



Site visit inspection report on compliance with HTA minimum standards

Central Manchester University Hospitals NHS Foundation Trust

HTA licensing number 22596

Licensed for the

- **procurement, processing, testing and storage 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**

08-09 May 2017

Summary of inspection findings

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

Although the HTA found that Central Manchester University Hospitals NHS Foundation Trust (the establishment) had met the majority of the HTA standards, two minor shortfalls were found in relation to governance and quality systems, and premises, facilities and equipment. One minor shortfall is related to donor selection and the other is in relation to reagent storage.

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.

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

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

Tissue type	Procurement	Processing	Testing	Storage	Distribution	Import	Export
PBSC	E / SLA	E	TPA	E			
BM	E	E	TPA	E			
DLI	E	E	TPA	E			
UCB		E		E			

Background to the establishment and description of inspection activities undertaken

This report refers to the activities carried out by the Therapeutic Stem Cell Laboratory which is based at the Central Manchester University Hospitals NHS Foundation Trust (CMFT). The establishment is licensed for the procurement, processing, testing and storage of human tissues and cells under the Human Tissue (Quality and Safety for Human Application) Regulations 2007. The establishment procures peripheral blood stem cells (PBSC) from adult patients for autologous and allogeneic use and bone marrow (BM) from adult and paediatric patients predominantly for allogeneic use. Procurement is carried out by trust staff working under the licence at the Royal Manchester Children's Hospital and the Manchester Royal Infirmary; two hospitals based within the Oxford Road site of the CMFT. Procurement of paediatric PBSC is carried out within the Children's Hospital by staff employed by another HTA-licensed establishment under the terms of an SLA. Additionally the establishment

receives umbilical cord blood units, PBSC and BM via the Anthony Nolan cord blood bank or stem cell donor registry. The establishment previously procured UCB on site at CMFT under this licence, but no longer carries out this activity.

The establishment is also licensed under the Human Tissue Act (2004) for the storage of relevant material, which has come from a human body, for use for a scheduled purpose. However, at the time of the inspection there was no material stored under this licence.

For units procured on site, donor selection and consent is carried out by CMFT consultants. Donor serology and NAT testing is carried out by a Public Health England laboratory based at the CMFT Oxford Road site under the terms of a TPA.

The Therapeutic Stem Cell Laboratory has an aseptic suite comprising a general laboratory area that leads on to two clean rooms. Access to the clean rooms is via separate change rooms and material is moved into the clean rooms via in/out hatches for each room. Stem cells are brought into the laboratory for a number of processes including volume reduction of bone marrow harvests, washing cryopreserved cord blood units, dilution of PBSC harvests and cryopreservation of stem cells. Total nucleated cell count (TNC), CD34 cell counts and colony-forming unit granulocyte-macrophage (CFU-GM) assays are used to ensure sufficient cell recoveries in all processes. Engraftment data is continually monitored and discussed at regular quality meetings attended by the Designated Individual (DI).

The establishment has an agreement with a clean room monitoring and validation service, which covers the monitoring of the clean room suite. The service includes weekly and sessional sampling of viable particulates (contact, settle plates and finger dabs) and provision of quarterly and annual testing. Non-viable particle monitoring is also carried out. All data is reviewed by the establishment and any alert or action limits are actioned appropriately. Staff undertake six-monthly broth test and gowning evaluations.

Samples are released once all of the associated paperwork and results have been reviewed by the DI or Lead BMS. There are a series of checks, which are documented on a signed release sheet.

This report describes the routine site visit inspection which took place on 08-09 May 2017. A visual inspection of the areas of the premises where licensable activities take place was conducted; this included the Adult Apheresis Unit and the Stem Cell Laboratory. Paediatric apheresis is conducted by a third party under the terms of an SLA, but is undertaken using the apheresis machines and consumables stored in the adult unit; the area where paediatric apheresis takes place was, therefore, not visited during the inspection.

