Licence Renewal Inspection Report for Treatment and Storage Centres

The Bridge Centre
0070

Date of Inspection: 22nd February 2007
Date of Licence Committee: TBA

TRIM: 06/3144

CENTRE DETAILS

Centre Address	1 St Thomas Street London SE1 9RY
Telephone Number	0207 403 3363
Type of Inspection	Renewal Inspection
Person Responsible	Professor Gedis Grudzinskas
Nominal Licensee	Mr Paul Williams
Licence Number	L0070-14-a
Inspector(s)	Mr Wil Lenton (Lead Inspector)
	Mr Tony Knox
	Dr Vicki Lamb
Fee Paid - date	Not Yet Due
Licence expiry date	30th September 2007

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About the Inspection:
This inspection visit was carried out on 22nd February 2007 and lasted for 8 hours. The report covers the pre-inspection analysis, the visit and information received between January and December 2006.

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, recommendations 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.

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 www.hfea.gov.uk .

Brief Description of the Centre and Person Responsible

The Bridge centre is a privately-run unit which offers a wide range of treatments. The centre has been licensed since 1992, is well established and carried out approximately 1800 cycles of licensed treatments during 2005/6. It is one of the largest licensed centres in the UK and one of only five to offer PGD/PGS.
The Centre is situated in central London close to London Bridge. It has good rail/underground links for patients. The majority of the centre's patients are private referrals. Approximately 20% of patients are funded by their own primary care trusts and are received at the Bridge via their network of satellite (7) and transport centres (5) Most patients are located within the south east of England although some patients travel from further afield in the UK and abroad.

The centre runs an International Egg Donor/Recipient and Egg-Sharing Programme for women who cannot find suitable egg-donors/sharers within the UK. The PR stated that the overseas centres have been thoroughly investigated by the Senior Management Team, in order to ensure that both the medical facilities and standards of care are satisfactory. Matched donors are prepared to a schedule at the overseas clinic, whilst UK recipients are prepared likewise at the Bridge. One of the centre's clinicians, together with the patients and a donor-coordinator travel to the overseas centre, where the UK clinician performs the embryo transfer, if the treatment cycle progresses to that stage.

A dialogue took place between the PR, members of the centre's Senior Management Team and the inspection team, concerning both:
i. the export of sperm for use with eggs derived from anonymous donors overseas and
II. the import of embryos derived from anonymous donors overseas.
The inspection team pointed out that in line with the SEED review, as of 1st April 2006, the centre should no longer be sanctioning the abovementioned practices. The PR reassured the team that since the aforementioned date the practices mentioned above had ceased, and that if subsequent frozen embryo transfers were required, UK patients travelled back overseas to the centre concerned, in order for this treatment to be performed. This was evidenced in interviews with laboratory staff on the day of inspection.

Activities of the Centre

Licensed treatment cycles	IVF ICSI FET Egg sharing Egg donation	557 664 273 8 15
Donor Insemination		326
Unlicensed treatments	GIFT IUI	
Research	None	
Storage	Yes	

Summary for Licence Committee

The Executive recommends the renewal of the centre's licence for three years and the removal of the additional condition from the centres licence

Risk Assessment

The HFEA risk assessment for this centre is 15%, which is regarded as low.

Overall judgement of the effectiveness of the centre

No Improvements required	Some Improvement required	Significant Improvement required
	x	

Evaluations from the inspection

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

Breaches of the Act or Code of Practice

Breach	Action required	Time scale
None		

Non-Compliance

Area for improvement	Action required	Time scale
None		

Recommendations	Time scale
An action-plan be devised and implemented to ensure better communication between the centre and its satellite/transport centres.	3 months
The centre should identify, purchase and install a supplementary back-up power-supply.	6 months
With the increased number of cryostorage and supply vessels, the centre should undertake a new risk-assessment of cryostorage area.	As soon as possible
The centre should consider having a separate theatre log for procedures carried out at the London Bridge theatre in order to protect patient confidentiality	3 months
Review of patient information relating to the Egg Donor/Recipient and Egg-Sharing Programmes, which takes into account the recommendations of the SEED review.	3 months
A consistent patient number format should be adopted for all documentation submitted to the HFEA.	3 months
The centre should develop a process which ensures the timely reporting of treatment cycles to the HFEA (ie two months after the outcome of treatments are known)	As soon as possible

