

Standard Operating Procedure

# RESEARCH STUDY SAMPLES

<b>SETTING</b>	Trustwide for research conducted within UHBW and/or sponsored by UHBW
<b>AUDIENCE</b>	Research and laboratory staff processing biological research samples for research conducted at UHBW
<b>ISSUE</b>	Processing and handling of research study samples
<b>QUERIES</b>	Contact Research & Development Department via <a href="mailto:research@uhbw.nhs.uk">research@uhbw.nhs.uk</a>

## Document History

<b>SOP number</b>	SOP 013	<b>SOP Version</b>	3.0
<b>Effective Date</b>	28/APR/2026	<b>Review Date</b>	28/APR/2028

Review date	Version number	Version date	Effective date	Author/Reviewer	Authorised by
N/A	V1.0	14/SEP/2015	03/NOV/2015	Jess Bisset	Diana Benton
02/DEC/2015	V1.1	02/DEC/2015	23/DEC/2015	Jess Bisset	Diana Benton
NOV/2016	V1.2	28/NOV/2016	23/DEC/2016	Jess Bisset	Diana Benton
JAN/2018	V1.3	16/JAN/2018	21/FEB/2018	Jake Harley	Jess Bisset
AUG/2020	V1.4	24/AUG/2020	02/NOV/2020	Sarah Bishop	Jess Bisset
JAN/2021	V2.0	13/JAN/2021	22/NOV/2021	Katharine Wale	Diana Benton
FEB/2023	V2.1	16/FEB/2023	01/APR/2023	Lucy Riddolls	Elinor Griffiths
OCT/2023	V2.2	12/OCT/2023	22/NOV/2023	Diana Benton	Jess Bisset
DEC/2025	V3.0	07/JAN/2026	28/APR/2026	Sarah Bishop Jess Bisset	Diana Benton (on behalf of TRG)

Version Number	Reason for change
Original V1.0	n/a original document
V1.1	Minor updates and clarifications
V1.2	Minor updates and clarifications
V1.3	Minor updates and clarifications
V1.4	Minor updates and clarifications as part of biennial review
V2.0	Major update in line with regulatory changes taking effect from 1 January 2021 after end of the EU transition period

V2.1	Departmental name change from Research & Innovation to Research & Development. Updated throughout SOP as a minor amendment.
V2.2	Minor updates as part of biennial review including updating SOP in line with UHBW Trust SOP template.
V3.0	Major amendment to include Medicines for Human Use (Clinical Trials) (Amendment) Regulations 2025, clarification on EORI requirements, a new section on destruction and other clarifications.

## 1. Introduction

UHBW clinical laboratory departments adhere to regulatory standards to ensure high-quality patient care and bring extensive experience and expertise to support research. Laboratory medicine at UHBW covers Blood Sciences (Haematology and Clinical Biochemistry), Histopathology (Essential Service Laboratory (ESL) only), Flow Cytometry and Aspiration. North Bristol NHS Trust provides Cellular Pathology services (under a service level agreement with UHBW) and hosts the UK Health Security Agency (UKHSA) laboratories.

Any laboratory work carried out for the purposes of a research study must be done in accordance with the relevant study documentation (protocol, participant information sheet, consent form) and all applicable regulations including The Medicines for Human Use (Clinical Trials) Regulations 2004 (and any amendments) for Clinical Trials of Investigational Medicinal Products (CTIMPs).

## 2. Purpose

The purpose of this SOP is to describe the minimum standards required for the processing and handling and storage of biological research samples on UHBW managed premises, and/or at external laboratories contracted by UHBW to process research samples (as relevant).

## 3. Scope

**In Scope:** Mandatory for UHBW sponsored CTIMPs and externally sponsored CTIMPs where the minimum standards defined by the sponsor do not meet those described within this SOP or agreement to use a different SOP(s) has not been made by sponsor. Good practice for all other relevant research.

**Out of scope:** Laboratory processes carried out within UHBW for provision of clinical services. Laboratories hosted within UHBW premises but managed by other organisations (e.g. University of Bristol), except where otherwise defined within the SOP.

## 4. Responsibilities

All research staff handling and processing study samples are responsible for ensuring appropriate consent has been sought for those samples and that they are managed in accordance with the study protocol.

