

Research and Development SOP011 - Research Training Standard Operating Procedure

V4.0

April 2026

Table of Contents

1. Introduction.....	4
1.6. Scope	4
1.7. Definitions / Glossary	4
2. Purpose of this Standard Operating Procedure (SOP)	6
3. Ownership and Responsibilities	7
3.1. Role of the R and D Clinical Director	7
3.2. Role of the Senior Management Team (SMT)	7
3.3. Role of the Sponsor	7
3.4. Role of the Chief Investigator	8
3.5. Role of Principal Investigator (PI)	8
3.6. Role of the Research Team	9
4. Standards and Practice	9
4.1. Chief Investigator (CI) Training	9
4.2. Principal Investigator (PI) Training	9
4.3. Curriculum Vitae (CV).....	10
4.4. Mandatory Training GCP Training	10
4.5. Training in Standard Operating Procedures	11
4.6. Protocol and Study Specific Training	11
4.7. New starters joining the study after the study has started	11
4.8. Exemptions to Training Requirements.....	11
4.9. Compliance	12
5. Dissemination and Implementation	12
5.11. Training and Development	13
5.12. SOP Deviations.....	13
6. Monitoring compliance and effectiveness	13
7. Updating and Review.....	14
8. Equality and Diversity	14
Appendix 1. Governance Information	15
Appendix 2. Quality and Equality Impact Assessment (QEIA) Guidance Form.....	18

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

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1. Introduction

- 1.1. The Medicines for Human Use (Clinical Trials) Regulations 2004 (“the Clinical Trials Regulations”) as amended by the Medicines in Human use (Clinical Trials) (Amendment) Regulations 2025 (referred to as the “amended Clinical Trials Regulations”) Section 37 states “Clinical trials must be conducted in accordance with the principles of good clinical practice set out in the International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use Guideline for Good Clinical Practice, as amended from time to time”.
<https://www.legislation.gov.uk/uksi/2025/538/regulation/37>
- 1.2. International Conference on Harmonisation Good Clinical Practice (ICH GCP) E6 (R3) Section II Principle 5 states; “Individuals with different expertise and training may be needed across all phases of a clinical trial, such as physicians, nurses, pharmacists, scientists, ethicists, technology experts, trial coordinators, monitors, auditors and biostatisticians. Individuals involved in a trial should be qualified by education, training and experience to perform their respective task(s).” [ICH E6\(R3\) Step4 FinalGuideline 2025 0106.pdf](#)
- 1.3. The UK Policy Framework for Health and Social Care Research (2017), Principle 2 (Competence) stipulates that “All the people involved in managing and conducting a research project are qualified by education, training and experience, or otherwise competent under the supervision of a suitably qualified person, to perform their tasks.” [UK Policy Framework for Health and Social Care Research - Health Research Authority](#)
- 1.4. Health Research Authority (HRA) and Medicines and Healthcare Products Regulatory Agency (MHRA) state that for Clinical Trials of Investigational Medicinal Products (CTIMPs) it is the high level ‘conditions and principles’ of Good Clinical Practice (GCP) set out in the UK Clinical Trials Regulations that must be complied with and interpreted in proportion to the risks posed to the participants and to the integrity of the results. [Joint Statement on the Application of Good Clinical Practice to Training for Researchers \(HRA, MHRA, Devolved Administrations for Northern Ireland, Scotland and Wales\) - Health Research Authority](#)
- 1.5. This version supersedes any previous versions of this document.

1.6. Scope

This SOP applies to all members of the multidisciplinary teams that are developing, setting up, conducting and supporting research for the Royal Cornwall Hospital NHS Trust (RCHT), according to the UK Policy Framework for Health and Social Care Research.

1.7. Definitions / Glossary

- 1.7.1. **Good Clinical Practice (GCP)** is an international ethical and scientific quality standard for the design, conduct, performance, monitoring, auditing, recording, analysis, and reporting of clinical trials that provides assurance that the data and reported results are credible and accurate, and that the rights, integrity, and confidentiality of trial subjects are protected.

