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Ohlsen, S., Sanders, T., Connell, J. et al. (1 more author) (2022) Integrating mental health care into home-based nursing services : a qualitative study utilising normalisation process theory. Journal of Clinical Nursing, 31 (9-10). pp. 1184-1201. ISSN 0962-1067

https://doi.org/10.1111/jocn.15975

Concise title: Integrating mental health care into home-based nursing services.

Descriptive title:

Integrating mental health care into home-based nursing services: A qualitative study utilising normalisation process theory.

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Acknowledgements: We would like to thank all our study participants, both service users and professionals, as well as the wider team and their partners including Sheffield IAPT service, Sheffield Health and Social Care foundation Trust, Sheffield Teaching Hospital foundation Trust, Sheffield Clinical Effectiveness Unit. We would like to thank Dr Moira Leahy for acting as gatekeeper to this study.

Conflict of Interest Statement: No conflict of interest has been declared by the authors.

Details of the source(s) of support in the form of grants: This report is independent research funded by the National Institute for Health Research Yorkshire and Humber Applied Research Collaboration. The views expressed in this publication are those of the author(s) and not necessarily those of the National Institute for Health Research or the Department of Health and Social Care

Abstract

Aims and objectives: To identify barriers and facilitators to implementing community nurses being trained as psychological wellbeing practitioners and integrating this practice into home-based primary care nursing, through key stakeholders' perceptions.

Background: Current drivers in UK primary care aim to increase access to mental health services and treatment, to achieve parity of esteem between physical and mental health care for patients who are housebound. However, there remains limited evidence on how to successfully implement this. Training community nurses as psychological wellbeing practitioners to offer mental health care alongside their current home-based services is one option.

Design: A pluralistic qualitative study. This study followed the COREQ checklist for reporting qualitative research.

Methods: Twenty key stakeholders were purposively recruited and interviewed including twelve health professionals and eight patients. Semi structured interviews were analysed using a theoretical thematic analysis informed by normalisation process theory concepts of coherence, cognitive participation, collective action and reflexive monitoring, to explore the barriers and facilitators to implementation**.**

Results: Staff and patients reported high coherence and cognitive participation, valuing the integrated roles. Facilitators included the development of clearer referral pathways and increased mental health knowledge in the wider team. However,

sustainability and current siloed health care systems were identified as barriers to implementation.

Conclusions: A key obstacle to long term implementation was the practical structures and financial boundaries of siloed health care systems, making long term sustainability unviable.

Relevance to clinical practice: Community nurses with additional mental health training can integrate these skills in practice and are valued by their team and patients offering holistic care to patients within their home and informal knowledge transfer to the wider team. However, long term sustainability is required if this is to be adopted routinely. Further evidence is needed to better understand the positive outcomes to patients and potential cost savings.

Keywords: Community nursing, Depression, Collaborative Care, Mental health, Normalisation Process Theory, Qualitative, Evaluation.

Introduction

Integration between physical and mental health care is paramount in home-based nursing services, due to the increases in numbers of patients experiencing multiple long term physical alongside common mental health conditions such as depression and anxiety (Barnett et al., 2012; Smith et al., 2014). More than 15 million people in England – 30 per cent of the population – have one or more long-term physical health conditions (Department of Health 2011). This includes people with a range of

conditions that can be managed but often not cured, such as diabetes, arthritis and asthma, or a number of cardiovascular diseases (Naylor et al., 2012). Many mental health problems such as depression can themselves be considered long-term conditions, but the term ‘long-term conditions’ is used here to refer specifically to physical health conditions. Internationally health and social care systems face major challenges in responding to an ageing population and the increasing levels of complex multi-morbidity (Mental Health Taskforce, 2016; World Health Organisation, 2015). Thirty per cent of people with a long-term condition have co-morbid mental health problems, of which twenty per cent may suffer from depression followed closely by anxiety (Daré et al., 2019). Patients with two or more long-term physical health conditions are seven times more likely to have depression than those without, raising healthcare costs by at least forty-five per cent per person (Naylor et al., 2012). Within the UK this is being addressed by two significant policy shifts. Firstly, by a move to care for patients with complex conditions out of hospitals and into community settings (National Health Service England, 2014), including treating people with complex co-morbidities in their own homes (Edwards, 2014). Secondly, through the recognition that there is ‘No health without mental health’ (HM Government, 2011), an ambition to achieve genuine parity of esteem between mental and physical health and a drive towards integrated ‘new models of care’ with a focus on a ‘whole person’ approach to care, (Mental Health Taskforce, 2016; Naylor et al., 2016). The recent report ‘Bringing together physical and mental health’ (Naylor et al., 2016) joins the mounting calls for primary care services to equally

value mental and physical health and treat them as part of one health service embedding the ‘whole person approach’ (AGE UK, 2016; Mental Health Taskforce, 2016; Millard & Border, 2015.). A whole person approach within primary care, has been defined as ensuring that the various needs of an individual using health and care services are met in a co-ordinated way, with medical, social and psychological needs being addressed together (Naylor et al., 2016).

In the UK community nurses, also known as ‘district nurses’, deliver much of the chronic health disease management in home based primary care (Maybin, Charles, & Honeyman, 2016). The terms ‘District Nurses’ and ‘Community Nurses’ are often used interchangeably within UK settings. The term community nurses is used here to refer to any non-specialist qualified nurse working within home based primary care services please see box 1.

BOX 1

Community nurse	a registered nurse working in the community with or without a specialist practitioner qualification. Registered nurses work at varying levels of seniority within community teams, depending on their level of experience and pay banding. It is possible for nurses without the district nursing qualification to hold management positions.
District nurse	a registered nurse with a district nursing specialist practitioner qualification recordable with the Nursing & Midwifery Council. The specialist practitioner qualification focuses on topics including: case management; clinical assessment skills; care coordination; autonomous decision-making; advanced clinical skills; leadership and team management. These nurses often hold senior or management positions within community nursing teams. In practice, the term ‘district nurse’ is often used to refer to nurses working in district nursing teams who do not have a specialist practitioner qualification, but occupy a ‘district nurse’ post.

Box 1 (adapted from Maybin 2016)

Traditionally the focus of home based nursing services has been on physical health care (Grundberg, Hansson, Hillerås, & Religa, 2016), however the shift to a ‘whole person approach’ has become more prominent (Maybin et al., 2016). Drivers for holistic care, such as recent best practice nursing guidelines ‘Care in the Community’, have redefined home based nursing roles to tackle 'social isolation and mental as well as physical health needs especially in frail older people’ (Department of Health Public health nursing, 2013 p11). However in the UK the main services

and clinicians delivering mental and physical health care remain largely siloed (Coventry et al., 2015; Knowles et al., 2013; Wood, Ohlsen, & Ricketts, 2017).

