

MLX 341

Comments of the Faculty of Pharmaceutical Medicine of the Royal Colleges of Physicians (UK) on the MHRA proposal for a voluntary accreditation scheme for Phase I clinical trial units in the UK.

Thank you for consulting the Faculty with respect to the MHRA proposal. We should state at the outset that we support the principle that Phase I Units in the UK should be accredited by the MHRA. We offer the following comments on your consultative document:

1. In the Background provided in Annex B, it is stated that the purpose of the accreditation scheme is to create public confidence (additional to the measures already taken). Whilst, it is hopefully true that public confidence will be increased by the implementation of an accreditation scheme, it seems to us that this aim is not sufficiently precise. First and foremost, we see the accreditation as an important step in maximising the safety of volunteers participating in studies. Secondly, the fact that a Unit has been accredited should provide volunteers (potential study subjects) and sponsors with some assurance that the Unit is up to a required standard and conversely that a Unit which has not been accredited does not provide such assurance. You have mentioned this assurance in the penultimate paragraph to the Background section and we are confident that there is no real difference between our views; it is really a matter of stating the objectives more explicitly, which will be important in any future MHRA documents describing the accreditation scheme.
2. We agree with the concept of two levels of accreditation i.e. standard and supplementary. The question that perhaps needs further consideration is exactly where the dividing line should be. Your current proposal is that supplementary accreditation should be restricted to Units capable of handling higher risk agents, which have required review by the EAG. Whilst we recognise the attractiveness of consistency between MHRA review procedures and the levels of accreditation, we are concerned that this implies that the level of vigilance and care required for agents falling outside this category is lower. We would argue that robust capability of providing life-support and efficient transfer to hospital, the presence of suitably trained and experienced staff on dosing days and contingency planning including availability of antidotes are requirements for all Units conducting experiments in humans.

Perhaps a more rational distinction would be between Units capable of doing FIH single and multiple dose studies of any new active substance (including 'me toos') and those who do not do FIH studies. The latter would include units undertaking only pharmacokinetic studies of licensed medicines and IMPs of which there is already experience in humans or tolerability studies of topical formulations of known substances or Units with specialist techniques e.g. psychopharmacology, imaging. It is reasonable to suppose that the risk of SUSARs in such units is lower than with FIH studies, though admittedly there is little evidence to support such a hypothesis.

3. The intended operation of the accreditation scheme seems very reasonable and we strongly support the requirement to report significant changes in the interim periods. Perhaps the certification could be extended to three years, rather than your proposed two, if the interim reporting is effected by completion of a brief annual questionnaire to pick up significant changes that have not been reported without prompting.
4. With regard to accreditation standards of staff to serve as principal investigators, as you know, the Faculty of Pharmaceutical Medicine is currently developing a training programme for a Diploma in Human Pharmacology, which we hope will become an internationally recognised standard. However, we must clarify that only the General Medical Council and the PMETB have authority to grant licences to practise medicine and Certificates of Completion of Specialty Training respectively. The FPM cannot grant accreditation though it is possible that in the future, we will be in a position to make recommendations to the PMETB, as currently occurs for CCTs in Pharmaceutical Medicine.

While our authority is limited, we certainly wish to offer our services to the MHRA for assistance with assessment of suitability of investigators and possibly other staff. We do believe that the assessment of personnel in the accreditation process is of no less importance than that of the facilities and that this is best done as a peer review process. If you agree with the principle, it would be sensible for appropriate representatives of the FPM and MHRA to meet in the near future to discuss.