Proposed licence variations

None

Changes/ improvements since last inspection

Recommendation	Action taken
No recommendations made by previous Licence Committee	

Additional licence conditions and actions taken by centre since last inspection

C	The PR must ensure that the storage dewars are fitted with low nitrogen alarms and an appropriate monitoring system by the end of June 2005
A	**Complied Y/N** Yes - All cryostorage vessels seen during the present inspection had low-nitrogen alarms fitted as per requirement
C	
A	**Complied Y/N**
C	
A	**Complied Y/N**

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 findings from inspection
Evidence is drawn from:

- Leadership and management
- Organisation of the centre
- Resource management
- Risk management
- Incident management
- Contingency arrangements
- Business planning
- Clinical governance
- Payment of treatment fees

Areas of firm compliance

The PR plays a lead role in the centre's activities and ensures that there are appropriate numbers of suitably qualified staff to deliver a good quality service to patients. This is evidenced by the recent strengthening of its management team via a series of key senior appointments and promotions. (see details below) . His personal involvement in the centre was evidenced by his ability to identify required information/data on the day of inspection and his recent proposed resolution of an outstanding complaint.

The centre has a well-defined organisational structure, with clearly defined accountabilities, reporting systems and relationships. This was evidenced by the organisational charts received with the pre-inspection information, and was clearly observed on the day of the inspection, as any additional information asked for was produced in good time, without any hesitation. This was also observed during staff interviews, where interviewees stated that they felt well supported by their managers, and that the reporting structures worked well.

The centre has a Health and Safety consultant in place. Two members of staff are IOSH trained and there are trained Health and Safety representatives. Risk assessments are carried out on an annual basis for:

- Manual handling
- Display screen equipment/workstations
- Fire risk and evacuation drills
- Estate management
- COSHH
- General work environment
- Waste management
- Cardiac arrest audit

Regular Health and Safety meetings take place where risk assessments are reviewed.
Attendance at mandatory annual training courses was evidenced via interviews with staff and observation of individual training logs.

There are named individuals in place to deal with complaints and incidents. A Quality Manager coordinates clinical governance issues, and performs trend-analysis on a quarterly basis, in order to determine any underlying problems which need addressing.

Implementation of the European Tissues and Cells Directive (EUTD) is well underway, with an electronic document file system in place, which can be accessed via most pc's, and is the backbone of the Quality Management System (QMS).
Regular minuted meetings take place, such as:

Monthly;
- Clinical management
- Clinical review

Weekly;
- Senior management
- Clinicians
- Nurses
- Embryologists

Daily;
- Results

Evidence of minuted meetings was observed during interviews with both nursing and scientific staff.

There is a documented plan and service level agreement in place for emergency admissions to go to either St Thomas' and/or London Bridge hospitals.

Areas for improvement

Although some evidence of a document control system was apparent via observation of documents, this did not appear to be universal. This was discussed during the interview with the Quality Manager (Lisa Howie), who informed the team that this was work in progress as documents were reviewed and updated.

With staff changes since the last inspection, there is a need to update the organisational charts provided.

