

Site visit audit report on compliance with licensing assessment criteria  
Site visit date: 19 March 2026



**University Hospitals Bristol and Weston NHS Foundation Trust**  
HTA licensing number 40049

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

**Licensed activities – Transplant**

Organ type	Kidney
Paediatric recipient	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**

Although the HTA found that University Hospital Bristol and Weston NHS Foundation Trust (the establishment) had met the majority of HTA's assessment criteria that were assessed as part of the audit, one minor shortfall was found against the assessment criteria for CT4 and P1.

**Compliance with HTA assessment criteria**

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 audit.

Assessment criteria	Audit findings	Level of shortfall
<b>Donor Characterisation and Organ Characterisation</b>		
<p>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.</p> <p>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</p>	<p>Currently the completed temperature monitoring forms for perfusion fluids are discarded after five years. These need to be retained by the establishment for the required 30 years.</p> <p>A review of temperature monitoring records for perfusion fluids showed a few instances where temperatures went above the expected range as set by the manufacturer. There was no evidence that the establishment followed up on this.</p>	<p>Minor</p>

## Advice

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

Number	Assessment Criterion	Advice
1.	CT1	During the traceability audit of records, there was a pending microbiology transport fluid result for one set of records, and no evidence of follow up by the establishment. The establishment is advised to ensure that where any test is initiated, there is a robust system in place for follow up.
2.	CT4	<p>During a review of donor and recipient clinical notes some examples of inconsistencies in recording information were found. Examples included:</p> <ul style="list-style-type: none"><li>• An incomplete parental consent form for day of surgery</li><li>• Inconsistent recording of perfusion fluid batch numbers in patient notes</li></ul> <p>For consistency and ease of access, the establishment may wish to standardise the procedures for recording information.</p>
3.	P3	<p>The temperature of the fridge used to store perfusion fluids is recorded, however, there were gaps in the records.</p> <p>The establishment may wish to consider adding the fridge containing perfusion fluids to the pharmacy department's temperature monitoring system.</p>
4.	TP1	The establishment is advised to have an additional section on the kidney arrival checklist for documenting if the kidney or samples are transported to the laboratory or another Centre.

## **Background**

The establishment has been licensed by the HTA since August 2012 and this was the establishment's fourth audit. Prior to that three site audits have been conducted; the most recent previous audit took place in January 2023.

Since the audit in January 2023 there have been no significant changes.

## **Description of audit activities undertaken**

The HTA's regulatory requirements are set out in Appendix 1 and 3

### *Criteria assessed against during the audit*

The establishment was assessed against all applicable criteria.

### *Review of governance documentation*

The audit team reviewed:

- Procedural documents relating to licensed activities
- Accreditation certificates for the Histocompatibility and Immunogenetics (H&I) and Histopathology and Microbiology laboratories
- Procurement policy demonstrating how the Medical Devices Regulations 2002 (SI 2002/618) (as amended) (UK MDR 2002) requirement is complied with
- Certification of the sterile services provider.

In addition, a selection of incidents was reviewed and discussed with establishment staff. Discussions around staff training also took place.

### *Visual inspection*

The audit team visited the ward where organs are received and discussions about monitoring the storage temperature of perfusion fluids were held with staff.

### *Audit of records*

A review of recipient clinical notes and associated donor files was undertaken by the audit team as described below:

- Three sets of notes relating to directed living donor kidney transplants
- Two sets of notes relating to deceased donor kidney transplants

The records reviewed included transplant coordinator notes, transport and records of receipt of organs, operation notes, records of perfusion fluids used, cross match and serology results and HTA - A and electronic HTA - B forms.

**Report sent for factual accuracy: 2 April 2026**

**Report returned with comments: No comments received.**

**Final report issued: 21 April 2026**

## **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 audit 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**

<b>NHSBT's licence).</b>
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.