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

**Trycare Limited**

**HTA licensing number 22587**

**Licensed for the**

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

**30 and 31 August 2018**

## Summary of inspection findings

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

Although the HTA found that Trycare Limited (the establishment) had met many of the HTA's standards, twelve shortfalls (three major, nine minor) were found. The major shortfalls were in relation to: an incomplete document control system; the absence of regular independent audit and; the absence of a system for reporting adverse events. The minor shortfalls were in relation to: the absence of meetings covering HTA-licensed activities; incomplete procedures for return of product from end users; incomplete serology validation by testing subcontractors working for the third country supplier; the absence of an internal audit system; the absence of a documented plan for contingency storage of records; incomplete traceability systems; the absence of procedures for applying the Single European Code (SEC); lack of availability of risk assessments, for staff, for HTA-licensed activities and; incomplete assessment of the product transportation procedure.

Advice has been given relating to the Governance and Quality, and Premises, Facility and Equipment standards, as well as advice on licence management.

Particular examples of strength 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 (DI), Licence Holder (LH), premises and practices are suitable.

The statutory duties of the DI 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 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.

## Licensable activities carried out by the establishment

'E' = Establishment is licensed to carry out this activity.

| Tissue Category; Tissue Type | Storage | Distribution | Import |
|---|---|---|---|
| **Musculoskeletal, Bone; Acellular Bone** | **E** | **E** | **E** |
| **Musculoskeletal, Bone; Cancellous and Cortical Bone Particles** | **E** | **E** | **E** |

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

This report refers to the activities carried out by Trycare Limited (the establishment), which was issued an HTA licence in October 2009. This was the fifth HTA site visit inspection of the establishment (the last inspection was in December 2015) and the first since the amended Human Tissue (Quality and Safety for Human Application) Regulations 2007 came into force

on 1 April 2018 [Q&S Regulations (as amended)]. The current inspection was a routine one to assess whether the establishment is continuing to meet the HTA's standards.

Trycare Limited was founded in 1996 and supplies a wide range of acellular bone products to dental surgeries throughout the UK. The products are sourced from a single supplier, Rocky Mountain Tissue Bank (RMTB), based in the United States of America (USA). RMTB is registered with the USA Food and Drug Administration (FDA) to process, package, store, label and distribute Human Cells, Tissues, and Cellular and Tissue based products (HCT/P's), specifically bone allografts, and is accredited by the American Association of Tissue Banks (AATB). RMTB has a quality management system that is compliant with International Organization for Standardization (ISO) standard 9001 (2015).

The establishment is licensed under the Q&S Regulations (as amended) for the storage, distribution and import of tissues and cells for human application.

The DI is the establishment's Product Operations Manager, the Corporate Licence Holder (CLH) is Trycare Limited and the CLH Contact (CLHC) is the establishment's Managing Director. There are no Persons Designated (PDs) currently working under the licence (see *Advice*, item 1).

Import

The establishment is an importing tissue establishment (ITE) and RMTB is the third country supplier (3CS). There is a 'Licensed Distributor Agreement' between the 3CS and the establishment, which covers the requirements of Annexes III and IV of EC Directive (EU) 2015/566. The agreement covers two lines of bone products, one consists of bone particles (separately cortical and cancellous) and the second blocks (separately bone blocks for dentistry and blocks for periodontry). The products are procured in several mortuaries based in the USA and are transported to a second organisation for ongoing shipment to the 3CS or, occasionally, for temporary storage (up to six months) before shipment (see *Advice*, item 4). These organisations (procurement and storage subcontractors, SCs) work under the terms of an agreement with the 3CS. The SCs are registered with the FDA and are accredited by the AATB.

Donor selection and the seeking of consent for bone procurement from deceased donors, as well as for mandatory serology tests, are carried out at each procurement SC. Samples for serology testing are taken within 24 hours of death and are transported to one of four testing organisations (testing SCs), all of which are regulated under the US 'Clinical Laboratory Improvement Amendments (CLIA)' scheme. Testing is carried out under the terms of an agreement with the 3CS. Antibody tests for the full range of infectious disease markers required by the Q&S Regulations (as amended) are carried out, as well as confirmatory serology and Nucleic Acid Amplification Technique (NAT) testing [see shortfall against standard GQ1(n)]. The testing SCs also carry out sterility analysis of the procured bone.

Bone products received at RMTB are snap frozen and then thawed. Bone particulates are produced by chipping, grinding and milling, and blocks by cutting to size. Bone products are then packaged, sealed and labelled.

