

The Innovative Medicines Fund

CRUK position statement - February 2022

Summary

In late 2021, NHS England (NHSE) and the National Institute for Health and Care Excellence (NICE) launched an engagement exercise on their proposals for the new Innovative Medicines Fund (IMF). Building on the success of the Cancer Drugs Fund (CDF), the IMF will support early access to clinically promising new treatments where further data is needed to support NICE decision-making around their routine use in the NHS.

Since 2016, the reformed CDF has been a beneficial innovation, providing earlier, time-limited access to promising new cancer medicines via managed access agreements (MAAs) while further evidence is collected on their clinical and cost-effectiveness. This has benefitted over 73,000 patients who have been able to access 91 CDF funded medicines treating 205 cancers.¹

The 2019 Conservative Manifesto committed to extending the CDF into an 'Innovative Medicines Fund', to expand access to innovative medicines for a range of other conditions beyond cancer.² For NHSE and NICE this change of approach is driven by a changing pharmaceutical landscape – where cancer medicines used to constitute over two thirds of NICE decisions, it is currently closer to an even split between cancer and other conditions.

The main question that remains unanswered is whether the CDF and IMF will be merged in the future, and operate as a single fund as was originally proposed by Government in 2019 and which NHSE have previously indicated. This lack of clarity means it is currently not possible to determine with certainty whether the proposals for the IMF will eventually apply to cancer medicines - although it seems this will not be the case at least for the foreseeable future.

We understand that initially the CDF and the IMF will operate as separate entities, due to many current commitments in the CDF. NHSE propose that the IMF should operate alongside and on broadly similar terms to the IMF, with NHSE confirming the CDF's annual £340m budget will be ringfenced, which CRUK welcomes. The IMF will also have an annual ringfenced budget of £340m.

Possible proposals that have been offered for the longer term include merging the CDF and IMF into a single fund, or freeze the CDF from a future date and direct new cancer medicines into the IMF. However, there is no confirmation on either approach or timelines at this stage.

Given remaining uncertainty on the approach in the longer term, it is important to ensure that the IMF could work for cancer medicines. CRUK has responded to the proposals as if they may eventually apply to cancer medicines and the CDF. This includes setting out which proposals we want to see taken forward and which proposals we want to see amended based on how they would affect medicines for cancer indications. This chiefly relates to entry criteria which are significantly more flexible in the CDF compared to the IMF.

As it may be the case that NHSE are not yet clear on the future policy direction for the two funds, CRUK has also set out what has worked well in the CDF and hence how it could be considered for the IMF. This includes flexibility in consideration and implementation of entry criteria and in the five-year data collection period time limit.

In developing this position statement, CRUK has gratefully received expert input from clinicians on our Clinical Advisory Panel, other cancer charities and patient groups, industry, and others.

Key recommendations

Converging approaches to managed access

- Government, NHSE, and NICE should at the earliest opportunity clarify the longer-term policy direction for how the CDF will interlink with the IMF and whether there will be plans to merge the funds.
- If a full merger is not planned, Government and system partners should establish a process for converging approaches to managed access via the CDF and the IMF. This process should include rolling reviews of the performance and impact of the two funds and a process by which the appropriate elements (as set out below) from one fund will be applied to the other.

Ringfencing IMF and CDF budgets

- If a full merger is planned, NHSE and NICE should establish long-term ring-fencing of the CDF budget to avoid:
 - The CDF being diluted and the current £340 million per year for cancer medicines being negatively affected, in turn risking adversely affecting cancer patients' outcomes.
 - The risk of cancer and non-cancer medicines competing for funds, thereby risking people with certain conditions missing out on access to medicines to treat their condition.

Aligning with other access initiatives

- To support the IMF and other access initiatives, the Government, NHSE, NICE, and other system partners should ensure the access landscape remains joined up across involved organisations to avoid fragmentation and overlap.
 - To achieve this, they should clarify how the overall impact on medicines access is measured and assessed, and where this responsibility lies.

Entry criteria

- NICE and NHSE should evaluate the IMF entry criteria, either on a rolling basis or at a fixed point after implementation, to ensure they do not arbitrarily exclude certain medicines, such as those at earlier stages where clinical trial data may be immature, resulting in uncertainty about their clinical benefit and the degree to which they address a high unmet need or constitute as step-change in treatment.
- Before any future merger of the CDF and the IMF, we urge NICE and NHSE to consider how these criteria would affect cancer medicines, to avoid restricting patient access to cancer medicines which do not do not treat cancers of high unmet need or are not deemed to constitute a step-change in treatment.

Managed access periods

- The proposed managed access period time limit of five years should be considered as flexible to ensure it does not arbitrarily exclude medicines that could benefit from a longer data collection period.

