

## **Site visit inspection report on performance against HTA quality standards**

**Derriford Hospital, Plymouth  
11093**

- **procurement, processing, testing, storage, distribution and import/export of human tissues and cells for human application under the Human Tissue (Quality and Safety for Human Application) Regulations 2007, and the**
- **storage of relevant material which has come from a human body for use for a scheduled purpose other than transplantation under the Human Tissue Act 2004**

**23 November 2010**

### **Executive Summary**

A site visit inspection of Derriford Hospital, Plymouth was carried out by the HTA on 23 November 2010.

The establishment was found to meet the majority of the HTA standards across the four areas of: consent; governance and quality; premises, facilities and equipment and disposal. A minor shortfall was found in relation to Governance and Quality, the details of which are contained in this report.

Examples of strengths and good practice are included in the concluding comments section of the report.

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

All reports of HTA inspections carried out from 1 November 2010 are published on the HTA website.

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

This report refers to activities carried out at Derriford Hospital under licence number 11093. Derriford Hospital is a District General Hospital with a range of specialist departments. The licence covers activities in two departments:

### **1. Orthopaedics**

The Orthopaedic department buys in allograft bone products from NHSBT, which is licenced by the HTA (11018). Frozen femoral heads are stored at -80c in a dedicated freezer within the operating theatre suite at the hospital, irradiated bone struts are stored at ambient temperature within the implant store, also within the operating theatre suite.

### **2. Haematology**

The Haematology department procures haemopoietic stem cells, for autologous and allogenic use, at Derriford Hospital by apheresis and by bone marrow harvest. Procured cells are then transported to Biovault Ltd (Licence number 11063), where staff from Derriford Hospital process the procured cells prior to storage by Biovault Ltd. The processed cells are returned to Derriford Hospital for reinfusion.

Patients also go through donor selection and consenting at Torbay Hospital, Torquay, before attending at Derriford Hospital for procurement and subsequently for reinfusion.

Derriford Hospital has a Third Party Agreement in place with The Royal Cornwall Hospital, Truro, where donor selection, consenting and procurement take place. Procured cells are then transported by courier to Derriford Hospital, where processing, storage and subsequent reinfusion takes place.

Serology testing is carried out at Derriford Hospital, The Royal Cornwall Hospital, Truro and at the Torbay Hospital.

The timetable for the inspection was agreed in advance with the DI, Mr Helmy Fekry, who is a Clinical Director and Consultant orthopaedic surgeon. The inspection comprised of a visual inspection of the bone storage facilities and the ward in which haematology patients are consented and cells procured.

A document review was carried out. Documents reviewed included (list not exhaustive):

- Trust wide policies and procedures relating to records management, document control, complaints, appraisal policy, incident management, risk management and assessment, consent policy.
- Local policies and procedures including SOPs for storage, use and disposal of allograft transplant tissue, incident reporting, serious untoward incident policy, health and safety policy, patient information sheet regarding transplant of allograft material, equipment instructions, records of equipment maintenance, monitoring and cleaning, Incident reporting procedure, risk assessments, training records and audits.

The HTA carried out the following audits:

In the Orthopaedic department two femoral heads were located within the freezer and the unique identification number and expiry date compared with that recorded in the Registration and Use log held by department staff. In addition, three patient records were examined for the existence of consent forms and to determine the unique identification numbers of allograft transplant material received. This information was compared against the Registration and Use log to confirm the unique numbers, date of operation and patient details matched.

In the haematology department, three patient records (two relating to Derriford patients and one relating to a patient seen at Torbay Hospital) were reviewed to ensure presence of consent and complete traceability of cells from procurement to infusion (where applicable). Transport records, processing logs and donor test results were reviewed.

No discrepancies were revealed during these audits.

Interviews took place with the Designated Individual, the staff nurse responsible for the Tissue Bank, the quality manager, and two consultant haematologists, one of whom is a named Person Designated on the licence.

## Meeting the HTA's licensing standards

The HTA developed its licensing standards with input from its stakeholders, in order to ensure the safe and ethical use of human tissue. The HTA expects licensed establishments to meet these standards.

