



Independent Evaluation of North East Hampshire and Farnham Vanguard

Using the Normalisation Process Theory [NPT] framework to evaluate a new care model [NCM]: the Happy Healthy at Home [HHH] Enhanced Recovery at Home [ER@H]

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Dr Catherine B Matheson-Monnet and Dr Andrew Sibley, Wessex AHSN took note of the non-participant observation. Dr Andrew Sibley took notes of the focus groups. Dr Catherine Matheson-Monnet took pictures of the brainstorming and ranking exercise undertaken during the focus group. The focus group was also audio-recorded.

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Disclaimer

This report presents the findings of an independent evaluation comprising a non-participant observation of a multi-disciplinary team meeting, a survey and a focus group undertaken with the Enhanced Recovery at Home team (ER@H). The findings and interpretations in this report were those of the author and do not necessarily represent the views of the ER@H team and other partners involved in the implementation and evaluation of North East Hampshire and Farnham Vanguard.

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Abstract

Background

In a context in which greater partnership working and new integrated models of care have been promoted as the way forward (Cameron and Lart, 2003; Banks, 2004; Williams and Sullivan, 2010; Ham and Curry, 2011; Rand Europe and Ernst and Young, 2012; NHS England, 2014; GovUK, 2015), ER@H brings together staff from a wide range of health and social care professions and organisations to provide holistic care and support to patients after they are discharged from hospital. The ER@H team agrees holistic care plan with patients and carers for patients on the ER@H caseload, focussing on rehabilitation after leaving hospital. All patients are visited by an ER@H team member on the day they leave hospital. If the discharge is late in the day, they are visited by the community nurses who provide support to ER@H.

Aims and objectives

The team evaluation sought to understand the experience of the staff involved in developing and delivering the implementation of the ER@H including enablers and barriers to embedding the ER@H in a sustainable way on a long term basis.

Methods

The conceptual framework was mixed methods (Plowright, 2015) informed by Normalisation Process Theory (May and Finch 2009), Force Field Analysis (Lewin, 1949; 1951) and Alexander (1985) team effectiveness as well as the NEHF Vanguard HHH ER@H Logic Model. Data collection was by way of: non-participant observation of a regular multi-disciplinary team meeting [MDT] (n=23); a focus group that took place directly following the MDT (n=23), which included an anonymous survey and brainstorming and a ranking exercise (n=23). Data were analysed using the constant comparative method (Glaser and Strauss, 1967) and thematic analysis (Braun and Clarke, 2006).

Results

The highest overall score (n=23) was for that *ER@H is worthwhile* [7.7] [with 8.3 for RSWs (n=14) and 6.7 for registered staff (n=9)]. Ranked second overall was *team members value the effect of ER@H on their work* followed by *feedback about ER@H can be used to improve it in future*. The top barrier categories were identified as changes x19 (28% of the votes), environment x17 (25% of the votes), communications x14 (20% of the votes), team x 11 (16% of the votes) and not feeling valued x5 (7% of the votes). The top driver categories were identified as team x29 (44% of the votes), patient outcomes x17 (26% of the votes), flexibility x11 (16% of the votes) and asset for the NHS x5 (8% of the votes). Overall, team members somewhat disagreed that ER@H had achieved the ER@H team goals which included a cultural shift in organisational integration [4.2] [with 4.1 for RSWs and 4.2 for registered staff] and successful upskilling of staff in generic roles [4.0] [with 3.5 for RSWs and 6.1 for registered staff].

Conclusion

This pragmatic evaluation of a pilot implementation of a NCM in a real life setting undertaken with limited resources found that despite difficulties with sense-making, participation and action and in particular operational barriers, team members had a belief in the worthwhileness of ER@H and its effect on their working practice that has persisted regardless (May et al, 2015). Together the team is working towards delivering its goal of bringing together staff from a wide range of health and social care backgrounds to provide holistic care and support to patients after they are discharged from hospital. The extent to which team members believed that ER@H was worthwhile is very encouraging.

Recommendations

The team should continue to improve sense-making, engagement, collective action and reflexive monitoring i.e. better defined roles, enhancing the capacity and willingness of team members to organise themselves to collectively contribute to the work involved, but most especially to make explicit and clarify operational issues. The team are already planning to put into action a plan to make ER@H more responsive in dealing with arising issues as soon as possible. The ER@H team should be encouraged to access all available information about ER@H and its effects in order to take steps to optimise the effectiveness and worthwhileness of ER@H.

Executive summary

Key findings

Together the team is working towards delivering its goal brings together staff from a wide range of health and social care backgrounds to provide holistic care and support to patients after they are discharged from hospital.

The highest overall score (n=23) was for that *ER@H is worthwhile* [7.7] [with 8.3 for RSWs and 6.7 for registered staff, ranked first for both RSWs and registered staff]. Ranked second overall was *team members value the effect of ER@H on their work* [with 7.2 for RSWs and 5.9 for registered staff, ranked 2nd and 9th respectively]. Ranked third overall was *feedback about ER@H can be used to improve it in future* [6.7] [with 7.2 for RSWs and 5.6 for registered staff, ranked 3rd and 13th respectively].

The lowest overall score (n=23) was for *team members are open and willing to work in new ways* [4.9] [5.2 for RSWs and 4.1 for registered staff, ranked 20th for both]. The second overall lowest score (ranked 19th) was for *NHS/ Vanguard programme management team adequately supports ER@H* [5.2] [5.0 for RSWs and 5.4 for registered staff, ranked 20th by RSWs and 14th by registered staff].

The third overall all lowest score (n=23) (ranked 17th) was for *sufficient training is provided to staff* [5.3] [5.6 for RSWs and 5.3 for registered staff, ranked 18th by RSWs and 19th by registered staff] closely followed by *team members have a shared understanding of specific responsibilities required* [5.5] ranked 17th [5.3 for RSWs and 5.7 for registered staff, ranked 17th by RSWs and 12th by registered staff]. See appendices 4-6.

The top barrier categories were identified as changes x19 (28% of the votes), environment x17 (25% of the votes), communications x14 (20% of the votes), team x 11 (16% of the votes) and not feeling valued x5 (7% of the votes). The top driver categories were identified as team x29 (44% of the votes), patient outcomes x17 (26% of the votes), flexibility x11 (16% of the votes) and asset for the NHS x5 (8% of the votes).

Neither RSWs (n=14) or registered staff (n=9) felt valued as members of the ER@H team [4.2 overall with 4.4 for RSWs and 4.0 for registered staff]. Overall, team members somewhat disagreed that ER@H had achieved the ER@H team goals which included a cultural shift in organisational integration [4.2] [with 4.1 for RSWs and 4.2 for registered staff] and successful upskilling of staff in generic roles [4.0] [with 3.5 for RSWs and 6.1 for registered staff]

Despite difficulties with sense-making, participation and action and in particular operational barriers, team members have a belief in the worthwhileness of ER@H and its effect on their working practice that has persisted regardless (May et al, 2015).

Recommendations

The ER@H team leader has been attempting to improve sense-making, cognitive engagement and collective action and would agree that

- ❑ attention needs to be paid to coherence and sense-making in relation to better defined roles, both of RSWs and of those of registered staff.
- ❑ attention also needs to be paid to enhance the capacity and willingness of team members to organise themselves to collectively contribute to the work involved.
- ❑ attention needs to be paid to operational issues that need to be clarified and addressed

The team are already planning to put into action a plan to make ER@H more responsive in dealing with arising issues as soon as possible. The ER@H team should be encouraged to access all available information about ER@H and its effects in order to take steps to optimise the effectiveness and worthwhileness of ER@H, the ER@H team is on track to embed the implementation of ER@H in a long term sustainable way.

Hopefully, the ER@H team and team leader will find the evaluative work undertaken in relation to the team useful and be better able to continue working towards embedding ER@H in daily practice in a long term sustainable way. After all, the extent to which team members believed that ER@H is worthwhile is very encouraging

1. Introduction

1.1. Context

The Centre for Implementation Science [CIS] at the University of Southampton is working with Wessex Academic Health Science Network [Wessex AHSN] to undertake the present evaluation of the ER@H new care model [NCM] as part of the overall evaluation of the ER@H and of HHH. NEHF CCG are funding the present evaluation and the overall evaluation of HHH.



Happy Healthy at Home is an Integrated Primary and Acute Care Systems vanguard site [PACS]. HHH was one of the 29 original 'vanguard' programmes announced by NHS England in March 2015. Vanguard sites are tasked with improving the health of local people by piloting New Care Models (NCMs) that involve working with partners to see how care can be provided in a better and more sustainable way in the future (HHH, 2017). HHH is working with partners to see how care can be provided in a better and more sustainable way in the future (HHH, 2017).

