Site visit inspection report on compliance with HTA minimum standards

Warwick Hospital

HTA licensing number 22543

Licensed for the

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

27 and 28th November 2018

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 Warwick Hospital (the establishment) had met many of the HTA standards, 14 minor shortfalls were found in relation to Governance and Quality systems (GQS) and the Premises, Facilities and Equipment (PFE) standards. Shortfalls were identified in relation to temperature monitoring of the reagent storage area, internal incident reporting procedures, SAEARs reporting procedures, risk assessment content and review, document control procedures, the consistency of standard operating procedures (SOPs) with current practice, the minuting of governance meetings, the scope of independent audits, internal audits of records, contingency arrangements in the event of termination of activities and application of the Single European Code (SEC).

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, PBSC; PBSC	**E**				**E***		

Background to the establishment and description of inspection activities undertaken

The establishment, which is part of South Warwickshire Hospitals NHS Foundation Trust (SWFT), provides an apheresis service for the procurement of autologous PBSCs from patients in the Coventry and Warwickshire region. Patients are referred to the service by the clinical team based at the transplant centre at University Hospitals of Coventry and Warwickshire (UHCW). PBSCs procured at Warwick Hospital are transported to another licensed establishment for processing and storage, before being distributed to UHCW for reinfusion. The processing and storage establishment also undertakes mandatory serology testing for this service.

The responsibilities of SWFT, UHCW and the processing and storage establishment are set out in formal agreements. There is a further agreement between SWFT and a courier for the transport of cells to the processing and storage establishment.

The clinical team at UHCW provide patients with information about the apheresis procedure, seek consent for mandatory serological testing, stem cell mobilisation and storage of the cells, and assess patient suitability. The UHCW team then initiate stem cell mobilisation and take samples for mandatory serological testing within the required timeframe.

The day before the planned procurement, UHCW perform full blood counts and CD34 counts to determine whether the target cell count will be achieved or if rescheduling is required. The UHCW clinical team liaise with staff at Warwick Hospital and the processing and storage establishment to identify suitable dates for procurement. They communicate relevant patient information and procurement targets through standardised forms, which are distributed via email to staff at each establishment.

On the day of procurement the patient attends the Aylesford Unit at Warwick Hospital. Apheresis staff explain the process to the patient, before seeking consent for the apheresis procedure and the taking of blood samples for serology testing. Consent is documented on an establishment consent form and NHS Blood and Transplant (NHSBT) consent form 2B. The establishment has one apheresis machine and a reciprocal contingency arrangement is in place with another licensed establishment to provide cover in the event of interruption of service.

Procurement is initiated based on the cell count data obtained the day before the planned collection. A further sample is taken and tested at Warwick Hospital at the start of procurement, and used to adjust the settings of the apheresis machine if required. Further samples are taken from the Hickman line during procurement for blood culture analysis.

PBSC units are labelled before they are disconnected from the apheresis machine. The labels are provided by the other HTA-licensed establishment responsible for processing and storage of procured cells. Both the labels and the procurement worksheet are checked by a second individual before packaging. The units are then sealed in validated transport boxes and collected from the Aylesford Unit by the courier, along with the blood samples for serology testing. The date and time of packaging, collection and delivery at the processing and storage establishment are recorded by Warwick Hospital, courier and processing establishment staff on a transport form. Completed copies of the form are held at Warwick Hospital.

The other HTA-licensed establishment relays the results for the processed cells to UHCW, who in turn liaise with Warwick Hospital to schedule further procurements with the patient, if required.

Warwick Hospital has held JACIE (Joint Accreditation Committee – International Society for Cellular Therapy & European Group for Blood and Marrow Transplantation) accreditation since 2006. The establishment has been licensed under the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (as amended) since 2008, and this was the fifth routine site visit. A visual inspection of the procurement area, storage areas and the laboratory where CD34+ and full blood count analysis are performed, was conducted. A document review was performed, which included the review of four sets of patient records, standard operating procedures (SOPs), agreements, audits and risk assessments. Roundtable discussions were held with establishment staff to review governance and quality systems, facility maintenance and establishment practices.

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

Governance and Quality

Standard	Inspection findings	Level of shortfall
GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process.		
b) There are procedures for all licensable activities that ensure integrity of tissue and / or cells and minimise the risk of contamination.	Establishment standard operating procedures (SOPs) do not accurately reflect current practices. For example: • The SOP detailing receipt and storage of reagents references an intermediate storage area for ACD-A which is no longer used. • The SOP describing the CD34 count used by the establishment as a pre-apheresis check does not accurately reflect the target range used by the establishment. The SOP also does not include the borderline CD34 counts that would trigger referral to the transplant team at UHCW for a clinical decision, prior to placing the patient on the apheresis machine. • The SOP for maintenance of the apheresis machine does not reflect the decontamination regime currently used for this activity. • The policy on raw data retention does not adequately define the scope of what is considered to be raw data at the establishment.	**Minor**
c) There are regular governance meetings, for example health and safety, risk management and clinical governance committees, which are recorded by agendas and minutes.	Governance meetings at Warwick are not minuted. Therefore important updates such as incidents and SOP changes are not formally disseminated to all staff who perform licensable activities.	**Minor**

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.	Establishment SOPs are stored and accessed for routine use electronically. Both active and archived versions are stored in an open, editable format. Therefore there is potential for procedural documents to be lost or altered without formal review and authorisation. Additionally, authorisation and review of SOPs is not formally captured via, for example, a hand-written or electronic signature. On occasion, SOPs were updated without altering the version number of the document. Therefore there is a risk is that obsolete versions of the SOPs may be used.	**Minor**
s) Third party agreements specify that the third party will inform the establishment in the event of a serious adverse reaction or event.	TPAs between the establishment and UHCW do not adequately specify the requirements for SAEARs reporting, as set out in Directions 002/2018.	**Minor**
GQ2 There is a documented system of quality management and audit.		
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.	Although an independent audit has been conducted since the last inspection, the scope did not cover the full range of activities carried out under the licence.	**Minor**

