Site visit audit report on compliance with HTA requirements
Audit date 17 and 18 October 2024

Imperial College Healthcare NHS Trust

HTA licensing number 40044

Licensed under the Human Tissue Quality and Safety of Organs Intended for Transplantation Regulations 2012 (as amended).

Licensed activities – Procurement

Organ type	Kidney
Adult living	**DC, OC, P, R**

Procurement Activities: donor characterisation (DC), organ characterisation (OC), preservation of an organ (P), making arrangements to transport an organ (T), retrieval of an organ (R)

Licensed activities – Transplantation

Organ type	Kidney	Pancreas
Adult living	**OC, P, T, I**	
Adult deceased	**OC, P, T, I**	**OC, P, T, I**

Transplantation Activities: organ characterisation (OC), preservation of an organ (P), making arrangements to transport an organ (T), implantation of an organ (I)

Summary of audit findings

The HTA found that Imperial College Healthcare NHS Trust (the establishment) had met the majority of the HTA's assessment criteria that were assessed during the site visit. One minor shortfall was found in relation to organ preservation.

Compliance with HTA assessment criteria

Minor Shortfall

Assessment criteria	Audit findings	Level of shortfall
Organ preservation		
P1) Material and equipment used in organ preservation meet the requirements of The Medical Devices Regulations 2002 (SI 2002/618), where these apply, and there is an operating procedure in place to demonstrate how this requirement is complied with.	To meet the requirements of the Medical Devices Regulations 2002 (SI 2002/618) (as amended) (UK MDR 2002), manufacturers must stipulate the storage conditions for material and equipment used in organ preservation. The perfusion fluid used by the establishment should be maintained at 2-8°C. The establishment stores a working stock of perfusion fluid in a fridge located in theatres. The fridge temperature is monitored using a minimum/maximum thermometer and the temperature readings are recorded in a logbook. A review of the recorded temperatures indicated regular temperature excursions with no evidence that these were addressed. Temperature excursions were also noted for the fridge used to store blood samples and lymph and spleen tissue required for tissue typing.	**Minor**

The HTA requires the establishment 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 establishment to consider the following to further improve practice:

Number	Assessment Criterion	Advice
1.	GN2	The establishment has updated training material to reflect recent changes in legislation. The establishment is advised to include and remind all healthcare personnel of the requirement to report if they have a 'reasonable suspicion' that an organ donation and transplantation-related offence may have been committed under the Human Tissue Act or Modern Slavery Act.
2.	R4	The establishment follows up living donors immediately post-surgery, at two weeks and at four-to-six-weeks post-surgery. Following that there are checks at three and six-months post-surgery before annual follow ups at the living donor clinic. The donor's GP is informed of all the tests results during the donor's workup and after an annual follow up. The establishment is advised to consider writing to the donor's GP to remind them that should the living donor present with any medical conditions which may have an impact for the organ recipient, that the establishment should be contacted immediately so that the recipient can be reviewed and followed up as necessary. This may facilitate earlier detection of medical conditions that could impact an organ recipient. This is of particular importance in cases of non-directed altruistic living donations where there is no link between a donor and recipient.
3.	S1	During the review of incidents, the establishment demonstrated that serious adverse events or serious reactions (SAEARs) incidents are identified and reported appropriately.

		The establishment is advised to link any transplant related incidents reported as SAEARs with the corresponding incident recorded on the Trust incident system. This may help establishment staff to have greater oversight of incidents and help ensure that all incidents have been followed up, closed and any lessons learnt have been shared.

Background

The establishment has been licensed by the HTA since December 2012. This was the establishment's fourth site visit. The most recent previous audit took place in March 2022.

Since the last audit, two legislative changes have been made. The first, which came into force on 1 July 2022 was an amendment to Section 32 of the Human Tissue Act 2004 and introduced section 32a. Offences related to financial or commercial dealings in human material for transplant, such as buying or selling human organs now has extraterritorial jurisdiction. The Human Tissue Act 2004 (Supply of Information about Transplants) Regulations 2024 came into force on 1 April 2024. The establishment has raised awareness of these requirements among the renal transplant team. In addition, awareness is also raised as part of the education package delivered to potential living kidney donors and recipients.

Previously the establishment set the surgery date for a living donation before the Independent Assessor report was submitted and HTA approval obtained. Surgery dates are now only confirmed when HTA approval has been obtained. The establishment has also introduced a transplant specific WHO checklist to include confirmation that HTA approval has been granted.

The establishment has introduced a 30-minute period between shift changes to enable staff to complete, for example, HTA B forms to help ensure these are returned in a timely fashion.

Description of audit activities undertaken

Criteria assessed against during the audit

All HTA assessment criteria apart from CT1, which is not applicable, were reviewed as part of the audit.

