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INTRODUCTION

Over the last couple of decades, scholars in the field of policy implementation studies have sought to develop conceptual models to understand better the policy implementation process (Goggin et al, 1990; Hill and Hupe, 2006; Kingdon, 1995; O'Toole, 2000, 2004; Sabatier, 1986, 1999). A particular focus of attention for policy implementation theorists, in response to the many depictions of the policy process as something that is driven from 'top down', has been to reverse the process and provide an understanding from the 'bottom-up', looking more qualitatively at the dynamics of organizational responses to policy initiatives (O'Toole 2000, Paudel 2009). These implementation studies thus seek to highlight the organizational context in which policies are implemented, and the constraints and motivations of actors who *translate* the policies into practice (Lipsky 1980, Kingdon 1995). The substantial body of existing empirical research on policy implementation has established that organisations and individuals who work within them are not merely recipients of policy that comes from outside or 'top-down'; they shape (in the sense of influencing) policy and practice through their day to day actions, beliefs, and motivations (Lipsky 1980; Barrett and Fudge 1981; Barrett and Hill 1984; Evans and Harris 2004; Schofield 2001).

Though policy implementation research has developed considerable insight into how actors make sense of new policies in applying them to their own context (Lipsky 1980; Schofield 2001), there remains a gap in our understanding of the dynamic and iterative nature of implementation, as central policy is enacted in practice. In healthcare policy implementation

insufficient attention has been paid to how knowledge from practice is routinely incorporated into the overall policy process, with a need to integrate both a 'top down' and 'bottom up' understanding of policy implementation (Ferlie et al 2009). In addition, there is a gap in research on policy design in terms of how the structural features of a policy's design influence implementation and in turn (re)shape policy content (Howlett, Mukherjee and Woo, 2014).

This paper seeks to contribute to this gap through a qualitative study of how a national policy in England was adapted and translated in local contexts during implementation.[1] Drawing on the concept of *local universality* (Timmermans and Berg 1997), the research examines how local infrastructure, contingencies and practice shape – meaning to recursively influence – policy implementation. Going beyond the agency of individual actors, we take into account how broader local realities – namely the local infrastructure, contingencies and practice – are shaped by policy whilst also working to (re)shape policy. These localization processes – how general rules, products or guidelines are shaped and tailored to fit into local contexts and enacted within practices – emphasise that policy is not implemented on a blank slate in a *de novo* context, but into an existing network of practices and infrastructure which work to adapt and translate the policy.

In so doing, we contribute to the literature on policy implementation, by highlighting the role of local realities in shaping policy implementation and the policy itself. We analyse the translation of policy through implementation, whereby it is not simply transmitted but transformed and modified through multiple distributed agencies including local actors, infrastructure, data sets and organisational practices. Our findings from the empirical case show how all these agencies require ongoing negotiation and adaptation over which no one actor has control. Second, we show how in contrast to a traditional focus on up-front learning to develop policy content which is subsequently 'rolled

out', policy design can enable varying levels of coordination between the multiple agencies as well as shape the ability of policy actors to learn from the ongoing implementation.

POLICY DESIGN

The current drive for 'evidence-based policy' by policy makers is premised on the belief that if policies can be designed based on the best evidence, it is more likely that they will be implemented with measurable effect in terms of desired outcomes (Cabinet Office, 1999; Pawson, 2002; Parsons, 2002; Sanderson, 2002; Young et al, 2002). Policy makers believe both in the positive effect of evidence behind the policy and the translation of that evidence-based policy into practice. Current UK policy design, and health policy in particular, tends to favour a rational approach, where putting policy into practice is a discrete linear process following clearly defined policy goals.

Policy design implies a knowledge based process in which the choice of mechanisms through which policy goals are given effect go beyond consideration of policy content (Howlett et al 2014; Howlett and Lejano 2013). There is also greater imperative to acknowledge that policy design is not isolated from either the formulation of policy content or the process of implementation (Junginger 2013). Despite this, there has been little attention given as to how policy design itself influences implementation (Junginger 2013; Howlett et al 2014; Howlett and Lejano 2013).

Policy design may influence how the centre engages with local organisations as well as the ongoing dynamic of the process (Oborn, Barrett & Exworthy 2011; Exworthy and Powell 2001). In their study of UK national policy implementation on health inequalities, Exworthy and Powell (2001) found relationships from the centre to localities important but also along horizontal

dimensions, from local to local and central to central. In terms of policy design, there were problems in achieving change locally when there were not clear objectives, mechanisms to achieve them and resources to fund them. National policy on inequalities was nobody's 'core business' and thus was not aligned to local priorities and existing programmes which drew on local health budgets. In contrast, policy design in the empirical case studied here was centrally focused, with clear objectives and targets to achieve throughout implementation or 'roll-out' and a central team distributing funding locally, monitored through regional health authorities.

POLICY IMPLEMENTATION IN HEALTHCARE

Top Down Strategy

A central concern of policy makers is how they can ensure policy design objectives and outcomes are accomplished. The work of policy implementation scholars as exemplified by Paul Sabatier (1986, 1999) sought to model the complexity of the policy implementation process, focusing initially on top-down implementation but through refinements to the original model, incorporating bottom up and learning processes. The top down perspective generally takes the policy makers' views and the general control mechanisms needed to achieve central policy objectives, and consequently sees local actors as impediments to successful implementation (Paudel 2009).

The healthcare policy implementation literature has addressed specific concerns with the adoption and promotion of evidence-based guidelines into healthcare policy and practice. In seeking to increase evidence-based policy and practice, scholars (Conroy and Shannon 1995; Picken et al. 1998; Shiffman et al 2004; Grimshaw and Grol, 2001) have focused on the requirement for fidelity to guideline implementation (Keith et al. 2010) and accumulating knowledge around the variables that impact the adoption and implementation of evidence into practice. Studies have explored the organisational complexities involved in guideline implementation (Green,

2011; Helfich et al, 2011) and the challenges of transferring experimental evidence to 'real world' clinical situations (Keith et al, 2010) involving multiple stakeholders who hold different perspectives and represent different organisational cultures.

