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CANCER TRIALS & DATA PROTECTION

A Review

DSSG stakeholder Meeting Outcome Report

April 2022

Introduction

"Cancer Trials & Data Protection – A review" brought together key players and 100+ members and stakeholders to examine the range of data protection issues besetting clinical health research in Ireland at present. This document contains summaries of speaker contributions, and survey results about cancer trial / data protection issues gathered from a range of perspectives.

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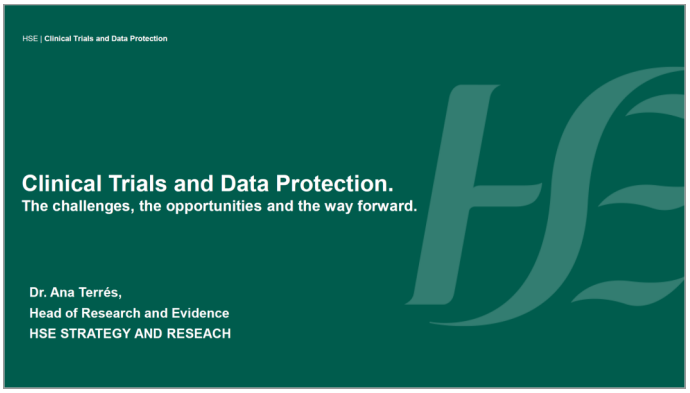

Who presented?

- *Dr Ana Terres, HSE*
- *Prof Joe Eustace, HRB-NCTO*
- *Aileen Sheehy, NREC*

Click here for meeting recording

Who was surveyed?

10 *Team leaders at hospital cancer trial sites*

10 *Data Protection Officers*

8 *Industry representatives working in cancer trials*

** Survey results can be found on page 8*

Facilitator

Professor Seamus O'Reilly, Vice-Clinical Lead, Cancer Trials Ireland

> ***"There's a widespread enthusiasm (among DPOs) about learning more about the conduct of clinical trials***

Opening the meeting, Prof O'Reilly noted that the meeting was taking place on the same day as Daffodil Day.

A survey carried out with data protection officers, industry representatives and others at sites around the country prior to the meeting had sought to understand the landscape of data protection as it pertains to cancer clinical trials in Ireland, what the issues are and how CTI could synergise and move forward in terms of improving trial logistics. Prof O'Reilly noted the rich individual responses received from respondents and some clear takeaways from the results of the survey (see: page 8).

The survey found that two-thirds of respondents reported getting a request for DPO review before achieving regulatory/ethics approval. The majority of reviews took less than a month but 40% went on longer than this. One in four said a trial had not proceeded based on the DPO review. "There was also a widespread enthusiasm about learning more about the conduct of clinical trials," noted the professor, with 90% of respondents agreeing to same.

Discrepancies were noted; while 75% said they are typically satisfied with the ethics approved patient information leaflet (PIL)/Informed consent form (ICF), as most are reviewed before ethics approval, the sequence of this could be changed, said Prof O'Reilly. One-eighth of respondents said they always request changes to the PIL/ICF and 75% said at least sometimes.

What was obvious was the variation in different DPIA forms e.g. from hospitals, CTI, etc; "some harmonisation of this process would be desirable, so that the DPOs would receive one form rather than a multiplicity of forms," Prof O'Reilly said.

Industry-sponsored studies had similar issues, with 50% requesting DPO review before regulatory/ethics approval had been granted. While review periods varied, however, they were far longer than with other types of trials, with 71% taking longer than one month. Again, a variety of different DPIA forms were submitted. Interestingly, 75% said they did not request changes to the PIL. "Again, if we could harmonise and facilitate the processes we could make this run more smoothly."

Prof O'Reilly summarised the survey results, saying the divergence on DPIA forms was obvious and there was a widespread recognition of the need for harmonisation.

Amendment requests for submitted PIL & ICF are common, he noted. DPOs have an appetite to learn more about clinical trials so a workshop or similar event might be helpful in this regard. "Before any forms are generated, this discussion needs to take place and Cancer Trials Ireland can play a facilitative role."

Prof O'Reilly was followed by Dr Ana Terrés, Head of Research and Evidence, Assistant National Director, Strategy and Research, HSE. Dr Terrés began by noting that this is a "hard topic", and one that is causing widespread anxiety in the system. "We have to comply with data protection legislation and there are challenges but hopefully we will be able to find a way forward.

