Site visit inspection report on compliance with HTA minimum standards

Robert Jones and Agnes Hunt Orthopaedic and District Hospital

HTA licensing number 11064

Licensed for the

- **procurement, testing, storage, and import 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**

25 – 26 February 2015

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.

The HTA found that the Robert Jones and Agnes Hunt Orthopaedic and District Hospital ("the establishment") had met the majority of the HTA standards. Four minor shortfalls were found in relation to the establishment's governance and quality systems. Three of these shortfalls were addressed by the establishment to the HTA's satisfaction before the report was issued.

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.

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

Tissue type	Procurement	Processing	Testing	Storage	Distribution	Import	Export
Bone	**E**		**TPA**	**E**		**E***	
Cartilage	**E**		**TPA**				

Background to the establishment and description of inspection activities undertaken

The Robert Jones and Agnes Hunt Orthopaedic and District Hospital is a specialist hospital for orthopaedic surgery and musculoskeletal medicine. The hospital also conducts research in these areas of medicine, including into disorders of bones, joints and muscles. The establishment has been licensed by the HTA under the Human Tissue (Quality and Safety for Human Application) Regulations 2007 and the Human Tissue Act 2004 since August 2006. This report describes the fifth, routine site visit inspection of the establishment.

Under the Human Tissue (Quality and Safety for Human Application) Regulations 2007, the establishment operates a bone bank and a cell therapy service termed 'Oscell'.

Bone bank: The bone bank has been in operation for over 25 years and has a well-established role in supporting specialist orthopaedic surgery undertaken at the hospital. The bone bank is managed by a dedicated team of staff who, in conjunction with the Designated Individual (DI), oversee all bone bank activities conducted under the HTA licence.

The core activity of the bone bank comprises the procurement and storage of femoral heads. Femoral heads are procured from patients undergoing surgery at the establishment involving removal of the femoral head. The establishment has a well-developed process for selecting patients who are suitable for femoral head donation and seeking their consent. Procurement of femoral heads is undertaken by a core team of staff in the establishment's specialist 'barn theatre' facility. This theatre is specially designed and includes high efficiency particulate air filtration (HEPA) and laminar air flow systems for each operating booth. The facilities also benefit from onsite sterilisation services. The establishment currently procures approximately 160 femoral heads each year and these are stored in the bone bank until required. Femoral heads are used only during surgery at the establishment and no material for patient treatment is distributed to other organisations.

The bone bank also procures bone for autologous use; although this is undertaken infrequently. The establishment uses a separate consent form for autologous donation. The HTA has given advice to the establishment to ensure that this consent form details all of the required information clearly (see advice item 1). Procurement of autologous bone samples is undertaken in the establishment's specialist surgical theatre facilities. Autologous bone is stored separately from other samples in the bone bank.

Donor testing is conducted by a third party organisation on behalf of the establishment, under a third party agreement (TPA). The HTA has given advice to the establishment to ensure that this TPA is reviewed in a timely manner (see advice item 5). At the time of the inspection, the establishment was storing a large number of femoral heads for which they were awaiting 180 day repeat donor testing results. The HTA has advised the establishment to review its process for collecting blood samples for repeat donor testing (see advice item 4).

Each year the bone bank receives around 15 tissue products from another HTA-licensed establishment, including Achilles tendons, strut grafts and femoral heads. This receipt of tissues takes place in accordance with an agreement between the bone bank and the other licensed establishment. Femoral heads distributed to the bone bank by the other licensed establishment are stored for contingency purposes in the event that the demand for femoral heads exceeds the number of femoral heads which have been procured and cleared for use within the establishment.

The bone bank is equipped with two -80°C mechanical freezers, which allow for separation of samples in quarantine and those cleared for use in patients. Freezer temperatures are continually monitored and there is an automated alarm with a call-out notification procedure in the event of a deviation from the set acceptable temperature ranges. The alarms and the response by switch board personnel are checked each week. Freezers are regularly maintained and the establishment has contingency arrangements for storage in the event of equipment failure. The establishment has reviewed its storage arrangements following the last HTA inspection to ensure separate storage of cleared allogenic and autologous bone.

