The Normalisation Process Theory (NPT) is an exciting new theory which has been developed in the United Kingdom by Professor Carl May and Dr Tracy Finch in collaboration with a host of national and international colleagues. NPT aims to explain and understand the processes by which innovations or interventions become routine (or not) in health care delivery or in people's daily activities. It focuses on the work that has to take place to implement innovation in day-to-day practice.
There are four components in the NPT:

- Coherence
  Does the new innovation make sense to those involved in the implementation work?)
- Cognitive Participation
  Is there 'buy-in' from key stakeholders for the implementation work?
- Collective Action
  What is the work that needs to happen for implementation to occur?
- Reflexive Monitoring
  How is the implementation work evaluated by those involved?

The NPT is not a rigid model but is designed to be used in a flexible manner to sensitise researchers to important features of implementation work. Each of its components can be used to 'alert' researchers to levers and barriers to successful implementation. If there is low coherence, cognitive participation, collective action or reflexive monitoring then the chances of successful implementation are reduced. For example, if an innovation doesn't make a lot of sense to healthcare providers and doesn't appear to offer something new and distinctly different (low coherence), this will impact negatively on implementation. If healthcare providers do 'buy-in' to an innovation but find that it is too hard to fit into their routine practice because of a lack of resources or skills (low collective action) then this will impact negatively on implementation.

In RESTORE, we will:

- Use NPT to explore and understand implementation processes related to the implementation of guidelines and/or training initiatives to address language and cultural barriers in primary care
- Test the robustness of NPT as a theoretical model for understanding and improving these implementation processes.
- In our fieldwork in each country, we will focus on groups of key stakeholders e.g. migrants using primary care services, primary care providers, policy makers, interpreters and/or cultural mediators. We will provide these stakeholder groups with an opportunity to examine guidelines

and/or training initiatives that have been designed to support communication in cross-cultural primary care consultations. Stakeholders will have time to explore which initiatives are particularly relevant to them and they will be encouraged to identify one initiative to implement in their local setting.

Through this phase of RESTORE we will examine whether initiatives make sense to stakeholders (coherence) and, also, whether there is buy-in from some/all stakeholders (cognitive participation). We will be particularly interested to see if RESTORE researchers' knowledge and understanding of these constructs can shape or improve the chances of high coherence and high cognitive participation.
Stakeholders will then have the opportunity to implement their chosen initiative in their local setting. Through this phase of RESTORE we will examine how the implementation work proceeds, what factors support or impede the work (collective action) and how the work is evaluated by all involved (reflexive monitoring). Again, we will be particularly interested to see if RESTORE researchers' knowledge and understanding of these constructs can shape or improve the chances of high collective action and high reflexive monitoring.

- How will we connect knowledge of NPT with the fieldwork?
- How can we bring these sensitising concepts into our fieldworK?

For this we are using an exciting participatory research approach called Participatory Learning and Action research.

NPT Resources:

May, C: 2006 **A rational model for assessing and evaluating complex interventions in health care** , BMC Health Services Research, 2006, 6: 86

May C, Finch T: **Implementation, embedding, and integration: an outline of Normalization Process Theory** . Sociology 2009, 43(3):535-554.

May, C., Finch, T., Mair, F., Ballini, L., Dowrick, C., Eccles, M., Gask, L., MacFarlane, A., Murray, E., Rapley, T., Rogers, A., Treweek, S., Wallace, P., Anderson, G., Burns, J. and Heaven, B: **Understanding the implementation of complex interventions in health care: the normalization process model** , BMC Health Services Research 2007, 7: 148

May C, Mair FS, Finch T, MacFarlane A, Dowrick C, Treweek S, Rapley T, Ballini L, Ong BN, Rogers A et al: **Development of a theory of implementation and integration: Normalization Process Theory** . Implement Sci 2009, 4(29).

May C, Mair, FS, Dowrick, C, Finch,T: **Process evaluation for complex interventions in primary care: Understanding trials using the Normalization Process Model** . BMC Family Practice 2007, 8:42.

May, C., Murray, E., Finch, T., Mair, F., Treweek, S., Ballini, L., Macfarlane, A. and Rapley, T. (2010) **Normalization Process Theory On-line Users' Manual and Toolkit** .