Site visit inspection report on compliance with HTA minimum standards

UCB Celltech

HTA licensing number 12504

Licensed under the Human Tissue Act 2004 for the

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

26 June 2012

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 UCB Celltech (the establishment) had met the majority of the HTA standards, one major and several minor shortfalls were found in relation to consent; governance and quality systems; premises, facilities and equipment; and disposal standards. A number of the shortfalls relate to the procurement of blood samples from members of staff for research projects. Action is required to ensure the provision of information is sufficient so that the consent taken is valid and that the systems of coding assure the anonymity which staff are promised. A shortfall has been identified in the out of hours alarm systems in the sample storage areas since staff responsibilities and the action taken in response to an alarm were unclear.

It was evident that a lot of effort had been made to raise the standard of documentation prior to the inspection, which had involved the input from a dedicated quality assurance team. Further support will be advantageous to ensure the outstanding governance issues are resolved.

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 Paragraph 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.

Background to the establishment and description of inspection activities undertaken

UCB Celltech carries out the storage of frozen and fixed relevant material for research within the scope of the Human Tissue Act 2004. Blood and tissue samples are obtained from NHSBT and commercial organisations in the UK and abroad. Urine samples are obtained from clinical trials. The tissue samples are obtained from either living or deceased donors, representing disease and non-disease states. The establishment also has trained phlebotomists who procure blood samples from members of staff for use in internal research projects, for which consent is obtained.

This was the first routine inspection of the establishment since the commencement of their licence in November 2007 The inspection comprised interviews with members of staff, a review of relevant documentation and visual inspection of the research laboratories and in particular the sample storage areas. An audit trail was carried out on frozen samples stored in -80°C freezers and liquid nitrogen tanks, as well as fixed blocks and slides. No anomalies were identified in the data recorded for samples and their storage location, but gaps were identified in the traceability of samples from receipt through to disposal (refer to shortfall against GQ6) and the records relating to the creation of slides from wax blocks are contained in researcher's personal notebooks and not easily reconciled with the number of slides created overall.

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

Consent

Standard	Inspection findings	Level of shortfall
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.	Generic consent is obtained from blood donors working within the establishment. Once consented, staff are encouraged to make repeat donations, however they are not required to confirm their consent again, or to answer the questions about lifestyle or medical history which may have changed since their last donation. Answering these questions is of particular importance in helping to protect staff that are handling and using these samples from exposure to infectious diseases and to prevent donors from donating when they should not due to their medical status, for example pregnant women.	**Minor**
C2 Information about the consent process is provided and in a variety of formats.	Several minor shortfalls relating to deficiencies in both the process and the information provided to donors combine to make a major shortfall against this standard. Donors are provided with information regarding the use of their blood samples in various research projects, in order that generic consent is obtained. However the process for providing information regarding exclusion criteria in advance of giving consent does not routinely happen and is not formalised or documented. The provision of information, including the donor exclusion criteria, prior to the discussion where consent is obtained gives the donor the opportunity to walk away without any questions asked. If this is overlooked, it could lead to unreliable information being provided when a colleague obtains consent from the donor. **Minor shortfall** A coding system is used to anonymise blood donors from their fellow members of staff, however staff are aware who the	**Major**

	donors are and break the coding to approach specific members of staff for repeat donations when their blood shows characteristics of interest. The donor is not adequately informed that they may be asked to donate repeatedly due to their biological characteristics nor is there provision for donors to decline these specific requests, which they could feel coerced into fulfilling. Overall the system does not assure the anonymity of staff, which they are told is in place at the point of consent, and could present further confidentiality problems if a member of staff is identified through the research conducted as having an underlying medical condition. **Minor shortfall** Some of the SOPs regarding consent contained conflicting information about how a donor could withdraw their consent if they no longer wanted to participate in research. In the absence of a clear process the establishment risk storing and using samples in research against the donors will. **Minor shortfall**	

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.	SOPs are in place for many of the establishment's key processes but tasks such as receipt and storage of samples have not been documented and, in an unforeseen staff absence, could lead to inappropriate handling of samples or no action at all and result in loss of the tissues or cells. The establishment have a process of document control, however there were some gaps in their system such as signage within the liquid nitrogen storage area was not document controlled. As a result it is not possible to know if the actions they state have been reviewed and/or are still applicable. There is also no system to ensure that staff have read the latest version of SOPs.	**Minor**

GQ6 A coding and records system facilitates traceability of bodies, body parts, tissues and cells, ensuring a robust audit trail.	A coding system is used to anonymise blood donors who are members of staff, however the system of anonymisation is inadequate as staff are aware of who the donors are and break the coding to approach specific members of staff for repeat donations. A variety of sample tracking systems are used between the different research groups. Some systems do not currently include the tracking of the receipt of tissue samples, to ensure all the samples expected have arrived safely, the recording of 'daughter' samples generated from the original specimen, for example blocks and slides, and the use of a sample to extinction or disposal.	**Minor** **Minor**

