Reference Number: *UHB 236* **Version Number: 4.0**	**Date of Next Review: 21/11/2026** **Previous Trust/LHB Reference Number:** *N/A*

RESEARCH AUDIT
Standard Operating Procedure

Introduction and Aim

As a legal Sponsor organisation (an institution that takes responsibility for initiation, management and/or financing of a clinical trial), Cardiff and Vale University Health Board (UHB) is responsible for auditing research practice and assuring adherence to current legislation and guidelines.
As such, it is necessary to audit research for which, the UHB is the Sponsor against the standards of the UK Policy Framework for Health and Social Care and the Medicines for Human Use (Clinical Trials) Regulations 2004 (and subsequent amendments) where applicable and against the quality systems of Good Clinical Practice intrinsic to the Regulations.
This standard operating procedure (SOP) is to assist researchers in understanding the audit process, so they are prepared should they be selected for internal audit or external audit/ inspection.

Objectives

- To describe the audit procedures of the JRO staff acting on behalf of CAVUHB as Sponsor or host organisation.
- To describe the processes for selecting studies for audit, the procedures for carrying out audits; and reporting audit results to Investigators.
- To describe the requirements for Investigators to respond to audit reports and implement corrective actions.

Scope

This procedure applies to staff in all locations including those with honorary contracts.

Equality Health Impact Assessment	An equality impact assessment has been carried out on the Research Governance Policy under which this Procedure falls. No adverse impact has been identified.
Documents to read alongside this Procedure	Research Governance Policy (UHB 099) Managing Breaches of GCP or the Study Protocol SOP (UHB 235) Investigating and Handling Allegations of Research Misconduct SOP (UHB145)
Approved by	Joint Research Governance Group

Accountable Executive or Clinical Board Director	Medical Director
Author(s)	Research Governance

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1.0	08/04/2014	23/06/2014	New document
2.0	17/10/2017	30/11/2017	Transferred into current UHB SOP template, addition of objectives and scope sections. Glossary updated Appendix 2, Template audit report updated. Reference documents updated
3.0	21/10/2020	15/12/2020	Minor updates to reference documentation. Replacement of Research Governance Framework by UK Policy Framework for Health and Social Care. Applying for Cardiff and Vale NHS University Health Board Sponsorship Guideline - GR-RG-008 superseded by Applying for Cardiff and Vale UHB Sponsorship SR-RG-018 UHB 453
4.0	02/11/2023	28/11/2023	References to RGG changed to JRGG. Minor updates to glossary. Updated routine audit selection section. Updated to reflect the audit report is to be shared with the relevant Research Delivery Manager/Team Lead.

Contents

GLOSSARY

ABBREVIATIONS AND DEFINITIONS

CAPA – Corrective and Preventative Action
CAVUHB – Cardiff and Vale University Health Board
CI - Chief Investigator
CTIMP - Clinical Trial of Investigational Medicinal Product
GCP - Good Clinical Practice
ICH - International Conference for Harmonisation
ISF- Investigator Site File
IMP - Investigational Medicinal Product
JRO – Joint Research Office
MHRA- Medicines and Healthcare Products Regulatory Agency
PI - Principal Investigator
R&D - Research & Development
ReDA – Research Database Application
SOP - Standard Operating Procedure
TMF – Trial Master File

Chief Investigator -The investigator with overall responsibility for the research. In a multi-site study, the CI has co-ordinating responsibility for the research at all sites. The main application for ethical review should be submitted by the CI.

Principal Investigator - The investigator responsible for the research site where the study involves specified procedures requiring site specific assessment by the local R&D Office. For multi-site studies, there should be one PI for each research site. In the case of a single-site study, the CI and the PI will normally be the same person.

External Sponsor – This means any Sponsor other than Cardiff and Vale UHB. An External Sponsor may be a Commercial organisation (e.g. a Pharmaceutical company) or a Non-Commercial organisation (e.g. another Local Health Board, NHS Trust or University, including Cardiff University).

1. PURPOSE

This Standard Operating Procedure (SOP) describes the research audit procedures of the JRO staff acting on behalf of CAVUHB.

It describes the processes for selecting those studies for audit, the procedures for carrying out audits and the reporting of audit results to Investigators. It also describes the requirements for Investigators to respond to audit reports and the implementation of corrective and preventative actions.

The SOP primarily covers the procedures to be followed for

- CAVUHB sponsored CTIMPS
- CAVUHB sponsored non-CTIMPS (including interventional studies such as surgical trials or trials involving devices).
- Externally sponsored studies hosted at CAVUHB

The purpose of research audit within the scope of this SOP is to verify that systems are in place to ensure:

- The rights and well-being of human subjects are protected

- The reported study data is accurate, complete, and verifiable from source documents.