There have been a number of international and national drivers that have established that the current model of care is unsustainable and that more integrated services should be introduced. This led to the introduction of new patient centred models of integrated primary and community care in England. These NCMs have been designed to be in line with the findings of successive reviews of successful national and international integrated care systems which recommended more collaborative approach and greater partnership working to provide person centred care, greater efficiency, improved health and well-being outcomes and quality of life for all (Cameron and Lart, 2003; Banks, 2004; Williams and Sullivan, 2010; Ham and Curry, 2011; Clark, 2012; Rand Europe and Ernst and Young, 2012; NHS England, 2014, 2014b; Robertson et al, 2014).

The evaluation of the implementation of Wessex multi-specialty integrated models of care has shown their effectiveness (Wessex AHSN 2016a, 2016b, 2016c, 2017) with a good potential to cost effectiveness and improve patient outcomes and was cost effective.

1.2 Background

In line with the Five Year Forward View (NHS England, 2014), ER@H is a NCM integrating acute [Frimley Park Hospital] and community healthcare professionals [Southern Health Foundation Trust] working together to pro-actively manage the health and social care of the population. This NCM provides intensive multi-disciplinary community support after patients leave hospital and, if applicable, before they are admitted to Accident and Emergency [A&E] or to an acute ward.

The ER@H team agrees holistic care plan with patients and carers for patients on the ER@H caseload, focussing on rehabilitation of patients after they leave hospital with care packages adapted to patients' needs. All patients are visited by an ER@H team member on the day they leave hospital. If the discharge is late in the day, they are visited by the community nurses who provide support to ER@H. In addition to value added in rehabilitation at home, if required, ER@H can offer initial trouble shooting, education and support of patients and carers, equipment provision, home environment reviews, falls assessments, and reassurance to the NEHF Vanguard HHH population (as well as population for some of Berkshire and Surrey).

GPs, paramedics and community matrons can refer to ER@H after patients leave hospital or refer them directly to Frimley Park Medical Assessment Unity [MAU] to try and avoid an unwarranted admission to an acute ward. Healthcare professionals based in Frimley Park Hospital try to identify individuals for whom early discharge from hospital is possible. In A&E, the Emergency Department Observation Unit [EDOU] and the MAU, a qualified nurse working full time and a GP working one day a week, attend ward round in acute wards and A&E as well key multi-disciplinary team meetings. If required they also liaise with Occupational Therapy and Physiotherapy staff to agree with medical and nursing practitioners early discharge from hospital for some patients and admission avoidance from hospital for other patients.

ER@H patients are typically in their early 80s taking on average 6-9 medications daily (some receive fewer medications and some receive more than 10). The work of ER@H is reviewed during weekly multi-disciplinary team meetings. The caseloads of specialist nurses (n=3), occupational therapists (n=3), physiotherapists (n=2), physician associates (n=2) and rehab support workers (n=13) vary from two to six weeks. Community matrons, community nurses, adult and social care staff, paramedic practitioners and GPs also support ER@H as required.

The key performance indicators and expected outcomes for ER@H are outlined in table 1.

Table 1: ER@H key performance indicators and expected outcomes

Key performance indicators	Short/medium term outcomes	Long term outcomes
<ul style="list-style-type: none"> ❑ number of visits performed ❑ number of early discharges ❑ number of admission avoidances ❑ number of re-admissions after 28 days avoidance 	<ul style="list-style-type: none"> ❑ better patient reported outcome measures ❑ better patient experience ❑ empowering patients to self-manage ❑ cultural shift in organisational integration ❑ upskilling of staff in generic roles. 	<ul style="list-style-type: none"> ❑ improved quality of appropriate and holistic care ❑ people remaining in their own home for longer ❑ greater involvement of patients in planning their own care ❑ patients remaining independent in their day-to-day lives

1.3. Purpose of the evaluation

Yateley ER@H brings together staff from a wide range of health and social care professions and organisations to provide holistic care and support to patients after they are discharged from hospital. The team evaluation sought to understand the experience of the staff involved in developing and delivering the implementation of the ER@H including enablers and barriers to embedding the ER@H in a sustainable way on a long term basis.

The objectives selected to achieve these aims are:

1. To identify and rank the enablers and drivers of implementing the ER@H [Force Field Analysis - Lewin 1943, 1951]
2. To consider the extent to which ER@H is conceptualised and held together in action [NPT - May and Finch 2009; Finch et al, 2013, 2015]
3. To explore how team members engage with ER@H [NPT - May and Finch 2009; Finch et al, 2013, 2015]
4. To gain a better understanding of how team members enact the ER@H model i.e. how the activities of team members are structured and constrained [NPT - May and Finch 2009; Finch et al, 2013, 2015]
5. To investigate the extent of reflexive monitoring i.e. extent to which team members appraise ER@H and the impact of this appraisal [NPT – May and Finch 2009; Finch et al, 2013, 2015]
6. To identify the extent of which members of the ER@H feel that the team is effective and productive and that their contribution is valued [Team effectiveness – Alexander 1985]
7. To assess the extent to which the team goals of ER@H have been met
 - Shared learning by working with partner agencies
 - Other providers are aware of/have an understanding of the range of services offered by ER@H
 - ER@H has successfully upskilled staff in generic roles
 - ER@H has achieved a cultural shift in organisational integration

2. Methods

2.1. Conceptual framework

The starting point of NPT is to understand processes related to the embedding of a practice i.e. what people actually do and how they work together. NPT provides an explanatory framework to better understand the routine embedding of healthcare interventions in their social contexts, in particular *why some processes seem to lead to a practice becoming sustained over a long term while others do not* (May and Finch, 2009, p539). Although May and Finch (2009a) make no claim of absolute predictive power, they argue that within certain limits the trajectory of a practice i.e. extent of sustainable long term embedding can be anticipated. This means that NPT can help ascertain the likelihood of the routine embedding of an intervention within certain limits.

Normalisation Process Theory (NPT) (May and Finch, 2009) is a validated instrument that has been widely used to evaluate quality improvement interventions in health care. The focus is on factors (beliefs and behaviours) that promote or inhibit (enablers and barriers) the implementation of an intervention, in this case the ER@H. The factors are divided into four themes:

- i. **Coherence:** the mobilisation of a practice – how it is conceptualised and held together in action
- ii. **Cognitive participation:** participation in a practice – how members decide to engage and actually engage
- iii. **Collective action:** enacting a practice – how the work is organised and activities structured and constrained
- iv. **Reflexive monitoring:** the appraisal of a practice – how it is appraised and the effects of appraisal, i.e how it is ‘understood’ and what changes the team make

The mixed methods (Plowright, 2015) conceptual framework was also informed by Force Field Analysis (Lewin, 1949; 1951) of enabling and restraining forces (drivers and barriers) in respect of the implementation process and Alexander (1985) team effectiveness as well as the NEHF Vanguard HHH ER@H Logic Model.

2.2. Scope and design, data collection and sampling

The elements of the evaluation were:

- 1) a non-participant observation of the weekly Rehabilitation Support Workers’ forum
- 2) a focus group that will take place directly following the weekly multi-disciplinary team meetings, which includes an anonymous paper based survey
- 3) an anonymous survey electronic survey sent after the focus group which was the same as the paper based survey completed during the focus group as a final opportunity to participate for those who cannot attend the focus group

To help make findings more robust and claims from the findings more warrantable (Gorard, 2001, 2003), a mixed methods design has been selected: two primarily qualitative data collection methods (non-participant observation and structured focus group) and a primarily quantitative data collection method (survey). Qualitative data collection methods such as observation, focus groups and interviews can provide insights into underlying complex social processes (Lincoln, 1995; Denzin and Lincoln, 2005). Surveys collecting quantitative data can examine patterns and trends in respect to one or more variables (Gillham 2000; Bell 2002). On its own or alongside other data collection methods, non-participant observation often reveals characteristics of groups that would have been difficult to discover by other means (Bell, 2002). Focus groups provide cost-effectiveness and speed in obtaining insights that would be difficult and time consuming to elicit by other means (Morgan and Krueger 1998) as well as a concentrated richness of data on the thoughts and feelings to provide a quick overview of differences, range of ideas and so on (Smithson, 2000).

Structured focus groups can involve one or several types of collective activities which include brainstorming, ranking exercises or surveys (Morgan and Krueger 1998; Bloor et al 2002). Ranking exercises that start individually and are completed collectively can be used to quickly and efficiently draw out implicit knowledge and assumptions before the participants are influenced by group dynamics. Such exercises also serve as warm up for the discussion (Matheson and Matheson, 2009).

