# Who Pays for a Medical Device?

*Commissioning architecture, funding flows, contracting levers and tendering routes in England — compiled 16 September 2026*

This briefing covers medical devices, diagnostics and health technologies in England: how a device is approved, who evaluates it, whose budget pays for it, how it is bought, and what a commercial team has to do at each stage. It is written for people who already understand pharmaceutical market access and need the equivalent map for medical technology. Scotland, Wales and Northern Ireland run parallel but distinct systems and are not covered here.

**Health warning.** The NHS in England is in the middle of the largest structural change since 2012. NHS England is being abolished and its functions transferred to DHSC under the Health Bill laid on 13 May 2026. Integrated care boards are merging to coterminosity with strategic local authorities in two waves, April 2026 and April 2027, having absorbed roughly 50% running-cost reductions. The 2026/27 NHS Payment Scheme is explicitly a one-year bridge, with a full price recalculation expected for 2027/28. The MedTech Funding Mandate is closed to new products pending review. Names, boundaries, contacts and prices in this briefing will move. The mechanisms and the logic will not.

## Executive summary

**Devices are not medicines, and the difference is structural rather than cosmetic.** A positive NICE technology appraisal of a medicine carries a statutory funding requirement, normally within 90 days. NICE HealthTech guidance carries no such requirement. For all but a handful of devices, approval is permission to sell, not a budget to be paid from.

**There are only four national mechanisms that create anything approaching an obligation to pay:** the National HealthTech Access Programme, launched in 2026 and deliberately narrow; the MedTech Funding Mandate, which has taken no new products for 2026/27 while it is reviewed; the high cost tariff-excluded device list, which is a procurement contest rather than a commissioning one; and, for everything else, local commissioning with no legal obligation at all. Establishing which of these a product can realistically reach is the first strategic decision in a device launch, because it determines the whole shape of the plan.

**The centre of gravity is local.** Roughly two thirds of a device market access plan is trust and ICB work — funding route, procurement route, pathway redesign. That is the opposite weighting to a specialty medicine, and mis-weighting it is the commonest cause of a stalled launch. Launches fail at the payment mechanism, the procurement route and the pathway redesign, not at NICE.

**Procurement has changed more than commissioning has.** Under DHSC's Value Based Procurement guidance the five non-price value domains must carry a minimum 60% of evaluation criteria, social value a minimum 10%, and whole life cost cannot exceed 40%. Price alone can no longer win a medtech tender. MedTech Compass and the Innovator Passport will standardise the evidence format nationally from 2027/28.

**The frameworks are the levers.** The eight instruments at section 3 determine whether a device is paid for inside tariff or outside it, whether a commissioner is looking for it, whether a provider is contractually obliged to adopt it, and whether the problem it solves is one the organisation is publicly measured on. The NHS Oversight Framework dashboard in particular is a public, pre-qualified list of every trust's failing metrics, and it is the most under-used account planning asset in the system.

## At a glance

| Instrument | What it controls | Your principal lever |
|---|---|---|
| **NHS Payment Scheme 2026/27** | Statutory prices and payment rules. In force 1 April 2026; one-year scheme, full price recalculation expected 2027/28 | Get outside the tariff — high cost tariff-excluded listing or MTFM pass-through. Failing that, attach the device to a Best Practice Tariff or a blended payment variable element |
| **Strategic Commissioning Framework** | What an ICB is for, from November 2025: population health strategies, market shaping, outcomes-based contracting | Rebuild the value story at cohort level in the ICB's own segmentation language, and bring a risk-share construct to the table before you are asked for one |
| **NHS Standard Contract 2026/27** | Binding commissioner–provider terms, published 28 January 2026 | Where a product is on the MTFM list, adoption is a contractual obligation rather than a preference — a legitimate, non-adversarial point to raise |
| **Medium Term Planning Framework 2026/27–2028/29** | Three-year delivery expectations and the financial envelope, from 27 October 2025 | Quote the specific target the technology moves, in the framework's own numbers. This is the value-proposition dictionary |
| **Better Care Fund** | Pooled NHS and local authority budget via Health and Wellbeing Boards; includes the Disabled Facilities Grant | The budget for community equipment, assistive technology, telecare, remote monitoring and adaptations — a different customer entirely |
| **Quality and Outcomes Framework** | GP incentive scheme within the 2026/27 GP contract | Map the product to the specific indicator a practice is missing, and quantify the points and the pounds |
| **NHS Oversight Framework 2026/27** | Segmentation and public league tables for ICBs and trusts, from 11 June 2026; 86 metrics, seven domains | Read the public dashboard for each account's failing metrics. It tells you both what to sell and who is receptive |

| Instrument | What it controls | Your principal lever |
|---|---|---|
| **Modern Service Frameworks** | National standards of care by clinical priority area; CVD and sepsis published July 2026 | Where a technology is named or implied, this is the closest thing to national pull outside NHAP and MTFM. Where a framework is still in development, influence it now |

## 1. What "approved" does and does not buy you

A medical device passes three independent gates. Clearing one says nothing about clearing the next. This is the point at which most pharmaceutical market access instinct misleads.

| Gate | Question | Who decides | What it does not give you |
|---|---|---|---|
| **1. Regulatory** | Is it safe and does it perform as claimed? | MHRA (UKCA), or an EU notified body under CE recognition | Any evidence of value, any budget, any route to market |
| **2. Evaluation** | Is it clinically and economically worth using? | NICE HealthTech programme; local and regional HTA groups; Modern Service Frameworks | Money. For most devices NICE guidance is advisory on funding |
| **3. Funding and procurement** | Whose budget, at what price, on what contract? | ICBs, trusts, NHS Supply Chain and regional collaboratives, NHSE specialised commissioning | Guaranteed volume — usage still depends on clinician and pathway adoption |

### 1.1 Gate 1 — regulatory approval, and the 2026–28 reform

Devices on the Great Britain market carry either a UKCA mark or a CE mark under transitional recognition, with MHRA registration either way. Northern Ireland continues to follow EU rules. MHRA consulted on indefinite recognition of CE-marked devices in Great Britain; that consultation closed 10 April 2026 and the decision on scope and duration is pending. For any supplier relying on CE-marked stock this is a live planning variable.