Challenges are multiple, she explained. Firstly, there is a basic lack of capacity for data protection oversight for clinical research. Often hospital DPOs work on a part-time basis and only a portion of that time can be dedicated to research. In addition, the HSE deputy DPOs (DDPOs) have responsibility not only for multiple hospitals but also for community health services. The National HSE R&D team, in consultation with key stakeholders, have developed a plan to increase organisational infrastructure to support research governance and data governance, but we are not there yet. She echoed Prof O'Reilly that the lack of standardised processes or templates is a major issue, one that is compounded and worsened by the structure of the Irish health service where a multitude of legal entities co-exist. There are 25 HSE acute hospitals that from the point of view of data protection function as a single legal entity, and are served by 4 HSE DDPOs. But there are also circa 20 S38 voluntary hospitals, that, while they are funded by the HSE, are independent legal entities and legally accountable for their own compliance with data protection legislation. These hospitals have their own DPOs and approval processes. When studies involve multiple of sites the lack of capacity together with the lack of a standard approval approach and standard templates results in inefficient processes and significant delays overall.

Dr Terrés added that DPO are often asked to review legal contracts, despite not necessarily being legally trained. There are also discrepancies of agreement with regards to who is the data controller, especially with sponsors that are not based in Ireland, as international data transfer requires an additional level of risk assessment. "Overall, the environment for clinical trials is very challenging," she asserted.

In practice, this means there is duplication of efforts throughout the process which is hugely resource intensive, and significant delays can occur. "This causes reputational damage for Ireland as a country and casts doubts on our ability to run clinical trials. This means that international sponsors may decide to go and run their trials somewhere else where the infrastructure is better developed, and things can be done a lot quicker." Ultimately this means that potential trial participants in Ireland are losing out on these opportunities, she added.

The way forward, in Dr Terrés' opinion, is a several pronged approach. Firstly, a standardised and simplified DPIA review processes for research in the health service needs to be agreed, and a national standardised DPIA template be developed. There is a need for more training for DPOs to learn about clinical trials and for researchers to learn about data protection, and for increased capacity for research data governance in hospitals and community services. Collaboration and consensus will be key to achieving some of these, and she noted that there are already several initiatives underway seeking a common way forward. The Health Research Data Protection Network (HRDPN), for example, is working on a standard DPIA; "they have been working on this for a period of time and has proven quite challenging," explained Dr Terrés, but she added that they have successfully developed a screening tool to determine when a DPIA is actually necessary. "You only really need a DPIA when you have a high-risk project from a data protection perspective." The National HSE R&D team are productively engaged with the HSE DDPO team and are seeking engagement with the S38 Hospital DPOs via the voluntary healthcare Risk Management Forum, while ongoing engagement with NREC will also support this consensus approach.

Increasing capacity for research data governance and contract management is required for the implementation of the HSE National RGMS Framework, which aims to develop organisational infrastructure for research in the health service. "At national level we have created some capacity but at local level there is a need to develop more capacity," Dr Terrés noted, saying that they would like to see data governance and contract officers appointed to support DPOs in their work and they are actively seeking funding for this. "Although there is a long road ahead, I believe there is a road, and we will be able to travel it together." Prof O'Reilly said that Dr Terrés' presentation showed the complexity and number of various players. Dr Terrés agreed that with the number of legal entities involved, it is difficult to engage with every single player.

Speaker #1

Dr Ana Terrés, Head of Research and Evidence, Assistant National Director, Strategy and Research, HSE

Speaker #2

Professor Joe Eustace, Director of the HRB's National Clinical Trials Office

Next was Professor Joe Eustace, Director of the HRB's National Clinical Trials Office, who was on hand to give what he said was the perspective from the non-cancer clinical trial domain. Prof Eustace asserted that the recent changes to the legislation from an EU and Irish perspective had been "enormously disruptive" to clinical research; "the downstream consequences that arose had not been anticipated and the necessary resourcing had not been put in place… to meet the requirement of the regulations." After a "fraught" experience over several months, he did say they have begun to see some progress in Cork, having come to a reasonable consensus, mainly driven by the hard work of the DPO and after multiple fora. "The key thing is that other hospitals and clinical research facilities are progressing in the same way - if each site comes to a bespoke solution but those solutions aren't aligned that will leave us in a state of absolute chaos."

