Site visit inspection report on compliance with HTA minimum standards

SCI Oxford

HTA licensing number 11042

Licensed for the

- **procurement, processing, storage and distribution 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**

11 – 12 April 2017

Summary of inspection findings

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.

Although the HTA found that SCI Oxford (the establishment) had met the majority of the HTA standards, a minor shortfall has been identified in relation to procedural documentation. The HTA has also given advice regarding independent audits.

Particular examples of 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
PBSC	**E**	**E**		**E**	**E & TPA**		
DLI	**E**	**E**		**E**	**E & TPA**		
UCB	**TPA**	**E**		**E**	**E & TPA**		

Background to the establishment and description of inspection activities undertaken

The establishment is licensed for the procurement, processing, storage and distribution of human tissues and cells for human application under the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (the Regulations). Additionally, the establishment is licensed for the storage of relevant material for use in a scheduled purpose under the Human Tissue Act 2004.

The establishment has been licensed by the HTA since August 2006 and this was the fifth routine site visit inspection to assess whether or not the establishment continues to meet the HTA standards. The timetable was developed in consideration of the establishment's annual activity data, previous inspection reports and pre-inspection discussions with the DI and other key establishment staff. During the inspection, the laboratory, clean room and cryogenic store where procured cells are received, processed, cryopreserved and stored were visited. In addition, the Therapeutic Apheresis Service (TAS) centre where the establishment procures peripheral blood stem cells (PBSC) was visited. The establishment does not undertake donor testing which is carried out by another HTA-licensed SCI establishment. Reviews of some key procedural documents were undertaken and round table discussions were held with key members of staff.

Donors are selected and consent is taken for testing, procurement, storage and discard of cells by clinicians working in hospitals within one of four regions. This consent is recorded using the establishment's documentation, a copy of which is forwarded to the establishment for filing with other donor information. Referring clinicians take a blood sample for mandatory donor serological testing which is sent to the establishment and then onto another HTA-licensed establishment for analysis.

Donors attend the TAS which procures autologous PBSC, allogeneic sibling PBSC and sibling Donor Lymphocyte Infusions (DLI). On the day of procurement, cell counts are undertaken prior to the procedure commencing to ensure that the required cell count can be collected. If insufficient cells have been mobilised into the donor's peripheral blood, a further course of mobilisation agent is given and the donor returns to the TAS on the following day for re-assessment. Prior to procurement, consent for the apheresis procedure is sought by establishment staff and a second donor blood sample is taken and sent for mandatory donor serological testing. As collection of cells commences, bags used to collect donor cells and plasma are labelled by the apheresis staff using pre-printed, donor-specific labels. Upon completion of the cell collection, apheresis staff transfer the procured cells and donor plasma to the nearby laboratory facility for processing.

The laboratory receives PBSC collections from the TAS, PBSC and DLI collections from another HTA-licensed procurement establishment and directed umbilical cord blood (UCB) collections which have been procured under a Third Party Agreement (TPA). The laboratory no longer receives bone marrow harvests. These are now sent to other HTA-licensed SCI sites if any processing is required. The establishment also received cells which have been procured outside of the UK. These cells are imported under the authority of an HTA-licensed donor registry's licence and are delivered directly to the establishment's laboratory. Processing of PBSC and DLI is undertaken using a closed process using a 'sterile docking' system. UCB collections, however, are always processed in the establishment's clean room in an 'open' processing environment. Processing within the clean room takes place in a Grade A environment with a Grade B background which satisfies the requirements of the Regulations. Post-processing samples are taken for microbiological sterility testing. The required in-processing environmental monitoring takes place to assure the DI that the environmental monitoring data supports the classification of the grade A and B areas.

Engraftment data is regularly reviewed in addition to cell viability analysis being performed on post-processing samples. If engraftment takes longer than expected or cells are requested that are over five years old, colony forming unit (CFU) assays are performed on cells from a pilot tube stored with the cells to assess functionality.

Processed cells are cryopreserved using controlled-rate freezers (CRFs) prior to being transferred into vapour phase liquid nitrogen storage. The establishment's liquid nitrogen storage tanks are monitored using a remote monitoring system which alerts establishment staff if the storage temperature deviates from the expected range. The establishment also has a back-up tank in case of a failure of one of the other storage tanks in addition to two quarantine tanks. The first quarantine tank is used for cells from donors with who are known to be positive for an infectious agent, and the second for cells from a donor for whom test results have not yet been received.

