TONIO BORG
MEMBER OF THE EUROPEAN COMMISSION

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Dear Mrs O'Reilly,

Thank you very much for your letter of 3 June 2014 addressed to President Barroso who has asked me to reply on his behalf. You request information about the contacts that the Commission has had with the European Medicines Agency ('EMA') regarding transparency of clinical trial data in order to better understand the development of EMA's policies on this issue.

In respect of our contacts with EMA since July 2013, please find in the Annex a list of the relevant documents on this topic together with copies of those documents. The Commission was informed of the developments of EMA's new policy primarily through various presentations made by EMA, e.g. in the meetings of EMA's Management Board. As you may recall, the consultation period of EMA of the first draft new policy ended on 30 September 2013 by which time EMA had received over 1,000 comments.

At the December 2013 meeting, the Management Board endorsed a set of key principles on the publication of and access to clinical trial data on the basis of a presentation made by EMA. Prior to that meeting, EMA representatives gave an oral presentation to the Commission Health and Consumers Directorate-General (DG SANCO) and Trade Directorate-General (DG TRADE) on the state of play (19 November 2013). As a follow-up to the December Management Board meeting, DG SANCO took the initiative to set up meetings (on 13 March and 4 June 2014) with representatives from other concerned DGs together with representatives from EMA who gave a presentation of the envisaged policy followed by an exchange of views. Documents concerning these meetings including the presentations of EMA, where available, are included in the Annex to this letter. In May 2014, EMA conducted targeted consultations of key stakeholders, such as academia, that led to further refinement of its policy.

Emily O'Reilly,
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Cc: *Mr Guido Rasi, Executive Director of EMA*
Mr Kent Woods, Chairman of the EMA Management Board

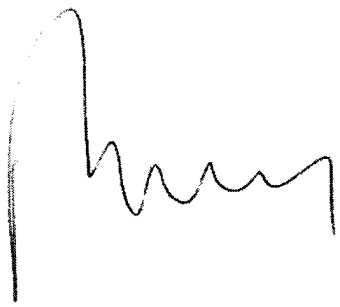
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Following these targeted consultations, EMA transmitted a draft policy document to the Commission (DG SANCO) on 20 May 2014. On 28 May, EMA sent a formal request to the Commission asking for its agreement in accordance with Article 80 of Regulation (EC) No 726/2004. On the basis of the draft policy document received from EMA on 28 May 2014 and after the discussions with other services of the Commission, DG SANCO sent a letter on 11 June 2014 to Mr Guido Rasi explaining that the Commission can give its agreement to the new policy, subject to its comments being taken into account. DG SANCO also submitted proposed changes to the draft policy document. This letter together with the revised policy document (with track-changes) is also in the Annex.

As you will have noticed from the press statement of EMA on 12 June 2014, the Management Board agreed to adopt the new policy through a written procedure which is expected to be concluded by mid-July 2014. The Commission considers this new policy as a step in the right direction as it will lead to a more pro-active publication of clinical data. Prior to this, the Commission had not agreed to the policy and required a number of amendments before giving its approval (see attached letter of 11 June in the Annex). In particular, the Commission underlined the need to clarify that the policy is without prejudice to Regulation (EC) No 1049/2001 on access to documents and to the new Clinical Trial Regulation (EU) No 536/2014. The Commission intends to follow this matter closely and has requested EMA to be consulted on any follow-up measures.

Yours sincerely,



Enclosed: Annex

Nr	Relevant document	Reference / Type of document
1	Minutes of the 81st meeting of the Management Board held in London, 3 October 2013 *(point B1, page 2/11)*	EMA/MB/584118/2013
2	Publication and access to clinical trial data, EMA Powerpoint presentation to EC, 19 November 2013	EC/EMA bilateral meeting, Brussels
3a	Minutes of the 82nd meeting of the Management Board held in London, 11–12 December 2013 *(point B6, page 7/13)*	EMA/MB/723234/2013
3b	Draft principles for implementing rules on publication of and access to clinical trial data, cover note of Agenda point B.6 of the 82nd meeting of the Management Board	EMA/MB/773284/2013
3c	Draft principles for implementing rules on publication of and access to clinical trial data, Agenda point B.6 of the 82nd meeting of the Management Board , PowerPoint presentation to the Board	EMA/743046/2013
4a	Meeting on EMA draft policy on publication of clinical data, 13 March 2014, presentation	Meeting documents
4b	Appendix 1: Mechanism for making the CSR available on the EMA web portal under the EMA proactive publication policy	
4c	Draft Terms of use	
4d	Draft redaction principles	
5a	Minutes of the 83rd meeting of the Management Board held in London, 19–20 March 2014 *(point B11, page 12/15)*	EMA/MB/169928/2014
5b	Draft EMA policy on publication of and access to clinical trial data – Update report	Agenda point B.11 of the 83rd meeting of the Management Board, PowerPoint presentation to the Board
6	Email EMA-SANCO 20 May 2014	
7	Email SANCO-EMA 23 May 2014	
8	Letter from Guido Rasi (EMA) to Paola Testori Coggi (DG SANCO) dated 28 May 2014	Ares(2014)1822620
9	Meeting on EMA draft policy on publication of clinical data, 4 June 2014	Summary note
10	Letter from Paola Testori Coggi (DG SANCO) to Guido Rasi (EMA) dated 11 June 2014	Ares(2014)1905076

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EUROPEAN MEDICINES AGENCY
SCIENCE MEDICINES HEALTH

8 November 2013
EMA/MB/584118/2013 Adopted
Management Board

Minutes of the 81st meeting of the Management Board
Held in London on 3 October 2013

Sir Kent Woods, chair of the Management Board of the European Medicines Agency (EMA), opened the meeting by welcoming new members Audun Hågå, representing Norway, and Ian Hudson, the new alternate member for the United Kingdom.

1. Draft agenda for 3 October 2013 meeting

[EMA/MB/197800/2013] The agenda was adopted with the addition of point B.10. 'Role of the Management Board in the discussion on the introduction of pharmacovigilance fees', requested by some members in view of developments in the discussion of the Working Party on Pharmaceuticals and Medical Devices at the Council of the European Union on the proposal for a regulation on the fees payable to the European Medicines Agency for the conduct of pharmacovigilance activities in respect of medicinal products for human use.

2. Declaration of conflicts of interests

The chair informed members of the Management Board that he had reviewed members' declared interests, together with the secretariat, in accordance with the Board's policy on conflicts of interests. No conflicts relating to today's agenda were identified.

The chair invited members to further declare any specific interests that could not be drawn from their declarations of interests that could be considered prejudicial to their independence with respect to the items on the agenda. No conflicts of interests were declared.

3. Minutes from the 80th meeting, held 13 June 2013

[EMA/MB/367978/2013] The Management Board noted the final minutes, adopted by written procedure on 1 August 2013.

A. Points for automatic adoption/endorsement

None.

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B. Points for discussion

B.1 Highlights from the Executive Director

Achieving savings

The reorganisation process 'Review and Reconnect' is proceeding well and it can be expected to start rendering benefits for the Agency soon. In the next few months, the Agency will put together a set of initiatives for the benefit of the whole network, and will submit them to the Board for discussion. They are very likely to concern:

- Additional funding for training. This might take the form of training directly supplied by the EMA, but also of support provided to training initiatives within the network. Currently provided training will be reviewed, along with the progress of the Heads of Medicines Agencies (HMA)/EMA training office. More details on the full programme will be available in December.
- The national experts programme should be expanded, as suggested by the topic coordinators during discussion of previous budgets.
- Support to committee members attending meetings at the Agency should be enhanced, to respond to requests and suggestions collected from one of the regularly conducted surveys on the satisfaction of delegates. Most comments will be taken into account in the planning of the new building the Agency will move into in 2014. Easier access to logistical information relating to meetings, to the documents provided and to databases will be achieved through restructuring of the IT architecture and via the extranet. Small but not unimportant needs, such as free Wi-Fi in hotels, will be satisfied.

Scientific Coordination Board

The Scientific Coordination Board (SciCoBo) met before summer. A pilot on rationalising the use of scientific resources by setting up a single Oncology SAG to support all seven committees was agreed.

Multinational teams

Support for administrative aspects relating to the creation of multinational teams is being tested within existing rules. The initial, limited scope of the trial spans co-rapporteurships for first evaluation.

Publication of clinical-trial data

The consultation on the draft policy was concluded on 30 September. Many comments were received and will now be analysed. A revised policy will be discussed at the December meeting of the Board.

Court cases

The cases concerning access to documents held by the Agency are ongoing. The Agency has been supported by many organisations and Member States, and would like to particularly thank Denmark, Finland, France, Portugal and Slovenia, who have taken an active role in the proceedings.

Workshop on conflicts of interests

A report has been published on the workshop held on 6 September, and a revised policy will be discussed at the December meeting of the Management Board. The workshop focused on the question of how to ensure the impartiality and independence of experts involved in the Agency's work, versus

the need to continually deliver high-quality scientific assessments. Three key elements emerged from the feedback provided by participants:

- The Agency should look at ways to make participation in its work more attractive for experts.
- There is a need for a methodology to identify the best expertise within the European Union.
- When determining a conflict of interests, it is necessary to move away from blanket timeframes, e.g. specific number of years, towards an approach that looks at the nature of the interest.

New Head of Legal Department

The Executive Director introduced the new Head of the Legal Department, Stefano Marino, who started work with the Agency on 16 June 2013.

B.2 Internal reorganisation of the Agency

The Executive Director updated the Board on progress with the internal exercise 'Review and Reconnect', which designed the Agency's new organisational structure, the main components of which were implemented on 16 September 2013. On that occasion, nine new heads of department were appointed. Further transition to the new structure will take place over the coming months, to ensure continuity of service and support to the scientific committees, with a view to complete implementation by July 2014, when the Agency moves to its new premises.

The exercise now moves into a new phase, in which roughly 60 of the Agency's processes will be reviewed and redesigned. Consultation with national competent authorities (NCAs) is crucial in this phase, to ensure the new processes meet all partners' needs. Project teams will identify, for each process, possible interfaces with the NCAs and the people who can provide input into the 'to-be' processes. Heads of NCAs will be consulted and will be provided with clear information on type of input and time requested from their staff. Type-IB and type-II procedures have been chosen as the first pilot processes, and will start in October. Involvement of the scientific committees might be achieved through different processes, such as through the reorganisation of the secretariats. The SciCoBo will assure permanent coordination, and the experts from the NCAs who will be consulted are likely in many cases to be delegates.

B.3 Report from the European Commission

The European Commission reported on EU legislative and policy developments in the public-health area:

- The implementation of the pharmacovigilance legislation is being further completed with the entry into force of the 'Pharmacovigilance II' amendments. The Commission is working on the delegated act on post-authorisation efficacy studies, and has completed the evaluation of projects for the joint action on pharmacovigilance systems.
- The report on experience with the Paediatric Regulation was published, and a full evaluation of the economic and public-health impact is planned for 2017. The report on the functioning of the Advanced Therapies Regulation is planned for the end of 2013.
- A number of implementing measures concerning the Falsified Medicines Directive have been published or are in the consultation phase. Adoption of the delegated acts on the unique identifier and for the establishment of a common EU logo is expected in 2014. No major problems occurred at the start (in July) of application of provisions concerning the import of active pharmaceutical

APIs. Regulators in third countries continue to build up their agencies to sustain written confirmations.

- After the 29 May vote on the Clinical Trials Regulation by the Environment, Public Health and Food Safety Committee (ENVI — the lead committee in the European Parliament), the Presidency is working towards agreeing a common text and starting negotiations with the European Parliament.
- The legislative proposal for the revision of the veterinary medicines legislation is expected to be adopted by the end of 2013, together with the proposal on medicated feed. Policy objectives are: enhancing the level of protection for humans, animals and the environment, and improving access to veterinary medicines by reducing administrative burdens and reducing barriers to free movements of goods.
- Several initiatives are planned on the topic of antimicrobial resistance, in November and December, including the release of results of the Eurobarometer on antibiotic use during the European Antibiotic Awareness day on 15 November.
- Work on the medical devices legislation is progressing at the Council, while the European Parliament will vote in a plenary on 22 October. Trialogues are expected to start in early 2014.
- Preparatory work for the implementation of Directive 2011/24/EU on patients' rights in cross-border healthcare is ongoing. The HTA[1] network will have its kick-off meeting on 16 October, and will be attended by the EMA; a guideline on minimum data sets for the eHealth network is expected to be adopted in November.
- Discussions at the Council on the legislative proposal on fees for pharmacovigilance are ongoing, with difficulties in relation to the annual flat fee, cost estimates for NCAs and reluctance concerning delegated acts.
- The proposal on the transparency directive is under discussion at the Council after having received a positive opinion by the European Parliament.
- The process on corporate responsibility in the field of pharmaceuticals is about to be finalised, at a meeting in Lithuania on 16 October 2013. Further discussion is foreseen as follow-up of progress achieved in each area of the three pillars of the process and how to foster industrial competitiveness in the pharmaceutical sector.

B.4 Mid-year report 2013 from the Executive Director (January–June 2013)

[EMA/MB/503866/2013] The Management Board noted the Agency's mid-year report for 2013. The report provides an overview of the progress on implementation of the work programme through objectives and performance targets. Overall, activities at the Agency are on track and the budgetary situation is stable.

Pre-authorisation procedures are in line with 2012 figures and the 2013 forecast for orphan-designation applications and protocol assistance. Scientific advice is below Q2 2012, but should reach above 2012 volume by the end of the year, while paediatric applications (paediatric investigation plans and waivers) have increased by 16%. Volumes of assessment procedures are stable, with a decrease in generic and biosimilar applications, a reduction in orphan-medicine applications and a decrease by 21% in type-II applications. The main performance indicators have improved from 91% in 2012 to 98% in 2013, with a target of reaching 100%. Production of certificates has increased by 7% over 2012. The increase in number of GMP and GCP inspections is unlikely to continue.

[1] Health-technology assessment.

With regard to advanced-therapy medicinal products, by Q2 one certification and one marketing-authorisation application were received, while scientific-recommendation requests remained at the same level. For herbal medicinal products, activities remained stable overall, with final Community monographs falling from 9 to 4 and monographs released for public consultation increasing to 9 from 6. There were, however, no Community list entries, due to unavailability of genotoxicity data. Referral procedures increased slightly over the Q2 2012 figure (24 over 22) but were fewer than initially estimated (55 for the whole of 2013).

Veterinary applications experienced a rising trend, with an increase in scientific advice, initial applications (11 compared to 3 in Q2 2012) and referrals, with a decrease in type-II applications and a stable number of requests for minor use/minor species (MUMS) classification.

The implementation of the new pharmacovigilance legislation progressed well, with the launch of new business processes, such as post-authorisation safety studies (PASSs), handling of periodic safety-update reports (PSURs) involving both centrally and nationally authorised products, and the creation of a list of products subject to additional monitoring. The activity on data-quality management for EudraVigilance continues.

Transparency and communication are high on the Agency's list of priorities, with work on track towards publication of agendas and minutes of all committees by 2013, a policy on proactive publication of clinical trials in its final drafting stage, and a comprehensive online project looking at internal and external websites and the EU medicines portal. Access-to-document requests increased substantially (242 compared to 109 in Q2 2012), while the number of pages released decreased by 36%. The European Parliament recognised achieved improvements by granting the discharge for the 2011 budget.

The first operational improvement from the Review & Reconnect exercise was achieved with the new organisational structure and the proposals for implementation. A road map for the new architecture of master data has been agreed and work on implementation has begun. Further highlights of the Agency's activities are the reflection on adaptive licensing (now awaiting European Commission review and concrete submissions), the preparation of a dry-run to verify the technical capacity for analysis and improvement of quality data submitted in applications, and a reflection on public hearings.

Satisfaction with the stable financial situation of the Agency in difficult economic times was expressed. The issue of why requests for access to documents are increasing was raised. The Agency is taking concrete action on transparency, but there is a time lag between policies and their implementation. The EMA has acted by creating a centralised task force, which will combine legal and scientific competence. The low uptake of the advanced-therapy legislation continued to cause concerns to some Board members, who wondered about possible measures to improve access to advanced therapies for patients. The increasing number of good-manufacturing-practice (GMP) inspections was interpreted by some as indicating a persistent trend, and not an unusual cluster. Some members also expressed interest for the reflection on adaptive licensing, and for whether and how this concept could develop within current existing legislation. This will be discussed at the March meeting of the Board. The European Commission stressed the importance of complying with the current legislative framework and suggested including in the discussion the subject of HTA.

B.5 Update on the progress of Project 2014

The Management Board noted progress with the planned move to the new premises of the Agency in July 2014, which was considered necessary as the lease in the current location expires at the end of 2014. After a feasibility study conducted in 2011, the option to move to a new site was approved, to allow for efficient and flexible working space in an environmentally efficient building. The EMA will

occupy nine floors, of which two will be devoted to conference space and facilities for delegates. Spaces in the new building are designed according to modern concepts, moving away from enclosed office spaces. The delegates' area will be configured as an open space, facilitating communication and cooperation, while retaining and upgrading technical working facilities provided.

B.6 Amending budget

[EMA/MB/536520/2013] The Management Board adopted the amending budget 01-2013. This was necessary as efficiency gains to the financial processing of the fee application in 2012 had resulted in fee invoices issued for EUR 28.7 million, which remained unpaid at the end of the year. Corresponding revenues were cashed in in early 2013. EUR 20 million will be used to pay the costs of the fitting-out of the new building as they occur.

The European Commission stated that it could agree to this amending budget provided that further explanation is provided by the Agency on the impact of these payments on future payments related to the new building and, in consequence, on futures budgets of the Agency. The European Commission also advised the Agency to inform the European Parliament of this amending budget.

A budget topic coordinator enquired about other expenditure trends discussed at previous meetings, such as the falling percentage of remuneration to NCAs for provision of scientific services. This is due to an increased share of the annual fee on overall fees shared. However, there has been a reversal in 2012, and the NCAs' share is now up to 43%. The Executive Director expressed his intention to continue to look for ways to support the efforts of NCAs working for the EMA by providing improved procedures and enhanced access to EMA-held data and knowledge systems.

B.7 Preparation of a written procedure for adoption of the EMA financial regulation

[EMA/MB/557966/2013; EMA/MB/559920/2013] The Management Board was informed that a new framework Financial Regulation has been prepared by the European Commission and should be adopted within a few weeks. As a result, the EMA financial regulation needs to be amended accordingly and adopted after a favourable opinion from the European Commission. The new EMA financial regulation will not diverge from the framework regulation, other than for references, and will be submitted to the Management Board for adoption by written procedure in October or November 2013. It will enter into force on 1 January 2014, as stipulated in Article 111 of the new framework regulation.

B.8 Report by the PRAC chair: Reflections one year on from the establishment, composition and functioning of the PRAC

June Raine, chair of the Pharmacovigilance Risk Assessment Committee (PRAC), presented her reflections on the functioning of the PRAC and on the challenges that lie ahead. The pharmacovigilance legislation's aim is to reduce societal costs from adverse drug reactions (ADRs), both in terms of lives and costs of care. The PRAC has been running very well from the beginning, cooperating with the other committees, and benefiting from contributions by patient and healthcare-professional representatives in all areas of its work. The work of the PRAC is based on three pillars: proactive safety monitoring, prompt benefit-risk action, and transparency and communication. Proactive pharmacovigilance is attained by means of signal management, which has achieved a shift from reactive firefighting to the rapid handling within the PRAC of validated signals, leading to a clear recommendation on regulatory outcome within a short timeframe. Signal descriptions, listings, recommendations and Q&As are published on the website.

Prompt benefit-risk action is obtained through safety referrals, achieving final outcome generally in a shorter timeframe than in the past. PSUR evaluation has taken on a new role in safety, as PRAC recommendations can lead to urgent binding regulatory action in all Member States. Transparency on PRAC action has reached an unprecedented rhythm, with highlights and recommendations regarding safety referrals being published at the end of the PRAC week, followed by the minutes after their adoption at the following meeting. Significant progress has been achieved towards risk-monitoring throughout the product lifecycle. Stakeholders have been successfully involved through improved communication and consultation.

Efficient management of workload is among the main challenges for the PRAC. After a steady increase in all types of procedures until May 2013, a steady state might have been reached, with workload taken up principally by 15 Member States. The Committee is reflecting on how to improve efficiency, and has recently approved an action plan that will focus, among other things, on scope and optimal use of referrals, currently making up one third of discussion time in meetings. Collaboration initiatives are ongoing, and will also be the object of the Joint Action SCOPE initiative (Strengthening Collaborations to Operate Pharmacovigilance in Europe). During its first year of operation, the PRAC has focused on using the new public-health protection tools, demonstrating a capability for robust scientific decision-making in demanding timeframes. Further goals are strengthening science and achieving clearly demonstrable public-health outcomes.

Several members congratulated the PRAC chair on her presentation and on the achievements of the Committee. Some concern was raised about the 'gap week' between the PRAC and the CHMP week, and it was suggested that a closer sequence would be in best interest of good communication. This issue has been flagged in various fora, and will be further discussed at the upcoming meeting of the Heads of Medicines Agencies. A further issue is the time lapse between decisions and implementation, and how this can be reduced or avoided altogether in certain cases. Outcome of communication is not easy to measure, and some members agreed with the chair that more information is needed on the impact of regulatory measures on behaviour by patients and healthcare professionals. This can only be achieved through collaboration with all stakeholders. The questions of how the PRAC was coping in the absence of pharmacovigilance fees, and whether success of the legislation could be considered risk-proportionate, were raised. The Board was informed that, currently, the PRAC is able to fulfil its duties, but needs to increase its efficiency through long-term rationalisations and clear definitions of roles and responsibilities, to avoid duplication, as well as addressing risk proportionality by minimising recourse to unnecessary and burdensome regulatory procedures, where possible.

B.9 Principles for publication of agendas and minutes of EMA scientific committees

[EMA/MB/555575/2013; EMA/127582/2010; EMA/391939/2013; EMA/434574/2013 Rev. 4 CONFIDENTIAL] The Management Board discussed the principles for the publication of agendas and minutes of the EMA scientific committees and endorsed the implementation plan. Agendas and minutes of the COMP, PDCO and PRAC, as well as pharmacovigilance sections of CMDh meetings, are already published. The Agency intends to also publish agendas and minutes of the CHMP, CAT, HMPC and CVMP according to an agreed set of principles and implementation plan, with a view to publishing all agendas and minutes of the committees by January 2014. The Board welcomed the proposal and expressed general support for the principles. Some amendments concerning equal treatment of personal data of (co-)rapporteurs and EMA staff, as well as further elaboration on some veterinary-specific aspects, were requested. Additional comments will be provided by the European Commission. The Board agreed that a revised text could be circulated by written procedure, and that the publication of agendas and minutes of all committees should proceed according to the implementation plan.

B.10 Role of the Management Board in the discussion on the introduction of pharmacovigilance fees

Some members informed the Board that the legislative proposal for a regulation on the fees payable to the Agency for the conduct of pharmacovigilance activities in respect of medicinal products for human use, currently under discussion at the Working Party on Pharmaceuticals and Medical Devices at the Council of the European Union, contains a provision empowering the Commission to adopt delegated acts to amend the fees. Members discussed possible changes that such a provision would have on the role of the Management Board and its prerogatives. The representative of the European Commission explained that, in the post-Lisbon context, an amendment of the amounts set in a basic legal act can only be introduced via delegated acts (or via the full ordinary legislative procedure). The use of delegated acts was therefore chosen by the Commission, to allow for more flexibility and a shorter timeframe. Some members of the Board questioned this position. Furthermore, there have been discussions on the split of the fees between the EMA and the Member States. The Executive Director offered to the Board the possibility of holding a dedicated informal session, if that would help provide advice that could help the discussion in the Council. The Board agreed that the legal forum for the discussion on the draft legislation remains the Council, but that it should be made aware of the discussion at the Board. With abstention by the representatives of the European Commission, the Board agreed the following statement, to be sent to representatives of the Lithuanian Council Presidency, the European Commission and the ENVI committee of the European Parliament:

The Management Board discussed at a high level the draft proposals presently being discussed at the Council working party and Parliament on the introduction of Pharmacovigilance fees. In particular, the members stressed that the final proposal must have regard to the development of the Pharmacovigilance activities of the network comprising the EMA and Member States, provide for adequate remuneration for the work load involved, and be fair, transparent and proportionate. Decisions of the Commission on the setting of fee amounts and the division of remuneration between the EMA and the NCA Rapporteurs and co -Rapporteurs should take due regard to these principles and to the concerns of the Management Board.

A.O.B.

Documents for information

- [EMA/MB/549873/2013, EMA/523568/2013] Update on Telematics from the EU Telematics Management Board (EU TMB).
- Report from the Heads of Medicines Agencies.
- [EMA/MB/378130/2013 V.2] Outcome of written procedures during the period 24 May 2013 to 30 August 2013.
- [EMA/MB/537811/2013] Summary of transfers of appropriations in the budget 2013.

Tabled documents

- Updated draft agenda version 4.

Written procedures during the period 24 May 2013 to 30 August 2013

- Consultation no. 8/2013 on the appointment of Jana Klimsová as CHMP alternate, proposed by Slovakia, ended on 7 March 2013. The mandate of the nominee commenced on 14 June 2013.

- Consultation no. 9/2013 on the appointment of Ljiljana Markuš-Cizelj as CVMP member, proposed by Croatia, ended on 19 June 2013. The mandate of the nominee commenced on 1 July 2013.
- Consultation no. 10/2013 on the appointment of Frane Božić as CVMP alternate, proposed by the Croatia, ended on 19 June 2013. The mandate of the nominee commenced on 1 July 2013.
- Consultation no. 11/2013 on the appointment of Ivana Mikačić as CHMP member, proposed by Croatia, ended on 27 June 2013. The mandate of the nominee commenced on 1 July 2013.
- Consultation no. 12/2013 on the appointment of Ana Dugonjić as CHMP alternate, proposed by Croatia, ended on 27 June 2013. The mandate of the nominee commenced on 1 July 2013.
- Consultation no. 13/2013 on the appointment of Bogdan Aminkov as CVMP alternate, proposed by Bulgaria, ended on 17 July 2013. The mandate of the nominee commenced on 18 July 2013.
- Consultation no. 14/2013 on the appointment of Greg Markey as CHMP member, proposed by the United Kingdom, ended on 27 August 2013. The mandate of the nominee commenced on 28 August 2013.
- Consultation no. 15/2013 on the appointment of Bart Van Der Schueren as CHMP alternate, proposed by Belgium, ended on 27 August 2013. The mandate of the nominee commenced on 28 August 2013.
- Consultation no. 16/2013 on the appointment of Daniel Brasseur as CHMP member, proposed by Belgium, ended on 27 August 2013. The mandate of the nominee commenced on 28 August 2013.
- Consultation no. 17/2013 on the appointment of Hans Hillege as CHMP alternate, proposed by The Netherlands, ended on 30 August 2013. The mandate of the nominee commenced on 30 August 2013.
- Written procedure for adoption of the Agency's final accounts, ended on 27 June 2013. The document was adopted.
- Written procedure for adoption of revised implementing rules to the Fee Regulation ended on 15 July 2013. The document was adopted.
- Consultation procedure on the revised policy for classification and incentives for veterinary medicinal products indicated for minor use, minor species (MUMS)/limited markets ended on 12 July 2013. The document was adopted.
- Written procedure for adoption of the 80th Management Board meeting minutes ended on 1 August 2013. The minutes were adopted.

List of participants at the 81st meeting of the Management Board, held in London, 3 October 2013

Chair: Sir Kent Woods

	Members	**Alternates (and other participants)**
Belgium	Xavier De Cuyper	
Bulgaria	*Apology received*	
Czech Republic	Doubravka Kostalova	
Croatia		Viola Macolić Šarinić (Croatia)
Denmark	Else Smith	Matilde Kyst Behrens
Germany	Walter Schwerdtfeger	Klaus Cichutek
Estonia	*Apology received*	
Ireland	Pat O'Mahony	Rita Purcell
Greece	*Apology received*	
Spain	Belén Crespo Sánchez-Eznarriaga	
France	Dominique Maraninchi	Miguel Bley
Italy	Luca Pani	Pietro Erba
Cyprus	Arthur Isseyegh	
Latvia	Inguna Adoviča	
Lithuania	Gintautas Barcys	
Luxembourg	Claude A Hemmer	
Hungary	Tamás L Paál	
Malta	*Nomination awaited*	Gavril Flores
Netherlands	Aginus Kalis	
Austria	Marcus Müllner	
Poland	Grzegorz Cessak	Magdalena Pajewska
Portugal	Hélder Mota-Filipe	
Romania		Simona Badoi
Slovakia	Jan Mazág	
Slovenia	Matej Breznik	
Finland		Pekka Kurki
Sweden		Bengt Wittgren
United Kingdom		Ian Hudson Saira Madden
European Parliament	Björn Lemmer Giuseppe Nisticó	
European Commission		Andrzej Rýs Salvatore D'Acunto Miroslav Griva
Representatives of patients' organisations	Nikos Dedes W.H.J.M. Wim Wientjens	
Representative of doctors' organisations	Wolf-Dieter Ludwig	
Representative of veterinarians' organisations	Christophe Hugnet	

	Members	Alternates (and other participants)
Observers	Rannveig Gunnarsdóttir (Iceland) Brigitte Batliner (Liechtenstein) Audun Hågå (Norway) June Raine (PRAC Chair)	

European Medicines Agency	Guido Rasi Andreas Pott Noël Wathion Agnès Saint Raymond Stefano Marino David Mackay Zaïde Frias Enrica Alteri Alexis Nolte Fergus Sweeney Nerimantas Steikūnas Michael Lenihan Tony Humphreys Peter Arlett Sylvie Benefice Isabelle Moulon Emer Cooke Martin Harvey Allchurch Silvia Fabiani Sophia Albuquerque	

EUROPEAN MEDICINES AGENCY
SCIENCE MEDICINES HEALTH

Publication and access to clinical trial data

EC/EMA bilateral meeting, Brussels
19 November 2013

Presented by: Noël Wathion
Chief Policy Adviser

An agency of the European Union

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Background (1/2)

- The draft policy was published for public consultation on 24 June 2013 and consultation ended 30 September 2013
- 169 entities submitted a total of 1138 individual comments
- Comments were received from: NCAs, industry organisations and individual companies, academia and individual doctors, clinical research organisations and individual citizens, companies involved in communication on medicines, and health technology assessment bodies

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Background (2/2)

- The comments have been divided into categories according to the groups who provided advice on following 5 themes:
  - Protecting patient confidentiality
  - Clinical trial data formats
  - Rules of engagement
  - Good analysis practice
  - Legal aspects
- This presentation will include the major objections within each of the advisory themes

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Protecting patient confidentiality (1/6)

Objection 1

- The informal consent given by patients participating in a clinical trial may not include consent to secondary analysis of the data
  - Does secondary analysis need to remain within the boundaries of informed consent?
  - Who would be responsible for determining whether secondary analysis is within the consent given?
  - Is it necessary to obtain re-consent from the patients?

