Site visit inspection report on compliance with HTA minimum standards

MRC Clinical Sciences Centre

HTA licensing number 12240

Licensed under the Human Tissue Act 2004 for the

- **storage of relevant material which has come from a human body for use for a scheduled purpose**

29 October 2015

Summary of inspection findings

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

The MRC Clinical Sciences centre was not storing relevant material under the licence at the time of the site visit inspection. However, advice was provided to the DI and establishment staff in order to improve practices further.

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 (the Act). 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 licenses 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.

Background to the establishment and description of inspection activities undertaken

This report describes the second site visit inspection of MRC Clinical Sciences Centre (the establishment).The establishment has been licensed by the HTA since September 2007 for storage of relevant material for use for a scheduled purpose, which in this case is 'research in connection with disorders, or the functioning, of the human body'.

At the time of the inspection, there was no storage of relevant material taking place under the licence because all relevant material was being held for specific research projects with approval from NHS Research Ethics Committees (RECs). However, a full assessment of compliance against the HTA standards was made by the inspection team, should relevant material be stored under the governance of a HTA licence in the future.

The inspection included a review of four research studies with REC favourable opinions from NHS RECs; one of which was a clinical trial of an investigational medicinal product and had received clinical trial authorisation from the MHRA. The inspection also included a round table discussion with key researchers for each group, a visual inspection of the areas where relevant material is stored, traceability audits and a document review. No imported samples were being stored at the time of the inspection.

The Group Heads for each research group are responsible for informing the DI if relevant material is being stored for research. This information is declared on an annual basis. The DI also undertakes audits of research groups annually, which focus on compliance with the HTA standards. If a researcher plans to import samples from outside of the UK or locally, through research collaboration in the UK, the DI will be notified by staff responsible for drafting Material Transfer Agreements (MTA). This ensures that he is aware of whether imported material is being stored for research.

Each research group is responsible for maintaining their own traceability system for the storage, use and disposal of relevant material. The DI has drafted a set of overarching SOPs that can be accessed by the researchers to ensure that they comply with the HTA standards. Researchers do use their own operating procedures, however they are advised to familiarise themselves with the overarching SOPs made available to them (see Advice, item 2).

Relevant material is stored in -80^{0}C freezers and liquid nitrogen tanks in dedicated rooms. The fridges and freezers are monitored using an electronic monitoring system which alerts the researcher if the temperature goes outside normal parameters. The liquid nitrogen dewars are not monitored electronically, however, they are filled with liquid nitrogen twice a week (see Advice, item 7). The DI had recently risk assessed the suitability of the storage areas, due to the number of -80^{0}C freezers and liquid nitrogen tanks being stored in the room. In light of this, the DI made arrangements to move some of the -80^{0}C freezers to enable all nitrogen dewars to be co-located with gas detection and extract ventilation systems. This also allows researchers to access the freezers more easily (see Advice, item 6).

A traceability audit of seven relevant material samples being stored under the governance of NHS REC approvals was carried out. One sample was an ‘existing holding’ as it has been stored for research before the Act came into force on 1 September 2006. The remaining six blood samples were from the same donor. The consent form was also reviewed. No discrepancies were identified.

Inspection findings

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

Compliance with HTA standards

All applicable HTA standards have been assessed as fully met.

Advice

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

No.	Standard	Advice
1.	C1	The DI is advised to review the Consent SOP as it contains the following sentence: *'The withdrawal of consent to the further use of samples for research does not mean that all existing information has to be withdrawn from the project. Neither does it mean that the samples have to be removed or destroyed'.* This wording should be reviewed in light of the guidance provided in the HTA Code of Practice on Consent which states: *'If someone gives consent for their tissue to be stored or used for more than one scheduled purpose and then withdraws consent for a particular scheduled purpose (e.g. research), this does not necessarily mean that the sample or samples have to be removed or destroyed. However, the samples may no longer be stored or used for the particular purpose for which consent has been withdrawn. In addition, if someone withdraws consent for samples to be used in any future projects, this does not mean that information and research data should be withdrawn from any existing projects'.* If the samples continue to be stored after consent has been withdrawn, there is a risk that these samples could be used for research in error.
2.	GQ1	There are three items of advice against standard GQ1: 1. The overarching SOPs are comprehensive. The DI has delegated responsibility to the Group Heads to ensure that staff are made aware of the SOPs and are appropriately trained. The DI may wish to request for the Group Heads to maintain a list of researchers that have read and understood the SOPs. 2. The DI is advised to draft a cleaning and decontamination procedure, so that researchers are aware of how often the freezers must be cleaned. 3. The DI is advised to draft a procedure on the maintenance of equipment, which provides information about; freezer and liquid nitrogen contingency, servicing and maintenance of freezers and liquid nitrogen tanks, testing of alarms and monitoring of critical storage conditions.
3.	GQ2	There are two items of advice against standard GQ2: 1. The DI has carried out audits of each research group using an audit pro-forma. The DI is advised to ensure that information collected during an