- 1.7.2. **Clinical Trial of Investigational Medicinal Product (CTIMP)** is any investigation in human subjects intended to discover or verify the clinical, pharmacological and/or other pharmacodynamics effects of one or more investigational medicinal product(s), and/or to identify any adverse reactions to one or more investigational medicinal products(s) and/or study absorption, distribution, metabolism and excretion of one or more investigational product(s) with the object of ascertaining its (their) safety and/or efficacy.
- 1.7.3. **Medicines and Healthcare products Regulatory Agency (MHRA)** is the executive agency of the Department of Health and Social Care in the UK which is responsible for regulating the use of medicines, medical devices and blood components for transfusion in the UK.
- 1.7.4. **Sponsor** is an individual, company, institution or organisation which takes responsibility for the initiation, management and/or financing of a clinical trial. A group of individuals and/or organisations may take on sponsorship responsibilities and distribute them by agreement among the members of the group, provided that, collectively, they make arrangements to allocate all the responsibilities that are relevant to the study in line with the UK Policy Framework for Health and Social Care Research.
- 1.7.5. **Chief Investigator (CI)** is the authorised health care professional who takes primary responsibility for the conduct of the trial. The CI must be a senior individual, with appropriate experience, expertise, and training to undertake the design, conduct and analysis of the study to meet the requirements set out in legislation.
- They must also lead and manage others who have been delegated responsibilities as part of the research project.
- 1.7.6. **Principal Investigator (PI)** is the person who takes responsibility for the initiation and conduct of the study at site. There is one Principal Investigator at each site participating in a research study. For a single site study, the Chief investigator may also take on the role of Principal Investigator.
- 1.7.7. **Associate PI** is a healthcare professional who does not have research as a core part of their role, who is given the opportunity to experience what it means to work and deliver a NIHR portfolio trial under the mentorship of a local PI.
- 1.7.8. **Sub-Investigator** is any individual other than the PI who is involved in the conduct of a research study and who with appropriate training and qualification may act on behalf of the PI when they are absent, their role should be clearly agreed and delegated with the Sponsor and CI.
- 1.7.9. **The Research Team** is a group of people involved in the conduct of a research project at site. It may include care professionals, academics, patients and service users, members of the public, research professionals, students and/or scientists.

1.7.10. **Trial Master File (TMF)** is a compilation of documents that prove that the clinical trial has been conducted following regulatory requirements (including Good Clinical Practice). The TMF plays a crucial role in ensuring that the trial has been managed successfully by the Investigator, Sponsor and Institution.

1.7.11. **Investigator Site File (ISF)** consists of trial documents from the initiation to close out of a study at a particular site. Maintaining the site file is the responsibility of principal investigators.

1.7.12. **Acronyms**

- **CI:** Chief Investigator.
- **CTIMP:** Clinical Trial of an Investigational Medicinal Product.
- **CV:** Curriculum Vitae.
- **GCP:** Good Clinical Practice.
- **HRA:** Health Research Authority.
- **IB:** Investigators Brochure.
- **ISF:** Investigator Site File.
- **MHRA:** Medicines and Healthcare products Regulatory Agency.
- **MRC:** Medical Research Council.
- **PI:** Principal Investigator.
- **QMS:** Quality Management System.
- **R and D:** Research and Development.
- **RCHT:** Royal Cornwall Hospitals NHS Trust.
- **REC:** Research Ethics Committee.
- **SOP:** Standard Operating Procedure.
- **Sub-I:** Sub Investigator.
- **TMF:** Trial Master File.

2. Purpose of this Standard Operating Procedure (SOP)

2.1. This Standard Operating Procedure (SOP) defines the training and level of competence required for the multidisciplinary teams that are developing, setting up, conducting and supporting research for the Royal Cornwall Hospitals NHS Trust (RCHT).

- 2.2. This SOP describes how training records should be recorded, documented and stored. Training records should be easily accessible and available on request.

3. Ownership and Responsibilities

3.1. Role of the R and D Clinical Director

The R and D Clinical Director is responsible for:

- Having oversight of the implementation of robust arrangements to ensure staff follow the processes described in [Section 4](#), Standards and Practice.
- Gaining assurance from the Senior Management Team (SMT) to ensure compliance with the processes outlined in [Section 4](#), Standards and Practice.

