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Who Pays for a NICE-Approved Oncology Medicine?

NHS management and funding in England, mapped for a Market Access Lead taking a NICE-recommended oncology product to launch

Compiled 15 September 2026; revised 23 September 2026. England only; Scotland, Wales and Northern Ireland run separate systems.

The short answer

For a NICE-recommended oncology medicine in England the money is, in principle, already committed and, in practice, almost never available at the speed a launch plan assumes. Three mechanisms do the real work. The **NICE funding requirement** obliges commissioners to make the medicine available within 90 calendar days. The **2026/27 NHS Payment Scheme** keeps most high-cost cancer medicines outside national prices, so the drug cost passes through to a commissioner rather than sitting inside a trust's tariff income. And **specialist cancer commissioning** now sits with ICBs under delegation, while NHS England remains the accountable commissioner and holds high-cost drug money centrally.

Everything else on the list you were given does one of three things: it tells you *who to talk to* (Strategic Commissioning Framework), *what they are measured on* (Medium Term Planning Framework, NHS Oversight Framework), or *what they cannot lawfully refuse* (NHS Standard Contract). Two of the eight — the Better Care Fund and QOF — are weak or absent levers for an oncology medicine, and there is no Modern Service Framework for cancer at all. Saying that out loud, with the reason, is worth more in an interview than pretending the list is homogeneous.

1. The default route: NICE, the funding requirement and the 90 days

A positive NICE Technology Appraisal (TA) or Highly Specialised Technologies (HST) recommendation creates a legal duty on commissioners to fund the treatment within **90 calendar days** of publication — reduced to **30 days** for products in the Early Access to Medicines Scheme or appraised through the Fast Track route, unless the guidance itself specifies otherwise. NICE's own compliance test is exacting: compliance means a patient, after discussion with a clinician, can choose the recommended treatment *"without any local funding or formulary restrictions"*.

Where the evidence is not yet mature, the **Cancer Drugs Fund** provides managed access: NICE recommends the drug for use within the CDF, it goes onto the CDF list, evidence is collected — principally through the Systemic Anti-Cancer Therapy (SACT) dataset — and the drug is re-appraised for routine commissioning. The fund operates a fixed budget with an expenditure control mechanism, and its non-cancer counterpart is the Innovative Medicines Fund.

Two 2026 changes alter the arithmetic. NICE's cost-effectiveness threshold rose from £20,000–£30,000 to **£25,000–£35,000 per QALY from April 2026**, which NICE expects to yield an additional three to five recommendations a year. And the VPAG payment rate for newer medicines fell to **14.5% for 2026** following the accelerated review. A more permissive threshold means more approvals — and a more crowded launch environment competing for the same finite delivery capacity.

What this does not buy you. The funding requirement compels a commissioner to pay. It does not build a prior-approval form, free an aseptic compounding slot, create a day-unit chair, or add a pharmacist to check the regimen. Every avoidable delay in the first six months of an oncology launch sits in that gap.

2. Who actually holds the budget

Specialised services in England account for roughly £25bn a year. Of the services on that list, around **70 (about £14bn) are delegated to ICBs** — including specialist cancer services — following phased delegation from April 2024 and April 2025. Around 100 services (about £2bn), including all highly specialised services, remain commissioned nationally. Crucially, NHS England *remains the accountable commissioner for all specialised services* whether delegated or not, and high-cost drug funding is excluded from needs-based allocation formulae and held centrally.

Delegation came with conditions that matter to you. In systems in the lower oversight segments, **any decision affecting overall spend on the specialised allocation requires NHS England regional approval** before the change is made. An enthusiastic "yes" at ICB level is not, in those systems, a decision.

The map is also moving. ICB mergers and boundary changes take effect in **April 2026 and April 2027**; ICB boundaries are being aligned to strategic authorities; and seven **Offices for Pan-ICB Commissioning** (one per region) are expected from April 2027 to hold complex commissioning as NHS England is absorbed into DHSC. Any account plan built on the 2025 footprint will be wrong twice inside eighteen months.

3. NHS Payment Scheme 2026/27: where the drug cost actually sits

The 2026/27 scheme runs from 1 April 2026. Most NHS commissioner–provider relationships above £1.5m a year are paid through the **Aligned Payment and Incentive (API)** mechanism — a fixed element plus variable payment for elective and other activity; smaller relationships use Low Volume Activity block payments; non-NHS providers are paid per unit of activity.

