Inspection report on compliance with HTA licensing standards
Inspection dates: **8 and 9 November 2023**

Addenbrooke's Hospital

HTA licensing number 11066

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

Licensable activities carried out by the establishment

'E' = Establishment is licensed to carry out this activity and is currently carrying it out.
'TPA' = Third-party agreement; the establishment is licensed for this activity but another establishment (not licensed by the HTA) carries out the activity on their behalf.

Site	Procurement	Processing	Testing	Storage	Distribution	Import	Export
Addenbrooke's Hospital	E	E	TPA	E	E		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.

Tissue Category; Tissue Type	Procurement	Processing	Testing	Storage	Distribution	Import	Export
Progenitor Cell, Haematopoietic, PBSC; PBSC	Authorised	Authorised	Authorised	Authorised	Authorised		Authorised
Progenitor Cell, Haematopoietic, Bone Marrow; Bone Marrow	Authorised	Authorised	Authorised	Authorised	Authorised		Authorised
Progenitor Cell, Haematopoietic, Bone Marrow; Bone Marrow (ATMP)	Authorised		Authorised				Authorised
Mature Cell, MNC; DLI	Authorised	Authorised	Authorised	Authorised	Authorised		Authorised
Mature Cell, MNC; PBMC	Authorised	Authorised	Authorised	Authorised			Authorised
Progenitor Cell, Hematopoietic, Cord Blood;			Authorised*	Authorised	Authorised		Authorised*

Cord Blood							
Musculoskeletal, Cartilage; Cartilage (ATMP)	Authorised*		Authorised*				Authorised*
Other; Tumour (ATMP)	Authorised		Authorised				Authorised

Summary of inspection 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 Addenbrooke's Hospital ('the establishment') had met the majority of the HTA's standards that were assessed during the inspection, three major and four minor shortfalls were found against standards for Consent, Governance and Quality, and Premises, Facilities and Equipment.

The HTA has assessed the establishment as suitable to be licensed for the activities specified, subject to corrective and preventative actions being implemented to meet the shortfalls identified during the inspection. However, the HTA is concerned about the recurrent nature of some of the inspection findings, most notably those relating to staffing levels and oversight of activities carried out by the third-party testing laboratory. Although the establishment has undertaken work to address the findings from the previous inspection, the underlying issues remain.

The HTA will consider the need for additional regulatory action in relation to these findings as part of the post-inspection process.

Compliance with HTA standards

Major shortfalls

GQ2 There is a documented system of quality management and audit.	At the last inspection a minor shortfall was identified related to the establishment's internal audit schedule which did not cover all licensable activities, including those carried out at the third-party testing laboratory. Whilst the establishment has commenced work on internal audits, the finding from the previous inspection has not been satisfactorily addressed. For example, a full internal audit schedule has not been developed and implemented and, despite efforts, the establishment has not been able to undertake an appropriate audit of the third-party testing laboratory. The grading of this shortfall reflects the fact the finding has not been addressed since the last inspection.	**Major**
b) There is an internal audit system for all licensable activities.		
GQ4 There is a systematic and planned approach to the management 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.		

GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and are continuously updating their skills.		
k) The establishment is sufficiently staffed to carry out its activities.	At the last inspection it was identified that the establishment was not sufficiently staffed to support the full range of activities under the licence. Although funding has been allocated for additional staff and there is ongoing recruitment, the current staffing levels remain insufficient to meet operational requirements. This is reflected in: • insufficient staff to undertake routine processing activities, resulting in the establishment regularly implementing its contingency plan of sending cells for processing at a third-party establishment; • insufficient numbers of trained staff to provide contingency for core activities (such as processing) during staff absences; • the nature, and investigation, of incidents; and • the scope and number of internal audits undertaken by Quality Assurance (QA) staff.	**Major**