Using an activity based structured focus group enabled the collection of quantitative data in addition to the discussion and will also help provide both depth and detail on the questions of interest (Smithson 2000; Hammersley, 2013; Plowright, 2015). The activities that took place during the focus group were:

- a) a survey using NPT NoMAD 20 questions (Finch et al, 2013, 2015), Alexander (1985), team effectiveness questions as well as questions about the extent to which the goals of the ER@H have been met
- b) a brief brainstorming and ranking exercise using Force Field Analysis (Lewin, 1951)
- c) discussion relating to a and b and suggestions for improvement

To further increase the validity of the study and the warrantability of claims derived from the findings (Gorard, 2001, 2003), team members who could not attend the focus group had the opportunity to complete the same survey in electronic form as the paper based survey undertaken by those who attended the structured focus group.

Two researchers undertook non-participant observation of the weekly multi-disciplinary Rehabilitation Support Workers' forum (n=25) and took notes. Two researchers attended the structured focus group (n=23) that immediately followed the MDT. The lead researcher facilitated the structured focus group and took pictures of the outcomes of the brainstorming and ranking exercise. The other researcher took notes. The focus group was also recorded.

At the beginning of the focus group participants undertook an anonymous 30 questions paper based survey based informed by the conceptual framework (See appendix 1 focus group schedule and appendix 2 survey questions). Participants (n=23) were asked to rate each question on a scale of 1-10 where 1=not at all agree and 10=completely agree. They could also use free text to provide more details in respect of their responses.

Except for the team leader, the entire team present on the day attended the focus group and completed the survey (n=23). A total of 14 Rehabilitation Support Workers [RSWs] and 9 members of staff registered with a healthcare related professional body took part in the focus group. The team leader facilitated the RSWs forum, but did not take part in the focus group and survey. The profile of participants who attended the focus group and completed the survey is outlined in table 1.

Table 2: Profile of the participants who took part in focus group and survey

Role	Number
Rehabilitation support workers	14
Physiotherapists	3
Occupational therapy lead	1
Occupational therapist	1
Nursing team lead	1
Nursing sister	1
Nurse	1
Associate practitioner	1
Total	23

Participants (n=23) then undertook a brainstorming and ranking exercise about identifying enabling (drivers) and restricting forces (barriers) in relation to the implementation of ER@H. These were briefly put into categories by the lead researcher, before asking participants to allocate three votes on what they felt to be the most important category or categories of drivers and barriers. Issues arising from the brainstorming and ranking exercise were discussed.

As a final opportunity to participate, those who could not attend the focus group had the opportunity to complete an electronic survey via SurveyMonkey to complete the same anonymous as those who attended the focus group. The ER@H team leader sent the link to the electronic survey after the focus group took place. No participant completed the electronic survey.

Quantitative data were analysed using numerical analysis. Negative scores start at 5.4 since 5.5 is the mid-point. Average scores between 5.5 and 6.9 are slightly positive and require attention. Average scores between 7 and 8.9 are positive. Average scores above 9 are highly positive. Qualitative data were analysed using the constant comparative method (Glaser and Strauss, 1967) and thematic analysis (Braun and Clarke, 2006).

2.3. Ethics

The research team was independent and have no prior relationship with the participants. No financial incentives were offered as part of the recruitment process. The evaluation received approval from the Ethics Committee of the Faculty of Health Sciences of the University of Southampton [26529].

3. Results

3.1. Coherence or sense-making

Table 3 summarises the survey results for the area of ‘coherence’ i.e. sense-making or how a practice is conceptualised and held together in action.

Table 3: Survey results for ‘coherence or sense making’ [Not at all agree =1 completely agree=10]

Coherence/sense-making	Average score all (n=23)	Difference higher/ lower score all (n=23)	Average score RSWs (n=14)	Difference higher/ lower score RSWs (n=14)	Average score REGs (n=9)	Difference higher/ lower score REGs (n=9)
1. ER@H is distinct from previous ways of working	6.2	8pts	5.9	6pts	6.6	9pts
2. Team members have a shared understanding of the purpose of ER@H and of specific responsibilities required	5.5	9 pts	5.3	9pts	5.7	6pts
3. Team members understand how ER@H affects the nature of their work	5.9	7pts	6.0	7pts	5.8	5pts
4. Team members can see potential value of ER@H for their work	6.6	7pts	6.8	7pts	6.3	6pts
Overall averages	6.1	7.8pts	6	7.3pts	6.1	7.8pts

Survey results for coherence or sense-making are less positive than the findings of the non-participant observation of the MDT and focus group and showed overall a slightly positive level of coherence or sense-making rather than an overall more positive level.

Overall, the highest average score (n=23) was 6.6 for q4 *Team members can see potential value of ER@H for their work* [6.8 for RSWs and 6.3 for registered staff (nurses, physiotherapists, occupational therapists)]. The lowest score was 5.5 for q2 *Team members have a shared understanding of the purpose of ER@H and of specific responsibilities required* [5.3 for RSWs and for 5.7 registered staff]. See table 3.

The registered staff (nurses, physiotherapists and occupational therapists) somewhat agreed that they clearly differentiated the ER@H way of working compared to the more traditional way [6.6] while the RSWs slightly disagreed [5.9]. See table 3.

The average score for coherence or sense making was 6.1 [6.0 for RSWs and 6.1 for registered staff], which is only a slightly positive score. See table 3.

Both RSWs and registered staff demonstrated more evidence of a shared vision as they somewhat agreed that they could see the potential value of ER@H for their work [6.2] than they could understand how ER@H affected the nature of their work [5.9] or had *a shared understanding of the purpose of ER@H and of specific responsibilities required* [5.5]. In relation to the latter question, many RSWs [5.3] and registered staff [5.7] struggled to understand the boundaries between the various roles and responsibilities, which were being redefined and were no longer aligned with former job descriptions. See table 3.

During the RSW developmental meeting team members said collectively they thought there was too much change ongoing and that it was difficult to keep up. The tension about the need to follow care plans which protects both patients and staff and adjusting to the needs of the patients during home visits was felt to have a potential negative impact on the autonomy of RSWs. In order to improve this, a system was being organized which allowed the RSWs to decide in what order they would do home visits. A working group was being set up to review job descriptions and develop these to reflect a recent change in the role of RSWs.

In view of the fact that RSWs would also like to learn additional skills, the team leader underlined that there was on-going work whereby registered staff (nurses, physiotherapists and occupational therapists) were looking at additional skills and responsibilities that could be delegated to RSWs to give them a chance at undertaking more autonomous and more clinical work.

In the focus group team members were enthusiastic about the purpose of the ER@H service. They constructed ER@H as being innovative and proactive at providing a value added service to patients, so they could come back home sooner with the support from a number of health and social care professionals, including ER@H staff. An additional benefit was breaking down traditional barriers and moving to a more integrated approach which also enabled common learning and learning from each other.

However, there was a feeling of a lack of clarity about roles and about the fact that roles had recently changed. *I don't quite yet understand all the bits of my job and all the roles within ER@H and I am still trying to make sense of things* [RSW] and *I understand my role. However, sometimes the boundaries as to what extent my role can be pro-active is unsure. Because now there are other functions like reporting to the key worker or occupational therapist, GP etc. Before I used to see a nurse band 6 or GP if needed* [RSW]

There was a sense of fragmentation and of lack of cohesion, and of having to keep up with a number of changes in relation to how things were done while at the same time there was still confusion about how ER@H was different or distinct from previous ways of working. *There is no definite clarity with my job role* [Associate practitioner] and *I recently joined the team and can see a number of different ways being pulled together* [Occupational therapist]

Many RSWs wanted to gain more skills and hence more autonomy in order to better help the ER@H team, but opportunities for this were felt to be limited by availability of upskilling and time pressures. *I wish I had more time for study leave or shadowing clinicians to become more knowledgeable so I can support patients better and also support clinicians better* [RSW].

3.2. Cognitive engagement

Table 4 shows the results for ‘cognitive engagement’ or how team members decide to engage and actually engage with ER@H.