For your product, section 3.4 is the sentence that matters: several high-cost drugs, devices and listed procedures are *"unbundled and excluded from prices"*. Excluded items are priced by local agreement under the excluded items pricing rule, at **the actual cost to the provider, the nominated supply cost, or another applicable reference price — whichever is lowest**. High-cost drugs funded under specialised commissioning are eligible for block or cost-and-volume payment.

Three consequences that commercial colleagues routinely get wrong:

- **List price is not what gets paid, and the trust cannot keep a discount.** The lowest-of rule means a purchasing gain flows to the commissioner, not the provider. Incentive arguments built on trust margin do not exist for excluded items.
- **Drug cost and delivery cost travel on different mechanisms.** Chemotherapy delivery is treated as elective activity, reimbursed through API unit prices, and sits squarely inside the 2% annual productivity requirement. The drug may be fully funded while the chair, pump and pharmacist time are not.
- **NICE-driven treatment costs are handled separately.** Rule 4 disapplies the standard payment rules for treatment costs relating to NICE decisions (CAR-T is the worked example), leaving payment to local agreement having regard to NHS England specialised commissioning guidance. For an ATMP or a cell therapy, the payment conversation is bespoke from the start.

The tariff cliff — plan for it at launch. From April 2026 a set of drugs moved out of the high-cost exclusion list and into tariff because generics or biosimilars had reduced acquisition cost, and the legacy

commissioning policies were amended to *remove the requirement for prior approval (Blueteq)*. Rituximab and sorafenib are among them. Once a molecule is in tariff, the provider carries the cost and switching becomes a local margin decision taken without you in the room. That is your product's end state; model it in year one, not at loss of exclusivity.

4. Strategic Commissioning Framework: who you are actually selling to

Published 4 November 2025, the framework recasts ICBs as strategic commissioners — payors, not providers — working through four stages (understand context, set long-term strategy, deliver through payor functions, evaluate impact) and at four levels: neighbourhood, place, system, and multi-system/national, with specialised and pan-ICB commissioning sitting at the multi-system level through regional offices. ICBs completed baseline assessments in March 2026 and are adopting the approach through 2026/27. From **April 2026 regional NHS teams took overall responsibility for provider trust performance**. The framework also introduces Integrated Health Organisations holding capitated whole-population budgets.

What it means for an account plan. The ICB is increasingly the wrong forum for a single-product argument and the right forum for a pathway and outcome argument. Split the conversation: pathway redesign, cohort identification and outcome measures with the ICB and the Cancer Alliance; formulary, prior approval and capacity with the provider; specialised spend and performance with the regional team.

5. NHS Standard Contract 2026/27: your only contractual lever

Clause	What it gives you
SC2.1.6	Providers must comply, where applicable, with the recommendations in NICE Technology Appraisals and have regard to other NICE guidance.
SC27	The provider's formulary must reflect all relevant positive NICE Technology Appraisals; the provider must make those treatments available to service users; and the current formulary must be published on its website.
SC29.4.1	Activity must be managed in accordance with any Prior Approval Scheme — the contractual home of Blueteq-style prior approval.
SC28.2 / Schedule 6A	Information requirements: the provider must submit data in the format and timescale specified — the route by which SACT data reaches the CDF and national audit.
SC11.9–11.11	Discharge medicines supply and prescribing responsibilities, including having regard to NHS guidance on prescribing responsibilities — relevant to any shared-care or homecare handover.

How to use it. When a formulary or medicines optimisation committee defers a mandated TA, the clause to cite is SC27 read with SC2.1.6, and the person who can act on it is the ICB or regional contract manager — not the chief pharmacist. Use it rarely and late. Escalating a formulary decision to a contract breach conversation works once, and costs you the clinical relationship that would have carried the next three products.

6. Medium Term Planning Framework 2026/27 to 2028/29

Published 27 October 2025, the framework replaces annual planning with a three-year settlement and requires five-year plans from every ICB and provider. Revenue funding rises to £226bn by 2028/29 in real

terms; organisations must reach and hold break-even without deficit support; and a **2% minimum annual productivity improvement** is the floor, not the ambition. The cancer trajectories are explicit:

Standard	By March 2027	By end 2028/29
28-day Faster Diagnosis Standard	Maintain 80%	Maintain 80%
31-day decision-to-treatment	94%	96%
62-day referral-to-treatment	80%	85%

Two further lines matter. The framework commits to a **Single National Formulary within two years** — the most consequential structural change on this list for a market access plan, and now far enough advanced to deserve its own section below. And the named 2026/27 medicines efficiency priorities (DOACs, SGLT-2 inhibitors, wet AMD) tell you where medicines optimisation attention and pharmacy capacity are being spent instead of on you.