Executive recommendations for Licence Committee

None

Areas not covered on this inspection

None

Evaluation

Some improvements required

Key senior appointments and promotions

The Bridge has made a series of key senior appointments and promotions since the last HFEA inspection in order to strengthen its management team, as indicated in the table below;

Date	Name	Position
August 2006	Professor Alan Handyside	Director
September 2006	Dr Alan Thornhill	Scientific Director
September 2006	Dr David Gillott	Research Manager
May 2006	Mr Trevor Bennett	Chief Operations Officer
February 2007	Ms Angela Arnold	Genetic Counsellor
September 2006	Pauline Wright	Clinical Services Manager/Matron
September 2006	Miss Katharine Hagues	Fertility Nurse Manager
September 2006	Ms Lisa Howie	Quality Manager

The first five personnel are new appointees, whilst the remaining three are due to internal promotion. This re-structuring of the team has been instigated due to both:

i. a development of expertise in preimplantation genetic screening.

ii. a desire to strengthen its core business team, in readiness for the implementation of the European Union Tissues and Cells Directive (EUTD)

2. Quality of service

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

Summary of findings from inspection:

- Live birth rates
- 'Welfare of the Child' arrangements
- Confidentiality (including safe storage of patients' records)
- Choice of treatments
- Privacy and dignity of patients
- Complaint handling
- Patient feedback and satisfaction
- Counselling facilities and services
- Donor selection
- Egg sharing and surrogacy
- Protection of children arrangements (for patients under 18yrs)

Live Birth Rates

Cumulative, validated HFEA data from April 2002 to March 2005 indicate that success rates for;

- IVF/ICSI for all age groups) are higher than the national average. (except the 40-42 year group
- FET are just below the national average (except for the 35-37year group)
- DI are just below the national average.

Areas of firm compliance

The centre has an induction process for all new staff. It has a documented confidentiality policy and all staff sign a confidentiality agreement at commencement of employment. This was evidenced during staff interviews.

An audit of counselling services was made available to the inspection team. A total of 459 sessions had been attended between February and November 2006. The non-attendance rate was 13%. As of April 2007, and in line with the development of their PGD/PGS service, a genetic counsellor will be available to patients.

The review of patients notes indicated that an appropriate 'Welfare of the Child' assessment had been carried out

During the tour of the premises, it was observed that patients notes were kept in secure lockers in two locations:

- In the nurses office – current patients
- In the administration area – all other notes

Access to both areas were controlled by keypads

The centre has a documented complaints procedure, with a named individual in charge of their management. In the previous year 37 complaints had been received and all but one had been resolved. The Quality Manager performs trend analyses on the complaints received on a quarterly basis. Discussion of the outstanding complaint took place following the inspection and a resolution was proposed by the PR.

From the 35 HFEA patient questionnaires reviewed it appeared that patients were generally happy with the quality of care they received at the centre. The most common areas of dissatisfaction were:

- Delayed appointments
- Small waiting area
- Communication problems

The Clinical Services Manager was aware of the problems and reception staff were currently monitoring any delays. This process was observed on the day of inspection.

Areas for improvement

Better communication is needed between the centre and its satellite and transport units. This was mentioned in the interim inspection in March 2006 (paragraph 98) and was evidenced again during the present inspection (mentioned in both patient feedback forms and via an incident report discussed at the inspection). There appears to be a need for clarity as to how this is to be actioned, as three different members of the Senior Management team have been identified as dealing with this issue:

- Deputy Medical Director - Mr Laurence Shaw - previous inspection (paragraph 19)
- Scientific Director - Dr Alan Thornhill - during the interview with the PR
- Clinical Services Manager - Pauline Wright – during interview .

However the problems still remain, as was clearly illustrated by a recent incident, involving the transport of follicular fluids from an associated centre.

A number of incidents have been reported to the HFEA, which were discussed at the inspection. It was agreed that the incident reporting process was working well, but that there was a need for the Senior Management team to investigate each incident carefully and identify any trends developing, in order to prevent them re-occurring in the future.

There has been a steady rise in the percentage of patient complaints;

- 2004 – 1.1%
- 2005 – 1.3%
- 2006 - 2.1%

This is acceptable in that the centre has a documented policy which is working, but at the same time raises concerns about whether the results of any trend analyses are being fed back into the QMS. This issue may require further investigation by the Quality Manager.

Executive recommendations for Licence Committee

An action-plan be devised and implemented to ensure better communication between the centre and its satellite/transport centres.