The UK the main primary care provider for common mental health problems is the Improving Access to Psychological Therapies (IAPT) service. IAPT services began in 2008 across England offering evidence-based treatments for people with depression and anxiety disorders. The IAPT service is often located in GP practices or central bases for patients to attend and offers a range of services over the telephone but does not deliver sessions within patient's homes. IAPT delivers a stepped care model of talking therapies, which works according to the principle that people are offered the least intrusive intervention appropriate for their needs first. Psychological wellbeing practitioners (PWPs) are specially trained non-registered health care professionals employed within IAPT services. They use a range of psychological interventions and skills based on cognitive behavioural therapy (CBT) to support individuals with mental health problems such as mild to moderate depression and anxiety ranging from signposting, self-help and group interventions delivered by often over the telephone or online. Peoples whose needs are not met are 'stepped up' to psychotherapy treatments such as counselling and CBT delivered by qualified professionals (Clark, 2011).

A move away from reliance on 'specialist practitioners' delivering mental health towards the current workforce being equipped with a foundation of common

competencies in both physical and mental health is now gaining traction (Naylor et al 2016). Recent studies have shown that primary care practice based nurses are well placed to manage mild to moderate depression in patients with long-term conditions (Ekers, Dawson, & Bailey, 2013), are acceptable to patients and colleagues to manage patients with long-term physical conditions and co-morbid depression (Buszewicz, Griffin, McMahon, Beecham, & King, 2010) and can be trained in delivering a range psychological support for mental health conditions such as mild to moderate anxiety and depression effectively alongside managing long term physical health conditions(Webster, Ekers, & Chew-Graham, 2016). This approach to integration has not been explored in home based primary care nursing.

Normalization Process Theory (NPT) is a framework which offers a set of conceptual and explanatory tools to understand how new complex interventions become embedded in routine practice (Finch et al., 2013; May & Finch, 2009; Murray et al., 2010). By employing a theoretical model of implementation, it helps to enable the identification of ‘what conditions’ are necessary for interventions to be successful and sustainably adopted in routine health care (Finch et al., 2013). NPT has been successfully used within qualitative healthcare service evaluation and implementation studies to provides theoretically informed recommendations that are transferrable to other settings (McEvoy, Tierney, & MacFarlane, 2019).

Aim

The aim of the study was to explore key stakeholders perceptions of the barriers and facilitators to successful implementation of an integrated approach where home based nurses have been given enhanced mental health training as psychological wellbeing practitioners and were attempting to integrate new ways of working within their current home based primary care nursing service.

Methods

Design

This study adopts qualitative methods to explore the barriers and enablers as well as considering the acceptability and adoptability of this approach to integrated care within routine clinical practice. It is reported in line with the consolidated criteria for reporting qualitative research (COREQ) checklist for qualitative studies to promote transparency (Tong, Sainsbury, & Craig, 2007) (see Supplementary File 1) .

A pluralistic study design was adopted, focusing on under-represented groups (Hall, 2004) namely housebound primary care patients. The study design ensures that all views exploring the barriers and facilitators to successful implementation of this integrated approach are encompassed, including both the consumer and service perspective. This design does not define success in terms of reaching total consensus but as attributing equal importance to multiple perspectives (Hall, 2004). The results were reported back to key stakeholders to enable the interpretations and implications for practice to be co-produced.

Study Setting

Context of study

A Yorkshire and Humber Health Education (YHHE) regional initiative explored innovative ways to integrate mental and physical health care by training a range of physical health practitioners as PWPs. PWPs deliver psychotherapy informed interventions for people with mild to moderate depression and anxiety disorders. This study focuses on part of this regional project to integrate mental health into home based nursing services by training three community nurses as PWPs. The community nurses worked primarily with individuals who are housebound with long term physical health conditions delivering home-based nursing interventions. They completed PWP training course accredited by the British Psychological Society which involved training in screening and identifying mild to moderate mental health conditions as well as delivering psychotherapy informed interventions to patients with mild to moderate mental health concerns, such as guided self-help around mood management, challenging negative thinking, problem solving and relaxation. Details of the project overview and PWP interventions are displayed in table 1. The three community nurses with additional PWP training were provided with protected time to deliver integrated interventions and receive clinical supervision by a senior IAPT manager. Integrated interventions included providing treatment for a physical health condition alongside PWP mental health assessments and interventions for patients

with mild to moderate common mental health problems. The project was a partnership between two NHS foundation trusts.

Sample and Recruitment

A purposeful sampling frame was used to recruit health care staff who represented a range of healthcare professionals who had been involved in this project. Permission was sought from team managers of services where the nurses with additional PWP training had been based, to recruit staff to interview. Recruitment emails including study information sheets and invitations were sent round by the team managers asking staff to directly contact the research team if they wanted to be involved. A purposeful sampling frame was used to identify housebound patients who were under the care of the home based primary care service for the treatment or management of a long term physical health condition and had also received an intervention from a PWP trained community nurse for a minimum of three contacts. Recruitment letters with study information were sent out by the service admin to a purposefully selected list of 15 patients asking them to contact the research staff if they wishes to be involved. Study information was provided orally and in writing. Each interviewee gave verbal informed consent to the interviewer prior to the interview starting. Anonymity of the interviewees was carefully maintained at all stages of the study.

Participants

20 key stakeholders (12 health professionals and 8 patients) were interviewed as part of this study. 12 staff consented to be interviewed included the three PWP trained nurses, one general practitioner (GP), two community nursing managers, one district nursing manager lead, one district nurse, one community support worker, two project leads and one IAPT manager. Nine patients responded to the recruitment letters and met the criteria of a minimum of three contacts with a PWP trained nurse, one patient could not be contacted due to ill-health at the point of interview. The sample was screened by a member of the district nursing team to ensure capacity to participate before being contacted by a member of the study team. The eight patients interviews (three females and five male), ages ranged from 50 to 72 years. Seven patients self-identified as housebound, five due to physical health conditions and a further two due to anxiety, one patient self-identified as not housebound but limited mobility. They all self-identified as having a minimum of two long-term health conditions. Seven patients identified depression or anxiety as one or more of these conditions. They had a mean of six contacts with a PWP trained community nurse prior to participation in the study.

The participants' characteristics are shown in table 2, staff are not included for confidentially reasons.

Data Collection

Semi structured interviews were conducted over a four-month period between May and August 2017 and lasted between 30 minutes to 1 hour. All participants were offered the choice of participating in face to face or telephone interviews. Four health professionals opted for face-to-face interviews, and all the remaining selected telephone interviews. Information sheets and consent forms were given to all participants prior to interview. Verbal consent was obtained at the beginning of each interview. All participants were offered their transcription to be posted or emailed to them to comment on.

Face-to-face interviews with staff took place in university premises, away from work bases. All interviews were at times chosen by the participants and completed by one researcher (S.O). An interview guide informed by NPT implementation toolkit (Murray et al., 2010) provided the framework for all interviews. Participants were asked about their personal experience of the trained nurse initiative, the perceived impact of the project, their perceived barriers and facilitators to the implementation of the project, as well as how the project could have been improved. The interview guide was piloted with one service user and one staff member, the results of these are not included in the results, and several modifications were made due to this, mainly the length of the interview for patients and wording to ensure lay terminology.