MHRA has published draft regulations reforming pre-market requirements, aligning the UK more closely with EU MDR and IVDR:

- an international reliance pathway allowing devices already authorised in the US, Canada or Australia to reach the GB market via a certificate of international reliance without UKCA marking — the EU is notably excluded;
- technical documentation retention for device lifetime plus 10 years, or 15 years for implantables;
- mandatory Unique Device Identifiers for all devices and IVDs, and implant cards for implantables;
- revised classification rules, tighter restrictions on equivalence claims, and new controls on misleading marketing claims;
- a Predetermined Change Control Plan pathway for software with explicit cybersecurity obligations, and expanded electronic instructions for use.

| Date | Milestone |
|---|---|
| **10 April 2026** | MHRA consultation on indefinite CE-mark recognition closed; decision pending |
| **19 June 2026** | MHRA impact survey on the draft pre-market regulations closed |
| **December 2026** | Expected adoption of the reformed pre-market regulations |
| **June 2027** | Provisions expected to enter into force |
| **Mid-2028** | International reliance pathway expected to go live |

**Access implication.** Tighter equivalence rules raise the cost of the evidence base market access will later sell from, so regulatory and evidence strategy have to be set together. UDI and implant card readiness is a procurement and catalogue question, not only a regulatory one — trusts will ask for it at tender. And claim controls mean Commercial and External Affairs copy needs sign-off discipline equivalent to pharmaceutical practice, notwithstanding the different code regime.

## 1.2 Gate 2 — the NICE HealthTech programme

NICE has consolidated the Medical Technologies Evaluation Programme, the Diagnostics Assessment Programme and the Interventional Procedures Programme into a single HealthTech programme. MedTech Innovation Briefings are discontinued. The organising principle has moved from technology category to product lifecycle stage.

| Route | For what | Access implications |
|---|---|---|
| **Early Use Assessment (formerly Early Value Assessment)** | Technologies still generating evidence — digital tools, diagnostics, devices without a full RCT portfolio. Conditional recommendations issued with an evidence generation plan, typically up to three years to close gaps before re-evaluation | The pragmatic front door. A conditional recommendation is a foothold, not a funding decision: it buys deployment sites on condition you collect the data. Budget and resource that collection from day one — it is a market access cost line, not a medical afterthought |
| **Routine Use Assessment** | Technologies ready for comparative evaluation. Multi-technology appraisals emphasising relative cost effectiveness, with pricing considerations | The closest analogue to classical HTA. You are assessed against competitors in the same exercise, not in isolation. Comparative value, not absolute value, decides it |
| **Existing Use Assessment (formerly Late-Stage Assessment)** | Technologies already embedded in NHS procurement, high-cost/low-volume and low-cost/high-volume alike. Assesses value for money, usability and user preference | A defensive exposure for incumbents. NICE rarely rules 'should not be used'; it more often sets selection factors that reshape the tender specification. Treat it as a live commercial threat to installed base |

### Mechanics that matter

- Manufacturers now respond to NICE-initiated information requests rather than making bespoke submissions, with evaluations run through external assessment groups. You are reacting to a NICE-set scope, so influencing topic selection and scoping early beats perfecting a submission late.
- Entry is via the NHS Innovation Service. Eligibility needs an appropriate UKCA, CE or equivalent mark (or one expected within 12 months), genuine novelty, DTAC approval for digital products, and NHS availability or credible launch plans.
- Initial priority areas are mental health, early cancer detection and diagnosis, diabetes, musculoskeletal, women's health, respiratory and neurology. If the product maps to one, say so explicitly and early.
- A complete dossier and a fully executable health economic model are expected up front. Health economics capability is no longer optional in a device commercial team.

## 1.3 The gap that defines the job

| For a NICE-approved medicine | For a NICE-approved device |
|---|---|
| **Statutory funding requirement, normally 90 days** | No statutory funding requirement unless routed through NHAP or listed on MTFM |
| **Commissioner identified by commissioning responsibility rules** | Budget has to be located: provider revenue, capital, ICB, specialised commissioning, or a pooled fund |
| **Priced nationally; often excluded from tariff automatically** | Usually inside an HRG, where it reads as added cost to the provider |
| **Blueteq or equivalent prior approval, then prescribe** | Business case, capital approval, procurement route, pathway redesign, EPR build, training |
| **Route to market largely settled at approval** | Route to market is a separate contest: catalogue listing, framework, or tender |

**The sentence to have ready.** For medicines, NICE approval triggers funding. For devices, NICE approval triggers a conversation. The job is to make that conversation short, by arriving with the business case, the pathway redesign, the procurement route and the clinical champion already lined up.

# 2. Who holds the money

Three simultaneous restructures bear on the account map: the national body, the commissioner footprint, and the commissioner's role.

