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INSIGHTS

Operationalising value-based procurement

CHAIRED BY DR MONIKA PREUSS

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ABOUT PPP

Public Policy Projects (PPP) is an independent organisation operating at the heart of health and life sciences policy delivery. We bring together senior leaders and practitioners in the public and private health and life sciences sectors to find realistic solutions to the most pressing issues relating to health and care delivery.

ABOUT THE 2025 WOUND CARE PROGRAMME

PPP's Wound Care Programme focuses on identifying unmet needs within wound care and how improvements to wound care provision within the UK can be implemented at scale to improve efficiency and patient outcomes. By discussing wound care through the lens of integrated care delivery, the programme continues to evolve as a collaborative endeavour emphasising the need for service reform.

ACKNOWLEDGEMENTS

This report, authored by Fredrik Matre, Programme Executive at PPP, summarises the insights from a roundtable held on 22 May 2025, supplemented with supporting and contextual evidence. The roundtable was chaired by Dr Monika Preuss, Deputy Director for Innovation and MedTech Policy, Strategy and Regulation at the Department of Health and Social Care. A full list of roundtable attendees is included at the end of this report.

Essity has provided sponsorship for this roundtable and report. PPP has retained full editorial control over roundtable agenda and report content, apart from the case study provided by Essity.

NEXT STEPS

PPP's Wound Care Programme is scheduled to host a roundtable on 17 July 2025, further developing discussions on value-based procurement. That roundtable, entitled "Smarter spending, better care: Implications of value-based procurement on operational efficiency of wound care provision", aims to interrogate the current ramifications of implementing value-based procurement as the standard for wound care in the NHS. An insight report will follow.

These roundtables and their related insight reports will, together, inform deliberations at our annual Wound Healing Forum in Westminster, London on 9 October 2025.

Stakeholders interested in contributing to the debate can contact Fredrik Matre, Programme Executive for PPP's Wound Care Programme, at Fredrik.Matre@PublicPolicyProjects.com

ABBREVIATIONS

DHSC	Department of Health and Social Care	**NWCSP**	National Wound Care Strategy Programme
ICB	Integrated care board	**PPP**	Public Policy Projects
ICS	Integrated care system	**SMEs**	Small and medium-sized enterprises
MedTech	Medical technology	**VBP**	Value-based procurement

Foreword

DR MONIKA PREUSS
Deputy Director Innovation and MedTech Policy, Strategy and Regulation, Department of Health and Social Care

Value-based procurement (VBP) represents a transformative opportunity for our NHS. It is about shifting the focus away from simply lowest cost to the assessment of value and outcomes, and a recognition of the role that medical devices can play as a key enabler to drive improvement to patient care. The Department of Health and Social Care's VBP Standard Guidance, due to be published in early 2026, represents the first step to realising these benefits.

It was a privilege to chair this roundtable and present its findings. As the report highlights, there are several challenges we must overcome to ensure the successful implementation and uptake of this guidance across MedTech categories, including wound care.

This report highlights the complexities inherent in this shift: from navigating entrenched budgeting structures and using a consistent and relevant definition of 'value', to fostering a culture that embraces innovation and shared risk.

The candid contributions from clinicians, procurement professionals, industry leaders, and NHS trust representatives provide invaluable perspectives on both the challenges and opportunities that lie ahead. The discussion underscored that while the ambition for VBP is clear, its successful implementation hinges on continued collaboration, a willingness to adapt current practices, and the development of robust frameworks that truly align processes across the healthcare ecosystem.

We will continue to collaborate with all those within the procurement community, from procurement professions to clinical colleagues and industry partners, to ensure that VBP is a success. With that in mind, I encourage you to write to us with any comments to ValueAssessment@DHSC.gov.uk. We look forward to hearing your thoughts and thank roundtable participants for sharing their valued insight.

Key Insights

- Value-based procurement is seen as a potential tool to improve equity of access and patient outcomes, thereby helping to mitigate health inequalities by promoting evidence-based care pathways and reducing regional variations.

- Emphasis on immediate cost savings often discourages innovation; companies developing innovative, value-adding products may be deterred from investing in the UK market if they believe higher initial costs of their innovative products will be dismissed, despite delivering superior outcomes and long-term value.

- Current departmental budgeting structures within the NHS can create disincentives for purchasing value-based products, as benefits or savings might accrue in different budgets, making it difficult to justify higher initial expenditures. Securing buy-in from senior financial stakeholders remains a key challenge for value-based procurements that may have higher upfront costs but offer long-term or indirect savings.