The inspection included discussions with key members of staff involved in the carrying out of licensable activities, including the Directors of the BM Transplant Units for paediatrics and adults, the Chief Biomedical Scientist (BMS), who is also the Designated Individual (DI), the Lead BMS for the Stem Cell Laboratory, the Quality Lead for the Stem Cell Laboratory, the Quality Lead for Haematology and the Apheresis Lead Nurse.

The management of the consent and donor selection process was examined during a roundtable with relevant staff. Policies, standard operating procedures (SOPs) and patient information material were reviewed.

The Quality Management System was examined. Establishment staff gave a detailed overview of the wide range of processes, vertical and horizontal audits carried out within the establishment including an independent audit against all HTA standards by an employee from another area within the trust, audits to ensure adherence to process SOPs for each member of staff annually and audits of actions associated with incidents. Five incidents were selected for closer examination including the investigation carried out and corrective and preventative

action (CAPA) plans. All SOPs and policies reviewed during the inspection were found to be appropriately authorised and within review date.

An audit of the records associated with six samples processed and tested by the establishment was performed. Donor files were reviewed to ensure that they contained all relevant documentation, including consent forms, apheresis worksheets, serology test results, request to process forms, microbiology results, transportation records, processing records, an incident report form and a stem cell infusion report as appropriate. A check was also made against computerised records for three of the files focusing on traceability, cell counts, virology screening and bags stored. There was a minor anomaly found for one harvest in terms of volume stored; however, this was discussed and would not impact any future releases. Two units that were distributed to other centres for transplant were also looked at. The documentation included request forms, dispatch forms and evidence of units being accepted by transplant centre. Forms to confirm that there have been no reactions and to collect engraftment data are provided with the distributed units. These forms had been returned for one of the distributed units looked at during the audit, but not for the other (see Advice, point 4).

Inspection findings

The establishment has been carrying out distribution activities related to the movement of frozen PBSC to patients that wish to attend other hospitals for transplant. Although this happens infrequently it is a licensable activity. The DI has submitted an application for the addition of distribution to the 22569 licence. The removal of the activity of storage of relevant material under the HT act was also discussed since this is not currently carried out. The DI agreed to the removal of this activity.

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
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.	Paediatric donors are assessed for their suitability to donate by an independent medical assessment that is carried out by a consultant from outside of the transplant team. The procedure does not ensure that all of the criteria required by Annex A of the "Guide to Quality and Safety Assurance for Human Tissues and Cells for Patient Treatment" which forms the Annex to Directions 003/2010 are considered and documented. In the establishment's procedure, the independent assessment is stated to be a requirement of JACIE accreditation rather than a legal requirement under the Human Tissue (Quality and Safety for Human Application) Regulations 2007.	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.		
c) Tissues and / or cells are stored in controlled, monitored and recorded conditions that maintain tissue and / or cell integrity.	The procedure that describes the monitoring of the temperature of the room used to store ACD-A states that the room temperature is permitted to go up to 27°C. If temperature is greater than or equal to 27°C then the internal temperature of any ACDA within original packaging will be checked using a probe. If the internal temperature is less than or equal to 25°C then the ACD-A can be used. This process does not provide sufficient temperature control and the validation used to support the 27°C room limit is insufficient.	Minor