Table 4: Survey results for ‘cognitive engagement’ [Not at all agree =1 completely agree=10]

Cognitive engagement	Average score (n=23)	Difference higher/ lower score (n=23)	Average score rsw (n=14)	Difference higher/ lower score rsw (n=14)	Average score REGs (n=9)	Difference higher/ REGs score (n=9)
5. Key individuals drive ER@H forward and get others involved	5.9	7pts	6.3	7pts	5.3	6pts
6. Team members are open and willing to work in new ways	4.9	7pts	5.2	9pts	4.1	5pts
7. Team members believe that contributing to ER@H is a legitimate part of their work	6.5	8pts	7	7pts	5.8	7pts
8. Team members continue to support ER@H	6.6	8pts	6.9	8pts	6.1	8pts
Overall averages	6.0	7.5pts	6.4	7.8pts	5.3	6.5pts

Survey results for cognitive engagement are less positive than the findings of the non-participant observation of the MDT and focus group as they showed overall a slightly positive level of cognitive engagement rather than an overall more positive level.

The highest overall (n=23) average score was 6.6 for q8 *Team members continue to support ER@H* [6.9 for RSWs and 6.1 for registered staff]. The lowest overall (n=23) average score was negative i.e. 4.9 for q6 *Team members are open and willing to work in new ways* [5.2 for RSWs and 4.1 for registered staff]. Despite the overall (n=23) highest score for q8 being only slightly positive, it is encouraging that the overall (n=23) highest score [6.6] in the cognitive engagement domain was *team members continue to support ER@H* which was the top score for registered staff (n=9) [6.1] and the second top score for RSWs [6.9]. See table 4.

The highest score for RSWs (n=14) was for q7 *team members believe that contributing to ER@H is a legitimate part of their work* [7.0] with the registered staff (n=9) attributing a far lower score [5.8]. See table 4.

The flexible nature of ER@H and willingness of RSWs to step in when and as required and their desire for upskilling to increase their responsiveness to the needs of patients are evidenced by a score of 7.0 which demonstrates their belief that contributing to ER@H is a legitimate part of their work. The fact that the RSWs (n=14) agreed more [6.3] than did the registered staff (n=9) [5.3] that *key individuals drive ER@H forward and get others involved* also seems to indicate that the RSWs have bought into ER@H to a greater extent than the registered staff. See table 4. A key individual who was highlighted as driving the ER@H forward was the team leader. *Recent change in team leader is allowing the team to have more autonomy and input into the decision making process* [Physiotherapist]

The average score for coherence or sense making was an overall slightly positive score of 6.0 [6.4 for RSWs and 5.3 for registered staff]. The score is somewhat positive for RSWs and negative for registered staff suggesting a higher degree of cognitive engagement with ER@H, which could be attributed to the regular RSWs forum which takes place on a weekly basis and addresses issues raised by RSWs.

The RSWs forum facilitated by the team leader acknowledged a lack of registered staff to create work and case load for RSWs and to enable the latter to shadow clinical staff to in order to upgrade their own clinical competencies. *A holistic assessment is done so we know a lot about the patient and upskilling would enable us to be more flexible and better respond to their needs* [RSW] and *I would like the opportunity of having a bit of doing something different each week, [but] the study list is already fully booked and there are no opportunities* [RSW]. The team leader indicated that Clinical Care Team was planning to put in place a rolling programme of training support for RSWs.

The focus group discussed echoed the overall (n=23) low score and hence somewhat negative score [4.9] for *team members are open and willing to work in new ways*. The low score was due to the registered staff somewhat disagreeing with the statement [4.1] to which they gave the very lowest of all scores while the RSWs attributed a higher score [5.3], but still not a positive score since positive scores start at 5.6. See table 4.

During the focus group discussion, more registered staff than RSWs underlined issues related to new ways of working. *There are a lot of unnecessary changes and these are always asked for in a short space of time* [RSW] and *A lot of things have changed when they already worked just fine* [Nurse] and *Members of the team are still stuck in the old ways of working* [Associate practitioner]

By way of example, operational issues of changes to allocations in the day and changes in working times were discussed during the RSW forum with RSWs underlining that they were losing protected time for one to one meetings and had to book visits instead, and asking for dedicated time for the buddy system and triage support. The team leader took this on board and said that any time away from clinical work (buddy, one to one meetings, study day) should be recorded on the daily planner.

3.3. Collective action

Table 5 describes the results for ‘collective action’ or how team members enact the ER@H i.e. how the ER@H work is organised and activities structured and constrained.

Table 5: Survey results for ‘collective action’ [Not at all agree =1 completely agree=10]

Collective action	Average score (n=23)	Difference higher/ lower score (n=23)	Average score RSWs (n=14)	Difference higher/ lower score RSWs (n=14)	Average score REGs (n=9)	Difference higher/ REGs score (n=9)
9. Team members can easily perform the required tasks	6.4	8pts	6.6	6pts	6.0	6pts
10. The intervention not disrupt working relationships	6.0	6 pts	5.9	7pts	6.1	5pts
11. Team members trust ER@H and trust each other	6.6	6pts	6.7	6pts	6.3	6pts
12. Work is seen as appropriately allocated to staff who with required skills	5.6	9 pts	6.2	6pts	5.1	9pts
13. Sufficient training is provided to staff	5.3	9 pts	5.6	8pts	4.9	7pts
14. Sufficient resources are available to support ER@H	6	7 pts	6.1	7pts	6.4	6pts
15. NHS/ Vanguard programme management team adequately supports ER@H	5.2	7pts	5.0	7pts	5.4	7pts
Overall average	5.9	7.4pts	6.0	6.7 pts	5.7	6.6pts

The results of the survey (n=23) broadly mirrored the views of team members articulated in the RSW forum (n=25) and focus group (n=23).

The highest overall (n=23) score and highest score for RSWs (n=14) was *Team members trust ER@H and trust each other* [6.6 for all and 6.7 for RSWs] closely followed by *Team members can easily perform the required tasks* [6.4 for all and 6.6 for RSWs]. The highest score for registered staff (n=9) was *Sufficient resources are available to support ER@H* [6.4] closely followed by *Team members trust ER@H and trust each other* [6.3]. These scores were only slightly positive as the ER@H team members only somewhat agreed with these statements. See table 5.

The lowest overall (n=23) score [5.2] was for *NHS/ Vanguard programme management team adequately supports ER@H* [5.0 for RSWs and 5.4 for registered staff], closely followed by [5.3] *sufficient training is provided to staff* [5.6 for RSWs and 4.9 for registered staff]. These scores were all slightly negative. The team felt they could have been more adequately trained or supported. See table 5.

Overall, the team somewhat agreed that work *was seen as appropriately allocated to staff who with the required skills* [5.6] with RSWs agreeing [6.2] to a greater extent than the registered staff who in fact somewhat disagreed [5.1]. Overall the team somewhat agreed that Team members could *easily perform the required tasks* [6.4] with RSWs agreeing more [6.6] than the registered staff [6.0].

The overall score for collective action was 5.9 [6.0 for RSWs and 5.7 for registered staff]. The score is very similar to that of coherence [6.1] and cognitive engagement [6.0].

The team leader facilitated the RSW forum by working through a list of largely operational issues that had been highlighted during a recent development day. Key concerns were:

- ❑ A system to claim for mileage had recently been introduced which caused a great deal of confusion and could not yet satisfactorily resolved. One hour per month had been allocated per member of staff to permit time to complete these claims. The team leader was trying to sort out the issue of how to fill the form with HR as it was not adapted to working patterns of RSWs and made assumptions that did not apply to RSWs
- ❑ Making changes to individuals work 'on the day' was an issue and Lisa was using a text message service to get around last minute changes to patient visits.
- ❑ Communication and new processes and procedures relating to recent changes caused a great deal of concerns:
 - RIO and the White Board system
 - Notifications of shift change
 - Notification of whether RSWs were working with the Complex Care Team [CCT]
 - Logging in from home
 - Some team members had to do work at home to keep up to date
 - Some said that logging in times from home were up to 15/20mins which affected their ability to keep up to date
 - Processes for informing the team re patients' visits and updates
 - RSWs reported missing several visits due to a lack of accurate information/planning '.
 - Some said when RIO was not working, the board was not updated/current enough to be useful.
 - Some said there was also a 'messages book' at the office to record last minute changes to patient visits - but some staff did not know that existed.
 - Time to get to know patients
 - Rostering issues

Using a table that summarised discussions held during a recent away day, the team leader updated the RSWs in some detail on how the ER@H was proposed to respond to the concerns raised by RSWs. The team leader also updated the team on recent developments. Some issues were difficult to resolve as they involved HR and Finance processes i.e. claims for mileage. This was because the new process did not take into account the flexible way in which ER@H worked and was built on more traditional ways of working.

Issues with communications and miscommunications and the introduction of new processes or procedures were discussed at length. The team leader talked of establishing working groups to look into some of these issues and reminded the team about established processes, of which many team members seemed unaware.

