Inspection report on compliance with HTA licensing standards
Inspection dates: **24-25 September 2024**

King's College Hospital

HTA licensing number 11006

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.
'SLA' = Service level agreement; the establishment is licensed for this activity but another HTA-licensed establishment carries out the activity on their behalf.

Site	Procurement	Processing	Testing	Storage	Distribution	Import	Export
King's College Hospital	E	E	TPA	E	E		E/SLA

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
Mature Cell, MNC; DLI*	Authorised	Authorised	Authorised	Authorised	Authorised		
Mature Cell, MNC; PBMC**	Authorised	Authorised	Authorised	Authorised			Authorised
Progenitor Cell, Hematopoietic, Bone Marrow; Bone Marrow	Authorised*	Authorised*	Authorised*	Authorised*	Authorised*		
Progenitor Cell, Hematopoietic, Cord Blood; Cord Blood	Authorised*	Authorised*	Authorised*	Authorised	Authorised*		
Progenitor Cell, Haematopoietic, PBSC; PBSC***	Authorised	Authorised	Authorised	Authorised	Authorised		

*Cells for Donor Lymphocyte Infusions (DLI)
**Peripheral Blood Mononuclear Cells (PBMC)
***Peripheral Blood Stem Cells (PBSC)

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 but is not carrying out this activity.

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 King's College Hospital (the establishment) had met the majority of the HTA's standards that were assessed during the inspection, one major and six minor shortfalls were found against standards for 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.

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
PFE1 The premises are fit for purpose.		
c) The premises have sufficient space for procedures to be carried out safely and efficiently.	There is insufficient space in the apheresis facility to allow for staff to carry out procedures effectively. This issue was highlighted in the previous HTA inspection report and has been noted in other accreditation inspections. A corrective and preventative action (CAPA) plan was agreed following the last HTA inspection to address this issue. However, the agreed action has not been carried out. The classification of this finding as a Major shortfall reflects this observation.	**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.		
b) There are procedures for all licensable activities that ensure integrity of tissue and / or cells and minimise the risk of contamination.	The establishment's documented procedures for the cryopreservation of cells for donor lymphocyte infusions (DLIs) do not specify a maximum permitted time from the addition of DMSO to the commencement of cryopreservation. Cells from donors that have positive infectious disease results are processed after all other samples. This practice is not documented within standard operating procedures.	**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.	The establishment has not conducted an independent audit in the preceding two years to verify compliance with HTA standards.	**Minor**

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.	During the inspection, it was noted that several alarms were not acknowledged for both cryostorage tanks and incubators, which implied the temperature deviations were not addressed. It was noted that the incident reports for the temperature deviations were not fully complete, which therefore did not allow for the alarm alerts to be resolved. Although staff confirmed verbally that the temperature deviations were rectified, the inspection team were advised that current staffing levels were insufficient to enable incident reports to be completed in such a way as to capture the full investigation and identified root causes for all temperature deviations. As a result, there is risk that temperature deviations are not managed appropriately to ensure the quality and safety of tissues and cells.	**Minor**

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.	The establishment's donor selection form does not include all of the donor exclusion criteria as set out in Annex A of the Guide to Quality and Safety Assurance for Human Tissues and Cells for Patient Treatment. Although the establishment indicated that these questions form part of the wider donor evaluation process, there is currently no documented evidence that the donors are asked about the presence, or history, of malignancy and autoimmune disease.	**Minor**

PFE2 Environmental controls are in place to avoid potential contamination.		
c) There are procedures for cleaning and decontamination.	The daily cleaning records of the clean room facility were not completed for a two-week period in July 2024. The establishment was unable to evidence that the clean room was cleaned during that period.	**Minor**

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.	The validation for the cool box used for the storage of cells at the apheresis ward, prior to collection by the courier, does not accurately mimic the process of warm cells being stored. In addition, the cool box has no asset number and is therefore not readily identifiable. In addition, the clean room facility's polymeric mat used to reduce contamination upon entry has not been replaced since its installation.	**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.

Advice

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

Number	Standard	Advice
1.	C1a	The form used by the establishment to obtain consent for the procurement of PBMCs that are used as the starting material in the manufacture of an advanced therapy medicinal product (ATMP) only describes a subset of the serology tests that will be performed. Although information on the tests that will be carried out is captured in a separate document, the DI should consider reviewing and updating the consent form to include this information.

