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1. PURPOSE AND SCOPE

1.1 The purpose of this Policy is to set out the rules governing the storage and use of tissue under the Human Tissue Authority (HTA) Licence 12217 (‘the Licence’).

1.2 In accordance with Section 16(2)(e)(ii) of the Human Tissue Act (2004)\(^E\)\(^1\) (‘the Act’), the University of Oxford (‘the University’) has several HTA research licences. This Policy relates to the multi-site Licence number 12217 and is primarily for staff with governance responsibilities under the Licence, and investigators seeking to register, store and/or use samples under the Licence.

1.3 Exclusions:

1.3.1 This Policy does not apply to sample collections that are already under the governance of other University licences (12168 Clinical Trials Service Unit, 12326 Oxford Centre for Diabetes, Endocrinology & Metabolism, 12433 Weatherall Institute of Molecular Medicine, 22496 Oxford DRWF Human Islet Isolation Facility, or 12178 Medical Sciences Teaching Centre).

1.3.2 This Policy does not apply to sample collections held under a current and valid approval from a recognised Research Ethics Committee (REC). Note: University ethics committees and overseas ethics committees are not considered to be recognised RECs.

2. KEY DEFINITIONS

2.1 HTA Licence 12217 (‘the Licence’)

The Licence refers to HTA Research Licence 12217 held by the University of Oxford. Details of the scope, purpose and governance of the Licence can be found in the Licence Constitution\(^\)\(^1\)\(^1\).

2.2 Licensed premises

The premises covered by the Licence are detailed in the Licence Constitution. Broadly, these include all buildings at the John Radcliffe Hospital, all buildings at the Nuffield Orthopaedic Centre, all buildings at the Churchill Hospital, all buildings at the Old Road Campus, the Peter Medawar Building and the Pharmacology building on Mansfield Road.

2.3 Recognised Research Ethics Committee (REC)

The Act defines a recognised REC as either:

- A REC established under and operating to the standards set out in the governance arrangements issued by the UK Health Departments or;
- An ethics committee recognised by the United Kingdom Ethics Committee Authority to review clinical trials of investigational medicinal products under the Medicines for Human Use (Clinical Trials) Regulations 2004.

2.4 Relevant material

Relevant material under the Act is defined as ‘material, other than gametes, which consists of or includes human cells’. Note that this does generally include cell deposits and tissue sections on slides, but not lysed cells, or samples which have been processed to remove
cellular components. Cell cultures comprised of cells which have divided outside the human body are not considered relevant material. Please refer to the HTA website\textsuperscript{E2} for the full list of relevant material and exemptions.

2.5 Scheduled purpose

The Act defines the activities requiring consent as scheduled purposes. Research is a scheduled purpose under the Act. In addition, for samples collected from deceased donors, scheduled purposes include: clinical audit, education and training relating to human health, performance assessment and quality assurance.

2.6 Import / export

The Act defines import / export as movement of samples into or out of England, Northern Ireland and Wales. Movement of samples to or from Scotland is considered export/import, because activities relating to the storage and use of human tissue in Scotland are regulated by the Human Tissue (Scotland) Act 2006.

2.7 Existing holding

An existing holding is defined as relevant material from a human body (whether living or dead) held before the day on which the Act commenced (1 September 2006) for use for a Scheduled Purpose. Such holdings are exempt from the consent requirements of the Act; however, researchers are still bound by the terms of any consent which was obtained from donors prior to this date, under common law.

2.8 Designated Individual (DI)

This is the person under whose supervision the licensed activity is authorised to be carried out. The DI has the primary (legal) responsibility under Section 18 of the Act to secure: that suitable practices are used in undertaking the licensed activity; that other persons working under the licence are suitable and; that the conditions of the licence are complied with. The DI for the Licence is Dr Brian Shine. The DI for the Licence is assisted by the Human Tissue Governance Team (HTGT) who are part of the University of Oxford’s Research Services office.

2.9 Corporate Licence Holder

The Corporate Licence Holder (University of Oxford) has the right to apply to the HTA to vary the Licence. This enables them to substitute another person as the DI and allows the establishment to cover circumstances where the DI is unable to oversee the licensable activities. The Corporate Licence Holder for the Licence is the University of Oxford; the University nominates a Contact Person for the Corporate Licence Holder.

2.10 Person Designated

Persons Designated (PDs) assist the DI in carrying out the legal duty of complying with the conditions of the Licence and the Act. PDs direct others in relation to the Act, assist in developing and implementing procedures to provide the DI with assurance of compliance. For example for the Licence, PDs work at each Medical Sciences Division Department with registered samples under the Licence, offering advice and guidance to those in the Department. This means other persons working under the direction of the PD are advised about how and why they need to follow procedures and systems agreed by the DI to comply
with the Act. The details of the governance structure of the Licence are presented in the Licence’s Constitution.

