Site visit inspection report on compliance with HTA minimum standards

Royal Devon and Exeter NHS Foundation Trust

HTA licensing number 11012

Licensed for the

- **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**

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

16 July 2014

Summary of inspection findings

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

Although the HTA found that the Royal Devon and Exeter NHS Foundation Trust (the establishment) had met the majority of the HTA standards, seven minor shortfalls were found in relation to governance and quality systems, and premises, facilities and equipment. The shortfalls relate to the establishment's Serious Adverse Event and Reaction (SAEARs) reporting procedures and documentation, its tissue distribution procedures, the scope of audits and risk assessments, and aspects of its donor serology testing regime. The majority of the shortfalls relate to the establishment's Autologous Chondrocyte Implantation (ACI) programme which was found to lack several of the governance and quality systems that should be in place to support and safeguard such work.

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

The HTA's regulatory requirements

The HTA must assure itself that the Designated Individual, Licence Holder, premises and practices are suitable.

The statutory duties of the Designated Individual are set down in Section 18 of the Human Tissue Act 2004. They are to secure that:

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

The HTA developed its licensing standards with input from its stakeholders. They are designed to ensure the safe and ethical use of human tissue and the dignified and respectful treatment of the deceased. The HTA inspects the establishments it licences against four groups of standards:

- consent
- governance and quality systems
- premises facilities and equipment
- disposal.

This is an exception-based report: only those standards that have been assessed as not met are included. Where the HTA determines that a standard is not met, the level of the shortfall is classified as 'Critical', 'Major' or 'Minor' (see Appendix 2: Classification of the level of shortfall). Where HTA standards are fully met, but the HTA has identified an area of practice that could be further improved, advice is given to the DI.

Reports of HTA inspections carried out from 1 November 2010 are published on the HTA's website.

Licensable activities carried out by the establishment

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

'TPA' = Third party agreement; the establishment is licensed for this activity but another establishment (unlicensed) carries out the activity on their behalf.

Tissue type	Procurement	Processing	Testing	Storage	Distribution	Import	Export
Bone	**E**		**E**	**E**	**E**		
Tendons				**E**	**E**		
Cartilage / Chondral tissue	**E**		**E**				

Background to the establishment and description of inspection activities undertaken

This report refers to the activities carried out by staff at the Princess Elizabeth Orthopaedic Centre, Exeter. The establishment, which is part of the Royal Devon and Exeter (RD&E) NHS Foundation Trust, is licensed for the procurement, testing, processing, storage, distribution and import/export of human tissues and cells under the Human Tissue (Quality and Safety for Human Application) Regulations 2007. It is also licensed for the storage of relevant material which has come from a human body for use for a scheduled purpose under the Human

Tissue Act 2004. The establishment has been licensed by the HTA since August 2006 and has been inspected on three previous occasions.

The Exeter Bone Bank has been in operation since the late 1980s and currently procures, tests and stores approximately 300 femoral heads each year from patients undergoing hip replacement surgery. The majority of procured femoral heads are stored in two -80^{o}C freezers located in close proximity to the operating theatres. One of the freezers serves as a quarantine freezer for samples awaiting 180-day donor serology test results; the other is used to store femoral heads that have been cleared for issue. A third freezer is used specifically for autologous donations by patients where there is potential for a second hip replacement operation. The temperature of each freezer is monitored and alarm systems are in place to alert staff both locally and remotely in the event of an unplanned excursion from prescribed limits. Although the majority of femoral heads are used within the Trust, a small number (approximately five each year) are distributed to hospitals in the local area and in the South-West of England.

Bone chips and swabs taken for microbiological testing at the time of femoral head procurement are sent to the microbiology laboratory within the RD&E hospital for analysis and only uncontaminated femoral heads are held for long term storage. Donor testing is also carried out by the hospital's laboratories. In all cases, donors are tested at the time of donation for HIV1 and 2, Hepatitis B, Hepatitis C and *T. pallidum*, Donors are tested again after 180 days for the above serological markers, and additionally for HTVL-1 and 2.

