

*LEARNING THE LESSONS  
FROM 'NEVER AGAIN?'*

Jill Rutter

Nicholas Timmins' case study of the National Health Service (NHS) reforms draws out 10 specific lessons from the story of the Health and Social Care Act.

1. Have a story to tell
2. Beware lack of internal challenge
3. Don't go quiet on plans ahead of an election; or misrepresent them. Do recognise that the world can change.
4. The coalition negotiations; take more time, involve some expertise
5. The need for a strong centre
6. The role of the Civil Service: recognise the weakness of the Civil Service in the face of a determined minister; weigh up sound advice.
7. Legislation should be an accurately targeted rifle shot, not a carpet bombing
8. Revolution v. Evolution
9. Don't overestimate how far key arguments over reform have already been won
10. Build a consensus, or at least some support

In this separate commentary, we link those lessons to earlier work that the Institute for Government has done on:

- policy making in opposition
- making coalition government work
- transitions to government
- the role of the centre of government
- being an effective minister
- better policy making.

In so doing we judge the extent to which this special case confirms or contradicts our earlier views and whether there are clear options available to avoid repeating mistakes. Finally we look at whether any of the issues identified are addressed in the recently published Civil Service Reform Plan.

There are also wider lessons to be drawn on the way we approach public service reform in the UK including:

- the way we legislate
- the role of Parliament
- the media
- the particular impact of elections on policy debate.

We leave others to draw those conclusions.

## Policy making in opposition

The health reforms had their origins in opposition – indeed their hallmark was the way they were developed during Andrew Lansley's long tenure as shadow health secretary.

Policy making in opposition matters – not least because, as we have seen with this government, the early years after an election victory are often seen as the best time for radical reform. If a government comes in determined to use its first year to get major legislation passed (as the Coalition was) it puts a premium on using opposition well.

This is illustrated in two of the case studies we looked at in our work on successful policy making.<sup>1</sup> Both the introduction of the national minimum wage and Scottish devolution were among the “top three most successful

policies of the last 30 years” according to our poll of political studies experts. And they were both characterised by using the opportunity of opposition not only to develop detail of the policy but also to build consensus beyond the party on how to take reform forward.

The Institute for Government is currently looking at case studies of policy development in opposition. One of the features of some of the areas we are looking at – for example, universal credit and Labour’s Commission on Social Justice<sup>2</sup> – is the way parties attempt to open out the policy process by bringing in outsiders and airing new ideas which go some way towards influencing the broader mood. Another lesson – also seen in the case study on welfare to work – is that many of the ideas that finally make it into manifestos or government programmes do not have their origins in this sort of formal process.

What is notable in the health case study is the extent to which policy making was the unchallenged province of the shadow secretary of state. Although the opposition produced a white paper on the proposed reforms and the shadow health secretary spoke about them often, there was no real attempt to build a body of support for them even among potential supporters in the medical profession. In a sense this is explained by the fact that they were very much going with the grain of the then government’s policy. This tactic would have made sense if the aim was to present the reforms as evolution not revolution. But, as Nick has shown, a strategy of differentiation was chosen deliberately.

Two things are particularly striking about the preparation for government. The Conservatives put in place specific mechanisms to help shadows come into government with implementable plans. Yet engagement with the Implementation Unit was at the discretion of the shadow minister concerned. There was no obligation to have the ideas stress-tested by the Implementation Unit. Some ministers chose to engage – but there was no penalty for failure to do so. This made sense if the Implementation Unit was there to serve appointed shadows – but not if its aim was to ensure the Government as a whole had a programme that the prime minister was sure could be implemented. That meant, as Nick suggests, that plans could go unchallenged, as was the case with health.

Second, as Nick points out, these plans were developed when the opposition was committed to matching the government’s rising spending. They were not revisited when the scale of the financial crisis emerged in 2008 and the opposition moved position on the pace of deficit reduction. That would have seemed an obvious time to review reform plans that had clear upfront costs and risked considerable distraction at a time when savings would have to be delivered. The constant refrain of former health secretary, Stephen Dorrell, was that the first focus needed to be on delivering savings.