Translation task. Your value story has to be expressed in 62-day and 31-day terms. A medicine that removes a step before the treatment decision, shortens an aseptic preparation, or converts an infusion into an injection buys a target. One that improves progression-free survival without touching the pathway clock does not — however good the data.

7. The Single National Formulary: the change that reorganises your job

This is no longer a commitment on a page. NHS England began **testing a prototype Single National Formulary in June 2026**, against the Medium Term Planning Framework's two-year delivery pledge. The stated purpose is to end the postcode lottery created by local formulary variation and to deliver *"fairer, faster access to medicines"* — a single national listing replacing the patchwork of trust and ICS formularies that a positive NICE appraisal currently has to be relitigated against, one committee at a time.

Why it belongs near the top of a market access plan. The entire discipline of local formulary submission — the document set, the committee calendar, the relationship map, the 42-times-over repetition — is built on a structure that is being consolidated. For a NICE-recommended oncology medicine, a national listing is the difference between one decision and dozens. It is also, for exactly the same reason, a single point of failure: one adverse national position replaces dozens of recoverable local ones, and there is no second committee to go back to.

What to do about it now. Three things. Find out whether your tumour type or therapy class is in the prototype scope. Make sure the evidence package is built to satisfy a national listing decision rather than a local committee's habits. And do not dismantle local formulary capability during the transition — the prototype is a prototype, local formularies remain live and contractually binding under SC27 in the meantime, and the period where both systems operate at once is where products get stranded.

8. Better Care Fund 2026/27: mostly not your fund

The BCF for 2026/27 totals **£9.154bn**: a minimum NHS contribution of £5,791m (uplifted 4.4%), the local authority Better Care Grant of £2,640m and the Disabled Facilities Grant of £723m, pooled through section 75 agreements by 30 September 2026 and signed off by health and wellbeing boards. Its three national conditions require joint plans linked to neighbourhood health development, and its four metrics are non-

elective admissions in the over-65s, average discharge delay from acute hospitals, long-term care admissions in the over-65s, and — new for 2026/27 — reablement outcomes after discharge.

Honest read. None of that money will buy your medicine, and no BCF metric will move because of it. There is exactly one real connection: if your product shifts treatment out of hospital — oral, subcutaneous, or homecare-delivered — then community capacity, discharge and reablement funded through the BCF are the enablers that let a day unit or ward release a patient safely. Use it as a systems argument to a place-based audience. Do not build a funding case on it; doing so signals you worked from a list rather than the system.

9. Quality and Outcomes Framework 2026/27: there is no cancer in it

QOF for 2026/27 runs to **582 points — 437 clinical and 145 public health**, with indicators retired and restructured across cardiovascular, diabetes, respiratory and stroke domains (CHD015, CHD016, DM012, HF003, HF006, HYP008, HYP009, NDH002, STIA014 and STIA015 among them). The domains cover cardiovascular disease, diabetes, respiratory conditions, mental health, dementia, obesity, smoking and vaccination, with cervical screening in the public health domain.

QOF did once carry a cancer indicator set — a cancer register, a cancer care review and safety-netting. **CAN004, the cancer care review indicator, was retired at v50 in 2025/26**, and the 2026/27 framework carries **no dedicated cancer indicators** at all. Anyone working from a pre-2025 briefing will tell you otherwise.

What follows from it. There is no QOF payment mechanism that will change referral behaviour for your tumour type. The primary care lever into cancer is now referral and diagnostic practice and screening uptake, driven through the National Cancer Plan, the Cancer Alliances and the early diagnosis programmes — not through the GP contract's incentive payments. If a launch plan claims QOF will drive earlier referral, ask which indicator; there isn't one.

