The Strategy Unit.

Value Based Procurement Guidance Pilot: Evaluation

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Document control

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Glossary

Term/acronym	Definition/expansion
Buyer	The NHS contracting authority purchasing a product and/or service
DHSC	Department of Health and Social Care
Draft/final Guidance	Refers to either the draft DHSC Value Based Procurement Guidance for Medical Technology, or the final version due to be published
Framework	A procurement framework is a contract between a contracting authority and one or more suppliers that provides for the future award of contracts by setting out the provisions under which future contracts for the supply of goods, services and/or works are to be awarded.
HES	Hospital Episode Statistics dataset
ICB	Integrated Care Board
Medical device	Any instrument, apparatus, appliance, software, implant, material, or other article (including accessories), used to diagnose, prevent, monitor, treat, or alleviate disease, injury, or disability; to investigate, replace, or modify the body or its functions; or to control conception
MedTech	Medical technology, the entire sector or industry that develops and uses technology (including medical devices) to improve healthcare
NHSE	NHS England
NHSSC	NHS Supply Chain
NICE	National Institute for Health and Care Excellence
Patient pathway	End-to-end treatment route for a patient in NHS and social care settings
Procurement	Set of processes used to source and purchase goods such as medical devices, involving an exchange of information between buyers and suppliers
QoL	Quality of life
Specification	A clear description of what a buyer needs to purchase, setting out the requirements that a product or service must meet
Supplier	A person, company, or organisation that provides goods or services to a buyer (such as a business or public body)
Supply chain	The people, organisations, activities, and processes involved in producing and delivering a product or service from supplier to end user
Tender	A formal invitation from a buyer asking suppliers to submit bids to provide goods, services, or works
VBP	Value-based procurement, used to distinguish between a general procurement approach from the draft Guidance
Whole life cost	Total costs incurred over the lifetime of a product or service, including purchase cost and, where relevant, implementation or operating costs; post-warranty service costs; disposal costs; and product/service lifetime (in uses or years)

1. Introduction

This report presents findings from The Strategy Unit's evaluation of the Department of Health and Social Care (DHSC) pilot of draft Value Based Procurement (VBP) Standard Guidance ('the draft Guidance') for Medical Technology (MedTech) in England.

VBP aims to shift the focus of procurement processes and decision-making away from potential immediate cost savings to how a product or solution can best deliver improved outcomes, reduce total costs of the patient pathway and provide long-term benefits to all partners in the health system.

Drawing on insights from local NHS trust staff and national framework procurement teams, who were asked to pilot the draft Guidance to structure and inform procurement exercises, the evaluation findings informed refinements to the Guidance before publication in June 2026.

1.1 Background to the draft Guidance

The NHS spends around £10 billion each year on MedTech through procurement (DHSC estimate, 2021), but there is considerable variation in how procurement processes are run across systems and local NHS trusts. This includes differences in how prospective bids are evaluated and the priority given to particular outcomes. Historically, this has meant that procurement decision-making has focused on products or services that have the lowest up-front cost.

The DHSC Medical Technology and Innovation Directorate co-developed the draft Guidance in early 2025, working in partnership with NHS England (NHSE), and NHS Supply Chain (NHSSC). This followed a period of engagement with senior staff and procurement teams across local NHS organisations including Integrated Care Boards (ICBs), National Institute for Health and Care Excellence (NICE), and with industry, including small and medium enterprises (SMEs). It delivered on the commitment made in *Fit for the Future: 10 Year Health Plan* (UK Government, 2025) to introduce VBP for procuring medical devices and digital products from 2026.

As acknowledged in the draft , the Guidance does not cover the end-to-end procurement process (for example, pre-market engagement or small-scale single-site piloting). Rather, for buyers at national, ICB or local NHS trust level, the draft Guidance provides a quality assurance methodology (including example questions and validation criteria) for:

- Developing a specification of requirements when procuring medical devices (including services that use medical devices)
- Evaluating tender response submissions for the provision of medical devices across both primary and secondary care.

The draft Guidance advises assessing value across five category domains, including: social value; efficiency; patient and staff; supply chain; and purpose (as shown in Figure 1.1), with buyers

selecting the most relevant domains to their context and the appropriate questions within them. It sets out how to run a proportionate evaluation process, including the level of effort expected from bidders, the information that must be shared, and the need to involve clinical and finance teams in validating evidence. It also clarifies practical requirements, such as including full question wording and scoring in procurement documents, allowing sufficient time for responses, and encouraging bidders to use clear, non-technical language. It recommends a word count for responses of 750 to 1250 words, depending on the question's complexity.

The draft Guidance also sets out how buyers should apply weightings in scoring responses, including the requirement to allocate at least 10% to the social value domain[1] and to ensure that all selected value domains together account for a minimum of 60%, with whole life cost capped at 40%. It also explains that each value domain must be evaluated using a standardised 0–5 scoring system, while whole life cost is assessed through a formula comparing each bid to the lowest-cost option.

Figure 1.1 Recommended value domains and weighting for questions and responses



Source: Graphic taken from DHSC draft Guidance

[1] As pre the Procurement Act 2023, and PPN 002, Cabinet Office, 2025 public contracts must apply a minimum 10% weighting (or an equivalent measurement) of the total score, for social value.

Alongside the example questions and validation criteria for each domain, the draft Guidance provides advice to suppliers on how to respond and the supporting information they should provide as part of their responses.

1.2 An overview of the VBP pilots

DHSC has been piloting the draft Guidance with thirteen local NHS trust sites across nine organisations (including one provider collaboration of five trusts, see section 2), their suppliers, and staff from two national procurement framework providers since September 2025. These organisations were:

Local NHS trusts

- Birmingham & Solihull Procurement Collaborative, made up of:
  - University Hospitals Birmingham NHS Foundation Trust
  - Birmingham Women's and Children's NHS Foundation Trust
  - Royal Orthopaedic Hospital NHS Foundation Trust
  - Birmingham Community Healthcare NHS Foundation Trust
  - Birmingham and Solihull Mental Health NHS Foundation Trust)
- St George's University Hospital NHS Foundation Trust
- Guy's and St Thomas's NHS Foundation Trust (London)
- Mid and South Essex NHS Foundation Trust
- North Bristol NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust
- UCL Hospitals NHS Foundation Trust (London)

National framework providers

- NHSSC
- NHS London Procurement Partnership.

The purpose of the pilots is to generate insights on the practical usability of the draft Guidance, compared to current business-as-usual processes, at both local trust and national framework levels.