One interesting consequence of the financial crisis was the effective conspiracy of silence on health in the 2010 election campaign. It was in no party’s particular interest to stir up a debate on what would happen to health over the next five years. There has also been a suggestion that the emphasis in the 2010 elections on the prime ministerial debates – with the leaders questioning each other rather than exposure to more forensic questioning – meant that some areas of policy were not probed as much as they might have been. That very conspiracy of silence meant people were taken by surprise and felt misled by the scale of the changes after what appeared to be a promise to end reorganisations. And that meant the Government was open throughout to the accusation that it did not have a mandate.

A final consequence of this approach was the failure to develop what Nick has called the “story to tell”. That is, the explanation of how the reforms would benefit patients (and taxpayers) and why they were the right thing to do at a time when the NHS had to make £20bn efficiency savings over the spending review period. Opposition could and should have been used to develop a compelling narrative – or modify a policy that could not stand up to such scrutiny.

## Coalition

The second big lesson from Nick's case study is the big difference that governing in coalition made. As he explains, the health reforms would not have happened with a minority Conservative government but the fact of the Coalition had important consequences for health reform.

There is a clear lesson about the way in which the Coalition Agreement was negotiated. The initial Coalition Agreement, which was ratified by the two parties, was nearly silent on health. As the study makes clear the problems came in the programme for government. This repeated the line about no top-down reorganisations, despite Andrew Lansley's plans, and contained plans for primary care trusts (PCTs) that no one from the secretary of state down in the Department of Health thought would work. That in turn set up a dynamic for even more radical structural reform. It also created scope for Liberal Democrat "loyal" opposition on the basis that what was being presented was not what they signed up for.

As we have shown, other countries, with more experience of coalition government, were surprised at the pace of the negotiation of the UK's Coalition Agreement. In countries such as Germany, it is the norm for negotiations to take a couple of months, during which far greater clarity is reached on the detail of policy and spending plans. In the Netherlands, party election platforms are audited before the election campaign starts by the Bureau of Economic Analysis.<sup>3</sup> These audited platforms form the basis for subsequent lengthy negotiations. The UK coalition negotiations were notable not just for their speed, but also for the absence of civil service input, unlike for example in Scotland<sup>4</sup>. Even more striking is that not only was there little health expertise in the Centre, but that so little importance appears to have been attached to the views of the secretary of state who objected to the health section, but whose objections were ignored. As Nick says, the clear lesson is to take more time and involve expertise in coalition negotiations.

Our work has pointed out other consequences of coalition. One is the increased role of the parliamentary and wider party in policy making, particularly for the Liberal Democrats who have more democratic internal processes. This also puts an additional burden on Liberal Democrat junior ministers who need to play a dual role within departments. That is, they must exercise their own ministerial responsibilities and play a "watching brief" role across the whole department to ensure new policy is acceptable to the wider party.<sup>5</sup> A lot of the burden falls by default on the deputy prime minister's office and his team of advisers. But at the time when the key decisions were being made on health, the office was under-resourced, with no adviser to cover the health brief, and too few people in general to cope with the large number of issues coming across the deputy prime minister's desk. This was, belatedly, rectified.

The subsequent negotiations over the bill showed the Coalition's internal decision-making processes working reasonably well. The health reforms were reportedly the first issue to be resolved in the new Coalition Committee, with Danny Alexander and Oliver Letwin being called in to go through the implementability of the changes. In the early days there was an attempt to make the Coalition look more than the sum of its parts. Indeed the health white paper foreword by Nick Clegg emphasised just that. But when the bill was finally published and the scale of change and opposition became clear, rank and file Liberal Democrats no longer felt bound by a policy that was different to the programme for government.

And after the "pause", and the loss of the alternative vote (AV) referendum, the mood changed. Most of the negotiations were conducted in semi-public with declarations on both sides of "redlines" in ways more akin to European summits. The NHS reform process is the clearest illustration of how the coalition parties have moved from their initial emphasis on seeking unity to a strategy of differentiation and assertiveness in negotiations with one another. The risk, as the Coalition moves forward, is that the two parties will increasingly cancel each other out, vetoing radical policies proposed by the other side. This could lead to deadlock and incoherent lowest common denominator policy making.

## Transitions

The Department of Health had a bad memory of the 1997 transition when the new secretary of state felt that officials were too wedded to their predecessor's policy and withdrew from engagement with the department. They were determined to manage the transition better in 2010 and take on board the lessons in Institute for Government's report *Transitions: Preparing for a Change in Government*.

