



From Escalation to Improvement

Breaking the doom loop in NHS Wales

Tim Daley · Victoria Ford · Steve Moore · Lee Waters

The Welsh NHS is stuck in a doom loop.

Lee Waters, former Welsh Government deputy minister

Contents

START HERE

— Who wrote this 04
— Summary 06
— The argument in six steps 09
— Our approach: test, learn and grow 10

THE PROBLEM

01 Why escalation is not working 13
02 De-escalation as the trigger 19
03 Why the NHS needs a different mindset 23

WHAT HAS TO CHANGE

04 Leadership, governance and culture 30
05 Waiting lists: where and how 33
06 Grow: spreading what works 39
07 What comes next: urgent and emergency care 47

WHAT TO DO

08 Recommendations 51
09 Timetable 54
10 What we are not claiming 56

BACK

— References 57

Who wrote this



TIM DALEY

Tim is Strategy & Transformation Director of Perago. He is a seasoned digital leader with over 15 years of senior leadership experience, specialising in strategy, delivery, and supplier management. He has operated at board level to successfully deliver a range of UK-wide services and initiatives.

With a strong focus on Agile methodologies, he has led the delivery of complex, large-scale, and high-risk IT applications and infrastructure developments within major business and cultural change programmes, spanning the full change life cycle.

Tim has also played a key role in shaping digital strategies at both national and organisational levels. He understands the importance of building strong, collaborative teams to produce high-quality outcomes within tight financial and time constraints.

Passionate about sharing best practices and real-world experiences, he is committed to upskilling individuals and organisations alike.



VICTORIA FORD

Victoria Ford is the Managing Director and Group CEO of Perago, a transformation delivery partner working across UK Government, local authorities, Welsh Government and the third sector. She co-founded Perago after a career as a senior civil servant, and has spent over 30 years in public sector delivery.

Victoria has led large operational delivery units, run award winning communications teams, and worked on digital communications and culture change, including support for the Digital Strategy for Wales. She has advised chief executives and senior leaders across sectors on communications, delivery and capability.

Victoria is a Fellow of the Institute of Internal Communications, an accredited PR practitioner through the Chartered Institute of Public Relations and mentors and coaches other leaders in the sector.





STEVE MOORE

Steve is the former Chief Executive of Hywel Dda University Health Board. He has worked in the NHS for nearly 40 years, around 15 of them as a chief executive, and most recently led NHS Devon Integrated Care Board until early 2026.

That gives him first-hand experience of running large health systems under sustained financial and performance scrutiny in both Wales and England, and of the gap between assurance and improvement that runs through this paper.

A CIMA-qualified accountant with an MSc in Health Economics, he brings a finance and value lens to questions of productivity, deficit and resource allocation. He leads Moore & Company, a health and care advisory practice focused on strategy, board effectiveness and organisational culture, and lives in Carmarthenshire. He believes that improvement comes from focusing on people, not problems.

LEE WATERS

Lee is a former deputy minister in the Welsh Government and a former member of the Senedd. He led the introduction of Wales' default 20mph speed limit and a series of reforms in climate, transport and digital policy. His Pumed Llawr / Fifth Floor documentary podcast series shed light on how the Welsh Government works.

Before politics, Lee was director of the think-tank the Institute of Welsh Affairs, after having been director of Sustrans Cymru, where he led the campaign for the world's first Active Travel Act.

He is a former chief political correspondent and House of Commons lobby correspondent for ITV Wales. He is an Associate at Perago and a Policy Fellow at Nesta.

ACKNOWLEDGEMENTS:

We are grateful to David Jones, Chair of DVLA and a former independent member of Cardiff and Vale and Aneurin Bevan university health boards, whose feedback shaped the section on leadership, governance and culture.

A NOTE ON INTEREST:

This paper argues that health boards should have skilled external support for improvement. That is the kind of work Perago and Moore & Company do, and readers should weigh what we say with that in mind. The case should be judged on the evidence, not on who might deliver it.

Summary

Every health board in Wales is in escalation, and most have been for years.

A process designed to highlight exceptional concern has become standard operating procedure. It uses up the time and attention of the very people improvement depends on.

This paper argues that handling escalation differently is the trigger for improvement. Give every escalated organisation a clear way out and practical support to get there, and boards get time back.

That time can go on the things the public cares about most. We use waiting lists as the worked example throughout: where to start, how to do it, and how to spread what works.

The paper is written by Perago, a Welsh transformation delivery partner experienced in transformation across the public sector; Steve Moore, former Chief Executive of Hywel Dda University Health Board; and Lee Waters, former Welsh Government deputy minister.

It brings views from inside the system together with what Perago has learned delivering complex change across Welsh and UK public services.

A fresh focus on continuous improvement would be needed under any funding settlement. The outlook makes it urgent. NHS spending has grown by an average of 3.6% a year in real terms since 2019/20, but the outlook for Welsh public finances is just 0.7% extra a year in real terms.

The capital budget is set to fall by almost 9% in real terms over the Senedd term (Wales Fiscal Analysis, 2026).

Unless performance improves, without significant extra funding, current pressures will become unsustainable.

The core of what we propose needs no legislation, no new money and no reorganisation of health boards.

Money alone has not solved the problem. Wales spends more per head on health than any other UK nation (Harker & Powell, 2026; Bodea et al., 2026). Revenue funding rose 4.5% in real terms to £11.57bn in 2024/25 (Audit Wales, 2025).

Yet 2025/26 ended with a £199m in-year deficit, a three-year cumulative overspend of £506m, and six of seven health boards missing their break-even duty (Audit Wales, 2026).

When more money and more staff produce the same output, the problem is how the work is organised.

The Accountability and Support Framework announced on 29 September 2026 moves in the direction we argue for. This paper sets out what it will take to make it work.

The argument in six steps

1 Make de-escalation the trigger. Every escalated organisation should get published, measurable exit criteria from day one and early, practical support to meet them. The few de-escalations that have held in Wales all had this.

2 Use the time it frees. Less time feeding the assurance process means more time for improvement. Fewer national measures, under ten rather than 53, and a single reporting channel will free up more time.

3 They are one of the most prominent measures that the public judges the NHS on, and they can move within a single Senedd term. But the longer-term challenge also needs to be addressed in parallel.

4 Build a team around the problem. Bring together the clinicians, managers, booking staff, analysts and patients who know where the delays happen, and build ongoing capability as they do the work.

5 Find what already works and test it. Wales is good at creating local excellence. Start there, rather than from scratch.

6 Grow it and share it. Spread what has been shown to work across every board, and fund the organisations taking it on, not just the one that came up with it.

None of this will succeed without the right leadership, governance and culture.

Boards have to make improvement their main business. Non-executives need the skills and information to scrutinise it.

Clinicians, consultants in particular, have to be part of the change. That thread runs through every section of this paper.

The same approach applies to the longer-term challenge of urgent and emergency care, which we cover in section 7.

That is a ten-year job, rooted in neighbourhoods, social care, therapy and reablement rather than more ambulances, emergency departments or beds.

Our Approach

Test, Learn & Grow

Our approach: Test, Learn and Grow

Perago has spent ten years delivering change with public bodies across Wales and the UK, including Dŵr Cymru Welsh Water, Digital Health and Care Wales, the Home Office, Welsh Government, and Caerphilly, Rhondda Cynon Taf and Neath Port Talbot councils. The organisations differ, but what makes change stick has been consistent.

Perago works in short cycles. A small external team with hands-on expertise works alongside the people who know the organisation best. Changes are tried on a small scale, adapted quickly and spread once they work.

Throughout, the organisation's own staff build the skills to keep improving, so the change lasts after Perago exits rather than creating a dependency on consultants.



TEST

Break big, complex problems into pieces small enough to deliver in weeks, each with its own measurable outcome.

Start in one place, with a team made up of the people who do the work, and get something real in use quickly. Testing small is not timid. It is the fastest way to find out what works and the cheapest way to find out what doesn't.

LEARN

Understand the problem from the user's side, whether that is a patient, a member of staff or a carer. Measure honestly and often, looking at trends rather than snapshots.

Be precise about why something worked: which parts are essential, which can be adapted locally, and what conditions it needed. Stop what isn't working and do so without blame.

GROW

Spread what has been shown to work, deliberately, with the people who made it work helping others do the same. Fund the organisations taking it on, not just the one that came up with it.

Build capability as you go, so the organisation keeps improving after external support has gone. Perago judges its work as much by what keeps going after it has left as by what it delivers while it is there.

Three principles sit underneath this approach:

Work in the open, amplify what already exists, and focus on delivery rather than documents. None of it works without leadership that gives teams permission to try things, a board that asks about improvement as often as it asks about performance, and a culture where stopping something that isn't working counts as progress, not failure.

This is not a private method. It matches what the evidence says about improvement in complex public services, and what the evidence says about escalation in Wales. The rest of this paper applies it to NHS Wales, with waiting lists as the worked example. Section 5 shows it in practice at Caerphilly County Borough Council and in the NHS.

01

Why escalation is not working

The escalation framework is where improvement in NHS Wales has stalled. As it operates today it is punitive, vague and self-defeating. Moving from “why are you failing?” to “how do we help this organisation succeed?” is the first and most important change. It needs no legislation and no new money.

In 2016, four of the seven health boards were in routine arrangements.

Since 13 September 2023, none has been.

(Welsh Government, 2023)

Betsi Cadwaladr has been escalated without a break since 8 June 2015, more than eleven years.

(Welsh Government, 2024a)

A decade of escalation

Our analysis of Welsh Government written statements on the escalation status of all seven health boards, from 2015 to August 2026, shows five things.

