

Supporting research, protecting patients

Cancer Research UK's
recommendations to reform
the Clinical Trials Directive



Together we will beat cancer

About Cancer Research UK

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Cancer Research UK is the world's largest independent cancer charity dedicated to saving lives through research, and the biggest funder of cancer research in Europe. To achieve our vision of beating cancer, we support high-quality groundbreaking research to prevent, diagnose and treat the disease. Our work has been at the heart of progress that has seen cancer survival rates double in the last 40 years.

In 2010/2011, we spent €388 million on research.¹ This all came from the generosity of the public – we receive no government funding for our research. With this funding, we aim to provide scientists with the facilities and environment they need to excel. We are also committed to developing the next generation of high calibre researchers, to drive forward the fight against cancer and ensure we continue to save more lives in the future. We currently support around 250 clinical trials and are involved in a number of international research projects, mainly through funding the UK arm of clinical trials.

We support over 4,000 doctors, nurses and scientists in the UK, carrying out research across more than 200 types of cancer to find new and better ways to beat the disease. Our research does not take place in isolation. It's only in partnership with others in the sector, including public and private organisations and charities, that we can meet our research aims and achieve the greatest impact in our fight against cancer. Cancer Research UK has increasingly become involved in international research collaborations. In November 2011, Cancer Research UK joined forces with international research groups from the UK, Europe and the US to launch the International Rare Cancers Initiative, which will boost the development of new treatments for patients with rare cancers.

We would be happy to provide any further information or an expert to discuss these issues further, as required. Please contact the Policy Department at publicaffairs@cancer.org.uk or telephone 020 3469 8127.

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The report was written by Daniel Bridge.

The case studies and evidence which contributed to producing this report were based on correspondence with the following individuals:

Roisin Cinneide – Pharmacovigilance Co-ordinator, University College London

Lindsey Connery – Pharmacovigilance Manager, Cancer Research UK Clinical Trials Unit, Glasgow

Nicky Gower – Regulatory Affairs Manager, Cancer Research UK & University College London Cancer Trials Centre

Andrea Harkin – Head of Trial Co-ordination, Cancer Research UK Clinical Trials Unit, Glasgow

Julie Hearn – Head of Clinical Trials Funding, Cancer Research UK

Alison Jenkins – Trial Manager, Wales Cancer Trials Unit

Peter Johnson – Chief Clinician, Cancer Research UK

Nicola Keat – Research Funding Manager, Cancer Research UK

Claire Snowdon – Deputy Director Operations, Institute for Cancer Research

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Executive Summary

Directive 2001/20/EC, the European Clinical Trials Directive (CTD), was passed in 2001 with the aim of standardising and improving the quality of clinical research across Europe. The Directive provides the legal framework for gaining approval to conduct clinical trials which test new therapies in EU Member States and maintaining Good Clinical Practice (GCP) while they are being conducted. The Directive is implemented in Member States through national legislation.

Clinical trials are the way in which new therapies are assessed to establish both their safety and efficacy in humans. They form the basis of deciding whether a new drug or change to existing therapy produces a clinical benefit to patients. Europe has traditionally had a strong research base for clinical trials, however, between 2006-2009 the number of participants taking part in clinical trials declined by 51%.² As Member States aim to achieve their 'Horizon 2020' goals of investing 3% of GDP in research, it is important that the regulatory environment will allow such an investment to produce tangible benefits in an acceptable timescale.

As well as providing evidence to advance medical knowledge and develop new therapies, participating in a clinical trial provides opportunities for participants to access high quality care and treatments. Patients taking part in clinical trials experience significant benefits including increased monitoring, access to leading research-active experts, one-to-one care from experienced research nurses, improved information and better continuity of care.³

Since the introduction of the Directive there has been extensive data collection and feedback on its impact on clinical research in the Member States in which it applies. A consensus view formed that the original objectives have not been achieved and the EU CTD has in fact damaged the competitiveness of European medical research. The Commission has acknowledged this and has undertaken a process of consultation to revise the Directive. The first proposals for the revision of the Directive have been scheduled to be published in the summer of 2012, with the final revision expected to take place in 2014. A co-ordinated and efficient system for regulating clinical trials in Europe can be achieved through reforming the CTD. Cancer Research UK experts (including clinical researchers, regulatory leads based in Clinical Trials Units, and in-house expertise) have highlighted in this report the key aspects of the Directive acting as a barrier to research.