Although it was agreed the holistic assessment by a named member of staff and the handover' process were helping this to happen, but this required the handover information be concise and be properly recorded and to happen as close to 2pm as possible. The team leader said that RIO was the bottom-line for knowing what patient visits to do on any given day and this was the responsibility of the whole team, not one person's responsibility and that RIO training will be provided to staff who are not confident with RIO and its functions

The discussion demonstrated the structural constraints of the ER@H NCM consequent to the integration of community and secondary care staff who had different cultures. RSWs were unclear about basic operational issues which if unresolved would negatively impact on the ER@H *i.e.* what to do about physiotherapists not picking up requests; how do we make sure that escalation works and whether all clinicians read notes made by RSWs.

Some of the issues were re-iterated during the focus group and came up during the brainstorming and ranking exercise which took place after the individually completed NPT survey. The brainstorming and ranking exercise highlighted key drivers and barriers identified by the ER@H team. See table 6 and table 7.

The brainstorming exercise enabled key barriers and drivers to be identified quickly that would complement the results of the survey and prompt a discussion to provide insights into the implementation of the ER@H.

The brainstorming exercise underlined changes x13, communication x9, environment x8; team working x7, not feeling valued x5 as the barriers that were most frequently mentioned.

The brainstorming exercise identified team x13, patient outcomes x8; support x5, flexibility x3 and job satisfaction x2 as the most frequently mentioned drivers. See table 6.

Table 6: Brainstorming exercise about barriers and drivers to ER@H

Barriers	Drivers
<ul style="list-style-type: none"> ❑ Changes x19 (2+11) [11 items] <ul style="list-style-type: none"> • Unnecessary changes • Too many changes in a short period of time • People prefer old ways of working • Not enough time for change to embed before the next change starts • Unwilling to embrace change • Negative feelings towards changes • Unwilling to change • Stubbornness • Stubborn ways of working • Reluctance • Limited time to implement and run with new changes before more change is introduced 	<ul style="list-style-type: none"> ❑ Team/ x6 [12 items] total x29 <ul style="list-style-type: none"> • Individual team members x2 • Team!! x2 • Starting to have a cohesive team • “Some” people • Mostly supportive colleagues • New nice people in the team • Linda/Mel • Individuals • Opportunity to learn from other members of MDT • Group feedback • Huge amount of expertise in the combination of team members • Learning new skills
<ul style="list-style-type: none"> ❑ Environment x17 (6+2) [2 items] <ul style="list-style-type: none"> • Working conditions • Poor working conditions ❑ Communication x14 [4 items] <ul style="list-style-type: none"> • Poor communication skills • Communications RSW and all professions • Too much communication • Miscommunication ❑ Team working x11 (2+5) [5 items] <ul style="list-style-type: none"> • Too many people not enough structure • Dynamics • Team is too big and one team has had to morph into the other • Recruitment and retention are poor and existing staff are being stretched more and more • Lack of understanding (between team members) of the different cultures we have come from workwise ❑ Not feeling valued x5 [5 items] <ul style="list-style-type: none"> • Lack of empathy • Feeling undervalued • No respect • Lack of respect in how to talk to each other • Some staff have difficulties seeing the importance of their role within the team ❑ Procedures/too much duplication x2 ❑ Documentation x1 ❑ Overwhelming pressure x2 ❑ Individual personal traits are good on their own 	<ul style="list-style-type: none"> ❑ Caring staff x11 ❑ Learning from others x6 ❑ Support x6 [1 item] ❑ Patient outcomes x17 [8 items] <ul style="list-style-type: none"> • Far more care in the community available to patients • A good service to the community • Quicker recovery of patients • Patients benefit due to having a larger team • Positive patient discharge • Staff caring towards patients • Opportunities to improve patient outcomes • Patient benefit positively from the service and its flexibility ❑ Flexibility x11 [1 item] ❑ Feeling an asset to the NHS when opportunity to individually develop exists x5 ❑ Job satisfaction [1 item] ❑ Willingness to change

After the brainstorming exercise, the lead researcher briefly categorised the drivers and barriers and selected the most important category of barriers and drivers so that they could be ranked in descending order by team members. See table 7.

Table 7: Results of ranking exercise about barriers and drivers to ER@H [descending order]

Barrier categories	Number of votes	% of votes	Driver categories	Number of votes	% of votes
Changes	19	28	Team	29	44
Environment	17	25	Caring staff	11	16
Communications	14	20	Learning from others	6	9
Team	11	16	Support 6	6	9
Lack of empathy/not feeling valued	5	7	Individuals/team	6	9
Procedures	2	3	Patient outcomes	17	26
Documentation	1	1%	Flexibility	11	16
			Asset for the NHS	5	8
			Feedback from patients	4	6

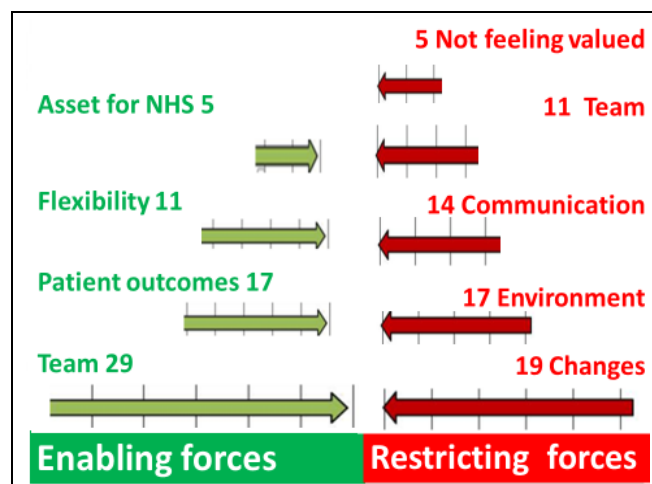


Figure 1: Results of ranking key driver and barrier categories

The top barrier categories were identified as changes x19 (28% of the votes), environment x17 (25% of the votes), communications x14 (20% of the votes), team x 11 (16% of the votes) and not feeling valued x5 (7% of the votes). The top driver categories were identified as team x29 (44% of the votes), patient outcomes x17 (26% of the votes), flexibility x11 (16% of the votes) and asset for the NHS x5 (8% of the votes). See table 7.

During the focus group discussion team members explained how they had identified the drivers and barriers and how and why they had voted for barrier and driver categories. The ER@H team members underlined collectively they thought there was too much change ongoing and that they had limited time to implement changes and get used to the changes, but not sooner had they got used to the changes, that new changes would be introduced. *Not enough time for change to embed before the next change starts [RSW].*

Some members did not understand why things that worked perfectly well had been changed. *If it is not broken why change it?* [Nurse]. However, learning was conceived as an ongoing process within the team. *It has been painful but cultures are beginning to change* [Physiotherapist]. In particular, discussion highlighted that many team members felt that *it was great knowing that any query or problem will be helped by a member of the team.*

A RSW explained how a registered member of the team had helped with upskilling clinical skills by giving the needed support enabling the RSW to perform a procedure on a real patient. *It is different doing it for real compared to when I was doing it in training and I was supported in being able to have the confidence to do the procedure live for the first time.*

3.4. Reflexive monitoring

Table 8 shows the results for ‘reflexive monitoring’ or how ER@H is ‘understood’ and the changes the team can make consequent to feedback.

Table 8: Survey results for ‘reflexive monitoring’ [Not at all agree =1 completely agree=10]

Reflexive monitoring	Average score (n=23)	Difference higher/ lower score (n=23)	Average score rsw (n=14)	Difference higher/ lower score rsw (n=14)	Average score REGs (n=9)	Difference higher/ REGs score (n=9)
16. Team members can access information about ER@H + are aware of the effects of ER@H	5.7	5pts	6.5	6pts	5.0	4pts
17. Team members agree that ER@H is worthwhile	7.7	6pts	8.3	5pts	6.7	6pts
18. Team members value the effect of ER@H on their work	6.7	5pts	7.2	5pts	5.9	5pts
19. Feedback about ER@H can be used to improve it in future	6.7	7pts	7.4	5pts	5.6	8pts
20. Team members can modify how they work with ER@H	5.7	5pts	6.1	4pts	5.1	5pts
Overall average	6.5	5.6 pts	7.1	5.0pts	5.7	5.6pts

The results of the survey are broadly in line with the findings of the non-participant observation and focus group. The highest overall score (n=23) was 7.7 for q17 *team members agree that ER@H is worthwhile* [8.3 for RSWs and 6.7 for registered staff]. Out of

the 20 NoMAD statements, this was the highest overall score or top score and also top score for both RSWs and registered staff. See table 8. See appendices 4-6.