In addition to the procurement and storage of femoral heads, orthopaedic surgeons at the RD&E hospital also perform matrix-joined Autologous Chondrocyte Implantation (ACI) for the repair of damaged knee cartilage. During this procedure, chondral tissue is procured from patients along with blood samples for serological testing. Tissue and blood samples are distributed to a company within the European Union who is responsible for processing the tissue samples into an Advanced Therapy Medicinal Product (ATMP). The manufacture and distribution for end use of the ATMP falls outside the remit of the HTA other than with regard to continued traceability and serious adverse event or reaction (SAEAR) reporting. The licensable activities carried out by organisations involved in such work are therefore restricted to procurement and testing. In this case, donor serology testing is performed by the ATMP manufacturer.

The establishment also stores tendons and demineralised bone products purchased from another HTA-licensed establishment. The former are stored in the establishment's issue freezer, and appropriate systems are in place for managing their receipt, storage and end use. As storage of acellular products for end use is not currently regulated, the systems used for the storage of the demineralised bone products were not assessed as part of this inspection.

This report describes the establishment's fourth routine site visit inspection which took place on 16 July 2014. The inspection included interviews with key members of staff working under the licence, including a Consultant Orthopaedic Surgeon, who is also the Designated Individual (DI), the Acting Bone Bank Co-ordinator and the Deputy Bone Bank Co-ordinator. A review of documentation relevant to the establishment's activities and a visual inspection of

the areas of the establishment where sample storage and testing take place were also conducted as part of the inspection.

An audit of three femoral heads held in storage was performed. Storage locations were cross-checked with appropriate records, including the whiteboard used to track samples in storage and the establishment's database and bone register. A further six donor files were reviewed to ensure that they contained all relevant documentation, including consent forms, serology and microbiology test results. Although some minor inconsistencies were noted in the completion of consent forms (see Advice below), no further discrepancies were found.

At the time of the inspection, relevant material was not being stored under this licence for use in a scheduled purpose as defined by the Human Tissue Act 2004. Consequently, the establishment's systems relating to the storage and use of such material were not assessed during this inspection.

Inspection findings

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

Compliance with HTA standards

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

Governance and Quality

Standard	Inspection findings	Level of shortfall
GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process.		
p) There are written agreements with third parties whenever an activity takes place that has the potential to influence the quality and safety of human tissues and / or cells.	At the time of the inspection, the establishment were unable to provide evidence of a written agreement between the Trust and the manufacturer of the chondrocyte-derived ATMP that sets out the roles and responsibilities of each party.	**Minor**
GQ2 There is a documented system of quality management and audit.		
b) There is an internal audit system for all licensable activities.	Although the establishment has a schedule of audits, both internal and independent, that aims to assess compliance with protocols and HTA standards, at the time of the inspection this did not extend to the work carried out in relation to the ACI programme.	**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.		
GQ5 There are documented procedures for donor selection and exclusion, including donor criteria.		
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 003/2010.	Under Annex II of Directive 2006/17/EC, HTLV-1 antibody testing must be performed for donors living in, or originating from, high incidence areas, or with sexual partners originating from those areas or where the donor's parents originate from those areas. The establishment's current donor selection procedures for the ACI programme do not ascertain whether such additional testing is needed. Furthermore, although the establishment carries out HTLV-1 testing for all donors of femoral heads, these tests are only conducted after an interval of 180 days and not, additionally, at the time of donation.	**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.	Although the bone bank has a number of documents that make reference to the reporting requirements associated with Serious Adverse Events and Reactions (SAEARs), they do not include the requirement to report SAEARs to the HTA within 24 hours as set out in the "Guide to Quality and Safety Assurance for Human Tissues and Cells for Patient Treatment" which forms the Annex to Directions 003/2010. Furthermore, the ACI programme's documentation does not reference the need to report SAEARs relating to the procurement process to the HTA. Procedures for the reporting of such incidents are also lacking.	**Minor**
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.	Although the establishment has a range of risk assessments in place relating to the work carried out by the bone bank, comparable documents are not in place for the ACI programme.	**Minor**