GQ5 There are documented procedures for donor selection and exclusion, including donor criteria. 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. **PFE3 There are appropriate facilities for the storage of tissues and / or cells, consumables and records.**	At the last inspection a major shortfall was identified related to systems and procedures at the third-party testing laboratory. Although the establishment has undertaken work to address the findings from the previous inspection, practices at the testing laboratory, and the establishment's oversight of activities carried out under the authority of the Addenbrooke's Hospital's licence, remain insufficient to meet the requirements of Directions 001/2021. For example: • It was identified at the last inspection that the laboratory's procedures for the reporting of incidents did not include a requirement to ensure that the DI would be informed of potential serious adverse events related to activities under the licence within 24 hours of discovery or determination. During this inspection it was noted that incidents reviewed at the inspection had not been reported to the DI within 24 hrs of discovery or determination. • If samples are received late in the day, they may be stored in a specified laboratory refrigerator until the next working day before being transferred to the partner testing laboratory, potentially over a bank holiday weekend. Frequent temperature excursions both at the	**Major**

a) Tissues, cells, consumables and records are stored in secure environments and precautions are taken to minimise risk of damage, theft or contamination.	upper and lower limits of the ranges were seen in the temperature monitoring records for this refrigerator, as had been noted at the previous inspection. Since the last inspection the testing laboratory has implemented a procedure where samples are receipted into the laboratory reception, processed into serum, and the serum sent to a United Kingdom Accreditation Service (UKAS)-accredited partner laboratory for testing. There was no standard operating procedure (SOP) available for review that described the process for sorting the sample tubes into racks and storing them in sample reception. In addition, other key procedural steps were not documented. For example, the timeframe a sample could be stored on the bench before being sent to pre-analysis and logged onto the laboratory system, and confirmation that samples analysed at the partner laboratory would be checked to confirm they had been processed within the timeframes specified by the test kit manufacturers.	

Minor Shortfalls

Standard	Inspection findings	Level of shortfall
C1 Consent is obtained in accordance with the requirements of the Human Tissue Act 2004 (HT Act), the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (as amended) and as set out in the HTA's Codes of Practice.		
e) Completed consent forms are included in records and are made accessible to those using or releasing tissue and / or cells for a Scheduled Purpose.	A review of patient records identified one consent form for a Bone Marrow collection where several sections of the consent form had not been completed. However, confirmation of appropriate consent was available in other forms. In addition, a review of consent records for procurement of autologous peripheral blood mononuclear cells (PBMCs) as starting material for an advanced therapy medicinal product (ATMP), identified one procurement where a date was logged incorrectly, and another where several questions had not been answered. Whilst the consent forms were incomplete these issues did not impact the overall suitability of the consent that had been provided.	**Minor**

GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process.		
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.	Since the last inspection the third-party testing laboratory has implemented a process where blood samples are separated on receipt at the laboratory, and then sent to a partner testing laboratory for analysis. Whilst there was a signed Memorandum of Understanding between the two testing laboratories, the TPA between the establishment and the testing laboratory had expired and was under review.	**Minor**

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.	At the last inspection a shortfall was identified related to issues with closing incident investigations in a timely manner, and with implementing appropriate actions to prevent a recurrence of incidents. During a review of the investigation and corrective action reports for several recent incidents, it was noted that the establishment had not identified the root causes of the incidents or captured sufficient detail of the investigation undertaken to assess if it was suitable. The establishment was therefore unable to demonstrate that the corrective and preventative actions that were implemented in response to the incident were appropriate.	**Minor**

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.	Since the last inspection the third-party testing laboratory has changed its process for analysing mandatory serology samples. Risks associated with this change, and other potential risks within the testing laboratory, have not been assessed or documented.	**Minor**

Advice

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

Number	Standard	Advice
1.	C1(d)	The DI is advised to consider whether the generic consent form, donor assessment form and the health questionnaire /medical review form can be amended to avoid repetition and streamlined for use in different clinical scenarios by the removal of redundant questions.
2.	GQ1(c)	The DI is advised to consider inviting representatives from the third-party testing laboratory (which is on site) to governance meetings to facilitate interactions between the establishment and testing laboratory.
3.	GQ2(b)	The DI is advised to document instances where internal audits cannot be completed due to staff shortages, so that the issue can be appropriately escalated within the Trust. As additional new staff are trained, the DI is advised to consider involving laboratory and clinical staff in internal audits to provide additional resource, and develop staff engagement and ownership of processes and procedures.