Analysis

With consent from participants, all interviews were audio recorded and transcribed verbatim. Analysis was aided by qualitative data management software, NVivo version 10 (http://www.qsrinternational.com/products_nvivo.aspx) to aid systematic analysis. The study used theoretical thematic analysis (Braun & Clarke, 2006) informed by NPT constructs coherence, cognitive participation, collective action, and reflexive monitoring to explore how they relate to the routinisation of new roles (Finch et al., 2013; May & Finch, 2009; Murray et al., 2010). We initially analysed the data thematically in line with standard qualitative techniques (Braun & Clarke, 2012, 2014), and subsequently map our findings onto the four NPT constructs to frame these themes as they were closely related. Authors (J.C, S.O & T.S) conducted the initial analysis independently on a subsection of the transcripts staff (n=4) and patient (n=3) transcripts, meeting regularly to discuss and agree by consensus the development of the emerging themes. The remaining initial thematic analysis was completed by two researchers (J.C & S.O), reporting any emerging findings regularly to the wider research team until it was agreed that a diverse range of opinions had been gathered and data saturation had been reached when no new themes emerged. The final theoretical thematic analysis (Braun & Clarke, 2006) involved mapping themes from the initial analysis onto the four core constructs of normalization process theory (NPT): coherence (sense making), cognitive participation (engagement), collective action (work to enable), and reflexive monitoring (appraisal). The purpose of this stage was to explore key stakeholders understanding of why it was being implemented; their engagement with and

commitment to implementation and their perceptions of the impact, benefits, barriers and disadvantages of implementation (May & Finch, 2009). A set of questions to consider for each construct were used to guide this stage of the analysis adapted from (Murray et al., 2010) (see table 3); this was applied to the entire data set. One researcher (S.O) completed stage two of the analysis. Any emergent findings that did not fit the NPT framework were cross checked through a series of meetings with the wider research team and remained key to the interpretations of the data and are included in the results discussion. A final stage of analysis was completed with a workshop, where the initial findings were presented back to key stakeholders including some participants, for comment and further interpretation.

Ethical considerations

The project was judged to be a service evaluation by the Research and Development Department at the site hospital. It was registered as service evaluation by the institute review board (Project approval number – 6054). However, ethical considerations in human research including informed research and consent, confidentiality, and privacy (Polit & Beck, 2014) were incorporated in the design to ensure the rigour of the project evaluation.

Results

The main body of the results are presented using the NPT concepts, following the initial thematic analysis, where the themes emerging from stage one were mapped

effectively onto the NPT framework (see table 4): coherence (sense making), cognitive participation (engagement), collective action (work to enable), and reflexive monitoring (appraisal). NPT overarching constructs of embedding, integration and implementation are discussed in relation to the implementation of this form of integrated care.

Coherence - Making Sense

Whilst staff participants reported being in favour of the additional approach, the level of understanding of the PWP trained community nurses' roles varied between their colleagues, with some initial confusion about what the nurses' new roles entailed and who the interventions were targeted at. This initial confusion appeared to transmit from the staff to the patients, especially for those patients who had not seen the PWP trained nurses before within their community nursing role.

"Well at the very start I were informed that I was going to have a health visitor, well I were really thinking what is the matter with me, what is really the matter with me to actually need a mental health nurse to come and see me and talk to me about …. I thought blimey things must be worse than I were thinking that they were" P4 (Patient)

Staff reported that their knowledge of mental health increased both because of formal training delivered by the PWP trained nurses and informal knowledge transfer through working in the same office. It also enhanced their knowledge of mental health pathways and how to access them.

As a lot of them (patients) didn't really know, and clinicians who didn't know anything about IAPT… Which means there is a gap in their knowledge, not just a mental health gap, but they don't know where to signpost people to, those who have got a problem. Although some of the housebound patients couldn't have signposted to IAPT as there is not the facilities at IAPT due to the nature of being housebound - S10 (IAPT manager)

Coherence of the PWP trained role was established by the co-location of the PWP trained nurses within the community nursing offices, enabling informal but frequent communication channels between professionals to increase their sense making and use of the services the nurses provided.

"I think it was actually knowing where the help was…and the fact that you could just go up to them and talk to them. Because they were just in the office. And you could just take the referral and just ask" - S5 (District nurse manager)

The mental health input within the community nursing team was seen by staff and managers to meet a gap in the service provision currently offered in community care and was reported to be highly valued by staff and patients alike. However not all staff demonstrated a clear understanding of the intervention. There were some comments from staff that they were unsure of the emphasis of the new intervention if it was weighted toward physical health or mental health or if it should be an even balance. Staff reported that the PWP-trained nurses appeared to be more concentrated on the mental health interventions and less on the integrated approach.

I knew that it was dual in that they were still physical health um staff… who were gaining a mental health expertise but, but the, the mental health focus attendance, some of the meetings and the supervision sessions, it just seemed quite intensive. - S8 (Community support worker)

Patients however, reported that they favoured the mental health integrated approach, demonstrating good understanding of the value of having access to mental health care delivered alongside their typical physical health care within their own home, compared to standard services.

I had thought well she might know and she did... and that's the other thing about having a district nurse do it rather than just a therapist you get, you can link into all kind of things, and they can recommend things that you would obviously get with a

therapist - P8

The concept of the dual approach was both valued and made sense by staff and patients. However, a variation in staff perspectives and understanding of the practical application was apparent, such as how much time should be allocated to the mental health work.

Cognitive Participation – Engagement

It was clear from staff interviews that the ethos of the approach fitted with the service needs and the personal ethos of staff. This was identified as a factor encouraging engagement from the teams and their local managers.

I think it exceeded what we thought it could be. I have always had a massive belief that…people with long term conditions … the psychological side of the illness is never dealt wit…, and I think it means that people are very isolated and lonely and then, it can often exasperate their illness because they are too busy focusing on it. S9 (District nurse manager)

The district and community nurse colleagues reported better engagement with the approach after gaining positive feedback from service users on the effectiveness of the interventions the PWP trained nurses delivered.

Because being a district nurse you often don't get to see the same patient each week or each day, so it's nice to know they have actually been followed up… So it's really nice to get feedback, rather than think oh I wonder what has happened with that patient. S5 (District nurse manager)

The concept of feedback also appeared to strengthen the PWP trained nurses' own investment in the approach they were delivering; with feedback from patients increasing their job satisfaction. Staff aspirations to engage with and invest their time and energy appears in the new approach to be linked to their pre-existing relationships with and the personal characteristics of the community nurses delivering it. It was queried that the effectiveness of the new approach hinged on 'who' the nurses were both in their prior experiences and personal attitudes. Suggesting that the characteristic of the nurses influenced the high level of engagement expressed by staff.

It's more about having a positive attitude and being helpful and, and being available, so I think… other people might not have done as well as those three, so there is something about their character.. the character of the three people... but also, they are experienced as district nurses, so they know the system and them know how to engage with their colleagues and they are all known to be district nurses within those teams, so they were already respected, - S4 (GP)

The importance of the personal characteristics of the nurses and their integrated approach was also recognised by patients interviewed.