This inspection of the bone bank included: donor selection; consent; donor testing, including review of the TPA with the party undertaking donor testing; procurement, and; storage of bone samples procured on site and materials distributed to the bone bank.

An audit of the bone bank was conducted for two femoral heads stored in quarantine and one femoral head cleared for use. This audit included: consent forms; procurement records, including donor test results and microbiological test results, and; storage records. A second audit was conducted for one strut graft distributed to the bone bank; this audit included the distribution and storage records for this sample. No anomalies were identified in these audits.

Although no autologous bone was being stored at the time of this inspection, the HTA inspection team reviewed the arrangements for the storage of autologous bone samples.

Oscell Laboratory: The establishment also operates 'Oscell'; a cell therapy service within the John Charnley Laboratory. The Oscell Laboratory was established 18 years ago and has been involved in the development of expanded cell therapies for use for patient treatment at the establishment. The Oscell Laboratory undertakes procurement, expansion and implantation of autologous chondrocytes and bone marrow derived mesenchymal stem cells for patient treatment. In addition to manufacturing unlicensed Advanced Therapy Medicinal Products (ATMPs) from chondrocytes under Hospital Exemption, Oscell is also conducting a clinical trial comparing 'Autologous Stem cells, Chondrocytes Or the Two' (ASCOT).

The Oscell Laboratory is managed by a core team of staff who oversee the activities undertaken by the laboratory under the HTA licence. Procurement of cartilage or bone marrow for cell expansion is undertaken in the establishment's theatre facilities by a core team of staff. Donor testing is conducted by a third party organisation on behalf of the establishment under a TPA. Patients are admitted to the hospital and blood samples for donor testing are taken within 20 hours before the procurement of bone marrow or chondrocytes. In 2014, the establishment treated seven patients using procured chondrocytes manufactured under the Hospital Exemption scheme, and as part of the ASCOT trial nine patients received stem cells (bone marrow), eight patients received chondrocytes and six patients received chondrocytes and stem cells.

The inspection of the Oscell Laboratory included: donor selection; consent; donor testing, including review of the TPA with the organisation undertaking donor testing, and; procurement of cartilage and bone marrow. The expansion of cells to form an ATMP for implantation falls under the ATMP legislation and the remit of the Medicines and Healthcare Products Regulatory Agency (MHRA), and was therefore not included in this inspection.

For the Oscell Laboratory, an audit was conducted of the procurement record, including donor testing results, for one chondrocyte procedure. This audit did not reveal any anomalies.

Storage of relevant material for use in research: Under the Human Tissue Act 2004, the establishment stores relevant material for use in research by three groups: Arthritis Research Centre, Spinal Studies and the Charles Salt Laboratory.

The majority of human samples stored for research are for projects which have received approval from a recognised research ethics committee (REC), thereby exempting storage of these samples from the licensing requirements of the Human Tissue Act 2004.

The majority of samples stored under the HTA licence are existing holdings. All samples are assigned a unique identification number which is used to track sample storage, use, distribution and disposal. The establishment uses electronic databases to provide traceability of samples. Samples are stored in three -20°C freezers and two liquid nitrogen tanks. Freezer temperature and liquid nitrogen levels are continually monitored and there is an automated alarm with a notification procedure in the event of a deviation from the set acceptable temperature ranges. All human samples are stored separately to non-human tissues.

An audit was conducted of two samples in storage for each of the three research groups. No anomalies were identified in the storage records for these samples.

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 – applicable to the bone bank and Oscell Laboratory