Laboratory staff are responsible for ensuring all research samples are processed in accordance with the protocol, laboratory manual (where available) and all applicable standards and regulations.

## 5. Abbreviations and Definitions

Abbreviations	
CI	Chief Investigator
CSV	Computer System Validation
EORI	Economic Operators Registration and Identification number
ESL	Essential Services Laboratory
GCP	Good Clinical Practice
GLP	Good Laboratory Practice
MEMO	Medical Equipment Management Organisation Clinical Engineering
PI	Principal Investigator
UHBW	University Hospitals Bristol and Weston NHS Foundation Trust
UoB	University of Bristol
UKHSA	UK Health Security Agency

## 6. Procedure

### 6.1 Engagement with UHBW laboratory

- CI/PI and research teams must engage at an early stage in the development or setup of research requiring use of a laboratory to ensure proper input is gained. Laboratory medicine at UHBW covers Blood Sciences (Haematology and Clinical Biochemistry), Histopathology (ESL only), Flow Cytometry and Aspiration. Cellular Pathology services are provided by North Bristol NHS Trust for UHBW under a Service Level Agreement. Also hosted by North Bristol NHS Trust are the UKHSA laboratories; these labs are also subject to this SOP. Contact details can be provided by the R&D department (research@uhbw.nhs.uk) as required.

### 6.2 Laboratory medicine authorisations to support research

- All relevant information regarding the specific laboratory requirements of the research study must be provided to the laboratory during study set up. This includes but is not limited to the following:
  - Latest version of the protocol (may be pending sponsor/ethical approval if study is in setup)
  - Normal/reference ranges for required laboratory tests (if research specific)
  - If results fall outside normal/reference ranges, process in place for rapidly disseminating results to relevant personnel and ensuring review and action take place

- Expectations of how samples will be received at the laboratory (frequency, any specific temperature requirements)
  - Instructions on required sample processing procedures, storage arrangements and archiving requirements of both the samples and the data generated as applicable
  - Funding arrangements
- Authorisation from the relevant laboratory department at UHBW or North Bristol as applicable to support the research study must be in place prior to commencement of the research study. Authorisation is obtained by completion and approval of the relevant 'lab pro-forma'. These pro-formas are standalone templates in the UHBW R&D Quality Management System, the latest versions are provided on the R&D section of UHBW's [website](#) or can be accessed by contacting R&D directly. The completed authorisation(s) must be stored within the Investigator Site File and R&D department at UHBW. A process must also be put in place during study set up to describe how updates to study documentation are to be disseminated to relevant laboratory staff e.g., updated protocol, laboratory manual/SOP, study end date extension, changes to required laboratory tests. If the laboratory is unable to implement the changes to the study a discussion with the PI and Sponsor must take place immediately and any required actions must be put in place and documented appropriately; for example, amendment not implemented, study halted to recruitment.
  - It is important that activities which would not take place as part of usual clinical care – i.e., those required just for the purposes of research - are captured within the laboratory pro-forma, as well as special research requirements for routinely collected samples. The financial arrangements must also be detailed in the pro-forma. Advice regarding the pro-formas can be obtained from lab medicine or the R&D team.

### 6.3 Engagement with external laboratories

- Where UHBW laboratory or other laboratory departments referred to in section 6.1 are unable to support the research an alternative laboratory may be sought. It is the responsibility of the Chief Investigator to ensure and to document that the external laboratory:
  - has certification and accreditation. Where none exist a documented discussion to take place with Sponsor regarding whether laboratory meets required standards.
  - is able to carry out the requirements of the approved research protocol
  - has a robust internal quality system that can assure validity of tests
  - has adequate facilities and an appropriate number of trained and qualified staff in place for the duration of the research
- A laboratory's ability to process high risk samples must be discussed at laboratory selection. Where a laboratory has been selected that is unable to process these samples the study protocol will reflect this in the study exclusion criteria.
- Once a decision has been made to select an appropriate external laboratory, a written agreement between UHBW and the laboratory should be put in place and the decision documented in accordance with SOP\_016 Research Contracts and Vendor Selection. It should be documented within this agreement that the laboratory agrees to work to the required regulations for the research study (i.e., SI 2004/1031 and any amendments for CTIMPs) and GLP. This agreement must also detail how the laboratory will be given access to the latest version of the protocol and notified of any changes to any laboratory requirements or study processes. If the selected laboratory needs to subcontract any of the work this must be agreed

with the Sponsor and appropriate contractual arrangements with the subcontracted organisation put in place.

