PSST's

MedDev's up-to-date: EU and beyond

A monthly information service for PSST customers and friends

No	No. 1 June + July 2015	page

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No. 1

Ireland, UK working on new medtech fee systems

By A Wenzel adapted from an article in scrip regulatory

Ireland and the UK are the latest EU member states to announce plans for a new fee-based system for the regulation of medical devices. It seems likely they will join the many other EU member states that have systems to recoup all, or the majority, of their costs associated with the regulation of medical devices.

Ireland has already developed a detailed proposal for a new annual fees for medical device manufacturers and distributors[1,2]. The UK intends to consult with stakeholders in the second quarter of this year on a new funding model that would contain a mix of a new periodic fee, adjustments to existing fees and minor central funding[3,4].

Other EU countries that already have fee-based systems include Austria, Belgium, Croatia, Denmark, France, Germany, Italy, Latvia, Lithuania, Portugal and Spain.

Irish proposal

The Irish Health Products Regulatory Authority is inviting feedback on its proposal to introduce a new annual fee for all manufacturers and other economic operators supplying or manufacturing medical devices.

The proposed fee is expected to come into effect early next year and would vary according to the company's size and activity. As part of the proposal, device manufacturers would have to be registered as entities in order to administer the fee, but no fee would be associated with the registration process itself. Specific details of the proposed fees are explained in Table 1 below.

Table 1. HPRA's annual fee model based on manufacturer's size and other factors

Fee model	**Amount**
Manufacturer with more than 150 employees	€30,000 ($33,167)
Manufacturer with 50 - 150 employees	€25,000
Manufacturer with 15 - 49 employees	€15,000
Manufacturer with 5 - 15 employees	€5,000
Manufacturer with less than 5 employees or a turnover of less than €500,000	€250
Manufacturer – legal manufacturer/Authorized Representative status (Subject to a cap: Manufacturers based in Ireland that hold legal manufacturer or authorized representative status for some or multiple entities would pay an additional fee per entity up to a maximum of €10,000 per year)*	€1,000

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Authorized representative	
(Subject to a cap: Entities who act as authorized representatives, without being a medical device manufacturer per year would be charged an additional fee up to a maximum of €30,000)*	€5,000
Large distributor with a turnover of more than €15 million	€5,500
Medium distributor with a turnover of €3 to €15 million	€3,500
Small distributor with a turnover of less than €3 million	€1,250
Distributor with a turnover of less than €500,000	€250
Certificate of Free Sale issuance	€250

*The fee would be calculated based on designation as a legal manufacturer/authorized representative for a particular manufacturer, which may cover a range of medical devices.

Companies considered to be SMEs would have to comply with all the registration and data provision requirements and pay an annual fee of €250.

Source: HPRA

The proposed model is based on estimates of the size of the manufacturing and distribution sectors. The HPRA clarifies that "any over or underestimates" would be addressed after the first year of operation of the fee model.

The aim of the proposal is to ensure that the regulation of the medical devices industry in Ireland is self-funded. While there are several approaches to recovering costs, the HPRA believes that its proposed fee model – which reflects the capacity of the manufacturer or the economic operator to impact the market place – is "the simplest and [the] least burdensome to administer".

The HPRA acknowledges that many manufacturers are already required to pay fees for pre-market conformity assessment and certification of their products, it clarifies that proposed fee is intended to recover the costs associated with market surveillance of medical devices.

While developing the fee proposal, the HPRA also explored the concept of a "fee per medical device on the Irish market with related fees". However, the agency believes that such a model is "unfeasible under the current regulatory framework", but it may become appropriate in the future following the revision of the EU medtech legislation. As part of its annual fee review, the HPRA will re-consider this model as the regulatory framework changes.

The European Commission's proposed revision of the medtech legislation includes specific provision for full cost recovery through fees levied by national authorities[5]. The HPRA believes that the most effective fee structure would be an EU level model with a single fee for each device, with an ongoing single annual maintenance payment to cover all of Europe along with funding distributed to competent authorities in accordance with their activities and responsibilities. However, this is unlikely to be achievable in the short- to medium-term without substantial change to the administration of the regulatory framework at the EU level. The HPRA notes that an array of different fee models for each medical device authority is likely to emerge until the EU proposal is finalized.