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.	Oscell Laboratory – Staff complete procurement records which include details of consumables used, batch numbers and expiry dates. However the establishment does not have documented procedures for: • procurement of a cartilage biopsy for the preparation of chondrocytes, or; • procurement of bone marrow for the preparation of stem cells. Documented procedures are required to ensure that these processes are conducted in a consistent manner and are subject to regular review in accordance with the establishment's quality management system. *The establishment submitted evidence that this shortfall has been addressed, prior to issue of the report. The HTA has assessed this information as satisfactory and considers this standard to be met.*	**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.	Bone bank – Each standard operating procedure (SOP) for the bone bank consists of two separate electronic documents: the front cover, which contains the document control information, and; the documented procedure. This formatting of SOPs does not provide a robust link between the document control information and the procedure. The document version number and effective date are not updated every time amendments are made to the documented procedure. This document control system does not provide evidence that documents are version controlled and have been regularly reviewed. *The establishment submitted evidence that this shortfall has been addressed, prior to issue of the report. The HTA has assessed this information as satisfactory and considers this standard to be met.*	**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.	Bone bank – The establishment maintains paper-based and electronic records of bone donation and implantation. Donation and implantation records are not regularly audited and are not included in the establishment's documented schedule of audits. *The establishment submitted evidence that this shortfall has been addressed, prior to issue of the report. The HTA has assessed this information as satisfactory and considers this standard to be met.*	**Minor**

Human Tissue Act 2004 Standards – applicable to the research groups

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.	Research groups – The establishment has documented risk assessments of the premises and risks to health and safety. However, the establishment does not have documented risk assessments of the risks associated with the activities undertaken under the HTA licence. (See advice item 13)	**Minor**

Advice

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

Human Tissue (Quality and Safety for Human Application) Regulations 2007 Standards – applicable to the bone bank and Oscell Laboratory

No.	Standard	Advice
1.	C2a	Bone bank – The DI is advised to review the consent form for autologous bone donation to ensure that it clearly details that the establishment will inform the donor of any positive serological test results.
2.	GQ1b	Bone bank – The establishment is advised to review the SOPs for the bone bank to ensure that they contain sufficient detail of procedures conducted under the HTA licence. This will ensure that the details of these procedures are up to date and that all relevant staff are familiar with these details. For example, bone bank SOP '15 – Collection Procedure' should also detail: the checks of consent forms immediately prior to commencing procurement, and; the records of all consumables coming into contact with tissues.

3.	GQ1d	The DI should ensure that all documents relating to the HTA licence are included within the document control system and contain document control information. For example, the organisational chart detailing the staff working under the HTA licence should be reviewed to ensure that the most recent version is in use. The addition of further document control information to this document may help this. Bone bank – The flow chart detailing the bone procurement process should also be formally document controlled. This will also help to ensure that sufficient details of procedures are documented and subject to review (see advice item 2).
4.	GQ1h	Bone bank – The establishment is also advised to document the process for repeat testing of donors. This should include details of the process for contacting donors. The establishment may also wish to consider the timing for contacting donors for repeat testing after 180 days, to take into account the stock of available heads stored in the 'cleared' freezer.
5.	GQ1p	The establishment is advised to consider its arrangements for reviewing the TPA with the organisation undertaking donor testing on its behalf to ensure that it is reviewed in a timely manner.
6.	GQ4j	Bone bank – The DI is advised to ensure that the establishment's documented policies and procedures for record retention reflect current practices. This will help to ensure that records of all products and material coming into contact with the tissues are stored for a minimum of 30 years as required by Directions 003/2010.
7.	GQ4j	Oscell Laboratory – The Oscell Laboratory records the details of all products and material coming into contact with the tissues and cells during procurement in batch records. The establishment is advised to also record these details in the individual procurement record for each patient. This will help to ensure that these records are readily available and are stored for a minimum of 30 years as required by Directions 003/2010.
8.	GQ4m	Bone bank – The establishment is advised to review document '2 – Bone Bank Policy' to include details of the arrangements for the transfer of records to another HTA-licensed establishment in the event of termination of activities at the establishment.
9.	GQ7a	Bone bank – The establishment is advised to review its SOPs for incident reporting to include additional details of the types of incidents that should be recorded, including non-conformances, and the methods to report these. For example, SOP '39 – SAEARs' should include the definition of serious adverse events (SAEs) and serious adverse reactions (SARs) and details that these are reported to the HTA using the online Portal. SOP '27 – Bone bank non-conformance procedure' should include the definition of a non-conformance and the details of who should complete the non-conformance log ('28 – Bone bank non-conformance form'). The establishment may also wish to include examples of non-conformances in this SOP. This will help to ensure that staff are aware of the types of non-conformances that must be reported and help to centralise the oversight and investigation of non-conformances by the bone bank team and DI.
10.	GQ8a	The establishment is advised to review the documented risk assessments in order to ensure that they cover all HTA licensable activities undertaken by the bone bank and Oscell Laboratory.

