Site visit inspection report on compliance with HTA minimum standards

Hospital of St Cross

HTA licensing number 12319

Licensed for the

- **procurement of human tissues and cells for human application under the Human Tissue (Quality and Safety for Human Application) Regulations 2007**

1 September 2015

Summary of inspection findings

The Hospital of St Cross (the establishment) was selected to receive a themed site visit inspection. The themes for 2014/15 include quality management, risk management and procurement of tissues and cells.

Although the HTA found that the establishment had met the majority of the HTA's licensing standards, one major shortfall was found with regard to quality management, risk management and donor selection. The major shortfall resulted from a number of related inspection findings which were viewed cumulatively as a major shortfall. The findings were in relation to an absence of: (i) documentation for specific procedures; (ii) internal audit; (iii) independent audit; and, (iv) full donor selection criteria. For a further set of findings identified at the site visit inspection, in relation to an absence of identified personnel to report serious adverse events and adverse reactions in the Designated Individual's absence, the establishment submitted suitable evidence to address this prior to the report being finalised.

The HTA previously found the Designated Individual and the Licence Holder to be suitable in accordance with the requirements of the legislation. Their suitability was not re-assessed during this inspection.

Particular examples of good practice are included in the concluding comments section of the report.

The HTA's regulatory requirements

The HTA must assure itself that the Designated Individual (DI), Licence Holder (LH), premises and practices are suitable.

The statutory duties of the DI are set down in Section 18 of the Human Tissue Act 2004. They are to secure that:

- the other persons to whom the licence applies are suitable persons to participate in the carrying-on of the licensed activity;
- suitable practices are used in the course of carrying on that activity; and
- the conditions of the licence are complied with.

The HTA developed its licensing standards with input from its stakeholders. They are designed to ensure the safe and ethical use of human tissue and the dignified and respectful treatment of the deceased. The HTA inspects the establishments it licences against four groups of standards:

- consent;
- governance and quality systems;
- premises facilities and equipment;
- disposal.

However, a themed inspection may be carried out on establishments which have been found previously to represent a lower risk. Themes target standards which the HTA has identified as common shortfalls across the human application sector. The themes selected for 2014/15 are outlined in the table below.

Themes	HTA Standards
Quality management	
Standard operating procedures for licensed activity	GQ1(b)
Document control system	GQ1(d)
Quality Management System – continuous and systematic improvement	GQ1(c) GQ2(a)-(c)
Internal audit system for licensable activities	
Risk Management	
Procedures for the identification, reporting, investigation and recording of adverse events and reactions	GQ7(a),(f)
Risk assessments of processes and premises	GQ8(a)-(d) PFE1(a)
Traceability	GQ4(e),(f),(h),(i) GQ6(a)-(c) D2(a)

Themes	HTA Standards
Procurement	
Donor selection	GQ5(a),(b), (d)
Equipment is appropriate for use and regularly maintained	PFE3(a) PFE5(a),(b),(c),(e),(f),(g),(k)
Packaging, labeling and agreement for distribution are suitable	PFE4(f),(h),(i),(j)

In addition to the standards listed above, the HTA will follow up on any other issues that have arisen since the establishment's last site visit inspection.

This is an exception-based report: only those standards that have been assessed as not met are included. Where the HTA determines that a standard is not met, the level of the shortfall is classified as 'Critical', 'Major' or 'Minor' (see Appendix 2: Classification of the level of shortfall). Where HTA standards are fully met, but the HTA has identified an area of practice that could be further improved, advice is given to the DI.

Reports of HTA inspections carried out from 1 November 2010 are published on the HTA's website.

Licensable activities carried out by the establishment

'E' = Establishment is licensed to carry out this activity.

Tissue type	Procurement	Processing	Testing	Storage	Distribution	Import	Export
Cartilage / chondral tissue	**E**	**-**	**-**	**-**	**-**	**-**	**-**

Background to the establishment and description of inspection activities undertaken

This report refers to the activities carried out by the Hospital of St Cross (the establishment). This was the fourth site visit inspection of the establishment since it was issued an HTA licence in January 2008 (the last inspection was in August 2013). It was a routine 'themed' site visit inspection to assess whether the establishment is continuing to meet the HTA's standards.