- Subsequent to the departure of the UK from the European Union, as of 1 January 2021 there is a change in procedures for the import and export of goods to and from the EEA/EU. Samples moved across a border require the EORI number of the originating organisation e.g participating site, university laboratory or external laboratory. All parties concerned should ensure that they are compliant with the latest government guidelines: <https://www.gov.uk/eori>  
Laboratory SOPs
- UHBW laboratory departments provide an extensive clinical service across the Trust and the purpose of this document is not to describe the different processes required for that service or any other service provided by an external laboratory unrelated to UHBW research. The development and control of SOPs relating to clinical work/other services therefore remains the responsibility of the laboratory departments. If there are however any conflicts between the processes described in this document and the existing laboratory SOPs, relevant laboratory staff must inform the R&D department immediately and assist in revision of the documentation.

## 6.4 Expected research standards

- Any laboratory work carried out for the purposes of a research study must be done in accordance with SI 2004/1031 regulations (and any amendments) where applicable (e.g., for CTIMPs), the latest version of the research protocol, participant consent, GCP and the laboratory's internal quality management system. Where specific laboratory procedures are required for a study which are not covered by or are different to the laboratory's existing internal operating procedures a study specific SOP must be written, controlled, reviewed and cover all required key activities.
- In accordance with regulation 28 of Medicines for Human Use (Clinical Trials) (Amendments) 2025 Sponsors are responsible for *(ii) the selection and oversight of a laboratory in relation to the analysis or evaluation of human samples collected as part of the clinical trial*; Where UHBW is the sponsor selection of the laboratories will be in accordance with SOP\_016 Research Contracts and Vendor Selection\_\_ and oversight will be maintained in accordance with SOP\_002 Research Sponsorship Sample analysis should be performed in accordance with a predefined plan. Where this is not detailed in the protocol or is additional to routine clinical data a written procedure should be created and agreed between the Sponsor and laboratory undertaking the analysis.

### 6.4.1 Blinded research

- Laboratories should be notified during study set up of any blinding requirements including which personnel must be blinded throughout the study. Laboratory staff must ensure that they take appropriate measures to ensure the blind is not compromised. Should this occur, the laboratories must inform the PI and sponsor immediately.

### 6.4.2 Sample receipt, identification and transfer

- Laboratory staff should ensure that on receipt of any samples they are in the expected condition according to the research protocol requirements. They must also document whether they have received the expected number of samples and whether samples are labelled appropriately. On receipt of the samples the laboratory staff should document the condition that the samples arrived in and alert the PI immediately if the samples are not in the appropriate condition/are missing or inadequately labelled. If any unexpected samples are received the PI must be contacted immediately. If any of the information provided with the

sample is ambiguous (specifically, the origin or type of sample), it should not be analysed until that information has been confirmed, except where a delay impacts negatively on the sample (degradation/loss) or patient (urgent clinical care). In this case, the sample should be analysed, and results quarantined until the identity/source is known. If samples are to be transferred, laboratory staff must ensure the transfer is carried out in accordance with the requirements of the protocol, study specific SOP/laboratory manual (if applicable) and material transfer clauses of the written agreement between sponsor and participating site and await positive confirmation of receipt from the organisation to whom the samples are transferred.

### 6.4.3 Sample storage

- The required storage conditions of research samples must be documented in the protocol, study specific SOP or other trial documentation. For 'relevant material', storage and retention requirements must be defined and complied with in accordance with the Human Tissue Act. Laboratory staff must have access to this documentation and adhere to the requirements, maintaining applicable records of storage locations and conditions for the duration of the study. If not already part of the laboratory internal quality management system, specific monitoring of storage locations (e.g. freezers) must be carried out with suitable calibrated equipment. There should be a description of what processes should be followed should a temperature excursion occur, and documentation that this has taken place (if required), should be completed and filed. At the end of the research, the samples must be destroyed or transferred to a licenced Tissue Bank in accordance with the approved REC application and HTA regulations. This should be carried out in consultation with the study sponsor. If future use is planned, appropriate patient consent and/or applicable REC approval must be in place (e.g. research or transfer to tissue bank).