In terms of preparations, the incoming secretary of state was able to give his officials clear plans for what he wanted to do. In other departments, coalition meant that the secretary of state civil servants had planned for did not cross the departmental threshold. Transition at the Department of Health was seamless. In our *Transitions* report, we argued that there was merit in such continuity.

However, one of the risks in transition is to the capacity of the Civil Service to challenge a determined minister. As Nick notes, the Civil Service can be at its weakest in the months after a change of government. Relationships are not yet established and there may be a lingering suspicion that civil servants have gone native under the previous government. This is what had happened in 1997 when departmental official advice to retain some elements of GP fundholding was interpreted as wholesale opposition to Labour policy of reversal of the internal market – a policy which Tony Blair told the Institute for Government he regretted.<sup>6</sup>

This is all compounded by the premium both the UK system and incoming governments put on speed at the start. Although the Queen's Speech was slightly later than usual, it still took place within 12 days of the election and the white paper was produced within only 60 days of the Government taking office. The mammoth bill itself appeared in early 2011. We have argued that this perceived need for speed in moving from manifesto to legislation is a weakness in our system: in this case there was no scope for any sort of pre-legislative scrutiny and no appetite to engage with any of the reaction to the white paper.

One thing that becomes clear is the extent of overload in the early phase of the Government. The Government was not only embarking on major reforms in health, but also in education, welfare, legal aid and criminal justice, and local government. At the same time it embarked on a crash programme to deliver in-year savings of £6bn and deliver the tightest ever comprehensive spending review. That includes a reduction in departmental running costs across the board of some 30%. Nick's study brings out some of the implications of the pace of reforms and the preoccupation with the deficit; a meeting of permanent secretaries where the scale of reform was noted – but no more; a Treasury focused on delivering the spending review – and asking only if the health plans would prejudice that; the 'quad' of David Cameron, Nick Clegg, George Osborne and Danny Alexander with more pressing things to consider than the health secretary's plans for the future of the NHS.

One potential lesson is to rethink the speed at which we force change through after changes in government – particularly now we have "guaranteed" five-year parliaments. The health bill required extremely long committee stages in the Lords and an enforced "pause"; if these had been incorporated at earlier stages in the process, some of the subsequent political furore might have been avoided.

## Policy challenge and the role of the centre

A key theme throughout Nick's study is the lack of challenge to the health secretary's plans, in government or opposition. Our work on policy making has identified this as a source of systemic weakness in the UK policy process.

There are a number of potential sources of challenge, once in government:

- departmental civil servants
- the Treasury
- fellow cabinet members – through the Cabinet Committee system

- the prime minister and No 10
- Parliament.

It is clear from Nick's narrative that there were many civil servants within the health department who had reservations, if not about the direction of travel, about the tactics being adopted. But it is very difficult, in our current system, for the Civil Service to do more than warn ministers and then accept ministers' judgement if those warnings are not accepted. And the immediate aftermath of a change of government is a difficult time to give those warnings.

As Nick indicates, one option is for the permanent secretary to insist that the secretary of state give an accounting officer direction – but in practice, as the civil servants point out, departments do not use that to distance themselves from a minister's flagship policy. Moreover – as we reported in *Policy Making in the Real World* – under the previous government, both ministers and civil servants thought that there was too little positive constructive engagement between them. Civil servants too often felt the need to self-censor their advice to ministers.<sup>7</sup> Sir David Nicholson was arguably in a stronger position to signal reservations as chief executive of the NHS. But the impact of his more independent line emphasising the scale of the change (but not its impossibility) was to convince people he needed to stay in place to see the reforms through.

Under the Conservatives' plan for enhanced accountability of departments – the counterpart to ending what was seen as central meddling. There were two devices to make sure departments were on the right track. The first was the new Business or Structural Reform Plans. But these were about whether the department was meeting key milestones, not about the substance of what the department was doing. Our monitoring of business plans showed the Department of Health missing more deadlines than any other department one year on.<sup>8</sup> But the No 10 Implementation Unit did not see its role as challenging the substance of the policy.

The second was to have the secretary of state chair the departmental board, but bolster the independent presence with three or four powerful non-executive directors. These non-executives were to focus on performance and delivery rather than policy, but could have been expected to assure themselves on the feasibility of implementing the reforms. It took some time for non-executives to be recruited however and the full non-executive team including the lead non-executive were not in place until 2011.<sup>9</sup>

The second source of challenge could have come from the Treasury. The Treasury had been very engaged in the health review that resulted in *Working for Patients*.<sup>10</sup> It had also had an active role on health policy under Gordon Brown, commissioning the Wanless review. But the new Government had made it clear that it expected the Treasury to perform its more traditional finance ministry role, and do less policy. And its attention was absorbed by delivering in rapid time an extremely ambitious spending review.