This is an exception-based report: only those standards that have been assessed as not met are included. Where the HTA determines that a licensing standard is not met, the level of the shortfall will be classified as 'Critical', 'Major' or 'Minor' (see Appendix 3: Classification of the level of shortfall).

**Unless otherwise advised, the establishment is required to inform the HTA within 14 days of the receipt of the final report of the corrective and preventative actions that will be taken to ensure that the improvements are addressed.** A template for this purpose is provided as a separate Word document.

Please see Appendix 2: Human Application standards, to view all human application standards. Standards which do not apply to this licence are highlighted in Appendix 2.

## HTA standards not met

### 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.	<b>Serology testing as required by the European Union Tissues and Cells Directives is carried out at Derriford Hospital, the Royal Cornwall Hospital, Truro and at Torbay Hospital, Torquay. This is a licensable activity and must be carried out on licensed premises or under the auspices of a Third Party Agreement. The establishment has a Third Party Agreement with The Royal Cornwall Hospital, but no such agreement is in place with Torbay Hospital.</b>	<b>Minor</b>

## Advice

- Below are matters which the HTA advises the DI to consider.

No.	Standard	Advice
-----	----------	--------

1	GQ1p	The DI is advised to consider reviewing the existing Third Party Agreement between the establishment and The Royal Cornwall Hospital, Truro to ensure it includes all of the detail required by the HTA Guide for Quality and Safety Assurance for Human Tissues and Cells for Patient Treatments (Annex E). The DI is advised to include the responsibilities relating to testing in agreements with third parties. He is also advised to consider reviewing the existing SLA with Biovault Ltd to clarify the relative obligations and responsibilities of both parties.
2	GQ3e	The DI is advised to consider reviewing the SOP "Self Assessed Competency for Orthopaedic Tissue Bank Staff" to clarify that assessment only occurs after training on a one to one or group basis has been provided.
3	GQ4i	The DI is advised to ensure that the Hospital Trust Records Retention policy contains detail to ensure that records relating to tissues or cells used for patient treatment are retained for the periods of 10 years (for raw data) or 30 years (in relation to traceability).
4	GQ7a	The DI is advised to ensure that, in addition to the existing local policy and procedure, the Hospital Trust Serious Untoward Incident policy makes reference to the need to advise the DI of any adverse event or reaction involving tissues or cells for patient treatment.
5	GQ8a	The DI is advised to ensure that the suite of risk assessments carried out includes all aspects of the licensed activities, including transport of stem cell harvests between the Royal Cornwall Hospital and Derriford Hospital and the overnight storage of procured blood within the hospital blood bank pending delivery to Biovault Ltd.

### Concluding comments

During the inspection, the HTA noted various examples of good practice. Within the orthopaedic department the Standard Operating Procedures relating to the receipt, storage and use of allograft material received into the department were clear and easily understood. Similarly the forms used to record information during that process were seen to be clear and recorded information in an easily understandable way. Information provided to patients receiving allografts as part of joint revision was comprehensive. Training of staff in the procedures used in receipt storage and use of allograft material is carried out annually and competence recorded.

In the Haematology department, the difficulties in ensuring that those taking consent are aware of the requirements of the Human Tissue Act and Code of Practice on Consent have been addressed by the use of a training programme. Again, training is recorded. There are very good relationships between the establishment and Biovault Ltd, helped by the close geographical location. Where cells were transported between establishments, dataloggers contained within packaging were used, currently on a periodic basis for trend analysis but the HTA noted that the intention is to use dataloggers for every transport.

In both departments there were good quality management systems in place and audits of records and processes had been carried out. Some advice has been provided in relation to governance documentation and systems.

There was good communication between the DI and those working under the licence, particularly within the orthopaedic department as he works as a surgeon within that field. However, despite not being involved on a day to day basis with the procurement of haemopoietic stem cells, communication had been maintained with those working within the haematology department as there is a named Person Designated in a senior role within that

department. This could perhaps be improved by arranging a more formal reporting structure, perhaps by setting up specific meetings related to HTA matters.

**Report sent to DI for factual accuracy: 3 December 2010**

**Report returned from DI: 14 December 2010**

**Final report issued: 14 December 2010**

Once the establishment has been able to comment on the factual accuracy of the report, it will be published on the HTA website.