Prof Eustace outlined some of the stumbling blocks they had navigated since the introduction of the regulations. Initially, he said, there was great deal of concern relating to the overlap between clinical trials and observational research, particularly in relation to pre screening activities and who was eligible to undertake those activities. "This has been proactively addressed and resolved so that university staff can continue to conduct the necessary pre screening activities without which the conduct of clinical trials would be absolutely impossible." However, staff carrying out the retrospective chart review must still be hospital employees and the professor noted that CRFC staff being able to do one but not the other wasn't "particularly logical".

Echoing Dr Terres' earlier point, Prof Eustace noted that the question of who was the data controller and who was the data processor was still a complex one. "For quite some time there was a great deal of uncertainty," he noted, adding that this in many cases delayed studies from progressing. There is now a "broad consensus", at least in Cork, that the controller is the trial sponsor and the hospital and other people working under the instruction of the principal investigator are the data processors. "That consensus is now emerging more broadly and is essential in delineating all the other responsibilities." That has also clarified that the DPIA is completed by the sponsor and reviewed by the national chief investigator's DPO prior to submission to NREC. Prof Eustace noted he does not know what happens if there is a discrepancy between the decision of the DPO and NREC but he assumed NREC take precedence. "It would seem far more efficient if the NREC was additionally resourced to allow for a definitive data protection review and removing the need of the local site to carry out one," he stated, adding that this also puts significant additional work on the chief investigator, meaning sites may try to avoid taking on this role in order to avoid that workload.

The professor also said that he "cannot reinforce enough" the call for standardisation of the DPIAs, as well as the processes involved, saying the challenges they face on an ongoing basis are almost wholly related to the form and what's on it or not on it, as the case may be. He also highlighted the process for data breach reporting and said this also consumes the time of the chief investigator.

When asked by Prof O'Reilly what he felt would be the best way forward, Prof Eustace replied that "multi site multi institution meetings" are critically needed so that stakeholders can come to a consensus on this. He also called for appropriate resourcing. "It is a matter of urgency and it is extraordinary that we find ourselves in this position."

> ***"Multi-site, multi-institution meetings are critically needed so that stakeholders can come to a consensus on this.***

The final speaker of the morning was Aileen Sheehy, Programme Manager, Clinical Trials, at the National Office for Research Ethics Committees (NREC). Ms Sheehy first clarified the role of the NREC-CT in data protection, saying it looks at data protection from an ethics perspective, and ensures participant rights are protected and all consent is informed. It also seeks assurance that legally compliant data protection measures are in place. It plays no role in study governance, however, and does not "approve" DPIAs or other data-related documents. "What they do is use the documentation provided to them to make a decision on whether a trial is ethical and that the participants are well-informed."

In relation to the regulatory landscape, Ms Sheehy explained that the latest EU CTR (536/2014), as a regulation, is binding across the EU, whereas the previous directive had the problem of being implemented slightly differently by each member state. "The benefit of it is that it is harmonised across Europe and the processes are harmonised." The NREC now has to work closely with HPRA and their colleagues in ethics committees across Europe, she added.

The transition period is ongoing between the two pieces of regulation, but Ms Sheehy noted the requirements under the Irish statutory instruments SI 041, which covers ethics, and SI 099, which covers clinical trials.

Data protection and consent was also discussed by Ms Sheehy, who advised that a PIL is not simply a regulatory "tick box" but must clearly inform the patient how their data will be used and by whom. "It is often written in a very regulatory language that is not understandable to the general public." All options and choices presented to participants must be clearly presented to ensure true informed consent, she said.

Ms Sheehy also explained some common clarifications required by the NREC, which include: transparency around transfer of personal data to third countries or other organisations; point in the study where personal data is coded or anonymised; reference to the Health Research Regulations in participant materials; reference to rules and regulations from other jurisdictions (mainly UK); separation of consent for trial participation and data processing; consistency around data retention periods; and consent vs assent for 16 -18 year olds. She concluded by highlighting some valuable resources available from the Department of Health and Data Protection Commission.

