

The NPT Framework: How to make successful change the new “normal”

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Introduction

Designing and developing useful interventions, methods, tools and solutions are challenging. However, implementing these changes successfully and ensuring it is used long enough to become embedded into routine care are much greater challenges. In fact, many ‘solutions’ are never implemented at all, or only partially adopted or not sustained despite being useful. As a result, precious time and resources are squandered on unsuccessful projects and staff become demoralized with ‘change fatigue’.

How can this be avoided? One way, is by identifying and understanding what factors determine whether changes are successfully implemented or not.

Definitions

- **Frameworks** consists of descriptive categories that provide outlines, structures or overviews of the concepts, constructs and variables that presumably give rise to outcomes (phenomena). (1)
- **‘Implementation’** is defined as ‘the process of putting to use or integrating new practices within a setting’.
- **Diffusion** refers to the passive, untargeted and unplanned spread of new practices
- **Dissemination** implies the active spread of new practices to a target audience using specific strategies.

There are many different implementation theories and frameworks

An oversimplified classification of the many different implementation theories and frameworks is to categorize them into one of two main groups: ‘institutionalization’ or ‘individual action’. (2)

‘Institutionalization’ theories understood implementation as the product of organisational activity.

Theories with an ‘individualized’ perspective describe implementation and implementation outcomes from the perspective of individual patients and health care workers. These theories assume individuals have ‘free will’ and actively choose to implement an intervention (or not).

Current evidence supports this perspective - at least to a degree – with a general consensus that ‘individual’ factors are indeed important determinants of successful implementation, but that they only account for an estimated quarter of the observed outcomes.

However, changes in health care are often imposed and individuals and teams have to work creatively to flexibly configure their existing practices to accommodate the changes according to their own specific requirements and local contexts. If there are workability issues with an



intervention that they cannot resolve it leads to problems with integration. In response to this problem, the Normalization Process Theory (NPT) was developed, with the perspective that **successful implementation is the product of the ‘work’ health care staff have to do individually and collectively to implement a change.**

Normalization Process Theory (NPT)

NPT is defined as an ‘explanatory framework for investigation the routine embedding of material practices in social contexts’. (2) **NPT is about the ‘work’ people do collectively and as individuals to implement a change and sustain an intervention. In other words, NPT is concerned with understanding ‘what people do rather than their attitudes or beliefs’.**

Normalization

‘Normalization’ is defined as the embedding of a technique, technology or organisational change as a routine and taken-for-granted element of clinical practice. (3) It includes all of the stages from **design, development and testing of an intervention, through to its implementation, embedding and finally integration. (2)**

Normalization should be differentiated from adoption (e.g. an intervention is accepted and is used from time to time) and **rejection** (e.g. an intervention is spurned).

Just because some innovations and interventions become normalized do not necessarily imply that they were effective in achieving their intended outcomes, nor that they are of high quality or that they are permanent, e.g. they may become de-normalized with time. (4) The converse is also true – an intervention may be useful and meet the organisational criteria for ‘successes and yet not become normalized. (5)

NPT constructs and components

The different types of implementation work are described and categorized according to four main constructs: coherence; cognitive participation; collective action; and reflexive monitoring. **For a change to become routine practice (‘normalized’), work has to be done to understand and organise the method (coherence), staff have to be enrolled into using it (cognitive participation), the method has to be enacted (collective action) and work has to be done to organise, collect and interpret data about the method’s effects (reflexive monitoring). (2)**

Each construct is divided further into four ‘components’, which allows the specific nature of the work to be described in more detail. Constructs and components constantly ‘interact’ with the potential to influence and change each other. The relative importance of each of the constructs and components fluctuate over the implementation period. The main constructs and all of their components are described in more detail below. (2, 6, 7)

Construct: Coherence

Coherence (CO) is the work individuals and teams have to do in order for them to make sense of an intervention. (2) In practical terms this means working to 'package' the solution or change so it becomes a unique and recognizable entity that can 'stick' within specific contexts. Health care staff understanding evolves over time and requires them to invest meaning in the change. Coherence has four components: differentiation; individual specification; communal specification; and internalization.

Differentiation

Differentiation (DI) is the work participants do to understand the differences and similarities between the proposed change and their existing methods, tools and practices.

Communal specification

Communal specification (CS) is the required work to understand the purpose of the intervention. In other words, what is the change or solution's likely value for each of them individually, for the HHS and for their patients? **Participants' understanding of the aims and benefits may be different from the HHS' intended aims and benefits.** If this difference is small, there is a 'high degree' of 'communal specification', which is desirable as it helps to facilitate normalization.

Individual specification

Individual specification (IS) is the work of considering and quantifying the expected 'effort', time and resources that will be required to successfully implement the intervention, and how this could best be done. **In other words, how feasible would it be to implement the change/solution?**

While a sound understanding of the task requirements are important, it does not necessarily mean that the resources or appropriately skilled, trained and experienced staff are available or willing to participate.

