

## **Site visit inspection report on compliance with HTA minimum standards**

### **New Cross Hospital**

**HTA licensing number 11134**

#### **Licensed for the**

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

**4 April 2019**

### **Summary of inspection findings**

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

Although the HTA found that New Cross Hospital (the establishment) had met the majority of the HTA standards, five minor shortfalls were found in relation to the Governance and Quality Systems (GQS) standards. The shortfalls related to the documented agreement with the testing laboratory, the independent audit, the retention of raw data, the records of products coming into contact with tissues and the donor selection criteria.

### **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.

<b>Tissue Category; Tissue Type</b>	<b>Procurement</b>	<b>Processing</b>	<b>Testing</b>	<b>Storage</b>	<b>Distribution</b>	<b>Import</b>	<b>Export</b>
<b>Musculoskeletal, Bone; Bone</b>	<b>E</b>		<b>E/TPA</b>	<b>E</b>	<b>E</b>		

### **Background to the establishment and description of inspection activities undertaken**

This report refers to the activities carried out by New Cross Hospital (the establishment) which is part of the Royal Wolverhampton Hospitals NHS Trust. The establishment was issued a HTA licence in September 2006. The establishment is licensed under the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (as amended; the Q&S Regulations) for the procurement, testing, storage and distribution of tissues and cells for human application. The establishment is also licensed for the storage of relevant material for use for a scheduled purpose under the Human Tissue Act 2004 (HT Act). Although licensed for this activity, the establishment does not currently store relevant material for use for a scheduled purpose.

The hospital procures femoral heads for use in reconstructive surgical procedures from two sites: New Cross Hospital (the hub) and Cannock Chase Hospital (the satellite). The majority of the femoral heads are procured at Cannock Chase Hospital, where elective hip replacement surgery takes place; storage is at New Cross Hospital only. Bone is distributed for end use from New Cross Hospital to Cannock Chase Hospital when required.

Patients attending the orthopaedic pre-assessment clinic for primary total hip replacements are provided with an information leaflet about donating bone. Pre-operative assessment nurses, trained to seek consent, assess the patient's medical and social history to identify

suitable donors. Once written consent has been obtained, a blood sample for mandatory serological testing is taken up to 30 days prior to surgery. When the femoral head is procured, a surface swab and small sample of bone are taken for microbiological testing to detect infection within the donor, and to monitor the procedure used during procurement. The femoral head is placed into a tamper-proof sterile double container and labelled with a unique patient bone bank reference number, the femoral head weight, date of surgery, date of expiry, blood group/Rhesus status and a red 'Not for Implantation' sticker. The container is placed into a plastic bag before placing in the -80°C quarantine freezer. Femoral heads procured at Cannock Chase Hospital are transported by hospital transport services to New Cross Hospital. Staff at New Cross Hospital are informed to expect a delivery once the bone has been picked up by transport services. Bone bank staff record the time of harvest and time of placement into the -80°C freezer, to ensure the establishment's four-hour time limit from harvest to freezing is maintained. The bone bank coordinator is responsible for entering the donor details, bone bank reference number and initial serology results into the bone bank ledger. If any microbiology or serology results are positive, the femoral head is discarded; otherwise the bone remains in the quarantine freezer until the 180-day repeat serology test is performed.

Movement of bone from the quarantine to release freezer is undertaken by two bone bank personnel. Patient identification, femoral head procurement and blood sample dates, and the results of the microbiology and serological testing are reviewed. Once cleared for use, the red sticker is removed from the femoral head container, and a green 'bone for implantation' sticker is attached. Occasionally, femoral heads for autologous use are procured; these are stored separately in the quarantine freezer. The femoral heads are stored for up to five years.

All tissue is stored securely in labelled, lockable freezers within a temperature-controlled room. Access is restricted to authorised and trained staff. The freezers are linked to the continuous temperature-monitoring unit. If the temperature deviates outside of the set range, the freezer alarm will activate and switchboard will be alerted. Switchboard operates 24 hours a day and will contact bone bank and theatre staff appropriately. Arrangements are in place for service, calibration and contingency.

The microbiology and serological testing for mandatory markers (except HTLV-I) are performed at the establishment's UKAS accredited laboratory; HTLV-I testing is undertaken by a third party organisation.