The objective of the revision of the CTD should be to provide clarity to Member States on how to implement the legislation. This will lead to greater certainty within the research community on what needs to be done to achieve compliance with regulators and also assist Member States to implement the CTD in a uniform and consistent way.

This briefing outlines Cancer Research UK's key recommendations for revision of the Directive. Decision makers have an opportunity to create a coherent and rational system of regulation for clinical trials that will benefit patients across the whole of Europe.

² Assessment of the functioning of the "Clinical Trials directive" 2001/20/EC, public consultation paper, p.6

³ Cancer Help, The advantages of being in a Clinical Trial, <http://cancerhelp.cancerresearchuk.org/trials/taking-part/the-advantages-of-being-in-a-trial>

Key recommendations

- 1 Retain the function of national competent authorities in regulating single country trials with multinational trials having the option to participate in a Co-ordinated Assessment Procedure (CAP)
- 2 The definition of an Investigational Medicinal Product should be limited to include only therapies which are genuinely investigational and novel
- 3 The Directive should allow for a risk-based approach to the assessment of clinical trials, ideally with the onus on the Sponsor to justify the assessment
- 4 Substantial amendments should be limited to changes that affect patient safety or the scientific outcome of a trial, as opposed to reporting purely administrative amendments
- 5 The safety reporting system should be overhauled so that SUSARs are reported in a manner which directly contributes to patient safety
- 6 Multiple organisations should be allowed to sponsor clinical trials in order for risk and responsibility to be shared and facilitate further collaborative working

The Directive in its current form is a major barrier to research in Europe. Cancer Research UK wants as many cancer patients as possible to have the opportunity to take part in clinical trials. The risk of not improving the Directive would be that important medical research will no longer take place in Europe or possibly at all. The revision of the CTD provides an important opportunity to significantly improve the regulatory landscape for clinical research across Europe. Ultimately patients will benefit from the increase in research as treatments improve and novel therapies are discovered.



Introduction

What is a Clinical Trial?

Clinical trials are the way in which new therapies are assessed to establish both their safety and efficacy in humans. They form the basis for deciding whether a new drug or an amendment to an existing therapy produces a clinical benefit to patients. Clinical trials can be conducted in many forms of health intervention from non-invasive screening trials, to trials where new therapies are tested in humans for the first time.

Different types of clinical trial

Testing new therapies

Researchers are recruiting over 2,000 lung cancer patients to test to see if a blood-thinning drug can improve treatment for the disease in the Cancer Research UK funded FRAGMATIC trial. They hope the drug will reduce the risk of blood clots, which can be common in people with lung cancer and can also be a side effect of treatment. This form of trial is regulated under the CTD.

Trialing screening techniques

The UKCTOCS trial is being conducted to test ovarian cancer screening techniques. It is testing whether either screening by ultrasound scanning, or a blood test for CA125 (a molecule linked to ovarian cancer) can save lives. The trial is the first of its kind, involving 200,000 post-menopausal women at 13 hospitals. Preliminary results look positive and the trial will continue until 2015 when the researchers will be able to conclude whether or not a wider screening programme could lead to a fall in deaths from ovarian cancer. Screening trials do not fall under the regulation of the CTD.

New medicines that are being tested for safety and efficacy in patients in a clinical trial are termed Investigative Medicinal Products (IMPs). Trials involving IMPs or those in which an approved therapy is tested on a new condition are regulated by the CTD. The majority of the 250 clinical research studies Cancer Research UK funds will fall under CTD regulations.