Much of the implementation literature focuses on the factors affecting the implementation of a service or change, and the 'climate' that enables this to occur. Such an approach to implementation does not sufficiently account for the transforming and relational nature of the implementation process. There are gaps in the study of how guidelines are 'rolled out' with need for attention to how local infrastructure is ingrained in the implementation process. Conceiving implementation and knowledge translation across organisations within the terms often applied in implementation science leads to an 'implementation gap' in health care (Davies and Nutley 2003; Cooksey 2006; Lomas 2007), often a lack of understanding that the process of transferring guidelines into practice is not a rational, linear process but one which must accommodate the enduring practices and cultural artefacts of the organisational context into which guidelines translate. Ferlie et al.'s (2009) analysis of evidence-based practice in health care concludes that implementation in health care is too 'top-down' and centrally focused. As such, the 'implementation gap' is considered the difference between what the centre's policy directs and what the local actors implement in practice as a deviation from the policy standard. For example, Wensing et al (2012) draw attention to the local versions of national guidelines that will occur through implementation. There is merit therefore in developing a conceptual implementation scheme in a healthcare setting that accommodates broad local realities which explores how local realities necessarily influence policy implementation in health care settings and goes beyond viewing this as a 'gap' in fidelity.

Localisation Approaches

Another stream of literature has studied the 'local realities' of policy implementation (Pressman and Wildavsky, 1973; Lindblom, 1979) – these

include Lipsky's 'street level bureaucrats' (1980) and the 'policy and action' focus of early work (Barrett and Fudge, 1981; Barrett and Hill, 1984). In healthcare studies within this field, the role of discretion, motivation and action of local actors is argued to be important in systematically accounting for the policy implementation (Evans and Harris 2004; Checkland 2004; Harrison 2004). The focus on everyday knowledge of local actors in shaping policy implementation has long concerned political science and public policy scholars, as they moved away from a rational, top-down approach (as exemplified by Simon, 1957) and developed thinking primarily focused on the public policy implementation 'gap' (Pressman and Wildavsky, 1973).

The bottom up perspective directs more attention to formal and informal relationships in policy subsystems, including how policies are designed and implemented (Paudel 2009; Howlett and Ramesh 2003). As such the local actors are conceived to be central in the policy process. Though both top down and bottom up perspectives identify the many actors that influence the policy problem and the role of local networks in implementation (Matland 1995), the latter emphasizes the complex organizational processes by which actors in multifarious environments such as in health care absorb and apply new information, new ways of working, and new policy guidelines (Harrison 2004). The emphasis on everyday enactment of policies, of decisions at the local level, of discretion and accommodation is important because it is necessary to explain and understand the complete policy process (Rhodes, 2013).

Understanding the complete policy process is neglected in policy implementation studies and this study seeks to bring together policy design with local realities. In, Lipsky's (1980) classic implementation study individual street level bureaucrats shape how policy is enacted and services delivered through professional autonomy, highlighting their resistance to, and manipulation of, new policies. In healthcare, Checkland (2004) provides an interpretation of GPs as 'street level bureaucrats' pursuing a strategy of resistance against top-down policy making (Checkland 2004). In Checkland's study decisions by GPs at the local level 'became the policies carried out by

their organisations' in line with Lipsky (p. 968). Policy was being enacted on the ground by GPs, and there was significant variation in how policy was implemented explained by the interpretation of policy in local primary care organisations. Hill (2003) explores the bottom-up constraints under which street level bureaucrats operate when new policies are introduced such as misunderstanding the terms of policy, or not having the skills to implement policy. In May and Winter (2007) a more positive assessment of street level bureaucrats is offered whereby they play a key role in translating policies into action. This study builds on the findings of previous localized approaches to implementation by examining the policy process from design through to implementation. While bottom-up accounts draw attention to the disjunct between policy design and implementation, the account presented here shows how adapting to local realities are a necessary part of the policy implementation process.

Implementation as sites of learning and improvement

Schofield (2004) puts organisational learning at the centre of local implementation; identifying competencies and capacities and exploring how learning is routinised and maintained. Coleman et al (2010) use dialogue and sensemaking to explain dynamic policy implementation processes in the UK NHS particularly when national policies are loosely defined. They find that individuals at all levels – policy makers, meso-level implementors and ground-level implementors – frame policy in different ways. They also find that change occurs in how policy is constructed at the local level as local personnel changes. Building on Pope at al (2006) they find local variability in policy implementation, which may be driven by local organizational knowledge and accumulated sensemaking by local actors; new organisations that were not aware of prevailing local context were placed at a disadvantage. In Peck and Perri 6 (2006) sensemaking as 'settlement' is used in an overarching narrative of empirical policy processes in recent UK government policy.

Taking a more cognitive approach, Gabbay and le May (2004, 2011) has used the concept of 'mindlines' to inform health policy guideline implementation. In

general practice organisations, clinicians use various sources of information in their day-to-day practice, including their personal networks of colleagues and other practitioners to evaluate new information (such as new clinical guidelines) or situations that challenge existing ways of practicing. New information (such as the introduction of a new policy or guideline) goes through a series of social processes before being internalized in the clinician's 'mindlines'. Those processes involve the following: gathering new ideas or information, collecting and sharing information, and combining new ideas with existing 'tacit and experiential knowledge before either incorporating them into their local policy or internalizing them (or not) into their mindlines' (p. 194).