2.11 Principal Investigator

The Principal Investigator (PI) is the lead researcher for a given project. In the context of this document, PIs are responsible for samples they are storing and using for research. Where several PIs work on the same project, the Chief Investigator (CI) on the corresponding ethical approval is considered responsible for the samples unless the responsibility has been formally passed to another PI.

2.12 Collection Responsible Officer

Collection Responsible Officers (CROs) assist PIs in the day-to-day governance and curation of samples. They are named staff members who serve as liaison between the DI/HTGT and the PIs and to whom responsibilities will be frequently delegated to perform actions related to HTA compliance and/or compliance with the terms of registration under the Licence. PIs may act as CROs if necessary.

2.13 Persons working under the Licence

For the purpose of this document, a person is considered as working under the Licence if any aspect of their work comprises collecting, using or storing samples which are registered under the Licence. Persons working on licensed premises, but whose samples are used / stored under a licensing exemption (see section 3.1) are not considered as working under the Licence, nor are persons working under another HTA licence.

3. LICENSING OF COLLECTIONS

3.1 Licensing exemptions

There are a number of situations where storing and using human tissue samples does not require an HTA Licence. These exemptions include:

3.1.1. Material that is not considered relevant by the HTA (i.e. 'non-relevant' material).

3.1.2. Material which is to be rendered acellular (cells removed or disrupted through a process intended to render acellular) within hours or days (and no more than 7 days).

3.1.3. Material which is to be transported to another establishment within a short period of time (and certainly within 7 days).

3.1.4. Material which is stored for diagnostic purposes, or for another purpose which is not a scheduled purpose. This includes material collected from living donors / healthy volunteers:

- For use as a reagent (e.g. feeder cells);
- For performance assessment (e.g. to test competency);
- For quality assurance (e.g. to provide assurance that an existing assay or method is working as expected).

NOTE that material which is held to serve as a control in an experiment conducted in the context of a research project (for example, immunohistochemistry control blocks) should be considered as being stored for research purposes (i.e. it would not be present on licensed premises were it not for the research project).
3.1.5. Material collected from a living person for use in training related to human health (e.g. for teaching new staff / students).

3.1.6. Material which was collected from an individual who died more than 100 years ago.

3.1.7. Material which is stored / used under a current and valid approval from a recognised REC, or where approval from a recognised REC is pending (i.e. the application form has been submitted to the REC). As an exception to this rule, Research Tissue Banks (RTBs) which have ethical approval from a recognised REC must be registered under an HTA Licence as well. Samples which do not have approval from a recognised REC may be subsumed into another project which does have such approval, or for which such approval is pending. This is only possible if said ethical approval makes reference to the samples to be subsumed, for example by amendment, and consent provisions allow it. This applies for example to a study making use of existing samples from a previously completed project. Collection custodians are encouraged to extend the same governance arrangements and standards to samples of material stored under a recognised REC as if they were registered under the Licence.

3.1.8. If the material has been obtained from a RTB in England, Wales or Northern Ireland and released under the tissue bank’s generic ethical approval. Ethical approval from a University ethics committee does not confer exemption and therefore material collected, stored and used under University ethical approval needs to be registered under an HTA Licence.

3.2 Samples requiring registration under the Licence

Samples of relevant material fitting one or more of the following conditions require registration under the Licence if they are stored on licensed premises, unless an exemption applies:

3.2.1. Samples held pending processing to render them acellular for more than 7 days.

3.2.2. Samples held pending transportation to another establishment for more than 7 days.

3.2.3. Samples stored for research purposes without a valid and current approval from a recognised REC. This includes:

- Samples for which ethical approval has lapsed after completion of a research project or clinical trial;
- Samples obtained from a collaborator where the scope of the research to be conducted is outside existing ethical approvals;
- Imported samples under ethical approval from a REC which is not recognised by the HTA (e.g. Oxford Tropical Research Ethics Committee OxTREC or Medical Sciences Interdivisional Research Ethics Committee (MS IDREC), overseas REC, University REC outside Oxford);
- Samples purchased from commercial companies where no approval has been obtained from a recognised REC for their use;
- Samples obtained from the NHS Blood and Transplant service (NHSBT) where no approval has been obtained from a recognised REC for their use;

3.2.4. Samples collected from deceased donors stored for training or teaching purposes.

3.2.5. Samples transferred from another HTA licence.

3.2.6. Samples forming part of a Research Tissue Bank which has obtained generic RTB approval from a REC.
3.3 Samples ineligible for registration under the Licence

Samples may not be registered under the Licence if:

3.3.1. There is no consent (or consent exemption, see the Licence core Standard Operating Procedure (SOP) for Consent[5]) for the storage and/or use of the material for the proposed purposes.

