Inspection report on compliance with HTA licensing standards
Inspection dates: **16-17 October and 06, 18 and 28 November 2024**

Biovault

HTA licensing number 11063

Licensed under the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (as amended)
and
Licensed under the Human Tissue Act 2004

Licensable activities carried out by the establishment
Licensed activities – Human Tissue (Quality and Safety for Human Application) Regulations 2007 (as amended)
'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. The activity is not currently being carried out.

Site	Procurement	Processing	Testing	Storage	Distribution	Import	Export
Biovault	TPA*	E	E	E	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, Bone Marrow; Bone Marrow		Authorised*		Authorised	Authorised*		
Progenitor Cell, Haematopoietic, PBSC; PBSC		Authorised		Authorised	Authorised		
Mature Cell, MNC; DLI		Authorised		Authorised	Authorised		
Progenitor Cell, Hematopoietic, Cord Blood; Cord Blood	Authorised*	Authorised*		Authorised	Authorised	Authorised*	Authorised
Umbilical Cord; Cord Tissue	Authorised*	Authorised*		Authorised	Authorised	Authorised*	Authorised
Musculoskeletal, Bone; Bone				Authorised	Authorised	Authorised	

Membrane, Fascia Lata; Fascia Lata				Authorised	Authorised	Authorised	
Musculoskeletal, Tendon & Ligament; Ligament						Authorised	
Musculoskeletal, Tendon & Ligament; Tendon				Authorised	Authorised	Authorised	
Musculoskeletal, Tendon & Ligament; Menisci						Authorised	
Musculoskeletal, Cartilage; Cartilage				Authorised	Authorised	Authorised	
Musculoskeletal, Bone; Cancellous Bone Particles				Authorised	Authorised	Authorised	
Skin						Authorised	
Musculoskeletal, Bone; DBM						Authorised	
Musculoskeletal, Bone; Acellular						Authorised	

bone							
Membrane, Amniotic; Amniotic membrane						Authorised	

Licensed activities – Human Tissue Act 2004
The establishment is licensed for the storage of relevant material which has come from a human body for use for a scheduled purpose.

Summary of inspection findings
Although the HTA found that Biovault (the establishment) had met many of the HTA's standards that were assessed during the inspection, three major and six minor shortfalls were found against standards for Governance and Quality, and Premises, Facilities and Equipment.

In addition to the above, at the time of this inspection the DI had not taken adequate steps to resolve the following shortfalls identified at the 2022 inspection:

- environmental monitoring procedures one of the establishment's third country suppliers (3CSs) remain unaligned with Directions 001/2021. Information provided by the DI on the steps taken by the 3CS to resolve this matter was also determined to be inaccurate; and related to this,

- the robustness of incoming tissue receipt checks and audits remains insufficient. This had been a minor finding at the previous inspection and was escalated to a major finding in 2022 as it was not sufficiently addressed and had recurred.

The nature of the recurrent shortfalls at the time of this inspection and the additional findings described in this report raise concerns that

the DI and CLH may have failed to discharge their duty to supervise the licensed activity, specifically in relation to their responsibility for ensuring that suitable practices are adopted. The HTA will review the suitability of the DI and CLH as the corrective actions are undertaken to address the shortfalls identified during the inspection.

Compliance with HTA standards

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

Major shortfalls

Standard	Inspection findings	Level of shortfall
GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process.		
b) There are procedures for all licensable activities that ensure integrity of tissue and / or cells and minimise the risk of contamination.	In early 2024, the establishment implemented a process to speciate any viable contaminants that were detected during environmental monitoring of the clean room suite. During the inspection, several concerns were identified relating to this process: • There was no standard operating procedure (SOP) in place to describe how the process should be carried out and overseen. For example, instructions on how colonies should be preserved before being sent to the laboratory that was contracted to undertake identification work have not been developed, nor have procedures setting out how results would be received,	**Major**

	documented, and assessed in relation to the suitability of the processing environment and any specific processing events. • Where contamination was identified, colonies were expanded on agar plates before being sent for identification. Examples were seen where two original colonies were expanded on one agar plate and in some cases overlapped. As a result, the method that was used introduced a risk of inaccurate speciation results. • Plates were stored in a refrigerator for up to five months before being sent for speciation. A rationale supporting the suitability of this practice was not available for review by the inspection team. • Plates were stored in a refrigerator that was marked as 'not in use' at the time of the inspection. In addition to the above, establishment procedures require updating to: • reflect the establishment's requirement for staff to use trays to separate temperature probes from which temperature data has been downloaded from those awaiting download; and, • to accurately reflect the frequency at which 'at rest' non-viable particle monitoring is undertaken.	