The pilots have run to similar briefs but different timelines:

- Local pilot sites were asked to use the draft Guidance as part of live procurement exercises – to inform tender specifications, response questionnaires and evaluation of responses – between September 2025 and March 2026
- National framework staff were asked to advise on how elements of the draft Guidance could be incorporated into the development of new category framework tender specifications and questionnaires, including any suggested adaptations to the question wording and suggested validation criteria. Given the complexity of framework procurement, this piloting will continue into late 2026, with further engagement with national framework staff planned post-publication.

With the local NHS trust pilots, DHSC adopted a minimal-intervention approach after the initial briefing and onboarding, avoiding extensive monitoring and reporting so that sites operated under conditions similar to those they will face once the draft Guidance is published. DHSC provided regular drop-in support sessions for pilot site staff to ask questions or raise concerns, but attendance was not mandatory. The approach was also intended to help DHSC better identify practical barriers to implementation and highlight areas where further training or supporting resources may be needed in the future (see section 1.3).

1.3 Evaluation aims and approach

The DHSC Medical Technology and Innovation Directorate commissioned The Strategy Unit to undertake an evaluation of the draft Guidance, working with the local NHS trust and national framework pilot participants to assess the design, implementation and outcomes of using it to structure and deliver specific procurement activities. The evaluation aimed to:

- Establish whether the draft Guidance improves current (business-as-usual) processes
- Establish whether the draft Guidance improves anticipated value for money
- Test usability and identify any changes that need to be made to the draft Guidance
- Identify barriers and solutions to uptake
- Identify training needs.

The evaluation approach included interviews with pilot site procurement, clinical and supplier staff, a survey and an in-depth workshop with national framework staff. For more details on the methodology, see section 2.

1.4 Report structure

This final report brings together evaluation findings at the end of the local NHS trust pilots and early stages of the national framework pilots. The structure is:

- **Section One:** Background information on the draft Guidance and pilots, alongside the aims and objectives of the evaluation
- **Section Two:** A summary of the methodology, alongside the methodological limitations which affect the strength of evaluation conclusions
- **Section Three:** Overview of the key evaluation findings
- **Section Four:** Conclusions and recommendations for future implementation and iterations of the final Guidance.

2. Methodology

2.1 Adapting the proposed approach

The evaluation was originally designed to include interviews with stakeholders (buyer, supplier (successful and unsuccessful), clinician and financial) across all nine pilot sites to assess the application of the draft Guidance in live procurement exercises. However, engagement with pilot sites in December 2025 identified that several of them would not be able to participate fully in the evaluation. In several cases, pilot procurement exercises had either stalled or were considered at risk of stalling, limiting opportunities to observe or evaluate the full application of the draft Guidance in practice.

Reported reasons for this included:

- Lack of stakeholder (clinical or financial) support to progress procurement activity
- Changes in organisational or budgetary priorities
- Staff absence, including sickness
- Pilot timelines considered too ambitious for completing the procurement
- Other unspecified delays.

As a result, the evaluation approach was adapted. Rather than drawing evidence from all nine pilot sites, a smaller number of interviews were conducted with participants who had engaged with the draft Guidance to varying degrees, either through active application or more generally as a document which they felt able to comment on based on their expectations of what would be involved in practice, still responding to the research questions specified in section 1.3.

In total, eight interviews were conducted across procurement, clinical and supplier stakeholders between February and March 2026. They were concentrated across a small number of pilot sites, with four participants from a single site (Sheffield), reflecting where procurement activity progressed furthest, as they had used the draft Guidance as part of a mini-competition procurement exercise to procure a heart-lung machine. A separate case study has been produced from this to share site-specific learning. A summary of the interviews conducted is provided in Table 2.1 below.

Table 2.1 Pilot site interview summary table

Pilot site	MedTech product	Interview participant group		
		Procurement	Clinical	Supplier
Oxford	Wound irrigation tool	-	1	-
Mid and South Essex	Surgical mesh	2	-	-
Sheffield	Heart-lung machine	2	1	1
St. George's (London)	Surgical boot	1	-	-

To supplement interview findings, a short survey was circulated to procurement and clinical pilot site staff to gather wider views on the usability of the draft Guidance. However, response rates were very limited, with only two respondents completing the survey. As a result, survey findings were used primarily as supporting evidence rather than as a standalone data source.

To inform an initial evaluation of the national framework pilots, an online workshop was held with staff from NHSSC in April 2026 to explore how the draft Guidance could be applied within framework-level procurement processes and to identify any additional considerations or constraints. Staff were asked to provide in-depth feedback on questions, validation criteria and other information within four of the five domains (with social value excluded due to its mandatory inclusion), as well as comment on the necessary implementation next steps to progress VBP at a national framework level.

Meetings were held with NHSLLP in December 2025 and May 2026 to understand plans for a forthcoming VBP-informed clinical AI framework tender; formal interviews will be conducted with NHSLPP procurement leads in later stages of 2026 following the completion of procurement stages, from tender specification drafting to completion of supplier response evaluation.

The Strategy Unit also supported DHSC to deliver two workshops (one online, one in-person) with industry representatives in April 2026. These were designed to share emerging findings from the pilots and gather industry input into the draft guidance domains, example wording, and the barriers and enablers they considered likely to affect the post-publication adoption and implementation of guidance. Although not part of the formal pilot evaluation analysis findings from these workshops can be found in Appendix 1 and informed the recommendations made in this report.

2.2 Limitations

The findings from this evaluation should be interpreted in light of the limited scale of applied testing. Evidence is primarily based on early-stage engagement with the draft Guidance, with only a small number of participants able to reflect on its use within completed or near-complete procurement exercises. As a result, the findings provide insight into perceived usability and anticipated barriers and enablers, rather than robust evidence of how VBP operates in practice at scale.

In particular, the evaluation does not provide a sufficient basis to assess the impact of VBP on procurement outcomes. Although participants were able to describe how the approach may influence decision-making processes, there is limited evidence on whether this translates into different supplier selections or improved outcomes. The findings should therefore be understood as indicative of early implementation experience and potential feasibility, with limited evidence available on effectiveness or impact in practice.

3. Key findings

Summary

This chapter presents the key findings from the evaluation of the draft Guidance, drawing on evidence from pilot site interviews, framework discussions, and survey responses. The findings are structured across five areas, covering current procurement practice, understanding of value, the usability of the Guidance, and anticipated barriers and enablers to implementation.