I've not met the other ones, but mine was fabulous, they had a really good way of connecting with people and it is far better, I have nothing against therapists at all but I think it is just better because they have got a more, I don't know, but perhaps it is because that are a district nurse and they are more used to dealing with people and have more caring attitude - P6

The patients interviewed reported that although they were not always aware of the approach prior to meeting the PWP trained nurses they engaged with having an integrated approach delivered by their community nurse.

It made a difference having, like, them come to my home… I already saw (name) to do my dressings, so I was happy to talk to (name) them about what else was going on, it made you, you know, comfortable and they got to know my life - P2

Positive cognitive participation for both staff and patients was strongly associated with the inter-personal qualities of the PWP trained staff enabling the intervention to function effectively.

Collective Action - Work done to enable

Whilst staff reported the new approach met the values of the existing service, they felt it was the practical structures of the existing service that acted as a barrier to full integration. They identified the need for time and funding to be ring fenced to allow integration to occur.

We haven't got the ability to give them the time, um to spend and just focus on the IAPT work but it's how we can raise awareness across the um broader community nursing therapy services of the importance of having that, you know, awareness of mental health and where you can go to and how a patient can be supported and is it the anxiety and depression that's actually impacting upon their physical health and preventing them self-managing.- S3 (PWP trained nurse)

It was clear from the interviews that the new approach needed additional resources to facilitate the new approach working effectively within the existing services, especially 'time'. Time was defined by some staff as being needed for additional mental health-focused supervision for the PWP trained nurses to be effectively supported; whilst other staff talked about time as being required for in-service training for the rest of the team about the purpose, pathway and need for the new approach. Others defined the time resource required as being the increased length of appointment required to effectively address the dual needs of patients.

It was having the backfill, because I mean we wouldn't have been able to do it without the backfill, because the normal role is so busy, we wouldn't have been able to make the time to engage the patients about their mental health or (the community nursing team) would be a man down - S7 (District nurse)

Staff reported appreciating the additional training which the PWP trained nurses provided allowed them the time to fully comprehend the change in approach and understand the new pathways to embed the process of the new way of working.

I think we were aware before, but it (the training) has brought it to the forefront, rather than right I'm there to do that and not that… you now go in now and think, oh I know what to do with that, when there are the signs - S5 (District nurse manager)

The current separation of health services into physical or mental health was seen as an area where collective action was weaker, whilst two Trusts had partnered for the project to occur, the current separate systems created complications for decision making around who provided supervision, who managed risk and communication pathways.

We are here in the middle but there are other parts of primary care that are run by … different bits of different organisations and it hasn't fed up to the top or crossed over as far as I can understand… because if it had, then I think the project would have

had more support and [there] would probably… um [have been] more understanding of the need. - S10 (IAPT manager)

The current IT service system was also criticised for impeding the new approach by technological barriers.

It is very difficult to share patients' notes, GPs have one system and district nurses have some access but IAPT have another one. So, they can see what they have written but they can't see what anyone else has written, so it all impacts on communication and understanding, also you end up going to see a patient with only half the information - S10 (IAPT manager)

Many of the staff claimed that the new approach simplified the wider team's roles, by having specific practitioners who were equipped to assess and if appropriate treat the housebound primary care patients with mental health concerns. Previously staff were unable to manage their mental health in the team due to lack of skill and knowledge or able refer them to mainstream mental health services due to their housebound status.

So then there was less pull on the community nurses to be going in because the person was self-managing more effectively - S12 (Clinical psychologist)

However, this pathway, which simplified the nursing workload when seeing patients with mental health comorbidities, was reported to create a conflicting pressure on manager's workloads. The management in both Trusts reported being faced with issues around economic costs of implementing this project on a short term basis whilst continuing to meet the current service demand and targets.

it was only funded for minimal hours, in some ways, I think if there was more hours, than we could have had more feedback in the team's between us and them, um, sometimes, I felt, that there were things, that they wanted to feedback to me and I didn't have time at that moment, and there were things I wanted to feedback to them, but I, it was a Wednesday or a Tuesday and by the time it got to Thursday I had forgotten about it… so there is that sort of thing, I think we could have worked better integrated um, if we had had that little bit more time to do - S9 (Nursing Manager)

Staff also recounted that the new approach increased collaborative ways of working across different teams; building and establishing a collective way of working with professions which may have been previously conducted individually. One manager reported;

The community nursing team also contribute to our weekly team meeting (yeah) and that provides like a sort of forum where patients with psychological problems as well as physical health problems could be discussed more widely. Uh, and we found the

input from the PWP trained workers very helpful in terms of their insights into patient difficulties in their mental health, we didn't have that input before. - S2 (PWP trained practitioner)

The dual approach whilst encouraging collaborative working practices and moving away from previously isolated and individualised care, require substantial resources such as time, investment in shared IT access and development of shared working policies to fully enable this.

Reflexive Monitoring - Appraisal

Patients reported positive views about the new approach regarding their physical and mental health whilst staff claimed that the approach met patients' needs in a more holistic way.

'In fact I have written to (nurse) and told them that, to be quite honest you have saved me because I had actually got the stuff to commit suicide and I would have done it and that's what we got talking about, me and (nurse). And anyone else I don't think I could have opened up like that'- P5

Patients and staff also reported how by having increased understanding of their mental wellbeing it resulted in increased physical activity, self-management and motivation.

I'm no longer stuck at home but that's more than just my leg being better, I don't feel so panicked about leaving the house. I'm not kidding, daily, daily she's in my head. Otherwise I'd be sat in a lump, curled up on, you know, on the sofa sobbing for myself. You know, feeling sorry for myself, whereas, er, I now volunteer at a local library since moving…. I help at a mother and toddler group one afternoon a week. It's only an hour but that's just enough. Um, I'm excited about that. - P5

Staff also recognised that addressing a patient's mental health had physical health implications had a positive influence on the patients' recovery journey with potential outcomes such as a reduction in physical health service use.

They [staff] are doing a better job with patients physically by addressing and acknowledging their mental health problems. Also by being able to manage some risk themselves, they you know, they don't always have to refer back to the GP because they actually have a process now to go through themselves and they'll only refer to the GP when it's absolutely necessary, in regards to mental health. - S11 (Project manager)

Despite the small scale nature of the new approach, staff and patients reflected that they were impressed with the scale of the impact that only three PWP trained nurses could have on both patient outcomes as well as the positive effect on team morale.

…a small number of … PWP trained workers in a large team can actually have a significant impact across that team for those patients that the team is seeing - S2 (PWP trained nurse)

Other staff appraised the project current scale positively but reported reservations on a larger-scale rollout of PWP trained nurses due to the current economic climate.