The second overall highest score for all (n=23) 6.7 was for q18 *team members value the effect of ER@H on their work* [7.2 for RSWs, which was the third highest overall score for RSWs, and 5.9 for registered staff] while q19 *feedback about ER@H can be used to improve it in future* [6.7] ranked third highest score for all (n=23) [7.4 for RSWs, which was the second overall highest score for RSWs, and 5.6 for registered staff] and second overall highest scores for RSWs [7.4]. See table 8. See appendices 4-6. The lowest score (n=23) was 5.7 for q20 *team members can modify how they work with ER@H* [6.1 for RSWs and 5.1 for registered staff] and 5.7 for p16 *team members can access information about ER@H and are aware of the effects of ER@H* [6.5 for RSWs and 5.0 for registered staff].

Overall (n=23), ER@H has a higher score for reflexive monitoring [6.5] than for coherence [6.1], cognitive engagement [6.0] and collective action [5.9]. It is not unreasonable to speculate that this is due to the approach of the team leader and the role played by the RSWs weekly forum. The overall score given by RSWs for reflexive monitoring was 7.1 while the registered staff gave 5.7.

Focus group discussion mirrored the results of the survey. Team members, and in particular RSWs underlined that ER@H was *the only service that doesn't say 'no', and we adapt at any time/in any way for the patient and We deal with patients no-one else with pick up, so in order to prevent a long inpatient stay we take them on.*

RSWs described how rewarding it was to see patients appreciate what the ER@H does and to see patients getting better when they are kept at home rather than in the hospital. *We are an asset to the NHS, they make us feel we are important.*

3.5. Non-NPT questions

Team effectiveness questions

Ranked first is *ER@H communicates effectively with other providers* [5.6 overall] which is the only overall positive response among the non-NPT questions. The registered staff gave a score of 6.1 which is somewhat positive while the RSWs gave a slightly negative score of 5.3. See table 9.

Neither RSWs (n=14) or registered staff (n=9) said they felt valued as members of the ER@H team [4.2] [4.4 for RSWs and 4.0 for registered staff]. See table 9.

The focus underlined *feeling undervalued/lack of empathy* as one of the barrier categories with comments such as no respect or a lack of respect in how some team members talked to each other and the difficulty in seeing the importance of their role within the team which also mirrored some of the NPT questions. See table 9.

Table 9 shows the results of the non NPT questions in descending order.

Table 9: Responses for non NPT questions re external relationship and feeling valued as a team member in descending order Not at all agree =1 completely agree=10]

Non NPT questions	Average score (n=23)	Difference higher/ lower score (n=23)	Average score RSWs (n=14)	Difference higher/ lower score RSWs (n=14)	Average score REGs (n=9)	Difference higher/ REGs score (n=9)
ER@H communicates effectively with other providers	5.6	8pts	5.3	8pts	6.1	6pts
ER@H has achieved shared learning by working with partners	4.6	8pts	4.1	8pts	5.3	5pts
I feel valued as a member of ER@H	4.2	6pts	4.4	8pts	4.0	5pts
ER@H has achieved a cultural shift in organisational integration	4.2	8pts	4.1	7pts	4.2	4pts
ER@H has successfully upskilled staff in generic roles	4.0	7pts	3.5	7pts	6.1	7pts
Members external to ER@H are aware of/have an understanding of the range of services offered by ER@H	3.5	6pts	3.3	6pts	3.9	6pts
Overall average	4.4	6.1 pts	4.1	7.3pts	4.5	5.4pts

ER@H team goals

Overall, team members somewhat disagreed that ER@H had achieved the ER@H team goals:

- ❑ shared learning by working with partner agencies [4.6] [4.1 for RSWs and 5.3 for registered staff]
- ❑ a cultural shift in organisational integration [4.2] [4.1 for RSWs and 4.2 for registered staff]
- ❑ successful upskilling of staff in generic roles [4.0] [3.5 for RSWs and 6.1 for registered staff]
- ❑ that members external to ER@H are aware of/have an understanding of the range of services offered by ER@H [3.5] [3.3 for RSWs and 3.9 for registered staff]

The negative scores for achievement of the team goals could be explained by the fact that the goals were extremely ambitious and the responses covered a wide spread of responses particularly among the RSWs. Goals of *better patient experience* and *empowering patients to self-manage* were included because the focus was on team goals.

4. Conclusion

4.1. Key findings

Together the team is working towards delivering its goal brings together staff from a wide range of health and social care backgrounds to provide holistic care and support to patients after they are discharged from hospital.

Four fifth of NPT NoMAD statements [16 out of 20] were rated positively i.e. above 5.5. However the team members only somewhat agreed with 16 statements and somewhat disagreed with 4 statements. The average rating was around 6 with on average 7 points difference between the highest and lowest individual score for statements. See tables 2-5.

The highest overall score (n=23) was for that *ER@H is worthwhile* [7.7] [with 8.3 for RSWs and 6.7 for registered staff, ranked first for both RSWs and registered staff]. Ranked second overall was *team members value the effect of ER@H on their work* [with 7.2 for RSWs and 5.9 for registered staff, ranked 2nd and 9th respectively]. Ranked third overall was *feedback about ER@H can be used to improve it in future* [6.7] [with 7.2 for RSWs and 5.6 for registered staff, ranked 3rd and 13th respectively]. See appendices 4-6.

The lowest overall score (n=23) was for *team members are open and willing to work in new ways* [4.9] [5.2 for RSWs and 4.1 for registered staff, ranked 20th for both]. The second overall lowest score (ranked 19th) was for *NHS/ Vanguard programme management team adequately supports ER@H* [5.2] [5.0 for RSWs and 5.4 for registered staff, ranked 20th by RSWs and 14th by registered staff]. See appendices 4-6.

The third overall all lowest score (n=23) (ranked 17th) was for *sufficient training is provided to staff* [5.3] [5.6 for RSWs and 5.3 for registered staff, ranked 18th by RSWs and 19th by registered staff] closely followed by *team members have a shared understanding of specific responsibilities required* [5.5] ranked 17th [5.3 for RSWs and 5.7 for registered staff, ranked 17th by RSWs and 12th by registered staff]. See appendices 4-6.

The top barrier categories were identified as changes x19 (28% of the votes), environment x17 (25% of the votes), communications x14 (20% of the votes), team x 11 (16% of the votes) and not feeling valued x5 (7% of the votes). The top driver categories were identified as team x29 (44% of the votes), patient outcomes x17 (26% of the votes), flexibility x11 (16% of the votes) and asset for the NHS x5 (8% of the votes).

The barriers of the number of changes that had been introduced were felt by many team members to be too many changes in a short period of time with not enough time for change to embed before the next change starts, poor working conditions, poor communication skills, miscommunication, too many people not enough structure, the team is too big and one team has had to morph into the other, recruitment and retention are poor and existing staff are being stretched more and more, lack of understanding (between team members)

of the work cultures and not feeling valued were being mitigated by mostly supportive colleagues, learning from others, group feedback, starting to have a cohesive team, huge amount of expertise in the combination of team members, a good service to the community, opportunities to improve patient outcomes, and patient benefit positively from the service and its flexibility.

Overview of responses to NPT questions and NPT four domains

Figure 1 shows that sense-making or coherence, cognitive engagement or participation and collective action have the potential for improvement and that reflexive monitoring is scored more highly than the other three NPT domains.

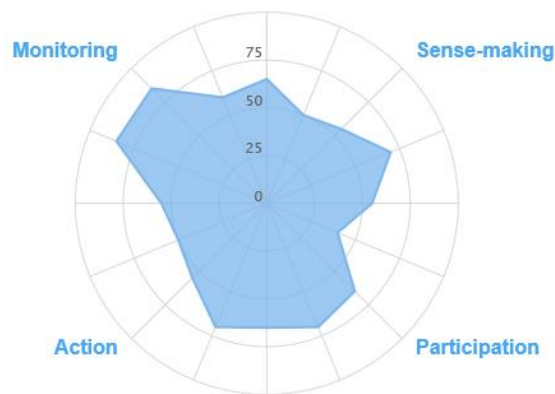


Figure 1: Overview of the 4 NPT domains all (n=23)

The responses that are closer to the centre indicate that team members may struggle with sense making and having a shared understanding of their role and that this may prevent them from buying into it or being able to enact ER@H in a way that works for them. In the case of ER@H despite difficulties with sense-making, participation and action and in particular operational barriers, team members have a belief in the worthwhileness of ER@H and its effect on their working practice that has persisted regardless (May et al, 2015). For more details on the ranking of the responses to the NPT questions see appendices 4-6.