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Protecting patient confidentiality (2/6)

Objection 2

- Study personnel data should not be classified as non-confidential
  - No overriding public health reason to disclose data
  - Protection from activists necessary
  - Inconsistent with policy on disclosure of EMA staff members (Access to documents policy)

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Protecting patient confidentiality (3/6)

Objection 3

- De-identification standards are not provided
  - Linkages to other data sources e.g. social media needs to be taken into account
  - Quality and adequacy of de-identification standards not well researched
  - CDISC mentioned in the draft policy is no a standard but a multiple of standards
  - Guidance is particularly needed for narratives
  - Companies not able to provided de-identified data sets before standards are known

Protecting patient confidentiality (4/6)

Objection 4

- Risk of identification of individuals
  - Risk to EMA as the Agency is responsible for publication
  - Aggregated data might not be sufficient in case of very rare diseases

Protecting patient confidentiality (5/6)

Objection 5

- Not clear which datasets will be made available through controlled access
  - Will it be all data sets or a relevant data set
  - Does the definition of raw data include individual patient line listings and individual case report forms

Protecting patient confidentiality (6/6)

Objection 6

- The cost to industry of de-identification and duplication of submissions is very high
  - Too costly to redact documents in particular data from clinical studies conducted before the policy comes into effect
  - More appropriate to allow controlled access to data than to request time and cost consuming to de-identify the individual case report forms

Clinical trial format (1/3)

Objection 1

- Not possible to provide individual patient data for trials not performed by applicant/MAH i.e. third party trials
  - For some studies e.g. pharmacoepidemiological studies the studies are performed on datasets via paid access to external data providers who own the data

Clinical trial format (2/3)

Objection 2

- Definition of raw data is no clear enough
  - The definition in the draft policy contains both integrated data (CTD overview, summary of case report forms) and individual patient data
  - Not clear why the statistical logs and statistical programs are included in the raw data definition (SAS code and logs)
  - Some of the data requested as raw data (Individual patient line data listings) are no longer produced with the introduction of electronic submissions

Clinical trial format (3/3)

Objection 3

- Software programming codes and logs should not be requested
  - Statistical programmes used to generate the statistical analyses use complex programming structures and utilities which are proprietary and may be owned by a third party
  - Developing and maintaining the software programming code and logs and they are considered intellectual property
  - Not every secondary analysis would require access to statistical programs and logs from the primary analysis and the statistical analysis plan should be sufficient to recreate the analysis

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Rules of Engagement (1/7)

Objection 1

- The timing of release of clinical trial reports is not optimal
  - It does not take into consideration the researchers who were involved in the clinical trials and time needed for them to publish the results
  - It does not take into account time needed for submissions to authorities in other regions
  - Information released in one region may undermine the integrity of the applicant/MAH's global regulatory processes

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Rules of Engagement (2/7)

Objection 2

- Data from withdrawn applications and applications for which the outcome was negative should not be released at the time of withdrawal/negative opinion
  - Release of data should not take place before it is ascertained that the development programme has been terminated otherwise the development may be affected and undermine the commercial viability of the product
  - Release of data could prejudice the integrity of the regulatory process for any future resubmissions and on-going/future application to other regulatory bodies
  - Publication of clinical data could provide competitors with valuable commercial information

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Rules of Engagement (3/7)

Objection 3

- The process for publication of data does not foresee a consultation with the applicant/MAH prior to release of data
  - Consultation is foreseen in Regulation 1049/2001/EC (Article 4.2)
  - A consultation is necessary to allow for a balanced assessment of the applicant/MAH's arguments and evidence as to the confidential nature of the data and to protect a company's legitimate commercial interests

Rules of Engagement (4/7)

Objection 4

- An appeal mechanism should be introduced in the policy to allow applicants/MAHs the possibility to appeal the decision to grant access to their data
  - Without an appeal mechanism there is no equitable application of the access policy

Rules of Engagement (5/7)

Objection 5

- The absence of commercially confidential information (CCI) in other sections than those pre-categorised as CCI in the draft policy can not be assumed
  - A consultation process with the applicant/MAH is necessary to confirm non-existence of CCI before publication
  - Overview of bio-pharmaceutics (section 2.5.2) could contain CCI in particular for novel formulations
  - Inter-laboratory standardisation methods (section 16.1.10) may contain CCI

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Rules of Engagement (6/7)

Objection 6

- Some sections that are proposed as CCI should be considered as open
  - Sections 5.3.1 and 5.3.2 "Reports of bio-analytical and analytical methods for human studies" should not be considered CCI
    - The information on bioavailability, biokinetics and drug interactions may be of public health interest
    - A complaint has previously been submitted to the EU Ombudsman when this data was considered CCI by EMA and the data was released
  - Section 16.2, 16.3, 16.4 and Annex VI should be provided that the data is de-identified

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Rules of Engagement (7/7)

Objection 7

- The identity of the requestor should be immediately disclosed
  - The information should be made public before the analysis is conducted
  - The same transparency standards should apply to the requestor as to the applicant/MAH

Good Analyses Practices (1/4)

Objection 1

- The public health benefits of the secondary analysis should balance the resources necessary for giving access to the data; therefore the highest scientific standards (analysis, conduct and reporting) must be ensured
  - Misuse, incorrect analysis and interpretation could be detrimental to public health
  - A robust review of the planned analysis is a prerequisite for data access
  - An independent statistical analysis committee should perform the analysis and the requestor would be provided with the results rather than with the individual data, this would ensure review of public health benefit and protection of personal patient data

Good Analyses Practices (2/4)

Objection 2

- It should be mandatory for the requestor to submit a statistical analysis plan
  - The same standards (ICH) should be applied to the requestor as is applied to sponsors of clinical trials
  - A robust review of the planned analysis is a prerequisite for data access
  - Safeguards needs to be in place against poor quality secondary analysis

Good Analyses Practices (3/4)

Objection 3

- The proposed deadline for publication of the secondary analysis of 1 year after accessing the data is not sufficient
  - Timeframe too short for a HTA comparative effectiveness purpose
  - When more than one clinical trial is involved in the analysis the time period should start from the access to the last data set
  - Timeframe too short for analysing, preparing and submitting publications, peer-review and time "in press", 2 years more should be a minimum

Good Analyses Practices (4/4)

Objection 4

- Destruction of accessed clinical trial data risks being in conflict with best practice in scientific publishing
  - Some peer-review journal require access to complete clinical trial data to ensure accessibility to data for replication of analysis

Legal aspects (1/7)

Objection 1

- Clinical trial data can be considered commercial confidential information (CCI)
  - The question of whether public health considerations outweighs considerations of CCI needs to be considered on a case by case basis (reference to European Ombudsman statement on the reverse (general assumption against disclosure)(case 2560/2007/BEH)
  - Disclosure could damage the legitimate interests of the owner of the data
  - EMA's interpretation is currently being subject to litigation
  - The ECJ has stated in case C453/03 that publication of detailed product data is against the principle of proportionality
  - EMA's interpretation is against statutory rules such as TRIPs

Legal aspects (2/7)

Objection 1 (cont'd)

- Clinical trial data can be considered commercial confidential information (CCI)
  - EMA's interpretation is against statutory rules such as TRIPs
  - EMA's interpretation does not take the Study on Trade Secrets and Confidential business information in the internal market (MARKT/2011/128/D) into account
  - Some national legislation (e.g. the Administrative Procedure act in Germany) considers unpublished study data submitted to authorities to be CCI data

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Legal aspects (3/7)

Objection 2

- There are no details as to how the EMA will protect the public and the pharmaceutical industry against inappropriate use of the data
  - The regulatory data protection period (as per Article 14 (11) of Regulation 726/2004/EC will not be ensured as data will be made available for commercial use within the data protection period within and outside EU
  - Disclosure of data may affect the possibility of obtaining patent protection
  - Companies rely heavily on confidential know-how which may not be protected

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Legal aspects (4/7)

Objection 3

- The legality and enforceability of the data sharing agreement between the EMA and the requestor is questioned
  - Monitoring and sanctions/penalties need to be included in the data sharing agreement
  - The sanctions/penalties must also be enforceable in cases where requestor uses data in non-EU jurisdictions or where data has been passed to competitors

Legal aspects (5/7)

Objection 4

- The policy does not acknowledge the rights of any third party except for the literature references and publications
  - Making third party copyright material available for downloading may be facilitating infringement of copy rights

Legal aspects (6/7)

Objection 5

- The policy is only applicable to centrally authorised products and therefore introduces different standards depending on route of authorisation
  - The policy will result in different standards being applied to national and centrally authorised products
  - The policy will result in personal data being protected differently by different regulatory authorities

Protecting patient confidentiality (7/7)

Objection 6

- No legal basis for requesting additional set of data
  - No clear legal basis when the data is not used for assessment
  - No legal basis for requesting de-identified data
  - No legal basis for requesting a data set for assessment and a data set for publication purposes
  - Questions enforceability in case the MAH refuses claiming that the data contains PDD

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EUROPEAN MEDICINES AGENCY
SCIENCE MEDICINES HEALTH

12 February 2014
EMA/MB/723234/2013 Adopted
Management Board

Minutes of the 82nd meeting of the Management Board
Held in London, 11-12 December 2013

Wednesday meeting, held on 11 December 2013

A formal Wednesday meeting session was held at the request of some members for a longer discussion of the Board's role with regard to funding in the European regulatory network, including the impact of the Lisbon treaty.

Session 1: Pharmacovigilance fee regulation — legislative aspects

Sir Kent Woods, Chair of the Management Board of the European Medicines Agency (EMA), introduced the session by reminding the Board of the issues that were identified as requiring further reflection after the last meeting of the Board in October. The Board should clarify its role in ensuring that the centralised system has enough resources, and that they are distributed efficiently and fairly. Furthermore, it needs to discuss how it can carry out this role in circumstances that have greatly changed since the Board was set up 20 years ago. Activities concerning the legislative proposal for a regulation on pharmacovigilance fees have brought to the attention of all the fact that the Lisbon Treaty has brought about changes that could affect the competence of the Board with regard to establishing fees. While discussions on the pharmacovigilance fee regulation are ongoing, it is important that the Board reflects on this experience and determines how it can best contribute to supporting a system that is feasible for Member States, the European Medicines Agency, the European Parliament, the European Commission and stakeholders alike.

The European Commission gave a presentation on the Lisbon Treaty and implementing acts, to clarify its new prerogatives and the role of the Management Board in respect of the EMA fees. Before the Lisbon Treaty, the Commission's and Council's powers were used through secondary legislation, and the Commission's exercise of its powers was controlled through comitology procedures in a rather complex system. In the post-Lisbon framework, the Commission adopts non-legislative acts through 'delegated acts', which supplement or amend non-essential elements of the legislative act, or 'implementing acts', which implement the legislative act.

The role of the Management Board was set out in the EMA Founding Regulation and in the Fees Regulation, giving the Board responsibility over establishing the remuneration for rapporteurs and fixing the rules for repaying part of the fees to the national competent authorities. However, after the

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Lisbon Treaty, any delegation of rule-making power has to be carried out by implementing or delegated acts. A case concerning which of the new non-legislative acts should be used to regulate fee-related matters is currently awaiting a Court ruling, which should provide further clarity in this regard.

In the past, the Court of Auditors and the European Parliament have requested that the remuneration of Member States should be cost-based. At its meeting of March 2013, the Board agreed that the remuneration of the rapporteurs should be considered within the overall revision of the fee legislation, which the Commission intends to start work on as soon as the regulation on pharmacovigilance fees has been adopted, working in close cooperation with the Member States.

One Member State representative reported a statement by his government, which addressed the perceived notion that the Management Board finds itself in a conflict of interests when dealing with issues concerning fees or their repartition. He reminded the Board that the legislation foresees that, in order to ensure close cooperation between the Agency and scientists operating in Member States, the composition of the Management Board should be such as to guarantee that the competent authorities of the Member States are closely involved in the overall management of the Union system for authorising medicinal products. This means that members of the Management Board should take a common interest in the functioning of the whole system, which relies on the contribution by national competent authorities.

The Chair invited the Board to be mindful of the risk of external perception of conflicts of interests in relation to the setting and repartition of fees. This had been explicitly referred to in a special report published by the Court of Auditors in 2012 and discussed at the European Parliament. Regardless of legislative evolutions due to the Lisbon Treaty, the Board's structure and composition continue to place it in a unique position to collect the best-possible evidence and provide trusted information on which the right decisions can be taken. It therefore has an important role to play in making its wide knowledge of the whole system available, and should assert its expert role in advising the legislator and by providing the best-possible evidence. There were therefore positive advantages in separating the expert advisory role from the decision-making role.

Some members expressed some reservations over the limitation of the Board's powers following the Lisbon treaty, but welcomed at the same time the perspective of providing the Commission with data that reflect accurately how the network works, including information on currently unremunerated activities that national competent authorities carry out for the common interest.

The representative of the European Commission reminded the Board that the current legislative proposal on pharmacovigilance fees is already dealing both with the level of fees and with their repartition, and that this would apply to all future legislation concerning fees. The possibility to finance all non-remunerated activities from European contributions in the foreseeable future does not seem realistic. The collection of complete and transparent data would be very welcome, as it would provide a solid and collaborative basis for the next legislative proposal on the overall fee regulation.

Session 2: Considerations on costing

Opening the second session, the Chair presented anonymised sample data for a few national competent authorities, differing greatly in budget size, significance of fees for centralised activities on overall budget, and public vs. fee-based funding models. The complexity of the system must be considered also in an evolving scenario, where over the past 5 years, payments from the EMA to national competent authorities have increased unequally by type of procedure, reflecting shifts in workload. They ranged from modest increases for marketing authorisations to a 90% increase in the area of inspections. While it is true that some of the observable trends might be short-term, it is of fundamental importance to be able to take long-term decisions based on reliable and robust data, also

looking into future developments. Costing might only be a part of the greater picture, as the Board needs to reassure itself of the sustainability of the entire system and network as a whole. A fresh, top-down approach is needed, allowing an overview of the whole system before assessing the cost of single activities. Time spent for work on a procedure might not be the only factor, as great variability has been detected in the past. It was observed that a certain degree of standardisation of activities is necessary, in order to make them comparable and achieve a fair remuneration. There was agreement on the fact that qualitative as well as quantitative information should be taken into account. The representative of the European Commission supported looking first at the best-possible distribution of tasks, and then defining their remuneration. Several members supported the idea of entrusting the Board with the task of gathering data through a dedicated working group, where Member States would be represented at a technical level, with strategic and analytical steer being provided by another, smaller group of members of the Board. Good systems for data collection could be discussed and shared. The Agency presented as an example its activity-based costing system, which combines data from the time-recording system with information on financial resources. Staff members are required to record their daily working time according to activities. These are then costed and form the basis of the activity-based budget, together with overhead costs allocated to the specific activities. Resulting information has been used to forecast the cost of activities in the 2014 work programme of the Agency. As for the possibility of standardising working time, the Executive Director stressed the need to complete the picture by matching the information on cost-based activity with qualitative KPIs and embedding it in improved and streamlined processes.

The Board supported the proposal to develop a programme to gather the evidence needed by the Commission in drafting the future legislative proposal on fees. This should ensure that the system is sustainable and supported by the right level of financial resources. A draft mandate and description of the data-gathering exercise will be presented at the next Board meeting in March, where the Wednesday afternoon session will be dedicated to this topic.

Thursday meeting, held on 12 December 2013

The Chair of the Management Board opened the meeting by welcoming new members Kiril Nenov, representing Bulgaria, and Beatrix Horváth, representing Hungary, as well as John Joseph Borg, representing Malta (in absentia on 12 December).

1. Draft agenda for 12 December 2013 meeting

[EMA/MB/531192/2013]. The agenda was adopted.

2. Declarations of conflicts of interests

The Chair informed members of the Management Board that he had reviewed their declared interests, together with the secretariat, in accordance with the Board's policy on conflicts of interests. No conflicts relating to today's agenda were identified.

The Chair invited members to further declare any specific interests that could not be drawn from their declarations of interests that could be considered prejudicial to their independence with respect to the items on the agenda. No conflict of interests was declared.

3. Minutes from the 81st meeting, held on 3 October 2013

[EMA/MB/584118/2013] The Management Board noted the final minutes, adopted by written procedure on 8 November 2013.

A. Points for automatic adoption/endorsement

A.1 Financial compensation for Member States' participation in the linguistic checking of product-related information

[EMA/MB/673504/2013; EMA/673506/2013] The Management Board endorsed the increased flat-hourly rate for 2014.

A.2 Amendment 2 to Annex II of the cooperation agreement relating to linguistic checking

[EMA/MB/688641/2013] The Management Board adopted the amendment increasing the frequency of payments to national competent authorities for financial compensation of linguistic checking from bi-annual to monthly payments.

B. Points for discussion

B.1 Highlights from the Executive Director

Meeting with Commissioner Borg

The meeting took place in Malta on 29 November 2013 and was hosted by Malta's Medicines Authority. A series of bilateral and trilateral meetings were held, involving also the Maltese Minister of Health.

Amsterdam summit 2013

The 8th International Summit of Heads of Medicines Regulatory Agencies was hosted by the Dutch Medicines Board on 3 to 6 December in Amsterdam. In addition to sessions on regulatory science, adaptive licensing, inspections and future perspectives in the global health area, the summit established an interim management committee to take forward a new International Coalition of Medicines Regulatory Authorities (ICMRA). The chair is to be held by Canada, with Ireland and Japan providing joint deputy chairs.

EMA-HTA workshop

The Agency offers parallel scientific advice with health-technology assessment (HTA) bodies in order to reduce the time and cost of medicines' development and facilitate access to medicines. An EMA-HTA workshop on parallel scientific advice in drug development took place on 26 November 2013, bringing together 300 participants in house and an additional 200 online. The workshop built on the experience accumulated with the 25 parallel EMA-HTA scientific-advice procedures conducted in the context of a pilot over the past 3 years. Following the workshop, a report and a procedure will be published for consultation. A significant number of parallel EMA-HTA procedures are in the pipeline for 2014. The Agency will also take part, in 2014, in three early dialogue procedures involving regulators and the HTAs that are part of a consortium funded by the Health Programme of the European Commission. Parallel EMA-HTA scientific advice is also in the 3-year work programme agreed with EUnetHTA.

Improving the efficiency and effectiveness of the Agency's operations

The Review and Reconnect programme is on track, with 12 high-priority projects now under way.

Since the last report to the Management Board, the exercise has delivered three initiatives, now in implementation phase, to improve fee processing, access to documents, and the creation of a central data-management service to support the EU data board, which will agree on common data standards and use of data in the network. A number of processes have been redesigned with the aim of achieving efficiency gains not only for the EMA but also for the EU network of medicines regulatory authorities, whose input, together with that of the Agency's scientific committees, is now sought through a consultation. The separation of technical and administrative roles and responsibilities will be implemented in a staggered approach by clusters of processes.

Update on the Court procedure — outcome of the appeal against interim measures

Early in July 2013, the EMA appealed against the Orders of the President of the General Court (Interim ruling) suspending the decisions to disclose documents contained in the dossiers for marketing authorisation of two medicinal products. The Vice President of the Court of Justice annulled the interim decision, and sent the case back to the General Court for a new assessment and a new decision on the interim relief. Pending the outcome of the new assessment by the President of the General Court, the EMA will not give access to the documents requested in these two cases until the General Court decides otherwise. The Agency will continue to consider all other applications for access to documents on a case-by-case basis, as is currently the case. The main Court cases, currently pending before the General Court, will follow their normal course.

B.2 Report from the European Commission

The European Commission reported on EU legislative and policy developments in the public-health area:

- The implementation of the pharmacovigilance legislation is ongoing, with progress being made on the delegated act on post-authorisation efficacy studies, and on the joint action on pharmacovigilance systems. A grant was awarded to the SCOPE project, under UK leadership and with the participation of 25 Member States.
- A Staff Working document on the Use of '-omics' technologies in the development of personalised medicine has been developed by DG SANCO and DG Research.
- A Report on the functioning of the Advanced Therapies Regulation is being finalised and should be published early in 2014.
- A number of implementing measures concerning the Falsified Medicines Directive have been published or are in the consultation phase. The adoption of the delegated act on the unique identifier and its verification is expected in 2014, as are the principles and guidelines of GMP for active substances in the EU, the establishment of a common EU logo for online pharmacies and the guidelines on GMP for API. After entry into force in July without significant shortages of provisions concerning the import of APIs, the Commission is now working on the follow-up of GMP non-compliance of API sites covered by written confirmations.
- After the 29 May vote on the Clinical Trials Regulation by the Environment, Public Health and Food Safety Committee (ENVI — the lead committee in the European Parliament), negotiations with the European Parliament are ongoing with a view to adopting the Regulation within the current term. The proposed text now assigns the development and maintenance of the clinical-trial portal and Union database to the Agency.
- The legislative proposal for the revision of the veterinary medicines legislation (including medicated feed and veterinary medicines) should be adopted in Q1 2014.

- A workshop on regulatory options in the fight against antimicrobial resistance was held on 8 November at the EMA and was very well received by stakeholders. A Commission conference on antimicrobial resistance took place on 12 December.
- The legislative proposal on the medical devices legislation is still under discussion at the Council Working Group, and it appears unlikely that it will be adopted within the current term of the European Parliament.
- The implementation of Directive 2011/24/EU on patients' rights in cross-border healthcare is ongoing. Unfortunately, transposition into national legislation is progressing slowly. The HTA network had its first meeting on 16 October, which was attended by all Member States and the EMA. The eHealth network aims at establishing cooperation among the national competent authorities. A first guideline on the electronic sharing of patient data has been adopted and will set a model for exchange of data to be shared across borders. The deadline for the implementation of mutual recognition of prescriptions elapsed on 25 October, but some Member States are still experiencing problems with introducing the model.
- Several international initiatives are in an active phase. Agreement has been reached on the reform of ICH, establishing a new governance model while defining criteria for membership. The International Pharmaceutical Regulators Forum (IPRF) has been set up for exchange of information and regulatory cooperation, as well as the International Coalition of Medicines Regulatory Authorities (ICMRA). EU-US trade negotiations (TTIP) include medicines and are focusing on recognition of GMP inspections.

Some members were concerned about the delays in transposition of legislation, as well as about the protracted legislative process required by some legislation, such as the clinical trials and medical devices regulations. There is a risk that if contradictory national legislation is adopted, some provisions, such as hospital exemption, may generate deregulation instead of control.

B.3 Roles and responsibilities of the Management Board

[EMA/MB/715306/2013; EMA/MB/186362/2007] The Management Board endorsed the revised document on the roles and responsibilities of the Management Board, which needed to be modified to include references to new legislation, improve the terminology used and update the working practices of the Board in order to reflect revisions of the code of conduct, rules of procedure and operating procedures for the Board.

B.4 Draft principles for a revised EMA conflicts-of-interests policy for scientific-committee members and experts

[EMA/MB/734303/2013; EMA/734296/2013] The Management Board endorsed the principles for a revised EMA conflicts-of-interests policy for scientific-committee members and experts. The proposal stemmed from an EMA public workshop on conflicts of interests held on 6 September 2013 that provided an occasion to hear the views of a wide range of stakeholders. It aims at striking the right balance between independence and impartiality of experts, and assuring access to the best-possible scientific expertise. The proposed principles include:

- establishing the nature of the declared interests and their bearing on a specific EMA activity in order to determine an appropriate cooling-off timeframe;
- differentiation of rules for involvement of experts between decision-making and advisory bodies;

- definition of a methodology to identify best expertise, acknowledge and recognise involvement of experts, also by developing a framework for interaction with academia.

The Board supported the proposed approach, which appears to be more proportionate while retaining the necessary stringency in the system. Some members advocated a clearer definition of financial interests concerning participation in educational events, and suggested to conduct an impact analysis of the proposed principles on the composition of the scientific committees and of the scientific advisory groups. A revised policy will be presented to the Board for endorsement at its March 2014 meeting. The need for apt communication about the new rules was also emphasised by many members.

B.5 ~~Revised implementing rules to the Fee Regulation as of 1 January 2014~~

The discussion of this point was deferred.

B.6 Draft principles for implementing rules on publication of and access to clinical-trial data

[EMA/MB/773284/2013; EMA/743046/2013] The Management Board endorsed a set of key principles for implementing rules on publication of and access to clinical-trial data.

During the consultation period on the draft policy, which was concluded on 30 September 2013, an exceptional number of contributions were received from a variety of stakeholders. The comments addressed mainly the areas of protection of patient confidentiality, rules of engagement and legal aspects. Following the review, revised principles were drafted. They principally relate to the scope of the implementing rules, suggesting a stepwise approach to implementation, commencing with the publication of clinical-study reports, redacted as appropriate, and subsequently assessing the issue of individual patient data (IPD) on the basis of discussion with stakeholders.

The principles need to be considered in light of developments in the ongoing court cases concerning access to documents and in conjunction with the provisions that will be contained in the Clinical Trial Regulation. The representative of the European Commission added that other Directorates-General would be affected by the proposed policy of the EMA, and thus need to be consulted.

The policy on publication of and access to clinical-trial data will be discussed at the March 2014 Board meeting.

B.7 Work programme 2014

[EMA/MB/719999/2013; EMA/695772/2013] The Management Board adopted the Agency's work programme 2014. Priorities will concern the delivery of core functions to a high level of quality, enhanced cooperation with the network and international partners, the ongoing implementation of the pharmacovigilance legislation, increased transparency, and facilitation of the early stages of medicines development. These will be supported by enabling priorities, such as improvement of integration and accessibility of data held by the Agency, and a continuous focus on improving operational effectiveness and efficiency at the Agency. A successful move to the Agency's new premises in July 2014 requires continuous attention, but also constitutes an opportunity for changes in culture and way of working.

The overall workload concerning human-medicines evaluation is stable, with a small decrease in initial evaluations, balanced out by a rise in variations. For veterinary-assessment activities, a drop is expected after the unusual surge in 2013, and remains in line with past trends. No significant change is expected concerning inspections and compliance activities.

Members of the Board appreciated the priorities chosen, with particular regard to the support to the network through training initiatives, IT systems delivering value to the network, and facilitating early stages of medicines development as a contribution towards reviving innovation in the EU, in particular supporting smaller companies. It was suggested that a high priority also be set for inspections and compliance activities, which is necessary given the rising numbers in critical findings, and to initiatives on antimicrobial resistance, which remains a serious public-health issue. Linking to the previous day's discussion, the Board also requested that the project on data gathering be included in the work programme. The Agency strives to achieve best distribution by further improving its activity-based costing, and matching it with qualitative KPIs to assess whether the best service is provided. A further analysis of the re-engineered processes will allow the optimal number and skills of staff needed to be assessed. The representative of the Commission pointed out that the Agency fulfils a wide variety of tasks that can only be carried out by an appropriate, centralised structure, and that are necessary to achieve integration and facilitate innovation in Europe through the provision of advice to small start-ups. It was also pointed out that the health ministries of the Member States have requested to streamline the IT systems, as there is a duplication of databases.

B.8.a Draft budget and establishment plan 2014

[EMA/MB/128714/2013; EMA/MB/686942/2013] The Management Board discussed and adopted the Agency's budget and establishment plan for 2014. The budget is in line with the work programme and amounts to EUR 297.2 million, with an increase of EUR 45.7 million (+18.1%) over the 2013 budget. The rise is caused by an increase in fee income due to additional variations, anticipated implementation of pharmacovigilance fees, and estimated inflationary increase of fees by 2.5%. The budget includes additional assigned revenue for the relocation of the Agency. The EU contribution is unchanged at EUR 39.23 million, but is going down in relative terms. In terms of expenditure, staff costs are expected to increase as a consequence of the anticipated exchange rate effect of adjustments required for 2011 and 2012 salaries. IT expenditure will also increase to accommodate rising demand on new IT developments concerning data integration, new pharmacovigilance systems, the eSubmission programme, the intranet and extranet, clinical trials, and the upgrade of datacentre and corporate IT platforms as part of the move to the new premises. Expenditure for activities of the network will increase significantly as well, providing different levels of support according to the needs of national competent authorities, particularly in the area of training and meetings.

The 2014 establishment plan foresees 599 posts, 12 fewer than the 2013 plan. The reduction was necessary due to the decision of the Council for all EU agencies to reduce their establishment plans by 10% (over a period of 5 years).

The topic coordinators Klaus Cichutek, Kristin Raudsepp and Grzegorz Cessak presented their views to the Board concerning the budget supporting the work programme. As the EMA's revenues increase, expenditure for shared fees to the network stays roughly at the same level of 40%. The Agency has reduced the number of posts on its establishment plan, while the total headcount may increase on account of contract agents and national experts. Concerning IT, after a decrease in expenditure in 2013, there is a small rise in 2014, mainly for maintenance and repair. However, the increase is expected to be of a temporary nature. The topic coordinators congratulated the EMA on improvements in the transparency of its budgetary documents, and recommended their adoption. A few points were raised for further discussion. The topic coordinators recognised that a modification of the repartition of fees between the EMA and national competent authorities is not possible at the present moment, and that a general reflection on the overall allocation of resources in the network will be undertaken over the next 12 months, as discussed in the Wednesday session. The Board welcomed the integrated view of the activities and resources used, and in the future would like to see it detailed even further.

The Board thanked the topic coordinators for their constructive contribution. Some members had further questions concerning high costs and headcount in IT. This is due to the fact that systems and databases in an organisation like the EMA are very complex, as they have to be highly integrated, and must furthermore be multilingual. The increased number of contract agents is necessary in order to provide staff substitutions. Additional seconded national experts have been foreseen in the 2014 budget as support to training activities, which will be of benefit to the entire network.

B.8.b Revision of the budget structure and remarks

[EMA/MB/152502/2013] The Management Board noted the revised budget structure, nomenclature and remarks, which are necessary to prepare for the invoicing of fees for pharmacovigilance and to clarify a few budget items.

B.8.c Revision of the establishment plan for 2014

[EMA/MB/700111/2013] The Management Board adopted the revised establishment plan 2014 amending the gradings of posts for 2014 within the parameters defined by the Financial Regulation.

