Silly RULES

Breaking the Rules for Better Care

Wales National Report

February 2026

Comisiwn Bevan Commission

LLAIS
Eich llais mewn iechyd a gofal cymdeithasol | Your voice in health and social care

Institute *for* Healthcare Improvement

Contents

The charts and graphs herein were made with Flourish

Introduction

Like many nations across the world, Wales is experiencing growing pressures across its health and care system, ranging from rising demand to workforce strain. At the same time, the way the system is organised can make it harder for staff to deliver care effectively, and for service users to access care in a way that feels timely, coordinated and responsive to their needs. Yet these challenges, albeit deep-rooted and complex, also create an opportunity to re-think how we can be more prudent and coordinate our capacity and resources to achieve a more sustainable and effective model of care.

Processes, policies and approval layers that once served a clear purpose have, in some cases, become rigid or outdated. Deeply embedded beliefs and behaviours, shaped by an earlier model of care and health needs, still influence current practice. At the same time, new rules and procedures are continually being introduced – often with good intentions, but without assessing the unintended consequences they create across the system. Together, this complex web of rules, habits and norms creates unnecessary friction in everyday practice, leading to wasted time, resources and frustration, alongside missed opportunities to improve how care is best delivered.

Estimates suggest that between 20–30% of all resources invested into healthcare systems are lost to waste,[1] with a large proportion of this attributed to inefficient processes, rather than clinical activity. Anecdotally, many health and care staff admit to bending rules if it means doing the right thing for those in their care. Evidence shows such 'workarounds' are widespread,[2] and services no doubt rely on this quiet flexibility to keep care moving, even though it might be individuals ultimately held responsible if things go wrong.

Tackling unnecessary bureaucracy, duplication and friction in daily practice therefore presents a significant opportunity to reduce the need for such workarounds in the first place. By simplifying processes and removing low-value rules, we can release capacity back into the system, improve efficiency and productivity, and support staff to deliver care without having to navigate avoidable obstacles. Ultimately, this strengthens both staff experience and the quality, safety and timeliness of care for service users.

This recognition is echoed across national policy. Welsh strategies have repeatedly acknowledged that excessive bureaucracy, fragmented governance and duplicated processes can absorb vital time, energy and resources that should be focused on care.

1 Berwick DM & Hackbarth AD (2012). Eliminating waste in US health care. JAMA.
2 Clark D., et al. (2025) Do healthcare professionals work around safety standards, and should we be worried? A scoping review. BMJ Quality & Safety.

Welsh Policy Alignment on Tackling Waste, Improving Efficiency and Streamlining Governance

Report by the Ministerial Advisory Group on NHS Wales Performance & Productivity

Welsh Government / MAG (2025)

Identifies *"a significant challenge in performance and in productivity"* across NHS Wales and emphasises that improved performance depends on "better operational management, reduced duplication and improved use of data." It sets out a series of recommendations aimed at streamlining governance and enabling efficiency including a call to develop a "total factor productivity model and workforce productivity model" to better understand where time, effort and resources are lost within the system.

Health and Social Care (Quality and Engagement) (Wales) Act

Welsh Government (2020)

Established a legal *duty of quality* across NHS Wales, requiring organisations to *"exercise their functions with a view to improving the quality of health services."* Defines quality as *"safe, effective, person-centred, timely, efficient and equitable care,"* embedding proportionate, transparent governance focused on learning and improvement rather than compliance-driven processes.

A Healthier Wales: Our Plan for Health and Social Care

Welsh Government (2018)

Calls for joined-up, preventative, and efficient systems. It states that *"services from different providers should be seamlessly co-ordinated."* This vision positions simplification, integration, and shared accountability as essential levers for sustainable improvement.

Prudent Healthcare Principles

Welsh Government / Bevan Commission (2016)

Form the foundation of Wales' prudent, value-based approach to care. Encourage systems and practitioners to *"do only what is needed, no more, no less; and do no harm,"* highlighting the importance of removing waste, duplication and unnecessary complexity. The framework argues that prudent use of resources must extend to governance, planning, and assurance as well as clinical activity.

Well-being of Future Generations (Wales) Act
Welsh Government (2015)
Defines sustainable development as *"the process of improving the economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals."* It commits public bodies to long-term, integrated and proportionate governance, ensuring that actions taken today do not compromise the needs of future generations.

The Bevan Commission and Llais' *Silly Rules* initiative was Inspired by the Institute for Healthcare Improvement (IHI) global leaders in health and care improvement original *Breaking the Rules for Better Care* campaign. Building upon the Bevan Commission's Prudent Healthcare work and Let's Not Waste and *Conversation with the Public* programmes, the aim was to identify Wales' *Silly Rules*: barriers that contribute little or no value to care, impede the work of clinicians, frustrate patients and families, and waste time and resources[3]. In partnership with the IHI and local health boards, we put one single and open question to the people of Wales:

If you could break or change any rule(s) to provide a better care experience for patients, families, or staff in Wales, what would it be?

We invited people from all walks of life, patients, service users, carers, families, clinicians, managers, and volunteers, to share their lived experiences of rules, routines, and practices that they felt get in the way of good quality care. In this report, we present what we heard from the people of Wales, the themes that emerged, and the opportunities for positive change they highlight.

Despite the name, *Silly Rules* is not about trivial irritations, nor is it intended to be a finger-pointing exercise. It is about surfacing opportunities for health and care services in Wales to unlock capacity, and reduce waste, redirecting scarce resources to where they could make the greatest difference.

3 Berwick, D. M., Loehrer, S., & Gunther-Murphy, C. (2017). Breaking the rules for better care. JAMA, 317(21), 2161-2162.

The Essence of *Silly Rules*: the 'Bicycle Book'

The IHI's original campaign illustrated its point through a striking story from an English hospital: for decades, staff who cycled to work were required to sign the 'bicycle book', a process first introduced during World War II when cyclists received extra food rations. Over time, the original reason was forgotten, but the practice was never questioned or challenged. Long after rationing ended, the books continued to be filled in, archived, and stored, a ritual that served no purpose other than consuming time and capacity. This story captures the essence of the *Silly Rules* initiative: practices that once made sense, but which now linger on, unchallenged, frustrating staff and wasting effort and resources.

The *Silly Rules* initiative is a practical contribution to the broader transformation Wales needs: releasing capacity, improving experiences, and enabling a system where people and communities can thrive, in alignment with the Bevan Commission's *Four Foundations for the Future of Health and Care*:

1. **Resilient and Resourceful People and Communities**
   Removing barriers empowers patients, carers, and families to navigate services more easily and take greater ownership of their care.

2. **Prudent, Integrated and Equally Well Care**
   Tackling duplication, siloed systems, and unnecessary rules supports more seamless integration and ensures resources are used where they add greatest value.

3. **Sustainable Workforce, Services and Systems**
   Freeing staff from low-value bureaucracy reduces frustration, protects morale, and allows more time for direct care – critical for workforce retention and sustainability.

4. **Dynamic, Innovative and Transformational Culture**
   Inviting the workforce and the public to challenge unnecessary practices, *Silly Rules* helps build a culture of innovation, learning, and continuous improvement.

What we did: *Listening and Learning*

The Bevan Commission and Llais designed an open and collaborative process to uncover Wales' *Silly Rules,* engaging the public and the health and social care workforce to share their perspectives and real-world experiences of 'rules' or processes that don't always serve people well. By listening to those who deliver and receive care, we identified how processes shape everyday practice, and where positive change could make the biggest difference.

What we asked: *A Simple Question*

At the heart of the campaign was a bilingual survey (in Welsh or English), available online, in print, and in easy-read versions to ensure maximum accessibility. It centred on a simple, open-ended question that invited people to share which rules or practices they would change to make health and social care services better for patients, families, and staff in Wales. To help interpret responses in context, participants were also asked whether they were a) responding as a member of the public or the workforce, b) referring to health, social care, or both, and c) to provide a few basic details such as location, gender, organisation, and role.

How we Spread the Word: *from Cardiff to Caernarfon; Families to Frontline Staff*

Silly Rules was promoted through the established networks of the Bevan Commission and Llais, with promotional packs distributed across health and care settings nationwide. Health boards shared the campaign internally through communication cascades, newsletters, and intranets, while the Welsh Government, universities, and professional bodies helped extend its reach.

Beyond health, social care and the voluntary sector, partners carried the message to frontline teams and communities. Posters, flyers, and QR codes made it easy to take part, supported by a multi-partner social media campaign that amplified the conversation nationally.

Between November 2024 and March 2025, the survey drew hundreds of responses from across Wales, reflecting a broad mix of staff, patients, carers, and families.

How we Made Sense of What we Heard

To make sense of what people told us, we analysed the responses systematically to identify patterns, themes, and insights. The methodological approach followed for this work is listed overleaf.

Figure 1: Public Poster

Complicated Communication

Complicated or out of date ways of communicating.

Test results cannot be sent by email - they are only available by post.

Pointless Paperwork

Filling in forms that seem to waste time.

You have to fill out the same health questionnaire at every visit even when your details haven't changed.

Annoying Approval

Needing permission for simple tasks.

You need to wait for GP referrals to access basic services, leading to delays in treatment.

Silent Standards

Unspoken social rules causing you worry.

You don't want to ask questions in case you seem difficult.

Silly Schedules

Difficult timetables.

You get letters for early morning appointments at hospitals far from home, causing you to travel long distances during rush hour.

Strange Systems

Ways of working that make things difficult.

To book a physiotherapy session,
you must first visit your GP for a referral, then call lots of different
departments to find available slots.

Ridiculous Rules

Rules that don't make sense.

Rules that make seeing a specialist difficult, even for conditions where direct access would
speed up care.

