# RDSOP30 Study Conduct

<table>
<thead>
<tr>
<th>Title of Standard Operating Procedure:</th>
<th>RDSOP30 Study Conduct</th>
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<tbody>
<tr>
<td>Document Summary:</td>
<td>This standard operating procedure (SOP) describes the procedure for study conduct in relation to GMMH Sponsored CTIMPs.</td>
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<tr>
<td>Document Author:</td>
<td>Rachel Rosenhead Research Support Coordinator</td>
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<td>Trust-wide, Research Community, Internal and External Researchers</td>
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<td>R&amp;I Office, research community and R&amp;I Committee members</td>
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<td>R&amp;I Committee</td>
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<td>Cross Reference Document(s):</td>
<td>Research Approval Policy All Trust R&amp;I SOPs</td>
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<tr>
<th>Minimum Monitoring Requirement</th>
<th>Frequency</th>
<th>Process for monitoring</th>
<th>Evidence</th>
<th>Responsible Individual(s)</th>
<th>Response Committee(s)</th>
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<tr>
<td>Review of SOP content</td>
<td>Annually</td>
<td>Review by Author, redraft, submission to R&amp;I Operational Group</td>
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<td>Head of R&amp;I Office</td>
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1. Introduction

This standard operating procedure (SOP) is needed to ensure that all GMMH-Sponsored Clinical Trials of Investigational Medicinal Products (CTIMPs) are conducted in line with Good Clinical Practice (GCP) and any other relevant regulatory requirements.

2. Purpose

This SOP describes the procedure for study conduct in relation to GMMH Sponsored CTIMPs

3. Roles and Responsibilities

3.1 Duties within the Organisation

It is the responsibility of the Research & Innovation Office to make Trust R&I SOPs available to all research active staff working on Trust-approved research studies.

It is the responsibility of the study Chief Investigator (CI) or local Principal Investigator (PI) to ensure that up-to-date copies of Trust R&I SOPs are available to research staff.

It is the responsibility of the study Chief Investigator or local Principal Investigator to ensure up-to-date SOPs are filed in the Investigator Site File and are available to research staff, and to inform the Research Support Co-ordinator of the names of all research staff involved on a study so that copies of SOPs can be distributed appropriately.

It is the responsibility of the study Chief Investigator or Principal Investigator to designate if the SOPs of another organisation are to be followed for a study. For example those of a Clinical Research Network or commercial sponsor. If there is significant conflict between the external SOP and the Trust R&I SOP it is the responsibility of the CI or PI to resolve these with the Research Office prior to starting the study.

It is the personal responsibility of all staff to follow Trust (or the designated alternative organisations) procedural documents.

The Research & Innovation Office is responsible for managing Trust R&I SOPs including their approval, dissemination and archiving. All Trust R&I SOPs must be made available via Q-Pulse and published on the Trust website.
3.2 Specific to this SOP

Responsible Personnel

This SOP applies to the R&I Office and all research teams conducting a GMMH-sponsored CTIMP.

It applies to the Chief Investigator (CI), in accordance with the Sponsor delegated responsibilities as described in the Sponsor/CI agreement issued by GMMH.

4. Procedures

4.1 Delegation Log Completion

Roles and responsibilities for protocol-related activities must be delegated and authorised by the Chief Investigator (CI) as GCP states that “The Investigator should maintain a list of appropriately qualified persons to whom the investigator has delegated significant trial-related duties” (ICH GCP Section 4.1.5). (A Delegation of Duties Log template (which may be modified to meet study requirements) is available via the R&I Office).

This may include staff that are directly involved in the research such as investigators, research nurses, data managers and study co-ordinators.

In addition, there may be staff associated with the research but who are not part of the core research study team but are carrying out protocol-specific activities which are not part of standard care, such as other clinicians, scientists, pharmacists, laboratory staff, specialist nurses, technicians or other support staff e.g. radiographers.

Exceptions may occur for protocol-related activities which are carried out by clinical staff as part of their normal role and the activity is being done as part of routine care, e.g. a phlebotomist taking blood as part of a routine clinic, but an extra sample is taken for a research study. For situations like this the research team should contact the R&I department for clarification on whether or not these members of staff should be on the delegation log or not.