## 2.1 National — the Health Bill (NHS Modernisation Bill 2026)

Laid before Parliament on 13 May 2026. It abolishes NHS England and transfers its functions to DHSC, expands the Secretary of State's powers over commissioning and resource allocation, strengthens ICBs as the primary strategic commissioners, creates a single patient record, abolishes Healthwatch in favour of a new patient voice function, and merges the Health Services Safety Investigations Body into the CQC.

**Access implication.** National relationships consolidate towards DHSC and a smaller central function. External Affairs influence becomes more concentrated and more valuable; day-to-day commissioning influence moves further down to ICBs and providers.

## 2.2 Footprint — ICB mergers

ICBs are moving to coterminosity with strategic local authorities, sharing the same borders, through mergers and boundary changes on 1 April 2026 and 1 April 2027. They have absorbed roughly 50% running-cost and headcount reductions. Fewer, larger commissioners with materially less capacity.

**Access implication.** Account maps have a short shelf life — territory design, named contacts and regional tender calendars all need re-basing against both waves. Thinner ICB teams have less appetite for bespoke local business cases, which raises the value of arriving with a ready-made, evidence-backed, implementation-ready package rather than a request for one to be built.

## 2.3 Role — ICBs as strategic commissioners

The Strategic Commissioning Framework, published November 2025, makes ICBs accountable for creating best value for the public from their NHS budget through continuous, evidence-based planning, purchasing, monitoring and evaluation. It sets a four-stage cycle: understand context through data, needs assessment and service review; develop five-year population health strategies and care pathways; allocate resources through contracting, procurement and market shaping; and evaluate outcomes and impact.

Three things follow for a device supplier:

- **Population health management becomes the organising logic.** Person-level segmentation and risk stratification run through the NHS Federated Data Platform. A proposition expressible as "this cohort, this many people, this outcome, this avoided cost" fits the machinery. One expressible only per procedure does not.
- **Payment moves toward outcomes-based and capitated models,** including year-of-care and best practice tariffs and risk-sharing. This opens the door to outcome-linked constructs for devices — and creates an expectation that you will offer one.
- **ICBs shape and manage the provider market,** including joint procurement with local government under the Provider Selection Regime, and may delegate commissioning authority to capable providers. Multi-Neighbourhood Providers and Integrated Health Organisations become buying entities in their own right.

Milestones: capability toolkit January 2026; ICB strategies and needs assessments January 2026; baseline assessment March 2026; development programme April 2026; full adoption through the 2026/27 planning cycle.

## 2.4 Where the money physically sits

| Budget | What it pays for, and who signs |
|---|---|
| **Provider revenue (inside tariff)** | Consumables and devices absorbed into the HRG. Signed by the clinical business unit and finance. The hardest sell, because the device reads as added cost |
| **Provider capital** | Equipment and systems. Capital programme, business case through trust capital group and board. Long cycle, annual rhythm, often the binding constraint |
| **ICB allocation** | Locally commissioned pathways, community-delivered technology. Signed by ICB commissioner, often via a policy or technology committee |
| **NHSE specialised commissioning** | High cost tariff-excluded devices in the 15 in-scope categories, bought through the national supply route |
| **Better Care Fund pool** | Community equipment, assistive technology, telecare, adaptations. Signed jointly by ICB and local authority through the Health and Wellbeing Board |
| **Primary care (GP contract)** | Practice-deployed diagnostics and monitoring, driven by QOF achievement rather than a device budget as such |

# 3. The eight instruments

Each instrument below is set out the same way: what it is, the mechanics that matter, and the access implications.

## 3.1 NHS Payment Scheme 2026/27

### What it is

The statutory pricing and payment rules for NHS-commissioned care, in force from 1 April 2026. Deliberately a one-year scheme; substantial change including a full price recalculation is expected for 2027/28.

### Mechanics that matter

- Aligned Payment and Incentive continues for almost all provider–commissioner relationships: a fixed element covering maternity, mental health, community, ambulance and outpatient follow-ups, and a variable element for elective activity at unit prices.
- New blended arrangements: urgent and emergency care (fixed plus 20% variable for activity variance, with break-glass clauses), radiotherapy (fixed plus 50% variable for external beam and SABR), and genomic testing (fixed plus a locally agreed variable, with a 2% incentive element).
- Cost uplift factor 2.03%; efficiency factor 2.0%, aligned to the 10 Year Health Plan productivity target. Prices otherwise largely frozen.
- New £33 unit price for patient-not-present activity that stops an RTT clock. Low volume activity threshold held at £1.5m with an 8.5% activity growth uplift.

- Best Practice Tariffs expanded: 22 new Day Case BPTs, 7 Referral-to-Treatment BPTs for straight-to-test and one-stop clinics, and an expanded Right Procedure Right Place BPT covering hip, knee, foot, hand, shoulder and elbow injection procedures.
- High cost tariff-excluded lists reviewed through steering groups: 47 drugs added, 65 removed, releasing £525.5m of which £458m was redirected into unit prices. On the devices list, Sonata was removed for no longer meeting specialised commissioning criteria.
- MTFM technologies sit on the "12c MedTech FM products" list, reimbursed at actual cost, at the price set under an applicable procurement framework, or at a reference price — outside core payment mechanisms.
- Payment principles now reference the Medium Term Planning Framework rather than annual operational guidance.