1. **Data Compilation.**
   All survey formats (Welsh, English, online, paper, easy read) were merged into a single dataset for analysis.

2. **Subset Review.**
   The dataset was divided into smaller batches and reviewed independently by researchers to identify recurring topics and emerging themes.

3. **Theme Development.**
   The team came together to agree a framework of ten core themes, reflecting the breadth of responses and aligning with national challenges.

4. **Thematic Coding.**
   Each response was coded against one or more core theme. Overlap between researchers was built in deliberately to check for consistency, with differences resolved collectively.

5. **Validation.**
   We engaged with health & care organisations and focus groups of medical professionals to clarify whether each "rule" was a) a national policy, b) a local rule, or c) not actually a rule but a myth or custom (like the "bicycle book").

6. **Synthesis & Interpretation.**
   Our analysis helped produce a picture of how *Silly Rules* shape daily experiences and get in the way of good care. Our findings are presented herein.

What we Found

Who Took Part

In total, we received 784 responses from people across Wales. When the submissions were analysed (Fig. 1), healthcare staff represented the largest group of contributors (498; ~64%), followed by members of the public (206; ~26%) and social care staff (31; ~4%). A small number of respondents didn't specify their origin. Because the number of social care submissions was relatively small, all references to "workforce" or "staff" throughout this report should be read as referring collectively to both health and care staff, unless otherwise stated.

Most respondents identified as females (564; ~72%), nearly three times the number identifying as males (195; ~25%). Around 1% identified as non-binary and ~1% did not state their gender (Fig. 2). These proportions were broadly similar across healthcare staff, social care staff, and members of the public They also broadly mirror gender distributions within the health and social care workforce in Wales, where women make up the majority of staff, as well as wider population patterns in which women are often overrepresented among survey respondents.[4,5,6,7]

4 Social Care Wales (2024). Social Care Delivery Plan 2024–2027. Cardiff: Social Care Wales. Available at: https://socialcare.wales/about-us/workforce-strategy/social-care-delivery-plan-2024-to-2027.

5 Welsh Government (2024). Staff directly employed by the NHS: at 30 September 2024. Cardiff: Welsh Government. Available at: https://www.gov.wales/staff-directly-employed-nhs-30-september-2024-html.

6 Becker, R. (2022). Gender and Survey Participation: An Event History Analysis of the Gender Effects of Survey Participation in a Probability-based Multi-wave Panel Study with a Sequential Mixed-mode Design.

7 Smith, William. (2008). Does Gender Influence Online Survey Participation? A Record-Linkage Analysis of University Faculty Online Survey Response Behavior.

Figure 2: In what capacity are you answering this survey?

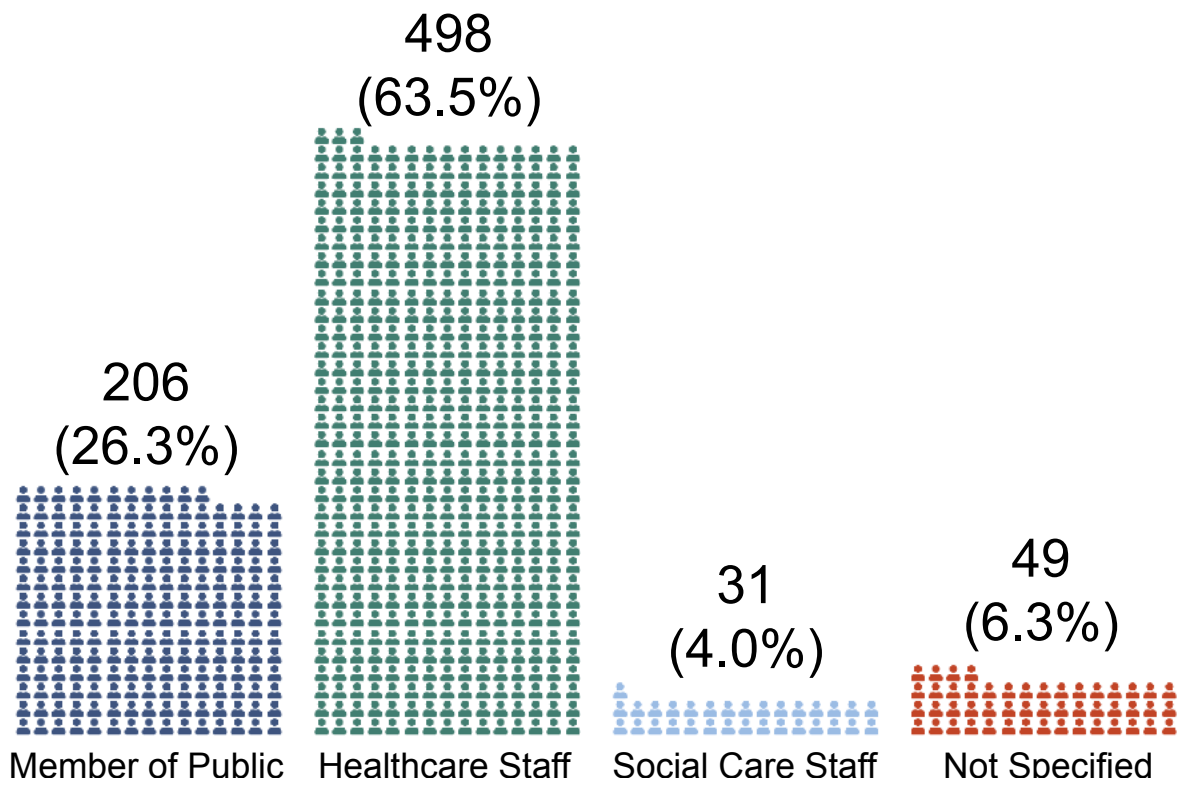
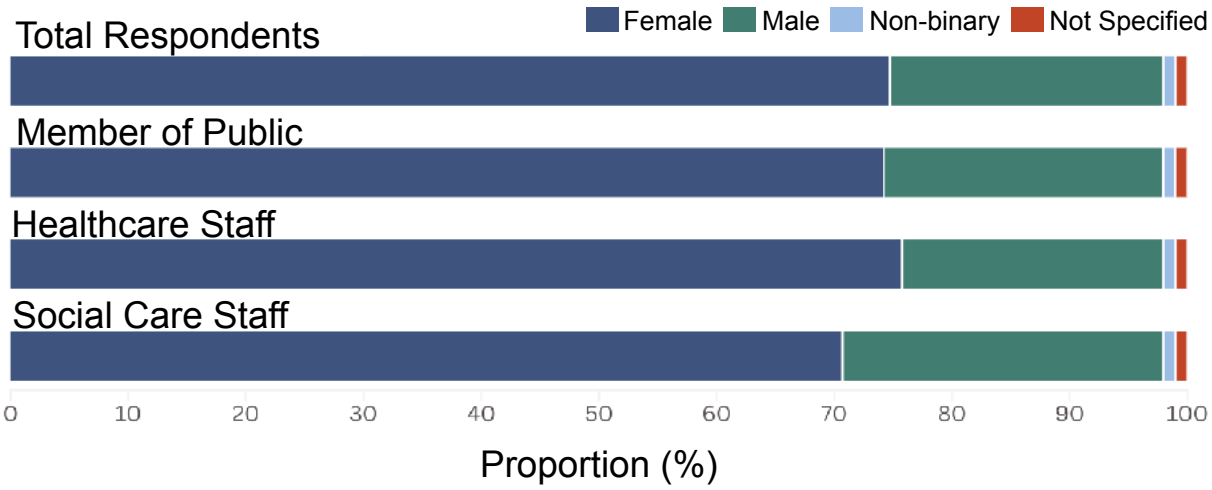


Figure 3: Gender of respondents



What the 'Rules' Related to and Where They Came From

Most responses (531; 68%) related specifically to healthcare services, while a smaller number (22; 3%) referred only to social care (Fig. 3). A further 179 submissions (23%) highlighted issues that cut across both health and social care.

We heard from people in every corner of Wales. For submissions relating to healthcare or across both services, we mapped these to individual health boards (Fig. 4) ranging from 131 in Betsi Cadwaladr to 18 in Powys. A further 53 respondents listed their location as 'Wales'. Because only a small number of responses related solely to social care, these were not mapped to local authority or organisation.

Figure 4: "The rule above is in relation to..."