In contrast, the literature on 'improvement science' in healthcare (Alexander and Hearld, 2011; Marshall et al, 2013) focuses on practical learning at the organisational level in order to improve quality of care and health care outcomes. While some contributors to improvement science focus on scientific and technical quality improvement, it is also emerging as an inclusive, pragmatic approach to implementation, encompassing broader components of the health care system, including practical learning, local wisdom and transferable knowledge (Marshall et al, 2013). There is support in this literature for an analytical focus on the translation of policy through local knowledge and practice; like Lipsky's street level bureaucrats and the bottom-up policy implementation scholars, knowledge and practice at the local level is important in making policy actionable and shaping policy outcomes. Whether there is an implementation 'gap' here depends on the extent to which the 'top' allows for variation in outcomes at the local level.

While policy implementation studies have contributed substantial knowledge and understanding to the local realities of policy implementation, their conceptualization of the process have been largely static with little emphasis on the recursive nature as to how it may influence the policy design and indeed the policy itself.

Our contribution to this literature is two-fold. First, our focus is specifically on understanding the dynamic, iterative nature of the implementation process,

and its effect on reshaping policy, which places the focus of study within the overall conceptualization of policy design, including feedback mechanisms to policy makers and lessons for policy design. Second, we seek to understand the role of policy design in enabling coordination between the multiple actors in a particular way during the implementation process.

A local universality perspective on health policy implementation

An important tension in implementing policy that is neglected in implementation literature and policy design studies, is the relationship of the new policy with the prevailing infrastructure, procedures and practice of any given context. For Timmermans and Berg (1997) the concept of 'local universality' is the product of these processes – what is enacted in each location (district, organisation, sector) as a result of a new policy is a unique product of the continuous negotiations, collectively produced, and also the creation of new relations, new beliefs, new knowledge in the practices wherein policy is implemented. Hence the uniqueness of each implementation site; the 'local universality' is recognizably adhering to overall policy design and specifications, but will - through the local implementation process – always be 'unique'.

Policy and guidelines, particularly in healthcare, can be considered a specific instance of 'standardisation', in that the aim is to control the actions of others in such a way that these actions become comparable across space and time. This standardisation follows the evidence-based policy and practice doctrine. It also means in a national policy context that the centre can more easily monitor what is happening locally. Drawing on Latour (1987) this can be conceptualised as extending an actor network so that the faithfulness and cohesion of action (for example the practice of treating depression or stroke) can be achieved at a distance (for example by the Department of Health through a policy or guideline). However, Timmermans and Berg argue that the Latourian perspective places undue attention to practices being established de novo; the emphasis is thus given to establishing new associations. The concept of local universality seeks in contrast to examine the enrolment and

alignment of an actor network from the perspective of those who are being enrolled and who are already within an existing network that is firmly in place.

The empirical case study research reported here uses the local universality perspective to explore adaptation and localisation processes in policy implementation by examining a national healthcare policy implementation process. The IAPT (Improving Access to Psychological Therapies) policy sought to provide a standardised service for the treatment of moderate depression and anxiety in primary health care in the English NHS. Between 2008 and 2011 following two extensive pilots of the new service, the IAPT policy was rolled out across the English NHS. Applying a local universality 'lens' (Timmermans and Berg 1997) to policy implementation, empirical case study research focused on what happens at the local level during policy implementation and the feedback mechanisms, negotiations and settlements between the 'centre' and through to local settings in addressing the following research question: 'How do design enabled adaptations around local realities enable and constrain the policy implementation process of IAPT?'

METHODS

IAPT was chosen as a policy case to study because of its unique design features, thus comprising what has been termed an 'extreme case' in order to maximize the theoretical insights derived from the case (Denzin and Lincoln, 2007). Important design features of the IAPT case include: extensive testing of an implementation 'model' through pilot studies; a service model which allowed local determination within a limited set of prescribed options; comprehensive, standardised data collection from every implementation site; strong clinical and economic evidence base for the policy and dedicated funding alongside national performance targets. Whilst numerous aspects of the policy design were influential in shaping the process of implementation, in this paper we focus on the first three named features of IAPT policy, namely the use of pilot studies, flexible service model and ongoing data collection.

Empirical analysis of IAPT policy implementation formed part of a larger regional CLAHRC[2] funded study on research into practice.

Multiple forms of data were collected across two phases. In phase 1, key documents that related to the IAPT policy were analysed (summarised in Annex 1). These included national policy documents produced over time relating to IAPT, regional and local reports produced relating to IAPT, and published academic findings, which included analysis of two substantial national pilot or 'demonstration sites' in relation to IAPT services (e.g. Clark et al, 2009; Richards and Borglin, 2011). During this phase 15 interviews were conducted with representatives from the DoH (Department of Health), and the SHA (Strategic Health Authority); implementation leads from administrative organisations across the East of England; therapists (within the IAPT system and without) and doctors; and data analysts from the IAPT programme. Interviews with local actors concentrated on those in three different IAPT providers in East of England. Interviews were semi-structured and primarily face-to-face, although three were conducted by telephone as this proved most convenient to the interviewees. All but two of the interviews were recorded and later transcribed; in the two that were not extensive notes were taken. The first ten interviews concerned general themes around the process of policy implementation. These included the practical implications of resource constraints and the challenges of creating a new workforce, as well as the interviewees' views on the treatments included in the IAPT service. In the subsequent five interviews, we delved more deeply into the specific themes reflected in this paper.

In the second phase, researchers observed four workshops regarding regional and national IAPT implementation and two IAPT performance management meetings for the East of England region. We conducted twelve further interviews; six with senior managers involved in the policy implementation and six with doctors involved in implementing national policy guidance. These interviews probed more deeply into themes of adaptation,

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[2] NIHR Collaboration for Leadership in Applied Health Research and Care

policy fidelity in relation to national policy. We also conducted two think tank meetings with (6) policy stakeholders where we fed back the results of our analysis and sought attendees' input on the validity of our themes, seeking to develop deeper insights. An important theme arising from think tank meetings was the multiple and often conflicting purposes of the IAPT policy data collection, which predominantly were used by central actors for performance management.