The establishment procures full thickness biopsies of articular chondral tissue to treat damaged knee cartilage by autologous chondrocyte implantation (ACI). In this procedure, chondrocytes are harvested arthroscopically from healthy cartilage tissue in the patient's knee. The cells are then used as a starting material for a cell-based Advanced Therapy Medicinal Product, ATMP. They are cultured (processed) for approximately six weeks and, in a second surgical procedure, the processed product is implanted into the damaged areas of the cartilage.

In 2014, three such operations were performed. Consent to tissue donation, ATMP implantation and donor testing is undertaken by trained clinicians in the Day Surgery Unit within the hospital. A blood sample for donor testing is taken by the anaesthetist in the pre-operative area and tissue procurement (harvesting) takes place in any one of four operating theatres.

Until 2014, the establishment used matrix-applied characterised autologous cultured chondrocyte implants (MACI) as part of the ACI procedure. The company previously manufacturing the MACI product has now been acquired by a separate organisation and MACI manufacture in Europe has been discontinued.

The establishment has now set up a service level agreement (SLA) with a different company for a separate ACI procedure (Characterised Chondrocyte Implantation using ChondroCelect). Tissue processing and serological testing is arranged by the company, which is licensed under the EU Tissue and Cells Directive by the Belgian Federal Agency for Medicines and Health Products. The company provides the cartilage biopsy kit with transport medium, blood tubes for testing and donor consent documentation. The kits are provided on the day of procurement in validated transport containers and are not stored on site. The receipt of the kit is recorded by the purchase order and delivery note, which are retained in the establishment's records. Samples are taken away on the same day by courier and the manufactured product is returned for implantation 9-12 weeks later.

The present site visit inspection included a visual inspection of the Day Surgery Unit, the pre-operative area and the area where records were kept. Meetings were held with the DI (Consultant Orthopaedic Surgeon) and the Person Designated (Lead Theatre Nurse).

A documentation review and vertical audit were carried out. Three patient files were reviewed for traceability from tissue procurement to ATMP implantation. No discrepancies were found in any of the cases.

Inspection findings

The HTA previously found the DI and the (Corporate) LH (CLH) to be suitable in accordance with the requirements of the legislation. Their suitability was not re-assessed during this inspection.

Compliance with HTA standards

Governance and Quality

Standard	Inspection findings	Level of shortfall
GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process.		
b) There are procedures for all licensable activities that ensure integrity of tissue and / or cells and minimise the risk of contamination.	Some standard operating procedures (SOPs) still need to be created and developed, specifically: • retention of critical raw data (for 10 years) • retention of traceability records (30 years).	**Major – cumulative** (Individually, the findings in this section of the report would constitute minor shortfalls against the relevant GQS standards. However, viewed cumulatively, they constitute a major shortfall by presenting a risk
GQ2 There is a documented system of quality management and audit.		
b) There is an internal audit system for all licensable activities.	There is no documented audit schedule in place. *See Advice item 2.*	

c) An audit is conducted in an independent manner at least every two years to verify compliance with protocols and HTA standards, and any findings and corrective actions are documented.	The establishment does not yet have a regular independent audit to verify compliance with protocols and HTA standards.	of failure of the management systems which ensure the quality and safety of the tissues and cells.
GQ5 There are documented procedures for donor selection and exclusion, including donor criteria.		
a) Donors are selected either by the establishment or the third party acting on its behalf in accordance with the criteria required by Directions 003/2010.	The DI is required to ensure that HTLV-1 antibody testing is performed for donors living in, or originating from, high prevalence areas, or with sexual partners originating from those areas, or where the donor's parents originate from those areas. Neither the establishment's current donor selection procedures, nor the SLA with the company responsible for serological testing, indicate that such additional testing may be needed or performed.	
GQ7 There are systems to ensure that all adverse events, reactions and/or incidents are investigated promptly.		
c) The responsibilities of personnel investigating adverse events and reactions are clearly defined.	There are no identified personnel who should report serious adverse events and adverse reactions (SAEARs) in the DI's absence. Although these findings were identified at the site visit inspection, the establishment has submitted suitable evidence to address this prior to the report being finalised.	