Review of governance documentation

Prior to the site visit, the following documents were reviewed: Establishment's policies and procedures, accreditation certificates for the Histocompatibility and Immunogenetics (H&I) and Microbiology and Pathology laboratories. The audit team also reviewed the certification of the sterile services provider and the records retention policy.

Site Visit inspection

Visual inspection

A visit to the room within the establishment's renal wards where organs are received, and to theatres where a supply of perfusion fluids are kept was undertaken. Discussions were held with staff about the receipt of organs, monitoring the storage temperature of blood samples, lymph and spleen as well as perfusion fluids.

Audit of records

The following transplant records were reviewed:

Four sets of deceased kidney transplant records, two from donors following death by neurological criteria (DBD) and two from donors whose death had been confirmed using circulatory criteria (DCD). Documents reviewed included donor serological test results, recipient consent form, crossmatch data, results of microbiology sterility checks on the perfusion fluids and HTA-A and HTA-B forms.

Two sets of living kidney donation transplant records, one for a directed donation and one non-directed altruistic donor. Donor records reviewed included the HTA approval, initial serological testing, results from testing prior to the retrieval and the records of a decision regarding donor suitability. In addition, letters sent to the donor's GP following discharge and the letters sent to the GP after annual assessments of the donor were seen. The review of the recipient's clinical notes included the establishment's operation notes, transplant record form, cross-matching records and HTA-B forms.

Meetings with establishment staff
Discussions were held with staff representing various areas of the transplant pathway. The discussions covered changes to the service since the previous audit, a review of the management of incidents and staff training.

Report sent for factual accuracy: 4 November 2024

Report returned with comments: 4 December 2024 No factual accuracy or request for redaction comments were made.

Final report issued: 5 December 2024

Appendix 1: The HTA's regulatory requirements

The HTA shall ensure that licence holders are audited for the purposes of ensuring compliance with the licensing conditions in schedule 1 of The Quality and Safety of Organs Intended for Transplantation Regulations 2012 (as amended) and any requirements imposed by directions made under these Regulations.

The assessment criteria reflect the requirements of the statutory conditions outlined in schedule 1 and the HTA's directions. They are designed to promote the safe use of human organs and ensure traceability is maintained between donor and recipient. The HTA audits establishments it licences against eight groups of assessment criteria:

- Donor characterisation and organ characterisation
- Retrieval of organs for transplantation
- Organ preservation
- Making arrangements to transport an organ
- Implantation
- Traceability
- Serious adverse events and serious adverse reactions
- General (apply to all licences)

Reports of HTA audits are published on the HTA's website.

Throughout the audit process, the HTA assesses the establishment against the assessment criteria. Where the HTA determines that an assessment criteria 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 assessment criteria are fully met, but the HTA has identified an area of practice that could be further improved, advice is provided in this report.

Appendix 2: Classification of the level of shortfall

Where the HTA determines that an assessment criterion 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 assessment criterion, 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 the risk of harm and/or a breach of the HT Act or associated Directions.

1. Critical shortfall:

A shortfall which poses a significant direct risk of causing harm to the quality of an organ intended for transplantation or which poses a significant direct risk of causing harm to a donor or recipient.

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:

(1) A notice of proposal being issued to revoke the licence

(2) 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.

(3) A notice of suspension of licensable activities

(4) Additional conditions being proposed

(5) 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 quality and safety of an organ intended for transplantation or which poses an indirect risk to the safety of a donor or recipient

or

A shortfall in the establishment's quality and safety procedures which poses an indirect risk to the quality and safety of an organ intended for transplantation or which poses an indirect risk to the safety of a donor or recipient;

or

A shortfall which indicates a major deviation from the **Human Tissue (The Quality and Safety of Organs Intended for Transplantation) Regulations 2012 (as amended)** or the **Documentary Framework for the Quality and Safety of Organs Intended for Transplantation**;

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 quality and safety of an organ intended for transplantation or the safety of a donor or recipient;

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 audit 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 audit.

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 audit report.

Follow up actions

A template corrective and preventative action plan will be sent as a separate Word document with the final audit report. The establishment 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 audit
- a request for information that shows completion of actions
- monitoring of the action plan completion
- follow up at next routine site-visit audit

After an assessment of the proposed action plan, the establishment will be notified of the follow-up approach the HTA will take.

Appendix 3: HTA Assessment criteria

The HTA assessment criteria 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.

