BIVDA

ABHI
HealthTech for Life

Questions and comments arising from the CTDA webinar – Monday 21st March 2022

- Questions have been grouped to help with responses, but please feel free to regroup.
- To make sure you have an unfiltered view of the webinar responses, nothing has been censored. Some questions will already have been answered elsewhere. It's a 'warts and all' view, so our apologies in advance.
- Although none of the questions are attributable, registrations came from ABHI and BIVDA members and non-members including some representation from the NHS.
- Over 200 people registered and there were about 150 participants throughout the webinar.
- We have given access to a webinar recording to all registrants.

Question	Response
Application	
If a company has PCR, LAMP & LFT - do they need three approvals at 3 separate cost? Thank you	Each individual test needs to apply for CTDA, as the legislation looks at the performance of each test
Are you able to reopen an application if an LFT has failed the desk top review. Submitting additional data since you have changed the evaluation requirements.	Once a decision has been made an application is closed. If you gather more data after a decision is made then a new application will need to be started and a new fee paid.
If an application is not approved dur to poor performance and feed back is provided. Would a re-application levy a new charge?	Once a decision has been made an application is closed. If you gather more data after a decision is made then a new application will need to be started and a new fee paid
The application time line of 20 days for each of the two main sections, section 2 & 3, is not correct, this has taken more like over 200 hundred days, with virtually zero dialogue and no access to anyone at the CTDA.	Queries raised through the CTDA inbox are addressed within 5 working days. While the timelines for applications that were made pre-December 2021 have been lengthy, this was due to trying to guide applicants to provide the required information, rather than failing them outright. New applications now

	receive the information about their initial review within the 20 day timeline.
Why would organisations that did submit their application before the end of the original deadline of 31 August 2021, be given priority, surely if you met this original deadline you should be prioritised or put on a first come first serve basis, after all this is a paid for service	Priority is based on public health need, however, now that the number of applications with outstanding decisions has come down most applications are being assessed as the data for them becomes available.
why the 20 working days limit for responses when for clinical data this takes much longer	An application should be complete when it is submitted and questions arising should therefore be easy to clarify. If you have not submitted the correct amount of clinical data and need to generate more you can withdraw your application.
Knowing that the process does support an application at the start (rather than pass/fail immediately) is very helpful. this was a key worry (correct # samples, ...).	We aim to provide full feedback on missing areas after the first review, allowing applicant to submit the complete data that is required. We would encourage application to make sure that they are submitting complete applications however, so that this does not slow down their review.
The approval process is currently very long with many companies having submitted their initial applications in August 2021, what are you doing to try and address this going forward in order to bring this back in line with the 20 working days initially stated?	We have worked hard with companies to try and get them to completion, rather than just rejecting them for poor applications. This has led to delays in the system. As we clear the older applications, we are now managing to do the first review of new applications quickly; the initial review is now usually within one week of submission
With only a small number of companies having passed the desktop review process are the current requirements too stringent? What is holding up the majority of the applications currently being assessed?	The major delay is in companies providing the data that is required in line with their IFU claims. Many companies submit data that does not support the performance of the actual test in the application
Our self-use tests which are approved will be replaced by a second generation version in the near future. e.g with improved sensitivity, change of buffer, testing for more than one infection. What is the mechanism to ensure that these product advances can transition with ease onto the annex?	If an application has been approved for a device that then undergoes a change, the applicant will need to email the CTDA team, outlining the changes. If these changes are minor then the new IFU details will be added to the register. If the changes are deemed

	substantial then a new application will need to be made. The process will be made public in the near future.
In light of the transition to living with COIVD we anticipate there will be an increased challenge in obtaining the required data. How will the process flex and provide guidance/support to developers in accessing, say, required samples?	Currently, and for the foreseeable future there are still many cases of COVID-19, and we encourage companies to engage with local healthcare facilities if they want to gather samples in a study. Primary care may be a better source than secondary care in the coming months
Comparator test	
Can you tell us which PCR brands are suitable comparators?	Any extracted molecular method listed on the register is a suitable comparator. When sourcing a comparator, you need to make sure that that test has substantial data behind it to prove their own claims about performance, they cannot be taken at face value. For example, if they have only tested using contrived samples, or very low numbers then they do not have sufficient evidence of their own performance.
The comparator test is being judged on its IFU, which was often created at the start of the pandemic so contains old data. Whereas the manufacturer has much newer public domain data showing sample size/performance matching the requirements. Why use the IFU as the evidence? It is a very big burden to update IFU, so is not current all the time	Where there is additional evidence over and above the IFU, for example a clinical study report, this can also be submitted.
Some very big tests e.g. Perkin Elmer not allowed as a comparator, even though been the work horse of the pandemic with millions of samples successfully measured	This assay is now on the register
Engagement	
It is difficult to engage with the CTDA process. How can we sustain, a structured, systematic process of engagement and communication with applicants going forward?	We are developing a pilot scheme to communicate face to face with applicants. If this is successful there may be further roll out

