendations for Licence Committee
The centre should ensure all third party agreements are in place and documented. (S.4.2.10)
Evaluation
Some improvement required.
Areas not covered on this inspection
All areas covered.

2. Quality of service

Desired Outcome: Patients receive a good standard of service, appropriate treatment and are treated with courtesy and respect.

Summary of the findings from the inspection of the following areas of practice:

- Quality management system
- Quality policy
- Quality manual
- Quality objectives and plans
- Quality management review/evaluation
- Feedback
- Document control
- Live birth rates

Live birth rates[1]
Outcome date submitted to the HFEA demonstrates a live birth rate of 6% following licensed treatment which is in line with national averages.
Areas of firm compliance
There is a quality manager in place who is currently able to dedicate approximately 4 hours per fortnight to the development and maintenance of the quality management system. A job description for this role was seen. The quality management system in place is effective and seen to be compliant. Evidence was seen of a number of audits having been conducted including tracking of patient records: patient satisfaction, incidence of high abnormal semen count vs. poor pregnancy rate /high miscarriage rate: record keeping. The centre has agreed a small number of key quality indicators, namely pregnancy rates, number of consultations, number of reviews and sickness rates among staff. Patient satisfaction questionnaires returned to the HFEA were entirely positive regarding their treatment and interaction with centre staff. Key comments included 'the nurses were very kind and helpful', 'everyone was very professional and caring, the service was excellent we are very grateful for all their help'. Service users are also given the centres own patient feedback questionnaire at consultation. Responses are collated and fed back to staff bi annually. Document control measures were seen to be compliant and in accordance with the Trust policy. Documents seen currently in circulation were noted to have appropriate footnotes including version control, review dates, document history and author details.
Areas for improvement
A review of the quality management system has not been conducted. Quality objectives have not been identified for the centre's core licensed activity. S.4.2.4
Areas for consideration

In the light of the regulatory requirement for the development of measurable quality indicators and other quality management activities, the PR should consider conducting a review of the processes needed for quality management activities and how best to ensure that the resources in support of the operation and monitoring of quality issues are available. (S.4.2.1.)
Executive recommendations for Licence Committee
Evaluation activities shall also include, but not be limited to, Evaluation of User Satisfaction, monitoring and resolution of users' complaints, encouraging staff suggestions. The results of Evaluation and improvement activities shall be included in the input to the management review. (S.9) A review of the Quality Management System should be conducted and include, but not be limited to, consideration of changes in the volume and scope of work, personnel, premises, and the performance of third parties (suppliers) that could affect the Quality Management System or the service provided to users and the results used for the ongoing evaluation and improvement activities. (S.4.2.9)
Evaluation
Some improvement required.
Areas not covered on this inspection
All areas covered.

3. Premises and Equipment

Desired outcome: The premises and equipment are safe, secure and suitable for their purpose.

Summary of the findings from the inspection of the following areas of practice:

- Premises
- Clinical facilities
- Counselling facilities
- Laboratory facilities
- Air quality
- Management of equipment and materials
- Storage facilities for gametes and embryos
- Staff facilities
- Storage of records

Areas of firm compliance
The centre is situated on the first floor of the maternity and women's health unit of Craigavon Area Hospital. Some of the premises are shared with the ante natal service, including the patient waiting area. Fertility clinics and treatments are conducted on separate sessions from ante natal clinics wherever possible. Clinical consultation, ultra sound scanning and treatment rooms observed appeared to be appropriate for their intended use, well maintained, private and adequately equipped. The andrology laboratory is located separately from the fertility clinic where licensed treatments are conducted and provides diagnostic semen analysis and preparation of semen for therapeutic use in the centre by third party agreement and as such were not inspected separately on this occasion. As part of the larger haematology laboratory, the andrology laboratory is Clinical Pathology Association (CPA) accredited. The laboratory was seen be fit for purpose and appropriately equipped. The laboratory and semen processing class II cabinet are currently tested by an independent indoor air quality testing company. Bacterial contamination is assessed using settle plates on a monthly basis. The most recent results (7.1.09) were seen to be compliant with the requirements of A.10.19. Cleaning and monitoring logs were seen to be in place and were compliant. Equipment in use was seen to be CE marked and preventatively maintained. Staff stated that scheduled maintenance and portable appliance testing (PAT) was arranged through the Trust biomedical engineering department, a sample of the records confirming this was seen. There is a staff restaurant close to the centre and facilities for changing and the secure storage personal belongings whilst on duty.