#### Access implications

Frozen HRG prices plus a 2% efficiency factor mean any device adding unit cost inside an existing tariff-paid procedure is, from the provider's point of view, a margin problem. Three routes work. Get outside the tariff, through high cost tariff-excluded listing or MTFM pass-through. Attach the device to a Best Practice Tariff — day-case conversion, straight-to-test, right procedure right place — where it enables the provider to earn a higher-value currency. Or land the saving in length of stay, readmission or theatre throughput, and evidence it. The new blended payments for UEC, radiotherapy and genomics are openings in their own right: where payment is fixed-plus-variable, a technology that changes activity mix has a cleaner financial story than under either a pure block or a pure tariff.

### 3.2 Strategic Commissioning Framework

#### What it is

Published November 2025. The operating manual for ICBs as strategic commissioners, set out at section 2.3.

#### Mechanics that matter

- The four-stage commissioning cycle, with five-year population health strategies as the planning unit.
- Explicit movement toward outcomes-based and capitated models, year-of-care and best practice tariffs, and risk-sharing arrangements that incentivise provider partnership.
- Flexibility under the Provider Selection Regime for joint procurement with local government, and potential delegation of commissioning authority to capable providers.
- ICBs are asked to consider supply chains and SME providers to promote social value and inclusive growth, while pursuing economies of scale for specialised services.

#### Access implications

The buying question shifts from "do we approve this product" to "does this change the five-year strategy for this cohort". Rebuild the value story at cohort level, in the ICB's own segmentation language, using their needs assessment where you can get it. Bring a risk-share or outcomes-linked option proactively — under this framework it reads as a differentiator rather than a concession. And check whether the organisation can credibly claim SME or social value advantage, because the framework invites commissioners to weigh it.

### 3.3 NHS Standard Contract 2026/27

### What it is

The mandated contract between commissioners and providers of NHS-funded care, published 28 January 2026. It is the enforcement layer: national policy becomes binding on providers through its clauses.

### Mechanics that matter

- The proposed removal of the Escalation Process was not implemented — providers retain it where commissioners have not followed required procedures.
- Commissioners must now comply with Technical Guidance paragraphs 42.25 and 42.38 as mandatory contractual obligations rather than discretionary ones.
- Activity Management Plan setting timeframe cut from 10 Operational Days to 1 where the parties cannot agree or a provider fails to attend without reasonable explanation.
- Commissioners may set local variations to certain National Quality Requirements, which then take precedence over national targets.
- 1 April 2026 was the deadline for agreeing Investment and Activity Plans on existing contracts.

### Access implications

This is where the MedTech Funding Mandate acquires teeth: providers are contractually required to comply with MTFM guidance, and the CQC may use adoption evidence in regulatory assessment. It is equally the route by which NICE technology appraisal funding obligations bind providers. Where a product is on the MTFM list, non-adoption is a compliance matter rather than a preference — a legitimate and non-adversarial point to raise. Quarterly Assurance Reporting Tool data and the MTFM dashboard on FutureNHS give site-level adoption stage data for targeting and for evidencing variation. The move to locally variable quality requirements also means a national benchmarking story now needs a local overlay.

## 3.4 Medium Term Planning Framework 2026/27 to 2028/29

### What it is

Published 27 October 2025. Replaces annual operational planning guidance with a three-year framework translating the 10 Year Health Plan into delivery expectations. The closest thing the NHS has to a published statement of where it will put attention and money for three years.

### Mechanics that matter

- Revenue funding grows 3% in real terms annually to £226bn by 2028/29; capital rises from £13.6bn in 2025/26 to £14.6bn in 2029/30.
- Sustained minimum 2% annual productivity improvement. All ICBs and providers must reach balanced positions without deficit support funding by the end of the horizon.
- Digital mandates by 2028/29: 95% of appointments available through the NHS App post-triage; full Federated Data Platform onboarding for acute, community and mental health; NHS Notify migration for all direct patient communications; 100% electronic patient record coverage; ambient voice technology deployed at pace. NHS Online, a digital-first specialist care portal, launches 2027.
- Providers are directed to adopt digital therapeutics where regulatory approval exists, and decision support tools such as i-Refer-CDS to optimise diagnostic demand.

| Domain | Target by 2028/29 | Device relevance |
|---|---|---|
| **Elective** | 92% RTT within 18 weeks | Throughput, day-case conversion, straight-to-test diagnostics |
| **Cancer** | 80% Faster Diagnosis; 96% 31-day; 85% 62-day | Diagnostics, AI triage, early detection |
| **Diagnostics** | Max 1% waiting over 6 weeks | Point-of-care and community diagnostics; imaging capacity |
| **Urgent and emergency care** | 85% A&E four-hour; 18-min mean Category 2 ambulance | Admission avoidance, remote monitoring, SDEC-enabling technology |
| **Community** | 80% within 18 weeks | Home-based and neighbourhood-deliverable technology |
| **Primary care** | 90% same-day urgent appointments | Practice-deployable diagnostics and triage tools |

### Access implications

This document is the value-proposition dictionary. Every business case should quote the specific target the technology moves, in the framework's own numbers. The stated deal for providers is that success will be rewarded with greater freedom, so a device that visibly moves a metric determining a trust's segment and autonomy has a materially easier internal sponsor. The digital mandates also make EPR and Federated Data Platform integration a procurement gating question rather than a desirable feature — a technology that cannot integrate is now failing a stated national requirement, not merely inconveniencing an IT team.

