

**Welsh Blood Service**  
HTA licensing number 22497

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.

'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
<b>Hub</b> <b>Welsh Blood Service</b>	E		E/SLA		E	E	E
<b>Satellite</b> <b>Velindre Cancer Centre</b>	E						

<b>Satellite</b> <b>Nuffield Health –</b> <b>The Vale Hospital</b>	E						
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### 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.

<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>Progenitor Cell, Haematopoietic, PBSC; PBSC</b>	Authorised		Authorised		Authorised	Authorised	Authorised
<b>Progenitor Cell, Haematopoietic, Bone Marrow; Bone Marrow</b>	Authorised*		Authorised		Authorised	Authorised	Authorised
<b>Mature Cell, MNC; DLI</b>	Authorised		Authorised		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 Welsh Blood Service (the establishment) had met the majority of the HTA's standards that were assessed during the inspection, 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

### *Minor Shortfalls*

Standard	Inspection findings	Level of shortfall
<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>		
b) There are procedures for all licensable activities that ensure integrity of tissue and / or cells and minimise the risk of contamination.	<p>The establishment's systems and procedures for the oversight of one of the procurement satellites are not sufficiently robust to provide assurance that requirements for temperature monitoring and raw data retention will be met, or that any deviations or serious adverse events and reactions (SAEARs) would be appropriately communicated for establishment assessment.</p> <p>In addition to this, the establishment's procedure for SAEARs reporting requires update to ensure that all applicable cases will be reported to the HTA.</p>	<b>Minor</b>

<p>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.</p>	<p>A review of agreements with third parties highlighted examples where regulatory requirements had not been fully achieved. For example, the establishment's agreement with two third parties responsible for microbiology sterility testing do not adequately address the requirements for raw data retention or the reporting of SAEARs. The establishment's agreement with a third party courier had been extended, but the extension expired in September 2022.</p>	<p><b>Minor</b></p>
<p>r) Third party agreements specify the responsibilities of the third party and meet the requirements set out in Directions 001/2021.</p>		
<p><b>GQ4 There is a systematic and planned approach to the management of records.</b></p>	<p>The inspection included a visit to the Velindre Cancer Centre (VCC), which is one of two new PBSC and DLI procurement sites added to the establishment's licence since the last inspection.</p> <p>The establishment stores reagents and consumables required for procurement at the VCC. There is a temperature monitoring system in place in the storage area, which is linked to the VCC Pharmacy.</p> <p>Examples were identified between July and August 2022 where the temperature in the storage area exceeded the upper alarm limit for the area, which is also the upper storage temperature limit assigned by the manufacturer for one of the reagents used during procurement. These excursions did not consistently result in alarms being generated within the monitoring system for the awareness of the Pharmacy team. When an alarm had been generated, evidence could not be provided to</p>	<p><b>Minor</b></p>
<p>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.</p>		
<p><b>PFE3 There are appropriate facilities for the storage of bodies, body parts, tissues, cells, consumables and records.</b></p>		

<p>a) Tissues, cells, consumables and records are stored in secure environments and precautions are taken to minimise risk of damage, theft or contamination.</p>	<p>demonstrate that the excursions had been communicated to the establishment so that they could be documented and to enable corrective and preventative actions to be taken.</p> <p>In addition to this, examples were discussed where server issues had resulted in the intermittent loss of temperature monitoring data. These occurrences had also not been communicated to the establishment.</p>	
<p><b>GQ5 There are documented procedures for donor selection and exclusion, including donor criteria.</b></p>		
<p>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>	<p>During a review of records associated with stand-alone donor lymphocyte infusion (DLI) procurement, examples were seen where the collection of blood for mandatory serological testing did not take place on the day of procurement or within seven days post-procurement, as required by Directions 001/2021.</p>	<p><b>Minor</b></p>
<p><b>PFE5 Equipment is appropriate for use, maintained, quality assured, validated and where appropriate monitored.</b></p>		
<p>b) Critical equipment is maintained and serviced in accordance with the manufacturer's instructions.</p>	<p>A review of cleaning records highlighted examples where the establishment's monthly cleaning of two apheresis machines had not been undertaken according to the schedule stipulated by the manufacturer of the equipment.</p>	<p><b>Minor</b></p>

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.	GQ2b	The DI is advised to update procedures to ensure that the manufacturer's requirements for the temperature of the procurement environment whilst the apheresis equipment is in operation are clearly defined.
2.	GQ4b	During a review of records an example was seen where an apheresis component authorisation form had been reviewed by one operator instead of two, as stipulated by establishment procedures. The DI is advised to review processes to ensure checks are undertaken in line with the establishment's procedures.
3.	PFE3a	In addressing the shortfall against PFE3a listed above, the DI is advised to ensure all arrangements for the storage of temperature-sensitive reagents and consumables across the sites under the licence are reviewed and risk assessments updated if appropriate to capture any changes or further mitigations that are identified through this exercise.
4.	PFE4d	<p>During a review of records one example was seen where staff were required to record both the date and time that cells were received, but only the date had been recorded. The DI is advised to ensure staff record all the required information in order to ensure validated transport times have not been exceeded.</p> <p>The DI is further advised to review systems for checking that time and temperature during transport have not been exceeded to determine whether any changes may be helpful to assist staff in calculating the total duration of transport where imported cells travel across several time zones.</p>

