Site visit inspection report on compliance with HTA minimum standards

University College London Hospitals

HTA licensing number 11025

Licensed for the

- **procurement, processing, storage, distribution and export 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**

28-29 November 2017

Summary of inspection findings

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

Although the HTA found that University College London Hospitals (the establishment) had met the majority of the HTA standards, two minor shortfalls were found in relation to the risk assessments and storage of reagents used in procurement.

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.

'E*' = Establishment is licensed to carry out this activity but is not currently carrying it out.

Tissue Category; Tissue Type	Procurement	Processing	Testing	Storage	Distribution	Import	Export
Progenitor Cell, Haematopoietic, Bone Marrow; Bone Marrow	**E**	**E**		**E**	**E***		
Progenitor Cell, Haematopoietic, Cord Blood; Cord Blood;	**E***	**E***		**E***	**E***		
Mature Cell, T Cell (DLI); DLI	**E**	**E**		**E**	**E***		
Progenitor Cell, Haematopoietic, PBSC; PBSC	**E**	**E**		**E**	**E***		**E***
Progenitor Cell, Haematopoietic, Unspecified; Peripheral Blood Mononuclear Cells (PBMC)	**E**	**E**		**E**	**E***		**E***

Background to the establishment and description of inspection activities undertaken

The establishment is part of the University College London Hospitals NHS Trust and is part of the Haematopoietic Stem Cell Transplantation (HSCT) clinical programme, which provides the largest transplant service in Europe performing approximately 350 transplants a year. The establishment is also accredited by the Joint Accreditation Committee - European Society for Blood and Marrow Transplantation (EBMT) and the International Society for Cellular Therapy (ISCT) (JACIE).

Under the HSCT programme the establishment undertakes the collection of bone marrow (BM), peripheral blood stem cells (PBSCs) and donor lymphocytes for infusions (DLI) for both UCLH patients and on behalf of the Anthony Nolan (AN) and British Bone Marrow Registry (BBMR). HSCT also offers transplant services to adolescent patients.

Consent for the stem cell collections is sought at the initial medical assessment by trained consultants and specialist nurses at the UCLH Macmillan Cancer Centre. For collections performed on behalf of the Registry, donor consent is taken twice - once using the Registry's consent forms, and a second time using the establishment's own consent forms, where the donors will give their consent for the testing of mandatory serological markers and storage of the stem cell collection for a maximum five-years, or for 12 weeks in the event of a positive serology result. The HSCT programme's own patients will be consented using the establishment's consent forms only. In the case of adolescent donors, the donor is assessed by independent assessors prior to any collections. There is a dedicated side room available for adolescent collections at the facility.

Blood samples are taken within 30 days prior to harvest and sent for mandatory serological testing at another HTA-licensed establishment. Nucleic acid amplification testing for HIV, HBV and HCV is performed for all allogeneic donations.

UCLH Macmillan Cancer Centre staff are responsible for transporting collections in cool boxes to the Wolfson Cellular Therapy Unit (WTCU) for processing and storage. Prior to processing, collections may be kept cool at 2-8ºC in dedicated refrigerators. The processing facility consists of two clean rooms and a Grade C area, where samples for sterility tests and CD34 counts are obtained from the collection bag using a closed system. The microbiological safety cabinets in the clean rooms maintain a Grade A environment within a Grade B background. All environmental monitoring is conducted in accordance with the requirements of Directions 003/2010 and Annex I of the EU Guidelines to Good Manufacturing Practice. Plates and samples for microbiological testing are incubated in-house, and any positive growth is sent to another HTA-licensed establishment for identification.

Cell products and their accompanying pilot vials for quality control tests are cryopreserved overnight by passive freezing in a dedicated -80ºC freezer. The products are then transferred to liquid nitrogen freezers for storage at -140ºC. Any product with a positive serology result is kept in a separate quarantine box at -80ºC. All equipment, including freezers for cryopreservation, liquid nitrogen storage freezers and refrigerators, are linked to a continuous temperature monitoring system which alerts staff remotely if there are deviations in temperature. There is contingency equipment available for all critical units. Dry shippers used to transfer the cell products to the Macmillan Centre for transplant are regularly qualified.

All harvests are tested pre- and post-cryopreservation for CD34 expression. If the CD34-positive cell count is below the minimum acceptance criteria for transplant, a colony forming unit assay will be performed to check functionality prior to release. The results of these quality checks are communicated to the transplant team via a product release form generated by the processing facility.

The establishment also procures PBSCs and peripheral blood mononuclear cells (PBMCs) as starting material for Advanced Therapy (Investigational) Medical Products (ATIMPs) in

several clinical trials. The clinical trials are carried out under agreements with establishments which are regulated by the Medicines and Healthcare products Regulatory Agency (MHRA) within the UK, or by the relevant competent authorities in other EU countries. Each clinical trial sponsor takes responsibility for identifying the donors, providing information and taking consent for the trial. Prior to collection, the staff responsible for the collection of the tissues and cells consent using the establishment's own forms to ensure the consent meets the required HTA standards.

The establishment is also HTA-licensed for storage of relevant material for use for a scheduled purpose under the Human Tissue Act 2004. Although licensed for this activity, the establishment does not currently store any relevant material.

