The All-Party Parliamentary Group on
Access to Medicines and Medical Devices

Evidence Session on Value Based Procurement for Medical Devices Across the NHS

Access to Medicines and Medical Devices APPG roundtable report

Online – Tuesday 24th, 15:00-16:00

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Hosts and contributors

Host: Lord Lansley, Officer of the Access to Medicines and Medical Devices APPG

Contributors: Subodh Tailor, Senior Policy Advisor for MedTech Adoption, Department of Health and Social Care; Andrew Quinn, General Manager Northern Europe, Terumo Blood and Cell Technologies; Steffen Uffenorde, Terumo Blood and Cell Technologies; Dan Curzake, Coloplast; Jeff Stonadge, Director of Public Affairs, Edwards Lifesciences; Daniel Jones, Government Affairs Director UK & Ireland, Stryker and Management Committee Member, Medical Technology Group; Chris Whitehouse, Director, Whitehouse Communications; Kevin Hodges, Strategic Engagement Manager, British Healthcare Trades Association; Wil Woan, Executive Director, Heart Valve Voice.

Key Findings

- Participants strongly supported the principle of value-based procurement (VBP) and its aim of shifting NHS procurement from acquisition cost to whole life value.
- DHSC's guidance is currently voluntary, meaning implementation is dependent on NHS Supply Chain, other framework providers, local trusts and integrated care systems.
- Early implementation appears mixed, with some positive changes in tender design but continued concern that frameworks remain heavily weighted towards price.
- Acquisition price thresholds were identified as a major risk, particularly where products can be rejected before clinical value, patient outcomes or wider system benefits are assessed.
- Procurement culture remains a barrier, with local teams often incentivised to deliver short term savings rather than longer term value.
- Premarket engagement is essential to ensure tender requirements are realistic, category specific and informed by suppliers, clinicians, trade associations and patient groups.
- Patient representatives stressed that procurement decisions must reflect evidence, quality of life and equitable access, rather than allowing "cheap enough" to become "good enough".
- The cardiology framework was identified as the clearest current example of concerns around VBP implementation, with other industry attendees noting that

they are following its development closely because it may shape how the guidance is applied to forthcoming frameworks, including orthopaedics, neuromodulation and imaging.

General Overview

The roundtable examined the implementation of VBP for medical devices following the publication of DHSC's national standard guidance. Chaired by Lord Lansley, Officer of the APPG on Access to Medicines and Medical Devices APPG, the discussion focused on whether the guidance is translating into meaningful change across NHS procurement, particularly through NHS Supply Chain frameworks and local purchasing decisions.

Participants welcomed the principle of value-based procurement, recognising its potential to shift NHS decision making away from acquisition price and towards whole life value, including clinical outcomes, patient experience, staff impact, efficiency, sustainability and wider system savings. However, the discussion highlighted concerns that the early implementation of VBP remains inconsistent.

DHSC explained that the guidance is currently non statutory and voluntary, with uptake being monitored by the NHS Strategy Unit. NHS Supply Chain has adopted a "comply or explain" model and DHSC is developing training and champion programmes to support cultural change across procurement teams.

Participants identified several implementation challenges, including the continued use of acquisition price thresholds, high price weightings, limited assessment of clinical outcomes, inconsistent pre-market engagement and procurement incentives focused on short term savings. Concerns were raised that frameworks described as value based may still exclude products on price before their wider value is properly assessed.

The roundtable concluded that value-based procurement remains a strongly supported policy direction, but its credibility will depend on clearer implementation, stronger transparency, better category expertise and continued scrutiny as further frameworks are developed.

DHSC update on value-based procurement guidance

The discussion began with an update on DHSC's national standard guidance for VBP. The guidance was developed by DHSC in partnership with NHS Supply Chain and NHS England and is intended to support procurement processes that assess value more broadly than acquisition price alone, including outcomes, wider system impact and whole-life cost.

The guidance is currently non-statutory and voluntary. DHSC is monitoring its use and considering whether it should be mandated in future, depending on how it is adopted by national framework providers, local trusts and integrated care systems.