Bone products are then subject to rapid freezing before being shipped to a separate organisation for terminal sterilisation (γ-irradiation) This is carried under the terms of an agreement with the 3CS. Bone products are then returned to RMTB for shipping to Trycare Limited, using a contracted courier service. All results are reviewed by the 3CS Medical Director before release.

Product Receipt

Upon receipt, the establishment carries out a quality control (integrity) check of each shipment to confirm receipt of the correct consignment and that the packaging is undamaged.

This is carried out by two members of staff. The establishment applies the Single European Code (SEC) to each product on the outer packaging before it is boxed up. There are inconsistencies several inconsistencies in this procedure [see shortfall against standard GQ6(d)]. The products are then placed within an appropriately labelled box to ensure that information on the establishment accompanies all products sent to end users.

The products are then logged onto the tissue register and onto the establishment's electronic database. Products failing to meet acceptance criteria upon arrival are quarantined in a dedicated storage area and returned to RMTB using the contracted courier. This area also includes products which have exceeded their expiry date and products returned from end users.

Storage

The site is a secure facility that houses the establishment's offices and product storage area. There is electronic access control.

Products are stored under controlled ambient temperature conditions. Temperatures are continuously monitored and recorded on a daily basis using maximum/minimum thermometers.

Distribution

End users comprise dental surgeries and products are distributed using the contracted courier. Distribution is carried out using the terms and conditions on the invoice as the end user agreement. The products are accompanied by documentation which includes information on the reporting of serious adverse events and adverse reactions (SAEARs) to the establishment and on the requirement to store traceability data. Delivery is tracked by the courier, with all delivery and dispatch notes retained on file at the establishment.

Products not required by the end user are returned to the establishment [see shortfall against standard GQ1(k)].

Disposal

The establishment does not dispose of any bone products but returns them to RMTB, maintaining a record of this.

Contingency

There is a documented plan for the management of bone products in the event of termination of activities but no such plan for the contingency storage of records [see shortfall against standard GQ4(m)].

The timetable for the site visit inspection was developed after consideration of the establishment's previous inspection report, communications with the HTA since the last inspection and annual activity data. The inspection included a visual inspection of the product storage area and the area for product receipt and distribution. Discussions and interviews were held with key staff and documentation was reviewed. Interviews were held with the DI, CLHC and the establishment's Events and Course Coordinator.

Audits of traceability were carried out:

- Four acellular products (two cancellous particulates, one bone block and one periodontal bone block) were selected at random from the stock list sent in advance of the inspection. Labelling details (of three of the products, the fourth had been released) and details of receipt, storage and (where applicable) release were compared to the tissue register and electronic database. There were several discrepancies noted [see shortfall against standard GQ6(d)].
- The following information for each product was received from RMTB and reviewed:

donor selection and consent forms, serological test results, environmental monitoring data and sample sterility analysis. There were no discrepancies noted.

## Inspection findings

The HTA found the DI and the CLH to be suitable in accordance with the requirements of the legislation.

## Compliance with HTA standards

### Governance and Quality

| Standard | Inspection findings | Level of shortfall |
|---|---|---|
| GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process. | | |
| c) There are regular governance meetings, for example health and safety, risk management and clinical governance committees, which are recorded by agendas and minutes. | There are meetings which discuss operational issues but currently no meetings which discuss HTA-related activities, such as: standardisation of documents, changes to standard operating procedures (SOPs), audits and their findings, competence and regulatory training, management of incidents, risk assessments, equipment maintenance, the setting up of agreements with other establishments and updates from the HTA (e.g. e-newsletter items). | **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. | During the inspection, it was noted that there were inconsistencies in the document control system. These included:<br>• Two versions of the form for monitoring the routine temperature of the storage area were being used (the older version stated the temperature limits to help ensure that any excursions were identified and their impact assessed but the newer version omitted these).<br>• Several of the SOPs had an author/owner but did not state the reviewer. | **Major** |
| k) There is a procedure for handling returned products. | During the inspection, it was noted that the SOP for 'Return of product from end user' did not document the checks the establishment undertakes to decide if the product remains suitable for re-issue.<br>See *Advice*, item 2. | **Minor** |