- The exception has become the rule. In 2016, four of the seven health boards were in routine arrangements. Since 13 September 2023, none has been (Welsh Government, 2023).
- Escalation has stopped being a phase. Betsi Cadwaladr has been escalated without a break since 8 June 2015, more than eleven years, and is the only board to have been in special measures twice (Welsh Government, 2024a). Hywel Dda and Swansea Bay have been escalated continuously since September 2016.
- De-escalation does not hold. Betsi Cadwaladr left special measures in November 2020 (Welsh Government, 2020) and was back in them 27 months later, on 27 February 2023 (Welsh Government, 2024a). Aneurin Bevan's finance domain moved from Level 3 to Level 4, back to 3 and back to 4 between September 2023 and December 2025 (Welsh Government, 2026j).
- Finance and planning are the main triggers. The largest escalation event of the decade came on 13 September 2023, when every board not already escalated was escalated at once for failing to submit a balanced Integrated Medium-Term Plan.

  The Minister linked the financial position to "inflation and austerity" (Welsh Government, 2023). In effect, boards were escalated for economic conditions outside their control.

  Failure to produce an approvable plan appears as a reason for escalation in 2016, 2019, 2022 and 2023, across five different boards.
- Only one board has fully de-escalated a service and held it. Cwm Taf Morgannwg's maternity and neonatal services went from special measures in April 2019 (Welsh Government, 2019) to routine arrangements in April 2024, along with its governance, leadership and culture domain (Welsh Government, 2024b).

  It is the framework's one clear success in a decade. It needed an independent oversight panel, a named external chair and published conditions.

What the successes have in common

The de-escalations that held were judged against a test that was specific, measurable and time-bound. Those that later unravelled had rested on general assessments of progress.

Four de-escalations in the decade met that standard: Cwm Taf Morgannwg's maternity services in 2022 and 2024, against conditions monitored by an independent panel (Welsh Government, 2022b, 2024b); Hywel Dda's cancer domain, on a numeric threshold sustained for three months (Welsh Government, 2026c); Cwm Taf Morgannwg's finances in 2025, on two consecutive years of in-year balance (Welsh Government, 2025d); and Swansea Bay's CAMHS in 2026, on improvement maintained for three months (Welsh Government, 2026d).

This is test and learn under another name: a clear outcome, a defined scope and an honest measure of whether the outcome has been met. The framework already contains the pattern that works, but it does not make it the rule.

Why the framework produces these results

Four features of the framework keep the pattern going.

GETTING OUT IS STRUCTURALLY HARD.

Domains can be de-escalated individually, but whole organisations rarely move down a level. When escalation happens across several or all domains at once, the public story is one of failure, even when parts of the organisation are improving.

Hywel Dda entered Level 4 across all six domains in January 2024. Two and a half years and four de-escalation decisions later, it still holds Level 4 on four areas, including finance and urgent and emergency care. (Welsh Government, 2026k) An improving board has no fast route out, and the public sees no sign of progress.

THE CRITERIA ARE TOO UNCLEAR TO PLAN TOWARDS.

In March 2022 the Welsh Government told the Senedd's Public Accounts and Public Administration Committee that the framework was "not clear about what factors would trigger a change in an organisation's status", and that the longer an organisation stays escalated "the more it becomes the 'norm'" (Welsh Government, 2022a).

It committed to refresh the framework. Four years later the diagnosis was the same. The new framework announced in September 2026 is the first serious attempt to act on it.

It still has gaps, and this paper sets out practical ways to close them.

ESCALATION USES UP THE CAPACITY TO IMPROVE.

When exit criteria are qualitative and shift over time, organisations do the rational thing.

They focus on producing the assurance evidence that might get them out, rather than the improvement that would let them succeed. Feeding the assurance process, which itself escalates if progress is judged too slow, pulls the board away from improvement and towards short-term fixes and clever arguments.

The English evidence found the same: extra assurance processes were a burden because of the time needed to gather data, competing demands and unrealistic timelines (Vindrola-Padros et al., 2022).

THE MODEL OF IMPROVEMENT IS WRONG.

An NIHR-funded evaluation of the English special measures and challenged provider regimes, covering eight trusts, sixty interviews and 291 documents, found turnaround was treated as a linear process.

It concluded that real improvement takes longer to embed than short-term turnaround interventions allow (Vindrola-Padros et al., 2022).

Staff described feeling shocked and ashamed on entering the regime. Stigma hurt recruitment and retention, and duplicate reporting created overwhelming workloads. What worked was engaged senior leadership, strong clinical input, collaborative external partnerships, real staff engagement and open cultures.

A regime that makes an organisation harder to staff, when its problems are partly caused by shortages of staff and skills, is a trap.

Cwm Taf as the model, Betsi as the warning

Cwm Taf worked because it was tight: one service, a dedicated team, clear accountability, a named external chair, published conditions and a defined scope. Even so, it took five years (Welsh Government, 2019, 2024b).

Betsi is the opposite. Its escalation covers everything, and on the current trajectory it is realistically ten years or more from meeting all its criteria.

That leaves the government with three poor choices: de-escalate on a judgement the evidence won't comfortably support, keep the board where it is indefinitely, or break it up.

Breaking it up is politically attractive. It is probably the worst option for tackling the underlying causes of north Wales' difficulties.

The lesson is that specific, measurable improvement in manageable pieces beats an all-encompassing framework that relies on judgement. That is true of escalation, and it is true of any complex change.

In Perago's experience, transformation succeeds when it is broken into pieces small enough to deliver and learn from within short time frames, each with its own outcome. It struggles when it is run as one large programme judged on general progress.

Language matters

Schools that struggle are not escalated. Support is wrapped around them, and the result is a school improvement plan. The NHS in Wales has an escalation framework, and Level 2, enhanced monitoring, mostly means more meetings and more "targets and terror" (Bevan & Hood, 2006).

Replace enhanced monitoring with early support, with the explicit aim of preventing escalation to Levels 3, 4 and 5, and it becomes the most useful tier in the framework. The scale can then describe a journey towards improvement rather than a slide into failure.

The 2025-26 framework started to move this way, with an "areas of concern" level designed to prevent further escalation (Welsh Government, 2025b).

The Accountability and Support Framework announced on 29 September 2026 goes further, promising earlier, proportionate and time-limited support with clearer thresholds (Welsh Government, 2026h). Whether it delivers depends on the design choices set out in the next section.

02

De-escalation as the trigger

Getting escalation right is the trigger for everything else in this paper. Clear exits and early support give boards their time back, and that time can go on improving services.

The new Welsh Government announced a review into the escalation framework reported as part of its 100 day plan for office. A new Accountability and Support Framework keeps five levels, assesses five domains, and promises earlier, proportionate and time-limited support.

Each level comes with a defined package of support, targets, deadlines and regular reviews, and the framework sets out what organisations must achieve before oversight is reduced (Welsh Government, 2026h).

That is welcome and consistent with the evidence above. The test is in the detail: whether exit criteria are published, specific and measurable for every organisation, including those already escalated.

We propose five design principles for the new framework as it is implemented. None needs legislation or money. Together they apply test, learn and grow to the framework itself.



1 DEFINE THE EXIT AT THE POINT OF ENTRY.

No organisation should be escalated without published, specific, measurable and time-bound de-escalation criteria, agreed with it at the outset.

Publish criteria now for every body already escalated. This is the test: a clear outcome everyone can see and plan towards.

2 MATCH THE TIMESCALE TO THE EVIDENCE.

Set escalation periods of three to five years, with staged milestones, and say so publicly at the start, so political and media expectations match the organisation's (Vindrola-Padros et al., 2022).

3 REPLACE ENHANCED MONITORING WITH EARLY SUPPORT.

Allocate an improvement partner when an organisation starts to struggle, not after it has failed.

The partner should bring capacity and method, and share accountability for the outcome with the board.

A partner is only as useful as its method, and three things matter most: short delivery cycles, with something real in use regularly; large ambitions broken into deliverable pieces, each with its own outcome; and changes tested in one place before they are scaled, so what spreads is what has been shown to work.

4 START WITH THE LEADERSHIP TEAM.

Before recovery planning begins, ask whether the board and executive work as a team. The turnaround evidence points to leadership team quality as the main difference between organisations that recover and those that don't (Vindrola-Padros et al., 2022; Burgess et al., 2022).

Where individuals are underperforming, act early and kindly, not as a last resort after a long period of public difficulty. Section 4 sets out what good board leadership looks like.

5 ONE REPORTING CHANNEL, AND DE-ESCALATION AS A DESIGNED EVENT.

Set a single, consolidated set of reporting requirements. Treat domain-level de-escalation as a public mark of success. Keep the improvement partner in place for a defined period afterwards so the gains hold.

At present de-escalation is simply the absence of escalation, which gives nobody anything to aim for.

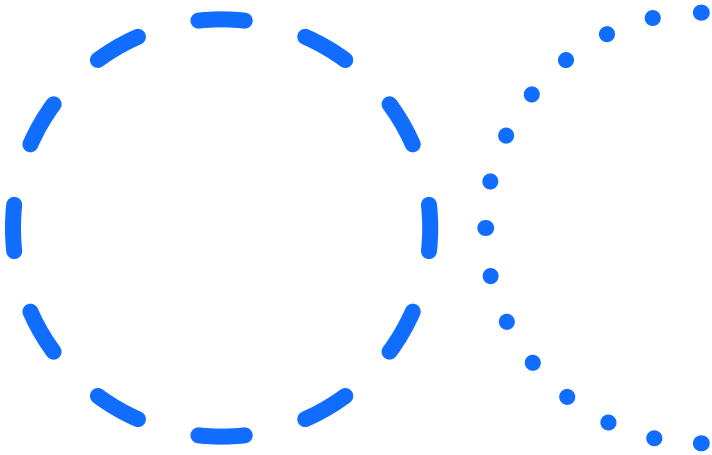
These principles turn escalation from a verdict into a learning loop: set a clear test, support the organisation to meet it, learn from what happens, and recognise progress when it comes.

What the time is for

De-escalation is not the goal in itself. What matters is what boards do with the time and attention it frees.

Today, executive teams spend much of that time producing evidence for the assurance process. Under a better framework, it should go on a small number of improvement priorities, chosen by the board, agreed with Welsh Government and reported simply.