Resolving uncertainty

- Patient groups should be included in the shaping of data collection agreements (DCAs) in the CDF guidance as they bring valuable knowledge of the research pipeline in their disease area and are committed to timely access to effective treatments as well as the sustainability of the healthcare system more widely.
- Depending on NICE and NHSE assessment of where potential future challenges may arise, we urge that adequate funding is provided to support the necessary data infrastructure to capture data on patient outcomes, which has been fundamental to the success of the CDF and will continue to be for the IMF.

Commercial access agreements

- To ensure the same level of flexibility for medicines in the CDF and the IMF, greater flexibilities for products that offer greater value in the potentially plausible cost effectiveness estimates should be reflected in the CDF guidance.

Converging approaches to managed access

CRUK agrees that the IMF should operate alongside and on similar terms to the CDF. We welcome that the CDF and IMF budgets have been ring-fenced. In the short term, this avoids disruption to cancer patients currently benefitting from medicines funded through the CDF. In the longer term, this limits the risk that cancer and non-cancer medicines compete for funding.

However, we are mindful of the rhetoric used at NHSE and NICE's engagement exercises during the Spring of 2021 which indicated that there might be plans to merge the two funds in the future. As there are no details on this in the IMF proposals, the future policy direction for the CDF, and whether the IMF proposals will eventually apply to cancer medicines, is unclear.

As set out in this consultation, CRUK has a number of concerns relating to a merger of the CDF and the IMF. These include:

- The risk of the CDF being diluted and the current £340 million per year for cancer medicines being negatively affected, in turn risking adversely affecting cancer patients' outcomes.
- The risk of cancer and non-cancer medicines competing for funds, thereby risking people with certain conditions missing out on access to medicines to treat their condition.
- The risk that the proposed IMF entry criteria will apply to cancer medicines, making entry for cancer medicines less flexible. This risks restricting access to some medicines (e.g. those that are deemed to not address a high unmet need or not constitute a step-change in treatment), meaning some people with cancer would have fewer treatment options.

NHSE and NICE should establish long-term ring-fencing of the CDF budget to avoid the risks described above. Furthermore, Government, NHSE, and NICE should at the earliest opportunity clarify the longer term policy direction for how the CDF will interlink with the IMF and whether there will be plans to merge the funds.

If a full merger is not planned, Government and system partners should establish a process for converging approaches to managed access via the CDF and the IMF. This process should include

rolling reviews of the performance and impact of the two funds and a process by which the appropriate elements (as set out below) from one fund will be applied to the other.

The IMF and other access initiatives

CRUK welcomes the Innovative Medicines Fund (IMF) and the ambition to support more patients to get early access to clinically promising new treatments. It is positive that a broader range of innovative medicines will be able to benefit from the successful managed access approach that has benefitted access to cancer medicines since the 2016 reform of the Cancer Drugs Fund (CDF).

We welcome that the MHRA Innovative Licensing and Access Pathway (ILAP) will help NICE and NHSE identify potential candidates for the IMF and provide an opportunity for multi-agency discussions about further data collection requirements. The ILAP should equally support identification of candidates and multi-agency discussions for cancer medicines for the CDF.

The establishment of the IMF is one of several welcome system level initiatives in recent years with the purpose of improving patients' access to medicines. Other initiatives include the NICE Methods Review, the NHSE Commercial Framework, the MHRA ILAP, Project Orbis, and the Accelerated Access Collaborative. While we welcome the individual ambitions of these initiatives, we emphasise the continuous need to consider access to medicines holistically and for **the Government and system partners to ensure the access landscape remains joined up across involved organisations to avoid fragmentation and overlap.**

It is currently not clear where in the system the ultimate responsibility lies for measuring and assessing the collective impact of these initiatives, and whether access to medicines is improving overall as a result. Therefore, **to support the IMF and other access initiatives, the Government, NHSE, and NICE should clarify how the overall impact on medicines access is measured and assessed, and where this responsibility lies.**

Entry criteria

CRUK agrees that the IMF should operate as a managed access fund for non-cancer medicines so that any patient, regardless of their condition, has equal potential opportunity to benefit from promising but uncertain medicines. We also recognise the case for extending managed access beyond cancer to address evidential uncertainty for broader range of conditions.

However, there is a dichotomy between Principle 1 and Principle 2 which states that any medicine may be recommended for the IMF (provided it satisfies the criteria listed). That conflicts with the principle that the IMF should operate as managed access fund for non-cancer medicines. **NICE and NHSE should clarify whether cancer medicines that satisfy the criteria mentioned in Principle 2 and elsewhere in the proposals will be eligible for recommended funding through the IMF.**

The notion that clear and robust criteria should ensure that the IMF targets the most promising medicines goes beyond the characteristics of the CDF, which include the following considerations:

1. Why is the drug not recommended? Is it due to clinical uncertainty?
2. Does the drug have plausible potential to be cost-effective at the current price?
3. Could data collection reduce clinical uncertainty?
4. Will ongoing studies provide useful data?
5. Is CDF data collection feasible?