Iterative analysis was part of the study design to provide grounding for conceptual development and occurred in three stages. First, documents and official reports were analysed. Documentary analysis of national policy documents relating to IAPT provided details of the distinctive features of the IAPT policy, its overall aims and policy design, and details relating to how implementation of the policy was to be executed, such as how IAPT services were to be organised and commissioned at the local level. Annual reports on IAPT including a substantial analysis after three years of national roll-out of the policy were used to assess progress on implementation and examine how local implementation was shaping policy at the national level, and what changes, if any, were made to the IAPT policy over time. Second, the first set of interviews were conducted and analysed inductively. Data segments were grouped into themes to develop higher order concepts (e.g. learning, adaptation, control, knowledge dynamics) by developing written narrative accounts (Golden-Biddle and Locke, 2007). During this phase we moved iteratively between data and concepts in the literature. In the third phase, we sought to validate our emerging themes and narrative analyses with further interviews, meetings and think tank feedback. Narrative analyses were presented to policy stakeholders as well as a conceptual synthesis of a policy implementation process. Feedback from the first think tank meeting was used to further develop our analysis which was then presented a second time to the same stakeholders in the follow up meeting, which also focused on practical implications of the work.

Case

The IAPT policy was a high profile policy for the then Labour Government, championed by Gordon Brown as chancellor and then Prime Minister. Lord Layard's *Depression Report* (2006), which made the economic and clinical case for the IAPT policy was promoted in national newspapers. It was supported by NICE, the National Institute of Health and Care Excellence, an entity which develops gold standard guidance for medical interventions.

The IAPT website lists that between October 2008 and the 31st March 2011, 142 (out of 151) PCTs in England moved to providing an IAPT service in at least part of their area (indicating high levels of implementation), and that just over 50% of the adult population has access to this service. The December 2011 *IAPT Programme Review* notes that, 'National numbers accessing treatment are at agreed trajectory levels' (p.6) highlighting the consensus of overall success in delivering the IAPT policy.

EMPIRICAL FINDINGS

Feature of Policy Design: Pilot Implementation Sites
Two pilot sites, Doncaster and Newham in England, were used to test out and inform IAPT implementation. These sites were not designed to test whether the IAPT policy was a good idea or not – substantive decisions about the IAPT policy content had already been taken. The pilot sites, as described in their final reports, were used as a 'bridge', designed to span the gap between policy and practice as both sites sought to enact the NICE guidance as specified in the policy. They facilitated larger scale implementation because they helped to reduce uncertainty about the new service, for example to assess some of the switch over costs or points of challenge in the implementation process. As such these pilots were also referred to as 'demonstration sites' by their organisers and central policy actors.

A number of interviewees highlighted that the 'demonstration sites' were implemented in a context where there was little if any overt resistance to the IAPT program.

> *They were not independent, they were carried out and led by people who believed that this was a good idea. (Psychiatry Professor)*

Yet, the pilot sites showed that despite the advantages and support they had compared to other locations later tasked with implementing the policy (for example, pilot sites were chosen because they had supportive leading local professionals, and were given significant resources to fund implementation of the new services, as stated in their final reports), there remained significant implementation challenges in conforming to the terms of the policy.

Design enabled adaptation around local population service use

The two pilot sites for IAPT were chosen for their differences, to demonstrate that the policy could be successfully implemented in different contexts. As suggested by one evaluation report of the two pilots,

> *[T]he Department of Health funded two pilot projects ….Both sites focused on individuals with depression and/or anxiety disorders. However, they concentrated on somewhat different populations (Clark et al 2009: 911).*

In Doncaster there was an existing psychological therapy service in place, so there was a ready workforce and established relationships in place prior to the pilot. The supportive actors around this site agreed with and fit the mainstream policy formulation, enabling higher levels of certainty over the unfolding process of implementation. High numbers of patients were quickly enrolled, as highlighted by an official evaluation report,

> *Individuals seen in Doncaster are predominantly white (in line with local demographics), whereas Newham has an ethnically mixed population with a significant number of people who do not usually speak English (Clark et al 2009).*

Newham, an area in London, was also characterized as a GP community that was supportive of psychological therapy but it also had to identify and engage a large group of potential patients who were not in contact with GP services. Newham also has the highest number of refugees of any borough in London, making traditional GP referral increasingly challenged as a mode of IAPT access.

> *What we were trying to do ... was ... broaden the appeal and the access to these services to different parts of the community; establishing a self-referral mechanism was an essential feature… [We were] trying to reach parts of the community that are traditionally 'under-doctored' (IAPT Policy Lead, Department of Health (DoH)).*

The implementation of the Newham service was modified to counter the unplanned problem of under-referral. This required a series of renegotiations with debate within the local providers about changing the referral criteria '*in order to generate more referrals of more people,*' (Newham Annual Report, 2007: 4). In order to facilitate self-referral, faith based community organisations were solicited for endorsement and assistance, and the following '*measures to elicit referrals from BME groups*' were used:

> *The employment of Therapists who speak the relevant BME languages in Newham namely: Bengali, Urdu, Hindi, Gujarati, Punjabi; the development of [depression and anxiety assessment tools] in the relevant BME languages namely: Bengali, Urdu, Hindi, Gujarati, Punjabi, Arabic; the use of translators where necessary for BME patients; marketing materials in relevant BME languages; use of a helpline with BME languages speakers; [and] engagement with local community and religious BME groups (Newham Annual Report 2007:9).*

Further, for all sectors of the community the programme was complemented by increased access to Employment Coaches. In the period covered by the

Newham IAPT service's annual report, fifty per cent of the referrals to the employment service came from the IAPT programme.