B.9.a Pharmacovigilance legislation: Functional requirements for EudraVigilance to be audited

[EMA/MB/739742/2013; EMA/626168/2013] The Management Board endorsed the EudraVigilance functional requirements to be audited. These will provide a basis for the EMA to develop a detailed plan, including the timeline for implementation and the plan for the conduct of an independent audit. Moreover, detailed business requirements will be developed by the Agency in consultation with Member States, with system delivery including user testing and training. The Pharmacovigilance Risk Assessment Committee (PRAC) will be regularly updated on the project milestones, and its recommendation will be sought for the audit that the functionalities have been delivered as required by legislation. Based on the independent audit report that takes into account the recommendations of the PRAC, the Management Board will confirm and announce when full functionality of the EudraVigilance database has been achieved and the system meets the defined functional specifications.

B.9.b. Functional requirements for the PSUR repository to be audited

[EMA/MB/742130/2013; EMA/681848/2013] The Management Board endorsed the functional requirements for the PSUR repository to be audited. These will provide a basis for the EMA to develop a detailed plan, including the timeline for implementation and the plan for the conduct of an independent audit. Moreover, detailed business requirements will be developed by the Agency in consultation with Member States, with system delivery including user testing and training. The PRAC will be regularly updated on the project milestones and its recommendation will be sought for the audit that the functionalities have been delivered as required by legislation. The Board will confirm and announce when full functionality of the PSUR repository has been achieved, based on the defined functional specifications. This confirmation by the Board will be based on the independent audit report that takes into account the recommendations of the PRAC.

Requirements for the automation of a two-way exchange interface, which is needed by some Member States, have been included, together with a timeframe, in the document 'PSUR repository functionalities to be audited', with a commitment to deliver them in the following post-audit releases.

B.10 Sixth Annual Report on the Interaction with Patients' and Consumers' Organisations (2012)

[EMA/MB/524015/2013; EMA/272219/2013] The Management Board noted the 'Sixth report on the interaction with patients' and consumers' organisations', which includes an assessment of the satisfaction questionnaire. Thirty-four eligible patients' and consumers' organisations work with the Agency. In 2012, the number of interactions continued to grow (307 in 2010, 423 in 2011, 525 in 2012). The increased collaboration mainly relates to participation in scientific-advice/protocol-assistance activities, as well as to scientific advisory groups, committee consultations, workshops and reviews of information intended for the public. Ninety per cent of package leaflets and 100% of EPAR summaries were reviewed in 2012. Patients' and Consumers' Working Party representatives continue to be involved in many EU-wide initiatives, such as Enpr-EMA, ENCePP and the IMI PROTECT consortium. Collaboration is generally perceived to be very good by all sides, as it allows patients to share their real-life experiences, contributing to the quality of Agency outputs. In 2014, a revision of the framework for interaction is envisaged, to take stock of progress made since 2006, and will be presented to the Management Board.

B.11 Publication of agendas and minutes of scientific committees

[EMA/MB745294; EMA/555647/2013] The Management Board endorsed the principles for the publication of agendas and minutes of the EMA scientific committees. The document had been presented at the October meeting of the Board, where some changes and clarification had been requested. A new version has been prepared, taking into account these comments as well as others collected during the course of a written procedure. The Agency will in December 2013 publish the agendas of the CHMP, CVMP and CAT. Minutes of the meetings held in December 2013 will be published in January 2014, once they have been adopted by the relevant committees. This procedure will become standard practice.

A.O.B.

Documents for information

- [EMA/MB/128713/2013; EMA/817331/2012] Multiannual staff policy plan 2014–2016.
- [EMA/MB/711217/2013] Update on telematics from the EU Telematics Management Board (EU TMB).
- Report from the Heads of Medicines Agencies.
- [EMA/MB/622839/2013] Outcome of written procedures during the period from 1 September 2013 to 21 November 2013.
- [EMA/MB/641206/2013] Amending budget, updated on 16 October 2013.
- [EMA/MB/703501/2013] Summary of transfer of appropriations in the budget 2013.
- [EMA/718145/2013; EMA/13787/2009] EudraVigilance report 2013 for veterinary medicinal products.

Tabled documents

- Report from the Heads of Medicines Agencies.

Written procedures during the period 1 September 2013 to 21 November 2013

- Consultation no. 18/2013 on the appointment of Marcel Bruch as CVMP alternate, proposed by Luxembourg, ended on 30 September 2013. The mandate of the nominee commenced on 1 October 2013.
- Consultation no. 19/2013 on the appointment of Aldona Paluchowska as CHMP alternate, proposed by Poland, ended on 24 October 2013. The mandate of the nominee commenced on 25 October 2013.
- Consultation no. 20/2013 on the appointment of Frida Hasslung Wikström as CVMP alternate, proposed by Sweden, ended on 21 November 2013. The mandate of the nominee commenced on 22 November 2013.
- Written procedure for adoption of the 81st Management Board meeting minutes, ended on 8 November 2013. The minutes were adopted.
- Written procedure for endorsement of the document on publication of agendas and minutes of EMA scientific committees, ended on 21 November 2013. The procedure was suspended.

List of participants at the 82nd meeting of the Management Board, held in London, 11–12 December 2013

Chair: Sir Kent Woods

	Members	**Alternates (and other participants)**
Belgium	Xavier De Cuyper	
Bulgaria	Kiril Nenov	Zlatina Gueorguieva
Czech Republic	Doubravka Kostalova	
Croatia	*Apology received*	Viola Macolić Šarinić (Croatia)
Denmark	Else Smith	Matilde Kyst Behrens
Germany	Walter Schwerdtfeger	Klaus Cichutek
Estonia	*Kristen Raudsepp*	
Ireland	*Apology received*	Rita Purcell
Greece	*Apology received*	
Spain	Belén Crespo Sánchez-Eznarriaga	
France	*Apology received*	Jean-Pierre Orand Miguel Bley
Italy	Luca Pani	Pietro Erba
Cyprus	*Apology received*	
Latvia	Inguna Adoviča	
Lithuania	Gintautas Barcys	
Luxembourg	*Apology received*	
Hungary	Beatrix Horváth	
Malta	John-Joseph Borg	Gavril Flores
Netherlands	Aginus Kalis	
Austria	*Apology received*	Sylvia Fueszl
Poland	Grzegorz Cessak	Magdalena Pajewska
Portugal	Hélder Mota-Filipe	Maria Morais
Romania	Marius Savu	
Slovakia	Jan Mazág	
Slovenia	Matej Breznik	David Obranovic
Finland		Pekka Kurki
Sweden		Bengt Wittgren
United Kingdom		Ian Hudson Saira Madden Jonathan Mogford
European Parliament	*Apology received*	
European Commission	Paola Testori-Coggi	Lenita Lindström Sabine Juelicher (on 11 December 2013) Thomas Heynisch
Representatives of patients' organisations	*Apology received* W.H.J.M. Wim Wientjens	
Representative of doctors' organisations	*Apology received*	

	Members	Alternates (and other participants)
Representative of veterinarians' organisations	Christophe Hugnet	
Observers	Rannveig Gunnarsdóttir (Iceland) *Apology received* (Liechtenstein) *Apology received* (Norway)	

European Medicines Agency	Guido Rasi Andreas Pott Noël Wathion Agnès Saint Raymond Stefano Marino David Mackay Zaïde Frias Enrica Alteri Alexis Nolte Fergus Sweeney Nerimantas Steikūnas Michael Lenihan Tony Humphreys Peter Arlett Sylvie Benefice Isabelle Moulon Emer Cooke Martin Harvey Allchurch Silvia Fabiani Sophia Albuquerque	

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EUROPEAN MEDICINES AGENCY
SCIENCE MEDICINES HEALTH

6 December 2013
EMA/MB/773284/2013
Management Board meeting of 11-12 December 2013

Agenda point B.6, for endorsement

Draft principles for implementing rules on publication of and access to clinical trial data

Issues for consideration

A draft policy on publication of and access to clinical trial data was released for public consultation in June 2013. The 3 months consultation period ended on 30 September 2013. A total of 1,138 individual comments were submitted by 169 entities, representing a wide range of stakeholders. The main comments made relate to:

- protecting patient confidentiality;
- rules of engagement;
- legal aspects.

Following a review of the comments, revised principles for implementing rules have now been drafted. These revised principles relate to:

- the scope of the implementing rules;
- the implementation of the implementing rules, whereby a stepwise approach is proposed;
- preliminary steps to be taken.

These revised principles are further elaborated upon in the attached presentation which is not for publication.

Following endorsement by the Management Board of the attached draft principles, implementing rules will be presented for discussion/endorsement at the March 2014 Management Board meeting.

Action requested of the Board

[redacted]

ENDORSE the attached document: EMA/743046/2013

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Additional background

N/A

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EUROPEAN MEDICINES AGENCY
SCIENCE MEDICINES HEALTH

Draft principles for implementing rules on publication of and access to clinical trial data

Management Board, Item B.6
12 December 2013

Presented by: Noël Wathion
Chief Policy Adviser

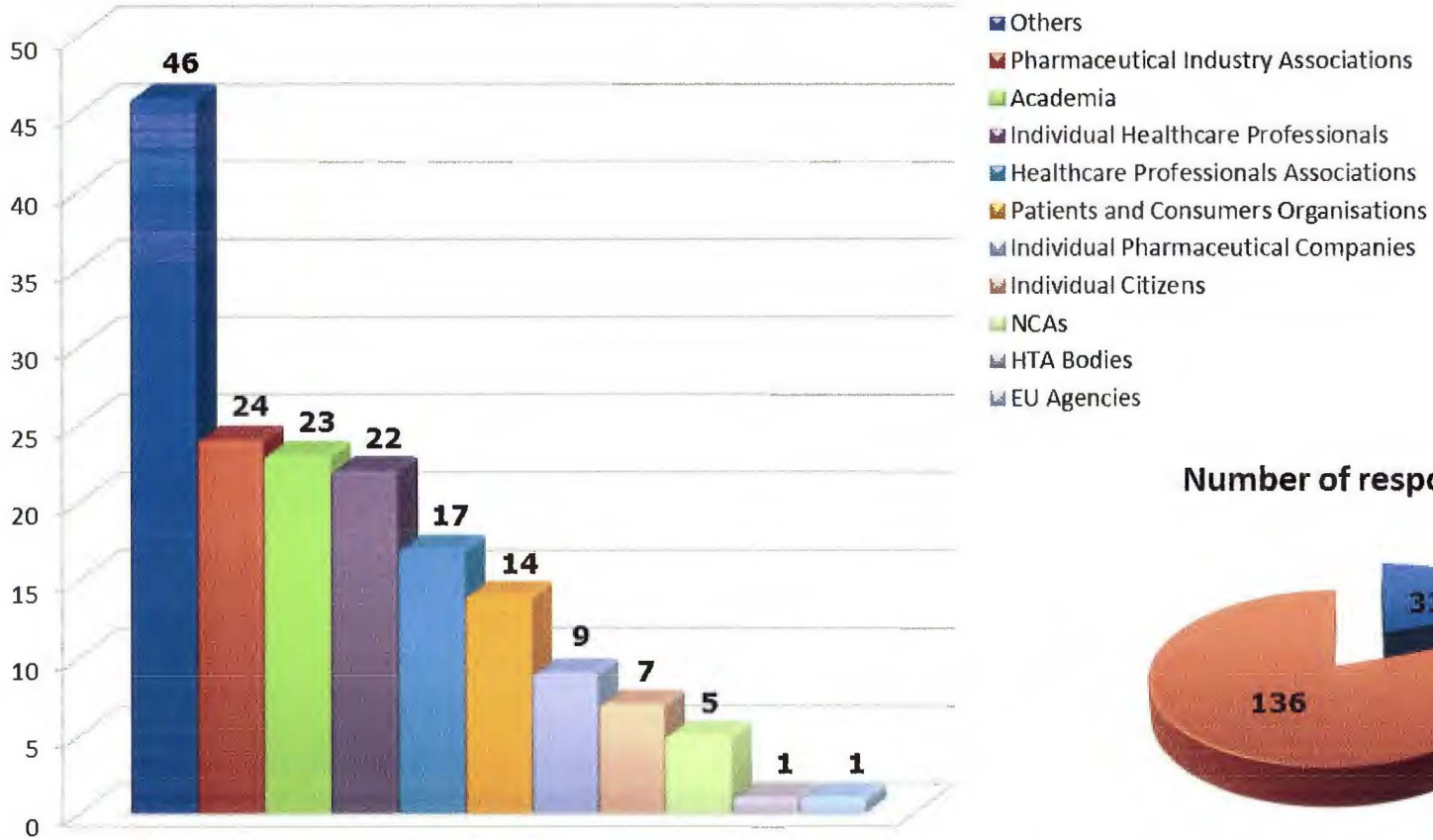
EMA/743046/2013

Outcome of public consultation on draft policy (1/2)

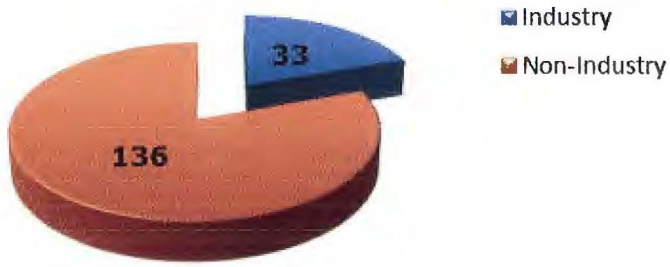
- 3 months consultation period ended on 30 September 2013
- Exceptional contribution from stakeholders: a total of 1,138 individual comments submitted by 169 entities (including NCAs; pharmaceutical industry associations and individual pharmaceutical companies; academia, healthcare professionals associations and individual doctors; clinical research organisations; patients organisations and individual citizens; drug bulletins; HTA bodies)

Outcome of public consultation on draft policy (2/2)

Number of responses received from respondents



Number of responses received from



Summary of main comments (1/3)

- The main comments made relate to the following areas:
  - Protecting patient confidentiality
  - Rules of engagement
  - Legal aspects
- Furthermore, there have been requests to clarify a number of statements in the draft policy, such as the concept of raw data

Summary of main comments (2/3)

- Protecting patient confidentiality:
  - Extent of informal consent in view of secondary analysis of the data
  - Study personnel data should be classified as confidential
  - Current absence of common de-identification standards
- Rules of engagement:
  - Concept of CCI for the purpose of the policy and its application to protect from inappropriate use
  - Timing of release of Clinical Study Reports (CSRs) including release of data from withdrawn applications/ applications with a negative outcome

Summary of main comments (3/3)

- Legal aspects (not yet addressed in the 2 aforementioned areas):
  - No legal basis to request additional set of (de-identified) data
  - Legality and enforceability of the data-sharing agreement between the EMA and the requestor for the proposed Category 3 ("C") data
  - Policy is only applicable to CAPs and not to non-CAPs and therefore it introduces different standards depending on the authorisation route

Follow-up to public consultation

- All comments have been reviewed
- Following such review, revised principles for implementing rules[1] have now been drafted
- EMA press release on the status of the project issued on 13 November 2013, indicating that an update on the timelines for finalisation will be provided at the latest following the December 2013 MB meeting

[1] The concept of "policy" has been replaced by "implementing rules" to reflect that this stems from implementation of EU legislation.

Additional elements to take into account for the finalisation of the implementing rules

- The Vice-President of the Court of Justice has ordered on 28 November 2013 to annul the Orders of the President of the General Court (suspending EMA decisions to disclose some documents in the MA dossier of 2 medicines). The matter has been referred back to the General Court for a new decision on the interim relief applications. The main procedures will follow their normal course
- Therefore, the EMA will have to carefully monitor the developments at Court level

Draft principles: Scope of the implementing rules

- Scope relates to clinical trial data:
  - Either submitted after the implementing rules come into effect ("effective date") as part of a MAA or a variation procedure
  - Or submitted as additional clinical trial data after the "effective date", requested by the EMA as a result of the scientific assessment
- These clinical trial data are composed of:
  - CSRs (Clinical Study Reports)
  - IPD (Individual Patient Data), when submitted within the context as referred to in the 1st bullet point
- Clinical trial data held by the EMA before the "effective date", as well as pre-existing clinical trial data submitted to the EMA in the context of an arbitration/referral procedure, are handled in accordance with the EMA access to documents policy

Draft principles: Stepwise approach for implementation

- First step: Publish CSRs, subject to certain preliminary steps
- Second step: Address the IPD issue by discussing with the stakeholders the concept of IPD (in terms of when to submit IPD for subsequent scientific review, and afterwards provision of access to such IPD)

Draft principles: Preliminary steps for publication of CSRs

- Re-confirm the concept of CCI and its application for the purpose of these implementing rules
- Clarify the scope of informed consent for the purpose of these implementing rules
- Develop a methodology for de-identification of patients
- Develop a standard format for the submission of CSRs
- Introduce a managed publication process for CSRs

Draft principles: Re-confirm the concept of CCI and its application

Discuss with the stakeholders the concept of CCI:

- Re-confirm the concept of CCI for the purpose of these implementing rules
- Review the application to the various parts of a CSR for those circumstances where information contained in CSRs is still considered CCI

Draft principles: Clarify the scope of informed consent for the purpose of these implementing rules

- Reflect, in liaison with the stakeholders, on the scope of informed consent for the purpose of secondary analysis of CSRs, in order to secure that informed consent is also given for the purpose of such secondary analysis

Draft principles: Develop a methodology for de-identification of patients

- Agree with the stakeholders on a common methodology for de-identification of patients, taking into account work already undertaken (e.g. Hrynaszkiewicz)
- Develop rules and procedures for de-identification to be applied by pharmaceutical industry when submitting CSRs after the "effective date"

Draft principles: Develop a standard format for the submission of CSRs

- Develop, in collaboration with the stakeholders, a guideline which defines the requirements on data standards, to be applied by pharmaceutical companies after the "effective date"

Draft principles: Introduce a managed publication process for CSRs

Define, in collaboration with the stakeholders, the criteria for managed publication of CSRs, including the following elements:

- Establish a registration process for any person wanting to have access to the published CSRs
- Put in place an information mechanism allowing the MAH to be informed upfront (e.g. through auto-forwarding)
- Provide for arrangements for giving access to the published clinical trial data
- Introduce disclaimers which persons wanting to access the published CSRs need to agree upon prior to such access (disclaimers to include: no unfair commercial use of the CSRs; EMA is not liable for any inappropriate use)

Draft principles: Preliminary steps for addressing the IPD issue

- Agree on the criteria for the submission of IPD, requested in the frame of the scientific assessment (relating to MAAs and subsequent variations) at the EMA
- Establish a "safe harbour" (concept to be further elaborated upon), including the principles and conditions to be adhered too
  - to provide access to those requesting access to IPD
  - whilst protecting and securing legitimate use of IPD
  - and limiting the risk of re-identification of patients

Next steps

- Following endorsement by the MB of the draft principles, EMA will prepare a policy for discussion/endorsement by the MB at its March 2014 meeting
- At such meeting the EMA will also present to the MB, for information, an implementation plan

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EUROPEAN MEDICINES AGENCY
SCIENCE MEDICINES HEALTH

Preparation EMA policy on publication of and access to clinical trial data - Update

EC/EMA discussion
13 March 2014, Brussels

December 2013 EMA MB outcome

- MB endorsed the proposed principles in terms of
  - Scope
  - Stepwise implementation

December 2013 EMA MB outcome: Scope

- Scope relates to clinical trial data:
  - Either submitted after the implementing rules come into effect ("effective date") as part of a MAA or a variation procedure
  - Or submitted as additional clinical trial data after the "effective date", requested by the EMA as a result of the scientific assessment
- These clinical trial data are composed of:
  - CSRs (Clinical Study Reports)
  - IPD (Individual Patient Data), when submitted within the context as referred to in the 1st bullet point
- Clinical trial data held by the EMA before the "effective date", as well as pre-existing clinical trial data submitted to the EMA in the context of an arbitration/referral procedure, are handled in accordance with the EMA access to documents policy

December 2013 EMA MB outcome: Stepwise implementation

- First step: Publish CSRs, subject to certain preliminary steps
- Second step: Address the IPD issue by discussing with the stakeholders the concept of IPD (in terms of when to submit IPD for subsequent scientific review, and afterwards provision of access to such IPD)

Progress made (1/6)

- Focus on the 1st step, with 2 workstreams:
  - Workstream 1: Introduce a managed publication process for CSRs
  - Workstream 2: Re-confirm the concept of CCI and its application
- For the 2 workstreams a team was set-up to work on the deliverables

Progress made (2/6)

- Workstream 1:
  - Objective: Introduce a managed publication process for Clinical Trial (CT) data
  - Deliverables:
    - Terms of use (ToU) which govern the access to and use of CT data
    - Technical tool

Progress made (3/6)

- Workstream 1 (cont'd):
  - ToU characteristics:
    - Definition of CT data: CSRs (Module 5) + Clinical Overviews (Module 2.5) + Clinical Summaries (Module 2.7) + Appendices to CSRs No. 16.1.1, 16.1.2 and 16.1.9
    - Information available in "view-on-screen-only" mode
    - Information may be used for information, research and other non-commercial purposes
    - Information may not be used to support an application for MA or make any unfair commercial use of information
  - Current status: Final stage of discussions with industry

Progress made (4/6)

- Workstream 1 (cont'd):
  - Technical tool characteristics:
    - Very user-friendly system
    - Simple procedural requirements
      - User ID/password
      - Acceptance of ToU ("view-on-screen-only", not downloadable, not printable)
      - Watermark to emphasise the proprietary nature of the information
    - Basically, all means foreseen aiming at preventing commercial/regulatory use of the information

Progress made (5/6)

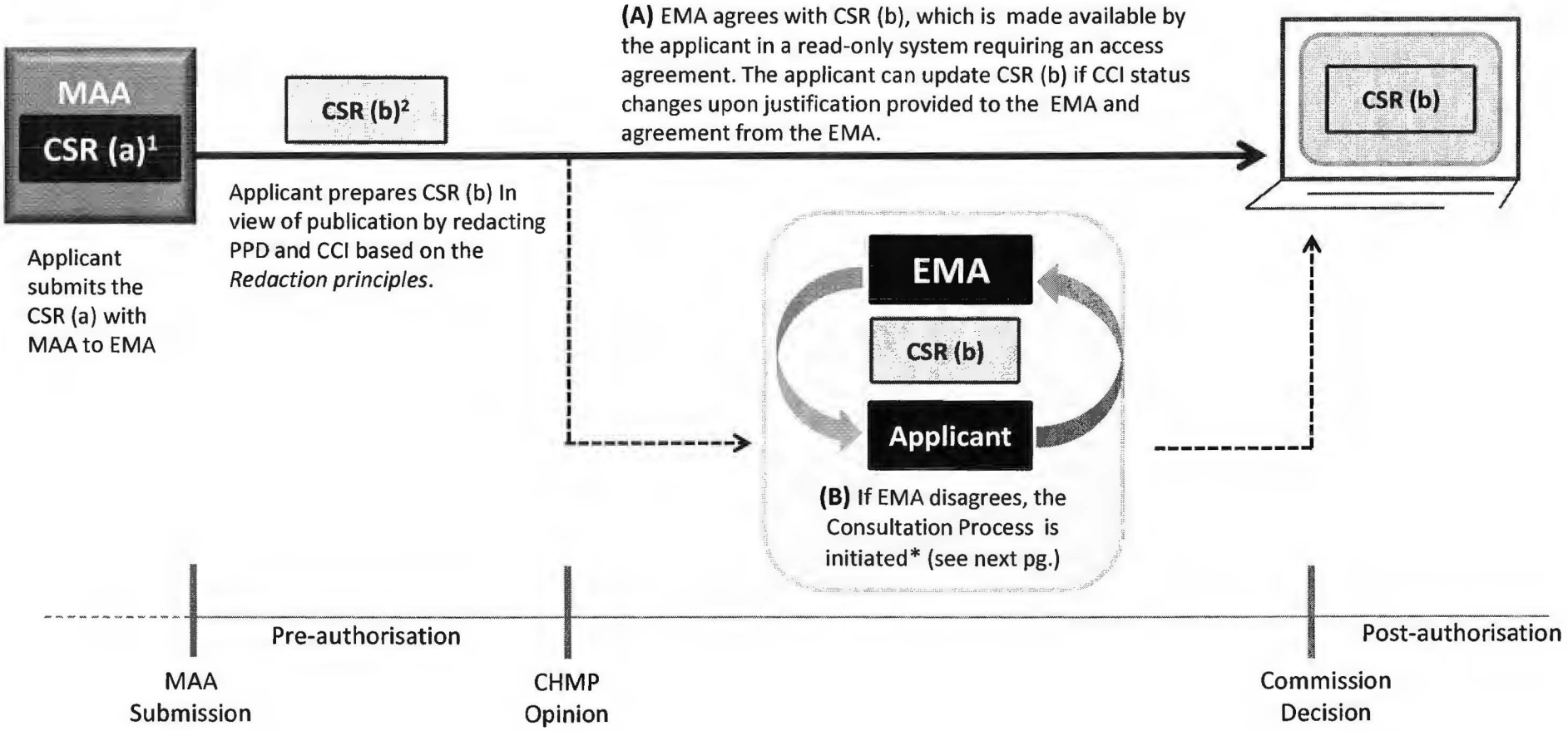
- Workstream 2:
  - Objective: Re-confirm the concept of CCI
  - Deliverable: Guidance document elaborating on
    - Redaction principles, complementing the use controls that need to be accepted (see workstream 1)
    - Procedural mechanism to conduct the redactions of CT data

Progress made (6/6)

- Workstream 2 (cont'd):
  - Characteristics:
    - Redaction principles:
      - Most of info in CT data is not CCI
      - Limited circumstances may lead to exceptions (examples listed)
    - Procedural mechanism for redaction:
      - Simple process based on the redaction principles
      - Consultation phase with pharmaceutical companies is foreseen
    - Current status: Final comments from industry awaited

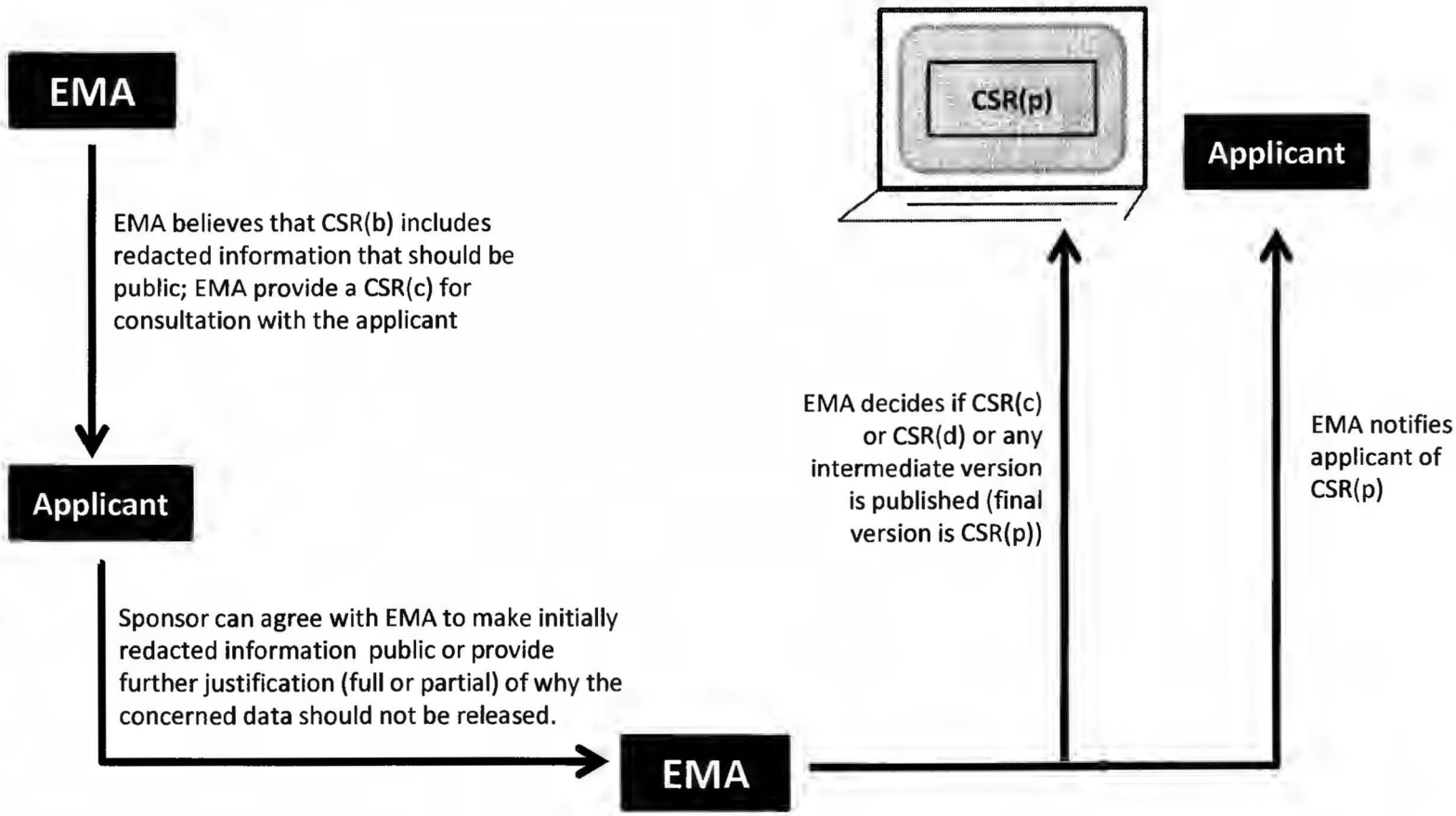
Ref. Ares(2014)2137017 - 27/06/2014

Appendix 1: Mechanism for making the CSR available on the EMA web portal under the EMA proactive publication policy



1. CSR (a) = CSR in accordance with EMA guidance (1995 and 2004)
2. CSR (b) = CSR available under the EMA proactive publication policy

*Consultation Process



* Consultation Process to be concluded within Decision making process timelines – exact timing to be agreed

Ref. Ares(2014)2137017 - 27/06/2014

Draft **Terms of Use**

These Terms of Use ("***Terms***") govern the access and use of clinical study reports ("**CSR**"), clinical overviews and related clinical trial data that are made available to Users via the Proactive Publication of Clinical Trials Policy of the European Medicines Agency, doc. no..... . ("**Policy**"). By accepting these Terms and upon being granted access to the Information, you agree to be bound by these Terms. Please read them carefully.

1. Definitions

In these *Terms* the terms below have the following meaning:

"**EMA**" means the European Medicines Agency.

"**Information**" means the Clinical Study Reports (Module 5, "CSR")~~SR~~, clinical overviews (Module 2.5) and clinical summaries (Module 2.7), together with Appendixes to the CSRs no. 16.1.1, 16.1.2 and 16.1.9 ~~and related clinical trial data~~ which are ~~provided~~accessible via the EMA web-portal as a result of the implementation of the Policy.