Advice

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

No.	Standard	Advice
1.	GQ1p	The establishment is implementing the use of a questionnaire when assessing the suppliers of critical reagents and materials. The DI is advised to include a question that will ensure suppliers inform the establishment of any impending change to products. The DI should ensure that information from suppliers will be directed to the stem cell laboratory.
2.	GQ2a	The DI is advised to add the audit schedule for the stem cell unit activities to the SOP that describes the other audits within the Haematology Department.
3.	GQ2a	The DI is advised to consider what control measures are in place to demonstrate that the activities of the third party that carry out mandatory biological tests comply with relevant HTA licensing standards.
4.	GQ4k	The establishment has distributed some units to other transplant centres for use with patients that have previously been treated at CMFT, but have moved out of the area. The DI is advised to review the paperwork associated with the distributed units to ensure that all required forms have been returned.
5.	GQ5a	The DI is advised to consider updating the references used within the procedure for the evaluation of adult sibling stem cells donors to include a link to the current Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC) donor selection guidelines.
6.	GQ8a	The thawing method used for units is dependent on the size of the unit. The DI should ensure that both methods are covered in risk assessments.
7.	PFE3a	The DI is advised to document the procedure for the replacement of the device used to monitor the temperature of the room used to store ACD-A. This should reflect the current practice of replacing the unit two months in advance of the manufacturer's expiry date for calibration.

Concluding comments

The HTA saw several examples of good practice during the inspection:

- The quality systems in place at the establishment are well developed and there is a strong emphasis on improvement.
- The establishment has a number of procedures in place to evaluate the quality and safety of processed products before release. This includes the routine use of CFU-GM assays on PBSC samples after processing and after cryopreservation.
- There is a varied range of audits in place that includes reviews of staff competency, closure of incidents, control of documents and traceability of units.
- The clean room facility is well laid out and there is a robust system of environmental monitoring.

Two areas of practice were identified during the course of the inspection that require improvement, and this has resulted in two minor shortfalls. The HTA has also given advice to the Designated Individual with respect to documentation, audit, donor selection and risk assessment.

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: 06 June 2017

Report returned from DI: No factual accuracy or request for redaction comments were made by the DI

Final report issued: 07 June 2017

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: 25 September 2017

Appendix 1: HTA standards

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

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

Consent

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

Governance and Quality

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

Consent standards
C1 Consent is obtained in accordance with the requirements of the Human Tissue Act 2004 (HT Act) and as set out in the code of practice
<ul style="list-style-type: none"> • Consent forms comply with the HTA's Code of Practice • Consent forms are in records and are made accessible to those using or releasing relevant material for a scheduled purpose • If the establishment obtains consent, a process is in place for acquiring consent in accordance with the requirements of the HT Act 2004 and the HTA's Codes of Practice • Where applicable, there are agreements with third parties to ensure that consent is obtained in accordance with the requirements of the HT Act 2004 and the HTA's Codes of Practice • Consent procedures have been ethically approved
C2 Information about the consent process is provided and in a variety of formats
<ul style="list-style-type: none"> • Standard operating procedures (SOPs) detail the procedure for providing information on consent • Agreements with third parties contain appropriate information • Independent interpreters are available when appropriate • Information is available in suitable formats, appropriate to the situation • Consent procedures have been ethically approved
C3 Staff involved in seeking consent receive training and support in the implications and essential requirements of taking consent
<ul style="list-style-type: none"> • Standard operating procedures (SOPs) detail the consent process • Evidence of suitable training of staff involved in seeking consent • Records demonstrate up-to-date staff training • Competency is assessed and maintained
Governance and quality system standards
GQ1 All aspects of the establishments work are supported by ratified documented policies and procedures as part of the overall governance process
<ul style="list-style-type: none"> • Policies and procedures are in place, covering all activities related to the storage of relevant material for research in connection with disorders, or the functioning, of the human body • Appropriate risk management systems are in place • Regular governance meetings are held; for example, health and safety and risk management committees, agendas and minutes • Complaints system
GQ2 There is a documented system of quality management and audit
<ul style="list-style-type: none"> • A document control system, covering all documented policies and standard operating