## 3.5 Better Care Fund

### What it is

A pooled budget between the NHS and local government, governed through Health and Wellbeing Boards and jointly overseen by DHSC and MHCLG. The 2026/27 framework comprises an NHS minimum contribution, a Better Care Grant, and the Disabled Facilities Grant under a revised distribution methodology, plus voluntary additional contributions from NHS and council partners.

### Mechanics that matter

- Two mandatory local goals: non-elective admissions for people aged 65 and over, and discharge delays.
- Additional measurement of avoidable long-term care admissions and reablement outcomes, including the proportion of people still at home at 12 weeks.
- Stronger focus for 2026/27 on intermediate care demand and capacity assessment, alignment to neighbourhood health, the VCSE sector as strategic partner, and new value-for-money and productivity demonstration requirements.

### Access implications

This is the principal funding route for community equipment, assistive technology, telecare, falls prevention, remote monitoring and home adaptations — the categories with no home in acute tariff. The Disabled Facilities Grant specifically funds aids and adaptations. If the technology keeps someone out of hospital or out of long-term care, this is the budget, and the Health and Wellbeing Board and joint commissioning team are the customer — not the ICB medicines or procurement function. Different stakeholder map, different evidence base (admissions avoided, reablement, days at home), different sales cycle. It is the section most often missed by teams that model the NHS as acute-only.

## 3.6 Quality and Outcomes Framework

### What it is

The primary care incentive scheme within the GP contract, paying practices points for achievement against clinical and organisational indicators. The most direct lever on general practice behaviour that exists.

### Mechanics that matter

- The 2026/27 GP contract carries a 3.6% cash uplift (£485m), plus £292m repurposed from the Capacity and Access Payment into practice-level reimbursement.
- QOF gains 18 additional points worth roughly £25m, focused on alignment with NICE guidance, across childhood vaccinations, diabetes, obesity and heart failure.
- The Obesity Enhanced Service is retired, replaced by two new QOF indicators for weight management services including delivery of weight-loss injections. The Advice and Guidance Enhanced Service is retired and embedded into core funding.
- A structural shift toward sliding-scale indicators rewarding incremental progress rather than binary threshold achievement, notably in childhood vaccination, intended to help practices in deprived areas.

### Access implications

QOF rarely names a device, but it decides whether the activity a device supports happens at all. Diabetes, heart failure, obesity and vaccination indicators drive case-finding, monitoring and review — which is where diagnostics, monitoring technology and point-of-care testing live. For any primary-care-deployed technology the decisive slide is the one showing how the product wins points the practice is currently missing: map to the specific indicator, quantify the points and the pounds, and the conversation stops being about cost. The sliding-scale change matters here — partial improvement now pays, which lowers the bar for a technology that improves a practice's position without getting it to the old threshold.

## 3.7 NHS Oversight Framework 2026/27

### What it is

Published 11 June 2026, updated 29 July 2026. Sets how ICBs and NHS trusts and foundation trusts are monitored, with stated aims of fairness, proportionality, consistency, transparency and predictability, supporting the three shifts — hospital to community, analogue to digital, sickness to prevention. It does not cover independent providers, who are overseen through contracts and IPRAF.

### Mechanics that matter

- 86 metrics across seven domains: population health and inequality; resource allocation (ICBs) or access (providers); experience; effectiveness of care; patient safety; finance, productivity and innovation; and people. Metrics are either scoring, feeding segmentation, or contextual.
- Segments 1 to 4, from high performance with a narrow range of issues to significantly below average requiring coordinated intervention. A financial deficit overrides segmentation and blocks segments 1 or 2 until resolved.
- A public dashboard publishes segmentation, domain scores, individual metrics and league table rankings.
- Consequences run from greater freedoms and advanced foundation trust eligibility for strong performers, through targeted support, to intensive oversight, mandated support, enforcement powers, very senior manager pay restrictions and recovery programme entry.

#### Access implications

The most under-used account planning asset in the system, and it is public. The dashboard tells you, for every trust and ICB in a territory, exactly which metrics they are failing and how visible that failure is — a pre-qualified list of problems the technology may solve. It also tells you who is receptive. A segment 3 or 4 organisation under intensive oversight has urgency but little money and little management bandwidth; a segment 1 or 2 organisation has freedom and capacity to innovate. Those need different propositions and different sequencing. Note too that innovation sits inside the finance, productivity and innovation domain, so adoption is itself a measured behaviour.

### 3.8 Modern Service Frameworks

#### What it is

The successor to the old National Service Frameworks, introduced through the 10 Year Health Plan. Each assembles the best available evidence for a priority area in one place to drive consistent, high-quality care across England, developed with national bodies, clinicians, commissioners, professional organisations and system partners, with NICE embedding its guidance, identifying evidence gaps and shaping the clinical approach.

#### Mechanics that matter

- Published July 2026: cardiovascular disease, including kidney and metabolic disease; and sepsis.
- In development for publication during 2026: severe mental illness; frailty and dementia; end-of-life care; and children and young people.
- NICE guidance underpins the frameworks, so a technology already carrying NICE HealthTech guidance in a framework's clinical area has a natural claim on inclusion.

#### Access implications

A Modern Service Framework is a national statement of what good looks like in a pathway, and becomes the reference point ICBs plan against and providers are held to. Where a technology is named or clearly implied in a framework's standard of care, that is the closest thing to national pull available outside NHAP and MTFM. Where the relevant framework is still in development, influencing it through clinical societies and the evidence submission process is the highest-leverage External Affairs activity available — and the window is closing during 2026. For a cardiovascular or sepsis-adjacent technology the frameworks are already published and should be quoted directly in every business case.