#### **Appendices**

Appendix 1: HTA inspection process .....	7
Appendix 2: HTA Standards.....	<b>Error! Bookmark not defined.</b>
Appendix 3: Classification of the level of shortfall .....	15

## Appendix 1: HTA inspection process

The Human Tissue Authority (HTA) was set up to regulate the removal, storage, use and disposal of human bodies, organs and tissue for a number of Scheduled Purposes such as research, transplantation, and education and training. The requirements of the HTA are set out in the Human Tissue Act 2004 (HT Act) and The Human Tissue Act 2004 (Ethical Approval, Exceptions from Licensing and Supply of Information about Transplants) Regulations 2006.

The Human Tissue Authority is also the designated Competent Authority for the purposes of the European Union Tissue and Cells Directives (the Directives) so far as they relate to tissues and cells for use in human application. On 5 July 2007 the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (the Regulations) came into force. The Regulations formally transposed the Directives into UK law. Under the Regulations the HTA regulates and licences the procurement, testing, processing, storage, distribution, import or export of tissues or cells intended for human application. The HTA has produced detailed Directions to complement the implementation of the Directives.

As part of the regulatory framework, the HTA licenses establishments and undertakes inspections to assess compliance with expected standards.

Under the HT Act and the Regulations, the HTA has a statutory responsibility to make judgements about the suitability of the Designated Individual (DI), Licence Applicant (Holder), premises and practices in relation to the licensed activities. These responsibilities are set out in Part 11 and 12 of the Regulations, which is the framework for the HTA's approach to licensing and inspection.

The HTA must satisfy itself that the (DI) is a suitable person to supervise the activity to be authorised by the licence and that they will undertake the following duties:

- secure that other persons to whom the licence applies are suitable persons to participate in the licensed activities;
- secure that suitable practices are used in the course of carrying on the activity;
- secure that the conditions of the licence are complied with.

Designated Individual's who are licensed under the Regulations have the following additional duties:

- secure the conditions of third party agreements, in relation to the licensed activities authorised to be carried on under his supervision
- and that the information and confidentiality requirements of Section 13 (1) are complied with

The HTA must satisfy itself that the applicant for the licence is a suitable person/entity to be the holder of the licence. It must also satisfy itself that the premises are suitable for the activity to be authorised by the licence. To enable the HTA to make effective judgements about the suitability of the DI and the Licence Holder, the suitability of the premises and the suitability of the practices taking place on the premises under the supervision of the DI, the HTA standards were developed under four high-level headings: Consent; Governance and Quality; Premises, Facilities and Equipment and Disposal

### Inspection Process

The HTA defines inspection as a process encompassing desk-based assessment, site-visit assessment and analysis of relevant written, numerical, verbal and visual information to evaluate how well establishments meet our expected standards. Desk-based assessments focus on the evaluation of the information provided by the establishment at the request of the HTA. Site visit inspections include review of the establishment's operational policies and procedures, inspection of its premises and scrutiny of its practices. HTA inspections can be routine or non-routine, announced or unannounced. Where the inspection process identifies that a standard is not met, the improvements required will be stated and the level of the shortfall will be classified as 'Critical', 'Major' or 'Other'. The HTA will take regulatory action that is proportionate to the level of the reported shortfall/s.

## Appendix 2: Human Application Standards

Standards shaded blue are not applicable to activities carried out by the Orthopaedic department.

Standards shaded green are not applicable to activities carried out by the Haematology department.

Standards shaded orange are not applicable to activities carried out under this licence.

Standards shaded red were not assessed during this inspection.