Like all major policy pronouncements the white paper was put through the Cabinet committee system. The system's strength is in sorting out interdepartmental wrangles – it is rarely a place where self-contained policies are questioned by relatively disinterested ministers with their own departmental briefs to argue. The role of policy challenger without portfolio would fall to the Minister for Government Policy, Oliver Letwin who, as Nick reports, saw health as one element of the wider reform programme of which he was a champion.

That is why the focus has fallen on the lack of health expertise in No 10 at the time legislation was being developed, and the hole created by the prime minister's decision to scale back the policy unit when he took office. Nick notes the absence of the usual back channel into No 10 for officials, created by the decision not to have a dedicated policy expert in the Policy Unit.

We argued last year<sup>11</sup> that prime ministers make a false economy when they skimp on the support they need within No 10. They need support not just on the detail and the merits of a policy but also on its political handling

and saleability. This is part of a more general picture of providing minimal support to prime ministers, as we showed in our report *Supporting the Centre*.<sup>12</sup> In the Australian system, for example, there would have been a team of civil servants in the prime minister's department – both able to challenge the department and provide the prime minister with an independent assessment of the impact of the reforms.

But prime ministers may need more than this too. In previous administrations, a senior politician has played a political minder role – Lord Whitelaw, Wakeham or Heseltine under the Conservatives or a Mandelson or Prescott under Labour – who would be as concerned about the politics as the substance. An alternative was the role Lord Irvine played in subjecting the devolution proposals to detailed scrutiny in the Cabinet's Constitution Committee.<sup>13</sup> There was no one playing this role for David Cameron, despite the acknowledged political toxicity of NHS reform.

There is a very strong case for believing that our Centre is underpowered in terms of technocratic and political support to the prime minister and that our system is not very resilient. This needs to be improved. But increasing the capacity of the Centre to act as an effective backstop is not a substitute for making sure that the policies emerging from departments can be implemented and are politically saleable.

The Government opted for a route that meant when challenge did come, it came very publicly from Parliament reacting to a well co-ordinated external opposition – though the bill passed all its initial Commons stages before Liberal Democrat anxiety forced the “pause”. There was no pre-legislative scrutiny of the bill. The Health Committee made clear it wanted to be actively engaged – and achieved some changes, for example over its concerns about skills and governance of GP consortia. It was left to the Lords to provide the substantive debate and changes to the bill. But by the time Parliament became involved, change was already on the way within the NHS, which meant there was no option to revert to the status quo.

## Ministerial effectiveness

As the case study makes clear, any verdict now on the ultimate success of the health reforms is inevitably premature. If they do prove to have set the NHS in a genuinely new direction and become entrenched, the secretary of state for health will deserve most of the credit for having a vision and driving it through against massed opposition and relentless personal criticism.

Being able to give a strategic lead, set vision and direction, and take decisions are characteristics of an effective minister.<sup>14</sup> Andrew Lansley could expect to score highly on all of these criteria. But ministers have to play other roles too. Our 360-degree assessment tool for ministers sets out four domains in which ministers need to function well:

- policy making and executive
- parliamentary
- external
- cross-governmental.

It is clear that Andrew Lansley would score less well on such important areas as:

- being open to a range of opinions and willing to engage in constructive debate
- managing risk and building relationships of trust and respect with civil servants
- and, in particular, developing fruitful relationships with external stakeholders.

One constant theme throughout the case study is his weakness in communication – both in developing a narrative but also in being able to use it persuasively with important audiences – and lack of engagement both with parliamentary colleagues and the wider health community.

In business (and even in the Civil Service) most senior leaders would have been subject to regular performance reviews and have a pretty clear view of their strengths and weaknesses. They would have been given opportunities to “develop”. And if there were areas beyond the help of development, their weakness in one area could be dealt with by the appointment of someone with complementary skills. But none of these management norms apply to ministers. They are not managed in any conventional sense. They are not given direct feedback on their performance. The sort of briefing of the lobby from No 10 sources cited by Nick is the closest most ministers get until they are promoted or sacked. And junior ministers are appointed for many reasons but rarely to maximise team effectiveness

The case of the health reforms suggests that prime ministers need to think more carefully about building the teams they need to take through major and controversial reforms. It is clear that Lord (Freddie) Howe did play a valuable complementary role in managing the bill through the minefield of the House of Lords. No 10 tried to strengthen the communications team within the Health Department. But there was no great communicator in the health ministerial team and no Darzi-style appointment of a leading clinician to a ministerial role to bridge the gap between the department and the professionals.

