

Site visit inspection report on compliance with HTA minimum standards

Oxford Heart Valve Bank

HTA licensing number 11106

Licensed for the

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

13 & 14 November 2014

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.

In 2013, the Oxford Heart Valve Bank (OHVB, the establishment) expanded the scope of its activities under the Quality and Safety Regulations to include processing and storage of ovarian tissue and procurement of whole blood for the manufacture of regulatory T cells as part of a clinical trial. These activities were being inspected by the HTA for the first time. In relation to all the activities taking place under HTA licences, the establishment was found to have met all relevant 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 (DI), Licence Holder, premises and practices are suitable.

The statutory duties of the Designated Individual are set down in Paragraph 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.

‘TPA’ = Third party agreement; the establishment is licensed for this activity but another establishment (unlicensed) carries out the activity on their behalf.

Tissue type	Procurement	Processing	Testing	Storage	Distribution	Import	Export
Heart valves, patches, conduits	E/TPA	E	SLA	E	E/TPA		
Ovarian tissue	E/TPA	E	SLA	E	E		
One Study Trial Whole blood	TPA		SLA				

Background to the establishment and description of inspection activities undertaken

The Oxford Heart Valve Bank is located in the Heart Centre of the John Radcliffe Hospital in Oxford. The Oxford University Hospitals NHS Trust is the corporate licence holder and the corporate licence holder contact is Reverend Philip Sutton, Head of Patient Services. The OHVB was set up in 1991 and has been licensed by the HTA since 2007. The premises include a clean room suite with a preparation room and an aseptic room (both containing Class II cabinets), an office area and a portacabin housing two liquid nitrogen cryovats and a controlled rate freezer. Nitrogen storage cryovats and all fridges and freezers have local alarms and are also linked to a proprietary temperature monitoring system, which is

monitored remotely. An alert is sent to a mobile phone if a temperature is out of specification for more than 40 minutes.

Donor testing is carried out under a service level agreement with another HTA licensed establishment. OHVB has contingency arrangements with another HTA licensed establishment for storage.

The OHVB Tissue Co-ordinators work with the Bereavement Services team to seek consent for donation of heart valves for patient treatment and brain tissue for research. This service was suspended in December 2013, pending re-organisation of the service. The HTA undertook an assurance visit in 2014, in response to a request from the Trust, and reviewed consent procedures and offered advice. Progress on the re-organisation of this service was discussed during this inspection.

Heart valves, patches and conduits

The NHS Blood and Transplant Specialist Nurses for Organ Donation, seek consent and inform OHVB of organ donors who may donate suitable heart valves in the Oxford area. OHVB staff take retrieval packs containing all required consumables to mortuaries and theatres to retrieve donated hearts. Hearts are transported to the OHVB, where dissection and quality assessment take place in the clean room suite. Heart valves and tissues such as patches and conduits are cryopreserved and stored in the vapour phase of liquid nitrogen.

Cardiovascular valves, conduits and patches are added to the OHVB cardiovascular stock list; the cardiovascular valves and conduit stock records are also forwarded to be added to the National Fulfilment Service database administered by NHS Blood and Transplant. Heart tissue is stored for a maximum of five years.

Heart valves and other tissue are packaged in dry ice and security tagged before the boxes are collected by dedicated couriers and transported to end users. On occasion, heart valves may be returned to the OHVB, if the planned surgical procedure is postponed. Due to the national shortage of heart valves, a policy with control measures is in place to review the quality of returned, unused heart valves, including checks on the level of ice, the security tag and packaging. The control measures also include a review by the DI or the Medical Director. Returned heart valves are stored in the -80°C freezer for up to six months and can only be sent back to the surgical centre which originally requested the heart valve.

Ovarian tissue

In 2013, the OHVB established an ovarian tissue storage service for women and children who are likely to be sub-fertile or infertile following chemotherapy or radiotherapy treatment. The HTA authorised the Preparation Process Dossier submitted by the OHVB which covered the processing of ovarian tissue which falls under the remit of their HTA licence. The Oxford Fertility Unit (OFU) works closely with the OHVB and staff attend relevant governance meetings. The OHVB is licensed by the Human Fertilisation and Embryology Authority (HFEA) for storage of reproductive tissue; the OFU is licensed by the HFEA for treatment with storage and for research. To date, the OHVB has not released ovarian tissue for transplantation.

ONE Study Cell Therapy Trial

The ONE Study trial, a multicentre international clinical trial (EudraCT 2013-002099-42) aims to assess the effectiveness of treating patients who receive kidneys from live donors with

regulatory T-cells (see www.onestudy.org). Since this is an Advanced Therapy Medicinal Product, the HTA regulates the procurement and donor testing steps; all other steps, including processing (manufacturing), storage and end use, are regulated by the Medicines and Healthcare products Regulatory Agency.

OHVB has third party agreements with clinicians at Churchill Hospital, Oxford, who undertake donor selection, seek consent and procure whole blood by venesection. Patients are informed that they can withdraw from the trial at any time. Seven procurements have taken place since July 2014, and a further six procurements are planned.