Stakeholders have until 6 August to comment on the proposed HPRA fee model. Following the consultation process, the HPRA will submit its final fee proposal to the Department of Health to seek its agreement on implementation, and thereafter the fees will be set on a statutory basis.

UK model

The UK Medicines and Healthcare Products Regulatory Agency states in its business plan for 2015-16, among other things, that it will focus on implementing a revised medical devices funding model that will enable it to deliver its regulatory responsibilities "at a financially sustainable level in the longer term".

MHRA activities in relation to the regulation of devices are largely derived from grant-in-aid from the Department of Health, and the agency points that this been reduced by over 30% in recent years "as a result of austerity measures"[6]. In fact, the agency points out that its funding for medtech regulation "is at half the level of that in 2003 in real terms".

For the regulation of medical devices in 2015-16, the MHRA estimates it will need £8.1m ($12.63m) plus another £1m for investment in further efficiencies.

To this end, the MHRA intends to deliver a funding scheme that will allow the agency to recover its anticipated costs of device regulation in 2016/17 through a new periodic fee, adjustments to existing fees and minor central funding by gaining ministerial agreement to the fees proposal and launching formal consultation in the second quarter.

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Source: *Vibha Sharma* , Scrip Regulatory

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Japan formally joins international pilot on single audit for medical devices

By A Wenzel adapted from an article in scrip regulatory

Japan's health ministry and healthcare products regulator agency have formally joined the pilot phase of the international medical device single audit program (MDSAP)[1]. Until now, the country's Ministry of Health, Labour and Welfare and the Pharmaceuticals and Medical Devices Agency have only been involved as observers and active participants in MDSAP's Regulatory Authority Council (the MDSAP's governing board) and its subject matter expert groups[2].

On 23 June, the MHLW and the PMDA decided to join the MDSAP pilot as full members. This means that medtech companies interested in marketing their products in Japan as well as in other MDSAP participating nations (ie Australia, Brazil, Canada, and the US) can now take part in the MDSAP pilot.

MDSAP is being run by the International Medical Device Regulators Forum. Companies participating in the MDSAP pilot need to undergo only a single inspection by an authorized auditing organization to demonstrate compliance with the regulatory requirements of all MDSAP participating nations.

During the pilot, audit reports issued to companies by authorized auditing organizations would be used by the MHLW and the PMDA in both pre-market and periodical post-market audits under regulations in Japan. "Undergoing the MDSAP Pilot audits is expected to reduce some burden on Japanese regulatory processes," the Japanese authorities said.

The IMDRF's MDSAP work stream is being co-ordinated by Kimberly Trautman, associate director for international affairs at the US Food and Drug Administration's devices unit. The FDA said: "Through the MDSAP pilot, the MHLW and the PMDA are willing to contribute in ensuring appropriate Quality Management System (QMS) and other regulatory requirements are being met by manufacturers, with effective resource allocation, while sharing knowledge and experiences of assessment of auditing organizations with the regulatory authorities, based on the more than 10 years' assessment experiences in Japan".

The MDSAP pilot will run until the end of 2016, followed by full implementation of the program sometime in 2017.

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Source: *Vibha Sharma* , Scrip Regulatory

The tricky business of when to classify an app as a medical device

By: Lincoln Tsang and Ben Jefferies 20 July 2015

mHealth increasingly plays a part in delivering and optimizing patient care in the EU but there is still room for interpretation as to the applicability of the medical device legislation to mobile apps, say *Lincoln Tsang* and *Ben Jefferies*.

Working out whether a software app qualifies as a medical device under EU law is complicated and it is getting even more difficult as the functionality and use of apps expands.

The European Commission last year released for consultation a green paper on mobile health or mHealth, which highlighted, amongst other things, the absence of binding rules as to the delimitation between lifestyle and wellbeing apps and a medical device or *in vitro* diagnostic (IVD) medical device as well as the lack of clarity around the rules that must be complied with should the EU medical device directives not apply[1-3]. The consultation closed in July 2014 and, on the basis of the responses, the commission is looking into taking steps to support the implementation of mHealth in the EU.

In the meantime, this article discusses of some of the guidance that is available in the EU and the UK to aid developers and manufacturers determine whether their products come within the remit of the EU medical device directives and what rules apply.