### Consent

Standard
C1 Consent is obtained in accordance with the requirements of the HT Act 2004, the Human Tissue (Quality and Safety for Human Application) Regulations 2007 and as set out in the HTA's Codes of Practice.
a) If the establishment acts as a procurer of tissues and / or cells, there is an established process for acquiring donor consent which meets the requirements of the HT Act 2004 the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (Q&S Regulations) and the HTA's Codes of Practice
b) If there is a third party procuring tissues and / or cells on behalf of the establishment the third party agreement ensures that consent is obtained in accordance with the requirements of the HT Act 2004, the Q&S Regulations and the HTA's Codes of Practice.
c) The establishment or the third party's procedure on obtaining donor consent includes how potential donors are identified and who is able to take consent.
d) Consent forms comply with the HTA Codes of Practice.
e) Completed consent forms are included in records and are made accessible to those using or releasing tissue and / or cells for a Scheduled Purpose.
C2 Information about the consent process is provided and in a variety of formats.
a) The procedure on obtaining consent details what information will be provided to donors. As a minimum, the information specified by Directions 001/2006 is included.
b) If third parties act as procurers of tissues and / or cells, the third party agreement details what information will be provided to donors. As a minimum, the information specified by Directions 001/2006 is included.
c) Information is available in suitable formats and there is access to independent interpreters when required.
d) There are procedures to ensure that information is provided to the donor or donor's family by trained personnel.
C3 Staff involved in seeking consent receive training and support in the implications and essential requirements of taking consent.
a) Staff involved in obtaining consent are provided with training on how to take informed consent in accordance with the requirements of the HT Act 2004 and Code of Practice on Consent.
b) Training records are kept demonstrating attendance at training on consent.



## Governance and Quality

Standard
GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process.
a) There is an organisational chart clearly defining the lines of accountability and reporting relationships.
b) There are procedures for all licensable activities that ensure integrity of tissue and / or cells and minimise the risk of contamination.
c) There are regular governance meetings, for example health and safety, risk management and clinical governance committees, which are recorded by agendas and minutes.
d) There is a document control system to ensure that changes to documents are reviewed, approved, dated and documented by an authorised person and only current documents are in use.
e) There are procedures for tissue and / or cell procurement, which ensure the safety of living donors.
f) There are procedures for tissue and / or cell procurement, which ensure the dignity of deceased donors.
g) There are procedures to ensure that an authorised person verifies that tissues and / or cells received by the establishment meet required specifications.
h) There are procedures for the management and quarantine of non-conforming consignments or those with incomplete test results, to ensure no risk of cross contamination.
i) There are procedures to ensure tissues and / or cells are not released from quarantine until verification has been completed and recorded.
j) There are procedures detailing the critical materials and reagents used and where applicable, materials and reagents meet the standards laid down by the European directives on medical devices and in vitro diagnostic medical devices.
k) There is a procedure for handling returned products.
l) There are procedures to ensure that in the event of termination of activities for whatever reason, stored tissues and / or cells are transferred to another licensed establishment or establishments.
m) The criteria for allocating tissues and / or cells to patients and health care institutions are documented and made available to these parties on request.
n) The establishment ensures imports from non EEA states meet the standards of quality and safety set out in Directions 001/2006 and 002/2007.
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 002/2007.

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 001/2006, is collected and maintained.
g) There is a system to ensure records are secure and that donor confidentiality is maintained in accordance with Directions 001/2006 and 002/2007.
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 002/2007 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 002/2007.
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.
<b>GQ5 There are documented procedures for donor selection and exclusion, including donor criteria.</b>
a) Donors are selected either by the establishment or the third party acting on its behalf in accordance with the criteria required by Directions 001/2006.
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 001/2006.
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.
<b>e) Testing of donor samples is carried out using CE marked diagnostic tests.</b>
f) Samples taken for donor testing are clearly labelled with the time and place the sample was taken and a unique donor identification code.
<b>GQ6 A coding and records system facilitates traceability of tissues and / or cells, ensuring a robust audit trail.</b>
a) There is a donor identification system which assigns a unique code to each donation and to each of the products associated with it.
b) An audit trail is maintained, which includes details of when the tissues and / or cells were acquired and from where, the uses to which the tissues and / or cells were put, when the tissues and / or cells were transferred elsewhere and to whom.
c) The establishment has procedures to ensure that tissues and / or cells imported, procured, processed, stored, distributed and exported are traceable from donor to recipient and vice versa.