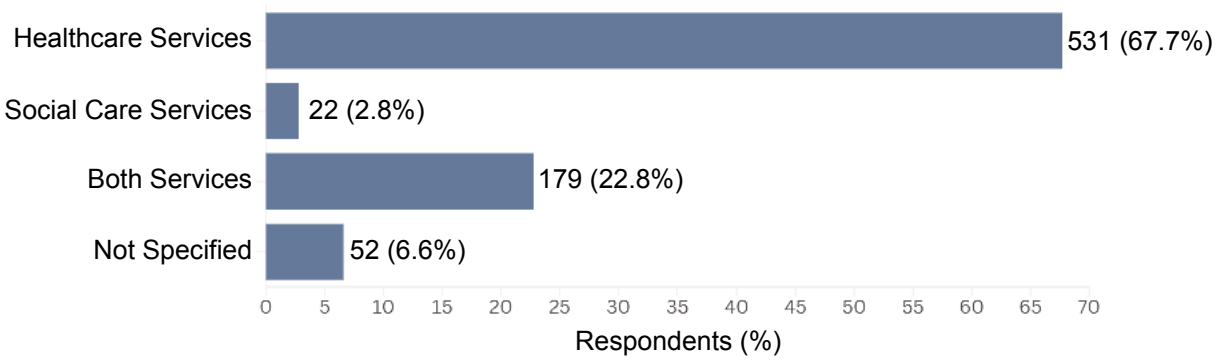
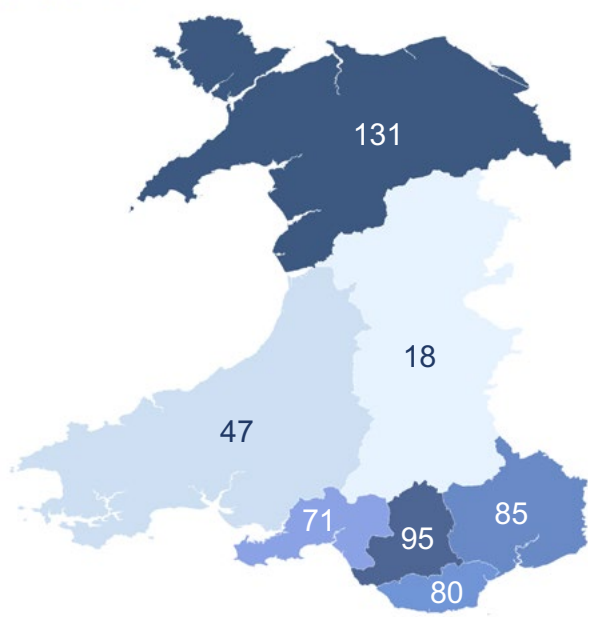


Figure 5: Responses relating to individual health boards



What People Told Us

Once the survey closed, we analysed the submissions and identified ten core themes that reflected the primary origins of 'rules' detailed in the submissions, providing a framework upon which to thematically code each against. These themes were as follows:

Clinical Services.
Primarily concerns direct clinical care, patient pathways, clinical decision-making, or diagnosis and treatment access.

Operations & Service Delivery.
How services are run, efficiency, capacity, or process flows.

Workforce & HR.
Staff management, workforce policy, or Human Resource processes.

Finance & Procurement.
Rules concerning budgets, procurement process, financial constraints, or economic incentives.

Digital & Information.
Digital systems (including logins, interoperability, access), electronic records, or information flows.

Quality & Patient Safety.
Patient safety, quality metrics, risk management, or care outcomes.

Strategic Planning & Transformation.
Long-term change, redesign, or system-wide innovation.

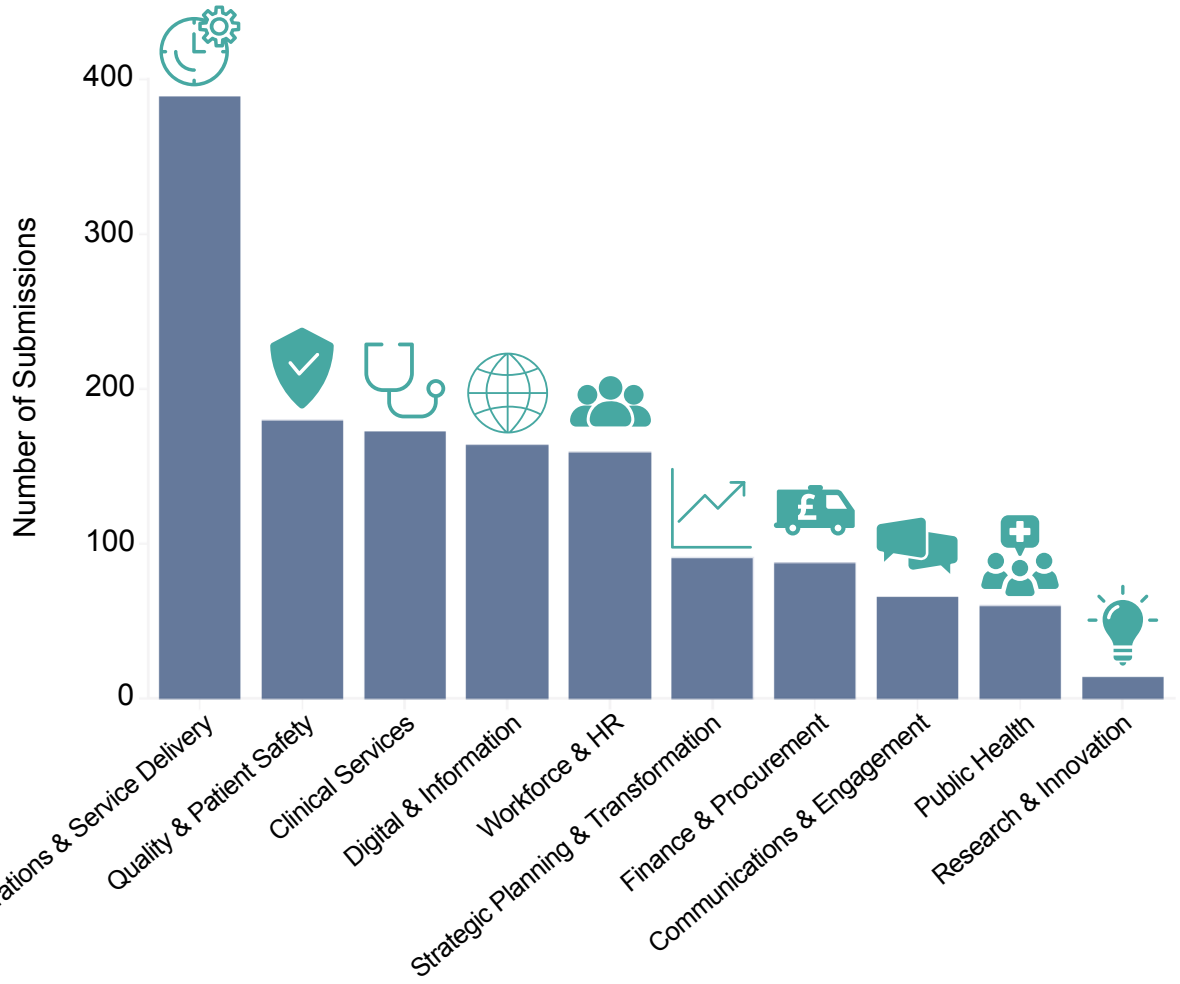
Public Health.
Health promotion, prevention, or equity across populations.

Communications & Engagement.
Communication processes, information provision, or stakeholder engagement.

Research & Innovation.
Research participation, evaluation, innovation funding, or spread of new practices.

When we coded submissions to each of these core themes, the most commonly cited theme was "Operations & Service Delivery" (389 submissions; 48%), nearly double the next most frequently cited theme.

Figure 6: Thematic analysis



This was followed by "Quality & Patient Safety" with 180 submissions (22%), and "Clinical Services" (173; 21%). Other commonly cited themes included "Digital & Information" (164; 20%), "Workforce & HR" (159; 19%), and "Strategic Planning & Transformation" (91; 11%). Less frequently referenced were "Finance & Procurement" (88; 11%), "Communications & Engagement" (66; 8%), "Public Health" (60; 7%) and lastly "Research & Innovation", which featured in only 14 submissions (2%).

It is important to note however, that due to the cross-cutting nature of the responses, any submission could be coded against more than one theme. Doing so allowed us to provide a more accurate depiction of responses.

Theme 1
Operations and Service Delivery

Operations and Service Delivery encompassed nearly half of all submissions (48% of workforce; 43% of public) , the clearest reflection of where process and procedure most often obstruct good care. This theme captures the everyday mechanics of the health and care system: how appointments are booked, patients are moved, and information flows between teams. Respondents described inefficient rules and duplicated tasks that drain capacity, frustrate staff, and slow access to care. Taken together, these examples expose a service in which bureaucracy and risk-aversion often eclipse common sense and good intent.

Administrative burden and workflow inefficiencies: Paperwork, approval chains and duplicated reporting were described as taking time away from clinical care and slowing decision-making. Some staff felt many rules were designed to control risk rather than support effective work.

> *"It would be good to have the ability to make decisions, get on with work and do things without always having to go through lengthy sign-off processes."*
>
> *"Too many digital systems that don't link together which hugely impacts service provision."*

Booking and appointment delays: Rigid or outdated booking systems were described as everyday barriers that ration access and create frustration. Inflexible routes, limited contact options and rules that prioritise process over need made it harder for people to obtain timely support.

> *"I was told I'd need to telephone to book an appointment even though I was stood in front of the receptionist."*
>
> *"Having to call at 8.00 am to make an appointment."*

Integrated pathways and referral barriers: Many respondents described having to repeat paperwork, assessments or referrals because services do not communicate effectively. Fragmentation between primary, community and secondary care created delays, duplicated tasks and reduced continuity.

> *"Continuing health care bureaucracy. Pathways of care delay data reporting."*
>
> *"The invisible border between primary care and other types of care in the NHS."*
>
> *"The need for full referral paperwork between physio and OT services."*

Accessibility and transport barriers: People described practical access challenges, including reliance on postal systems, lack of digital alternatives and rules that restrict the use of remote advice. These barriers disproportionately affect those with mobility, transport or communication needs.

> *"… The appointment had to be carried out in Brecon Hospital rather than my local GP surgery … It meant travelling 30 minutes and due to my own health condition I cannot drive. There wasn't suitable public transport … "*
>
> *"… dragging people 60 mile round trip … having to then wait to talk to someone for 5 mins is a waste of everyone's time and money … "*

Hospital and community support gaps: Discharge processes, access to community rehabilitation teams and hand-offs between acute and community services created delays that prolonged hospital stays or led to people remaining in the wrong setting for longer than necessary.

> *"Patients have to wait in hospital for CRT start dates before they can go home."*

Case study 1 – The Six-Hour Incident Report

A ward manager described spending six hours completing paperwork, meetings and assurance panels after a minor incident:

"When an incident occurs on the ward (falls, PU), a ward manager wastes 6 hours … attending meetings, gathering information, scrutiny panels, filling out a DATIX incident report that is massive."