I think that a drastically mainstream service would be difficult at this stage because, you know, all the funding streams. But if you think of IAPT 'increased access [participant emphasis] *to psychological therapies'. If the government is serious about this then they need to have a service for housebound and district nurses are in a prime position, they are the natural partners to IAPT to meet this need being located in the community - S2 (PWP trained nurse)*

The new approach was appraised by staff as going some way to meet the mental health needs of a very complex population, but at times not going far enough. There were limitations with nurses' PWP training since it only focused on mild to moderate mental health conditions, whilst the house bound population seen in the community had largely moderate and severe mental health patients. These patients often cannot access main stream services. Whilst community nurses continue to see these

patients for physical health care, concern was raised PWP trained staff would be working beyond their training

They were seeing patients who were very complex, but they were doing a good job with what skills they had, they were using effectively. It might not have moved those people to recovery, but I think it will have made a positive impact on lots of people - S2 (PWP trained nurse)

Staff and managers acknowledged a concern that there was a lack of 'hard' data to validate the effectiveness and benefits of the new role. Whilst staff and patients felt that the new approach met a gap in the service need, they reported that with no in-house funding available to maintain this initiative, the gap is still there and now more apparent due to the increase in mental health knowledge. Staff highlighted the negative impact of short term projects.

It's alright having little set pots of money, we can work towards, we can set up projects and get it going. But then there's no onwards funding. There's no kind of long-term view, to see that actually this is making a lot of cost savings. They get too absorbed in the short term savings that they have to make and they can't see the impact that this might have in the long term – S11 (Project manager)

Well I would have carried on seeing (PWP) but they told me they had to stop because of funding, I would have liked it to carry on for a bit, it was helping me – P3

The nurses largely appraised the new role in a positive way in that it was leading to clinical benefits which were seen to be more holistic in their approach. However structural constraints were viewed as a major barrier to continuation of the service.

Discussion

This paper reports the views of professionals and patients regarding the implementation and acceptability of PWP trained community nurses delivering a mental health care model within home-based nursing services. By applying NPT to the data it has offered a framework to understand how this complex approach can become embedded in current practice alongside the difficulties associated with that. The stakeholders reported that the PWP trained community nurses new integrated approach was acceptable to both the housebound patients receiving the care and the wider team. Examples of the acceptability and perceived effectiveness of the interventions delivered by the PWP trained nurses were clear in both patient and staff comments. This paper is a new contribution to the literature by showing how integrated care can be adapted to meet the needs of patients receiving care at home and be acceptable to both staff delivering and patient receiving the service, whilst have a perceived positive impact on both physical and mental health outcomes. By using NPT to aid analysis, it has enabled the interplay between how an intervention

is understood and engaged with at different levels within the service structures, as well as looking at what it takes for a ‘new intervention’ to become normalised into routine practice. Although all four NPT constructs appeared to operate concurrently, coherence (sense making) and cognitive participation (engagement) appeared to be crucial in embedding the new complex intervention and allowing key stakeholders to adapt to new ways of working. Furthermore, they evolved alongside the intervention trajectory, rather than just being needed at the beginning of the process as other research has suggested (Franx, Oud, de Lange, Wensing, & Grol, 2012).

Themes which did not map on to the NPT structure included a theme on the ‘effectiveness of the intervention’ from the perspectives of those involved. Overwhelmingly both staff and patients reported positive outcomes from the intervention in terms of mental and physical health outcomes as well as benefits to service provision, team dynamics and cost savings. Positive descriptions of the effectiveness of the new approach included service benefits around perceived cost savings with increased patient self-management and reduced service use as well as simpler referral pathways. The effectiveness of the intervention was also perceived to be linked to staff benefits including ‘increased job satisfaction’, ‘Increased mental health knowledge’, ‘better working relationships’ and ‘increased staff wellbeing’. Reoccurring themes of effectiveness demonstrated ‘Patient benefits’ including ‘increased knowledge of mental health’, ‘increased hope and optimism’ as well as ‘increased engagement with and use of interventions’. Some themes identified a

negative impact on the effectiveness of the new approach. One limitation was that training was insufficient to deal with the challenges of patients with severe or complex mental health problems.

Examining the data using NPT, the primary findings of this qualitative study show that patients and local staff both understood, valued and engaged with the introduction of the new approach to integrating mental health interventions as part of an additional home based nursing role. They reported positive outcomes for patients' physical and mental health as well as the wider team. This contradicts some previous research which reports that ingrained cultures in primary care at a local professional level can be a barrier to new integrated ways of working (Knowles et al., 2013). Rather our findings suggest positive engagement and buy-in from professionals working within the local services and patients can result in adaptations to new ways of working.

However, the findings also revealed a limitation in the resources available for longer term sustainability and implementation of the project, due to it being 'short term' and as two NHS Hospital Trusts were involved, staff reported confusion over who had direct ownership. Without clear consensus over ownership, small projects may be hampered by the lack of investment for sustainability and to scale up. The findings here are consistent with the previously reported limited sustainability when complex interventions are trialled in naturalistic settings beyond the lifespan of an RCT, as

well as the continuation of interventions being dependent on research funding or in this case short-term service development grants (Chaney et al., 2011; Wells et al., 2000).

This study has given a voice to patients, around the acceptability and impact of new ways of implementing their health care, similar to Maybin (2016) who found that patients desired a ‘whole person approach’ to care rather than separating physical and mental health services. The patient stakeholders reported being open to engage in new ways of accessing mental healthcare alongside physical healthcare within their homes. Patients gave detailed case studies of the positive impact this new approach had on their lives, physical and mental recovery and outlook, suggesting that they were supportive of their mental health needs being met at home by PWP trained community nurses. This adds weight to the call for primary care services to look at innovative ways to engage this housebound population in accessing mental health services (AGE UK, 2016; Department of Health Public Health Nursing, 2013; Maybin et al., 2016)

Previous literature has focused on collaborative care (Gunn, Diggens, Hegarty, & Blashki, 2006) where external mental health professionals are brought in as case managers to meet the needs of those with comorbid physical and mental health difficulties (Coventry et al., 2015; Knowles et al., 2013). Our findings support those of Webster and colleagues (Webster et al., 2016), that integration of physical and

mental health can be successfully facilitated through training of current staff and made acceptable to patients. The need for whole teams to be given mental health training was not seen as paramount by staff or patients interviewed, team wide positive effects of the new approach was seen largely due to informal knowledge transfer that occurred as a result of having ‘within service experts’. This is in keeping with recommendations of integrated care that part of the process of integration is skill sharing and learning from each other (Naylor et al., 2016). This internal resource within the community nursing team was a vital link enhancing nurses’ ability to understand the new approach (sense making) and engaging to facilitate new ways of working (work done to enable). The secondary benefits of having a few professionals with higher level of training formally or informally transmitting knowledge within a wider team was an increase in the overall mental health knowledge and confidence levels of the wider teams involved.

In this study, nurses were trained to screen, refer and deliver interventions targeted at mild to moderate comorbid mental health conditions in housebound patients in keeping with an integrated approach. The reflexive monitoring in NPT discussed how in reality, and despite the limits of the training, the PWP trained nurses were often managing patients who had complex moderate to severe mental health conditions but did not meet the threshold of other mental health services. Staff highlighted the need for the training to go further, suggesting that a low level integration of skills may not fully meet the needs of housebound primary care services. This study went some

way to addressing the gap in service but failed to fully integrate physical and mental health services due to training limitations to meet the full range of patient's needs. .