Since 2016, the CDF has largely focused on providing early access for a range of cancer medicines that would benefit from conditional approval and further data collection. This includes some earlier stage medicines where clinical trial data may be immature, resulting in uncertainty about their clinical benefit. This flexible approach has broadly been successful in ensuring early and improved access to medicines for cancer patients.

We recognise that since the IMF is essentially for any non-cancer indication, there may be a need to establish a more robust set of criteria for the IMF than what is currently in place for the CDF to achieve the objective of ensuring the most promising medicines receive funding. However, it is important that reserving entry to these medicines does not exclude earlier stage medicines which due to immature clinical trial data may not be categorised as ‘the most promising.’ **NICE and NHSE should evaluate the IMF entry criteria, either on a rolling basis or at a fixed point after implementation, to ensure they do not arbitrarily exclude certain medicines, such as those at earlier stages where clinical trial data may be immature, resulting in uncertainty about their clinical benefit and the degree to which they address a high unmet need or constitute as step-change in treatment.**

NICE and NHSE should further clarify the criteria set out in Principle 2, including how high unmet need is defined and what constitutes a step-change in treatment (e.g. does it require a novel mechanism of action, a novel target, or something else?).

If the above-mentioned potential plans to merge the CDF and the IMF were to be realised, these criteria would risk being overly stringent and negatively impact patient access to some cancer medicines. Depending on the interpretation of the criteria set out in this principle, it is likely that a number of indications approved for funding on the CDF since 2016 would be deemed to not satisfy all of them. This could for example affect cancer medicines that do not treat cancers of high unmet need or constitute a step-change in treatment, but rather offer a treatment option that some patients tolerate better and with less severe side effects than current standard of care, such as targeted therapies instead of chemotherapies. **We therefore urge NICE and NHSE to consider how these criteria would affect cancer medicines before any future merger of the CDF and the IMF, to avoid restricting patient access to cancer medicines which do not do not treat cancers of high unmet need or are not deemed to constitute a step-change in treatment.**

Resolving uncertainty through data collection

CRUK agrees that managed access should be for the shortest time necessary to collect the data required to resolve any uncertainties identified by NICE. **The proposed time limit of five years should be considered as flexible to ensure it does not arbitrarily exclude medicines that could benefit from a longer data collection period.**

The CDF has benefitted from a level of flexibility in this respect. While the time limit is normally up to two years, it can be longer depending on the issues of uncertainty, the rarity of the cancer, and whether the CDF data collection will be the sole source of data to address the issues of uncertainty.

Certain data collection agreements - such as those covering *axicabtagene ciloleucel* for treating diffuse large B-cell lymphoma and primary mediastinal B-cell lymphoma³, and *tisagenlecleucel* for treating relapsed or refractory diffuse large B-cell lymphoma⁴ - have been around 3 and 4 years, respectively. As 5-year follow-up data from the ZUMA-1 clinical trial was identified as key to resolving clinical uncertainty for *axicabtagene ciloleucel*, this flexibility has allowed patients to access the treatment until that data becomes available. Similarly, this flexibility has allowed patients to

access *tisagenlecleucel* until the JULIET clinical trial is expected to end in February 2023 or until enough data has been collected from it to address clinical uncertainty.

CRUK welcomes that NICE will seek advice from clinicians, patient groups, academics, and data custodians to ensure each Data Collection Agreement (DCA) takes account of the complexities in relevant treatment pathways, patient access, ongoing or planned clinical trials, existing studies, routine population-based datasets and real-world data collections, in light of the identified clinical uncertainties.

Patient groups bring valuable knowledge of the research pipeline in their disease area and are committed to timely access to effective treatments as well as the sustainability of the healthcare system more widely. Current CDF guidance states that NICE will seek advice from NHSE and Public Health England in these matters. **Patient groups should be included in the shaping of DCA's in the CDF guidance.**

As with the CDF, ongoing clinical trials and real-world evidence may be the sources of data for the IMF. Although the CDF tends to most heavily rely on data from clinical trials, it has benefitted from having the SACT dataset available for collection and analysis of real-world data.

The capture and analysis of high-quality data on the use of new medicines in the NHS will be crucial for the success in resolving uncertainty through the IMF. The absence of the equivalent of the SACT dataset for most non-cancer conditions may create challenges in collecting real-world data for the IMF. Therefore, it is welcome that NHSE will ensure that all NHS providers responsible for submitting data are able to do so.