3.2. Role of the Senior Management Team (SMT)

The SMT is responsible for:

- Providing assurance to the R and D Clinical Director of the compliance with the processes outlined in [Section 4](#), Standards and Practice.
- Ensuring adequate provision of training for staff to perform their roles and responsibilities in association with the processes described in [Section 4](#), Standards and Practice.
- Arranging monitoring and auditing of the systems and processes associated with the standards and practice described in [Section 4](#).
- Ensuring any non-compliance associated with the standards and practice are processed in accordance with the R and D SOP004 Reporting and Managing Non-compliance and Serious Breaches (see Documents folder in EDGE).

3.3. Role of the Sponsor

The sponsor is responsible for:

- Ensuring that the investigators and key researchers have the necessary expertise and experience to successfully conduct the proposed trials and studies.
- Providing the investigator(s) with the necessary information to conduct the clinical trial or research study and ensuring that they are suitably trained.
- Obtaining evidence that relevant qualifications, experience, and research training for the Chief Investigator.

3.4. Role of the Chief Investigator

The Chief Investigator (CI) as defined by the Clinical Trials Regulations (SI 2004/1031) and the Amended Clinical Trials Regulations (SI 2025/538), is the health care professional who takes primary responsibility for the conduct of the trial.

The Chief Investigator is the overall lead researcher for a research study or clinical trial and is responsible for:

- Having oversight of the research team, ensuring that everyone involved in the conduct of the research is qualified by education, training and experience, to perform their respective delegated task(s).
- Ensuring training is proportionate to the activities undertaken by the staff involved in the clinical trial or research study. The training should be appropriate and tailored to the needs and risks of the associated research and aligned with the relevant regulatory requirements and standards.
- Ensuring all research staff have received appropriate training and have provided evidence of that training before any trial or study related activity is undertaken.

3.5. Role of Principal Investigator (PI)

The Principal Investigator (PI) is the individual responsible for research conducted at the local site, including the safety of all participants and the integrity and validity of the collected data. PIs may delegate tasks to appropriately trained and qualified members of their research team; however, they must maintain oversight and retain ultimate responsibility for the conduct of those to whom they delegate responsibilities. The PI can also be the Chief Investigator, with responsibilities as outlined in [Section 3.4](#).

The PI is responsible for:

- Demonstrating an understanding of the study and disease area in order to offer a full explanation of the study to participants and be deemed competent in the pharmacological aspects, where applicable.
- Ensuring that the site research team are suitably qualified, experienced and have received appropriate training to undertake the delegated activities and have provided evidence of that training before any trial or study-related activity is undertaken.
- Ensuring trial or study related training to research staff involved in the conduct of the clinical trial or research study corresponds to what is necessary to enable them to fulfil their delegated activities that go beyond their usual training and experience.

3.6. Role of the Research Team

All members of the Research Team are responsible for:

- Completing appropriate training, the extent of the training will depend on the activities being undertaken, ensuring that they have the knowledge and skills required to carry out the delegated duties.
- Maintaining and updating their own personal training records.
- Having an up-to-date Curriculum Vitae (CV).

4. Standards and Practice

4.1. Chief Investigator (CI) Training

- 4.1.1. It is important that the CI understands their responsibilities and the sponsor expectations. During the sponsor application process the experience of the CI will be taken into consideration. The risk profile of the study will determine whether or not individual training will be required, and an assessment will be made as part of the sponsor review.
- 4.1.2. Where a risk assessment has been undertaken by the sponsor, there may be a requirement that the sponsor representative and the CI review and approve. The risks and mitigation are discussed, as well as the specific role and responsibilities of the CI. This is often deemed adequate, and it is where gaps in knowledge or experience are highlighted, and relevant support offered.
- 4.1.3. CIs of studies where a risk assessment is not required may wish to meet with the sponsor representative as part of the sponsor review. Where this is requested or advisable the sponsor representative will talk through the specific roles and responsibilities and the expectations of the sponsor.
- 4.1.4. Individuals who have not undertaken research as a CI previously or who have not been responsible for a Trial Master File (TMF) may benefit from a session focusing specifically on the management of the file.