When does UKHSA plan to clarify next steps and timelines for review completion ahead of the May and August temporary protocol deadlines?	The team worked hard to make sure that all applicants that had submitted data before the May deadline were reviewed and a decision reached; including applicants who submitted data the day before the deadline. Those outstanding were due to the applicants not supplying data. If an applicant is on the protocol ending in August we would encourage them to supply outstanding data as soon as possible.
CTDA decisions have a significant operational and business impact on participating companies, what steps will UKHSA take to ensure better transparency around where a product sits within the process 'queue' and to provide companies with ongoing review updates?	We are assessing potential solutions to this issue, but cannot resolve immediately.
Approvals were slow to come through the system, this looks to have improved. How will you ensure this is sustained?	This was largely due to the poor quality of the applications. We have worked hard with applicants to help them ensure that they are providing all the information that is requested. Once we have that, a decision can be made relatively quickly
Can I get a one-to-one at the start of a submission process? We have a very rapid POC test that uses infrared and patient samples with high sensitivity & specificity compared directly with PCR tests.	We are in the process of instigating a 'how to' webinar series that will help new applicants.
Has the CTDA made the process map shown in this presentation or the details around a good application, been made available? if not why, if applications are a problem.	We are looking to make process maps made available on the website to aid applicants understanding of the process
Additional data has been requested from NHS users (in Scotland) rather than companies. Is that routine?	CTDA is not responsible for sourcing addition data to support performance claims. This was routine practice within the TVG group however, to support the national deployment of tests.
This session should have been run last year - it makes things a lot clearer and could have saved manufacturers and yourselves a lot of time by enabling quality applications in the first place.	Thank you for the positive feedback. We are hoping to instigate further webinars to help people navigate the process
Useful webinar - better late than never but think you need to engage with the DAs / users.	Thank you for the positive feedback. We are hoping to instigate further webinars to help people navigate the process

Specifications	
CT values for IC often not available for negative results. Manufacturers only report a negative result if IC has passed for negative results, so why is CT for IC needed for negatives (if the comparator only gives negative in case of valid IC)	If it can be demonstrated, eg via highlighting a section of the IFU, that this the case, then negatives without IC values would be acceptable. It should however be common practice when conducting performance studies to record ALL data generated by tests.
Study design	
Since prospective study is not required, are pre-identified frozen COVID-19 samples acceptable (e.g. archived samples)?thank you	Frozen samples are only acceptable where this is listed as acceptable within the IFU. Freeze/thawing can affect sample integrity, and this can be highly detrimental to some assays, especially LAMP, so careful thought should be given to this area by the applicant. If you wish to use frozen samples but it is not included within your IFU you would need to submit a suitable equivalency report to demonstrate no impact on using this sample type.
Future	
Legislation which enacts CTDA states that the UK must remain a favourable place to do business. What metrics are being used to determine whether this extra regulatory process is adding value?	The Medicine and Medical Devices act states that the Secretary of State must make an assessment of the legislation impact on the UK as favourable place to do business. Though UKG is always keen to support business the Health Secretary's overriding concern remains the protection of public health. Please read the full impact assessment for our analysis.
CTDA is an additional regulatory process, it is costly and burdensome. It is not aligned with existing regulatory frameworks, for instance the third party conformity assessment system.	The analysis of CTDA does not support the claim. Both the cost and scientific work required helps remove