Clinical trials are funded and conducted by a multitude of different organisations ranging from large pharmaceutical companies to academic centres. An organisation must be nominated as a Sponsor of a trial under the Directive. Sponsors assume responsibility for the initiation, conduct and management of a trial as well as the liability involved in conducting a trial. The CTD has promoted the standardisation of data a trial produces. This has meant that all clinical trials can now contribute to the marketing authorisation of a product.

As new therapies are developed to target smaller patient population, such as in rarer cancers, it is becoming necessary for organisations looking to conduct trials to open sites in several countries. By widening the geographical area for participation through multi-national trials researchers are able to recruit the required numbers of patients to deliver effective trial data.

Case Study: Nigel Lewis-Baker, Cancer Research UK Ambassador and cancer survivor

I have been on two clinical trials. The first one was a 14 month vaccine offered when my current treatment was beginning to fail. When this trial ended I took part in a second trial involving the drug zibotentan, which produced horrendous side effects including excruciating headaches followed by lymphoedema swelling, making breathing quite difficult, and profound deafness that remained until I came off the drug. However, it was worth all the discomfort to progress treatment and, eventually, get some personal benefit and I would do it all again and am currently waiting for another suitable trial to become available.

Clinical trials are essential to developing future treatments and I would not be here now if others had not co-operated in the past. Not only that but they give me a feeling of being more in control and creating something useful out of my situation. It is sometimes difficult to keep positive but trials are a tremendous help and the close scrutiny and care I get also give me comfort and confidence to carry on.

The current Directive

The CTD set out three principal objectives:

- Provide greater protection to subjects participating in clinical trials
- Ensure quality of conduct
- Harmonise regulation and conduct of clinical trials throughout Europe

The CTD introduced the system in which a single regulatory body within each of the Member States acts as a National Competent Authority (NCA). An NCA has the ability to grant Clinical Trials Authorisation (CTA) which gives a legal mandate for a trial to take place and inspects clinical sites to check compliance with the CTD and Good Clinical Practice (GCP).

Once Member States began operating under the Directive it became clear it was not achieving its desired aim of harmonising the regulatory requirements to facilitate the conduct of research.

Since the introduction of the CTD to the UK in 2004 the UK's share of commercial clinical trials has plummeted globally from 6% to 2% in 2008, while this can be linked to the implementation of the CTD the decline can also be attributed to range of factors affecting life sciences.

UK Department of Health figures show that the number of mid-stage, late-stage and post-approval clinical trials fell from 728 in 2008 to 470 in 2009, the lowest level in the past decade.⁴ A recent assessment found that non-commercial sponsors required an increase from 1.5 to 2.8 full-time equivalent staff to manage administrative tasks associated with a Clinical Trial Authorisation, and that there was an increase in time between finalisation of protocol and first patient recruited from 144 to 178 days.⁵

Despite the general trend for decline there are still notable successes as a result of the strong research base in Europe, for example in the UK one in five cancer patients take part in clinical research.⁶ An excellent regulatory framework would capitalise on existing European strengths to deliver better, faster trials across Europe to the benefit of patients, healthcare systems and industry.

The Directive should balance the need to conduct high quality research efficiently, with the need to maintain safety for patients. Striking the right balance is important to clinical research as scientists and funders have limited sources of funding, and unnecessary delays or unexpected problems with administration increase costs significantly.

⁴ NHS confederation calls for action to halt decline in UK Clinical Trials,

<http://www.nhsconfed.org/PressReleases/Archive/2011/Pages/NHS-Confederation-calls-for-action-to-halt-decline-in-UK-clinical-trials.aspx>

⁵ Impact on Clinical Research of European Legislation, European Forum for Good Clinical Practice report, p.197

⁶ NIHR Cancer Research Network: Annual Report 2010-11 [http://ncrndev.org.uk/downloads/MiscDocs/NCRN%20Annual%20Report%202010-11%20with%20appendices%20\(updated%20Sept%2011\).pdf](http://ncrndev.org.uk/downloads/MiscDocs/NCRN%20Annual%20Report%202010-11%20with%20appendices%20(updated%20Sept%2011).pdf)

The revision of the Directive

The implementation of the Directive has led to trials conducted both multi-nationally and in individual Member States experiencing increased bureaucracy and as a result increased cost and set-up time. In part, this is because different Member States interpret and implement the Directive differently. This has resulted in a fragmented system for regulating clinical trials across Europe which can produce conflicting assessments when conducting studies across several countries.