Human Tissue Act 2004 Standards – applicable to the research groups

11.	GQ5	The establishment is advised to ensure that the SOPs for distributing relevant material to other organisations include details of transport arrangements and the agreements which must be in place with the receiving organisation. The DI is also advised to include details of the information which should be included in these agreements; for example, details of consent for use of the samples and the responsibility to dispose of samples by sensitive means.
12.	GQ7	The establishment is advised to review the adverse incidents policy and procedures for each research group to include details of the types of incidents that should be reported to the Persons Designated (PDs) and DI. The establishment is advised to remove all references to the requirement to report SAEs and SARs to the HTA from these documents as this requirement applies only to activities under the Human Tissue (Quality and Safety for Human Application) Regulations 2007.
13.	GQ8	The establishment should ensure that risk assessments are completed for all activities conducted under the HTA licence. These risks may include, for example: • storage and use of relevant material without valid consent; • loss of traceability of relevant material; • failure of storage facilities or improper storage of relevant material; • transport of relevant material to other organisations, and; • accidental or inappropriate disposal of relevant material. The DI is advised to ensure that these risk assessments are reviewed regularly and that all staff undertaking licensable activities are aware of these risk assessments.
14.	D2	The establishment is advised to update its traceability databases to include a mandatory field to record the fate of samples. Where samples are disposed of, this field should require the date, method and reason of disposal to be recorded.

Concluding comments

The report outlines the fifth HTA site visit inspection of the HTA licence at the Robert Jones and Agnes Hunt Orthopaedic and District Hospital. There were a number of areas of good practice identified during the inspection in each of the areas covered by the HTA licence.

The DI has a good oversight of activities undertaken under the HTA licence and has demonstrated a commitment to continual improvement of practices and compliance with requirements of the legislation. The DI has established a strong network of PDs to cover each group working under the HTA licence, and has sought to ensure that these staff are supported by a nominated member of staff, which they term ‘deputy PDs’. The establishment has addressed a number of the areas of advice provided by the HTA at previous inspections. In addition, the establishment has worked to address a number of the shortfalls identified by this HTA inspection, prior to the issue of the report.

The establishment’s traceability systems for each of the groups working under the HTA licence were found to be robust. This thorough approach to sample traceability facilitated the ease of sample traceability observed during the inspection team’s audits.

The bone bank is well-established and the PD and 'deputy PD' for this group oversee the day-to-day running and ongoing quality management system for the bone bank. The team demonstrated that they are committed to compliance with the Human Tissue (Quality and Safety for Human Application) Regulations 2007. They have a good knowledge of these Regulations and are willing to seek and act on advice from the HTA. The team also demonstrated a commitment to the delivery of patient service and have an established system to seek feedback from patients using the bone bank. The DI recognises the important role these staff undertake for the operation and HTA compliance of the bone bank and seeks to ensure that they are afforded protected time within their roles for this.

The Oscell Laboratory is also well-established at the hospital and is managed by a core team of staff, including the PD. The activities of the laboratory are well-embedded and found to meet the majority of the HTA standards. The team are also dedicated to HTA compliance and provided evidence to the HTA that the one shortfall relating to the Oscell Laboratory (for standard GQ1d) was met prior to the report being issued.

The research groups have worked towards HTA compliance and addressed the shortfalls identified at previous HTA inspections. The staff demonstrated willingness for HTA compliance and continual improvement. The DI and research groups also have links with the DI of another HTA licence held by the establishment, to allow them to share good practice relating to the activities licensed under the Human Tissue Act 2004.

The HTA found some areas of the governance and quality systems that required improvement, including: two minor shortfalls relating to the bone bank; one minor shortfall relating to the Oscell Laboratory, and; one minor shortfall relating to the research groups. The establishment submitted evidence that three of these shortfalls have been addressed to the HTA's satisfaction, prior to the issue of the report.

The HTA has given advice to the DI with respect to further strengthening the consent documentation and governance and quality systems.