Advancing technology

As technology advances at an ever increasing rate, a growing number of medical device manufacturers, software developers, academics, clinicians and health providers are using software for healthcare and social delivery.

With the expanding use of smart phones and their ability to record and store information, apps are increasingly becoming a part of delivering and optimizing patient care. Examples include lifestyle and wellbeing apps that may connect to medical devices or sensors (eg bracelets or watches), personal guidance systems, health information and medication reminders, and apps providing clinical healthcare at a distance (ie telemedicine or telehealth), which all fall under the wider umbrella of mHealth. As this field develops, the question of whether an app could be regulated as a medical device is becoming increasingly more relevant.

In the EU, the medical device directives[4] set out the requirements with which manufacturers must comply in order to place a product on the market; this includes the affixing of a CE mark to indicate conformity.

In 2007, the definition of a medical device under these directives was amended to include software. Interpreting this purposively, some electronic systems, such as mobile apps, can be regulated as medical devices, requiring manufacturers to comply with the relevant provisions of the aforementioned directives.

However, the analysis of whether an app qualifies as a medical device is complex and must be carried out on a product-by-product basis. Furthermore, the number of grey areas is increasing as the functionality and use of apps expands.

Guidance from the commission

Since 2012, the commission has published a series of guidance documents that can aid in the qualification and classification of mobile apps. According to the guidance, any stand-alone app (ie not used exclusively for a medical device or incorporated in a medical device) may be considered a medical device if it falls within the definition of a medical device under the medical device directives, ie it is intended by the manufacturer to be used for a medical purpose.

The determination of whether an app qualifies as a medical device should be based on a proper assessment of: (a) the characteristics of the product; (b) the intended purpose; and (c) the claim made by the manufacturer on the product label or promotional materials such as brochures or webpages.

The MEDDEV 2.1/6 guideline published in January 2012[5] includes a useful decision diagram to assist in the qualification of software as a medical device with some key questions to aid in the determination process: (a) is the software performing an action on data different from storage, archival lossless compression, communication or simple search; (b) is that action for the benefit of individual patients; and (c) is that action for any of the purposes specified in the medical device directives such as the diagnosis, prevention, monitoring, treatment or alleviation of disease.

The MEDDEV 2.1/6 guidance also provides some illustrative examples of qualification for software used in the healthcare environment. Examples that may be of interest to developers of healthcare apps include the qualification of decision support tools that are intended to provide healthcare professionals with recommendations for diagnosis, prognosis, monitoring and treatment of individual patients and telemedicine systems intended to allow monitoring and delivery of healthcare to patients remotely.

In July 2014, the commission issued an updated version of its manual on borderline and classification in the community regulatory framework for medical devices[6], which includes a new section on borderline classification of software and mobile apps.

The manual supplements the MEDDEV 2.1/6 guidance and provides classification guidance for three specific types of mobile app: (a) an app for processing ECGs to allow for more timely and accurate diagnosis and treatment of patients, which the commission considers to be a Class IIa medical device as it would perform an action on data other than just storage for the medical benefit of individual patients; (b) an app intended to improve the quality of communication between patients and caregivers during childbirth by storing data on contractions, which the commission does not consider to be a medical device as its actions would be limited to storage and simple search; and (c) an app for learning about the anatomy of the human body through illustrations, imaging and terminology, which the commission does not consider to be a medical device as it would not be used directly for the medical benefit of the individual patient.

The commission's updated manual re-emphasis the two key questions to be asked when determining whether an app could be regulated as a medical device: is the app performing an action on data other than just storage and is the app is intended for the medical benefit of individual patients?

MHRA guidance

In March 2014, the UK's Medicines and Healthcare Products Regulatory Agency published guidance[7] on medical device standalone software, which includes mobile apps. The guidance is designed to help healthcare and software developers determine whether a specific piece of stand-alone software or an app constitutes a medical device.

The underlying principles and the approach set out in the MHRA guidance are not significantly different from those in the commission guidance and the case law of the Court of Justice of the European Union. The guidance confirms that a key element of the qualification process is determining whether or not the app is intended by the manufacturer to have a medical purpose. An app that has a medical purpose could be a medical device.

The MHRA guidance also provides some more practical examples of the qualification of software apps (including a list of words likely to contribute to the MHRA determining that an app is a medical device), decision support or decision-making software and telehealth.