Areas not covered on this inspection

None

Evaluation

Some improvements required

3. Premises and Equipment

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

Summary of findings from inspection:

- Suitable premises
- Storage facilities for embryos and gametes
- Safe equipment, servicing and maintenance
- Prevention of incidents/ accidents

Areas of firm compliance
The premises have not changed since the previous inspection and are situated over three floors and a basement. The centre shares its premises with centre 0171, the Bridge Cryoservices, which is licensed separately. *Third floor*: Keypad entry access to a staff room with internet access, counselling room, consultation room, changing room with keypad lock, Fluorescence in-situ hybridisation (FISH) room (locked), computer server room (locked), three offices and two cryostorage rooms (lockable.) All cryostorage vessels in use were seen to be connected to low-nitrogen alarms, and a warning klaxon was present on the external wall. A warning sign gave instructions on what to do if the alarm sounded. *Second floor:* Keypad entry access to an office area for the administrative team, including the accounts department. Patient notes are securely stored. There is also a purpose-built seminar/teaching room. *First floor:* Keypad entry to a small reception/waiting area outside of the main laboratory which had keypad access. Two treatment rooms connected to the laboratory. Two sperm production rooms (fit for purpose). A staff changing room with keypad access and a laboratory gas cylinder store with automatic changeover device, which was checked daily as evidenced at the inspection. *Ground floor*: Main access to the premises and is CCTV access-controlled via the reception desk. There was a secondary waiting area adjacent to two scan rooms, together with a phlebotomy room. Entry to the nurse's office is off the corridor. This room contained securely stored current patient notes together with six pc workstations, where data input took place. The team were informed that discussions were underway, to provide some alternative office space for the nursing staff on the upper floors as part of a planned refurbishment. *Basement:* Housing the main operating theatre, recovery room and five recovery bays. Patients have a choice of general anaesthesia or local anaesthesia with sedation. . A 'crash trolley' was present which had been checked by staff. The recovery bays were adequate, although it was acknowledged that on occasion patients had mentioned about being able to hear staff discussions. Within the laboratory all cryostorage vessels were locked and connected to low nitrogen alarms. Low oxygen alarms were in evidence in both the laboratory and main cryostorage area (third floor)

All laboratory equipment is serviced and maintained according to a preventative maintenance schedule. Service logs were evidenced during inspection. All electrical appliances are tested for safety on an annual basis.

Since the last inspection new equipment has been purchased and some existing equipment upgraded, This has included;

- New FISH station
- 2 new Class II workstations
- 2 new cameras + LCD screens
- Stereo microscope + heated stage
- CBS straw-sealing system for embryo storage

Dr Thornhill was presently sourcing an uninterrupted power supply as a back-up to cover short-term (3h) power failures. It was hoped to have this in place by the end of March 2007

A barrier system was in place to prevent staff/patients using the lifts when liquid nitrogen vessels were being replenished.

Areas for improvement

The supplementary back-up power-supply needs to be sourced and in place as soon as possible, as loss of power to the laboratory and/or operating theatre could prove problematic.

With the increase in the number of cryostorage vessels stored together on the third floor, a new risk-assessment should be carried out for this area, as staff would be vulnerable if there was a sudden loss of nitrogen.

Occasionally the centre utilises a theatre within the London Bridge hospital. It was noted that some arrangement concerning the theatre log needed to be put in place to protect patient confidentiality when this occurred.

Executive recommendations for Licence Committee

The centre should identify, purchase and install a supplementary back-up power-supply.

With the increased number of cryostorage and supply vessels, the centre should undertake a new risk-assessment of the cryostorage area.

