

Site visit inspection report on compliance with HTA minimum standards

NHSBT Colindale

HTA licensing number 22600

Licensed for the

- **procurement, testing, storage and distribution of human tissues and cells for human application under the Human Tissue (Quality and Safety for Human Application) Regulations 2007; and**
- **storage of relevant material which has come from a human body for use for a scheduled purpose**

07 March 2017

Summary of inspection findings

The HTA found the Designated Individual, the Licence Holder, the premises and the practices to be suitable in accordance with the requirements of the legislation.

NHSBT Colindale (the establishment) was found to have met all HTA standards.

Particular examples of strengths and 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, Licence Holder, premises and practices are suitable.

The statutory duties of the Designated Individual 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.

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.

'SLA' = Service Level Agreement; the establishment is licensed for this activity but another establishment (licensed) carries out the activity on their behalf.

Tissue type	Procurement	Processing	Testing	Storage	Distribution
Cord blood	E		E / SLA		E
Bone				E	E
Tendons				E	E
Skin				E	E

Background to the establishment and description of inspection activities undertaken

This report refers to the activities carried out by National Health Service Blood and Transplant (NHSBT) Colindale (the establishment). The establishment carries out procurement, testing, storage and distribution of human tissue and cells for human application under the Human Tissue (Quality and Safety for Human Application) Regulations 2007. The establishment is also licensed under the Human Tissue Act 2004 for the storage of relevant material for the scheduled purpose of research; however, the establishment does not currently store any research material.

Cord Blood

Colindale forms part of NHSBT's cord blood bank (CBB) facility together with NHSBT Filton. The Colindale site acts as a CBB collection evaluation facility and receives blood that has been procured at six local hospitals. Procurement staff are based at the collection sites but are employed by NHSBT Colindale. Parents are given information about cord blood donation during their routine visits to the hospital during pregnancy. A mini consent form is used

initially to give consent for the collection of cord blood. The collection of the placenta during childbirth is carried out by hospital midwives. Mothers are identified using standard procedures at individual hospital trusts. The midwives fill in a record of the birth and the mother's details on a placenta identification form. This form also contains a reminder of some of the exclusion criteria that would prevent the collection of cord blood. The midwife delivers the placenta, she then hands the placenta to the NHS Cord Bank collection staff with a placenta identification form. The NHS Cord Bank staff transfer the placenta to the dedicated collection area where they then go on to complete the procurement process. The unit is labelled with a unique identifier and stored in a monitored 20-22°C incubator. A courier collects the stored units twice a day using validated transport boxes and they are delivered, along with the accompanying consent and procurement paperwork, to Colindale for evaluation. At Colindale, the units are assessed against criteria for weight and total nucleated cell (TNC) count. Details of the donor, procurement and unit are entered onto the establishment's laboratory information management system (LIMS). Acceptable units are put into a monitored incubator ready for collection by courier and delivery to the processing site at Filton. Units that are not acceptable may be sent to an establishment that has requested fresh cord blood for research providing appropriate consent is in place. Otherwise, units not meeting the establishment's acceptance criteria are disposed of.

Once the units have been accepted the mother is approached to complete the full consent paperwork for banking of the cord blood unit. This is usually within one or two days of giving birth and maternal bloods for biological tests are also taken and sent to Colindale at this time. The mother is reminded to contact NHSBT if there are any health issues with her or the baby once they have left the hospital. A twelve-week post-natal check on the mother by phone is carried out where any special circumstances are identified by the hospital (see advice item 1).

Cord Bank Team Managers based at Colindale visit allocated teams at the hospital sites on a weekly basis to monitor the facilities, equipment, collection kits, procedures and training. Medical staff involved in the collection of the placenta are made aware of the HTA regulations and of expectations in terms of handling the placenta before it is given to the NHSBT collection staff and record keeping. Collection staff have a full induction programme and are signed-off once competent. Competency is checked during audits that cover an observation of consent or collection procedures or questions that demonstrate the operator's knowledge of the activities. The sampling of the cord units are carried out at Filton and the microbiology tests are carried out at National Bacteriology lab in Colindale. The results of the microbiology tests are trended monthly for each site and action is taken should a site breach the action level on two consecutive months.

Stored Tissues

The establishment also acts as a small-scale storage facility for NHSBT Tissue Services. The storage facility consists of two -80°C freezers and an assigned area for storing freeze-dried material at room temperature all within a controlled access area. Most of the stock held at this site is material returned from local hospitals under NHSBT's 'sale or return policy' and is therefore fit for re-distribution. Stock is controlled by a proprietary software system used by NHSBT and receipt and distribution is described in written procedures. Barcodes are used to track the stock along with accompanying tracking records.

NTMRL

The National Transfusion Microbiology Reference Laboratory (NTMRL) is based at the Colindale site. This laboratory carries out biological testing on samples from deceased tissue donors, confirmatory tests and tests on samples that are non-routine e.g. small volume samples. This testing is carried out on behalf of a number of HTA-licensed establishments, internal and external to NHSBT, under a series of service level agreements.

