Inspection report on compliance with HTA licensing standards
Inspection dates: 28-29 April and 13 May 2022

University Hospitals Bristol

HTA licensing number 22538

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

Licensable activities carried out by the establishment

'E' = Establishment is licensed to carry out this activity and is currently carrying it out.
'E*' = Establishment is licensed to carry out this activity but is not 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
University Hospitals Bristol	E		TPA/SLA				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, Hematopoietic, Bone Marrow; Bone Marrow	Authorised		Authorised				
Mature Cell, MNC; PBMC	Authorised*		Authorised*				
Other; Tumour (ATMP)	Authorised*		Authorised*				Authorised*

Summary of inspection findings

The HTA found the Designated Individual (DI) and the Licence Holder (LH) to be suitable in accordance with the requirements of the legislation.

Although the HTA found that University Hospitals Bristol (the establishment) had met the majority of the HTA's standards that were assessed during the inspection, three major and eight 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

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.		
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.	The current agreement between the establishment and the third party laboratory that undertakes serological testing does not include instructions requiring the laboratory to meet regulatory requirements for adverse event reporting and the retention of raw data. The suitability of the agreement was a finding at the establishment's last inspection in October 2018. In addition to this, a communication from the laboratory to service users informing them of a change to arrangements for the testing of certain mandatory viral markers was not issued to establishment staff, and as a result donor test results were delayed. The agreement currently in place between the two parties has expired.	**Major**
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.		

GQ2 There is a documented system of quality management and audit.	The establishment's internal audit system does not encompass all activities under the licence. For example, the establishment has not audited staff training records, temperature monitoring records, or the third party laboratory that undertakes donor serological testing under the authority of the establishment's licence. Additionally, since the last inspection the establishment has not routinely audited patient and donor records. A review undertaken shortly before the inspection identified recurrent findings which could have been addressed earlier had an effective audit schedule been in place. The audit did not include records associated with clinical trial activities. The scope of the establishment's internal audits and lack of evidence of audits of patient and donor records were findings at the last inspection in October 2018.	**Major**
b) There is an internal audit system for all licensable activities.		
GQ4 There is a systematic and planned approach to the management of records.		
b) There is a system for the regular audit of records and their content to check for completeness, legibility and accuracy and to resolve any discrepancies found.		
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.	Donor selection, assessment and consent is the responsibility of Bristol Stem Cell Transplant and Cellular Therapy (SCTCT) programme consultants. A review of records identified examples where the stem cell donor health check questionnaire used to capture donor health and lifestyle risks was not completed for allogenic paediatric donors. This is not aligned with regulatory requirements or the establishment's documented procedures. Although a further documented assessment of donor suitability is undertaken, it does not document assessment against all the donor	**Major**

	selection criteria stipulated by Directions 001/2021. Related to this, the establishment's procedure and questionnaire do not list all exclusion criteria stipulated by Directions 001/2021, such as exposure to dangerous substances, systemic infection, risk of transmission of inherited conditions and transplantation with xenografts.	

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 procedure for tumour tissue procurement for the manufacture of an Advanced Therapy (Investigational) Medicinal Product (ATIMP) does not provide detailed instructions to staff for how trial protocol requirements will be addressed at the establishment. For example, arrangements for reagent storage and preparation are not adequately specified, and requirements for the reporting and review of day of donation serological tests are not set out. Related to this, the form used to capture the handover of the procured tissue to the sponsor's courier does not capture the signatures of the person releasing and person collecting the tissue, or the date and time at which handover took place.	**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 commissioned an independent audit against applicable standards since the last HTA inspection took place in October 2018. *The establishment submitted sufficient evidence to address this shortfall before the report was finalised.*	**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 third party testing laboratory was unable to provide evidence that a staff member undertaking the serological testing of donor samples had been trained in the current version of relevant procedures, or that they had received refresher training in accordance with the biennial laboratory schedule, the last documented training having been undertaken in 2018 when their employment commenced. In addition to this, the member of staff was signed off as competent to practice in November 2018 but did not document their reading of the associated procedures until March 2019. A further example was identified in which a current employee undertaking routine serological testing had not read the most recent version of an applicable procedure, issued in October 2021.	**Minor**