Advice

The HTA advises the DI to consider the following to further improve practices:

No.	Standard	Advice
1.	GQ1(b)	The DI is advised to ensure that all locally stored Trust policies are up to date. This refers specifically to the following policy: 'Complaints policy (GOV-POL-004-06)', which is out of date.
2.	Principally GQ2(b) but also relevant to standard	The DI is advised to divide the audit schedule into small increments, carried out by different team members. This should include horizontal audits to ensure that SOPs accurately reflect current practices and vertical traceability audits, from records of procurement to implantation.

	GQ4(b)	The results of all audit findings, and actions taken, should be formally recorded to ensure continuing improvement of processes and practices.
4.	GQ4(e)	An electronic spreadsheet has been set up to record all traceability details from tissue procurement and serological testing to ATMP implantation. The DI is advised to extend the spreadsheet to include details of the batch number and expiry date of the biopsy kit.
6.	GQ8(a), (b)	Risk assessments should be reviewed regularly and also after changes to key procedures. The DI is advised to ensure that staff have access to such risk assessments and that familiarity with them is incorporated into the staff training programme.

Assessment of existing shortfalls against standards

From the last site visit inspection, three minor shortfalls have been met and four minor shortfalls remain unmet. This current site visit inspection has revealed that, of these four, progress had been made with two of them. This is summarised below.

At the last site visit inspection, a minor shortfall was given against standard GQ1(b), where procedures for the following needed to be created and developed: record creation, access, amendment and destruction; cleaning and decontamination; and, retention of critical raw data (for 10 years) and traceability records (30 years). All procedures have now been created apart from those for retention of critical raw data (for 10 years) and traceability records (30 years).

At the last site visit inspection, a minor shortfall was given against standard GQ2(b), where there was no documented audit schedule in place. The DI has now created an audit timetable template and template for audit findings but no audit has been carried out.

There is no progress on meeting shortfalls given against standards GQ2(c) (independent audit) and GQ5(a) (donor selection criteria) at the last site visit inspection. These shortfalls have been included as part of the major shortfall found during this current inspection.

Concluding comments

During the site visit inspection of the Hospital of St Cross areas of good practice were noted:

- All surgeons undertaking licensable activities have been trained and have signed certificates of training provided by the company responsible for tissue processing.
- Quality management has developed further since the last HTA site visit inspection.
- There is a small, cohesive body of staff working under the licence. This provides continuity and the establishment derives benefits from this stability and commitment.
- The surgical team has developed a good working relationship with the local representative of the company responsible for tissue processing.

There are a number of areas of practice that require improvement, including one major shortfall. The major shortfall results from a number of related Governance and Quality Systems inspection findings which, when viewed cumulatively, constitute a major shortfall since they present a risk of failure of the management systems which ensure the quality and safety of the tissues and cells (see Appendix 2). Two sets of findings were identified at the previous site visit inspection and have still not been addressed. For a further set of findings, against standard GQ7(c), the establishment submitted suitable evidence to address this prior to this report being

finalised.

The HTA has given advice to the DI with respect to the Governance and Quality Systems standards.

The HTA requires that the DI addresses the shortfalls by submitting a completed corrective and preventative action (CAPA) plan within 14 days of receipt of the final report (refer to Appendix 2 for recommended timeframes within which to complete actions). The HTA will then inform the establishment of the evidence required to demonstrate that the actions agreed in the plan have been completed.

The HTA has assessed the establishment as suitable to be licensed for the activities specified subject to corrective and preventative actions being implemented to meet the shortfalls identified during the inspection.

Report sent to DI for factual accuracy: 28 September 2015

Report returned from DI: 11 October 2015

Final report issued: 2 November 2015

Appendix 1: HTA standards

The HTA standards applicable to this establishment are shown below; those applicable but not assessed during the inspection are shown in grey text. Individual standards which are not applicable to this establishment are marked as '**N/A**'.