- Clear metrics and robust data demonstrating the tangible value and impact of new products are necessary, but there are difficulties in collecting and presenting this evidence in a way that resonates with financial decision-makers.

- Involving clinicians, procurement, finance and operational stakeholders early in the decision-making process is vital for successfully implementing value-based procurement. Shared alignment and understandings of goals and risks aids establishing outcome-based metrics and facilitates comprehensive change management.

- Ingrained organisational cultures and mindsets can act as a barrier to embedding value-based procurement as standard practice, with ongoing efforts to change 'hearts and minds' and overcome resistance to change. Focus on lowest upfront price, loyalty to existing suppliers, siloed priorities and lack of emphasis on data-driven change all need to be reconsidered.

- Consistently defining and measuring 'value' is complex, as perceptions of value can vary significantly among and between stakeholders; standardised methodology and guidance will therefore provide consistency of expectations for procurement and industry.

- Those working in or adjacent to NHS procurement already have a comprehensive and sophisticated understanding of value and what value-based procurement should aim to do. Such clarity is beneficial as shared understanding with colleagues enables easier implementation of value-based procurement.

- Breaking down budget silos is one of the most difficult, yet essential, challenges for value-based procurement to succeed; considering total lifecycle costs necessarily requires budget holders to take account of the full impact of decisions.

Recommendations

1. Key performance indicators (KPIs) should be established from the outset to retain long-term value as the key to continuous improvement.

2. Budget holders should encourage innovative contracting mechanisms, such as risk-sharing agreements, that align financial incentives between procurement and industry and thereby facilitate the adoption of higher-value innovations. This can help bridge the gap between immediate cost pressures and future value realisation.

3. With the support of DHSC guidance, trusts and integrated care boards (ICBs) should provide comprehensive, ongoing training and practical support for all relevant staff, including clinical and operational teams, to ensure a full understanding and effective implementation of high-value products and new care pathways.

4. Processes for continuous, early engagement and collaborative involvement of multidisciplinary stakeholders in value-based procurement need to be formally established. This will help secure shared ownership over decision-making and implementation lifecycle. ICBs and Trusts should engage their procurement teams to implement standardised methodology and integrated data systems, enabling clinicians to easily understand what the best value intervention is for a patient.

Roundtable findings

INTRODUCTION

Value-based procurement (VBP) in healthcare represents a transformative shift from traditional purchasing models, prioritising lowest upfront costs, toward a more strategic approach, emphasising outcomes, efficiency, and long-term value. Historically, procurement in healthcare has focused primarily on price. Decision-makers typically have selected products and services based on immediate financial considerations, sometimes at the detriment of broader impacts on patient outcomes, total cost of care, and system performance.

The shift towards VBP was driven by escalating healthcare costs and the growing recognition that optimal resource allocation delivers the best outcomes at the lowest possible overall cost.[1] Consequently, VBP has gained traction globally, with international bodies promoting principles like total cost of ownership, outcome-based contracts, and supplier partnerships.[2]

A recent legislative change, the Procurement Act 2023 (which took effect on 24 February 2025), aims to *"improve and streamline the way procurement is done"* with special emphasis on facilitating small and medium enterprises' (SMEs) market access for innovative, value-adding offerings.[3] It is worth noting that two of the four goals of integrated care systems (ICSs) are: to enhance productivity and value for money, and; help the NHS support broader social and economic development. As the NHS has worked towards integrating VBP into standard procurement practices, several substantive findings have informed the developments.

A 2015 joint research study by NHS North West Procurement Development and the University of Liverpool found that the NHS needed to transition away from adversarial, short-term relationships with suppliers pressing for price suppression with *"considerable limitations in the price-based procurement practices prevalent within the NHS."*[4] In 2019, NHS Supply Chain engaged 20 strategic suppliers and subject matter specialists on 13 pilot projects aimed at demonstrating the practices and principles of VBP. Findings demonstrated benefits such as reduced waste, shorter hospital stays, and improved patient safety, resultant from applying VBP methodologies.[5] These findings have all informed the development of the most-comprehensive-yet guidance on VBP for the NHS currently underway at the Department of Health and Social Care (DHSC).[6]