Any product that is deemed to be a medical device must bear a CE mark before it can be placed on the market. The steps required to obtain a CE mark will depend upon the risk classification for the device and the MHRA has provided useful guidance on how to make this assessment in relation to software and apps. Many apps that qualify as medical devices are likely to fall within Class I, in which case, subject to certain exceptions, the manufacturer only has to self-certify compliance with the essential requirements before it can register the device and place it on the market.

Other useful aids

Standards company BSI published a code of practice in April this year specifically for health and wellness apps, which it developed in conjunction with the public body Innovate UK. The code of practice, entitled "PAS 277 Health and wellness apps - Quality criteria across the life cycle"[8], establishes a set of principles that health app developers should follow throughout an app project life cycle in order to ensure that their products and services can be trusted by healthcare professionals, patients and the public.

PAS 277 includes a set of quality criteria that should be considered for a health and wellness app including regulatory and legal compliance, functionality, usability and user experience, reliability, performance and scalability, security and privacy, safety (including patient safety), compatibility and portability, and maintainability. The code covers native, hybrid and web based apps as well as those associated with wearable, ambient and other health equipment.

It should be noted that PAS 277 does not provide guidance on the process or criteria to establish whether a health and wellness app is subject to regulatory control as a medical device.

The Royal College of Physicians, in conjunction with the MHRA and the General Medical Council, have also produced a short guidance document on the use of medical apps. The factsheet advises that doctors should not use medical apps, including web apps, that do not have a CE mark and should always exercise professional judgement before relying on information from an app.

The requirement that doctors only use medical apps with a CE mark means, in simple terms, that developers of medical apps intended for use by doctors must ensure that their app is subject to the CE

conformity assessment. The factsheet also raises awareness amongst healthcare professionals about the use of apps in clinical practice and the related regulatory requirements.

The future of medical device and mobile health regulation in Europe

The regulatory framework for medical devices in the EU is currently undergoing refom[9]. In September 2012, the commission published two draft regulations – one covering medical devices and one IVD medical devices – that, once finalized, will replace the medical device directives. The main aim of the regulations is to improve the harmonization of medical device rules across Europe. Although still in draft form, the changes under the new regulations largely relate to medical devices generally rather than mobile apps specifically. However, some rules have been modified to account for technological and scientific progress; one example being the adaption of safety and performance requirements applicable to new software technologies used in healthcare. It is anticipated that the new legislation will tighten up the regulatory framework rather than revise it completely.

The EU regulatory reform passed an important milestone in June, after the Latvian Presidency of the Council of the European Union reached an agreement on amendments to both regulations. The documents have now moved towards trialogue discussions involving the council, the commission and the European Parliament. Final agreement on the new regulations is not expected to occur before 2016. The new rules would gradually come in to effect over the five years after that date.

Also at the EU level, responses to the consultation on the green paper on mobile health that the commission launched in April 2014 are also likely to lead to changes that will support the implementation of mHealth in the EU.

Conclusion

Regulators are struggling to keep up with the rapid developments in the mHealth sector and there is still room for interpretation as to the applicability of medical device legislation to mobile apps.

The MHRA guidance read together with the commission guidelines provide a greater degree of clarity on the principles underlying the classification and regulation of mobile apps. The product characteristics and the claim assigned by the manufacturer are decisive on whether an app can be properly regulated as a medical device. However, in the end, one still needs to carry out a factual assessment of the product characteristics to inform the decision of whether an app will be regulated as a medical device and to determine what rules apply.

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Swissmedic updates guidance on medical device clinical trials

By A Wenzel

Swissmedic has updated its guidance on clinical investigation of medical devices with new examples that explain how trial investigators should record incidents and device deficiencies in case report forms[1].

The document, which deals with the requirements for the authorization, reporting and surveillance of clinical trials, also contains new information on performing a causality assessment between an adverse event and the investigational device/intervention procedure.

The guideline states, for example, that causality cannot be ruled out if: no other clear cause can be identified, and there is a correlation in time or with the bodily part concerned; if the investigational device or a procedure could affect the bodily part concerned; if similar events have already been recorded as side-effects or complications with other similar devices and procedures; or if user errors are involved (eg, in case of an injury due to an operating error).