Human Tissue (Quality and Safety for Human Application) Regulations 2007 Standards

Consent

Standard
C1 Consent is obtained in accordance with the requirements of the HT Act 2004, the Human Tissue (Quality and Safety for Human Application) Regulations 2007 and as set out in the HTA's Codes of Practice.
a) If the establishment acts as a procurer of tissues and / or cells, there is an established process for acquiring donor consent which meets the requirements of the HT Act 2004 the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (Q&S Regulations) and the HTA's Codes of Practice
b) If there is a third party procuring tissues and / or cells on behalf of the establishment the third party agreement ensures that consent is obtained in accordance with the requirements of the HT Act 2004, the Q&S Regulations and the HTA's Codes of Practice. **N/A**
c) The establishment or the third party's procedure on obtaining donor consent includes how potential donors are identified and who is able to take consent.
d) Consent forms comply with the HTA Codes of Practice.
e) Completed consent forms are included in records and are made accessible to those using or releasing tissue and / or cells for a Scheduled Purpose.
C2 Information about the consent process is provided and in a variety of formats.
a) The procedure on obtaining consent details what information will be provided to donors. As a minimum, the information specified by Directions 003/2010 is included.
b) If third parties act as procurers of tissues and / or cells, the third party agreement details what information will be provided to donors. As a minimum, the information specified by Directions 003/2010 is included. **N/A**
c) Information is available in suitable formats and there is access to independent interpreters when required.
d) There are procedures to ensure that information is provided to the donor or donor's family by trained personnel.
C3 Staff involved in seeking consent receive training and support in the implications and essential requirements of taking consent.
a) Staff involved in obtaining consent are provided with training on how to take informed consent in accordance with the requirements of the HT Act 2004 and Code of Practice on Consent.
b) Training records are kept demonstrating attendance at training on consent.

Governance and Quality

Standard
GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process.
a) There is an organisational chart clearly defining the lines of accountability and reporting relationships.
b) There are procedures for all licensable activities that ensure integrity of tissue and / or cells and minimise the risk of contamination.
c) There are regular governance meetings, for example health and safety, risk management and clinical governance committees, which are recorded by agendas and minutes.
d) There is a document control system to ensure that changes to documents are reviewed, approved, dated and documented by an authorised person and only current documents are in use.
e) There are procedures for tissue and / or cell procurement, which ensure the safety of living donors.
f) There are procedures for tissue and / or cell procurement, which ensure the dignity of deceased donors. **N/A**
g) There are procedures to ensure that an authorised person verifies that tissues and / or cells received by the establishment meet required specifications. **N/A**
h) There are procedures for the management and quarantine of non-conforming consignments or those with incomplete test results, to ensure no risk of cross contamination. **N/A**
i) There are procedures to ensure tissues and / or cells are not released from quarantine until verification has been completed and recorded. **N/A**
j) There are procedures detailing the critical materials and reagents used and where applicable, materials and reagents meet the standards laid down by the European directives on medical devices and in vitro diagnostic medical devices.
k) There is a procedure for handling returned products. **N/A**
l) There are procedures to ensure that in the event of termination of activities for whatever reason, stored tissues and / or cells are transferred to another licensed establishment or establishments. **N/A**
m) The criteria for allocating tissues and / or cells to patients and health care institutions are documented and made available to these parties on request. **N/A**
n) The establishment ensures imports from non EEA states meet the standards of quality and safety set out in Directions 003/2010. **N/A**
o) There is a complaints system in place.
p) There are written agreements with third parties whenever an activity takes place that has the potential to influence the quality and safety of human tissues and / or cells. **N/A**
q) There is a record of agreements established with third parties. **N/A**

r) Third party agreements specify the responsibilities of the third party and meet the requirements set out in Directions 003/2010. **N/A**
s) Third party agreements specify that the third party will inform the establishment in the event of a serious adverse reaction or event. **N/A**
t) There are procedures for the re-provision of service in an emergency.
GQ2 There is a documented system of quality management and audit.
a) There is a quality management system which ensures continuous and systematic improvement.
b) There is an internal audit system for all licensable activities.
c) An audit is conducted in an independent manner at least every two years to verify compliance with protocols and HTA standards, and any findings and corrective actions are documented.
d) Processes affecting the quality and safety of tissues and / or cells are validated and undergo regular evaluation to ensure they continue to achieve the intended results.
GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and are continuously updating their skills.
a) There are clearly documented job descriptions for all staff.
b) There are orientation and induction programmes for new staff.
c) There are continuous professional development (CPD) plans for staff and attendance at training is recorded.
d) There is annual documented mandatory training (e.g. health and safety and fire).
e) Personnel are trained in all tasks relevant to their work and their competence is recorded.
f) There is a documented training programme that ensures that staff have adequate knowledge of the scientific and ethical principles relevant to their work, and the regulatory context.
g) There is a documented training programme that ensures that staff understand the organisational structure and the quality systems used within the establishment.
h) There is a system of staff appraisal.
i) Where appropriate, staff are registered with a professional or statutory body.
j) There are training and reference manuals available.
k) The establishment is sufficiently staffed to carry out its activities.
GQ4 There is a systematic and planned approach to the management of records.
a) There are procedures for the creation, identification, maintenance, access, amendment, retention and destruction of records.
b) There is a system for the regular audit of records and their content to check for completeness,