Overall, the findings indicate that while the draft Guidance is considered clear and usable, its successful adoption will depend less on the content of the document itself and more on the conditions in which it is implemented. Participants highlighted strong alignment between the principles of VBP and existing clinical and procurement priorities, but also identified a range of structural, organisational and capability-related challenges that may constrain its uptake. The sections that follow set out these findings in detail.

3.1 Improving current procurement practice

Interview participants (those commenting in general and based on applied experience) were very positive about the potential of VBP (as shaped by the draft Guidance) to improve current procurement practice. Local NHS trust staff who had used the draft Guidance to structure a procurement exercise in Sheffield reported that it had done this, as intended, by enabling a more balanced approach to decision-making, bringing together clinical, operational and financial considerations rather than relying predominantly on cost. They described following the draft Guidance to ensure that a wider range of factors were formally considered within tender evaluations, supporting more holistic and consistent assessments of bids across teams and procurements.

> *"I didn't feel like, 'Oh, who's the cheapest and who can we get in quickest?' It was a more considered process, I thought."* Clinical interviewee

Clinical and procurement interviewees in Sheffield also reported that the example questions and prompts within the draft Guidance provided a helpful starting point for developing evaluation criteria – reducing the need to build specifications from first principles, which was useful for those with less experience of the VBP approach. Participants described this as helping to guide thinking and "*expedite*" the process, giving confidence that relevant areas were being considered while avoiding more ad hoc or inconsistent approaches between individuals or teams. Survey responses from other pilot participants reinforced these findings; they agreed that the draft Guidance supports communication and scoring within procurement teams and provides sufficient structure to support supplier engagement. At the same time, some participants thought that this approach can feel somewhat prescriptive and should still require interpretation and discussion to ensure questions are applied appropriately.

"It [was] more or less going through and picking which questions to fit, rather than us coming up with our own questions… which, [is] probably good and bad." Procurement interviewee

Local NHS trust staff (including those yet to progress their VBP procurement exercise) also emphasised that the VBP approach does not necessarily significantly increase the workload associated with procurement but instead changes the nature of the work involved. Participants from Sheffield noted that this required an initial adjustment and suggested that, once familiar, the approach would become easier to apply and integrate into routine practice; however, as most had only applied it once, this reflected anticipated rather than fully evidenced experience. Survey responses align with this perspective, indicating no perceived clear overall impact on capacity or timescales compared to business as usual, reinforcing that VBP primarily alters how procurement activities are structured rather than the volume of work required.

"It's more just getting used to it rather than creating additional work. Once you're used to it, it'll be dead simple." Procurement interviewee

From a supplier perspective, VBP was also seen to influence how bids are developed by providing a clearer framework for articulating offers. A supplier reported that this enabled them to adapt existing materials to respond to value-based questions, thereby presenting a more complete picture of their products or services without increasing the burden of participation.

"It didn't require more work than we've already got… it was just a case of translating it." Supplier interviewee

Beyond these observed impacts, interviewees described some expected or anticipated benefits of the VBP approach. In many cases, these were based on broader experience of procurement rather than direct application of the draft Guidance.

Procurement interviewees highlighted that VBP is not a fundamentally new approach but rather reflects established principles of good procurement practice. However, they noted that these principles have not always been applied consistently in practice due to financial and organisational pressures, with procurement often driven by short-term cost considerations rather than longer-term value.

"To be honest, the principles of value-based procurement aren't rocket science… for me, this is basic procurement, but we very rarely get the opportunity to do this." Procurement interviewee

Nonetheless, interviewees suggested that applying the draft Guidance could strengthen collaboration between procurement and clinical teams by providing a framework to incorporate clinical input more consistently into decision-making. This was seen as enabling greater visibility of clinical perspectives within procurement processes where these have historically varied.

In considering how the draft Guidance is applied in practice, interviewees also highlighted the wider procurement context within which it operates. Procurement processes were described as often non-linear and varying significantly depending on the context, rather than following a standardised sequence of pre-market engagement, tender, submission, evaluation and award. Participants described a range of approaches, including: pilot testing solutions prior to formal procurement; direct awards to suppliers where products or capabilities are unique; the use of both framework-led and internally run procurement exercises; and differing levels of clinical or stakeholder involvement.

In this context, interviewees emphasised that the draft Guidance needs to be sufficiently flexible to be applied across a range of scenarios, and that its effectiveness depends on how well it can support decision-making at different stages of the procurement process, including earlier phases such as problem definition and pre-market engagement.

3.2 Improving anticipated value for money

Interview participants were again positive about the potential of the VBP approach to improve value for money by enabling procurement decisions to move beyond the use of price as a primary proxy for value, which was often viewed as an incomplete or potentially misleading basis for comparison. Across pilot sites, interviewees reflected on past procurement decisions based primarily on cost that had resulted in poorer-quality products and additional downstream expenditure – including situations where lower-cost suppliers were selected despite not being the most appropriate option for delivering required quality or performance – reinforcing the rationale for adopting a VBP approach.

"*You're probably less likely to get somebody putting a low-ball bid in and winning that business when they're not the most suitable supplier… which… is going to save money in the long-term.*"
Procurement interviewee

In contrast, they viewed the draft Guidance as providing a more comprehensive assessment of both benefits and costs, including outcomes, product performance and longer-term impacts. In practice, this was seen to support consideration of downstream effects, such as product performance, operational efficiency and longer-term costs, which are not typically captured in cost-only approaches.

"You're factoring in more factors that could influence… costs further down the life cycle of the product." Clinical interviewee

From a supplier perspective, this was also seen as particularly beneficial where products involve higher upfront costs, as it enables suppliers to compete on the basis of value rather than being disadvantaged by price alone.

"We're not a company that likes to compete on price… we win on value." Supplier interviewee

In this context, interviewees emphasised that the value for money benefits of VBP are particularly significant in larger and more complex procurements, such as MedTech, where decisions involve substantial financial investment and have direct implications for patient outcomes and service delivery.

In Sheffield, for example, interviewees described how following the draft Guidance enabled them to consider heart-lung machines with higher upfront costs but that participants estimated would deliver significant cost savings over the expected lifespan of the equipment, reflecting a shift away from short-term cost considerations towards longer-term value.

"I think the upfront cost was slightly higher… but projecting the cost savings over ten years, we're hundreds of thousands of pounds better off…" Clinical interviewee

Clinical interviewees, in particular, also emphasised that incorporating patient outcomes and product quality into evaluation criteria allows value for money to be assessed in terms that more closely reflect real-world impact, rather than relying on price alone as an indicator of value. They described this as enabling procurement decisions to take account of how products perform in practice and the extent to which they contribute to improved outcomes and reduced downstream costs over time.