Strengths and Limitations

This evaluation has examined a new approach to collaborative care for physical-mental multi-morbidity in the UK where community nurses have received formal training up to the standard of being qualified PWPs and attempted to integrate this within core community nursing practice. The findings are also strengthened by the incorporation of patients' views. The two-staged approach to analysis and the quality checks on the coding frameworks that were developed during the analysis ensured rigour in the research process. This study's findings contribute to further understanding about overcoming the translational gap between research and practice associated with collaborative care from a wide range of stakeholders. A further strength is the use of a theoretical framework (NPT) to aid interpretation of the barriers and enablers within implementation of collaborative care in routine services.

The main limitations of this study are that the barriers and facilitators of implementation are purely based upon stakeholder views, and are not underpinned by observations in practice contexts, quantitative outcome data or economic evaluation. Using NPT enabled insights to be gathered on the perspectives associated with implementation. However, as acknowledged by May and colleagues,

NPT places emphasis on individual agency without explicitly locating this within, and as shaped by, the organisational and relational context in which implementation occurs (May et al 2011). Additionally, we do not know the extent to which some mechanisms are more important than others in determining implementation process outcome. The small study sample and recruitment method may potentially have only included participants who were directly invested in successful implementation. However, the purposive sampling frame, ensured that we obtained diversity in clinical setting, professional group and grade. A larger scale mixed methods design might reveal a wider range of constructs with which to explain the acceptability and adoption of PWP trained nursing services. However, the experiences and perspectives of end users and those charged with service delivery cannot go unnoticed in the value that they add to implementation studies of this type.

Conclusions

The inclusion of multiple perspectives has provided greater understanding of potential barriers and facilitators to the embedding, integration, implementation and sustainability of new integrated approaches within primary care. Community nurses working in home based primary care settings are now expected to adhere to the 'whole person approach', having a workforce that can actively identify and participate in promoting good mental health alongside physical health is fundamental to insuring integration and holistic care. Having a 'pool' of primary health care professionals such as community nurses trained as psychological well-being practitioners within a

primary care team has been reported in this evaluation to be acceptable and valued by housebound patients with co-morbid mental health problems as well as the wider home-based primary care team. This study demonstrates one approach for integrating mental health within home-based primary care for a hard to reach complex patient group, but further research is required to review the evidence base of approaches to integrate mental health within community nursing as well as evaluating the economic impact of any implementations tested. The findings of this study indicate that implementation models such as this one can go some way to addressing the translational gap between research and clinical practice aiding future development of complex interventions in primary care and the ability to make sense of what organisational change and processes are needed for successful embedding. Future work should further explore the interplay of organisational ownership as well as building evidence on outcome measures and the economic impact of integrated mental health interventions within community nursing.

Relevance for clinical practice

This study provides valuable insight into how the whole person approach can be successfully implemented within home based community nursing services by up training a small number of the existing working force with additional mental health intervention skills. This can enable new holistic approaches to be acceptable to and valued by the wider team as well as the service user population. Being involved with

trialling new approaches to holistic practice appeared to have wider team benefits such as increased moral and job satisfaction as well as improved confidence in practice through informal knowledge transfer. However, if home based primary care nursing is to be fully sustainable at delivering a 'whole person approach' then new services needs to be adopted routinely with agreed care pathways and sustained organisational support. Further evidence is needed to better understand the positive outcomes to patients and potential cost savings.

Summary Box
What does this paper contribute to the wider global clinical community?

- A small number of PWP trained community nurses can implement integrated mental health care into their standard home based nursing practice in a way that is acceptable and valued by staff and patients.

- NPT can be effectively used as a framework to evaluate new healthcare roles, to increase our understanding around what inhibits and enables these roles to become embedded and sustained in routine practice.

- New roles and complex intervention require further research using mixed methods to build the evidence base for cost saving implications alongside detailed qualitative evaluations.

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Supporting information – supplementary tables and figures.

List

Table 1: Nurses with additional PWP training **project overview**

Project Overview:-	**Description:**
Integrated pathway referral criteria:	Adults who are housebound AND required a community/district nurse intervention to help with managing physical health problems AND where low mood/anxiety/negative thinking is thought to be impacting on long term condition management but are not actively suicidal. Interventions will be delivered in or close by to the patients' home. If the patient is currently receiving psychological input from other services, this will be reviewed on a case by case basis.
Referrals accepted from:	GPs, Practice Nurses, Community Nurses and Community Support Workers within 10 GP surgeries.
Setting	All mental health focused interventions were delivered within the patients' home or in close proximity to patients home. Delivered alongside physical interventions such as medication management, wound dressing, physical observations.
PWP Interventions delivered.	'Guided Self-Help' based on cognitive behavioural therapy. This includes setting realistic goals, looking at how patients spend time and how this can impact on mood, learning new ways to solve

	difficult problems, and learning how to overcome and face fears. A focus is also on supporting new ways to challenge and overcome negative thinking. Additional interventions may also include signposting to additional services, medication support and monitoring, sleep hygiene advice, problem solving techniques such as brief solution focused therapy, mindfulness as well as relaxation and controlled breathing for anxiety/ panic cases.
Typical length of intervention	Following assessment, PWP treatment is usually 4 to 7 sessions. This is delivered predominately within the patient's home with some additional telephone contact.
Screening and outcome measures used.	Routine outcome measures were introduced later in the project and therefore are not discussed within this paper. PHQ-2 or PHQ-9 GAD2 or GAD 7 EQ5D-5L Case study reports
Up skilling within community nursing teams (lead by dual trained community nurses)	A core principle of this project has been to share mental health skills, to increase awareness and build the confidence of peer Community Nurse colleagues to enable mental health to become part and parcel of district nursing. A three-phased approach to training to the wider community nursing team was taken, including a 'Brief supportive guide to screening for depression and anxiety' ● Session One: Screening for anxiety and depression ● Session Two: Assessing suicidal risk ● Session Three: Self-help tools and information

Table 2: Demographics characteristics of patients

Patient Participant ID	Gender	Age Group	House-bound (self-identified)	Physical health long term condition (Self-identified)	Mental health condition (Self-identified)	Number of contacts with Dual Trained Community Nurse.	PWP intervention received
P1	Male	70 – 79	Y	COPD IBS	Anxiety	4	Goal setting, challenging negative thinking, low mood monitoring, problem solving.
P2	Female	60-69	N	Cerebral Palsy	Depression	4	Goal setting, signposting, routines, problem solving techniques.
P3	Male	60-69	Y	Throat Cancer	Depression	6	Goal setting, relaxation and controlled breathing for anxiety/ panic case, low mood monitoring.
P4	Male	50-59	N †	Bariatric Arthritis Hiatus Hernia Ulcerations	Depression Anxiety	7	Goal setting, relaxation and breathing, challenging negative thinking, problem solving technique, low mood monitoring.
P5	Female	50-59	Y	Arthritis Incontinence		8	Goal setting, sleep hygiene, low mood

							monitoring, challenging negative thinking.
P6	Male	60-69	Y	COPD Arthritis	Depression	10	Goal setting, low mood monitoring, problem solving, relaxation.
P7	Female	60-69	N †	Diabetes II	Anxiety Depression	7	Goal setting, relaxation and breathing , challenging negative thinking, problem solving technique, low mood monitoring.
P8	Male	70-79	Y	COPD Heart condition Asthma Diabetes II	Depression	5	Goal setting, relaxation and controlled breathing for anxiety/ panic cases, routine/daily self-care, medication management.
† Self-identified as not fully housebound, but restricted due to anxiety rather than physical condition							

Table 3: Normalisation process theory as an evaluation tool.