For most health boards, the first of those priorities should be waiting lists. Section 4 sets out the leadership, governance and culture that make this possible. Section 5 then works through waiting lists as the example.



03

Why the NHS needs a different mindset

Many familiar assumptions about managing public services work differently in the NHS. That includes how productivity is measured, how demand is managed, the value of managers, how the workforce is negotiated with, how governance works, the gap in time between investment and savings, and the absence of an “intelligent client” at the centre of government.

Deficit has become normal

The NHS has no equivalent of a local authority Section 114 notice, and deficit has been normalised. People with long memories of the west Wales health system describe Hywel Dda as having been in recurrent deficit for the better part of thirty years.

Years of restructuring and one-off financial measures make that hard to verify, but its deficits are long-standing and pre-date the escalation framework. Its position remains the most severe in Wales.

Auditors found it exceeded its cumulative revenue resource limit by £112m over 2023/24 to 2025/26, and the Auditor General classed the excess as irregular expenditure (Audit Wales, 2026).

Escalation hits senior leaders hard. Many staff barely feel it. Inside the organisation it becomes normal, met with a shrug by people who have watched leaders come and go.

The bigger risk is that people are voting with their feet where they can.

Private spending is the fastest-growing part of UK healthcare spending, from a low base. Voluntary health insurance grew 13.8% in real terms in 2024, faster than any other way of paying for care, though it is still under 3% of the total.

The ONS links that growth to employer-funded policies, rising demand for private care and pressures in the NHS (Office for National Statistics, 2026). A slow unravelling of the social contract behind the NHS is what should worry us most.



An ecosystem, not a machine

The NHS behaves more like an ecosystem than an organisation. It reacts to change in complex, non-linear ways, which is a direct problem for improvement plans built around overly simplistic metrics.

Turnaround in the NHS has to be relational. It works through people, relationships and power, with a clear grasp of how the parts depend on each other (Vindrola-Padros et al., 2022). Local government interventions can often be blunter and more direct.

This is why test, learn and grow suits the NHS. In a complex system you cannot plan your way to improvement in advance.

You make a small change, see what happens, learn and adjust. Large, fixed plans assume a predictability the system doesn't have.

Eight sources of complexity

1 PRODUCTIVITY MEASUREMENT.

NHS Wales has no published productivity index equivalent to NHS England's or the ONS UK healthcare series, and even those take a narrow view.

On a wider definition, prevention is likely to be one of the biggest productivity gains available. Study after study shows a strong return on most prevention measures, but the opportunity is rarely assessed systematically, let alone acted on.

Process measures suffer from data gaps and a lack of detailed pathway costs, so organisations are largely in the dark about where to focus. The Auditor General has called for a sharper focus on value for money and a shift towards prevention and the longer term (Audit Wales, 2026).

2 COSTS AND BENEFITS DON'T LINE UP IN TIME.

Even with a strong focus on productivity, organisations in deficit face a gap between when they spend and when they save. Payback can take years and the money is needed up front.

3 A FOCUS ON PRODUCTIVITY IS NOW ESSENTIAL.

With tight settlements for the foreseeable future, Baumol's cost disease makes productivity the only long-term option (Baumol, 2012). Without it, NHS pay keeps tracking productivity growth in the wider economy while NHS productivity falls further behind.

4 DEMAND DOESN'T GO AWAY.

Most public services can ration by queue or eligibility, and unmet demand disperses.

In health it comes back later, costs more and usually arrives through the emergency department.

5 MANAGERS MATTER.

The NHS is widely argued to be undermanaged, despite public perception. Everyone is firefighting, clinicians are pulled into administration, and nobody has time to look ahead. Change and organisational development capability is often the first thing cut because it is seen as a nice-to-have, when it is mission critical. Section 4 returns to this.

6 THE WORKFORCE.

National contracts, professional regulation and a difficult labour market, especially in rural and coastal areas, make workforce management complex and constant.

7 GOVERNANCE.

A unitary board responsible for a wide range of services, sometimes over a large geography, has to work through a thicket of national measures, strategic priorities and escalation conditions (Welsh Government, 2025b).

Assurance crowds out scrutiny, and scrutiny crowds out strategy. Section 4 sets out how boards can change that.

8 THE INTELLIGENT CLIENT.

Every system that improved and sustained it had a centre that did three things: set a small number of aims, built improvement capability, and held named people accountable through a published agreement.

Scotland's Patient Safety Programme worked because the centre convened, taught and measured, with board executives and non-executives directly engaged through more than 1,000 ward-level leadership walkrounds (The Commonwealth Fund, 2011).

The US Veterans Health Administration worked because its Under Secretary for Health signed an annual performance contract with each network director across six value domains: quality, access, patient function, patient satisfaction, community health and cost-effectiveness (Kizer & Dudley, 2009; Perlin et al., 2004).

The lack of such a centre in Wales has been a recurring criticism, including in the OECD review and the 2018 Parliamentary Review (Bodea et al., 2026).

The right structure, the wrong accountability

The health board structure in Wales is not the problem. In fact, England is now moving towards the same model. Seven boards responsible for the health of their whole population removes the barriers that often divide primary and secondary care, and physical and mental health. The issue is that those advantages are not being used.

The NHS Wales Performance Framework 2025-26 has 53 measures: ten on population health, 25 on quality and access, four on workforce and fourteen on a higher-value system. Above them sit five strategic priorities (Welsh Government, 2025b).

Below them sit integrated medium-term plans, the escalation framework and organisation-specific escalation conditions. Reporting goes to four bodies, Welsh Government, Audit Wales, Healthcare Inspectorate Wales and NHS Wales Performance and Improvement, with overlapping authority between them, since each retains the right to take its own action (Welsh Government, 2025c).

Compare that with the Veterans Health Administration's six domains (Kizer & Dudley, 2009), or East London NHS Foundation Trust, whose board moved from red-amber-green ratings to control-chart reporting during 2018, with measures owned by the teams doing the work (East London NHS Foundation Trust, 2018). Fifty-three measures dilute focus and create competing priorities.

The best natural experiment in UK health policy is the post-devolution split in waiting times. England set maximum waiting times that fell each year, from eighteen months in 2000/01 to six months by 2005, with hospital-level publication and real consequences. Wales and Scotland did not.

Using Scotland as the comparator, Propper and colleagues found the English regime cut the share waiting over six months by six to nine percentage points, over nine months by around 35% and over twelve months by around 60% (Propper et al., 2008).

Besley, Bevan and Burchardi (2009), using Wales as the control, found the same, and noted that in Wales missing targets was seen to bring extra resources.

What worked in England was not the number of targets. It was focus: a small number of aims, published for each delivery unit, with real and differentiated consequences (Propper et al., 2008).

Wales has 53 measures, published in aggregate, under a consequence regime that catches everyone and so distinguishes no one. It has taken on the costs of a target regime without the thing that made one work.

Not the time for reorganisation

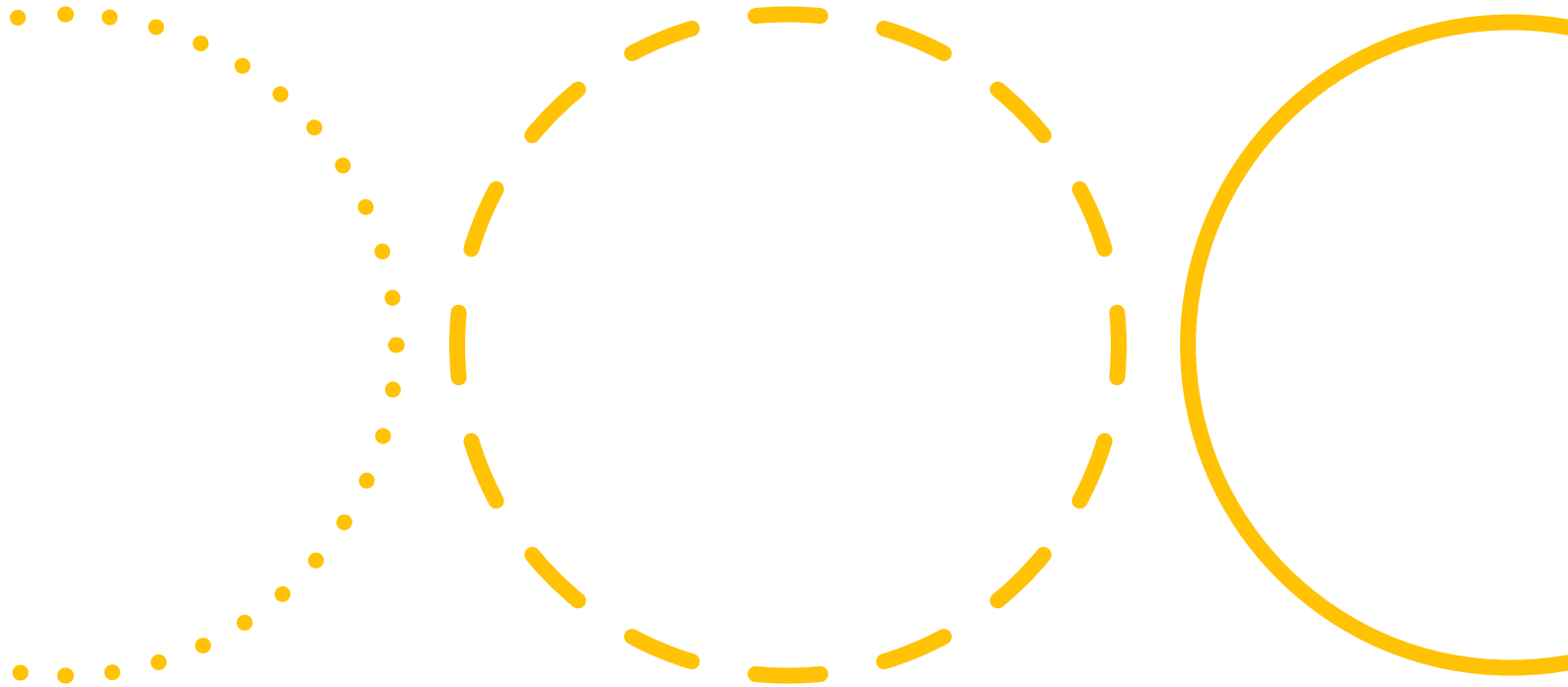
Pressure for structural change will build during this Senedd term. It always does, and it can be politically attractive.