"I go around the UK telling everybody about our outcomes. And I said, well, it's really easy. It's this skin prep. It's this clipper. It's this suture. It's this stapler. Those are what we use. And they've saved us millions of pounds." Clinical interviewee

Although interviewees were strongly supportive of this broader understanding of value for money, they also highlighted challenges in realising these benefits in practice. In particular, procurement interviewees described difficulties in making the case for selecting products where value for money is realised over longer time horizons, is harder to quantify, or accrues outside the organisation leading the procurement. This included situations where improved product performance or quality could reduce complications, readmissions or follow-up care, but where these benefits were experienced in other parts of the system, such as primary or community care, rather than within the budget of the procuring service.

As a result, value for money was not always directly visible within existing financial frameworks, creating a disconnect between system-wide benefits and local decision-making. Interviewees described how procurement decisions therefore continued to be influenced by a need to demonstrate short-term, measurable savings, even where this did not fully capture overall value.

"We do get bogged down with savings…" Procurement interviewee

This was seen as limiting the extent to which the full benefits of a VBP approach can be realised in practice and highlights the importance of wider organisational and financial alignment in enabling the implementation of the draft, and when published final, Guidance (see section 1.4 for further detail on implementation factors).

3.3 Improving the draft Guidance

As well as commenting on a VBP approach in general, evaluation participants provided feedback on the draft Guidance document, including the question bank during interviews and in the survey responses. As the draft Guidance was predominantly structured in a way that is easily applied to local NHS trust competitive procurement exercises, the feedback has been broken down to highlight its utility and acceptability in different contexts – local NHS trusts and national frameworks.

3.3.1 Feedback from local NHS trusts

All local NHS trust staff, particularly those who had applied the draft Guidance in a live procurement exercise, considered it to be easy to understand and apply. Survey responses reinforce this, with respondents agreeing or strongly agreeing that the draft Guidance is clear, provides sufficient information, and can be applied in practice across procurement stages. Interviewees described being able to work through the document quickly and use it to structure their thinking without requiring significant additional support. The inclusion of example questions and evaluation criteria was particularly welcomed (as discussed in section 3.1), as these were seen as practical and readily usable, reducing the need for users to invest time in developing content themselves.

"The document itself was…very self-explanatory… very easy to populate." Clinical interviewee

Local NHS trust staff also highlighted that the draft Guidance was perceived to reduce the effort associated with initiating a procurement exercise, particularly where teams had limited prior experience of VBP. Rather than developing criteria from first principles, staff described being able to draw on the material provided and adapt it to local priorities, supporting a more efficient starting point. Survey respondents agreed that the draft Guidance supports communication and scoring within procurement teams, aligning with its structured presentation of evaluation criteria.

They also agreed that the draft Guidance enables communication and scoring within procurement teams and provides sufficient information to support supplier engagement.

However, some local NHS trust staff also reported that in its current form the draft Guidance might feel long and overly detailed, particularly when first approached. Several staff described needing to work through the document to understand how it applied in practice and thought that this level of detail may discourage initial engagement among time-pressured clinicians who are less directly involved in procurement activity.

"The [question and validation guidance] is quite wordy and quite detailed… very few clinicians are going to read through that." Clinical interviewee

Local NHS trust staff suggested that, in practice, many clinicians might be unlikely to read the draft Guidance end-to-end before engaging with it and instead would benefit from more immediate and accessible summaries or prompts. One clinical interviewee suggested that the draft Guidance would benefit from the inclusion of a concise one-page summary outlining the key principles of VBP and how they translate into practice, to support awareness and engagement before users need to apply the full detail.

"Your one page has got to tell a story- what it is, why we're doing it, and what it means in practice." Clinical interviewee

Local NHS trust staff consistently valued the flexibility built into the draft Guidance, particularly the ability to select relevant domains of value and adjust weightings depending on the procurement context. While the suggested 60/40 split between cost and value was seen as a helpful starting point and indicative of the intended balance, staff did not treat this as fixed and instead adapted weightings to suit the specific procurement. Staff described actively making decisions about which domains were most relevant and applying lower weightings to those seen as less directly applicable, rather than treating all domains equally. This flexibility was seen as critical to ensuring that the approach could be tailored to different services, patient groups, and organisational priorities, and staff indicated that they would not support more prescriptive requirements.

"It gave us enough flexibility to adapt… I wouldn't like to be told you must use these weightings." Procurement interviewee

Local NHS trust staff also indicated that, in practice, they did not apply the draft Guidance as a strictly linear process. Instead, they use it iteratively to structure conversations between procurement teams, clinicians, and other stakeholders, often revisiting domains and criteria as their understanding of priorities develops. Staff described procurement processes as influenced by factors such as existing frameworks, clinician interest, and immediate service needs, and therefore not always aligned to a single structured pathway.

"It's a lot more messy than just giving people draft guidance." Clinical interviewee

In a small number of cases, local NHS trust staff, including one survey respondent, identified specific areas where the draft Guidance could provide more practical support to implementation. These included providing standardised supporting materials for use in evaluation (for example slide decks or templates for panel members), and clearer guidance on how example questions can be interpreted and adapted across different types of procurement, particularly where teams are less familiar with VBP.

A supplier interviewee would have welcomed more structure in the tender specification they responded to, which had been informed by the draft Guidance but used relatively open-ended questions (they did not see a copy of the draft Guidance itself). They reported that, while the flexibility allowed space to describe value, it also made it less clear how to prioritise different elements within their response. The supplier suggested that clearer definition of value across different timeframes or benefit types would help ensure that responses are focused and aligned to expectations.

"Do they want to see value from day one? Do they want to see value in five to ten years? Do they want to see monetary value? Do they want to see patient value? We want to make sure our effort is going into the right sort of responses." Supplier interviewee

3.3.2 Feedback from national framework procurement staff

Participants in the NHSSC staff workshop valued the flexibility of the draft Guidance and expressed strong enthusiasm for adopting a value-based procurement approach at a national level. The general barriers and enablers to implementation they identified are outlined in section 3.4. In addition, drawing on participants' experience in framework procurement and, in some cases, recent application of the draft Guidance in developing tender specifications, detailed feedback on four domains (excluding the mandatory social value domain which was not discussed[2]) is summarised below, with common themes consolidated where appropriate.