Donor Characterisation and Organ Characterisation

CT1) Where a donor is deceased, a registered medical practitioner, or a person acting under the supervision of a registered medical practitioner, has endeavored to obtain information from the relatives or other persons about the donor, and has explained the importance of swift transmission of information. **(The establishment is not responsible for obtaining information relating to a deceased donor. This will be carried out by the specialist nurse – organ donation (SN-OD) under NHSBT's licence).**
CT2) Donors and organs are characterised before implantation by the collection of information specified in Annex A of The Quality and Safety of Organs Intended for Transplantation: A documentary framework.
CT3) Donors and organs are characterised before implantation by, where considered appropriate, the collection of information specified in Annex B of The Quality and Safety of Organs Intended for Transplantation: A documentary framework.
CT4) All information relating to donor and organ characterisation is kept for a period of 30 years from the date of retrieval of the organ and there is an operating procedure in place to demonstrate how this requirement is complied with.
CT5) Tests required for donor and organ characterisation are carried out by laboratories with United Kingdom Accreditation Service (UKAS) accreditation (to ISO15189:2021).
CT6) Information on organ and donor characterisation reaches the person who will be implanting an organ within a time period that would not compromise the quality and safety of the organ and there is an operating procedure in place to demonstrate how this requirement is complied with.

Retrieval of Organs for transplantation

R1) Procurement is only carried out after all the requirements relating to consent (or authorisation in Scotland) have been met.
R2) Material and equipment used in retrieval meets the requirements of The Medical Devices Regulations 2002 (SI 2002/618) (as amended) (UK MDR 2002), where these apply, and there is an operating procedure in place to demonstrate how this requirement is complied with.
R3) Reusable instruments used in retrieval are subject to a validated cleaning and sterilisation procedure for removal of infectious agents, which is documented.
R4) Endeavours are made to follow-up a living donor for the purposes of identifying and managing any event potentially relating to the quality and safety of the donated organ and any serious adverse reaction in the living donor that may result from the donation

Organ preservation

P1) Material and equipment used in organ preservation meet the requirements of The Medical Devices Regulations 2002 (SI 2002/618) (as amended) (UK MDR 2002), where these apply, and there is an operating procedure in place to demonstrate how this requirement is complied with.
P2) Reusable instruments used in organ preservation are subject to a validated cleaning and sterilisation procedure for removal of infectious agents, which is documented.

P3) Records of perfusion fluid coming into contact with organs are made on the appropriate HTA A and B forms.

Making arrangements to transport an organ

TP1) The integrity of the organ is maintained during transport and the transport time is suitable to ensure the quality and safety of the organ, and there is an operating procedure in place to demonstrate how this requirement is complied with.
TP2) The organ shipping container is suitable for transport of the specified organ.
TP3) The organ shipping container used for transporting organs from the licensed premises is labelled with the information specified in The Quality and Safety of Organs Intended for Transplantation: A documentary framework, and there is an operating procedure in place to demonstrate how this requirement is complied with.
TP4) Transported organs are accompanied by a report on the organ and donor characterisation, and there is an operating procedure in place to demonstrate how this requirement is complied with.
TP5) Arrangements are in place to ensure that any organisations transporting organs on behalf of the licence holder meet the requirements for transportation and serious adverse event and reaction reporting specified in the framework document.

Implantation

I1) The identification of the donor and the collection of the information in Annex A and B of The Quality and Safety of Organs Intended for transplantation: A documentary framework, are verified prior proceeding to implant an organ, and there is an operating procedure in place to demonstrate how this requirement is complied with.

I2) Compliance with the conditions of preservation and transport outlined in The Quality and Safety of Organs Intended for Transplantation: A documentary framework are verified prior to proceeding to implant an organ.
I3) Where any of the information specified in Annex A of The Quality and Safety of Organs Intended for Transplantation: A documentary framework is not available; a risk-benefit analysis is conducted to determine whether the expected benefits for the recipient of the organ outweigh the risks posed by the lack of any information.

Traceability – (*these criteria apply to all licensed activities*)

TC1) The data required to ensure traceability of organs are recorded using the HTA A and B forms, which are returned to NHSBT within 7 days, and there is an operating procedure in place to demonstrate how this requirement is complied with.
TC2) There is an identification system for donor and recipient to identify each donation and each of the organs and recipients associated with it.
TC3) A record (date and time) of the transportation of organs arriving at and/or leaving the establishment is kept for 30 years as part of the traceability information.

Serious adverse events and adverse reactions (SAEARs) – (these criteria apply to all licensed activities)

S1) Operating procedures are in place for the management of a serious adverse event or a serious adverse reaction.
S2) Serious adverse events and reactions are reported to NHSBT within 24 hours of discovery, a follow-up report is provided

within 90 days, and there is an operating procedure in place to demonstrate how this requirement is complied with.
S3) Third parties, such as those undertaking testing or transportation, are instructed to report any serious adverse events and reactions to the licence holder within 24 hours of discovery.

General – (*these criteria apply to all licensed activities*)

GN1) Healthcare personnel directly involved in the chain from donation to the transplantation or disposal of an organ are competent and suitably qualified or trained to perform their tasks.
GN2) Healthcare personnel directly involved in the chain from donation to the transplantation or disposal of an organ are provided with the training necessary to perform their tasks.
GN3) Medical activities are performed under the advice and guidance of a registered medical practitioner, and there are operating procedures in place to demonstrate this.