Now is not the time, and the delivery system is not the place. Reorganisation reliably absorbs senior attention for limited return, and the research consistently finds structure matters less to performance than funding, targets and culture (Nuffield Trust, 2023).

A capable centre with fewer aims makes health board reform unnecessary.

The answer to pressure for restructuring is a working improvement system, published in year one and delivered in years two and three.

That makes leadership, governance and culture more important in the NHS, not less. They are the subject of the next section.



04

Leadership, governance and culture

Test, learn and grow will not succeed without the right governance, strong leadership and a culture that supports and embeds change. That has been true in every organisation Perago has worked with. It matters even more in the NHS, where clinical professions, national contracts and public boards all shape what can change. This section sets out what that means in practice for health boards in Wales.

PUT IMPROVEMENT AT THE TOP TABLE

Test, learn and grow has to be a central part of the formal board agenda. Detailed scrutiny can sit with a performance committee or the audit and risk committee. But if improvement is going to get traction, it needs oversight at the top table. The board should own it, ask about it at every meeting and see the results.

KEEP REPORTING SIMPLE

Cutting 53 national measures to fewer than ten creates a real opportunity for simple board reporting. It won't happen on its own.

Large organisations, and acute hospital services in particular, are skilled at finding ways to add complexity back in. Welsh Government shouldn't mandate a reporting template.

It should set a clear expectation that boards see a small number of measures, shown as trends, in plain language.

REBALANCE THE BOARD

A health board typically has nine executive members and a similar number of independent members, plus others who attend.

Large executive attendance spreads attention thinly and tilts the balance of the room towards management. Boards should consider a smaller core of executives for the board's main business, for example the chief executive, the medical director and the directors of finance, planning, workforce and digital, with other executives attending for the items they lead.

That focuses attention on a few key people and gives independent members a stronger default voice.

There is a constraint. The executive members of a health board, including the officers responsible for nursing, public health, and therapies and health science, are set in regulations (Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009).

Changing formal membership would need those regulations amended. What boards can do now is decide how their meetings run, which items need which executives, and where detailed discussion happens.

BRING CONSULTANTS INTO THE CHANGE

Transformation depends on movement from doctors, usually consultants.

The line of accountability from medical director to assistant medical directors to clinical directors suggests a degree of control that is often more apparent than real.

Consultants frequently choose their own course, whatever the agreed plans say.

There is already an annual, formal process for agreeing what consultants do, at both contractual and individual level: job planning. Boards should use it.

That includes looking at the balance between direct clinical care and supporting professional activities, the protected time for teaching, audit and service improvement.

Improvement work should be planned into consultants' time, not squeezed around it. A short, regular board item on clinical engagement in improvement would give this the attention it needs.

PROFESSIONALISE SCRUTINY

Good scrutiny is the board's main tool for keeping improvement on track. Too often it is crowded out by assurance. Independent members are appointed for their expertise, but many get little structured development in how to scrutinise complex clinical and operational performance, read trend data or challenge an improvement plan.

The independent member role should be treated as a professional one, with:

- a clear competency framework for all board members, used in recruitment, induction and annual appraisal. NHS England introduced one in 2024 for executive and non-executive board members alike (NHS England, 2024), and Wales could adapt it.
- structured induction and ongoing development in improvement methods, data and scrutiny.
- information presented so that it can be scrutinised: trends rather than snapshots, and a small number of measures.

Effective scrutiny asks whether a change is working, why, and what the board is doing to spread it. That is a different question from whether a target was met this month.

SET EXPECTATIONS FROM THE TOP

The chair sets the tone. Welsh Ministers should include transformation and continuous improvement in the essential criteria when recruiting health board chairs, and reference them in each chair's annual remit letter. Independent member recruitment already requires a digital lead. There is no need to change that. As long as the chair is committed to the approach, the rest of the board will follow.

KEEP MEETINGS PUBLIC

Public board meetings are not the ideal setting for raw scrutiny. But they are part of how health boards answer to the people they serve, and removing them would send the wrong signal. The answer is to do detailed scrutiny well in committee, and to use the public meeting to show progress openly.

BUILD A CULTURE THAT EMBEDS CHANGE

Governance sets the frame, but culture decides whether change sticks. In the organisations that improve and stay improved, teams are trusted to try things, stopping something that isn't working is seen as progress rather than failure, and the people who make change happen get the credit. The turnaround evidence is consistent on this: the quality of the leadership team is the main difference between organisations that recover and those that don't (Vindrola-Padros et al., 2022; Burgess et al., 2022).

That is why test, learn and grow builds skills inside the organisation as it goes. The real test of any change programme is whether it is still running once the external team has gone.

05

Waiting lists: where and how

Waiting lists are where we would start. They are the most visible and intuitively understood measure that the public judges the NHS on, and they can move within a single Senedd term.

They also show the whole approach at work: a clear outcome, a team built around the problem, good practice found and tested, then grown across Wales. Run well, a national elective programme is the best place to build the improvement capability the rest of the system needs. But there is a warning from the past. Previous waiting-list pushes have absorbed a lot of money on short-term capacity boosts that were not sustained, often at the expense of the longer-term measures we set out in this paper. A national programme must not repeat that mistake.

Where waiting lists stand

At the end of March 2026 there were 666,700 patient pathways waiting, around 529,100 individual patients (Welsh Government, 2026e).

Against a Welsh population of 3,187,000 that is about one in six people, though the figure counts patients on NHS Wales lists rather than Welsh residents, so Welsh residents treated in England are excluded (Office for National Statistics, 2025; Senedd Research, 2026a).

The total has risen every month since, to just under 709,700 by the end of July 2026, after ten consecutive monthly falls (Welsh Government, 2026i).

Two-year waits rose from just under 2,600 in March to just under 3,700 in April.

They are still 96.3% below their March 2022 peak, but growing again (Welsh Government, 2026e, 2026f).

On the comparable consultant-led measure, Wales had around 589,500 pathways in March 2026, or 18 per 100 people against 12 in England, down from 23 per 100 a year earlier (Welsh Government, 2025a, 2026e).

A big gain that is now eroding suggests improvement has come from one-off effort rather than changed process.

History is a warning. The £1bn Planned Care Recovery Plan of April 2022 set five targets at once, covering outpatient waits, two-year treatment waits, diagnostic and therapy waits, a one-year maximum wait, and cancer treatment within 62 days (Senedd Research, 2025a).

By the end of the Sixth Senedd, none had been met (Senedd Research, 2026a). Five simultaneous targets produced five missed targets.

One aim, one national programme

We propose a single aim for the term: Wales to be the fastest-improving nation in the UK on elective waiting times by the end of this Senedd term, closing the gap with England on pathways per head.

Health board chief executives and medical directors should commit to one national programme with a shared team, focused first on getting the most out of existing capacity rather than building new.

START WITH THE CAPACITY THAT ALREADY EXISTS.

Surgical hubs are being approached in the traditional way, buildings first. There is very likely spare capacity in existing theatres.

Get every chief executive and medical director in one room, build a shared mission, and remove the barriers to pooling staff and patients across Wales.

Alongside the hubs, this will do more for waiting times than is currently planned.

PROTECT THE HUBS.

New surgical hubs in England delivered a 21.9% increase in high-volume, low-complexity surgery in their first year, around 29,000 extra procedures a year across 31 trusts (Co et al., 2025).

Ring-fencing staff and theatres from emergency pressures is what defines a hub. The evaluation could not separate the effect of greater efficiency from the extra resource that came with opening a hub, and the gain took about three months to appear.

PUBLISH THE WHOLE PICTURE, MONTHLY, BY BOARD, AS CONTROL CHARTS.

In the early years of the English regime some patients were shuffled to hit specific targets in ways that pushed up average waits (Besley et al., 2009; Bevan & Hood, 2006).

The current focus on the longest waits in Wales risks storing up a bigger problem for 2029. Comparing boards on trend rather than ranking them on breaches makes that visible.

VALIDATE RELENTLESSLY.

Require and reward better recording, checking and validation of waiting lists, with peer review between boards so list management becomes self-regulating and self-improving.

How: build a team around the problem

The programme should not be run from the centre as a set of instructions. It should work the way test, learn and grow works in any organisation.

Form a multidisciplinary team for each part of the problem. For waiting lists that means consultants and surgeons, theatre and ward staff, booking and administrative teams, managers, data analysts and patients.

These are the people who know where the delays happen and why. A small external team can bring method and pace, working alongside them.

Find the good practice that already exists. Somewhere in Wales a board is already validating its list well, running theatres efficiently or booking patients without repeated calls. Start by finding it, understanding why it works and testing whether it works elsewhere.

Test in one place. Pick one speciality or one site, make a change, measure it honestly and adjust. Something real should be in use within weeks.

Develop skills as you go. Staff on the team learn improvement methods by doing the work, then take those skills back to their own services. That is how capability grows inside the organisation.

Grow it. Once a change has been shown to work, spread it deliberately to other sites and boards, with the original team helping. Section 6 sets out how.

Appointment booking shows why this works. At Hywel Dda, a patient rings and can't be given a date, another member of staff has to follow up, the patient misses the call and rings back, and the loop eats staff time.

The answers are almost always already in the room. What frontline teams lack is not ideas. It is capacity, permission and skilled support.

That is where governance comes in. The board's job is to protect the team's time, clear obstacles and keep the programme on its agenda. Consultants' job plans should include time for the work.

Independent members should ask whether changes are working and spreading, not only whether this month's target was met.

Run this way, the elective programme tests the whole approach. It has a single clear outcome, a shared delivery team, honest measurement and a deliberate plan to build skills that boards keep.