Enrolment of this BME group of patients was important for central policy makers to demonstrate the universal relevance of the policy; that it was suitable for the diverse populations across the UK. Hence pilot sites were allowed to trial the self-referral mechanisms, though the policy stipulated referrals should be funneled through the GP. In populations where potential patients did not ordinarily register with GPs or access healthcare organisations, other institutions and cultural norms were accessed. Using faith-based and employment services to access hard-to-reach patients meant forming new alliances within the locality, and created new local realities for IAPT implementation.

Design enabled adaptation around infrastructure
The other demonstration site, Doncaster, also created new local realities and adaptations for IAPT implementation through the introduction of a telephone-based therapy service which was unexpected, yet popular. However, it provided an innovative route for the new IAPT service within the infrastructure limitations of a small facility space which was restricting the throughput of patients. Data collected showed that the same outcomes in terms of recovery could be achieved with fewer resources in a telephone-based service, as the telephone based therapy sessions lasted on average 22 min, compared with 40 min for face to face meetings. Thus in this location they focused on enrolling low and medium intensity patients (in terms of depression severity) which could be treated through telephone sessions. Doncaster's pilot was thus described as:

> *'[A] high throughput, stepped-care service with a marked emphasis on low-intensity work (especially guided self-help), although high intensity work is also available. (Clarke et al 2009: 911)*

Yet, due to the high number of telephone based sessions, Doncaster reported difficulties in collecting some of the routine required data on patient satisfaction with the service as:

> *Case managers find the [patient satisfaction] measure extremely difficult to complete since their telephone-based working protocol requires them to read it out over the telephone. Given the questionnaire contains items relating to the performance of the clinician reading out the questionnaire, the measure is frequently omitted through embarrassment (Doncaster Annual Report 2007:17).*

In Doncaster the data collection surrounding patient satisfaction was silently dropped by actors engaged in providing telephone treatment (Satisfaction data was collected from 206 of the 869 patients with post-treatment measures at the time of the first annual report (Doncaster Annual Report, 2007: 17)). Thus the way that survey forms were filled out was altered in order to maintain adequate programme roll out.

These adaptations of the IAPT policy demonstrate a process of localisation of the generalised universal policy. There was fidelity to the IAPT policy guidance as set down in national policy guidelines and yet with sufficient adaptation to local resources and context; the sites were able to demonstrate the plausibility of IAPT implementation, but also create narratives around how you could adapt the policy to suit local infrastructure. Increased emphasis on telephone sessions and removal of the emphasis on GP referral was eventually incorporated into a revised version of the IAPT policy.

Feature of Policy Design: flexible service model with prescribed options

In IAPT a type of 'buffet menu approach' to treatment was produced, and based on a stepped approach to care in relation to intensity of treatment deemed necessary. The 'menu-based approach' allowed each area to choose from a list of options such as face-to-face talking therapies, group interventions, telephone interventions, as well as self-help guides to be

prescribed. Each option was founded on NICE guidance; each therapist could pick any combination of the treatment modes, and could decide the relative emphasis, but they were encouraged to utilize a mix of all the resources available. Thus there was flexibility, but within strict limits:

> [The] style of service offered might differ a little bit by the provider, but it's very much a service by recipe book. People have [been] given the recipe. (Psychiatrist)

Design enabled adaptation around resource availability
Building on the earlier theme of adapting around available infrastructure, if a region lacked buildings which could be used for treatment then they could have proportionately more telephone treatments which take up less space, as was witnessed in the Doncaster area. Equally it was argued that a menu of choices could be used by managers to enhance efficiency in a context of fiscal austerity. Given that each region implemented the guidelines with different emphases and at different rates, often in relation to what services were preexisting to the IAPT program, new ideas emerged;

> [Our region] has started offering workshops [for self-referring patients] … So sometimes GPs would refer people to [one of the program options but] they weren't quite sure which would help. So we found the workshop was just, as you say, helpful for guiding people into which therapy option. And then the workshop facilitators would follow them up a week after the workshop with a phone call. … [But] it's difficult in other service [region] where there's not a central point. [Our region is set up] different from [other region] and we find that people are more motivated to attend [when offered workshops]. (CBT therapist)

The regional authorities, (SHAs) coordinated the overall implementation process, administering funding, and monitoring progress across the various providers. This became an important way of sharing practices that produced best results between the different IAPT providers. In addition, the regional authority (SHAs) offered training specifically for IAPT therapists (for example,

conducting low, or medium level therapy), augmenting the resources available to individual providers.

> *'my role is … to advise and maintain the standards within IAPT but also we have the monies come to us from the central team so it's up to us to allocate that funding, to organise training and to try to ensure some sort of consistency across the regions.' (Regional administration manager)*

Adaptation to local and regional conditions worked to increase the likelihood that universal standards would be adopted: first, because it heightened the autonomy and control of local actors which increases the likelihood that they will accept the standards in principle and be compliant; second, because it enabled negotiation of resources across multiple providers and achieving a level of consistency through unified training programs and learning necessary to effect the change

In this way the implementation process was being shaped by the resources made available through the existing health service structures. The regional authorities acted as a conduit between the centre and localities in the implementation process, translating guidance from the centre to the local level, and also performance managing local services.

Design enabled adaptation around patient choice and engagement

From the patient or user's perspective, IAPT enabled patient choice in two ways. Firstly, the program offered greater treatment capacity, thus whilst prior to the program patient might not seek treatment because of lengthy waitlists, or lack of system capacity, the program and the publicity around IAPT offered the option of treatment.

> *What previously happened to patients is that, pre-IAPT those who present were then referred to a secondary care service – that would increase the waiting list for … psychological treatment because the demand was so high… So IAPT has introduced a huge, a new level of choice and opportunity for patients that would not have been seen previously.* (Clinical Psychologist)

Secondly, patients also had opportunity to choose around options as to how the treatment might be delivered. They could indicate preferences as to which treatment methods would best suit their lifestyle.