3.3.2. The samples are stored outside of licensed premises.

3.3.3. The DI has deemed that compliance with the Act cannot be achieved for the samples.

3.4 Registration procedure

3.4.1. Registration procedures are detailed in the Licence core SOP for Registration[12].

3.4.2. Specific procedures are required for samples being registered under the Licence by adoption into an existing registered collection or Research Tissue Bank. These are detailed in the Licence core SOP for Registration as well.

3.5 Quarantine of material registered under the Licence

3.5.1. The DI may decide to place samples registered under the Licence under quarantine, either at the time of registration or at any time after registration (for example in response to changes of circumstances giving rise to risk, in response to findings from an audit or in response to an adverse event).

3.5.2. Quarantine is used to limit access to the samples for a defined time period to allow for severe breaches of compliance with HTA Standards or Licence procedures to be investigated and/or rectified. The length of quarantine is at the discretion of the DI.

3.5.3. Failure to address the shortfalls leading to quarantine may lead to the registration of the collection being revoked by the DI. Samples for which registration has been revoked by the DI must not be kept on licensed premises; immediate disposal, processing to render acellular or transfer to other premises may be required by the DI.

3.6 Withdrawal of material from the Licence

3.6.1. Material can be withdrawn from the Licence at any time by the custodian of the material. Details of the procedure to withdraw material from the Licence are provided in the Licence core SOP for Registration[12].

3.6.2. Continued storage on licensed premises of material which has been withdrawn from the Licence may only take place if a licensing exemption now applies to the material. This includes:

- Material processed to render acellular;
- Material adopted into a project with current and valid approval from a recognised REC (if the project is a Research Tissue Bank, the material must now be declared as stored as part of the tissue bank’s holdings, or released to a research team under the tissue bank’s generic REC approval);
- Material no longer stored for a scheduled purpose.

3.7 Transfer of material between registered collections under the Licence

3.7.1. Material may be transferred to an existing collection under the Licence from another registered collection. Details of the procedure are given in the core SOP for Registration[12].
3.8 Delay between the end of an ethically approved study and registration

3.8.1. To ensure there is no breach in licensing requirements, samples of relevant material stored on licensed premises and left over at the end of a REC approved study must be either registered under the Licence or covered by an exemption as detailed above within twelve months of the date the end of study notification being submitted to the REC. Samples held outside the governance of the Licence for any length of time after the twelve months have expired will be held in breach of the licensing requirements of the Act and incident reporting procedures (HTA003)\(^2\) will have to be followed.

3.8.2. Note that this twelve months delay does not apply to studies with ethical approval from a REC that is not recognised by the HTA; relevant samples from such studies must be registered under the Licence prior to storage on licensed premises.

3.9 Storage of non-relevant material in collections registered under the Licence

3.9.1. Collections registered under the Licence may contain non-relevant material in addition to the relevant material warranting registration. Specific information regarding such samples is sought at the time of registration and on annual return forms to allow the DI to have oversight over how many samples of non-relevant material are stored under the Licence.

3.9.2. Collection custodians are encouraged to extend the same governance arrangements and standards to samples of non-relevant material stored alongside relevant material under the Licence.

4. MANDATORY TERMS OF REGISTRATION UNDER THE LICENCE

Registered collections under the Licence must comply with the requirements outlined below.

4.1 Compliance with Licence core documents

4.1.1. Staff working under the Licence must read and acknowledge all Licence core documents which are applicable to their work. The PI for each collection is responsible for ensuring staff have read and acknowledged the appropriate documents.

4.1.2. PIs (or delegated staff) must provide the HTGT with up-to-date lists of all staff members working under the Licence so that they may be given access to the Licence’s Quality Management System, iPassport. For this purpose, details of any new starters must be forwarded to HTGT before staff can begin their duties with registered samples. The names and contact details of staff working under the Licence are collected for operational purposes and will be retained as part of the DI’s records for each collection.

4.1.3. The core documents for the Licence are available on the HTGT iPassport site [https://htg.ipassportqms.com/](https://htg.ipassportqms.com/) and include:

- Licence Core SOPs\(^2\) on Consent (HTA001), Traceability (HTA002), Adverse Event Reporting and Impact Assessment (HTA003), Disposal (HTA005), Audit (HTA006), Use of iPassport for Document Control and Records Management (HTA009), Risk Management (HTA010), Registration (HTA011) and iPassport procedures for users with view only access (HTA013).

- The present Policy (HTA007).

- The Licence Constitution (HTA008)\(^4\).

- The Licence Risk Management Strategy (HTA012)\(^3\) and core Risk Assessment (HTA-RA001)\(^4\).

