Normalisation Process Theory: a useful method for informing the evaluation of complex interventions?

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AIM of presentation

• Overview of Normalisation Process Theory (NPT)

• Give some examples
What is NPT?

• Mid-range theory
• A way to understand how new practices become normalised
• NPT aims to provide a way to “understand the collaborative ‘work’ that needs to be done for a new intervention to become embedded within a given context” (Finch et al 2014)

• Designed to be used in institutional/organisational settings e.g. healthcare
• For use with qualitative and quantitative data
Where did NPT come from?

- Carl May and Tracy Finch co-developed NPT
- First paper – 2003
- Explored NPT in telemedicine, then patient compliance
- Released NPT to be used in whatever way researchers want to apply it, a tool that is still evolving
Core constructs of NPT

Four core constructs within NPT:
• coherence
• cognitive participation
• collective action
• reflexive monitoring

Normalisation is affected by factors that promote or inhibit routine embedding.
Definitions of core constructs

• Coherence – sense-making work (meaning)
• Cognitive participation – relationship work (commitment/buy-in)
• Collective action – enacting work (action)
• Reflexive monitoring – appraisal (formal and informal)
How has NPT been used?

• To sensitise researchers to the issues of embedding complex interventions (Murray et al 2010)

Examples:-

• MacFarlane & O'Reilly-de Brún (2012) assessed general practitioners' uptake of a free, pilot, language interpreting service in the Republic of Ireland.

• Kennedy et al (2013) used the NPT to question why training on introducing more self-management support in long term conditions had not been normalised into primary care practice.

• Thomas et al (2014) used NPT to identify how conducive the organisational context was before introducing a change.
babyClear® as an example

What is babyClear?
Enhanced stop smoking service to support pregnant women to quit

Project title:
Process evaluation of a complex intervention to promote increased smoking cessation rates among pregnant women in maternity care

Evaluation has two parts: quantitative (Newcastle University); qualitative (Teesside University).

NPT used to inform the qualitative evaluation of the implementation of babyClear®.
babyClear© - Key enhancements

• Based on National Institute for Health and Clinical Excellence (NICE) public health guidance 26. How to stop smoking in pregnancy and following childbirth (2010).

• Universal carbon monoxide monitoring; lower CO thresholds; opt out referral pathway; training in conversations by maternity, stop smoking advisors and SSS admin staff to encourage engagement; specific and speedy time frames for action; risk perception intervention (RPI); data management software.
Using NPT to evaluate babyClear®

- Observing the training
- Framing the interview schedules
- Codes for analysis
How well did NPT work out in data collection?

Strengths
• Easy flow
• Gave a common-sense structure to interviews
• Leant itself to answering our research questions (assessing acceptability, fidelity and sustainability from a staff perspective)
• Created questions that participants had plenty to say about
• Pioneering, flexible, used it to meet our requirements

Limitations
• Not many similar examples to follow
What about the data analysis stage?

Strengths

• Neat set of *a priori* codes for Framework Analysis (Ritchie et al 2003, p219-62)

Limitations

• Definitions of sub-categories rather difficult to remember
Exploring using NPT

• Considering analysing pregnant women’s transcripts using the NPT

• Questionnaire amongst midwives
Conclusions

• NPT useful in evaluating the implementation of a complex, public health intervention
• Applied to a number of studies, although predominantly qualitative
• NPT has been used in nursing, although babyClear is the first time it has been used with midwifery and stop smoking services
• Theory continues to evolve and develop


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Framing the interview schedules - 1

COHERENCE – sense making/meaning

What were your thoughts about the intervention before you came to the training?

Prompt: How clear was your sense of the purpose of the intervention beforehand?

How clear was the intervention made to you in the training?

Prompt: When you finished the training was what you had to do clearly defined in your mind?

Do you have any particular comments you would like to make about the training?
Framing the interview schedules – 2

COGNITIVE PARTICIPATION – commitment/buy-in
Has everyone joined in when you have taken it back into practice?
Prompt: Do you think everyone has taken it on board as an idea? Do people think it is a good idea?
Framing the interview schedules – 3

• COGNITIVE PARTICIPATION – commitment/buy-in
• Has everyone joined in when you have taken it back into practice?
• Prompt: Do you think everyone has taken it on board as an idea? Do people think it is a good idea?
Framing the interview schedules – 4

REFLEXIVE MONITORING – appraising/sustaining
Are you reviewing the changes in any way?
Prompt: How do you know if the intervention is making any difference?
How do you see it working out in the future?
For midwives only: Prompt: Is it likely to continue as it is? Are people going to struggle to continue to give a brief intervention or come in with the ‘tough love’ approach for any reason?

Are there any elements of the intervention that you foresee will be readily sustainable/ difficult to sustain?
Are there any developments / changes that you would like to see into the future?
Prompt: Anything that you feel doesn’t work well at the moment – how might it be improved?
How else has NPT been used?

• To understand the “components of treatment burden” for individual, chronic heart failure patients as a way of identifying why some treatments are not easily normalised by patients (Gallacher et al 2011).