legibility and accuracy and to resolve any discrepancies found.
c) Written records are legible and indelible. Records kept in other formats such as computerised records are stored on a validated system.
d) There is a system for back-up / recovery in the event of loss of computerised records.
e) The establishment keeps a register of the types and quantities of tissues and / or cells that are procured, tested, preserved, processed, stored and distributed or otherwise disposed of, and on the origin and destination of tissues and cells intended for human application.
f) There are procedures to ensure that donor documentation, as specified by Directions 003/2010, is collected and maintained.
g) There is a system to ensure records are secure and that donor confidentiality is maintained in accordance with Directions 003/2010.
h) Raw data which are critical to the safety and quality of tissues and cells are kept for 10 years after the use, expiry date or disposal of tissues and / or cells.
i) The minimum data to ensure traceability from donor to recipient as required by Directions 003/2010 are kept for 30 years after the use, expiry or disposal of tissues and / or cells.
j) Records are kept of products and material coming into contact with the tissues and / or cells.
k) There are documented agreements with end users to ensure they record and store the data required by Directions 003/2010. **N/A**
l) The establishment records the acceptance or rejection of tissue and / or cells that it receives and in the case of rejection why this rejection occurred.
m) In the event of termination of activities of the establishment a contingency plan to ensure records of traceability are maintained for 10 or 30 years as required.
GQ5 There are documented procedures for donor selection and exclusion, including donor criteria.
a) Donors are selected either by the establishment or the third party acting on its behalf in accordance with the criteria required by Directions 003/2010.
b) The testing of donors by the establishment or a third party on behalf of the establishment is carried out in accordance with the requirements of Directions 003/2010. **N/A**
c) In cases other than autologous donors, donor selection is carried out by authorised personnel and signed and reviewed by a qualified health professional. **N/A**
d) There is a system in place either at the establishment or at a third party acting on its behalf to record results of donor selection and associated tests.
e) Testing of donor samples is carried out using CE marked diagnostic tests. **N/A**
f) Samples taken for donor testing are clearly labelled with the time and place the sample was taken and a unique donor identification code.

GQ6 A coding and records system facilitates traceability of tissues and / or cells, ensuring a robust audit trail.
a) There is a donor identification system which assigns a unique code to each donation and to each of the products associated with it.
b) An audit trail is maintained, which includes details of when the tissues and / or cells were acquired and from where, the uses to which the tissues and / or cells were put, when the tissues and / or cells were transferred elsewhere and to whom.
c) The establishment has procedures to ensure that tissues and / or cells imported, procured, processed, stored, distributed and exported are traceable from donor to recipient and vice versa.
GQ7 There are systems to ensure that all adverse events, reactions and/or incidents are investigated promptly.
a) There are procedures for the identification, reporting, investigation and recording of adverse events and reactions, including documentation of any corrective or preventative actions.
b) There is a system to receive and distribute national and local information (e.g. HTA regulatory alerts) and notify the HTA and other establishments as necessary of serious adverse events or reactions.
c) The responsibilities of personnel investigating adverse events and reactions are clearly defined.
d) There are procedures to identify and decide the fate of tissues and / or cells affected by an adverse event, reaction or deviation from the required quality and safety standards.
e) In the event of a recall, there are personnel authorised within the establishment to assess the need for a recall and if appropriate initiate and coordinate a recall. **N/A**
f) There is an effective, documented recall procedure which includes a description of responsibilities and actions to be taken in the event of a recall including notification of the HTA and pre-defined times in which actions must be taken. **N/A**
g) Establishments distributing tissue and / or cells provide information to end users on how to report a serious adverse event or reaction and have agreements with them specifying that they will report these events or reactions. **N/A**
h) Establishments distributing tissues and / or cells have systems to receive notifications of serious adverse events and reactions from end users and notify the HTA. **N/A**
GQ8 Risk assessments of the establishment’s practices and processes are completed regularly and are recorded and monitored appropriately.
a) There are documented risk assessments for all practices and processes.
b) Risk assessments are reviewed regularly, as a minimum annually or when any changes are made that may affect the quality and safety of tissues and cells.
c) Staff can access risk assessments and are made aware of local hazards at training.
d) A documented risk assessment is carried out to decide the fate of any tissue and / or cells stored prior to the introduction of a new donor selection criteria or a new processing step, which enhances