The site visit included a visual inspection of the freezer storage facilities and the testing laboratory at the hub site, and the theatre department at the satellite site. A review of the establishment's documentation was undertaken and a round table discussion was held with the DI and bone bank staff. A traceability audit was undertaken of two femoral heads from the quarantine (red) freezer and two from the released (green) freezer. Labelling details were compared to the bone freezer log and the bone bank ledger; there were no discrepancies noted. Three sets of donor and recipient patient records, and one donor record for which the femoral head was disposed of, were reviewed. Consent documentation, results of serological tests, bone transfer forms and records relating to the use of the femoral heads or disposal as applicable, were checked; no discrepancies were noted. For one patient, the results of the serological tests were cross-referenced to the testing laboratory results system; no discrepancies were noted.

### **Inspection findings**

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

## Compliance with HTA standards

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

#### Governance and Quality

Standard	Inspection findings	Level of shortfall
GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process.		
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.	A third party conducts serological testing for HTLV-I. The establishment was unable to provide a valid in-date agreement at the time of the inspection.	Minor
GQ2 There is a documented system of quality management and audit.		
c) An audit is conducted in an independent manner at least every two years to verify compliance with protocols and HTA standards, and any findings and corrective actions are documented.	Although audits of some standards have been completed, the establishment has not carried out an independent audit against all of the applicable HTA standards.	Minor
GQ4 There is a systematic and planned approach to the management of records.		
h) Raw data which are critical to the safety and quality of tissues and cells are kept for 10 years after the use, expiry date or disposal of tissues and / or cells.	The policy for Management and Control of Records, Data and Information (D2.001P.PAT), does not state the correct retention time for raw data which are critical to the safety and quality of tissues and cells.	Minor
j) Records are kept of products and material coming into contact with the tissues and / or cells.	The establishment does not record the batch numbers of the microbiology swabs or saline that come into contact with a femoral head upon procurement.	Minor
GQ5 There are documented procedures for donor selection and exclusion, including donor criteria.		
a) Donors are selected either by the establishment or the third party acting on its behalf in accordance with the criteria required by Directions 002/2018.	The Bone Donor Consent Form Checklist does not include a question relating to 'Transplantation with xenografts', which is a requirement of Annex A of the Guide to Quality and Safety Assurance for Human Tissues and Cells for Patient Treatment.	Minor

## Advice

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

No.	Standard	Advice
1.	C3a	Consent training includes the trainee observing consent being taken by trained staff members, observation of trainees when obtaining consent and a final interview with the DI to ensure understanding of the process and procedure. The DI reviews staff obtaining consent annually. The initial training and subsequent reviews are documented. The DI is advised to consider documenting in a standard operating procedure (SOP), the process for consent training.
2.	GQ1c	The establishment has bone bank meetings that are minuted and include actions. The DI is advised to consider including a representative from the testing laboratory, periodically, at these meetings.
3.	GQ1d GQ3f GQ7a	The DI is advised to update the bone bank training folder with the Bone Bank policy (CP24) once it has been approved, in order to maintain consistency in the documents referred to by staff.  The above policy could also be used for staff training to highlight the role of the HTA, the relevant legislation, and reporting requirements of serious adverse events and reactions (SAEARs).
4.	GQ2b GQ4b	The DI is advised to consider documenting the ongoing checks undertaken by bone bank staff within an audit and include these within the ongoing internal audit schedule. For example, the recording of the temperature before and after bone is removed from the freezer, the review of the electronic report for microbiology results.
5.	GQ4h	The DI is advised to consider some additional labelling on the -80°C freezer temperature traces (e.g. the start / end of the month) in order that any temperature deviations can be referenced to a specific date.
6.	GQ4k GQ6d	The establishment has previously distributed femoral heads to a private hospital, but this has not taken place since the last inspection. The DI is advised to consider the requirement for a documented agreement and the Single European Code (SEC) if this activity were to be undertaken again.
7.	GQ8c	The DI is advised to consider including the risk assessments within the bone bank training folder.

## Concluding comments

Good practices were observed during the inspection. The bone bank is well established and the DI and bone bank coordinator oversee an experienced team and robust practices. Consent training is assessed by the DI and this ensures consistency of the process. The use of large colour-coordinated posters, displayed next to the quarantine and release freezers, provides an effective reference when tasks are undertaken.

There are a number of areas of practice that require improvement, including five minor shortfalls. These relate to the documented agreement with the testing laboratory, the independent audit, the retention of raw data, the records of products coming into contact with tissues and the donor selection criteria. The HTA has given advice to the Designated

Individual with respect to documenting the process for consent training, attendance of staff at meetings, document control, staff training on the awareness of the regulatory context of their role, audit documentation, management of temperature records, documented agreements with end users and risk assessments.