4.2. Principal Investigator (PI) Training

- 4.2.1. PIs must be appropriately qualified by education, training and experience, to discharge their responsibilities competently, and be trained in the trial or study protocol. They must demonstrate an understanding of the clinical trial or research study and disease area in order to offer a full explanation of the trial and study to participants and be deemed competent in the pharmacological aspects of the trial or study where applicable.
- 4.2.2. It is important that the PI understands their role and individual responsibilities. It is recommended that PIs with no previous experience undertake appropriate training.

- 4.2.3. Where monitoring or audit findings indicate lack of PI oversight it is likely that corrective action will include a mandate to attend additional training.

4.3. Curriculum Vitae (CV)

- 4.3.1. In order to provide evidence of compliance with this requirement to regulatory authorities, records of research team experience, education and training are required. The maintenance and updating of the research curriculum vitae (CV) to provide a means of demonstrating the adequate training and experience of research staff involved in the conduct of clinical trials.
- 4.3.2. All research staff should prepare the templated research CV, which outlines qualifications and experience pertinent to the role and delegated activities which they are undertaking. The CV should contain details of clinical experience (where relevant) and relevant training, including GCP training.
- 4.3.3. All research staff should maintain an up-to-date CV, which is evidenced in the Investigator Site File (ISF) for hosted studies and the Trial Master File (TMF) for studies sponsored by RCHT or if requested by the sponsor for hosted studies.
- 4.3.4. Expired CVs and training records must also be retained to demonstrate that members of the study team were appropriately qualified and trained throughout the whole period of the clinical trial or research study.
- 4.3.5. Copies of original evidence is acceptable, original documentation should be retained by the individual.

4.4. Mandatory Training GCP Training

- 4.4.1. All investigators and delegated staff active on the clinical trial or research study at RCHT must undertake Good Clinical Practice (GCP) training at a level that is commensurate with their role.
- 4.4.2. GCP training should be completed prior to commencing work on a clinical trial or research study and GCP Refresher training must be subsequently updated every three years.
- 4.4.3. Sponsors may request GCP training more frequently than every three years. The type and extent of the clinical research training is at the discretion of the external sponsor. These requests should be referred to R and D SMT, to clarify and negotiate the requirement, as appropriate.
- 4.4.4. The level of GCP training required for each individual involved in a clinical trial or research study should be proportionate to their involvement in the research. It may be appropriate for the GCP training course to be tailored for staff carrying out certain activities for a clinical trial or research study.

- 4.4.5. There may be staff involved in supporting activities who do not require specific GCP training; for example, phlebotomists and chemotherapy nurses, where no trial-related activities are undertaken outside of their usual role (GCP Guidance 14.2.1).

4.5. Training in Standard Operating Procedures

- 4.5.1. Research staff must demonstrate knowledge and understanding of RCHT R and D Standard Operating Procedures (SOPs) and any Trust or professional procedural guidance, relevant to their role and delegated activities.
- 4.5.2. Confirmation that the relevant R and D SOPs have been read by individual study team members should be recorded in EDGE.

4.6. Protocol and Study Specific Training

- 4.6.1. Clinical trials and research studies can generate specific training requirements. Research staff must be trained appropriately to carry out the requirements of the protocol. The CI or PI should provide or arrange training to enable research teams to follow and comply with the protocol and to facilitate recruitment of participants, this may include, amongst others:
- Training in the most recent versions of the protocol, investigators brochure (IB) and relevant digital databases.
 - Training in the use of devices, particularly if they are novel or being used unconventionally.
- 4.6.2. All study specific training must be documented in the Training Log as filed in the Trial Master File (TMF) or Investigator Site File (ISF), as appropriate.
- 4.6.3. Research training completion should be filed within individual personal training records.

4.7. New starters joining the study after the study has started

- 4.7.1. New team members who join after the study has started must complete training in GCP and the protocol, and be delegated appropriate responsibilities, that are recorded in the delegation log, prior to undertaking any activities within the clinical trial or research study.
- 4.7.2. The PI must ensure that all individuals are adequately trained and familiar with the protocol and appropriate study documents.

4.8. Exemptions to Training Requirements

There may be certain types of research activity which are exempt from the requirements detailed in this SOP, for example, studies involving the use of surveys only or the use of anonymous data. The Head of Research and Development will consider the requirements on a case-by-case basis.