## Better policy making

It is too early to say whether the political trauma of the Health and Social Care Act will turn into a successful policy or not. It is clear though that Andrew Lansley’s intention was to make a once-and-for-all change. This would mean that NHS governance – and in particular its relationship with ministers – was put on a permanently new basis which would avoid the “backsliding” from the purity of reforms seen after the Clarke and Milburn changes.

He made two crucial tactical choices to underline his intent, both questionable with the benefit of hindsight: first to present his changes as “revolution not evolution” and second to go for what Nick has called a “carpet bombing rather than a rifle shot” approach to legislation. In both cases, other options were available and presented by the department. But in neither case was Andrew Lansley’s judgement challenged within government.

He also overestimated the extent to which the battle on competition and choice had been won with the Labour party. This was perhaps because he underestimated the extent to which the move into opposition can trigger a rethinking of policies espoused in government – particularly when there is clear political advantage in doing so. After all, William Hague’s stance on the euro when he became Conservative leader in 1997 was very different from the compromise on which the Conservatives fought that election.

Better policy making has been a big theme of Institute for Government work over the past year. The Health and Social Care Act exemplifies many of the problems reported in policy making in the preceding government, in particular:

- the lack of locus for the Civil Service to challenge legitimately
- the closed nature of the policy process
- and the unsystematic use of evidence and evaluation of earlier policies.

In our report, *Making Policy Better* we set out seven “policy fundamentals” (see box below) to serve as a checklist for whether a policy is in a fit state to proceed. We also proposed that senior civil servants should sign off a public “policy assessment” to state how the policy meets the criteria, as a discipline to make sure poorly-thought-out proposals do not make it out of the department. If they think that there is not a robust enough case for going ahead, a minister should have to give a “policy direction”.

Again, this is not about the political choices the minister makes: rather it would give the civil service an independent role as the guarantor of the quality of the policy process. We also proposed that each department –

secretary of state and permanent secretary – publish a statement of how the department proposes to meet the policy fundamentals.

#### **Policy fundamentals**

- Clarity on goals
- Open and evidence-based idea generation
- Rigorous policy design
- Responsive external engagement
- Thorough appraisal
- Clarity on the role of central government and accountabilities
- Establishment of effective mechanisms for feedback and evaluation

It is impossible to replay history and say whether Department of Health officials would have felt better placed to take on a new secretary of state if they had had to put their name to a published assessment of the policy. A systematic appraisal of the *Liberating the NHS* white paper against these criteria could have:

- exposed the lack of clarity on goals
- highlighted some of the initial flaws in design – particularly around accountabilities and governance
- and forced the department to look at alternatives and say why it had rejected them.

It would also have forced them to engage more constructively with the likely objections to the reforms. The argument about the publication of the NHS risk register shows that the Department of Health did highlight potential problems. But the secrecy around the register means that ministers are not obliged to show that they have addressed them.

It is clear that Andrew Lansley was trying to enact definitive health reforms – ones that would meet our definition of a successful policy, set out in our report *The S Factors*:

*The most successful policies are ones which achieve or exceed their initial goals in such a way that they become embedded; able to survive a change of government; represent a starting point for subsequent policy development or remove the issue from the immediate policy agenda.<sup>15</sup>*

We stressed in *The S Factors* that the seven lessons we distilled from our six case studies –privatisation, devolution, the minimum wage, pensions reform, the smoking ban and the Climate Change Act – do not represent a blueprint for policy success. Nonetheless it is interesting to benchmark the process underpinning the health reforms against the seven factors we found present in successful policies:

1. Understand the past and learn from failure
2. Open up the policy process
3. Be rigorous in analysis and use of evidence
4. Take time and build in scope for iteration and adaptation
5. Recognise the importance of individual leadership and strong personal relationships
6. Create new institutions to overcome policy inertia
7. Build a wider constituency of support.