Prior to each research study commencing, it is the responsibility of the CI at the CI site and PI at the PI site to designate staff members to a specific role within the research. This is done using a delegation log.

The delegation log should detail each staff member’s full name, job title, research responsibilities, and the start and end dates of their participation in the research project. Should any member of staff change their name during the course of the research they are required to sign the delegation log again showing their new name, signature and initials.
The CI at the CI site and PI at the PI site should ensure that the tasks are appropriate to the assigned individual and usually certain roles undertake certain tasks (although this is not compulsory). For example:

<table>
<thead>
<tr>
<th>Task</th>
<th>At CI site usually undertaken by</th>
<th>For multi-centre studies: At PI site usually undertaken by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sign off individuals on the Delegation Log</td>
<td>CI</td>
<td>PI</td>
</tr>
<tr>
<td>Informed Consent</td>
<td>CI/Co-Investigator/Study Physician</td>
<td>PI/Co-Investigator/Study Physician</td>
</tr>
<tr>
<td>Identifying potential participants</td>
<td>CI/Co-Investigator/Study Physician/Research Nurse</td>
<td>PI/Co-Investigator/Study Physician/Research Nurse</td>
</tr>
<tr>
<td>Randomisation</td>
<td>CI/Co-Investigator/Study Physician/Research Nurse</td>
<td>PI/Co-Investigator/Study Physician/Research Nurse</td>
</tr>
<tr>
<td>Physical examination</td>
<td>CI/Co-Investigator/Study Physician</td>
<td>PI/Co-Investigator/Study Physician</td>
</tr>
<tr>
<td>Venepuncture</td>
<td>Research Nurse</td>
<td>Research Nurse</td>
</tr>
<tr>
<td>Cannulation</td>
<td>Research Nurse</td>
<td>Research Nurse</td>
</tr>
<tr>
<td>Sample collection</td>
<td>CI/Co-Investigator/Study Physician/Research Nurse</td>
<td>PI/Co-Investigator/Study Physician/Research Nurse</td>
</tr>
<tr>
<td>Sample processing</td>
<td>CI/Co-Investigator/Study Physician/Research Nurse /Laboratory Technician</td>
<td>PI/Study Physician/Research Nurse/Laboratory Technician</td>
</tr>
<tr>
<td>CRF completion</td>
<td>Research Nurse / Trial Administration staff</td>
<td>Research Nurse / Trial Administration staff</td>
</tr>
<tr>
<td>SAE reporting</td>
<td>CI/Co-Investigator/Study Physician</td>
<td>PI/Co-Investigator/Study Physician</td>
</tr>
<tr>
<td>Clinical Trial Prescription completion</td>
<td>CI/Co-Investigator/Study Physician</td>
<td>PI/Co-Investigator/Study Physician</td>
</tr>
<tr>
<td>Drug dispensing and accountability</td>
<td>Clinical Trials Pharmacist</td>
<td>Clinical Trials Pharmacist</td>
</tr>
<tr>
<td>Drug administration</td>
<td>CI/Co-Investigator/Study</td>
<td>PI/Co-Investigator/Study</td>
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<table>
<thead>
<tr>
<th></th>
<th>Physician/Research Nurse</th>
<th>Physician/Research Nurse</th>
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</thead>
<tbody>
<tr>
<td>Medical Care</td>
<td>CI/Co-Investigator/Study Physician/Research Nurse</td>
<td>PI/Co-Investigator/Study Physician/Research Nurse</td>
</tr>
<tr>
<td>Ethics and R&amp;D submissions</td>
<td>Trial Administration staff</td>
<td>Trial Administration staff</td>
</tr>
<tr>
<td>Maintaining study site files</td>
<td>Research Nurse / Trial Administration staff</td>
<td>Research Nurse / Trial Administration staff</td>
</tr>
</tbody>
</table>

The responsibilities will normally be listed and given a letter as a reference, for example:

- A = Taking informed consent
- B = Physical examination
- C = Performing randomisation

Each individual involved in conducting a trial should be qualified by education, training and experience to perform his or her respective task(s) (ICH GCP Section 2.8) and the CI and PI must ensure that this is the case for all individuals named on the delegation log.