Team questions and ER@H team goals

Neither RSWs (n=14) or registered staff (n=9) felt valued as members of the ER@H team [4.2 overall with 4.4 for RSWs and 4.0 for registered staff]. See table 9.

Overall, team members somewhat disagreed that ER@H had achieved the ER@H team goals:

- ❑ shared learning by working with partner agencies [4.6] [with 4.1 for RSWs and 5.3 for registered staff]
- ❑ a cultural shift in organisational integration [4.2] [with 4.1 for RSWs and 4.2 for registered staff]
- ❑ successful upskilling of staff in generic roles [4.0] [with 3.5 for RSWs and 6.1 for registered staff]
- ❑ that members external to ER@H are aware of/have an understanding of the range of services offered by ER@H [3.5] [with 3.3 for RSWs and 3.9 for registered staff]

Statistical significance of responses to NPT and non NPT questions

As the sample was small and the distribution not normal or parametric, a Man-Whitney U statistical test was performed to ascertain whether there was a statistical difference between the responses of RSWs and registered staff. Of all 26 questions (20 NPT and 6 Non-NPT), the only question demonstrating a (weak) statistically significant difference [$p < 0.046$] was q17 *team members agree that ER@H is worthwhile*, which was ranked first overall (n=23) in terms of the highest score or greatest level of agreement with 7.7 or somewhat agree [8.3 for RSWs or agree and 6.7 for registered staff or somewhat agree].

4.2. Limitation of the evaluation

This was a pragmatic evaluation of a pilot implementation of a new model of care in a real life setting undertaken with limited resources (without a control group to see what things were like for GP practices with a similar demographic and burden of illness profiles).

4.3. Benefits of the evaluation

A main benefit was a mixed methods approach with a validated conceptual framework [NPT, Force Field analysis, team effectiveness and extent of meeting team goals as per the logic model] and three different data collection methods: non-participant observation, survey and structured focus group, including brainstorming and ranking exercise of drivers and barriers to the embedding of a successful implementation that could be sustained in the long term. Most of the ER@H team members took part. The sample size was more than twice that of Farnham and Yateley ICTs which used a similar conceptual framework and methodology.

5. Recommendations

The ER@H team leader has been attempting to improve sense-making, cognitive engagement and collective action and would agree that:

- ❑ attention needs to be paid to coherence and sense-making in relation to better defined roles, both of RSWs and of those of registered staff.
- ❑ attention also needs to be paid to enhance the capacity and willingness of team members to organise themselves to collectively contribute to the work involved.
- ❑ attention needs to be paid to operational issues that need to be clarified and addressed

The team are already planning to put into action a plan to make ER@H more responsive in dealing with arising issues as soon as possible. The ER@H team should be encouraged to access all available information about ER@H and its effects in order to take steps to optimise the effectiveness and worthwhileness of ER@H, the ER@H team is on track to embed the implementation of ER@H in a long term sustainable way.

Hopefully, the ER@H team and team leader will find the evaluative work undertaken in relation to the team useful and be better able to continue working towards embedding

ER@H in daily practice in a long term sustainable way. After all, the extent to which team members believed that ER@H is worthwhile is very encouraging.

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Appendices

Appendix 1

Non-participant observation schedule

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1. To consider the extent to which ER@H is conceptualised and held together in action [NPT]
 - a) **Team members distinguish ER@H from current ways of working** + appreciate how ER@H differs or is clearly distinct from current ways of working.
 - b) **Team members collectively agree about the purpose of ER@H**+ shared understanding of the aims, objectives, and expected outcomes of ER@H
 - c) **Team members individually understand what ER@H requires of them** + make sense of the work – specific tasks and responsibilities of ER@H
 - d) **Team members construct potential value of ER@H for their work** + easily grasp the potential value, benefits and importance of ER@H

2. To explore how team members engage with ER@H [NPT]
 - a) **Key individuals drive ER@H forward** + key individuals are able and willing to get others involved in ER@H
 - b) **Team members agree that ER@H should be part of their work** + participants believe it is right for them to be involved, and that they can make a contribution to ER@H
 - c) **Team members buy in to ER@H** + capacity and willingness to organize themselves to collectively contribute to the work involved in ER@H.
 - d) **Team members continue to support ER@H** + capacity and willingness to collectively define the actions and procedures needed to keep ER@H going.

3. To gain a better understanding of how team members enact ER@H model i.e. how the activities of team members are structured and constrained [NPT]
 - a) **Team members perform the tasks required by ER@H.** Whether people are able to enact ER@H and operationalise its components in practice.
 - b) **ER@H Team members maintain their trust in each other's work and expertise.** Whether people maintain trust in ER@H and in each other.
 - c) **The work of ER@H is appropriately allocated to team members.** Whether the work required by ER@H is seen to be parcelled out to participants with the right mix of skills and training to do it.
 - d) **ER@H is adequately supported by the NHS/Learning and Development provider.** Whether ER@H is supported by management and other stakeholders, policy, money and material resources.

4. To investigate the extent to which team members appraise ER@H and the impact of this appraisal [NPT]
 - a) **Team members access information about the effects of ER@H**+ can determine how effective and useful ER@H is
 - b) **Team members collectively assess ER@H as worthwhile** + participants collectively agree about the worth of the effects of ER@H
 - c) **Team members individually assess ER@H as worthwhile** + if involved with, or affected by ER@H and think it is worthwhile.
 - d) **Team members modify their work in response to individual and collective appraisal of ER@H** + can make changes as a result

Reference

May CR and Finch TL (2009) Implementing, embedding, and integrating practices: an outline of normalization process theory. *Sociology*, 43, 3, 535-554. [doi:10.1177/0038038509103208](https://doi.org/10.1177/0038038509103208)

Appendix 2

Focus group schedule

Individual activity

1. Complete survey [i.e. NPT (Finch et al, 2013, 2015), Alexander (1985) and extent to which goals of ER@H were met]

Individual then collective activity and discussion

2. Force Field Analysis exercise [4 drivers and 4 barriers identified and ranked]
 - a) Identity up to four enablers or barriers re ER@Hs – write a few words re each enabler on up to four post-its
 - b) Categorise post-its, then distribute your 5 votes on most important categories i.e 1 for each of five categories or all post-its on one category because it is such an important category. See what ranking looks like. Brief discussion.
 - c) Identity up to four barriers or enablers re ER@Hs – write a few words re each enabler on up to four post-its
 - d) Categorise post-its, then distribute your 5 votes on most important categories i.e 1 for each of five categories or all post-its on one category because it is such an important category. See what ranking looks like. Brief discussion.

Appendix 3

Survey

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What is your role in ER@H? e.g GP, community matron, specialist nurse, nurse, rehab support work, occupational therapist, physiotherapist, manager, etc.

Item 1 - NPT NoMAd¹ questionnaire (Finch et al, 2013 based on May and Finch, 2009)

To what extent do you agree with the following statements?

Not at all					Completely				
1	2	3	4	5	6	7	8	9	10

Coherence

1. ER@H is distinct from previous ways of working 1 2 3 4 5 6 7 8 9 10
2. Team members have shared understanding/collectively agree *re* the purpose of ER@H and of specific responsibilities required –roles clearly defined 1 2 3 4 5 6 7 8 9 10
3. Team members understand how ER@H affects the nature of their work 1 2 3 4 5 6 7 8 9 10
4. Team members can see/construct potential value for ER@H in respect of their work 1 2 3 4 5 6 7 8 9 10

Coherence free text box

Cognitive participation

1. Key individuals drive ER@H forward and get others involved 1 2 3 4 5 6 7 8 9 10
2. Team members are open and willing to work in new ways 1 2 3 4 5 6 7 8 9 10
3. Team members believe that contributing to ER@His a legitimate part of their work 1 2 3 4 5 6 7 8 9 10
4. Team members continue to support ER@H 1 2 3 4 5 6 7 8 9 10

Cognitive participation free text

¹ NoMAD: Implementation measure/measurement instruments/questions based on Normalization Process Theory.