Normalisation Process Theory (NPT): 4 components	**Description - Questions to consider:**
Coherence – 'Make sense'	How people **make sense** of the new intervention? Does everyone have a clear understanding of the project? Are people able to tell the difference between this intervention and normal practice? Do the teams and wider service involved value the need for the project?
Cognitive Participation- 'engage'	How people **engage** with the new intervention Is everyone prepared to buy-into the new project? (engagement) How does the introduction of a new approach affect relationships with colleagues? (interpersonal factors)
Collective Action – 'Work done to enable'	**Work done to enable** the intervention How does the new approach fit into existing routines?/ Do the current systems support this intervention? Do staff need additional knowledge and training for this intervention to work? Does the new approach simplify or complicate daily work for professionals? What additional resource are needed to make this intervention work?
Reflexive monitoring – 'appraisal'	How people formally and informally **appraisal** of the benefits and cost of the intervention How effective and useful is this intervention for staff and patients? How do we know if it is working?

	Does it need to be modified or redefined?

Table 4: Results interpreted using NPT framework.

NPT components	Questions to consider within the NPT framework	Summary of findings/ themes mapped on to NPT construct.	Evidence
Coherence **Making sense** of intervention by participants	**Does everyone have a clear understanding of the intervention?**	Majority of staff and patients had a clear understanding of intervention. Some concern that it was too MH weighted.	*because we could now offer people something, above and beyond what we can give… And that did mean, I think, that it lessened some of the teams anxiety about leaving people in circumstances that are less than ideal, - S9* *I knew that it was dual in that they were still physical health staff who were gaining a mental health expertise but the mental health focus , but some of the meetings and the supervision sessions, it just seemed quite intensive. - S8*
		Knowledge and awareness increased as project continued	*more could have been done at the beginning to be clear about who would be helped and who wouldn't. - S4* *I was off on holiday and when I came back they were there and had introduced the yellow sheets for the patients with scores on you know. And obviously (name) had worked with us before, so we had a conversation about it And they informed me what you needed to do with the forms and what to do with them after. And then it went from there really - S5*
		Being collocated aided understanding .	*I think it was actually knowing where the help was .and the fact that you could just go up to them and talk to them. Because they were just in the office. And you could just take the referral and just ask, rather than it just being up in the air and nothing done about it a month or more later - S5*
		Communication pathways established	*they were there just in case you wanted to pick their brains about something, It wasn't necessary just making referrals… sometimes you just needed some additional input, and I even phone (name) about that lady that I was having problems with, and (name) told me what to do - S5*
	Are people able to tell the difference between this intervention and	Staff able tell difference, seen as a new element to community nursing.	*with those combined skills, they're able to provide um, a deeper level of care for patients... with physical health problems but also with psychological health problems. - S1*
		Patients able to differentiate between	On 'normal' district nurses - *they have something set in their mind what they are going to do and they won't deviate, ..and it's not an open conversation , if it's a skin problem*

	normal practice?	services, valued having mental health addressed within home.	*they have come for it's a skin problem they will look at, yeah end of story and if you bring up something else they always say well I will have to refer to my manager and they will send someone else out, and yet a good nurse would have pick something up themselves and said I think I will get some advice and come back to you, but a lot don't they don't pick up on anything other than the complaint which they have come for and that's it they don't seem able to look - P8* Within the home - *it was good that she'd see the mental sort of side of it as well... so she was the best one I've ever had. I mean I've seen counsellors at the doctors …who were sort of like, he put a smiley face on that, how do you feel, you know, one out of ten, numbers mean nowt to me. You know, .. but she, lived through one of the worst times of my life… made me feel comfortable and she got to know my life, and my kids coming to the house and… things like that - P4*
		Some patients thought is was normal role of DN	*Thought they all do it or should be doing it - P7*
	Do the teams, wider service and patients involved value the need for the interventio n?	Staff valued intervention Some staff felt training of DTN did not go far enough. 'Better than not having it'	*patients who previously um had... psychological difficulties which were either unrecognised or if they were recognised they weren't able to access um a practice based service… were now able, were then provided with um psychological service - S2*
		Patients valued intervention - some increased understanding in condition to 'life saving'	*she gave me one or two good bits of advice, you know, to … like,, you're down somewhere and you can't get yourself out, and she slowly fetched me out of it a bit, - P5* *told him that.. to quite honest, I said to him, in the end you actually saved me because I have actually got the stuff to actually commit suicide .. and I would have done it .. to be honest with you, and that's what we got talking about, me and *. And anyone else I don't think I could have opened up like that - P2*
		Valued support coming from a community nurse.	*I have nothing against therapist at all but I just think it is better because they (DTN) have got a more, I don't know, perhaps it's because they are a district nurse and they are more used to deal with people and have a more caring attitude, I mean therapist are very good but you are just a patient, you know you are just a number with them and you don't quite get that kind of connect with them - P7* Asking about additional services [wheelchair services] *I had thought well she might know and she did... and that's the other thing about having a district nurse do it rather than just a therapist you get, you can link into all kind of things, and they can recommend things that you would obviously get with a therapist - P8*

Cognitive Participation **Engagement** by participants	**Is everyone prepared to buy-into the new project?**	Fits with ethos of managers, DTN and key stakeholders.	*I think it exceeded what we thought it could be. I have always had a massive belief that, people with long term conditions … the psychological side of the illness is never dealt with, as well as the physical side, and that is a gap in the service... and I think it means that people are very isolated and lonely and then often all they can do is reflect on their illness and then it can often exasperate their illness because they are too busy focusing on it, so I already think , I already had that belief system in place - S9*
		Positive feedback from patients reinforced buy-in	*getting feedback, really from the patients, the job satisfaction from that is really… immense. Because, in another role, you are working as a team…. doing bits and parts and you doesn't see it as a whole, something which you can take ownership… Because with feedback you actually get positive comments and you think ohh, I've done that. - S10*
		Driven by characteristics of DTN (staff and patients)	*no its more about having a positive attitude and being helpful and, and being available, so I think… other people might not have done as well as those three, so there is something about their character .. the character of the three people …, but experienced as district nurses, so they know the system and them know how to engage with their colleagues and they are all known to be district nurses within those team, so they were already respected, - S4*
		Buy-in positive at local level but concerns that buy-in did not filter up the management structure and commissioners.	*the near manager, perhaps, understands … but it's not been transmitted up as it should have been….. We are here in the middle but there are other parts of primary care that are run by … um.. Different bits of different organisations and it hasn't fed up to the top or crossed over as far as I can understand… because if it had, then I think the project would have had more support and would probably… um more understanding of the need. - S10*
		Lack of Ownership - Whose responsibility?	*it's the ownership of the project that has never been- S10* *personally, I do feel that IAPT and their organisation should take more, should take stronger ownership of this - S4*
Collective Action **Work done to enable** the intervention	**How does the new approach fit into existing routines?**	Fits service ideology and values but not practicalities. Time and funding needed to be ring fencing. Unable to be fully integrated without back-filling time.	*we haven't got the ability to give them the time, um to spend and just focus on the IAPT work but it's how we can raise awareness across the um broader community nursing therapy services of the importance of having that, you know, awareness of mental health and where you can go to and how a patient can be supported and is it the anxiety and depression that's actually impacting upon their physical health and preventing them self-managing.- S3*
		Service structure barriers (IT, Funding, Time)	
	What additional resources	Training of DNT and whole team	*nurses who become community nurses, um, their core training doesn't reach into this role, the psychological training or um mental health awareness. And there's a potential lack of confidence in terms of*