The centre should consider having a separate theatre log for procedures carried out at the London Bridge theatre in order to protect patient confidentiality

Areas not covered on this inspection

None

Evaluation

Some improvements required

4. Information

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

Summary of findings from inspection:

- Information management
- Information to patients and donors
- Information to the HFEA registry and updates
- Consent
- Protocols
- Record keeping

Outcome of audit of records

Fifteen sets of patients notes were reviewed at the inspection. Errors relating to consents were found in three sets of notes. During discussions with the Clinical Services Manager it was agreed that a notes audit should be commenced and be ongoing, to look for and correct any such errors. Staff were to be made aware of these issues in order to help prevent them happening in future.

Areas of firm compliance

Information concerning the current HFEA licence (expires 30/09/07), employees liability insurance certificate (expires 31/12/07) and HCC licences (registration date 01/04/02) were displayed behind the main reception desk on the ground floor. The main waiting area displayed information concerning the complaints procedure, counselling and chaperone services, and clinic results for January-December 2006.

Secure storage areas for patient notes were evidenced during the inspection, and during discussions with staff it was mentioned that only authorised centre staff had access to either paper or electronic versions of them, via password-controlled processes. .

As part of the QMS, staff had individual, password-controlled access to an electronic database which contained links to all current documentation such as, SOP's, minuted meetings, incidents, complaints and results. As documents are reviewed/updated they were being included in the document control system.

Areas for improvement

A recent HFEA Operational Audit had been carried out between 30th November to 1st December 2006 and had highlighted a number of concerns such as;

- A significant number (27%) of DI treatments had still to be reported to the Authority
- A significant proportion (25%) of treatments had been reported late to the Authority (ie in excess of 15 weeks post treatment)
- A number of inaccuracies on forms that could impact adversely on the Authority's ability, or ease with which it is able to fulfil its obligations to offspring

- Inconsistencies between consents for the use and storage of gametes and embryos, which might introduce uncertainty as regards intentions of the patient and/or partner

The report had not been addressed at the time of the inspection, although it was acknowledged that part of the problem had been due to the lack of reliable EDI equipment, which was in the process of being rectified by the HFEA IT department. Since the inspection a response has been received from the centre addressing these issues.

Patient information relating to the International Egg Donor/Recipient and Egg-Sharing Programmes, needed to be updated, to take into account the recent SEED review guidelines, concerning the rights of children born from gametes procured overseas.

It was noted that in the centre literature concerning the International Egg Donation Programme, it was mentioned that a success rate of 30% was quoted for a group of patients up to the age 52, whereas the upper limit for this type of treatment had been previously quoted as 48 years in the Initial Assessment literature. This information needs to reviewed and made consistent.

Notes audit to be ongoing in order to identify and correct any errors. Communication to staff emphasising the need for diligence when assessing patient consent forms.

Executive recommendations for Licence Committee

Review of patient information relating to International Egg Donor/Recipient and Egg-Sharing Programmes, which takes into account the recommendations of the SEED review.

A consistent patient number format should be adopted for all documentation submitted to the HFEA.

The centre should develop a process which ensures the timely reporting of treatment cycles to the HFEA (ie two months after the outcome of treatments are known)

Areas not covered on this inspection

None

Evaluation

Some improvements required

5. Laboratory and Clinical Practice

Desired outcome: Staff are competent and recruited in sufficient numbers to ensure safe clinical and laboratory practice.

Summary of findings from inspection:

- Assessment of patients and donors
- Safe handling systems
- Procedures in practice
- Laboratory processes and practice
- Clinical practice
- PGD/ PGS
- Recruitment and retention of staff
- Staff competence, qualifications, training and CPD

Full time equivalent staff

GMC registered doctors	6
NMC registered nurses	14 (plus 6 Health Care Assistants)
HPC registered scientists	6
Scientists working towards registration	4
Support staff (receptionists, record managers, quality and risk managers etc)	10

