

**Luton and Dunstable University Hospital**  
HTA licensing number 22605

Licensed under the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (as amended)

**Licensable activities carried out by the establishment**

**Licensed activities**

‘E’ = Establishment is licensed to carry out this activity and is currently carrying it out.

Site	Procurement	Processing	Testing	Storage	Distribution	Import	Export
Luton and Dunstable University Hospital				E			

### Tissue types authorised for licensed activities

Authorised = Establishment is authorised to carry out this activity and is currently carrying it out.

Authorised\* = Establishment is authorised to carry out this activity but is not currently carrying it out.

<b>Tissue Category; Tissue Type</b>	<b>Procurement</b>	<b>Processing</b>	<b>Testing</b>	<b>Storage</b>	<b>Distribution</b>	<b>Import</b>	<b>Export</b>
<b>Musculoskeletal, Bone; Bone</b>				Authorised			
<b>Musculoskeletal, Cartilage; Cartilage</b>				Authorised*			
<b>Musculoskeletal, Tendon and Ligament; Tendons</b>				Authorised			

### Summary of VRA findings

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

Although the HTA found that Luton and Dunstable University Hospital (the establishment) had met the majority of the HTA's standards that were assessed during the VRA, six minor shortfalls were found against standards for Governance and Quality.

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 VRA.

## Compliance with HTA standards

### Minor Shortfalls

Standard	VRA findings	Level of shortfall
<b>GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process.</b>		
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.	The establishment does not have a documented procedure detailing what steps would be taken if activities within the bone bank were to cease.	<b>Minor</b>
t) There are procedures for the re-provision of service in an emergency.	The establishment does not have a documented procedure for the re-provision of bone bank service in an emergency.	<b>Minor</b>
<b>GQ2 There is a documented system of quality management and audit.</b>		
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.	The last independent audit was carried out using only the overarching HTA licensing standard categories. However, the individual standards within each category were not audited. Following the audit, no documented corrective and preventative action plan was put in place despite shortfalls being identified during the audit.	<b>Minor</b>

<b>GQ4 There is a systematic and planned approach to the management of records.</b>		
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.	The requirement to retain raw data for 10 years is not captured in the establishment's documentation (e.g., in the 'Human Tissue Quality Management Policy' and the 'Record Management Policy').  See <i>Advice</i> , item 9.	<b>Minor</b>
i) The minimum data to ensure traceability from donor to recipient as required by Directions 001/2021 are kept for 30 years after the use, expiry or disposal of tissues and / or cells.	The requirement to retain traceability data for 30 years is not captured in the establishment's documentation (e.g., in the 'Human Tissue Quality Management Policy' and the 'Record Management Policy').  See <i>Advice</i> , item 9.	<b>Minor</b>
<b>GQ8 Risk assessments of the establishment's practices and processes are completed regularly and are recorded and monitored appropriately.</b>		
c) Staff can access risk assessments and are made aware of local hazards at training.	Although there is a detailed suite of risk assessments the establishment was unable to demonstrate that these were accessible to staff working under the licence.	<b>Minor</b>

The HTA requires the DI to submit a completed corrective and preventative action (CAPA) plan setting out how the shortfalls will be addressed, within 14 days of receipt of the final report (refer to Appendix 3 for recommended timeframes within which to complete actions). The HTA will then inform the establishment of the evidence required to demonstrate that the actions agreed in the plan have been completed.

## Advice

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

Number	Standard	Advice
1.	N/A	The establishment does not store cartilage. The DI is advised to consider removing this tissue type from the storage licence.
2.	GQ1(c)	<p>Joint governance meetings, involving DIs across the different sectors, are a feature in several other organisations that hold multiple HTA licences.</p> <p>Bedfordshire Hospitals NHS FT is Corporate Licence Holder (CLH) on two HTA licences and the CLH contact (CLHc) is the representative on both licences. There are currently no meetings between DIs and individuals named on these licences.</p> <p>The CLHc and DI are advised to consider setting up joint governance meetings involving staff on both licences, to ensure consistency of good practice.</p>
3.	GQ1(d)	Some of the establishment's documents were not subject to document control. For instance, the 'Waste Management Policy', the 'Record Management Policy', the 'Business Continuity Plan' and the 'Adverse Incident Reporting and Investigation Policy' were out of date.
4.	GQ2(b)	Regular audits are carried out by establishment governance staff. The DI is advised to consider recording all audits in an audit schedule to indicate the full scope of audits undertaken and those planned.
5.	GQ2(b)	Audit findings and actions taken are often recorded on an <i>ad hoc</i> basis by e-mail. The DI is advised to consider formalising the process of recording audit findings, discussions about the audit, who is responsible for follow-up