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

### Premises, Facilities and Equipment

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

dignity of deceased persons.
e) There are procedures to ensure that the premises are secure and confidentiality is maintained.
f) There is access to a nominated, registered medical practitioner and / or a scientific advisor to provide advice and oversee the establishment's medical and scientific activities.
PFE2 Environmental controls are in place to avoid potential contamination.
a) Tissues and / or cells stored in quarantine are stored separately from tissue and / or cells that have been released from quarantine.
b) Where processing of tissues and / or cells involves exposure to the environment, it occurs in an appropriate, monitored environment as required by Directions 002/2007.
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 001/2006 and 002/2007.
b) There are procedures for the transport of tissues and / or cells which reflect identified risks associated with transport.
c) There is a system to ensure that traceability of tissues and / or cells is maintained during transport.
d) Records are kept of transportation and delivery.
e) Tissues and / or cells are packaged and transported in a manner and under conditions that minimise the risk of contamination and ensure their safety and quality.
f) There are third party agreements with courier or transport companies to ensure that any specific transport conditions required are maintained.
g) Critical transport conditions required to maintain the properties of tissue and / or cells are defined and documented.
h) Packaging and containers used for transportation are validated to ensure they are fit for purpose.
i) Primary packaging containing tissues and / or cells is labelled with the information required by Directions.

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

## Disposal

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

## Appendix 3: 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 direct risk of causing harm to a recipient patient or to a living donor,

*or*

A number of 'major' shortfalls, which individually do not pose a direct risk of harm to a recipient or living donor, but viewed cumulatively represent a systemic failure and therefore are considered 'critical'.

A critical shortfall may result in one or more of the following:

- (1) A notice of proposal being issued to revoke the licence
- (2) Some or all of the licensable activity at the establishment ceasing with immediate effect until a corrective action plan is developed, agreed by the HTA and implemented.
- (3) A notice of suspension of licensable activities
- (4) Additional conditions being proposed
- (5) Directions being issued requiring specific action to be taken straightaway

### 2. Major shortfall:

A non-critical shortfall:

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

*or*

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

*or*

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

*or*

A shortfall which indicates a failure to carry out satisfactory procedures for the release of tissues or 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/or cells.

### 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 at the time of the next inspection.

## Follow up actions

A template corrective and preventative action plan is available as a separate Word document. 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.

## Appendix 3: Human Application Standards

Standards shaded blue are not applicable to activities carried out by the Orthopaedic department.

Standards shaded green are not applicable to activities carried out by the Haematology department.

Standards shaded orange are not applicable to activities carried out under this licence.

Standards shaded red were not assessed during this inspection.

### Consent

Standard
C1 Consent is obtained in accordance with the requirements of the HT Act 2004, the Human Tissue (Quality and Safety for Human Application) Regulations 2007 and as set out in the HTA's Codes of Practice.
a) If the establishment acts as a procurer of tissues and / or cells, there is an established process for acquiring donor consent which meets the requirements of the HT Act 2004 the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (Q&S Regulations) and the HTA's Codes of Practice
b) If there is a third party procuring tissues and / or cells on behalf of the establishment the third party agreement ensures that consent is obtained in accordance with the requirements of the HT Act 2004, the Q&S Regulations and the HTA's Codes of Practice.
c) The establishment or the third party's procedure on obtaining donor consent includes how potential donors



are identified and who is able to take consent.
d) Consent forms comply with the HTA Codes of Practice.
e) Completed consent forms are included in records and are made accessible to those using or releasing tissue and / or cells for a Scheduled Purpose.
C2 Information about the consent process is provided and in a variety of formats.
a) The procedure on obtaining consent details what information will be provided to donors. As a minimum, the information specified by Directions 001/2006 is included.
b) If third parties act as procurers of tissues and / or cells, the third party agreement details what information will be provided to donors. As a minimum, the information specified by Directions 001/2006 is included.
c) Information is available in suitable formats and there is access to independent interpreters when required.
d) There are procedures to ensure that information is provided to the donor or donor's family by trained personnel.
C3 Staff involved in seeking consent receive training and support in the implications and essential requirements of taking consent.
a) Staff involved in obtaining consent are provided with training on how to take informed consent in accordance with the requirements of the HT Act 2004 and Code of Practice on Consent.
b) Training records are kept demonstrating attendance at training on consent.