4.9. Compliance

- 4.9.1. This SOP should be used as a minimum standard. If a sponsor requires a research team to work to its own training SOP which exceeds these standards, the research team will assess whether the sponsor's standards and practices can be adopted. All research staff should continue to demonstrate compliance with the requirements of this SOP.
- 4.9.2. Audit and monitoring findings may identify additional training requirements; research staff should complete the necessary training in line with the recommendations of the auditor or monitor.
- 4.9.3. Where it has been identified that research staff have not been adequately trained, or the training certification has lapsed, appropriate action should be taken in accordance with R and D SOP004 Reporting, Managing Non-compliance and Serious Breaches (see Documents folder in EDGE).

5. Dissemination and Implementation

- 5.1. Trust-wide Research and Development (R and D) procedural documents will be stored on the Trust's Document Library, and a working copy will be accessible through EDGE providing alternative access for research staff.
- 5.2. The Research Governance Manager or delegate will arrange for documents to be published on the Trust Documents Library and EDGE.
- 5.3. The Research Governance Manager or delegate will ensure that any previous versions of the document are made inaccessible to general EDGE users, in accordance with the EDGE document archiving procedure.
- 5.4. R and D SMT to define any training requirements prior to the implementation of any procedural documentation. There will be appropriate time allowed for such training prior to the publishing of the SOP or WI.
- 5.5. Relevant research staff registered on EDGE will be notified by email of the new or reviewed document. Relevant staff will be identified from the ownership and responsibilities ([Section 3](#)) of this procedural document and the R and D AD19 Training Matrix (see Documents folder in EDGE).
- 5.6. Details of how to access EDGE is available by contacting the Research Systems Officer via rch-tr.edge@nhs.net.
- 5.7. It is the responsibility of all staff to check the website regularly, in order to see if SOPs have been added or amended. R and D will endeavour to notify research staff of any SOP developments that may be relevant to them via staff communications, for example, R and D Newsletters, Leadership Huddle and Workstream Huddles. A list of any new or updated SOPs will be reviewed and ratified at the R and D Senior Management Team Governance and Performance monthly meetings.
- 5.8. Consideration must be given at study set up as to which SOPs will not apply to a specific study, with agreement from the R and D Senior Management Team (SMT). Full details must be included as a written statement in the study site file.

5.9. Whilst SOPs may be printed, the electronic version maintained on R and D internet page is the controlled copy. Any printed copies are not controlled documents.

5.10. Chief and Principal Investigators will be notified as per the Trust's process for notifying all staff of new procedural documents.

5.11. Training and Development

5.11.1. When a new SOP is authorised, or when an existing SOP is revised, self-directed training as specified and detailed by the SMT must be carried out by all staff to which the SOP is relevant, and this training documented on EDGE.

5.11.2. Staff should take time to read and fully understand the SOP and relevant documents, ensuring that they are able to implement the SOP as required. If clarification is needed, the staff member should approach the Research Governance Manager, or another member of the SMT, who will arrange additional training. All staff are responsible for maintaining their own training logs and copies must be made available to study monitors on request.

5.12. SOP Deviations

5.12.1. If a process deviates from an approved SOP, a risk assessment will be undertaken to determine the consequences and identify any remedial action(s) that needs to be taken. It may also be appropriate to submit an incident report via the Datix system.

5.12.2. The author of the risk assessment must submit the risk assessment to SMT.

6. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Successful implementation of the procedures described in this SOP ensures that there is a clear understanding of the roles and responsibilities and associated training requirements for staff conducting research studies and clinical trials.
Lead	Research Governance Manager.
Tool	Internal and external monitoring of research studies and clinical trial will monitor implementation of this SOP and compliance with Good Clinical Practice (GCP).

Information Category	Detail of process and methodology for monitoring compliance
Frequency	Compliance with this procedural document will be monitored as part of the R and D risk-based, audit and monitoring process directed through the SMT Governance Meetings.
Reporting arrangements	The Research Governance Manager will provide monthly reports to the R and D Governance SMT.
Acting on recommendations and Lead(s)	The R and D Governance SMT will provide effective oversight and corrective actions.
Change in practice and lessons to be shared	The R and D Governance SMT will identify non-compliance and appoint a member of the SMT to provide support and advice to identify training needs and improve practice. Required changes to practice will be implemented as soon as practically possible.