The inspection included a visual inspection of the apheresis and BM collection facilities where collections take place and the storage facilities for reagents and consumables used, the processing clean rooms and storage facility for cryopreserved products. The inspection also included round table discussions with the DI, who is also the Processing Facility Director, the Quality Management team, the Laboratory Manager and key staff members of the apheresis and bone marrow collection team. Audits included a review of five patient notes – two autologous PBSC collections, one allogeneic PBSC donor and two PBSC sibling donors, where evidence of appropriate consent, serology testing, recording of consumables and traceability were reviewed. Four processing records were also reviewed looking at serology results, recording of reagents and consumables, environmental monitoring, traceability and quality checks. No discrepancies were found.

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

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

Governance and Quality

Standard	Inspection findings	Level of shortfall
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.	There are no risk assessments in place for the licensable activities of processing and storage. While the establishment includes contingency arrangements within certain standard operation procedures (SOPs), the risks associated with these activities have not been identified and documented. The establishment's regime for the incubation of settle plates used for monitoring the processing environment is not in line with recommendations of the European Directorate for the Quality of Medicines. The protocol risks not detecting micro-organisms of both bacteria and fungi origin. The risk assessment for this alternate incubation protocol and evidence-based rationale for this approach is not available.	**Minor**

Premises, Facilities and Equipment

Standard	Inspection findings	Level of shortfall
PFE3 There are appropriate facilities for the storage of bodies, body parts, tissues, 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.	The reagents used for BM procurement are stored in an unlocked cupboard in theatres. The cupboard is not temperature monitored. Whilst access to theatres is controlled, the control measures were not deemed secure enough due the high volume of traffic within the department.	**Minor**

Advice

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

No.	Standard	Advice
1.	C1d	The DI is advised to amend the establishment's consent forms to include all the serological tests that will be performed as standard, and include the stipulation that other medical tests may be performed if required.
2.	GQ2b	The DI is advised to update the SOP for the qualification of dry shippers to clearly state the required temperature range for transportation of products, and the SOP for high risk samples to state that these samples will only be stored for a maximum of 12 weeks at -80ºC.
3.	GQ4h	Certain data output during processing is recorded on thermal paper. While the establishment retains this raw data for the required 10 year period, there is a potential for the records to fade over time. The DI is advised to ensure all forms of raw data is retained in a suitable format to prevent any loss of information.
4.	GQ7a	The DI should ensure agreements with clinical trial sponsors clearly set out the responsibility of the courier to report a serious adverse events (SAEAR) to the DI during the transportation of the starting material to the manufacturing site.
5.	GQ8a	The DI is advised to review the format of the risks assessments to ensure where there is low risk classification, all factors that contribute to that risk rating is clearly documented and is regularly reviewed to ensure there are no changes in the risks.
6.	GQ8a	The DI is advised to review the risk assessments which are documented in all SOPs to state the actual risks of each SOP, rather than a repetition of the same three risks regardless of the procedure being performed.
7.	GQ3d	Although the gowning procedure for entering the clean room is assessed during staff induction, there is no refresher training or revalidation of gowning procedures following this induction. The DI is advised to implement gowning revalidation checks to ensure that staff continue to follow the correct gowning procedure.
8.	PFE5f	The DI is advised to ensure the apheresis machines are cleaned according to schedule. During the inspection, the monthly decontamination of all the machines was overdue by four days.
9.	-	The DI is advised to ensure agreements with third party clinical trial sponsors refer to the Human Tissue (Quality and Safety for Human Application) Regulations 2007 for the procurement and testing of starting material, and not the Human Tissue Act 2004.

Concluding comments

There are a number strengths and good practices observed during the inspection. The DI is highly experienced in the field of haematopoietic stem cell transplantation, and the establishment regularly reviews procedures and clinical engraftment data in the field to

ensure their practices are optimised. The establishment has in place an efficient online management system to coordinate all licensable activities that is clearly working well with practices. Documents are uploaded promptly and all relevant information is easily accessible by all staff. There are plans to develop the online management system to further improve the communication of processing results between WTCU and the transplant team.

There are a number of areas of practice that require improvement, resulting in two minor shortfalls. The HTA has given advice to the Designated Individual with respect to risk assessments, consent forms, updating SOPs, third party agreements, gowning revalidation, routine cleaning of apheresis machines and licensing agreements.

The HTA requires that the Designated Individual 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: 19 December 2017

Report returned from DI: 22 January 2018

Final report issued: 23 January 2018

Completion of corrective and preventative actions (CAPA) plan

Based on information provided, the HTA is satisfied that the establishment has completed the agreed actions in the CAPA plan and in doing so has taken sufficient action to correct all shortfalls addressed in the Inspection Report.

Date: 05 June 2018

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
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.
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.
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 shortfall which poses a significant risk to human safety and/or dignity or is a breach of the Human Tissue Act 2004 (HT Act) or associated Directions,

   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 breach in the relevant Codes of Practices, the HT Act and other relevant professional and statutory guidelines;

   or

A shortfall which indicates a failure to carry out satisfactory procedures 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.

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.