n) The establishment ensures imports from third countries meet the standards of quality and safety set out in Directions 001/2021.	The establishment imports tissues and cells for human application from two 3CSs. During the inspection it was determined that the procedures in place to assess donor suitability at one of the 3CS were not sufficiently robust to allow application of the exclusion criteria defined by Directions 001/2021. Specifically, there was not a suitably robust process in place to ensure that risks associated with factors such as donor lifestyle, behaviour and travel history would be identified. In addition to the above, at the establishment's last inspection it was determined that the 3CS's approach to environmental monitoring was not aligned with the requirements of Directions 001/2021. The supplier had taken steps to investigate the implementation of environmental monitoring for tissue made available for import, and the HTA had been provided with assurance that viable and non-viable monitoring had been implemented from January 2024 onwards. However, at the time of the subsequent 2024 inspection it was confirmed that viable and non-viable monitoring had been undertaken for validation runs but was not in routine use for tissue imported under the establishment's licence. Separately, the establishment provides a brokerage service through which tissue is imported directly from one of the establishment's 3CS to end-use premises. The establishment's audits of this activity did not include all stages of the tissue pathway, including those undertaken prior to the tissue being imported into the European Union by the establishment's 3CS. The establishment's documented procedure relating to the undertaking and oversight of this activity was not	**Major**

	sufficiently detailed to ensure it would be carried out consistently in the manner that was described to the inspection team. Furthermore, arrangements between the supplier and the establishment require strengthening to ensure that events that have the potential to impact on the quality and safety of the imported tissue are reported to the establishment in a timely manner, to allow for assessment and onward reporting to the HTA where applicable in line with Directions 001/2021.	
GQ2 There is a documented system of quality management and audit.		
a) There is a quality management system which ensures continuous and systematic improvement.	The establishment's quality management system (QMS) and governance arrangements do not support continuous improvement, as evidenced by: • a lack of critical appraisal of activities undertaken by the 3CS; • inaccurate information being provided to the HTA regarding actions taken to address the findings from the 2022 inspection; • the number and nature of open shortfalls from the last inspection and the recurrent nature of some of the shortfalls identified during this inspection; and, • a lack of a robust change control system, as evidenced by a number of concerns relating to the implementation of the speciation of environmental contaminants in the establishment's clean room suite. Where relevant, further details on each specific area of concern are captured under the applicable licensing standards within in this report.	**Major**

Minor Shortfalls

Standard	Inspection findings	Level of shortfall
GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process.		
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).	The establishment has a process in place whereby critical consumables and reagents within the clean rooms are recorded against a checklist on each day of processing. During the inspection, it was identified that the required checks were not carried out on two out of a total of five processing days for which data was reviewed. The process requires updating to ensure the expiry dates are recorded as well as batch information.	**Minor**

r) Third party agreements specify the responsibilities of the third party and meet the requirements set out in Directions 001/2021.	The establishment has an agreement in place with a testing laboratory for serological testing activities related to stored cord blood and tissue. At the establishment's 2022 inspection it was identified that the agreement did not clearly set out the responsibilities of each party for the carrying out of this activity or for reporting of SAEARs within 24 hours of discovery. Although the establishment has explored options to resolve this finding, it remained open at the 2024 inspection.	**Minor**
GQ2 There is a documented system of quality management and audit.		
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.	Although the establishment had undertaken an independent audit of activities under the licence, the audit did not include a review of cord blood and tissue activities. Records of the audit that were available for review at the time of the inspection did not specify which traceability records had been reviewed or the date(s) upon which the audit had been undertaken.	**Minor**

GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and are continuously updating their skills.		
e) Personnel are trained in all tasks relevant to their work and their competence is recorded.	The establishment has systems and procedures in place to undertake and document the training of personnel working under the licence. The arrangements require a review to ensure that personnel are competent in each task they undertake prior to working unsupervised. During the inspection, an example was reviewed in which a member of staff prepared product labels that contained an error. The individual was not signed-off as competent to undertake the procedure unsupervised at the time the error occurred.. Separately, training records for a member of staff undertaking processing activities did not identify the person who undertook the training.	**Minor**
GQ4 There is a systematic and planned approach to the management of records.	The establishment documents daily cleaning and maintenance activities using a checklist. A limited review of past records identified gaps and errors in the recorded information, such that the record did not accurately reflect the dates when a clean room had been used for processing. As a result, the checklist could not be used to verify that activities that must be undertaken on processing days were indeed carried out. In the example reviewed, the reagents used to clean the processing suite had not been used in the rotation that is specified in establishment procedures. These inconsistencies and deviations had not been identified by staff undertaking review and acceptance of the completed checklist.	**Minor**
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.		
PFE2 Environmental controls are in place to avoid potential contamination.		

c) There are procedures for cleaning and decontamination.		
PFE1 The premises are fit for purpose.		
b) There are procedures to review and maintain the safety of staff, visitors and patients.	During the inspection, large pools of water were observed around the liquid nitrogen storage tanks as the result of a build-up of condensation. This issue had been identified as a risk and discussed in establishment governance meetings. However, the establishment had not implemented sufficient mitigations to address the health and safety risk the pooled water presented to staff and visitors.	**Minor**

The HTA requires the DI to submit a completed corrective and preventative action (CAPA) plan setting out how the shortfalls will be addressed, within 14 days of receipt of the final report (refer to Appendix 2 for recommended timeframes within which to complete actions). The HTA will then inform the establishment of the evidence required to demonstrate that the actions agreed in the plan have been completed.

DI and CLH/LH suitability

The nature of the open shortfalls at the time of this inspection and the additional findings described in this report raise concerns that both the DI and CLH may have failed to discharge their duty to supervise the licensed activity, specifically in relation to their responsibility for ensuring that suitable practices are adopted. The HTA will review the suitability of the DI and CLH as the corrective actions are undertaken to address the shortfalls identified during the inspection.

Advice

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

Number	Standard	Advice
1.	GQ1c	The DI is advised to update the standing agenda items reviewed at establishment's governance meetings to help ensure oversight of all activities and topics relevant to the licence. Examples include active quality incident reports, active change controls captured within a robust change control process, and planned future changes.
2.	GQ1n	The establishment has a process in place to remotely authorise the import of tissue for human application under a brokerage agreement with one of it's 3CS. The DI is advised to ensure that correspondence capturing each authorisation event is stored within the establishment's quality management system rather than, or in addition to, staff email accounts. This will help ensure such records are securely maintained.
3.	GQ3j	The DI is advised to update training record templates to require personnel to record their reading of relevant procedures as part of their training activities. The DI is further advised to review the establishments practice of allowing personnel to review and approve data associated with their own training activities without a second review by another member of staff competent in the activity that is being assessed.
4.	GQ3k	The DI is advised to review and strengthen the establishment's Quality Assurance (QA) resource and QA staff access to independent training opportunities. This may support the DI in maintaining oversight of all activities under the licence, support alignment with current best practice, and ensure that routine QA activities such as audits, governance meetings and document reviews are undertaken to schedule.

5.	GQ4h,i	The DI is advised to continue with plans to digitise paper records held in the establishment's warehouse area. In the meantime, the DI is advised to ensure that the establishment's documented risk assessments include an assessment of the suitability of the storage environment, including temperature and humidity ranges over time, for the maintenance of traceability and raw data records in line with the requirements of Directions 001/2021.
6.	GQ4k	The establishment requires end users to provide feedback on the use and outcomes of tissue they have supplied, but this is not consistently returned. The DI is advised to review current arrangements for tissue supplied directly and under a brokerage agreement and consider implementing a procedure to provide assurance that end users are adhering to the terms of their agreements with regard to maintaining traceability and reporting serious adverse events and reactions.
7.	GQ7a	The establishment has a detailed template that is used to document incidents, deviations and progress towards completing identified corrective and preventative actions. The DI is advised to update this template to prompt staff to also explicitly document their assessment of the impact, if any, of the incident on the quality and safety of the tissues and cells associated with the incident.
8.	PFE2a	The DI is advised to review storage arrangements for imported tissue held at -80°C and ensure there is a secure area for any tissue that may need to be quarantined that is separate from tissue available for release.
9.	PFE2b	The DI is advised to ensure that the establishment's non-viable particle monitor inlets are positioned to face the direction of airflow within the establishment's microbiological safety cabinets, so that the monitors are able to sample the quality of air cells are exposed to during aseptic processing.
10.	PFE3a	The establishment has a procedure in place to regularly review temperature monitoring records for critical storage equipment. The review focuses on reviewing any alarms that may have been triggered since the last review, to ensure the matter was suitably investigated and resolved. The DI is advised to