> *We've got to accept that there are different people coming along with different needs … so there's an online way of doing it under supervision, or guided self-help work… That's what I mean about personalising. (IAPT Policy Lead, DoH)*

The menu based approach was argued to enable patients to become empowered through choice. The menu based process necessarily operates as a negotiation between a clinician or therapist who holds the menu interface and understands the options available in conjunction with the patient who understands their own life patterns and preferences. Given that patient compliance with mental health treatment regimes is notoriously low, and the general lack of initiative common in depression, empowering patients was crucial for improving clinical outcomes. A manager explained:

> *Menus enable patient choice… What type of intervention are they likely to respond to; and what are their preferences? If people are in employment then telephone counselling may fit into their work schedule better … Or if someone likes to sit at the computer, or if they live in remote parts of [the county], then they may think internet based program is the best thing. (IAPT Regional Manager)*

In addition to choice about treatment, the detailed manner in delivering the treatment options in a standard way so that patient scores from therapy sessions could be projected against national and regional averages, enabled patients to have a role interpreting their own outcomes. By integrating feedback from the data, with their own knowledge of their life circumstances and stresses, patients could gain increased control over their recovery process. Thus they were able to interlink data and metrics on their recent moods and anxiety levels in association with their recent past events, such as

quarrels or work life balance, they could make new associations regarding how their mood was influenced, as explained by a regional manager.

> *Having access to their data gives … patients ownership of their care pathway; they understand their condition better for example can see what triggers a setback in becoming more anxious- was it a fight with their spouse or something at work, for example. They can make links with the type of days that improve their condition and help them sustain a recovery. That is the overall goal – to get the patient themselves to be able to sustain their own recovery and thus they have to take an active part in the process. (IAPT performance manager)*

Design enabled adaptation around familiar and measurable treatments
NICE offered guidance (2004) on a range of therapies to treat mild depression and anxiety but in practice Cognitive Behavioural Therapy (CBT) dominated how IAPT was implemented in the early stages. CBT was a relatively well known – though contested – treatment. It was also simpler for new services to be set up around fewer options as this meant that therapists only needed to be skilled in delivering one treatment regime.

> *When IAPT came out of the treasury it was not meant to be pure CBT, it was meant to be, you know, increased access to psychological therapies. And somehow along the line, the purists interpreted it as pure CBT (GP Practice Manager)*

> *When IAPT was first talked about and first delivered CBT was the main focus and to be honest that got a lot of people very upset, and it meant that some stakeholders who would have run with it didn't choose to … Now we're looking at bringing in the other modalities, and I think, to be honest, that it's come in a little too late. (*IAPT Regional Manager)

One of the drivers behind the focus on CBT over other treatments was that it was measurable, and in the IAPT policy design measuring outcomes was key to demonstrating its success.

> *I mean I can understand that how CBT came to dominate because it is very measurable, and when you're looking for funding and need to prove what you do, it's a good tool. It doesn't tackle the real issue but it's measurable (Private Counsellor)*

Resistance to implementation came in several forms; for example, from mental health counsellors who were already providing primary care services and drew on a wider range of treatment options beyond CBT. This created tension with GPs who did not want disruption to existing services and their successful relationships with counsellors.

> *These counsellors have been operating out of GP surgeries for long periods of time. Now GPs are being asked, to bypass these counsellors, and counsellors are being asked to enter a system in which they will probably be paid less and asked to work hours less of their choosing (IAPT Performance Analyst).*

An important factor influencing the process of resistance and sensemaking was whether there was supportive local infrastructure already in place; for example, one area observed already had a service using CBT "*so they had that on their doorstep, they had the experience, they knew [CBT] worked, and so therefore, there was less resistance, and it was easier to understand the argument"*. However, in another area, where CBT was not part of established practice, implementation of the policy was constrained. Over time, pressure increased to expand the range of services offered by the local providers, moving beyond the CBT option. The regional authorities played an important role in this by providing training programmes to upskill therapists in delivering a wider range of talking therapies, highlighting to the providers that this would improve access and enable them to meet central targets. However, the manner in which regional authorities supported implementation was not standardised by the centre.

The main focus has been on CBT, but there are others that are NICE approved and in the guidelines; but these are not used as much. So we are trying to get people using a broader range of services and therapies. So I am training therapists to deliver couples therapy, Interpersonal therapy etc. (Regional Manager and Trainer)

We can therefore identify a clear policy design in how the IAPT policy was articulated from the centre that was further shaped by the local realities and infrastructure. The IAPT model of policy and implementation was designed to standardise the provision of primary care therapy services from what preceded which led to an unexpected focus on CBT use shaping implementation. Yet the ongoing use of CBT and associated learning through implementation also reshaped the IAPT programme, changing the importance and focus of the CBT treatment.

Feature of Policy Design: Ongoing data collection creating new evidence

Collating data from local service providers was another crucial feature of IAPT policy design. National roll-out of IAPT involved standardised data recording from each IAPT provider.

The way it works currently is that each of the services are responsible for collecting their own data and they send this in personally to … a central (DoH) team who performance manage the IAPT nationally looks at it. The service providers can look at their data first and if they see something isn't right, then they can clear the data up a bit- then they send it on. (IAPT Regional Manager)

As a consequence central policy makers were able to assess IAPT's progress during its implementation (Department of Health, 2012). This ever-expanding data set from across the country contained the details of types of therapy offered, to which types of patient, over how many sessions, as well as treatment outcomes. From a local universality perspective, each service was

continually documenting how it chose to adapt the treatment options. This form of evolving evidence no longer implies a rupture with the 'local' but the transforming of universal standards in and through it.

> *In IAPT the richness and accuracy of the data is the best we have ever seen- it is amazing. We have never had anything like this before (IAPT Regional Manager)*

Design enabled adaptation around regional comparisons

IAPT data at national level was able to show by 2012 session-by-session data on 90% of contacts across all local providers. This was used to show comparisons between different sections of the population and highlight some of the challenges in national implementation. For example, it showed how rates of patients completing treatment reached 66% in 2010 but then dropped to 60% by 2012, which led to further analysis as to why. It also showed that recovery rates in IAPT rose over its first three years (from 17% to 45%) as services became increasingly effective.