10. NHS Oversight Framework 2026/27: your best-aligned lever

Published 11 June 2026, the framework segments organisations from 1 (highest performing) to 4 (significantly underperforming, including those in financial deficit), scores them across **86 metrics in seven domains**, and publishes the results as public dashboards and league tables against peer groups. Organisations in segments 3 and 4 face intensive scrutiny, mandated support and a high likelihood of enforcement powers being used. ICBs are assessed annually on their statutory and commissioning functions, with formal capability assessments expected from 2027/28.

Three of those 86 metrics are cancer metrics: the **28-day Faster Diagnosis Standard**, the **62-day referral-to-treatment standard**, and the **proportion of cancers diagnosed at stage 1 or 2**.

Why this is the sharpest instrument you have. A named metric in a published league table is something a chief operating officer is personally and visibly exposed to. If your product or the service model around it can be tied to one of those three, you have converted a medicines conversation into a performance conversation. The same framework cuts the other way: in segment 3 and 4 systems, specialised spend decisions need regional sign-off, and a new cost pressure is the last thing a recovery plan wants.

11. Modern Service Frameworks: there isn't one for cancer

The first Modern Service Frameworks cover **cardiovascular disease, severe mental illness and sepsis**, with dementia and frailty to follow. Cancer is not among them, and you should expect to be asked about this.

Cancer's equivalent is the **National Cancer Plan for England**, published 4 February 2026 (accessible version updated 20 April 2026), which sets a headline ambition of 75% five-year survival by 2035 and commits to meeting all three cancer waiting-time standards by March 2029. The commitments with commercial consequences:

- **£80m for four new aseptic medicines production hubs, operational by 2027** — the single most commercially significant line in the plan for an IV oncology launch, because compounding capacity is the binding constraint on delivery.
- **£200m ring-fenced in 2026/27 distributed through Cancer Alliances** for sustainable performance improvement, alongside £2.3bn for diagnostics over three years and £70m for 28 radiotherapy machines.
- **Genomics**: universal access to needed genomic tests with results returned in time to change treatment, Lynch syndrome testing in newly diagnosed bowel and endometrial cancer, BRCA1/2 testing in breast and ovarian cancer, and ctDNA extended to further cancer types by 2030 — the eligibility gate for most targeted oncology products.
- **New cancer manuals** to standardise quality, and personalised cancer plans for every patient.

Delivery runs through **20 Cancer Alliances**, each aligned to one or more ICB footprints. They receive ring-fenced service development funding and provide clinical leadership and advice on commissioning — but they *do not commission services*. Treat them as the fastest route to clinical consensus and pathway change, and never as the signatory. Note too that the plan's funding adequacy is publicly contested, including by Cancer Research UK: assume implementation money is scarcer than the headline figures suggest.

12. Local and regional tendering: two different worlds

The role spec's “local and regional tendering processes” covers two regimes that are routinely conflated.

Services: the Provider Selection Regime

The PSR governs how relevant authorities procure healthcare *services* — pathway and service contracts — through direct award processes, the most suitable provider process, or a competitive process, with published award decisions and a standstill period. You are affected by the PSR when your company is a partner in a service model (a diagnostic pathway, a nurse-delivered service, a hub-and-spoke delivery model), not when a hospital buys your medicine.

Medicines and delivery services: procurement as goods and services

Branded medicines are procured nationally through tranches run by **Medicines Procurement and Supply Chain (MPSC)**, the successor to the Commercial Medicines Unit. Below that, **nine regional Collaborative Purchasing Organisations** procure what MPSC and NHS Supply Chain do not — and their scope includes the things that decide whether your oncology product can actually be given: **compounding services including dose-banded chemotherapy**, radiopharmaceuticals, cleanroom consumables, and homecare outside nationally managed contracts. Biosimilar and best-value biological switching runs through NHS England's commissioning framework for best value biological medicines.

The practical point. For an in-patent oncology medicine, your “tender” is usually not a price competition at all. It is three things: the formulary submission and prior-approval form build; a compounding or aseptic capacity decision at CPO or trust level; and a homecare contract. Know which of the nine CPOs covers each

of your priority accounts, and when their compounding and homecare frameworks are re-let. That calendar, not the financial year, is what your launch plan should be sequenced against.