DHSC DRAFT VALUE BASED PROCUREMENT STANDARD GUIDANCE

Published in 2023, the government's medical technology (MedTech) strategy identified three core procurement challenges: ensuring the right product reaches the right place at the right price. Roundtable chair Dr Monika Preuss, Deputy Director for Innovation and MedTech Policy, Strategy and Regulation at DHSC together with DHSC Senior Policy Advisor, Subodh Tailor, outlined for roundtable attendees how DHSC is developing the answer to this central problem within the MedTech strategy. DHSC is spearheading a major policy initiative to standardise and implement VBP across the NHS, with VBP having been identified as a central solution to address these issues of the right product in the right place for the right price. This national guidance, currently in development and undergoing shadow testing, aims to shift procurement decisions away from prioritising lowest upfront cost and toward a more holistic notion of value.

The MedTech Strategy is aligned with wider government and NHS priorities, including the three shifts guiding the development of the recently published 10-Year Health Plan (hospital to community, cure to prevention, analogue to digital) and the life sciences sector strategy. MedTech, defined by DHSC as any instrument, apparatus, software (including digital and AI), or material used for diagnosis, prevention, and

treatment, contributes approximately £34 billion to the UK economy annually and its procurement is intended to be optimised to:

- Enhance patient safety and outcomes
- Improve operational efficiency
- Generate positive social and environmental impacts
- Support greater supply chain resilience

DHSC defines **value-based procurement (VBP)** as *"a procurement model that shifts focus to how a product or solution can best deliver improved outcomes, reduce total costs of the patient pathway and provide long-term benefits."*

DHSC's VBP policy aims to embed value within all procurement processes, from framework tenders to local trust-level decisions, by introducing national guidance and a shared evaluation framework. Procurement decisions will be structured using a min. 60: max. 40 weighting system:

- **Minimum 60 per cent for value,** including a mandatory 10 per cent for social value.
- **Maximum 40 per cent for whole life cost,** encompassing purchase price, aftercare, and consumables.

This value component is divided into five domains:

1. **Social Value:** Contribution to social and environmental goals
2. **Efficiency:** Impact on patient pathway productivity and system efficiency
3. **Patient and Staff:** Enhancements to safety, experience, and reduction in health inequalities
4. **Supply Chain:** Resilience, sustainability, and UK manufacturing capacity
5. **Purpose:** Alignment with product specification, ease of implementation, and training needs

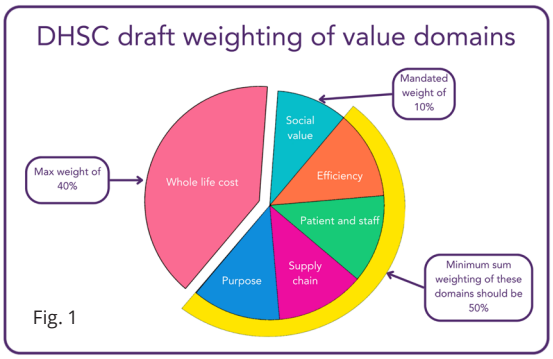

Fig. 1

When making procurement decisions, teams can select the most relevant domains and corresponding questions from a national question bank, offering flexibility within consistent Standard Guidance. In developing the Standard Guidance, DHSC has worked with industry partners to co-develop model answers, with a view to providing greater consistency on evidence expectations.

To further reduce burdens on suppliers and facilitate adoption, DHSC is proposing a central 'passport' mechanism. Product value claims will be stored centrally through a digital platform called Compass, serving as a central repository for validated data, and supporting transparency, efficiency, and national consistency. This will enable NHS trusts to adopt technologies more easily with the confidence of supplier claims having been validated, simultaneously allowing suppliers to avoid duplicative evidence submissions or having to adapt to divergent asks from different procurement groups. The concept of passporting will be investigated in an Alpha phase to test the riskiest assumptions identified in DHSC's discovery.

DHSC's VBP initiative is advancing through a structured multi-phase plan:

1. **Feedback and shadow testing:** Draft Standard Guidance is being tested with selected trusts in parallel to real procurement exercises to evaluate usability.

2. **Lessons learned and refinement:** Insights from shadow testing will inform refinements to the guidance.

3. **Pilot phase:** Live procurement exercises using VBP will be conducted across trusts with varying levels of procurement maturity.

4. **National rollout (2026):** Subject to successful pilot results, full implementation is scheduled to proceed in early 2026.

5. **Training and continuous improvement:** Tailored training and ongoing evaluation will accompany rollout to ensure effectiveness and adaptability.