Also, further details have been added to the guidance document under the sections on: authorization of clinical trials; review and surveillance activities by Swissmedic; and submissions to Swissmedic by sponsors during clinical trials. In addition, information in the guideline has been re-arranged and streamlined, and updated links and contact details have been added.

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Ukraine's new medtech regulations in force, transition decision awaited

Delayed by a year, Ukraine's new system of conformity assessment and notified bodies for medical devices came into effect on 1 July 2015 - although uncertainty over transition arrangements and some doubts over the level of preparedness persist. But the Ministry of Health remained true to its word: in autumn 2014 it committed to introducing the three technical regulations/decrees, in replacement of the state system of registration, by Q3 2015[1].

The new system has been beset by slow progress since it appeared in a government proposal in 2013. The first attempts to introduce conformity assessment for medical devices date back as far as 2008.

With the three medical device decrees (Nos 753, 754 and 755) now obligatory, Decree 1497 on state registration of medical devices) is now repealed. The possibility of submitting applications for new state registrations or renewals has ceased, says Kiev-based healthcare products regulatory consultant Cratia.

Rules for device imports

However, under already-agreed transition arrangements, imports of state-registered medical devices can continue until the relevant licenses expire, and by 1 July 2016 at the latest (under Decree No 181).

Imports into Ukraine post 1 July must be accompanied by one of the following: a declaration of conformity to the technical regulations; an application for special purpose use (such as clinical studies); or proof of entry in the State Registry of Medical Devices, according to a letter addressed to the Association of Market Operators of Medical Devices (www.amomd.com) from the State Fiscal Service.

Doubts about speed of transition

Other transition arrangements are less certain. Although – as of now – all new approvals and license amendments must be done via the conformity assessment procedure, there are understood to be discussions ongoing that would allow a gradual implementation of the three technical regulations over a six-month period until 1 January 2016. This leaves open the possibility of a residual use of what Cratia terms the "classic" (ie state) registration system.

The Cabinet of Ministers was due to decide on these matters on 1 July, but official reports on its deliberations have not been released, perhaps indicating ongoing high-level nervousness about the speed of introduction.

The American Chamber of Commerce in Ukraine has been clear over its fears. In a letter to Ukraine Prime Minister Arseniy Petrovych Yatsenyuk and health minister Alexander Kvitashvili dated 30 June, the ACCU stated its concern over the "lack of appropriate legal framework" and minimum experience of implementing the new procedure. This makes a smooth transition to conformity assessment "impossible", it opined.

The letter also pointed to the small number of Ukraine conformity assessment bodies – eight so far – and their small staff and lack of expertise in active implantables. It also noted the long-term processes

involved in performing conformity assessment (document examination, manufacturing process examination, etc) as well as the auditing requirements. It further suggested that without a new register of products (having repealed Decree 1497), imports and public procurement of medical products will grind to a halt.

It also claims that, of over the 290 or more national standards needed in Ukraine (equating to EU harmonized standards), fewer than 90 have been put in place. All of which leads the ACCU to suggest that Decree 1497 should be maintained in amended form (for an undefined period) to allow the transit to conformity assessment and the three decrees/regulations (below) in a gradual and controlled way so as not to disrupt the supply of medical products in a country undergoing regional conflict.

The text of the decrees is almost identical to that of the three main EU medical device directives, with several important national differences[2]. Decree 753 concerns medical devices (based on EU Council Directive 93/42/EEC); Decree 754 concerns IVDs (based on EU Parliament and Council Directive 98/79/EC); and Decree 755 concerns active implantable medical devices (based on EU Council Directive 90/385/EEC).

But while the entry in force date is fixed and certain, the substance of the changes seems far less so at present.

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Source: scrip reg Aff

Demystifying medical device GCPs

By Vibha Sharma , Scrip

Jean-Paul Eycken, president and CEO of FormaliS, a quality management service provider, says he sometimes fancies himself playing the role of Winston Wolf in the movie *Pulp Fiction* (as portrayed by Harvey Keitel) when he assists drug and medical device companies prepare for regulatory inspections.