		actions and the timeframes for completing these. This will ensure that all audits are captured and acted upon consistently.
6.	GQ2(c)	The HTA has published guidance on independent audits, which can be found on the ' <a href="#">Independent audits</a> ' page of the HTA website. The DI is advised to consider reading this guidance when preparing the audit strategy.
7.	GQ3(f)	The DI is advised to consider incorporating the relevant parts (storage section) of the ' <a href="#">HTA Guide to Quality and Safety Assurance for Tissues and Cells for Patient Treatment</a> ' into the establishment's regulatory training programme.
8.	GQ4(e)	The DI is advised to consider adding the following to the bone bank register: the time from release by the supplier to placement in the freezer.
9.	GQ4(m)	The DI is advised to consider updating the contingency plan for storage of records of traceability (30 years) and raw data (10 years) in the event of termination of activities. The electronic patient notes will need to be highlighted appropriately and stored in the Trust archives, and the raw data stored securely.
10.	GQ7(a)	Recording of adverse events is through the Trust system. The DI and his team are sometimes not informed when these are closed and what actions have been taken. The DI is advised to consider formalising the process of recording adverse event findings, discussions about the adverse event, root cause analysis and resulting corrective and preventative actions. This will ensure that all adverse events are captured and closed consistently.
11.	PFE3(c)	The DI is advised to consider regularly challenging the temperature alarm callout system to ensure that it functions as expected.
12.	PFE3(c)	The DI is advised to consider initiating a programme by which, at suitable intervals, the temperature plots from the freezers are reviewed. This may help to identify a potential failure of the equipment before it occurs.

13.	PFE5(f)	Bone bank staff defrost and clean the freezers once a year. The DI is advised to document when cleaning of the freezer takes place.
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## Background

The Orthopaedic and Trauma Unit within Luton and Dunstable University Hospital (the 'establishment') stores cryopreserved bone and tendons for use in adult hip replacement/revision procedures and in knee revision and foot and ankle reconstructive surgery. This material is stored in the Unit's bone bank.

The establishment has been licensed by the HTA since August 2010. This was the establishment's first VRA. Prior to this, five site visit inspections of the establishment had been conducted; the most recent previous inspection took place in May 2019.

Since the site inspection in May 2019, two Persons Designated (PDs) have been added to the licence and one PD has been removed.

## Description of VRA activities undertaken

The HTA's regulatory requirements are set out in Appendix 2. The following areas were covered during the VRA:

### *Review of governance documentation*

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

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

### *Audit of records and other documentation*

The traceability audit included a review of five products (four bone units, one tendon unit). The products were selected from the electronic tissue register previously provided by the establishment. Labelling information, as well as details of order, receipt, product location, storage temperature,

release and transplantation (two products), and disposal (one product) were reviewed. There were no discrepancies noted. The training records of the members of staff who handled the products were also checked. No discrepancies were noted.

Two of the establishment's internal audits were reviewed. Advice is provided about the management of audits (see *Advice*, item 5).

Five of the establishment's reported adverse events were reviewed. Advice is provided about the management of audits (see *Advice*, item 10).

**Report sent to DI for factual accuracy: 24 September 2021**

**Report returned from DI: No factual accuracy or request for redaction comments were made by the DI**

**Final Report issued: 29 October 2021**

### **Completion of corrective and preventative actions (CAPA) plan**

Based on information provided, the HTA is satisfied that the establishment has completed the agreed actions in the CAPA plan and in doing so has taken sufficient action to correct all shortfalls addressed in the Virtual Regulatory Assessment Report.

**Date: 15 February 2023**



## Appendix 1: HTA standards

The HTA standards applicable to this establishment are shown below; those not assessed during the VRA 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.
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.
C2 Information about the consent process is provided and in a variety of formats.
b) If third parties act as procurers of tissues and / or cells, the third party agreement details what information will be provided to donors. As a minimum, the information specified by Directions 001/2021 is included.

## 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.
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.
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 001/2021.
s) Third party agreements specify serious adverse reaction or event reporting requirements.
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.
<b>GQ4 There is a systematic and planned approach to the management of records.</b>
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.
g) There is a system to ensure records are secure and that donor confidentiality is maintained in accordance with Directions 001/2021.

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 001/2021 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.
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 001/2021.
b) The testing of donors by the establishment or a third party on behalf of the establishment is carried out in accordance with the requirements of Directions 001/2021.
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.
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.
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.
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.
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 001/2021.
j) Shipping packaging containing tissues and / or cells is labelled with the information required by Directions 001/2021.
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.
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.

## **Appendix 2: The HTA's regulatory requirements**

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

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

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

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 3: 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 and VRAs carried out from 1 November 2010 are published on the HTA's website.

### **Appendix 3: 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 Human Tissue Act 2004, Human Tissue (Quality and Safety for Human Application) Regulations 2007, or associated Directions.

#### **1. Critical shortfall:**

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

*or*

A number of 'major' shortfalls, 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:

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

#### **2. Major shortfall:**

A non-critical shortfall.

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

*or*

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

*or*

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

*or*

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

*or*

A combination of several 'minor' shortfalls, none of which is major on its own, but which, viewed cumulatively, could constitute a major shortfall by adversely affecting the quality and safety of the tissues and cells.

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 VRA 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 on-site inspection or VRA.

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 VRA report.

### **Follow up actions**

A template corrective and preventative action plan will be sent as a separate Word document with the final VRA report. Establishments must

complete this template and return it to the HTA within 14 days of the issue of the final report.

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

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

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