the quality and safety of tissue and / or cells. **N/A**

Premises, Facilities and Equipment

Standard
PFE1 The premises are fit for purpose.
a) A risk assessment has been carried out of the premises to ensure that they are fit for purpose.
b) There are procedures to review and maintain the safety of staff, visitors and patients.
c) The premises have sufficient space for procedures to be carried out safely and efficiently.
d) Where appropriate, there are procedures to ensure that the premises are of a standard that ensures the dignity of deceased persons. **N/A**
e) There are procedures to ensure that the premises are secure and confidentiality is maintained.
f) There is access to a nominated, registered medical practitioner and / or a scientific advisor to provide advice and oversee the establishment's medical and scientific activities.
PFE2 Environmental controls are in place to avoid potential contamination.
a) Tissues and / or cells stored in quarantine are stored separately from tissue and / or cells that have been released from quarantine. **N/A**
b) Where processing of tissues and / or cells involves exposure to the environment, it occurs in an appropriate, monitored environment as required by Directions 003/2010. **N/A**
c) There are procedures for cleaning and decontamination.
d) Staff are provided with appropriate protective clothing and equipment that minimise the risk of contamination of tissue and / or cells and the risk of infection to themselves.
PFE3 There are appropriate facilities for the storage of tissues and / or cells, consumables and records.
a) Tissues, cells, consumables and records are stored in secure environments and precautions are taken to minimise risk of damage, theft or contamination.
b) There are systems to deal with emergencies on a 24 hour basis. **N/A**
c) Tissues and / or cells are stored in controlled, monitored and recorded conditions that maintain tissue and / or cell integrity. **N/A**
d) There is a documented, specified maximum storage period for tissues and / or cells. **N/A**
PFE4 Systems are in place to protect the quality and integrity of tissues and / or cells during transport and delivery to its destination.
a) There is a system to ensure tissue and / or cells are not distributed until they meet the standards laid down by Directions 003/2010. **N/A**

b) There are procedures for the transport of tissues and / or cells which reflect identified risks associated with transport. **N/A**
c) There is a system to ensure that traceability of tissues and / or cells is maintained during transport.
d) Records are kept of transportation and delivery.
e) Tissues and / or cells are packaged and transported in a manner and under conditions that minimise the risk of contamination and ensure their safety and quality.
f) There are third party agreements with courier or transport companies to ensure that any specific transport conditions required are maintained. **N/A**
g) Critical transport conditions required to maintain the properties of tissue and / or cells are defined and documented.
h) Packaging and containers used for transportation are validated to ensure they are fit for purpose.
i) Primary packaging containing tissues and / or cells is labelled with the information required by Directions.
j) Shipping packaging containing tissues and / or cells is labelled with the information required by Directions.
PFE5 Equipment is appropriate for use, maintained, quality assured, validated and where appropriate monitored.
a) Critical equipment and technical devices are identified, validated, regularly inspected and records are maintained. **N/A**
b) Critical equipment is maintained and serviced in accordance with the manufacturer's instructions. **N/A**
c) Equipment affecting critical processes and storage parameters is identified and monitored to detect malfunctions and defects and procedures are in place to take any corrective actions. **N/A**
d) New and repaired equipment is validated before use and this is documented. **N/A**
e) There are documented agreements with maintenance companies. **N/A**
f) Cleaning, disinfection and sanitation of critical equipment is performed regularly and this is recorded. **N/A**
g) Instruments and devices used for procurement are sterile, validated and regularly maintained.
h) Users have access to instructions for equipment and receive training in the use of equipment and maintenance where appropriate. **N/A**
i) Staff are aware of how to report an equipment problem. **N/A**
j) For each critical process, the materials, equipment and personnel are identified and documented.
k) There are contingency plans for equipment failure. **N/A**