If it works, the government gets both a result the public can see and a working model for improvement everywhere else.

The approach in practice

CAERPHILLY COUNTY BOROUGH COUNCIL

Caerphilly County Borough Council faced a projected £65m funding gap as financial pressures combined with rising demand for services, a challenge familiar to NHS organisations.

Rather than salami-slicing budgets, the council worked with Perago on an organisation-wide programme that changed how it planned, delivered and managed services, and how it engaged its staff.

The first job was to make the landscape visible. Audit Wales had found the council's medium-term financial plan underdeveloped (Audit Wales, 2022). The council was also trying to do too much at once, with 370 live initiatives.

Moving to a single portfolio let leaders prioritise, see dependencies between programmes, track benefits and direct limited resources where need was greatest. Just as important, people were given the authority and permission to stop things.

Contact management shows the method. Rather than starting with a new system, the team started with what happened when a resident got in touch: how often they got an answer first time, and what happened when they didn't. First-contact resolution rose from 38.8% to 76.1%, and average telephone waits fell below two minutes.

Much of the culture change came from small, tangible wins, such as spend controls and reining in Amazon Prime accounts and duplicate spend.

These gave staff a way to see the bigger mission and contribute to it through everyday decisions. Sustained sponsorship from senior leaders and elected members kept up momentum through difficult decisions.

The programme delivered £20m of realised savings in its initial phase. In 2025/26, a year after the Perago team had left, the council delivered a further £13.5m on its own.

It now holds lasting in-house capability in portfolio management, benefits realisation, spend control, supplier management and leadership development.

The parallels with the NHS are direct: too many initiatives without shared priorities, repeat contact eating into capacity, and savings that came from changing how the organisation works rather than treating financial targets as an end in themselves.

Caerphilly shows what can happen when change is built to last. The next example, from NHS Wales, shows what happens when it isn't.



An example from NHS Wales

THEATRE PRODUCTIVITY: A GAIN THAT WORKED BUT DIDN'T LAST

In one of the authors' former organisations, a small district general hospital in Wales, theatres routinely started late and finished early, so lists were cancelled, patients waited days on wards for a slot, and surgeons and anaesthetists felt underused.

Everybody was working hard to get patients treated. But getting a patient from ward to theatre to recovery needs porters, ward staff, operating department practitioners, anaesthetists and surgeons to work in concert.

Every link and handover has to work, and when something fails it is all too easy to assume it was someone else's fault.

With waiting lists rising, the hospital tried something different. It put everyone on the pathway in one room with the baseline data, led by a manager with the authority to make changes happen.

The meetings were about teamwork and improvement, not blame, and ideas came thick and fast.

Testing those ideas became a discipline in itself. The team met every week to check the results of the previous week's changes.

Some worked, some needed tweaking and some were dropped. Within a few months theatre utilisation had improved by around 20%, so many more patients were treated and could go home sooner.

Then the lead manager was moved to "more urgent" work. Within a few months the gains had gone.

The improvement didn't fail. The system around it did. A board answering to too many measures and an overbearing escalation regime lacks the bandwidth to keep every plate spinning, and staff on the ground are too stretched by daily pressures to hold the gains on their own.

That is the problem this paper sets out to solve: not how to make change happen once, but how to make it last and spread.

That is the route to real productivity gains and the long-term sustainability of the NHS.





06

Grow: spreading what works

Wales is good at creating local excellence and poor at spreading it. Spreading what already works is the biggest and cheapest gain available. It is what turns a successful waiting list pilot into change across the whole system, and it is where the longer-term productivity gains come from.

NHS spending rose from 39.8% of the Welsh Government's total resource budget in 2010/11 to 52.3% by 2019, and health and social care now accounts for more than half of day-to-day spending (Senedd Research, 2019, 2026b). Demography, rising acuity, medical inflation and Baumol's cost disease drive it (Baumol, 2012).

The acute sector absorbs almost all growth funding, leaving nothing to invest in community and primary care. That creates a vicious circle: underinvestment upstream drives more acute demand, which consumes even more money. Wales cannot "move care left" because the up-front investment isn't there.

Secondary care's share of health board resource rose from 75% to 78% between 2019/20 and 2023/24, while primary care's fell from 23% to 20%. Wales has 89 GPs per 100,000 people, the lowest of any UK nation (Bodea et al., 2026).

Money has been moving towards acute care for years, the opposite direction to every system in the international evidence that sustained a productivity gain.

The only medium-term lever is productivity, delivered through funded prevention, adoption of existing improvements that haven't spread, AI-enabled redesign and workforce redesign.

The health literature is clear that non-adoption and abandonment, not technical failure, are the main reasons new approaches fail (Greenhalgh et al., 2017). A system that is weak at adoption turns technology into procurement spend and very little else.

Measure what matters

You cannot learn without honest measurement. Most political debate about NHS productivity confuses two things. Technical efficiency means doing the same work with less: more procedures per theatre list, shorter stays, fewer agency shifts, better procurement.

Allocative value means not doing work that shouldn't be done at all. Intermountain Healthcare in Utah found its biggest single productivity gain came from stopping inappropriate elective inductions of labour, which fell from 28% of inductions to under 2%. The protocol saves an estimated $50m a year across Utah and costs Intermountain about $9m a year in lost revenue (James & Savitz, 2011).

An efficiency programme would never have found it, because the work was being done efficiently. It just shouldn't have been happening.

Wales has a lot to build on: Prudent Healthcare from 2014 (Welsh Government, 2014), a National Clinical Director for Value-Based Healthcare since 2018 (Lewis, 2020), national outcome dashboards, extensive patient-reported outcome data and the Welsh Value in Health Centre. What it lacks is a published, system-level productivity measure.

The government should commission one jointly with the new health finance efficiency team (Welsh Government, 2026a), publish it quarterly, and include at least one measure of allocative value: activity not done because it was found to add no value.

That would mark this government's productivity agenda out from what came before.



Why good practice doesn't spread

Wales' core weakness is spreading and scaling good practice, two related but different things. Improvements stay stuck in local pilots that never become system change. Pilots often depend on passionate individuals and sit outside normal operations.

Wales needs national programmes that start small but are designed from the outset to spread, with shared learning and common measures.

The civil service cannot run this. Its role is oversight, not operational redesign. Health boards must lead, supported by specialists in service design and digital delivery.

The reasons good practice travels badly are well established (Greenhalgh et al., 2004, 2017; Horton et al., 2018).

Local best practice is a configuration: a technique, a set of working relationships, some spare capacity, tacit knowledge and a local story about why it matters, all aligned for a time. Spreading is therefore not transfer but re-achievement.

The receiving site has to achieve something similar with different people under different constraints.

Public systems fund the original achievement and almost never fund the re-achievement. That is why toolkits, case studies, awards and conference presentations rarely move anything.

Drawing on that literature and Perago's delivery experience, we see eight reasons spread fails. Nobody has established which parts of the original success caused it.

The original site had advantages nobody noticed, such as spare capacity or a stable team. Adopters copy the visible version and nothing changes. They have no capacity to absorb it (Harvey et al., 2015).

Enthusiasm at the first site paid for work that never gets funded elsewhere. Connections between teams are weak. Pilots are funded to be new, with no route into base budgets.

And practice drifts back to the baseline about eighteen months after the programme team leaves.

These usually work together, which is why single fixes such as better evidence, a mandate, a champions network or another fund tend to disappoint.

Four remedies

1 REQUIRE AN ADOPTION PLAN BEFORE ANYTHING SPREADS.

Two to four pages, produced jointly by the originating team, prospective adopters and an evaluator.

It should set out how the change works; the core elements that must not vary; the elements to adapt locally; the conditions a site must meet; the implementation effort in staff days; the minimum dataset; the effect a typical site should expect once regression to the mean is allowed for; and what the adopting site will stop doing to make room. This is the learning step made formal.

2 FUND THE RECEIVING END, NOT JUST THE SENDING END.

Cost protected time for the implementing team into the adoption case, spread improvement method rather than holding it centrally, provide analytical support, and name an individual with authority (Vindrola-Padros et al., 2022).

3 BUILD THE CAPABILITY ONCE, NATIONALLY, AND DEPLOY IT.

Wales cannot afford deep implementation capability in seven health boards and 22 local authorities, and 29 thin versions is the worst possible arrangement.

Create one strong national function that sends teams into adopting sites for the life of each adoption. Build it from what already exists in existing national improvement, workforce and digital bodies, and host it so that improvement and data sit together from the start.

4 MAKE STOPPING THINGS A FUNDED NATIONAL PROGRAMME

It is hard to spread change into a system that is already full. An explicit stop-list of practices, reports, meetings and returns to be discontinued, with the released capacity ring-fenced for adoption, creates the room.

A home for good ideas?

One option worth exploring is a front door for that national function: an improvement and innovation hub for health in Wales. Something like it already exists: Cardiff and Vale University Health Board's Dragon's Heart Institute gives staff a single point of contact for new ideas and support to develop them, and is open to staff across Wales.

The question is whether to grow that model nationally, alongside what existing national bodies already do, so that teams anywhere can bring ideas, find practice already tested elsewhere in Wales, and get support to adapt it. We don't make this a recommendation. Like everything else in this paper, it should be tested with the people who would use it before anyone builds it.

The Health Foundation's research on spread independently reaches the first two remedies (Horton et al., 2018). Start where readiness is highest.

Five English trusts received the same lean method, the same resource and five years of support from the Virginia Mason Institute. Their results diverged sharply, and the independent evaluation put the difference down to cultural readiness and senior leadership engagement, not method (Burgess et al., 2022). Begin in two or three boards and make them the teachers for the rest.

From practice: DVLA and Welsh Water

The Driver and Vehicle Licensing Agency in Swansea is the clearest Wales-based example of a large, complex public organisation transformed step by step rather than through one big programme.

In 2013 its IT had been outsourced for more than thirty years, most recently through a single large contract with IBM, Fujitsu and Concentrix that had run since 2002, under which every change was a contract variation.