Depending on NICE and NHSE's assessment of where potential future challenges may arise, we would urge that adequate funding is provided to support the necessary data infrastructure, to capture data on patient outcomes, which has been fundamental to the success of the CDF and will continue to be for the IMF. Investment in data infrastructure could enable the NHS to routinely capture a broader range of quality-of-life outcomes such as patient reported outcome measures (PROMs), both for cancer and non-cancer medicines.

This could support better understanding of patient outcomes and treatments' value during managed access periods. It could also support greater commercial flexibilities such as outcome-based payments (OBP). OBP has the potential to improve and accelerate access to some new cancer medicines and ensure the NHS only pays for outcomes that are actually achieved for individual patients. Instead of funding a drug while more data is collected to inform a new cost-effectiveness assessment and a fixed price – as the CDF and the IMF do – OBP could dynamically adjust the price of a drug based on how well it works for individual patients.⁵

Continuing treatment after managed access period

CRUK agrees with and welcomes the guarantee that any patient who starts treatment with an Innovative Medicines Fund recommended medicine during the period of managed access should have the option of continuing treatment in the event that NICE is unable to recommend its routine use in the NHS at the point of re-evaluation. This mirrors current practice in the CDF. Although this may be more financially challenging for manufacturers of certain non-cancer medicines (e.g. those for chronic diseases that require lifelong treatment) compared to cancer medicines, it is important that patients do not risk losing access to the treatment they have received while available through the IMF.

CRUK also welcomes that the IMF should provide a discretionary source of early funding for certain medicines that NICE can recommend for routine commissioning in the NHS. This mirrors current arrangements in the CDF which, due to their time limited nature, have been cost-effective and impactful in providing earlier access to medicines that receive a positive NICE recommendation.⁶

Commercial Access Agreements

It is welcome that greater flexibilities in the level of reimbursement during the managed access period will be reserved for products in the IMF that offer greater value and potential health gain to the health service. While this may currently be applied in practice for some cancer medicines in the CDF, **these flexibilities in the potentially plausible cost effectiveness estimates should be reflected in the CDF guidance to ensure the same level of flexibility for medicines in the CDF and the IMF.**

Similarly to the CDF, the IMF proposals state that to be approved any CAA must be operationally manageable for the NHS, without unduly complex monitoring, disproportionate additional costs and bureaucracy. As mentioned above, the absence of the equivalent of SACT for most non-cancer conditions may make data capture and analysis more complex. NICE and NHSE should therefore clarify how they determine whether Commercial Access Agreements are operationally manageable and whether complex monitoring is unduly. **These criteria should be considered as flexible to avoid the exclusion of medicines that can provide clinical benefits but require complex data capture.**

About CRUK

Cancer Research UK (CRUK) is the world's largest independent cancer charity dedicated to saving lives through research. At CRUK, we support research into all aspects of cancer through the work of over 4,000 scientists, doctors, and nurses. Together with our supporters we have played a role in developing 8 of the world's top 10 cancer drugs. In 2020/21, we committed £421 million to fund and facilitate research in institutes, hospitals, and universities across the UK. We want to accelerate progress so that 3 in 4 people survive their cancer for 10 years or more by 2034.

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¹ NHS England, 2021, The Innovative Medicines Fund: engagement on proposals. Accessed December 2021 via: <https://www.engage.england.nhs.uk/consultation/imf-engagement-on-proposals/>

² The Conservative Party, 2019, Conservative Party Manifesto 2019. Accessed December 2021, via: <https://www.conservatives.com/our-plan/conservative-party-manifesto-2019>

³ Cancer Drugs Fund. 2019. Managed Access Agreement Axicabtagene ciloleucel for treating diffuse large B-cell lymphoma and primary mediastinal B-cell lymphoma after 2 or more systemic therapies [TA559]. Accessed February 2022 via: <https://www.nice.org.uk/guidance/ta559/resources/managed-access-agreement-january-2019-pdf-6660053245>

⁴ Cancer Drugs Fund. 2019. Managed Access Agreement Tisagenlecleucel for treating relapsed or refractory diffuse large B-cell lymphoma after 2 or more systemic therapies [TA567]. Accessed February 2022 via: <https://www.nice.org.uk/guidance/ta567/resources/managed-access-agreement-march-2019-pdf-6718513213>

⁵ Cole, A. et al, 2021. Making Outcome-Based Payment a Reality in the NHS Phase 2: Practical Considerations. Accessed February 2022 via https://www.cancerresearchuk.org/sites/default/files/making_outcome-based_payment_a_reality_in_the_nhs_phase_2- practical_considerations_november_2021.pdf

⁶ NHS England. Cancer Drugs Fund (CDF) activity update. Accessed February 2022 via: <https://www.england.nhs.uk/publication/cancer-drugs-fund-cdf-activity-update/>