> *It's really incredibly helpful because we've been able to, get people to shift from collecting data to actually using it to commission better – there's some unique information that no one else has got; but it's been really difficult. But once people see what can be done by using information more sensibly then it becomes much more reasonable to ask people to collect that information. I think we missed that in the early stages. (Policy Advisor, DoH)*

In a regional performance management meeting, a local manager referred to the fact that they had data and evidence to support their services but this data was '*not getting through to service commissioners*'; and without wider commissioning of IAPT services, the local area could not expand its access and meet targets. The National Policy Actor at the meeting was astonished that '*you are performing the services so well and the commissioners don't commission more*'. A commissioner responded that they had many competing demands for resources. Another commissioner was brought in to the

discussion when a participant said '*there is a dog that hasn't barked*', explaining that commissioners wouldn't invest more in the service while GPs were not demanding an expanded IAPT service.

The prevalence of performance data in IAPT meant that certain regions and providers could be seen to be meeting their targets and thus considered successful implementers and held up as exemplars to others, as observed in performance management meetings. Meeting targets were rewarded with financial incentives, further contributing to the resources available for implementation, iteratively enabling further success. In this way, data sets themselves exerted their own influence on the trajectory of the multiple actors involved in delivering the policy.

Design enabled adaptation around predictive modeling
Researchers at several regional authorities became aware of the data being collected in IAPT and began to generate statistical data to inform the on-going implementation process, using modelling and other techniques to examine the flow of patients, and make predictions about who was benefitting from IAPT services. Whilst the gold standard for medical evidence has rested on prospective controlled clinical trials, the IAPT programme had the potential to be informed by a new genre of evidence, that is, data produced in response to on-going practice. Yet in the context of our study, engagement with learning from these datasets remained largely within the academic field rather than being adopted by local (or national) policy actors.

> *The data hasn't been used to improve the quality of the care which they provide. So it's been done because this is what you must do, not because it's this is how we improve the quality of care we expect from you…It's dominated by performance management and targets that aren't particularly helpful, rather than people saying, well if I had this bit of information I could use it to provide a better care. (Policy Advisor, DoH)*

Yet, locally generated IAPT data did provide some local learning in IAPT implementation. Research showed that the clinical effectiveness of providing CBT by telephone was the same as with face-to-face interviews across the region, but more cost-effective. As time progressed service provision was influenced by the outcomes being measured, with eventually the centre promoting the widespread use of telephone based treatments, and highlighting this mode of delivery in the policy updates.

> *The research project showed that face to face and telephone had similar outcomes; But it is more cost effective to do telephone. Data was being directly extracted, straight out of the patient record. (Psychiatry Professor)*

In order to generate learning and translate this knowledge into practice, service providers had to cover additional training for telephone-based interviewing. Further, empirical research also showed that older men responded well to group treatment, although it was hard to get them involved.

> *And it is possible to look at trajectories over time in terms of the scores in depression and anxiety, and summarise the infinite number of trajectories that 10,000 people can take … So [quantitative researcher] has been doing some work on trying to predict as soon as you can people who are not made better by IAPT. So you don't waste IAPT time or the patient's time and resources. (Psychiatry Professor)*

The ongoing data collection in IAPT was also a means of enabling the patient to understand their unique recovery trajectory. By seeing their scores and charts indicating improvement, this held sway over the patient that indeed they were improving, controlling their view of how they were feeling and thus their own recovery process. In a sense, the data had a level of control over the patient's progress by defining it; if the charts said they were better, they must be better.

The patients have access to their data and … will see the trajectory of their recovery, if they are improving and the trends…patients have given strong positive feedback on the usefulness of seeing the progress of their treatment, seeing the maps and the charts. (IAPT Regional Manager)

Because I think that part of the process is that as a patient you might not feel that you are improving, but if your therapist can show you that your scores show you have improved that can actually reinforce the improvement (IAPT Policy Lead, DoH).

Research showed that detailed data collection was used in IAPT implementation at national and local level to inform policy makers about progress and to identify problems, though at the outset this was not a stated intent. The central policy actor responsible for implementation of the programme became aware that the process of implementation not only required local translation to accommodate local realities, but that the ongoing IAPT implementation also reshaped the policy itself.

In some ways, [we have been] different from other policy makers where you have to work through in detail the …evidence-base … and then come up with a fully worked out service delivery model you've dreamed up in a smoke filled room with a few experts . . . We kind of were more organic about the process . . . the evidence-base was there but we developed and stretched and interpreted it in the way it was implemented. I think that all worked really well (IAPT Policy Lead, DoH).

Thus in addition to having policy evidence that could be 'stretched' and needing interpretation in order to implement, a central policy actor at the department of health acknowledged that the policy itself evolved '*as a moving target*' during the implementation process. This further highlights how the policy content and implementation process engage in a dynamic and iterative negotiation.

DISCUSSION AND CONCLUSION

In addressing our research question of '*how local adaptations (realities) enable and constrain the policy implementation process of IAPT*' our analysis shows that local adaptations enabled the policy implementation process in ways that could not have been predicted. Where the IAPT policy design allowed for flexibility in implementation, local decisions created innovation and learning which helped to secure the implementation process; such as in recruiting hard to reach patient groups, enhancing efficiencies through telephone-based treatment and securing early benefits as well as problems with a reliance on CBT as a treatment option. This has occurred throughout the IAPT roll-out where it continues to be re-shaped in line with new practice-based evidence as it emerges.