When cells are requested by clinicians for end use, the establishment packages the cells ready for transport which is undertaken by the establishment's own transport or on occasion, by a courier acting under a third part agreement. The agreement was not reviewed as part of this inspection.

During the inspection, audits of donor records were undertaken as detailed below:

Two sets of donor records relating to procurement of cells were reviewed with establishment staff. In each case the following documentation was present and reviewed:

- Donor referral form
- Consent for collection, storage and discard of cells
- Mandatory serological test results
- Donor clearance form – includes behavioural and lifestyle donor selection questions
- Apheresis collection worksheet which details items and reagents used during procurement
- Pre-apheresis blood counts and
- Consent for the apheresis procedure.

In one donor's case, recent travel history meant that an additional pre-collection malarial test was carried out and in the other donor's case, a CD34 count was undertaken as the initial HPC channel analysis was below the set threshold to start collection of cells. Both of these additional procedures supported the descriptions of donor selection and testing given by establishment staff during the round table discussions.

For one of the above donors, the associated laboratory records were also reviewed. Documents reviewed included:

- Handover sheet for cells from apheresis to laboratory
- Final cell count from the collection
- Cryopreservation worksheet which details items and reagents used during processing
- Controlled-rate freezer graph
- Records of where cells had been stored – which were also cross-checked against the cell tracking database and tank map spreadsheets
- Request for cells to be issued
- Microbiological sterility test results and
- A transfusion record sheet which would be used to capture any serious adverse events or reactions during infusion of cells and which was blank.

In summary, no anomalies were found in any of the audits undertaken.

In addition to the review above, laboratory records for a UCB collection that was processed at the establishment was also reviewed. Items reviewed included:

- Consent for collection, and consent for testing and storage
- Checklist for arranging a UCB collection covering the sending of items to the donor's hospital
- Risk assessment of the procurement premises undertaken by the third party procurer

- Cryopreservation worksheet which details items and reagents used during processing
- Applicable environmental monitoring data of the Grade A and Grade B areas
- Clean room cleaning records around the time of processing
- Weekly and monthly monitoring data of the clean room facility
- Records of where cells had been stored – which were also cross-checked against the cell tracking database and tank map spread sheets

During the inspection, some documentation and records associated with tissue being held for use in a scheduled purpose as defined by the Human Tissue Act 2004 (HT Act) were reviewed. A liquid nitrogen storage facility used for the storage of relevant material for use in research was also visited. The storage tanks are appropriately alarmed and automatically fill with liquid nitrogen from the establishment's main supply.

An audit of tissue being stored for use in research was not undertaken. Discussions regarding ethical approval of studies and consent procedures were held with one of the researchers at the establishment who was storing tissue for use in research. The establishment stores relevant material for use in a scheduled purpose under a mixture of recognised research ethical approval and the HTA licence. When the ethical approval for studies expires and if there is consent in place for the continued retention of relevant material, the samples are stored under the governance of the HT Act licence associated with the establishment's Human Application licence.

An example of a participant information leaflet was reviewed in addition to examples of completed consent forms. Both information leaflets and forms met the requirements of the HTA's codes of practice.

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.		
GQ1 b) There are procedures for all licensable activities that ensure integrity of tissue and / or cells and minimise the risk of contamination.	During the inspection, it was found that some of the establishment's procedural documents did not fully reflect practices taking place at the establishment or did not contain sufficient detail to ensure that the quality and safety of the tissues and cells are maintained. Details of the standard operating procedures (SOPs) where discrepancies were found are listed below: **Controlled-rate freezing SOP –** Although the SOP captures that laboratory staff must return to the CRF to verify that it is operating as expected, it does not include the detail whereby a second laboratory timer is set to prompt establishment staff to return and undertake this verification. In addition, the CRF SOP states that the number of bags of cells being frozen should be recorded on the associated CRF freezing record from (FRM3871/2). However, the form in use has no field to capture this information which therefore was not being recorded as described by the SOP. **Receipt of donations SOP –** The procedure described in the SOP is not explicit about what the temperature of the cells should be upon receipt or what actions to take if they are not within the expected range. In addition, the SOP does not reference an associated data sheet which sets out the expected temperature ranges within which cells should be received and the actions to take if the temperature is outside of these ranges.	**Minor**