Summary of laboratory audit
On the day of the inspection, the Laboratory Manager informed the inspection team, that she had recently performed a risk assessment (30/01/07) of the annual physical audit of all stored sperm and embryos, which identified a medium risk of damage to stored material, via partial/complete thawing, together with a high risk to staff undertaking the audit, due to exposure to nitrogen vapour. Due to this assessment she had proposed that only a paper audit be performed this year in order to prevent the risks identified.
Summary of spot check of stored material
No discrepancies were observed while carrying out a spot check, tracking two sperm samples and two embryos, from laboratory file to cryostorage tank and from cryostorage tank to file.
Areas of firm compliance
The initial assessment protocol provided by the centre was considered to be fit for purpose. An appointment pack, consisting of a registration form, 'Welfare of the Child' forms and Consent to Disclosure forms are sent out to patients prior to their first consultation. Patients are screened for Hepatitis B/C and HIV prior to commencement of treatment. Completion of the consent forms were evidenced during the inspection.

The centre discourages treatment for women over the age of 42 years, unless they are to use donated eggs, the age limit for which is usually 48 years. The 3-ET log provided on the day of the inspection included 38 cycles (36 patients) with 7 ongoing clinical pregnancies (18% CPR/cycle). All women were over 40 years of age. (mean age = 41.8 years) The protocol for embryo transfer does address the issues surrounding 3-embryo transfer, which, if requested is discussed by all parties and documented. If the patient fulfils set criteria, there is a specific 3-embryo transfer form which has to be completed prior to any such event occurring.

It was confirmed during staff interviews that double witnessing takes place within the laboratory as described within the laboratory protocol. It was suggested that double-witnessing should take place when any frozen semen samples are removed from cryostorage vessels.

Good laboratory practice was evidenced during observations of procedures performed within the laboratory.

Appropriately completed laboratory check sheets were evidenced for;

- refrigerator temperature
- incubator CO_2
- incubator temperature
- weekly cryovessel liquid nitrogen replenishment
- weekly work rota
- leave and weekend work rota
- cleaning list
- air-conditioning unit monitoring

Individual ICSI practitioner results were observed to be satisfactory to good..

During both laboratory and nursing staff interviews, personal training logs were observed and seen to include both annual mandatory sessions as well as individual training.

Areas for improvement

An annual biopsy report is required to be submitted. (This was provided post-inspection.)

Executive recommendations for Licence Committee

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An annual biopsy report is required to be submitted. (This was provided post-inspection.)

Areas not covered on this inspection

None

Evaluation

Some improvements required.

Report compiled by:

Name…Mr Wil Lenton…….

Designation…HFEA Inspector…….

Date……20/03/07……

Appendix A: Centre Staff interviewed

Person Responsible – Professor Gedis Grudzinskas

Six other members of staff

Appendix B: Licence history for previous 3 years

2006

Licence Committee 1st November 2006
The Committee agreed to continue the Centre's licence, to expire on 30th September 2007 with no conditions and no recommendations
A variation to include PGD Beta Hydroxyisobuyryl CoA Hydrolase Deficiency approved

Licence Committee 1st September 2006
A variation to include PGD Charcot Marie Tooth approved

Licence Committee 1st May 2006
A variation to include PGD to avoid Congenital Fibrosis of the Extraocular Muscles

Licence Committee 1st January 2006
Re-licensing project and PGD Conditions added to licence

2005

Licence Committee 18th February 2005
Licence continued with no conditions

2004

Licence Committee 1st October 2004
Licence continued with no conditions

Licence Committee 16th June 2004
A variation to include PGD Translocations

Licence Committee 18th March 2004
A variation to include PGS and Chemical Assisted Hatching

Appendix C:

RESPONSE OF PERSON RESPONSIBLE TO THE INSPECTION REPORT

Centre Number……

Name of PR……..

Date of Inspection……..

Date of Response……

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

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

Signed……

Name…….

Date……

2. Correction of factual inaccuracies

Please let us know of any factual corrections that you believe need to be made (NB we will make any alterations to the report where there are factual inaccuracies. Any other comments about the inspection report will be appended to the report).

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

Please return Appendix C of the report to:
Regulation Department
Human Fertilisation & Embryology Authority
21 Bloomsbury Street
London
WC1B 3HF