Our local universality perspective highlights the importance of considering the many contingencies, infrastructures and actors brought together by a policy, each of which requires ongoing negotiation and adaptation. The case findings support a renewed focus for scholars on the dynamic nature of policy implementation. Our local universality perspective emphasises how a policy cannot specify all the activities entailed in achieving its objective; hence flexibility and looseness of the policy's actor network is its stabilising feature. Policy implementation does not result from the increasing docility of the local actors and entities whilst the centre exerts control; rather local universality emerges from the complex interaction over which no one actor controls. Stability and coordination is temporarily achieved through a 'continuous balancing of temporary agreements, suspended disbeliefs or mini-social contracts' (Timmermans and Berg 1997: 297).

We make two contributions to policy implementation literature. First, our novel theoretical perspective seeks to go beyond the role of local and central actors in policy implementation by taking account of the wider actor network. We show how infrastructure, data sets and organisational practices are also consequential, decentering local human agencies. Further, a bottom-up policy implementation perspective has implicitly viewed policies as forms of control that local actors, such as street level bureaucrats, resist in order to protect

their interests. In this view, universality is achieved through the subjugation of the involved actors to the network builder's goals; in the view of actor network theory, this implies extending the network and tying together more allies (Latour 1987; Timmermans and Berg 1997). Instead, Timmermans and Berg (1997) wish to highlight the mutuality of the real time process of maintaining the links needed to align the multiple trajectories needed in a guideline. Rather than suggesting that adaptation is a form of resistance, discretion and adaptation is necessarily part of how policies work in practice.

Building on Harrison's (2004) analysis, our perspective expands on an interpretive framing of policy implementation showing how, as policy implementation is defined and enacted, meaning is negotiated by local and central actors. In this way, adaptation occurs in order to account for local realities, and these adaptations can in turn reshape the policy content. Recent accounts from organisation studies (Brunsson et al, 2012; Botzem and Dobusch, 2012; Ende et al, 2012) highlight the dynamic negotiation that takes place through the adoption and implementation of new standards or guidelines in local organisations that is relevant to policy implementation studies. For example, Brunsson et al (2012) refer to a two way process of 'translation' and 'adjustment' that draws on Latour's notion of translation to highlight that what is translated is not simply transmitted but is transformed and modified according to goals (Laven, 2008). A dynamic process is observed which changes both the organisational context, and also the artifact [or policy] itself. In other words, 'to adopt is to adapt' (Akrich, Callon and Latour cited in Laven, 2008). The ability to change or adapt is then used to enroll other actors, and this increases the likelihood that this results in further adaptation and implementation (van den Ende et al, 2012).

Secondly, we show how policy designs also enable varying levels of coordination between the multiple actors involved as well as shaping the ability of central and local policy actors to learn from the ongoing process of implementation.   As local organisations respond to policy objectives by themselves through implementation of policy activities, they shape social understandings of the policy and of the meaning of compliance. Drawing on

scholarship in employment discrimination (Edelman 2005; Edelman, Uggen, Erlanger 1999), the recursive relationship between the policy content and its implementation is influenced by the actual features of the policy as it confers benefits and structure on the actual compliance. As our analysis shows, pilot studies, flexibility in service model, and data collection throughout the policy were enabling and constraining features in IAPT implementation. For example, as shown in the preferred adoption of CBT over other talking therapies in early stages of IAPT, local actors promoted a particular compliance strategy as a rational response that would conserve training costs which in turn became interpreted as being the IAPT policy.

Further, policy design goes beyond the formulation of policy content (Junginger 2013; Howlett and Lejano 2013). Our study found that the inherent flexibility afforded to IAPT policy through the menu based approach, as well as the built-in mechanisms for learning through feedback loops such as preliminary pilot studies and systematic data collection and review, were consequential to the adaptation process. Whilst extensive research attests that local adaptation is inevitable (e.g. Lipsky 1980; O'Toole 2000) specific policy features that promote flexibility can further enable the ongoing process of negotiation. This builds on an emerging consensus that policies (and their implementation) are themselves an outcome of designing (Junginger 2013; Howlett and Lejano 2013; Howlett 2011). In the current context of evidence-based policy processes, our findings provide an important challenge to the notion of the overriding importance of up-front learning; that there is, in fact, an ongoing dynamic relationship which is observed locally, in responding to national outcome measures and targets and managing the localising process of implementation. Learning through this process is an important aspect of policy design as it provides important feedback to policy makers.

Our findings suggest two implications for practice. First, our research highlights the need for building evidence on policy design that includes learning from implementation processes. In addition to the focus of the current UK government on up-front evidence-gathering, and trial-based or pilot-based evidence for policy making, empirical research on IAPT has shown the

importance of experiential learning from policy implementation. Practice-based, experiential policy learning through implementation can be fed back to policy makers in order to improve overall policy design. In IAPT and possibly in other policy areas as well, these feedback loops from localized learning to policy makers are currently not strong. Learning from practice to understand and support implementation could help policy makers understand why policies are still perceived to succeed in one location but fail in another.

Second, our findings highlight the balance required between maintaining adherence to policies, whilst at the same time allowing local adaptation in achieving a 'standard' implementation – achieving adherence to the universal policy in a way that is attentive to, and accounts for, local uniqueness (Oborn, Barrett and Davidson 2011). This understanding has bearing on the current large-scale transference of health policy guidelines to local organisations in the UK NHS, a process which, has been characterized as a 'top down' process to date (Ferlie at al 2009). In the health care sector, practice is now a highly complex world due to the range of overlapping policies; to continually updated, practice-based guidelines already in place; with a changing infrastructure and local populations. Empirical research has confirmed that local actors need the discretion to make sense of, and adapt, where appropriate, national policies to the local setting.

Our research relies on the findings of a single case study of the IAPT policy initiative in the UK. Future work could usefully build on this research by examining the policy design in other policy implementations across a variety of organizational and national contexts. Of particular interest would be to develop an understanding of how practice based evidence can be effectively incorporated into policy learning as well as the current emphasis on performance management.

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