



EUROPEAN COMMISSION
HEALTH AND FOOD SAFETY DIRECTORATE-GENERAL

Health systems and products
Medicinal products – quality, safety and efficacy
Head of Unit

Brussels,
SANTE/D6

MINUTES OF THE MEETING OF THE AD HOC GROUP ON CLINICAL TRIALS

**'Centre de Conference Albert Borschette' CCAB,
Room AB-4B, rue Froissart 36,
1040 Brussels.
20 April 2015, from 10.00 h.**

1. Welcome

The Commission Service representative (COM) welcomed the participants.

2. Adoption of the draft agenda

COM included a point under AOB to give a short update on EFPIA's request to update Annex VI on labelling. The agenda was otherwise adopted.

3. Adoption of the minutes of the meeting held on 9 March 2015.

COM stated that the comments from ES were not yet integrated due to late receipt. The DK delegate asked to specifically refer also to the RMS and not just the MSC on page 5 regarding access to documents. The ES delegate considered that there were still pending issues requiring discussion, such as regarding the withdrawal of applications. In this respect, COM stated that during the last meeting the delegates agreed on the direction to take in some scenarios and therefore the discussions on these should not be reopened. Therefore the ES was invited to provide comments on these aspects to be included in the Q&A. Following this the minutes were tentatively agreed. The comments put forward will be integrated and the minutes will be sent to delegates for written adoption.

4. Update by EMA on the development of the EU CT Portal and Database

EMA updated the group on the development of the Portal and Database.

a) *Transparency*: The addendum, on transparency, to the functional specifications presents the rules for transparency of the data that sponsors and Member States will submit to the portal and the database. The addendum is being dealt with in 2 steps, the first of which is a document explaining the technical features to enable documents and structured data to be made public. This was endorsed by the EMA Management Board (MB) on 8 March 2015 and was published on the EMA website. The second step regards the actual transparency rules for the technical features in the database to enable the documents to be made public. These need to be endorsed by the EMA MB by October

2015. Teleconferences (TC) and Adobe Connect sessions will be held with MS starting in May, during which EMA will present and discuss the first draft of the transparency rules.

b) *Gathering of requirements for portal and database*: Extensive work has been done since September 2014 with sub groups made up of experts from MS to prepare process maps defining detailed requirements. EMA has done a consolidation of the work carried out till now, to allow EMA to get a good understanding of what is needed to potentially finalise most requirements by late June/early July. Following this EMA presented updated consolidated process maps to MS, during 3 sessions that were held at the end of March and at the beginning of April. These sessions were key to consolidate the work done on the process maps and to see what work is still expected. EMA has collected comments from MS to which EMA will respond. TC with the subgroup would resume during that week in order to start working on use cases, which are the documents that will enable developers to start building the database. Additional subgroup meetings with stakeholders will be held later on in the month.

A discussion followed during which the BE delegate stated that he had in the past asked EMA for a comparison of requirements with other countries regarding communication of results of studies and technical aspects of studies. He added that the EU will be far more transparent than, for example, the US with respect to aspects such as methodology, which he fears may lead to sponsors not carrying out phase 1 studies in Europe. Therefore he asked the group to consider how to address this problem.

The DE delegate added that in DE ethics committees are in favour of transparency. He made reference to the Declaration of Helsinki which states that each participant should be informed of the results of clinical studies in which s/he has participated. He emphasised that, to an extent, volunteers want to promote the gain of new knowledge on medicines thereby taking risks by participating in CT. In this respect, the EU should keep in line with the Helsinki Declaration and ensure that results are not kept private. The delegate asked whether EMA will provide quality controls of results in database to check the accuracy of information provided by sponsors, as in done in the US.

The FR delegate asked EMA whether the latter still anticipates finalising the portal and database by Oct 2016 and asked for an update on the timelines.

COM specified that the Clinical Trials Regulation does provide more transparency in the EU than other countries, such as US and Japan. However, COM pointed out that the document on transparency that EMA launched for public consultation considers various options to protect early phase Clinical Trials (CT) for a period of time. This does not mean the information will always be kept confidential, but the proposals being put by EMA provide various tools to ensure transparency while at the same time ensuring adequate protection of commercially confidential data ensuring in this way also that CT will not be conducted outside of EU.