The lack of clarity within the Directive has also resulted in ambiguity for both Sponsors and regulators in deciding whether a trial should or should not fall within its scope. An inflexible approach to regulation has caused significant problems for many trials especially those which are not developing a new therapeutic product. Many trials are conducted using the standard level of care and medicines for their intended indication, in order to advance the clinical knowledge of a drug's effects and improve the quality of treatment for cancer patients.

The Directive's focus on creating high standards of patient safety is welcomed by the research community. However, the systems put in place to monitor and record patient safety data have put a significant administrative burden on researchers with no evidence suggesting that it improves patient safety. The way in which patient safety data is collected also suggests that it is not utilised effectively by regulators to recognise serious incidents in patients. The revision of the Directive should maintain the high standards of patient safety that exist while also reducing the burden of unnecessary reporting of information on researchers and institutions.

Ensuring that the proposed revision of the CTD is fully consulted on and has had a full impact assessment is important to make sure the research community in Europe benefits and changes do not have any unintended consequences. However, it is important the timeline for revision is maintained in order to bring about an improvement to the clinical research environment as soon as possible.

It is vital that the revised Directive supports greater harmonisation. While it is important that there is scope within the application of the legislation to allow for national differences, harmonisation will make it easier to undertake international clinical trials.



These photos show the difference in paperwork needed before and after the implementation of the Clinical Trials Directive

Action needed

Divergent assessments

Retain the function of national competent authorities in regulating single country trials with multinational trials having the option to participate in a Co-ordinated Assessment Procedure (CAP)

In order to carry out a clinical trial, an organisation must be designated as a Sponsor. The Sponsor must obtain Clinical Trial Authorisation (CTA) from the National Competent Authority (NCA) in order to get permission to conduct a trial. For multinational trials, authorisation is required from each national regulatory body in which the trial takes place.

NCAs in different Member States take a different approach to applying the CTD. Researchers commonly complain about the divergent requests from different national regulators when submitting applications. National regulators can reach different conclusions about whether to grant authorisations, but more commonly request amendments to research protocols. Multiple regulators making different requests for amendments complicate trials and make it difficult for Sponsors and the investigators leading the trial to co-ordinate changes to the research protocol in different countries.

A Voluntary Harmonisation Procedure (VHP) was introduced as a way to co-ordinate and harmonise assessments across Member States in an acceptable timeframe. However the VHP continues to experience similar issues with divergent opinions from NCAs.

Case Study: Divergent views within the VHP

A CR-UK funded trial used the VHP to apply for CTAs in five European countries. Issues arose due to the French NCA's requirement to inspect non-pharmaceutical manufacturers of cellular products (including gene therapy products) according to the Cell and Tissue Directives, rather than Good Manufacturing Practice (GMP) which is standard in most other European nations. This discrepancy compared to the requirements in other EU Member States has led to two countries withdrawing from the VHP process.

Among those NCAs participating in the VHP process, there is a discrepancy in assessments at national level, since one of the remaining three countries granted CTAs subject to the condition that a "Manufacturer's Authorisation/GMP certificate" is submitted. Clarification is currently being sought whether a Manufacturer's Authorisation according to the French regulations for an academic manufacturer (i.e. the Cell and Tissue Directives) will be acceptable. The process has been ongoing for approximately one year.

Clinical trials conducted in a single country clearly benefit from the straightforward approach to gaining authorisation from their own national competent authority. The system is effective in fostering close working between funders, researchers and regulators and allows for Member States to work towards improving their internal environments for medical research.