Internalisation

Internalisation (IT) describes the work participants do to understand and interpret the TRM in relation to their own principles and beliefs and also the prevailing culture in their team or organisation. It includes the work they have to do to interpret the findings from the implementing the change/solution to their own contexts and whether they decide to take further action .

Construct: Cognitive participation

The cognitive participation (CP) construct describes the relational work that is required to build and sustain a community of practice around an intervention and requires participants to invest 'commitment'. This involves identifying who should be involved with the change, recruiting and organizing them and keeping them engaged throughout the implementation process. CP's four components are: initiation, enrolment, activation and legitimation.



Initiation

Initiation (IN) is the initial work of successfully 'bringing forth' an intervention. It is usually performed by key participants who are capable of 'driving forward' an intervention. Examples of initiation work include promoting and raising awareness of the solution and planning and delivering educational events.

Enrolment

Enrolment (EN) is the work of recruiting participants who will implement the intervention and keeping them engaged in the process. In other words, EN describes who is involved with the solution and when, in what capacity and to what degree they contributed. However, the work of determining who should be involved in implementing the change is described by the 'skill set workability' component.

Activation

The activation (AC) component describes the continuing support work that is necessary to sustain the use of an intervention. For this work to be successful, participants need to remain actively involved in the process. This, in turn, depends on whether they feel 'empowered' to enact change and they consider ongoing participation as 'right' for them (the work of Legitimation – see below).

Legitimation

Legitimation (LE) is the work clinicians and general practice staff have to do, but also the work of policy makers and professional organisations, in order to legitimize and justify their involvement with the change.

Construct: Collective action

Collective action (CA) is the operational work required to enact the solution or change and requires participants to invest **effort**. The CA construct describes the organisational, external, immediate and internal factors that may hinder or facilitate the implementation process. The four components of CA are: interactional workability, relational integration, skill-set workability and contextual integration.

Interactional workability

Interactional workability (IW) is the work of applying the change in practice – e.g. to 'operationalize' it. It is important to consider whether informal work-place rules may be affecting this work, and if the intervention helps or hinders clinicians' 'normal' work. The IW component includes the actual **time and effort the work required**, whereas participants' perceptions of the time and effort they invested is described by the 'individual specification' component.



Relational integration

Relational integration (RI) is the work of building and maintaining confidence, trust and accountability in an intervention and in each other's ability to successfully implement it. In other words, RI is the work of incorporating a change within existing relationships.

Skill-set workability

The Skill-set workability (SW) component describes the work of dividing and allocating resources so that an intervention can successfully be implemented. This requires division of labour, e.g. 'who does what?' The SW component also includes the work of deciding who has the 'power' to make the decisions about resource allocation and work delegation. To be effective, skill-set workability requires consideration of the knowledge, skills, attitudes and capacity of staff.

Contextual integration

Contextual integration (CI) is the work of integrating the intervention into existing structures and contexts. In addition, there is work to incorporate the change within the prevailing organisational culture (work that is shared with the 'initiation' component) and professional roles (work that is shared with the relational integration component). The work of CI depends on the availability of adequate and appropriate resources and therefore also includes: provision of new resources or re-allocating existing resources; senior leadership support; restructuring current policies and infrastructure.

Construct: Reflexive monitoring

Reflexive monitoring (RM) is the work of assessing the individual and communal worth of the intervention. (8) It requires staff to invest 'comprehension'. This work requires adequate time, reliable metrics and sharing of results. The four components of RM are: systematisation, individual appraisal, communal appraisal and reconfiguration.

Systematisation

Systematization (SY) is the work of collecting and organizing adequate and reliable data about the TRM to enable evaluation. This work is normally undertaken through a combination of formal and informal methods. This component is therefore also concerned with the methodological formality with which implementers derive value-judgements about the intervention's usefulness.

Individual appraisal

The Individual appraisal (IA) component describes the work participants do to evaluate the intervention's worth for them, e.g. the clinician reviewer, the reviewer's practice team and their patients. IA is typically informed by data derived from informal methods.

Communal appraisal

This component describes the work of participants to evaluate the intervention's worth to others, e.g. clinicians, specific professional and patient groups other than their own. Communal appraisal is typically informed by data derived from formal methods (at least in comparison with IA).

Reconfiguration

Reconfiguration (RE) is the work participants do to modify the intervention, themselves (e.g. their attitudes, skills, knowledge, tasks) or their contexts (practice procedures, policies and infrastructure).

Potential usefulness of the NPT framework

- To describe, understand and evaluate complex health care interventions and change
- To help design, develop and test complex interventions and to optimize implementation conditions.
- To assess the potential of a change to become normalized over time. In other words, NPT can be applied to determine the more likely outcomes of an intervention, e.g. whether it will be successfully normalized or not.

References

Available on request