COM asked EMA whether the Adobe Connect sessions and TCs will involve all experts from MS or subgroups only. Additionally COM asked for more information regarding the involvement of stakeholders, as well as on the agenda for the 2 meetings on 11th and 12th May specifically on whether they will focus on technical details of portal and database or on the transparency rules.

In reply to delegates' questions, EMA stated that with respect to transparency, it is correct that some other countries such as the US do not have the same rules that the EU will have

once the CT regulation becomes applicable. They do not publish information on the protocol but they have structured data similar to that in EudraCT. EMA is looking at ways for enhancing structured data to have more alignment with clinicaltrials.gov. With respect to results, FDA in the US requires results to be published after a Marketing Authorisation (MA) is issued and only for studies that support MA. Additionally, there are not many voluntary registrations of CT in clinicaltrials.gov. In the past EMA compared data fields for results in EudraCT with those in clinicaltrials.gov and communicated this mapping to EFPIA who has asked for it. This information can be shared with a wider audience.

To address the question regarding transparency made by DE, EMA stated that the rules that will be set should be in line with the Declaration of Helsinki and asked for the delegate's contribution to this aspect.

EMA continued that with respect to timelines once all elements are finalised: i) the consolidation of process map, ii) the gathering of the business requirements, as well as iii) the transparency rules, EMA we will be in a position to inform of the timelines on database, audit date and launch. The timelines are expected to be set by mid-June once a better picture is available. Various milestones have to be completed to ensure the launch is done on time.

EMA added that it is foreseen that the first Adobe connect sessions will be with all MS and not just with the EMA IT system expert group. With respect to stakeholders EMA is looking into planning additional TCs once the discussion of the topics start with MS.

To conclude, EMA clarified that the meetings that will be held on 11th and 12th May are crucial for EMA to further understand and present where they are with the process map and requirements. Additionally, these meetings will not focus much on transparency since the sessions with MS would not have yet been held.

5. Points for discussion and clarification

COM gave a presentation with the aim of clarifying and discussing with delegates certain outstanding issues that have arisen during discussions that were held within different groups such as the EMA IT system expert group, the ad hoc group on clinical trials, as well as during discussions between COM and EMA.

a. Possibility of negative opinion of EC

COM stated that the relevant provisions of the Regulation that apply to the Ethics Committee (EC) are Articles 4, 5, and 8(4) and recital 18. It is possible to have a scenario where part I and part II are positive and a “national” EC issues a negative opinion that can lead a negative decision on the CT, depending on national legislation. In this respect MS were invited to carefully consider the national procedures and legislation.

The DE delegate stated that the text of the Regulation, such as Article 4 on timelines, is clear on these aspects, so did not consider any clarifications were necessary. He added that the functioning of the EC is not the competence of the COM, as was also stated during the negotiations on the CT Regulation. COM clarified that this topic was put forward to the ad hoc group since certain misunderstandings arose during discussions within the expert group meeting regarding Article 8(4) of the Regulation, specifically regarding the possibility of a negative opinion by an ethics committee. Certain experts had the impression that the EC could work independently of the national competent

authorities and the Regulation requirements. The Expert Group asked for clarification and COM wanted to share the clarification in a group where all MS are represented.

COM emphasised that it is up to MS to organise their internal structure and decide how to integrate the EC in the procedure. Article 8(4) was included to allow EC to give a negative opinion if, in exceptional cases, its views are considered, it can block the authorisation of the CT in that MS. This is also in line with Declaration of Helsinki.

The ES delegate stated that the ECs opinion can relate to Part I or II and if the sponsor does not give a satisfactory response to questions, MS can follow Article 8(2) of the Regulation which sets out the reasons for MS to disagree. Therefore, if MSC disagree it would be in line with the Regulation. In the view of the ES delegate it would be possible for a sponsor to comment on an EC negative opinion once this is sent to them during the assessment process. However COM clarified that this is a separate issue since the EC may not be happy with the reply provided or the assessment and may therefore veto the CT.