Fertility patient health records are stored in locked cabinets within an office to which access is restricted. The current HFEA licence for the centre was also seen to be on display in this room.
Areas for improvement
The most recent air particle count conducted (6.3.08) shows particles to be above the permitted maximum in the open laboratory (background) but no particles were detected in the semen processing class II cabinet.. This means that the background air quality falls below Grade D. Procedures for air quality monitoring have not been validated.
Areas for consideration
Executive recommendations for Licence Committee
Gametes and embryos must be processed in an environment of at least grade C, with a background of at least grade D as defined in GMP Annex 1 and Directive 2003/94/EC. The centre should monitor background air quality as a matter of urgency and document measures to be implemented to ensure that the critical parameters are maintained within acceptable limits at all times and relevant corrective actions in compliance with S.6.4.2. The frequency of air quality testing should be validated. (S.6.3.6)
Evaluation
Some improvement required.
Areas not covered on this inspection
Gametes are not stored at this centre.

4. Information

Desired outcome: Information is relevant, clear and up to date for patients and the HFEA

Summary of the findings from the inspection of the following areas of practice:

- Information for service users
- Consent
- Welfare of the child
- Access to health records
- Provision of information to the HFEA register

Areas of firm compliance
Information submitted to the HFEA prior to the inspection visit and viewed on the day was seen to be clear and compliant. Due to the limited number of treatments offered by this centre, the information routinely available to prospective patients is limited but appeared appropriate for the service users needs. It was noted that a comprehensive information check list was in use by centre staff to note what information and documentation had been supplied to patients considering or having treatment. In 6 randomly selected patient records, consent forms were present and were compatible with the treatment provided. The patient records viewed were seen to be in good order and the relevant information easy to find. Valid consent is sought from service users by a clinician deciding treatment or either of two fertility co-ordinators. The fertility co-ordinators are both registered nurses and midwives and have received training and had their competency assessed in seeking valid consent. Evidence that the welfare of the child is considered when treating patients was seen in patients records and in conversation with centre staff. The centre adheres to the Trust's 'Access to health records' policy which was seen to be compliant with HFEA requirements. The registration department of the HFEA reports the timely submission of treatment data to the HFEA.
Areas for improvement
None
Areas for consideration
None
Executive recommendations for Licence Committee
None
Evaluation

No improvement required
Areas not covered on this inspection
All areas covered.

5. Clinical, laboratory and counselling practice

Desired outcome: Clinical, counselling and laboratory practices are suitable and are provided by competent staff.

Summary of findings from inspection:

- Staff training and competency
- Clinical practice
  - Screening of donors
  - Three embryo transfer
- Laboratory practice
  - Procurement, distribution and receipt of gametes and embryos
  - Traceability and coding
  - Selection and validation of laboratory procedures
  - Coding/ identification of samples
  - Witnessing
- Counselling practice
  - Counselling audit
- Storage of gametes and embryos

Full time equivalent staff

GMC registered doctors	1
NMC registered nurses	2 – 30 hrs collectively
Non NMC registered clinical staff	
HPC registered scientists	1
Scientists working towards registration	0
Support staff (receptionists, record managers, quality and risk managers etc)	20 hrs
Counsellors	0

Summary of laboratory audit
There are no gametes stored at this centre.
Summary of spot check of stored material
There are no stored gametes at this centre.
Areas of firm compliance
Evidence of professional development was seen for staff members at the centre in the areas of mandatory training and attendance at specialist meetings where possible. Evidence of appropriate professional registration was also seen. A sample of up to date job descriptions and curriculum vitae for staff currently in post were seen. There is a comprehensive staff induction programme in place. Staff members were seen to have individual clinical professional development plans (CPD), and training and competency assessment logs. A competency assessment policy is in place.

