How practical is a Single National Formulary in the real world?

Would the NHS be swapping one bureaucratic process for another – just to put all the eggs in one basket?

& How would the NHS put it into practice?

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Foreword

The NHS is entering a defining moment in its evolution. As the government's 10 Year Health Plan and the Life Sciences Sector Plan[1,2] set out a bold vision for universal, high-quality care, the proposal for a single national formulary represents one of the most ambitious reforms in decades. At its heart, the idea seeks to simplify, standardise and accelerate access to the most effective medicines, with the aim of removing the postcode lottery that has long challenged both patients and clinicians.

Other health systems have already taken this path. While we must take caution when looking at other countries, as no countries' systems are alike, we can see that Australia and New Zealand operate single national formularies that guide prescribing nationally, and, locally, Wales and Scotland have also moved towards a more centralised model. Their experiences offer valuable lessons: national consistency can drive equity and purchasing power, but this requires careful governance to ensure local flexibility, responsiveness to population needs and sustainable supply.

For England, the challenge is how to learn from these models while adapting them to the complexity of the NHS. A national formulary promises the potential for efficiency, equity and innovation; yet it also raises fundamental questions about governance, funding, local autonomy and clinical engagement. Will it cut bureaucracy or create new layers of it? Will it deliver on its promise of fairness or risk stifling innovation, flexibility and responsiveness to local needs?

This paper seeks to address those questions. Drawing on perspectives from across the NHS and life sciences sector, it sets out both the perceived benefits and the practical challenges of a Single National Formulary and explores what it would take to translate the concept into a workable reality.

Jonathan Carney
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Our aim is not to advocate for or against the proposal but to provide clarity, context and critical insight at a time when the debate is intensifying. By highlighting the opportunities, risks, required safeguards, and international comparisons, we hope to inform decision-makers and spark constructive dialogue on how the NHS can best balance national consistency with local responsiveness.

Only through such debate, reviewing evidence, exploring experiences and having an openness to innovation can we ensure that this reform strengthens rather than destabilises the health service. This report is intended as a contribution to that debate and as a starting point for the collaboration that will be essential if a Single National Formulary (SNF) is to move from aspiration to reality.

Background

> **The National Health Service needs a National Formulary.**

10 Year Health Plan for England – 'Fit for the Future'[1]

In July 2025, the UK Government released its 10 Year Health Plan for England – 'Fit for the Future'.

The overall plan is to create a new model of care that builds on the NHS's founding principles of universal care, free at the point of delivery, based on need and funded through general taxation to ensure patients have choice and control over their health and care.[1]

The plan centres around three key shifts within the NHS, supported by four pillars.[1]

NHS 10 Year Health Plan: Fit for the Future[1]

- **From hospital to community[1]** – The neighbourhood health service, designed around you[1]
- **From analogue to digital[1]** – Power in your hands[1]
- **From sickness to prevention[1]** – Power to make the healthy choice[1]

- An NHS workforce, fit for the future[1]
- A devolved and diverse NHS: a new operating model[1]
- Powering transformation: innovation to drive healthcare reform[1]
- Productivity and a new financial foundation[1]

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Life Sciences Sector Plan[2]

The Life Sciences Sector Plan builds on the overall 10 Year Health Plan, describing how the life sciences sector specifically can support the three health shifts with funding from the government, UK Research and Innovation (UKRI) and the National Institute for Health and Care Research (NIHR).[2]

This will involve a new model of partnership between science and society, government and industry, and economic and health policy, recognising that better health and stronger growth go hand in hand and that the most effective healthcare relies on the rapid adoption of new technologies and treatments.[2]

NHS 10 Year Health Plan: Fit for the Future[1]

From hospital to community[1]

The neighbourhood health service, designed around you[1]

From analogue to digital[1]

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Life Sciences Sector Plan[2]

Enabling care closer to home, supported by new diagnostics and digital tools[2]

Using genomics, early detection, and personalised medicine to keep people healthier for longer[2]

Embedding data and artificial intelligence (AI) to improve outcomes and reduce pressure on frontline staff[2]`

A Single National Formulary

One of the key areas of the 10 Year Health Plan is the introduction of a Single National Formulary (SNF) within the next 2 years.[1]

- The rationale is that the current system for getting new medications to patients is needlessly complicated through a bureaucratic process, while all medicines are listed in the British National Formulary (BNF), and once a medicine receives approval from the National Institute for Health and Care Excellence (NICE), it is up to each local area to decide whether to make that drug available.[1]
- The assertion is that local formularies create a postcode lottery that does not make sense in a universal service that should provide a core standard of high-quality care to everyone.[1]

> **At a meeting I was told the SNF was about pathways not necessarily reviewing individual medicines for addition to a formulary. I think we need to be absolutely clear about what an SNF is and is not for all stakeholders involved.**

An SNF also forms part of the Life Sciences Sector Plan.

- Action 28 of this plan is to reduce friction in the system to optimise access and uptake of new medicines so the most clinically and cost-effective can reach patients faster.[2]
- This includes the NHS working with industry to contribute to the SNF.[2]

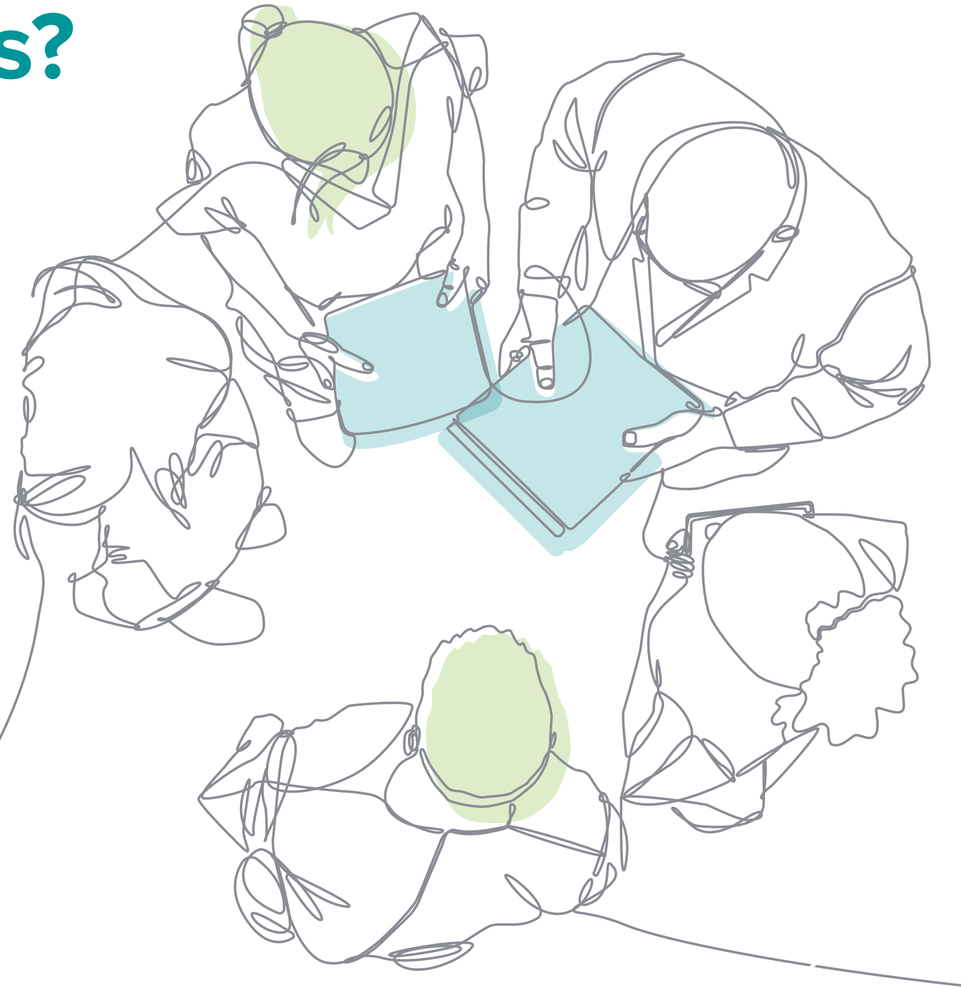
Implementation of an SNF for England would represent a major shift in how medicines are commissioned and accessed. Such reform could have far-reaching consequences for the NHS and for those providing medicines to patients.