GQ4 There is a systematic and planned approach to the management 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.	During the review of patient records and associated transport forms, several gaps in the records were noted, indicating that audits of these records were not sufficiently robust. For example: • The two-person check of labelling of the procured product was not consistently captured on the relevant form. Related to this, the wording of the signature point does not clearly define what the member of staff is signing for (i.e. that both the procurement worksheet and the primary cell labelling have been completed and checked). • On one occasion the unique donation number was not present on the transport form documenting the transfer of cells from the procurement to the processing establishment. On another occasion the receipt of the cells at the processing establishment was not documented.	**Minor**
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.	The SOP on record retention does not define the scope of documents that are raw data. Therefore there is a risk that raw data related to the safety and quality of the tissues and cells will not be retained for the required period.	**Minor**
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.	Contingency arrangements for the retention of records in the event of termination of activities have not been defined in establishment policies.	**Minor**
GQ6 A coding and records system facilitates traceability of bodies, body parts, tissues and cells, ensuring a robust audit trail.		
d) The requirements of the Single European Code are adhered to as set out in Directions 002/2018.	The establishment does not currently have procedures in place to ensure the SEC-DI is applied prior to the release of cells to the other licensed establishment for processing and storage.	**Minor**

GQ7 There are systems to ensure that all adverse events 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.	Although the establishment has documented procedures in place for the reporting of SAEARs to the HTA, there is no local procedure in place for documenting incidents at an establishment level. Such a system would enable consistent reporting and, where applicable, trend analysis of incidents such as the broken temperature monitor in the reagent storage area, temperature excursions from required ranges, and positive blood culture results.	**Minor**
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.	Although risk assessments have been performed for licensable activities, adequate controls have not documented to mitigate all risks. For example, staff awareness of the use of a temperature monitor in the reagent storage area was an identified risk that contributed to shortfall listed against standard PFE3a. However, no actions were documented to mitigate this risk and prevent recurrence of the incident.	**Minor**
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.	The establishment's risk assessments are currently reviewed on a two-yearly cycle instead of annually.	**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.	Temperature monitoring was not performed between September 2017 and July 2018 due to the temperature monitor being broken. This was not detected by the establishment until an audit in April 2018, and monitoring was not restored until August 2018 when the monitor was repaired. An alternative monitor was not substituted in the interim period. Related to this, temperature monitoring data was not consistently downloaded on a monthly basis in accordance with the SOP, thereby delaying the period between the temperature monitor being broken and the incident being detected. In addition, the temperature monitor has not been calibrated since it was purchased four years ago. The acceptable temperature range documented in temperature monitoring records is not consistent with the range specified in the related SOP or the temperature range specified on the ACD-A packaging. During occasions when the temperature exceeded the limit stated in the SOP, no action was taken.	**Minor**
PFE5 Equipment is appropriate for use, maintained, quality assured, validated and where appropriate monitored.		
f) Cleaning, disinfection and sanitation of critical equipment is performed regularly and this is recorded.	Weekly cleaning of the apheresis machine was not documented in the two months leading up to the inspection.	**Minor**

Advice

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

No.	Standard	Advice
1.	GQ1b	The DI is advised to rationalise the three SOPs related to variance reporting, adverse event reporting and notification of adverse events to the HTA, so that there is a single point of reference in the event of an incident. This SOP should clearly define the methods of reporting, documenting and managing incidents at an establishment level, including effective CAPA plan procedures and communication of events and outcomes to all relevant staff. Routes of escalation in the event of a serious incident should be described, and include reporting of SAEARs to the HTA within 24 hours of discovery. Note that the HTA reporting portal login is accessible via a link at the top left of every page of the website.
2.	GQ1b	The DI is advised to review and, where necessary, update SOPs and agreements to remove reference to the Human Tissue Act, which is not relevant to the establishment's activities, and update the Directions implementing the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (as amended) to the current version: 002/2018.
3.	GQ1s	The DI is advised to ensure the reciprocal contingency arrangement with another licensed establishment defines the responsibilities of each party to report SAEARs as set out in Directions 002/2018.
4.	GQ4a/GQ3k	Email communication relevant to ongoing procurement activities between Warwick Hospital, UHCW and the processing/storage establishment is limited to the DI alone at Warwick. The DI is advised to review communication procedures to minimise the risk of updated information not being available to procurement staff at the point of need.
5.	GQ7a	At present only the DI has access to the HTA portal to report SAEARs. The DI is advised to appoint an additional Person Designated (PD) and request they have access rights to the HTA portal, to provide cover when the DI is unavailable.

Concluding comments

There are a number of areas of practice that require improvement, resulting in 14 minor shortfalls. These related to temperature monitoring of the reagent storage area, internal incident reporting procedures, SAEARs reporting procedures, risk assessment content and review, document control procedures, the consistency of SOPs with current practice, the minuting of governance meetings, the scope of independent audits, internal audits of records, contingency arrangements in the event of termination of activities and application of the SEC.

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: 22 December 2018

Report returned from DI: 11 January 2018

Final report issued: 24 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: 26 February 2020

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 002/2018 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 002/2018 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 002/2018.
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 002/2018.

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 002/2018, is collected and maintained.
g) There is a system to ensure records are secure and that donor confidentiality is maintained in accordance with Directions 002/2018.
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 002/2018 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 002/2018.
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 002/2018.
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 002/2018.
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.
d) The requirements of the Single European Code are adhered to as set out in Directions 002/2018.
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 002/2018.
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 002/2018.
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.