The AT delegate asked whether it is possible that in some MS there are distinct opinions from a NCA and EC while in other MS there will be a joint NCA and EC document, to which COM replied that if an EC issues an opinion it is best that it is integrated in the process and challenged through the procedures. It is important to have only a single decision at the end. COM repeated that it is up to each MS to organise their internal structure and clearly define the tasks, procedures and the responsibilities of the EC.

The IT delegate sought clarification of whether an ethics committee is the one integrated in the assessment, or whether it is another EC, outside the regulator process. COM explain that the EC who can veto a CT and issue a negative opinion would not be a local one who carried out an assessment on 1 site, but an EC that can issue an opinion for all sites in MS.

The FR delegate mentioned that in FR there are 39 EC so they will be carrying out a pilot study which will start later this year to experience how to proceed with this assessment with part 1 and 2. They would be happy to share results. She also asked whether other MS have made such pilots. She then asked who will be responsible in appeal procedures of cases when a positive opinion from NCA and negative opinion from EC was issued. COM clarified that the appeal will be against the decision on the trial so against the authority that issued the opinion which will depend on MS national law.

The SE delegate reiterated the importance of having only one decision which can be appealed to one authority and that the EC assessment could not take place outside the procedure provided in the Regulation. She added that there was some misunderstanding due some wording in an EMA presentation given during the expert group meeting on 16 March.

The IT and BE delegates stated that they too will carry out a pilot study with EC.

To conclude COM mentioned that it would be interesting to share the results of such pilots, perhaps early next year through the ad hoc group or another forum and urged MS again to start reflecting on how NCAs and ECs have to work together in the future.

b. Application of SM to be submitted after the end of a CT, Q&A 2.11

COM maintained its position given in Dec 2014 that no substantial modification (SM) can happen after the end of the CT, however that is specified. Sponsors have to be careful

about specifying the end of the CT. COM's position is unchanged, but since some MS still find such SM useful COM asked MS to justify the need for this SM.

A discussion followed during which delegates from AT, ES, DE, DK, FR, NL and SE gave their views on this. There seemed to be an understanding that the submission of a SM after the end of a trial should be allowed but it would be restricted to exceptional cases such as for reasons of safety of patients and to ensure robustness of data. For example if during the analysis of results it is necessary to follow up patients, it should be possible to submit a SM as it would be impractical and impossible to carry out a new study to do a safety research.

Delegates therefore suggested that a SM would be necessary after the end of a CT, such as in cases:

- a) when a CT ends e.g. because of toxicity of the medicine and given the safety profile, further monitoring of subjects is necessary. Here the solution could be that instead of notifying early termination, the sponsor notifies the halt of the CT.
- b) after the sponsor has notified the normal end of a trial further analysis is found necessary, e.g. a re-analysis is required triggered by an inspection
- c) after the sponsor has notified the normal end of a clinical trial new data on safety (any source) require further monitoring
- d) following the end of the CT, subsequent to discussion with other NCAs there could be another aspect, such as the inclusion of another variable, that was not described in the protocol, that needs to be added to a CT, and
- e) in the context of adaptive pathways and ATMPs questions regarding patient follow up may come up and companies may need to go back to obtain additional information e.g biomarkers

Delegates acknowledged that the cases, where SM after the end of a CT is necessary, are unpredictable and rare.

Delegates also held discussions on what would be considered as the end date of a trial. Some indicated that this date should be stipulated in the protocol, and it should not necessarily be "the last visit of the last patient". Perhaps changing this criterion could give more flexibility to allow the submission of a late SM..Other delegates suggested keeping the same end date but requiring the sponsor to take into account the results of the follow-up of clinical trial subjects after the end of the trial when reporting the summary of results.

With respect to the database and portal functionality delegates added that there should be the flexibility of submitting a potential SM after the end of a CT. In this respect COM pointed out that it has to be seen how a SM after the end of a CT would affect the due date of the submission of results and when the clock will start counting. If the end of trial date changes following a protocol change, the obligation for the submission and publication of results will change too. In this regard delegates put forward suggestions such as asking sponsors for the submission of interim results based on the original protocol or keeping the same end of trial date and therefore results are published on the foreseen date. It was also suggested to include a condition when authorising the SM to ensure that results or interim results are submitted in due time.

