

Inspection report on compliance with HTA licensing standards  
Inspection dates: 7-9 November 2023



**Future Health Technologies Ltd**  
HTA licensing number 22503

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**

‘E’ = Establishment is licensed to carry out this activity and is currently carrying it out.

‘TPA’ = Third party agreement; the establishment is licensed for this activity but another establishment (not licensed by the HTA) carries out the activity on their behalf.

Site	Procurement	Processing	Testing	Storage	Distribution	Import	Export
Hub Future Health Technologies Ltd	TPA	E	E	E	E	E	E

## Tissue types authorised for licensed activities

Authorised = Establishment is authorised to carry out this activity and is currently carrying it out.

<b>Tissue Category; Tissue Type</b>	<b>Procurement</b>	<b>Processing</b>	<b>Testing</b>	<b>Storage</b>	<b>Distribution</b>	<b>Import</b>	<b>Export</b>
<b>Cardiovascular, Valves; Heart Valves</b>				Authorised			
<b>Progenitor Cell, Hematopoietic, Cord Blood; Cord Blood</b>	Authorised	Authorised	Authorised	Authorised	Authorised	Authorised	Authorised
<b>Progenitor Cell, Hematopoietic; Peripheral Blood Stem Cells (PBSC)</b>				Authorised			
<b>Progenitor Cell, Haematopoietic, Bone Marrow; Bone Marrow</b>				Authorised			
<b>Mature Cell, T Cell (DLI); DLI*</b>				Authorised			
<b>Other; Dental Pulp</b>	Authorised	Authorised	Authorised	Authorised	Authorised	Authorised	Authorised
<b>Other; Cord Tissue</b>	Authorised	Authorised	Authorised	Authorised	Authorised	Authorised	Authorised
<b>Reproductive, Ovarian; Ovarian</b>				Authorised			

<b>tissue</b>							
<b>Reproductive, Testicular; Testicular tissue</b>				Authorised			
<b>Skin; Skin</b>				Authorised			

\* DLI - donor lymphocytes for infusion

### **Licensed activities – Human Tissue Act 2004**

The establishment is licensed for the storage of relevant material which has come from a human body for use for a scheduled purpose.

### **Summary of inspection findings**

Although the HTA found that Future Health Technologies Ltd (the establishment) had met the majority of the HTA’s standards that were assessed, two major and five 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*

<b>GQ5 There are documented procedures for donor selection and exclusion, including donor criteria.</b>		
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.	<p>The establishment performs in-house testing of the maternal blood samples. Before the samples are tested, a daily maintenance cycle must be performed, and controls run. A review of the instrument data indicated that there were regular periods every month where the weekly maintenance cycle had not been performed and that some of the controls did not run. The establishment was not aware of these issues.</p> <p>The establishment's subsequent analysis of data indicated that results were reported for 354 client samples where one or more of the controls were not run.</p>	<b>Major</b>

**PFE2 Environmental controls are in place to avoid potential contamination.**

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.

During observation of the processing of cord blood samples the sampling head of the non-viable particle monitor (NVPM) was positioned to face the wall of the grade A cabinet. The NVPM was subsequently repositioned in the direction of the cells being processed rather than in the direction of the filtered air flow. This does not provide a representative analysis of the airflow in the Grade A environment.

**Major**

c) There are procedures for cleaning and decontamination

The operator was observed to handle multiple client samples and move in and out of the Grade A cabinet without changing or decontaminating their gloves.

*The establishment submitted sufficient evidence to address this shortfall before the report was finalised.*

**Minor Shortfalls**

Standard	Inspection findings	Level of shortfall
<p><b>GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process.</b></p>		
<p>b) There are procedures for all licensable activities that ensure integrity of tissue and/ or cells and minimise the risk of contamination.</p>	<p>The establishment's standard operating procedures (SOPs) do not contain sufficient detail to fully describe the processes that they relate to. For example:</p> <ul style="list-style-type: none"> <li>• The base of the transport box can only be used a maximum of five times. This is controlled during the procurement kit assembly procedure. The procedure does not include a secondary Quality Assurance checking process.</li> <li>• After the release of a client sample, the client will be contacted to discuss the fate of their remaining Quality Control samples. This procedure is not documented.</li> <li>• Operators are advised to inform the DI or the laboratory manager if a controlled freezer run fails. The actions the DI or laboratory manager will take are not documented.</li> <li>• The procedure for the processing of dental pulp currently states 50,000 cells rather than 50,000 viable cells is required.</li> </ul> <p><i>The establishment submitted sufficient evidence to address this shortfall before the report was finalised.</i></p>	<p><b>Minor</b></p>

**GQ2 There is a documented system of quality management and audit.**

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.