HTA inspection

The fourth routine inspection of Oxford Heart Valve Bank was undertaken on 13th and 14th December. The inspection included a visual inspection of the premises where processing takes place and interviews with the Manager of the Heart Valve Bank who is the DI, the Head of Patient Services, who is the Corporate Licence Holder Contact, a Consultant Paediatric Oncologist, who seeks consent for procurement and storage of ovarian tissue, and scientists who procure, process and cryopreserve heart valves and ovarian tissue. The Nephrology Clinical Research Fellow, who is a researcher on the ONE Study trial, was interviewed over the telephone before the inspection. The HTA team also discussed licensing arrangements relating to proposed activities with the Professor of Reproductive Medicine, who is the Clinical Lead for Oxford University Hospitals Women's and Children's Hospital and a Consultant Gynaecologist.

A document review was undertaken. Documents reviewed included standard operating procedures (SOPs) relating to procurement, cryopreservation, storage and distribution (as appropriate), environmental monitoring and quality assurance reviews of heart valves, ovarian tissue and blood procured under the ONE Study trial. Third party agreements, service level agreements, meeting minutes, training records, incident reports and audit reports were also reviewed.

The establishment has an agreement with Buckingham Healthcare NHS Trust. This covers the services provided by the Stoke Mandeville Hospital Pharmacy Quality Assurance Department (SMPQA), which oversees environmental monitoring of viable and non-viable particulates (active air sampling, contact plates, swab tests) and provides monthly environmental monitoring reports to OHVB. SMPQA assesses staff competencies within the clean room.

The HTA completed an audit trail. Two ovarian tissue samples and two heart valves were traced from their location in liquid nitrogen cryovats to the relevant donor files. Records relating to two donors recruited into the ONE study trial and who donated blood were also reviewed. Donor files were found to be comprehensive and included information for each step of the donation pathway, as well as processing and cryopreservation records.

There were no discrepancies noted in the records

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.	GQ3e	<p>Staff competencies are monitored and an aseptic processing performance review is completed every 12 months. In addition the SOPs for several procedures, including processing of ovarian tissue, heart valve dissection, disinfection medium preparation, disinfection procedure for heart valves, cryopreservation and packaging state that if a member of staff has not processed tissues for more than 12 weeks, they have to be retrained and a performance review must be undertaken. During the inspection it was noted that a member of staff carried out a procedure without being subject to a performance review, even though they had carried out that process more than 12 weeks previously.</p> <p>The DI is advised to implement a system to remind individual members of staff when their competence in relation to dissection and processing for each tissue type needs to be re-assessed.</p>
2.	GQ7 d and PFE 2b	<p>In some cases, active air particle monitoring has not been taking place when ovarian tissue is processed in the Class II cabinet located in the aseptic room within the cleanroom suite. A risk assessment has been undertaken as this was a deviation from the SOP. The DI is advised to provide this risk assessment to the implanting surgeon when the tissues are released for re-implantation. Other environmental monitoring data and microbiology assessment of the tissues were undertaken and were assessed to have met the required quality standards.</p>
3.	PFE3 a, b, c, d.	<p>The establishment intends to use a secure fridge near cardiac theatres to store thawed heart valves for use during emergency surgery. The DI is advised to obtain expert advice on the shelf life of thawed heart valves stored in a fridge, before deciding of the length of storage of thawed heart valves. The HTA understands that the fridge will be linked to the proprietary temperature monitoring system and that the OHVB will train theatre staff on documentation required to maintain traceability of stored heart valves and how to respond in the event that the fridge alarm sounds.</p>

Concluding comments

Several areas of good practice were identified during the inspection. The establishment has a wide range of detailed and well drafted SOPs which cover licensable activities. The SMPQA has overall responsibility for environmental monitoring and supports staff at the establishment to monitor non-conformances. Aseptic processing performance review for each trained member of staff is undertaken every 12 months. If a member of staff has not performed a process for 12 weeks, they are retrained and a performance review is undertaken before they can carry out that procedure again. Archive blood samples are kept for 30 years in the event that retesting is required. There are good systems in place to monitor the areas where procurement takes place. Two person checks take place at key stages during processing and cryopreservation. Comprehensive quality checks are undertaken on products before and after

cryopreservation.

There are close working relationships within the OHVB and other organisations such as the OFU and the SMPQA which helps to ensure the quality of tissues procured and stored at the OHVB.

The HTA has given advice to the Designated Individual on a range of matters relating to governance and quality standards, and on the storage of thawed heart valves to ensure they remain suitable for use.

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

Report sent to DI for factual accuracy: 12 December 2014

Report returned from DI: 6 January 2015

Final report issued: 19 January 2015

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.
f) There are procedures for tissue and / or cell procurement, which ensure the dignity of deceased 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.
n) The establishment ensures imports from non EEA states meet the standards of quality and safety set out in Directions 003/2010.
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.

d) Where appropriate, there are procedures to ensure that the premises are of a standard that ensures the dignity of deceased persons.
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.
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.
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.
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.
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.