GQ5 There are documented procedures for donor selection and exclusion, including donor criteria.		
b) The testing of donors by the establishment or a third party on behalf of the establishment is carried out in accordance with the requirements of Directions 001/2021.	An audit of patient records identified an example where blood for serological testing of an autologous adult bone marrow donor was not collected within 30 days of procurement, as required by the establishment's documented procedures. Although a serology sample was collected for testing by the establishment responsible for processing on the day of procurement, there is no documented system in place to ensure that the result of serology tests undertaken by the processing establishment are communicated and reviewed.	**Minor**
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.	Samples are transported to the third party testing laboratory at ambient temperature and receipted using a sample tracking system. The system generates an alert if a sample is received 14 days or more after it was collected. These arrangements are not aligned with the requirements set out in the serology test kit instructions, which state that samples can be stored at ambient temperature (15 to 30°C) for up to three days before testing. However, it was noted that none of the examples reviewed during the inspection had exceeded the manufacturer's validated timeframe.	**Minor**

GQ8 Risk assessments of the establishment's practices and processes are completed regularly and are recorded and monitored appropriately.		
a) There are documented risk assessments for all practices and processes.	The establishment does not have suitable risk assessments in place for all practices and processes relating to activities under the licence. For example, risk assessments relating to tumour tissue procurement as a starting material for ATMP manufacture are limited in scope and do not consider risks to the quality, safety and traceability of the procured tissue.	**Minor**
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.	The establishment has not been able to provide a risk assessment covering all premises under the licence.	**Minor**
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.	Temperature monitoring arrangements for fridges and freezers used to store reagents related to the procurement and packaging of tumour tissue are not aligned with regulatory requirements. The establishment has been unable to provide the equipment identification and calibration records for the temperature monitor that was in use at the time of a tissue procurement event in 2019.	**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.	General	The establishment is considering expanding activities under the licence to include the import of corneal tissue from suppliers based outside the United Kingdom. If the proposed arrangement is approved within the Trust, the DI is advised to contact the HTA to discuss their plans further.
2.	General	The establishment works closely with another HTA-licensed establishment in delivering the SCTCT programme. At the time of the inspection the establishment's DI also held the role of Medical Director at the other licensed establishment. This helped to ensure effective communication between the establishments. The DI role has subsequently transferred to a new post holder. The incoming DI is advised to work closely with the other establishment to ensure the lines of communication and information sharing remain effective, and that the responsibilities of each party regarding activities and incidents are clearly defined and understood. Related to this, the new DI is advised to ensure that regulatory requirements defined by Directions 001/2021 are robustly incorporated into governance systems such as the Bone Marrow Transplant Quality Management programme (BMT QM) and associated meetings, to help ensure that the resource and awareness required to effectively maintain the licence in future will be embedded within the wider programme.

3.	C1a	The DI is advised to review the number of Accredited Assessors (AA) available to the SCTCT programme and to ensure there is a process in place to recruit and train new AA as necessary.
4.	C2a	Prior to procurement and donor serological testing, donors attend several out-patient appointments in which the procedure and associated serological testing are explained. Blood samples for serological testing collected up to 30 days prior to bone marrow procurement may be collected prior to the consent for serological testing being physically documented in consent forms. Whilst this does not conflict with consent requirements under the Human Tissue Act, 2004, the DI is advised to clearly document this process to ensure that appropriate information is provided to donors prior to the collection of serology samples.
5.	GQ1a	The DI is advised to review the proposed processes and procedures related to clinical trial activities before activities recommence, to ensure that the activity is fully incorporated into the establishment's governance systems and that all necessary training, documentation, premises, facilities and governance procedures are in place.
6.	GQ1b	The DI is advised to update the establishment's quality manual and applicable agreements to ensure that they reflect the correct regulatory context, specifically the Human Tissue (Quality and Safety for Human Application) Regulations, 2007 (as amended) and remove references to compliance with European Union Tissues and Cells Directives (EUTCDs). The DI is further advised to update references to the third party testing laboratory to reflect its change in name.
7.	GQ7a	The establishment's adverse incident reporting procedure states that only the DI can report serious adverse events and reactions (SAEARs) to the HTA. The DI is advised to extend this responsibility to Persons Designated (PDs) under the licence to provide contingency when the DI is absent. The DI is

		further advised to update the link to the HTA website within the standard operating procedure, as the current link is no longer functional.
8.	GQ1d	The establishment intends to introduce a commercially available quality management system to manage records and documents currently saved in a number of different file locations. The DI is advised to ensure that the process of migrating to the new system is subject to a robust documented change control process to ensure all records are complete and maintained in accordance with regulatory requirements.
9.	GQ5a	The third party testing laboratory's contingency plan states that contingency testing arrangements will be fulfilled by other laboratories within the same laboratory network. The laboratory is advised to updated this contingency plan to reflect current contingency arrangements for HIV NAT testing.
10.	GQ5b	The DI is advised to request that the third party testing laboratory updates its contact list for service updates to include the DI and any nominated colleagues. This will provide assurance that notifications relevant to activities under the licence will be received and assessed promptly.
11.	PFE4i	The establishment intends to enter into an arrangement in which the establishment responsible for processing, storage and distribution of procured bone marrow provides the traceability labels for tumour tissue procured as a starting material for ATMP manufacture. The DI is advised to ensure this arrangement is robustly controlled through documented procedures and agreements between the parties.