Current understanding around the SNF within the NHS and industry seems to be limited, with more questions than answers and no clear plan as to how an SNF would be achieved.

This report is based on a survey of the opinions of around 50 key stakeholders in the NHS and industry on the anticipated impact of a national formulary.

Do the practical challenges outweigh the perceived benefits?

> I see no benefits since the point of a formulary is to limit choice and delay progression to the next stage of drugs that are more expensive than the previous stage. If they ever did get first-line listed, it could cause supply problems with the whole country trying to buy that agent.
> How reactive will it be to new generic entrants? Where does this all sit with genomic medicines?



Benefits and challenges

According to our survey respondents, the introduction of an SNF has the potential for positive implications and benefits.

However, overall, the number of challenges and concerns raised outweigh the perceived benefits overall.

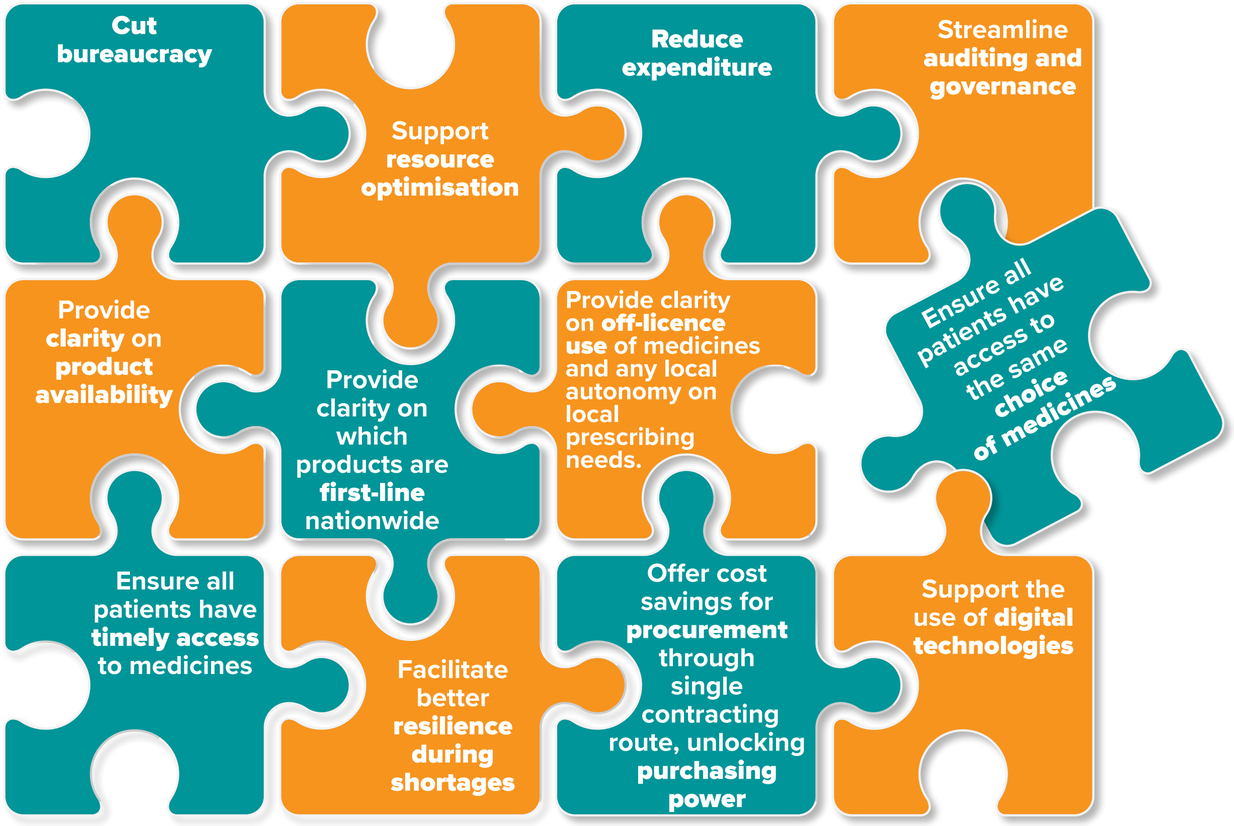
> **Ensure best value for money within NHS medicines services.**

> **More effective prescribing for maximising clinical outcomes.**

> **To be honest, I do not see any benefits from this.**

> **Isn't an SNF the original intention of the BNF, would we not just be repeating this and find, for exactly the same reasons, you end up with something that does not work?**

Click on puzzle piece to discover more



> **Currently being part of a regional formulary, I am finding it increasingly not useful or relevant for my organisation.**

Benefits and challenges

Cut bureaucracy

Our respondents listed a vast range of stakeholders who would need to be involved in the development of an SNF.

With this in mind, there would likely need to be an overarching formulary committee supported by sub-committees with specific tasks – similar to the development process for professional society guidelines – especially if, as some respondents suggested, each specialty and disease would need to be reviewed separately.

Rather than cutting bureaucracy, this could actually add another layer of bureaucracy – while the government is dismantling NHS England as a bureaucratic quango, an SNF is likely to need the creation of the equivalent of an NHS England for the SNF.

> **An SNF or NICE should not rely on shared care as a default formulary status, this should only be used when absolutely necessary, as we are already seeing large secondary care caseloads that can never be discharged under current arrangements.**

Learnings from other countries

From Australia and New Zealand, we learn that whilst decisions are made once at national level, the process for stakeholder involvement needs to be transparent and not restrictive and it has found to be slow in exceptional circumstances and for compassionate use; not forgetting rare conditions.