Across all domains, a consistent theme was the distinction between what can be assessed meaningfully at a national framework level and what would be better addressed at trust level through call-off contracts or contract management. Participants emphasised that elements of different domain questions and validation text that references local pathways, baseline setting, detailed modelling, or validation of impact are not suited to framework procurement. These included assessing pathway redesign (Efficiency domain); agreeing baselines and data inputs,

[2] Social value was not discussed during this workshop due to mandatory procurement requirements which apply to all NHS procurements. NHSSC have been working to ensure that social value considerations are proportionate and appropriate to a given contract.

validating supplier claims and evaluating workload shifts or staff impacts (Efficiency and Patient and Staff domains); understanding patient level outcomes and inequalities (Patient and Staff domain), and establishing monitoring arrangements (Efficiency, Patient and Staff, and Purpose domains). Participants suggested that, rather than requiring detailed evidence upfront, frameworks should focus on suppliers' approach to measurement, capability and mechanisms of impact, with a clear expectation that outcomes will be validated and monitored locally through call-off contracts. They also noted that this could be reinforced through contract management (in the Efficiency, Patient and Staff, and Purpose domains), with suppliers held accountable for delivering the benefits they commit to.

3.3.2.1 Efficiency domain

Participants were broadly positive about the Efficiency domain, noting strong alignment with existing procurement practice and NHS productivity priorities. The domain was seen as offering a structured way to articulate value, provided it is adapted for national application. However, current question wording was considered too dependent on trust specific pathways, baselines and service models, making it difficult for suppliers to provide meaningful or comparable responses. Concerns were also raised about the feasibility of validating numerical claims centrally and the potential disadvantage for smaller suppliers without access to national datasets such as Hospital Episode Statistics (HES). Participants therefore recommended a greater focus on describing how products support efficient care pathways in general terms, supported by UK case studies, rather than requiring detailed modelling or quantified improvements at framework stage.

3.3.2.2 Patient and Staff domain

Participants recognised the importance of this domain and supported its focus on patient experience, safety, and staff outcomes. Elements linked to supplier capability, such as regulatory compliance, safety certification, usability and training approaches, were seen as appropriate for national frameworks. However, similar to the Efficiency domain, participants highlighted challenges where evidence requirements rely on locally collected data such as patient-reported measures or incident reporting, which are not consistently available across the NHS. They also noted that many outcomes in this domain depend on local implementation rather than the product alone. As a result, participants felt that validation of impact, including harm reduction and staff workflow changes, would be better undertaken at trust level, with frameworks setting expectations but not requiring detailed proof at award stage.

3.3.2.3 Supply Chain domain

Participants responded positively to the Supply Chain domain, particularly its clear and structured approach to circularity and whole life cycle thinking. The framing of circularity as a system wide challenge, alongside practical prompts and indicative metrics, was seen as a key strength and well suited to informing a national framework. The focus on value retention, design for longevity and

enabling conditions such as infrastructure and supply chains was widely supported, as was the recognition of behavioural change alongside technical solutions. However, participants highlighted challenges relating to definitional clarity, consistency of interpretation, and the feasibility of some metrics given current data limitations. There were also concerns about how to manage trade-offs between cost, carbon and material efficiency without clearer guidance.

3.3.2.4 Purpose domain

Participants expressed more mixed views on the Purpose domain, noting that some elements overlap with core specification requirements and may add limited value at framework level. There was concern that suppliers may present standard features as enhancements, making comparison difficult. Participants suggested greater clarity is needed on minimum requirements versus differentiating factors. Questions that function primarily as compliance checks (for example 5.1) were seen as less useful for scoring, and there were calls for clearer and more precise wording, particularly around after-care, training and implementation support. A further challenge identified was how to fairly assess features that some suppliers include at no cost while others charge for. Participants also noted that aspects such as aftercare, training, KPIs and implementation support are often tailored locally and therefore more appropriately addressed at call-off contract stage. They suggested that these areas could be linked back to the framework through clear expectations, while ensuring sufficient flexibility for trusts to assess them in context.

3.4 Implementation factors

All evaluation participants across both national and local procurement pilots highlighted factors which they thought would influence the adoption of VBP across the NHS when the final Guidance is published. Although they raised some significant concerns about some of their perceived challenges (section 3.4.1), participants also highlighted factors they considered to be either supportive or potential levers to support more widespread implementation (3.4.2).

3.4.1 Barriers to uptake

The key barrier that was highlighted by NHS staff was the challenge in persuading directors of finance to adopt VBP in procurement rather than using lowest cost as the main award criteria, particularly at a time when NHS organisations are being expected to reduce spending. Procurement interviewees consistently described system-wide pressure to prioritise short-term financial savings, limiting the adoption of VBP.

"We are very much based as a system on savings within a financial year. So if we do something that might not see a return on investment for 24 or 36 months, it's never going to get support from the finance teams because they need to show savings a lot quicker." Procurement interviewee

One procurement interviewee noted that, without greater support from government or academia to help procurement teams, clinicians, or suppliers to quantify softer outcomes – such as quality of life as budget-relevant savings – it will remain difficult to convince finance leads to accept wider use of VBP or move away from cost-led decisions.

"Particularly on VBP… it's about outcomes… reduction on infection, length of stay… they're not quantifiable for finance. So that becomes very difficult to put a number to, and therefore your project on paper might seem that it has no value." Procurement interviewee

This challenge is further compounded by constraints relating to the availability, quality and consistency of data needed to evidence value in practice. While the draft Guidance can be applied at trust level, where local data and context are better understood, framework-level procurement staff highlighted the difficulty of accessing reliable and comparable data to assess outcomes, efficiency gains or pathway impacts across organisations. In particular, participants noted that datasets required to evidence value are not always available at a national level, are inconsistently collected, and can be difficult to access.

Participants also highlighted the absence of clear and standardised methodologies for validating supplier claims or comparing impacts across different settings. Differences in measurement approaches, assumptions and available evidence can make it difficult to assess bids on a consistent basis, while the burden of validating supplier responses was seen as potentially unrealistic in the absence of clearer expectations about what can be evidenced and how. In some cases, the complexity of responses and the volume of quantitative information provided were also seen as limiting the ability of procurement teams to meaningfully assess value.

In addition, participants noted that data limitations and evidence requirements can have implications for the supplier market. In particular, smaller suppliers may be disadvantaged by requirements to provide detailed or large-scale evidence where such data is not readily available, potentially affecting competition and innovation. While the guidance includes provisions intended to mitigate this risk, including through pre-market engagement to help ensure evidence requirements are proportionate to market capability, some stakeholders were still concerned about that these mitigations might not fully address the challenges faced by smaller suppliers in practice.