		audit is recorded clearly. After reviewing a completed audit pro-forma, it was unclear as to whether some of the notes made during the audit indicated if there was a problem or not. 2. The DI may wish to consider allowing researchers to audit one another's research areas, with the aim of promoting shared learning across the department.
4.	GQ6	There are two items of advice against this standard: 1. Currently, researchers use their own traceability systems. Moving forward, the DI may wish to consider whether the use of a standardised database to record human tissue traceability would be beneficial. 2. A small proportion of human tissue samples were being stored under the governance of an ethically approved research study. These samples had been collected and stored before 1 September 2006, before the HT Act came into force, and therefore are not subject to the HT Act's consent requirements 2004. At the time of the inspection, the samples were not being used for research, however they were being stored under the governance of an NHS REC approval. Once the NHS REC approval ends, the researchers intend to use the samples in future research, under a university ethics approval. The DI is reminded that these samples, along with any other samples collected, must be stored under the governance of the HTA licence, unless further ethical approval is sought from an NHS REC. As the researchers also plan to source samples from a third party provider, the DI is advised to set up agreements to provide the assurance that only samples with valid consent for research will be provided.
	GQ7	SOP CSC/HTA/ADM/008.01 relates to the procedure for reporting adverse events. Section 1.2 of the procedure refers to a 'HTA definition of an adverse event'. Although there is currently no requirement for establishments in the research sector to report adverse incidents to the HTA, if a DI has concerns about an adverse event, they are encouraged to contact the HTA for further advice. Relevant examples of adverse events include: • specimen loss; • missing or incorrect documentation; • security breach; • abnormalities in storage temperature readings; • inappropriate disposal.
5	GQ8	There are comprehensive risk assessments in place that account for the health and safety risks to staff as well as the risks to the human tissue samples. Although a detailed assessment has been made the current risk assessment, template could be re-drafted to include a risk matrix system. This would enable the levels of risks and the likelihood of an incident occurring to be clearly defined Furthermore, risk assessments should be subject to ongoing review to ensure that they are still valid if there are changes to practices and procedures.
6	PFE1	The DI is advised to extend the scope of the premises risk assessment, which considers the risks associated with the high number of freezers and liquid nitrogen tanks in the room, to also cover the effectiveness of (and therefore the

		risks posed by) the current ventilation system as it was identified that the dampers were not working efficiently. In addition, the DI should review access arrangements to the room, as the doors on either side of the room remain open at all times, and could pose a potential security risk. Although a significant amount of work has been carried out to ensure the room is fit for purpose, the DI may wish to consider whether the liquid nitrogen tanks should be stored separately from the -80^{0}C freezers.
7	PFE3	There are three items of advice against this standard: 1. The liquid nitrogen tanks are not electronically monitored and alarmed. Although the tanks are filled on a Monday and Friday, every week, this is not being recorded. The DI is advised to implement a checklist that can be completed by researchers so that they can record every time a dewar is filled. 2. The DI is advised that the temperature alarms should be regularly tested and manually challenged periodically to ensure they are operating as expected. 3. The DI is advised to consider fixing signs on the freezers that detail the alarm set points for the temperature ranges so that all staff that have access to the freezers are visually reminded of the minimum and maximum storage temperatures.

Concluding comments

Although licensable activities were not taking place at the time of the site visit, the DI and establishment staff demonstrated a good understanding of the HTA legislation. The DI was keen for the establishment to continue to be licensed by the HTA. Although the DI has been in post since March 2015, he has ensured that procedures have been reviewed and updated and has also ensured that he has audited respective groups to assess compliance with the HTA standards. Furthermore, the DI has pro-actively risk assessed the storage area to ensure there is adequate space and ventilation for those requiring access to the -80^{0}C freezers and liquid nitrogen tanks. Advice against standards, C1, GQ1, GQ2, GQ6, GQ7, GQ8, PFE1 and PFE3 has been provided to improve practices further.

Report sent to DI for factual accuracy: 23 November 2015

Report returned from DI: 3 December 2015 (with comments)

Final report issued: 7 December 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.

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

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 risk to human safety and/or dignity or is a breach of the Human Tissue Act 2004 (HT Act) or associated Directions

   or

A combination of several major shortfalls, none of which is critical on its own, but which together could constitute a critical shortfall and should be explained and reported as such.

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 that:

- poses a risk to human safety and/or dignity, or
- indicates a failure to carry out satisfactory procedures, or
- indicates a breach of the relevant CoPs, the HT Act and other relevant professional and statutory guidelines, or
- has the potential to become a critical shortfall unless addressed

or

A combination of several minor shortfalls, none of which is major on its own, but which, together, could constitute a major shortfall and should be explained and reported as such.

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, but which indicates a departure from expected standards.

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 or site visit.

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.