Inspection report on compliance with HTA licensing standards
Site visit date: **07 December 2021**
Virtual Regulatory Assessment (VRA) date: **08 December 2021**

CRF GMP Unit

HTA licensing number 22643

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

Licensable activities carried out by the establishment

Licensed activities

'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.

Site	Procurement	Processing	Testing	Storage	Distribution	Import	Export
Hub **CRF GMP Unit**	E/TPA	E*	TPA				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
Mature Cell; MNC; PBMC	Authorised	Authorised*	Authorised				Authorised*
Skin; Skin (ATMP)	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 the CRF GMP Unit (the establishment) had met the majority of the HTA's standards, seven 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

Minor Shortfalls

Standard	Inspection findings	Level of shortfall
GQ2 There is a documented system of quality management and audit.		
b) There is an internal audit system for all licensable activities.	The internal audits have been conducted against the establishment's Good Manufacturing Practice (GMP) activities but not the HTA licensable activities.	**Minor**
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 since 2018.	**Minor**

GQ4 There is a systematic and planned approach to the management of records.		
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.	The establishment's third party testing laboratory currently retains raw data related to the testing activities for eight years which does not meet the regulatory requirement.	**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.	The establishment's third party laboratory uses an external laboratory for confirmatory HTLV testing. However, the establishment was unable to provide assurance that the external laboratory is working in accordance with the HTA's standards and regulatory requirements.	**Minor**

GQ7 There are systems to ensure that all adverse events 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.	The establishment's serious adverse events and reactions (SAEARs) reporting procedure does not accurately reflect who must be notified if an adverse event or reaction occurs, and who is responsible for reporting SAEARs to the HTA in the absence of the DI. In addition to this, the establishment's third party testing laboratory does not have procedures in place to report serious adverse events to the DI within 24 hours of discovery.	**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.	A risk assessment has not been completed for the premises used to store kits and reagents prior to use in tumour procurement.	**Minor**

PFE4 Systems are in place to protect the quality and integrity of bodies, body parts, tissues and cells during transport and delivery to a destination.		
h) Packaging and containers used for transportation are validated to ensure they are fit for purpose.	The establishment could not provide evidence that the containers used to transport whole blood from the procurement site to the CRF GMP Unit have been validated to ensure that they maintain the necessary temperature during transit.	**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.	GQ1d, GQ1e	The DI is advised to ensure that all documents relevant to the establishment's activities are adequately controlled and managed within the establishment's document control system, such as the prompt sheets used by staff during procurement. The DI is also advised to capture the volume of whole blood to be collected on the relevant form(s) and record the actual volume collected, as this may vary per study, to help ensure that the patient is not subject to an over or under collection.
2.	GQ1g, GQ3e	The DI is advised to update the staff competency training matrix to include the procedure for receipting tissues and cells to ensure the required specifications are met.

3.	GQ1q, GQ1d	Some of the establishment's third party agreements were reviewed after the two-year period stipulated in the agreements. In addition to this, the latest version of one of the agreements was not saved onto the establishment's electronic document control system. The DI is advised to put systems in place to ensure agreements are reviewed and uploaded in a timely manner. The DI is also advised to consider updating the agreements on the next revision to reflect the responsibilities of the current staff, up-to-date contact details and the current HTA Directions 001/2021, which have superseded Directions 003/2010 and 002/2018.
4.	GQ2b	The DI is advised to incorporate the testing laboratory activities into the internal audit schedule to ensure that samples are stored and processed in accordance with the testing kit specifications, the laboratory's policies and procedures and the regulatory requirements.
5.	GQ4a, GQ8b	Some of the risk assessments related to the licensable activities fall outside of the establishment's document control system, therefore reminders are not sent to the DI when these are due for review. The DI is advised to put systems in place to keep track of the external risk assessments to ensure these are reviewed in a timely manner.
6.	GQ5d, GQ6c	The DI is advised to put a documented procedure in place to ensure that donor testing results received from third parties are verified and fully traceable to the correct donor.