As a result, even where value can be demonstrated in principle, stakeholders considered that the absence of robust and accessible data, along with challenges in interpreting and validating that data, could limit the ability to evidence, compare and apply value consistently within procurement processes. This reinforces the challenges identified in section 3.2 relating to the quantification and recognition of value within existing decision-making frameworks.

Both clinical and procurement participants highlighted the importance of collaboration between their teams to ensure that value is properly understood and reflected in procurement decisions.

However, this is not consistently facilitated across different trusts, with some procurement processes remaining predominantly cost-driven. As discussed in section 3.1, this variation in practice limits the extent to which the potential benefits of VBP can be realised in practice. One clinical interviewee suggested that unless multidisciplinary procurement structures are more formally embedded, with representation from staff who will be using the product, this inconsistency is likely to continue:

"This is about empowering the end user to have a voice… and if we don't have that, you'll just carry on making the wrong decisions." Clinical interviewee

Finally, participants noted that although the draft Guidance was seen as a strong foundation, successful national adoption would depend on factors beyond the Guidance itself. As discussed in section 3.3, stakeholders considered that additional development and supporting mechanisms would be required for it to be applied consistently and effectively within a national framework context. Key factors included the availability of supporting infrastructure, clearer market incentives and stronger policy alignment across different areas, as well as more clearly defined governance and accountability mechanisms. Participants also highlighted that adopting VBP requires a shift in organisational mindset, particularly in recognising value that is realised over time rather than immediately:

"*For value-based procurement… it takes time and effort… and you cannot see the benefits straight away… that's a shift in culture and mentality that we need to have."* Procurement interviewee

3.4.2 Enablers to uptake

Interview participants identified several factors that they expected would increase the likelihood that organisations would adopt the Guidance, drawing on both their experience of applying the approach in specific procurement exercises and their wider understanding of procurement practice. Participants emphasised that these enablers would operate within the constraints outlined in section 3.4.1 and suggested that they would support adoption where those barriers can be addressed or mitigated.

Participants identified limited awareness of a value-based procurement approach, particularly among clinical stakeholders, as a key factor constraining adoption of the draft Guidance. They suggested that increasing awareness would make adoption more likely by ensuring that individuals recognise the approach and understand how it can be used in practice, particularly where staff are not routinely involved in procurement processes.

"Because I didn't know it was a thing until procurement mentioned it to us. And I think if a lot of people did know it was a thing, there'd be a lot more uptake and a lot more appetite for it…" Clinical interviewee

Participants also identified alignment with existing procurement practices as a factor that would increase the likelihood of adoption. They suggested that the final Guidance should continue to build on approaches already used in procurement rather than requiring entirely new processes, allowing organisations to incorporate value-based considerations within existing workflows. Participants indicated that this alignment may extend to some suppliers, where relevant evidence on value is already available and can be articulated if expectations are clearly defined.

"It didn't feel like something completely new… it's more just putting what we already do into a better format." Procurement interviewee

Participants also identified the availability of a structured methodology as a factor that would increase the likelihood of adoption. They suggested that the structured domains and prompts within the draft Guidance would provide procurement teams with a clear and practical starting point for introducing value-based considerations into procurement processes.

"It gives you something to have a conversation around… rather than just going straight to price." Procurement interviewee

Participants indicated that the ability to justify decisions within existing governance processes would influence whether organisations adopt the final published Guidance. They suggested that evaluating options across multiple criteria would allow procurement teams to explain and defend their decisions more clearly, particularly where these involve selecting options that are not the lowest cost.

"You feel more comfortable in the decision because you've looked at it from different angles." Clinical interviewee

Finally, participants emphasised that allowing sufficient time and flexibility would support adoption. They suggested that longer timelines for testing and piloting would allow organisations to build familiarity with the final Guidance and adapt the VBP approach to local contexts, increasing the likelihood that it can be successfully applied in practice.

3.5 Training needs

Participants across interviews and framework workshop discussions identified a number of training and capability needs that would need to be addressed to support the implementation of the final Guidance in practice. These related primarily to the ability of procurement and clinical staff to develop value-based business cases and quantify value in a way that aligns with existing financial processes. Participants indicated that this requires a combination of analytical, financial and clinical skills that are not always currently present within teams.

"There's a real shortage of the skills needed to build the business case… particularly around being able to quantify value properly." Procurement interviewee

Participants also identified the need for greater support in interpreting and using data and evidence to assess value in practice. Framework discussions highlighted that applying the draft Guidance requires not only access to data, but also the ability to understand what constitutes robust evidence and how it should be used within procurement processes. Participants suggested that targeted training and guidance in these areas would support implementation by enabling more consistent and confident application of the final Guidance across organisations.

Finally, participants highlighted that applying the final Guidance places additional expectations on those involved in procurement, particularly where changes to clinical pathways or service delivery are required. Some interviewees indicated that these responsibilities may currently fall on individuals without dedicated support or training, particularly in clinical roles. Participants suggested that these capability gaps would need to be addressed to enable consistent implementation of the final Guidance in practice, particularly where its application depends on skills and inputs that are not currently embedded within existing roles.

"A lot of this ends up falling on the clinicians… but they don't necessarily have the time or training to do that type of work." Clinical interviewee

4. Conclusions and recommendations

Based on emerging findings, although drawn from a limited sample of interviews and workshop participants (as well as two survey responses), there does not appear to be a strong demand for significant changes to the overall content or structure of the draft Guidance. Participants consistently indicated that the draft Guidance is clear, usable, and sufficiently flexible to support application across a range of procurement contexts. In particular, the use of example questions, structured domains, and flexibility in weighting were viewed positively and should be maintained.

However, findings from national framework discussions highlighted that adaptation of the wording of example questions and validation criteria may be required to ensure that the draft Guidance is fully applicable across different procurement stages. They indicated that certain aspects of value are difficult to assess at framework level due to local variation and limitations in available evidence. This suggests that, while the draft Guidance is broadly fit for purpose, additional clarification may be needed to ensure it can be applied effectively in both national framework and local procurement contexts.

Only a small number of participants had direct experience of applying the approach in full procurement processes, with most reflecting on its use based on partial application or theoretical review. As a result, findings relating to implementation should be interpreted as indicative rather than conclusive.