13. Who signs what

Decision	Where it is actually made
Is the medicine recommended?	NICE appraisal committee — TA, HST, or recommendation for use within the Cancer Drugs Fund.
Who must fund it?	The responsible commissioner within 90 days (30 for EAMS/Fast Track): the ICB for delegated specialist cancer services, NHS England for retained and highly specialised services, with NHS England accountable commissioner throughout.
Is it on the formulary?	Trust or ICS formulary / medicines optimisation / area prescribing committee — constrained by SC27 and SC2.1.6 of the NHS Standard Contract.
Can a clinician actually prescribe it?	Prior approval scheme (Blueteq-style form) under SC29.4.1 — and the form has to exist and be built.
Can the service deliver it?	Chief pharmacist and aseptic services lead, plus the divisional director who owns chair time and nursing capacity. This is where launches stall.
Can the pathway change?	ICB as strategic commissioner, with clinical consensus brokered through the Cancer Alliance; provider performance held by the NHS England regional team from April 2026.
What price is paid?	MPSC nationally for branded tranches; regional CPO for compounding and homecare services; excluded-items pricing rule for high-cost drugs (lowest of actual cost, nominated supply cost or reference price).
Who carries the consequence of delay?	Trust chief operating officer, through the NHS Oversight Framework's published cancer metrics and segmentation.

14. What usually goes wrong

1. **Treating the 90-day mandate as an access plan.** It compels funding. It does not create a Blueteq form, an aseptic slot, a clinic chair or a pharmacist. Those are the rate-limiters on your first two hundred patients.
2. **Selling to the ICB when the decision sits elsewhere.** Since the Strategic Commissioning Framework, ICBs are being pushed towards pathways and outcomes; the named decision about your molecule increasingly sits with the provider or the regional specialised team.
3. **Pricing and incentive stories built on trust margin.** The excluded-items rule reimburses at the lowest of actual cost, nominated supply cost or reference price. The provider cannot keep the gain, so the incentive you designed does not exist.
4. **Missing the tariff cliff.** When biosimilars or generics arrive, the molecule moves into tariff and prior approval falls away — April 2026 did exactly that to rituximab and sorafenib among others. Switching then becomes a local margin decision taken without you.
5. **Building the case on the wrong framework.** The Better Care Fund and QOF are weak-to-absent levers for an oncology medicine. Citing them as funding routes tells an interviewer you have read a list, not a system.

6. **Ignoring the delivery constraint.** The National Cancer Plan is spending £80m on four aseptic hubs because compounding is the bottleneck. A subcutaneous or oral formulation is therefore a capacity argument, not a convenience one — and that is a much stronger argument.
7. **Planning against a map that is about to change.** ICB mergers in April 2026 and April 2027, seven Offices for Pan-ICB Commissioning from April 2027, and NHS England's absorption into DHSC will redraw your account list mid-plan.
8. **Forgetting the oversight brake.** In segment 3 and 4 systems, decisions affecting specialised allocation spend need regional approval. A local yes is not a yes.

15. What I would do in the first 90 days

Mapped to the cross-functional requirement in the role — Medical, Commercial and External Affairs — and to account plans, funding pathways and tendering.

- **With Commercial:** rebuild the account map on post-merger ICB footprints and the 20 Cancer Alliances; identify which of the nine CPOs covers each priority account and when their compounding and homecare frameworks are re-let; segment accounts by NHS Oversight Framework segment and 62-day performance, because a segment 4 trust and a segment 1 trust need opposite conversations.
- **With Medical:** translate the clinical evidence into the three cancer metrics that are actually in the Oversight Framework, plus the delivery consequence in chair time, pharmacy time and aseptic capacity. Agree the genomic testing pathway and turnaround that gates eligibility, and the SACT coding that will carry any managed-access data collection.
- **With External Affairs:** position against the National Cancer Plan's named commitments — aseptic hubs, genomic turnaround, cancer manuals, the March 2029 waiting-time deadline — and engage honestly with the funded/not-funded debate around the plan rather than quoting its headline numbers back at people who know they are contested.
- **Own the unglamorous paperwork nobody else owns:** the prior-approval form (or its absence), the SC27 formulary submission, the homecare pathway, the SACT coding. In oncology these four artefacts, not the value proposition, determine when the first patients are treated.

A note on limits

This is a map of the mechanisms as published up to 23 September 2026, with every material claim traced to the primary source below. Two areas are moving fast enough that you should re-check them on the day you need them: the scope and timetable of the Single National Formulary prototype, and the post-2027 commissioning architecture as NHS England is absorbed into DHSC. Framing, judgement and the warnings above are mine; retrieval and first draft were AI-assisted.

Not advice — a map.

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