The HTA requires that the DI addresses the remaining 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: 20 March 2015

Report returned from DI: 27 March 2015

Final report issued: 27 March 2015

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: 24 April 2015

Appendix 1: HTA standards

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

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

Consent

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

Governance and Quality

Standard
GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process.
a) There is an organisational chart clearly defining the lines of accountability and reporting relationships.
b) There are procedures for all licensable activities that ensure integrity of tissue and / or cells and minimise the risk of contamination.
c) There are regular governance meetings, for example health and safety, risk management and clinical governance committees, which are recorded by agendas and minutes.
d) There is a document control system to ensure that changes to documents are reviewed, approved, dated and documented by an authorised person and only current documents are in use.
e) There are procedures for tissue and / or cell procurement, which ensure the safety of living donors.
f) There are procedures for tissue and / or cell procurement, which ensure the dignity of deceased donors.
g) There are procedures to ensure that an authorised person verifies that tissues and / or cells received by the establishment meet required specifications.
h) There are procedures for the management and quarantine of non-conforming consignments or those with incomplete test results, to ensure no risk of cross contamination.
i) There are procedures to ensure tissues and / or cells are not released from quarantine until verification has been completed and recorded.
j) There are procedures detailing the critical materials and reagents used and where applicable, materials and reagents meet the standards laid down by the European directives on medical devices and in vitro diagnostic medical devices.
k) There is a procedure for handling returned products.
l) There are procedures to ensure that in the event of termination of activities for whatever reason, stored tissues and / or cells are transferred to another licensed establishment or establishments.
m) The criteria for allocating tissues and / or cells to patients and health care institutions are documented and made available to these parties on request.
n) The establishment ensures imports from non EEA states meet the standards of quality and safety set out in Directions 003/2010.
o) There is a complaints system in place.
p) There are written agreements with third parties whenever an activity takes place that has the potential to influence the quality and safety of human tissues and / or cells.
q) There is a record of agreements established with third parties.
r) Third party agreements specify the responsibilities of the third party and meet the requirements set out in Directions 003/2010.

s) Third party agreements specify that the third party will inform the establishment in the event of a serious adverse reaction or event.
t) There are procedures for the re-provision of service in an emergency.
GQ2 There is a documented system of quality management and audit.
a) There is a quality management system which ensures continuous and systematic improvement.
b) There is an internal audit system for all licensable activities.
c) An audit is conducted in an independent manner at least every two years to verify compliance with protocols and HTA standards, and any findings and corrective actions are documented.
d) Processes affecting the quality and safety of tissues and / or cells are validated and undergo regular evaluation to ensure they continue to achieve the intended results.
GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and are continuously updating their skills.
a) There are clearly documented job descriptions for all staff.
b) There are orientation and induction programmes for new staff.
c) There are continuous professional development (CPD) plans for staff and attendance at training is recorded.
d) There is annual documented mandatory training (e.g. health and safety and fire).
e) Personnel are trained in all tasks relevant to their work and their competence is recorded.
f) There is a documented training programme that ensures that staff have adequate knowledge of the scientific and ethical principles relevant to their work, and the regulatory context.
g) There is a documented training programme that ensures that staff understand the organisational structure and the quality systems used within the establishment.
h) There is a system of staff appraisal.
i) Where appropriate, staff are registered with a professional or statutory body.
j) There are training and reference manuals available.
k) The establishment is sufficiently staffed to carry out its activities.
GQ4 There is a systematic and planned approach to the management of records.
a) There are procedures for the creation, identification, maintenance, access, amendment, retention and destruction of records.
b) There is a system for the regular audit of records and their content to check for completeness, legibility and accuracy and to resolve any discrepancies found.
c) Written records are legible and indelible. Records kept in other formats such as computerised records are stored on a validated system.
d) There is a system for back-up / recovery in the event of loss of computerised records.