Across NHS Wales, more than 100,000 patient-safety incidents are reported each year, roughly one for every seven patient admissions (Welsh Government, National Incident Reporting Framework Statistics, 2023). If even half involve a similar six-hour administrative process, that equates to about 300,000 staff hours spent on reporting and assurance activity.

Using an Agenda for Change Band 6 mid-point cost of £30 per hour including on-costs (NHS England, National Cost Collection Guidance, 2023), this represents a productivity cost of around £9 million annually across Wales. If processes were redesigned to save just one hour per incident, the system could recover over 100,000 staff hours, the equivalent of 60 full-time nurses or approximately £3 million in workforce capacity (Health Foundation, Productivity in the NHS, 2024). Streamlining incident review to focus on learning rather than repetition would maintain accountability while returning valuable clinical time to patient care.

Case Study 2 - Automatic Ambulance Dispatch for any Chest-pain Calls

"Unwritten rule and practice of sending ambulances to all chest pains from NHS111 originating calls"

In some NHS 111 pathways, submissions suggest that any mention of chest pain triggers an automatic 999 ambulance response, even without red-flag symptoms.

If we assume ten such calls a day per health board, each taking 1.5–2.5 hours of crew time and costing £292 per dispatch, this equates to over £1 million a year per health board and as much as £8 million across Wales (3,650 dispatches a year at £292 would equal ~ £1.07m p.a., per Health Board).

With most patients transported "just in case", this could also generate around 20,000 unnecessary emergency department attendances annually, plus further costs from short-stay admissions. Introducing clinical validation, refining call-handling protocols, and creating rapid community chest-pain pathways could release ambulance hours, reduce avoidable ED pressure, and restore confidence in professional judgement.

Theme 2
Quality and Patient Safety

Quality and Patient Safety accounted for 14% of workforce and 20% of public submissions. Respondents described how rules intended to uphold safety and quality sometimes create the opposite effect, delaying discharges, duplicating assessments, or enforcing protocols that displace clinical judgement. Many saw a culture of compliance over care, where paperwork substitutes for understanding. The examples together show a system struggling to balance assurance with agility.

Discharge delays, social-work assessments and bed safety: Rules around discharge criteria and bed management were widely seen as creating delays and risk. Sequential or repeated capacity assessments often hold up safe discharge and strain relationships between agencies.

> *"The strict criteria applied to discharging patient safely."*
>
> *"Having social workers repeat capacity assessments when one has been done by a consultant geriatrician who knows the patient is absurd."*
>
> *"The need for a patient to be medically fit for discharge before being able to refer to social services for care."*

Clinical judgement versus rigid protocols: Strict adherence to procedure was described as delaying care and potentially overriding professional expertise.

> *"Understanding across the NHS that protocols that would delay or hinder care or patient wellbeing can and should be overruled by clinical judgement."*
>
> *"In order to meet essential needs and reduce risk of harm, provide care immediately without seeking 'higher' approvals."*
>
> *"When the emergency department refer a patient to a team they then cease caring for the patient at the point of referral… Patient is then left in limbo."*

Time-wasting practices and safety inefficiencies: Safety initiatives that rely on repetitive documentation were often viewed as counterproductive.

> *"Safe rounding is not 'safe'. it's a waste of time and resources."*
>
> *"Benchmarking - all nurses are required to record unnecessary information on a monthly basis since 2020."*

Consent, dignity and family involvement: Rigid visiting and consent policies were said to compromise patient experience and wellbeing.

> *"Strict and outdated visiting hour policies in hospitals, which don't accommodate family members' work schedules or long travel times."*
>
> *"Allow families to bring in their own food for their loved ones."*
>
> *"Making it easier for patients' family to access services on their behalf."*

Case study 3 – When Safety Rules Create Risk

"Patients have to wait in hospital for CRT start dates before they can go home. This causes delayed discharges and increases a patient's LOS. It also exposes patients to hospital-acquired infections and deconditioning."

In Wales, around 1,000 patients each week experience a delayed discharge from hospital (StatsWales, Delayed Transfers of Care, 2023). Each excess bed-day costs roughly £400 (Audit Wales, NHS Hospital Capacity Review, 2022). If 10% of these delays could be avoided through more proportionate discharge rules, the system would save about 40,000 bed-days per year (equivalent to £16 million). Reducing avoidable delays would also lessen infection risk, staff workload and patient deconditioning. Re-focusing discharge protocols on clinical readiness and person-centred support rather than rigid thresholds could deliver safer, more compassionate and more efficient care.

Theme 3
Workforce and HR

Workforce and HR accounted for 19% of workforce and 23% of public submissions, highlighting the extent to which staffing systems, recruitment rules and training obligations constrain rather than enable people to work effectively. Respondents described an environment where excessive oversight and inflexible processes drain time, limit autonomy and erode morale. Many rules appear designed for control rather than competence, reflecting a culture where trust is the exception, not the norm.

Recruitment, retention and staffing shortages: Processes for attracting and retaining staff were described as overly bureaucratic, contributing to chronic vacancies and reliance on temporary cover.

> *"'Like for like' vacancies cannot be placed on Trac without higher level sign-off."*
>
> *"Reduce the red tape with staff recruitment – too many hoops to jump through causing delays and gaps in staffing."*

Training, competence and skill development: Mandatory and repetitive training modules were seen as disproportionate and disconnected from role requirements.

> *"There has been an explosion of training modules and assessments that staff are asked to complete … The lack of oversight impacts doctors' availability to deliver clinical care."*
>
> *"Spending time doing e-learning on topics that aren't relevant, instead of using the time in a more constructive manner."*

Workforce planning, rotas and deployment capacity: Rigid rostering and deployment rules were highlighted, echoing concerns raised on workforce flexibility and prudent deployment.

> *"Enable all Consultants employed by NHS Wales to work in any health board across Wales without bureaucratic checks."*
>
> *"Give managers more power and influence over their directorates … so they are able to support staff and move staff across directorates at ease."*

Morale, wellbeing and workload pressures: Many described fatigue from bureaucratic demands and limited agency in decision-making.

> *"I waste 90 minutes a day travelling unnecessarily … and have a poorer work life balance."*
>
> *"We have to complete a monthly SitRep … it uses up 5–6 hours of the team's time … and they are never referred to again. It is a pointless piece of accountability theatre."*

HR processes, policy and governance: Outdated or disproportionate policies were seen as draining morale and trust.

> *"After a single day off … I had to have a back-to-work meeting and fill out and sign two forms."*
>
> *"We also have to complete a weekly time sheet to prove we have done our hours … We are not working in a factory or on a ward. I work hard - why do I have to spend time keeping this record? … This must take the admin person at least an hour a week."*

Case study 4 – Mandatory Training Overload

A clinician reflected on the growing volume of online modules required each year:

"The growth of mandatory training hasn't been managed with any overarching perspective… For doctors who work part time the percentage of their working lives devoted to such training can become ludicrous."

NHS Wales employs roughly 100,000 staff (StatsWales, NHS Workforce 2024). If each spends six hours per year on unnecessary or duplicated training, that equates to 600,000 staff hours, costing around £18 million at a Band 6 rate of £30/hour (NHS England, National Cost Collection Guidance 2023). Reducing this burden by just 25% would release 150,000 hours - the equivalent of 90 full-time posts or £4.5 million in capacity. Introducing role-based renewal intervals and a national tracking system could preserve assurance while eliminating duplication, restoring morale and freeing time for patient care.

Case Study 5 - Unlocking Consultant Mobility

"Enable all Consultants employed by NHS Wales to work in any health board across Wales without bureaucratic checks. They all have been through a recruitment process and have the same standards and checks across Wales…"

This implies that consultants in Wales are tied to their employing health board, unable to work easily across boundaries without duplicative checks and approvals. This prevents flexible deployment, even when nearby patients face long waits in the same specialty.

If we assume 100 specialists could share one day a week across boards, this could release more than 5,000 days of additional capacity, equivalent to over 50,000 extra appointments each year. If half of this capacity replaced expensive locums, the saving could be around £3 million; if the other half created new appointments, this might add almost £4 million in value. In total, the system could benefit by roughly £7 million annually.

A "Once for Wales" Consultant Passport and a platform for pooling specialist capacity would help break down bureaucratic borders, reduce backlogs, and improve equity of access across the country.

Theme 4
Digital and Information

Digital and Information accounted for 20% of workforce and 19% of public submissions, reflecting widespread frustration with disconnected systems, repeated log-ins and uncoordinated data processes. Respondents consistently emphasised that the issue is not a lack of technology, but a lack of connection. Rules governing digital systems were seen as adding work rather than removing it, forcing staff to spend valuable time re-entering data and reconciling mismatched information. The result is a system rich in technology but poor in usability and insight.

GP booking, online access and appointment barriers: While digital booking systems are intended to simplify access, many described them as inconsistent, time-restricted or exclusionary. GP access in particular was raised repeatedly across multiple themes, especially Operations and Service Delivery, reflecting wider frustrations about rigid access routes.

> *"Only being able to get a GP appointment by filling out a form at 7am in the morning."*
>
> *"Ringing the GP practice at 8am "hoping" to get an appointment."*

Connected care, interoperability, record access and shared information: Respondents repeatedly described delays and duplication caused by unconnected systems across primary, community and secondary care. Lack of shared access to records, test results and updates forces staff to rely on discharge summaries, workarounds or repeated assessments. This affects patient flow, continuity and safety.