Prof O'Reilly asked if she felt that issues with the ethics regulations are "growing, plateauing, or reducing"? Ms Sheehy replied that NREC has found they had to be consistent around the feedback they provide, and they have since seen a distinct improvement in the standard of material that is

Speaker #3

Aileen Sheehy, Programme Manager, Clinical Trials, National Office for Research Ethics Committees (NREC)

provided to them. When asked if there is an appetite at the NREC level for harmonisation, Ms Sheehy replied "absolutely", saying they would welcome it but noted they are not in a position to set what a national DPIA looks like but would be "happy to support and endorse where there is consensus".

Cancer Trials Ireland CEO Eibhlin Mulroe noted that one of the reasons they had decided to bring this topic to the fore was that there are now DPOs employed by the hospital to review their documentation, despite having NREC and HPRA approval already, before the contract is signed for the clinical trial. "That's the piece that is really causing issues for us. Some joined-up thinking would be great and there should be trust in the assurances given by NREC. We have to trust that the system works." Dr Terres noted that the NREC does not ensure compliance with legal requirements, rather they look at the ethical consequences of the data processing. "It is the hospital's responsibility to ensure that all the research carried out on their premises is done in a legally compliant manner so that is why they send it to the DPO." Ms Mulroe noted that NREC does seek assurances around data protection so she sees a basis for them to work together.

> ***"(PIL) is often written in a very regulatory language not understandable to the general public***

Q&A

A brief Q&A took place before the conclusion of the meeting.

Professor John Kennedy asked which EU country has best practice in this area and what can we learn from them. Dr Terres noted that it is difficult to simply copy other countries due to their unique legal structure compounded by the complexity of the Irish health service. "We can look abroad for other ways of doing things but we still need to find our own solution."

Mary Deasy (Deputy Data Protection Officer, HSE South) noted that following a meeting between the HSE and the DPC last week, it is clear that the DPC is moving from a process of engagement to enforcement "very strongly", including financial sanctions. "We don't want to see the HSE or a university receiving a substantial fine. It would be extremely damaging to research in the short-term and the long-term.

Rachael Batten (Specialist in Clinical Research Trials and Agreements with the HSE) agreed that a standard DPIA template would be of help and said work is ongoing within the HSE in this regard.

Patricia Heckmann (Chief Pharmacist at NCCP) then called for any barriers to trials to be removed as soon as possible and expressed her wish to work with Ms Batten offline in order to help this process.

Keith Egan (Programme Manager, Cancer Clinical Trials & Research Unit, Beaumont Hospital) expressed his concern that "we will be having the same conversation in five years time" and stated his desire to see a national DPO/legal person liaising directly with the different institutions. Prof O'Reilly agreed with this, saying he also shares these concerns.

The meeting concluded with **Prof O'Reilly** saying this had been the biggest stakeholder meeting Cancer Trials Ireland had held to date. This indicates the level of interest in the topic and that this is a priority for people. "There is a recognition by all of the speakers today of the need to change this process to make it more efficient for everybody involved for a multitude of reasons."

Summary

Capacity

- **There is a basic lack of capacity for data protection oversight for clinical research. Increasing capacity for research data governance is needed. Furthermore, DPO roles are typically only part-time – and only a portion of that time can be dedicated to research. DPOs are often not trained to review legal agreements, which the role demands. Data governance and contract officers would be desirable to support DPOs – and funding is actively being sought for them.**

Harmonisation / Standardisation Vs. Complexity

- **Standardised processes & creating templates is a major issue, one that is compounded by the unwieldy Irish health service (25 acute hospitals; 20 voluntary hospitals, each a different legal entity, each with its own DPO). The HRDPN is working on a standardised DPIA and has developed a screening tool for assessing if DPIA is even needed. Engagement with DPOs in voluntary hospitals is also being sought via the voluntary healthcare risk management forum. Ireland's unique legal environment and complex health system precludes simple adoption of another country's model.**
- **These issues contribute to delays – and thus reputation damage to Ireland as a clinical research destination.**

Potential actions

- **Multi-site, multi-institution meetings are critically needed so that stakeholders can come to a consensus on this.**
- **Most DPOs (90%) would welcome further training on the conduct of cancer clinical trials.**

Survey Results