	Collection of PBSC / Lymphocytes / Mononuclear cells SOP- The SOP for cell collection does not refer to the HPC channel cell analysis as part of the primary pre-apheresis check. In addition, the SOP does not include the step where, if the HPC channel result is less than 0.045, a flow cytometric test will be done to determine the CD34 level. **Instructions for directed cord blood collection SOP -** There is a potential risk that the maternity unit staff do not see the instructions regarding the cool packs on the second page of the information document that accompanies UCB collection kits sent to hospitals since the document could be interpreted as being intended for use by the phlebotomist. An information document relating to the UCB collection kits (INF 428/4) refers to a kit identification number which is now incorrect following the update of the kits. The information document does not specify a minimum time that the cool packs should be in the fridge prior to their use in the transport container with the collected cells. Without specifying a minimum time that packs should be cooled for, the DI cannot assure himself that the cool packs will have reached +4^{o}C and therefore, the cool packs may not maintain an appropriate temperature for the cells during transit to the processing laboratory. In summary, the above four findings relating to the establishment's procedural documents means that this Standard is not met and a minor shortfall has been identified.	

Advice

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

No.	Standard	Advice
1.	GQ2(c)	The establishment is currently updating the way in which it audits activity independently. As part of this, the establishment is undertaking an exercise to map the areas which will be included in the independent audits to the relevant HTA compliance standards. The DI is advised to continue with this mapping exercise to help assure himself that during the envisaged two-year independent audit cycle, all relevant HTA standards will be audited independently.

Concluding comments

In addition to the above findings, areas of good practice were observed during the inspection and examples of these are given below:

As required by the Regulations, the establishment has put in place a recall procedure for cells which it distributes for end use. The distributed cells, however, are not stored by the end user and are normally thawed upon receipt and infused immediately. The establishment has therefore considered under what circumstances a recall may be required and has included these considerations within the procedural document. Consideration of the factors that may result in the need for a recall of distributed cells demonstrates that the establishment has considered some of the risks around release and distribution of cells and these have helped to inform the production of the procedural document.

The establishment undertakes internal audits whereby three donor files selected at random representing one allogeneic donor, one autologous donor and one UCB donor are reviewed. These internal audits take place monthly with results, findings and corrective/preventative actions being recorded in the establishment's quality management system. The establishment has developed a standardised audit form to define what is audited and the results of the audit. The standardised audit form helps to assure the DI that during the internal audits, the areas which he wishes to be reviewed are being audited as expected.

There are a number of areas of practice that require improvement resulting in one minor shortfall. The HTA has given advice to the Designated Individual with respect to independent audits.

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: 15 May 2017

Report returned from DI: 26 May 2017

Final report issued: 10 June 2017

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: 5 September 2017

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.
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 003/2010.
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.
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 003/2010.
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.

Human Tissue Act 2004 Standards

Consent standards
C1 Consent is obtained in accordance with the requirements of the Human Tissue Act 2004 (HT Act) and as set out in the code of practice
• Consent forms comply with the HTA's Code of Practice • Consent forms are in records and are made accessible to those using or releasing relevant material for a scheduled purpose • If the establishment obtains consent, a process is in place for acquiring consent in accordance with the requirements of the HT Act 2004 and the HTA's Codes of Practice • Where applicable, there are agreements with third parties to ensure that consent is obtained in accordance with the requirements of the HT Act 2004 and the HTA's Codes of Practice • Consent procedures have been ethically approved
C2 Information about the consent process is provided and in a variety of formats
• Standard operating procedures (SOPs) detail the procedure for providing information on consent • Agreements with third parties contain appropriate information • Independent interpreters are available when appropriate • Information is available in suitable formats, appropriate to the situation • Consent procedures have been ethically approved
C3 Staff involved in seeking consent receive training and support in the implications and essential requirements of taking consent
• Standard operating procedures (SOPs) detail the consent process • Evidence of suitable training of staff involved in seeking consent • Records demonstrate up-to-date staff training • Competency is assessed and maintained