Stakeholders that need to be involved in the process

Healthcare bodies	Systems and organisation leadership	Clinical	Pharmacy	Finance	Patients and service users
■ DHSC ■ NICE	■ Senior ICB management ■ Senior trust management ■ Chief executives ■ APC representatives ■ Primary care ■ Secondary care ■ Community health services ■ Health and justice settings ■ Commissioning teams ■ ICB JFC members	■ Chief medical officers ■ Lead clinicians from each trust ■ Specialists ■ GPs ■ Nurses ■ Allied health professionals	■ System medicines optimisation leaders ■ Chief pharmacists ■ Formulary pharmacists ■ IMOC pharmacists ■ Medicines safety ■ Pharmacy technicians ■ Pharmacy staff ■ Specialist pharmacists ■ Primary care pharmacists ■ Secondary care pharmacists ■ SPS horizon scanning team	■ Finance directors ■ Chief finance officers ■ National, regional and local finance professionals ■ National, regional and local procurement teams	■ Patient organisation representatives ■ Patients/service users

APC, Area Prescribing Committee; DHSC, Department of Health and Social Care; GP, general practitioner; ICB, integrated care board; IMOC, Integrated Medicines Optimisation Committee; JFC, Joint Formulary Committee; NICE, National Institute for Health and Care Excellence; SPS, Specialist Pharmacy Services.

Benefits and challenges

An SNF could support resource optimisation by cutting bureaucracy, preventing duplication, and reducing the need for local teams to implement local formularies. A clearly defined and equitable route to formulary decisions – "*a do once approach by a highly specialist team*" – should, in principle, facilitate faster, better resourced and evidence-based decision-making, reduce variation across regions, and reduce expenditure. The time saved reviewing local applications could release time for clinical tasks.

However, the operational burden of developing and transitioning to an SNF would be substantial. A robust governance structure would be needed so that decisions are made fairly and equitably, and a clear reporting structure on how decisions are implemented nationally would need to be in place.

> **There is only one benefit and that is releasing what are bureaucratic quangos into developing the local health and social care pathways so they work.**

> **Whilst it's a great idea in practice, we need to consider that, for example, London's population and its disease management, with many specialist hospitals looking after patients from across the nation, needs to be looked in detail. It's a big shame that, for example, the Pan London formulary was decommissioned, as its purpose and objective sat well with what we deliver. All other formularies outside London could consult and adopt accordingly.**

> **The SNF assumes Drugs and Therapeutic Committees (DTCs) will not be required but they serve an important governance function in trusts other than formulary drug consideration so they need to stay.**

Even within an ICB, achieving consensus on formulary content can be difficult, so scaling this to a national level introduces significant complexity, especially given the diversity of local prescribing practices, population health needs, and existing contractual arrangements. The administrative burden would be significant, with time-consuming consultations needed across multiple trusts, even for a single drug. Centralising decisions may slow down the process of adding new treatments and regionally relevant treatments or responding to emerging local health threats.

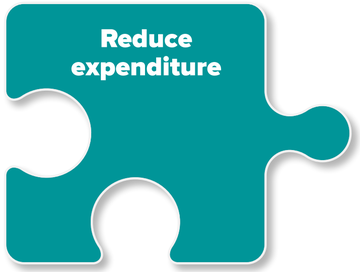
Learnings from other countries

Avoid duplication where possible and lift and shift from others. For example, in Wales and Scotland, additional resources are saved by not having to commit to developing their own full health technology appraisal or formulary assessments for all drugs. Instead, they leverage NICE or run selective health technology appraisals (HTAs) via the All Wales Medicines Strategy Group (AWMSG) and Scottish Medicines Consortium (SMC). This reduces administrative costs.

New Zealand has one body resource, which is often constrained and can be a bottleneck.

A policy insight here is that an SNF should be adequately resourced and perhaps mandated to deliver decisions within a clear timeframe to avoid excessive delays.

Benefits and challenges



Learnings from other countries

This is difficult to directly benchmark and access as often each country's system is set up very differently – some may spend more in primary care than hospital care or private healthcare and others spend more on the preventive agenda. The UK internationally is seen to have a very cost-effective healthcare system and as such the UK is likely to be spending less than many countries per GDP.

Areas often develop local pathways, guidelines and shared care agreements as resources to support local formularies. This will not be possible with the SNF, which may reduce local engagement with supportive documents and guidelines. There will need to be a clear communication route for changes to the SNF so that local areas can implement these changes and update relevant guidance. National pathways would also have to be developed – e.g. for chronic diseases, rheumatoid arthritis, psoriasis, etc.

Organisations should not underestimate the amount of time and resource required to implement decisions from an SNF at a local level. Indeed, the initial work to resolve differences in current prescribing patterns and behaviours could create an unanticipated cost pressure. Transitioning from diverse local formularies to a national formulary will involve significant coordination, time, training, system upgrades and funding, which one respondent stated "the NHS is not capable of achieving". There is no guarantee that expenditure will go down, especially if discount given does not trickle down to systems. Most would say that local systems would need to overhaul digital prescribing systems, update clinical pathways, and retrain staff. Tools such as Netformulary would be needed to help trusts manage implementation.

Consideration will need to be given to how to prioritise new applications when there may be competing priorities in different areas of the country, hence different budget requirements. If a new medicine is approved but is not affordable, there will discrepancies in how different systems manage that medicine. From a secondary care perspective, not all drugs will be commissioned for each organisation or stocked within pharmacy, so the local governance structure will still be needed to ensure only commissioned drugs for indications are being used. If local systems are no longer resourced or staffed adequately, decision support and addressing challenges will need to be managed centrally and that will include rare diseases. Prescribers in primary care, particularly less experienced doctors, may not feel comfortable using certain medicines if red–amber–green (RAG) ratings are aligned nationally.

> **"Primary care may face increased pressure if expected to prescribe unfamiliar or specialist medicines without adequate support."**

> **"Ensure best value for money within NHS medicines services."**

> **"Who wants to carry the financial or budgetary responsibility if the decisions on what can be prescribed are being made centrally?"**

Benefits and challenges

Learnings from other countries

Scotland and New Zealand also see the importance of setting up a governance structure that includes regional and local representatives, with a diverse set of voices.

Audit mechanisms would be required to monitor adherence to the SNF. The move to pathways using the same drugs for different tertiary centres would have a huge advantage for integrated care systems (ICSs) with multiple acute trusts connected to a different tertiary centre, as the current system creates significant barriers in streamlining. With standardisation of available treatments, organisations will be better able to benchmark data and compare prescribing.

Formularies are not static but evolve with the availability of new products and emergence of new evidence on effectiveness, safety and cost-effectiveness. An SNF could be used as a mechanism to remove outdated or less effective treatments – an aim mentioned under NICE's expanded remit – and encourage disinvestment of low-value medicines.

None of this will be cheap and may well negate any financial and workforce benefits. The funding implications and time investment of adding products will need to be considered, as local areas may struggle to implement without appropriate funding in place. In the words of one respondent, "a single national formulary needs a national formulary budget".