Routine Site Visit

A routine site visit inspection of NHSBT Colindale took place on 7 March 2017. The inspection consisted of a visual inspection of the Colindale site including observation of the receipt of a cord blood unit, receipt of samples to NTMRL and the hospital services storage area. The hospital collection sites were not visited during this inspection. Discussions were held with key members of staff at the site including the Designated Individual (DI), the QA Manager, members of the QA team, Team Managers responsible for hospital sites and the collection laboratory, and Hospital Services staff.

The management of the consent, donor selection and procurement procedures was examined during a roundtable with relevant staff. Policies, standard operating procedures (SOPs) and patient information material were reviewed. Trend analysis data for the monthly microbial contamination rates were viewed along with the validation documentation for the transport boxes used for transferring CB units from the hospital sites to Colindale.

The Quality Management System was examined. Three incidents were selected for closer examination including the root cause analysis and corrective and preventative action (CAPA) plans (see advice item 3). All SOPs and policies reviewed during the inspection were found to be appropriately authorised and within review date.

Three cord blood donor files were reviewed. Records reviewed included medical review forms, consent forms, placenta identification forms, donor test results and TNC assessment. Audit trails were undertaken of one femoral head and one unit of skin stored in the hospital services. The audit trail was followed from the freezer to the stock management software. No discrepancies were noted.

Inspection findings

The HTA found the Designated Individual and the Licence Holder to be suitable in accordance with the requirements of the legislation.

Compliance with HTA standards

All applicable HTA standards have been assessed as fully met.

Advice

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

No.	Standard	Advice
1.	GQ1b	A twelve week post-natal phone call to mothers was carried out routinely but is now restricted to certain clinical circumstances. The DI is advised to review the relevant CBB SOPs, forms and agreements to reflect this change.
2.	GQ5a	The establishment has assessed that there would be no risk of transmission of a substance (such as cyanide, lead, mercury, gold) from a cord blood donor to a recipient in a dose that would endanger their health. This is because significant exposure would result in pregnancy complications. The DI is advised to document this rationale.
3.	GQ7a	The DI is advised to ensure that incidents are sufficiently investigated and that corrective actions are effective. In an example looked at during the inspection

		concerning an error that was made by a member of the collection staff, it was not clear whether this was due to a problem restricted to this member of staff or in wider training and supervision that could have had implications for other staff.
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Concluding comments

The CBB functions that are managed from Colindale i.e. collection and evaluation are carried out with a high level of quality management. Collection sites and staff are visited regularly by Team Managers and there are regular checks on the facilities and areas such as temperature monitoring, staff training and competency, and microbial contamination rates in collected units. There is a general commitment to high standards of practice from staff and any non-compliances / incidents are captured effectively. Critical data concerning the traceability of the cord blood units is entered onto the LIMS software using a double blind entry system to minimise errors. The CBB relies on efficient donor recruitment to obtain CB units and staff engagement is enhanced through the use of compilation sheets that document the fate of collections of CB units at individual sites that have been issued for treatment.

The HTA has given advice to the Designated Individual with respect to document review, donor selection rationale and incident investigation.

The HTA has assessed the establishment as suitable to be licensed for the activities specified.

Report sent to DI for factual accuracy: 30 March 2017

Report returned from DI: 12 April 2017

Final report issued: 18 April 2017

Appendix 1: HTA standards

The HTA standards applicable to this establishment are shown below; those not assessed during the inspection are shown in grey text. Individual standards which are not applicable to this establishment have been excluded.

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.
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.
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.
g) There are procedures to ensure that an authorised person verifies that tissues and / or cells received by the establishment meet required specifications.
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.
i) There are procedures to ensure tissues and / or cells are not released from quarantine until verification has been completed and recorded.
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.
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.
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.
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.
q) There is a record of agreements established with third parties.
r) Third party agreements specify the responsibilities of the third party and meet the requirements set out in Directions 003/2010.
s) Third party agreements specify that the third party will inform the establishment in the event of a serious adverse reaction or event.
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.
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.
c) In cases other than autologous donors, donor selection is carried out by authorised personnel and signed and reviewed by a qualified health professional.
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.
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.
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.
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.
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.
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.

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.
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.
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.
c) Tissues and / or cells are stored in controlled, monitored and recorded conditions that maintain tissue and / or cell integrity.
d) There is a documented, specified maximum storage period for tissues and / or cells.
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.
b) There are procedures for the transport of tissues and / or cells which reflect identified risks associated with transport.
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.
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.

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.
b) Critical equipment is maintained and serviced in accordance with the manufacturer's instructions.
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.
d) New and repaired equipment is validated before use and this is documented.
e) There are documented agreements with maintenance companies.
f) Cleaning, disinfection and sanitation of critical equipment is performed regularly and this is recorded.
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.
i) Staff are aware of how to report an equipment problem.
j) For each critical process, the materials, equipment and personnel are identified and documented.
k) There are contingency plans for equipment failure.

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.

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 HT Act or associated Directions.

1. **Critical shortfall:**

A shortfall which poses a significant direct risk of 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 straightaway

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.