4.	GQ2(c)	The establishment included an overview of primary records and raw data reviewed as part of its independent audit. The DI is advised to document the specific numbers of records and data sets reviewed to allow a critical assessment of the audit findings, particularly when determining compliance.
5.	GQ2(d)	With the agreement of the external ATMP manufacturer, the establishment has updated the controlled-rate freezer profile used for cryopreservation of PBMCs procured as ATMP starting material. The DI is advised to update the HTA Preparation Process Dossier (PPD) for this process to ensure that it reflects the current procedure.
6.	GQ3(k)	The establishment's contingency plan for processing involves sending cells to another HTA-licensed establishment under a Service Level Agreement (SLA) for processing and storage, should it have insufficient resource to process the cells on site. Stored samples are sent back to the establishment for clinical use. Due to the current staffing issues, this contingency has been enacted on an almost weekly basis, resulting in significant numbers of cells being processed and stored off-site. The intention is to eventually repatriate the stored cells and processing activity to the establishment as staff are recruited and trained. The DI is strongly advised to ensure that the repatriation of the processing activity and storage is phased to ensure that it does not exceed local resources.
7.	GQ3(k)	The DI is advised to ensure that there are sufficient staff available before undertaking any additional activities under the licence, such as recommencing procurement, testing and export of cartilage as an ATMP starting material.
8.	GQ4(h)	The DI is advised to implement periodic scanning of paper-based records, such as temperature records and cleaning logs, to provide assurance that they will continue to be retained.

9.	PFE2(b)	The DI is advised to consider including high contact areas, such as light switches and door handles, and difficult to reach areas, such as the corners of the hatches, in the environmental monitoring of the clean room.
10.	PFE3(a)	The establishment records the temperature of the storage areas in the apheresis unit. The DI is advised to update the temperature record sheet to indicate the action to be undertaken if there is a temperature deviation.
11.	PFE3(a)	The DI is strongly advised to review the arrangements for the temporary storage of samples at the third-party testing laboratory to ensure that they are fit-for-purpose.
12.	PFE5(d)	In light of the issues the establishment has experienced sourcing back-up particle counters for use in environmental monitoring, the DI is advised to take steps to follow-up the current order to ensure that the equipment is delivered as soon as possible.

Background

Addenbrooke's Hospital is part of the Cambridge University Hospital (CUH) NHS Foundation Trust. The establishment's core team are based at the hospital's Cambridge Cellular Therapy Laboratory (CCTL), which is part of the bone marrow transplant (BMT) programme within the Department of Haematology. Licensable activities are undertaken at the laboratory, within hospital theatres and apheresis areas, and the third-party testing laboratory, which is also located on the Addenbrooke's site.

The establishment has been licensed by the HTA since August 2006. This was the establishment's eighth inspection; the last inspection took place in November 2021.

Following the last inspection, an interim DI and an interim laboratory manager oversaw the quality and laboratory activities during the CAPA response period. This temporary change in DI's was managed through the HTA licensing framework. The current DI returned to

the role approximately two months before this inspection took place. The third-party testing laboratory has implemented new arrangements with a partner testing laboratory to undertake the serology testing required by the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (as amended). In addition, the establishment made changes to its authorised PPD. The establishment has a SLA in place with another HTA-licensed establishment to undertake processing and storage of cells, as a contingency arrangement, should it be unable to undertake these activities. Due to staffing issues this contingency has been implemented on an almost weekly basis.

Description of inspection activities undertaken

The HTA's regulatory requirements are set out in Appendix 1. The following areas were covered during the inspection:

Review of governance documentation

The inspection included a review of policies, procedural documentation, and agreements relevant to the establishment's licensable activities. The inspection also included a review of equipment service records, temperature monitoring records, environmental monitoring records, risk assessments, meeting minutes, incidents, audits, and staff training records.

Visual inspection

The inspection included a visual inspection of the apheresis facility, including a review of the area where apheresis takes place, along with areas where consumables and reagents are stored. In addition, the areas within the processing laboratory where tissue is received, processed, cryopreserved, stored and released were inspected, together with the storage areas for consumables and reagents.

The inspection also included a visual inspection of the third-party testing laboratory including the areas where samples are receipted, sorted, held prior to transfer to pre-analytical processing, and where the processed samples are held prior to transfer to the partner serology laboratory for testing. The visual review also included the area where results are manually transcribed into the establishment's electronic system.