> **There should be an appeals & exceptions process. Formulary should be dynamic, with a way for local expertise to input into it. Robust monitoring of formulary with impact on health inequalities, patient outcomes and prescribing trends noted. An ability to amend formulary in a timely manner if negative consequences emerge.**

> **Unless there is funding for medicines then the SNF won't work for any of the groups.**

> **Formularies are pointless, bureaucratic machinery to prevent choice and misplaced attempts to control budgets.**

> **Medicines optimisation approach reduces the need for formularies – ICBs are still stuck in a rut with medicines management approach and governance.**

> **The impact on workforce is a potential issue – with ICBs cutting staff by 50%, who is going to implement local formulary decisions?**

Benefits and challenges

An SNF could provide clarity on product availability, reduce time checking Electronic Prescribing and Medicines Administration (EPMA)/guidelines for choice of medicine, and increase familiarity with drugs due to fewer products being on formulary, thus leading to more informed prescribing. It could also reduce interface issues due to different formularies in different areas, with clinicians benefiting from consistency of available drugs regardless of where they work and if they move between workplaces.

> **There is a risk of conflicting decisions, where medicines previously rejected locally for clinical reasons are included, potentially increasing costs and creating issues around patient expectations.**

> **I've always felt that system formularies are pointless. The biggest issue is developing care pathways – creating more local networking between clinical teams, through system leadership and medicines optimisation – is the better approach. I would suggest moving away from a traffic light system and moving towards locally agreed clinical management plans between clinicians responsible for the care of patients – this fits better with virtual models of care where you can escalate and deescalate between providers.**

However, a number of respondents mentioned confusion about the scope of an SNF. Some respondents raised concern that the SNF will just be a summary of NICE or a repeat of the BNF. Others pondered whether there would be a bucket of drugs for each condition or whether the order of first-, second-, and third-line use will be prescriptively described in the SNF.

> **As long as it is comprehensive and addresses all nuances that may not be shared in all localities.**

> **This should always have been the case. Having multiple different decisions locally benefited very few. Contracts for primary care and trusts need to reflect the need to follow it, with consequence for not doing so.**

> **Local transparency may suffer, as decision-making becomes more removed from individual trusts.**

> **Where there are differences, particularly with the need for shared care or GP prescribing, these should not cause organisations or patients with progressive arrangements to take backward steps**

Benefits and challenges

The prospect of a centralised formulary raised questions about who would hold decision-making authority and how local clinical autonomy would be preserved. The wording around this in the 10 Year Health Plan only reinforces the potential for such confusion:

"...the transition will involve the creation of a formulary oversight board responsible for sequencing products included in the formulary based on clinical and cost effectiveness supported by NICE."

However,

"Local prescribers will be encouraged to use products ranked highly in the SNF but will retain clinical autonomy as long as they prescribe in line with NICE guidance."[1]

Without a clear implementation plan, a number of questions have been raised. Essentially, there will be an official SNF but prescribing can be implemented at a local or even clinician level – what one respondent described as "a free for all".

> **Will the SNF provide guidance on who should be prescribing these drugs (e.g. primary/secondary care)? If not, local areas will continue to make different decisions, and equity of access continues to be an issue.**

> **Standardised care, accessible across the country.**

> **An SNF would need medical/clinician/specialty engagement and buy in.**

Some of the concerns raised by our respondents further play into this scenario. When local formularies are developed, local clinicians are consulted, which encourages adherence to formulary and ensures they can access the treatments they want to use. The development process for the SNF would be too remote for clinicians to have any buy-in, and the less specific a formulary is to local requirements, the less likely that clinicians will feel any ownership and feel obliged to follow it.

Overall, there is likely to be a sense of loss of clinical autonomy, with limitations on local clinical discretion, ability to tailor to local needs, and personalisation of therapy.

Ultimately, prescribers may disengage from the formulary and not use it, which is likely to result in less – rather than more – control over appropriate prescribing and expenditure.

> **A top-down approach could disengage clinicians who are used to tailoring decisions to local needs.**

> **Primary care may face increased pressure if expected to prescribe unfamiliar or specialist medicines without adequate support.**

Benefits and challenges

Many local formularies include off-label use of medicines, unlicensed medicines, and specialist medicines, especially for large tertiary trusts with specialist services. Specialist medicines may not be suitable for routine use across the country, so this will need to be managed carefully and communicated clearly in the SNF, and challenges about product choice may be made by specialist teams. Many local areas also have separate paediatric formularies, for which much of the use is off-label or unlicensed; if the SNF does not cover paediatric prescribing, equity issues will not be resolved.

There is currently no national process to review off-label, unlicensed and specialist treatments, so local decisions have to be made. If they are not included in the SNF, what happens to medicines that have been approved locally? Would local areas have to stop using drugs that are not on the SNF or would they still need to keep a separate formulary and continue with inequitable access?

Local discretion is not just about individual or organisational clinical preferences. A particularly pertinent example relates to antimicrobial formularies, which reflect local patterns of antimicrobial resistance, where a simple one-size-fits-all approach will not work. In addition to alignment of the SNF with antimicrobial stewardship, adherence with NICE and safe prescribing practices would also be needed.

> **Clarity across health economies on prescribing expectations, and for practitioners. It is essentially NICE.**

> **While the SNF aims to promote equity, it must also allow for flexibility to accommodate local innovation and patient-specific needs. A rigid national list could inadvertently stifle clinical discretion or delay access to newer therapies not yet adopted nationally.**

> **Clinicians used to local formularies are less likely to engage with and follow pathways/guidance that they have not been involved in co-creating, which may result in them resisting top-down imposition of drug choice.**

> **Unless there is a clear directive nationally, there may still be a requirement for 'local adoption,' which will then off-set the benefits of an SNF. Adoption of an SNF should be at a system level. There needs to be greater clarity if we are talking about individual medicines or pathways.**

Benefits and challenges

Most local formularies specify which medicines can be started by which prescribers – for example, medicines prescribed only by specialist hospitals, those that can be initiated in primary care, those that can be initiated by prescribers with a specialist interest, and those that are started by the hospital and continued by primary care. This varies from area to area in line with how services are commissioned and organised locally. If decisions such as who can prescribe are not decided at a national level, an SNF will not achieve the aim of ensuring all patients have access to the same choice of drugs. To set categories like this nationally would require a major review of how all clinical services are set up to ensure they are all appropriately aligned. If the SNF includes national shared care templates, changes to local custom and practice may be needed, increasing bureaucracy.

> **Local pathways don't always align – e.g. ophthalmology pathways only fit 80% of the population – an SNF would reduce access for those that need it.**

> **I believe that adopting a single formulary for NICE Technology Appraisals (TAs), Cancer Drugs Fund (CDF) treatments, high-cost drugs, and other nationally commissioned medicines is the most appropriate and efficient approach. This unified formulary should include supporting resources such as clinical pathways and nationally agreed RAG rating decisions, providing clear and consistent guidance to clinicians across all care settings.**

> **"How do you pick or enter a medicine not on the list in EPMA systems?"**

While equality is important when considering unwarranted variation, differences in population health result in appropriate variation across the UK, with different areas having different priorities based on the local population.However removing choice of treatments in the SNF may result in the lack in access to certain treatments that are durable or allow for extended treatment intervals, which may be needed for certain systems where services are remote or situations where patients cannot attend more frequently.

Learnings from other countries

It is important to ensure patients have access to the right choice of medicine. Taking the simple example of statins: all five are available across all countries. The time taken to gain approval was immediate in England, Wales and Scotland but over in Australia it took up to 4 years to get all five, whereas in New Zealand it took as long as 19 years to get funding for rosuvastatin.

