Consultation item n°1:
Can you give examples for an improved protection? - No
Are you aware of studies/data showing the benefits of Clinical Trials Directive? – No

Consultation item n°2:
Is this an accurate description of the situation? – Yes, that is an accurate description
What is your appraisal of the situation? - Only a central CTA application and one central review and decision process accepted by all CA in all member states for multinational CTIMPs will be the solution.

Consultation item n°3:
Is this an accurate description ? Yes, that is accurate
Can you quantify the impacts? The level of staffing and personnel needed has exploded to an extend which is difficult to sustain for academic institutions and hospitals acting as Sponsors for non-commercial trials.
Are there other examples for consequences? The major impact is that it makes academic, non-commercial multicentre - multinational trials very costly and sometimes nearly impossible.

Consultation item n°4:
Can you give indications/quantifications/examples for the impact of each option?
Both options would save time and resources.
Which option is preferable? Both 3.3.1 and 3.3.2 are an option. However, a real cooperation between all NCA needs to be the outcome to be beneficial. Hence, second option possible better.
What practical/legal aspects would need to be considered in further detail?
This should only be an option for real multinational trials, not for national trials

Consultation item n°5:
Can you give indications/quantifications/examples for the impact of each option?
Option 1: already partly possible as one-stop-shop via the IRAS system in the UK, which is an extremely helpful system, reducing the necessity to complete many different forms with the same information - would be a good way for all member states.
Option 2: This would be a very welcome development, since it seems that the national Ethics Committees are organized, managed and run still in very different ways across the Member States.
Option 3: That would have a good impact for more consistent approach throughout the member states.
Which option is preferable? Option 1 and 3;
What practical/legal aspects would need to be considered in further detail? No comment.

Consultation item n°6:
Is this an accurate description of the situation? Regarding inconsistent implementation the issues listed are accurate, as are the problems with SUSAR reporting.
Can you give other examples? There were inconsistent interpretations in the advanced therapy field of what and what is not considered to be an IMP, and what is considered starting material/s for the manufacture of IMPs.

Consultation item n°7:
Is this an accurate description? Absolutely, especially regarding the increased administrative costs for non-commercial/ academic Sponsors. This leads to the situation that pervious successful international collaborations are crippled, because no academic/hospital Sponsor is found who would be able and/or willing to take on costs and risks for the sponsorship of a complex multinational academic trial.
Can you quantify the impacts? More and more, only national and/or single centre trials are being sponsored by academic /hospital sponsors. Multi-center or even multi-national center trials are being seen as too costly and too high risk for academic/NHS institutions
Are there other examples for consequences? Funds which were awarded by charities or other research funding giving bodies are being diverted to cover trial administrative and sponsor functions.

Consultation item n°8: -
Can you give indications/quantifications/examples for the impact of each option?
Both options will result a lengthy process, whereby for Option 1 the CT Directive needs to be amended first, followed by all national legislation; Option 2 will need the agreement of all Member States to abolish their national CT legislation.
Which option is preferable? Option 2 would be preferable on the long term, since any changes and amendments to the CT Directive/Regulation need then to be done only once, and there is no need for another step, the transposition to national law.
What practical/legal aspects would need to be considered in further detail? In particular, are the divergent applications really a consequence of transposing national laws, or rather their concrete application on a case by- case basis? It is probably the latter. However, having just one central CT Directive/Regulation instead of different national CT legislation, would be better on the long run.

Consultation item n°9:
Can you give examples for an insufficient risk -differentiation? If a trial uses licenced medicines within the indication for example: labeling and pharmacovigilance should be as for the licenced product. For example, in a study investigating if reducing the drug burden by taking one prescription drug a way in a condition where usually several drugs are taken concomitant would increase the quality of life needs to be run under the CT Directive. The drugs are well known and licensed for this use - the risk minimal and hence the amount of funds and adminis trative work to run a CTIMP un-proportional.
How should this be addressed? Different risk levels of trials should be considered. However, each risk-level should be accompanied by clear guidance notes what is needed to be GCP compliant, for example the expected level of audit/monitoring shold be determined.