In particular, there is limited evidence from the pilot activity on how the use of the draft Guidance influences supplier selection in practice. While participants described how the approach supports more structured and transparent decision-making, there is insufficient evidence to conclude that the VBP approach set out in the draft Guidance consistently leads to different procurement outcomes. In some cases, supplier selection was influenced by specification and eligibility requirements alongside the draft Guidance process, rather than being clearly determined by value-based evaluation alone.

The primary challenges associated with wider adoption of a VBP approach do not relate to the design of the draft Guidance itself, but to the organisational and system context in which it would be implemented. Participants consistently highlighted:

- Difficulty securing buy-in from senior and financial leadership
- A system-wide focus on short-term cost reduction
- Variation in procurement practices and multidisciplinary working.

Taken together, these findings suggest that publication of the draft Guidance alone is unlikely to result in widespread adoption. Instead, the draft Guidance represents a broader change in procurement practice that depends on alignment across financial, governance and organisational factors.

The draft Guidance provides a strong and usable foundation for a VBP approach. However, its impact will depend less on further refinement of the document itself and more on the extent to which the wider system enables its adoption in practice. In particular, the findings indicate that VBP requires not only a clear framework, but also supportive financial, governance and organisational conditions, as well as sufficient awareness and capability among those involved in procurement.

Although these evaluation findings suggest that the draft Guidance can support more structured approaches to procurement, further evaluation of the application of the final Guidance across a wider range of procurement contexts will be required to understand its impact on decision-making and procurement outcomes in practice at scale.

4.1 Recommendations for DHSC

Table 4.1 below summarises the recommended actions for DHSC and the rationale for each, based on the evaluation findings.

Table 4.1 Recommendations for implementation next steps

Recommendation	Rationale (based on findings)	What DHSC should do
1. Prioritise implementation over redesign of the final Guidance	The draft Guidance is already seen as usable; barriers relate to implementation context, not design.	Maintain the current structure, example questions and flexibility. Add a short introductory summary to improve accessibility.
2. Clarify application across procurement contexts	Framework staff highlighted challenges using the draft Guidance as written consistently at national level	Provide additional information within the final Guidance for how to apply it at different stages (e.g. frameworks vs local), either through a framework-specific domain or explicit flexibility in wording.
3. Increase awareness and visibility of the final Guidance	Limited awareness is a key constraint on adoption, particularly among clinical stakeholders.	Promote the final Guidance across clinical, procurement and senior audiences using targeted communications and practical examples.
4. Work with system partners to address structural barriers to implementation	Key barriers sit outside procurement, including financial rules, data limitations and expectations for local evidence.	Work with the Healthcare Financial Management Association, NHS finance leads, data registries, and/or policy stakeholders to address financial, data and evidence-related constraints.
5. Develop targeted	Capability gaps may limit the ability of local NHS	Provide practical guidance and training on business case development, use of

Recommendation	Rationale (based on findings)	What DHSC should do
capability and training support	trust staff to apply the final Guidance within existing governance processes.	evidence, and linking value to financial decision-making.
6. Support further evaluation of the final Guidance in practice	Current evidence is limited and largely perception-based; further evaluation is needed to assess impact in practice.	Commission evaluation to track impact on supplier selection, financial outcomes, consistency of application, and supplier behaviour, and develop more practical case studies to share practice.

Annex 1: Industry workshop insights

Value Based Procurement

What we heard: industry workshop insights

Summary of feedback from MedTech industry workshops, April 2026

Introduction

The Department of Health and Social Care (DHSC) ran two workshops with representatives from the medical technology (MedTech) industry to gather views on the development and implementation of draft Value Based Procurement (VBP) Guidance within the NHS. Sessions were held virtually on 28 April 2026 and in person on 30 April 2026.

Discussions focused on how value should be demonstrated, how value gains should be measured, and how impact should be delivered in practice. This document summarises the key themes, recommendations and considerations raised by participants, and **reflects the perspective of industry rather than DHSC policy positions**.

DHSC is grateful to all participants for their time and candour and will use this feedback to inform the ongoing development of VBP policy and guidance.

Evidence Standards

Participants called for clearer, more proportionate national guidance on what counts as good evidence for MedTech products.

- Publish clear national guidance on the evidence required for each value domain, including timeframes, acceptable evidence types and a supporting grading system with worked examples for each category of care.
- Recognise a broader range of evidence, including real-world evidence, pilot data, journal publications and case studies, reflecting that randomised controlled trials are not always appropriate for MedTech.
- Align evidence standards with the NICE Evidence Standards Framework for digital health technologies, and ensure consistency with wider NICE, MHRA and GIRFT requirements.
- Involve clinicians alongside procurement teams in defining evidence needs, and provide training so procurement staff can assess MedTech evidence appropriately.
- Develop the framework with input from across MedTech subsectors rather than modelling it on pharmaceutical evidence standards, and build in proportionality by product cost, complexity and organisational maturity.
- Establish a national mechanism so evidence accepted in one region or pilot is recognised across the system, avoiding duplicated effort.

DHSC response

- *DHSC notes the desire for flexibility and consistency in evidence standards used in procurements. The VBP Guidance, as drafted provides, a steer on the types of evidence that may be requested to answer each value question, including real world evidence, pilot evidence and journal publications. Evidence standards will be refined as the guidance is used but we anticipate that these will remain non-prescriptive. Procurement teams and clinicians should engage with the market to identify proportionate evidence standards for specific products.*
- *MedTech Compass will support procurement professionals to make evidence-based purchasing decisions by providing a single, trusted location for NHS procurement teams and clinicians to find product evidence and information from trusted sources. This will make evidence more accessible and improve the visibility of high-quality MedTech, empowering procurement teams and clinicians with the information they need to adopt innovations.*

Baselining and Data

Participants emphasised the need for shared, reliable baselines before value can be measured.

- Publish a national data map of what NHS trusts routinely collect, across both acute and community settings, so suppliers can design evidence approaches against real baselines.
- Make pre-market engagement a mandatory, meaningful stage in VBP procurement, with sufficient time for both sides to agree baselines and data responsibilities before collection begins.
- Develop a standardised data collection framework covering terminology, definitions and recording practices, and improve interoperability between primary and secondary care systems.
- Identify a named, dedicated contact within each trust responsible for VBP data collection and sharing.
- Explore incentive and gain-share models for trusts and suppliers that invest in robust data collection, and build outcome-based KPI tracking into contracts.

DHSC response:

- *DHSC recognises that data gaps exist across the system and work is underway to ensure that data is more routinely captured and shared across the system. The MedTech and Innovation team will work with colleagues across DHSC and NHSE to ensure that those teams are aware of the data requirements needed for VBP to be a success.*

Funding for Evidence Generation

Cost and access to funding were raised as key barriers, particularly for smaller suppliers.