> *"A unified digital system across all health boards... Reduces delays in care, minimises administrative burdens, and improves communication between primary and secondary care."*
>
> *"Health professionals to have access to old health records from different GPs and better electronic record sharing between certain disciplines."*
>
> *"Let patients have access to their digital and other records in real time."*
>
> *"IT blocks to information sharing with third sector orgs."*

Fragmented clinical systems and multiple log-ins: Frontline staff described losing significant time navigating between unlinked systems and duplicating entries across platforms. Many highlighted the impact this has on safety, responsiveness and the overall experience of care.

"Too many digital systems that don't link together which hugely impact on service provision."

"Multiple clinical systems to record one clinical contact with a patient."

"Stop using IT systems which are not fit for purpose, e.g. WPAS."

Paper-based workflows and non-digital processes: Even where electronic systems exist, outdated rules still require printing, scanning or manual processing of simple tasks. These hybrid workflows slow down care, create duplication and undermine the value of digital tools.

"We have specific referral forms that are very simple to use on a computer, people print them!? Fill them out by hand, scan them!!! And send via email."

"Why are we still writing notes on paper in 2024?"

Interestingly, a small number of respondents described the opposite problem - being told not to use paper even when no workable digital alternative exists.

"You mustn't use paper (but there is no other way!!)."

This shows that the challenge is not simply eliminating paper, but the lack of consistent, functional digital pathways. Staff often end up trapped between two systems: one they are told not to use, and one that does not fully work.

Information-sharing and reporting burden: Respondents described being inundated with requests for the same data in multiple formats, often for oversight rather than improvement. These rules were seen as contributing to avoidable workload and diverting time from clinical or analytical work.

> *"Duplication of data, spreadsheets, utilisation of data sharing safely and efficiently."*
>
> *"Use of multiple clinical systems."*
>
> *"Sharing of primary care data with secondary care services."*

Case study 6 – Fragmented Systems; Multiple Log-ins, Duplicate Entry, and Delays to Care

"Current rule to not cut and paste information (not patient identifiable) within systems to avoid the need to type in several screens is prohibited in NHS111. This creates inefficiencies in time to care for patients where information sharing/automation or interoperability would benefit."

"Multiple clinical systems to record one clinical contact with a patient – these clinical systems are then not used across Wales so that information is not shared efficiently."

"... for medical and social care systems to communicate so that the information is all in one place!"

These examples epitomise digital inefficiency in modern healthcare. Across NHS Wales, frontline staff routinely use multiple systems per shift, re-entering the same data into unconnected databases. If 50,000 staff lose just five minutes per shift to unnecessary log-ins or duplicate entries, this equates to over 20 million minutes (≈333,000 hours) of lost time each year – worth around £10 million at an average Band 6 rate of £30/hour (NHS England, National Cost Collection Guidance 2023). Beyond cost, these inefficiencies undermine safety and staff morale. A single-sign-on approach and shared access to core clinical data across health boards could reclaim thousands of clinical hours while improving reliability and patient experience.

Theme 5
Clinical Services

Clinical Services accounted for 23% of workforce and 9% of public submissions, focusing on how service structures, referral pathways and professional boundaries shape patient care. Respondents described rules that interrupt clinical continuity, impose unnecessary hand-offs, and restrict scope of practice even when staff are qualified to act. The result is duplication, delay and confusion for patients navigating between specialties. This theme highlights how clinical and operational inefficiencies often stem from the same underlying rigidity.

Referral and diagnostic access: Referral processes were repeatedly criticised for their complexity and duplication, with respondents describing multiple forms, repeated information and unnecessary administrative steps that slow access to services and diagnostics.

> *"The need for full referral paper work between physio and OT services."*
>
> *"Better triaging of patient need for services so the right people get treated first."*

Variation in clinical decision-making and scope of practice: Rules that limit professionals' ability to work to the top of their licence, or apply clear criteria, were described as contributing to delay and inconsistency.

> *"Ambiguous referral criteria set by services."*
>
> *"I would be more diverse in my role and not have to refer people on to other services when I possess the skill set to help them myself."*

Continuity of care and communication: Transitions between teams and specialties were described as fragmented and confusing, with information frequently lost in hand-offs.

> *"The division between specialties in secondary care … confusing for patients who are handed over even when nothing has changed."*
>
> *"Constantly giving your details to be put on another form. I don't mind confirming who I am, but why don't they all have access to my basic information?"*

Access to treatment and service capacity: Policies designed to manage demand or drive performance can unintentionally restrict timely or equitable access. Instead of enabling flexibility, they often prioritise compliance with processes or targets over meeting patient need.

> *"Cross border treatment should be an option. Eg in other parts of Wales or in England where waiting lists for specific treatments may be shorter."*
>
> *"Step away from processes around waiting targets to take time to coproduce the right service for patients."*

Across all of these areas, the same story emerges: pathway rules that may once have been pragmatic now interact with capacity pressures to create stop-start journeys for patients.

Case study 7 – When Pathway Rules Force Patients to Start Again

"Self-referral and prescription repeats."

"Patient needed a CT. The CT request was cancelled without a reason."

Across Wales, physiotherapy services receive an estimated 450,000–500,000 referrals per year (Public Health Wales MSK Activity Estimates, 2022). If around 5% of these expire before assessment because of capacity-related delays, this would equate to 22,500–25,000 referrals that must be re-submitted. Each one requires approximately 10–15 minutes of new triage (NHS MSK Triage Audits, 2021), equalling 3,750–6,250 hours of repeated clinical work. At a Band 6 cost of £30/hour (Agenda for Change, 2023–24), this represents £112,500–£187,500 in avoidable clinical time every year.

Diagnostic cancellations produce similar effects. Wales conducts roughly 300,000 CT scans annually (Public Health Wales Imaging Statistics, 2022). If just 1% are cancelled or lost without explanation, this would result in 3,000 wasted appointments. With each CT slot costing £70–£100 in staff and resource (NHS England National Cost Collection, 2023), this equates to £210,00–£300,000 of lost diagnostic capacity.

More importantly however, these pathway resets have significant consequences for individuals. People must repeat their referral, re-explain their symptoms and restart waiting periods, causing delays that can worsen symptoms, undermine clinical outcomes, and negatively affect wider physical and mental health and wellbeing. Together, these examples show how rigid pathway rules, when combined with capacity constraints, can fracture clinical continuity, slow down treatment and undermine trust in the system.

While the first five themes accounted for the majority of submissions, several smaller but strategically significant themes also emerged. Together, these five accounted for the remaining proportion of rules and provide valuable insight into the underlying conditions that shape the wider system.

Theme 6
Finance and Procurement

Finance and Procurement accounted for 11% of workforce and 11% of public sumbmissions. This theme was how national frameworks, financial controls and procurement rules shape what services and teams are able to do. It captures rules that restrict local autonomy, prevent cost-effective decision-making, or require disproportionate administrative effort for small expenditures. Respondents described processes designed to ensure fairness and probity, but which in practice limit flexibility, slow progress and inflate system costs.

> *"... It's frustrating to be forced to spend significantly more on items we can see we could independently source for a fraction of the cost."*
>
> *"I would change the requirement to hire external contractors to complete any estates/minor works jobs."*

Case study 8 – When Procurement Rules Cost More Than They Save

"I would change the requirement to hire external contractors to complete any estates/minor works jobs. The organisation has skilled and experienced staff... who can carry out these jobs just as effectively and safely, and at a fraction of the cost."

External estates contractors typically cost £45–£60 per hour (industry benchmarking; NHS Estates & Facilities rates, 2023), compared to NHS in-house estates staff at roughly £20–£25 per hour including on-costs (NHS AfC Band 4–5, 2023–24). This means external contracting may cost 2–3 times more for equivalent work.

If a medium-sized health board commissions 3,500 hours of minor works annually (Audit Wales, Estates Benchmarking, 2022), and even 25% of this work could safely be carried out internally, this represents 875 hours that need not be outsourced.
At £50/hour, outsourcing costs £43,750; delivered internally at £22/hour, it would cost about £19,250.

This equates to a direct saving of around £24,500 per year per health board, or over £170,000 across Wales (costing aligned with Welsh NHS finance modelling).

Theme 7
Strategic Planning and Transformation

Strategic planning and transformation accounted for 10% of workforce and 6% of public sumbmissions. This theme captured rules and processes related to system-wide change, improvement structures and organisational oversight. It includes repeated planning cycles, duplicated reporting, multiple assurance bodies and transformation programmes that overlap or compete for attention. Respondents described an improvement landscape characterised by complexity, parallel paperwork and competing governance arrangements.

Together, these submissions point to a system where transformation is often slowed not by lack of ideas, but by the administrative machinery surrounding them.

> *"Engage in innovative cluster projects without always having governance in place."*
>
> *"Making changes is so difficult 'it's not my job, we can't do that,' etc."*
>
> *"Step away from processes around waiting targets to take time to coproduce the right service for patients."*

Case study 9 – Three Plans, One Idea: How Duplication Slows Transformation

"Avoid unnecessary duplication of approval on policies."

This rule requires teams to rewrite the same improvement plan multiple times for different committees, even when the core content is identical. Instead of producing one clear plan, staff are asked to reformat, reword or repackage it to meet slightly different expectations, a process that adds no value but absorbs significant managerial time. The result is slower progress, delayed decisions and reduced capacity for genuine improvement work.

The costs scale quickly. Preparing a single improvement plan requires around 20 manager-hours (Audit Wales, Governance & Accountability, 2023). Rewriting it twice for separate approval groups adds a further 40 hours of effort without improving the quality of the plan. Across Wales' seven health boards, this equates to 280 duplicated hours per cycle, costing approximately £9,800 at a Band 8a rate of £35/hour including on-costs (NHS England AfC 2023–24). If repeated quarterly, as many improvement processes are, the annual cost exceeds £40,000 in duplicated managerial time for this single behaviour alone.