<p>procedures (SOPs).</p> <ul style="list-style-type: none"> • Schedule of audits • Change control mechanisms for the implementation of new operational procedures
<p>GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and are continuously updating their skills</p>
<ul style="list-style-type: none"> • Qualifications of staff and training are recorded, records showing attendance at training • Orientation and induction programmes • Documented training programme, (e.g. health and safety, fire, risk management, infection control), including developmental training • Training and reference manuals • Staff appraisal / review records and personal development plans are in place
<p>GQ4 There is a systematic and planned approach to the management of records</p>
<ul style="list-style-type: none"> • Documented procedures for the creation, amendment, retention and destruction of records • Regular audit of record content to check for completeness, legibility and accuracy • Back-up / recovery facility in the event of loss of records • Systems ensure data protection, confidentiality and public disclosure (whistle-blowing)
<p>GQ5 There are documented procedures for distribution of body parts, tissues or cells</p>
<ul style="list-style-type: none"> • A process is in place to review the release of relevant material to other organisations • An agreement is in place between the establishment and the organisation to whom relevant material is supplied regarding the tracking and use of material and eventual disposal or return
<p>GQ6 A coding and records system facilitates traceability of bodies, body parts, tissues and cells, ensuring a robust audit trail</p>
<ul style="list-style-type: none"> • There is an identification system which assigns a unique code to each donation and to each of the products associated with it • An audit trail is maintained, which includes details of when and where the relevant material was acquired, the consent obtained, the uses to which the material was put, when the material was transferred and to whom
<p>GQ7 There are systems to ensure that all adverse events are investigated promptly</p>
<ul style="list-style-type: none"> • Corrective and preventive actions are taken where necessary and improvements in practice are made • System to receive and distribute national and local information (e.g. HTA communications)

GQ8 Risk assessments of the establishment's practices and processes are completed regularly and are recorded and monitored appropriately

- Documented risk assessments for all practices and processes
- Risk assessments are reviewed when appropriate
- Staff can access risk assessments and are made aware of local hazards at training

Premises, facilities and equipment standards

PFE1 The premises are fit for purpose

- A risk assessment has been carried out of the premises to ensure that they are appropriate for the purpose
- Policies in place to review and maintain the safety of staff, authorised visitors and students
- The premises have sufficient space for procedures to be carried out safely and efficiently
- Policies are in place to ensure that the premises are secure and confidentiality is maintained

PFE 2 Environmental controls are in place to avoid potential contamination

- Documented cleaning and decontamination procedures
- Staff are provided with appropriate protective equipment and facilities that minimise risks from contamination
- Appropriate health and safety controls are in place

PFE3 There are appropriate facilities for the storage of bodies, body parts, tissues and cells, consumables and records.

- Relevant material, consumables and records are stored in suitable secure environments and precautions are taken to minimise risk of damage, theft or contamination
- Contingency plans are in place in case of failure in storage area
- Critical storage conditions are monitored and recorded
- System to deal with emergencies on 24 hour basis
- Records indicating where the material is stored in the premises

PFE 4 Systems are in place to protect the quality and integrity of bodies, body parts, tissues and cells during transport and delivery to a destination

- Documented policies and procedures for the appropriate transport of relevant material, including a risk assessment of transportation
- A system is in place to ensure that traceability of relevant material is maintained during transport
- Records of transportation and delivery
- Records are kept of any agreements with recipients of relevant material

<ul style="list-style-type: none"> Records are kept of any agreements with courier or transport companies
PFE5 Equipment is appropriate for use, maintained, quality assured, validated and where appropriate monitored
<ul style="list-style-type: none"> Records of calibration, validation and maintenance, including any agreements with maintenance companies Users have access to instructions for equipment and receive training in use and maintenance where appropriate Staff aware of how to report an equipment problem Contingency plan for equipment failure
Disposal Standards
D1 There is a clear and sensitive policy for disposing of human organs and tissue
<ul style="list-style-type: none"> Documented disposal policy Policy is made available to the public Compliance with health and safety recommendations
D2 The reason for disposal and the methods used are carefully documented
<ul style="list-style-type: none"> Standard operating procedures (SOPs) for tracking the disposal of relevant material detail the method and reason for disposal Where applicable, disposal arrangements reflect specified wishes

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.