



April 2026 | NHS Commercial Strategy | growth-iq.group

The NHS will not be fixed in this parliament. What does that mean for your commercial strategy?

Over the past four weeks we have covered a lot of ground commissioning restructure, population health, condition-by-condition data. This week's question is the one that follows from all three: what is the commercially intelligent response to a system that will remain under severe pressure for longer than most product planning cycles?

THE SERIES SO FAR

Week 1	42 ICBs became 26. Structural reset not a fix for capacity.
Week 2	Gyms, smoking, GLP-1s. Working but not for the people driving NHS demand.
Week 3	Condition by condition. CVD reversing. Cancer diagnosis stalled. Mental health overwhelmed.

The question that follows from all three is this:

If the NHS is not going to be fixed quickly and it is not what should a pharma or med-tech company actually do in an environment where the system it is trying to sell into will remain under severe pressure for longer than most product planning cycles?

Not who is to blame. Not which plan will eventually work. The answer starts with understanding who needs to change what, and why none of them are moving fast enough.

01 THE GOVERNMENT

Is it funding the change it is asking for?

For pharma and med-tech: if the government is not adequately funding the shift to prevention and community care which commissioning decisions actually have budget behind them, and which are aspirational?

The government's structural logic is sound. NHS England and DHSC combined doubled their headcount since 2010. ICBs were created in 2022 and immediately asked to cut their running costs by 30%, then 50%. The bureaucratic case for reorganisation is real.

But structural reform is not the same as capacity. NHS spending will grow by 2.8% in real terms annually between 2025 and 2029. The historic average required to maintain a stable service is 3.7%. The 10-Year Plan is a serious strategic document. It was not accompanied by a specific implementation plan, a new workforce plan, or a capital settlement adequate to deliver its ambitions.

"The NHS 10-Year Plan commits to neighbourhood health, prevention, community-based care and digital transformation. The funding flowing into them right now, in the financial year you are trying to close, is far more constrained than the policy language suggests."

Knowing the difference between where policy rhetoric leads and where commissioning budgets actually follow is not a minor operational detail. It is the foundation of a market access strategy that works.

02 THE NHS

Are ways of working the real constraint?

For pharma and med-tech: if variation in NHS performance is explained more by ways of working than by resources what does that mean for how you choose your early adopter sites?

The NHS is not a passive victim of underfunding. It is the largest employer in England, with 1.5 million staff, and an institution that has absorbed decades of reform mandates without consistently changing how it operates at the front line.

The Further Faster 20 programme deployed specialist teams into the 20 NHS trusts with the highest economic inactivity. Over 12 months, waiting lists in those trusts fell three times faster than the national average, and more than five times faster for working-age adults. The resources were broadly the same. The ways of working changed.

Online appointment adoption across general practice varies from 33.5% at the most digitally progressive practices to effectively zero at others with no obvious correlation to resource or population profile. Over a million GP appointments a month go unattended without cancellation: the equivalent of over 2,300 full-time GP salaries lost annually to non-attendance.

"The best-performing NHS systems are not the best-funded. They are the ones with the clearest leadership, the strongest clinical engagement, and the least institutional resistance to doing things differently."

Identifying those systems and building your early adopter strategy around them rather than around geography or population size is one of the highest-value things a market access team can do.

03 THE PUBLIC

Is prevention a realistic ask without structural support?

For pharma and med-tech: if the populations driving the greatest NHS burden are the least likely to be reached by prevention programmes whose job is it to close that gap, and is your product positioned to help?

Long-term conditions affect around 15 million people in England. They account for 70% of acute and primary care budgets, 70% of hospital bed days and 50% of all GP appointments. Many of those conditions are driven by factors that are structurally shaped as much as they are individually chosen food environments, sedentary work, housing quality, financial stress.

But the data is also clear that the people most at risk are the least likely to be reached by the interventions that exist. The gym boom has not reduced obesity. The NHS Diabetes Prevention Programme works well for people who engage with it. Smoking rates in the most deprived communities remain nearly double those in the least deprived, despite twenty years of national progress.

Products that are designed for and can demonstrate outcomes in the populations the NHS is actually most concerned about: older adults, deprived communities, people with multiple long-term conditions. These are not just clinically important. They are strategically aligned with where commissioning pressure is heading.

"The Core20PLUS5 framework is not a compliance exercise. It is a signal about where NHS decision-makers believe they have both the greatest unmet need and the greatest obligation to spend."

Is the industry making it easy enough?

For pharma and med-tech: does your product make the NHS's job easier or harder and can you prove it?

The life sciences industry has a consistent habit of presenting innovation as the solution to NHS capacity pressures while designing products and commercial models that place additional demands on a workforce already at its limit. Every medicine that requires specialist initiation, hospital-based administration, complex monitoring or multi-step pathway management adds to the burden of a system that has 100,000 unfilled posts, 7.25 million people on waiting lists and bed occupancy consistently above 90%.

That is not an argument against innovation. It is an argument for building deploy ability into how innovation is designed and positioned from the start rather than retrofitting a capacity argument onto a clinical data package that was never built around it.

From April 2026, NICE's technology appraisal process expands to cover medical devices and diagnostics creating for the first time a mandated funding pathway for medtech that mirrors the one medicines have had for twenty-five years. The Life Sciences Sector Plan sets a target for the UK to become one of the three fastest places in Europe for patient access by 2030.

"The products that will gain ground are not necessarily the ones with the strongest clinical data packages. They are the ones whose evidence is accompanied by a credible, quantified answer to the question every commissioner will ask: does this free up clinical time or consume it?"

Released nurse hours, avoided A&E attendances, reduced outpatient follow-up, earlier community-based diagnosis these are not supplementary commercial arguments. In the current NHS environment, they are the primary ones.

The four parties and the question each needs to answer

Government	<i>Funding what it's asking for?</i>	2.8% real-terms growth vs 3.7% historic average. No implementation plan. No new workforce plan.
The NHS	<i>Closing the variation gap?</i>	Further Faster 20 cut waiting lists 3× faster with the same resources. The best systems lead differently they don't spend differently.
The Public	<i>Prevention without structural support?</i>	Long-term conditions = 70% of NHS budgets. But the people most at risk are least reached by the interventions that exist.

Industry	<i>Designing for the NHS that exists?</i>	100k unfilled posts. 7.25m on waiting lists. 90%+ bed occupancy. Does your product free up clinical time or consume it?
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So what is the commercially intelligent response?

Not waiting for the system to sort itself out. It will not quickly, and not on a timescale that maps onto most commercial planning horizons.

The four parties each need to move. Governments need to fund what they are asking for. The NHS needs to close the variation gap between its best and the rest. The public needs a genuine, structural conversation about prevention that goes beyond lifestyle messaging. And industry needs to stop designing for the NHS it wishes existed and start designing for the one that does.

Of those four, only one is in this room.

The companies that navigate the next five years well in the NHS will not be the ones with the largest field forces or the most complete clinical dossiers. They will be the ones that understood the environment clearly, positioned their products as solutions to the pressures commissioners are actually facing, and built the commercial infrastructure to deliver on that positioning at the point of care.

Growth-iQ works with pharma and med-tech teams on exactly that.
Market access strategy, value proposition development, service design and implementation support built around the NHS as it actually is. If that conversation is where your brand needs to be right now, it is worth starting.
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