Consultation item n°10:
Do you agree with this description? Fully agree, this is **the major** problem for academic/NHS hospital sponsors. If that could be arranged in a way, that in each Member State there is a national academic Sponsor organisation dealing with all national requirements - that would make academic trials easier to set -up and manage. These trials are in most cases not about a marketing authorisation, but based on academic questions and within long standing collaborations, where academic collaborators work together as peers to solve important questions. This would save funds, time and major delays for academic trials.

Can you give other examples? In academic trials where the Sponsor hardly ever is the manufacturer of the IMP under investigation, the practicalities to comply with requirements for IMP shipment/distribution to the participating sites is a big problem.

Consultation item n°11:
Can a revision of guidelines address this problem in a satisfactory way? We agree of what is listed about the revision and we also agree that this option would not address issues which are directly vested in Community legislation, such as the requirement of a single sponsor per trial, which in our opinion is the most hindering aspect for the non-commercial sector.
Which guidelines would need revision, and in what sense, in order to address this problem? The guidelines listed would benefit from a revision; but a more far-reaching change of applicable rules addressing the actual directive/regulations are necessary.

Consultation item n°12:
In what areas would an amendment of the Clinical Trials Directive be required in order to address the issue? Sponsorship and IMP distribution/shipment requirements.
If this was addressed, can the impacts be described and quantified? Collaborative academic trials would be made possible again in a way any other academic collaborations are working outside the CTIMP setting.

Consultation item n°13:
Would you agree to this option and if so what would be the impact? We would not agree that the exclusion of academic CTIMPs from the CT Directive would be helpful. The overall GCP standard of academic trials has improved due to the Directives and national legislation on clinical trials, especially regarding the design, conduct and commitment to complete the trials. However, the requirement of a single sponsorship for academic trials is the biggest problem and could be solved by giving the option of multiple national academic sponsors for a multinational academic trial. Also, requirements absolutely necessary for marketing authorisation submissions should be reviewed, if they are really necessary for the academic setting, where the trial is not about marketing authorisation. Also, there should be better provisions for academic "proof of concept" studies and low-risk academic studies.

Consultation item n°14:
In terms of clinical trials regulation, what options could be considered in order to promote clinical research for paediatric medicines, while safeguarding the safety of the clinical trial participants? Promote paediatric academic trials as there are many academic trials running successfully in the academic/non-commerical sector. Academic researchers in paediatrics have the knowledge and expertise in this field, so should be consulted more often. It should also be considered if for example SMEs are really able to cope with the necessity of test a new compound in all age groups (PIP) - a very well intended move to get evidence based medicines for children could actually be hindering more, than promoting commercial trials run by SMEs.

Consultation item n°15:
Should this issue be addressed? Yes
What ways have been found in order to reconcile patient's rights and the peculiarities of emergency clinical trials? UK clinical trails regulation has satisfactory provision.

Which approach is favourable in view of past experiences? UK clinical trials legislation has satisfactory provision.

Consultation item n°16:
Please comment? Needs to be better addressed on a national level with clear guidance to commercial and academic sponsor organisations of what is required. Agree that there is enough guidance available, and it is more about supervision and enforcement of such good practice guidance.
Do you have additional information, including quantitative information and data? No

Consultation item n°17:
What other options could be considered, taking into account the legal and practical limitations? Agree with all what is listed and feel that education and especially capacity building is the key to the future of trials in such countries.

Consultation item n°18:
What other aspect would you like to highlight in view of ensuring the better regulation principles? Do you have additional comments?
There should be clear guidance notes released on the requirements on quality control and quality assurance, monitoring and audit. The importance of these are not to be queried here at all, but the extent of such audit and monitoring, requested from non-commercial, academic sponsors (Universities and Hospitals) is. The perceived necessary extend of audit prove to be extremely costly. New posts have to be created and paid for, or independent external GCP auditors contracted, even for a relatively small academic trials portfolio. It seems to promote an entire new area of independent consultants (GCP auditors etc) which charge very high fees from NHS Trusts and Universities in the UK. The question really is, if this is proportional to the actual risk involved and if this actually improves the safety and rights of the patients and the accuracy and reporting of trial results - or if this is an over-interpretation by the "experts" in the field to create business opportunities, which are paid from tax payers money or research funds awarded by charitable organisations.
Are SME aspects already fully taken into account? Not an SME, hence not able to comment.