Delegates stated that, in any case, at the assessment level MS can decide to reject a SM if this is not based on justified reasons. Assessors should be aware that SM can only be accepted in exceptional cases for safety and robustness of data otherwise a CT could

never end. Although it is recognised that assessors will have the final word they may be flooded with assessments. Therefore COM suggested to have more criteria given in the Q&A.

However, finally, delegates suggested avoiding wording in the Q&A that would limit possibilities for acting in the future and to wait until the Regulation applies in order to gain experience in this area. Therefore it was proposed not to include a Q&A on this topic. Instead, for the time being, sponsors can refer to the Q&A of the CTFG regarding follow up of patients.

COM concluded this topic by stating that COM will reflect to see what is legally possible, taking into consideration transparency implications, will discuss with EMA on flexibility in this area for the portal and database and will get back to the group during the next meeting.

c. Concerns resulting from a trial that has ended.

EMA explained that a discussion has been held regarding the functional requirements related to corrective measures and wanted to hear from MS whether they ask for corrective measures after a trial ends. If this aspect needs to be addressed within the EU portal and database EMA would like to know would MS deal with concerns after a clinical trial end.

From the discussion that followed it seems that MS do request corrective measures even after a trial ends, which in the future would fall under Article 77(1)(c). Delegates from NL, UK, FR, DE, AT and SE put forward their experiences and mentioned that in case of major concerns based on an inspection report this is followed up with a corrective measure combined with an assessment. They mentioned some examples of when they encountered concerns such as cases when patients were found to be ineligible after carrying out an inspection, requiring re-analysis of the data and re-writing of the clinical study report. Other cases regarded safety issues that arose after the end of trial, for which a corrective measure was placed for follow up and monitoring. Certain MS, such as FR, ask for withdrawal of clinical trials with the same active substance in cases of a major concern. The delegate from SE asked whether an authorisation can be revoked after the end of a CT. COM will look into whether this is legally possible.

Delegates agreed that measures should be submitted in the portal and database in order to be to share information between MS on measures taken in cases when Regulation requirements are not met and sponsors need to correct submitted data.

A discussion was held on who would have the responsibility of dealing with a concern. Some delegates were in favour of the RMS taking action for multi-national trials where concerns affect multiple CT as well as other trials with same IMP where monitoring is required, to ensure there is a harmonised approach. However, COM pointed out to the group that according to Article 77 there is no obligation for the RMS to take upon it that task. Although it would be good practice for MS to collaborate on the assessment, it is up to each MS to take a decision autonomously.

Therefore delegates advised that the Portal allows for both coordinated assessments/actions, with a role for the RMS and for mono-national ones. Additionally the responsible actor/s should provide information in the portal regarding whether a CT

was inspected and if there were major issues. Delegates stated that they would like to be made aware whether a trial has been inspected. In case concerns arise a link to the inspection report would be a useful tool to provide information to other MS during their own assessment and to the public. Additionally delegates mentioned that it would be good practice if both inspectors and assessors are involved in the assessment.

With respect to the portal it was suggested that the system sends an alert to NCAs in cases of severely compromised trials and that information is shared among MS through the portal. Delegates emphasised that caution is taken when preparing any messages to the public so as not to cause potential undue alarm prior to completion of the assessment. COM stated that during ongoing investigations and/or court cases it should be possible not to make certain information public. However, MS can still share information amongst themselves.

A discussion followed on how to proceed in multi-national CT when cases of irregularities in results arise after the latter are published, and whether the results should be corrected or not. There seemed to be an agreement among delegates that the results are not re-drafted. COM agreed that since the inspection report would be made public, further information would be provided here. It would also be important to avoid divergences among MS whereby some ask for a re-draft of results while others do not.

To conclude EMA stated that from the discussion it is clear that after the end of trial corrective measures are required due to various concerns. In this respect further discussions on the requirements for the portal are required within the subgroup.