- Core forms used to convey information between collection staff and the DI / HTGT which are all available on iPassport.
4.1.4. The HTGT are responsible for reviewing and updating the core documents for the Licence. The PI and CROs are advised by HTGT by automated email from the iPassport software when new documents or new versions of existing documents are released. In addition, iPassport will alert all relevant staff when new documents or new versions of existing documents require their acknowledgement by issuing automated tasks to relevant staff groups.

4.2 Consent requirements

4.2.1. Consent records must be held for all samples stored under the Licence, unless an exemption applies. Details of consent requirements, including consent exemptions, are given in the Licence core SOP for Consent\textsuperscript{12}.

4.2.2. Regular audits of consent records must be undertaken in each collection, where applicable (see section 4.5). Existing holdings (collected before 1 September 2006) are exempt from the consent requirements of the Act; however, if consent records exist for such holdings, they must be audited regularly.

4.2.3. For samples stored under the Licence, collected after 1 September 2006 and obtained from other sites / collaborators, where consent forms remain with the originator, assurance that informed consent has been sought from all participants / donors must be provided. This can be evidenced for example by a Material Transfer Agreement or other research contract explicitly stating that the provider of the material warrants that appropriate informed consent is in place for all samples.

4.2.4. Although imported samples are exempt from the consent requirements of the HT Act, the DI for the Licence requires that researchers importing relevant material gain assurance that informed consent has been sought from all participants / donors. This can be evidenced for example by a Material Transfer Agreement.

4.2.5. The DI may request input or advice from the HTA or relevant REC for resolution of matters relating to consent validity, suitability of consent assurances or other matters to support their decisions.

4.3 Governance requirements

4.3.1. The HTA Code of practice for Research\textsuperscript{3} stipulates that matters relating to HTA-licensed activities must be discussed at regular governance meetings, involving establishment staff. Details of the governance structure of the Licence are provided in the Licence Constitution\textsuperscript{11}.

4.3.2. A PI and a CRO (they may be the same person) must be nominated for each collection. Their names may be shared with the HTA or other Research Services teams, for example as part of performance or compliance reports or to resolve adverse events.

4.3.3. PIs and CROs are required to report to the PD for their Department and to the DI and HTGT for matters relating to HTA-licensed activities. This includes participation in the Licence’s Operational Management committee which includes all CROs and meets termly.

4.3.4. In addition, RTBs are required to have their own governance structure as detailed in their ethically approved Protocol, including access committees if applicable.

4.3.5. PDs and PIs are encouraged to discuss matters relating to HTA-licensed activities as part of existing governance structures at the local, institute or departmental level (for example facilities committees, Unit Heads / PIs meetings, Health and Safety committees etc.).

4.3.6. Any local governance arrangements in place for collections registered under the licence (e.g. for Departments, Institutes, individual buildings or Research Tissue
4.3.7. Minutes of any formal meetings relevant to licensed activities must be kept on iPAssport, with details of action points and follow-up on the completion of these. The minutes should be disseminated to all relevant staff to ensure personnel working under the Licence are aware of all important information relating to the licensed activities they undertake.

4.3.8. National and local information relevant to licensed activities (e.g. communications from the HTA, change in Licence level policies) must be disseminated to relevant staff by Departmental PDs who will be instructed to do so by DI and the HTGT on behalf of the DI.

4.3.9. Staff dealing with complaints from participants in clinical research conducted under the auspices of the University of Oxford must comply with the procedure detailed in University core SOP 009 for managing complaints.

4.4 Document and record management requirements

4.4.1. All procedures related to licensed activities in licensed collections must be documented in controlled SOPs. SOPs are required to ensure that licensed activities are undertaken consistently, in accordance with regulatory requirements.

4.4.2. Generic template SOPs are provided by the HTGT on iPAssport for local adaptation in order that licensed activities are undertaken consistently. If SOPs are already in place and are consistent with the procedures in the Licence core SOPs, these do not need to be re-written but will be checked as part of the HTGT’s audit schedule.

4.4.3. A list of procedures that must be covered by local level SOPs (where applicable) for sample collections stored under the Licence is as follows:

- Production and control of documents;
- Procedure for obtaining informed consent, including procedure to deal with withdrawal of consent;
- Induction and training;
- Internal audit;
- Security and storage;
- Equipment use and maintenance;
- Sample collection, sample receipt and logging;
- Specimen preparation / preservation;
- Sample labelling, sample tracking and sample use;
- Transporting Samples;
- Cleaning and decontamination;
- Laboratory contingency plan;
- Data contingency plan;
- Human material disposal (if more detail is required than in the Core Disposal SOP HTA005)
- Management of records (to include how records are maintained, how they are backed up, where records are kept, how long each type of records is retained,
who has access to each type of record, how errors in written records should be corrected and how records are destroyed).