Comment [MS1]: We do not provide the Information, but rather make it accessible via the web portal under the Terms of Use.

Comment [MS2]: This is consistent with the changes in the Redaction Principles.

"**Information Owner**" means the natural or legal person(s) or organisation(s) that submitted the *Information* to the *EMA* in the context of applications in support of centralized marketing authorisations under Regulation (EC) No 726/2004, as well as any person(s) or organisation(s) who owns copyright or other intellectual property or proprietary rights in the *Information*.

"**User**" means the natural or legal person or organization who, having registered with the EMA's web-portal in connection with the implementation of the Policy, receives access to the *Information*.

2. Access to the Information under the Policy

The *User* acknowledges that the *Information* is protected by copyright and proprietary rights of the *Information Owner* ~~and, by their nature,~~and can be considered ~~confidential and~~ commercially valuable when used for commercial and regulatory purposes.

Comment [MS3]: EMA recognizes that the Information may be commercially valuable. Qualifying the Information as confidential in this section is misleading and also in contradiction with the general rule set forth in the Redaction Principles.

The *User* acknowledges that the Information will be made available to the *User* in a "view-on-screen-only" mode, after ~~accurately~~ completing the registration process. The *User* agrees that the *User* is not permitted to download, save, edit, photograph print, distribute or transfer the *Information*. The *User* agrees not to access the *Information* using a method other than the interface provided by the *EMA*, or remove, bypass, circumvent, neutralise or modify any technological protection measures which apply to the *Information*.

Comment [MS4]: If the User does not accurately follow the registration process, the system will block his/her application and the Information will not be accessible. This is a fact, governed by technical procedures. We do not intend to give discretion on the interpretation of whether the User has "accurately" registered.

3. Use of the Information

~~In return for being granted access to the Information, t~~The *User* agrees ~~with the EMA and the Information Owner~~ to use the Information according to these Terms and, in particular, that:

Comment [MS5]: The Terms of Use are a unilateral acceptance of the conditions to access the Information. The Information Owner's Rights are protected under Section 5. There is no need to add anything else.

a) The *User* may use the *Information* solely for information, research and other non-commercial purposes, subject to these Terms.

b) The *User* is not granted any intellectual property or other commercial rights in relation to the *Information* other than as expressly set out in these Terms.

When using the *Information*, the *User* shall:

a) acknowledge its source and include any attribution statement specified by the *Information Owner*;

b) not use it in a way that suggests that the *Information Owner* endorses the *User* or the *User*'s use of the *Information* for any other purpose than information, research and other non-commercial purposes;

c) ensure that the use of the *Information* complies at all times with applicable law;

d) not misrepresent the source of the *Information*;

e) not seek to re-identify the trial subjects or other individuals from the *Information* in breach of applicable privacy laws.

The *User* may not:

- use the *Information* to support an application to obtain any kind of regulatory and subsequent approval for a product anywhere in the world;
- share the *User*'s username, password or other account details with a third party or otherwise provide a third party with access to the *User*'s account;
- make any unfair commercial use of the *Information*.

If the *User* fails to accurately complete the registration process, ~~–~~comply with these conditions, or uses the *Information* in breach of these Terms of Use, the rights to access and use- the *Information* will be revoked.-.

4. Warranties and Liability

Without prejudice to any obligation of the marketing authorization holders/applicants in accordance with the Union legislation:

- The *EMA* and the *Information Owner* exclude all representations, warranties, obligations and liabilities in relation to the *Information* as ~~provided~~accessible via the EMA web-portal to the maximum extent permitted by law;
- Neither the *EMA* nor the *Information Owner* are liable for any errors or omissions in the *Information* as provided via the EMA web-portal and shall not be liable for any loss, injury or damage of any kind caused by its use.

Comment [MS6]: See above.

5. Third Party Rights

The restrictions and conditions and the warranty and liability provisions of these Terms are also made for the benefit of any and all *Information Owners* and, accordingly, each such *Information Owner* may in its own right enforce these Terms in accordance with the provisions of the Contracts (Rights of Third Parties) Act 1999.

~~Users acknowledge that if there is reason to believe that the Information has been used not in accordance with the Terms of Use, such Users or those persons who may receive the Information inappropriately, may be liable to the Information Owner, and that in such cases EMA may need to share the identity of Users with the Information Owner.~~

Comment [MS7]: This adds no teeth to this document and instead represents an irritating thorn for good faith users of the system.

6. Governing Law

These Terms and any dispute or claim arising out of or in connection with them or their subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the law of England and Wales.

7. Jurisdiction

The courts of England and Wales shall have non-exclusive jurisdiction to settle any dispute or claim arising out of or in connection with these Terms or their subject matter or formation (including non-contractual disputes or claims).

Redaction Principles

The Clinical Study Reports (Module 5, "CSRs"), Clinical Overviews (Module 2.5) and Clinical Summaries (Module 2.7), together with Appendixes to the CSRs no. 16.1.1, 16.1.2 and 16.1.9 (collectively "CT Data") that will be made available on the EMA web portal in compliance with the EMA proactive publication policy shall be subject to redactions needed to protect those specific elements which qualify as commercially confidential information that should not be released. This complements the use controls that will need to be accepted by recipients of the documents in order to protect the originator against misuse of the data as a whole. This covers information that is not in the public domain or publicly available and where disclosure may undermine the economic or competitive position of the owner of the information. In this regard, the assessment of the relevant information will also take into account the evidence shown by the information owner with regard to various factors, including the nature of the product concerned, the competitive situation of the therapeutic market in question, the approval status in other jurisdictions, the novelty of the clinical development, and new developments by the same company.

In general, much of the information in CSRs pertaining to study designs, statistical analyses, and study results would not be considered CCI. There, are, however, limited circumstances where such information could constitute CCI such as in the case of novel statistical or other analytical methods and exploratory endpoint results about potential new uses of a medicine that are not the subject of the marketing authorisation application.

Exceptions to the general principle above are included in the table below. This information may have to be redacted. If justification for additional redaction is provided by industry in the future, the EMA and industry associations will discuss in good faith whether to integrate the table below with the new proposed redaction, based on real life experience (including applicants' comments) in the implementation of the EMA proactive publication policy.

ANNEX I			
Detailed list of the elements relating to clinical trials and contained in 'The common technical document for the registration of pharmaceuticals for human use' (from ICH harmonised tripartite guideline, Modules 2 and 5); Official guidance which is noted in column three advises what should be discussed in the following components.			
2.5 CLINICAL OVERVIEW			
Section	**Title**	**Information that may be CCI**	**Justification for redaction**
2.5.1	**Product Development**	• "Describe the clinical development programme of the medicinal product,	• Information for planned clinical studies may include "exploratory endpoints" that are not intended to yield

	Rationale	including ongoing and planned clinical studies and the basis for the decision to submit the application at this point in the programme..." • "Regulatory guidance and advice (at least from the region(s) where the Clinical Overview is being submitted) should be identified, with discussion of how that advice was implemented." • "Formal advice documents (e.g., official meeting minutes, official guidance, letters from regulatory authorities) should be referenced...."	data in support of the then-current approval of a use or indication, but could provide clues to potential uses and indications for competitors. • Regulatory advice from outside the EU is typically non-public and includes agreements with regulators on study design, strategies for organization and presentation of findings, and other aspects of the regulatory process that competitors could copy. • Same justification as above
2.5.2	**Overview of Biopharmaceutics**	• Detailed assay information	• As the Biopharmaceutical Summary Documents (2.7.1) are considered CCI, this section may contain some overlapping information.
2.5.3	**Overview of Clinical Pharmacology**	• Stereochemistry issues	• Competitors could gain a detailed understanding of the stereoisomers and three-dimensionality of the molecule
2.5.6	**Benefits and Risks Conclusions**	• Implications of any deviations from regulatory advice or guidelines	• The company may include justifications for any deviation from regulatory advice or guidance outside of the EU jurisdiction, a competitor may have an unwarranted new perception of the regulatory risk associated with a certain regulatory strategy.
2.7 CLINICAL SUMMARY			
Section	**Title**	**Information that may be CCI**	**Justification for redaction**
2.7.1	**Summary of Biopharmaceutic Studies and Associated Analytical Methods**	• Information about specifications on company assays	• This section may contain CCI in the form of details and specifications on assays developed by the company. The information may bring significant advantages to competitors if published.
2.7.2	**Summary of Clinical Pharmacology Studies**	• Information about specifications on company assays and immunogenicity	• This section may contain CCI in the form of details and specifications on assays developed by the company. The information may bring significant advantages to competitors if published.

MODULE 5 CLINICAL STUDY REPORTS			
5.3.1	Reports of Biopharmaceutic Studies	• Information about specifications on company assays (e.g., Bioavailability, In Vitro – In Vivo Correlation)	• This section may contain CCI in the form of details and specifications on assays developed by the company. The information may bring significant advantages to competitors if published.
ANNEX II			
Structure and content of clinical study reports (CSRs) (From ICH harmonised tripartite guideline, E3)			
Section	**Title**	**Information that may be CCI**	**Justification for redaction**
7	INTRODUCTION	• Development of the protocol or any other agreements/meetings between the sponsor/company and regulatory authorities that are relevant to the particular study, should be identified or described.	• May contain non-public information that the sponsor agreed in another jurisdiction outside of the EU.
8	**Study Objectives (including Exploratory Endpoints and Efficacy and Safety Variables; 9.5, 11.4)**	• Statements / descriptions relating to objectives that are not supportive of a label claim and do not contribute to the overall benefit/risk evaluation. This includes the definition of efficacy and safety variables collected and analysed in support of exploratory objectives.	• The exploratory study objectives could be used by a competitor to gain insights into additional future study plans and/or indications for the product. For example, in some trials for a new anti-inflammatory medicinal product, an exploratory lipid profile was included, investigating the lipid metabolism in patients treated with the product, to inform future studies rather than to support the MAA. The results of these analyses were included in the CSRs submitted to the EMA in the course of the MAA procedure. • Alternatively the exploratory objectives may include biomarkers that could be used as 'hypothesis generating' for future studies. At that stage there would not be enough information to file patent applications on these objectives until some data are available from clinical and non-clinical studies. Disclosing these exploratory objectives may preclude obtaining patents that would cover biomarkers/diagnostics themselves, as well as method of use patents directed to patient subpopulations.

9.7.2	**Determination of Sample Size**	• CCI concern is also applicable to Documentation of statistical methods in 16.1.9.	• The sample size *per se* is not considered CCI. However there may be occasions when the intellectual consideration that goes into the analysis of the information that drives the sample size calculation (e.g. estimates of endpoint variability, measurement precision, screening and retention rates) is considered CCI.
14.4	**Method of PK/PD determination**		• This section may have proprietary information on how analyses are performed.

Procedural mechanism to conduct redactions of Full CSRs

See Figures in Appendix 1 (File name: Redaction of CCI mechanism.pptx)

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EUROPEAN MEDICINES AGENCY
SCIENCE MEDICINES HEALTH

5 May 2014
EMA/MB/169928/2014 Adopted
Management Board

Minutes of the 83rd meeting of the Management Board
Held in London, 19–20 March 2014

Wednesday meeting, held on 19 March 2014

Sir Kent Woods, Chair of the Management Board of the European Medicines Agency (EMA), welcomed participants and opened the meeting by reminding all participants that the Wednesday afternoon session would be considered a formal part of the March meeting.

Session 1: Management Board data-gathering initiative

The Chair summarised the decision taken by the Board at the December 2013 meeting to develop a programme to gather the evidence needed by the European Commission in drafting the future legislative proposal on fees. A draft mandate and description of the data-gathering initiative have been circulated to the Board members for discussion and adoption at the current meeting. The draft mandate foresees the creation of a steering group, reporting to the Management Board plenary, working closely with contact persons in the Members States able to provide the required data.

The Director of the Paul-Ehrlich-Institut informed the Board on the outline of the initiative of the HMA Task Force on sustainability of the resources within the EMA/NCAs (national competent authorities) network, aiming at developing a vision of the European medicines regulatory network comprising the EMA, NCAs and the European Commission. He supported participation of members of this Task Force in the steering group of the Management Board data-gathering initiative. Civil-society representatives at the Board also proposed to be among the members, to provide a different perspective.

Members of the Board suggested various elements that should be considered within the data-gathering exercise. Clear definitions of scientific work and scientific-coordination work are needed; a vision of the relation between EMA and NCA tasks is necessary; the exercise should look at both remunerated and non-remunerated activities; support needed for committees to make good scientific decisions needs to be described; the methodology should be geared to capture time spent on activities, rather than their financial cost; membership of the steering group should reflect experience with centralised activities, but also the complexity of the system, as different NCAs need different levels of support; time recording alone cannot convey the totality of what is being done and which can be termed 'regulatory science'; systems to maintain collected data sets for the future should be explored.

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The representative of the European Commission underlined the need to achieve an end-result that is agreeable to all parties involved. The Commission will provide indications on which data it needs to prepare for the impact assessment of a future legislative proposal on fees. Veterinary as well as human data should be prepared in a single package, but if it makes the task easier, the initiative could be started around human data only, and then extended to veterinary data once the methodology is stable. As to the timing, a timeframe of approximately one year should be adequate, with a few months to be added for an independent assessment body to deliver a final validation to the European Commission as foreseen following the recent trialogues on fees for pharmacovigilance.

Session 2: Review & Reconnect update

The Head of the Procedure Management and Business Support Division and the Head of the Scientific Committee Support Department informed the Board about recent developments in the Review & Reconnect project concerning changes in the operating model for scientific and procedure management throughout the lifecycle of a medicine. Since 2003, product team leaders (PTLs) have supported expert teams drawing on a variety of regulatory, scientific and communication expertise. Over the years, their tasks have expanded as the task of providing product oversight became more and more complex. The PTL will now be split into two new roles: a procedure manager (PM) to oversee the management of specific procedures and act as a primary contact point, and an EMA product lead (EPL) to maintain oversight of a medicine through the different stages of its lifecycle. Roles will be distinguished without new jobs being created. This fact is mirrored also in the new organisation of the two central divisions handling evaluation procedures for human medicinal products. The Procedure Management Department has been set up to improve consistency in the handling of procedures via the role of the PM. The EPL will maintain product oversight and overall knowledge about a medicine in the context of therapeutic groups and of previous interactions with the Agency. Both regulatory and legal advice will be sought at an early stage and throughout the processes as appropriate. The processes have been redesigned and streamlined, and NCAs have been consulted on interfaces between the EMA and staff at the NCAs. These new processes should provide benefits for the NCAs as well, as it will allow them to focus their contribution on high-value work. As knowledge is transferred through the lifecycle, the capacity of scientific committees to deliver high-quality opinions is increased. The transition to the new operating model will be implemented in two waves, the first taking place in April 2014 and the second in August 2014, at the time of the move to the new building.

The Board, in particular Board members with direct personal experience in the scientific committees, supported this approach. The role of the PTL was always appreciated as it channels contacts to the applicants without implicating the experts who are involved in the decision-making. The PTL further provides assessment teams with all other relevant information on a product available at the Agency, which can in some cases date back several years. Through this new structure, the PTL function continues to exist through the EPL and PM, and can further improve efficiency of the process and quality of the scientific opinions. Satisfaction was also expressed on the upcoming provision to the NCAs of dashboards on the EMA procedure-tracking system. Access to further systems is envisaged. The Executive Director concluded by inviting NCAs to provide feedback from their experts should they have any specific concerns on the new handling of evaluation procedures.

New building and new structure – what will be different

The Head of the Administration Division reminded the Board of the discussions that led in March 2011 to the decision of the Management Board to relocate the Agency to 30 Churchill Place. Five factors were decisive: a positive cost/benefit profile of the new building; an option on expansion over four additional floors for a few years to come; easy access to a wide range of transportation, including the

future availability of Crossrail to Heathrow; security of the environs of the Agency for the over 7,000 delegates who visit the Agency annually and who often leave meetings late in the evenings; and high capacity of hotels near the Agency. A particularly favourable offer for the 10th floor has been taken up by the EMA as additional tasks were recently allocated to the Agency, and further space was required. No further expansion is expected for the time being.

A presentation providing information on the current status of the new building and of the new facilities was provided by the Head of the Infrastructure Services Department, as was information on the stepwise move into the new building, which will start at the end of June and be completed by the end of July.

Thursday meeting, held on 20 March 2014

The Chair of the Management Board opened the meeting by welcoming new members Ioannis Kkolos (alternate), representing Cyprus, Katerina Fameli (member), representing Greece, Constant van Belkum (alternate), representing The Netherlands, and Marius Tanasa (alternate), representing Romania.

The Board was reminded that the term of office of the current Chair of the Management Board will expire in early June. Elections of a new chair will take place at the beginning of the June meeting. The Chair informed the Board that since he is eligible for re-election, he would be willing to stand for a second mandate. The Executive Director will write to members of the Board inviting nominations for the appointment of a chair.

The Chair further asked for volunteer topic coordinators for the analysis and assessment of the Executive Director's annual activity report 2013, which will be discussed at the June meeting.

1. Draft agenda for 20 March 2014 meeting

[EMA/MB/2712/2014] The agenda was adopted.

Resuming the topic of the Management Board data-gathering initiative from Session 1 of the previous day, the Chair expressed concern that the detailed discussion of the proposed amendments to the mandate would be too time consuming. He proposed to the Board that it adopt instead the composition of the steering group of the initiative to assemble evidence on workload and resources to inform the Commission's proposal for the revision of the fees regulations. The Management Board will work through a steering group chaired by the Management Board chair, with initial membership composed of one representative of the European Commission, four representatives of Member States (Germany, Ireland, Estonia and the United Kingdom), one civil-society representative and two EMA representatives. It will be the steering committee's first task to draft a mandate to be submitted to the Management Board. Veterinary fees will be included at a second stage, and will be part of the final output. The Management Board may add or substitute members if needed as the work progresses, and will review progress at each plenary meeting, with a final report to be completed in twelve months' time.

The Management Board agreed to this approach.

2. Declarations of conflicts of interests

The Chair informed members of the Management Board that he had reviewed their declared interests, together with the secretariat, in accordance with the Board's policy on conflicts of interests. No concern about conflicts relating to today's agenda was identified.

The Chair invited members to further declare any specific interests that could not be drawn from their declarations of interests that could be considered prejudicial to their independence with respect to the items on the agenda. No conflict of interests was declared.

3. Minutes from the 82nd meeting, held 11–12 December 2013

[EMA/MB/723234/2013] The Management Board noted the final minutes, adopted by written procedure on 12 February 2014.

A. Points for automatic adoption/endorsement

A.1 Revised Management Board rules of procedure

[EMA/MB/91953/2014; EMA/MB/115339/2004/en/Rev.5 Draft] The Management Board adopted the revised Management Board Rules of Procedure, including the publication of the agenda ahead of the meeting of the Management Board and clarifying the concept of 'oldest member'.

A.2 Revision of PRAC Rules of Procedure following the implementation of pharmacovigilance legislation in the European Economic Area

[EMA/MB/130072/2014; EMA/PRAC/567515/2012 Rev.1] The Management Board adopted the revised Rules of Procedure of the Pharmacovigilance Risk Assessment Committee (PRAC), bringing them in line with those of other EMA scientific committees to reflect the involvement of Members nominated by the EEA-EFTA countries in the PRAC following incorporation of Regulation (EU) 1235/2010 and Directive 2010/84/EU into the Agreement on the European Economic Area.

A.3 Implementing rules to the Financial Regulation applicable to the budget of the European Medicines Agency

[EMA/MB/100697/2014; EMA/61802/2014; EMA/MB/99010/2014] The Management Board adopted the Implementing rules to the Financial Regulation applicable to the budget of the European Medicines Agency. On 15 January 2014, the Management Board had adopted a new Financial Regulation for the Agency. The implementing rules are based on model implementing rules developed by an inter-agency and Commission working group. The European Commission has provided prior consent. The implementing rules shall apply as of 1 January 2014.

B. Points for discussion

B.1 Highlights from the Executive Director

Staffing for the 2015 work programme

The Executive Director sent a message to the Board about a recent development concerning reduction of staffing levels in decentralised agencies of the EU. This has repercussions on the EMA establishment plan and preliminary draft budget (PDB) for 2015, which will have to be discussed under Point B.6.

Outcome of the discharge procedure 2012

The European Parliament's Committee on Budgetary Control adopted the draft report for the discharge procedure for the financial year 2012 on 17 March 2014, proposing the granting of the discharge. The final adoption in plenary in Strasbourg is planned for April 2014.

Scientific Coordination Board

A meeting with the Scientific Coordination Board took place. Members took a tour of the new premises in Churchill Place, where meeting-room facilities and delegates' break-out areas were appreciated by the Chairs. The Committee for Medicinal Products for Veterinary Use (CVMP) will hold the kick-off meeting in the new building in July. The Chairs were consulted on the development of a 'one-stop shop' concept to foster early dialogue on product development. There was broad support, with requests for extension into later phases of development to allow knowledge transfer to be maintained. The Chairs also supported an initiative on professional development and continued education of experts/assessors across the network. The veterinary colleagues requested an extension of the 'multinational assessment team' pilot to co-rapporteurs at the CVMP, and this was agreed for initial marketing authorisations, at both the CVMP and the Committee for Advanced Therapies (CAT). Furthermore, the possibility to compensate NCAs for part-time chairs of the Committee for Medicinal Products for Human Use (CHMP), the CVMP and the PRAC could be explored.

Availability of detailed pipeline of submissions for centrally authorised products

As part of the business-pipeline-monitoring service, the Agency is proposing to accelerate the provision of information on upcoming centralised marketing authorisations, with an end-of-April report target to CxMP members and the Heads of Medicines Agencies (HMA), as well as increased transparency of content. It is hoped that this will facilitate forward planning of assessment resources across the network.

Access to SIAMED data

In the past, access to the procedure-tracking systems of the Agency could not be provided to NCAs, due to technical issues. A business-intelligence tool can now offer user-friendly access to information in the form of real-time or historic 'dashboards' (procedural timelines, assigned workload for NCAs, status of procedures, etc.). In the next few weeks, a pilot with interested NCAs will be organised, with a view to offering access to all NCAs very soon.

Payments to rapporteurs concerning applications with fee reductions

The scale of fees is based on a percentage share of the fee charged to the applicant from the pharmaceutical industry. However, for applications with fee reductions, actual euro amounts paid to NCAs differ, depending on the legal grounds for the reduction. Subject to the availability of funds, and in all cases where the workload for rapporteurs and co-rapporteurs is not reduced, the Agency would like to harmonise payments to NCAs and keep them financially neutral when a fee reduction is granted to the applicants. Reductions will be charged only to the EMA's part. For 2014, subject to all conditions being fulfilled, this would apply to the following cases:

- Fee Regulation 297/95 Article 9 (1st paragraph) (human and veterinary) - Reductions granted on case-by-case requests for exceptional circumstances and imperative public-health reasons.
- Minor uses, minor species (MUMS) (veterinary).
- Pandemic (human) scientific advice and post-authorisation (except annual fee).

Following the review of the budget, and if the budgetary trends are positive, a separate document on extending these payments will be presented to the Board in June.

Training

The current outlook on the 2015 budget might be further adjusted to allow further funds for training activities. The Agency has kicked off an initiative to set up and run professional development and continued education, capitalising on previous work done in the OTSG. The first step is the prospective collection of planned courses at the Agency and within the EU network, creating a two-year overall training calendar. This calendar will be made available through the use of an intuitive interface accessing a repository of available trainings. Christa Wirthumer-Hoche and Zaide Frias were appointed as co-chairs of the joint HMA/EMA OTSG initiative at the Athens HMA meeting.

EU telematics

As can be seen from the Agency's budget, around EUR 14 million of the IT budget relates to development and maintenance of telematics projects. The Agency aims to ensure that the development budget for telematics projects is agreed jointly with NCAs.

Adaptive licensing

When the topic of adaptive licensing was discussed at the Management Board in the past, the feedback received was very positive. Since then, there have been extensive discussions with the Commission, EMA committees, patient groups and informally with EU health-technology-assessment (HTA) representatives. It was concluded that an appropriate next step to explore the potential benefits and challenges of adaptive licensing pathways would be to invite industry to present 'live assets' for informal discussion; this should happen in a non-committal safe-harbour environment. An invitation for industry to engage in these discussions has now been published on the Agency's website.

International initiatives

The recent visit to Japan has highlighted how an integrated and coherent vision facilitates leadership in medical innovation. A strong political will to advance Japan as a global lead in drug development has led to a staff increase of 30% from 2009 to 2013, and to strengthen Japan's role as first authorising authority, particularly in the field of cell therapy. There is a risk that diverse research strategies and approaches to innovation, as well as national versus European fragmentation, could leave Europe further behind on innovation and access to medicines.

EMA/EC-FDA bilateral

The periodic meeting will take place at the EMA from 31 March to 1 April. Among the topics to be discussed is a request from the U.S. Food and Drug Administration (FDA) for increased inspection capacity. A strategic reflection is needed on how best to support bilateral and multilateral activities (ICH, IPRF, ICMRA, IGDRP).

B.2 Report from the European Commission

The representative of the European Commission provided an update on legislative and policy developments, including the following:

- Preparation of Delegated Act on Post-authorisation efficacy studies (planned publication Q2 2014).
- Progress with Joint Action SCOPE – Strengthening Collaboration for Operating Pharmacovigilance in Europe.

- Procedural aspects of fees for pharmacovigilance (planned applicability Q3 2014 for procedure-based fees and 1 July 2015 for annual fee).
- Report on the functioning of the Advanced Therapies Regulation expected to be adopted and published in March 2014.
- Implementing measures for the falsified medicines legislation (delegated act on the detailed rule for a unique identifier for medicinal products to be adopted end of 2014; delegated act on principles and guidelines of GMP for active substances in the EU planned for Q2 2014; establishment of a common EU logo for online pharmacies adoption before summer; guidelines on GDP for API and risk assessment for GMP excipients ongoing.
- Status of implementation of importation of active substances.
- Progress of Clinical Trials Regulation to be adopted in April and enter into force two years after publication.
- Draft legislative proposal for revision of veterinary medicines legislation planned for adoption during 2014.
- Initiatives on antimicrobial resistance in the human and veterinary sector.
- Status of legislation on revision of medical devices (MD) and in vitro diagnostic medical devices (IVD), first reading to be completed in April.
- Creation of a Health Technology Assessment Network started with a meeting in October 2013. All Member States and the EMA are involved. Cooperation between the EMA and EUnetHTA is ongoing at the scientific level.
- Progress with the e-Health network with first guidelines on sharing of patient summary data adopted November 2103 and Guidelines on ePrescription in preparation. Two Commission Decisions on European References Networks (ERN) have been adopted.
- Mutual recognition of prescriptions – transposition measures are currently under assessment.

The Board recommended timely implementation of practical arrangements for the administrative processing of the pharmacovigilance fees that are expected to become applicable as of August or September 2014 (July 2015 for the annual fee). Some members addressed the issue of advanced-therapy products under hospital exemption. It is important to strike the right balance between providing experimental innovative treatment to patients with severe diseases where processing in industrial facilities is not obtainable, and preventing commercial interests to avoid regulatory scrutiny. The representative of the European Commission pointed out that two types of legislation exist: ATMP, and tissues and cells. It might be interesting to further examine the interactions between these areas, but the way forward will be a matter for decision under the next Commission. Concerning safety features, the role of NCAs in supervision of the repository was considered unclear. The European Commission will provide further information. Finally, the Board was informed that the Italian Presidency will try to organise a common meeting between HMA and HTA bodies in Rome.

B.3 Annual report 2013

[EMA/MB/145678/2014; EMA/88206/2014] The Management Board discussed and adopted the Annual report 2013. As in last year's report, three essays, provided jointly by an expert from an NCA and a member of the EMA staff, highlight thought-leadership on current topics. The content of the report focuses on high-impact projects and initiatives, such as the implementation of new legislation, the reorganisation of the Agency, the instigation of a global debate on access to clinical-trial data,

collaboration with HTA bodies, reflection on the right balance in handling conflicts of interests, and attention to antimicrobial resistance and medication errors. Overall, the level of activities at the Agency was stable in 2013, despite a decrease by 17% of initial marketing authorisations, with 81 new recommendations and 45 safety reviews finalised for human products, and 12 positive opinions issued for veterinary medicines. Scientific advice and protocol assistance increased by 12%. Pharmacovigilance-related activities were high, reaching over 1 million adverse drug reactions reported to EudraVigilance (an increase of 26%), 2,449 signals reviewed (increase of 11%), 436 PRAC recommendations on periodic safety-update reports (PSURs), and 487 risk-management plans assessed.

B.4 Amending budget 01-2014

[EMA/MB/45191/2014] The Board adopted the amending budget. This was necessary due to a reduction in revenues, as the fee revenue for 2014 was estimated taking account of the full impact of the changes in the variations guideline as of 4 August 2013, as well as a 2.5% inflationary increase in fee levels. Following clarifications and interpretation of the variations guideline by the European Commission, these had to be revised with a decrease of EUR 5.8 million. A further decrease of EUR 2.2 million is due to the fact that inflation in the 2014 budget forecast was estimated at 2.5%, but has now been assessed by Eurostat to amount to only 1.5%. On the expenditure side, allocation to NCAs for evaluation work will consequently be reduced by an estimated amount of EUR 3.4 million. Furthermore, the correction coefficient for salaries adopted by the European Commission in January 2014 is set at 39.2, instead of at 48 as expected by the Agency. An adjustment of minus EUR 4.6 million was proposed as a consequence, with a total revenue and expenditure reduction in the 2014 budget of EUR 8 million.

B.5 Preliminary draft work programme 2015

[EMA/MB/121028/2014; EMA/80156/2014] The Management Board discussed and endorsed the preliminary draft work programme, providing comments that were noted and will be proposed in the next version of the document. This will be due for adoption in December 2014, in line with the normal cycle. The document will be discussed with the topic coordinators ahead of the December meeting.