Additionally COM stated that will reflect further on this view of the delegates and suggested discussing this topic within the GCP IWG, to also identify whether they consider it to be their role to flag potentially flawed trials.

d. Suspension of CT after a corrective measure (CM)

Within the context of the development of the EU portal and database, COM asked delegates to explain how they proceed when they request a suspension of a CT as a corrective measure, whether conditions and timelines are set to avoid a CT being left suspended indefinitely if a sponsor does not take action. This would also affect reporting obligations.

Certain delegates stated that conditions are set in cases of suspension. In MS, such as DE, a substantial modification is required for the re-start of CT when issues are clarified. With respect to timelines, some MS set timelines which can be extended if the sponsor so requests or if there is an ongoing court case, while others do not. However, this does not rule out that some CTs would remain suspended forever.

It is difficult to decide on timelines beforehand. However, the portal should provide the possibility for setting a deadline if a CT is suspended. If there is no reaction from the sponsor MS may decide to contact the sponsor or end a clinical trial. Due to the fact that the regulation does not provide timelines for CM, and that these are set on a case by case basis the portal cannot provide an automatic solution. The MS have to take the necessary follow up steps.

In this respect it was suggested that MS communicate a deadline to the sponsor when to provide input/correct information. The Portal will therefore not allow the submission of a request for CM unless a date is set by the MS. Additionally the MS has to take the

decision to switch from "suspended" to "authorised" when relevant. The NL delegate suggested that the system gives the possibility of generating an overview of suspended trials. In all cases the portal could allow the discussed actions, however MS have to take a formal decision and take action.

The UK delegate suggested an alternative solution of using a temporary halt under Article 37 rather than suspension as the Regulation provide for a 2 year timeline, after which the trial would be considered to be ended.

With respect to mandatory coordination of action between MS, COM stated that the Regulation does not provide for this. Article 77 gives possibility to consult before taking a decision. However, it is not an obligation to consult other MS and to implement the same measure. Once the information is shared, each MS will act accordingly and ask for further information. Therefore it is possible that MS end up with different positions since this is a national decision. COM mentioned that it would be a best practice for MS to coordinate their work in case of suspension due to safety reasons affecting sites in various MS to ensure MS adopt a harmonised approach but consultation is optional. A best practice regarding these processes could be considered in the future.

e. Extension of timelines for the assessment of ATMPs

The delegate from SE gave a presentation outlining the possibility for the extension of 50 days for Part I assessment for ATMPs and those IMPs mentioned in point 1 of the Annex to Regulation (EC) No 726/2004.. MS, through the EMA groups, have discussed options as to where in the procedure the additional 50 days can be applied, since the CT Regulation does not specify where they can be used.

The 50 days can be invoked at any stage in the assessment, but it was proposed that a stepwise extension is used. The RMS would be responsible for documenting this and informing in which part of the process this would apply. A clear calendar display would be available in the system and MSC would be able to request additional time for the coordinated review if necessary. The sponsor would be informed of extensions through the portal. It was pointed out that problems may arise because additional time is not possible for the evaluation of Part II.

The IT delegate suggested having a standardised approach such as a SOP of how to go about extending the timelines, to ensure harmonisation and better planning for assessors and to provide more certainty to sponsors to on deadlines.

The SE delegate argued that flexibility is required to take into consideration local circumstances such as when external consultation is necessary. If standard procedures are set, procedures may need to be extended also in MS that do not need to. The Regulation also provides for RMS to reduce timelines when relevant, such as in emergency cases.

It was agreed that at this time it would be best to go for flexible approach allowing extensions in portions when needed, such as when MSC require external expertise. In such cases MSC should inform other MSC as soon as possible. Once more experience is gained, the procedure may be reviewed.

f. How to deal with part II when timelines of Part I are extended

Following comments received from delegates after the last meeting, COM outlined some possible solutions on how to deal with situations when Part I has extended timelines and is on-going, but has impact on Part II and it is no longer possible to send additional info

on Part II. IT and NL delegates supported the option of including in the conclusion of Part I a condition stating that the CT can only start after a SM is submitted and authorised to update Part II.

However other delegates argued that this solution may not always be the most practical for example in cases when Part II is negative a SM is not possible. The UK delegate suggested an alternative solution in cases of complex applications such as for certain ATMPs by advising sponsors to apply Article 11 whereby Part I is assessed separately from Part II. Certain delegates supported this option, and could result in shorter timelines than if a SM is submitted afterwards. However others mentioned limited resources for holding pre-submission scientific advice sessions.