> **If decision-making at national level is not timely, patients may feel obliged or inclined to use private healthcare, giving rise to inequality on a financial access level and putting undue pressure on primary care to continue medicine not within commissioning.**

Benefits and challenges

The 10 Year Health Plan and Life Science Sector Plan describe the importance of putting power in patients' hands, including allowing people to personalise their care to their own individual needs, choices and preferences.[1,2]

An SNF should ensure that patients in a timely fashion across all regions have access to the same medicines, reducing postcode prescribing inequalities; however, with limited options comes limited patient choice.

> **It makes sense and especially from a patient perspective they would assume that this is already in place.**

> **An SNF that is not comprehensive will not be useful, there is a risk of confused implementation, and areas will still need to make local decisions on off-label use of medicines.**

> **Equality, saves time, saves money, simpler.**

> **What happens to existing approvals for medicines that are in use locally if these aren't on the SNF, and how is this managed nationally?**

Patients may be at a disadvantage if SNF options are ineffective or cause adverse reactions or if there is no SNF-approved treatment for a rare disease or off-licence indication. In such situations, it may be more difficult to obtain unusual medicines not included in the SNF, which could lead to more 'red tape' to go off formulary, which could result in delays to treatment.

Learnings from other countries

Taking the example of biologics: Australia and New Zealand have been 1–4 years and 3–6 years behind the UK and European countries, respectively.

To ensure that launches happen swiftly and smoothly, clear processes and guidance on implementation needs to be set out.

> **How will the SNF incorporate specials and aseptics?**

> **Patients may see certain drugs on the formulary which local areas do not have the financial ability to fund.**

Benefits and challenges

Nationally and globally, there has been recognition of supply issues in medicines.

Some respondents felt that an SNF could provide better access to medicines for patients with fewer supply issues and could allow more frameworks for the use of national Patient Group Directions (PGDs), which could be issued for emergency supplies.

However, the majority of respondents felt an SNF could actually increase vulnerability to shortages.

> **The use of a single product across England for an indication means there is no alternative treatment to switch to should there be a supply shortage, which will have wider treatment implications.**

> **Losing flexibility and diversity in the market for medicines could lead to worsening availability. This would include both brands and moieties.**

In a current scenario with a drug shortage, patterns of impact across the country vary because of differences between local formularies. An SNF could reduce the number of alternative products available on the market, as a product that is excluded from the national formulary would be unlikely to be viable and remain in the market long term.

Consequently, alternative options in the event of a shortage may become even more limited due to the nationwide impact. Reliance on one product may also make the NHS more vulnerable to price changes.

Learnings from other countries

The medicines shortage issue is a global problem. However, it is worse for countries where there are only a few suppliers. This has led to most countries requiring greater holding stock quantities to be kept within those countries.

> **I have significant concerns that an unintended consequence of an SNF would be introducing vulnerabilities into the supply chain through reduction of alternative products in the event of shortage of an SNF product.**

Benefits and challenges

Offer **cost savings** for procurement through single contracting route, unlocking purchasing power

A national formulary could lead to efficiency in procurement and cost savings by:

- streamlining procurement processes
- leveraging the NHS's single-payer strength to negotiate better prices through economy of scale
- ensuring consistent supply across the country
- better value and efficiency through reduced waste due to reduced stock range on pharmacy shelves
- using suppliers who have a better carbon footprint, align with the green agenda or have a more sustainable provision.

However, an SNF may increase medicines spend for organisations that have taken a conservative approach to new drug entry. There is also potential for cost considerations to take priority over clinical benefit, but cheaper medicines do not always equate to lower costs for the NHS. For example, immediate-release medicines are often cheaper than prolonged-release drugs, but when a patient needs support from nurses or carers to take their medicines, this can increase the costs due to extra unnecessary visits. Similarly, oral medicines are often less expensive than long-acting injections, but oral dosing requires patients to take their drugs, and they can end up in hospital, with associated costs, if they fail to take them.

National standardisation could disrupt existing procurement frameworks and supply chains, particularly where local contracts or preferred supplier arrangements are in place. This could lead to unintended consequences such as medicine shortages or increased costs in the short term.

Benefits and challenges

One of the three shifts in healthcare in the 10 Year Health Plan is to move from analogue to digital and use digital technology more effectively. The SNF provides this opportunity.

An SNF would facilitate better planning and organisation of information technology (IT) systems to improve intraoperability and allow staff to move within the work environment more easily. It could support innovation by facilitating integration of standardised treatment options into technology-driven strategies – for example, digital prescribing and AI decision tools. It could also allow for standardisation of resources such as EPMA systems, with development of a single EPMA system drug file that tailors prescribing guidance in line with the SNF. This could be adopted by all health system providers, releasing staff from guideline- and formulary-based work maintaining individual drug files at every site to focus more on clinical activities.

An SNF should ease the interoperability issues with a standard formulary. It would allow the electronic transfer of formularies across systems with ease. It would also allow for a more consistent level of patient education provision on treatment options, counselling and advice across all the systems, with plenty of opportunity for digital tools and solutions that can be used nationally.

The downside is considering who owns, controls implementation and monitors the technology and whether it connects into the fabric of the system rather than another piece in silo often adding another complexity to a complex system.

> **Newer, more expensive drugs may be pushed out, and newer medication with less hands-on experience may struggle to have wider assessment.**

> **Some treatments can be administered closer to patients home with digital technology monitoring - but our system structure and contracting does not allow for it. Is it not time to put into practice what we preach?**

What does the NHS think about working with industry in the era of an SNF?

As the SNF would represent the NHS's recommended list of medicines, there are likely to be challenges from the pharmaceutical industry, and bodies such as the Association of the British Pharmaceutical Industry (ABPI) and British Generic Manufacturers Association (BGMA), if sufficient choices in each therapeutic class are not available. Another concern is that challenges and complaints would slow down the formulary development process. The larger the area a formulary covers, the more legal challenges from the manufacturers and so the slower the process.

There is also the risk that industry would question formulary leads around products not included in the SNF; and they may remove funding from projects. A single contract may lead to monopoly on supply, inflated prices and rebate schemes could be affected.

Respondents had additional concerns about supply chains and were concerned that industry might discontinue cheaper products (that are currently being made exclusively for the UK market) or alternatively charge a premium for universal formulary choices. It is important to remember that industry often provides funding support for place-based work and reviews, e.g. sponsoring a practice-based nurse review service. While project work and formulary choices are currently separate, industry may withdraw from project offerings unless their products are on the SNF.

Manufacturers might have less commercial incentive to launch competing products in the UK, leading to lack of adherence and lack of investment from industry for future development, ultimately stifling innovation.

