Site visit inspection report on compliance with HTA minimum standards

Clatterbridge Cancer Centre

HTA licensing number 12629

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**

25 February 2016

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.

Clatterbridge Cancer Centre (the establishment) was found to have met all HTA standards.

Advice has been offered to the establishment with regards to documentation, audits and risk assessments.

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.

Background to the establishment and description of inspection activities undertaken

The establishment has been licensed since March 2015 and this was the first site visit inspection undertaken by the HTA to assess whether it continues to meet the HTA standards. The timetable for the site visit was developed in consideration of the establishment's licence application information, and pre-inspection discussions with the Person Designated (PD). During the site visit, a visual inspection of the premises, review of documentation and interviews with establishment staff were undertaken.

The establishment is based around a clinical service treating various types of cancers in its locality. It has received ethical approval, from an NHS research ethics committee, to collect samples from both patients and healthy volunteers and to store them in a newly created biobank. Researchers from outside the establishment are able to request samples from the biobank for use in their research.

The establishment has commissioned a bespoke laboratory information system (LIMS) which is used to track all samples that are collected. The LIMS generates unique codes for each sample and any sub-samples derived from the initial sample; for example, plasma or serum. Each sample is placed into an appropriate sample tube, labelled with a barcode generated by the LIMS. This means that all samples are anonymous to researchers who are using them as the unique identifier does not contain donor information.

The establishment plans to use barcode scanners to track the labelled samples. However, at the time of the inspection, the label printing had not yet been fully validated and the establishment was using the human readable unique identifier code which also appears on the label. The LIMS also tracks the location of each sample including details of the freezer, sample rack, shelf within the rack, the sample storage box identification number and position of the sample within the sample box, which can contain up to 81 samples.

Consent for donation of samples is sought by clinicians who have received Good Clinical Practice (GCP) training. The consent process is supported by a documented procedure and information leaflets about donating tissue for research which are given to donors. Samples, currently whole blood and urine, are collected by the clinician, specialist nurse or phlebotomist. Samples are then collected by a member of biobank staff for processing prior to storage. The sample is collected using a kit which contains the appropriate labelled containers and spare identification labels which are attached to the completed consent from to aid traceability.

During the inspection an audit of traceability was undertaken. The scope of the audit was limited due to the small number of samples that had been collected and stored at the time of the inspection. The establishment had only been collecting samples during the four days prior to the inspection and all were from healthy volunteers. Additionally, the LIMS system had failed during the processing of some samples and the establishment had implemented their contingency process using a paper-based tracking system, with the intention of later updating the LIMS with the information. Six samples were chosen at random from those being stored. The physical locations of the samples were cross-checked against the establishment's traceability records, held either electronically in the LIMS, or on the paper-based contingency records. Additionally, the identity of each sample's donor was found and the relevant consent from reviewed. No anomalies were found during the audit and a signed, fully completed consent form was present in all cases.

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

All applicable HTA standards have been assessed as fully met.

Advice

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

No.	Standard	Advice
1.	C1	The establishment has amended the donor consent form to include a statement regarding any genetic analysis undertaken on the donated samples. The consent form indicates that results of any genetic analysis will not be fed back to the establishment. This is not the case as the results of research, including any genetic analysis, will be shared with the establishment and ultimately may be passed to other researchers to aid their research. The DI is advised to amend the wording on the consent form so that it is clear to those giving their consent that any results of genetic analysis of samples or their implications will not be fed back to the donor although results will be fed back to the establishment as part of the research data normally collected.

2.	C2	The participant information leaflet given to the donors of samples includes a section informing donors about withdrawal of their consent and how this can be done, at any time. It also aims to inform donors that if they withdraw their consent, no further research will be undertaken on their samples and any remaining samples will be disposed of sensitively; however, prior to withdrawal of consent, data may have been generated from the samples that could not be destroyed and may even have been published in a scientific journal. The DI is advised to amend the wording of the participant information leaflet and remove the reference to withdrawal of consent 'after a long time' as it may be the case that data has been generated from samples after only a short period following their donation to the biobank. This may help to clarify to those giving their consent that, although they can withdraw their consent at any time, some data may already have been generated which may not be destroyed.
3.	GQ1	The establishment has a range of standard operating procedures (SOPs) and associated work instructions covering the work being undertaken under the licence. The DI is advised to review these documents and where appropriate, cross reference the relevant work instruction in the SOP and vice versa. This will help to assure the DI that anyone following an SOP or work instruction will be made aware that additional procedural guidance is available.
4.	GQ1	Due to the limited time that the establishment has been collecting samples, not all of the documentation has been finalised as some of the procedures are still being developed. The DI is advised to keep under review the SOPs that have been finalised and continue with his plans to develop appropriate work instructions which will be linked to those SOPs; for example, logging samples into the establishment's LIMS.
5.	GQ2	Since the establishment had only been actively collecting samples for four days at the time of the inspection, no audits had taken place. The DI is advised to continue with his plans and to develop a suitable schedule of audits through which he may assure himself that the establishment's processes are being carried out as planned. Additionally, the DI is advised to consider including audits of the consent seeking process in the schedule of audits, which will again help to assure him that staff working under the licence are doing so in accordance with his procedures.
6.	GQ7	The DI is advised to request that the Person Designated, and any other appropriate staff working under the licence, sign up to receive the HTA newsletter which may help to keep them informed about relevant matters.
7.	GQ8	The establishment has a range of risk assessments in place covering risks associated with health and safety and sample specific risks relating to the licensable activity. These risk assessments are not recorded in a uniform format which may make it more difficult for establishment staff to review them. The DI is advised to standardise the approach towards recording the establishment's risk assessments. The DI may wish to consider using the Clatterbridge Cancer Centre risk assessment form, used to record health and safety risk assessments, for the sample specific risks. This should facilitate their review and help the DI to assure himself when assessing these risks that the measures in place to mitigate against them remain appropriate.

Concluding comments

Good practices were observed during the inspection, examples of which are included below.

Most evident was the well-considered approach of the establishment in preparing for undertaking the licensed activity. The establishment has been keen to have appropriate systems in place prior to the collection of any samples. This has meant that important samples donated by research participants have not been collected while appropriate systems to process, record and track them are being put in place, developed and tested. Although the establishment experienced an issue with the LIMS upon commencing to collect samples, this has only affected a relatively small number of samples due to an approach of a gradual increase in activity.

Another area of good practice is that the establishment has established a delegation log which clearly records the staff working under the licence and which activities the DI has authorised them to carry out; for example, the seeking of donor consent.

The HTA has given advice to the Designated Individual with respect to consent documentation, procedural documentation, audits and risk assessments.

The HTA has assessed the establishment as suitable to be licensed for the activities specified.

Report sent to DI for factual accuracy: 15 March 2016

Report returned from DI: No Comments received

Final report issued: 28 April 2016

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 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.