



April 2026 | NHS Commissioning & Market Access | growth-iq.group

ICB mergers, NHS England abolished will any of it actually fix capacity?

Next week, 42 NHS Integrated Care Boards become 26. The abolition of NHS England itself, underway since March 2025, will reach completion by early 2027. The government's logic is sound: less bureaucracy, more frontline care. But the NHS's single most pressing problem is not bureaucracy. It is capacity.

7.25m elective waiting list	100k unfilled NHS posts	-550 fewer GPs vs 2015	42 min avg ambulance wait (target: 18 min)
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01 THE CAPACITY PICTURE

The numbers stated plainly

The elective waiting list stood at 7.25 million cases in January 2026, representing around 6.13 million individual patients. The 18-week treatment target has not been met since 2016. There were 550 fewer fully qualified full-time GPs in England in January 2026 than in 2015 despite the patient population growing by 14.2% over the same period. A single full-time GP is now responsible on average for 2,214 patients.

There are roughly 100,000 unfilled posts across the NHS, with vacancy rates highest in mental health (9%) and community services (7%). England has 3.2 doctors per 1,000 people against an

OECD EU average of 3.9 and Germany's 4.5. To match the OECD EU average, England would need 40,000 more doctors.

The cardiovascular waiting list rose 82% over the first half of this decade, reaching 421,683. Average ambulance response times for heart attacks and strokes have reached 42 minutes against an 18-minute target. In the year to March 2025, nearly 152,000 people left active NHS service: significantly more than the 15,577 who left a decade earlier.

"This is a system under structural strain that predates COVID-19, was worsened by it, and has not recovered. It is the dominant reality for any pharma or med-tech company trying to get a product used, embedded, and sustained in NHS clinical pathways."

02 WILL THE REORGANISATION HELP?

The case for and against

The case for	The case against
• ~£500m/yr in running costs freed for frontline care • Less commissioning duplication across fewer ICBs • Larger bodies = stronger analytical capacity • More consistent adoption of new pathways in theory	• Reorganisation consumes the capacity it promises to free • Institutional knowledge leaves with merging teams • ICBs still absorbing the 2022 CCG transition • Reform and waiting list reduction may pull in opposite directions

The case against is more substantial. Reorganisation consumes exactly the clinical and management capacity it promises to free up. Merging organisations lose institutional knowledge. The people who understood local provider relationships, commissioning history and population health data leave or are redeployed.

The Health Foundation noted in 2025 that ICBs are in many cases still dealing with the transition from their forerunners Clinical Commissioning Groups, which were only replaced in 2022 and the evidence that successive versions of NHS commissioning have had a significant impact on patient outcomes is limited.

"The NHS Confederation was direct: the transition for ICBs should support and not hinder their focus on delivering the 10 Year Health Plan. The word 'should' is doing a lot of work in that sentence."

The Institute for Government's Performance Tracker 2025 drew an uncomfortable parallel. The focus on elective waiting times risks drawing political attention and resource back toward hospitals

working directly against the stated ambition to shift care into the community. The reorganisation and the reform agenda may be pulling in opposite directions at the same time.

03 THE STRUCTURAL PROBLEM BENEATH THE REFORM

You cannot commission your way to more anaesthetists

The capacity crisis is not primarily a commissioning problem. It is a workforce problem, a capital problem, and to some extent a social care problem.

The Royal College of Anaesthetists reported in 2025 that 89% of clinical leaders managing anaesthetic departments say elective surgery is being delayed because of a shortage of anaesthetists with 43% saying this happens daily or weekly. The shortfall has grown from 1,483 in 2020 to 2,147 in 2025. Almost nine in ten small cancer centres had consultant vacancies unfilled for 12 months or more.

Nor can you commission your way around blocked hospital beds. General and acute bed occupancy has been consistently above 90% since September 2021. The primary reason patients remain in hospital beyond clinical need is the absence of social care capacity to support discharge a local authority funding problem, not an ICB design problem.

And you cannot reorganise the NHS into having more GPs in the short term. The Long Term Workforce Plan committed to doubling medical school places to 15,000 per year by 2031. The first of those additional doctors will not be in post, trained and ready, until the mid-2030s at the earliest. The workforce decisions being made now or not made now will determine NHS capacity a decade hence.

04 WHAT THIS MEANS IN PRACTICE

Challenge and opportunity simultaneously

THE CHALLENGE

A system under this kind of pressure defaults to the familiar. Products that require additional clinical time to prescribe, initiate, administer or monitor face a structural headwind that no amount of clinical data resolves on its own. NICE approval does not equal patient access. It never has. The gap between a positive recommendation and actual clinical use at Trust and ICB level is where the majority of products stall and that gap tends to widen during reorganisation as commissioning relationships reset.

THE OPPORTUNITY

Commissioners under pressure are, in theory, highly receptive to products and services that demonstrably free up clinical capacity, reduce avoidable admissions, shift workload out of secondary care, or enable earlier diagnosis. The value proposition that speaks to released workforce capacity rather than clinical features alone — is not a nice-to-have in this environment. It is the difference between getting funded and not.

The ICB mergers and the abolition of NHS England will not fix NHS capacity in any meaningful timeframe. The workforce pipeline is a decade-long problem. The social care crisis is structural and underfunded. The capital deficit is real.

What the reorganisation may do, over time, is create fewer, more strategically capable commissioners who are better positioned to make consistent, system-level decisions rather than incremental local ones. The companies that will benefit from that shift are the ones that understand the new commissioning geography, have built the right relationships in the right new organisations, and can present their product as a genuine solution to the pressures commissioners are actually facing not the pressures they faced three years ago.

Next week the map changes. April 2027 it changes again. The capacity crisis will still be there when both reorganisations are complete. That is the environment your commercial strategy needs to be built for.

Growth-iQ works with pharma and med-tech teams on market access strategy, service design and value proposition development in the NHS.

If this is landing at a difficult time for your brand, it is worth a conversation.

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