e) The establishment keeps a register of the types and quantities of tissues and / or cells that are procured, tested, preserved, processed, stored and distributed or otherwise disposed of, and on the origin and destination of tissues and cells intended for human application.
f) There are procedures to ensure that donor documentation, as specified by Directions 003/2010, is collected and maintained.
g) There is a system to ensure records are secure and that donor confidentiality is maintained in accordance with Directions 003/2010.
h) Raw data which are critical to the safety and quality of tissues and cells are kept for 10 years after the use, expiry date or disposal of tissues and / or cells.
i) The minimum data to ensure traceability from donor to recipient as required by Directions 003/2010 are kept for 30 years after the use, expiry or disposal of tissues and / or cells.
j) Records are kept of products and material coming into contact with the tissues and / or cells.
k) There are documented agreements with end users to ensure they record and store the data required by Directions 003/2010.
l) The establishment records the acceptance or rejection of tissue and / or cells that it receives and in the case of rejection why this rejection occurred.
m) In the event of termination of activities of the establishment a contingency plan to ensure records of traceability are maintained for 10 or 30 years as required.
GQ5 There are documented procedures for donor selection and exclusion, including donor criteria.
a) Donors are selected either by the establishment or the third party acting on its behalf in accordance with the criteria required by Directions 003/2010.
b) The testing of donors by the establishment or a third party on behalf of the establishment is carried out in accordance with the requirements of Directions 003/2010.
c) In cases other than autologous donors, donor selection is carried out by authorised personnel and signed and reviewed by a qualified health professional.
d) There is a system in place either at the establishment or at a third party acting on its behalf to record results of donor selection and associated tests.
e) Testing of donor samples is carried out using CE marked diagnostic tests.
f) Samples taken for donor testing are clearly labelled with the time and place the sample was taken and a unique donor identification code.
GQ6 A coding and records system facilitates traceability of tissues and / or cells, ensuring a robust audit trail.
a) There is a donor identification system which assigns a unique code to each donation and to each of the products associated with it.
b) An audit trail is maintained, which includes details of when the tissues and / or cells were acquired and from where, the uses to which the tissues and / or cells were put, when the tissues and / or cells were transferred elsewhere and to whom.
c) The establishment has procedures to ensure that tissues and / or cells imported, procured,

processed, stored, distributed and exported are traceable from donor to recipient and vice versa.
GQ7 There are systems to ensure that all adverse events, reactions and/or incidents are investigated promptly.
a) There are procedures for the identification, reporting, investigation and recording of adverse events and reactions, including documentation of any corrective or preventative actions.
b) There is a system to receive and distribute national and local information (e.g. HTA regulatory alerts) and notify the HTA and other establishments as necessary of serious adverse events or reactions.
c) The responsibilities of personnel investigating adverse events and reactions are clearly defined.
d) There are procedures to identify and decide the fate of tissues and / or cells affected by an adverse event, reaction or deviation from the required quality and safety standards.
e) In the event of a recall, there are personnel authorised within the establishment to assess the need for a recall and if appropriate initiate and coordinate a recall.
f) There is an effective, documented recall procedure which includes a description of responsibilities and actions to be taken in the event of a recall including notification of the HTA and pre-defined times in which actions must be taken.
g) Establishments distributing tissue and / or cells provide information to end users on how to report a serious adverse event or reaction and have agreements with them specifying that they will report these events or reactions.
h) Establishments distributing tissues and / or cells have systems to receive notifications of serious adverse events and reactions from end users and notify the HTA.
GQ8 Risk assessments of the establishment's practices and processes are completed regularly and are recorded and monitored appropriately.
a) There are documented risk assessments for all practices and processes.
b) Risk assessments are reviewed regularly, as a minimum annually or when any changes are made that may affect the quality and safety of tissues and cells.
c) Staff can access risk assessments and are made aware of local hazards at training.
d) A documented risk assessment is carried out to decide the fate of any tissue and / or cells stored prior to the introduction of a new donor selection criteria or a new processing step, which enhances the quality and safety of tissue and / or cells.