Rather than attempt a big-bang replacement, DVLA started with three small exemplar services, View Driving Licence, vehicle management and personalised registrations, built by in-house teams working in short, iterative cycles.

Those exemplars built the capability for the bigger moves: abolishing the paper tax disc after 93 years, introducing Direct Debit for vehicle tax and, in September 2015, becoming the first government body to exit a contract of that scale, bringing more than 300 staff in-house.

Digital take-up rose from 49% to 58% in a single year and reached 92.3% by 2015/16 (Driver and Vehicle Licensing Agency [DVLA], 2016; Gye, 2015). Savings equivalent to £100m off the baseline running cost were realised within a year of completion. Perago's team held key leadership roles in defining and delivering this change.

Dŵr Cymru Welsh Water followed a similar path. Perago supported delivery of its digital transformation programme, using incremental delivery and continuous user research to keep customers at the centre of decisions while building in-house skills. The result was 97% customer satisfaction with online services, more than 60% of online transactions automated, around half of all contact arriving digitally, and online billing registrations growing by around 15,000 a month, all contributing to lower operating costs against the 2019/20 baseline.

The lesson for NHS Wales is the sequence. Test with small, visible wins. Learn from them. Use them deliberately to grow the capability for the structural change that follows.

Give boards the time to improve

Annual allocations produce annual behaviour and one-off fixes. When a health board plans to release recurrent cost through redesign, the savings often arrive years after the investment.

Wales' multi-year allocation process supports this, but escalated boards revert to an annual regime, so the only viable savings are those that pay back within the year. Decisions skew towards short-term fixes.

Audit Wales has warned that continuing financial pressure risks pushing NHS bodies towards short-term decisions to manage the annual position rather than longer-term reform (Audit Wales, 2026).

Jönköping in Sweden shows the alternative. Over two decades it treated quality as strategy, using resources released by improving existing work to fund new development (Baker et al., 2008).

Canterbury District Health Board in New Zealand shows the risk of forcing a challenged organisation into short-term decisions. It ran the most successful integrated demand-management programme in the evidence base for more than a decade.

In 2020 seven of its executive team, including the chief executive, resigned within six weeks. They had faced sustained pressure from the Ministry of Health, a Crown-appointed monitor and the board to cut the deficit by NZ$90m in a single year and return to break-even within two.

The executive's own thirty-month plan was rejected as insufficient (Williams, 2020).

Much of the deficit came from earthquake-related depreciation, capital charges and delays to a new hospital, and four external reviews had found the organisation operationally efficient compared with its peers. More than a decade of relational capital was lost.

What five-year success looks like

Less administrative load, faster access to primary care, shorter acute stays, fewer unnecessary referrals and redesigned pathways that reduce demand.

Crucially, these improvements are spread across every board, not trapped in isolated pockets.

That steadies budgets and creates room to invest upstream, breaking the vicious circle.

07

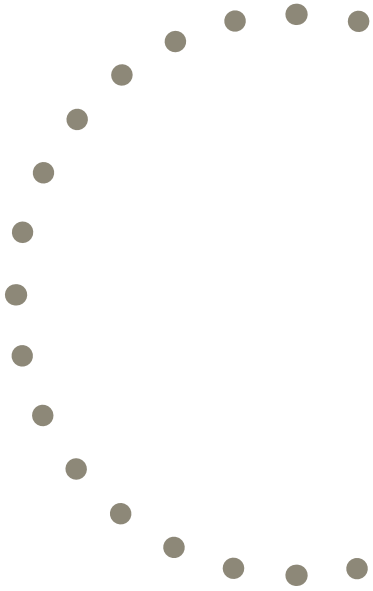
What comes next: urgent and emergency care

We need to start with an honest diagnosis. Urgent and emergency care is not a winter-pressure problem. It is a ten-year system reform challenge.

Urgent and emergency care is not a winter-pressure problem. It is a ten-year system reform challenge, and the next place to apply the same approach.

Emergency department overcrowding, ambulance delays and corridor care will not be fixed by operational tweaks or by adding ambulances, emergency departments or beds.

The real work is in social care, rehabilitation and therapy, the services that decide discharge, flow and avoidable demand based as close as possible to where people live.



The diagnosis

Average length of stay is 6.7 days in Wales against 5.1 in England (2024/25), so Welsh patients occupy a bed roughly one and a half times as long (Bodea et al., 2026).

Deprivation, rurality and demography explain part of that. Flow explains a large part: the speed of decisions, the time of day people are discharged, and whether community, reablement and social care teams are ready to receive them.

Delayed discharges, measured in bed-days, fell from over 95,000 a month in April 2023 to just over 60,000 by February 2026 (Bodea et al., 2026). The rest will be harder, because the earlier fall came mostly from buying extra capacity rather than changing the model.

The Senedd's Health and Social Care Committee has pointed to vacancies in social and domiciliary care, too little intermediate care with therapeutic input, and IT systems that stop health and social care sharing information (Senedd Research, 2025b).

Test the most promising models

The evidence points towards a therapy-led model built alongside social care, rather than simply more home care or care home places.

A 2025 rapid review for the Health and Care Research Wales Evidence Centre found strong evidence that time-limited reablement at home improves mobility, daily living and quality of life, and moderate evidence that it reduces the need for ongoing home care (Health and Care Research Wales Evidence Centre, 2025).

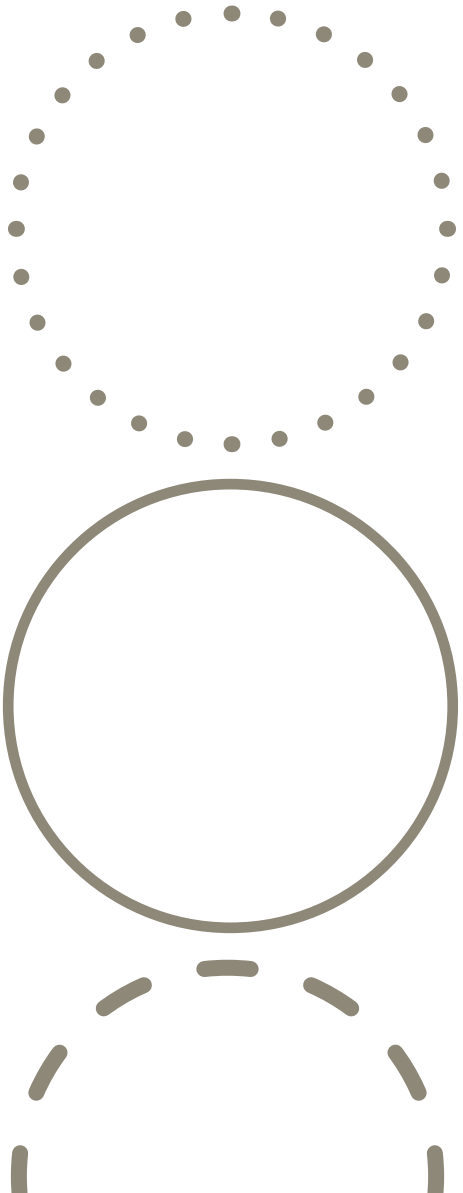
The evidence on hospital admissions is mixed (O'Shaughnessy et al., 2022; Conroy et al., 2014).

International models show what a different approach can look like. Buurtzorg in the Netherlands organises community nursing in small self-managing teams, with overheads of about 8% against a sector average of 25% (Gray et al., 2015).

Jönköping's Esther network in Sweden reframed every decision that crossed an organisational boundary around what was best for one older person with complex needs, and cut hospital admissions and rehabilitation stays (Gray, Winblad, et al., 2016).

Nuka in Alaska rebuilt primary care around integrated teams and same-day access (Southcentral Foundation, 2016). Closer to home, Hilary Cottam's work on relational welfare offers the design principles: continuity, relationship, capability, time, and the person's own goals (Cottam, 2018).

Because the evidence is promising but mixed, the right response is not a national rollout on day one. It is to test these models in real places in Wales, evaluate them properly and grow what works.



What to do first

MAKE REABLEMENT THE DEFAULT FIRST RESPONSE

to any new or post-discharge package of home care, with ongoing maintenance care the exception that needs justifying.

Measure the proportion of people who need less care after reablement than before (Health and Care Research Wales Evidence Centre, 2025).

RUN AN ESTHER-STYLE NETWORK WITH LOCAL GOVERNMENT ON FRAILTY AND DISCHARGE.

It costs little and is quick to set up (Gray, Winblad, et al., 2016). Consider giving Regional Partnership Boards legal status as corporate bodies, able to hold budgets and employ staff, so the network has a natural home.

TEST ONE BUURTZORG-MODEL DISTRICT NURSING SERVICE IN A SINGLE HEALTH BOARD,

with the 8% overhead ratio and self-managing teams as explicit design constraints, and evaluate it independently (Gray et al., 2015).

UNDERSTAND THE THERAPY WORKFORCE BEFORE PUBLISHING THE POLICY.

There is no published analysis of community occupational therapy, physiotherapy and rehabilitation support worker capacity, vacancies and distribution against what a reablement-first model would need. That constraint has to be understood first.

Sustainable improvement here depends on multi-year investment in workforce, estates and community capacity, not hospital-centred fixes.

08

Recommendations

We make eight recommendations to the Welsh Government and NHS Wales. They follow the story of this paper: de-escalation first, then the time it frees, then waiting lists as the first test, with leadership and governance running through. The first three need no legislation and no new money, and can be taken forward as the new Accountability and Support Framework is implemented (Welsh Government, 2026h).

1 MAKE IMPROVEMENT THE GOVERNING TEST.

The oversight and escalation framework should exist to drive measurable improvement and create the conditions for organisations to succeed.

2 DEFINE THE EXIT AT ENTRY, AND CELEBRATE DE-ESCALATION.

Publish specific, time-bound de-escalation criteria, agreed at the point of escalation, for every organisation already escalated as well as future ones. Recognise partial recovery where it has happened – optimism breeds optimism.