Four national framework tenders were identified as being within the scope of early pilot work: cardiology, negative pressure wound care, infusion pumps and clinical AI through the London Procurement Partnership. NHS Supply Chain has also moved internally to a "comply

or explain" model, meaning future frameworks should follow VBP principles unless category teams can explain why deviation is necessary.

DHSC is developing a wider implementation programme, including monitoring and evaluation by the NHS Strategy Unit, training for NHS procurement staff and VBP champions within trusts and integrated care systems. The Department emphasised that feedback from suppliers, framework providers and NHS users will be important in identifying what is working, where barriers remain and how future iterations of the guidance should be improved.

Acquisition price thresholds and the risk to value-based procurement

A major focus of the discussion was the use of maximum acquisition price thresholds within procurement frameworks. Participants questioned how such thresholds sit alongside the purpose of VBP, given that the guidance is intended to shift assessment away from acquisition price and towards whole-life cost and value.

Concern was raised that where a threshold price acts as a pass-or-fail requirement, products may be excluded before their value is assessed. This was seen as particularly problematic in device categories where higher upfront cost may be offset by better outcomes, reduced complications, fewer readmissions, lower staff burden, reduced waste or improved patient quality of life.

Experience from structural heart procurement was highlighted as an example of where participants felt VBP was not being applied in the way it was intended. Concerns were raised that some frameworks continue to weight price heavily, while giving limited influence to clinical performance, patient outcomes and wider value considerations. In such cases, threshold pricing may result in automatic rejection before the value proposition has been meaningfully assessed. Similarly, the 'hurdle rate' in specific lots within the Framework can be achieved on price alone, rendering the value assessment obsolete.

The discussion identified a distinction between budgetary control and value-based procurement. Participants recognised that, in some circumstances, the NHS may need to set a maximum acquisition price for budgetary reasons. However, there was concern that such processes should not be presented as fully value-based if whole-life value is not genuinely assessed.

DHSC noted that NHS Supply Chain's position is that threshold pricing may be used on a case-by-case basis, informed by market engagement, research and intelligence, and is not intended to be arbitrary. However, the Department acknowledged the strength of feeling from suppliers and confirmed that it is looking into specific examples raised during the discussion.

Implementation challenges and procurement culture

Participants emphasised that the success of VBP will depend on implementation. While the guidance was welcomed in principle, the discussion highlighted concern that procurement culture across parts of the NHS remains heavily focused on short-term cost savings.

Some positive movement was noted, including examples where tender specifications are being reconsidered considering the guidance. However, participants cautioned that execution will be challenging unless procurement teams are equipped and incentivised to assess value over the longer term. Local teams are often judged on savings delivered within annual cycles, which can conflict with the aim of assessing wider system value.

The UK approach was described as pioneering compared with other markets, but participants stressed that the key challenge is moving from guidance to practical uptake. While mandatory application may eventually be necessary, there was recognition that mandating the guidance alone would not guarantee successful adoption without training, capability building and cultural change.

The discussion also highlighted the importance of procurement teams having the skills and capacity to evaluate complex value propositions. Assessing whole-life value requires knowledge of clinical pathways, product categories, patient outcomes, operational impact, sustainability and long-term system costs. Without this expertise, there is a risk that VBP becomes a formal process rather than a meaningful change in decision-making.

Pre-market engagement and category expertise

Robust pre-market engagement was identified as a critical part of effective VBP. Participants stressed that engagement with suppliers and trade associations before tender documents are finalised can help ensure procurement requirements are realistic, evidence-based and fit for purpose.

Poorly designed requirements can create wasted time, cost and frustration for both suppliers and procurement bodies. In some cases, requirements may be included that are not technically feasible or do not reflect how products are used in practice. Stronger pre-market engagement could help avoid this by drawing on category expertise before tenders are issued.

Trade associations were highlighted as a useful source of insight because they can represent broader market experience rather than only the position of one supplier. Participants suggested that procurement teams should make better use of category experts, clinicians, patient organisations and suppliers to understand what value looks like in each product area.

The discussion also noted that VBP cannot be applied uniformly across all product categories. In some categories, differences in patient outcomes, staff experience or service efficiency may be substantial. In others, products may appear closer to commodities, with more limited variation. Effective VBP therefore requires weightings to reflect those differences rather than applying a uniform approach across all categories.