When a staff member has been identified for each research task and their name, role and responsibilities have been listed on the delegation log:

The staff member must sign the log in a column next to their name to acknowledge that they have agreed to undertake the delegated duties and responsibilities.

The CI or PI must also sign and date the delegation log next to each staff member’s name.

This provides evidence that the CI/PI has acknowledged that each staff member has the appropriate qualifications, training and experience to undertake the specific duties/responsibilities for the safe conduct of the study. This also formally authorises that the specific duties/responsibilities have been delegated by the individual that has overall responsibility for the conduct of the study.

The delegation log must also identify the date when each staff member began working on the research study, and also the date when they finished working on the study (if the staff member should leave before the research study is completed).

The delegation log also provides a record of staff signatures and initials, so that individuals outside of the research team, for example external trial centres, know which signatures and initials are authorised on case report forms.
If a member of clinical staff can be identified from the Trial Master File (TMF) or Investigator Site File (ISF), for example through a signature on an Essential Document, then that member of staff should be listed on the trial delegation log.

The delegation log must be stored in the TMF and ISF, and must be updated each time a new staff member is recruited or an existing staff member leaves. Superseded versions should not be destroyed and should be kept in the TMF/ISF marked as 'superseded' in order to provide an audit trail for future inspections.

### 4.2 Training

GCP requirements: All members of staff on the trial delegation log should have attended a GCP course in the last two years and have a certificate of attendance available for review. For activities carried out as part of the staff member's normal role, bespoke GCP training covering the areas relating to a particular task only may be suitable instead of full GCP training. For situations like this the research team should contact the R&I department for clarification on the extent of GCP training these members of staff require.

Study specific training: All members of the research team should be trained in the research protocol (including training in protocol-related procedures) to ensure it can be followed accurately.

Evidence of this training needs documenting in the TMF/ISF and in individuals training folders. Types of training can include:

- Initiation meeting training
- Online training
- Other study specific training sessions
- Trust provided training
- External organisation training sessions
- Sponsor training sessions

### 4.3 Informed Consent

The procedure for Informed Consent is described in RDSOP6 Informed Consent and RDSOP7 Informed Consent – Incapacitated Adults.

### 4.4 Eligibility

In GCP it is the expectation that “A qualified physician who is an investigator or a sub-investigator for the trial should be responsible for all trial-related medical decisions” (ICH GCP 4.3.1) and therefore the CI, Sub-Investigator (Co-Investigator)
or PI must have assessed each individual eligibility criterion and taken the final decision to include the subject in the trial.

This decision should be documented prior to the subject receiving the first dose of the IMP.

GCP inspections have revealed a substantial amount of cases where the overall eligibility statement in the CRF confirms subject eligibility but where source data shows that the subject did not fulfil all eligibility criteria.

Adherence to all individual inclusion and exclusion criteria must be able to be evidenced in the source data. This can originate from different sources like blood samples, physical examination, medical history, information from the subject etc.

In addition, it has often not been documented that an investigator/sub-investigator has reviewed all criteria prior to inclusion.

Any statement confirming eligibility, for example “Did the subject satisfy all study entry criteria”, must be accompanied by a signature of a qualified physician and they must have reviewed the source data to confirm eligibility prior to signing.

All eligibility decisions made by a delegated clinician must be documented in the patient notes.

4.5 Recruitment Management and Monitoring

Clinical Trial Managers should develop a recruitment plan which includes:

- What will the primary recruitment methods be?
  a) Nurse/doctor approaching patient
  b) Database
  c) Posters
  d) Radio ads/newspaper ads

- How will patients be identified?
- Who will be responsible for identifying patients?
- Who will be responsible for driving recruitment?
- Do other departments/people need to be contacted to make them aware of the study (think of the patient pathway)? Who will do this?
- Is there anything in the protocol design or inclusion/exclusion criteria which may impact recruitment?
- What is the anticipated screen failure rate?
- How many patients will need to be randomised to meet the target?
- Will this study compete with any other studies?