Greater clarity and efficiency for multi-national clinical trials could be derived from applying the proposed Co-ordinated Assessments Procedure (CAP). Under a CAP a sponsor of a clinical trial would elect a single country to be a "Reporting Member State" to take a lead in assessing the application for a clinical trial and reducing the levels of work needed from NCAs in other countries involved in the trial to gain approval. Before the CAP is introduced an impact assessment should take place to ensure it does have a positive effect on approval timelines.

Investigational Medicinal Products (IMP)

The definition of an Investigational Medicinal Product should be limited to include only therapies which are genuinely investigational and novel

Divergent assessments of the Directive across Europe stem from the unclear definitions in the Directive leading to inconsistent application across different Member States. Of particular concern is the definition of Investigational Medicinal Product (IMP) which forms the basis of the data requirements and regulation associated with the trial.

Standard levels of care indicate what treatment a patient would be receiving if they were in non-research hospital settings. Existing guidance on what constitutes the standard level of care is not applied consistently leading to certain National Competent Authorities classifying licensed drugs involved in trials as IMPs even if they are being used for their existing indication.

Case Study: Uncertainty of definition for IMPs across member states

EuroNet-PHL-C1 is a Cancer Research UK funded trial for children and young people under 18 years old, comparing different ways of treating Hodgkin's lymphoma to help lower the risk of long-term side effects. Doctors usually treat Hodgkin's lymphoma with a combination of chemotherapy drugs and many people have radiotherapy after chemotherapy.

For this trial, the number of IMPs included on the Clinical Trials Authorisation (CTA) in different Member States varies from as many as 14 to as few as two. This clearly demonstrates the lack of common understanding of the definition of an IMP by National Competent Authorities and researchers.

The revision of the CTD must limit the scope of IMPs to treatments that are truly investigational and exclude therapies which are used in studies for their intended purpose. A tighter and clearer definition will substantially reduce unnecessary regulatory oversight in many clinical trials while maintaining patient safety when testing novel therapies for the first time. Any revision on the definition of an IMP must not expand the scope of products it could include.

A revised Directive should set out clearly what constitutes an IMP in a way that will be applied consistently across all Member States. Updating the guidance on which therapies used in a clinical trial are used as a non-investigative medicinal product (NIMP) will provide additional guidance to researchers and regulators to ensure the requirements placed on a trial are proportionate to the nature of the product that is being assessed.

Risk-based approach

The Directive should allow for a risk-based approach to the assessment of clinical trials, ideally with the onus on the Sponsor to justify the assessment

Cancer Research UK funds a range of different types of trials including those in which a new therapy is first tried in humans, and to those evaluating existing medicines. The difference in risk between different trials is not acknowledged in the CTD and has led to regulators being over cautious in their approach to allowing trials to go ahead.

Within a substantial number of non-commercial drug treatment trials, the control treatment is a drug or combination of drugs used within their existing indication. The CTD does not effectively recognise these problems, instead applying a 'one size fits all' approach to clinical research which leads to trials being over-regulated.

Case Study: Lack of clarity for labelling approved drugs for new indications

TNT is a Cancer Research UK funded study that aims to recruit 400 patients with metastatic breast cancer (i.e. patients whose chances of survival are poor). The aim is to see if an intravenous chemotherapy drug called carboplatin can delay disease progression compared with docetaxel (also an i.v. drug), which is the widely used standard of care. Docetaxel is used within its licensed indication. Carboplatin is used to treat lung and ovarian cancer, and has also been widely used to treat metastatic breast cancer outside the clinical trial setting for years.

When used in exactly the same way within the trial, there is a theoretical requirement for full labelling according to regulatory requirements. However, whether this labelling is actually required for an i.v. drug which is administered within the hospital and that the patient never handles is still disputed, and there is lack of clarity from the regulator on this issue.

The process of formulating a risk-based approach within the legislation of the EU CTD is currently underway. National competent authorities such as the UK Medicines and Healthcare products Regulatory Agency (MHRA) have already devised their own programmes for stratifying risk in elements of clinical trials. It is likely that the new guidance will lead to change for individual authorities and a move towards a harmonised approach across Europe.