The wider impact is harder to quantify but more significant. Every hour spent re-writing the same plan is an hour not spent analysing data, engaging teams, testing changes, or accelerating improvement. Duplication fragments attention, slows momentum and increases the risk that plans become compliance exercises rather than tools for transformation. Instead of supporting learning, governance becomes a bottleneck — absorbing scarce leadership capacity at a time when services need clarity and pace.

This is not an argument against oversight, scrutiny or quality assurance. It is a call for proportionate, Once-for-Wales approaches that remove duplication while strengthening accountability. One plan, shared once, should be enough. When governance consumes more time than improvement itself, the system pays twice: in avoidable cost and in missed opportunity for change.

Theme 8
Public Health

Public Health accounted for 6% of workforce and 11% of public sumbmissions. These were rules relating to prevention, community wellbeing, health promotion and local public health interventions. Respondents highlighted barriers created by duplicated reporting frameworks, rigid campaign requirements, and processes that divert time from proactive prevention work. While smaller in number, these submissions reveal how administrative burden can limit capacity for essential population-level activity.

Collectively, they suggest that public health teams face disproportionate reporting and governance requirements relative to their size and resources.

> *"I see so many clients who do not meet the high thresholds for care and support, but cannot access community-based groups without this support."*
>
> *"A stop to all local guidelines — there should be a Once for Wales approach to health care. Local guidelines to roll out of national services are causing confusion for patients and health care staff."*
>
> *"Healthy food should be the default in all hospital canteens."*

Case study 10 – Having to be 'Ill Enough' Misses the Point of Prevention

"Threshold criteria for support. I see so many clients who do not meet the high thresholds for care and support, but cannot access community based groups without this support."

This rule blocks people from accessing simple preventive support unless their health has already deteriorated. Individuals seeking help with weight, wellbeing or lifestyle change are told they do not meet the threshold and must return when things are worse. Instead of supporting people early, the system waits for escalation, leading to more appointments, more tests and greater pressure elsewhere.

The costs are predictable. A typical community lifestyle or wellbeing session costs around £80–£120 per participant (Public Health England, Weight Management Economic Assessment, 2017; NICE PH53). When early help is blocked, studies show 20–40% of people will deteriorate and require clinical input within 12–24 months (PHE Behaviour Change Evidence Review, 2018). Downstream demand typically includes additional GP appointments (PSSRU 2023: £38 per consultation), blood tests or simple investigations (NHS Reference Costs 2022–23: £20–£60), and onward referrals (average outpatient follow-up £120; NHS Reference Costs 2022–23) together producing around £450–£550 in reactive care per escalated case. Wider evidence shows that preventive interventions generally return around £14 for every £1 invested (Masters et al., BMJ Open, 2017).

If 1,000 people attempt to access early support and a third are blocked, around 80 will deteriorate, generating £40,000+ in avoidable demand. Scaled modestly across Wales, even a small number of missed preventive opportunities each year creates hundreds of thousands of pounds in reactive treatment costs - all caused by a rule that requires people to be "ill enough" before they can get help.

Theme 9
Communications and Engagement

Communications and Engagement accounted for 4% of workforce and 11% of public sumbmissions. These included rules affecting how information is shared with staff, patients and the public. Respondents described multi-stage sign-off processes, rigid translation policies, duplicated feedback routes and inconsistent information for patients. These rules illustrate how communication systems often prioritise process over purpose.

> *"Stop making every poster in Welsh … told to remove scientific posters because there isn't a Welsh equivalent."*
>
> *"Provide appointment letters that actually tell the patient what the appointment is for."*

These rules illustrate how communication can become a bottleneck - slowing down important updates, reducing transparency and leaving people unclear about what to expect.

Case study 11 - When Communication Rules Become Barriers to Prevention

"The ban on the printing of information leaflets and posters to support campaigns to raise awareness of wellbeing services and support. This is exacerbating health inequalities."

"Approval rules – gaining approval to put basic things into place, such as a poster in a GP surgery to give easy read information about annual health checks."

If these rules prevents people from receiving the basic information they need to access early support. Risk-averse approval processes for simple materials like easy-read health check reminders mean that key wellbeing messages never reach those who rely on physical information.

Evidence shows that accessible, timely health information increases uptake of screening, lifestyle programmes and early-support services by 10–25% (PHE Behavioural Insights Review, 2019; NICE QS94). When information isn't shared, 30–50% of people who miss preventive opportunities deteriorate and require reactive clinical input within 6–18 months (PHE Behaviour Change Evidence Review, 2018). This typically involves additional GP appointments (£38 each, PSSRU 2023), basic investigations (£20–£60, NHS Reference Costs 2022–23), and outpatient follow-up (£120), together producing £350–£500 in avoidable reactive care per person.

If 2,000 people would normally see a poster or leaflet, and even 20% miss early support due to communication restrictions, 80–100 individuals will deteriorate, creating £30,000–£50,000 in preventable demand. Scaled across Wales, rigid communications rules, slow approvals, printing bans, and lack of easy-read materials, generate hundreds of thousands of pounds in downstream costs while widening inequalities.

Theme 10
Research and Innovation

Research and Innovation accounted for 2% of workforce and 0.5% of public sumbmissions. This theme captured rules that block or delay testing new approaches and simplifying governance for pilots. Respondents highlighted duplicated ethics requirements, slow approval processes and unclear governance routes. Though the smallest theme by numbers of submissions, it points to systemic barriers to improvement and learning.

> *"Excessive regulation and complex processes for funding approvals, service changes, or adopting innovations slow down progress."*
>
> *"We need less red tape around testing new ideas."*

Case study 12 – The "One-Time Only" Rule

"'Rules' around use of cluster funding limit investment in 'innovation' as you can only fund an innovative intervention once and restrict ability to trial again and/or extend. Use of cluster funds are rarely evaluated effectively and schemes are not supported to become sustainable - or develop exit strategies to safely remove funded services."

These 'rules' restrict clusters to funding an innovative intervention only once, preventing services from re-running, refining or scaling ideas that show promise. Even successful pilots cannot be repeated in another practice or extended to build evidence, meaning many initiatives remain isolated, short-lived projects rather than sustainable improvements.

Because most schemes are not supported to evaluate outcomes or develop exit strategies, learning is limited and benefits end when the funding does.

The costs are significant. Innovation programmes show that without replication or follow-through, pilots have 60–80% lower impact, and most of their learning value is lost. Across Wales, if even 10 cluster-funded schemes per health board are piloted but never repeated or scaled, the system risks £1–£2 million of sunk innovation costs annually, with little long-term benefit for patients or services.

This is not a call for endless pilots, but for proportionate flexibility: the ability to re-test promising interventions, evaluate them properly and support those that work to become sustainable. Without this, innovation starts but rarely lasts.

Taken together, the submissions suggest that many of the barriers people encounter are often not the result of clinical complexity, but of small rules, conventions and legacy practices that have accumulated over time. Individually they may appear minor, but collectively they create friction at multiple points in the journey through care, slowing decisions, constraining professional judgement, and making services harder to navigate for both staff and service users. These *Silly Rules* do not simply inconvenience the system; they absorb capacity, delay care and erode confidence, revealing a pattern of structural rigidity rather than isolated error.

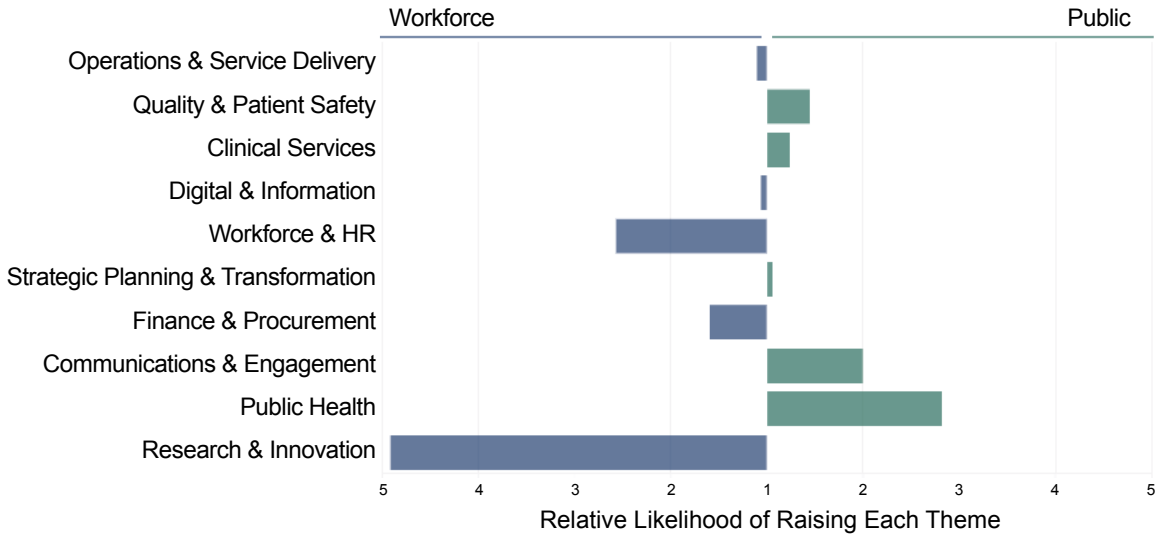
Different Voices, Different Views

While women made up the majority of respondents, men and non-binary groups brought different emphasis, shaping varied perspectives across the themes:

	Women	Men	Non-binary
Themes with stronger representation	Public Health, Quality & Patient Safety	Digital & Information, Comms & Engagement	Clinical Services, Strategic Planning
Terms emphasised	*'access', 'appointments', 'patients', 'care'*	*'training', 'data', 'services', 'work'*	*'crisis', 'mental', 'person', 'health'*

Comparing staff and public submissions provides insight into how different groups responded. Staff respondents were more likely to raise themes such as Workforce & HR, or Finance & Procurement or Research & Innovation, whilst public respondents placed greater emphasis on Public Health, Quality & Patient Safety, and Communications & Engagement.