Audit of records

Records for the following tissues and cells were reviewed:

- One autologous PBSC procured at the establishment.
- One autologous PBSC procured at another HTA-licensed establishment and received for processing and storage.
- One allogeneic PBSC and subsequent DLI procurement, both of which were subsequently disposed for clinical reasons.
- One allogeneic DLI received from a registry.
- Two allogeneic bone marrows, one paediatric bone marrow procured at Addenbrooke's Hospital and one received from a registry.
- Two autologous PBMC procurements for ATMP manufacture that were shipped unprocessed.
- One autologous PBMC procurement for ATMP manufacture that was processed before shipment.
- Two autologous tumour tissue procurements for ATMP manufacture.

The audit of the records above included a review of donor selection and consent, tissue collection records, shipping records, timing of blood sample collection for mandatory serology testing and the testing results, microbiology sterility testing results, processing records, records of materials coming into contact with the tissues, and environmental monitoring records. Where applicable, release, implantation or disposal records were also reviewed.

Meetings with establishment staff

The inspection included discussions with the DI, the establishment's Quality Managers for the Clinical and Laboratory activities, representatives of staff undertaking consent, apheresis and laboratory processing, and other staff working under the licence. The inspection also included discussions with the Laboratory Manager for the third-party testing laboratory.

Report sent to DI for factual accuracy: 21 December 2023

Report returned from DI: 12 January 2024

Final report issued: 16 January 2024

Appendix 1: 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 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.

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 Human Tissue Act 2004, Human Tissue (Quality and Safety for Human Application) Regulations 2007 (as amended), 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 (as amended) 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 inspection report. Major shortfalls pose a higher level of risk and therefore a shorter deadline is given, compared to minor shortfalls, to ensure the level of risk is reduced in an appropriate timeframe.

3. Minor shortfall:

A shortfall which cannot be classified as either critical or major and, which can be addressed by further development by the establishment.

This category of shortfall requires the development of a corrective action plan, the results of which will usually be assessed by

the HTA either by desk-based review or at the time of the next on-site inspection.

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

Follow up actions

A template corrective and preventative action plan will be sent as a separate Word document with the final inspection 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 inspection
- a request for information that shows completion of actions
- monitoring of the action plan completion
- follow up at next routine inspection.

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

Appendix 3: HTA standards
The HTA standards applicable to this establishment are shown below; those not assessed during the inspection are shown in grey text. Individual standards which are not applicable to this establishment have been excluded.

Human Tissue (Quality and Safety for Human Application) Regulations 2007 Standards (as amended)

Consent

Standard
C1 Consent is obtained in accordance with the requirements of the Human Tissue Act 2004 (HT Act), the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (as amended) and as set out in the HTA's Codes of Practice.
a) If the establishment acts as a procurer of tissues and / or cells, there is an established process for acquiring donor consent which meets the requirements of the HT Act 2004 the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (as amended) and the HTA's Codes of Practice.
c) The establishment or the third-party's procedure on obtaining donor consent includes how potential donors are identified and who is able to take consent.
d) Consent forms comply with the HTA Codes of Practice.
e) Completed consent forms are included in records and are made accessible to those using or releasing tissue and / or cells for a Scheduled Purpose.
C2 Information about the consent process is provided and in a variety of formats.
a) The procedure on obtaining consent details what information will be provided to donors. As a minimum, the information specified by Directions 001/2021 is included.
c) Information is available in suitable formats and there is access to independent interpreters when required.

d) There are procedures to ensure that information is provided to the donor or donor's family by trained personnel.
C3 Staff involved in seeking consent receive training and support in the implications and essential requirements of taking consent.
a) Staff involved in obtaining consent are provided with training on how to take informed consent in accordance with the requirements of the HT Act 2004 and Code of Practice on Consent.
b) Training records are kept demonstrating attendance at training on consent.