Background

The Bristol SCTCT programme is a combined adult and paediatric service providing a range of autologous and allogeneic cellular therapies. The service holds a holds a Joint Accreditation Committee of the International Society for Cellular Therapy and the European Group for Blood and Marrow Transplantation (JACIE) accreditation.

Whilst the clinical team are responsible for all aspects of consent and donor selection, responsibilities for licensable activities associated with the SCTCT programme are shared between the University Hospitals Bristol licence and another HTA-licensed establishment. There is an SLA in place between the parties.

Under the University Hospitals Bristol licence, the establishment procures autologous and allogenic bone marrow from adult and paediatric donors. Adult harvests are performed in Brachytheatre, Bristol Hospital Oncology Centre (BHOC), whilst paediatric patients and donors undergo procurement in the Bristol Royal Hospital for Children (BRHC) theatres. Staff from the other licensed establishment are present in the theatre during procurement and take responsibility for packing, transporting and subsequent processing, storage (if required) and distribution of the cells for end use.

Apheresis activities relating to the SCTCT programme are undertaken under the authority of the other establishment's licence. The other establishment also undertakes serological testing of the bone marrow donors using blood samples obtained on the day of donation. Donors are additionally tested up to 30 days prior to donation under the establishment's own HTA licence under the terms of a third party agreement with the United Kingdom Health and Security (UKHSA) laboratory based at the Southmead Hospital campus in Bristol.

The establishment is also licensed for the procurement of tumour tissue as a starting material for ATMP manufacture, and associated serological testing. A previous trial involving the procurement of blood and bone marrow for a clinical trial relating to the treatment of multiple sclerosis, has closed.

The establishment has been licensed by the HTA since September 2008. This was the establishment's sixth inspection; the last inspection took place in October 2018. Since the last inspection, the establishment's licence has been updated to add export of tumour tissue for ATMP manufacture, although this activity has not yet been undertaken. The named Corporate Licence Holder contact has also changed. There have been no other significant changes to the licence arrangements or the activities carried out under the licence.

Description of inspection activities undertaken

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

Review of governance documentation
The inspection included a review of policies and procedural documents relating to licensed activities as well as records of audits, risk assessments, reported incidents, meeting minutes, temperature monitoring records and staff training records.

Visual inspection
The inspection included a tour of BRI and BRHC premises including storage locations for consumables and reagents associated with tumour tissue procurement for ATMP manufacture. Consumables and reagents associated with bone marrow procurement are provided on the day of procurement by the processing establishment, and are not stored under the University Hospitals Bristol licence. The inspection also included a review of the pathway for serology samples collected for testing at the third party testing laboratory, and a visit to the laboratory itself. The visit to the laboratory included a review of sample receipt and management processes, sample and consumable storage locations, equipment maintenance and staff training. The theatres where procurement is undertaken were not visited during the inspection.

Audit of records
The inspection included a review of patient and recipient records relating to one adult autologous bone marrow patient, one allogeneic paediatric bone marrow donor and linked patient file, and one patient from whom tumour tissue was procured as the starting material for ATMP manufacture.

Meetings with establishment staff
The inspection included discussions with the establishment's DI, who is a Consultant Haematologist and Medical Director of the processing establishment, and the incoming DI, who is a BMT Associate Specialist and took over the DI role shortly after the inspection in May 2022. Discussions also included other staff working under the licence including: the establishment's Quality Manger, Quality Administrator, co-ordinators for adult, paediatric and clinical trial collections, and the senior clinical trials co-ordinator. The inspection team also met with the establishment's Corporate Licence Holder contact (CLHc), who is the Trust Medical Director.

Report sent to DI for factual accuracy: 13 June 2022

Report returned from DI: 27 June 2022

Final report issued: 29 November 2022

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

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.
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).
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.
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 to ensure records of traceability are maintained for 10 or 30 years 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.
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.
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.
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.
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.
i) Primary 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.