## 4. Funding routes ranked by realism

Four national mechanisms create anything approaching an obligation to pay. They are listed below in descending order of force and ascending order of likelihood — the strongest route is the hardest to reach, and the default route is the one with no obligation at all.

| Route | What it does | Realism |
|---|---|---|
| **1. National HealthTech Access Programme (NHAP)** | Launched 2026. Extends NICE's technology appraisal route to health technologies so a small number of high-impact products are reimbursed NHS-wide, medicines-style. Run jointly by NICE, DHSC, NHS England, MHRA and the Office for Life Sciences | Deliberately narrow. First topics are capsule sponge testing for oesophageal cancer and AI tools for prostate and breast cancer detection, with endometrial cancer detection and AI chest X-ray referred for further evidence review. Assume you are out of scope unless you have a credible case for NHS-wide transformation |
| **2. MedTech Funding Mandate (MTFM)** | Since 2021. Commissioners must fund listed technologies from existing allocations via pass-through payment at actual cost and volume; providers must ensure eligible patients can access them. Compliance is a Standard Contract obligation, monitored via the Quarterly Assurance Reporting Tool | Closed to new products for 2026/27 while the policy is reviewed against the 10 Year Health Plan and Life Sciences Sector Plan. Criteria are tight even when open: positive NICE guidance, net saving within three years, national budget impact under £20m in each of the first three years. In 2025/26 only one device was newly supported |
| **3. High Cost Tariff-Excluded Devices / Specialised Services Devices Programme** | Fifteen device categories — cardiac devices, neural stimulators, bone-conducting hearing implants, vascular stents and others — lifted out of the HRG tariff and bought through a mandated national supply route via NHS Supply Chain category towers, with central financial reconciliation | Available only to the in-scope categories. Listing brings national price competition and clinically chaired Device Working Groups setting product selection and specification. Winning here is a procurement and specification exercise, not a commissioning one |
| **4. Local and regional commissioning** | Everything else. An ICB or trust funds adoption from existing budgets, with no legal obligation | The default for most devices, and where launches stall: trust-by-trust business cases against competing pressures, repeated at every site. Plan for this and treat anything better as upside |

## 5. Tendering and procurement

Funding and procurement are separate problems. A trust can agree it wants the device and still be unable to buy it, because it is not on a compliant route to market.

## 5.1 The legal split

| Regime | Applies to |
|---|---|
| **Procurement Act 2023 (in force 24 February 2025)** | Goods — medical devices, equipment, consumables, diagnostics. Competitive procedures above threshold; all opportunities advertised on Find a Tender |
| **Provider Selection Regime** | Healthcare services commissioned by NHS bodies. More flexible, permitting direct award and joint procurement with local government where the criteria are met. Relevant where the device is embedded in a managed service or pathway contract rather than sold as a product |

The distinction is commercially usable. An offer structured as a service — managed equipment service, outcome-based pathway contract, diagnostics-as-a-service — may sit under the more flexible Provider Selection Regime rather than full competitive procurement. That is legitimate, increasingly common, and worth designing for rather than discovering.

## 5.2 Value Based Procurement — the weighting change

DHSC has issued Value Based Procurement guidance for NHS buyers of medical technology, applying at the assessment stage across consumables, implantables, general devices, equipment, diagnostics, imaging, and digital and AI products, in primary and secondary care. Buyers judge whether it is appropriate and proportionate to value, complexity and risk, while staying compliant with the Procurement Act or PSR. Value is assessed across five domains:

1. **Social value** — environmental and sustainability benefits
2. **Efficiency** — streamlined patient pathways, reduced duplication
3. **Patient and staff** — outcomes and experience
4. **Supply chain** — resilience, circular economy practices
5. **Purpose** — meeting the specification and enabling effective implementation

**The number that matters:** the five domains combined must carry a minimum 60% of evaluation criteria, with social value at a minimum 10%. Whole life cost cannot exceed 40%. Price can no longer win a medtech tender on its own. Non-price value carries the majority of the score, and you are expected to evidence it with real-world data against established baselines. Suppliers who take part in pre-market engagement — setting realistic expectations about what evidence exists — do materially better.

## 5.3 The buying bodies

- **NHS Supply Chain,** structured as category towers, is the principal national route. For high cost tariff-excluded devices the Specialised Services Devices Programme mandates the national supply route, currently delivered through the Health Solutions team and the Collaborative Procurement Partnership, with clinically chaired Device Working Groups setting product selection and specification and a central financial reconciliation process for payment.

- **Regional collaboratives and procurement hubs —** the Collaborative Procurement Partnership, NHS London Procurement Partnership, NOE CPC and equivalents — run frameworks at sub-national level. These are the bodies a regional or national KAM most often faces in practice.
- **Individual trusts and provider collaboratives** run local tenders, mini-competitions and framework call-offs, increasingly aggregated at provider collaborative or ICS level.
- **ICBs,** under the Strategic Commissioning Framework, shape the market and may procure jointly with local government, particularly for community, neighbourhood and social-care-adjacent technologies.

## 5.4 Mechanics and prerequisites

NHS Supply Chain tenders run through the Jaggaer eProcurement portal, with opportunities advertised on Find a Tender and a published procurement calendar showing scheduled activity. To be eligible at all a supplier needs:

- UKAS-accredited ISO 9001:2015 or ISO 13485:2016 certification, or internationally recognised equivalent;
- UKCA marking or CE marking with MHRA registration;
- a Carbon Reduction Plan, sustainability assessments and modern slavery compliance;
- Economic and Financial Standing clearance;
- Cyber Essentials Plus where in scope of PPN 014.