Background

The CRF GMP Unit has been licensed by the HTA since January 2013. This was the third inspection of the establishment; the most recent previous inspection took place in March 2018.

The establishment is licensed for the procurement of whole blood for peripheral blood mononuclear cells (PBMCs), and the testing of donors under a third party agreement with a laboratory located at St Thomas' Hospital. The procurement of skin tissue and the processing of whole blood is currently inactive.

Since the previous inspection, there have been significant changes to the activities carried out under the licence. The establishment has added a new third party for the procurement of whole blood, and a second third party for serological testing of the donors; both sites are located in Oxford. The whole blood is sent to the establishment as a starting material for Advanced Therapy Medicinal Product (ATMP) manufacture *(see Shortfall PFE4h)*.

The procurement of tumour tissue and serological testing of the donors were added to the licence in 2019. Tumour tissue is procured at Guy's Hospital and sent off-site for ATMP manufacture and later returned to the patient for an autologous treatment.

The establishment applied for the activity of export to be added to the licence in 2021. Upon application, some of the establishment's procedures were reviewed and two minor shortfalls were identified. The export licence for PBMCs and tumour tissue was authorised in August 2021 with a CAPA plan to address the shortfalls. The CAPA plan has now been closed, however the establishment has not yet started the export activity.

The establishment is licensed by the Medicines and Healthcare products Regulatory Agency (MHRA) for the manufacture of Investigational Medicinal Products and Specials. The last MHRA inspection was carried out in November 2021 and the outcome was shared with the HTA prior to this inspection.

Description of inspection activities undertaken

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

Site visit inspection

The visual inspection took place at the CRF GMP Unit on the 15th floor of Tower Wing and the Innovation Hub at Guy's Cancer Centre. The inspector visited the wards where whole blood procurement is carried out, the clean room where tissues and cells are receipted and areas where the equipment, consumables, kits and reagents are stored. Discussions regarding the establishment's licensable activities were held with the Clinical Research Facility Matron, Senior Clinical Research Nurse, Lead Cell Therapy Research Nurse, Senior Specialist Technician and the DI who is the Head of Advanced Therapy Quality.

Traceability audits were carried out across the scope of the establishment's clinical studies. The audits included:

- two whole blood units procured by a third party for the same study;
- three whole blood units procured on-site for two different studies; and
- three tumour tissue procurements on-site for two different studies.

As part of the traceability audit, records related to consent, donor selection, patient information leaflets, donor serological testing, procurement, sample receipt and staff training were reviewed. At the time of the site visit, it was identified that the establishment did not have systems in place to verify the testing results received from the third party laboratory, located in Oxford, were traceable to the correct donor. From the records reviewed, the testing results could not be linked to one of the donors. The establishment was able to provide evidence after the inspection that the results were traceable to the patient (*see Advice item 6*).

VRA activities undertaken

The VRA included a discussion with the Quality Manager from the third party testing laboratory, located at St Thomas' Hospital, regarding the activities carried out under the licence. A traceability audit was carried out of the serological testing results linked to the donor records which were reviewed on the site visit. No discrepancies were noted during the traceability audit. Minor shortfalls were identified which are described in the report above (*see Shortfalls GQ4h, GQ5b and GQ7a*).

Some of the policies and procedures relating to the licensable activities were reviewed prior to the VRA by the inspector. A VRA was carried out for areas covering governance and quality systems which included a discussion with the DI regarding the establishment's audits, risk assessments, some of the reported incidents, record management, staff training, agreements with third parties and governance meetings.

Report sent to DI for factual accuracy: 10 January 2022

Report returned from DI: No factual accuracy or request for redaction comments were made by the DI

Final report issued: 24 January 2022

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: 6 July 2023

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 (HA)

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 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 site-visit inspection
- a request for information that shows completion of actions
- monitoring of the action plan completion
- follow up at next routine site-visit inspection.

After an assessment of your proposed action plan you 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 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 (Q&S Regulations) 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 Q&S Regulations 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).

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.
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.
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.
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.