The draft work programme 2015 is influenced by the global business environment trends. The high cost of R&D raises expectations by industry for predictability of regulatory decisions, and support to SMEs in a complex regulatory environment, if Europe intends to remain attractive for innovation. Globalisation is moving clinical trials and manufacturing to other world regions, straining inspection resources. The Agency intends to respond to these challenges by supporting early stages of medicines development through a 'one-stop shop' approach, facilitating provision of scientific advice, which has proven to have a positive effect on the outcome of marketing-authorisation applications and the availability of medicines to patients. The Agency intends to continue to focus on international collaboration among regulators, particularly in the field of inspections, and on openness and patient engagement, with its efforts concerning access to clinical-trial data. The Agency must further continue to manage increasing tasks stemming from new legislation, effectively managing complexity and constant growth in workload. Focus remains on delivering high-quality assessment activities and contributing towards building a strong network. This is dependent on NCAs being strong, healthy and adequately funded. The Agency intends to further develop its collaboration with the NCAs by developing IT systems that deliver benefit to the network through joint allocation of telematics funds, support to training initiatives, increased exchange of experts, and support to the multinational-assessment-teams initiative, facilitating participation of smaller NCAs in the centralised activities. Overall, the outlook for number of applications in 2015 is stable, with some increase expected for scientific-advice procedures and orphan-medicine designations. However, the complexity, including

interdependencies and interfaces between procedures, is rising. In post-authorisation, variations are likely to continue to increase moderately, while PSURs should increase significantly, due to the new pharmacovigilance provisions concerning nationally authorised products. Veterinary activities are expected to remain stable, with some increase in scientific advice and variations. Steady growth is forecast for inspections, particularly for good-manufacturing-practice (GMP) inspections. Workload dependent on transparency and access-to-document requests, as well as demands on legal services, are also expected to increase. Finally, in January 2015, there will be the 20th anniversary of the inauguration of the EMA.

Grzegorz Cessak, as topic coordinator, provided the Board with an analysis of the priorities and key objectives in the draft work programme. He highlighted the focus on efficient use of resources, which sees cooperation with international and European partners as the basis for efficiency, and recommended the endorsement of the document to the Board.

In the discussion that followed, the representative of the patients' organisations suggested putting greater emphasis in the work programme on initiatives to provide faster access to medicines for patients, e.g. through adaptive licensing, as well as mentioning work on shortages and the needs of special groups, such as the elderly. Concerning the need for strengthening scientific advice, it was mentioned that this is also carried out at the NCAs, and engagement by all is needed to achieve progress. Furthermore, the inclusion of simplification initiatives on some processes and interactions would be desirable. While the ambitions, priorities and objectives of the work programmes were fully supported by all, some members pointed out the connection between the Agency's work programme and the work programmes of individual NCAs. These are affected by the objectives set out by the Agency, and the work programme should reflect this fact in an even more explicit reference to the contribution of the network, providing adequate visibility on its efforts.

The Agency noted all comments and will provide an updated version of the document at the next occasion at which it will be discussed by the Board.

B.6.a Preliminary draft budget and establishment plan 2015

[EMA/MB/120006/2014; EMA/MB/651/2014] The Management Board discussed and endorsed the preliminary draft budget (PDB) and establishment plan 2015, with the understanding that the current version will be substituted by an amended document, reducing the overall number of temporary posts to remain at the 2014 level of 599, while increasing the number of contract agents by 20, as well as modifying a position grading in the establishment plan. This was necessary due to a very recent communication by the European Commission. An amended version of the document will be circulated to the Board after the meeting.

Compared to the budget 2014, the PDB 2015 increases by 2.2%. It presents a reduction of 15.8% in the EU contribution and of 18.7% in assigned revenue, while revenue from fees increases by approximately EUR 16 million, or 7.3%. IT expenditure has been reduced as the IT requirements for the new premises are planned to be completed in 2014, but includes provisions for systems related to the new clinical-trials legislation. The share of IT expenditure for network rather than corporate systems has been steadily increasing, and amounts in 2015 to 54% of total expenditure, of which 62.5% for development within telematics projects. Similarly, allocations for network-related activities (scientific evaluation, meetings, workshops and training, national experts as well as telematics) total over EUR 140 million.

The topic coordinators Klaus Cichutek, Grzegorz Cessak and Kristin Raudsepp presented their analysis of the PDB 2015 and proposed its endorsement. They considered that while the overall budget increases by 2% compared to 2014, if the relocation effect is excluded, the so-called 'workable budget'

is reduced by 4% compared to 2014. The main increases in revenue stem from the new fee income due the pharmacovigilance fee regulation and from inflationary adjustments. Of these, the main expenditure is payments to NCAs. The increase in number of national experts was welcomed. An increase in the EMA staff allocation can be supported subject to an increase in the workload. Activity-based budgeting should continue, and provide more transparency to the Management Board, as well as contribute to an integrated view of the whole network. The German Board member presented his Member State's objection to the endorsement of the PDB on instruction by his Ministry of Finance.

B.6.b Multi-annual staff policy plan 2015-2017

[EMA/MB/120236/2014; EMA/120424/2014] The multi-annual staff policy plan is an overview document that is provided to the European Commission for planning purposes. The plan will be updated according to the endorsed preliminary draft budget and establishment plan 2015.

B.7 Revised implementing rules to the Fee Regulation as of 1 April 2014

[EMA/MB/785541/2013; EMA/MB/153694/2014; EMA/145687/2014] The Management Board adopted the revised implementing rules to the Fee Regulation as of 1 April 2014. In accordance with legal provisions on adjustment to inflation, all fees are increased by an inflation rate of 1.5%, rounded up to the nearest EUR 100, or EUR 10 for administrative changes. Furthermore, amendments to Annex III (new fee for notification of bulk changes in notifications of parallel distribution) and Annex VII (exemptions from payment of fees for applications for MUMS, certain activities by SMEs, bluetongue vaccines) are included, along with some clarifications.

B.8.a Update on the implementation of pharmacovigilance legislation proposed principles for improving the RMP process

The Board noted an update on implementation of the pharmacovigilance legislation. The issue of a possible revision of the risk-management plan (RMP) process after the experience of 12 months in operation has been discussed on various occasions. Several options have been developed by the CHMP and the PRAC. Since the preferred options were not aligned, the Agency's secretariat has been looking for a solution and discussed options with the (vice-)chairs of both Committees. A solution is now being considered that will take into consideration the workload in pharmacovigilance departments at the NCAs, and for all parties involved. In April/May, a new proposal will be presented to the PRAC and CHMP, and then discussed at the May HMA meeting and June Management Board meeting.

B.8.b PSUR single-assessment procedure for NAPs

[EMA/MB/141196/2014; EMA/146102/2014] The Management Board endorsed a proposal on handling of single assessment of PSURs (PSUSAs) for nationally authorised products (NAPs). The Agency has now proposed to accept submissions as originally foreseen. Cooperation by the NCAs with transitional support was requested until certain systems are fully functional (1Q 2015). Pilots on PSUSAs with cantrally authorised products (CAPs) and NAPs will start immediately.

B.9 Report by the CHMP Chair

Tomas Salmonson, chair of the Committee for Medicinal Products for Human Use (CHMP), presented his views on the current situation of the CHMP to the Board. In general, the Committee works well and can count on many committed members, who are willing to take up even unpaid work. Since the creation of the PRAC, work inthe CHMP has decreased, and even more attention can be given to quality of opinions. The Scientific Advice Working Party (SAWP) is particularly active, and processes

approximately 200 procedures in a year. Thought should also be given to developing post-approval scientific advice and expanding the range of competence. The SAWP's structure seems to contribute to its success, as the workplan is agreed first, and afterwards the group is populated with experts. Interactions with other committees are good, also because of some overlaps in composition. Some processes could be improved, such as the RMP process currently under discussion at the PRAC and CHMP. The new organisation at the Agency was highly needed, as it was developed 20 years ago, when the organisation was new. The Chair of the CHMP supported the separation of procedural and scientific support, which should benefit committee functionality. Interaction with other organisations is an area where support from the EMA is very useful. The Agency has worked a lot on transparency and has an intensive dialogue with HTA bodies, helping to explain positions in ways that can be used in relative-effectiveness discussions. New approaches to post-authorisation efficacy studies (PAES) and adaptive licensing mean that the Committee must work with other stakeholders, in particular with patients, who do not have voting rights, but can provide direct advice on products. The current model is sustainable, thanks also to the Agency's administrative support to the multinational-teams initiative. This allows for a better allocation of scientific resources, which benefits not only small NCAs, as even larger NCAs might sometimes need additional experts to complete a team. This is not only perceived as an optimisation of resources, but also as a way of working according to a European spirit. There is, however, a general sense that some NCAs are under pressure, and financial contribution from the EMA for currently unremunerated work would be welcome. In conclusion, the Committee is proud of its work and feels very much part of the rather complex EU regulatory system.

Members of the Board were appreciative of the work done in the CHMP. A representative of the European Parliament thanked the Chair for the guidelines on Alzheimer's disease, and suggested that a guideline on antidepressant medicines for elderly patients is also needed, which the Chair noted. The Chair of the CHMP further assured members that, with support from the EMA, cooperation with the FDA is good, as divergent decisions can be explained. There may, however, be some problems for the external world in understanding the interaction and different roles of the PRAC and the CHMP. Concerning quality of opinions, there seems to have been significant improvement; however, early access to regulatory/legal advice would improve interaction with the European Commission. The Executive Director welcomed support from the Chair of the CHMP on separation of regulatory and scientific activities, and assured him that implementation of the reorganisation is proceeding on target. Further support to the CHMP members will be available through detailed early pipelines and through access to procedural tracking-system data, allowing for better planning and managing of procedures at the NCA level. Concerning financial support, the Agency is looking into the matter and is working on identifying budgets saved through efficiency gains, along with finding the appropriate provisions.

B.10 Draft revised EMA policy on the handling of declarations of interests of scientific committees' members and experts

EMA/MB/144336/2014; EMA/145339/2014; EMA/513078/2010] The Management Board endorsed the revised EMA policy on the handling of declarations of interests of scientific committees' members and experts. The revised policy takes into account the outcome of the 6 September 2013 EMA public workshop 'Best expertise vs conflicts of interests: Striking the right balance'. The nature of declared interests has been organised in three categories, determining different consequences in the extension of conflict over time and in the involvement in EMA activities. Key definitions and concepts were revised. Among these, a much debated distinction on the recipients of grants or funds from organisations and institutions was achieved. A first impact assessment has been conducted on four scientific committees and two scientific advisory groups, leading to different restrictions than the ones previously applied, but not changing on balance the ability of the groups to perform. The main changes

to the current policy will be explained in the revised policy and a guidance document (currently being drafted), which will be published shortly.

The Board supported the new revised policy, which was perceived to bring a more balanced approach, particularly with regard to experts in academia. The representative of the European Commission stressed the importance for clear communication of the new policy and suggested aligning the wording of the document with the memorandum of understanding with the NCAs regarding the responsibility of NCAs for national experts. Further, the representative of the Commission suggested providing information in EMA's annual report on mitigating measures applied where situations of conflicts of interests have arisen. The Agency explained that, while NCAs remain responsible for staff at a national level, it will now be required from the (co-)rapporteur to declare that all experts in the team comply with the minimum requirements of the EMA policy.

B.11 Draft EMA policy on the publication of and access to clinical-trial data

The Board noted the progress made on the draft policy on proactive publication of clinical-trial data. After endorsement by the Management Board at its December 2013 meeting of a set of key principles, two workstreams have worked to draw up a managed publication process for clinical summary reports, a set of limited exceptions to the concept of commercially confidential information in CSRs and a consultation process with the marketing-authorisation holder in case of disagreement. A targeted consultation with key stakeholders will next take place in May on the further developed principles.

The final policy will be presented to the Management Board for endorsement at its June 2014 meeting.

A representative of the European Commission stated that they consider this topic to be complex and multi-faceted; therefore, some other parameters should be evaluated before proceeding to any final decisions, such as interaction with the TRIPS Agreement and the European patent system. In addition, it was proposed to include among the parties to be consulted SMEs specialising in innovative projects and other agencies, notably the European Chemicals Agency, to ensure that there will be no precedents set that could affect them.

B.12 Fourth annual report on the veterinary MUMS/limited market scheme

[EMA/MB/102900/2014; EMA/14945/2014] The Management Board endorsed the fourth annual report on the operation of the veterinary MUMS/limited-market scheme. The report provides information on the operation of the scheme, which represents joint activity between the Agency and the regulatory network intended to increase the availability of veterinary medicines. Under the policy, there has been an increase in demand for classification of products as MUMS/limited market by the CVMP, which allows applicants to access a range of incentives for authorisation of MUMS products. To ensure that public funds are directed to products of most benefit to animal and human health, since September 2013, financial incentives have been restricted to food-producing animals only, and the effect of this measure is being monitored. A review of the policy is ongoing and will be presented to the Management Board at a later meeting.

4. A.O.B.

Documents for information

- [EMA/MB/130082/2014] Update on Telematics from the EU Telematics Management Board (EU TMB).
- [EMA/MB/9624/2014] Outcome of written procedures finalised during the period from 22 November 2013 to 21 February 2014.
- [EMA/MB/85740/2014] Summary of transfer of appropriations in the budget 2013.
- [EMA/MB/143919/2014; EMA/145085/2014] EudraVigilance report 2013 for human medicinal products.
- [EMA/MB/121745/2014] Overview of Staff Regulation implementing rules signed by the MB Chair during the period from 16 November 2012 to 26 February 2014.

Written procedures from 22 November 2013 to 21 February 2014

- Consultation no. 21/2013 on the appointment of Helen Vella as CHMP alternate, proposed by Malta, ended on 4 December 2013. The mandate of the nominee commenced on 5 December 2013.
- Consultation no. 01/2014 on the appointment of Dimitrios Kouvelas as CHMP member, proposed by Greece, ended on 14 February 2014. The mandate of the nominee commenced on 15 February 2014.
- Written procedure for adoption of the new EMA Financial Regulation ended on 15 January 2014. The new EMA Financial Regulation was adopted.
- Written procedure for adoption of 82nd Management Board meeting minutes ended on 7 February 2014. The minutes were adopted.

List of participants at the 83rd meeting of the Management Board, held in London, 19-20 March 2014

Chair: Sir Kent Woods

	Members	**Alternates (and other participants)**
Belgium	Xavier De Cuyper	
Bulgaria	*Apology received*	
Czech Republic	Doubravka Kostalova	
Croatia		Viola Macolić Šarinić
Denmark		Nina Moss
Germany	Walter Schwerdtfeger	Klaus Cichutek
Estonia	Kristen Raudsepp	
Ireland		Rita Purcell
Greece	Katerina Fameli	
Spain	Belén Crespo Sánchez-Eznarriaga	Laura Franqueza García
France	Dominique Maraninchi	Miguel Bley Jean-Claude Ghislain
Italy	Luca Pani	Pietro Erba
Cyprus		Ioannis Kkolos
Latvia	Inguna Adoviča	
Lithuania	Gintautas Barcys	
Luxembourg	*Apology received*	
Hungary	Beatrix Horváth	
Malta		Gavril Flores
Netherlands		Constant van Belkum Birte van Elk
Austria	Christa Wirthumer-Hoche	
Poland	Grzegorz Cessak	Magdalena Pajewska
Portugal	Hélder Mota-Filipe	Maria Morais
Romania		Marius Tanasa
Slovakia	Jan Mazág	
Slovenia	Matej Breznik	Katarina Štraus
Finland		Pekka Kurki
Sweden		Bengt Wittgren
United Kingdom		Ian Hudson Jonathan Mogford
European Parliament	Giuseppe Nisticò Björn Lemmer	
European Commission	Gwenole Cozigou (DG ENTR)	Andrzej Rys (DG SANCO) Sabine Juelicher (partly) Olga Solomon (partly) Miroslav Griva Chloe Spathari
Representatives of patients' organisations	W.H.J.M. Wim Wientjens Nikos Dedes	

	Members	Alternates (and other participants)
Representative of doctors' organisations	Wolf-Dieter Ludwig	
Representative of veterinarians' organisations	Christophe Hugnet	
Observers	Rannveig Gunnarsdóttir (Iceland) Brigitte Batliner (Liechtenstein) *Apology received* (Norway)	

European Medicines Agency	Guido Rasi Andreas Pott Noël Wathion Hans-Georg Eichler Agnès Saint Raymond Stefano Marino David Mackay Luc Verhelst Zaïde Frias Enrica Alteri Alexis Nolte Fergus Sweeney Nerimantas Steikūnas Michael Lenihan Tony Humphreys Sylvie Benefice Isabelle Moulon Martin Harvey Allchurch Monika Benstetter Dina Tsiambaou Silvia Fabiani Sophia Albuquerque	

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EUROPEAN MEDICINES AGENCY
SCIENCE MEDICINES HEALTH

Draft EMA policy on publication of and access to clinical trial data – Update report

Management Board, topic B.11
20 March 2014

Presented by: Noël Wathion

December 2013 MB outcome (1/3)

- MB endorsed the proposed principles to finalise the EMA draft policy in terms of
  - The scope of the policy
  - A stepwise approach for implementation of the policy

December 2013 MB outcome (2/3)

- Endorsed principles in terms of the scope:
  - Clinical trial (CT) data are composed of CSRs (Clinical Study Reports) and IPD (Individual Patient Data)
  - CT data are submitted as part of a MAA, a variation procedure, or requested as additional CT data, after the "effective" date
  - Legacy data are handled in accordance with the EMA Access to Documents policy

December 2013 MB outcome (3/3)

- Endorsed principles in terms of the stepwise implementation of the policy:
  - First phase: publication of CSRs, subject to certain preliminary steps
  - Second phase: discuss with stakeholders the concept of IPD

Progress made (1/6)

- Focus on the first phase through 2 workstreams:
  - Workstream 1: Introduce a managed publication process for CSRs
  - Workstream 2: Re-confirm the concept of CCI and its application

Progress made (2/6)

- Workstream 1:
  - Objective: Introduce a managed publication process for CT data
  - Deliverables:
    - Terms of use (ToU) which govern the access to and use of CT data
    - Technical tool

Progress made (3/6)

- Workstream 1 (cont'd):
  - ToU characteristics:
    - Definition of CT data: CSRs (Module 5) + Clinical Overviews (Module 2.5) + Clinical Summaries (Module 2.7) + Appendices to CSRs No. 16.1.1, 16.1.2 and 16.1.9
    - Information available in "view-on-screen-only" mode
    - Information may be used for information, research and other non-commercial purposes
    - Information may not be used to support an application for MA or make any unfair commercial use of information

Progress made (4/6)

- Workstream 1 (cont'd):
  - Technical tool characteristics:
    - Very user-friendly system
    - Simple procedural requirements
      - User ID/password
      - Acceptance of ToU ("view-on-screen-only", not downloadable, not printable)
      - Watermark to emphasise the proprietary nature of the information
    - Basically, all means foreseen aiming at preventing commercial/regulatory use of the information

Progress made (5/6)

- Workstream 2:
  - Objective: Re-confirm the concept of CCI
  - Deliverable: Guidance document elaborating on
    - Redaction principles, complementing the use controls that need to be accepted (see workstream 1)
    - Procedural mechanism to conduct the redactions of CT data

Progress made (6/6)

- Workstream 2 (cont'd):
  - Characteristics:
    - Redaction principles:
      - Most of info in CT data is not CCI
      - Limited circumstances may lead to exceptions (examples listed)
    - Procedural mechanism for redaction:
      - Simple process based on the redaction principles
      - Consultation phase with pharmaceutical companies is foreseen

MB is invited

- To note progress made, in particular as regards the further elaboration of already endorsed principles
- To note the following next steps:
  - Targeted consultation over the next weeks with key stakeholders on the further developed principles
  - Presentation of revised draft policy for endorsement at the June 2014 MB meeting, together with a high-level implementation plan (the latter for information)

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EUROPEAN MEDICINES AGENCY
SCIENCE MEDICINES HEALTH

19 May 2014
EMA/240810/2013

European Medicines Agency policy on publication of clinical data

POLICY/0070
Status: Draft for endorsement
Effective date: 1 October 2014
Review date: No later than March 2016
Supersedes: Not applicable

1. Introduction and purpose

The aim of the European Medicines Agency ('the Agency') is to protect and foster public health. Transparency is a key consideration for the Agency in delivering its service to patients and society.

Although the Agency has since its creation launched several initiatives to increase transparency of information on medicinal products, there is growing demand from stakeholders for full transparency, not only about the Agency's deliberations and actions, but also about the clinical data on which regulatory decisions are based. The Agency is committed to continuously extend its approach to transparency and has, therefore, taken the initiative to develop a policy on publication of clinical data, in accordance with article 80 of Regulation (EC) No 726/2004[1]. Consultations with a broad range of stakeholders and European Union (EU) bodies have taken place in drafting this policy. It should be noted that this policy complements the existing 'Policy on access to documents (related to medicinal products for human and veterinary use)' (POLICY/0043) (EMA/110196/2006), which came into effect in December 2010[2].

[1] Regulation (EC) No 726/2004 of the European Parliament and of the Council of 31 March 2004 laying down community procedures for the authorisation and supervision of medicinal products for human and veterinary use and establishing a European Medicines Agency.
[2] To ensure consistency, the existing policy on access to documents will be aligned with this policy on publication of clinical data.

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2. Scope

The scope of the policy relates to clinical data, composed of clinical study reports (CSRs) including individual patient data (IPD). In particular, the policy relates to clinical data submitted under the centralised marketing authorisation procedure after the effective date (see section 4.3. for further information):

- as part of a marketing authorisation application (MAA);
- or as part of a post-authorisation procedure for an already centrally authorised medicine;
- or as part of a referral procedure for a centrally authorised product;
- or requested by the Agency/ submitted by the applicant/marketing authorisation holder (MAH) as additional clinical data in the context of the scientific assessment process for the aforementioned situations.

The following clinical data are not covered by the scope of the policy:

- Clinical data currently held by the Agency for medicinal products authorised under the centralised procedure before the "effective" date (hereafter referred to as legacy data).
- Clinical data (either legacy data or data not yet held by the Agency) submitted to the Agency for non-centrally authorised products.

These clinical data continue to be made available to external requesters on a reactive basis in accordance with the aforementioned Agency's policy on access to documents. For the legacy data described above, the MAH may take the initiative to resubmit the clinical data for medicinal products already authorised under the centralised procedure, which will then be published.

In addition, the following clinical data are not covered by the scope of the policy:

- Clinical data that are not held by the Agency, even if they concern a medicinal product that has been authorised by the Agency (e.g. clinical trials on an authorised product conducted by independent investigators and not submitted to the Agency).
- Pharmacovigilance data based on Individual Case Safety Reports (ICSRs). Access by third parties to ICSR data is addressed in the Agency's 'EudraVigilance access policy for medicines for human use' (EMA/759287/2009 corr.).
- Clinical data held by the Agency under the scope of the Clinical Trials Directive 2001/20/EC[3] or the Clinical Trial Regulation (EC) No xxxx/2014.

3. Definitions

- **Clinical data:**

In the context of this policy, clinical data shall mean the CSR including IPD.

- **Clinical study:**

Clinical study shall mean any investigation in relation to humans intended to:

[3] Directive 2001/20/EC of the European Parliament and of the Council of 4 April 2001 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use.

- discover or verify the clinical, pharmacological or other pharmacodynamic effects of one or more medicinal products;
- identify any adverse reactions to one or more medicinal products; or
- study the absorption, distribution, metabolism and excretion of one or more medicinal products;

with the objective of ascertaining the safety or efficacy of those medicinal products.

- **Clinical study report (CSR):**

CSR shall mean a clinical study report presented in a searchable format, submitted in Module 5 of a MA or in any subsequent post-authorisation submissions.

- **Individual patient data (IPD):**

IPD shall mean the individual data separately recorded for each participant in a clinical study.

- **Personal data:**

Personal data shall mean any information relating to an identified or identifiable natural person ('data subject'); an identifiable person is one who can be identified, directly or indirectly, in particular by reference to an identification number or to one or more factors specific to their physical, physiological, mental, economic, cultural or social identity (Article 2(a) of Regulation (EC) No 45/2001).

- **Commercially confidential information (CCI):**

For the purpose of the policy, CCI shall mean any information that is not in the public domain or publicly available and where disclosure may undermine the legitimate economic interest of the owner of the information. CCI falls broadly into two categories: trade secrets (including formulas, programs, process or information contained or embodied in a product, etc.) and commercial confidences.

4. Policy statement

The following aspects are addressed in this policy:

- Objectives of the policy.
- Characteristics of the policy.
- Date of coming into effect of the policy.

4.1. Objectives of the policy

The main objectives of the policy are to enable public scrutiny and secondary analysis of clinical data. A high degree of transparency will take regulatory decision-making one step closer to EU citizens, and promote better-informed use of medicines. In addition, the Agency takes the view that access to clinical data will benefit public health in future. The policy has the potential to make medicine development more efficient by establishing a level playing field that allows all medicine developers to learn from past successes and failures. Furthermore, it will enable the wider scientific community to make use of detailed clinical data to develop new knowledge in the interest of public health. Access to clinical data will allow third parties to verify the original analysis and conclusions, to conduct further analyses, and to examine the regulatory authority's positions and challenge them where appropriate.

The Agency also takes the view that transparency should be mutually respected. Those who make secondary use of clinical data, published in accordance with this policy, must be held to the same

standard of transparency as those who generate clinical data in the first place. Hence, all secondary analyses shall also be in the public domain and accessible for further scrutiny by the scientific community. In addition, the Agency should be provided with a copy of any article resulting from such secondary analysis before publication, in particular in those circumstances where the secondary analysis might result in the need for regulatory action to protect public health. This is a critical consideration in view of the Agency's role and responsibilities for a timely review of all available information which might have an impact on the benefit/risk ratio of centrally authorised products.

The Agency cannot guarantee that all secondary data analyses that are enabled by the policy will be conducted and reported to the highest possible scientific standard; this is not possible with a truly open approach.

Allowing external parties access to clinical data held by the Agency will directly or indirectly affect different stakeholders' rights, interests and values. In developing this policy the Agency had to consider a number of competing principles which needed to be carefully balanced in order to best ensure the overarching, long-term goal of protecting and fostering public health. These principles, as well as the Agency's positions and views, are described below:

- **Protecting personal data:**

The protection of personal data is enshrined in EU legislation; it is a fundamental right of EU citizens. The policy has to ensure adequate personal data protection; it must be fully compliant with applicable regulations in the EU, in particular Regulation (EC) No 45/2001 and Directive 95/46/EC. There are ways and means to anonymise data and protect patients from retroactive identification. Yet, the Agency is concerned that emerging technologies for data mining and database linkage will increase the potential for unlawful retroactive patient identification. The Agency, therefore, takes a guarded approach to the sharing of patient-level data, which is done to enable legitimate learning from sharing patient-level data while preventing rare but potentially damaging instances of patient identification. Furthermore, patients' informed consent should be respected.

- **Protecting CCI:**

The Agency respects and will not divulge commercially confidential data or information. In general, however, clinical data cannot be considered CCI. The Agency acknowledges that there are limited circumstances where information could constitute CCI.

- **Protecting the Agency's and the European Commission's deliberations and decision-making process:**

Regulators have a legal mandate to evaluate medicines. In doing so, they should only focus on the science and the best interests of patients. The decision-making process should be protected against external pressures from whatever direction. Once a decision has been reached, this consideration no longer applies.

- **Ensuring future investment in bio-pharmaceutical research and development (R&D):**

Sustained and extensive bio-pharmaceutical research activity is a precondition for future improvements in public health. The policy has no intention to negatively impact on the incentives to invest in future bio-pharmaceutical R&D. It is designed to guard against unintended consequences, e.g. breaches of intellectual property rights that might disincentivise future investment in R&D.

4.2. Characteristics of the policy

The main characteristics of the policy are:

- Introduction of a managed publication process for clinical data.
- Management of CCI in clinical data.
- Methods for balancing the protection of patients' privacy whilst retaining scientific value of the data.
- Stepwise implementation of the policy.

4.2.1. Introduction of a managed publication process for clinical data

The introduction of a managed publication process for clinical data is based on 2 pillars:

- Terms of use (ToU) which govern the access to and use of clinical data.
- A technical tool allowing access to such clinical data.

The ToU, attached as annex 1, provide more information in relation to the access to the information and the use of such information. Particular aspects to be highlighted relate to the fact that the information is made available in a "view-on-screen-only" mode after completing a registration process, as described below. This means that the information cannot be downloaded, saved, printed, distributed, transferred. Furthermore, no attempt can be made to re-identify the trial subjects or other individuals from the information. The information cannot be used to support a MAA nor to make any unfair commercial use of such information.

In addition, a technical tool will be available to allow access to such clinical data. This technical tool will be a user-friendly system, with simple procedural requirements in terms of firstly obtaining a user ID or password, secondly the acceptance of the aforementioned ToU by the person wanting access to the clinical data, and finally the availability of a watermark on the published information to emphasise the proprietary nature of the information.

These two pillars should allow to prevent unfair commercial use/the use of such information for regulatory purposes.

4.2.2. Management of CCI in clinical data

Although generally the information contained in clinical data should not be considered CCI, the Agency acknowledges that in limited circumstances such information could constitute CCI, and could, therefore, be subject to redaction prior to publication. Where redaction of information considered to contain CCI is proposed, a consultation with the applicant/MAH will be undertaken, following scrutiny by the Agency of the proposed redaction including the justification.

4.2.2.1. Redaction principles

The clinical data that will be published in accordance with this policy shall only be subject to redactions when needed to protect those specific elements which qualify as CCI that should not be released. This complements the aforementioned use controls that will need to be accepted by recipients of the documents in order to protect the originator against misuse of the data as a whole. This covers information that is not in the public domain or publicly available and where disclosure may undermine the economic or competitive position of the owner of the information. In this regard, the assessment of this information will also take into account the evidence shown by the information owner with regard to various factors, including the nature of the product concerned, the competitive situation of the

therapeutic market in question, the approval status in other jurisdictions, the novelty of the clinical development, and new developments by the same company.

In general, as already mentioned, most of the information in CSRs would not be considered CCI. There, are, however, limited circumstances where such information could constitute CCI.

Exceptions to the general principle that CSRs are not CCI are included in the table provided as annex 2. The information described in these exceptions may have to be redacted as per the aforementioned redaction principles, after assessment by the Agency of the justification provided by the applicant/MAH. If justification for additional redaction going beyond these exceptions is provided by applicants/MAHs in the future, the Agency will discuss with pharmaceutical industry whether to revise the attached table with the new proposed redaction, based on real life experience (including applicants'/MAHs' comments) following the implementation of this policy.

4.2.2.2. Process for publication of CSRs

The process for publication of CSRs is described in annex 3. This process foresees in consultation with the applicant/MAH in case EMA disagrees with the redaction proposed by the applicant/MAH.

4.2.3. Methods for balancing the protection of patient's privacy whilst retaining scientific value of the data

Protection of patients' identity is of crucial importance. In order to achieve this objective both identification and re-identification of patients need to be avoided. Particular challenges in this respect are continuous developments in the field of technologies relating to data mining and database linkage, as well as specific scenarios to be considered in the area of medicine regulation, for instance the situation of rare diseases. In deciding on the most optimal approach (anonymisation versus pseudonymisation) the Agency will take due account of recent developments, e.g. the work undertaken by the network of EU Data Protection Authorities on anonymisation techniques[5], and subsequently discuss with stakeholders (e.g. patients' organisations, academia, pharmaceutical industry) to agree on the best way forward.