The revision of the Directive and associated guidance should enshrine a risk based approach so that researchers across Member States are regulated in a proportionate manner to allow important research to take place with the appropriate safety guidelines but without significant delays.

Substantial amendments

Substantial amendments should be limited to changes that affect patient safety or the scientific outcome of a trial, as opposed to reporting purely administrative amendments

Substantial amendments occur when researchers need to make a change to an aspect of a trial that has been approved by the regulator when it originally granted permission for the trial to go ahead. Substantial amendments are needed to ensure that regulators are aware of how a trial is progressing and that the approved study is being conducted without significant deviations from the initial mandated proposal.

Similar to many other aspects of the CTD, the lack of clarity of what constitutes a substantial amendment has led to uncertainty over whether or not to submit amendments, leading to over-reporting and extra bureaucracy for both researchers and regulators. Simple changes which can require a substantial amendment include additional clarifications in the protocol of the trial which do not actually affect procedures or reporting associated. Differences of opinion across Member States on what constitutes a substantial amendment further demonstrates the need for a clear and exhaustive definition.

An additional concern is that while approvals may be governed by timelines to ensure that studies are not unnecessarily delayed waiting for regulatory decisions, substantial amendments which carry almost equal importance, in terms of allowing a trial to progress, do not have mandated response times.

A substantial amendment should only be warranted for a change to a trial that affects patient care or the outcome of the trial. The revision of the CTD should look at the issue of substantial amendments to both clarify to sponsors what needs to be submitted but also to make commitments to process these amendments within a set time frame.



Suspected Unexpected Serious Adverse Reactions (SUSAR)

The safety reporting system should be overhauled with SUSARs being reported in a manner which only contributes to patients' safety

Clinical trials must have in place safety reporting systems in order to monitor patients while a trial is taking place. A Suspected Unexpected Serious Adverse Reaction (SUSAR) occurs when an event takes place in the trial that is considered serious to a participant's health. Each time a serious event occurs the researchers must report it in a centralised database.

Reporting SUSARs can take a significant amount of time, up to two days for each event. This is because of the information required including a patient's case and treatment history. This puts significant strain on the resources of Clinical Trials Units.

SUSAR reporting is particularly burdensome for trials that involve licensed drugs where the 'Undesirable Effects' section of the Summary of Product Characteristics (SPC) on the label of a drug does not reflect what is commonly observed in routine clinical practice. This leads to known common side effects being reported as SUSARs.

Case Study: Requirement to report well known side effects

The RaTHL trial is a Cancer Research UK funded trial which uses three established multi-drug regimens (AVD, ABVD and BEACOPP) for the treatment of Hodgkin's lymphoma, which include nine IMPs. All of these drugs are licensed, so SPCs are used to determine whether or not serious adverse reactions are SUSARs. An issue has arisen as several of the licensed drugs' SPCs do not list well-known side-effects, therefore, by definition, they are SUSARs. This has resulted in the reporting of 110 SUSARs within a 35 month period for 710 patients.

This problem is particularly common with haematology trials where treatment involves numerous licensed drugs.

Under the current CTD every SUSAR that occurs must be reported to each site taking part in the trial. This generates a significant amount of information much of which is not relevant to maintaining patient safety. As individual incidents are updated with new data, additional reports are generated which further contribute to the excess of data. The current system not only proves burdensome to researchers but also jeopardises patient safety as the volume of reports make it difficult to discern which reports should be flagged and acted on.

SUSARs should be analysed and assessed by the sponsor, with additional sites taking part in the trial only being informed if there are material considerations for the conduct of the study, such as safety. SUSAR details could be included in a quarterly or annual summary report to sites which would be much more useful and efficient for researchers managing patient safety.

Sponsorship of trials

Multiple organisations should be allowed to sponsor clinical trials in order for risk and responsibility to be shared and facilitate further collaborative working

Every clinical trial must have an organisation nominated as Sponsor. Sponsors assume responsibility for reporting progress and ensuring the requirements of the CTD are adhered to. Currently regulators within most Member States favour a single sponsor as it gives clarity and accountability to an organisation to maintain patient safety.