While these plans are promising, roundtable attendees broadly acknowledged that centrally led initiatives to effect local change in the NHS have had mixed results: *"I love the idea of a central approach [... but] a central approach has not been something the NHS has been historically good at doing."* DHSC is addressing this by collaborating with early adopters and pilot sites to refine the guidance and demonstrate its practical benefits.

Great efforts are being expended to ensure that VBP is not overly burdensome for both NHS trusts and integrated care boards (ICBs), as well as for industry suppliers. By centralising validated product claims through a passporting mechanism, suppliers will be spared from having to repeatedly provide the same evidence to different trusts while also providing reassurance and ease-of-access to procurement teams.

OVERCOMING OBSTACLES: CULTURE, COMMUNICATION, COLLABORATION

While VBP is far from new, it is still not engrained as standard practice in the NHS. As such, there are hurdles to overcome in successfully implementing VBP as standard. Current budgeting practices inadvertently discourage the purchase of more value-based products, as benefits such as cost avoidance are not necessarily reflected in tracked KPIs when they accrue in different departments. There is also a lack of a consistent, shared understanding and common language for 'value' across the NHS. Many of these barriers are reflections of engrained cultures, requiring early and sustained engagement with all stakeholders to foster common ownership over continuous improvement.

One clinical attendee remarked that they had *"noticed that clinical staff abuse VBP as a whole".* When asked to clarify, they explained that when staff were presented with a superior product secured through VBP they initially *"look at it as if all this is like a golden egg. [They think] 'we're going to put these on everybody, we're going use [these products] and we won't have to spend our time to do patient care.'"* With support and training, however, clinicians soon come to realise the benefits different solutions can provide – not as a solve-all, but to enable specific care to be delivered more effectively.

> *Clinicians like to be involved in the choice process and not told what to use. Take them on the journey with you and it will be easier.*
> **Clinical representative**

Delegates recognised the importance of involving multidisciplinary groups in procurement decisions. By taking account of the impacts that procurement choices have in different settings, value can be realised in streamlining care provision. When patients heal quicker, savings are made in clinical time and direct costs avoided on further product spend.

Non-cost outcomes, like patient benefits, are hard to quantify or capture and suppliers are frequently faced with fragmented and

inconsistent demands for data and evidence to demonstrate product value. These cumbersome and inefficient processes will hopefully be made redundant through a central passporting mechanism and standardised question bank, providing greater certainty and consistency for suppliers.

Industry representatives noted that recent NICE late-stage assessment for MedTech had found evidence lacking. This was attributed to industry being asked for types of evidence they had not been asked for previously, as well as such evidence being difficult to generate. DHSC's engagement with industry in developing its guidance, including in drafting sample answers to standard value questions, is therefore encouraging.

THE CHALLENGE IN WOUND CARE: NOT JUST PRODUCT SPEND

> *I don't think we should focus on the unit costs of the products because I think the costs of products is in the outcome and the health improvement for the patient.*
> **Procurement lead**

Overemphasising upfront product cost, through prevailing focus on the lowest unit cost of wound care products (such as dressings), detracts from appreciating the total cost of healing a wound. Switching to a cheaper dressing might initially appear more economical, yet that saving can lead to greater overall costs for the healthcare system if it requires increased nurse time for frequent changes, causes prolonged healing times, or results in higher rates of complications (like infection or maceration).

Measuring the true 'value' of a wound care intervention is complex. Value in wound care extends beyond healing to include patient comfort, reduced pain, improved quality of life, and staff satisfaction. A challenge remains in translating these qualitative benefits into quantifiable metrics that justify a higher upfront investment in a product or pathway.

Effective VBP in wound care requires comprehensive data beyond just product prices, including healing rates, infection rates, patient experience, nurse workload, and product wear time. To demonstrate the quantitative and qualitative benefits of VBP initiatives, capacity must be built to collect, analyse, and interpret this data. Doing so should not, however, become onerous for clinicians: standardised methodology and integrated data systems are therefore required.