Premises, Facilities and Equipment

Standard
PFE1 The premises are fit for purpose.
a) A risk assessment has been carried out of the premises to ensure that they are fit for purpose.
b) There are procedures to review and maintain the safety of staff, visitors and patients.
c) The premises have sufficient space for procedures to be carried out safely and efficiently.

d) Where appropriate, there are procedures to ensure that the premises are of a standard that ensures the dignity of deceased persons.
e) There are procedures to ensure that the premises are secure and confidentiality is maintained.
f) There is access to a nominated, registered medical practitioner and / or a scientific advisor to provide advice and oversee the establishment's medical and scientific activities.
PFE2 Environmental controls are in place to avoid potential contamination.
a) Tissues and / or cells stored in quarantine are stored separately from tissue and / or cells that have been released from quarantine.
b) Where processing of tissues and / or cells involves exposure to the environment, it occurs in an appropriate, monitored environment as required by Directions 003/2010.
c) There are procedures for cleaning and decontamination.
d) Staff are provided with appropriate protective clothing and equipment that minimise the risk of contamination of tissue and / or cells and the risk of infection to themselves.
PFE3 There are appropriate facilities for the storage of tissues and / or cells, consumables and records.
a) Tissues, cells, consumables and records are stored in secure environments and precautions are taken to minimise risk of damage, theft or contamination.
b) There are systems to deal with emergencies on a 24 hour basis.
c) Tissues and / or cells are stored in controlled, monitored and recorded conditions that maintain tissue and / or cell integrity.
d) There is a documented, specified maximum storage period for tissues and / or cells.
PFE4 Systems are in place to protect the quality and integrity of tissues and / or cells during transport and delivery to its destination.
a) There is a system to ensure tissue and / or cells are not distributed until they meet the standards laid down by Directions 003/2010.
b) There are procedures for the transport of tissues and / or cells which reflect identified risks associated with transport.
c) There is a system to ensure that traceability of tissues and / or cells is maintained during transport.
d) Records are kept of transportation and delivery.
e) Tissues and / or cells are packaged and transported in a manner and under conditions that minimise the risk of contamination and ensure their safety and quality.
f) There are third party agreements with courier or transport companies to ensure that any specific transport conditions required are maintained.
g) Critical transport conditions required to maintain the properties of tissue and / or cells are defined and documented.
h) Packaging and containers used for transportation are validated to ensure they are fit for purpose.

i) Primary packaging containing tissues and / or cells is labelled with the information required by Directions.
j) Shipping packaging containing tissues and / or cells is labelled with the information required by Directions.
PFE5 Equipment is appropriate for use, maintained, quality assured, validated and where appropriate monitored.
a) Critical equipment and technical devices are identified, validated, regularly inspected and records are maintained.
b) Critical equipment is maintained and serviced in accordance with the manufacturer's instructions.
c) Equipment affecting critical processes and storage parameters is identified and monitored to detect malfunctions and defects and procedures are in place to take any corrective actions.
d) New and repaired equipment is validated before use and this is documented.
e) There are documented agreements with maintenance companies.
f) Cleaning, disinfection and sanitation of critical equipment is performed regularly and this is recorded.
g) Instruments and devices used for procurement are sterile, validated and regularly maintained.
h) Users have access to instructions for equipment and receive training in the use of equipment and maintenance where appropriate.
i) Staff are aware of how to report an equipment problem.
j) For each critical process, the materials, equipment and personnel are identified and documented.
k) There are contingency plans for equipment failure.

Disposal

Standard
D1 There is a clear and sensitive policy for disposing of tissues and / or cells.
a) The disposal policy complies with HTA's Codes of Practice.
b) The disposal procedure complies with Health and Safety recommendations.
c) There is a documented procedure on disposal which ensures that there is no cross contamination.
D2 The reasons for disposal and the methods used are carefully documented.
a) There is a procedure for tracking the disposal of tissue and / or cells that details the method and reason for disposal.
b) Disposal arrangements reflect (where applicable) the consent given for disposal.

Human Tissue Act 2004 Standards

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
• 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
• 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
• 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
• 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
• A document control system, covering all documented policies and standard operating procedures (SOPs). • Schedule of audits • Change control mechanisms for the implementation of new operational procedures
GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and are continuously updating their skills
• 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
GQ4 There is a systematic and planned approach to the management of records
• 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)
GQ5 There are documented procedures for distribution of body parts, tissues or cells
• 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
GQ6 A coding and records system facilitates traceability of bodies, body parts, tissues and cells, ensuring a robust audit trail
• 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
GQ7 There are systems to ensure that all adverse events are investigated promptly
• 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

- 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

- 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

- 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

- 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 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.