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| n) The establishment ensures imports from non-EEA states meet the standards of quality and safety set out in Directions 002/2018. | During the inspection, the establishment was not able to provide evidence to demonstrate that all infectious disease marker tests had been evaluated for use on blood samples taken from cadaveric donors.<br>Specifically, this applied to the HTLV-1, HBc and *T pallidum* (syphilis) tests. | **Minor** |
| GQ2 There is a documented system of quality management and audit. | | |
| b) There is an internal audit system for all licensable activities. | An internal audit system encompassing the full range of licensed activities has not been implemented.<br>The establishment performs regular checks to ensure that the inventory of acellular products matches records in the tissue register and electronic database. However, this does not constitute an internal audit aimed at assessing compliance against the full range of applicable standards under the Q&S Regulations (as amended).<br>See *Advice*, item 6. | **Minor** |
| 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. | There has been no independent audit carried out against the full range of applicable standards under the Q&S Regulations (as amended) since January 2012.<br>This was identified as a minor shortfall at the last inspection but has still not been addressed. | **Major** |
| GQ4 There is a systematic and planned approach to the management of records. | | |
| 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. | There is no documented plan for the contingency storage of records of traceability and raw data in the event of termination of activities. | **Minor** |
| GQ6 A coding and records system facilitates traceability of bodies, body parts, tissues and cells, ensuring a robust audit trail. | | |
| 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. | During the traceability audit, it was noted that there were no SEC labels included in the packaging of two of the products audited. | **Minor** |

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| d) The requirements of the Single European Code are adhered to as set out in Directions 002/2018. | Although a coding label is applied to products prior to release for end use, this does not meet the requirements of the SEC as set out in Directions 002/2018.<br>See *Advice*, item 8. | **Minor** |
| GQ7 There are systems to ensure that all adverse events are investigated promptly. | | |
| a) There are procedures for the identification, reporting, investigation and recording of adverse events and reactions, including documentation of any corrective or preventative actions. | The establishment does not have a system in place for recording and investigating adverse events.<br>For example, it was noted that a number of incidents had taken place that should have been formally logged and investigated, including a security breach and the receipt of incorrect/damaged products from RMTB. | **Major** |
| GQ8 Risk assessments of the establishment's practices and processes are completed regularly and are recorded and monitored appropriately. | | |
| c) Staff can access risk assessments and are made aware of local hazards at training. | Although there are risk assessments these are not currently available to staff. | **Minor** |

**Premises, Facilities and Equipment**

| Standard | Inspection findings | Level of shortfall |
|---|---|---|
| PFE4 Systems are in place to protect the quality and integrity of bodies, body parts, tissues and cells during transport and delivery to a destination. | | |
| g) Critical transport conditions required to maintain the properties of tissue and / or cells are defined and documented. | The establishment uses the same courier service for both medicinal and bone products. It has carried out periodic audits of the service for medicinal products and identified a number of occasions where temperatures exceeded the limits which were also set for bone products. As the same packaging is used for both sets of products, it would have been expected that a formal review of the suitability of the transport procedure for bone products had been initiated but this was not the case. | **Minor** |

## Advice

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

| No. | Standard | Advice |
|---|---|---|
| 1. | N/A | The DI is advised to consider appointing a PD at the establishment to assist him in his role as DI. Having a PD would ensure that, on those occasions when the DI is unavailable: (i) SAEARs are reported on time and (ii) a recall of products distributed to end users is initiated, if required.<br><br>The PD could also assist with completing and sending compliance and annual activity data.<br><br>The HTA should be notified of such an appointment. |
| 2. | GQ1(k) | The DI is advised to include a risk assessment for inappropriate storage by the end user as part of the documented checklist. |
| 3. | GQ1(n) | During a review of the donor records and checklists (e.g. 'Imported tissue Verification Form', SOP26), there were several instances where boxes for certain microbiological tests had not been ticked and others (e.g. for *clostridium* and *streptococcus)* had been ticked to indicated positivity. Although detailed acceptance criteria for such products had been given in the RMTB Technical Files the DI was not aware of these.<br><br>The DI is advised to ensure that he is fully aware of the significance of acceptance criteria for receipt of bone products from RMTB. |
| 4. | GQ1(p) | The DI is advised to request an update to the wording of the RMTB Technical File to reflect the fact that, in certain circumstances and under appropriate controls, bone products can be stored at procurement/storage SCs for a period greater than six months prior to processing in order for the donor assessment process to be completed. This will bring the technical file in line with the 3CS's current procedures and enable the DI to conduct more accurate audits of donor records going forward. |
| 5. | GQ2(a) | The Quality Management System (QMS) labels all documents as SOPs, although many of these documents are 'forms'.<br><br>The DI is advised to incorporate the range of relevant RMTB Technical Files into this QMS. |
| 6. | GQ2(b) | Although this is not exhaustive, the DI is advised to include in the audit schedule: (i) audits of documentation (e.g. temperature record sheets) to ensure accuracy and consistency and; (ii) procedural audits of the establishment's activities to help assure the DI that current practices being followed adequately reflect the content of SOPs. |
| 7. | GQ3(f) | The DI is advised to consider incorporating the relevant parts of the 'Guide to Quality and Safety Assurance of Human Tissues and Cells for Patient Treatment' in the establishment's regulatory training programme. |
| 8. | GQ6(d) | The DI is advised to refer to the 'HTA guidance on coding and import regulations for tissues and cells in the human application sector' for the different SEC requirements to assist in producing a label which conforms to requirements. |
| 9. | PFE3(d) | The electronic database currently records bone product expiry dates in an approximate form (dates are not exact matches to the product as the system defaults to the 28th or 30th of the month). The DI is advised to amend this system. |