- Establish a dedicated funding stream for MedTech evidence generation, with a less competitive route than existing NIHR applications.
- Make dedicated funding available for SMEs to develop value propositions and case studies.
- Recognise the real cost of negotiating and monitoring outcomes-based contracts, and reflect this explicitly in procurement guidance and budgets.

- Address silo budgeting that limits whole-pathway value assessment, and the mismatch between NHS funding cycles and the longer timeframes needed to demonstrate outcomes.

DHSC response:

- *DHSC acknowledges the barriers to evidence generation, particularly for SMEs. The Life Sciences Sector Plan commits to establishing Regional Health Innovation Zones which will bring together Integrated Care Boards (ICBs), providers, industry and other partners to experiment, test and generate evidence for complex interventions. This will include working with and through existing infrastructure and innovation asses including NIHR and Health Innovation Networks (HINs). In addition, HINs exist to support innovators to develop evidence and evaluations to support adoption in the NHS.*

Procurement and Implementation

Participants sought clearer accountability, more workable contract terms, and stronger protection for early adopters.

- Publish clear national guidance on who is responsible for driving VBP and demonstrating value across NHS organisations, including a dedicated VBP lead role at regional or ICB level.
- Involve clinicians throughout, in question design, outcome definition and decision-making rather than only at the point of challenge.
- Review standard contract terms to ensure they are proportionate and negotiable, and ensure tender questions are clear, unambiguous and supported by a named contact.
- Provide a clear safety net for early adopters of VBP, addressing concerns about legal and reputational risk that can otherwise push trusts toward familiar procurement routes.
- Consider a lot-based approach to procurement to make it more feasible for SMEs to compete for elements of larger contracts.
- Establish a formal feedback mechanism on VBP frameworks, with a clear commitment to act on what is heard.

DHSC response:

- *DHSC has published the VBP Standard Guidance, and the expectation is that procurement teams will adopt this guidance. To have clear leadership and accountability within procurement teams, DHSC is convening a network of VBP champions to support adoption, this includes a senior level sponsor and manager-level colleague as members.*
- *A best practice approach to VBP requires the involvement of clinicians, patients and service managers to ensure that the questions selected are proportionate and relevant.*

Risk Sharing

Risk-sharing arrangements were seen as central to VBP, but need to be simple, fair and phased in.

- Develop a national risk-sharing framework template with agreed endpoints, baselining requirements and outcome measures, starting with KPIs that can already be measured in routine data.

- Phase in outcome expectations gradually, allowing for implementation and adjustment periods rather than requiring full performance from day one.
- Ensure risk is genuinely shared and does not default to suppliers where outcomes are affected by factors outside their control.
- Build in post-market surveillance and short evaluation cycles so issues can be identified and addressed early.
- Proactively collect and publish anonymised UK examples of risk-sharing that has worked well, to build confidence and capability across the system.

DHSC response:

- *The Department shares the ambition to expand the use of risk share and outcomes based agreements. The NHS Centre for Commercial Excellence is developing training which seeks to embed the skills required for best practice contract management which will support the use of such agreements. The Department and NHS England are also working with organisations such as the Healthcare Financial Managers Association (HFMA) as part of ongoing work to support contracting for value.*
- *As part of VBP monitoring and evaluation, the Department will review the use of risk-share, gain-share and outcomes-based agreements across the system.*

Patient-Reported Data and Outcomes

Participants wanted patient experience and quality-of-life evidence embedded more explicitly in the framework.

- Commission a standardised, simple quality-of-life measure for use in VBP, drawing on existing good-practice models.
- Address data linkage challenges for patient-reported experience and outcome measures, enabling datasets to capture pathway activity, outcomes and wider determinants of health.
- Explicitly require patient experience and quality-of-life evidence within the VBP framework.

DHSC response

- *The VBP guidance includes questions on patient experience and patient outcomes while the supporting information references the EQ-5D-5L measure of health related quality of life. DHSC has engaged with organisations such as ICHOM and will consider reference to those measures within updated guidance.*
- *DHSC is also aware of challenges in capturing patient-reported experience and outcome measures and will continue to engage with relevant teams to ensure that non-financial data can be captured and shared across the system.*

SME-Specific Considerations

Smaller suppliers highlighted specific barriers to participating in VBP on equal terms.

- Work with Health Innovation Networks to improve SME access to collaboration and evidence-generation support.
- Develop a dedicated VBP onboarding resource for SMEs, explaining what value-based pricing means in practice and how to engage with procurement.

DHSC response:

- *DHSC is committed to reducing barriers for SMEs to participate in tenders and to this end published the SME Action Plan 2025 to 2028.*
- *DHSC is continuing to scope appropriate training materials for SMEs in collaboration with trade associations.*

Good Practice and Scaling

Participants wanted to see what works shared more systematically across the system.

- Collect and share case studies and real-world evidence of successful VBP implementation to support scale-up and wider adoption.
- Account for differences in organisational size and resource when planning how contracts and projects scale.
- Consider national-level guidance on interoperability, recognising that system-wide data-sharing challenges cannot be solved locally alone.

DHSC response

- *The VBP Champions Network will support the collate and share best practice case studies of VBP implementation. MedTech Compass will also enable NHS teams to upload and share product evaluations and other real-world evidence with other NHS users of the platform.*

Stakeholder Engagement

A recurring theme was the need for genuine collaboration and culture change, not just new guidance.

- Lead a culture change programme moving procurement from a transactional, cost-focused model to a collaborative, outcomes-focused one, including learning openly from past procurement challenges.
- Adopt a co-design approach to framework and guidance development, involving suppliers, clinicians, finance and procurement teams from the outset.
- Establish a community of practice for VBP, bringing together procurement teams, suppliers and clinical stakeholders to share learning and good practice.

DHSC response

- *DHSC acknowledges the desire for partnership working from both industry and NHS procurement stakeholders. The Department will seek to utilise the VBP Champions Network to*

encourage this change within organisations while also setting the ambition for collaboration a the national level.

Next Steps

This feedback will be used to shape the next phase of the VBP Guidance and supporting tools. DHSC will test, validate and refine these themes with industry, NHS and clinical stakeholders, translating the strongest insights into practical improvements. We recognise that some of these policies sit outside of the remit of the MedTech and Innovation directorate, and we will therefore work with relevant teams within DHSC and NHS England responsible for those areas.



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