> **There might be commercial negatives if just one or two drugs in a class are included on the formulary. I can see this may be of benefit to primary care but not so much for secondary care.**

> **The detail of what an SNF will affect is important to know. Introducing an SNF for all BNF chapters, while sounds good, will have far reaching consequences about supply and innovation. If just targeting new meds to try to boost rapid uptake, then I suspect that pharma will be more inclined to participate.**

> **We do work with pharma to get the best prices we can. They also help to support our supply models.**

> **Need not to be pharma led to get 'innovations' into practice with no budget. VPAG [Voluntary scheme for branded medicines pricing, access and growth] link essential so if innovations are used it reflects directly into the same-year budget. Although unlikely on past record!**

> **Work we would have done on new products could be aided by this – it will remove local blockages to implementation, e.g. biosimilars, inclisiran – areas of work that have ended up not going ahead.**

Industry responses to the prospect of an SNF

Industry opinions around the SNF depended on the role of the respondent:

- Those in market access roles believed that an SNF would simplify procurement, whereas respondents in sales and senior leadership believed otherwise.
- Most respondents believed that it would make no change, or make the UK market less attractive to new launches, but were waiting for more detail on the implementation plan.

> **Avoid a race to the bottom on price.**

> **Ensure complete stakeholder engagement with all partners.**

> **Have a transparent process for adding and removing products.**

> **Ensure the inclusion of 2–3 choices for each option – should help spread the risk and safeguard against supply chain problems.**

What is needed from the industry perspective?

- A clear transparent framework for establishing value.
- Choices focused on value for money not just on cost.
- Very transparent and challengeable process, with right to appeal and challenge.
- Health outcomes/long-term benefits captured – not just drug costs.
- Alignment with NHS values, national consistency, local flexibility, integration with NICE and NHS England, robust cost-effectiveness and pricing strategy, timely access and innovation pathways, stakeholder trust and participation, transparency, accountability and governance, professional development and communication.

Identifying the sweet spot for both the NHS and pharmaceutical industry

	Challenges	Benefits
NHS	■ Products may be introduced later into the UK market – stifles innovation and patient access to innovative medicines ■ Command and control becomes centrally driven ■ Systems will have to stick to formularies and within allocated funding, therefore lack of local autonomy based on population needs, leading to more dissatisfaction, especially if processes become excessively long when referred to centre for decisions	■ One formulary – no local duplications of work, no local postcode lottery decision – responsibility for decisions sits centrally ■ Staff focused on clinical delivery and no need for local contracting or rebates ■ Prices driven down – better deals for NHS but making the UK less attractive to the pharmaceutical industry ■ Predictability of system budget needs, with less room for local innovation and negotiations
Pharmaceutical industry	■ Whether to put effort into introducing a medicine into the UK ■ High risk if product does not get onto formulary or funding process does not align with formulary process ■ No justification for investing into NHS projects if treatments are no longer on formulary ■ Financial viability of operating a high-volume–low-margin model	■ For those incumbents higher barriers to entry means fewer new suppliers in the market – market share held by key players. NHS will need to ensure that suppliers can meet the national demand and that there is sufficient stock of all formulary choices nationally ■ Predictability on process, demand and planning supplies for the UK – better manufacturing and distribution coordination ■ Fewer negotiations needed locally – fewer pharmaceutical negotiations at a local or system level. NHS challenge will be to ensure that all negotiations for treatments options are considered across the whole system to include primary, secondary and community services and pharmacies

Basics of a common ground

- A clear and transparent process for both NHS and pharma.
- A guaranteed supply process – predictable and transparent processes for approvals, procurement and supply.
- National medicines funding that follows the SNF nationally – removal of postcode lottery for all medicines on the formulary, funding allocated based on approved formulary and each system's population requirements, ensuring all approved drugs are accessible to all those who need them.
- An environment that nurtures doing things only once and a process that evaluates each medicine and its value proposition across the complete system, including its unique selling point (USP). For example, prescribing from tertiary or secondary care through the community pharmacy and when looking to the future to include genomic testing and precision medicine considerations as part of the approval process.

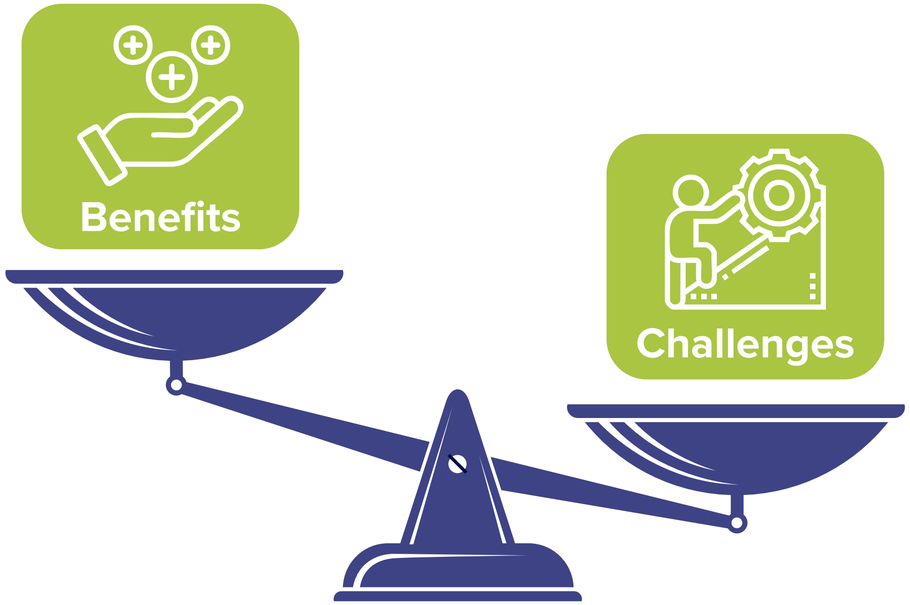
A summary of the balance

The SNF is a part of the 10 Year Health Plan to be implemented in the next two years.

While there are benefits of implementing it on various levels, if done poorly it may result in another version of the BNF. To do it properly requires a body like NHS England to lead it, which would need to be supported by the integrated care boards (ICBs). Both NHS England and ICBs have been significantly reduced in resource or have been removed, hence where would such a role of producing, implementing, auditing and governance sit?

According to our survey respondents, the introduction of an SNF has the potential for positive implications and benefits; however, without a clear implementation plan and timelines to match, the number of challenges and concerns raised outweigh the perceived benefits overall.

What has also become clear is that an independent national budget needs to be assigned to medicines to avoid medicines budgets being used to plug other financial holes in systems.



> **It makes sense and especially from a patient perspective they would assume that this is already in place.**

> **As tempting as it might seem, don't do it!**

How does the NHS translate an SNF from concept to practice?

> This appears to be ok in principle but my concern is that it would be a practical challenge to implement.