> *The cost of wound care products is almost irrelevant in the patient's journey. The cost is in the treatment and management of the patient's comorbidity preventing the wound from healing.*
> **Procurement lead**

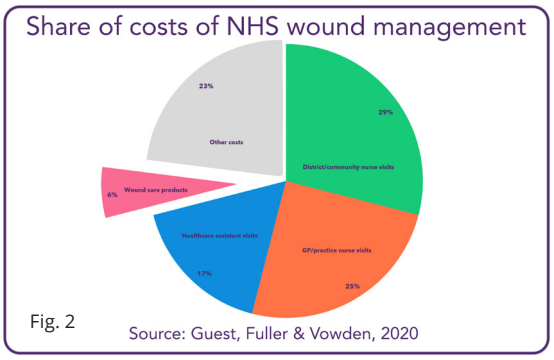

Fig. 2 Source: Guest, Fuller & Vowden, 2020

The estimated distribution of the costs of wound management in the NHS is outlined in Fig. 2 (above).

Product spend is a minority cost in wound care and while some immediate savings are possible through procurement, greater value can be attained by examining how product spend can be used to minimise clinician time required for wound management. Savings on product spend

are limited in scope, as the increase in wound prevalence will naturally see a corresponding increase in dressing volumes needed.

With the overall number of wound patients with a wound increasing by 71 per cent over five years and real-term spending rising by 48 per cent (8-9 per cent annually), the greatest opportunity for long-term savings lies in community settings, which account for 81 per cent of overall costs.[7] Upfront investment in products and pathways that optimise healing and lead to reductions in clinical care time pay dividends in avoided costs across care settings.

The case study that follows demonstrates that a higher spend on a product can lead to savings in avoided infections and readmissions, saving clinical time and improving patient outcomes.

The roundtable was given a presentation of a case study conducted at Barking, Havering and Redbridge University Hospitals NHS Trust, where a simple product swap reduced the high resource demands of a complex clinical case. One change resulted in clinical outcomes improving and both direct and indirect costs decreasing, with NICE having recognised the cost and clinical benefits in its guidance.

CASE STUDY: CLINICAL AND COST-EFFECTIVE PREVENTION OF SURGICAL SITE INFECTIONS FOLLOWING CAESAREAN SECTIONS

Surgical site infections (SSIs) remain a common and costly complication following Caesarean sections (CS), impacting patient outcomes, antimicrobial stewardship, and healthcare resources. Leukomed Sorbact, a dialkylcarbamoyl chloride (DACC)-coated, bacteria-binding dressing, offers a non-antibiotic approach by physically removing pathogens from the wound environment.

Clinical findings
A pilot study at Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), in collaboration with NHS Supply Chain, assessed the impact of Leukomed Sorbact on SSI rates. A 2021 audit showed a baseline SSI rate of 6.1 per cent (149 infections among 2,436 procedures) with standard dressings. After introducing Leukomed Sorbact in 2022 across 2,368 CS patients, the rate fell to 3.8 per cent (91 infections), a 37.7 per cent relative reduction.[8]

Antibiotic use dropped from 2.3 per cent to 1.6 per cent, a 30.4 per cent reduction, aligning with national goals to reduce antibiotic overuse and supporting broader antimicrobial resistance strategies.[9]

Patient feedback
Women reported greater comfort and ease of movement with Leukomed Sorbact, citing its soft material, strong adhesion, and moisture control. Fewer dressing changes and reduced wound exudate supported improved recovery, echoing evidence that DACC-coated dressings aid wound healing without promoting resistance.[10]

Cost benefit
Financial analysis showed significant savings. Direct hospital savings totalled £49,750, attributed to:

- A 30 per cent drop in readmission rates (from 32 to 22 cases), saving £3,083 per avoided readmission
- Reduced bed days, which lowered the average cost per readmission from £3,942.25 in 2021 to £3,083 in 2022

System-wide, estimated savings reached £234,784 due to the reduced incidence of SSIs, each costing the NHS approximately £4048 when including community care costs.[11]

Mature guidance for future use
NICE guidance MTG55 recommends Leukomed Sorbact for closed surgical incisions, citing clinical benefit and cost savings in high-volume surgeries such as CS, orthopaedics, and vascular operations. This supports broader adoption based on BHRUT's outcomes.[12] This aligns with the outcomes observed at BHRUT and supports scaling adoption nationally.

Conclusion
Leukomed Sorbact significantly reduced SSIs post-Caesarean section while improving patient experience and delivering substantial cost savings. With its non-antibiotic mechanism, it contributes to antimicrobial stewardship. These findings support its broader integration into surgical practice as a best-in-class infection prevention dressing.

To read further about the BHRUT pilot study, see Michael Magro's 2023 article in the International Journal of Women's Health.[13]

The preparation of this case study was supported by Essity, who also supported the pilot conducted at BHRUT together with NHS Supply Chain.