Recalling the scene in the movie where Mr Wolf's services as a no-nonsense, problem-solver were required to clear up a blood-stained car, Mr Eycken says: "I feel like Mr Wolf because sometimes I get calls from sponsors [of medical products] asking if I can come over the next day because the company may have just received a letter from [a regulatory authority like] the US Food and Drug Administration, and the [FDA] inspectors may visit the site in three weeks."

While Mr Eycken's clients do not present him with such diabolical problems as clearing up murder scenes, he does get asked by companies dealing with healthcare products to help highlight any shortcomings that may get them into trouble with competent authority inspectors.

During the course of his work, Mr Eycken says he has noticed that –unlike for drug studies – there exists "some basic misunderstandings" regarding GCP requirements for device studies. Mr Eycken made these remarks at a London conference on 15 June jointly organized by Mectech Europe (an alliance of EU medtech industry associations) and the EU Forum for Good Clinical Practice (a non-profit organization working to promote GCP principles in medical research)[1].

With regard to the applicability of GCP requirements, Mr Eycken says that he often comes across this attitude among clinical trial investigators that in the case of device studies, one can apply "some sort of a light [touch] version of GCP requirements… What this approach entails, I don't know but there is no such 'light version' of GCP requirements for device investigations," he clarifies.

The mindset that one does not have to "comply with all [the] requirements of a [study] protocol because it's a device study" is wrong as the "rights, safety and well-being of a patient is independent of the type of study," Mr Eycken explains.

Mr Eycken says that some of the other GCP-related mistakes that companies make in device studies relate to:

- **Interpreting study protocols in a flexible manner** – A protocol should not be interpreted in a flexible manner, but it should be written in such a way as to provide the flexibility needed to support a device study. Mr Eycken says he has seen problems on this front "in a lot of studies" and he recommends that a protocol should provide clear criteria for including or excluding patients in a study, and should describe "conditions, limits and exceptions". Also, he points out that competent authority inspectors are "very strict" with regard to companies updating the investigator's brochure with safety information on the device. Sometimes a device can "evolve" during a study, and "if you wait six months to tell [the authorities] that there is a serious safety threat with your device if it is used in a certain way then you are exposing patients to safety risk and this is unacceptable," he explains.

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- **Consent process not addressing peculiarities of device studies** – Obtaining patient's consent is mandatory for both drug and device trials, but depending on the type of device being investigated (eg implantable devices) there may be "no way back" for patients taking part in a device study. Other issues relating to studies with implantable devices include informing patients about the risk of infection with an implantation procedure, and ensuring authorization for explanation of the device in case the patient dies. Mr Eycken says he has seen several studies where the omission by companies to seek authorization to explant a device during the consent process led to them being involved in long discussions with families to explant the device so that they could examine it to check what went wrong. Another problem that Mr Eycken has noticed is that in some cases, patients are "prepared" to be included in a study without consent. This is "absolutely unacceptable", he says.
- **Patient privacy issues** – Ensuring the privacy of patients is necessary in both drug and device studies. But in some device studies (eg implantable devices), the identity of the patient may "flow to the sponsor" because the implantation surgery is not performed by the investigator, "but by a specialist from the device manufacturer and there may be two to three people from the sponsor present during surgery to see that everything is going well," Mr Eycken says. The patient and the ethics committee should be made aware of this.
- **Non-reporting of expected adverse events** – There is a misunderstanding regarding device studies that adverse events that are expected should not be reported. Recalling his experience from "a very tough inspection by a European authority" last year, Mr Eycken says he remembers the investigator being pulled up for not reporting post-surgery pain. "I remember the discussion between the inspector and the investigator" and the latter said it did not make sense to report post-surgery pain as an adverse event "because this is normal". Mr Eycken clarifies that all adverse events, including increase in body temperature, stiffness, limitation in movement etc, should be reported as adverse events and these can be later sorted out as serious or non-serious. In the case of drug trials, many of the contract research organizations and sponsors have a lot of experience on reporting of adverse events, Mr Eycken says. But in the case of device studies this "is not going well as it should be… it's a matter of habit", he says.
- **Data collection not being a key concern** – Mr Eycken says he has noticed that in device studies, the implantation of the device or use of the device is considered as the "key" part of the study, while data collection is considered to be secondary and left up to the study nurse. Also, there have been instances of data being collected that was not specified in the protocol. "That's not allowed… either you have to be quite flexible with your protocol [on the issue of data collection] or you cannot collect those data unless you amend the protocol," Mr Eycken explains. He also believes that compared to drug trials, not enough data is collected in device studies and accuracy of data is lower.
- **Quality of research** – With regard to device studies specially, Mr Eycken says that some companies appear to have the attitude that the quality of a study is good if the "intervention is successful and the patient is happy". He points out that there is a difference between a successful intervention and a well-conducted study, which means that sponsors should pay attention to the quality of data. Among other things, Mr Eycken says there is lack of documentation on training provided to the investigator's team, and the specialist performing the surgery.
- **Issues with handling of an investigational device** – While it is important to follow local requirements for devices in clinical research, Mr Eycken points out that "strangely enough, the tracking, storage, handling of these devices is really an issue".