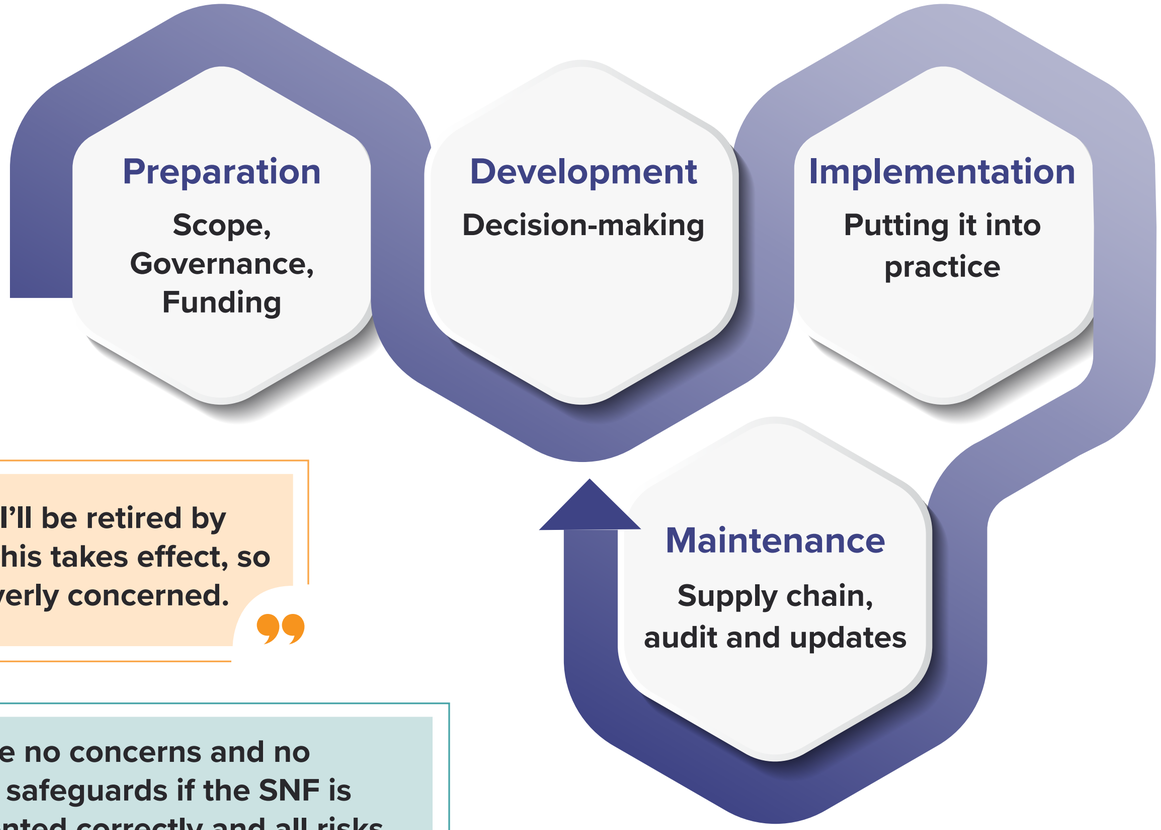
> It is a good idea in principle that could be a disaster in implementation if driven by too narrow an approach. We can't disentangle the clinical decision-making from the financial. An SNF needs an SNB (single national budget).

Translating the concept into reality

It is clear from our survey that respondents, overall, felt that the possible challenges would outweigh the potential benefits.

However, given the government is likely to continue to support the concept of an SNF, the NHS will have to work out how to implement it in practice.

We asked our respondents what would be the next steps and what mitigations and safeguards would be needed to minimise the impact of the challenges.



> It's about time – great idea – let's go!

> I suspect I'll be retired by the time this takes effect, so I'm not overly concerned.

> Go for it with real determination and challenging timescales – ignore the naysayers who think it's too difficult.

> There are no concerns and no need for safeguards if the SNF is implemented correctly and all risks mitigated against.

Preparation

Scope

Decide on the scope and model of the SNF early in the process. Considerations include:

- Adopt a unified approach across the country.
  - Consider a guideline or framework to move gradually towards regional or cluster harmonisation.
  - Allow local adaptations to facilitate clinical autonomy.
  - Build in regional variation while maintaining the evidence base to ensure sufficient medication supplies if the whole country was to adopt a pathway.
  - Build in some scope for providers to order off-formulary if the prescribing criteria are tight.
  - Local specialist hospitals keep their formularies that include drug in-tariff drugs, with all other drugs included in the SNF.
- Cover all prescribing areas to minimise risk.
- Covers off-label and unlicensed medicines, as well as licensed medicines.
- Include harmonised treatment pathways aligned with national guidelines

> **The SNF should commence with a focus on only a targeted range of drug groups to establish the process and test the impact.**

> **They will not be able to designate first-line and second-line treatment. Instead you will get a number of drugs in each bucket which will increase choice and cost and still require local formularies.**

- Phased approach:
  - Only apply to new innovative drugs to support consistency of adoption across the NHS and promote innovation.
  - Set the scene for additional retrospective reviews of other drug groups in due course.
  - Exclude lower cost and generic drugs to enable continued supplies of a choice of drugs within a drug group, with local formularies for lower cost drugs.

> **I think it could operate national to local rather than the other way around. A central body could take the formulary and traffic light reasoning from a sample of large and small ICBs and create a national process from that, which could be divided up among the regions to look at particular families of products in the future.**

> **Do not simply reproduce the BNF – the SNF needs to be a slimmed down, prioritised list.**

> **They can't since ABPI and BGMA will not allow for a single drug to be listed as first-line in a therapeutic class.**

Preparation

Governance

Develop a clear governance structure on decision-making, with a process for drug choice that is transparent, agreed, inclusive, progressive and linked to affordability for struggling systems. Considerations include:

- Separate lobbying from evidence presentation and decision-making.
- Legal framework to prevent manufacturers tying this up in court for years.
- Ensure alignment between current reimbursement processes (e.g. NICE, Medicines and Healthcare products Regulatory Agency (MHRA), SMC, etc).
- Provide clear guidance and communication on governance, clinical engagement, processes, evidence and costing models as soon as possible.
- Provide clear directives nationally in the same way NICE TAs are managed locally.
- Consider developing a digital consultation platform for the SNF.
- Update GP contracting to drive more consistent uptake of shared care.
- Ensure there is a clear governance structure or legal requirement as the SNF needs to be mandatory to ensure that ICBs/trusts implement it.
- Strong partnership with industry to minimise disruption to supply chains and medicine shortages.

> **System leadership should develop a more standardised NHS model.**

> **I would like to see it led by NICE, and I would also like to see an approach that adopts the model of medicines optimisation and not medicines management.**

> **Governance wise, it could be a big challenge such as formatting shared care and transfer of care documents, terms of reference, and policy.**

> **The centralised decision-making team would need to understand both formulary and primary care interface issues and be able to keep abreast of ongoing supply shortages. I would also be concerned that this team might suddenly get decommissioned, for example, by a major NHS reorganisation.**

Preparation

Funding

The SNF should have appropriate funding to ensure it can be adopted universally. Considerations include:

- Provide proper funding for new innovative medicines and recognise the growth in medicine use and expenditure in chronic disease.
- Centralise budget setting or reform medicines expenditure accountability.
- Remove unfair value added tax (VAT) processes that disadvantage NHS trusts.
- Be clear about the funding implications for drugs that are approved – if in tariff, how are trusts expected to implement drugs with large financial impact?
- Work closely with procurement and pharma to ensure supply chains.
- Provide resource impact modelling to support implementation locally.
- Provide clear communication about costing models.
- Provide clarity around funding streams and a steer on what is expected to be managed in specialist settings versus primary care.
- Limit deals with single providers, including dispensing doctors.