## Concluding comments

During the inspection, areas of strength and good practice were noted:

- There is a good working relationship and a comprehensive and effective system of communication between the establishment and RMTB. The CLHC attends RMTB board meetings twice a year.

There are a number of areas of practice that require improvement, including three major and nine minor shortfalls. The HTA has given advice to the DI with respect to the Governance and Quality, and Premises, Facilities and Equipment standards, as well as advice on licence management.

The HTA requires that the DI 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: 28 September 2018**

**Report returned from DI: 12 October 2018**

**Final report issued: 1 November 2018**

## Completion of corrective and preventative actions (CAPA) plan

Based on information provided, the HTA is satisfied that the establishment has completed the agreed actions in the CAPA plan and in doing so has taken sufficient action to correct all shortfalls addressed in the Inspection Report.

**Date: 12 May 2020**

## Appendix 1: HTA standards

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

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

**Consent**

| **Standard** |
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| 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. |
| 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. |
| C2 Information about the consent process is provided and in a variety of formats. |
| b) If third parties act as procurers of tissues and / or cells, the third party agreement details what information will be provided to donors. As a minimum, the information specified by Directions 002/2018 is included. |

**Governance and Quality**

| **Standard** |
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| 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. |
| 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. |

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| k) There is a procedure for handling returned products. |
| l) There are procedures to ensure that in the event of termination of activities for whatever reason, stored tissues and / or cells are transferred to another licensed establishment or establishments. |
| m) The criteria for allocating tissues and / or cells to patients and health care institutions are documented and made available to these parties on request. |
| n) The establishment ensures imports from non EEA states meet the standards of quality and safety set out in Directions 002/2018. |
| o) There is a complaints system in place. |
| p) There are written agreements with third parties whenever an activity takes place that has the potential to influence the quality and safety of human tissues and / or cells. |
| q) There is a record of agreements established with third parties. |
| r) Third party agreements specify the responsibilities of the third party and meet the requirements set out in Directions 002/2018. |
| s) Third party agreements specify that the third party will inform the establishment in the event of a serious adverse reaction or event. |
| t) There are procedures for the re-provision of service in an emergency. |
| GQ2 There is a documented system of quality management and audit. |
| a) There is a quality management system which ensures continuous and systematic improvement. |
| b) There is an internal audit system for all licensable activities. |
| c) An audit is conducted in an independent manner at least every two years to verify compliance with protocols and HTA standards, and any findings and corrective actions are documented. |
| d) Processes affecting the quality and safety of tissues and / or cells are validated and undergo regular evaluation to ensure they continue to achieve the intended results. |
| GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and are continuously updating their skills. |
| a) There are clearly documented job descriptions for all staff. |
| b) There are orientation and induction programmes for new staff. |
| c) There are continuous professional development (CPD) plans for staff and attendance at training is recorded. |
| d) There is annual documented mandatory training (e.g. health and safety and fire). |
| e) Personnel are trained in all tasks relevant to their work and their competence is recorded. |
| f) There is a documented training programme that ensures that staff have adequate knowledge of the scientific and ethical principles relevant to their work, and the regulatory context. |
| g) There is a documented training programme that ensures that staff understand the organisational structure and the quality systems used within the establishment. |

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| 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. |
| 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. |
| 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. |