3 REPLACE ENHANCED MONITORING WITH EARLY SUPPORT.

Allocate an improvement partner with capacity, capability and method when an organisation starts to struggle, not after it has failed, with board and executive culture as the first diagnostic step (Burgess et al., 2022).

4 PUT IMPROVEMENT AT THE HEART OF BOARD GOVERNANCE.

Make test, learn and grow a standing item on every board agenda; set a clear expectation of simple, trend-based reporting; include transformation in the essential criteria for chairs and in their annual remit letters; give independent members a competency framework and structured development in scrutiny; and use consultant job planning to build time for improvement.

5 RUN ONE NATIONAL ELECTIVE PROGRAMME AS THE FIRST TEST.

Aim for Wales to be the fastest-improving nation in the UK on elective waiting times. Led by health board chief executives and medical directors with a shared team, built around multidisciplinary teams that find, test and spread good practice, aimed first at existing capacity, with hubs protected from emergency pressures by design (Co et al., 2025), linked to a maximum waiting time that carries consequences (Propper et al., 2008), and built deliberately to grow improvement capability.

6 ASK FOR LESS, AND REPORT IT DIFFERENTLY.

Fewer than ten published measures, a single consolidated reporting channel, control charts instead of red-amber-green, and a named owner for each measure.

7 BUILD THE CAPABILITY TO IMPROVE INSIDE NHS WALES.

One national implementation function built from what already exists; an adoption plan before any practice spreads; a funded stop-list; multi-year allocations with savings retention so improvement pays for itself; and a published Welsh productivity measure to judge it all by.

8 MAKE BETSI CADWALADR UNIVERSITY HEALTH BOARD THE FIRST TEST OF THE NEW APPROACH TO ESCALATION.

The north Wales health board has been under Welsh Government intervention for the longest and has most to gain from published exit criteria, a realistic horizon and early support. It is the place to show that the new framework offers a route out rather than a verdict. But continuous improvement depends on absorptive capacity, and Betsi Cadwaladr does not yet have enough of it. It will need a significant injection of leadership, organisational development and improvement capacity, and a change of tone from Welsh Government that reengages staff. However, the elective programme and the spread of good practice should start where readiness is highest.

09 -10

Timetable and what we are not claiming

Timetable

The timetable follows the test, learn and grow sequence and is aligned to the current Senedd term. The test phase runs from the implementation of the new Accountability and Support Framework to spring 2027. Learn and grow runs to the end of the Senedd term in 2030. Sustaining the change runs to 2036.

TEST: TO SPRING 2027

- Publish de-escalation criteria for every escalated organisation, including those already escalated.
- Replace Level 2 enhanced monitoring with early support and an improvement partner.
- Make test, learn and grow a standing board agenda item, and include transformation in chairs' remit letters.
- Set escalation horizons of three to five years publicly, with staged milestones.
- Move to a single reporting channel and fewer than ten measures, with a named owner for removing the rest.
- Agree one elective aim for the term, settle the maximum waiting time model, and agree hub protection rules before the first hub opens.
- Form the first multidisciplinary waiting list teams, and find the good practice they will test.
- Publish each organisation's deficit reduction path alongside its improvement programme.
- Commission the Welsh productivity measure and pathway value index, and set up national validation of the elective waiting list.
- Require an adoption plan before any practice spreads nationally, and publish the first funded stop-list.

LEARN AND GROW: TO 2030

- Improvement partners in place in every escalated health board, and control charts replacing red-amber-green at every board.
- First programmes run in two or three boards chosen for readiness, then spread by those boards.
- A competency framework and development programme in place for all board members, and consultant job plans that include time for improvement.
- Reablement the default first response in home care, with an Esther-style network and one Buurtzorg-model service running and evaluated.
- Multi-year allocations and savings retention for boards in escalation.
- The first de-escalation under the new framework, run as a designed public event.
- Community therapy capacity built to match a reablement-first model, and primary care's share of resource rising from 20%.

SUSTAIN: TO 2036

- Length of stay closing on 5.1 days, emergency admissions of older people falling, and delayed bed-days below 40,000 a month.
- Improvement capability held inside every board rather than centrally, and the external partner gone.

What we are not claiming

THAT ANY NAMED BOARD WILL BE FIXED.

We are not predicting outcomes for any board, and we offer no judgement on any board's leadership.

We are setting out a pattern that holds across all seven over more than a decade, and asking what follows from it.

THAT ASSURANCE IS THE PROBLEM.

Assurance is necessary. Public money, patient safety and ministerial accountability to the Senedd all require it.

The problem is assurance taking the place of improvement. The argument is about proportion and sequence, not abolition.

THAT ANY REGULATOR'S WORK IS UNNECESSARY.

Audit Wales and Healthcare Inspectorate Wales supply much of the evidence in this paper and are named participants in the escalation review (Welsh Government, 2026b).

The point about reporting burden is about how their requirements interact. No individual body is asking for anything unreasonable. There is a coordination problem.

References

Audit Wales. (2022). Assurance and risk assessment review: Caerphilly County Borough Council. https://wao.gov.uk/sites/default/files/publications/caerphilly_council_assurance_risk_assessment_review_english.pdf

Audit Wales. (2025, September 25). Health boards in Wales continue to experience significant financial challenges. https://www.audit.wales/news/health-boards-wales-continue-experience-significant-financial-challenges

Audit Wales. (2026, July 15). NHS struggling to control day-to-day costs despite continued funding increases. https://www.audit.wales/news/nhs-struggling-control-day-day-costs-despite-continued-funding-increases

Baker, G. R., MacIntosh-Murray, A., Porcellato, C., Dionne, L., Stelmacovich, K., & Born, K. (2008). Jönköping County Council. In High performing healthcare systems: Delivering quality by design (pp. 121-144). Longwoods Publishing. https://www.longwoods.com/content/20144

Baumol, W. J. (2012). The cost disease: Why computers get cheaper and health care doesn't. Yale University Press.

Besley, T., Bevan, G., & Burchardi, K. B. (2009). Naming and shaming: The impacts of different regimes on hospital waiting times in England and Wales (CEPR Discussion Paper No. 7306). Centre for Economic Policy Research.

Bevan, G., & Hood, C. (2006). What's measured is what matters: Targets and gaming in the English public health care system. Public Administration, 84(3), 517-538. https://doi.org/10.1111/j.1467-9299.2006.00600.x

Bodea, M., Dayan, M., & Oung, C. (2026, April 23). Health and care performance and promises: The track record for Wales. Nuffield Trust. https://www.nuffieldtrust.org.uk/resource/wales-health-and-care-issues-for-the-2026-election

Burgess, N., Currie, G., Crump, B., & Dawson, A. (2022). Leading change across a healthcare system: How to build improvement capability and foster a culture of continuous improvement - Lessons from an evaluation of the NHS-VMI partnership. Warwick Business School. https://wrap.warwick.ac.uk/169460/

Caerphilly County Borough Council. (2024). Council budget setting 2024 - 2025 [Consultation]. https://conversation.caerphilly.gov.uk/council-budget-setting-2024-2025

Co, M., Marks, T., Tracey, F., Conti, S., & Clarke, G. M. (2025). The impact of elective surgical hubs on elective surgery in acute hospital trusts in England. Nature Communications, 16(1), Article 6192. https://doi.org/10.1038/s41467-025-60936-6

The Commonwealth Fund. (2011). The Scottish approach to patient safety [Blog post]. https://www.commonwealthfund.org/blog/2011/scottish-approach-patient-safety

Conroy, S. P., Ansari, K., Williams, M., Laithwaite, E., Teasdale, B., Dawson, J., Mason, S., & Banerjee, J. (2014). A controlled evaluation of comprehensive geriatric assessment in the emergency department: The 'Emergency Frailty Unit'. Age and Ageing, 43(1), 109-114. https://doi.org/10.1093/ageing/aft087

Cottam, H. (2018). Radical help: How we can remake the relationships between us and revolutionise the welfare state. Virago.

Driver and Vehicle Licensing Agency (2016) DVLA's annual report and accounts 2015 to 2016. Swansea: DVLA. Available at: https://www.gov.uk/government/publications/dvla-annual-report-and-accounts-2015-to-2016

East London NHS Foundation Trust. (2018, November 14). Integrated quality and performance report (inc. CRES) [Trust Board paper]. https://www.elft.nhs.uk/sites/default/files/2022-02/13._tbd-2018-11-14_integrated_quality_and_performance_report_inc_cres.pdf

Gray, B. H., Sarnak, D. O., & Burgers, J. S. (2015). Home care by self-governing nursing teams: The Netherlands' Buurtzorg model. The Commonwealth Fund. https://www.commonwealthfund.org/publications/case-study/2015/may/home-care-self-governing-nursing-teams-netherlands-buurtzorg-model

Gray, B. H., Winblad, U., & Sarnak, D. O. (2016). Sweden's Esther model: Improving care for elderly patients with complex needs (Commonwealth Fund Publication No. 1901). The Commonwealth Fund. https://www.commonwealthfund.org/publications/case-study/2016/sep/swedens-esther-model-improving-care-elderly-patients-complex-needs

Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: Systematic review and recommendations. The Milbank Quarterly, 82(4), 581-629. https://doi.org/10.1111/j.0887-378X.2004.00325.x

Greenhalgh, T., Wherton, J., Papoutsi, C., Lynch, J., Hughes, G., A'Court, C., Hinder, S., Fahy, N., Procter, R., & Shaw, S. (2017). Beyond adoption: A new framework for theorizing and evaluating nonadoption, abandonment, and challenges to the diffusion, scale-up, spread, and sustainability of health and care technologies. Journal of Medical Internet Research, 19(11), Article e367. https://doi.org/10.2196/jmir.8775

Gye, R. (2015) 400 days of transformation. DVLA Digital blog, 5 March. Available at: https://dvladigital.blog.gov.uk/2015/03/05/400-days-of-transformation

Harker, R., & Powell, A. (2026). NHS expenditure (Research Briefing SN00724). House of Commons Library. https://commonslibrary.parliament.uk/research-briefings/sn00724/