These are hygiene factors that sink bids when discovered late. Hold a live tender calendar mapped to framework expiry dates with compliance evidence pre-assembled, rather than reacting to an ITT. The procurement calendar is published — a framework renewal should never be a surprise.

## 5.5 MedTech Compass and the Innovator Passport

Announced 2 July 2025 under the 10 Year Health Plan, the Innovator Passport addresses suppliers being repeatedly asked for the same data in different formats by different trusts. A technology assessed by one NHS organisation gains recognition across others, removing duplicate compliance checks. It is delivered through MedTech Compass, a DHSC platform where NHS buyers discover, compare and adopt technologies on value rather than price alone, on a submit-once, use-many-times basis.

| Phase | Timing |
|---|---|
| **Alpha — prototype testing; achieved a Green rating** | November 2025 to March 2026 |
| **Beta — approximately 12 months; DHSC expected to issue an ITT** | From summer 2026 |
| **Live rollout** | 2027/28 financial year |

**Access implication.** Compass will become both the shop window and the standardised evidence format for NHS medtech buying. The preparation is data: comprehensive, accurate product data aligned to the five value domains, assembled once and maintained. Teams treating it as an administrative chore will be

outcompeted by those treating it as their primary national evidence asset. The beta through 2026/27 is the window to shape how the category is represented.

## 6. Cross-functional operating model

Working cross-functionally with Medical, Commercial and External Affairs is really four distinct jobs. Treating them as one is the common failure mode.

| Function | Owns | What market access needs from them |
|---|---|---|
| **Medical / MSL** | Clinical evidence; KOL and clinical society relationships; guideline and Modern Service Framework influence; evidence generation plans; real-world data; clinical protocol design | Named clinical champions per account; a clinically credible pathway redesign; evidence tailored to the specific commissioner objection rather than the generic dossier; compliance separation maintained |
| **Commercial / Sales** | Account relationships; usage and revenue; site-level implementation and training; day-to-day intelligence on what is happening in theatre and clinic | Early warning of contract and framework expiry; accurate account intelligence; disciplined follow-through once a funding decision is won — access without pull-through is wasted |
| **External Affairs / Policy** | National and regional policy engagement; DHSC and NHS England relationships; trade association work (ABHI, BHTA); public affairs; consultation responses | Advance sight of policy change; influence on Modern Service Frameworks and NICE topic selection while the window is open; category-level air cover no single account conversation can carry |
| **Market Access** | Funding pathway strategy; value proposition and health economics; pricing and contracting models; business case tooling; tender strategy and delivery; commissioner relationships | The integrating function — the one that turns clinical evidence into a paid-for pathway |

The mechanism that makes it work is a single account plan per priority account, jointly owned, one named owner per action, and a shared decision map. Where it breaks down the cause is usually sequencing: Commercial pushing for usage before a funding route exists, or Medical building evidence that answers a question no commissioner is asking.

### 6.1 Contracting constructs worth having ready

- **Risk-share on outcome:** payment adjusted against an agreed clinical or utilisation endpoint. Fits the outcomes-based direction of travel and de-risks a commissioner who cannot fund uncertainty.
- **Managed service or equipment-as-a-service:** converts capital to revenue, may bring the arrangement under PSR rather than full competitive procurement, and bundles training and implementation — which directly addresses the commonest implementation failure.

- **Volume or cohort-based agreements** tied to a population health segment, speaking the Strategic Commissioning Framework's language directly.
- **Pathway pilots with pre-agreed evaluation and scale-up triggers:** the natural fit with a NICE Early Use Assessment evidence generation plan, turning a conditional recommendation into funded deployment sites.

## 7. Account plan architecture and planning calendar

### 7.1 The six questions

A device account plan that does not answer these six is a contact list, not a plan.

6. **Where does the money come from?** Name the budget — tariff-excluded, pass-through, Better Care Fund pool, provider revenue, capital, specialised commissioning — and the person who controls it.
7. **What problem does this account have that we solve?** From its Oversight Framework segment and failing metrics, its Medium Term Planning Framework trajectory, its waiting list position — in their numbers, not ours.
8. **Who decides, who influences, who blocks?** Clinical champion, clinical director, finance, procurement, ICB commissioner, medicines or technology committee — and, post-merger, which ICB this actually now is.
9. **What is the compliant route to buy?** Existing framework, catalogue listing, tender due when, or a PSR-compliant service option.
10. **What has to change in the pathway?** Referral criteria, workflow, EPR build, training, capacity — and who inside the trust owns each.
11. **What is the evidence and reporting commitment?** What we collect, what we report back, and what that buys us at review.