Figure 6: Thematic analysis



When is a Rule not a Rule?

1) Rules, suggestions, and experiences. One of the initial observations from this study was that, while many submissions referred to formal rules or procedures, others reflected broader frustrations or, in some cases, constructive suggestions for improvement. For example:

"Allowing patients to view their test results without having to wait on prior approval from a GP."

"Introduce one referral form for community services instead of different ones for each team."

"Better resources online for bone breaks/muscle tears so patients know what to expect."

Although not all of these were technically 'rules', they were included in the analysis, as they still provide valuable insight into how people experience health and care in Wales and where systems could be simplified or improved. For this reason, we use the term 'submissions' throughout.

2) Rules, habits, and myths. Some other submissions described 'rules' or practices that people faced, which are likely not official rules at all. Rather, these appeared to be long-standing cultural habits, assumptions, or myths that have taken on the power of rules over time, exemplified by the 'Bicycle Book' in the original IHI study. These can be just as influential in shaping behaviour and experience.

Working across Welsh Health Boards validation was sought to determine which submissions constituted formal organisational rules or policies and which were more accurately classified as myths, cultural practices or unwritten conventions, for example:

"Being able to directly communicate with the person you need to talk to rather than through their manager."

"I would be more diverse in my role and not have to fit into a certain type of person because of the job title."

"No ESR time, expected to do it at home."

3) Not All Rules Are 'Silly'. While we asked specifically for *Silly Rules*, some respondents were also clear that not all rules are silly. Mosy rules exist for good reasons - to protect safety, maintain standards or meet legal requirements - and frustrations often arise from how rules are interpreted or applied rather than from the rules themselves.

"Rules are there for a reason on the whole - it's the people who overstate their authority or don't understand the rules. Common sense and empathy are lost."

"Rules are usually there for good reasons. Problems arise when they are ignored or not enforced."

Strategic Observations and Gaps

While the thematic analysis captures the main clusters of *Silly Rules*, several strategically important areas cut across multiple themes and point to wider priorities for improvement in Wales. These observations highlight where deeper system focus or further engagement will be required to maximise the value of this work.

Administrative Rules. We found that ~35% submissions related to administrative systems and processes. This is significant given that administrative and estates staff represent around a quarter of the total NHS workforce in Wales. Administrative and clerical staff are often the first and last people we interact with when using health and care services; they shape how easily people can access care, how smoothly information flows, and how supported staff feel in delivering it. Yet conversations about efficiency and productivity often focus primarily on clinical services. These findings underline that administrative flow, documentation and approvals are not peripheral but are central to system performance. Improving how administrative work is designed, valued and enabled could therefore unlock substantial time, capacity and morale across the system, while also promoting fairness between professional groups whose contributions are often overlooked.

Primary Care and Access. We saw that ~15% of submissions related to General Practice and primary care, with many focused on the difficulties people face accessing GP services and the barriers created by fragmented data-sharing between primary and secondary care. However, whilst primary care is estimated to account for around 80–90% of NHS Wales activity, GP practices operate under distinct contractual and digital arrangements, meaning that some of these issues sit outside direct health-board control. Addressing these barriers is essential not only for efficiency but for equity, ensuring that access to care is based on need rather than navigation skill, geography or digital literacy.

Further work is therefore needed to understand how these access challenges relate to wider reforms in primary care and how future primary care models can better support seamless, fair and timely access for the public.

Whole-System Integration. Across nearly every theme, there were strong calls for greater system coherence, including shared digital records, cross-boundary working, and joined-up accountability. Respondents repeatedly highlighted the frustration of having to duplicate data or navigate multiple systems that cannot talk to each other. This points to a broader need for

interoperability not only in technology but in culture, governance and workforce deployment. Wales' ambition for a "Once for Wales" approach depends on aligning these dimensions, so that people, data and decisions can move seamlessly around the person, not the organisation.

Social Care. Despite targeted outreach, relatively few submissions were received directly from social care staff or people using social care services. Where social care was mentioned, it was often in relation to hospital discharge or interface issues rather than rules internal to the sector itself. This highlights an important gap. Social care is an essential part of the health and wellbeing system, and understanding its specific bureaucratic and cultural barriers will be crucial to achieving truly integrated, person-centred care. A dedicated focus on social care participation should therefore form a key priority for the next phase of this work to ensure that future reforms reflect the experiences of all sectors and communities, not just those with the loudest or most visible voices.

Equity and Inclusion. Across the dataset, some submissions hinted at inequities in how rules are applied or experienced e.g., between professions, regions, and service users. Overly rigid processes can disproportionately affect groups already facing disadvantage, such as those with limited digital access, language barriers, or disabilities. Embedding equality considerations into every stage of system design and simplification will be essential to avoid perpetuating existing gaps. Removing *Silly Rules* is not just about efficiency; it is also about fairness - ensuring that the system works equally well for everyone.

Waste: Across the entire dataset, almost every 'silly rule' ultimately links back to waste: wasted time, effort, information, resources and opportunities. We heard of processes that absorb hours of staff time without adding value: duplicated forms, digital systems requiring manual workarounds, and approval chains that delay simple decisions. For patients, rules that force them to repeat their story, navigate multiple disconnected services, or wait unnecessarily for care. These represent a systemic loss of productivity and capacity at a time when services are already under immense pressure. Addressing waste is therefore not simply an efficiency exercise; it is central to delivering prudent, high-value care. Simplifying rules, removing duplication and redesigning processes around purpose and proportionate risk would release time, restore professional autonomy and reinvest capacity where it matters most.

Together, these strategic observations show where the next phase of work could concentrate, complementing the immediate, locally actionable 'quick wins' that follow, with deeper attention to the structural and cultural and equity barriers that underpin them.

Quick wins – 'Just Do It's' and 'Just Stop It's'

In addition to the case studies presented, we worked with organisations to determine which 'rules' reflected national policy, locally applied organisational requirements, or were not formal rules at all but cultural norms, assumptions or habitual behaviours, aligning with the classifications set out in the original IHI work by Berwick and colleagues.

Building on this clarification, we identified a large number of locally actionable issues across the dataset - practical barriers that could be improved without national policy change or major reform. These were 'rules' which appeared amenable to local change or improvement without the need for large-scale or time-consuming intervention. This has been included to support teams to make small changes that could make a big difference at their service level.

These typically relate to operational processes, administrative systems, and information flows, areas where frontline staff and service users identified tangible adjustments that could simplify work, improve efficiency, or remove unnecessary duplication. Where identified, a selection of actionable recommendations have been provided below

1. Excessive Administration and Paperwork:

This was the most frequently observed area for improvement. Many staff described the burden of manual paperwork, repetitive data entry, and layered approval processes. Rules pointed to duplication of forms, multiple signatures for low-risk activities, and reliance on paper-based records even where digital systems existed. Examples included suggestions to simplify risk assessments, merge overlapping templates, or remove unnecessary sign-off layers. Examples include:

"Benchmarking - all nurses are required to record everything. A lot of time spent doing paperwork rather than patient care."

"Approval rules - gaining approval to put basic training into place takes too long."

"Get rid of paper referrals - we have specific forms for specific services and it is too time consuming."

Contributors emphasised a need for streamlined documentation and proportionate governance, not reduced accountability.

Suggestions for Improvement:

✓ Review and consolidate forms or templates that capture overlapping information.

✓ Remove unnecessary signature or approval stages where risks are minimal and oversight is already built in.

✓ Move from paper-based to electronic processes where practical, using shared folders or simple digital tools rather than introducing new systems.

✓ Introduce clear criteria for when documentation is required, ensuring proportionality between task and governance requirement.

2. Inefficient Processes and Time Delays:

Many submissions described procedures that are more complex or time-consuming than actually necessary. These often appear a result of legacy processes or incremental policy changes. Staff referred to long approval routes, repetitive checks, and delays in decision-making that impacted both workflow and service user experience. Examples include:

"Awaiting approval of SBAR documents, even though the content has not changed."

"Too many people wanting to approve things and so the process slows down."

"The governance process to approve a guideline/ policy is complicated."

The overall tone was constructive, respondents sought faster, clearer processes that maintained safety and oversight but reduced wasted effort.

Suggestions for Improvement:

- ✓ Map current approval or escalation routes and identify steps that add limited value or duplication.
- ✓ Delegate low-risk operational decisions to team leaders or managers with clear parameters.
- ✓ Introduce standard turnaround expectations for common tasks (e.g., rota sign-offs, resource requests).
- ✓ Encourage regular review and feedback of legacy procedures to check continued relevance.

3. Information and Data Systems:

A variety of submissions related to digital systems, data entry, and communication tools. Staff described fragmented platforms, poor interoperability, and the need to input the same information multiple times. Examples include:

"Double recording system - CarePartner and WPAS, I've always wondered why they aren't combined."

"Enable quick, efficient sharing of medical records between departments and organisations."

"Too many digital systems that don't link together which hugely impact on service provision."

Submissions also referenced challenges with access permissions and governance barriers that prevented legitimate data sharing.