		ensure that these reviews include a documented check of the raw data, to provide assurance that the alarm system is functioning correctly and that there has been no loss of data. During the inspection, a build up of ice was noted in a -80°C freezer used to store tissue prior to distribution. The DI is advised to implement a schedule of regular checks, to include the removal of ice when required and associated tasks such as the removal of any dust from freezer grills.
11.	PFE5c	The establishment uses a reference probe to verify the accuracy of temperature probes that are used to monitor critical storage equipment. During a review of records a labelling error was identified, but the establishment were able to confirm which probe the record related to. The DI is advised to risk assess the current process to determine whether further safeguards, such as a second check of the verification records, would help to avoid a recurrence.
12.	PFE5b,d	The DI is advised to ensure that staff are consistently documenting their assurance that equipment is suitable to be returned to use after servicing or repair. The DI is further advised to ensure that this process includes a documented review of any documentation provided by the contractor that undertook the work.

Background

Biovault (the establishment) has been licensed by the HTA since July 2006. This was the establishment's ninth inspection; the last inspection took place in September 2022.

The establishment provides a processing, storage and distribution service for peripheral blood stem cells (PBSCs) and peripheral blood lymphocytes for donor lymphocyte infusion (DLI), which have been procured under another establishment's HTA licence. The cells are processed by Biomedical Scientists (BMSs) from the second establishment within one of the establishment's two clean room suites, under an agreement with Biovault.

In the period since the last inspection the establishment provided this service on a temporary basis for a second licensed establishment. At the time of the inspection this temporary arrangement was ending, with some cells still in storage awaiting return to the procuring establishment. The establishment also stores bone marrow units but has not undertaken processing or distribution of bone marrow since the last inspection.

The establishment stores cord blood and cord tissue for potential human application and imports a range of tissue products for human application from two third country suppliers (3CS). Tissue from one 3CS is imported under a brokerage arrangement, whilst tissue supplied by the other 3CS is received and stored at the establishment before onward distribution to end users.

Since the previous inspection there has been a change to the CLHc and changes to range of tissue imported under the licence. The establishment has also ceased the import of cord blood and cord tissue.

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 procedural documents relating to licensed activities, equipment and facility servicing and maintenance records, audit records, risk assessments, incident records, meeting minutes, temperature monitoring data, and staff training records.

Visual inspection
The inspection team undertook a visual inspection of the establishment's premises, visiting areas of tissue and cell receipt, storage and distribution. The team also reviewed the establishment's clean room suite where the establishment undertakes aseptic processing activities, as well as reagent and equipment storage areas and laboratory areas where agar plates used in the monitoring of the processing environment are incubated and assessed.

Audit of records
Representative records were reviewed. These included:

- a traceability audit of two tendon products that had been imported to the establishment's premises and subsequently distributed to end users.
- A traceability audit for one dermis product imported directly to the end user under the terms of a brokerage arrangement.
- two sets of records associated with the receipt, processing, storage and, where applicable, distribution of peripheral blood stem cells (PBSCs) processed and distributed on behalf of other licensed establishments under the terms of service level agreements.

Meetings with establishment staff
Discussions were held with the establishment's DI, the Quality Manager, the Technical Manager, and staff working under the licence. The team also met with representatives of one of the establishment's 3CS as part of the review of records associated with tissue imported under the licence since the last inspection.

The establishment is also licensed for the storage of relevant material for use in a Scheduled Purpose. This activity was not reviewed as part of this inspection.

Report sent to DI for factual accuracy: 26 March 2025

Report returned from DI: 11 April 2025

Final report issued: 14 July 2025

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.
b) If there is a third-party procuring tissues and / or cells on behalf of the establishment the third-party agreement ensures that consent is obtained in accordance with the requirements of the HT Act 2004, the 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.
b) If third parties act as procurers of tissues and / or cells, the third-party agreement details what information will be provided to donors. As a minimum, the information specified by Directions 001/2021 is included.
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.
n) The establishment ensures imports from third countries meet the standards of quality and safety set out in Directions 001/2021.

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.