### 6.4.4 Method validation

- Analysis of research samples should be performed in accordance with a validated method. The only exception to this is where the validation of a method is one of the study objectives and this has appropriate regulatory and ethical approval.

### 6.4.5 Breaches and patient safety, including dose adjustments

- Processes must be in place prior to commencement of the study to describe how deviations from the protocol or serious breaches of the protocol or GCP/GLP originating in the laboratory will be managed and reported. For definition of a serious breach, please refer to the MHRA website; <https://www.gov.uk/guidance/good-clinical-practice-for-clinical-trials> or contact the R&D department. The Chief Investigator should also discuss with laboratory staff during study set up any requirements to expedite reporting of laboratory results e.g., results which affect whether dose adjustments are required; laboratory staff must ensure these are adhered to. Laboratory staff may define 'alert' values for safety concerns where results are outside the normal/reference range and laboratory staff must ensure these results are communicated rapidly to the investigator and treating clinician to ensure appropriate care of the participant in line with Trust policies and Sponsor requirements.

### 6.4.6 Repeat analysis

- Circumstances under which repeat analysis of research samples may be undertaken must be documented and carried out only in accordance with an applicable written procedure. Any repeat analysis carried out must be documented during the course of the trial providing an explanation for the repeat results and why a specific result is accepted as the correct one.

This documentation must be kept within both the laboratory files and trial master file in case reconstruction of data is required.

#### 6.4.7 Consent

- Any laboratory work undertaken must be in line with the provision of informed consent provided by a research participant or their legal representative. The Sponsor, CI and PI are all responsible in ensuring the laboratory work is in compliance with consent and only appropriate samples are sent to the laboratory for processing. If consent is withdrawn the laboratory must be immediately informed by the research team or Sponsor and appropriate actions taken depending on the nature of the withdrawal.
- Patient confidentiality must be maintained at all times and in accordance with the patient consent. If laboratory staff receive identifiable data in error, they must immediately inform the PI and Sponsor, ensure no further disclosure of the identifiable information, and follow instruction from the Sponsor of remedial actions.

#### 6.5 Validity of laboratory data

- It is integral to the research study that the data generated by the laboratory are valid and credible. Therefore, if the laboratory does not perform regular Quality Control checks of its processes these should be set up for each specific study to ensure validity of research data. Any changes made to data generated by the laboratory, the reason for the changes, when, and by whom they were made must be clearly documented. If the data are created electronically an audit trail within the electronic system must be maintained. It is also essential that source laboratory data are identified at the study start and it is agreed with sponsor how laboratory data is to be reported. In addition to laboratory QC checks the Research & Development department monitors UHBW laboratories for Quality Assurance purposes. Please refer to SOP\_010 Monitoring & Oversight of Research Activity for further information.

##### 6.5.1 Computer System Validation (CSV)

- Any computer systems implemented within the lab solely for the purposes of research must be validated prior to using them, and this must be checked periodically during use to ensure they are fit for purpose. Further information on CSV requirements can be found in SOP\_011 Validation & Backup of Computer Systems used in Research.

##### 6.5.2 Laboratory equipment

- If a laboratory is required to use specific equipment solely for the purposes of a research study (i.e., non-standard laboratory equipment), the equipment must be maintained to ensure it is performing its required function. Service contracts with the equipment manufacturer or a maintenance company must be put in place to ensure that the equipment operates according to its intended purpose. If maintenance is carried out by staff within the laboratory itself, it is essential that the staff are appropriately trained and that this is adequately documented. Records of any maintenance, calibration and servicing must be kept. Prior to agreeing to host a new piece of equipment that will be subject to a maintenance contract, the PI should ensure, in discussion with the laboratory manager, that funding is in place to support the contract.
- If laboratory equipment is provided by the sponsor solely for the purposes of a research study the ownership, maintenance, and insurance and indemnity arrangements for the equipment should be documented in a written agreement between sponsor/supplier and UHBW.

- Prior to agreeing to host a new piece of equipment, the PI and laboratory manager should enter into discussions with the Trusts MEMO department and the R&D team to ensure that appropriate insurance and indemnity arrangements for its use in the research study are in place.
- If not already captured within a laboratory's own quality management system, general lab equipment (centrifuges, refrigerators etc) should undergo periodic calibration by appropriately qualified technicians to ensure equipment is fit for purpose. Any checks carried out must be documented.