Governance and quality system standards
GQ1 All aspects of the establishments work are supported by ratified documented policies and procedures as part of the overall governance process
• Policies and procedures are in place, covering all activities related to the storage of relevant material for research in connection with disorders, or the functioning, of the human body • Appropriate risk management systems are in place • Regular governance meetings are held; for example, health and safety and risk management committees, agendas and minutes • Complaints system

GQ2 There is a documented system of quality management and audit
• A document control system, covering all documented policies and standard operating procedures (SOPs). • Schedule of audits • Change control mechanisms for the implementation of new operational procedures
GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and are continuously updating their skills
• Qualifications of staff and training are recorded, records showing attendance at training • Orientation and induction programmes • Documented training programme, (e.g. health and safety, fire, risk management, infection control), including developmental training • Training and reference manuals • Staff appraisal / review records and personal development plans are in place
GQ4 There is a systematic and planned approach to the management of records
• Documented procedures for the creation, amendment, retention and destruction of records • Regular audit of record content to check for completeness, legibility and accuracy • Back-up / recovery facility in the event of loss of records • Systems ensure data protection, confidentiality and public disclosure (whistle-blowing)
GQ5 There are documented procedures for distribution of body parts, tissues or cells
• A process is in place to review the release of relevant material to other organisations • An agreement is in place between the establishment and the organisation to whom relevant material is supplied regarding the tracking and use of material and eventual disposal or return
GQ6 A coding and records system facilitates traceability of bodies, body parts, tissues and cells, ensuring a robust audit trail
• There is an identification system which assigns a unique code to each donation and to each of the products associated with it • An audit trail is maintained, which includes details of when and where the relevant material was acquired, the consent obtained, the uses to which the material was put, when the material was transferred and to whom
GQ7 There are systems to ensure that all adverse events are investigated promptly
• Corrective and preventive actions are taken where necessary and improvements in practice are made • System to receive and distribute national and local information (e.g. HTA communications)

GQ8 Risk assessments of the establishment's practices and processes are completed regularly and are recorded and monitored appropriately
• Documented risk assessments for all practices and processes • Risk assessments are reviewed when appropriate • Staff can access risk assessments and are made aware of local hazards at training

Premises, facilities and equipment standards
PFE1 The premises are fit for purpose
• A risk assessment has been carried out of the premises to ensure that they are appropriate for the purpose • Policies in place to review and maintain the safety of staff, authorised visitors and students • The premises have sufficient space for procedures to be carried out safely and efficiently • Policies are in place to ensure that the premises are secure and confidentiality is maintained
PFE 2 Environmental controls are in place to avoid potential contamination
• Documented cleaning and decontamination procedures • Staff are provided with appropriate protective equipment and facilities that minimise risks from contamination • Appropriate health and safety controls are in place
PFE3 There are appropriate facilities for the storage of bodies, body parts, tissues and cells, consumables and records.
• Relevant material, consumables and records are stored in suitable secure environments and precautions are taken to minimise risk of damage, theft or contamination • Contingency plans are in place in case of failure in storage area • Critical storage conditions are monitored and recorded • System to deal with emergencies on 24 hour basis • Records indicating where the material is stored in the premises
PFE 4 Systems are in place to protect the quality and integrity of bodies, body parts, tissues and cells during transport and delivery to a destination
• Documented policies and procedures for the appropriate transport of relevant material, including a risk assessment of transportation • A system is in place to ensure that traceability of relevant material is maintained during transport • Records of transportation and delivery • Records are kept of any agreements with recipients of relevant material

- Records are kept of any agreements with courier or transport companies

PFE5 Equipment is appropriate for use, maintained, quality assured, validated and where appropriate monitored

- Records of calibration, validation and maintenance, including any agreements with maintenance companies
- Users have access to instructions for equipment and receive training in use and maintenance where appropriate
- Staff aware of how to report an equipment problem
- Contingency plan for equipment failure

Disposal Standards

D1 There is a clear and sensitive policy for disposing of human organs and tissue

- Documented disposal policy
- Policy is made available to the public
- Compliance with health and safety recommendations

D2 The reason for disposal and the methods used are carefully documented

- Standard operating procedures (SOPs) for tracking the disposal of relevant material detail the method and reason for disposal
- Where applicable, disposal arrangements reflect specified wishes

Appendix 2: Classification of the level of shortfall (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.