The establishment undertakes an annual programme of ongoing evaluation of its preparation processes, as set out in its procedures.

However, the samples selected are not representative of the samples that are banked. Banked samples received outside of the validated time and temperature in transit are not included.

*The establishment submitted sufficient evidence to address this shortfall before the report was finalised.*

**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 uses an automated cell counter to assess the number of viable cells present in a dental pulp culture. The data from the cell counter is not retained but is transcribed to the processing records.

*The establishment submitted sufficient evidence to address this shortfall before the report was finalised.*

**Minor**

<b>GQ5 There are documented procedures for donor selection and exclusion, including donor criteria.</b>		
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.	<p>The donor selection questionnaire did not include a question regarding transplantation with xenografts.</p> <p><i>The establishment submitted sufficient evidence to address this shortfall before the report was finalised.</i></p>	<b>Minor</b>

<b>PFE2 Environmental controls are in place to avoid potential contamination.</b>		
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	<p>The establishment does not investigate microbial contamination events detected in client samples. As a result, the root causes of such events have not been identified and corrective actions have not been implemented.</p> <p><i>The establishment submitted sufficient evidence to address this shortfall before the report was finalised.</i></p>	<b>Minor</b>

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 3 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.	GQ1b	The DI is advised to revise the form used to document the weekly cleaning of the incubator to include details of what and why additional cleaning measures were undertaken.
2.	GQ1q	The DI is advised that third party agreements with healthcare professionals (HCP) should include the full name of the HCP as well as their professional registration details.
3.	GQ3e	The DI is advised to implement a programme of annual retraining of international agents and personnel responsible for the procurement of tissue and cells, as is currently in place for UK phlebotomists, to address recurring incidents linked to overseas personnel not following documented procedures.
4.	GQ4f	Information provided by clients on documents such as the consent form and medical questionnaire are reviewed, and any discrepancies or issues are raised with the client. The DI is advised that all information provided in response should be formally recorded.
5.	GQ7a	During the review of temperature data for the area where consumables are stored, it was identified that in the period leading up to the inspection there was an episode when there was a loss of temperature monitoring data. This incident was investigated by the establishment and closed on the basis that the temperature monitoring systems had not alarmed in the same period. Should such a situation occur again in the future, the DI is advised to test the alarm system to assure themselves that the absence of an alarm is not due to the system not working.
6.	PFE2b	The establishment's environmental monitoring procedure stipulates that the maximum exposure time for settle plates is two hours. Operators rely on checking the time on the NVPM to determine whether

		two hours have elapsed. The DI is advised that the start and end time of each processing session is recorded to assure themselves that the settle plates are only exposed according to procedure.
7.	PFE5c	During the review of NVPM data, a recurring pattern of the same reading for 0.3 µm particles was identified for all the NVPMs used. Although this is below the prescribed particle size that should be measured for clean rooms, these readings had not been noticed by the establishment. As a result, no action has been taken to investigate their significance. The DI is advised to ensure that staff critically review data to assure themselves that instruments and equipment are functioning as expected.
8.	PFE5c	The DI is advised to consider implementing a procedure to monitor for contamination in hard-to-reach areas of the processing facility, such as the corners of the transfer hatches which cannot be reached using contact plates.

## Background

Future Health Technologies Ltd has been licensed by the HTA since 2006. This was the eleventh site visit of the establishment; the most recent previous inspection took place in November 2021.

The establishment's activities include the procurement of tissues and cells at hospitals in the UK under third party agreements. Tissues and cells are also imported from outside the UK, which have been procured by individuals trained in the establishment's procurement and shipping procedures.

## **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 team undertook a review of documentation relevant to the establishment's licensable activities, including: policies and procedural documents, donor information sheets, medical history questionnaires, consent documentation, agreements with third parties, shipping and receipt records, donor-related records including records of procurement and donor testing, equipment servicing records, environmental monitoring records, temperature monitoring records relating to tissue, cell, reagent and consumables storage, incident logs, adverse events, audits, risk assessments and staff training records.

### *Visual inspection*

A visual inspection of areas where licensable activity is carried out was undertaken. This included areas where samples are received, tested, processed and stored. The areas where consumables and reagents are stored was also inspected.

### *Audit of records and other documentation*

The traceability audit included a review of records relating to nine client samples received from abroad and procured within the UK. The records for a sample that was released for clinical use were also reviewed and discussed. The establishment also stores tissue and cells on behalf of other licensed establishments. Records for the storage and distribution of three samples were examined.