Human Tissue Act 2004 standards

Consent

Standard
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
a) Consent procedures are documented and these, along with any associated documents, comply with the HT Act and the HTA's Codes of Practice.
b) Where applicable, there are agreements with other parties to ensure that consent is obtained in accordance with the requirements of the HT Act and the HTA's Codes of Practice.
c) Where applicable, there are agreements with other parties to ensure that consent is obtained in accordance with the requirements of the HT Act and the HTA's Codes of Practice.
d) Written information is provided to those from whom consent is sought, which reflects the requirements of the HT Act and the HTA's Codes of Practice.
e) Language translations are available when appropriate.
f) Information is available in formats appropriate to the situation.
C2 Staff involved in seeking consent receive training and support in the essential requirements of taking consent
a) There is suitable training and support of staff involved in seeking consent, which addresses the requirements of the HT Act and the HTA's Codes of Practice.
b) Records demonstrate up-to-date staff training.
c) Competency is assessed and maintained.

Governance and Quality

Standard
GQ1 All aspects of the establishments work are governed by documented policies and procedures as part of the overall governance process
a) Ratified, documented and up-to-date policies and procedures are in place, covering all licensable activities.
b) There is a document control system.
c) There are change control mechanisms for the implementation of new operational procedures.
d) Matters relating to HTA-licensed activities are discussed at regular governance meetings, involving establishment staff.
e) There is a system for managing complaints.
GQ2 There is a documented system of audit
a) There is a documented schedule of audits covering licensable activities.
b) Audit findings include who is responsible for follow-up actions and the timeframes for completing these.
GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and are continuously updating their skills
a) Qualifications of staff and all training are recorded, records showing attendance at training.
b) There are documented induction training programmes for new staff.
c) Training provisions include those for visiting staff.

d) Staff have appraisals and personal development plans.
GQ4 There is a systematic and planned approach to the management of records
a) There are suitable systems for the creation, review, amendment, retention and destruction of records.
b) There are provisions for back-up / recovery in the event of loss of records.
c) Systems ensure data protection, confidentiality and public disclosure (whistleblowing).
GQ5 There are systems to ensure that all adverse events are investigated promptly
a) Staff are instructed in how to use incident reporting systems.
b) Effective corrective and preventive actions are taken where necessary and improvements in practice are made.
GQ6 Risk assessments of the establishment’s practices and processes are completed regularly, recorded and monitored
a) There are documented risk assessments for all practices and processes requiring compliance with the HT Act and the HTA’s Codes of Practice.
b) Risk assessments are reviewed regularly.
c) Staff can access risk assessments and are made aware of risks during training.

Traceability

Standard
T1 A coding and records system facilitates the traceability of bodies and human tissue, ensuring a robust audit trail
a) There is an identification system which assigns a unique code to each donation and to each of the products associated with it.
b) A register of donated material, and the associated products where relevant, is maintained.
c) An audit trail is maintained, which includes details of: when and where the bodies or tissue were acquired and received; the consent obtained; all sample storage locations; the uses to which any material was put; when and where the material was transferred, and to whom.
d) A system is in place to ensure that traceability of relevant material is maintained during transport.
e) Records of transportation and delivery are kept.
f) Records of any agreements with courier or transport companies are kept.
g) Records of any agreements with recipients of relevant material are kept.
T2 Bodies and human tissue are disposed of in an appropriate manner
a) Disposal is carried out in accordance with the HTA’s Codes of Practice.
b) The date, reason for disposal and the method used are documented.

Premises, facilities and equipment

Standard
PFE1 The premises are secure and fit for purpose
a) An assessment of the premises has been carried out to ensure that they are appropriate for the purpose.
b) Arrangements are in place to ensure that the premises are secure and confidentiality is maintained.
c) There are documented cleaning and decontamination procedures.
PFE2 There are appropriate facilities for the storage of bodies and human tissue
a) There is sufficient storage capacity.
b) Where relevant, storage arrangements ensure the dignity of the deceased.
c) Storage conditions are monitored, recorded and acted on when required.
d) There are documented contingency plans in place in case of failure in storage area.
PFE3 Equipment is appropriate for use, maintained, validated and where appropriate monitored
a) Equipment is subject to recommended calibration, validation, maintenance, monitoring, and records are kept.
b) Users have access to instructions for equipment and are aware of how to report an equipment problem.
c) Staff are provided with suitable personal protective equipment.