Certain delegates suggested having assessments in parallel, re-opening Part II or extending the timelines of Part II. However COM reminded the group that this is not provided for by the Regulation. These aspects were discussed at length during the negotiations between Council and European Parliament.

To conclude COM stated that a text for the Q&A will be proposed to the group whereby sponsors will be advised to consider applying Article 11 in cases of complex applications. It was agreed that if a sponsor instead applies Article 5 MS are free to use other solutions, such as setting a condition for the submission of a SM, depending on the whether Part II is positive or not.

6. Criteria for the selection of the Reporting Member State and for the delegation of the Reporting Member State *(for discussion on the basis of the CTFG proposal)*

The SE delegate gave a presentation outlining the CTFG decisions from the meeting held during the previous week regarding the criteria for selecting the RMS for multi-national trials. All MSC who are willing to be RMS will have 3 days to indicate their willingness.

The selection procedure itself would take place in the workspace and will not be visible to the sponsor. Certain information would be generated automatically by the system, e.g. trial no and title. The main criterion is the relative share of RMSs of a MS where the MSC with the smallest share gets the first priority. Relative shares will not be available when the Regulation becomes applicable, so CTFG proposed to use target data from EudraCT for the first year to express the “relative share”. She emphasised the importance of MS to ensure that data are reported in EudraCT. Thereafter the data will reflect the reality of the “relative share”.

3 scenarios were presented:

- a) one willing MSC – selected RMS is the willing MSC,
- b) no willing RMS – selected RMS is the one suggested by sponsor,;
- c) more than one willing MSC – selected RMS is the willing MS with the lowest relative share, unless another MSC is more appropriate and it is agreed in the discussion forum. However, if no agreement is reached, the selected RMS is the one suggested by sponsor.

Once the selection procedure is completed in case the RMS selected is not the one proposed by the system, the RMS proposed by the system will then change to the selected MSC. The selected RMS will indicate in the system that it will be the RMS and a notification will be sent to the sponsor and the other MSC. However, if the selected

RMS does not act in the system within the set timeframe then automatically the RMS proposed by sponsor will be the RMS.

The SE delegate finalised the presentation highlighting the importance of having an equal standard of assessment of CT in the EU which is ensured by all MS taking part, fostering work-sharing and supporting effective use of resources.

COM asked why in cases when there are more than 1 MSC willing to be RMS but the one proposed by the system disagrees, the proposed procedure goes for the MSC suggested by the sponsor and not to another willing MSC

The SE explained that if just 1 willing MSC disagrees automatically the one proposed by sponsor is chosen. If one MSC absolutely wants to do be the RMS, this MSC can veto.

The IT delegate suggested taking inspiration from the CMDh worksharing to set some criteria for selecting in case of more willing RMS. From this experience it is seen that not all MS can be counted on. If this algorithm proposed is used, there is a risk that it will keep choosing those MSC that may not have enough resources and then the RMS chosen by sponsor keeps getting the role. The DE delegate explained that the system will also show which MSC will be ready to take part in the assessment.

The SE delegate highlighted that MS are organised very differently, and given the short timeframe available for the selection of the RMS a simple and transparent system is needed to ensure work-sharing. She argued that the proposed algorithm would invite the active participation of MS as RMS and encourage availability of a broad pool of MS that can assess CT applications.

In terms of functionalities of the portal and database EMA asked delegates whether they want the system to provide a manual option for indicating the decision of the RMS or whether the system would decide, whereby the MSC with the lowest share and who is willing would be selected to be RMS and have the rights to change the RMS proposed by the sponsor. If the proposed procedure will be adopted various tools will be required in the workspace: a selection tool, an agreement tool, as well as a disagreement tool (even for cases when no MSC is willing). Delegates expressed the wish of having a possibility of re-discussion should be allowed after disagreement has been indicated by a MS.

EMA asked whether timelines should be set for MSC to agree/disagree with potential willingness. The IT delegate mentioned that in cases where no MSC is willing, a special tool may be required as well as a deadline for cut-off to close the discussion.

