Concept Paper SANCO/C/8/PB/SF D(2011) 143488
Revision of the 'Clinical Trials Directive' 2001/02/EC

King's Health Partners Response

Submitted by Jackie Powell, Director, Joint Clinical Trials Office, King's Health Partners

Consultation Item 1: Single submission

We agree with this appraisal

Consultation Item 2: Separate assessment

We agree with this appraisal

Consultation Item 3: Single submission and central assessment

We agree with this appraisal

Consultation Item 4: Single Submission and CAP - catalogue

We agree the list is complete

Consultation Item 5: Single Submission and CAP – aspects for scope

We agree that option a) is the only suitable option for CAP. Furthermore, a) is only suitable if an 'opt out' provision is in place (see Item 6)

Consultation Item 6: Disagreement about assessment report

We have a strong preference for the 'opt out' approach. This will enable the Member State to take account the impact of local demographics, standards of care and the operating environment. The majority vote will have the effect of imposing a decision in spite of national considerations. Similarly, an EU decision will impose a decision that may be contrary to local imperatives and would have the disadvantage of adding process, delay and cost.

Consultation Item 7: CAP to be mandatory or optional

We prefer the second option on the understanding that there is provision for an 'opt out' (per Items 5 and 6). If there is no provision to opt out then the third option is to be preferred. For multinational trials a CAP approach with the possibility for opt out in the event of a Member State disagreeing with the assessment would be the most operationally streamlined option. Regarding the first option, it would be expected that to have all trials, including single-country trials, assessed through a CAP would be unnecessarily bureaucratic and substantially increase the throughput of assessments. Furthermore, it would seem that this option would only be operable if there was central assessment given that there would only be one Concerned Member State. This has already been assessed as not appropriate in 1.2 of the Concept Paper.

Consultation Item 8: Pre-assessment for risk

We agree that a pre- assessment would be workable, although how workable will depend on who does the assessment and how. We suggest that Type A trials should be proposed by the Sponsor in the CTA application, with argumentation. The concerned Member States would ratify the risk assessment before proceeding with the shortened process.

Consultation Item 9: Harmonised and proportionate requirements for all clinical trials

We agree with this appraisal.

Consultation Item 10: It is not desirable to exempt non-commercial sponsors

We strongly agree with this appraisal. As the CTD is intended to ensure that Clinical Trials are conducted to standards that will maximise patient safety and data integrity, there is no justification for exemption of non-commercial sponsors. As a large proportion of non-commercial clinical trials would fall into the Type A category, a well designed, proportionate approach based on risk and divorced from the nature of sponsor, will deal with this issue for these trials. At the same time this will ensure appropriate, harmonised regulation of the growing number of higher risk non-commercial trials that we are seeing with the growth of translational research initiatives in the academic sector.

Consultation Item 11: Risk-adapted rules for application dossiers and safety reporting

We agree with the appraisal. For non-commercial sponsors who often lack substantial regulatory expertise, the assembling of the dossier can prove daunting. Regarding safety reporting, the DSUR will prove onerous in the non-commercial sector. If this is risk-adapted, with more detailed guidance this would be a welcome development.

Consultation Item 12: Other key areas for more detailed rules

More detailed, risk adapted rules on IMP labelling exemptions when using commercially available stock. Also, rules and guidance for hospital exemptions could be clarified and relaxed to simplify the rules for distribution of commercial IMP stock to multiple sites for non-commercial trials. Currently, distributing commercial stock for a trial by a Sponsor hospital is classed as manufacturing and an MIA(IMP) License is required. An Exemption to allow Sponsor NHS Trusts to distribute commercially available stock to other hospitals participating in the trial without an MIA(IMP) is needed for Type A trials.

Consultation Item 13: Clarifying the definition of 'Investigational Medicinal Product'

We agree with the concept of narrowing the definition to confine IMPs to the test and reference medicinal products (first bullet point). We also agree that all other products used in the context of the clinical trial should be deemed 'auxiliary medicinal products' (second bullet point), however, we would wish to know the nature of the proportionate regulatory regime before we agreed with the third and fourth bullet points. To generate a whole new suite of rules for these could result in little improvement over the current arrangements. We would favour a "hands off" approach to auxiliary medicinal products that, almost invariably, have a MA and could be handled within a trial in a manner analogous to concomitant medications.

Consultation Item 14: Insurance/indemnisation

We do not favour the first option. Low risk does not equate to zero risk and we would prefer to explore possibilities to arrange a stratified cover with insurers that would recognise the low risk trials and cover them at much lower premiums. In order to simplify and harmonise within and across Member States a consensus on determination of risk and levels of cover. The second option would seem preferable, although the attractiveness would be dependant on how the scheme would work. If the scheme provided blanket cover regardless of sponsor (in effect an indemnity for trials approved within the EU) without significant paperwork and permissions to include trials on the national policy this would be a very welcome development. Furthermore, for non-commercial trials in the UK where the sponsor is an NHS Trust this would clarify the position. Currently NHS trusts cannot/do not provide additional indemnity beyond CNST.

Consultation Item 15: Single Sponsor

Whilst acknowledging that the stated provisions in the appraisal would improve the position for Option 1 when conducting multinational trials, we categorically disagree with the appraisal and would strongly prefer Option 2. For non-commercial sponsors in England both for single MS trials and for multinational trials the trial is often the result of collaboration between academic/NHS and, sometimes, commercial organisations. We already operate a co-sponsorship arrangement to take account of the shared interests in the trial. If the regulatory framework were to be truly harmonised in the EU this would make the Sponsorship of multinational trials less onerous for non-commercial bodies but, whilst it is clear that a commercial organisation will want full control of its trials under its single Sponsorship, non-commercial organisations prefer to share the responsibilities and the upsides of acting as Sponsor. In fact, without the option of shared Sponsorship many academic trials would not be able to take place which could be a disaster for the non-commercial sector's translational research programmes. The point about having a person who is the primary conduit for communication with regulatory authorities is well taken but can be and is dealt with effectively in documentation that sets out the division of responsibilities. This is not dissimilar to the provisions requiring a Legal Representative for trials sponsored by non-EU bodies.

Consultation Item 16: Consent in Emergency Trials

We agree with this appraisal and would welcome any simplification of the consent arrangements that are compatible with subject safety and rights.

Consultation Item 17: GCP in Third Countries

We agree with this appraisal