There is little difference between ISO 14155 (the international standard on GCP requirements for medical device investigations) and the guidance on GCP requirements for drug trials issued by the International Conference on Harmonisation, says Nicky Dodsworth, vice president for global quality assurance at Premier Research, a contract research organization. Ms Dodsworth was also speaking at the Medtech Europe-EFGCP conference.

Ms Dodsworth believes that the ICH GCP guideline "is outdated in some areas" when compared to the latest version of the ISO standard. "ISO 14155:2011 is far more up to date [than the ICH GCP guideline]…. For example, the ISO standard lays much more emphasis on risk assessment and monitoring plans," she explains.

Legal requirements around clinical evaluation of medical devices are evolving and under the proposed EU regulations for medical devices and IVDs that are under debate in the European Parliament[2], "manufacturers, sponsors, notified bodies and [competent] authorities will [all] be held to a higher standard," said John Brennan, director (regulations and industrial policy) at Medtech Europe, who also spoke at the conference.

Mr Brennan explains that under ISO 14155, a sponsor is currently responsible for: clinical quality assurance and quality control; planning and conduct of clinical investigation; selection of clinical personnel; preparation of documents and materials; monitoring of clinical investigation; safety evaluation and reporting; clinical investigation close-out; outsourcing of duties and functions; and communicating with regulatory authorities.

Under the proposed EU regulations, Mr Brennan points out that new responsibilities are being considered for sponsors, including: data entry; damage compensation; applying for and conducting a clinical investigation; making substantial modifications to a clinical investigation; submitting information in the event of a temporary halt or termination of a clinical investigation; recording and reporting of events occurring during clinical investigations; and certain general requirements regarding clinical investigations.

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No. 7

Fewer Swiss medtech notified bodies as EU-aligned rules enacted

By A Wenzel adapted from an article of Ashley Yeo

The number of conformity assessment bodies/notified bodies (CABs/NBs) accredited to work on medtech files in Switzerland has dropped from five to three, following the implementation of new rules, along EU lines, that tighten the oversight of CABs.

The healthcare products regulatory authority Swissmedic confirms that two Swiss CABs have withdrawn from participation in medtech regulatory activities as a consequence of the publication of the amended Medical Devices Ordinance (MedDO) on 1 April[1,2]. The legislation, which came into force on 15 April, made provision for the authority to conduct announced or unannounced onsite assessments and observe audits conducted by CABs at the premises of its clients.

The measures are designed to keep Swiss medtech law on a par with EU law, and thereby guarantee the free circulation of Swiss-approved devices in the EU. In September 2013, the European Commission adopted two measures to strengthen safety and restore consumer confidence following the PIP breast implant affair[3]. These measures provided a clearer basis for unannounced audits, sample testing and joint assessments by NBs.

A notice published by Swissmedic on 1 July lists the active authorized CABs as: SQS Schweizerische Vereinigung für Qualitäts- und Management-Systeme (Zollikofen); QS Schaffhausen AG (Beringen); and QS Zürich AG (Therwil). Swissmedic told *Scrip Regulatory Affairs* that certain CABs could not fulfil the tougher new demands and have given up their medtech certification responsibilities as a result.

The certificates issued by the two CABs that are no longer active in medtech regulation have been revoked. Medtech manufacturers which used them have been told by Swissmedic to use other CABs if they want to keep their products on the Swiss and EU markets. A similar pattern is being seen in the EU.

This article has also been published in Clinica Medtech Intelligence.

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By L. Wenzel

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