With respect to the applicable calendar days for the selection phase, EMA confirmed that this will be calculated for this period, in line with Regulation (EEC, euratom) No 1182/71 of the Council taking into account National holidays. The calendar of the longest MSC will apply until the RMS is selected.

COM invited the Ad hoc group to reflect on the proposal and send their comments to COM by 8 May, which will then be forwarded to CTFG to be discussed furthered with the group during next meeting.

7. Draft text of the revised Q&A document on the CT Regulation

COM outlined the updates that were carried out to the Q&A document on the Clinical Trials Regulation following the meeting held on 1 December 2014 which included update of the text following feedback received from delegates and inclusion of new Q&As such as those suggested by delegates and those related to the issues discussed during the ad hoc group meeting in March 2015. Q&As from two CTFG documents - on DSUR of December 2011 and on RSI of December 2013 - were also taken up.

The draft text, which was sent to delegates the week prior to the meeting, was not complete but was a "works in progress" and would be further updated. COM asked delegates to provide comments and clarifications on the document as well as to provide additional input to suggested Q&As in writing to by 8 May 2015.

8. State of play on the involvement of the ad hoc group in the preparation of new and revised guidelines on clinical trials

COM mentioned that only 3 MS - DE, NL and UK - have indicated that they were willing to act as volunteers to update the two existing guidelines and to prepare the two new ones. In this respect DE and NL indicated that they will get back to COM as they were prepared only to collaborate rather than to be in the lead.

The UK delegate expressed interest in developing guidance for a proportionate approach to clinical trials but queried if, since this guidance is largely concerned with the conduct of the clinical trial and with GCP aspects, it would not be more logical for the EMA GCP IWG to develop this, with input from CTFG and the ad hoc group as necessary. COM stated that they will look into this with EMA.

COM asked delegates once again to come forward and volunteer for the work that needs to be done.

9. AOB

Following advice received from the Commission Legal Service, COM gave an update on the status regarding the EFPIA request to amend Annex VI of the regulation. COM explained that, due to Article 89 of the CT regulation, a delegated act cannot be adopted before the CT Regulation becomes applicable. COM added that, at this stage, due to lack of resources in COM and no immediate green light given by Legal Service to go ahead, this task is not considered to be a priority by hierarchy.

Please note that the views expressed in this note do not represent the official position of the Commission and are not legally binding, since only the Court of Justice of the European Union can give an authoritative interpretation of EU law.

List of participants

| COUNTRY | ORGANISATION |
|---------|--|
| AT | AGES/BASG |
| BE | CPME - Comité Permanent des Médecins Européens/ EUREC - European research Ethics Committees |
| BE | Federal agency for medicines and health products |
| CZ | State Institute for Drug Control |
| DE | IBE - Ludwig Maximilians University |
| DE | BfArM |
| DK | Danish National Committee on Biomedical Research Ethics |
| DK | Danish Health and Medicines Authority |
| EE | State Agency of Medicines |
| ES | AEMPS |
| FI | Finnish Medicines Agency (FIMEA) |
| FI | National Committee on Medicinal Research Ethics |
| FR | ANSM |
| HU | National Institute of Pharmacy and Nutrition |
| HU | Ethics Committee for Clinical Pharmacology Medical Research Council of Hungary |
| IE | Health Information and Quality Authority |
| IT | Agenzia Italiana del Farmaco (AIFA) |
| LT | Lithuanian Bioethics Committee |
| LT | Ministry of Health |
| LV | Ministry of Health |
| NL | Central Committee on Research Involving Human Subjects (CCMO) |
| NO | Norwegian Medicines Agency |
| PL | The Office for Registration of Medicinal Products |
| PL | Main Pharmaceutical Inspectorate |
| PL | Ministry of Health |
| PT | INFARMED |
| PT | National Ethics Committee for Clinical Research - CEIC |
| SE | Medical Products Agency |
| SI | JAZMP |
| SK | Ministry of Health |
| UK | Health Research Authority |
| UK | Medicines and Healthcare products Regulatory Agency (MHRA) |
| EMA | European Medicines Agency |