4.2.4. Stepwise implementation of the policy

The implementation of the policy will be undertaken in a stepwise manner:

- In a first phase, the publication of clinical data will relate to CSRs only.
- In a second phase, IPD will be made available.

4.2.4.1. First phase: publication of CSRs

The publication of CSRs will be in accordance with the arrangements described in sections 4.2.1., 4.2.2. and 4.2.3. of the policy.

In addition, the following principles will apply:

- **Elements of the CSRs to be published:**

[5] Opinion 05/2014 on anonymisation techniques, adopted on 10 April 2014 by the Article 29 Data Protection Working Party.

The elements of the CSRs that will be published are module 2.5 (clinical overview), module 2.7 (clinical summary), module 5 (clinical study reports and appendices 16.1.1 (protocol and protocol amendments), 16.1.2 (sample case report form) and 16.1.9 (documentation of statistical methods)).

- **Timing of publication:**

The timing of publication takes into account the need to protect the Agency's and the European Commission's deliberations and decision-making process. In order not to undermine such decision-making process the Agency will only publish clinical data once the concerned procedure has been finalised. In practical terms this means:

- following the European Commission Decision granting or refusing the marketing authorisation (MA)/post-authorisation submission outcome; or
- following the scientific committee Opinion if there is no subsequent European Commission Decision; or
- following the scientific committee conclusion if there is no Opinion;
- following receipt of the applicant's/MAH's letter notifying the withdrawal of the MAA/post-authorisation submission.

The process described in section 4.2.2.2. for publication of CSRs, including where necessary interaction with the applicant/MAH, will start following the adoption of the scientific Committee Opinion/conclusion or the receipt of the withdrawal letter, as referred to above.

4.2.4.2. Second phase: making available IPD

Before IPD can be made available, there is a need to first clarify the concept of IPD in terms of:

- when to submit IPD for subsequent scientific review by the Agency, and
- how to best provide access to such IPD, including the conditions to be fulfilled.

It is important to emphasise in this regard that the Agency will not request applicants/MAHs to submit IPD for the sole purpose of publication of IPD.

The Agency will first undertake a targeted public consultation with all concerned stakeholder on the concept of IPD to provide clarification on the aforementioned aspects. Subsequently, the policy will be amended to reflect the outcome of this targeted public consultation.

4.3. Date of coming into effect of the policy

For the coming into effect of the policy a stepwise approach will be applied. The effective date will be:

- 1 October 2014 for any new MAAs under the centralised procedure submitted as of that date.
- 1 January 2015 for applications for new indications. For these variation procedures a 6 months' pilot phase will be undertaken to acquire further experience, after which a decision will be taken with respect to the effective date for all post-authorisation procedures relating to centrally authorised products where supporting clinical data have been submitted.
- 1 July 2015 for those legacy data relating to centrally authorised products where the MAH takes the initiative to resubmit the clinical data for already authorised medicines under the centralised procedure.

As regards the effective date for making available IPD, this will be determined following the amendment of the policy as referred to in section 4.2.4.2.

5. Related documents

European Medicines Agency policy on access to documents (POLICY/0043) (EMA/110196/2006).

6. Changes since last revision

Not applicable, new policy.

The impact of the policy shall be assessed and the policy revised as appropriate not later than 18 months after coming into effect.

London, <DD Month YYYY>

Guido Rasi

Executive Director

Annex 1

Term of Use

These Terms of Use ("***Terms***") govern the access and use of clinical data, as defined in section 2. of the EMA policy on publication of clinical data, Policy 0070 ("***Policy***"), that are made available to Users via such Policy. By accepting these *Terms* and upon being granted access to the Information, you agree to be bound by these *Terms*. Please read them carefully.

1. Definitions

In these *Terms* the terms below have the following meaning:

"**EMA**" means the European Medicines Agency.

"**Information**" means the Clinical Study Reports (Module 5, "CSR"), clinical overviews (Module 2.5) and clinical summaries (Module 2.7), together with Appendixes to the CSRs no. 16.1.1, 16.1.2 and 16.1.9 which are accessible via the *EMA* web-site as a result of the implementation of the Policy.

"**Information Owner**" means the natural or legal person(s) or organisation(s) that submitted the *Information* to the *EMA* in the context of applications in support of centralised marketing authorisations/post-authorisation submissions under Regulation (EC) No 726/2004, as well as any person(s) or organisation(s) who owns copyright or other intellectual property or proprietary rights in the *Information*.

"**User**" means the natural or legal person or organization who, having registered with the EMA's web-site in connection with the implementation of the Policy, receives access to the *Information*.

2. Access to the information under the policy

The *User* acknowledges that the *Information* is protected by copyright and proprietary rights of the *Information Owner* and can be considered commercially valuable when used for commercial and regulatory purposes.

The *User* acknowledges that the *Information* will be made available to the *User* in a "view-on-screen-only" mode, after completing the registration process. The *User* agrees that the *User* is not permitted to download, save, edit, photograph, print, distribute or transfer the *Information*. The *User* agrees not to access the *Information* using a method other than the interface provided by the *EMA*, or remove, bypass, circumvent, neutralise or modify any technological protection measures which apply to the *Information*.

3. Use of the information

The *User* agrees to use the *Information* according to these *Terms* and, in particular, that:

a) The *User* may use the *Information* solely for information, research and/non-commercial purposes, subject to these *Terms*.

b) The *User* is not granted any intellectual property or other commercial rights in relation to the *Information* other than as expressly set out in these *Terms*.

When using the *Information*, the *User* shall:

a) acknowledge its source and include any attribution statement specified by the *Information Owner*;

b) not use it in a way that suggests that the *Information Owner* endorses the *User* or the *User's* use of the *Information* for any other purpose than information, research and other non-commercial purposes;

c) ensure that the use of the *Information* complies at all times with applicable law;

d) not misrepresent the source of the *Information*;

e) not seek to re-identify the trial subjects or other individuals from the *Information* in breach of applicable privacy laws.

The *User* may not:

- use the *Information* to support an application to obtain any kind of regulatory and subsequent approval for a product anywhere in the world;
- share the *User's* username, password or other account details with a third party or otherwise provide a third party with access to the *User's* account;
- make any unfair commercial use of the *Information*.

If the *User* fails to accurately complete the registration process, comply with these conditions, or uses the *Information* in breach of these *Terms* of Use, the rights to access and use the *Information* will be revoked.

4. Warranties and liability

Without prejudice to any obligation of the marketing authorisation holders/applicants in accordance with the Union legislation:

- The *EMA* and the *Information Owner* exclude all representations, warranties, obligations and liabilities in relation to the *Information* as accessible via the *EMA* web-site to the maximum extent permitted by law;
- Neither the *EMA* nor the *Information Owner* are liable for any errors or omissions in the *Information* as provided via the *EMA* web-site and shall not be liable for any loss, injury or damage of any kind caused by its use.

5. Third party rights

The restrictions and conditions and the warranty and liability provisions of these *Terms* are also made for the benefit of any and all *Information Owners* and, accordingly, each such *Information Owner* may in its own right enforce these *Terms* in accordance with the provisions of the Contracts (Rights of Third Parties) Act 1999.

6. Governing law

These *Terms* and any dispute or claim arising out of or in connection with them or their subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the law of England and Wales.

7. Jurisdiction

The courts of England and Wales shall have non-exclusive jurisdiction to settle any dispute or claim arising out of or in connection with these *Terms* or their subject matter or formation (including non-contractual disputes or claims).

Annex 2

Examples that may be considered CCI

Exceptions to the general redaction principles outlined in section 4.2.2.1. of the policy are provided in the tables below. Guidance described in column 2 advices what should be discussed in case of information that may be considered CCI.

346 # Table 1

347 **Detailed list of the elements relating to clinical data and contained in 'The common technical document for the registration of**
348 **pharmaceuticals for human use' (from ICH harmonised tripartite guideline, Modules 2 and 5).**

Section	Title	Justification for redaction	Information that may be CCI
2.5 CLINICAL OVERVIEW			
2.5.1	Product Development Rationale	• Information for planned clinical studies may include "exploratory endpoints" that are not intended to yield data in support of the then-current approval of a use or indication, but could provide clues to potential uses and indications for competitors.	• "Describe the clinical development programme of the medicinal product, including ongoing and planned clinical studies and the basis for the decision to submit the application at this point in the programme...."
		• Regulatory advice from outside the EU is typically non-public and includes agreements with regulators on study design, strategies for organization and presentation of findings, and other aspects of the regulatory process that competitors could copy.	• "Regulatory guidance and advice (at least from the region(s) where the Clinical Overview is being submitted) should be identified, with discussion of how that advice was implemented."
		• Same justification as above.	• "Formal advice documents (e.g., official meeting minutes, official guidance, letters from regulatory authorities) should be referenced...."
2.5.2	Overview of Biopharmaceutics	• As the Biopharmaceutical Summary Documents (2.7.1) are considered CCI, this section may contain some overlapping information.	• Detailed assay information.
2.5.3	Overview of Clinical Pharmacology	• Competitors could gain a detailed understanding of the stereoisomers and three-	• Stereochemistry issues.

Section	Title	Justification for redaction	Information that may be CCI
		dimensionality of the molecule.	
2.5.6	Benefits and Risks Conclusions	• The company may include justifications for any deviation from regulatory advice or guidance outside of the EU jurisdiction, a competitor may have an unwarranted new perception of the regulatory risk associated with a certain regulatory strategy.	• Implications of any deviations from regulatory advice or guidelines.
2.7 CLINICAL SUMMARY			
2.7.1	Summary of Biopharmaceutic Studies and Associated Analytical Methods	• This section may contain CCI in the form of details and specifications on assays developed by the company. The information may bring significant advantages to competitors if published.	• Information about specifications on company assays.
2.7.2	Summary of Clinical Pharmacology Studies	• This section may contain CCI in the form of details and specifications on assays developed by the company. The information may bring significant advantages to competitors if published.	• Information about specifications on company assays and immunogenicity.
MODULE 5 CLINICAL STUDY REPORTS			
5.3.1	Reports of Biopharmaceutic Studies	• This section may contain CCI in the form of details and specifications on assays developed by the company. The information may bring significant advantages to competitors if published.	• Information about specifications on company assays (e.g. Bioavailability, In Vitro – In Vivo Correlation).

349

Table 2

Structure and content of clinical study reports (CSRs) (From ICH harmonised tripartite guideline, E3).

Section	Title	Justification for redaction	Information that may be CCI
7	Introduction	• May contain non-public information that the sponsor agreed in another jurisdiction outside of the EU.	• Development of the protocol or any other agreements/meetings between the sponsor/company and regulatory authorities that are relevant to the particular study, should be identified or described.
8	Study Objectives (including Exploratory Endpoints and Efficacy and Safety Variables; 9.5, 11.4)	• The exploratory study objectives could be used by a competitor to gain insights into additional future study plans and/or indications for the product. For example, in some trials for a new anti-inflammatory medicinal product, an exploratory lipid profile was included, investigating the lipid metabolism in patients treated with the product, to inform future studies rather than to support the MAA. The results of these analyses were included in the CSRs submitted to the EMA in the course of the MAA procedure. • Alternatively the exploratory objectives may include biomarkers that could be used as 'hypothesis generating' for future studies. At that stage there would not be enough information to file patent applications on these objectives until some data are available from clinical and non-clinical studies. Disclosing	• Statements/descriptions relating to objectives that are not supportive of a label claim and do not contribute to the overall benefit/risk evaluation. This includes the definition of efficacy and safety variables collected and analysed in support of exploratory objectives.

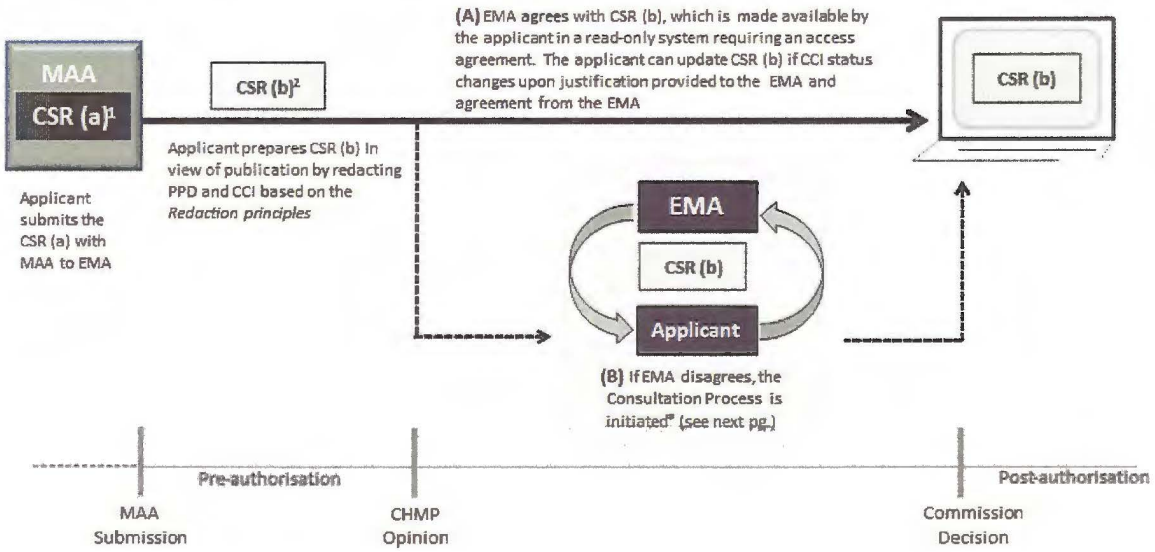
Section	Title	Justification for redaction	Information that may be CCI
		these exploratory objectives may preclude obtaining patents that would cover biomarkers/diagnostics themselves, as well as method of use patents directed to patient subpopulations.	
9.7.2	Determination of Sample Size	• The sample size per se is not considered CCI. However there may be occasions when the intellectual consideration that goes into the analysis of the information that drives the sample size calculation (e.g. estimates of endpoint variability, measurement precision, screening and retention rates) is considered CCI.	• CCI concern is also applicable to Documentation of statistical methods in 16.1.9.
14.4	Method of PK/PD determination	• This section may have proprietary information on how analyses are performed.	

352

353

354 **Annex 3**

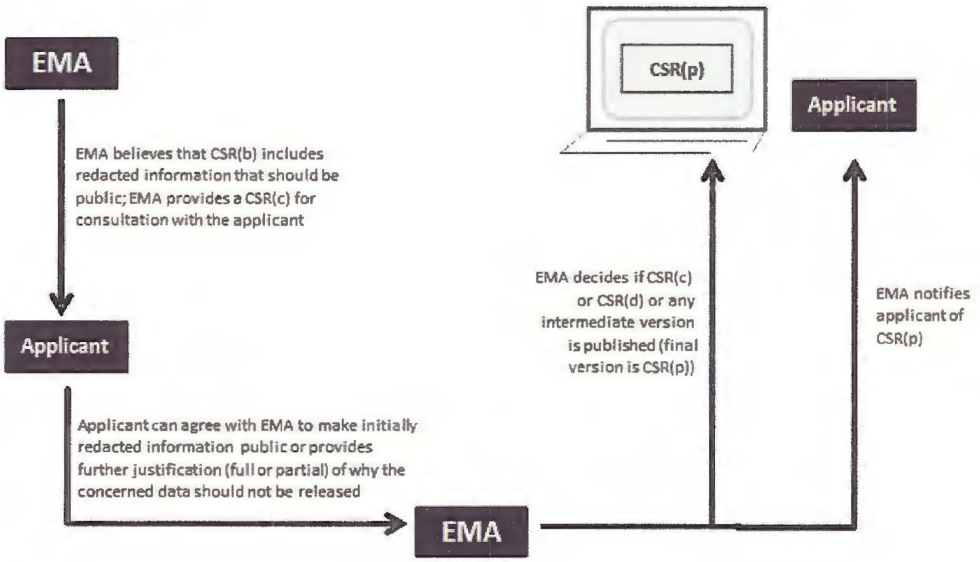
355 **Process for publication of CSRs (scenario: MAA)**



1. CSR (a) = CSR in accordance with EMA guidance (1995 and 2004)
2. CSR (b) = CSR available under the EMA policy

356

357 ***Consultation process**



* Consultation process to be concluded within Decision making process timelines – exact timing still to be determined.

358

SANCO FEES PHARMACOVIGILANCE

From: SANCO PHARMACEUTICALS D5
Subject: FW: Draft EMA policy on publication of clinical data
Attachments: 0070 Policy - Publication and access to clinical-trial data.doc

From: Wathion Noel [mailto:[redacted]
Sent: Tuesday, May 20, 2014 10:26 AM
To: JUELICHER Sabine (SANCO)
Cc: RASI Guido (EMA); EICHLER Hans-Georg (EMA); MARINO Stefano (EMA); NUTTALL Frances (EMA); BUGGE Christine (EMA); DIAS Monica (EMA); SWEENEY Fergus (EMA); HUMPHREYS Anthony (EMA); HENRY-EUDE Anne-Sophie (EMA)
Subject: Draft EMA policy on publication of clinical data

Dear Sabine,

As agreed please find enclosed the draft document which we can discuss tomorrow over lunch.
Some finetuning of the annexes is ongoing following the discussions with stakeholders.
KR,

Noel

Noël Wathion
Chief Policy Adviser
Head of Stakeholders and Communication Division (ad interim)

Office 7-729 | Ext. 8592

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Ref. Ares(2014)2137017 - 27/06/2014

SANCO FEES PHARMACOVIGILANCE

From: SANCO PHARMACEUTICALS D5
Subject: FW: Draft EMA policy on publication of clinical data
Attachments: 0070 Policy - Publication and access to clinical-trial data.doc

From: JUELICHER Sabine (SANCO)
Sent: Friday, May 23, 2014 1:14 PM
To: WATHION Noel (EMA)
Cc: MARINO Stefano (EMA); DIAS Monica (EMA); SCHMIDT Florian (SANCO); LINDSTROM-GOMMERS Lenita (SANCO); GRIVA Miroslav (SANCO); DATRI Fabio (SANCO); SOLOMON Olga (SANCO)
Subject: RE: Draft EMA policy on publication of clinical data

Dear Noel,

as agreed on Wednesday, we had an initial look at the current drafting of the policy paper. Going through the document we identified some points that could be further clarified or raised questions. We would like to share those comments with you, so that you can take them into account in the finalisation of the document.

Best regards,
Sabine

From: Wathion Noel [mailto:[redacted]
Sent: Tuesday, May 20, 2014 10:26 AM
To: JUELICHER Sabine (SANCO)
Cc: RASI Guido (EMA); EICHLER Hans-Georg (EMA); MARINO Stefano (EMA); NUTTALL Frances (EMA); BUGGE Christine (EMA); DIAS Monica (EMA); SWEENEY Fergus (EMA); HUMPHREYS Anthony (EMA); HENRY-EUDE Anne-Sophie (EMA)
Subject: Draft EMA policy on publication of clinical data

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KR,

Noel

Noël Wathion
Chief Policy Adviser
Head of Stakeholders and Communication Division (ad interim)

Office 7-729 | Ext. 8592

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Ref. Ares(2014)2137017 - 27/06/2014

EUROPEAN MEDICINES AGENCY

19 May 2014
EMA/240810/2013

European Medicines Agency policy on publication of clinical data

POLICY/0070
Status: Draft for endorsement
Effective date: 1 October 2014
Review date: No later than March 2016
Supersedes: Not applicable

1. Introduction and purpose

The aim of the European Medicines Agency ('the Agency') is to protect and foster public health. Transparency is a key consideration for the Agency in delivering its service to patients and society.

Although the Agency has since its creation launched several initiatives to increase transparency of information on medicinal products, there is growing demand from stakeholders for full transparency, not only about the Agency's deliberations and actions, but also about the clinical data on which regulatory decisions are based. The Agency is committed to continuously extend its approach to transparency and has, therefore, taken the initiative to develop a policy on publication of clinical data, in accordance with article 80 of Regulation (EC) No 726/2004[1]. Consultations with a broad range of stakeholders and European Union (EU) bodies have taken place in drafting this policy. It should be noted that this policy complements the existing 'Policy on access to documents (related to medicinal products for human and veterinary use)' (POLICY/0043) (EMA/110196/2006), which came into effect in December 2010[2].

Comment [DF(1]: Following the discussion we have had, I would delete FN2. The existing policy should not be adapted but they remains as 2 parallel procedures.

[1] Regulation (EC) No 726/2004 of the European Parliament and of the Council of 31 March 2004 laying down community procedures for the authorisation and supervision of medicinal products for human and veterinary use and establishing a European Medicines Agency.
[2] To ensure consistency, the existing policy on access to documents will be aligned with this policy on publication of clinical data.

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An agency of the European Union

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2. Scope

The scope of the policy relates to clinical data, composed of clinical study reports (CSRs) including individual patient data (IPD). In particular, the policy relates to clinical data submitted under the centralised marketing authorisation procedure after the effective date (see section 4.3. for further information):

- as part of a marketing authorisation application (MAA);
- or as part of a post-authorisation procedure for an already centrally authorised medicine;
- or as part of a referral procedure for a centrally authorised product;
- or requested by the Agency/ submitted by the applicant/marketing authorisation holder (MAH) as additional clinical data in the context of the scientific assessment process for the aforementioned situations.

The following clinical data are not covered by the scope of the policy:

- Clinical data currently held by the Agency for medicinal products authorised under the centralised procedure before the "effective" date (hereafter referred to as legacy data).
- Clinical data (either legacy data or data not yet held by the Agency) submitted to the Agency for non-centrally authorised products.

These clinical data continue to be made available to external requesters on a reactive basis in accordance with the aforementioned Agency's policy on access to documents. For the legacy data described above, the MAH may take the initiative to resubmit the clinical data for medicinal products already authorised under the centralised procedure, which will then be published.

In addition, the following clinical data are not covered by the scope of the policy:

- Clinical data that are not held by the Agency, even if they concern a medicinal product that has been authorised by the Agency (e.g. clinical trials on an authorised product conducted by independent investigators and not submitted to the Agency).
- Pharmacovigilance data based on Individual Case Safety Reports (ICSRs). Access by third parties to ICSR data is addressed in the Agency's 'EudraVigilance access policy for medicines for human use' (EMA/759287/2009 corr.).
- Clinical data held by the Agency under the scope of the Clinical Trials Directive 2001/20/EC[3] or the Clinical Trial Regulation (EC) No xxxx/2014.

3. Definitions

- **Clinical data:**

In the context of this policy, clinical data shall mean the CSR including IPD.

- **Clinical study:**

Clinical study shall mean any investigation in relation to humans intended to:

[3] Directive 2001/20/EC of the European Parliament and of the Council of 4 April 2001 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use.

Comment [FS2]: The scope of the policy is unclear. According to this part, it only covers CSR and IPD. CSR is defined later as the CSR contained in module 5 of the application. However, then in point 4 it is said that the policy covers module 2.5 and 2.7. While these modules contain (critical) summaries/overviews of module 5, they are not identical to module 5. Hence, it seems the scope is broader than CSRs (as defined) and IPD.

Comment [FS3]: The term submission implies an activity of the MAH. However, the Agency could for post-authorisation procedures also obtain/receive clinical data from third parties. Are they covered?

Comment [FS4]: A referral procedure is a post-authorisation procedure, so it may also be covered by the previous bullet. Moreover, documents submitted under a referral procedure may not be presented as a module of a MA, but as independent evidence.

Comment [FS5]: Unclear. Most of the clinical data held by the Agency will fall under the scope of the CTD and the new Regulation as the clinical trials have been authorised/conducted in accordance with that legislation. Perhaps better to say that this policy is without prejudice to the publication of documents under the CT Regulation.

Comment [FS6]: Would this definition really include module 2.5 and 2.7?

Field Code Changed

- discover or verify the clinical, pharmacological or other pharmacodynamic effects of one or more medicinal products;
- identify any adverse reactions to one or more medicinal products; or
- study the absorption, distribution, metabolism and excretion of one or more medicinal products;

with the objective of ascertaining the safety or efficacy of those medicinal products.

- **Clinical study report (CSR):**

CSR shall mean a clinical study report presented in a searchable format, submitted in Module 5 of a MA or in any subsequent post-authorisation submissions.

Comment [FS7]: Definition is slightly different than the definition that will be used in the new CT Regulation.

- **Individual patient data (IPD):**

IPD shall mean the individual data separately recorded for each participant in a clinical study.

- **Personal data:**

Personal data shall mean any information relating to an identified or identifiable natural person ('data subject'); an identifiable person is one who can be identified, directly or indirectly, in particular by reference to an identification number or to one or more factors specific to their physical, physiological, mental, economic, cultural or social identity (Article 2(a) of Regulation (EC) No 45/2001).

- **Commercially confidential information (CCI):**

For the purpose of the policy, CCI shall mean any information that is not in the public domain or publicly available and where disclosure may undermine the legitimate economic interest of the owner of the information. CCI falls broadly into two categories: trade secrets (including formulas, programs, process or information contained or embodied in a product, etc.) and commercial confidences.

4. Policy statement

The following aspects are addressed in this policy:

- Objectives of the policy.
- Characteristics of the policy.
- Date of coming into effect of the policy.

4.1. Objectives of the policy

The main objectives of the policy are to enable public scrutiny and secondary analysis of clinical data. A high degree of transparency will take regulatory decision-making one step closer to EU citizens, and promote better-informed use of medicines. In addition, the Agency takes the view that access to clinical data will benefit public health in future. The policy has the potential to make medicine development more efficient by establishing a level playing field that allows all medicine developers to learn from past successes and failures. Furthermore, it will enable the wider scientific community to make use of detailed clinical data to develop new knowledge in the interest of public health. Access to clinical data will allow third parties to verify the original analysis and conclusions, to conduct further analyses, and to examine the regulatory authority's positions and challenge them where appropriate.

Comment [FS8]: What does secondary analysis mean? A re-analysis of the data for the same purpose or a re-use of the data for different purposes?

The Agency also takes the view that transparency should be mutually respected. Those who make secondary use of clinical data, published in accordance with this policy, must be held to the same

Comment [FS9]: Is secondary use broader than secondary analysis?

Field Code Changed

standard of transparency as those who generate clinical data in the first place. Hence, all secondary analyses shall also be in the public domain and accessible for further scrutiny by the scientific community. In addition, the Agency should be provided with a copy of any article resulting from such secondary analysis before publication, in particular in those circumstances where the secondary analysis might result in the need for regulatory action to protect public health. This is a critical consideration in view of the Agency's role and responsibilities for a timely review of all available information which might have an impact on the benefit/risk ratio of centrally authorised products.

The Agency cannot guarantee that all secondary data analyses that are enabled by the policy will be conducted and reported to the highest possible scientific standard; this is not possible with a truly open approach.

Allowing external parties access to clinical data held by the Agency will directly or indirectly affect different stakeholders' rights, interests and values. In developing this policy the Agency had to consider a number of competing principles which needed to be carefully balanced in order to best ensure the overarching, long-term goal of protecting and fostering public health. These principles, as well as the Agency's positions and views, are described below:

- **Protecting personal data:**

The protection of personal data is enshrined in EU legislation; it is a fundamental right of EU citizens. The policy has to ensure adequate personal data protection; it must be fully compliant with applicable regulations in the EU, in particular Regulation (EC) No 45/2001 and Directive 95/46/EC. There are ways and means to anonymise data and protect patients from retroactive identification. Yet, the Agency is concerned that emerging technologies for data mining and database linkage will increase the potential for unlawful retroactive patient identification. The Agency, therefore, takes a guarded approach to the sharing of patient-level data, which is done to enable legitimate learning from sharing patient-level data while preventing rare but potentially damaging instances of patient identification. Furthermore, patients' informed consent should be respected.

- **Protecting CCI:**

The Agency respects and will not divulge commercially confidential ~~data or~~ information. In general, however, clinical data cannot be considered CCI. The Agency acknowledges that there are limited circumstances where information could constitute CCI.

- **Protecting the Agency's and the European Commission's deliberations and decision-making process:**

Regulators have a legal mandate to evaluate medicines. In doing so, they should only focus on the science and the best interests of patients. The decision-making process should be protected against external pressures from whatever direction. Once a decision has been reached, this consideration no longer applies.

- **Ensuring future investment in bio-pharmaceutical research and development (R&D):**

Sustained and extensive bio-pharmaceutical research activity is a precondition for future improvements in public health. The policy has no intention to negatively impact on the incentives to invest in future bio-pharmaceutical R&D. It is designed to guard against unintended consequences, e.g. breaches of intellectual property rights that might disincentivise future investment in R&D.

Comment [FS10]: Are there specific reasons to limit this paragraph to a sub-category of all pharmaceutical research? My impression was that the policy has no intention to negatively affect pharmaceutical R&D as such and not just limited to biological products.

4.2. Characteristics of the policy

The main characteristics of the policy are:

Field Code Changed

- Introduction of a managed publication process for clinical data.
- Management of CCI in clinical data.
- Methods for balancing the protection of patients' privacy whilst retaining scientific value of the data.
- Stepwise implementation of the policy.

4.2.1. Introduction of a managed publication process for clinical data

The introduction of a managed publication process for clinical data is based on 2 pillars:

- Terms of use (ToU) which govern the access to and use of clinical data.
- A technical tool allowing access to such clinical data.

The ToU, attached as annex 1, provide more information in relation to the access to the information and the use of such information. Particular aspects to be highlighted relate to the fact that the information is made available in a "view-on-screen-only" mode after completing a registration process, as described below. This means that the information cannot be downloaded, saved, printed, distributed, transferred. Furthermore, no attempt can be made to re-identify the trial subjects or other individuals from the information. The information cannot be used to support a MAA nor to make any unfair commercial use of such information.

In addition, a technical tool will be available to allow access to such clinical data. This technical tool will be a user-friendly system, with simple procedural requirements in terms of firstly obtaining a user ID or password, secondly the acceptance of the aforementioned ToU by the person wanting access to the clinical data, and finally the availability of a watermark on the published information to emphasise the proprietary nature of the information.

These two pillars should allow to prevent unfair commercial use/the use of such information for regulatory purposes.

4.2.2. Management of CCI in clinical data

Although generally the information contained in clinical data should not be considered CCI, the Agency acknowledges that in limited circumstances such information could constitute CCI, and could, therefore, be subject to redaction prior to publication. Where redaction of information considered to contain CCI is proposed, a consultation with the applicant/MAH will be undertaken, following scrutiny by the Agency of the proposed redaction including the justification.