> **Would there be price differentials between primary and secondary care?**

> **NICE technology appraisals are not affordable now. If NICE insists on all being in, we will be in financial meltdown. If an organisation is financially challenged and unable to control choices and overspends, who will bear the consequences?**

Development

Decision-making

A dedicated national team should review with input from a broad range of professionals, including specialists and experienced formulary/interface pharmacists, and from all regions.

- Make decisions based on the overall pathway, not just the drug/product.
- Include key clinicians/specialties from the start.
- Engage with relevant royal colleges/professional leadership organisations.
- Rotate decision-makers every 2–3 years or distribute evaluation around regions.
- Ensure more than one choice is available on formulary.
  - Be clear when it is appropriate for each drug to be prescribed and the order of products.
  - Vary the order of first-line choices regionally to minimise the impact of shortages.
- Ensure business-style advice is available so that cost-effectiveness and opportunity are not outweighed by clinical evaluation.

> **You need channels for the stakeholders to feed in to so they have a voice in the decision-making. This is why engagement with clinical networks and royal colleges is imperative to success. NICE also has a model and actually makes a lot of decisions already – so I would see it as a widening of its arm rather than needing to redevelop the wheel.**

- Include traffic light coding
  - Link the SNF to the work of Specialist Pharmacy Services (SPS) and the national protocols.
  - Ensure all areas are adopting the national shared care protocols and develop new national protocols as a priority to standardise this care.
- Align to the SNF or have a route to influence the SNF through an application process.
- Guidance will be needed to ensure that specialist drugs on the SNF are prescribed by prescribers with appropriate expertise.
  - Specify services that can use specialist drugs.
  - Deliver shared care documents with formulary status.
- Include guidance on how to manage requests for high-cost drugs not on the SNF.
- Provide clarity on and provision of timely and robust escalation routes to support access to individualised treatments as needed.
- For antimicrobials, although an SNF can determine which antimicrobials should be available nationally, local guidelines would still be required to tailor to specific resistance patterns.

> **If NICE was to determine treatment pathways and look at affordability when they approve medicines, it would reduce a lot of the duplication in the system, and you wouldn't need a National Formulary Group.**

Implementation

Putting it into practice

Agreement on implementation across all systems will be needed. Considerations include:

- Multidisciplinary membership of implementation group.
- Consider phased roll-out that includes allowances for current prescribing practices to:
  - avoid issues around decommissioning of medicines that prove appropriate for patients but do not adhere to the SNF
  - allow areas to understand local variation and how they will address this
  - avoid unanticipated cost pressures.
- Develop training to ensure workforce readiness to work with the SNF team for smooth transition
- Clear communication about where to access the SNF and what has been approved/removed.
- Provide support for decommissioning of treatments previously used but not on SNF and prepare to switch patients from older treatments.
- Include digital patient file notes with agreed alternatives for patients with allergies and contraindicated treatments.
- Include some scope for organisations to order via their own supply routes:
  - Keep more than one supplier for each product
  - Include early warning systems in supply chains
  - Anticipate supply chain issues for non-generic medicines.
- Ensure local implementation safeguards are in place.
- Provide stewardship for legal challenges by patients who wanted access to medicines not on the SNF.

> **Collaborate with medicines procurement and supply chain/ DHSC to actively manage the market.**

> **There will be learning with implementation.**

> **The timeframe for roll-out needs to be agreed in advance with a one big bang approach to avoid postcode lotteries and unequal care if staggered roll-out.**

Maintenance

Supply chain, audit and updates

A process will need to be in place to add and remove products and update the preferred order of products in a responsive manner.

- Set up an SNF management group.
- Be agile enough to change in line with new evidence on efficacy, safety and cost-effectiveness and based on feedback from the front line.
- Ensure a route to cascade of information to local teams that is quick and easy to search – i.e. monthly updates containing all changes would need to be separated into clinical areas and easily searchable.
- Designate a team to deal with potential supply issues, which should be thoroughly investigated, with clear communication channels to inform local managers how these are to be dealt with and ensure medicines access is equitable.
- Develop a process/framework to actively restrict non-evidenced non-formulary use.
- Clearly defined horizon scanning.

> **How will it be monitored? To be fair you don't actually need a formulary (already have one in the BNF) if people took a medicines optimisation approach. You could just scrap them altogether and call them local pathways – which is what they've become anyway.**

> **Effective oversight mechanisms will be critical to ensure the SNF remains up to date, evidence-based, and responsive to clinical feedback. I don't have faith national or colleagues at DHSC can do this.**

> **Formularies need to be a living resource that is constantly updated to work well. This means it requires constant maintenance.**

> **What will be the process for removing things from formulary due to safety concerns, cost changes, etc?**

Critical next steps

- Decide on format and scope of an SNF.
- Agree governance structure.
- Identify existing resources that could be used as a starting point with gap analysis:
  - Existing formularies
  - Existing evidence reviews
  - BNF, as an existing national list of medicines
  - NICE, as an existing national source of cost-effectiveness appraisals.
- Establish national committee/decision-making bodies to review medicines for inclusion.
  - Agree stakeholders and terms of reference
  - Develop and communicate processes and criteria for decisions and appeals
  - Set up procedures nationally, with flowchart for local approval
  - Separate into disease areas and target one at a time, inviting specialist areas to input into a shared formulary.
- Develop training packages and digital tool integration.
- Consider phased implementation to minimise impact on local areas.
- Set up processes and frameworks for audit and maintenance of the SNF.

Appendices

Appendix 1:
Abbreviations

ABPI	Association of the British Pharmaceutical Industry
AI	artificial intelligence
APC	Area Prescribing Committee
AWMSG	All Wales Medicines Strategy Group
BGMA	British Generic Manufacturers Association
BNF	British National Formulary
CDF	Cancer Drugs Fund
DHSC	Department of Health and Social Care
DTC	Drugs and Therapeutics Committee
EPMA	Electronic Prescribing and Medicines Administration
GDP	gross domestic product
GP	general practitioner
HTA	health technology appraisal
ICB	integrated care board
ICS	integrated care system
IMOC	Integrated Medicines Optimisation Committee
IT	information technology
JFC	Joint Formulary Committee
MHRA	Medicines and Healthcare products Regulatory Agency
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health and Care Research
PGD	Patient Group Direction
RAG	red–amber–green
SMC	Scottish Medicines Consortium
SNB	single national budget
SNF	single national formulary
SPS	Specialist Pharmacy Services.
TA	technology appraisal
UKRI	UK Research and Innovation
USP	unique selling point
VAT	value added tax
VPAG	Voluntary scheme for branded medicines pricing, access and growth

Appendix 2:
References

1. UK Government. *10 Year Health Plan for England: fit for the future.* 2025. Available at: https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future (accessed August 2025).
2. UK Government. *Life Sciences: sector plan.* 2025. Available at: https://assets.publishing.service.gov.uk/media/688c90a8e8ba9507fc1b090c/Life_Sciences_Sector_Plan.pdf (accessed August 2025).

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