4.4.4. SOPs and risk assessments may be in place at the level of the collection, or at higher level where applicable (e.g. group level, institute / building level, departmental level). The SOPs in place must be sufficiently detailed and locally relevant to enable staff to perform each procedure – generic or vague SOPs must not be used if they do not fulfil this requirement.

4.4.5. It is not necessary to have SOPs in place for activities that staff do not currently undertake; for example, there is no need for a Consent SOP for archived collections for which no consent seeking is taking place.

4.4.6. The Quality Management System iPassport must be used for local document management unless a collection requires the use of an equivalent existing system (for example, RTBs using multi-centre / national document management sites). "Manual" (paper-based) document control must not be used.

4.4.7. A controlled SOP must detail the process for creation, review, amendment, release and recall of key documents, on iPassport or equivalent system. Where collections use iPassport, it is not necessary to duplicate instructions provided by the core SOP HTA009 but local documentation must cover collection-specific elements such as review frequency, naming conventions and any mechanisms for ensuring that staff know how to access the current version of a document and any process in place to recall and destroy or archive obsolete copies of documents.

4.4.8. Policies, risk assessments, forms and templates must be controlled as part of the document management system.

4.4.9. Only current, approved, non-editable versions of controlled documents must be available at the point of use. Non-authorised modifications to documents are not permitted.

4.4.10. Documents must be reviewed regularly. At a minimum, SOPs and risk assessments must undergo review at least every three years. One copy of superseded versions, retired or withdrawn documents must be archived and any other copies must be destroyed. Any controlled hard copies of the obsolete document must be recalled and destroyed and new controlled copies issued, if applicable.

4.4.11. As well as the scheduled review, controlled documents may be amended / updated in the event of an adverse event / incident as part of the corrective and preventative actions resulting from the incident. Furthermore, SOPs may be reviewed and amended if a change in procedure is required.

4.4.12. For Licence core documents, the copies available on iPassport are the only controlled copies; any copies printed or saved elsewhere are uncontrolled copies.

4.4.13. If iPassport is not used for local document control, alternative local systems must ensure records are kept showing staff acknowledgement of new or amended local SOPs and the date of acknowledgement.

4.4.14. Personnel working under the licence may request amendments to core SOPs by raising change request on iPassport; amendments will be made at the discretion of the HTGT and DI.

4.4.15. In addition to controlled documents, collections must have systems in place to manage other records relating to licensed activities. Records may include but are not limited to:

- Consent records,
- Training records,
- Inventories and manifests including electronic databases,
- Tissue request forms,
- Material Transfer Agreements or other contracts,
- Tissue transfer logs,
- Courier slips,
- Temperature, maintenance or calibration logs,
- Cleaning and decontamination logs,
- Disposal logs etc.

The format of these records may be paper-based or electronic.

4.4.16. Systems for the creation, amendment, retention and destruction of records must be documented in SOPs.

4.4.17. Back-up and recovery provisions should be in place where possible, and documented in a SOP.

4.4.18. Systems ensuring data protection, confidentiality and public disclosure to comply with the Data Protection Act 2018 and General Data Protection Regulation must be in place and documented in a SOP.

4.5 Audit requirements

4.5.1. An audit is the inspection or examination of a process or system, to ensure compliance to agreed standards. In this context, the purpose of audit is to evaluate a sample collection’s compliance with its own SOPs, the Licence core SOPs and/or against the HTA standards. PIs must ensure that procedures in the collection(s) they are responsible for comply with:

- Legislation and regulations, including the HT Act
- Licence 12217 procedures
- University policies
- Local procedures as documented in local SOPs.

4.5.2. It is a condition of registration under the Licence that each collection undergoes the following audits:

- Registration audit within 30 days of acceptance of the collection under the Licence, conducted by the HTGT;
- Scheduled audits conducted by the HTGT on behalf of the DI;
- Internal audits.

4.5.3. A documented schedule of internal audits must be in place for each collection. It is the responsibility of the PI to ensure that schedules of audit are drawn up for their collections and to make sure the schedule is followed. This is monitored by the HTGT who will audit collections to check adherence to audit schedules. If audits are not performed or are performed late, reasons for this must be documented within the internal audit schedule.

4.5.4. Audit should be a formal, documented process undertaken by a trained objective person who has no vested interests in the audit results. As such, staff should not be auditing their own work; where possible, colleagues should audit each other’s work. CROs, PIs and/or PDs are encouraged to audit each other’s collections (peer-to-peer audits).
4.5.5. Collection staff are encouraged to use the Audit module of iPassport to conduct local audits (the procedure to do this is described in HTA006I2); however, they may conduct these audits by utilising their own audit forms (the audit form template HTA_TEMP019 Template internal audit formI7 can be used as a guide) to provide assurance that the collection is robust and compliant with the HTA standards.