Patient outcomes, evidence and equitable access

The patient perspective was central to the discussion. Participants emphasised the importance of evidence, quality of life and equitable access in procurement decisions. For patient communities, procurement decisions are not abstract financial exercises; they can directly affect access to treatment, outcomes, mortality risk and quality of life.

Concerns were raised that if procurement decisions are driven too heavily by price, there is a risk that "cheap enough" becomes treated as "good enough". This could exacerbate inequalities, with some patients accessing optimal treatment while others face barriers depending on local decisions or procurement frameworks.

The discussion highlighted the importance of incorporating clinical guidelines, health technology assessment evidence, patient-reported outcomes and international outcome measures into procurement decisions. Building on the cardiology example, participants noted the relevance of ICHOM's work on heart valve disease and the outcomes that matter most to patients, including quality of life, symptom improvement and longer-term treatment planning. Participants stressed that VBP must reflect what matters to patients, including long-term outcomes, recovery, quality of life and the ability to access the right treatment at the right time.

Participants also noted that VBP should not be limited to high-cost or advanced technologies. Everyday medical products can generate significant system value if better quality reduces waste, complications, staff burden, hospital admissions or wider care costs. This reinforces the need for procurement processes to assess whole-life value across a wide range of medical technologies.

Monitoring, evaluation and future APPG engagement

DHSC confirmed that monitoring and evaluation will be central to the next phase of implementation. The NHS Strategy Unit will assess uptake and provide learning to inform future iterations of the guidance. DHSC also intends to collect feedback from suppliers, framework providers, procurement teams and other stakeholders involved in or affected by procurement decisions.

Participants welcomed this approach but stressed that feedback must be linked to action. Where frameworks are described as value-based but appear to remain primarily price-led, DHSC should review whether the guidance is being applied properly and whether deviation is being clearly explained.

The cardiology framework was identified as the strongest current example of concerns around how VBP is being implemented in practice, particularly in relation to threshold pricing, weighting and the assessment of clinical value. Participants noted that this concern extended beyond cardiology, with other industry attendees following the framework closely because it may set expectations for how VBP is interpreted in forthcoming procurements across other device areas, including orthopaedics, neuromodulation and imaging. Participants suggested that the APPG should consider reconvening later in the year as further tender experience emerges, allowing suppliers, trade associations, patient representatives and policymakers to assess whether implementation is improving and whether concerns about threshold pricing, weighting, pre-market engagement and value assessment are being addressed.

Policy Recommendations

1. **Clarify the role of price thresholds** - DHSC and NHS Supply Chain should clarify when acquisition price thresholds are compatible with VBP. Where thresholds prevent

assessment of whole life value, frameworks should not be presented as fully value based.

2. **Strengthen transparency** - Framework providers should clearly explain any deviation from the guidance, including the rationale for price weightings, threshold pricing and selected value criteria.
3. **Ensure value is meaningfully assessed** - Procurement frameworks should give appropriate weight to clinical outcomes, patient experience, staff impact, efficiency, sustainability and wider system savings.
4. **Improve pre-market engagement** - NHS Supply Chain and other framework providers should engage suppliers, clinicians, trade associations and patient organisations before finalising tender requirements.
5. **Build procurement capability** - DHSC should continue developing training, champions and practical tools to help procurement teams assess whole life value and move beyond short term cost savings.
6. **Embed patient outcomes** - Value based procurement should reflect patient relevant evidence, including quality of life, complications, recovery, equitable access and lifetime management.
7. **Monitor future frameworks** - DHSC and the APPG should closely monitor forthcoming frameworks, including orthopaedics, neuromodulation and imaging, as test cases for implementation.

Conclusion

The roundtable demonstrated strong support for VBP but also highlighted concerns about how the guidance is being applied in practice. Participants agreed that the policy has significant potential to improve outcomes, support innovation and deliver better value for the NHS, but only if frameworks genuinely assess whole-life value.

The continued use of price thresholds, high financial weightings and limited assessment of clinical outcomes risks undermining confidence in the policy. Further scrutiny will be needed to ensure VBP does not become a price-led process under a different name.

The APPG should revisit the issue later in the year as more frameworks come forward, allowing stakeholders to assess whether implementation is improving and whether further ministerial or parliamentary engagement is required.