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: 30 April 2019**

**Report returned from DI: 15 May 2019**

**Final report issued: 17 May 2019**

### **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: 30 December 2019**

## Appendix 1: HTA standards

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

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

#### Consent

Standard
C1 Consent is obtained in accordance with the requirements of the HT Act 2004, the Human Tissue (Quality and Safety for Human Application) Regulations 2007 and as set out in the HTA's Codes of Practice.
a) If the establishment acts as a procurer of tissues and / or cells, there is an established process for acquiring donor consent which meets the requirements of the HT Act 2004 the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (Q&S Regulations) and the HTA's Codes of Practice
c) The establishment or the third party's procedure on obtaining donor consent includes how potential donors are identified and who is able to take consent.
d) Consent forms comply with the HTA Codes of Practice.
e) Completed consent forms are included in records and are made accessible to those using or releasing tissue and / or cells for a Scheduled Purpose.
C2 Information about the consent process is provided and in a variety of formats.
a) The procedure on obtaining consent details what information will be provided to donors. As a minimum, the information specified by Directions 002/2018 is included.
c) Information is available in suitable formats and there is access to independent interpreters when required.
d) There are procedures to ensure that information is provided to the donor or donor's family by trained personnel.
C3 Staff involved in seeking consent receive training and support in the implications and essential requirements of taking consent.
a) Staff involved in obtaining consent are provided with training on how to take informed consent in accordance with the requirements of the HT Act 2004 and Code of Practice on Consent.
b) Training records are kept demonstrating attendance at training on consent.

#### Governance and Quality

Standard
GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process.
a) There is an organisational chart clearly defining the lines of accountability and reporting relationships.

b) There are procedures for all licensable activities that ensure integrity of tissue and / or cells and minimise the risk of contamination.
c) There are regular governance meetings, for example health and safety, risk management and clinical governance committees, which are recorded by agendas and minutes.
d) There is a document control system to ensure that changes to documents are reviewed, approved, dated and documented by an authorised person and only current documents are in use.
e) There are procedures for tissue and / or cell procurement, which ensure the safety of living donors.
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.
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.
o) There is a complaints system in place.
p) There are written agreements with third parties whenever an activity takes place that has the potential to influence the quality and safety of human tissues and / or cells.
q) There is a record of agreements established with third parties.
r) Third party agreements specify the responsibilities of the third party and meet the requirements set out in Directions 002/2018.
s) Third party agreements specify that the third party will inform the establishment in the event of a serious adverse reaction or event.
t) There are procedures for the re-provision of service in an emergency.
GQ2 There is a documented system of quality management and audit.
a) There is a quality management system which ensures continuous and systematic improvement.
b) There is an internal audit system for all licensable activities.
c) An audit is conducted in an independent manner at least every two years to verify compliance with protocols and HTA standards, and any findings and corrective actions are documented.
d) Processes affecting the quality and safety of tissues and / or cells are validated and undergo regular evaluation to ensure they continue to achieve the intended results.



GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and are continuously updating their skills.
a) There are clearly documented job descriptions for all staff.
b) There are orientation and induction programmes for new staff.
c) There are continuous professional development (CPD) plans for staff and attendance at training is recorded.
d) There is annual documented mandatory training (e.g. health and safety and fire).
e) Personnel are trained in all tasks relevant to their work and their competence is recorded.
f) There is a documented training programme that ensures that staff have adequate knowledge of the scientific and ethical principles relevant to their work, and the regulatory context.
g) There is a documented training programme that ensures that staff understand the organisational structure and the quality systems used within the establishment.
h) There is a system of staff appraisal.
i) Where appropriate, staff are registered with a professional or statutory body.
j) There are training and reference manuals available.
k) The establishment is sufficiently staffed to carry out its activities.
GQ4 There is a systematic and planned approach to the management of records.
a) There are procedures for the creation, identification, maintenance, access, amendment, retention and destruction of records.
b) There is a system for the regular audit of records and their content to check for completeness, legibility and accuracy and to resolve any discrepancies found.
c) Written records are legible and indelible. Records kept in other formats such as computerised records are stored on a validated system.
d) There is a system for back-up / recovery in the event of loss of computerised records.
e) The establishment keeps a register of the types and quantities of tissues and / or cells that are procured, tested, preserved, processed, stored and distributed or otherwise disposed of, and on the origin and destination of tissues and cells intended for human application.
f) There are procedures to ensure that donor documentation, as specified by Directions 002/2018, is collected and maintained.
g) There is a system to ensure records are secure and that donor confidentiality is maintained in accordance with Directions 002/2018.
h) Raw data which are critical to the safety and quality of tissues and cells are kept for 10 years after the use, expiry date or disposal of tissues and / or cells.
i) The minimum data to ensure traceability from donor to recipient as required by Directions 002/2018 are kept for 30 years after the use, expiry or disposal of tissues and / or cells.