Clinical Trial Managers should monitor the recruitment against the required target and troubleshoot recruitment issues alongside the research team to ensure that where possible all recruitment targets are met within the required timescales.
issues impacting on patient recruitment should be escalated to a senior member of the R&I team and where necessary the R&I Committee if they cannot be resolved.

### 4.6 Study Documentation

The procedure for the Trial Master File, source data storage, patient file storage, version control management & Investigator Site File Management is described in RDSOP5 Maintaining a Study File and Version Control.

The procedure for archiving is described in RDSOP37 Retention of Data, Off-site Archiving and Destroying Documents.

The procedure for Version Control is described in RDSOP29 Version Control.

It is a requirement of ICH GCP that an entry is made in the medical notes of individuals participating in a clinical research trial. In June 2009, the Department of Health issued further guidance to ensure that local medical notes clearly reference the fact that a patient or healthy volunteer is participating on a research study (DH Gateway Reference 11985). The protocol should specify which details must be recorded in the medical notes.

Where a protocol is not clear about this, the following minimum details must be recorded:

- Copy of Participant Information Sheet (PIS)
- Informed Consent Form (ICF) as signed by participant (or legal guardian/witness)
- Copy of GP letter or letter to other health carers
- Record of visits and results (source data)
- Qualitative studies usually only record visit dates in the patient notes, unless medical details are requested by the protocol.
- Visit information to record:

  **Consent**
  - Details of the consent or that a patient has been spoken to about a study but has chosen not to participate.

  **First visit**
  - Visit date, visit number
  - Medical History
  - Drug history
  - Allergies
  - Randomised controlled study/single-blinded/double-blinded study
  - If blinded; study arm - study medication/intervention name and briefly therapeutic effect (if blinded; specify all drugs/including placebo)
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- Study medication administered/or study arm

Each participant visit
- Visit date, visit number; participant consented to continue on research
- Drug history: any changes to medication or other treatments since last visit
- Study medication/interventions administered - examinations (clinically relevant findings/test results)
- Adverse events/reactions (where clinically relevant)
- Details of any SAE/SUSAR since last visit
- Date of next visit

4.7 IMP Management

The procedure for IMP management is described in RDSOP10 IMP Management and Accountability.

4.8 Data Management

The procedure for data management is described in RDSOP17 Research Data Management and Security.

4.9 Pharmacovigilance

The procedure for safety reporting is described in RDSOP8a Pharmacovigilance for Trust-Sponsored MHRA-regulated Clinical Trials.

The procedure for unblinding procedures is described in RD SOP28 Randomisation and Unblinding.

4.10 Monitoring and Audit

The procedure for the monitoring requirements of the study should be described in the protocol and is described in the Clinical Systems and Data Policy available here.

4.11 Planned Reporting

The procedure for reporting requirements for trials is described in RDSOP34 Development Safety Update Reporting and RDSOP31 Study Close Out.
4.12 Unplanned Reporting

The procedure for Unplanned Reporting is described in RDSOP9 Notification of a Serious Breach of GCP or the Clinical Trial Protocol.

4.13 Clinical Facilities

Requirements for research areas include:

- Emergency resuscitation trolley and other rhesus related equipment available
- Emergency call buttons/alarms available
- Trained resuscitation staff available

4.14 Amendments

The procedure for Amendments to GMMH-Sponsored CTIMPs is described in RDSOP39 Sponsorship of Clinical Trials of Investigational Medicinal Products.

4.15 Temporary Halts

Should the research need to be suspended due to a breach of GCP or the Clinical Trial Protocol, the research team should refer to RDSOP9 Notification of a Serious Breach of GCP or the Clinical Trial Protocol.

4.16 Closure of Study

Procedure for the closure of studies is described in RDSOP31 Study Close Out.

5. References

Terms of Reference for the GMMH R&I Committee

UK Policy Framework for Health and Social Care Research v3.3 07/11/17

ICH Topic E6 (R2) Guideline for Good Clinical Practice (GCP)