Andrew Lansley would argue that the experience of backsliding from previous reforms drove him towards a definitive bill that would need legislation to reverse the changes it introduced. But these lessons suggest the alternative, more evolutionary, strategy would have much to commend it. It would have allowed a clear line of sight from previous reforms and made it harder for the opposition to oppose. Evolution – which had characterised the introduction of earlier market reforms into health with reform being rolled out in “waves” – would also have allowed more scope for iteration.

The interesting thing about the health reforms was that the policy process was opened up – through the establishment of the Future Forum – but only after the legislation had already passed its initial Commons stages. Andrew Lansley himself now admits that it could have been helpful to have had that stage before the bill was introduced.<sup>16</sup>

Earlier health reforms had taken place against the opposition of the profession – as Nick points out the British Medical Association (BMA) were, if anything, more implacably opposed to *Working for Patients*. But in earlier reforms there were some supporters within the system to work with. When Labour wanted to push clinical quality up the agenda it appointed a minister from within the medical profession to lead it, in the shape of Lord Darzi. In other countries health reforms have been undertaken in a more inclusive way which paralleled the Turner Commission approach to pensions. If a government ever wanted to look beyond reforms to NHS structures, a Turner-like process of lengthy consensus-building would seem to be essential.

It is not as impossible as it seems. In other countries, this sort of process is used for reforming health. An article in the *Lancet* by the former Mexican health minister, Julio Frenk, set out the process of reforming health in Mexico – it presents quite a contrast to the story presented in *Never Again*:

*The political pillar refers to the development of a consensus for achieving shared objectives. The Mexican reform benefited from the notion that health is an aspiration of all political forces and can thus generate broad agreements and help enhance social cohesion. The strong emphasis on democratic principles – transparency, accountability, and the empowerment of citizens – also helped to gather support and consolidate much-needed public participation in all issues related to health care. The early involvement of key stakeholders was essential once the necessary changes were acknowledged and policy options had been identified. Part of the political process included intensive nationwide campaigns aimed at raising consciousness and debate on the health reform. Conciliation was pursued between private and public actors, federal and local authorities, patient advocacy groups, trade unions, legislators, and policymakers, around a highly sensitive issue such as health. Finally, phase-in was organised with a gradual approach, which provided the time necessary to generate political acceptance and to develop a local supply response.<sup>17</sup>*

Ironically, the critical decision to go for a big bill – rather than an incremental “stealth” approach with minimal legislation to make the changes irreversible – may end up having the opposite effect. Opposition from the professions and the reopening of the debate on choice and competition within the Labour party make it more likely that a future government may be committed to reverse at least some of the reforms. This opens up the Government to the accusation from the Blairite reformers that: “The debacle ‘has set back for a generation the cause of market-based reform in the NHS’.”<sup>18</sup>

Whatever the merits of the changes themselves, the story of the health reforms is the story of a failure to get the politics right. We have argued that good policy needs to have the right blend of technocracy and politics.<sup>19</sup> In particular, ministers need to do the politics well. The health secretary focused on the technocrats and did not do the politics – and no one else did it for him.

## Conclusions

The health reforms provide a useful illumination of many key Institute themes – in particular:

- the importance of effective policy making in opposition
- the risks inherent in transition before relations within departments are fully formed but when decisions are being made at speed
- the consequences of prime ministerial decisions to economise on support for themselves early in their administration
- the weakness of mechanisms for internal challenge at an early stage: both in departments and at the Centre
- more generally the lack of “quality control” on policy development
- the need for more focus on ministerial strengths and weaknesses – both for development and in constructing ministerial teams.

These long-standing issues were compounded by the fact that the UK was getting to grip with its first coalition since the war. That meant the programme for government was agreed too quickly and without sufficient consideration of whether what was being agreed was workable. There was no expertise in the negotiating team – and the health secretary’s comments were ignored. The Government had a massive reform agenda which it was pushing through at the same time as settling a challenging spending review. This meant no one outside the department took the time to stand back and examine the substance and strategy behind the health reforms. There was no one with the position, authority or inclination to challenge the health secretary’s plans before they went public. Once they did, new ways of campaigning meant opposition could form very quickly – and play into Parliament through the new dynamic of the Coalition.

The interesting final question is whether the changes unveiled in the Civil Service reform plan on 19 June would have made a difference. That plan sets a priority of “improving policy making capability” and states that “at its best policy making in the Civil Service can be highly innovative and effective, but the quality of policy making is not always consistent or designed with the implementation of policy in mind”. It has three particularly relevant recommendations.