## Governance and Quality

Standard
GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process.
a) There is an organisational chart clearly defining the lines of accountability and reporting relationships.
b) There are procedures for all licensable activities that ensure integrity of tissue and / or cells and minimise the risk of contamination.
c) There are regular governance meetings, for example health and safety, risk management and clinical governance committees, which are recorded by agendas and minutes.
d) There is a document control system to ensure that changes to documents are reviewed, approved, dated and documented by an authorised person and only current documents are in use.
e) There are procedures for tissue and / or cell procurement, which ensure the safety of living donors.
f) There are procedures for tissue and / or cell procurement, which ensure the dignity of deceased donors.
g) There are procedures to ensure that an authorised person verifies that tissues and / or cells received by the establishment meet required specifications.
h) There are procedures for the management and quarantine of non-conforming consignments or those with incomplete test results, to ensure no risk of cross contamination.
i) There are procedures to ensure tissues and / or cells are not released from quarantine until verification has been completed and recorded.
j) There are procedures detailing the critical materials and reagents used and where applicable, materials and reagents meet the standards laid down by the European directives on medical devices and in vitro diagnostic medical devices.
k) There is a procedure for handling returned products.
l) There are procedures to ensure that in the event of termination of activities for whatever reason, stored tissues and / or cells are transferred to another licensed establishment or establishments.
m) The criteria for allocating tissues and / or cells to patients and health care institutions are documented and made available to these parties on request.
n) The establishment ensures imports from non EEA states meet the standards of quality and safety set out in Directions 001/2006 and 002/2007.
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 002/2007.

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 001/2006, is collected and maintained.
g) There is a system to ensure records are secure and that donor confidentiality is maintained in accordance with Directions 001/2006 and 002/2007.
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 002/2007 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 002/2007.
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.
<b>GQ5 There are documented procedures for donor selection and exclusion, including donor criteria.</b>
a) Donors are selected either by the establishment or the third party acting on its behalf in accordance with the criteria required by Directions 001/2006.
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 001/2006.
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.
<b>e) Testing of donor samples is carried out using CE marked diagnostic tests.</b>
f) Samples taken for donor testing are clearly labelled with the time and place the sample was taken and a unique donor identification code.
<b>GQ6 A coding and records system facilitates traceability of tissues and / or cells, ensuring a robust audit trail.</b>
a) There is a donor identification system which assigns a unique code to each donation and to each of the products associated with it.
b) An audit trail is maintained, which includes details of when the tissues and / or cells were acquired and from where, the uses to which the tissues and / or cells were put, when the tissues and / or cells were transferred elsewhere and to whom.
c) The establishment has procedures to ensure that tissues and / or cells imported, procured, processed, stored, distributed and exported are traceable from donor to recipient and vice versa.

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

### Premises, Facilities and Equipment

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

dignity of deceased persons.
e) There are procedures to ensure that the premises are secure and confidentiality is maintained.
f) There is access to a nominated, registered medical practitioner and / or a scientific advisor to provide advice and oversee the establishment's medical and scientific activities.
PFE2 Environmental controls are in place to avoid potential contamination.
a) Tissues and / or cells stored in quarantine are stored separately from tissue and / or cells that have been released from quarantine.
b) Where processing of tissues and / or cells involves exposure to the environment, it occurs in an appropriate, monitored environment as required by Directions 002/2007.
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 001/2006 and 002/2007.
b) There are procedures for the transport of tissues and / or cells which reflect identified risks associated with transport.
c) There is a system to ensure that traceability of tissues and / or cells is maintained during transport.
d) Records are kept of transportation and delivery.
e) Tissues and / or cells are packaged and transported in a manner and under conditions that minimise the risk of contamination and ensure their safety and quality.
f) There are third party agreements with courier or transport companies to ensure that any specific transport conditions required are maintained.
g) Critical transport conditions required to maintain the properties of tissue and / or cells are defined and documented.
h) Packaging and containers used for transportation are validated to ensure they are fit for purpose.
i) Primary packaging containing tissues and / or cells is labelled with the information required by Directions.

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

## Disposal

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

