**Hospital Blood Bank Closure Form**

This form is for organisations that plan to change their activities such that they will no longer meet the definition of a hospital blood bank (HBB)\*. This may be because they will cease to perform compatibility tests on blood and blood components but will continue to receive blood from another HBB or that there will be no further transfusion activities at the site.

\* *An HBB performs compatibility tests on blood and blood components exclusively for use in hospital facilities. If you receive blood from an HBB for transfusion purposes but do not perform compatibility tests on site you are a ‘facility’*.

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|  | Hospital Blood Bank Closure Form | |
| 1 | Hospital Name |  |
| 2 | Address | Post code: |
| 3 | Trust or Private Healthcare Provider Name | *This should be the body that manages the hospital that the blood bank is located in.* |
| 4 | Third Party Service Provider name  (where applicable) | *Refer to any party responsible for the provision of the blood bank services such as a private company or pathology partnership.* |

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| Details of termination of HBB activities | | |
| 5 | Date of termination of HBB activities |  |
| 6 | What transfusion related activities will continue at the site? | If none please put N/A in qs 12-14 |
| 7 | Has the organisation that provides current components been informed of the change? |  |
| 8 | Has this termination been managed within the HBB change control system? |  |

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| Traceability and document retention | | |
| 9 | Please confirm that records of traceability will be retained for a minimum of 30 years |  |
| 10 | Please confirm that documentation regarding investigations into Serious Adverse Events and Serious Adverse Reactions will be retained for a minimum of 15 years |  |
| 11 | Please confirm that quality system documentation and associated records will be retained for a minimum of 10 years. |  |
| Please provide details of how the above will be achieved (data must be retained in an appropriate and readable storage medium). | | |

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| Continued activity as a blood facility | | |
| 12 | Which HBB will supply your blood components? |  |
| 13 | Is the proposed supplying HBB within the same legal entity? |  |
| 14 | What documentation has been put in place to describe the relevant responsibilities of the new facility and supplying HBB? |  |

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| Closure Form completed by: | |
| Name | BLOCK CAPITALS |
| Date |  |
| Position |  |
| Email |  |
| Employer |  |

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| Declaration by the person responsible for the management of a blood bank\*\* | |
| *To the best of my knowledge and belief the particulars given in this form are correct and complete.*  *(The provision of this information is a requirement under regulation 10 of the Blood Safety and Quality Regulations 2005).* | |
| Signature | *Ensure wet signature not typed or cut and paste* |
| Name | BLOCK CAPITALS |
| Date |  |
| Position | *Note* ***must*** *be Chief Executive in the case of a site managed by a Health Service Body or CQC Registered Person in the case of an independent hospital\*\** |
| Employer |  |

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| When complete please return the closure form electronically to [gmpinspectorate@mhra.gov.uk](mailto:gmpinspectorate@mhra.gov.uk) |

*\*\* As noted signatories should include the person completing the form and the "person responsible for management of a hospital blood bank" (Section 10.1), as defined by Regulation 1 of the Blood Safety and Quality Regulations, SI 2005 No. 50, which in the case of hospital blood bank located in a hospital managed by a health service body is the Chief Executive of that body, or in the case of an independent hospital the Registered Person.*