Premises, Facilities and Equipment

Standard	Inspection findings	Level of shortfall
PFE3 There are appropriate facilities for the storage of bodies, body parts, tissues, cells, consumables and records.		
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.	Each year, the establishment distribute a small number of femoral heads to hospitals in the area and in the South-West of England. Although staff involved in this activity were able to describe the process that is followed on such occasions, the procedure had not been formally documented nor validated. As a result, there is a risk, albeit slight, that the tissues may not be packaged and transported in a manner that ensures their safety and quality.	**Minor**
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.		
PFE5 Equipment is appropriate for use, maintained, quality assured, validated and where appropriate monitored.		
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.	The SOP and checklist provided by the manufacturer in conjunction with the ACI programme sets out a number of storage parameters for the media and cooling box used during the procurement and transportation of chondrocytes. However, the establishment does not have procedures in place that ensure that these requirements are being met or that any excursions are appropriately reviewed and acted upon.	**Minor**

Advice

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

No.	Standard	Advice
1.	C1a	Although the Trust's consent policy includes reference to the consent requirements of the Human Tissue Act 2004, the relevant paragraphs of this document focus on the consent needed for the storage of relevant material for use in a scheduled purpose (e.g. research, clinical audit, etc). The DI is advised to update this document at an appropriate juncture to ensure that it also clearly sets out the consent requirements for tissues and cells that are to be used for human application.

2.	C1d	The DI is advised to review the way in which consent forms are structured and/or completed to ensure that working practices are aligned with the establishment's documentation. For example, the current consent form stipulates that where consent was taken in advance of a procedure, a health professional should check and document that the potential donor hasn't changed their mind on the day of the surgery. The form also states that the version number of the patient information booklet that was offered to the donor should be recorded. In practice, neither of these fields was being completed consistently which could raise doubts over the rigor of the consent process.
3.	C1e	Although the establishment keep completed Trust consent forms in the records of patients undergoing ACI, the DI is advised to retain copies of the third party consent forms that are also used as part of this procedure.
4.	C2a	The DI is advised to update the work instruction relating to the consent process (WI3) to include reference to the latest version of the establishment's patient information booklet.
5.	C3a	The DI is advised to formalise the consent training process to ensure that all new members of staff involved in the taking of consent continue to do so in accordance with the requirements of the HT Act and Code of Practice on Consent. This could include setting out which documents must be read and understood by prospective consent takers, any e-learning modules that must be completed and the procedure for competency sign off.
6.	GQ1c	The DI is advised to ensure that there is a representative from the establishment's ACI programme at governance meetings discussing HTA-related matters. This will help raise awareness amongst staff involved in this work of the associated regulatory requirements, and facilitate the integration of this activity into the governance and quality management system used by the bone bank. The DI is also advised to consider nominating a Person Designated for the ACI programme.
7.	GQ1d	Although an effective document control system was in place for the work undertaken by the bone bank, inconsistencies were noted in some of documents produced in relation to the ACI programme. For example, the reagent and kit storage conditions described in the tissue biopsy checklist and the SOP differ, and two versions of the third party consent forms were in circulation. The DI is therefore advised to review the ACI programme's documentation and procedures to ensure that they are all up-to-date.
8.	GQ2a	Since the last inspection, the establishment has purchased and implemented the use of two new -80^{o}C freezers. Although this process was managed effectively by the members of staff involved, the DI is advised to consider implementing a more formal change control process to underpin any future changes to the way in which licensable activities are conducted. This will help ensure that the consequences of any significant changes to working practices are robustly identified and, if necessary, addressed. For example, this could include the need for revised documentation, additional training, or for new agreements to be drafted.
9.	GQ2b and c	The DI is advised to review the way in which audit findings are documented and reported to ensure that there is a robust system in place for ensuring that any actions arising from audits are completed in an appropriate timeframe. The inclusion of audit findings as a standing agenda item at the EBB Management Review Group meetings may help in this regard, as might a change to the establishment's internal audit template to include dedicated sections for