- The conduct of the study is in compliance with the approved study protocol/amendments, with UK Policy Framework for Health and Social Care Research, the applicable regulatory requirements and CAVUHB policies and SOPs.

2. PROCEDURE

2.1 Routine Audit Selection

The JRO will select a representative sub-set of CAVUHB sponsored studies and non-commercial hosted CTIMPs for auditing as documented in the annual CAVUHB audit plan.

- **CAVUHB sponsored studies**

Routine audits of CAVUHB sponsored CTIMPs and non-CTIMP interventional studies such as surgical trials or trials involving devices, will follow a risk-based approach. During the sponsor assessment process, a Risk Assessment Form (RAF) will be completed which categorises studies into 3 areas of risk:

Type A = comparable to the risk of standard medical care
Type B = somewhat higher than the risk of standard medical care
Type C = markedly higher than the risk of standard medical care

Routine audits may be performed with priority to Type C studies followed by Type B and Type A. The following will be excluded: Studies closed to recruitment, studies in set up and studies that have recently been audited or inspected. All MHRA regulated studies require the appointment of a Clinical Trials Unit to manage study conduct and will each have a monitoring plan outlining oversight.

- **Non-Commercial Studies**

A representative sub-set of studies of non-commercial hosted CTIMPs will be audited as documented in the annual CAVUHB audit plan.

- **Commercial Studies**

Commercially sponsored studies will not be included within the programme of routine audit, unless there are particular audit/inspection findings in relation to quality management systems that warrant it. The responsibility for auditing lies with the Sponsor, in accordance with GCP and the applicable regulatory guidelines.

Commercial sponsors will however be requested to supply copies of monitoring and audit reports to the JRO for oversight.

2.2 Audit Preparation

The auditor will draft an audit plan using a template (see Appendix 1) and develop audit tools according to the aim of the audit. The audit activities to be undertaken will be proportionate to the risks associated with the study.

The audit plan will:

- Define scope and objectives for audit
- Provide timelines for audit conduct
- Identify where and when the audit will take place
- Identify requirements to be audited against
- Identify areas to be audited
- List documents and records to be reviewed.
- List responsibilities i.e. list who is responsible for each stage of the audit process.

The study documentation contained within the R&D study file and the ReDA database will be reviewed ahead of the audit. If any issues are highlighted from this review, these should be discussed with the research team at the audit meeting.

The auditor should contact the CI/PI (as applicable) to arrange a convenient appointment and ensure they are aware of the documents which will be required at the audit (e.g. hospital notes, ISF/TMF and completed case report forms). Generally, four weeks' notice will be given in order to allow time for preparation, unless the audit is "for cause".

2.3 Audit Activities

The auditor will need to meet the appropriate members of the research team by way of an opening meeting to inform them of the remit of the audit and also to ask any relevant questions to address the audit aim.

The auditor should review the study documentation and complete the audit checklist, according to the audit remit as outlined in the audit plan. The review should consist of (but not exclusive to):

- review of the Trial Master/ Investigator Site File
- adherence to study specific and CAVUHB SOPs
- review of consent process
- adherence to protocol e.g. inclusion/exclusion criteria
- research team – delegation log, training, honorary contracts
- event reporting (adverse events, serious breaches of protocol or GCP)
- progress with recruitment

Once the audit is complete, the auditor will provide verbal feedback to the study team. The CI/PI is expected to be present if the findings are critical or major. Any potential serious breaches in GCP or the study protocol identified during audit should be reported to the Sponsor as described in Managing Breaches of GCP or the Study Protocol SOP (UHB 235)

2.4 Reporting

After the visit, the auditor will prepare an audit report (Appendix 2**).** All findings identified during the audit will be documented and categorised as follows:-

- CRITICAL - where non-compliance with GCP standards is affecting the integrity of the clinical trial or patient safety and immediate corrective action is required.
- MAJOR - Where non-compliance with GCP standards has the potential to affect the clinical trial or patient safety if not corrected in a timely fashion
- OTHER- minor non-compliances with no significant impact on the outcome of the trial or patient safety.

The audit report will be shared with the R&D Manager (or delegate) and the categorisation of findings identified during the audit agreed. The auditor will aim to send the audit report to the CI/PI and clinical trial pharmacist (if applicable) within two weeks of the audit. The report should be reviewed and agreed by the investigator. If however a critical non-compliance is identified the auditor will forward initial findings within 48 hours to the R&D Manager and the JRO Director for review and agreement of the proposed corrective and preventative actions. This is to ensure the CAPA to address the critical non-compliance can be implemented as soon as possible.