4.5.6. Internal audits should include:

- Traceability audits of records and specimens to provide assurance that the process for tracking and tracing samples, from the point of receipt through to the point of release for research or eventual disposal, is robust and consistent with the HTA Traceability StandardsE3, according to the principles detailed in core Traceability SOP HTA002I2. A template form for traceability audits (HTA_FRM004)I6 is available on iPassport.

- Audits against some or all of the HTA Standards

- Audits against SOPs to ensure that documented procedures reflect actual practices.

4.5.7. Details of audit procedures are given in the Licence core SOP for Audit (HTA006I2).

4.6 Training requirements

4.6.1. Records must be kept of staff qualifications and all training relevant to licensed activities received by all personnel working under the Licence.

4.6.2. Staff must be able to demonstrate knowledge of regulatory requirements, internal policies and procedures for the Licence, University policies and procedures, as well as any local policies and procedures relevant to the collection(s) they are involved with.

4.6.3. All staff working under the Licence must receive documented training on the HT Act, HTA Codes of Practice and Standards, including licensing requirements. This is provided online via the WebLearn platformI8 and access is controlled by the Oxford Single Sign On. This training is mandatory for anyone declaring (via the annual Human Tissues Declaration which is organised via PDs and Departmental Administrators) that any aspect of their work involves human tissue, unless they are working under another HTA Licence.

4.6.4. Certificates are automatically issued to staff who have passed the WebLearn training for inclusion in their training records.

4.6.5. Staff working under the Licence who do not have an Oxford Single Sign On (for example, NHS employees, visiting academics) can request access to the WebLearn training by emailing the HTGT at hta_help@admin.ox.ac.ukI8.

4.6.6. It is the responsibility of each Department of the Medical Science Division to ensure that new staff and visitors starting work with human tissue receive appropriate training on the HT Act and HTA codes of practice as part of a documented induction programme. Training provisions must be extended to visiting staff. Monitoring of completion of the training by staff will be carried out by departmental staff.

4.6.7. Training packages including induction programmes must be reviewed at regular intervals.

4.6.8. Persons working under the Licence will be required to update their training on WebLearn once every two years. This may be checked as part of the audits conducted by HTGT.

4.6.9. Training on Licence core SOPs may be provided by the HTGT as required or as requested by collection staff upon release of new documents or amended versions.
4.6.10. Training provisions for new staff working with samples registered under the Licence must include training on and acknowledgement of the Licence core documents and of any local documents.

4.6.11. Staff seeking consent must receive appropriate training on how to perform this activity and must maintain competency. Details of training requirements relating to consent are given in the Licence core SOP for Consent (HTA001).

4.6.12. Mechanisms for recording training include:

- Acknowledgement of new documents or amended documents, either electronic or on paper;
- Competency assessments;
- Records of training on procedures;
- Completion of induction programme(s);
- Certificates from formal training courses or programmes, including online courses;
- Learning logs;
- Details of attendance at conferences and workshops;
- Personal training logs.

4.6.13. All staff working under the Licence must have a Personal Development Review (PDR). The University PDR scheme should be in place for all staff.

4.7 Adverse event reporting requirements

4.7.1. Adverse events relating to HTA licensed activities must be reported consistently to the DI and HTGT within 4 working days according to the Core SOP for Adverse Event Reporting and Impact Assessment (HTA003). The SOP provides extensive definitions of what constitutes an adverse event in the context of the Licence. This is to ensure the DI retains oversight of all such incidents and to ensure that incidents are reported by the DI to the HTA, where appropriate.

4.7.2. Collection staff are encouraged to log all incidents including those which are not reportable to the HTGT.

4.7.3. All personnel working under the Licence must be instructed during local induction on how to use incident reporting systems; this includes incident reporting at the level of the HTA licence, but also any local incident reporting procedures, University or NHS Trust procedures, as well as any additional reporting requirements.

4.8 Risk management requirements

4.8.1. Documented risk assessments must be in place for all practices and processes requiring compliance with the HT Act and HTA’s Codes of Practice, and must include sufficient details of the risks and mitigating actions. In addition to a core Risk Assessment for activities conducted across the Licence, local risks assessments must be in place for specific activities.

4.8.2. Assessment of risk may be appropriate to be carried out at departmental, institute or building level, in which case a documented copy of the assessment should be made available to all relevant staff.

4.8.3. When documented risk assessments are in place, there should be a clear procedure for allowing staff to access these documents. There should be documented staff training on the risks and mitigating actions relating to activities conducted under the Licence, in order to provide evidence that staff are informed.
4.8.4. Risks assessments must be included in a document control management process to ensure staff are accessing the latest version.