		summarising audit findings and any actions arising.
10.	GQ5b	The DI is advised to update the work instruction concerning the 180-day retesting of donors (WI13) to ensure that it captures the requirement for Hepatitis C tests to be performed at this time point. This will bring the establishment's documentation in line with current working practices.
11.	GQ5d	In keeping with past practice, the DI is advised to request a copy of the donor serology test results from the third party responsible for carrying out the tests for the ACI programme.
12.	GQ7b	The DI is advised to ensure that there is another member of staff at the establishment who is able to access the HTA's Portal for the purposes of reporting SAEARs in his absence.
13.	GQ8a	The establishment has a range of risk assessments covering activities such as the procurement, storage and distribution of human tissue. However, the DI is advised to expand the scope of these documents to include the taking of consent to ensure that all licensable activities have been appropriately risk assessed.
14.	PFE4d	The DI is advised to review the establishment's procedures for distributing femoral heads to ensure that appropriate records are kept of sample collection by couriers. This will help ensure that records demonstrating the chain of custody for any particular sample are complete from procurement through to end use.
15.	Licence	The DI is advised to review the range of activities that the establishment is licensed to carry out with a view to removing any that are surplus to requirements. At the time of the inspection, this would include the activities of processing, import and export. This will help ensure that the establishment's annual licence fee reflects the work that is actually being performed under the authority of their HTA licence, and that staff are clear which of the HTA's standards are applicable to their work.

Concluding comments

The HTA saw several examples of good practice throughout the course of the inspection.

As has been noted on previous occasions, the establishment has a range of comprehensive and well-thought out procedures to support the consent process for femoral head donation. Despite this, bone bank staff continue to look for further opportunities to develop and improve existing working practices and have recently introduced a system for receiving feedback from bone donors with this in mind. This level of care for the donor experience continues throughout the donation process and extends to the sending of a 'thank you' letter once the femoral head has been used.

Seven areas of practice were identified during the inspection that require improvement, each resulting in minor shortfalls. The majority of these, including those pertaining to audit, risk assessment and reagent/kit storage, relate to the establishment's ACI programme which was not supported by the same well-developed governance and quality systems as were evident elsewhere. The HTA has also given advice to the Designated Individual with respect to a number of the establishment's procedures and documents with a view to helping the organisation further develop its working practices.

The HTA requires that the Designated Individual addresses the shortfalls by submitting a completed corrective and preventative action (CAPA) plan within 14 days of receipt of the final report (refer to Appendix 2 for recommended timeframes within which to complete actions). The HTA will then inform the establishment of the evidence required to demonstrate that the actions agreed in the plan have been completed.

The HTA has assessed the establishment as suitable to be licensed for the activities specified subject to corrective and preventative actions being implemented to meet the shortfalls identified during the inspection.

Report sent to DI for factual accuracy: 13 August 2014

Report returned from DI: 4 September 2014

Final report issued: 9 September 2014

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: 6 August 2015

Appendix 1: HTA standards

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

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

Consent

Standard
C1 Consent is obtained in accordance with the requirements of the HT Act 2004, the Human Tissue (Quality and Safety for Human Application) Regulations 2007 and as set out in the HTA's Codes of Practice.
a) If the establishment acts as a procurer of tissues and / or cells, there is an established process for acquiring donor consent which meets the requirements of the HT Act 2004 the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (Q&S Regulations) and the HTA's Codes of Practice
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 003/2010 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 003/2010 is included.
c) Information is available in suitable formats and there is access to independent interpreters when required.
d) There are procedures to ensure that information is provided to the donor or donor's family by trained personnel.
C3 Staff involved in seeking consent receive training and support in the implications and essential requirements of taking consent.
a) Staff involved in obtaining consent are provided with training on how to take informed consent in accordance with the requirements of the HT Act 2004 and Code of Practice on Consent.
b) Training records are kept demonstrating attendance at training on consent.