Disposal

Standard
D1 There is a clear and sensitive policy for disposing of tissues and / or cells.
a) The disposal policy complies with HTA's Codes of Practice.
b) The disposal procedure complies with Health and Safety recommendations.
c) There is a documented procedure on disposal which ensures that there is no cross contamination.
D2 The reasons for disposal and the methods used are carefully documented.
a) There is a procedure for tracking the disposal of tissue and / or cells that details the method and reason for disposal.
b) Disposal arrangements reflect (where applicable) the consent given for disposal. **N/A**

Appendix 2: Classification of the level of shortfall (HA)

Where the HTA determines that a licensing standard is not met, the improvements required will be stated and the level of the shortfall will be classified as 'Critical', 'Major' or 'Minor'. Where the HTA is not presented with evidence that an establishment meets the requirements of an expected standard, it works on the premise that a lack of evidence indicates a shortfall.

The action an establishment will be required to make following the identification of a shortfall is based on the HTA's assessment of risk of harm and/or a breach of the Human Tissue (Quality and Safety for Human Application) Regulations 2007 or the HTA Directions.

1. **Critical shortfall:**

   A shortfall which poses a significant risk to causing harm to a recipient patient or to a living donor,

   or

   A number of 'major' shortfalls, none of which is critical on its own, but viewed cumulatively represent a systemic failure and therefore are considered 'critical'.

   A critical shortfall may result in one or more of the following:

   (1) A notice of proposal being issued to revoke the licence

   (2) Some or all of the licensable activity at the establishment ceasing with immediate effect until a corrective action plan is developed, agreed by the HTA and implemented

   (3) A notice of suspension of licensable activities

   (4) Additional conditions being proposed

   (5) Directions being issued requiring specific action to be taken straight away.

2. **Major shortfall:**

   A non-critical shortfall.

   A shortfall in the carrying out of licensable activities which poses an indirect risk to the safety of a donor or a recipient

   or

   A shortfall in the establishment's quality and safety procedures which poses an indirect risk to the safety of a donor or a recipient;

   or

   A shortfall which indicates a major deviation from the Human Tissue (Quality and Safety for Human Application) Regulations 2007 or the HTA Directions;

   or

   A shortfall which indicates a failure to carry out satisfactory procedures for the release of tissues and cells or a failure on the part of the designated individual to fulfil his or her legal duties;

   or

   A combination of several 'minor' shortfalls, none of which is major on its own, but which, viewed cumulatively, could constitute a major shortfall by adversely affecting the quality and safety of the tissues and cells.

   In response to a major shortfall, an establishment is expected to implement corrective and preventative actions within 1-2 months of the issue of the final inspection report. Major shortfalls pose a higher level of risk and therefore a shorter deadline is given, compared to minor shortfalls, to ensure the level of risk is reduced in an appropriate timeframe.

3. **Minor shortfall:**

A shortfall which cannot be classified as either critical or major and which can be addressed by further development by the establishment.

This category of shortfall requires the development of a corrective action plan, the results of which will usually be assessed by the HTA either by desk based review or at the time of the next inspection.

In response to a minor shortfall, an establishment is expected to implement corrective and preventative actions within 3-4 months of the issue of the final inspection report.

Follow up actions

A template corrective and preventative action plan will be sent as a separate Word document with both the draft and final inspection report. You must complete this template and return it to the HTA within 14 days of the issue of the final report.

Based on the level of the shortfall, the HTA will consider the most suitable type of follow-up of the completion of the corrective and preventative action plan. This may include a combination of

- a follow-up site visit inspection
- a request for information that shows completion of actions
- monitoring of the action plan completion
- follow up at next desk-based or site-visit inspection.

After an assessment of your proposed action plan you will be notified of the follow-up approach the HTA will take.