Governance and Quality

Standard
GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process.
a) There is an organisational chart clearly defining the lines of accountability and reporting relationships.
b) There are procedures for all licensable activities that ensure integrity of tissue and / or cells and minimise the risk of contamination.
c) There are regular governance meetings, for example health and safety, risk management and clinical governance committees, which are recorded by agendas and minutes.
d) There is a document control system to ensure that changes to documents are reviewed, approved, dated and documented by an authorised person and only current documents are in use.
e) There are procedures for tissue and / or cell procurement, which ensure the safety of living donors.

g) There are procedures to ensure that an authorised person verifies that tissues and / or cells received by the establishment meet required specifications.
h) There are procedures for the management and quarantine of non-conforming consignments or those with incomplete test results, to ensure no risk of cross contamination.
i) There are procedures to ensure tissues and / or cells are not released from quarantine until verification has been completed and recorded.
j) There are procedures detailing the critical materials and reagents used and where applicable, materials and reagents meet the standards laid down by the Medical Devices Regulation 2002 (SI 2002 618, as amended) (UK MDR 2002) and United Kingdom Conformity Assessed (UKCA).
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 that the third-party will inform the establishment in the event of a serious adverse reaction or event.

t) There are procedures for the re-provision of service in an emergency.
GQ2 There is a documented system of quality management and audit.
a) There is a quality management system which ensures continuous and systematic improvement.
b) There is an internal audit system for all licensable activities.
c) An audit is conducted in an independent manner at least every two years to verify compliance with protocols and HTA standards, and any findings and corrective actions are documented.
d) Processes affecting the quality and safety of tissues and / or cells are validated and undergo regular evaluation to ensure they continue to achieve the intended results.
GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and are continuously updating their skills.
a) There are clearly documented job descriptions for all staff.
b) There are orientation and induction programmes for new staff.
c) There are continuous professional development (CPD) plans for staff and attendance at training is recorded.
d) There is annual documented mandatory training (e.g. health and safety and fire).
e) Personnel are trained in all tasks relevant to their work and their competence is recorded.
f) There is a documented training programme that ensures that staff have adequate knowledge of the scientific and ethical principles relevant to their work, and the regulatory context.
g) There is a documented training programme that ensures that staff understand the organisational structure and the quality systems used within the establishment.

h) There is a system of staff appraisal.
i) Where appropriate, staff are registered with a professional or statutory body.
j) There are training and reference manuals available.
k) The establishment is sufficiently staffed to carry out its activities.
GQ4 There is a systematic and planned approach to the management of records.
a) There are procedures for the creation, identification, maintenance, access, amendment, retention and destruction of records.
b) There is a system for the regular audit of records and their content to check for completeness, legibility and accuracy and to resolve any discrepancies found.
c) Written records are legible and indelible. Records kept in other formats such as computerised records are stored on a validated system.
d) There is a system for back-up / recovery in the event of loss of computerised records.
e) The establishment keeps a register of the types and quantities of tissues and / or cells that are procured, tested, preserved, processed, stored and distributed or otherwise disposed of, and on the origin and destination of tissues and cells intended for human application.
f) There are procedures to ensure that donor documentation, as specified by Directions 001/2021, is collected and maintained.
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.
k) There are documented agreements with end users to ensure they record and store the data required by Directions 001/2021.
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 is in place to ensure raw data and records of traceability are maintained for 10 or 30 years respectively, 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.
e) Testing of donor samples is carried out using UKCA or CE marked diagnostic tests, in line with the requirements set out in Directions 001/2021.
f) Samples taken for donor testing are clearly labelled with the time and place the sample was taken and a unique donor identification code.

GQ6 A coding and records system facilitates traceability of tissues and / or cells, ensuring a robust audit trail.
a) There is a donor identification system which assigns a unique code to each donation and to each of the products associated with it.
b) An audit trail is maintained, which includes details of when the tissues and / or cells were acquired and from where, the uses to which the tissues and / or cells were put, when the tissues and / or cells were transferred elsewhere and to whom.
c) The establishment has procedures to ensure that tissues and / or cells imported, procured, processed, stored, distributed and exported are traceable from donor to recipient and vice versa.
GQ7 There are systems to ensure that all adverse events, reactions and/or incidents are investigated promptly.
a) There are procedures for the identification, reporting, investigation and recording of adverse events and reactions, including documentation of any corrective or preventative actions.
b) There is a system to receive and distribute national and local information (e.g. HTA regulatory alerts) and notify the HTA and other establishments as necessary of serious adverse events or reactions.
c) The responsibilities of personnel investigating adverse events and reactions are clearly defined.
d) There are procedures to identify and decide the fate of tissues and / or cells affected by an adverse event, reaction or deviation from the required quality and safety standards.
e) In the event of a recall, there are personnel authorised within the establishment to assess the need for a recall and if appropriate initiate and coordinate a recall.
f) There is an effective, documented recall procedure which includes a description of responsibilities and actions to be taken in the event of a recall including notification of the HTA and pre-defined times in which actions must be taken.
g) Establishments distributing tissue and / or cells provide information to end users on how to report a serious adverse event or reaction and have agreements with them specifying that they will report these events or reactions.