Harvey, G., Jas, P., & Walshe, K. (2015). Analysing organisational context: Case studies on the contribution of absorptive capacity theory to understanding inter-organisational variation in performance improvement. BMJ Quality & Safety, 24(1), 48-55. https://doi.org/10.1136/bmjqs-2014-002928

Health and Care Research Wales Evidence Centre. (2025). What is the effectiveness and cost-effectiveness of at-home time-limited reablement services for improving an individual's independence and health outcomes and reducing the need for long term care: A rapid review. https://www.researchwalesevidencecentre.co.uk/Reablement

Horton, T., Illingworth, J., & Warburton, W. (2018). The spread challenge: How to support the successful uptake of innovations and improvements in health care. The Health Foundation. https://www.health.org.uk/publications/the-spread-challenge

James, B. C., & Savitz, L. A. (2011). How Intermountain trimmed health care costs through robust quality improvement efforts. Health Affairs, 30(6), 1185-1191. https://doi.org/10.1377/hlthaff.2011.0358

Kizer, K. W., & Dudley, R. A. (2009). Extreme makeover: Transformation of the Veterans Health Care System. Annual Review of Public Health, 30, 313-339. https://doi.org/10.1146/annurev.publhealth.29.020907.090940

Lewis, S. (2020). Interview [Interview transcript]. International Consortium for Health Outcomes Measurement (ICHOM). https://conference.ichom.org/wp-content/uploads/2020/06/Dr-Sally-Lewis-Interview.pdf

Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (SI 2009/779 (W.67)). https://www.legislation.gov.uk/wsi/2009/779/contents/made

NHS England. (2024, February 28). NHS leadership competency framework for board members. https://www.england.nhs.uk/long-read/leadership-competency-framework-for-board-members/

Nuffield Trust. (2023). Lesson 5: Don't overrate structural reorganisation. https://www.nuffieldtrust.org.uk/news-item/lesson-5-don-t-overrate-structural-reorganisation

O'Shaughnessy, Í., Robinson, K., O'Connor, M., Conneely, M., Ryan, D., Steed, F., Carey, L., Leahy, A., Shanahan, E., Quinn, C., & Galvin, R. (2022). Effectiveness of acute geriatric unit care on functional decline, clinical and process outcomes among hospitalised older adults with acute medical complaints: A systematic review and meta-analysis. Age and Ageing, 51(4), afac081. https://doi.org/10.1093/ageing/afac081

Office for National Statistics. (2025, July 30). Population estimates for England and Wales: Mid-2024. https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/poppulationestimates/bulletins/poulationestimatesforengland andwales/mid2024

Perlin, J. B., Kolodner, R. M., & Roswell, R. H. (2004). The Veterans Health Administration: Quality, value, accountability, and information as transforming strategies for patient-centered care. The American Journal of Managed Care, 10(11 Pt 2), 828-836. https://www.ajmc.com/view/nov04-1955p828-836

Propper, C., Sutton, M., Whitnall, C., & Windmeijer, F. (2008). Did 'targets and terror' reduce waiting times in England for hospital care? The B.E. Journal of Economic Analysis & Policy, 8(2), Article 5. https://doi.org/10.2202/1935-1682.1863

Senedd Research. (2019). Devolution 20: Are we a healthier nation? Welsh Parliament. https://research.senedd.wales/research-articles/devolution-20-are-we-a-healthier-nation/

Senedd Research. (2025a). NHS waiting times in Wales: Promises made, targets missed? Welsh Parliament. https://research.senedd.wales/research-articles/nhs-waiting-times-in-wales-promises-made-targets-missed/

Senedd Research. (2025b). Bridging the gap: Tackling delays in hospital discharge. Welsh Parliament. https://research.senedd.wales/research-articles/bridging-the-gap-tackling-delays-in-hospital-discharge/

Senedd Research. (2026a). NHS waiting times in Wales: The position at the start of the Seventh Senedd. Welsh Parliament. https://research.senedd.wales/research-articles/nhs-waiting-times-in-wales-the-position-at-the-start-of-the-seventh-senedd/

Senedd Research. (2026b). Wales' budget and public finances: Past changes and future challenges. Welsh Parliament. https://research.senedd.wales/research-articles/wales-budget-and-public-finances-past-changes-and-future-challenges/

Southcentral Foundation. (2016). The Nuka system of care [Case study]. https://scfnuka.com/wp-content/uploads/2016/09/NUKA-CaseStudy.pdf

Vindrola-Padros, C., Ledger, J., Hill, M., Tomini, S., Spencer, J., & Fulop, N. J. (2022). The Special Measures for Quality and Challenged Provider regimes in the English NHS: A rapid evaluation of a national improvement initiative for failing healthcare organisations. International Journal of Health Policy and Management, 11(12), 2917-2926. https://doi.org/10.34172/ijhpm.2022.6619

Wales Fiscal Analysis. (2026, April 1). 2026 Senedd election analysis: The fiscal outlook. Cardiff University. https://blogs.cardiff.ac.uk/thinking-wales/2026-senedd-election-analysis-the-fiscal-outlook/

Welsh Government. (2014, July 11). Written statement: Delivering prudent healthcare in Wales. https://www.gov.wales/written-statement-delivering-prudent-healthcare-wales

Welsh Government. (2019, April 30). Cwm Taf Morgannwg maternity services put into special measures as report identifies serious failings. https://www.gov.wales/cwm-taf-morgannwg-maternity-services-put-special-measures-report-identifies-serious-failings

Welsh Government. (2020, November 24). Betsi Cadwaladr University Health Board taken out of special measures. https://www.gov.wales/betsi-cadwaladr-university-health-board-taken-out-special-measures

Welsh Government. (2022a). Written evidence to the Public Accounts and Public Administration Committee [PAPAC6-04-22 P2]. Senedd Cymru. https://business.senedd.wales/documents/s123139/PAPAC6-04-22%20P2%20-%20WG%20paper.pdf

Welsh Government. (2022b, November 14). Written statement: Escalation and intervention arrangements - Betsi Cadwaladr and Cwm Taf Morgannwg university health boards. https://www.gov.wales/written-statement-escalation-and-intervention-arrangements-betsi-cadwaladr-and-cwm-taf-morgannwg

Welsh Government. (2023, September 13). New escalation levels of Welsh health boards announced. https://www.gov.wales/new-escalation-levels-welsh-health-boards-announced

Welsh Government. (2024a). Betsi Cadwaladr University Health Board special measures framework, March to December 2023. https://www.gov.wales/betsi-cadwaladr-university-health-board-special-measures-framework-march-december-2023-html

Welsh Government. (2024b, April 26). Written statement: Escalation and intervention arrangements - Cwm Taf Morgannwg University Health Board. https://www.gov.wales/written-statement-escalation-and-intervention-arrangements-cwm-taf-morgannwg-university-health

Welsh Government. (2025a). NHS activity and performance summary: March and April 2025. https://www.gov.wales/nhs-activity-and-performance-summary-march-and-april-2025-html

Welsh Government. (2025b). NHS Wales performance framework 2025-2026. https://www.gov.wales/sites/default/files/publications/2025-01/nhs-wales-performance-framework-2025-to-2026.pdf

Welsh Government (2025c) NHS Wales Oversight and Escalation Framework. Version 3.5. Cardiff: Welsh Government. Available at: https://www.gov.wales/sites/default/files/publications/2025-08/oversight-and-escalation-framework-nhswales-organisations-august_0.pdf (Accessed: 23 October 2026).

Welsh Government (2025d) Written Statement: Escalation and Intervention Arrangements. Statement by Jeremy Miles MS, Cabinet Secretary for Health and Care, 15 July 2025. Available at: https://www.gov.wales/written-statement-escalation-and-intervention-arrangements-6

Welsh Government. (2026a). The first 100 days plan: May to August 2026. https://www.gov.wales/first-100-days-plan-may-august-2026-html

Welsh Government. (2026b, July 30). Written statement: 100-day plan commitment - Review of NHS Wales escalation and intervention arrangements. https://www.gov.wales/written-statement-100-day-plan-commitment-review-nhs-wales-escalation-and-intervention-arrangements

Welsh Government. (2026c, February 18). Written statement: Escalation and intervention arrangements. https://www.gov.wales/written-statement-escalation-and-intervention-arrangements-8

Welsh Government. (2026d, August 19). Written statement: Escalation and intervention arrangements. https://www.gov.wales/written-statement-escalation-and-intervention-arrangements-9

Welsh Government. (2026e). NHS activity and performance summary: March and April 2026. https://www.gov.wales/nhs-activity-and-performance-summary-march-and-april-2026-html

Welsh Government. (2026f). NHS activity and performance summary: April and May 2026. https://www.gov.wales/nhs-activity-and-performance-summary-april-and-may-2026-html

Welsh Government. (2026h, September 29). NHS Wales Accountability and Support Framework. https://www.gov.wales/sites/default/files/publications/2026-09/nhs-wales-accountability-and-support-framework.pdf

Welsh Government. (2026i, September 17). NHS activity and performance summary: July and August 2026. https://www.gov.wales/nhs-activity-and-performance-summary-july-and-august-2026-html

Welsh Government (2026j) Aneurin Bevan University Health Board oversight and escalation framework: February 2026. Cardiff: Welsh Government. Available at: https://www.gov.wales/node/75000 (Accessed: 22 October 2026).

Welsh Government (2026k) Hywel Dda University Health Board escalation framework: August 2026. Cardiff: Welsh Government. Available at: https://www.gov.wales/node/78560

Western Mail. (2018, June 29). 'No forced council mergers' - minister. https://www.pressreader.com/uk/western-mail/20180629/282376925319042

Williams, D. (2020, September 10). Why we left: Ex-DHB bosses speak out. Newsroom. https://newsroom.co.nz/2020/09/10/why-we-left-ex-dhb-bosses-speak-out/



To find out more and discuss working with us, email:

victoria.ford@perago.co.uk

–

steve@moorecompany.co.uk