Premises, Facilities and Equipment

Standard	Inspection findings	Level of shortfall
PFE1 The premises are fit for purpose. PFE3 There are appropriate facilities for the storage of bodies, body parts, tissues, cells, consumables and records.	Freezer alarms are connected to the security control panel and security staff patrol the building out of hours. The inspection team received conflicting information as to whether the security staff responsibility would be to call an engineer or move the samples to a fully operational freezer themselves. It was also unclear as to whether the oxygen depletion monitor in the liquid nitrogen store was just a local alarm or if it was also connected to the security control panel and if on seeing this alarm security staff would call an engineer, or go to investigate to see if someone needed help. The functionality of the alarm system and the responsibilities of the security staff and any risks associated with these have not been clearly documented and communicated.	**Minor**

Disposal

Standard	Inspection findings	Level of shortfall
D1 There is a clear and sensitive policy for disposing of human body parts and tissue.	There is a waste disposal policy in place, however this does not address the sensitive disposal of tissues from the deceased as set out in HTA's code of practice.	**Minor**

Advice

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

No.	Standard	Advice
1.	GQ1	Several of the SOPs provided high level information and lacked detail that is useful for staff new to the task. The DI is advised to review and, if necessary, revise SOPs to include details which optimise the chances of tasks being completed in a standardised manner. Addition of links to related documents should also be considered.
2.	GQ2	The establishment have recently started to audit their processes and two audits have been completed. The DI is advised to implement the audit schedule, as described during inspection, and verify that the establishment remains compliant with HTA standards.
3.	GQ6	The establishment is in a process of implementing new electronic note books to assist with the accessibility of data. The DI is advised to review the data that needs to be captured for traceability purposes so that standardised practice is implemented.
4.	GQ7	Incident reporting is carried out well in the GLP-compliant laboratories. A less formal system is used in the other research. The DI is advised to implement the same incident reporting system across all laboratories, taking into account the seriousness of the incident and the likelihood of reoccurrence. The reporting system should also allow for the identification of trends in incidents, which require corrective or preventative actions.
5.	GQ8	Documented risk assessments have been carried out relating to risks to the health and safety of staff. Some additional areas of risk have been discussed at the 'HTA Ops' meeting, but have not yet been documented. The DI is advised to assess, document and where possible mitigate, any further risks to the samples or to compliance with HTA standards.
6.	PFE2	Blood samples collected from staff are termed 'low risk', even though these samples are not screened for infectious diseases. The DI is advised to reassess the risk posed by using these samples in research and ensure appropriate protective measures are in place to safeguard staff.
7.	PFE3	Maintenance of freezers used to store samples and validation of temperature probes has been carried out on some freezers, but it was unclear if this was the case for all freezers used by different researchers. The DI is advised to check that freezer maintenance and calibration is carried out for all freezers where relevant material is stored.

Concluding comments

During the inspection a number of areas of good practice were identified. There is a good awareness of the HTA's licensing requirements due to the training provided by the DI. This training is provided to all staff who may become involved in using human tissue or cells as part of their research and is regularly repeated to maintain staff awareness. The establishment has a HTA committee meeting each month where any new areas of work, arising issues, review of SOPs and audits are discussed. The establishment places priority on

reporting incidents and ‘near misses’, and this is incentivised by drawing a voucher prize each month out of those who have made a report.

Although there was variability within the systems of traceability used, a spreadsheet system to track the storage of cone cells within the liquid nitrogen store was particularly good. It recorded the type of sample, the exact location of each cryovial, when it had been used and by whom. The spreadsheet had an electronic back up and restricted access to ensure that only selected users could make data entries and thereby reduce errors or mismanagement of the database.

There are a number of areas of practice that require improvement, including one major and six minor shortfalls. The HTA has given advice to the Designated Individual with respect to governance systems and in particular improvements that could be made to SOPs and additional risk assessments that should be completed. The HTA has also made recommendations that the schedule of audit, electronic laboratory notebook and the inclusion of the research laboratories in the formal incident reporting system should be fully implemented as discussed during the inspection. It is hoped that the dedicated quality assurance team will continue to provide their valuable support throughout the implementation of these actions.

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: 24 July 2012

Report returned from DI: 7 August 2012

Final report issued: 8 August 2012

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: 31 January 2013

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.

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 in place 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

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 risk to human safety and/or dignity or is a breach of the Human Tissue Act 2004 (HT Act) or associated Directions

   or

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

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

   (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 that:

   - poses a risk to human safety and/or dignity, or
   - indicates a failure to carry out satisfactory procedures, or
   - indicates a breach of the relevant CoPs, the HT Act and other relevant professional and statutory guidelines, or
   - has the potential to become a critical shortfall unless addressed

   or

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

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

3. **Minor shortfall:**

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

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

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

Follow up actions

A template corrective and preventative action plan will be sent as a separate Word document with 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.