Governance and Quality

Standard
GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process.
a) There is an organisational chart clearly defining the lines of accountability and reporting relationships.
b) There are procedures for all licensable activities that ensure integrity of tissue and / or cells and minimise the risk of contamination.
c) There are regular governance meetings, for example health and safety, risk management and clinical governance committees, which are recorded by agendas and minutes.
d) There is a document control system to ensure that changes to documents are reviewed, approved, dated and documented by an authorised person and only current documents are in use.
e) There are procedures for tissue and / or cell procurement, which ensure the safety of living donors.
g) There are procedures to ensure that an authorised person verifies that tissues and / or cells received by the establishment meet required specifications.
h) There are procedures for the management and quarantine of non-conforming consignments or those with incomplete test results, to ensure no risk of cross contamination.
i) There are procedures to ensure tissues and / or cells are not released from quarantine until verification has been completed and recorded.
j) There are procedures detailing the critical materials and reagents used and where applicable, materials and reagents meet the standards laid down by the European directives on medical devices and in vitro diagnostic medical devices.
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.
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 003/2010.
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 003/2010, is collected and maintained.
g) There is a system to ensure records are secure and that donor confidentiality is maintained in accordance with Directions 003/2010.
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 003/2010 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 003/2010.
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 003/2010.
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 003/2010.
c) In cases other than autologous donors, donor selection is carried out by authorised personnel and signed and reviewed by a qualified health professional.
d) There is a system in place either at the establishment or at a third party acting on its behalf to record results of donor selection and associated tests.
e) Testing of donor samples is carried out using CE marked diagnostic tests.
f) Samples taken for donor testing are clearly labelled with the time and place the sample was taken and a unique donor identification code.
GQ6 A coding and records system facilitates traceability of tissues and / or cells, ensuring a robust audit trail.
a) There is a donor identification system which assigns a unique code to each donation and to each of the products associated with it.
b) An audit trail is maintained, which includes details of when the tissues and / or cells were acquired and from where, the uses to which the tissues and / or cells were put, when the tissues and / or cells were transferred elsewhere and to whom.
c) The establishment has procedures to ensure that tissues and / or cells imported, procured, processed, stored, distributed and exported are traceable from donor to recipient and vice versa.

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

Premises, Facilities and Equipment

Standard
PFE1 The premises are fit for purpose.
a) A risk assessment has been carried out of the premises to ensure that they are fit for purpose.
b) There are procedures to review and maintain the safety of staff, visitors and patients.
c) The premises have sufficient space for procedures to be carried out safely and efficiently.
e) There are procedures to ensure that the premises are secure and confidentiality is maintained.

f) There is access to a nominated, registered medical practitioner and / or a scientific advisor to provide advice and oversee the establishment's medical and scientific activities.
PFE2 Environmental controls are in place to avoid potential contamination.
a) Tissues and / or cells stored in quarantine are stored separately from tissue and / or cells that have been released from quarantine.
c) There are procedures for cleaning and decontamination.
d) Staff are provided with appropriate protective clothing and equipment that minimise the risk of contamination of tissue and / or cells and the risk of infection to themselves.
PFE3 There are appropriate facilities for the storage of tissues and / or cells, consumables and records.
a) Tissues, cells, consumables and records are stored in secure environments and precautions are taken to minimise risk of damage, theft or contamination.
b) There are systems to deal with emergencies on a 24 hour basis.
c) Tissues and / or cells are stored in controlled, monitored and recorded conditions that maintain tissue and / or cell integrity.
d) There is a documented, specified maximum storage period for tissues and / or cells.
PFE4 Systems are in place to protect the quality and integrity of tissues and / or cells during transport and delivery to its destination.
a) There is a system to ensure tissue and / or cells are not distributed until they meet the standards laid down by Directions 003/2010.
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 2: Classification of the level of shortfall (HA)

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

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

1. Critical shortfall:

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

Or

A shortfall which poses a significant risk to human safety and/or dignity or is a breach of the Human Tissue Act 2004 (HT Act) or associated Directions,

Or

A number of 'major' shortfalls, none of which is critical on its own, but viewed cumulatively represent a systemic failure and therefore are considered 'critical'.

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

(1) A notice of proposal being issued to revoke the licence

(2) Some or all of the licensable activity at the establishment ceasing with immediate effect until a corrective action plan is developed, agreed by the HTA and implemented.

(3) A notice of suspension of licensable activities

(4) Additional conditions being proposed

(5) Directions being issued requiring specific action to be taken straightaway

2. Major shortfall:

A non-critical shortfall.

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

or

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

or

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

or

A shortfall which indicates a breach in the relevant Codes of Practices, the HT Act and other relevant professional and statutory guidelines;

or

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

or

A combination of several 'minor' shortfalls, none of which is major on its own, but which, viewed cumulatively, could constitute a major shortfall.

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

3. **Minor shortfall:**

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

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

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

Follow up actions

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

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

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

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