Suggestions for Improvement:

- ✓ Identify where staff are required to enter the same data multiple times and explore options for system integration or shared access.
- ✓ Rationalise the number of local databases or spreadsheets used to manage the same information.
- ✓ Ensure system access and permissions reflect current roles and legitimate information needs.
- ✓ Provide clear guidance on information governance to support appropriate communication rather than restrict it.
- ✓ Explore low-cost interoperability solutions (e.g., data exports, shared dashboards) before major IT change programmes.

4. Referral and Handover Issues:

Several submissions focused on referral pathways, information transfer, and clarity of responsibility between services. Staff often described situations where processes for referring, signposting, or handing over cases were unclear, inconsistent, or overly dependent on individual initiative.

These issues were most evident at interface points between teams or organisations, particularly between health and social care, but also between community and hospital settings.

Respondents noted that referrals could be delayed or lost due to unclear ownership, multiple email-based systems, or a lack of acknowledgement when referrals were received. In some cases, teams developed workarounds, such as direct personal contacts or duplicate forms. Examples include:

"Multiple Referrals for One Issue: Patients must be referred separately to each service even when needs overlap."

"Use an integrated communication platform such as Microsoft Teams or similar to improve communication across services."

"Having to complete a full re referral to ALAS even if previously referred."

Suggestions for Improvement:

- ✓ Develop or adopt a single referral template used consistently across teams and partner agencies.
- ✓ Introduce automated acknowledgements or visible status updates to confirm receipt and progress.
- ✓ Establish clear points of contact and accountability, and defined timeframes for handover or feedback.
- ✓ Provide joint training or briefings for staff on agreed referral pathways and responsibilities.

5. Duplication of Work:

Duplication appeared across multiple contexts, sometimes raised directly, and sometimes as a knock-on effect of wider administrative or system issues. Staff described needing to re-enter information, repeat checks, or complete parallel forms for similar purposes. Much of this duplication appeared to stem from unconnected systems or differing templates between teams and partner organisations, rather than clinical necessity. Examples include:

"Remove the rule that social workers have to do their own assessment and can't use other assessments."

"If i could change anything it would be the amount of data we have to input on a daily basis. A lot of this is repetitive and duplicated across different systems."

The general message was one of 'effort without added value', with calls for simpler, consolidated processes and shared access to information to reduce unnecessary repetition.

Suggestions for Improvement:

- ✓ Audit areas where data are collected multiple times and consolidate reporting requirements.
- ✓ Align templates across departments or partner organisations to ensure consistency.
- ✓ Introduce shared repositories or document management tools to avoid multiple versions of the same record.
- ✓ Rationalise governance or approval processes that require the same information in different formats.
- ✓ Encourage teams to flag recurrent duplication during service reviews

Where National Policy Creates Local Constraints

It is also clear from the submissions that many of the *Silly Rules* submitted relate to national policies imposed onto local organisations. While these were created with good intent, their implementation has, in many cases, introduced rigidity, duplication, and delay that can make improvement harder rather than easier. The following examples illustrate how such National 'rules' can hold back local innovation and efficiency.

While many locally actionable issues could theoretically be addressed quickly, the 'National Opportunities' outlined below would involve national policy and system-wide reform and therefore should not be viewed as 'quick wins', but as potential longer-term enablers of improvement.

1. Repeated Employment Checks Across Health Boards:

"Enable all Consultants employed by NHS Wales to work in other hospitals across Health Boards."

National workforce policies require each Health Board to repeat employment checks, occupational-health assessments and onboarding processes, even for staff who have already been cleared elsewhere. This restricts staff mobility, slows recruitment and makes it harder to manage pressure points across Wales.

Opportunity: Develop a Wales-wide "consultant passport" - extended over time to other staff groups - to allow safe, rapid deployment across organisations, reduce duplication, strengthen rota resilience and support a more flexible national workforce model.

2. National Information-governance (IG) Restrictions:

"Sharing of primary care data with secondary care services."

"Sharing of information between departments and commissioners."

"The rules around information sharing between organisations."

Current national IG rules and their differing interpretations across sectors prevent timely information-sharing, forcing repeated assessments and disconnected care. Staff report that this creates major barriers to integrated working and safe transitions.

Opportunity: Develop a clearer, proportionate national IG model, including a standard consent process, cross-sector data-sharing agreements and unified guidance, which would enable safe, timely information flow and reduce unnecessary repetition.

3. National IT Systems That aren't Interoperable:

"Too many digital systems that don't link together which hugely impact on service provision."

Many respondents pointed to the rigidity of national digital systems that fail to integrate with local platforms. When systems can't share data across settings, staff are forced into workarounds, double-entering information, printing and scanning documents, or relying on emails and spreadsheets. This not only wastes time but also creates risk, as information can be delayed or lost between services. For organisations trying to deliver integrated care, these digital silos undermine progress.

Opportunity: A single, interoperable Wales-wide digital record, supported by shared infrastructure, common standards and co-designed workflows, might reduce duplication, improve safety and support genuinely integrated care across health and social services.

4. Repeated Mandatory Training:

"Mandatory training - stop it all; revalidation/CRB/mandatory training should be linked together and not done separately."

Staff across health and social care described the time lost to annual mandatory training that repeats identical content. While assurance and safety are essential, the blanket requirement for yearly re-completion, often through multiple platforms, diverts tens of thousands of staff hours from patient care. For organisations already struggling with workforce challenges, this creates avoidable backlogs and adds to stress levels.

Opportunity: Utilise a streamlined, risk-based national framework for mandatory training, with digital tracking, role-specific requirements and proportionate refresh intervals, to maintain assurance while freeing up significant staff capacity and reducing duplication across organisations.

These examples represent just a proportion of the submissions relating to national *Silly Rules*, but they illustrate a common pattern: policies designed to create consistency at a national level can unintentionally create rigidity, delay and extra workload locally. When services have no discretion to adapt national rules to real-world need, innovation is slowed, resources are wasted, and staff are left navigating workarounds instead of delivering care. More flexible, proportionate national frameworks could enable local teams to respond more effectively while still maintaining standards and equity.

In Summary: What we have Learned

1. People are ready to share and improve

The strong response to this campaign shows that staff, patients, and carers are committed and eager to contribute. When given the chance, they offered clear and practical ideas for simplifying care. Rather than just pointing the finger, this energy should be a powerful resource for continued improvement in Wales.

2. The scale of the opportunity

Out of all the submissions, some were minor irritants while others may have major impacts. Together, they reveal where processes have become overly complex, and how much potential there is to free up time, capacity, and energy for what matters most.

3. Not isolated issues, but a system-wide problem

We heard similar experiences echoed across hospitals, GP practices, care homes, and community services. Repeated themes of duplication, disconnection, and delay highlight shared challenges that call for coordinated, system-wide solutions that deliver benefits for people, services, and the country as a whole.

4. Time, money, and morale at stake

Rules that add little value can drain time and energy. Removing them could unlock precious capacity and improve experiences. In a system under pressure, simplicity might be one of the strongest tools for better health and care.

5. Quick wins and urgent priorities

Many of the changes suggested are straightforward: reducing duplicate forms, streamlining approval and referral routes, and improving digital access and information flow. Addressing these quickly would deliver immediate benefits, freeing up time and capacity while showing staff that their voices are heard and acted upon.

6. Individuals feel the consequences

For people, patients, and families, bureaucracy is not abstract. It manifests as delayed communication, missed appointments, and barriers to timely care, experiences that can increase stress and reduce confidence in services.

7. A call to act differently

The findings echo what major reviews have already highlighted: our systems have become overly fragmented and complex, creating unnecessary obstacles for people, the workforce, and the organisations trying to deliver care and support. What *Silly Rules* adds is the human voice, real lived experiences from across Wales that show both the challenges and the opportunities for change.

This is not about blame or criticism, but about understanding those realities and working together to remove the barriers that hold us back. By acting on what people have told us, we can unlock time, capacity and confidence, building a simpler, fairer, and more effective health and care system for everyone.

What's Next?

The *Silly Rules* campaign does not end here. We will continue to work closely with organisations across health and social care, using these insights to explore potential changes.

Together, we will

- ✓ Continue collaborating with health boards, local authorities, and partner organisations to explore which 'rules' could be fixed, changed or removed to generate value for our health and care services.
- ✓ Share and engage widely with the findings (locally and nationally), helping staff, citizens, and leaders to use this evidence to drive practical change within their own settings.
- ✓ Feedback to contributors on how their insights are informing reform and improvement work across Wales.
- ✓ Capture and share learning nationally, helping adopt, spread and embed good practice and monitor impact.
- ✓ Support a cycle of listening and improvement, embedding the *Silly Rules* approach into wider transformation and culture-change programmes.
- ✓ Continue working with Llais to ensure people's lived experience helps identify and challenge *Silly Rules* across Wales

By continuing to listen, learn, and act together, we can turn *Silly Rules* into fuel for change, creating a health and care system that truly works for the people who live in it, work in it, and rely on it.

Conclusion

The *Silly Rules* campaign has shone a light on imprudence and the hidden barriers that drain time, energy, and money from Wales' health and social care system. With over 800 submissions, this work shows that unnecessary bureaucracy is more than just an irritation; it is a sustainability challenge that directly affects service users, as well as organisations and their staff.

On the ground, real system change will not come from another restructure or top down policy intervention alone, but by removing the everyday obstacles and frustrations that make simple things so challenging. The findings of this work highlight both the power and potential of small wins, demonstrating that when friction is taken away from the system, time, trust and energy can be restored, creating momentum for wider change.

If Wales is to build a truly sustainable model of health and social care that is fit for the future, it will not be built in an isolated boardroom, but at the interface of care, where design meets delivery and outcomes that matter to people and professionals are shaped. It begins by removing the hidden, low-value barriers that slow, frustrate and fragment the care experience. When small inefficiencies are removed at scale, the cumulative impact is system-wide transformation.

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