j) Records are kept of products and material coming into contact with the tissues and / or cells.
k) There are documented agreements with end users to ensure they record and store the data required by Directions 002/2018.
l) The establishment records the acceptance or rejection of tissue and / or cells that it receives and in the case of rejection why this rejection occurred.
m) In the event of termination of activities of the establishment a contingency plan to ensure records of traceability are maintained for 10 or 30 years as required.
GQ5 There are documented procedures for donor selection and exclusion, including donor criteria.
a) Donors are selected either by the establishment or the third party acting on its behalf in accordance with the criteria required by Directions 002/2018.
b) The testing of donors by the establishment or a third party on behalf of the establishment is carried out in accordance with the requirements of Directions 002/2018.
c) In cases other than autologous donors, donor selection is carried out by authorised personnel and signed and reviewed by a qualified health professional.
d) There is a system in place either at the establishment or at a third party acting on its behalf to record results of donor selection and associated tests.
e) Testing of donor samples is carried out using CE marked diagnostic tests.
f) Samples taken for donor testing are clearly labelled with the time and place the sample was taken and a unique donor identification code.
GQ6 A coding and records system facilitates traceability of tissues and / or cells, ensuring a robust audit trail.
a) There is a donor identification system which assigns a unique code to each donation and to each of the products associated with it.
b) An audit trail is maintained, which includes details of when the tissues and / or cells were acquired and from where, the uses to which the tissues and / or cells were put, when the tissues and / or cells were transferred elsewhere and to whom.
c) The establishment has procedures to ensure that tissues and / or cells imported, procured, processed, stored, distributed and exported are traceable from donor to recipient and vice versa.
d) The requirements of the Single European Code are adhered to as set out in Directions 002/2018.
GQ7 There are systems to ensure that all adverse events, reactions and/or incidents are investigated promptly.
a) There are procedures for the identification, reporting, investigation and recording of adverse events and reactions, including documentation of any corrective or preventative actions.
b) There is a system to receive and distribute national and local information (e.g. HTA regulatory alerts) and notify the HTA and other establishments as necessary of serious adverse events or reactions.
c) The responsibilities of personnel investigating adverse events and reactions are clearly defined.

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

## Premises, Facilities and Equipment

Standard
PFE1 The premises are fit for purpose.
a) A risk assessment has been carried out of the premises to ensure that they are fit for purpose.
b) There are procedures to review and maintain the safety of staff, visitors and patients.
c) The premises have sufficient space for procedures to be carried out safely and efficiently.
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.
c) There are procedures for cleaning and decontamination.
d) Staff are provided with appropriate protective clothing and equipment that minimise the risk of contamination of tissue and / or cells and the risk of infection to themselves.

PFE3 There are appropriate facilities for the storage of tissues and / or cells, consumables and records.
a) Tissues, cells, consumables and records are stored in secure environments and precautions are taken to minimise risk of damage, theft or contamination.
b) There are systems to deal with emergencies on a 24 hour basis.
c) Tissues and / or cells are stored in controlled, monitored and recorded conditions that maintain tissue and / or cell integrity.
d) There is a documented, specified maximum storage period for tissues and / or cells.
PFE4 Systems are in place to protect the quality and integrity of tissues and / or cells during transport and delivery to its destination.
a) There is a system to ensure tissue and / or cells are not distributed until they meet the standards laid down by Directions 002/2018.
b) There are procedures for the transport of tissues and / or cells which reflect identified risks associated with transport.
c) There is a system to ensure that traceability of tissues and / or cells is maintained during transport.
d) Records are kept of transportation and delivery.
e) Tissues and / or cells are packaged and transported in a manner and under conditions that minimise the risk of contamination and ensure their safety and quality.
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
<b>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</b>
<p>a) Consent procedures are documented and these, along with any associated documents, comply with the HT Act and the HTA's Codes of Practice.</p> <p>b) Consent forms are available to those using or releasing relevant material for a scheduled purpose.</p> <p>c) Where applicable, there are agreements with other parties to ensure that consent is obtained in accordance with the requirements of the HT Act and the HTA's Codes of Practice.</p> <p>d) Written information is provided to those from whom consent is sought, which reflects the requirements of the HT Act and the HTA's Codes of Practice.</p> <p>e) Language translations are available when appropriate.</p> <p>f) Information is available in formats appropriate to the situation.</p>