4.8.5. Regular review of risk assessments is mandatory. The risk assessments must be reviewed every three years at a minimum; in addition, a review of relevant risk assessment(s) must be conducted following an adverse event.

4.8.6. Further details on risk management and risk assessments can be found in the Core SOP on Risk Management and the Risk Management Strategy for the Licence.

4.9 Reporting requirements

4.9.1. PIs (or delegated staff) are required to submit a yearly report on each collection to the DI / HTGT using the annual returns form (HTA_FRM006), a partly filled in copy of which will be provided to each CRO for completion.

4.9.2. As well as the yearly report, PIs must report any major changes to the collection as they occur, such as:

- Arrival of new staff working on registered samples;
- Change of PI or CRO;
- Transfer of all or part of the samples to a different storage location;
- Addition of a new storage location, or loss of a storage location;
- Adoption of another set of samples (such as samples from a completed REC-approved study) into the collection / RTB;
- Disposal of samples from the collection;
- Implementation of a new traceability system, or quality management system.

4.9.3. RTBs are only required to report samples they release to researchers as part of the annual report; it is not necessary to let the DI know every time a tissue request is fulfilled.

4.10 Supplementary requirements for Research Tissue Banks

4.10.1. RTBs must send a yearly activity report to the REC who approved the RTB. This report must be forwarded to the HTGT each year.

4.10.2. Any amendments to the RTB’s ethical approval must be reported to the DI/HTGT when they are approved. This includes changes to the RTB’s protocol and consent documentation.

4.10.3. Renewal or closure of an RTB’s ethical approval must be reported to the DI/HTGT if and when they occur.

4.11 Consequence of non-compliance with the terms of registration

4.11.1. The PI for any collection found to be in breach of the terms detailed above in sections 4.1 to 4.10 will be warned in writing by the DI.

4.11.2. Should the warning remain unheeded the DI may decide to place the collection under quarantine, or revoke registration under the Licence. Unresolved issues will be escalated to the Departmental level via the relevant PD; continued failure to resolve matters may result in involvement of the Head of the Medical Science Division.

4.11.3. Samples for which registration has been revoked by the DI must not be kept on licensed premises; immediate disposal, processing to render acellular or transfer to other premises may be mandated by the DI.
5. USE OF SAMPLES REGISTERED UNDER THE LICENCE IN RESEARCH

5.1 Release of samples from registered Research Tissue Banks (RTBs)

5.1.1. Samples stored in RTBs may be accessed by researchers through the biobanks’ access processes; each RTB may release samples under the biobank’s generic ethics approval, which confers a licensing exemption on the released samples.

5.1.2. Samples released under RTB generic REC approval to researchers from biobanks operating under Licence 12217 effectively leave the Licence at the point of release. Such samples may re-enter the Licence upon completion of the research project (for example by being returned to the RTB), or they may be used to extinction or disposed of by the receiving researcher.

5.1.3. RTBs under the Licence are required to hold a full traceability audit trail for all samples they release to researchers, up to the point the sample is received by the requester. Thereafter, the receiving researcher is responsible for maintaining sample traceability.

5.1.4. RTBs under the Licence may operate a cost recovery scheme whereby they recover some of their running costs from requestors.

5.1.5. RTBs under the Licence are required to feature on the UK Clinical Research Collaboration (UKCRC) Tissue Directory and Coordination Centre database https://www.biobankinguk.org/.

5.2 Release of samples stored under the Licence outside RTBs for research projects

5.2.1. Samples stored under the Licence without ethical approval (for example, from completed studies or clinical trials) may be released to researchers for use in a research project if the consent is in place for the samples allows the proposed use in research and one of the following conditions is fulfilled:

- Ethical approval from a recognised REC is sought for the new project.
- The proposed use is covered by an existing ethical approval from a recognised REC (either as is or by amendment submitted to the REC).
- Ethical approval is in place from a REC which is not recognised by the HTA, but where there is robust assurance of ethical scrutiny for the project (e.g. approval from one of the committees forming the Central University Research Ethics Committee (CUREC); approval from a REC abroad; approval from a RTB abroad). This is subject to the agreement of the DI
- The proposed use does not require ethical approval.

5.2.2. Samples used for research with ethical approval from a non-recognised REC remain registered under the Licence throughout the duration of their storage on licensed premises, including throughout their use in research. As such, the compliance requirements against HTA standards for traceability, governance and premises, facilities and equipment remain in place while the samples are being used.

5.2.3. Samples released from the Licence under ethical approval from a recognised REC (including samples released from a RTB under generic ethical approval) leave the Licence at the point of release and are subject to whatever compliance requirements are in place locally for samples stored under REC approval. The compliance requirements against HTA standards and Licence policy cease to apply for these samples for as long as the REC approval is in place.

