Bridging the Uncertainty: Cancer Drugs Fund Entry and Exit Outcomes Over Three Years

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INTRODUCTION

The Cancer Drugs Fund (CDF) enables early NHS access to promising oncology treatments while generating real-world evidence to resolve clinical and cost-effectiveness uncertainties.[1] Following a defined managed access period, NICE re-appraises all CDF medicines to determine eligibility for routine commissioning.[1]

Despite the CDF's central role in England's health technology assessment pathway, **limited published evidence describes recent re-appraisal outcomes,** the impact of additional evidence on decision-making, or the relative contribution of new clinical evidence versus commercial arrangements in facilitating successful transitions to routine commissioning.

OBJECTIVES

To conduct a systematic evaluation of NICE re-appraisal outcomes for CDF-approved therapies since February 2022[2], with the aim of understanding:

1. **The proportion of medicines successfully recommended** for routine commissioning
2. **The extent to which new evidence resolved the uncertainties** identified at initial appraisal
3. **Any changes in approved indications or modelled benefits** (life years [LYs], quality-adjusted life years [QALYs]) between CDF entry and exit
4. **The duration of managed access periods** relative to original expectations

METHODS

A retrospective review was conducted of all CDF therapies that completed re-appraisal by NICE between February 2022 and March 2025. The cut-off period of February 2022 was selected because this is when the revised NICE manual for processes and methods came into effect.

Publicly available NICE documents were systematically analysed, including Final Appraisal Documents (FADs), Committee Papers, and Evidence Review Group (ERG) reports.

Extracted variables included:
- Recommendation status at re-appraisal
- Time from CDF entry to routine commissioning
- Changes in licensed or recommended indication
- Reported incremental LY and QALY gains at both appraisal stages
- Persisting areas of uncertainty post-re-appraisal
- Committee discussion of evidence maturity and uncertainty resolution

RESULTS

Outcomes: 24 medicines had completed CDF re-appraisal during the three-year study period. 23 (95.8%) received a positive recommendation for routine commissioning; 1 was not recommended.

Duration: The median time from CDF entry to exit was 43.6 months. This exceeded the originally planned managed access duration in several cases, mainly due to evidence maturity and re-appraisal scheduling.

Uncertainties: All re-appraisals at least partially addressed prior uncertainties. 5 (20.8%) appraisals were judged to have no substantial residual uncertainty.

Common remaining uncertainties included:
- Long-term survival extrapolation and data immaturity
- Absence of robust comparative evidence against all scoped comparators
- Structural model assumptions not fully validated
- Trial generalisability to routine NHS practice

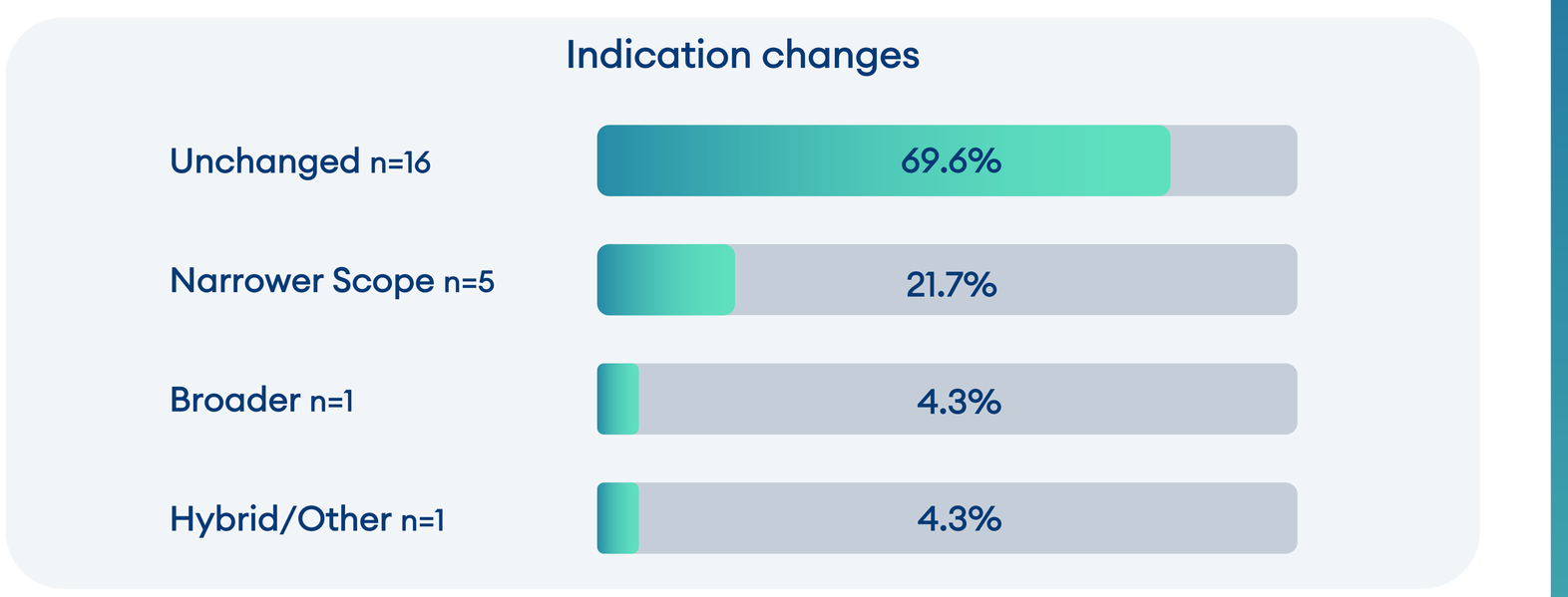
Model outcomes: Incremental LYs and QALYs were generally consistent between entry and exit appraisals, suggesting that initial modelling assumptions were broadly reliable despite early uncertainty.

24 medicines completed CDF re-appraisal

95.8% received a positive recommendation

Median time from CDF entry to exit was **43.6** months

78.3% medicines had persistent uncertainties



CONCLUSIONS

The vast majority of recent CDF exits have transitioned successfully into routine commissioning, reflecting the CDF's success in facilitating patient access and data generation. Importantly, changes in commercial arrangements between entry and exit are not publicly available. **We do not know the degree to which this success reflects improved clinical evidence or enhanced pricing agreements.** In reality, this is likely to be a combination of both.

Stable benefit estimates between entry and exit suggest initial modelling was generally appropriate, though 78.3% of therapies retained substantial uncertainty at exit. This indicates some evidence gaps in oncology–particularly long-term outcomes in rare cancers–may be inherently difficult to resolve within practical managed access timeframes.

This raises a number of questions for further research:

1. What characteristics predict meaningful uncertainty resolution?
2. Should CDF entry be reserved for a smaller subset of therapies with the most resolvable evidence gaps?
3. **Is the current duration of managed access periods sufficient to generate meaningful new evidence for decision-making?**

REFERENCES

1. https://www.england.nhs.uk/cancer/cdf/
2. https://www.england.nhs.uk/cancer/cdf/cancer-drugs-fund-list/

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