2.	GQ1b	The establishment's documented procedure for the cryopreservation of PBSCs stipulates a maximum permitted time for the addition of DMSO to the start of cryopreservation. On occasions when the maximum time is exceeded, an incident is raised and the cells will be released under concession. The DI should consider reviewing engraftment data to support the conclusion that small excursions to DMSO contact time does not render the cells clinically ineffective, and to document this review.
3.	GQ1r	Although the agreement between the establishment and third party testing laboratory sets out that raw and traceability data will be retained in line with the requirements set out in Directions 001/2021, the laboratory's documented procedure for data retention indicates that the retention period for both sets of records is only eight years. The DI is advised to review policies and procedures at the third party testing laboratory, and associated referral laboratories, to ensure they support regulatory compliance.
4.	GQ2d	The establishment performs post-thaw viability assays on cryopreserved cells annually. The results are compiled into a report as part of their ongoing programme of evaluation. The results from the 2023 and 2024 reports differ significantly; less than 50% of samples achieved the required viability criteria in 2024, whereas 100% of samples met the establishment's viability criteria in 2023. The establishment's engraftment data for both 2023 and 2024 are within national limits. In the latest report, the low viability rate achieved in 2024 was attributed to the method used to detect viability. However, a similar method was used in 2023. The DI is advised to further investigate the reason for the disparate results and to include in future reports any variables which may have impact on the results, such as the age of samples used, the types of samples assayed, which may include samples in vials or from bags, and the corresponding engraftment data, if available.
5.	GQ3e	During a review of staff training records, it was noted the training record of a member of staff who processes samples indicated they had not been trained to use one of the electronic databases used

		for patient management. Although no data entry issues were identified, the DI is advised to review training records to ensure they are up-to-date and complete.
6.	GQ7a	The DI is advised to review the procedures for managing temperature excursions as the alerts are not closed in a timely manner and incident reports are not sufficiently thorough. During the review of incidents looking at temperature excursions, one report was incorrect in referring to a temperature excursion in an empty contingency tank, when it was actually a tank storing cryopreserved cells. In addition, the DI should document within reports whether an incident had any impact on the quality and safety of the cells. For example, a temperature excursion was noted in the refrigerator used for the storage of cells prior to processing. The refrigerator was confirmed to be empty during the excursion but the report did not include this detail. The DI should also consider carrying out a trend analysis on incidents relating to temperature excursions to determine whether they are linked to particular users or tanks, for example.
7.	PFE2c	The DI should also ensure that where cleaning reagents are rotated, the cleaning reagents used is accurately recorded.
8.	PFE5a	The establishment uses a dry shipper for the transport of cryopreserved cells from the contingency controlled rate freezer to the cryostorage tanks. The shipper is not on a regular maintenance schedule. The DI is advised to ensure all shippers are requalified as necessary to ensure they remain effective.
9.	PFE5f	The DI should ensure that the schedule for monitoring the clean room facility includes swabbing of the hatches, in addition to the use of contact plates.

Background

The establishment undertakes the procurement, donor testing, processing and storage of PBSC and peripheral blood lymphocytes for donor lymphocyte infusions (DLI). The establishment also procures PBSCs and DLIs on behalf of registries based in the UK. Cells collected for autologous use are sent to another HTA-licensed facility for processing and temporary storage.
In addition, the establishment procures, tests and exports peripheral blood mononuclear cells used as starting material for ATMPs.

The establishment has been licensed by the HTA since August 2006. This was the ninth site visit inspection of the establishment; the most recent previous inspection took place in June 2022.

There have been no significant changes to the licence arrangements or the activities carried out under the licence since the previous inspection.

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 relevant to the establishment's licensable activities. This included a review of standard operating procedures, agreements, reported incidents, equipment service records and temperature monitoring records for freezers, incubators and storage areas for consumables and reagents. The review also included information relating to the quality management system, such as audits and staff training records.

Visual inspection

The inspection included a visual inspection of the clean room processing facility, the cryostorage room, the apheresis ward and the testing laboratory.

Audit of records
The following procurement and processing records (where applicable) were reviewed:

- an allogeneic PBSC collection;
- an autologous PBSC collection;
- a DLI collection independent of a PBSC collection;
- a PBSC collection for a registry; and
- two PBMC collections to be used as starting material for ATMPs.

The audit included a review of donor consent and medical assessment, apheresis records, timings of blood sample collection, serology test results, cell processing records and shipping information, where applicable.

Meetings with establishment staff
The inspection included discussions with the DI and key staff working under the licence.

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

Report sent to DI for factual accuracy: 22 October 2024

Report returned from DI: 4 November 2024

Final report issued: 18 November 2024
Completion of corrective and preventative actions (CAPA) plan

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

Date: 29 September 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.
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.
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.