## 6.6 Laboratory essential documents

- For each research study requiring UHBW laboratory's involvement or an externally sourced laboratory it is essential that laboratory staff maintain records relating to the research study including but not limited to;
  - latest version of protocol and any amendments
  - delegation log of laboratory staff with assigned tasks
  - documented qualifications of laboratory staff (this may be held centrally to cover more than one study if appropriate – see SOP\_007 Research Training)
  - study specific laboratory procedure documentation (as applicable)
  - documentation of quality control checks
  - documentation of equipment maintenance and checks (again can be held centrally if part of laboratory's internal quality management system)
  - sample log including storage location and destruction details
- The records maintained within the laboratory should enable the laboratory work to be reconstructed at any point as required and to demonstrate the quality of the work undertaken.

### 6.6.1 Archiving

- If a laboratory is storing any research data (including source data), agreement about the details of the storage arrangements for that data, including location and duration must be made with the Sponsor. This can be documented in a contract or other written agreement if applicable and arrangements must be adhered to.

### 6.6.2 Destruction

- Where sample destruction is indicated before the end of the study the samples must not be destroyed without prior authorisation from the Sponsor/CI unless otherwise agreed at the start of the study.
- At the end of the study if samples are to be destroyed this will be done according to HTA regulations and the laboratory SOPs upon authorisation from sponsor/CI.

## 7. Dissemination and training in the SOP

This SOP should be disseminated to applicable research staff (including R&D) and is available on the R&D website.

Plan Elements	Plan Details
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<b>The Dissemination Lead is:</b>	Research Operations Manager
<b>Is this document: A – replacing the same titled, expired SOP, B – replacing an alternative SOP, C – a new SOP:</b>	A – replacing the same titled, expired SOP.
<b>If answer above is B: Alternative documentation this SOP will replace (if applicable):</b>	N/A
<b>This document is to be disseminated to:</b>	All applicable research staff (including R&D)
<b>Method of dissemination:</b>	<p>For major updates to the SOP dissemination will be:</p> <ol style="list-style-type: none"> <li>1. To Chief Investigators of UHBW Sponsored CTIMPs</li> <li>2. Research Unit leads across UHBW</li> <li>3. Head of Research Governance at UoB (where SOP is applicable)</li> </ol> <p>All updates (major and minor to the SOP) will be:</p> <ol style="list-style-type: none"> <li>1. Updated on the trust MyStaff App</li> <li>2. Updated on the R&amp;D website</li> <li>3. Cascaded in R&amp;D communications</li> </ol>
<b>Is Training required:</b>	All staff whose activities are subject to this SOP should ensure that they read and understand the content of the SOP. The personal training log of the individual (and the Investigator Site File/Trial Master File if required) should be completed to document that the content of this SOP has been read and understood as described in <i>SOP_007 Research Training UHBW</i>

<b>REFERENCES</b>	<ul style="list-style-type: none"> <li>• Medicines for Human Use (Clinical Trials) Regulations 2004 (and any amendments)</li> <li>• MHRA website <a href="https://www.gov.uk/guidance/good-clinical-practice-for-clinical-trials">https://www.gov.uk/guidance/good-clinical-practice-for-clinical-trials</a></li> <li>• Good Clinical Practice</li> <li>• Good Laboratory Practice</li> <li>• Human Tissue Act 2004</li> </ul>
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<b>RELATED DOCUMENTS AND PAGES</b>	<ul style="list-style-type: none"> <li>• SOP_007 Research Training</li> <li>• SOP_010 Monitoring &amp; Oversight of Research</li> <li>• SOP_011 Validation &amp; Backup of Computer Systems used in Research</li> <li>• SOP_016 Research Contracts &amp; Vendor Selection</li> </ul>
<b>AUTHORISING BODY</b>	Trust Research Group
<b>SAFETY</b>	N/A
<b>QUERIES AND CONTACT</b>	Research and Development Department via <a href="mailto:research@uhbw.nhs.uk">research@uhbw.nhs.uk</a>
<b>AUDIT REQUIREMENTS</b>	R&D departmental Quality Management System audits are undertaken annually