**C2 Staff involved in seeking consent receive training and support in the essential requirements of taking consent**

- a) There is suitable training and support of staff involved in seeking consent, which addresses the requirements of the HT Act and the HTA's Codes of Practice.
- b) Records demonstrate up-to-date staff training.
- c) Competency is assessed and maintained.

**Governance and quality system standards****GQ1 All aspects of the establishments work are governed by documented policies and procedures as part of the overall governance process**

- a) Ratified, documented and up-to-date policies and procedures are in place, covering all licensable activities.
- b) There is a document control system.
- c) There are change control mechanisms for the implementation of new operational procedures.
- d) Matters relating to HTA-licensed activities are discussed at regular governance meetings, involving establishment staff.
- e) There is a system for managing complaints.

**GQ2 There is a documented system of audit**

- a) There is a documented schedule of audits covering licensable activities.
- b) Audit findings include who is responsible for follow-up actions and the timeframes for completing these.

**GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and are continuously updating their skills**

- a) Qualifications of staff and all training are recorded, records showing attendance at training.
- b) There are documented induction training programmes for new staff.
- c) Training provisions include those for visiting staff.
- d) Staff have appraisals and personal development plans.

**GQ4 There is a systematic and planned approach to the management of records**

- a) There are suitable systems for the creation, review, amendment, retention and destruction of records.
- b) There are provisions for back-up / recovery in the event of loss of records.
- c) Systems ensure data protection, confidentiality and public disclosure (whistleblowing).

**GQ5 There are systems to ensure that all adverse events are investigated promptly**

- a) Staff are instructed in how to use incident reporting systems.

b) Effective corrective and preventive actions are taken where necessary and improvements in practice are made.

**GQ6 Risk assessments of the establishment's practices and processes are completed regularly, recorded and monitored**

a) There are documented risk assessments for all practices and processes requiring compliance with the HT Act and the HTA's Codes of Practice.

b) Risk assessments are reviewed regularly.

c) Staff can access risk assessments and are made aware of risks during training.

**Traceability standards**

**T1 A coding and records system facilitates the traceability of bodies and human tissue, ensuring a robust audit trail**

a) There is an identification system which assigns a unique code to each donation and to each of the products associated with it.

b) A register of donated material, and the associated products where relevant, is maintained.

c) An audit trail is maintained, which includes details of: when and where the bodies or tissue were acquired and received; the consent obtained; all sample storage locations; the uses to which any material was put; when and where the material was transferred, and to whom.

d) A system is in place to ensure that traceability of relevant material is maintained during transport.

e) Records of transportation and delivery are kept.

f) Records of any agreements with courier or transport companies are kept.

g) Records of any agreements with recipients of relevant material are kept.

**T2 Bodies and human tissue are disposed of in an appropriate manner**

a) Disposal is carried out in accordance with the HTA's Codes of Practice.

b) The date, reason for disposal and the method used are documented.

**Premises, facilities and equipment standards**

**PFE1 The premises are secure and fit for purpose**

a) An assessment of the premises has been carried out to ensure that they are appropriate for the purpose.

b) Arrangements are in place to ensure that the premises are secure and confidentiality is maintained.

c) There are documented cleaning and decontamination procedures.

**PFE2 There are appropriate facilities for the storage of bodies and human tissue**

- a) There is sufficient storage capacity.
- b) Where relevant, storage arrangements ensure the dignity of the deceased.
- c) Storage conditions are monitored, recorded and acted on when required.
- d) There are documented contingency plans in place in case of failure in storage area.

**PFE3 Equipment is appropriate for use, maintained, validated and where appropriate monitored**

- a) Equipment is subject to recommended calibration, validation, maintenance, monitoring, and records are kept.
- b) Users have access to instructions for equipment and are aware of how to report an equipment problem.
- c) Staff are provided with suitable personal protective equipment.

**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.