The audit included a review of the client consent, donor selection criteria, maternal serology results and processing records, including environmental monitoring and quality control checks such as flow cytometry data. As part of the audit, related procedures, agreements with third parties and client communications were reviewed.

Twenty-three non-conformances were selected for review. The incident and the root cause of each incident were discussed, along with corrective and preventative actions undertaken.

A review of the corrective and preventative actions (CAPAs) taken to address all the shortfalls identified during the last inspection were reviewed and discussed with the establishment.

*Meetings with establishment staff*

Discussions were held with the DI, the Corporate Licence Holder contact, the deputy Quality Manager and the laboratory manager.

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

**Report sent to DI for factual accuracy: 6 December 2023**

**Report returned from DI: 21 December 2023**

**Final Report issued: 19 March 2024**

## **Final Report issued:**

### **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 VRA 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

##### 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

<b>Standard</b>
GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process.
a) There is an organisational chart clearly defining the lines of accountability and reporting relationships.
b) There are procedures for all licensable activities that ensure integrity of tissue and / or cells and minimise the risk of contamination.

c) There are regular governance meetings, for example health and safety, risk management and clinical governance committees, which are recorded by agendas and minutes.
d) There is a document control system to ensure that changes to documents are reviewed, approved, dated and documented by an authorised person and only current documents are in use.
e) There are procedures for tissue and / or cell procurement, which ensure the safety of living donors.
g) There are procedures to ensure that an authorised person verifies that tissues and / or cells received by the establishment meet required specifications.
h) There are procedures for the management and quarantine of non-conforming consignments or those with incomplete test results, to ensure no risk of cross contamination.
i) There are procedures to ensure tissues and / or cells are not released from quarantine until verification has been completed and recorded.
j) There are procedures detailing the critical materials and reagents used and where applicable, materials and reagents meet the standards laid down by the Medical Devices Regulation 2002 (SI 2002 618, as amended) (UK MDR 2002) and United Kingdom Conformity Assessed (UKCA).
k) There is a procedure for handling returned products.
l) There are procedures to ensure that in the event of termination of activities for whatever reason, stored tissues and / or cells are transferred to another licensed establishment or establishments.
m) The criteria for allocating tissues and / or cells to patients and health care institutions are documented and made available to these parties on request.
n) The establishment ensures imports from third countries meet the standards of quality and safety set out in Directions 001/2021.
o) There is a complaints system in place.

p) There are written agreements with third parties whenever an activity takes place that has the potential to influence the quality and safety of human tissues and / or cells.
q) There is a record of agreements established with third parties.
r) Third party agreements specify the responsibilities of the third party and meet the requirements set out in Directions 001/2021.
s) Third party agreements specify that the third party will inform the establishment in the event of a serious adverse reaction or event.
t) There are procedures for the re-provision of service in an emergency.
GQ2 There is a documented system of quality management and audit.
a) There is a quality management system which ensures continuous and systematic improvement.
b) There is an internal audit system for all licensable activities.
c) An audit is conducted in an independent manner at least every two years to verify compliance with protocols and HTA standards, and any findings and corrective actions are documented.
d) Processes affecting the quality and safety of tissues and / or cells are validated and undergo regular evaluation to ensure they continue to achieve the intended results.
GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and are continuously updating their skills.
a) There are clearly documented job descriptions for all staff.
b) There are orientation and induction programmes for new staff.
c) There are continuous professional development (CPD) plans for staff and attendance at training is recorded.
d) There is annual documented mandatory training (e.g. health and safety and fire).

e) Personnel are trained in all tasks relevant to their work and their competence is recorded.
f) There is a documented training programme that ensures that staff have adequate knowledge of the scientific and ethical principles relevant to their work, and the regulatory context.
g) There is a documented training programme that ensures that staff understand the organisational structure and the quality systems used within the establishment.
h) There is a system of staff appraisal.
i) Where appropriate, staff are registered with a professional or statutory body.
j) There are training and reference manuals available.
k) The establishment is sufficiently staffed to carry out its activities.
GQ4 There is a systematic and planned approach to the management of records.
a) There are procedures for the creation, identification, maintenance, access, amendment, retention and destruction of records.
b) There is a system for the regular audit of records and their content to check for completeness, legibility and accuracy and to resolve any discrepancies found.
c) Written records are legible and indelible. Records kept in other formats such as computerised records are stored on a validated system.
d) There is a system for back-up / recovery in the event of loss of computerised records.
e) The establishment keeps a register of the types and quantities of tissues and / or cells that are procured, tested, preserved, processed, stored and distributed or otherwise disposed of, and on the origin and destination of tissues and cells intended for human application.