Collective action

1. Team members can easily perform the required tasks 1 2 3 4 5 6 7 8 9 10
2. Work is seen as appropriately allocated to staff who have the required skills 1 2 3 4 5 6 7 8 9 10
3. Sufficient training is provided to staff 1 2 3 4 5 6 7 8 9 10
4. Sufficient resources are available to support ER@H 1 2 3 4 5 6 7 8 9 10
5. NHS/ Vanguard programme team adequately support ER@H 1 2 3 4 5 6 7 8 9 10
6. ER@H does NOT disrupt working relationships 1 2 3 4 5 6 7 8 9 10
7. Team members trust ER@H and trust each other

Collective action free text

Reflexive monitoring

1. Team members can access information about ER@H and are aware of its effects 1 2 3 4 5 6 7 8 9 10
2. Team members agree that ER@H is worthwhile 1 2 3 4 5 6 7 8 9 10
3. Team members value the effect of ER@H on their work 1 2 3 4 5 6 7 8 9 10
4. Feedback about the intervention can be used to improve it in future 1 2 3 4 5 6 7 8 9 10
5. Team members have the opportunity to modify how they work with the intervention 1 2 3 4 5 6 7 8 9 10

Reflexive monitoring free text

Item 2: Team effectiveness questions (Based on Alexander, 1985)

Extent of agreement with the following statements

<i>Not at all</i>	<i>Completely</i>
1 2 3 4 5	6 7 8 9 10

1. I feel valued as core/extended [cross out as required] member of ER@H 1 2 3 4 5 6 7 8 9 10
2. ER@H communicates effectively with other providers 1 2 3 4 5 6 7 8 9 10

Team effectiveness free text box

Item 3: Goals of ER@H (Based on HHH ER@H logic model)

Extent of meeting each goal

<i>Not at all</i>					<i>Completely</i>				
1	2	3	4	5	6	7	8	9	10

1. ER@H has achieved shared learning by working with partner agencies 1 2 3 4 5 6 7 8 9 10
2. Members external to ER@H are aware of/have an understanding of the range of services offered by ER@H 1 2 3 4 5 6 7 8 9 10
3. Those external to ER@H value the work of ER@H 1 2 3 4 5 6 7 8 9 10
4. ER@H has successfully upskilled staff in generic roles 1 2 3 4 5 6 7 8 9 10
5. ER@H has achieved a cultural shift in organisational integration 1 2 3 4 5 6 7 8 9 10

Goals of ER@H free text box

Appendix 4

NPT NoMAD q20 all (n=23) in descending order	Average score ER@H (n=23)
17. Team members agree that ER@H is worthwhile [reflexive monitoring]	7.7.
18. Team members value the effect of ER@H on their work [reflexive monitoring]	6.7
19. Feedback about ER@H can be used to improve it in future [reflexive monitoring]	6.7
4. Team members can see potential value of ER@H for their work [coherence]	6.6
8. Team members continue to support ER@H [cognitive engagement]	6.6
11. Team members trust ER@H and trust each other [collective action]	6.6
7. Team members believe that contributing to ER@H is a legitimate part of their work [cognitive engagement]	6.5
9. Team members can easily perform the required tasks [collective action]	6.4
1. ER@H is distinct from previous ways of working [coherence]	6.2
3. Team members understand how ER@H affects the nature of their work [coherence]	6
10. The intervention not disrupt working relationships [collective action]	6.0
14. Sufficient resources are available to support ER@H [collective action]	6
5. Key individuals drive ER@H forward and get others involved 136 [cognitive engagement]	5.9
16. Team members can access information about ER@H + are aware of the effects of ER@H [reflexive monitoring]	5.7
20. Team members can modify how they work with ER@H [reflexive monitoring]	5.7
12. Work is seen as appropriately allocated to staff who with required skills [collective action]	5.6
2. Team members have a shared understanding of the purpose of ER@H and of specific responsibilities required [coherence]	5.5
13. Sufficient training is provided to staff [collective action]	5.3
15. NHS/ Vanguard programme management team adequately supports ER@H [collective action]	5.2
6. Team members are open and willing to work in new ways [cognitive engagement]	4.9

Appendix 5

NPT nomad q20 RSWs (n=14) in descending order	Scores
17. Team members agree that ER@H is worthwhile [reflexive monitoring]	8.3
19. Feedback about ER@H can be used to improve it in future [reflexive monitoring]	7.4
18. Team members value the effect of ER@H on their work [reflexive monitoring]	7.2
7. Team members believe that contributing to ER@H is a legitimate part of their work [cognitive engagement]	7
8. Team members continue to support ER@H [cognitive engagement]	6.9
4. Team members can see potential value of ER@H for their work [coherence]	6.8
11. Team members trust ER@H and trust each other [collective action]	6.7
9. Team members can easily perform the required tasks [collective action]	6.6
16. Team members can access information about ER@H/are aware of effects of ER@H [reflexive monitoring]	6.5
5. Key individuals drive ER@H forward and get others involved [cognitive engagement]	6.3
12. Work is seen as appropriately allocated to staff who with required skills [collective action]	6.2
14. Sufficient resources are available to support ER@H [collective action]	6.1
20. Team members can modify how they work with ER@H [reflexive monitoring]	6.1
3. Team members understand how ER@H affects the nature of their work [coherence]	6.0
1. ER@H is distinct from previous ways of working [coherence]	5.9
10. The intervention not disrupt working relationships [collective action]	5.9
13. Sufficient training is provided to staff [collective action]	5.6
2. Team members have a shared understanding of the purpose of ER@H and of specific responsibilities required [coherence]	5.3
6. Team members are open and willing to work in new ways [cognitive engagement]	5.2
15. NHS/ Vanguard programme management team adequately supports ER@H [collective action]	5.0

Appendix 6

NPT NoMaD q20 REGs (n=9) in descending order	Scores
17. Team members agree that ER@H is worthwhile [reflexive monitoring]	6.7
1. ER@H is distinct from previous ways of working [coherence]	6.6
14. Sufficient resources are available to support ER@H [collective action]	6.4
4. Team members can see potential value of ER@H for their work [coherence]	6.3
11. Team members trust ER@H and trust each other [collective action]	6.3
8. Team members continue to support ER@H	6.1
10. The intervention not disrupt working relationships [collective action]	6.1
9. Team members can easily perform the required tasks [collective action]	6.0
18. Team members value the effect of ER@H on their work [reflexive monitoring]	5.9
3. Team members understand how ER@H affects the nature of their work [coherence]	5.8
7. Team members believe that contributing to ER@H is a legitimate part of their work [cognitive engagement]	5.8
2. Team members have a shared understanding of the purpose of ER@H and of specific responsibilities required [coherence]	5.7
19. Feedback about ER@H can be used to improve it in future [reflexive monitoring]	5.6
15. NHS/ Vanguard programme management team adequately supports ER@H [collective action]	5.4
5. Key individuals drive ER@H forward and get others involved [cognitive engagement]	5.3
12. Work is seen as appropriately allocated to staff who with required skills [collective action]	5.1
20. Team members can modify how they work with ER@H [reflexive monitoring]	5.1
16. Team members can access information about ER@H/are aware of effects of ER@H [reflexive monitoring]	5.0
13. Sufficient training is provided to staff [collective action]	4.9
6. Team members are open and willing to work in new ways [cognitive engagement]	4.1

Appendix 7

Non NPT questions all (n=23) in descending order	Average scores all
1. ER@H communicates effectively with other providers	5.6
2. ER@H has achieved shared learning by working with partner agencies	4.6
3. I feel valued as core/extended member of ER@H	4.2
4. ER@H has achieved a cultural shift in organisational integration	4.2
5. ER@H has successfully upskilled staff in generic roles	4.0
6. Members external to ER@H are aware of/have an understanding of the range of services offered by ER@H	3.5

- Shared learning by working with partner agencies
- Other providers are aware of/have an understanding of the range of services offered by ER@H
- Other providers value the work of ER@H
- ER@H has successfully upskilled staff in generic roles
- ER@H has achieved a cultural shift in organisational integration

Appendix 8

Non NPT questions RSWs (n=14)	Average scores RSWs
ER@H communicates effectively with other providers	5.3
I feel valued as core/extended member of ER@H	4.4
ER@H has achieved shared learning by working with partner agencies	4.1
ER@H has achieved a cultural shift in organisational integration	4.1
ER@H has successfully upskilled staff in generic roles	3.5
Members external to ER@H are aware of/have an understanding of the range of services offered by ER@H	3.3

Appendix 9

Non NPT questions REGs (n=9)	Average scores REGs
ER@H communicates effectively with other providers	6.1
ER@H has successfully upskilled staff in generic roles	6.1
ER@H has achieved shared learning by working with partner agencies	5.3
ER@H has achieved a cultural shift in organisational integration	4.2
I feel valued as core/extended member of ER@H	4.0
Members external to ER@H are aware of/have an understanding of the range of services offered by ER@H	3.9