Virtual Regulatory Assessment (VRA) report on compliance with HTA licensing standards
Assessment date: **14 July 2021**

St George's, University of London

HTA licensing number 12335

Licensed under the Human Tissue Act 2004

Licensed activities

Area	Storage of relevant material which has come from a human body for use for a scheduled purpose	Removal from the body of a deceased person (otherwise than in the course of an anatomical examination or post-mortem examination) of relevant material of which the body consists or which it contains, for use for a scheduled purpose other than transplantation
St George's, University of London	Licensed	Licensed

Summary of assessment findings

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

Although the HTA found that St George's, University of London (the establishment) had met the majority of the HTA's standards, one minor shortfall was found against a standard for Governance and Quality systems.

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 shortfall identified during the assessment.

Compliance with HTA standards

Minor Shortfall

Standard	Assessment findings	Level of shortfall
GQ1 All aspects of the establishments work are governed by documented policies and procedures as part of the overall governance process		
b) There is a document control system	Although there is a detailed quality management system, there are some inconsistencies: • The quality manual is duplicated ('Human Tissue Governance Policy Master File', 'Laboratory Manual and Standard Operating Procedures') • There are three different versions of the procedure for reporting adverse events (SOPR11: 'Procedure for reporting serious adverse events including complaints', SOP14: 'Adverse event reporting', SOP15: 'Cardiovascular sciences incident reporting policy') • The procedure for disposal is duplicated (SOP16: 'Sample disposal', SOPR8: 'Disposal of human tissue and organs by incineration') • Some documents are missing (Appendices 1-6 in the 'Laboratory Manual and Standard Operating Procedures') • The SOP on 'Creating and reviewing a standard operating procedure' (SOPGEN1) indicates that SOPs will be approved for a maximum period of two years. However, there were some examples where the review period was longer than this.	**Minor**

The HTA requires the DI to submit a completed corrective and preventative action (CAPA) plan setting out how the shortfalls will be addressed, 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.

Advice

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

Number	Standard	Advice
1.	N/A	The DI is advised to consider revoking the removal licence as this licence is no longer being used.
2.	GQ1(a)	Before setting up a Material Transfer Agreement (MTA) with an organisation supplying relevant material, a number of organisations complete a 'due diligence form' for that supplier. This includes details of the supplier's governance structure, regulatory compliance (where appropriate), consent warranties and procedures, and ethical warranties. As the establishment receives relevant material from several different sources, including collaborators, private companies, NHS organisations and NHS Trusts, the DI is advised to consider this.
3.	GQ1(d)	Joint governance meetings, involving DIs across the different sectors, are a feature in several other organisations that hold multiple HTA licences. St George's, University of London is Corporate Licence Holder (CLH) on two HTA licences and the CLH contact (CLHc) is the representative on both licences. There are quarterly meetings between DIs and individuals named on these licences. The adjacent St George's University Hospitals NHS Foundation Trust is CLH on two further licences. The CLHcs and DIs on the Trust and University licences are advised to consider setting up joint governance meetings involving staff on all of these licences, to ensure consistency of good practice.
4.	GQ2(a)	Regular audits are carried out by both establishment governance staff and external auditors. The DI is advised to consider recording all these audits in an audit schedule to indicate the full scope of audits undertaken and those

		planned.
5.	GQ2(b)	Recording and management of audits is generally on an *ad hoc* basis. The DI is advised to consider formalising the process of recording: audit findings, discussions about the audit, who is responsible for follow-up actions and the timeframes for completing these. This will ensure that all audits are captured consistently.
6.	GQ5(b)	Recording and management of adverse events is generally on an *ad hoc* basis. The DI is advised to consider formalising the process of recording: adverse event findings, discussions about the adverse event, root cause analysis and corrective and preventative actions. This will ensure that all adverse events are captured consistently.
7.	GQ6(c)	To ensure that all staff can access risk assessments, the DI is advised to consider introducing a system whereby staff 'sign-off' that they have read and are familiar with risk assessments, similar to the process used by the establishment for standard operating procedures.
8.	T2(b)	The establishment occasionally disposes of relevant material via the Institute of Medical and Biomedical Education (HTA Anatomy licence 12330) on campus or via the adjacent Trust mortuary (HTA PM licence 12387). Only one of these routes is described in SOPR8: 'Disposal of human tissue and organs by incineration'. The DI is advised to consider including all disposal routes in the Disposal SOP so that current practice is reflected.
9.	PFE2(c)	The DI is advised to consider regularly challenging the temperature alarm callout system for each storage unit to ensure that it functions as expected.
10.	PFE2(c)	The DI is advised to consider initiating a programme by which, at suitable intervals, the temperature plots from the mechanical storage units are reviewed. This may help to identify a potential failure of the equipment before it occurs.
11.	PFE2(c)	The DI is advised to consider regularly monitoring the temperature of the storage cabinets, which contain formalin-fixed tissue and formalin-fixed paraffin wax-embedded blocks and sections at ambient temperature.