The first is that “open policy making will become the default. Whitehall does not have a monopoly on policy-making expertise”. In particular it points to the need to be open to new thinking and “gather evidence and insight from external experts”.

The second is a new stress that policies need to bring “policy and implementation expertise ...together at the design stage” to make sure that policy design is considered alongside implementation.

The third and most crucial change is the acknowledgement that “permanent secretaries must be accountable for the quality of the policy advice in their department, and be prepared to challenge policies which do not have a sound base in evidence or practice. They must also ensure they are content that the implementation of any policy is in line with their responsibility for managing their departments and public money in an effective and efficient way”. This is a very important recommendation – but needs to be backed up with specific proposals and clear support from both the civil service leadership and the political centre so that permanent secretaries and senior officials know they will be supported if they challenge their minister in this way.

These changes are very much in line with the recommendations we made in *Making Policy Better*. When we developed those recommendations people asked whether they could withstand the force of a committed secretary of state coming into office with an apparent electoral mandate for controversial and radical change developed in opposition. It is easier to see them being immediately applied to new policy issues which arise while

a government is in office and which are less politically important. But if a real change is to occur, they need to be worked through in a way which is robust enough to pass that test.

Meanwhile, the Civil Service needs to have so improved its performance before the next transition that no secretary of state will want to proceed without his or her civil servants being able to assure them that the plans are not just workable, but offer the most cost-effective way of achieving their objectives.

## Endnotes

- 
- <sup>1</sup> Jill Rutter, Edward Marshall and Sam Sims: [\*The S Factors: Lessons from IFG's policy success reunions\*](#) (January 2012)
- <sup>2</sup> Catherine Haddon, *Policy Making in Opposition: case studies* (forthcoming, September)
- <sup>3</sup> IFG event report: [\*Making Policy Better: are independent evaluation offices the answer?\*](#)
- <sup>4</sup> Sir John Elvidge, [\*Northern Exposure\*](#) (September 2011)
- <sup>5</sup> Akash Paun: [\*United We Stand\*](#) (September 2010)
- <sup>6</sup> Institute for Government, 28 June 2010
- <sup>7</sup> Michael Hallsworth, Simon Parker and Jill Rutter: [\*Policy making in the Real World\*](#) (April 2011), chapter 8
- <sup>8</sup> [\*Whitehall Monitor 5\*](#)
- <sup>9</sup> Peter Sands was appointed as lead non-executive at Department of Health on 19 May 2011. Press notice at [http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/MediaCentre/Pressreleases/DH\\_126985](http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_126985)
- <sup>10</sup> Nigel Lawson, *The View from No.11* pps 614-616
- <sup>11</sup> Jill Rutter and David Atkinson: Number 10 and the Centre in Paun et al [\*The Coalition: One Year On\*](#) (May 2011); see also Simon Parker, Akash Paun and Jonathan McClory, [\*Shaping Up\*](#) (January 2010)
- <sup>12</sup> Emma Truswell and David Atkinson, [\*Supporting the Centre\*](#), Institute for Government (2011) p.21: "One senior Australian official commented that the ability of the Australian Prime Minister to receive advice from her own department helps in three main ways. First, the department ensures that the right policies are brought to Cabinet. Second, civil service advisers help the Cabinet to discuss the most important aspects of those policies. Third, the department provides the important contestability function of ensuring that someone other than the prime minister has spent time analysing the merits of a proposal after it was created. The same official commented that the knowledge that there will ultimately be an extra pair of eyes and ears from a central agency evaluating a proposal should also improve the quality of original policy proposals".
- <sup>13</sup> [\*Policy success case study: Scottish Devolution\*](#)
- <sup>14</sup> Peter Riddell, Zoe Gruhn and Liz Carolan: [\*The Challenge of Being a Minister\*](#) (May 2011)
- <sup>15</sup> *The S Factors*
- <sup>16</sup> *Never again?* p.140
- <sup>17</sup> 'Health Service reform in Mexico', Frenk et al, *Lancet* 2006: 368: 1524-1534. Our bold.
- <sup>18</sup> Alan Milburn quoted in *Never Again?* p.102
- <sup>19</sup> Michael Hallsworth and Jill Rutter, [\*Making Policy Better\*](#) (April 2011)