Following induction and initial competency assessment there are measures in place for the reassessment of competency on a six monthly or annual basis depending on the competency to be assessed.

All clinical staff were seen to participate in an annual appraisal with a senior person of appropriate professional standing.

The person responsible for the andrology service participates in NEQAS assessments, the results of which were seen to be satisfactory.

Photographic ID is requested of service users ahead of treatment and is then used to verify the identify of male partners attending the andrology laboratory with semen samples for analysis or preparation for treatment.

The centre has comprehensive documented procedures for the receipt of semen samples produced away from the centre and records were seen to be kept.

Evidence was seen that all gametes are packaged in a manner that minimises the risk of contamination and aims to ensure quality and safety en route to the laboratory and from the laboratory to the centre for insemination.

Documented procedures and practice for the tracing of gametes, materials and equipment from procurement through processing and in treatment were seen to be comprehensive and compliant.

The centre's documented and actual witnessing measures were observed to be contemporaneous, thorough and compliant with HFEA guidance, both in the andrology laboratory and in the centre. A policy for the training of personnel in witnessing was seen.

Counselling is not conducted at the centre but is offered to service users. The service may be accessed independently of the centre and is conducted at the premises of the host counselling service. The service is free to service users.

Areas for improvement

Laboratory procedures and processes have not been validated. (A.11.11)

Areas for consideration

Executive recommendations for Licence Committee

Procedures and processes should be validated in accordance with professional guidelines and operate within legal and regulatory constraints. Validations should be based on previously published studies, or retrospective evaluation of the centre's own data. Records of all validation should be kept. (S.7.8.3)

Evaluation

Some improvement required.

Areas not covered on this inspection

Donors are not recruited at this centre.
No gametes or embryos are stored and no embryos transferred at this centre.
Counselling (consent to basic partner treatment exempt from the requirements of schedule 3 of the Act).

Report compiled by:

Name Gill Walsh

Designation Inspector

Date 10 April 2009

Appendix A: Centre staff interviewed

The PR and four members of the team

Appendix B: Licence history for previous 3 years

E0294/1/a Licence for Treatment (IUI) granted

Centre Number 0294

Name of PR……Mr R N Heasley

Date of Inspection 25 February 2009

Date of Response…14/05/09

I have read the inspection report and agree to meet the requirements of the report.

Signed (by email)

Name R N Heasley

Date 14/05/09

1. Correction of factual inaccuracies

Please let us know of any factual corrections that you believe need to be made. We will make alterations to the report where there are factual inaccuracies.

There are no factual inaccuracies in this inspection report.

2. Please use the space below to document any comments or additional information that you would like to be considered by a Licence Committee.

I accept this report as a fair and accurate reflection of our centre's activities. The areas where improvements are required are noted and we have already put in motion measures to correct such deficiencies . As these measures occur I will inform the Authority via our inspector.

3. Please state any actions you have taken or are planning to take following the inspection with time scales

As noted in the reply above we intend to implement the improvements in line with the recommended time scale in the inspection report.

We welcome comments about the inspection on the inspection feedback form, a copy of which should have been provided at the inspection. If you require a copy of the feedback form, please let us know.

Please return Appendix C of the report electronically to your inspector or in hard copy to:
Regulation Department
Human Fertilisation & Embryology Authority
21 Bloomsbury Street
London
WC1B 3HF

HFEA Licence Committee Meeting
22 June 2009

21 Bloomsbury Street London WC1B 3HF

Minutes – Item 2

Craigavon Area Hospital (0294) – Licence Renewal

Members of the Committee:	Committee Secretary:
David Archard (lay) – Chair Jennifer Hunt (counsellor) Hossam Abdalla (clinician)	Kristen Veblen Legal Adviser: Mary Timms, Field Fisher Waterhouse Observers: Mark Bennett, HFEA Peter Thompson, HFEA

Declarations of Interest: members of the Committee declared that they had no conflicts of interest in relation to this item.