4.2.2.1. Redaction principles

The clinical data that will be published in accordance with this policy shall only be subject to redactions when needed to protect those specific elements which qualify as CCI that should not be released. This complements the aforementioned use controls that will need to be accepted by recipients of the documents in order to protect the originator against misuse of the data as a whole. This covers information that is not in the public domain or publicly available and where disclosure may undermine the economic or competitive position of the owner of the information. In this regard, the assessment of this information will also take into account the evidence shown by the information owner with regard to various factors, including the nature of the product concerned, the competitive situation of the

Comment [DF(11]: The definition of CRS indicate that they should be presented in a searchable format. Would the platform you are preparing provide for a search tool? I would suggest to add some reference to this aspect which could facilitate the navigation in the documents.

Comment [FS12]: Should the term be defined?

Field Code Changed

therapeutic market in question, the approval status in other jurisdictions, the novelty of the clinical development, and new developments by the same company.

In general, as already mentioned, most of the information in CSRs would not be considered CCI. There, are, however, limited circumstances where such information could constitute CCI.

Exceptions to the general principle that CSRs are not CCI are included in the table provided as annex 2. The information described in these exceptions may have to be redacted as per the aforementioned redaction principles, after assessment by the Agency of the justification provided by the applicant/MAH. If justification for additional redaction going beyond these exceptions is provided by applicants/MAHs in the future, the Agency will discuss with ~~pharmaceutical industry~~stakeholders whether to revise the attached table with the new proposed redaction, based on real life experience (including applicants'/MAHs' comments) following the implementation of this policy.

4.2.2.2. Process for publication of CSRs

The process for publication of CSRs is described in annex 3. This process foresees in consultation with the applicant/MAH in case EMA disagrees with the redaction proposed by the applicant/MAH.

4.2.3. Methods for balancing the protection of patient's privacy whilst retaining scientific value of the data

Protection of patients' identity is of crucial importance. In order to achieve this objective both identification and re-identification of patients need to be avoided. Particular challenges in this respect are continuous developments in the field of technologies relating to data mining and database linkage, as well as specific scenarios to be considered in the area of medicine regulation, for instance the situation of rare diseases. In deciding on the most optimal approach (anonymisation versus pseudonymisation) the Agency will take due account of recent developments, e.g. the work undertaken by the network of EU Data Protection Authorities on anonymisation techniques[4], and subsequently discuss with stakeholders (e.g. patients' organisations, academia, pharmaceutical industry) to agree on the best way forward.

Comment [FS13]: Does it mean you fear that an IT tool could extract/mine data from the protected area of the future web-portal?

4.2.4. Stepwise implementation of the policy

The implementation of the policy will be undertaken in a stepwise manner:

- In a first phase, the publication of clinical data will relate to CSRs only.
- In a second phase, IPD will be made available.

Comment [FS14]: Two comments: First this clear statement may trigger the EDPS prior notification requirement under Regulation 45/2001 (Article 25). Has such a notification taken place? Secondly, use of IPD outside the protocol of the clinical trial (secondary use) may require the informed consent of the subject. Information on whether the subject agreed to such use may not be available to the EMA. Therefore, it may be from an operational point impossible to make IPD available. Therefore, the second phase may be better presented as something that will be explored; but not as something which will definitely happen.

4.2.4.1. First phase: publication of CSRs

The publication of CSRs will be in accordance with the arrangements described in sections 4.2.1., 4.2.2. and 4.2.3. of the policy.

In addition, the following principles will apply:

- **Elements of the CSRs to be published:**

[4] Opinion 05/2014 on anonymisation techniques, adopted on 10 April 2014 by the Article 29 Data Protection Working Party.

Field Code Changed

The elements of the CSRs that will be published are module 2.5 (clinical overview), module 2.7 (clinical summary), module 5 (clinical study reports and appendices 16.1.1 (protocol and protocol amendments), 16.1.2 (sample case report form) and 16.1.9 (documentation of statistical methods)).

- **Timing of publication:**

The timing of publication takes into account the need to protect the Agency's and the European Commission's deliberations and decision-making process. In order not to undermine such decision-making process the Agency will only publish clinical data once the concerned procedure has been finalised. In practical terms this means:

- following the European Commission Decision granting or refusing the marketing authorisation (MA)/post-authorisation submission outcome; or
- following the scientific committee Opinion if there is no subsequent European Commission Decision; or
- following the scientific committee conclusion if there is no Opinion;
- following receipt of the applicant's/MAH's letter notifying the withdrawal of the MAA/post-authorisation submission.

Comment [FS15]: Which procedures are covered? Wouldn't it be better to align this paragraph to the wording that is used in the new CT Regulation regarding the timing of CSR publications?

The process described in section 4.2.2.2. for publication of CSRs, including where necessary interaction with the applicant/MAH, will start following the adoption of the scientific Committee Opinion/conclusion or the receipt of the withdrawal letter, as referred to above.

4.2.4.2. Second phase: making available IPD

Before IPD can be made available, there is a need to first clarify the concept of IPD in terms of:

- when to submit IPD for subsequent scientific review by the Agency, and
- how to best provide access to such IPD, including the conditions to be fulfilled.

It is important to emphasise in this regard that the Agency will not request applicants/MAHs to submit IPD for the sole purpose of publication of IPD.

The Agency will first undertake a targeted public consultation with all concerned stakeholder on the concept of IPD to provide clarification on the aforementioned aspects. Subsequently, the policy will be amended to reflect the outcome of this targeted public consultation.

Comment [FS16]: Is it necessary/appropriate to provide details regarding the process for extending the scope of the current document?

4.3. Date of coming into effect of the policy

For the coming into effect of the policy a stepwise approach will be applied. The effective date will be:

- 1 October 2014 for any new MAAs under the centralised procedure submitted as of that date.
- 1 January 2015 for applications for new indications. For these variation procedures a 6 months' pilot phase will be undertaken to acquire further experience, after which a decision will be taken with respect to the effective date for all post-authorisation procedures relating to centrally authorised products where supporting clinical data have been submitted.

Comment [FS17]: Are you confident to have already sufficient experience after 6 months.

- 1 July 2015 for those legacy data relating to centrally authorised products where the MAH takes the initiative to resubmit the clinical data for already authorised medicines under the centralised procedure.

Field Code Changed

As regards the effective date for making available IPD, this will be determined following the amendment of the policy as referred to in section 4.2.4.2.

5. Related documents

European Medicines Agency policy on access to documents (POLICY/0043) (EMA/110196/2006).

Comment [FS18]: The need for explicit reference to AtD documents should be considered.

6. Changes since last revision

Not applicable, new policy.

The impact of the policy shall be assessed and the policy revised as appropriate not later than 18 months after coming into effect.

Comment [FS19]: May be misunderstood as if the impact will only be evaluated ex-post and was not considered ex-ante.

Comment [FS20]: In view of the timelines for assessing new MA, it may take 12 to 18 months before the first data will be published.

London, <DD Month YYYY>

Guido Rasi

Executive Director

Field Code Changed

Annex 1

Term of Use

These Terms of Use ("***Terms***") govern the access and use of clinical data, as defined in section 2. of the EMA policy on publication of clinical data, Policy 0070 ("***Policy***"), that are made available to Users via such Policy. By accepting these *Terms* and upon being granted access to the Information, you agree to be bound by these *Terms*. Please read them carefully.

1. Definitions

In these *Terms* the terms below have the following meaning:

"**EMA**" means the European Medicines Agency.

"**Information**" means the Clinical Study Reports (Module 5, "CSR"), clinical overviews (Module 2.5) and clinical summaries (Module 2.7), together with Appendixes to the CSRs no. 16.1.1, 16.1.2 and 16.1.9 which are accessible via the *EMA* web-site as a result of the implementation of the Policy.

"**Information Owner**" means the natural or legal person(s) or organisation(s) that submitted the *Information* to the *EMA* in the context of applications in support of centralised marketing authorisations/post-authorisation submissions under Regulation (EC) No 726/2004, as well as any person(s) or organisation(s) who owns copyright or other intellectual property or proprietary rights in the *Information*.

"**User**" means the natural or legal person or organization who, having registered with the EMA's web-site in connection with the implementation of the Policy, receives access to the *Information*.

2. Access to the information under the policy

Comment [FS21]: You may want to consider to limit the validity of the access right in time, so that the user may need to reapply after some years to avoid indefinite access.

The *User* acknowledges that the *Information* is protected by copyright and proprietary rights of the *Information Owner* and can be considered commercially valuable when used for commercial and regulatory purposes.

The *User* acknowledges that the *Information* will be made available to the *User* in a "view-on-screen-only" mode, after completing the registration process. The *User* agrees that the *User* is not permitted to download, save, edit, photograph, print, distribute or transfer the *Information*. The *User* agrees not to access the *Information* using a method other than the interface provided by the *EMA*, or remove, bypass, circumvent, neutralise or modify any technological protection measures which apply to the *Information*.

3. Use of the information

The *User* agrees to use the *Information* according to these *Terms* and, in particular, that:

a) The *User* may use the *Information* solely for information, research and non-commercial purposes, subject to these *Terms*.

b) The *User* is not granted any intellectual property or other commercial rights in relation to the *Information* other than as expressly set out in these *Terms*.

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When using the *Information*, the *User* shall:

a) acknowledge its source and include any attribution statement specified by the *Information Owner*;

b) not use it in a way that suggests that the *Information Owner* endorses the *User* or the *User's* use of the *Information* for any other purpose than information, research and other non-commercial purposes;

c) ensure that the use of the *Information* complies at all times with applicable law;

d) not misrepresent the source of the *Information*;

e) not seek to re-identify the trial subjects or other individuals from the *Information* in breach of applicable privacy laws.

The *User* may not:

- use the *Information* to support an application to obtain any kind of regulatory and subsequent approval for a product anywhere in the world;
- share the *User's* username, password or other account details with a third party or otherwise provide a third party with access to the *User's* account;
- make any unfair commercial use of the *Information*.

If the *User* fails to accurately complete the registration process, comply with these conditions, or uses the *Information* in breach of these *Terms* of Use, the rights to access and use the *Information* will be revoked.

4. Warranties and liability

Without prejudice to any obligation of the marketing authorisation holders/applicants in accordance with the Union legislation:

- The *EMA* and the *Information Owner* exclude all representations, warranties, obligations and liabilities in relation to the *Information* as accessible via the *EMA* web-site to the maximum extent permitted by law;
- Neither the *EMA* nor the *Information Owner* are liable for any errors or omissions in the *Information* as provided via the *EMA* web-site and shall not be liable for any loss, injury or damage of any kind caused by its use.

5. Third party rights

The restrictions and conditions and the warranty and liability provisions of these *Terms* are also made for the benefit of any and all *Information Owners* and, accordingly, each such *Information Owner* may in its own right enforce these *Terms* in accordance with the provisions of the Contracts (Rights of Third Parties) Act 1999.

6. Governing law

These *Terms* and any dispute or claim arising out of or in connection with them or their subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the law of England and Wales.

Field Code Changed

7. Jurisdiction

The courts of England and Wales shall have non-exclusive jurisdiction to settle any dispute or claim arising out of or in connection with these *Terms* or their subject matter or formation (including non-contractual disputes or claims).

Field Code Changed

Annex 2

Examples that may be considered CCI

Comment [DF(22]: I understand that these are not examples but the only cases identified as possible cci. The title could be misleading.

Exceptions to the general redaction principles outlined in section 4.2.2.1. of the policy are provided in the tables below. Guidance described in column 2 advices what should be discussed in case of information that may be considered CCI.

Comment [FS23]: Column 4?

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Table 1

Detailed list of the elements relating to clinical data and contained in 'The common technical document for the registration of pharmaceuticals for human use' (from ICH harmonised tripartite guideline, Modules 2 and 5).

Section	Title	Justification for redaction	Information that may be CCI
2.5 CLINICAL OVERVIEW			
2.5.1	Product Development Rationale	• Information for planned clinical studies may include "exploratory endpoints" that are not intended to yield data in support of the then-current approval of a use or indication, but could provide clues to potential uses and indications for competitors.	• "Describe the clinical development programme of the medicinal product, including ongoing and planned clinical studies and the basis for the decision to submit the application at this point in the programme...."
		• Regulatory advice from outside the EU is typically non-public and includes agreements with regulators on study design, strategies for organization and presentation of findings, and other aspects of the regulatory process that competitors could copy.	• "Regulatory guidance and advice (at least from the region(s) where the Clinical Overview is being submitted) should be identified, with discussion of how that advice was implemented."
		• Same justification as above.	• "Formal advice documents (e.g., official meeting minutes, official guidance, letters from regulatory authorities) should be referenced...."
2.5.2	Overview of Biopharmaceutics	• As the Biopharmaceutical Summary Documents (2.7.1) are considered CCI, this section may contain some overlapping information.	• Detailed assay information.
2.5.3	Overview of Clinical Pharmacology	• Competitors could gain a detailed understanding of the stereoisomers and three-	• Stereochemistry issues.

Comment [FS24]: Ambiguous drafting. Could be understood as if only the sections below contain clinical data.

Comment [DF(25]: The section refer to the pharma code, not to the ICH guidelines, but the heading does.

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Section	Title	Justification for redaction	Information that may be CCI
		dimensionality of the molecule.	
2.5.6	Benefits and Risks Conclusions	• The company may include justifications for any deviation from regulatory advice or guidance outside of the EU jurisdiction, a competitor may have an unwarranted new perception of the regulatory risk associated with a certain regulatory strategy.	• Implications of any deviations from regulatory advice or guidelines.
2.7 CLINICAL SUMMARY			
2.7.1	Summary of Biopharmaceutic Studies and Associated Analytical Methods	• This section may contain CCI in the form of details and specifications on assays developed by the company. The information may bring significant advantages to competitors if published.	• Information about specifications on company assays.
2.7.2	Summary of Clinical Pharmacology Studies	• This section may contain CCI in the form of details and specifications on assays developed by the company. The information may bring significant advantages to competitors if published.	• Information about specifications on company assays and immunogenicity.
MODULE 5 CLINICAL STUDY REPORTS			
5.3.1	Reports of Biopharmaceutic Studies	• This section may contain CCI in the form of details and specifications on assays developed by the company. The information may bring significant advantages to competitors if published.	• Information about specifications on company assays (e.g. Bioavailability, In Vitro – In Vivo Correlation).

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Table 2

Structure and content of clinical study reports (CSRs) (From ICH harmonised tripartite guideline, E3).

Section	Title	Justification for redaction	Information that may be CCI
7	Introduction	• May contain non-public information that the sponsor agreed in another jurisdiction outside of the EU.	• Development of the protocol or any other agreements/meetings between the sponsor/company and regulatory authorities that are relevant to the particular study, should be identified or described.
8	Study Objectives (including Exploratory Endpoints and Efficacy and Safety Variables; 9.5, 11.4)	• The exploratory study objectives could be used by a competitor to gain insights into additional future study plans and/or indications for the product. For example, in some trials for a new anti-inflammatory medicinal product, an exploratory lipid profile was included, investigating the lipid metabolism in patients treated with the product, to inform future studies rather than to support the MAA. The results of these analyses were included in the CSRs submitted to the EMA in the course of the MAA procedure. • Alternatively the exploratory objectives may include biomarkers that could be used as 'hypothesis generating' for future studies. At that stage there would not be enough information to file patent applications on these objectives until some data are available from clinical and non-clinical studies. Disclosing	• Statements/descriptions relating to objectives that are not supportive of a label claim and do not contribute to the overall benefit/risk evaluation. This includes the definition of efficacy and safety variables collected and analysed in support of exploratory objectives.

Comment [DF(26]: Could you clarify the relation between table 1 and table 2? I understand that table 2 is a specification of the part of the CSR (module 5) that may be CCI. If my interpretation is correct, the last raw of table 1 is misleading. Interaction between table 1 and 2 should be clarified in the body on the document.

Comment [DF(27]: The section number in table 2 refer to the ICH E3 guideline. This should be clarified otherwise it is difficult to understand that in table 1 and 2 you are referring to different documents.

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Section	Title	Justification for redaction	Information that may be CCI
		these exploratory objectives may preclude obtaining patents that would cover biomarkers/diagnostics themselves, as well as method of use patents directed to patient subpopulations.	
9.7.2	Determination of Sample Size	• The sample size per se is not considered CCI. However there may be occasions when the intellectual consideration that goes into the analysis of the information that drives the sample size calculation (e.g. estimates of endpoint variability, measurement precision, screening and retention rates) is considered CCI.	• CCI concern is also applicable to Documentation of statistical methods in 16.1.9.
14.4	Method of PK/PD determination	• This section may have proprietary information on how analyses are performed.	

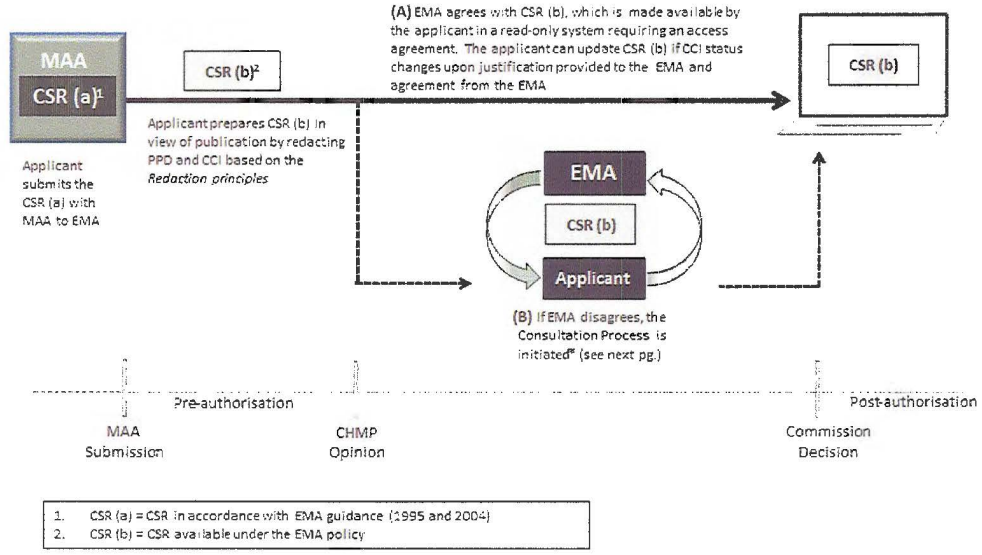
350

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Field Code Changed

352 **Annex 3**

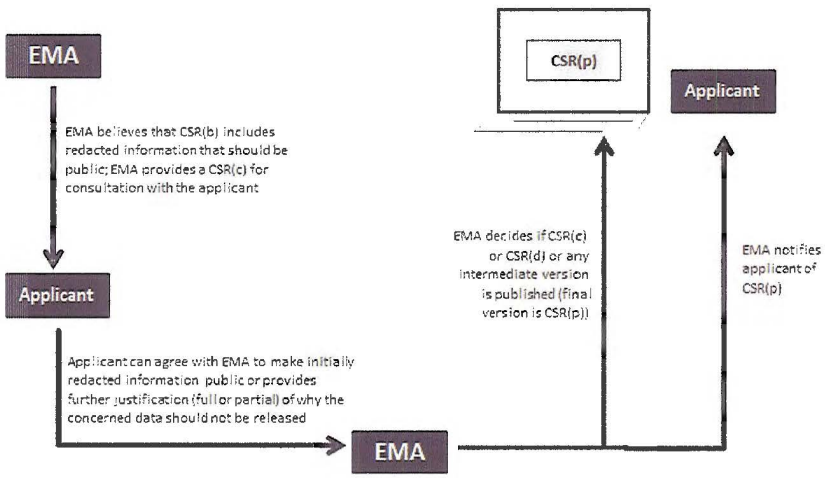
353 **Process for publication of CSRs (scenario: MAA)**



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355 ***Consultation process**



* Consultation process to be concluded within Decision making process timelines – exact timing still to be determined.

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Field Code Changed

Ref. Ares(2014)2332620 - 27/06/2014

EUROPEAN MEDICINES AGENCY
SCIENCE MEDICINES HEALTH

Mrs Paola Testori Coggi
European Commission
DG Health and Consumers (DG Sanco)
Rue Breydel 4
B232 07/095
1049 Bruxelles
BELGIUM

28 May 2014
EMA/327040/2014
Executive Director

Dear Mrs Testori Coggi,

Subject: EMA policy on publication of clinical data

As you will be aware, the Agency launched in November 2012 a public debate on the release of data from clinical trials. Following a public workshop with all stakeholders, a draft policy was released for public consultation in June 2013.

The three months public consultation generated input from an unprecedented range of stakeholders. More than 1,100 comments were received and have been carefully reviewed by the Agency. Since these comments often represented competing viewpoints expressed by the stakeholders including the EU Institutions, the Agency has tried to find the most optimal balance when revising its draft policy. The Management Board at its December 2013 meeting endorsed a set of principles for the revision of the draft policy.

These agreed principles have been subject to further targeted consultations with stakeholders (patients' organisations, academia and pharmaceutical industry) over the past weeks. This has resulted in the attached policy which is now being submitted to the Management Board for discussion/ endorsement at its 12 June 2014 meeting.

Since this policy comes within the scope of Article 80 of the Regulation (EC) No 726/2014, the Agency invites the European Commission to agree with this measure which aims at further increasing the Agency's transparency on the clinical trial information on which the scientific assessments are based.

I am available to provide you with any further clarification or information.

Yours sincerely,

[redacted]

Guido Rasi
Executive Director

cc. Mrs S. Juelicher
Mr S. Soro
Mrs O. Solomon
Mr F. D'Atri

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Ref. Ares(2014)2137017 - 27/06/2014

EUROPEAN MEDICINES AGENCY

3 June 2014
EMA/240810/2013

European Medicines Agency policy on publication of clinical data

POLICY/0070
Status: Draft for discussion/endorsement
Effective date: 1 October 2014
Review date: No later than March 2016
Supersedes: Not applicable

1. Introduction and purpose

The aim of the European Medicines Agency ('the Agency') is to protect and foster public health. Transparency is a key consideration for the Agency in delivering its service to patients and society.

Although the Agency since its creation has launched several initiatives to increase transparency of information on medicinal products, there is growing demand from stakeholders for additional transparency, not only about the Agency's deliberations and actions, but also about the clinical data on which regulatory decisions are based. The Agency is committed to continuously extend its approach to transparency and has, therefore, taken the initiative to develop a policy on publication of clinical data, in accordance with article 80 of Regulation (EC) No 726/2004[1]. Consultations with a broad range of stakeholders and European Union (EU) bodies have taken place in drafting this policy. This policy is without prejudice to Regulation (EC) No 1049/2001[2] and Regulation (EU) No 536/2014[3]. It should be noted that this policy does not replace the existing 'Policy on access to documents (related to medicinal products for human and veterinary use)' (POLICY/0043) (EMA/110196/2006), which came into effect in December 2010~~., nor is it meant to create any hurdles to the implementation of Regulation (EC) No~~

[1] Regulation (EC) No 726/2004 of the European Parliament and of the Council of 31 March 2004 laying down community procedures for the authorisation and supervision of medicinal products for human and veterinary use and establishing a European Medicines Agency.
[2] Regulation (EC) No 1049/2001 of the European Parliament and of the Council of 30 May 2001 regarding public access to European Parliament, Council and Commission documents.
[3] Regulation (EU) No 536/2014 of the European Parliament and the Council of 16 April 2014 on clinical trials on medicinal products for human use, and repealing Directive 2001/20/EC.

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~~1049/2001[4]. This policy is also without prejudice to the publication of documents under Regulation (EU) No 536/2014[5].~~

2. Scope

The scope of the policy relates to clinical data, composed of clinical reports and individual patient data (IPD). ~~In particular, t~~The policy relates to clinical data submitted under the centralised marketing authorisation procedure for medicinal product for human use after the effective date (see section 4.3. for further information), either using the common technical document (CTD) format or another format:

- as part of a marketing authorisation application (MAA);
- or as part of a post-authorisation procedure for an already centrally authorised medicinal product;
- or as part of a procedure under Article 58 of Regulation (EC) No 726/2004;
- or submitted by a third party in the context of a MAA or a post-authorisation procedure for an already centrally authorised medicinal product;
- or requested by the Agency/ submitted by the applicant/marketing authorisation holder (MAH) as additional clinical data in the context of the scientific assessment process for the aforementioned situations.

The following clinical data are not covered by the scope of the policy:

- Clinical data currently held by the Agency for medicinal products authorised under the centralised procedure before the "effective" date (hereafter referred to as legacy data).
- Clinical data (either legacy data or data not yet held by the Agency) submitted to the Agency for non-centrally authorised products.

These clinical data continue to be made available to external requesters on a reactive basis in accordance with the aforementioned Agency's policy on access to documents.

In addition, the following clinical data are not covered by the scope of the policy:

- Clinical data that are not held by the Agency, even if they concern a medicinal product that has been authorised by the Agency (e.g. clinical trials on an authorised product conducted by independent investigators and not submitted to the Agency).
- Pharmacovigilance data based on Individual Case Safety Reports (ICSRs). Access by third parties to ICSR data is addressed in the Agency's 'EudraVigilance access policy for medicines for human use' (EMA/759287/2009 corr.).

3. Definitions

- **Clinical data:**

In the context of this policy, clinical data shall mean the clinical reports and IPD.

- **Clinical study:**

~~[4] Regulation (EC) No 1049/2001 of the European Parliament and of the Council of 30 May 2001 regarding public access to European Parliament, Council and Commission documents.~~
~~[5] Regulation (EU) No 536/2014 of the European Parliament and the Council of 16 April 2014 on clinical trials on medicinal products for human use, and repealing Directive 2001/20/EC.~~

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Clinical study shall mean any investigation in relation to humans intended to:

- discover or verify the clinical, pharmacological or other pharmacodynamic effects of one or more medicinal products;
- identify any adverse reactions to one or more medicinal products; or
- study the absorption, distribution, metabolism and excretion of one or more medicinal products;

with the objective of ascertaining the safety or efficacy of those medicinal products.

- **Clinical reports:**

Clinical reports shall mean the clinical study reports (generally submitted in module 5, "CSR"), clinical overviews (generally submitted in module 2.5) and clinical summaries (generally submitted in module 2.7), together with appendixes to the CSRs no. 16.1.1, 16.1.2 and 16.1.9.

- **Individual patient data (IPD):**

IPD shall mean the individual data separately recorded for each participant in a clinical study.

- **Personal data:**

Personal data shall mean any information relating to an identified or identifiable natural person ('data subject'); an identifiable person is one who can be identified, directly or indirectly, in particular by reference to an identification number or to one or more factors specific to their physical, physiological, mental, economic, cultural or social identity (Article 2(a) of Regulation (EC) No 45/2001).

- **Commercially confidential information (CCI):**

For the purpose of the policy, CCI shall mean any information that is not in the public domain or publicly available and where disclosure may undermine the legitimate economic interest of the owner of the information. CCI falls broadly into two categories: trade secrets ~~(including formulas, programs, process or information contained or embodied in a product, etc.)~~ and commercial confidences.

Comment [A1]: Of note, the protection of trade secrets is currently subject to a pending legal proposal (COM(2013)813 final). The reference to trade secrets may therefore need to be reviewed once that legal proposal is adopted.

4. Policy statement

The following aspects are addressed in this policy:

- Objectives of the policy.
- Characteristics of the policy.
- Date of coming into effect of the policy.

4.1. Objectives of the policy

The main objectives of the policy are to enable public scrutiny and secondary analysis of clinical data. A high degree of transparency will take regulatory decision-making one step closer to EU citizens, and promote better-informed use of medicines. In addition, the Agency takes the view that access to clinical data will benefit public health in future. The policy has the potential to make medicine development more efficient by establishing a level playing field that allows all medicine developers to learn from past successes and failures. Furthermore, it will enable the wider scientific community to make use of detailed clinical data to develop new knowledge in the interest of public health. Access to

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clinical data will allow third parties to verify the original analysis and conclusions, to conduct further analyses, and to examine the regulatory authority's positions and challenge them where appropriate.

The Agency also takes the view that transparency should be mutually respected. Those who perform secondary analysis of clinical data, published in accordance with this policy, must be held to the same standard of transparency as those who generate clinical data in the first place. Hence, all secondary analyses shall also be in the public domain and accessible for further scrutiny by the scientific community. In addition, ~~the Agency would~~those who perform secondary analysis of clinical data, published in accordance with this policy, shall provide the Agency ~~expect to be provided~~ with a copy of any article resulting from such secondary analysis before publication, in particular in those circumstances where the secondary analysis might result in the need for regulatory action to protect public health. This is a critical consideration in view of the Agency's role and responsibilities for a timely review of all available information which might have an impact on the benefit/risk ratio of centrally authorised products.

The Agency cannot guarantee that all secondary data analyses that are enabled by the policy will be conducted and reported to the highest possible scientific standard; this is not possible with a truly open approach.

Allowing external parties access to clinical data held by the Agency will directly or indirectly affect different stakeholders' rights, interests and values. In developing this policy the Agency had to consider a number of competing principles which needed to be carefully balanced in order to best ensure the overarching, long-term goal of protecting and fostering public health. These principles, as well as the Agency's positions and views, are described below:

- **Protecting personal data:**

The protection of personal data is enshrined in EU legislation; it is a fundamental right of EU citizens. The policy has to ensure adequate personal data protection; it must be fully compliant with applicable regulations in the EU, in particular Regulation (EC) No 45/2001 and Directive 95/46/EC. There are ways and means to anonymise data and protect patients from retroactive identification. Yet, the Agency is concerned that emerging technologies for data mining and database linkage will increase the potential for unlawful retroactive patient identification. The Agency, therefore, takes a guarded approach to the sharing of patient-level data, which is done to enable legitimate learning from sharing patient-level data while preventing rare but potentially damaging instances of patient identification. Furthermore, patients' informed consent should be respected. The secondary analysis of personal data will have to be fully compatible with the individual privacy of clinical trial participants and data protection.

- **Protecting CCI:**

The Agency respects and will not divulge commercially confidential information. In general, however, clinical data cannot be considered CCI. The Agency acknowledges that there are limited circumstances where information could constitute CCI.

- **Protecting the Agency's and the European Commission's deliberations and decision-making process:**

Regulators have a legal mandate to evaluate medicines. In doing so, they should only focus on the science and the best interests of patients. The decision-making process should be protected against external pressures from whatever direction. Once a decision has been reached, this consideration no longer applies.

Field Code Changed

- **Ensuring future investment in pharmaceutical research and development (R&D):**

Sustained and extensive pharmaceutical research activity is a precondition for future improvements in public health. The policy has no intention to negatively impact on the incentives to invest in future pharmaceutical R&D. It is designed to guard against unintended consequences, e.g. breaches of intellectual property rights that might disincentivise future investment in R&D.