h) Establishments distributing tissues and / or cells have systems to receive notifications of serious adverse events and reactions from end users and notify the HTA.
GQ8 Risk assessments of the establishment's practices and processes are completed regularly and are recorded and monitored appropriately.
a) There are documented risk assessments for all practices and processes.
b) Risk assessments are reviewed regularly, as a minimum annually or when any changes are made that may affect the quality and safety of tissues and cells.
c) Staff can access risk assessments and are made aware of local hazards at training.
d) A documented risk assessment is carried out to decide the fate of any tissue and / or cells stored prior to the introduction of a new donor selection criteria or a new processing step, which enhances the quality and safety of tissue and / or cells.

Premises, Facilities and Equipment

Standard
PFE1 The premises are fit for purpose.
a) A risk assessment has been carried out of the premises to ensure that they are fit for purpose.
b) There are procedures to review and maintain the safety of staff, visitors and patients.
c) The premises have sufficient space for procedures to be carried out safely and efficiently.
e) There are procedures to ensure that the premises are secure, and confidentiality is maintained.
f) There is access to a nominated, registered medical practitioner and / or a scientific advisor to provide advice and oversee the establishment's medical and scientific activities.

PFE2 Environmental controls are in place to avoid potential contamination.
a) Tissues and / or cells stored in quarantine are stored separately from tissue and / or cells that have been released from quarantine.
b) Where processing of tissues and / or cells involves exposure to the environment, it occurs in an appropriate, monitored environment as required by Directions 001/2021.
c) There are procedures for cleaning and decontamination.
d) Staff are provided with appropriate protective clothing and equipment that minimise the risk of contamination of tissue and / or cells and the risk of infection to themselves.
PFE3 There are appropriate facilities for the storage of tissues and / or cells, consumables and records.
a) Tissues, cells, consumables and records are stored in secure environments and precautions are taken to minimise risk of damage, theft or contamination.
b) There are systems to deal with emergencies on a 24-hour basis.
c) Tissues and / or cells are stored in controlled, monitored and recorded conditions that maintain tissue and / or cell integrity.
d) There is a documented, specified maximum storage period for tissues and / or cells.
PFE4 Systems are in place to protect the quality and integrity of tissues and / or cells during transport and delivery to its destination.
a) There is a system to ensure tissue and / or cells are not distributed until they meet the standards laid down by Directions 001/2021.
b) There are procedures for the transport of tissues and / or cells which reflect identified risks associated with transport.

c) There is a system to ensure that traceability of tissues and / or cells is maintained during transport.
d) Records are kept of transportation and delivery.
e) Tissues and / or cells are packaged and transported in a manner and under conditions that minimise the risk of contamination and ensure their safety and quality.
f) There are third-party agreements with courier or transport companies to ensure that any specific transport conditions required are maintained.
g) Critical transport conditions required to maintain the properties of tissue and / or cells are defined and documented.
h) Packaging and containers used for transportation are validated to ensure they are fit for purpose.
i) Primary packaging containing tissues and / or cells is labelled with the information required by Directions 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.

g) Instruments and devices used for procurement are sterile, validated and regularly maintained.
h) Users have access to instructions for equipment and receive training in the use of equipment and maintenance where appropriate.
i) Staff are aware of how to report an equipment problem.
j) For each critical process, the materials, equipment and personnel are identified and documented.
k) There are contingency plans for equipment failure.

Disposal

Standard
D1 There is a clear and sensitive policy for disposing of tissues and / or cells.
a) The disposal policy complies with HTA's Codes of Practice.
b) The disposal procedure complies with Health and Safety recommendations.
c) There is a documented procedure on disposal which ensures that there is no cross contamination.
D2 The reasons for disposal and the methods used are carefully documented.
a) There is a procedure for tracking the disposal of tissue and / or cells that details the method and reason for disposal.
b) Disposal arrangements reflect (where applicable) the consent given for disposal.