7. Updating and Review

The R and D procedural documents will be reviewed no less than every three years by the R and D SMT unless an earlier review is required and in accordance with Section 9 of the Trust Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies).

8. Equality and Diversity

8.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the '[Equality, Inclusion and Human Rights Policy](#)' or the Trust's [Equality and Diversity website](#).

8.2. Equality Impact Assessment.

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Research and Development SOP011 - Research Training Standard Operating Procedure V4.0
This document replaces (exact title of previous version):	Research and Development SOP011 - Research Training Policy and Procedure V3.1
Date Issued/Approved:	March 2026
Date Valid From:	April 2026
Date Valid To:	April 2029
Directorate / Department responsible (author/owner):	Caroline Phillips - Research Governance Manager R and D.
Contact details:	rcht.researchqualityassurance@nhs.net
Brief summary of contents:	Defines the training requirements for research staff, providing clear guidance on the conduct of Research Studies and Clinical Trials, aligned to the HRA Framework for Health and Social Care Research
Suggested Keywords:	Standard Operating Procedures (SOP). Good Clinical Practice (GCP). Research and Development (R and D).
Target Audience:	RCHT: Yes CFT: No CIOB ICB: No
Executive Director responsible for Policy:	Chief Strategy Officer
Approval route for consultation and ratification:	R and D Senior Management Team (SMT)
General Manager confirming approval processes:	Bianca Mills, Head of Research and Development
Name of Governance Lead confirming approval by specialty and care group management meetings:	Caroline Phillips, Research Governance Manager
Links to key external standards:	Good Clinical Practice for Clinical Trials https://www.gov.uk/guidance/good-clinical-practice-for-clinical-trials

Information Category	Detailed Information
Related Documents:	The Medicines for Human Use (Clinical Trials) Regulations 2004 The Medicines for Human Use (Clinical Trials) Regulations 2004 The Medicines for Human Use (Clinical Trials) (Amendment) Regulations 2025 The Medicines for Human Use (Clinical Trials) (Amendment) Regulations 2025 International Council for Harmonisation (ICH) Guideline for Good Clinical Practice E6 (R3), (06 January 2025). https://database.ich.org/sites/default/files/ICH_E6%28R3%29_Step4_FinalGuideline_2025_0106.pdf UK Policy Framework for Health and Social Care Research UK Policy Framework for Health and Social Care Research - Health Research Authority Good Clinical Practice – HRA Guidance https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/good-clinical-practice/ R and D SOP004 Reporting and Managing Non-compliance and Serious Breaches. R and D AD19 Training Matrix.
Training Need Identified?	Yes – details provided in Section 5
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Research and Innovation

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
16/02/2015	V1.0	New document – complete revision to reflect current practice	Dr Nick Morley
05/02/2015	V2.0	Review of SOP	Dr Nick Morley
03/03/2023	V3.0	New Standard Operating Procedure (SOP) for Research Training. Requirement for the SOP has been identified through the findings in monitoring visits and audits.	Caroline Phillips Research Governance Manager
16/06/2023	V3.1	Title updated to reflect the document is a Standard Operating procedure (SOP). Section fore Scope and Definition moved to under Section 1 – to align with SOP Template.	Caroline Phillips Research Governance Manager
12/03/2026	V4.0	Review to reflect the changes to the clinical trials regulations and ICH GCP guidance. Review of SOP in line with GCP guidance, feedback from external monitoring and audits and changes to R and D procedures. Review and update in accordance with Trust policies.	Caroline Phillips Research Governance Manager

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust [The Policy on Policies \(Development and Management of Knowledge Procedural and Web Documents Policy\)](#). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Quality and Equality Impact Assessment (QEIA) Guidance Form

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged.

Please ensure you have completed a Quality and Equality Impact Assessment (QEIA) using this link to complete the form:

[E11 QEIA Policy](#).

For guidance, please see the [QEIA Essentials – Quick Reference Guide](#) or contact as required below:

Equality, Diversity and Inclusion guidance, please contact: rcht.inclusion@nhs.net.

Quality Governance guidance, please contact Jillian Tozer: jillian.tozer3@nhs.net