4.2. Characteristics of the policy

The main characteristics of the policy are:

- Introduction of a managed publication process for clinical reports.
- Management of CCI in clinical reports.
- Methods for balancing the protection of patients' privacy whilst retaining scientific value of the data.
- Stepwise implementation of the policy.

4.2.1. Introduction of a managed publication process for clinical data

The introduction of a managed publication process for clinical reports is based on 2 pillars:

- Terms of use (ToU) which govern the access to and use of clinical reports.
- A technical tool allowing access to such clinical reports.

The ToU, attached as annex 1, provide more information in relation to the access to the information contained in the clinical reports and the use of such information. Particular aspects to be highlighted relate to the fact that the information is made available in a "view-on-screen-only" mode after completing a registration process, as described below. The clinical data will be made available in a searchable format and will be permanently available. No attempt shall be made to re-identify the trial subjects or other individuals from the information. The information may not be used to support a MAA/ extensions or variations to a MA nor to make any unfair commercial use of such information.

In addition, a technical tool will be available to allow access to such clinical data. This technical tool will be a user-friendly system, with simple procedural requirements in terms of firstly obtaining a user ID/ password, secondly the acceptance of the aforementioned ToU by the person wanting access to the clinical data, and finally the availability of a watermark on the published information to emphasise the ban to use it for commercial purposes.

4.2.2. Management of CCI in clinical reports

Although generally the information contained in clinical reports should not be considered CCI, the Agency acknowledges that in limited circumstances the clinical reports could contain CCI, and could, therefore, be subject to redaction prior to publication. CCI can only be contained in the titles referred to in Annex 2. Where redaction of CCI is proposed by the applicant/MAH, a consultation with the applicant/MAH will be undertaken, following scrutiny by the Agency of the proposed redaction including the justification as to whether the definition of CCI is fulfilled.

Field Code Changed

4.2.2.1. Redaction principles

The clinical reports that will be published in accordance with this policy shall only be subject to redactions when needed to protect those specific elements which qualify as CCI that should not be released. This complements the aforementioned use controls that will need to be accepted by recipients of the documents in order to protect the originator against misuse of the data as a whole. This covers information that is not in the public domain or publicly available and where disclosure may undermine the economic or competitive position of the applicant/MAH. In this regard, the assessment of this information will take into account the justification provided by the applicant/MAH with regard to various factors, including the nature of the product concerned, the competitive situation of the therapeutic market in question, the approval status in other jurisdictions, the novelty of the clinical development, and new developments by the same company.

In general, as already mentioned, most of the information in clinical reports would not be considered CCI. There, are, however, limited circumstances where the clinical reports could contain CCI.

~~Exceptions to the general principle that clinical reports are not CCI are included in the table provided as annex 2. The information described in these exceptions~~Information contained in the sections referred to in Annex 2 may have to be redacted as per the aforementioned redaction principles, after assessment by the Agency of the justification provided by the applicant/MAH. Where redaction has been agreed, this may also apply to the same information being present in other sections. If justification for additional redaction going beyond these exceptions is provided by applicants/MAHs in the future, the Agency will discuss with stakeholders whether to revise the attached table with the new proposed redaction, based on real life experience (including applicants'/MAHs' comments) following the implementation of this policy.

4.2.2.2. Process for publication of clinical reports

The process for publication of clinical reports is described in annex 3. This process foresees in consultation with the applicant/MAH in case the Agency disagrees with the redaction proposed by the applicant/MAH.

4.2.3. Methods for balancing the protection of patient's privacy whilst retaining scientific value of the data

Protection of patients' identity is of crucial importance. In order to achieve this objective both identification and re-identification of patients need to be avoided. Particular challenges in this respect are continuous developments in the field of technologies relating to data mining and database linkage, as well as specific scenarios to be considered in the area of medicine regulation, for instance the situation of rare diseases. In deciding on the most optimal approach (anonymisation versus pseudonymisation) the Agency will take due account of recent developments, e.g. the work undertaken by the network of EU Data Protection Authorities on anonymisation techniques[6], and subsequently discuss with stakeholders (e.g. patients' organisations, academia, pharmaceutical industry) to agree on the best way forward.

4.2.4. Stepwise implementation of the policy

The implementation of the policy will be undertaken in a stepwise manner:

[6] Opinion 05/2014 on anonymisation techniques, adopted on 10 April 2014 by the Article 29 Data Protection Working Party.

Field Code Changed

- In a first phase, the publication of clinical data will relate to clinical reports only.
- In a second phase, the Agency will endeavour to find the most appropriate way to make IPD available, in compliance with privacy and data protection laws[7].

4.2.4.1. First phase: publication of clinical reports

The publication of clinical reports will be in accordance with the arrangements described in sections 4.2.1., 4.2.2. and 4.2.3. of the policy.

In addition, the following principles will apply:

- ~~**Elements of the clinical reports to be published:**~~

~~The elements of the clinical reports that will be published are module 2.5 (clinical overview), module 2.7 (clinical summary), module 5 (CSRs and appendices 16.1.1 (protocol and protocol amendments), 16.1.2 (sample case report form) and 16.1.9 (documentation of statistical methods)).~~

~~The same rules regarding CCI will apply to the same information presented in other formats or places in the application.~~

Comment [A2]: Duplication. It is identical with the definition of clinical report. Is not in line with the concept whereby CCI are only contained in the titles referred to in Annex 2.

- **Timing of publication:**

The timing of publication takes into account the need to protect the Agency's and the European Commission's deliberations and decision-making process. In order not to undermine such decision-making process the Agency will only publish clinical data once the concerned procedure has been finalised. In practical terms this means:

- following the European Commission Decision granting or refusing the marketing authorisation (MA)/post-authorisation submission outcome; or
- following the scientific committee Opinion if there is no subsequent European Commission Decision; or
- following the scientific committee conclusion if there is no Opinion;
- following receipt of the applicant's/MAH's letter notifying the withdrawal of the MAA/post-authorisation submission.

Comment [A3]: To be clarified, especially for new MA, what happens if a company intends to resubmit at a later stage. An early publication despite an envisaged resubmission might put the applicant in a difficult situation, especially in case of innovative products.

The process described in section 4.2.2.2. for publication of clinical reports, including where necessary interaction with the applicant/MAH, will start following the adoption of the scientific Committee Opinion/conclusion or the receipt of the withdrawal letter, as referred to above.

4.2.4.2. Second phase: making available IPD

Before IPD can be made available, there is a need to first clarify the concept of IPD in terms of:

- when to submit IPD for subsequent scientific review by the Agency, and
- how to best provide access to such IPD, including the conditions to be fulfilled.

[7] The Agency will notify the EDPS accordingly.

Field Code Changed

It is important to emphasise in this regard that the Agency will not request applicants/MAHs to submit IPD for the sole purpose of publication of IPD.

The Agency will first undertake a targeted public consultation with all concerned stakeholder on the concept of IPD to provide clarification on the aforementioned aspects. Subsequently, the policy will be amended to reflect the outcome of this targeted public consultation.

4.3. Date of coming into effect of the policy

For the coming into effect of the policy a stepwise approach will be applied.

The effective date will be 1 October 2014 for any new MAAs, extension of indication applications and line extension applications under the centralised procedure, and Article 58 applications submitted as of that date.

For all other post-authorisation procedures relating to centrally authorised products where supporting clinical data have been submitted, the effective date will be determined in 2015.

As regards the effective date for making available IPD, this will be determined following the amendment of the policy as referred to in section 4.2.4.2.

5. Related documents

Not applicable.

6. Changes since last revision

Not applicable, new policy.

The policy will be revised, as appropriate taking into account the experience obtained, not later than 18 months after coming into effect.

London, <DD Month YYYY>

Guido Rasi

Executive Director

Field Code Changed

Annex 1

Terms of Use

These Terms of Use ("***Terms***") govern the access and use of clinical data, as defined in section 2. of the EMA policy on publication of clinical data, Policy 0070 ("***Policy***"), that are made available to Users via such Policy. By accepting these *Terms* and upon being granted access to the *Clinical Reports*, you agree to be bound by these *Terms*. Please read them carefully.

1. Definitions

In these *Terms* the terms below have the following meaning:

"**EMA**" means the European Medicines Agency.

"**Clinical Reports**" means the clinical study reports (module 5, "CSR"), clinical overviews (module 2.5) and clinical summaries (module 2.7), together with appendixes to the CSRs no. 16.1.1, 16.1.2 and 16.1.9 which are accessible via the *EMA* website as a result of the implementation of the Policy.

"**Applicant/MAH**" means the natural or legal person(s) or organisation(s) that submitted the *Clinical Reports* to the *EMA* in the context of applications in support of centralised marketing authorisations/post-authorisation submissions under Regulation (EC) No 726/2004, as well as any person(s) or organisation(s) who owns copyright or other intellectual property rights in the *Clinical Reports*.

"**User**" means the natural or legal person or organization who, having registered with the EMA's website in connection with the implementation of the Policy, receives access to the *Clinical Reports*.

Comment [A4]: It may be useful to provide for the same definition of applicant/MAH in the main body of the document, too (point 3 – definitions).

2. Access to the *Clinical Reports* under the policy

The *User* acknowledges that the *Clinical Reports* are protected by copyright or other intellectual property rights of the applicant/MAH and can be considered commercially valuable when used for commercial and regulatory purposes.

The *User* acknowledges that the *Clinical Reports* will be made available to the *User* on the EMA website in a "view-on-screen-only" mode, after completing the registration process. The *User* agrees that the *User* is not permitted to download, save, edit, photograph, print, distribute or transfer the *Clinical Reports*. The *User* agrees not to access the *Clinical Reports* using a method other than the interface provided by the *EMA*, or remove, bypass, circumvent, neutralise or modify any technological protection measures which apply to the *Clinical Reports*.

3. Use of the *Clinical Reports*

The *User* agrees to use the *Clinical Reports* according to these *Terms* and, in particular, that:

a) The *User* may use the *Clinical Reports* solely for information, research and/non-commercial purposes, subject to these *Terms*.

b) The *User* is not granted any intellectual property or other commercial rights in relation to the *Clinical Reports* other than as expressly set out in these *Terms*.

Field Code Changed

When using the *Clinical Reports*, the *User* shall:

a) acknowledge that its source is the applicant/MAH;

b) not use it in a way that suggests that the applicant/MAH endorses the *User* or the *User's* use of the *Clinical Reports* for any other purpose than information, research and non-commercial purposes;

c) ensure that the use of the *Clinical Reports* comply at all times with applicable law;

d) not misrepresent the source of the *Clinical Reports*;

e) not seek to re-identify the trial subjects or other individuals from the *Clinical Reports* in breach of applicable privacy laws.

The *User* may not:

- use the *Clinical Reports* to support an application to obtain a marketing authorisation and any extensions or variations thereof for a product anywhere in the world;
- share the *User's* username, password or other account details with a third party or otherwise provide a third party with access to the *User's* account;
- make any unfair commercial use of the *Clinical Reports*.

If the *User* fails to accurately complete the registration process, comply with these conditions, or uses the *Clinical Reports* in breach of these *Terms* of Use, the rights to access and use the *Clinical Reports* will be revoked.

4. Warranties and liability

Without prejudice to any obligation of the marketing authorisation holders/applicants in accordance with the Union legislation:

- The *EMA* and the applicant/MAH exclude all representations, warranties, obligations and liabilities in relation to the *Clinical Reports* as accessible via the *EMA* website to the maximum extent permitted by law;
- Neither the *EMA* nor the applicant/MAH are liable for any errors or omissions in the *Clinical Reports* as provided via the *EMA* website and shall not be liable for any loss, injury or damage of any kind caused by its use.

5. Third party rights

The restrictions and conditions and the warranty and liability provisions of these *Terms* are also made for the benefit of any and all applicants/MAHs and, accordingly, each such applicant/MAH may in its own right enforce these *Terms* in accordance with the provisions of the Contracts (Rights of Third Parties) Act 1999.

6. Governing law

These *Terms* and any dispute or claim arising out of or in connection with them or their subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the law of England and Wales.

Comment [A5]: To be considered whether the Agency would give the identity and log files of users to a marketing authorisation holders upon request or only in case of a judicial order in order to protect their personal data.

Field Code Changed

7. Jurisdiction

The courts of England and Wales shall have non-exclusive jurisdiction to settle any dispute or claim arising out of or in connection with these *Terms* or their subject matter or formation (including non-contractual disputes or claims).

Field Code Changed

Annex 2

~~List of exceptions that may be considered CCI~~Sections which can contain CCI – information which may be redacted

Exceptions to the general redaction principles outlined in section 4.2.2.1. of the policy are provided in the table below. Guidance described in column 3 advises what should be discussed in case of information that may be considered CCI.

Field Code Changed

354 **Table**

355

Title	[redacted]	[redacted]
Product Development Rationale *Information expected to be found in section 2.5.1 of the clinical overview as per ICH M4(R3) guideline*	• Information for planned clinical studies may include "exploratory endpoints" that are not intended to yield data in support of the then-current approval of a use or indication, but could provide clues to potential uses and indications for competitors. • Regulatory advice from outside the EU is typically non-public and includes agreements with regulators on study design, strategies for organisation and presentation of findings, and other aspects of the regulatory process that competitors could copy. • Same justification as above.	• "Describe the clinical development programme of the medicinal product, including ongoing and planned clinical studies and the basis for the decision to submit the application at this point in the programme...." • "Regulatory guidance and advice from outside the EU should be identified, with discussion of how that advice was implemented." • "Formal advice documents (e.g., official meeting minutes, official guidance, letters from non EU regulatory authorities) should be referenced...."
Overview of Biopharmaceutics *Information expected to be found in section 2.5.2 of the clinical overview as per ICH M4(R3) guideline*	• As the Biopharmaceutical Summary Documents (2.7.1) are considered CCI, this section may contain some overlapping information.	• Detailed assay information.
Overview of Clinical Pharmacology *Information expected to be found in section 2.5.3 of the clinical overview as per ICH M4(R3) guideline*	• Competitors could gain a detailed understanding of the stereoisomers and three-dimensionality of the molecule.	• Stereochemistry issues.

Comment [A6]: It may be considered to invert columns 2 and 3, as it is more intuitive to first present the 'information that may be CCI', then the justification.

Field Code Changed

Title		
Benefits and Risks Conclusions *Information expected to be found in section 2.5.6 of the clinical overview as per ICH M4(R3) guideline*	• The company may include justifications for any deviation from regulatory advice or guidance outside of the EU jurisdiction, a competitor may have an unwarranted new perception of the regulatory risk associated with a certain regulatory strategy.	• Implications of any deviations from non EU regulatory advice or guidelines.
Summary of Biopharmaceutic Studies and Associated Analytical Methods *Information expected to be found in section 2.7.1 of the clinical summary as per ICH M4(R3) guideline*	• This section may contain CCI in the form of details and specifications on assays developed by the company. The information may bring significant advantages to competitors if published.	• Information about specifications on company assays.
Summary of Clinical Pharmacology Studies *Information expected to be found in section 2.7.2 of the clinical summary as per ICH M4(R3) guideline*	• This section may contain CCI in the form of details and specifications on assays developed by the company. The information may bring significant advantages to competitors if published.	• Information about specifications on company assays and immunogenicity assays.
Reports of Biopharmaceutic Studies *Information expected to be found in section 5.3.1 of module 5 "Clinical study reports" as per ICH M4(R3) guideline*	• This section may contain CCI in the form of details and specifications on assays developed by the company. The information may bring significant advantages to competitors if published.	• Information about specifications on company assays (e.g. Bioavailability, In Vitro – In Vivo Correlation).
Introduction *Information expected to be found in section 7 of the clinical study reports as per ICH ~~M3~~ E3 guideline*	• May contain non-public information that the sponsor agreed in another jurisdiction outside of the EU.	• Development of the protocol or any other agreements/meetings between the sponsor/company and non EU regulatory authorities that are relevant to the particular study, should be identified or described.

Comment [A6]: It may be considered to invert columns 2 and 3, as it is more intuitive to first present the 'information that may be CCI', then the justification.

Field Code Changed

Title			
Study Objectives (including Exploratory Endpoints and Efficacy and Safety Variables; 9.5, 11.4) *Information expected to be found in section 8 of the clinical study reports as per ICH ~~M3~~ E3 guideline*	• The exploratory study objectives could be used by a competitor to gain insights into additional future study plans and/or indications for the product. For example, in some trials for a new anti-inflammatory medicinal product, an exploratory lipid profile was included, investigating the lipid metabolism in patients treated with the product, to inform future studies rather than to support the MAA. The results of these analyses were included in the CSRs submitted to the EMA in the course of the MAA procedure. • Alternatively the exploratory objectives may include biomarkers that could be used as 'hypothesis generating' for future studies. At that stage there would not be enough information to file patent applications on these objectives until some data are available from clinical and non-clinical studies. Disclosing these exploratory objectives may preclude obtaining patents that would cover biomarkers/diagnostics themselves, as well as method of use patents directed to patient subpopulations.	• Statements/descriptions relating to objectives that are not supportive of a label claim and they were not taken into consideration in the overall benefit/risk evaluation. This includes the definition of efficacy and safety variables collected and analysed in support of exploratory objectives.	
Determination of Sample Size *Information expected to be found in section 9.7.2 of the clinical study reports as per ICH ~~M3~~ E3 guideline*	• The sample size per se is not considered CCI. However there may be occasions when the intellectual consideration that goes into the analysis of the information that drives the sample size calculation (e.g. estimates of endpoint variability, measurement precision, screening and	• CCI concern is also applicable to Documentation of statistical methods in appendix 16.1.9 of the CSR.	

Comment [A6]: It may be considered to invert columns 2 and 3, as it is more intuitive to first present the 'information that may be CCI', then the justification.

Field Code Changed

Title			
	retention rates) is considered CCI.		
Method of PK/PD determination *Information expected to be found in section 14.4 of the clinical study reports as per ICH ~~M3~~ E3 guideline*	• This section may have proprietary information on how analyses are performed.	• CCI on analytical methods.	

Comment [A6]: It may be considered to invert columns 2 and 3, as it is more intuitive to first present the 'information that may be CCI', then the justification.

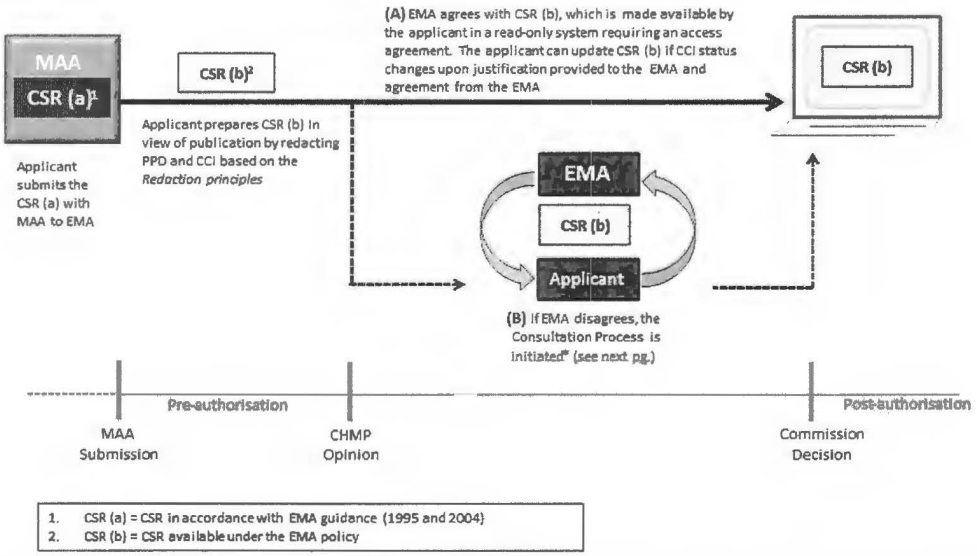
356

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Field Code Changed

358 **Annex 3**

359 **Process for publication of clinical reports (scenario: MAA)**

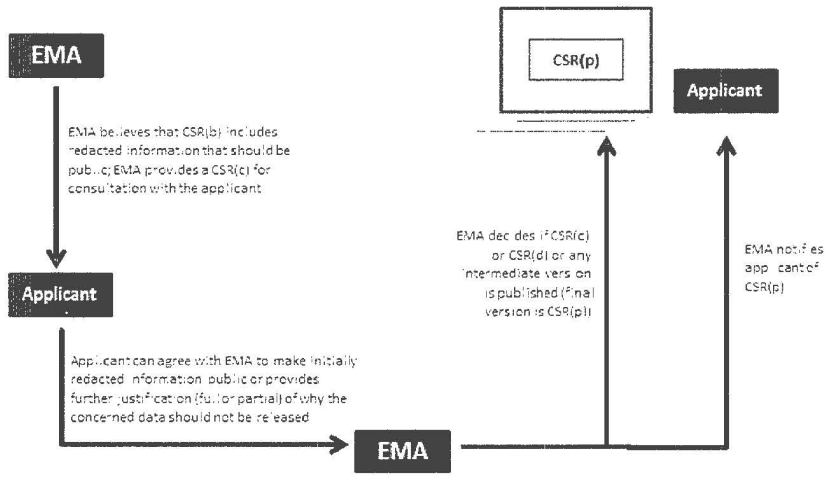


1. CSR (a) = CSR in accordance with EMA guidance (1995 and 2004)
2. CSR (b) = CSR available under the EMA policy

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Field Code Changed

*Consultation process



* Consultation process to be concluded within Decision making process timelines – exact timing still to be determined.

Field Code Changed

Ref. Ares(2014)2137017 - 27/06/2014

Meeting on EMA draft policy on publication of clinical data

4 June 2014, Brussels (DM24 02/67)

Participants

EMA
Noël Wathion
Stefano Marino
Anthony Humphreys

DG SANCO
Andrzej Rys, Director D
Sabine Jülicher, HoU D5
Olga Solomon, DHoU D5
Stefano Soro, HoU D6,
Fabio D'Atri, DHoU D6
Miroslav Griva, D5
Florian Schmidt, D5
Marina Marini 03

DG ENTR
Salvatore D'Acunto, HoU F4
Thomas Heynisch, DHoU F4
Chloë Spathari, F4

DG MARKT
Alfonso Calles Sanchez, D2

DG RTD
Catherine Berens, E4

DG TRADE
Pedro Velasco Martins, DHoU B3

SG
Nusrut Bahadur, trainee

LS
Attila Sipos, SJ.H

I. Introduction

EMA started the process in 2012. In June 2013 EMA organised a public consultation on its draft policy on the pro-active publication of clinical trial data received in the framework of a marketing authorisation application. EMA received more than 1000 comments with sometimes competing views. Building on the results of the consultation, the Agency proposed some basic principles that were agreed by EMA Management Board in December 2013. On the basis of those principles, the initial draft was reviewed and subsequently made subject to targeted consultation in May 2014 with:

- Patients and Consumers Working Party of EMA
- Pharmaceutical industry associations
- Academia and medical journals

Among the topics that were debated:

- the elements in the to be published clinical data that could constitute "commercially confidential information" (CCI),
- the terms of use in order to access the clinical data.

Moreover, EMA liaised with ECHA in order to exchange views on the publication of information contained in an application dossier. The situation is, however, not fully comparable, as the legal framework under which ECHA works contains a specific clause whereby they are fully entitled to publish all received documents. ECHA also has a very robust system of checking the presence of copyright and confidential information and, EMA's view is that as a result, ECHA publishes less than what EMA draft policy intends to publish.

EMA also discussed patent related questions with staff of the EPO. This discussion relates to concerns that a publication may endanger the possibility of filing secondary patents in view of the loss of novelty due to the publication of data. To address this concern, EMA considers an increased period of time between the regulatory decision (e.g. marketing authorisation) and the publication of data under the new scheme. This would leave companies 10-12 months to verify their filing strategy regarding patents. According to EMA, EPO, as well as industry (including Biotech companies and SMEs) confirmed that an increased lead time is likely to solve the issue.

II. Concerns expressed by DGs

Concerns were voiced regarding the broader impact of the policy, including the question whether companies could reduce their research activities in the EU and transfer them to the US. It was asked whether this policy could distort the harmonisation of the approach between FDA/EMA. At the same time, it was pointed out that R&D activities are internationalised anyway. A Clinical Study (CS) performed outside the EU would be published, according to the policy. It was also pointed out that other regions also seem to move into the direction of more transparency. The same is true for several industry initiatives.

DGs expressed concerns that the 'novelty' aspect would be lost which could hamper patentability. They asked for a more robust confirmation from EPO that publishing unexpected ADRs would not endanger the concept of novelty.

It was reckoned that a 12-month period is not sufficient, especially in some non-EU countries where the filing period takes longer.

It was replied that industry feedback is positive. Moreover, the access currently granted under transparency provisions is *erga omnes* and with very little redaction, so in general, the novelty aspect is not a new discussion. As far as the EU is concerned, there is an agreed position (cf. 'Notice to applicants') that clinical data obtained via transparency channels cannot be used for regulatory purposes.

Another issue raised was the problem of the 'grace period'. In the US, the 'grace period' gives another 12 months *after* the publication during which it is still possible to obtain a patent. Such a possibility does not exist under the European Patent Convention.

It would seem that this was not raised by EPO staff. At the stakeholder meeting organised by EMA, industry representatives seemed satisfied when EMA proposed the solution that no publication should take place before the actual granting of the marketing authorisation.

Some participants considered that the question of patentability is open and requested a formal position of the EPO. It was underlined that the consequences of this policy can extend well beyond EMA. Therefore, further discussion and proper analysis were needed.

Participating DGs requested an accompanying document providing an overview of the different positions and concerns expressed and the solutions proposed to address those, as well as minutes of the consultations undertaken by EMA. This was necessary in order to provide an opinion.

It was clarified that if the policy is adopted by the Board, EMA will publish:

1/ A Q&A document explaining the policy in lay language
2/ The comments received during the public consultation
3/ A high-level summary of how the comments were addressed (this 3d document will not be published immediately)

Some DGs were concerned with the enforceability of the Terms of use (ToU): how would the owner of the data be protected if someone uses the data for unauthorised purposes (e.g. for another application)? It was clarified in reply that accepting the ToU is considered as a contractual obligation, therefore English courts are competent in case of failure to comply / if the user acts in breach of the ToU. In case a MAH disagrees with the content of the published data, the company may lodge an action before EU courts.

III. Relationship between EMA policy and Regulation 1049/2001 on access to documents

The question was whether a document which has undergone the process of managed publication, as described in the policy, is still subject to the provisions of regulation 1049/2001 or should be considered as published. It was concluded that the new policy and the current policy on access to documents will apply in parallel, meaning that a request for access to documents will be handled as currently, regardless of whether these documents have already been subject to the managed publication proposed in the EMA new policy.

If adopted, the policy would be effective for new applications submitted after October 2014. However, as any submitted data will only be published after the completion of the regulatory process, the availability of any data before end of 2015/beginning of 2016 is unlikely.

All DGs were asked to send comments by Friday of the current week.

Ref. Ares(2014)2963075 - 27/06/2014

EUROPEAN COMMISSION
HEALTH AND CONSUMERS DIRECTORATE-GENERAL

Director-General

Brussels,
SANCO/D5/FS/iv(2014)ddg1.d5.2048075

Dear Dr Rasi,

Subject: EMA Policy on publication of clinical data

I refer to your letter dated 28 May and your request to receive the Commission's agreement on the draft policy on publication of clinical data in accordance with Article 80 of Regulation (EC) No 726/2004.

This policy aims to increase transparency as far as the clinical data is concerned that has been submitted to and was assessed by the Agency in the framework of a marketing authorisation procedure for human medicinal products. It corresponds with a well-founded societal demand towards more openness and easy access, especially in areas relating to public health. In this context, it is also worth noting that recent developments in the EU pharmaceutical legislation reinforce the approach towards transparency; an evolution that has been long advocated by patients and researchers alike.

At the same time, it is important that the European Union remains a hub for a competitive and innovative pharmaceutical industry that considers the EU as a first choice for placing new products on the market and make them accessible to patients.

Against this background, I welcome the broad consultation process that has taken place and which was essential to come to an informed proposal in an area that involves many different, sometimes competing interests.

I am pleased to inform you that the Commission can submit its agreement to the draft proposal that has been circulated to the Management Board of the European Medicines Agency on 3 June 2014 (EMA/240810/2013), subject to the following comments being taken into account:

- The policy document should state clearly that it is without prejudice to Regulation (EC) No 1049/2001 on access to documents. This is necessary to avoid any misinterpretation as regards the impact of the policy in relation to the established and univocal rights under the Union law on access to documents. (See our drafting in the annex to this note).

Dr Guido Rasi
Executive Director
European Medicines Agency
7 Westferry Circus - Canary Wharf
London El4 4 HB - UK
E-mail: [redacted]

- The policy is without prejudice to the new Clinical Trial Regulation (EU) No 536/2014 and the publication requirements established thereunder. While this is already stated in the policy document, it is an important element for the Commission in giving its agreement.

- The 'Terms of Use' governing the access of clinical data must specify more clearly which way of transcribing/processing/using the data is permissible for research purposes. As a minimum, it needs to be specified that manual transcription of data for information, research and non-commercial purposes is permissible. The Commission would appreciate that other, more user-friendly ways of making data available for legitimate research purposes are considered.

- As far as any dispute between the marketing authorisation holder and the user of the data is concerned, the 'Terms of Use' provide for the enforceability of third party rights under a statutory instrument of English law. The Commission needs to be reassured that this instrument is appropriate for this purpose taking into account that the parties may neither be established in nor residents of the United Kingdom.

- While the policy document acknowledges that the justifications for redacting commercially confidential information may evolve over time and sets out a consultation process for agreeing on modifications (section 4.2.2.1), it should also clarify what will happen in the interim, i.e. until the consultation process of stakeholder discussion and potential revisions of the current table is completed.

Additionally, we identified some drafting issues that point to inaccuracies or imprecise terminology and which should be taken into account in the finalisation of the policy. Those elements are highlighted in track changes in an annex to this letter.

Finally, we understand that the publication of the new policy will be accompanied by

(1) a document summarising the results of the consultation process and how different suggestions and concerns have been taken into account; and

(2) a Q&A document and/or implementation guidance.

From the Commission's point of view, it will be essential that the first document provides a comprehensive summary of the process that lead to the draft proposal in order to allow the public to understand how the draft evolved. It should address issues discussed during the public and the targeted stakeholder consultation, as well as points for clarifications raised in the Management Board meetings.

Moreover, it is expected that any Q&A document and/or implementation guidance will be consulted with the Commission services prior to its publication.

Yours sincerely,

Paola Testori Coggi

Annex: Drafting suggestions/comments in track changes

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