Clinical Trials Units are a unique asset to the UK, they exist to run clinical trials and manage trial data. These Units bring together experts in statistics, data management, IT and administration. Cancer Research UK funds seven cancer trials units in the UK specialising in adult cancer, and one focusing on childhood cancer. Most Cancer Research UK trials that we fund are run by one of these units.

CR-UK's non-commercial Clinical Trials Units, have found benefit from the UK's current regulatory approach that allows allocation of the sponsors' responsibilities between two or more institutions (co-sponsors) or joint responsibility shared by institutions. Sharing responsibility allows institutions and organisations which are not capable of taking on the full liability of sponsoring a trial to participate and share responsibility with other organisations. For this approach to be truly effective it needs to be recognised across Member States.

Case Study: Recognition of co-sponsorship across member states

The SCOT trial is a Cancer Research UK funded trial taking place in Glasgow and is co-sponsored by the University of Glasgow and the Greater Glasgow Clyde Health Board. The trial looked to set up a site in Denmark.

Issues arose when the Danish site submitted their SCOT application to the Danish NCA. The application was rejected on the grounds that co-sponsorship was a division of Sponsor responsibilities on risk, despite the UK NCA accepting this arrangement.

Further documentation has been produced demonstrating the formal relationship between the University of Glasgow and NHS Greater Glasgow and Clyde. This process has delayed the Danish centre from undertaking its research by a month.

Recognition of co-sponsorship will not in itself help alleviate the regulatory issues caused by the CTD, but it will assist non-commercial entities with some of the administrative burdens caused by the Directive.

Summary

Cancer Research UK's recommendations would maintain patient safety at the highest possible level while allowing researchers to efficiently conduct critically important research for patient benefit.

It is clear that the major failing of the original Directive was the scope it left for interpretation. Lawmakers and regulators implemented the Directive in different ways, which has led to uncertainty for researchers and a fragmented system across Europe. Clear language and proportionate requirements would significantly benefit the research environment for clinical trials in Europe. We still believe that a Directive continues to be the best way in which to standardise and improve the environment for clinical research in Europe as opposed to a Regulation which would be too prescriptive for the different healthcare and research structures within different Member States.

To ensure unintended consequences do not emerge from the revision of the CTD a full impact assessment report should be conducted on proposals put forward by the Commission. A carefully considered revision of the Directive offers an important opportunity to create a stable framework of legislation that benefits the European life sciences industry.



Glossary of terms

CTA	Clinical Trials Authorisation
CTD	Clinical Trials Directive
EMA	European Medicines Agency
GCP	Good Clinical Practice
GMP	Good Manufacturing Practice
IMP	Innovative Medicinal Product
MHRA	Medicines and Healthcare products Regulatory Agency
RSI	Reported Safety Information
SPC	Summary of Product Characteristics
SUSAR	Suspected Unexpected Serious Adverse Reaction
VHP	Voluntary Harmonisation Procedure

More information

Cancer Research UK
<http://www.cancerresearchuk.org/>

Cancer Research UK: Cancer Help
<http://cancerhelp.cancerresearchuk.org/>

Cancer Research UK: Trials and Research Information
<http://cancerhelp.cancerresearchuk.org/trials/>

European Commission – Clinical Trials
http://ec.europa.eu/health/human-use/clinical-trials/index_en.htm

European Forum for Good Clinical Practice
<http://www.efgcp.be/>

Medicines and Healthcare products Regulatory Agency
<http://www.mhra.gov.uk/Howweregulate/Medicines/Licensingofmedicines/Clinicaltrials/index.htm>

National Cancer Research Network
<http://www.ncrn.org.uk/>

Cancer Research UK
Angel Building
407 St John Street
London EC1V 4AD
Telephone: 020 3469 8523

www.cancerresearchuk.org

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(1089464) and in Scotland (SC041666)