f) There are procedures to ensure that donor documentation, as specified by Directions 001/2021, is collected and maintained.
g) There is a system to ensure records are secure and that donor confidentiality is maintained in accordance with Directions 001/2021.
h) Raw data which are critical to the safety and quality of tissues and cells are kept for 10 years after the use, expiry date or disposal of tissues and / or cells.
i) The minimum data to ensure traceability from donor to recipient as required by Directions 001/2021 are kept for 30 years after the use, expiry or disposal of tissues and / or cells.
j) Records are kept of products and material coming into contact with the tissues and / or cells.
k) There are documented agreements with end users to ensure they record and store the data required by Directions 001/2021.
l) The establishment records the acceptance or rejection of tissue and / or cells that it receives and in the case of rejection why this rejection occurred.
m) In the event of termination of activities of the establishment a contingency plan 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.
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**

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

## Human Tissue Act 2004 Standards

### Consent standards

#### **C1 Consent is obtained in accordance with the requirements of the Human Tissue Act 2004 (HT Act) and as set out in the code of practice**

b) Where applicable, there are agreements with other parties to ensure that consent is obtained in accordance with the requirements of the HT Act and the HTA's Codes of Practice.

### Governance and quality system standards

#### **GQ1 All aspects of the establishments work are governed by documented policies and procedures as part of the overall governance process**

- a) Ratified, documented and up-to-date policies and procedures are in place, covering all licensable activities.
- b) There is a document control system.
- c) There are change control mechanisms for the implementation of new operational procedures.
- d) Matters relating to HTA-licensed activities are discussed at regular governance meetings, involving establishment staff.
- e) There is a system for managing complaints.

#### **GQ2 There is a documented system of audit**

- a) There is a documented schedule of audits covering licensable activities.
- b) Audit findings include who is responsible for follow-up actions and the timeframes for completing these.

**GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and are continuously updating their skills**

- a) Qualifications of staff and all training are recorded, records showing attendance at training.
- b) There are documented induction training programmes for new staff.
- c) Training provisions include those for visiting staff.
- d) Staff have appraisals and personal development plans.

**GQ4 There is a systematic and planned approach to the management of records**

- a) There are suitable systems for the creation, review, amendment, retention and destruction of records.
- b) There are provisions for back-up / recovery in the event of loss of records.
- c) Systems ensure data protection, confidentiality and public disclosure (whistleblowing).

**GQ5 There are systems to ensure that all adverse events are investigated promptly**

- a) Staff are instructed in how to use incident reporting systems.
- b) Effective corrective and preventive actions are taken where necessary and improvements in practice are made.

**GQ6 Risk assessments of the establishment's practices and processes are completed regularly, recorded and monitored**

- a) There are documented risk assessments for all practices and processes requiring compliance with the HT Act and the HTA's Codes of Practice.
- b) Risk assessments are reviewed regularly.
- c) Staff can access risk assessments and are made aware of risks during training.

## Traceability standards

### **T1 A coding and records system facilitates the traceability of bodies and human tissue, ensuring a robust audit trail**

- a) There is an identification system which assigns a unique code to each donation and to each of the products associated with it.
- b) A register of donated material, and the associated products where relevant, is maintained.
- c) An audit trail is maintained, which includes details of: when and where the bodies or tissue were acquired and received; the consent obtained; all sample storage locations; the uses to which any material was put; when and where the material was transferred, and to whom.
- d) A system is in place to ensure that traceability of relevant material is maintained during transport.
- e) Records of transportation and delivery are kept.
- f) Records of any agreements with courier or transport companies are kept.
- g) Records of any agreements with recipients of relevant material are kept.

### **T2 Bodies and human tissue are disposed of in an appropriate manner**

- a) Disposal is carried out in accordance with the HTA's Codes of Practice.
- b) The date, reason for disposal and the method used are documented.

**Premises, facilities and equipment standards**

**PFE1 The premises are secure and fit for purpose**

- a) An assessment of the premises has been carried out to ensure that they are appropriate for the purpose.
- b) Arrangements are in place to ensure that the premises are secure and confidentiality is maintained.
- c) There are documented cleaning and decontamination procedures.

**PFE2 There are appropriate facilities for the storage of bodies and human tissue**

- a) There is sufficient storage capacity.
- c) Storage conditions are monitored, recorded and acted on when required.
- d) There are documented contingency plans in place in case of failure in storage area.

**PFE3 Equipment is appropriate for use, maintained, validated and where appropriate monitored**

- a) Equipment is subject to recommended calibration, validation, maintenance, monitoring, and records are kept.
- b) Users have access to instructions for equipment and are aware of how to report an equipment problem.
- c) Staff are provided with suitable personal protective equipment.