It is the CI/PI's responsibility to ensure action is taken to correct any identified gaps in compliance. If any advice or assistance is required the auditor will be able to help with this. The CI/PI and clinical trial pharmacist (if applicable) is expected to respond to the audit report within 1 month and corrective actions made within an agreed time frame. The auditor should ensure that the agreed actions have been completed. When all actions have been completed the auditor will inform all parties in writing that the audit is complete.

A copy of the final audit report should be filed electronically in the R&D study folder. The audit report be shared with the relevant Directorate R&D Lead and the relevant Research Delivery Manager/Team Lead

2.5 Follow up/Escalation

Where there are one or more critical findings or multiple major findings, a meeting will be arranged with the research team to ensure appropriate corrective and preventative actions are implemented.

The auditor should follow up with the CI/PI and clinical trial pharmacist (if applicable) to ensure the actions have been completed in the agreed timescales. A follow up visit will be scheduled if appropriate to ensure corrective actions have been taken.

Evidence of continued non-compliance or failure to address the audit findings in the agreed timelines, will be escalated to the JRO Director. Failure to complete CAPAs within the agreed timescales will be escalated through the Joint Research Governance Group, and may be considered as possible research misconduct. If the non-compliance is deemed to be research misconduct then such cases will be managed using the Investigating and Handling Allegations of Research Misconduct Procedure (UHB 145)

A summary of key findings will be presented to the Joint Research Governance Group.

2.6 For-cause audit

Where there are concerns in relation to the conduct of a study, a for-cause audit may be required as part of an investigation to better understand the root of the concern(s).

Incidents, serious breaches of GCP, internal/external audits or inspections may also prompt for-cause audits of other studies within the investigator's portfolio of research. Findings from the for-cause audit may help to establish the extent of the concern.

The process outlined in sections 2.2 Audit Preparation, 2.3 Audit Activities, 2.4. Reporting and 2.5 Follow up/Escalation as above should be followed.

3. TRAINING

Education and support should be available from the JRO for researchers who are involved in conducting clinical research studies. JRO staff should receive relevant training (internal and external as necessary) in order for them to become competent auditors.

4. IMPLEMENTATION

The Clinical Board R&D Leads should facilitate implementation by ensuring that all relevant research active personnel within their Boards are aware of the Procedure and the implications for their practice.

5. EQUALITY

An equality impact assessment has been carried out on the Research Governance Policy, under which this Procedure falls. No adverse impact has been identified.

6. REVIEW

The Procedure should be reviewed every 3 years, or more regularly if important new legislation so requires.

7. REFERENCES

UK Policy Framework for Health and Social Care Research - Version 3.3

UK Clinical Trials (Medicines for Human Use) Regulations 2004 (and subsequent amendments)

ICH GCP Guideline E6 (R2) dated 9 Nov 2016

8. RELATED SOPs and DOCUMENTS

Managing Breaches of GCP or the Study Protocol SOP (UHB 235)

Investigating and Handling Allegations of Research Misconduct SOP (UHB 145)

Consent audit checklist FRM-009-01

RG audit checklist FRM-009-02

FPFV audit checklist TMP-010-01

9. APPENDICES

Appendix 1- Example Audit Plan

Objectives
The objective of this audit is to ensure compliance with <if IMP study> Medicines for Human Use (Clinical Trials) Directive 2004, incorporating amendments (2006) from the EU Directive 2005/28/EC on GCP <if non-IMP study> UK Policy Framework for Health and Social Care Research For all studies, we will be looking for adherence to Good Clinical Practice as outlined in the ICH Harmonised Tripartite Guideline for Good Clinical Practice. The final audit report will document findings against these guidelines.

Project Title
R&D Ref No:
CI/PI
Type of study
Clinical trial IMP
Audit site
Date of audit

Essential documents to be available during the audit include

- Protocol and amendments
- Consent forms and Participant Information Sheets
- HRA approval and correspondence
- Ethics approvals and correspondence
- C&C and correspondence
- Regulatory approvals and correspondence (e.g. MHRA, GTAC etc)
- General Study Correspondence.
- Delegation log and training documents
- SOPs
- Serious Adverse Events reports
- Pharmacy/Product-Related (IMP study only)
- Monitoring and Audit documentation
- Source data

Audit Timeline

On the day, the auditor(s) will introduce themselves and explain the planned procedure for the day. It would be useful if a separate room could be organised for the auditors to review the documents. The patient notes as requested by the auditor must be made available for source data verification.

Once the audit is complete, the auditor(s) will briefly go through the findings with the study personnel, and PI if present. A formal report will be provided within two weeks of the audit.

The CI/PI and clinical trial pharmacist (if applicable) is expected to respond to the audit report within 1 month and corrective actions made within an agreed time frame. The auditor should ensure that the agreed actions have been completed. When all actions have been completed the auditor will inform all parties in writing that the audit is complete.