The following papers were considered by the Committee:

- papers for licence committee (32 pages)
- no tabled papers.

The Committee also had before it:

- HFEA Protocol for the Conduct of Licence Committee Meetings and Hearings
- 7th edition of the HFEA Code of Practice
- Human Fertilisation and Embryology Act 1990 (as amended)
- HFEA (Licence Committees and Appeals) Regulations 1991 (SI 1991/1889)
- Decision Trees for Granting and Renewing Licences and Considering Requests to Vary a Licence; and
- Guidance for members of Authority and Committees on the handling of conflicts of interest approved by the Authority on 21 January 2009.

1. The Committee noted that the Centre had been licensed since June 2007 and had received an advisory visit from the HFEA in August of the same year. Therefore this was the first inspection of the Centre.

2. The Committee considered the papers, which included the renewal inspection report, renewal application and previous Committee minutes from 13 September 2007.

3. The Committee noted that the inspection took place on 25 February 2009 and the response of the Person Responsible (PR) in Appendix C was dated 14 May 2009. The Committee also requested and received confirmation that no correspondence had been received from the PR since this date.

4. It was noted by the Committee that the inspection report had identified four breaches:
    - a review of the quality management system had not been conducted, contrary to 7th Code of Practice S.4.2.8, S.4.2.9 and S.9
    - one third party agreement was still outstanding, contrary to 7th Code of Practice S.4.2.10 and Standard Licence Condition A.5
    - key equipment and processes, including those for air quality monitoring had not been validated, contrary to 7th Code of Practice Standard Licence Conditions A.10.13 and A.11.11
    - the most recent air particle count, which had been conducted in March 2008, showed that the background air quality in the laboratory had fallen below the required level, Grade D, indicated by Directive 2003/94/EC and contrary to 7th Code of Practice S.6.4.2.

5. Particularly, the Committee noted that although the PR had responded to the report and promised to take action and inform the Authority of the action taken, there had been no subsequent communication from the Centre. There was therefore no evidence that the breaches had been rectified and the Committee was concerned that some deadlines for correcting the breaches fell during the current month.

6. The Committee additionally noted that the Committee had previously considered breaches in relation to air quality at this Centre on 13 September 2007 and that the minutes of that meeting indicated that a class 2 air flow candidate had been ordered. However at the February inspection, air quality had remained an issue.

<u>The Committee's Decision</u>

7. The Committee noted that there were no issues regarding the character, qualifications or experience of the Person Responsible or his ability to perform his duties under section 17 of the HFE Act 1990 (as amended). It was noted that the PR was registered with the General Medical Council, was a Consultant Gynaecologist at the Infirmary with a special interest in infertility and had completed the PR Entry Programme to the satisfaction of the Executive. Therefore, the Committee was satisfied as to the suitability of the PR.

8. During the inspection, it had been demonstrated that the Centre's premises were fit for purpose and the Committee, on this basis, was satisfied regarding the suitability of the premises.

9. The Committee noted that there were four breaches, listed above, in relation to the practices of the Centre. However, the Committee was satisfied, on the basis of the response from the PR, that action was being taken in relation to the four breaches and therefore agreed that it was satisfied that the Centre had suitable practices.

10. It was agreed that the Committee had sufficient and satisfactory information to make a decision, and noted that it was in receipt of a signed application form and that the necessary fee had been paid.

11. The Committee noted the Executive's recommendation to grant a licence for 5 years, but was concerned that the breach identified in relation to air quality had also been identified in 2007 and that this was a recurrent problem that had yet to be satisfactorily addressed.

12. In light of this concern, the Committee decided to renew the licence for 3 years with no additional conditions.

13. The Committee decided that the next inspection should take place in January 2010, to ensure that action has been taken in relation to all four breaches identified. The Committee reminded the Centre that the breach in relation to air quality, particularly, must be addressed as a matter of urgency and the Committee would like to be satisfied following the January inspection that this issue had been dealt with as a matter of priority.

Signed..... Date..7/July/09
David Archard (Chair)