### 7.2 The nine-step access sequence

Each step is a point of failure. The job is to have pre-solved as many as possible before the first meeting.

| | Step | What has to be true, and who makes it true |
|---|---|---|
| 1 | Regulatory clearance | UKCA or recognised CE mark, MHRA registration, UDI and (for implants) implant card ready. Owner: Regulatory |
| 2 | Evidence position | NICE HealthTech guidance, or a defensible dossier plus an executable economic model. Alignment to a Modern Service Framework, NICE guideline or service specification. Owner: Medical / HEOR |
| 3 | Funding designation | NHAP, MTFM, HCTED or — most often — nothing, meaning a local business case. Determined early; it sets the whole go-to-market shape. Owner: Market Access |

| | Step | What has to be true, and who makes it true |
|---|---|---|
| 4 | Payment mechanism identified | Where the money comes from under the NHS Payment Scheme: tariff-excluded, pass-through, inside an HRG, a Best Practice Tariff uplift, a blended payment variable element, or a BCF pool. Owner: Market Access |
| 5 | Commissioner or provider decision | ICB commissioning intent; trust business case through capital or revenue approval; technology committee; sometimes a regional policy. Owner: Market Access with Medical support |
| 6 | Procurement route secured | On the NHS Supply Chain catalogue or a live framework; or a compliant tender won; or a PSR-compliant service contract. Owner: Market Access / Commercial with tender specialists |
| 7 | Pathway and workflow redesign | Clinical protocol agreed, EPR integration, referral criteria, patient identification, capacity in the right place. Where most approved technologies die. Owner: Medical / field implementation |
| 8 | Clinician and patient adoption | Training, champions, audit, patient information, sustained usage. Owner: Commercial with Medical |
| 9 | Post-adoption evidence | Real-world data feeding evidence generation plans; QART and MTFM reporting; outcome data for risk-share contracts; defence against an Existing Use Assessment. Owner: Medical / Market Access |

**Where launches actually fail:** steps 4, 6 and 7 — payment mechanism, procurement route and pathway redesign. Not at NICE. A team that can only argue clinical benefit is stopped at step 4 every time. Implementation readiness is assessed as seriously as clinical evidence: EPR integration, staff training, framework inclusion and workflow compatibility are frequently decisive.

## 7.3 Planning calendar

| When | What happens | What you do |
|---|---|---|
| **April** | New NHS Payment Scheme, Standard Contract and BCF plans take effect; new financial year; ICB mergers land (2026 and 2027) | Re-base the account map. Confirm which entity now holds each budget and which contacts survived |
| **June–July** | NHS Oversight Framework published; segmentation and league tables go live | Re-read every account's failing metrics. Re-prioritise the territory on that basis |
| **Summer** | NHS Supply Chain and regional collaborative tender activity; MedTech Compass beta running through 2026/27 | Pre-market engagement on anything due. Maintain the Compass data set |

| When | What happens | What you do |
|---|---|---|
| **September–October** | Medium-term planning and priorities set; ICB five-year plan development | Get the technology named in local plan development, where clinical relationships allow |
| **October–December** | NHS Payment Scheme consultation; Standard Contract consultation | Respond, directly or through ABHI / BHTA. This is the window to argue for tariff treatment of the category |
| **January** | Standard Contract published (28 January in 2026); ICB strategies and needs assessments finalised | Read the changes for anything that shifts provider obligations on your category |
| **February–March** | Contract round; Investment and Activity Plans agreed; BCF plan sign-off; financial year-end | Business cases must already be in. Anything landing now waits a year |
| **Rolling** | NICE HealthTech topic selection; Find a Tender notices; framework expiry dates | Standing watch. Topic selection influence is the cheapest leverage available |

## 8. Objections and the answer shape

The eight objections below account for most of what a device market access team hears. In each case the stated objection is not usually the real one.

| What they say | What they mean | The answer shape |
|---|---|---|
| **"NICE has approved it, so why isn't it funded?" — said by your own commercial team** | The team has imported pharmaceutical logic | Correct it early and internally. HealthTech guidance carries no statutory funding requirement. Re-set the internal forecast and the resourcing on that basis before it becomes a credibility problem in the field |
| **"There's no budget for this"** | There is no identified budget, and I am not going to go looking for one | Do the locating yourself. Name the budget line, the payment mechanism and the approval route, and bring the business case pre-populated with their own activity data. Thin ICB and trust teams have no capacity to build it for you |
| **"It adds cost to the procedure"** | It sits inside an HRG that is frozen while I carry a 2% efficiency factor | Move the argument off unit cost. Either get outside the tariff, or show the device enables a better-paying currency — day case, straight-to-test, right procedure right place — or land the saving in length of stay, readmission or theatre throughput with evidence |

| What they say | What they mean | The answer shape |
|---|---|---|
| **"We'd have to change the pathway"** | This is a workload and workforce problem, not a product problem | Arrive with the redesign done: protocol, referral criteria, patient identification, EPR build, training plan, and a named owner for each. This is step 7, and it is where most approved technologies die |
| **"Procurement won't let us buy it"** | You are not on a compliant route to market | Know the route before the meeting: catalogue listing, live framework, framework expiry date, or a PSR-compliant service structure. If there is genuinely no route, say so and give the realistic timeline rather than pressing |
| **"Show me it works in our population"** | I do not believe the trial population resembles mine | Real-world data against an established baseline, ideally from a comparable segment or a neighbouring trust. This is also the argument for accepting an evidence generation commitment as part of the deal |
| **"We already use a competitor product"** | Switching cost is real and I have no reason to absorb it | Look for the Existing Use Assessment angle and the framework renewal date. Switching rarely happens between tenders; the work is to shape the specification before the next one |
| **"We can't integrate it with the EPR"** | This will fail at implementation and I will own that failure | Treat integration as a gating requirement, not a feature. The Medium Term Planning Framework mandates 100% EPR coverage and full Federated Data Platform onboarding — a technology that cannot integrate is now failing a stated national requirement |

## Not advice — a map.

*Compiled 16 September 2026. Curated AI Research, Healthcare Acumen Ltd. Every material claim is traced to a primary source and linked below. Framing and judgement are the author's.*

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