5.	PFE4e	To further strengthen the establishment's review of transportation records the DI is advised to consider implementing a check that the temperature probe identified in temperature records provided by the courier matches the identification of the probe elsewhere in the documentation, to provide assurance that the correct data has been provided.
6.	PFE4h	<p>The establishment's transport containers were validated in 2015 and each transportation event arranged by the establishment includes the use of a calibrated datalogger.</p> <p>The DI is advised to consider adding the establishment's transportation containers to the establishment's 'System Inventory' and introduce a process to individually identify each box or panel insert, to support decision making about revalidation requirements and help identify any equipment that may have become damaged or less reliable over time.</p>

## Background

The establishment has been licensed by the HTA since December 2007. This was the establishment's seventh inspection; the last inspection took place in April 2019.

The establishment is licensed for the procurement, testing, distribution and import/export of tissues and cells for human application. The establishment is a division of the Velindre NHS Trust and is the main volunteer blood collection centre for Wales. The Welsh Bone Marrow Donor Registry (WBMDR) is a section of the Welsh Transplantation and Immunogenetics Laboratory (WTAIL) which, with three other national registries, forms the NHS Aligned Stem Cell Registry that operates throughout the UK.

Since the last inspection, the establishment no longer undertakes procurement under a third party agreement (TPA) with a nearby hospital and instead has updated the licence to add two new local hospitals as satellites where procurement is undertaken. Bone marrow procurement under the licence is currently on hold and is being undertaken by a nearby establishment with whom the establishment has

a pre-existing close working relationship and a service level agreement (SLA). In 2020, the establishment's Special Directions were updated to include the import of cryopreserved hematopoietic stem cells and DLI.

### **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, records of cleaning, servicing, and maintenance, audits, reported incidents, temperature monitoring records and staff training records.

#### *Visual inspection*

At the hub site the inspection team visited the laboratory areas where serology and CD34 marker testing are undertaken, as well as the room within which procured cells were received, checked, sampled and diluted with the donor's plasma prior to release. Sample and reagent storage areas were reviewed along with records associated with analyser use and maintenance, temperature monitoring, and staff training. Specific examples from pre-selected procurement events were used to trace the management of samples through laboratory systems and review reported results data.

At the VCC the inspection team reviewed the premises used for reagent and consumable storage and apheresis activities. The laboratory where full blood count (FBC) analysis is undertaken prior to procurement and the Pharmacy responsible for the temperature monitoring system were also visited. Records associated with equipment maintenance, cleaning and the temperature monitoring of reagent and consumable storage areas were reviewed.

#### *Audit of records*

The inspection included a review of records associated with one PBSC procurement, one bone marrow procurement, two DLI procurements and two import events.



*Meetings with establishment staff*

The inspection included discussions with the DI (who is the Head of the WTAIL and Chief Scientific Officer), the Head of the WBMDR, the WBMDR Medical Director and staff working under the licence at the hub and satellite site. The inspection also included a discussion with staff from a nearby licensed establishment with which the WBMDR has a close working relationship, regarding the potential for expansion of existing arrangements between the parties to include establishment involvement in the procurement of starting material for the manufacture of Chimeric Antigen Receptor (CAR) T-cell therapies. Guidance on the applicable regulatory and licensing requirements was provided.

**Report sent to DI for factual accuracy: 15 November 2022**

**Report returned from DI: 08 December 2022**

**Final report issued: 08 December 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.
b) If there is a third-party procuring tissues and / or cells on behalf of the establishment the third-party agreement ensures that consent is obtained in accordance with the requirements of the HT Act 2004, the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (as amended) and the HTA's Codes of Practice.
c) The establishment or the third party's procedure on obtaining donor consent includes how potential donors are identified and who is able to take consent.
d) Consent forms comply with the HTA Codes of Practice.
e) Completed consent forms are included in records and are made accessible to those using or releasing tissue and / or cells for a Scheduled Purpose.

C2 Information about the consent process is provided and in a variety of formats.
a) The procedure on obtaining consent details what information will be provided to donors. As a minimum, the information specified by Directions 001/2021 is included.
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.
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.
<b>GQ2 There is a documented system of quality management and audit.</b>
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.
<b>GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and are continuously updating their skills.</b>
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.
<b>GQ4 There is a systematic and planned approach to the management of records.</b>
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.
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.
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.