Once we have gone through the process of validating Coronavirus tests, what role will CTDA have in the future regulatory system, i.e. UKCA.	poor performing tests from the market as many simply self-select out of the UK market rather than an attempt a regulatory process they can not pass. This removes misleading tests from retailers protecting consumers and the public health. This in turn leaves more shelf space for high quality tests. The CTDA process provided an agile, light touch regulation to effectively address the market failures occurring during the pandemic by providing more stringent validation than the previous model. UKHSA has sole responsibility for the regulation of coronavirus diagnostics and we are working with MHRA and DHSC to ensure any new regulation fits around our existing and evolving regulatory functions.
why CE self-test that have a third party review require a further assessment?	As was set out in our first consultation the Government does not believe the 3rd party process provides the same level of quality scrutiny as that provided through impartial government scientists as under the CTDA. As coronavirus was a pandemic it was vital the highest quality of oversight and scrutiny was implemented to protect the public. The Government remains committed to ensuring high quality tests are the only ones on the UK market. It is important that consumers have confidence that the COVID-19 detection tests they use give reliable and accurate results. The government must manage risk and cannot put the public health in danger by not applying the same

	rigorous regulatory process for all tests in-scope of the regulations.
You should provide a biobank of samples already with the comparator method measured on them.	As part of the review into the CTDA due by the end of the year, we will consider the efficiency of the CTDA process, as well as wider issues impacting its implementation. It is not usually the responsibility of a regulatory to provide samples to manufacturers required for performance demonstration. This would also potentially increase fees, and limit the flexibility applicants have in developing their evidence.
Pleased to hear improved engagement with companies. Would suggest improved engagement with the devolved administrations. Perception in Scotland is that assays in use in England have been prioritised.	This is not reflective of opinions shared during our regular engagement with colleagues in Scottish Government. Even though this is a reserved matter, we have worked closely with colleagues in all the Devolved Administrations, and we continue to engage on a weekly basis with officials on the current status and outcomes of CTDA. They were consulted early and often on all policy proposals and their contributions have been taken on board and incorporated into the regulations.
This is an unsatisfactory discussion. Youve set up a process and then said that you cant resource it. Time to approval is now in excess of 6 months. Why not publish a list of requirements and have companies self certify to that performance list? Then use your limited resources to audit them? Proper, British based manufacturers will never want to have products recalled or withdrawn, so an audit based system seems a practical resolution to the bureaucratic quagmire that has been created. Accepting the current status quo is not acceptable.	The principal issue has not been resourcing, it has been the poor quality of applications. The scientific advisors could simply have failed all those initial applications. However, they instead supported companies, engaging in dialogues to explain how to improve applications and giving copious time to provide new evidence.

	The poor quality of applications is clear evidence that a self-certifying system would have been ineffective. CTDA was established in the midst of the pandemic and our scientific advisors who assess each application, require particular skills that were in high demand globally. However, we have steadily increased the number of assessors and will continue to do so. Our current establishment plan comprises of an 80% increase in full time equivalent Scientific Advisors for CTDA, compared to January. A majority of COVID-19 tests did not pass government validation when considered for use in the NHS and many did not meet the stated performance thresholds set out in their own instructions for use. These devices could still legally be sold on the UK market. In a situation where quality, accurate testing was vital, this presented an acute market failure and serious risk to UK public health We believe robust regulation is the right approach to protect British consumers, so they can be empowered when making decisions about their own health, whilst still enabling high-quality tests to enter the market. UKHSA is continually improving the CTDA process and will consider what further improvements for applicants' experience can be made.

	As a fair and impartial regulator, we cannot show bias towards British companies.
Do you think CTDA will be expanded to other pathogens/tests?	The CTDA process was designed to evaluate mature COVID-19 testing technologies in response to the challenges of the pandemic, and we continually monitor the scope of the policy for its appropriateness. UKHSA has consulted with industry and the public on the expansion of the CTDA process through a consultation. We are currently analysing this feedback. UKHSA is currently considering its regulatory role in relation to testing for other infectious diseases and we are committed to reviewing the policy on the CTDA process by the end of the year.
Re: future of CTDA - is there discussions about applying new regs beyond just COVID?	UKHSA is currently considering its regulatory role in relation to testing for other infectious diseases. We are committed to reviewing the policy on the CTDA process by the end of the year, allowing us to identify lessons and good practice we can potentially transfer to future medical device regulation.
Following the completion of the desktop reviews is it still the intention to complete a laboratory review? If so what will this entail?	We consulted on the next steps of the policy last year. We are considering what action to take in the wider strategic context of the current phase of the pandemic and the radical change the market has undergone since the introduction of CTDA. In considering the effect of the desktop review to date it has been significantly more successful in its regulatory functions than we had predicted. This in

	turn lessens the need for the lab stage and we must consider if it is still in the interest of taxpayers.