	are need to make this interventio n work?	required to integrate.	*identifying, recognising and managing those aspects, which then leads on to saying that dual trained IAPT personnel can actually be that bridge and can actually also be the trainers and be the facilitators and the supporters of the nurses and wider team - S2*
		Supervision of DTN needed for success (MH)	
		FUNDING - more time, more nurses	*I think from my point of view, um, the main hindrance has been that it only on two days a week .. , it would have been nicer to have it a bit more , across five days or whatever - S9*
	Does the new interventio n lead to a change in workload for the teams involved?	Simplified wider teams roles having a depression pathway and feedback from the DNT.	*we felt that we had somewhere we could go, with some of our more complex patients , because we know, we go in and… we do the best that we can, with our skill set.. with our knowledge base, um , but we know that we are leaving people, in less than ideal circumstances, and this was like, manor from heaven, because we could now offer people something - S9*
		Reduced workload	*So then there was less pull on the community nurses to be going in because the person was self-managing more effectively - S13*
		Complicated management as a Short term project role-funding and time.	*it was only funded for minimal hours , in some ways , I think if there was more hours, then we could have had more feedback in the team's between us and them, um, sometimes, I felt, that there were things, that they wanted to feed back to me and I didn't have time at that moment.., and there were things I wanted to feed back to them, but I, it was a Wednesday or a Tuesday .. and by the time it got to Thursday I had forgotten about it. … so there is that sort of thing, I think we could have worked better integrated .. um, if we had had that little bit more time to do - S9*
	How does the introductio n of a new approach affect relationshi ps with colleagues ?	Increase collaborative working reported	*The community nursing team also contribute to our weekly team meeting and that provides like a sort of forum where patients with psychological problems as well as physical health problems could be discussed more widely. Uh, and we found the input from the dual trained workers very helpful in terms of their insights into patient difficulties. - S2*
		Increased understanding of IAPT services	*Have promoted IAPT, as a lot of them didn't really know, and clinicians who didn't know anything about IAPT… Which means there is a gap in their knowledge, not just a mental health gap, but they don't know where to signpost people to who have got a problems. Although some of the housebound patients couldn't have signposted to as there is not the facilities at IAPT due to the nature of being house bound But if they are a group of individuals didn't know about IAPT then they would then be going to their GP with problems of anxiety and stress and have to be signposted from there. but they are professionals so they should have know really - S10*
		Initial scepticism	*there is sometimes that, 'humph, we are run off our feet and there are three nurses there' and so you do get a little bit of that initially but once they understood the role… I think people just thought , saw the value of it and it's like, no, actually its, we don't all work in the same way and we can't all be out doing things all the time, and so I think people now generally understood it - S9*

		Personal support	*I think we have used A as well to our benefit, and running a large team- there's 18 of us, you know we have, I have spoken, I know other staff, I have one staff member who was suffering from an', quite a lot of anxiety, and I asked A if he minded having a word with her and he gave her some processes to go through to help her and that was really beneficial - S3*
Reflexive Monitoring How people formally and informally **appraisal** of the benefits and cost of the intervention	**How effective and useful is this interventio n for staff and patients? How do we know if it is working?**	Patients and staff report positive effect of interventions	*a small number of trained, dual trained workers in a large team can actually have a significant impact across that team for those patients ..that the team is seeing* - S2 **<u>Upskilling staff</u>** *being able to manage some risk themselves, they you know, they don't always have to refer back to the GP because they actually have a process now to go through themselves and they'll only refer to the GP when it's absolutely necessary, in regards to mental health.- S11* **<u>Staff wellbeing</u>** *And you listen to them and to what they say and when you say 'yes we can go and see this person', you can see their shoulders coming down from being up around their ears, thinking 'I don't know what I'm going to do with this, I don't know how I am going to manage it'… So yes it has made a difference to them. - S10* **<u>Patient effects</u>** *I'm not kidding, daily, daily she's in my head. Otherwise I'd be sat in a lump, crawled up on, you know, on the sofa sobbing for myself. You know, feeling .. sorry for myself, whereas, I volunteered at a local library since moving, since moving flat. I help at a mother and toddler group one afternoon a week .. It's only an hour but that's just enough. I'm excited about that - P5* *I don't think everyone would benefit by it, but I didn't benefit from it 100% but what the mental health nurse told me and told me what to do, I think I lot of it came across and I am still trying to apply it now, because I'm still, very anxious and this mental illness if you want to call it, is still there and I don't think it is ever going to go away. - P1*
	Does it need to be modified or redefined?	Concern about lack of 'hard' data collected to evidence based findings to evidence success	*it has been a too smaller project to do that... but it has shown that it is effective, it makes a difference to people and I think with more investment it could easily prove that less hospital admission, stays, less investigations that's the sort of thing that they are managing to avoid, and also improvements in peoples qualities of life, and I think that has happen beyond a shadow of a doubt but I'm not sure that that will come out of what you have here - S2*
		Lack of sustainability within funding structure	*we really need them there all the time rather than just a trial Because the need is always there it doesn't stop - S5* *We've had positive feedback from most people that we've been involved with and now the funding's finished, unfortunately we're getting patients wanting to know if the DTN can contact them... So we're now, um struggling…. because unfortunately we've got patients who were having the service delivered who now haven't got a service- S13*
		Issues with training not meeting the	*they were seeing patients who were very complex, but they were doing a good job with what skills they had, they were using effectively, It might not have moved those people to recovery but I think it will have made a*

		needs of patients within service - Risk associated with complex patients.	*positive impact on lots of people - S2* *both the physical and mental states of some of the patients is really quite entrenched and has been, um, it was a good job that we had the dual training and the time and even if we just made a little bit of difference… even though some of them had problems that were really step three and beyond us - S10*
		A gap in service is still there.	*Yes , I guess at least we are more aware of it, but at the same time we don't know what to do, with the ones the IAPT people won't take.- S5* *at least I think there should be at least one person in each team to do the role that * did , as it is needed, well I think it is needed, it helped me, - P3*