IS RISK SHARING THE KEY?

VBP frameworks intend to create a more appealing domestic market for innovative products, encouraging industry to bring its best solutions to the UK and granting UK clinicians and patients access to cutting-edge solutions which provide value for the taxpayer.

> *How do you implement something longer-term for a longer-term saving benefit when the pressure is so here-and-now today to be able to save that money?*
> **Industry representative**

A prevailing focus on cost savings has led to an expectation that MedTech innovations show upfront cost reductions or return on investment within the same accounting period. These unrealistic expectations hindering innovation adoption in the NHS — alongside siloed budgeting, ill-defined routes to market, and widespread perception of innovation as a luxury rather than routine part of continual service improvement — have been well-documented for decades.[14] However, overcoming these engrained cultural perceptions remains challenging.

An increasingly popular means of incentivising and facilitating higher-value innovations is through risk-sharing agreements between procurement and industry suppliers. A risk-sharing agreement is a contractual arrangement where the financial risk associated with the performance or outcome of a procured product

or service is shared between the supplier and the buyer. The roundtable queried how this could be incorporated into VBP initiatives to entice buy-in for the long term.

> *Risk sharing is very easy as a concept, but much more difficult to put into practice.*
> **Roundtable participant**

VBP can benefit from *"more innovative ways of drawing up risk sharing agreements"* but the practical terms can be complicated to align. In wound care, for example, outcomes can be less binary that in some other medical interventions (e.g., successful surgery, disease remission). Wound healing is a dynamic, continuous process, influenced by numerous variables, making 'successful' wound care difficult to quantify or code. Heterogeneity of wound types (e.g., pressure ulcers, diabetic foot ulcers, venous leg ulcers) and patient comorbidities make it challenging to set standardised, universally applicable outcome targets for risk-sharing agreements. What constitutes a successful outcome for a complex, chronic wound in an immunocompromised patient might differ significantly from a simple acute wound.

Furthermore, as highlighted above, the relatively small fraction of total cost represented by product spend means that risk-sharing models need to account for the broader 'total cost of care' components beyond just the product price. This can tip the risk equation such that "many industry partners are not as forthcoming" in agreeing to risk-sharing.

A risk sharing agreement can be a tool to secure commitment from budget holders. By agreeing to *"risk sharing across the life of the contract for however many years that is, [procurement] maintains that momentum"* to realise longer-term 'value points' reflecting service improvement and financial recouperation. Outcomes-based payments or performance guarantees can be options, but it is important to stress that risk sharing involves shared risk acceptance and therefore requires *"a shared understanding that certain metrics will have to be shared each way".*

Conclusion

MAKING VBP A SUCCESS

VBP represents a paradigm shift for the NHS, moving beyond short-term cost considerations to embrace a holistic view of value that prioritises patient outcomes, system efficiency, and long-term sustainability. Roundtable deliberations underscored a collective recognition of VBP's potential, alongside candid acknowledgement of the significant hurdles that remain. These hurdles cannot be leapt over easily; systemic, financial and organisational reforms are requiredfor successful implementation of VBP as the new NHS standard.

> *Hopefully, there will be changes within the 10-Year Health Plan that will support a more holistic view and uptake of VBP, looking at things like multi-year budgeting. The ICB level changes will, hopefully, also support that strategic commissioning function across a pathway resulting in less siloed budgets.*
> **Roundtable participant**

However, the journey towards fully embedding VBP is not merely a structural one – it also requires cultural transformation. *"There are definitely a few hearts and minds still to be won,"* as DHSC acknowledges. Shifting ingrained mindsets away from a cost-first approach towards a holistic value consideration will require engagement with all stakeholders, from clinicians to finance managers, fostering shared understanding and commitment.

Implementing VBP as standard does not require wholesale reinvention of the wheel. Existing structures can be utilised and adapted to drive this shift. Collaborative NHS procurement groups, for example, are a pre-existing vehicle through which VBP can be implemented *"at scale across quite large organisations because [they] have that umbrella view and possess those relationships with the clinical teams."*

As the NHS undergoes major reform, it remains to be seen how innovations in procurement practice will become embedded. But the groundwork, from both DHSC and procurement colleagues as well as committed industry partners, has been laid. The will is there. With considered effort, patients, staff and the taxpayer will all benefit.

Attendees

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