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| 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** |
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| 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. |
| b) Where processing of tissues and / or cells involves exposure to the environment, it occurs in an appropriate, monitored environment as required by Directions 002/2018. |
| c) There are procedures for cleaning and decontamination. |
| d) Staff are provided with appropriate protective clothing and equipment that minimise the risk of contamination of tissue and / or cells and the risk of infection to themselves. |
| PFE3 There are appropriate facilities for the storage of tissues and / or cells, consumables and records. |
| a) Tissues, cells, consumables and records are stored in secure environments and precautions are taken to minimise risk of damage, theft or contamination. |
| b) There are systems to deal with emergencies on a 24 hour basis. |
| c) Tissues and / or cells are stored in controlled, monitored and recorded conditions that maintain tissue and / or cell integrity. |
| d) There is a documented, specified maximum storage period for tissues and / or cells. |
| PFE4 Systems are in place to protect the quality and integrity of tissues and / or cells during transport and delivery to its destination. |
| a) There is a system to ensure tissue and / or cells are not distributed until they meet the standards laid down by Directions 002/2018. |
| b) There are procedures for the transport of tissues and / or cells which reflect identified risks associated with transport. |
| c) There is a system to ensure that traceability of tissues and / or cells is maintained during transport. |
| d) Records are kept of transportation and delivery. |
| e) Tissues and / or cells are packaged and transported in a manner and under conditions that |

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| 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. |
| h) Users have access to instructions for equipment and receive training in the use of equipment and maintenance where appropriate. |
| i) Staff are aware of how to report an equipment problem. |
| j) For each critical process, the materials, equipment and personnel are identified and documented. |
| k) There are contingency plans for equipment failure. |

**Disposal**

| **Standard** |
|---|
| D1 There is a clear and sensitive policy for disposing of tissues and / or cells. |
| a) The disposal policy complies with HTA's Codes of Practice. |
| b) The disposal procedure complies with Health and Safety recommendations. |
| c) There is a documented procedure on disposal which ensures that there is no cross contamination. |

| D2 The reasons for disposal and the methods used are carefully documented. |
| --- |
| a) There is a procedure for tracking the disposal of tissue and / or cells that details the method and reason for disposal. |
| b) Disposal arrangements reflect (where applicable) the consent given for disposal. |

## Appendix 2: Classification of the level of shortfall (HA)

Where the HTA determines that a licensing standard is not met, the improvements required will be stated and the level of the shortfall will be classified as 'Critical', 'Major' or 'Minor'. Where the HTA is not presented with evidence that an establishment meets the requirements of an expected standard, it works on the premise that a lack of evidence indicates a shortfall.

The action an establishment will be required to make following the identification of a shortfall is based on the HTA's assessment of risk of harm and/or a breach of the Human Tissue Act 2004, Human Tissue (Quality and Safety for Human Application) Regulations 2007 or the HTA Directions.

1. **Critical shortfall:**

   A shortfall which poses a significant risk to causing harm to a recipient patient or to a living donor,

   *or*

   A number of 'major' shortfalls, none of which is critical on its own, but viewed cumulatively represents a systemic failure and therefore is 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 straight away.

2. **Major shortfall:**

   A non-critical shortfall.

   A shortfall in the carrying out of licensable activities which poses an indirect risk to the safety of a donor or a recipient

   *or*

   A shortfall in the establishment's quality and safety procedures which poses an indirect risk to the safety of a donor or a recipient;

   *or*

   A shortfall which indicates a major deviation from the Human Tissue (Quality and Safety for Human Application) Regulations 2007 or the HTA Directions;

   *or*

   A shortfall which indicates a failure to carry out satisfactory procedures for the release of tissues and cells or a failure on the part of the designated individual to fulfil his or her legal duties;

   *or*

   A combination of several 'minor' shortfalls, none of which is major on its own, but which, viewed cumulatively, could constitute a major shortfall by adversely affecting the quality and safety of the tissues and cells.

   In response to a major shortfall, an establishment is expected to implement corrective and preventative actions within 1-2 months of the issue of the final inspection report. Major shortfalls pose a higher level of risk and therefore a shorter deadline is given, compared to

minor shortfalls, to ensure the level of risk is reduced in an appropriate timeframe.

3. **Minor shortfall:**

   A shortfall which cannot be classified as either critical or major and which can be addressed by further development by the establishment.

   This category of shortfall requires the development of a corrective action plan, the results of which will usually be assessed by the HTA either by desk-based review or at the time of the next inspection.

   In response to a minor shortfall, an establishment is expected to implement corrective and preventative actions within 3-4 months of the issue of the final inspection report.

## Follow up actions

A template corrective and preventative action plan will be sent as a separate Word document with both the draft and final inspection report. You must complete this template and return it to the HTA within 14 days of the issue of the final report.

Based on the level of the shortfall, the HTA will consider the most suitable type of follow-up of the completion of the corrective and preventative action plan. This may include a combination of

- a follow-up site visit inspection
- a request for information that shows completion of actions
- monitoring of the action plan completion
- follow up at next desk-based or site-visit inspection.

After an assessment of the proposed action plan the establishment will be notified of the follow-up approach the HTA will take.