		Excessive or prolonged raised temperatures in these rooms may lead to biomarker degradation.

Background

St Georges, University of London (the establishment) stores relevant material from approximately 35 research groups on campus, from living and deceased donors. At the time of the VRA, relevant material from 100 collections was being stored. The vast majority of these have current UK Ethics Committee Authority (UKECA) approval or NHS Research Ethics Committee (REC) project-specific approval and the storage of these samples is exempted from HTA licensing. The remaining studies (n=25) fall under the licence. The establishment also contains an NHS REC-approved Research Tissue Bank (RTB).

Previously, a REC-approved study involving the removal of relevant material from deceased donors was carried out; this study is now complete.

The establishment has been licensed by the HTA since July 2007. This was the first VRA of the establishment; the most recent previous site visit took place in November 2012.

Since the previous inspection, the following changes have been made to the licensing arrangements: the current DI was approved in October 2016, the current CLHc was registered with the HTA in January 2017 and the establishment added the activity of 'removal of relevant material from the deceased' to its licence in August 2017.

Description of assessment activities undertaken

The HTA's regulatory requirements are set out in Appendix 1. The Regulation Manager covered the following areas during the assessment:

Standards assessed against during the VRA

All 47 HTA licensing standards were covered during the assessment (standards published 3 April 2017).

Review of governance documentation

The following documents were reviewed: policies and procedural documents relating to licensed activities, contracts for servicing of equipment and records of servicing, temperature monitoring records, contingency arrangements, and MTAs.

The review of information relating to the quality management system included: document control, meeting minutes, the management of audits, staff training records, reported adverse events and risk assessments.

Six of the establishment's internal audits were reviewed. There were *ad hoc* records of summary of findings and actions implemented.

Three reported incidents were reviewed. There were *ad hoc* records that the root cause of each incident had been identified and preventative actions had been implemented.

Visual inspection

There was no site visit inspection associated with the assessment.

Meetings with establishment staff

The VRA included meetings with the following staff: DI, CLHc, Person Designated, RTB manager, three Principal Investigators (PIs) and four researchers representing other PIs. The meetings covered: consent, distribution and disposal procedures; quality management, document control, governance meetings, staff training; audits/traceability, incidents/complaints, risk assessments; premises security, facilities and equipment maintenance, temperature monitoring and contingency arrangements.

Report sent to DI for factual accuracy: 5 August 2021

Report returned from DI: 18 August 2021

Final report issued: 3 September 2021

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 Virtual Regulatory Assessment Report.

Date: 17 December 2021

Appendix 1: The HTA's regulatory requirements

Prior to the grant of a licence, the HTA must assure itself that the DI is a suitable person to supervise the activity authorised by the licence and that the premises are suitable for the activity.

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.

Its programme of site visit inspections to assess compliance with HTA licensing standards is one of the assurance mechanisms used by the HTA.

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. They are grouped under four headings:

- consent
- governance and quality systems
- traceability
- premises, facilities and equipment.

This is an exception-based report: only those standards that have been assessed as not met are included. Where the HTA determines that there has been a shortfall against a standard, 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 provided.

HTA inspection reports are published on the HTA's website.

Appendix 2: Classification of the level of shortfall

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

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

1. **Critical shortfall:**

   A shortfall which poses a significant risk to human safety and/or dignity or is a breach of the HT Act or associated Directions

   or

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

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

   - A notice of proposal being issued to revoke the licence
   - 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
   - A notice of suspension of licensable activities
   - Additional conditions being proposed
   - Directions being issued requiring specific action to be taken straightaway.

2. **Major shortfall:**

   A non-critical shortfall that:

   - poses a risk to human safety and/or dignity; or

- indicates a failure to carry out satisfactory procedures; or
- indicates a breach of the relevant Codes of Practice, the HT Act and other relevant professional and statutory guidelines; or
- has the potential to become a critical shortfall unless addressed

or

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

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

3. **Minor shortfall:**

   A shortfall which cannot be classified as either critical or major, but which indicates a departure from expected standards.

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

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

Follow up actions

A template corrective and preventative action plan will be sent as a separate Word document with the final inspection report. Establishments 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 routine site visit inspection.

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