5.2.4. Prior to releasing any material stored under the Licence for use for a Scheduled Purpose (note that this includes teaching/education for tissue from the deceased), the collection staff must perform a consent check to ensure that consent is in place for the
proposed use of the samples. Assumed consent (for example, because the donor consented to other research projects, or because the sample is stored in a biobank) is not acceptable. Records should be kept that a consent check has taken place for each release of material for a Scheduled Purpose. Specific arrangements for checking consent for samples held in diagnostic archives are detailed in section 6.

5.2.5. If consent records are in place for samples collected before the HT Act came into force (1 September 2006), they must be checked and any conditions respected.

5.2.6. A researcher requesting access to samples for a use which is not explicitly covered by the terms of the consent in place for the samples, or a collection PI wishing to store samples beyond the terms of the original consent provided by donors, must seek approval to proceed by applying to a recognised REC. In the absence of such approval, samples may not be released / stored beyond the terms of the consent explicitly in place.

5.2.7. Prior to releasing any material stored under the Licence for use in research, the collection staff must ensure that ethical approval is either in place or is not required (for example if the proposed use is not a Scheduled Purpose) for the proposed use. The proposed research must be explicitly covered by the terms of the ethical approval / described in the study protocol. This may be achieved by submitting an amendment to an existing research protocol; advice is available on this topic from CTRG\(^5\).

6. ACCESS TO DIAGNOSTIC MATERIAL

6.1 OUHFT diagnostic archives are an invaluable resource for research in Oxford. The archives contain predominantly formalin-fixed, paraffin-embedded (FFPE) tissue blocks and stained microscope slides taken from living patients during clinical procedures in the OUHFT hospitals, for the purpose of medical diagnosis. These samples are stored under the custodianship of the OUHFT as part of the patients’ medical record.

6.2 However, they may be accessed for research through a licensed RTB (see paragraph 6.4) under the following conditions:

6.2.1. There is explicit consent for the use of the sample for research, OR

6.2.2. The material was collected before 1 September 2006, OR

6.2.3. The material is released under recognised REC approval and mechanisms ensure the researcher(s) cannot identify the donor(s) of the material.

6.3 Material must not be released from a diagnostic archive if the patient has objected to the use of the sample(s) in research, regardless of whether the sample was collected before or after 1 September 2006.

6.4 There are currently two RTBs offering access to diagnostic archives under the Licence: the Oxford Radcliffe Biobank and the Oxford Brain Bank, accessing the Cellular Pathology archive and the Neuropathology archive, respectively. Both biobanks have Service Level Agreements (SLAs) with OUHFT detailing the responsibilities of both parties to ensure
material is collected, released and used in accordance with the patients' wishes, and without negatively impacting the clinical process.

6.5 The DI must have oversight over any access to diagnostic archives for research. Any RTB wishing to start offering access to diagnostic samples must contact the DI for formal authorisation of this activity and audit of the processes in place for the activity.

7. REFERENCES

7.1 Internal references

11 HTA008 - Licence 12217 Constitution accessible on iPassport
https://htg.ipassportqms.com/show_document?doc_id=5fb5a773c8f6b6e1b002981b60029504 and on the website:
https://researchsupport.admin.ox.ac.uk/governance/human-tissue/resources

12 Licence Core SOPs accessible on iPassport:
https://htg.ipassportqms.com/
(then search for the document number or name)

13 HTA012 - Risk Management Strategy for the Licence accessible on iPassport:
https://htg.ipassportqms.com/show_document?doc_id=eccd0dca09c017429a8b29e7d4d9d6eb

14 HTA_RA001 - Core Risk Assessment for the Licence accessible on iPassport:
https://htg.ipassportqms.com/show_document?doc_id=28b5b90ebb40bb7db0c684528442e752

15 University core SOP 009 on Managing Complaints Arising from Clinical Research accessible from CTRG web page at:
https://researchsupport.admin.ox.ac.uk/ctrgr/resources

16 HTA_FRM004 Traceability audit form, accessible from iPassport:
https://htg.ipassportqms.com/show_document?doc_id=d673aeebbd9cc9bb18a86814ef6e0cc

17 HTA_TEMP019 Internal audit template form, accessible from iPassport:
https://htg.ipassportqms.com/show_document?doc_id=c952dd75f72477d082ab1ab632e330c7

18 WebLearn training on the HT Act and HTA codes of practice:
https://weblearn.ox.ac.uk/portal/site/:medsci:hta

19 Annual returns form HTA_FRM006, accessible from iPassport:
https://htg.ipassportqms.com/show_document?doc_id=40ac835c7f2b6f24f88467221aa88d

7.2 External references


E2 Relevant material under the Human Tissue Act:

E2 HTA Code of Practice E and Standards for the Research sector: