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# National Evaluation of the Department of Health's Integrated Care Pilots

Appendices

RAND Europe, Ernst & Young LLP

Prepared for the Department of Health

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**Integrated Care Pilots evaluation: final report**

# **Appendix A: Study protocol**

## Research and Theory

# Evaluation of UK Integrated Care Pilots: research protocol

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## Abstract

**Background:** In response to concerns that the needs of the aging population for well-integrated care were increasing, the English National Health Service (NHS) appointed 16 Integrated Care Pilots following a national competition. The pilots have a range of aims including development of new organisational structures to support integration, changes in staff roles, reducing unscheduled emergency hospital admissions, reduced length of hospital stay, increasing patient satisfaction, and reducing cost. This paper describes the evaluation of the initiative which has been commissioned.

**Study design and data collection methods:** A mixed methods approach has been adopted including interviews with staff and patients, non-participant observation of meetings, structured written feedback from sites, questionnaires to patients and staff, and analysis of routinely collected hospital utilisation data for patients/service users. The qualitative analysis aims to identify the approaches taken to integration by the sites, the benefits which result, the context in which benefits have resulted, and the mechanisms by which they occur.

**Methods of analysis:** The quantitative analysis adopts a ‘difference in differences’ approach comparing health care utilisation before and after the intervention with risk-matched controls. The qualitative data analysis adopts a ‘theory of change’ approach in which we triangulate data from the quantitative analysis with qualitative data in order to describe causal effects (what happens when an independent variable changes) and causal mechanisms (what connects causes to their effects). An economic analysis will identify what incremental resources are required to make integration succeed and how they can be combined efficiently to produce better outcomes for patients.

**Conclusion:** This evaluation will produce a portfolio of evidence aimed at strengthening the evidence base for integrated care, and in particular identifying the context in which interventions are likely to be effective. These data will support a series of evaluation judgements aimed at reducing uncertainties about the role of integrated care in improving the efficient and effective delivery of healthcare.

## Keywords

**integrated care, evaluation, protocol**

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## Background

There are growing numbers of people with chronic conditions with a particularly rapid rise in the number with multiple care needs. The complex needs of people with multiple chronic conditions require the development of delivery systems that bring together a range of professionals and skills from both the cure and care sectors to meet those needs. Despite this, service delivery has developed in ways that have tended to fragment care, both within and between sectors, through for example structural and financial barriers dividing providers at the primary/secondary care and at the health and social care interface; distinct organizational and professional cultures; and differences in terms of governance and accountability [1].

A substantial number of evaluations have been carried out of interventions designed to improve the integration or coordination of care. A systematic review based on 21 reviews and 85 primary studies [2] showed that many of these initiatives were effective in improving care, though many fewer resulted in a reduction

in healthcare costs (Table 1). One of the conclusions of this and other reviews is that the effectiveness of attempts to provide better integrated care is highly dependent on the context in which the intervention takes place. Interventions cannot be seen separated from the context in which they are introduced, and this has been an important guiding principle in the evaluation described in this paper.

In response to concerns that the needs of the aging population for well-integrated care were increasing, the UK Department of Health for England announced in 2008 that a number of 'Integrated Care Pilots' would be established. Healthcare purchasers and providers were invited to submit proposals for innovative approaches to providing better integrated care [3]. There was no specification as to the form that such integration should take, or client groups who should receive the intervention. There were over 100 applications, and after a two-stage selection process, the Department of Health selected 16 pilots. The localities of selected pilots and the main focus of each are described in Annex 1.

**Table 1.** Summary of the evidence on the effectiveness of interventions to improve coordination in health care, from Powell Davies et al. [2]

Main focus of intervention	Proportion (%) of studies with positive outcome for health	Proportion (%) of studies with positive outcome for health/ social care service user satisfaction	Proportion (%) of studies with positive outcome for cost saving
<i>Changed relationships between service providers</i> Structured relationships between service providers including co-location, case management, multi-disciplinary teams or assigning health/social care service users to a particular PHC provider (33 studies)	19/29 (65.5%)	8/12 (66.7%)	2/12 (16.7%)
<i>Coordination of clinical activities</i> Using structured arrangements for coordinating service provision between providers, including joint consultations, shared assessments and priority access to another clinical service (37 studies)	19/31 (61.3%)	4/12 (33.3%)	3/15 (20%)
<i>Improving communication between service providers</i> Interventions designed to improve communication between service providers, e.g. case conferences (56 studies)	26/47 (55.3%)	12/22 (54.5%)	2/21 (14.3%)
<i>Support for clinicians</i> Interventions include support or supervision for clinicians, training (joint or relating to collaboration), and reminder systems (33 studies)	16/28 (57.1%)	8/14 (57.1%)	1/12 (8.3%)
<i>Information systems to support co-ordination</i> Using information systems to support the coordination of care, including care plans; decision support, proformas; health/social care service user held or shared records; shared information or communication systems; and a register of health/social care service users (47 studies)	23/38 (60.5%)	7/19 (36.8%)	2/13 (15.4%)
<i>Support for health/social care service users</i> Interventions include education, reminders and assistance in accessing care (19 studies)	6/17 (35.3%)	3/6 (50.0%)	1/7 (14.3%)
All studies	36/65 (55.4%)	14/31 (45.2%)	5/28 (17.9%)



A team from RAND Europe, Ernst and Young LLP and the University of Cambridge were appointed to carry out a three-year evaluation that was augmented by the inclusion in the evaluation of experts from the Nuffield Trust. The evaluation aims to answer the following questions:

- What approaches to integration have been employed by the pilots?
- What approaches to integration work well and in what contexts?
- Who benefits from integration, in what ways, and with what consequences for equity?
- What resources are required to make integration succeed and how can these be efficiently used?
- In delivering integrated care in the English National Health Service, what policies and practices are: most likely to deliver the intended outcome, most capable of being implemented and most acceptable to patients, users, clinicians, managers and the wider public.

A mixed methods approach was adopted including interviews with staff and patients, non-participant observation of meetings, structured written feedback from sites, questionnaires to service users and staff, and analysis of routinely collected hospital utilisation data for patients/users who had been recruited into the pilots.

## Analytical framework

Our approach to understanding the context in which integration takes place is based on two classifications relating to structure and function. At the start of the evaluation these classifications were deliberately general to avoid focusing too early on very specific approaches to integrated care. We wanted to accommodate the fact that the pilots themselves were still refining their approaches.

### a) Structure

Integration can be seen as occurring at three levels [4, 5]

- *Micro-level integration activities.* These promote integration among individual practitioners within a single organisation (e.g. between doctors and nurses in a primary care practice setting).
- *Meso-level integration activities.* These promote integration among practitioners working in different organisations (e.g. between GPs and specialists). This might include co-location of services, which could occur with or without *macro-level activities*, such as pooled budgets.
- *Macro-level integration activities.* These promote integration designed to facilitate organisation-to-

organisation working, e.g. across different sectors. These may include policy agreements and financial arrangements. Examples of these are pooled budgets or joint budget holding between health and social care services, employment of care staff in a single organisation, or structural changes to facilitate work across two or more organisations.

### b) Function

Integration can be classified [6] in terms of

- *Organisational integration*, where organisations are brought together by mergers or by structural change.
- *Service integration*, where different clinical services or support/back-office functions are integrated.
- *Clinical integration*, where the focus is on care for a particular condition.

This classification will guide our analysis of the data, and our testing of the various hypotheses which arose during the course of the study. These included hypotheses that integrated care would lead to the development of new organisational structures to support integration, changes in staff roles, increased staff job satisfaction, fewer unscheduled emergency hospital admissions, reduced length of hospital stay, increased patient satisfaction, and reduced cost.

It should be noted that the evaluation was designed and funded prior to the appointment of the integrated care pilots, so these hypotheses were developed during the first six months of the evaluation as a result of detailed interaction with the sites. This unusual research design allowed for the evaluation to be tailored to the aims of the sites which were not known at the time the evaluation team was appointed.

## Research methods

### Principles guiding the evaluation

The evaluation described here adopts the approach of the 'embedded evaluator'. The evaluation activities form a distinct strand within the Integrated Care Pilot programme, helping to co-produce the successful delivery of the programme, rather than a completely separate study focused solely on contributing to the scientific understanding of integrated care. However, it is equally important that the evaluation contributes to scientific understanding and that it generates valid and independent evidence to support decision-making in the future. The approach combines systematically collecting and synthesizing evidence from across all the pilots together with a deeper investigation of a smaller number of pilots in order to gain more detailed

understanding of the structures, processes, costs and outcomes of integration.

Integrated Care Pilots use a variety of integrating activities (ranging from influencing, creating incentives, sharing information, creating new information systems and so forth) and have a variety of objectives (including improving the effectiveness and efficiency of services, enhancing patient reported outcomes and delivering measurable health improvements. In this context, the research approach is multi-method in order to understand both the activities pursued and the outcomes achieved. The evaluation is based on six approaches to data collection and analysis:

1. Systematic qualitative data collection from all sites (through a 'Living Document' which is a semi-structured document completed regularly by each pilot site).
2. In-depth case studies of six sites ('Deep Dives') including interviews with staff and patients/service users and non-participant observation of meetings [see Section Systematic qualitative data collection from all sites (the 'Living Document') for more on why we decided to use case studies].
3. Difference in differences analysis of data on hospital utilization comparing patients/service users enrolled in pilots with control data.
4. Data from patient questionnaires.
5. Data from staff questionnaires.
6. Analysis of costs (combining data from qualitative case studies and quantitative data on service utilization).

Evaluation involves a number of activities leading to an exercise of judgement [7, 8]. In evaluating the complex set of activities which broadly sit under the heading of 'Integrated Care Pilots' we also seek to arrive at judgements which are seen to be legitimate by the stakeholders involved [9]. This requirement for legitimacy is one of the many ways in which 'pure' research is distinct from evaluation. This legitimacy potentially involves five steps (similar to those identified by Scriven [10]):

1. Understand from those delivering the pilots and from those funding the initiative the criteria they consider to be applicable.
2. Agree the standards and intended outcomes that are applicable.
3. Gather data relating to these standards and outcomes.
4. Assess the contribution made by the agency/activity in achieving these standards and outcomes.
5. Form a performance audit judgement.

These steps protect the evaluators from the accusation of being arbitrary or otherwise non-rational, but an important part of the logic of the evaluation is to

develop a set of hypotheses based on the 'theory of change' offered up by the pilots themselves. Implicitly or explicitly, many evaluations of complex interventions use a 'theory of change' approach. These evaluations aim not only to understand the contribution made by a programme or activity to achieving outcomes, but also to interrogate evidence and communicate findings to support both learning and accountability. Our approach takes as its starting point the argument of Weiss [11, p. 66–67] that: *"The concept of grounding evaluation in theories of change takes for granted that social programmes are based on explicit or implicit theories about how and why the programme will work...The evaluation should surface those theories and lay them out in as fine detail as possible, identifying all the assumptions and sub-assumptions built into the programme. The evaluators then construct methods for data collection and analysis to track the unfolding assumptions. The aim is to examine the extent to which programme theories hold...the evaluation should show which of the assumptions underlying the programme are best supported by the evidence."*

In this sense, 'theories of change' is a guiding approach rather than a methodology, and its successful delivery requires harnessing a range of methodologies, such as those outlined elsewhere in this paper. Our 'theories of change' approach has five precepts. First the approach requires us to not only look at the outcomes of the programme but to pay equal attention to processes. This contrasts with more classical evaluation approaches which tend to look at outcomes first and then to look for evidence to support attribution. Secondly, the approach requires a more 'embedded' evaluator where the evaluator works closely with policy makers, practitioners and end users to understand and elaborate a sometimes changing theory of change. Without losing their independence, successful evaluators will understand the world of the policy makers, practitioners and service users, including an understanding of what motivates their behaviour. Thirdly, the approach requires an ability to reconstruct and represent the sequence of events connecting actions to each other and how these contributed to the outcomes identified, reconstructing at least the sequence of events and statistical co-variations, but preferably also identifying the causal mechanisms at work. Fourthly, the approach is sensitive to the possibility that during the life of a programme or intervention, initial theories of change may alter in response to learning or to exogenous events and that the evaluation needs to capture these changing understandings and actions. Fifthly, it will also be sensitive to the fact that different and potentially conflicting theories of change might be simultaneously pursued within any one programme. Collectively, these precepts describe an interest not only in *causal*

effects (what happens when an independent variable changes) but also *causal mechanisms* (what connects causes to their effects); not only what officials say they do but what the evidence *shows* they do; and not only what contribution stories practitioners tell themselves and others but also what really *contributes* to benefit. Therefore, theory building and testing is an important part of the approach taken but it does not start with a *priori* theoretical claims or assumptions.

## Systematic qualitative data collection from all sites (the 'Living Document')

The Living Document involves semi-structured data collection from all Integrated Care Pilots at approximately six-monthly intervals during the evaluation. A lead person is designated in each site to collate responses in the Living Document, but in most cases, this individual draws on a variety of sources in collating responses, and there is an expectation that the views of a wide range of stakeholders will be represented in the completion of the document. The data collected in the Living Document are organised into a series of broad questions:

- Development of the pilot and background information. Questions identifying the background, purpose and background setting of the pilot.
- Who is doing what? Identifying the main people and organisations involved, and their roles in implementing the pilot.
- Processes—identifying the intended processes, and processes which have been implemented so far.
- Outputs and outcomes achieved so far.
- Progress to date. A description of progress to date, an assessment of progress against plan, and an outline of what has facilitated/prevented progress.
- Sustainability. Assessment of how arrangements to promote sustainability are progressing.
- Attribution of changes to specific initiatives relating to the pilot. An assessment of how much difference is really being made by the pilot itself, in the context of other health policy initiatives which are taking place concurrently.
- Resource implications of the pilot. Without attempting to provide a precise monetary value to the outcomes of the pilot, an assessment of the costs of the pilot, and whether benefits might have been achieved more easily in other ways.

After each round of data collection, data from the Living Document are analysed, and feedback is given in two ways. First, limited feedback is given to each site, including the opportunity to specify where more detailed information is needed in future rounds of

Living Document completion. Second, the overall themes emerging from the Living Document are analysed, and these are fed back in a single document to all sites after each round of data collection. This analysis also contributes to 'learning events' (conferences and teleconferences to address different issues of relevance to pilots) which are being run by the Department of Health throughout the pilot period, and subsequent rounds of the Living Document are adapted in light of feedback from the sites.

## In-depth case studies of six sites ('Deep Dives')

We selected a range of types of pilots for in-depth case study to reflect the range of approaches in the pilots and then select a sample from these reflecting the need for variety and site's ability to support a more detailed evaluation. For the depth case studies in six sites, we will structure the evaluation using an approach that combines logic modeling with process mapping of the patient journey. These methods will complement each other in creating a full picture of the integration pathways. Logic models [12] provide a brief summary of the key elements of an intervention (or programme, or project) and organize inputs, processes, outputs and outcomes systematically. They facilitate a focus on the causal links in the chain connecting the allocation of resources to the intended outcomes. As such, they are well suited to supporting an understanding the 'theory of change' underpinning the activity and simultaneously identifying the sorts of data that might support or weaken that theory [11].

This approach will provide both a way to describe and communicate the different interventions but also to provide a basis for what, causally, is happening. It will provide the framework for understanding how the inputs of a pilot are related to its outcomes and impacts. They are especially helpful in developing a shared understanding of a process between stakeholders and serve as a reference point for stakeholders in the initiative or programme. Process mapping the service user experience, by contrast, involves understanding the motivations, experiences and outcomes of the various interactions between the service user and the (integrated) service [13].

Using these case studies, we will address the following questions:

- What approaches to integration have been employed by the pilots? This will provide a richer description of models than is possible in the overall national evaluation by exploring experiences, motivations, relationships, processes and costs in more detail.

- What approaches to integration work well and in what contexts? This will generate data linking putative causes to observed effects i.e. understanding causal mechanisms.
- Who benefits from integration and in what ways (what definitions are there of 'success')? This will identify how benefits are distributed and with what implications for equality.
- What resources are required to make integration succeed and how can these be efficiently used? This will identify the descriptive categories of costs, establishing their dimensions, estimating overall costs, and suggesting how generalisable these findings might be. The Living Document will help identify what types of costs become apparent at various stages of development of a project.
- How the development of integrated care is facilitated or impeded by other current policies, e.g. payment by results, practice-based commissioning etc.

From these analyses, we aim to identify what policies and practices are most suitable (i.e. fit for purpose and likely to deliver the intended outcome); most feasible (i.e. capable of being implemented given the existing architecture of delivery and accountability); and most acceptable (i.e. likely to generate the support of the people who use services, clinicians and other professionals, managers and the wider public).

There will be three key data collection methods: semi-structured interviews with professionals and patients/service users, documentary analysis, non-participant observation of meetings. The qualitative data collection in the Deep Dive sites will also be used to collect data for the economic analysis (see below).

Interviews with staff will concentrate on the experience of delivering care, interactions with other professional groups and organizations within the Integrated Care Pilot, and understanding of implications for the wider care system. Interviews with patients and users will focus on the patient/user journey and experience and its relationship to changes in the Integrated Care Pilots.

## Service utilisation

In analysing data on service utilisation, we will focus principally on hospital admissions as a key variable, as many of the sites have a focus on reducing such admissions.

Data will be taken from Hospital Episode Statistics (HES), both for outpatient referrals, accident and emergency attendances and inpatient stays. These will enable analyses of changes in a number of measures of hospital use including overall rates of emergency admissions, admissions for 'ambulatory sensitive'

conditions (see [Annex 2](#)), and length of stay. We derived the list of ambulatory sensitive conditions from AHRQ [14] and Purdy et al. [15].

Information will be available for the individuals enrolled in any intervention, and also for the whole populations of general practices which are participating in the Integrated Care Pilot. The data will be at person level but anonymised so that the research team cannot identify sensitive personal information or individual identities. The NHS Information Centre for Health and Social Care will act a trusted third party to handle any confidential information and create the anonymised linked fields for use by the research team.

One of the key challenges in undertaking analyses of changes in hospital use for complex interventions is that individuals may be selected for an intervention because they have a high use of health services. The problem is that any subsequent fall in utilisation in this group may simply be due to regression to the mean—that is people reverting to a normal level of use irrespective of the intervention. One way round this is to use an approach that allows us to standardise for differences in the risk of future admissions.

First, we will assess the impact of the intervention on individuals enrolled in the Integrated Care Pilots. Information on the prior patterns of diagnoses and hospital utilisation will be used to stratify cases according to the risk of admission. The actual level of utilisation before and after the agreed starting point in each pilot will be compared. In this way we will be able to track levels of hospital use for cohorts of people for 2–3 years before they became part of the pilot. We will then test for subsequent change and compare results by risk strata.

In addition, we will undertake a more sophisticated analysis to create a matched 'control group' constructed by identifying individuals within national data. These control cases will be matched on a number of variables including risk of admission (or other hospital use); major diseases recorded; history of hospital use; and characteristics of the area of residence, such as levels of deprivation. Matching will be conducted using propensity scoring techniques [16] and prognostic scoring techniques [17]. Trends in hospital use within the groups of selected control cases will then be used as a test of observed differences in those enrolled in the Integrated Care Pilots.

Second, we will quantify the effect of the interventions on wider groups of patients (e.g. practice populations) by matching utilization data to that from similar practice populations in national HES datasets. The population level analysis will assess whether the intervention might not only have an impact on individual patients but also upon the wider population.

Both of these approaches to analysis are required as there might be an impact of the interventions on individuals (e.g. a reduction in admissions) which could not be demonstrated in the wider population. This might be because resources were simply redistributed between groups at equal risk of admission, or because the numbers enrolled in the pilots were too small to show an effect on the wider population.

Sample size calculations suggest that few of the Integrated Care Pilot sites will enroll sufficient numbers for data from individual sites to be analysed. We therefore intend to pool data from sites which have similar aims and are providing broadly comparable interventions. It is not possible to say which sites will provide data that can be pooled, as all sites are still developing their interventions. However, it looks likely, for example, that several sites will be using a form of case management of high-risk patients with the aim of reducing hospital admission, and we will be able to pool data from such sites. Data will also be analysed on primary and social care utilisation (from patient questionnaires). However, these data are being collected primarily for the economic analysis, as none of the sites has reduction in primary care utilisation as their main goal.

Our analysis strategy is built around a generalized difference-of-differences regression approach at the person level. Regression models appropriate for each of the outcome measures (e.g. emergency admissions) will be developed. These may be Poisson models, negative binomial models, or gamma models as required by the form of the measure. Each individual will contribute one or more time periods to the dataset in both the pre- and post-intervention periods. Non-intervention controls will come from routinely collected national data. These models will use covariates including basic demographics and historical utilization to control for potential differences between the intervention and control cases. Person level random effects will also be included in the models to adjust standard errors for the repeated measures within person.

In addition to the traditional covariate adjustment in the difference-of-differences model we will use propensity score based methods. In a combined dataset of intervention cases and non-intervention controls a propensity score model will be fitted that uses available covariates to predict intervention vs. control status. The predicted treatment status probabilities can be used to match intervention and control cases. We may also use the propensity scores to produce analysis weights which can be combined with covariate adjustment to support 'doubly robust' estimation of intervention effects [18]. Doubly robust estimation combined with difference-of-differences modeling will provide intervention effect estimates that control for

both observed differences between intervention and control groups as well controlling for unobserved but fixed person characteristics.

The aim of identifying risk-matched controls and using propensity score analysis is to allow so far as possible for unmeasured patient and system effects and therefore to increase our ability to draw conclusions about likely cause and effect from what inevitably remains observational data.

## **Questionnaires for service users**

We are conducting two surveys to assess the experience of service users in 11 of the 16 pilots. The survey is being administered in autumn/winter 2009 and will be repeated on the same sample of service users in autumn 2010. The questionnaire was developed using the intended outcomes identified by pilot sites in their applications to join the scheme. This identified a number of domains which were common to most pilots and were therefore included in the questionnaire. These were:

- Communication with primary care doctors and nurses.
- Organisation and coordination of care.
- Care planning.
- Assessment of care from social services.
- Arrangements following discharge from hospital.
- Frequency of certain critical events (notes unavailable, test duplicated, wrong medication or wrong dose of medication prescribed, no follow-up arrangements after hospital discharge).

In addition, a question on service usage was included to contribute to the analysis of health service costs (see below). The questionnaire is available from the authors.

In selecting items to represent these domains, we drew questions where possible from existing validated instruments. In particular we drew a substantial number of questions from the English National GP patient survey which is currently sent annually to 5.5 million randomly sampled patients ([www.gp-patient.co.uk](http://www.gp-patient.co.uk)). By matching the socio-demographic and health questions to this survey also, we will be able to conduct a difference in differences analysis with individual control patients drawn from responders to the national survey.

For five pilot sites it was not appropriate to collect patient information using this questionnaire because of the nature of the intervention and/or the population group targeted by the intervention (for example, some pilots were focusing on end of life care). These sites are excluded from this part of the evaluation.

Questionnaires are being sent to up to 500 service users in each site. Where the site has identified more than 500 service users by autumn 2009, a random sample of 500 will be taken. Where fewer than 500 service users have been identified by March 2010, the questionnaire is sent to them all. Where a site is enrolling patients/service users sequentially during autumn 2009/spring 2010, all patients receive a questionnaire until 500 have been enrolled. Those individuals who receive a questionnaire in autumn 2009/spring 2010 will receive a second questionnaire in autumn 2010. For all service users, the site identifies the start data of any intervention, so that we can determine whether questionnaires returned have been completed before or after the start of the intervention.

### **Questionnaires for health and social care staff**

We are conducting two cross-sectional staff surveys within the 16 pilot sites, involving health and social care staff (including community nurses, GPs and social workers), in spring 2010, and repeated in spring 2011. The staff questionnaire has substantial sections for free text to allow staff to describe their experience of the pilot in more detail, and these sections will be transcribed for qualitative analysis. The questionnaire includes sections on:

- Job changes since the introduction of the Integrated Care Pilot.
- Perceived changes to the care that patients/service users receive.
- Changes in communication within and between employing organisations.
- Changes in team working.
- Communication with other health and social care staff.
- Job satisfaction, ability to deliver high quality care.

For the staff survey the targeted sample size is 50 staff from each site. The first are staffs who are closely involved in the development of the pilot (e.g. employed by the pilot). There are expected to be between 5 and 15 of these per site. The additional 35–45 will be sent to stratified random samples of practitioners whose work might be altered by the pilot—e.g. GPs, community nurses, social workers.

### **Economic analysis**

There are two approaches to the economic evaluation. The first is to estimate costs in order to provide decision-makers in the health and social care systems with a basis for understanding the categories and potential range of costs associated with the Integrated

Care Pilots. This will provide a sense of how much the approach might cost if it were implemented elsewhere. An important part of this will be through data collection in the Deep Dive sites where we will use the logic model, process maps, key informant interviews, and documentary evidence to produce estimates of the costs of providing integrated care. This will enable us to identify the categories of cost and the scale of resources required to deliver different models of integration. We aim to produce a clear understanding of the main categories of cost (staff by grade, equipment, building, travel etc.), the likely range of costs within each category, and subsequently estimate best, worst and most likely case scenarios.

We will also distinguish between ‘set-up’ costs and ‘running costs’, although in a fluid, adaptive and improving system it may be difficult to draw this distinction. For both of these we need to distinguish between the costs associated with participating in the DH programme (including, for example, participation in events, reporting, contributing to the national evaluation) and the costs solely required to deliver the integrated care programme. We also aim to gather data through time that can show how costs have altered in response to actual service delivery or in order to overcome changing circumstances etc. We propose only to look at costs internal to the health and social care system (including private sector partners) but we will be aware that costs could potentially be externalised onto service users and carers and we will ask service users and staff to comment on their sense of the types and magnitudes of these costs.

Across the Integrated Care Pilots where we are collecting quantitative data on hospital utilisation, data on hospital admissions and length of stay will be costed using standard NHS costs, and included in the controlled difference in differences analysis described in above.

### **Conclusion**

Selecting evaluation frameworks always involves a degree of compromise to meet conflicting demands within a finite budget. We have opted to balance the collection of data from across all the pilots with more detailed data from six Deep Dive sites. We have also opted to focus the evaluation on what the pilots themselves told us they were seeking to achieve. The benefit of this is that we will be in a position to provide an evaluation which is grounded firmly in what the pilots are seeking to do. This increases the chances that findings will be acceptable and used. However, it also means that some theoretical propositions will be under-explored and that attention may be directed

more towards intended outcomes than unintended outcomes. However, we are satisfied that this risk is managed by independent data collection (for example on service utilisation, service user surveys and staff surveys) and by the iterative way of working with those responsible for running each project.

In planning to assess the evidence produced by this evaluation, we have been influenced by the principles of realistic evaluation [19] in which the mechanism (the intervention) acts in context to produce the outcome. If there is a single lesson from previous evaluations of attempts to integrate or coordinate care, it is that the context in which an intervention is introduced is crucially important to its success or failure. So, in this evaluation, we have committed substantial resources to the qualitative evaluation, knowing that these analyses will be critical to interpreting the results of quantitative analyses. Our approach is to understand not only the 'dose, frequency and effect' but to identify the way pilots learn, respond and evolve and to take into account the expectations and motivations of staff and patients to understand how complex and evolving projects might have lessons for others seeking to do related things in different contexts. Policy makers, professionals, managers, carers and patients are all part of an emergent process. We do not expect to measure precisely all effects but we do expect to understand the likely scope of benefits and the scale of efforts required, to contribute to the analysis of health service interventions and so reduce decision-makers' uncertainties about integrated care.

This evaluation will produce a portfolio of evidence including interviews, surveys, cost estimations and service utilisation data aimed at strengthening the

evidence base for integrated care, and in particular identifying the context in which interventions are likely to be effective. These data will support a series of evaluation judgements but it is important to recognise that they cannot be arrived at by simple aggregation of data [20]. Rather, the process locates the new data within the existing body of research and forms judgements about what is added and how compelling this additional evidence is, thus reducing uncertainties about the role of integrated care in improving the efficient and effective delivery of healthcare.

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## Annex 1

### Summary of focus of individual Integrated Care Pilot sites

Pilot	Main focus (some sites have other objectives also)
Bournemouth and Poole Cambridge Church View Medical Practice Cumbria Durham Dales	Structured support for people with dementia in the community Support for end of life care in the community; reduction in unnecessary admissions to hospital Improved support for people with long-term conditions at risk of admission to hospital Improved support for people with long-term conditions at risk of admission to hospital Providing integrated primary and secondary care service for acutely ill people, improved community services, moving specialist services into the community, identification of people at risk of fuel poverty
Northamptonshire Integrated Care Partnership (NENE) Newquay Norfolk North Tyneside Northumbria North Cornwall Principia Partners in Health	Improved support for people with long-term conditions at risk of admission to hospital Structured support for people with dementia in the community Improved support for people with long-term conditions at risk of admission to hospital Screening of patients at risk of falls: assessment by multi-disciplinary team Improved support for people with COPD with a history of admissions to hospital Mental health care Improved support for people with long-term conditions at risk of admission to hospital. Second stream has specific focus on people with COPD
Tameside and Glossop	Structured programme of identification and management of people at risk of cardio-vascular disease (CVD). Second stream of work for people with established CVD
Torbay	Improved discharge planning. Support for GPs from community geriatrician. Improved support for people in the community with dementia, COPD and congestive cardiac failure. Falls prevention programme
Tower Hamlets Wakefield Integrated Substance Misuse Service	Structured care for people with diabetes Implementation of ‘dashboard’ routinely feeding back performance data for services providing care for people with substance misuse



## Annex 2

List of ‘ambulatory care sensitive conditions’ (ACSCs) and associated ICD-10 codes (derived from AHRQ [14] and Purdy et al. [15]). These are admissions for diagnoses that in principle may be preventable by good quality primary care

Ambulatory care sensitive condition	ICD-10 code	Definition
Alcohol-related disease	F10	Mental and behavioural disorders due to use of alcohol
Angina	I20	Angina pectoris
Angina	I240	Coronary thrombosis not resulting in myocardial infarction
Angina	I248	Other forms of acute ischemic heart disease
Angina	I249	Acute ischemic heart disease, unspecified
Angina	I25	Chronic ischemic heart disease
Angina	R072	Precordial pain
Asthma	J45	Asthma
Asthma	J46	Status asthmaticus
Atrial fibrillation and flutter	I471	Supra-ventricular tachycardia
Atrial fibrillation and flutter	I479	Paroxysmal tachycardia, unspecified
Atrial fibrillation and flutter	I495	Sick sinus syndrome
Atrial fibrillation and flutter	I498	Other specified cardiac arrhythmias
Atrial fibrillation and flutter	I499	Cardiac arrhythmia, unspecified
Atrial fibrillation and flutter	R000	Tachycardia, unspecified
Atrial fibrillation and flutter	R002	Palpitations
Atrial fibrillation and flutter	R008	Other and unspecified abnormalities of heart beat
Cellulitis	I891	Lymphangitis
Cellulitis	L010	Impetigo [any organism] [any site]
Cellulitis	L011	Impetiginization of other dermatoses
Cellulitis	L020	Cutaneous abscess, furuncle, and carbuncle of face
Cellulitis	L021	Cutaneous abscess, furuncle, and carbuncle of neck
Cellulitis	L022	Cutaneous abscess, furuncle, and carbuncle of trunk
Cellulitis	L023	Cutaneous abscess, furuncle, and carbuncle of buttock
Cellulitis	L024	Cutaneous abscess, furuncle, and carbuncle of limb
Cellulitis	L028	Cutaneous abscess, furuncle, and carbuncle of other sites
Cellulitis	L029	Cutaneous abscess, furuncle, and carbuncle, unspecified
Cellulitis	L03	Cellulitis
Cellulitis	L04	Acute lymphadenitis
Cellulitis	L080	Pyoderma
Cellulitis	L088	Other specified local infections of skin and subcutaneous tissue
Cellulitis	L089	Local infection of skin and subcutaneous tissue, unspecified
Cellulitis	L88	Pyoderma gangrenosum
Cellulitis	L980	Pyogenic granuloma
Congestive heart failure	I110	Hypertensive heart disease with (congestive) heart failure
Congestive heart failure	I130	Hypertensive heart and renal disease with (congestive) heart failure
Congestive heart failure	I132	Hypertensive heart and renal disease with both (congestive) heart failure and renal failure
Congestive heart failure	I255	Ischemic cardiomyopathy
Congestive heart failure	I50	Heart failure
Congestive heart failure	J81	Pulmonary edema
Constipation	K590	Constipation
Convulsions and Epilepsy	G253	Myoclonus
Convulsions and Epilepsy	G40	Epilepsy
Convulsions and Epilepsy	G41	Status epilepticus
Convulsions and Epilepsy	R56	Convulsions, not elsewhere classified
COPD	J40	Bronchitis, not specified as acute or chronic
COPD	J41	Simple and mucopurulent chronic bronchitis
COPD	J42	Unspecified chronic bronchitis
COPD	J43	Emphysema
COPD	J44	Other chronic obstructive pulmonary disease
COPD	J47	Bronchiectasis
COPD	J20	Acute bronchitis
Dehydration and gastroenteritis	A020	Salmonella gastroenteritis
Dehydration and gastroenteritis	A04	Other bacterial intestinal infections
Dehydration and gastroenteritis	A059	Bacterial food-borne intoxication, unspecified
Dehydration and gastroenteritis	A072	Cryptosporidiosis
Dehydration and gastroenteritis	A080	Rotaviral enteritis

Annex 2 (Continued)

Ambulatory care sensitive condition	ICD-10 code	Definition
Dehydration and gastroenteritis	A081	Acute gastroenteropathy due to Norwalk agent
Dehydration and gastroenteritis	A082	Adenoviral enteritis
Dehydration and gastroenteritis	A083	Other viral enteritis
Dehydration and gastroenteritis	A084	Viral intestinal infection, unspecified
Dehydration and gastroenteritis	A085	Other specified intestinal infections
Dehydration and gastroenteritis	A09	Diarrhea and gastroenteritis of presumed infectious origin
Dehydration and gastroenteritis	E86	Volume depletion
Dehydration and gastroenteritis	K520	Gastroenteritis and colitis due to radiation
Dehydration and gastroenteritis	K521	Toxic gastroenteritis and colitis
Dehydration and gastroenteritis	K522	Allergic and dietetic gastroenteritis and colitis
Dehydration and gastroenteritis	K528	Other specified non-infective gastroenteritis and colitis
Dehydration and gastroenteritis	K529	Non-infective gastroenteritis and colitis, unspecified
Dementia	F00	Dementia in Alzheimer's disease
Dementia	F01	Vascular dementia
Dementia	F02	Dementia in other diseases classified elsewhere
Dementia	F03	Unclassified dementia
Dementia	R54	Senility
Dental conditions	A690	Necrotizing ulcerative stomatitis
Dental conditions	K02	Dental caries
Dental conditions	K03	Other diseases of hard tissues of teeth
Dental conditions	K04	Diseases of pulp and periapical tissues
Dental conditions	K05	Gingivitis and periodontal diseases
Dental conditions	K06	Other disorders of gingiva and edentulous alveolar ridge
Dental conditions	K08	Other disorders of teeth and supporting structures
Dental conditions	K098	Other cysts of oral region, not elsewhere classified
Dental conditions	K099	Cyst of oral region, unspecified
Dental conditions	K12	Stomatitis and related lesions
Dental conditions	K13	Other diseases of lip and oral mucosa
Diabetes complications	E100	Insulin-dependent diabetes mellitus with coma
Diabetes complications	E101	Insulin-dependent diabetes mellitus with ketoacidosis
Diabetes complications	E102	Insulin-dependent diabetes mellitus with renal complications
Diabetes complications	E103	Insulin-dependent diabetes mellitus with ophthalmic comps
Diabetes complications	E104	Insulin-dependent diabetes mellitus with neurological comps
Diabetes complications	E105	Insulin-dependent diabetes mellitus with periph circ comps
Diabetes complications	E106	Insulin-dependent diabetes mellitus with other spec comps
Diabetes complications	E107	Insulin-dependent diabetes mellitus with multiple comps
Diabetes complications	E108	Insulin-dependent diabetes mellitus with unspec comps
Diabetes complications	E110	Non-insulin-dependent diabetes mellitus with coma
Diabetes complications	E111	Non-insulin-dependent diabetes mellitus with ketoacidosis
Diabetes complications	E112	Non-insulin-dependent diabetes mellitus with renal comps
Diabetes complications	E113	Non-insulin-dependent diabetes mellitus with ophthalm comps
Diabetes complications	E114	Non-insulin-dependent diabetes mellitus with neuro comps
Diabetes complications	E115	Non-insulin-dependent diabetes mellitus with periph circ comp
Diabetes complications	E116	Non-insulin-dependent diabetes mellitus with other spec comp
Diabetes complications	E117	Non-insulin-dependent diabetes mellitus with multiple comps
Diabetes complications	E118	Non-insulin-dependent diabetes mellitus with unspec comps
Diabetes complications	E120	Malnutrition-related diabetes mellitus with coma
Diabetes complications	E121	Malnutrition-related diabetes mellitus with ketoacidosis
Diabetes complications	E122	Malnutrition-related diabetes mellitus with renal comps
Diabetes complications	E128	Malnutrition-related diabetes mellitus with unspec comps
Diabetes complications	E130	Other specified diabetes mellitus with coma
Diabetes complications	E131	Other specified diabetes mellitus with ketoacidosis
Diabetes complications	E132	Other specified diabetes mellitus with renal complications
Diabetes complications	E133	Other specified diabetes mellitus with ophthalmic comps
Diabetes complications	E134	Other specified diabetes mellitus with neurological comps
Diabetes complications	E135	Other specified diabetes mellitus with periph circ comps
Diabetes complications	E136	Other specified diabetes mellitus with other spec comps
Diabetes complications	E137	Other specified diabetes mellitus with multiple comps
Diabetes complications	E138	Other specified diabetes mellitus with unspecified comps
Diabetes complications	E140	Unspecified diabetes mellitus with coma
Diabetes complications	E141	Unspecified diabetes mellitus with ketoacidosis
Diabetes complications	E142	Unspecified diabetes mellitus with renal complications
Diabetes complications	E143	Unspecified diabetes mellitus with ophthalmic complications

Annex 2 (Continued)

Ambulatory care sensitive condition	ICD-10 code	Definition
Diabetes complications	E144	Unspecified diabetes mellitus with neurological comps
Diabetes complications	E145	Unspecified diabetes mellitus with periph circulatory comps
Diabetes complications	E146	Unspecified diabetes mellitus with other specified comps
Diabetes complications	E147	Unspecified diabetes mellitus with multiple complications
Diabetes complications	E148	Unspecified diabetes mellitus with unspecified complications
Dyspepsia and other stomach function disorders	K21	Gastroesophageal reflux disease
Dyspepsia and other stomach function disorders	K30	Dyspepsia
Ear, nose and throat infections	H66	Suppurative and unspecified otitis media
Ear, nose and throat infections	H67	Otitis media in diseases classified elsewhere
Ear, nose and throat infections	J02	Acute pharyngitis
Ear, nose and throat infections	J03	Acute tonsillitis
Ear, nose and throat infections	J040	Acute laryngitis
Ear, nose and throat infections	J06	Acute upper respiratory infections of multiple and unspecified sites
Ear, nose and throat infections	J312	Chronic pharyngitis
Fractured proximal femur	S720	Fracture of neck of femur
Fractured proximal femur	S721	Pertrochanteric fracture
Fractured proximal femur	S722	Subtrochanteric fracture
Gangrene	R02	Gangrene, not elsewhere classified
Hypertension	I10	Essential (primary) hypertension
Hypertension	I119	Hypertensive heart disease without (congestive) heart failure
Hypertension	I129	Hypertensive renal disease without renal failure
Hypertension	I139	Hypertensive heart and renal disease, unspecified
Hypokalaemia	E876	Hypokalemia
Influenza and pneumonia	A481	Legionnaires' disease
Influenza and pneumonia	A70	Chlamydia psittaci infection
Influenza and pneumonia	J10	Influenza due to identified influenza virus
Influenza and pneumonia	J11	Influenza, virus not identified
Influenza and pneumonia	J120	Adenoviral pneumonia
Influenza and pneumonia	J121	Respiratory syncytial virus pneumonia
Influenza and pneumonia	J122	Parainfluenza virus pneumonia
Influenza and pneumonia	J128	Other viral pneumonia
Influenza and pneumonia	J129	Viral pneumonia, unspecified
Influenza and pneumonia	J13	Pneumonia due to Streptococcus pneumoniae
Influenza and pneumonia	J14	Pneumonia due to Hemophilus influenzae
Influenza and pneumonia	J153	Pneumonia due to streptococcus, group B
Influenza and pneumonia	J154	Pneumonia due to other streptococci
Influenza and pneumonia	J157	Pneumonia due to Mycoplasma pneumoniae
Influenza and pneumonia	J159	Bacterial pneumonia, unspecified
Influenza and pneumonia	J160	Chlamydial pneumonia
Influenza and pneumonia	J168	Pneumonia due to other specified infectious organisms
Influenza and pneumonia	J18	Pneumonia, organism unspecified
Iron-deficiency anaemia	D460	Refractory anemia without sideroblasts, so stated
Iron-deficiency anaemia	D461	Refractory anemia with sideroblasts
Iron-deficiency anaemia	D463	Refractory anemia with excess of blasts with transformation
Iron-deficiency anaemia	D464	Refractory anemia, unspecified
Iron-deficiency anaemia	D501	Sideropenic dysphagia
Iron-deficiency anaemia	D508	Other iron deficiency anemias
Iron-deficiency anaemia	D509	Iron deficiency anemia, unspecified
Iron-deficiency anaemia	D510	Vitamin B12 deficiency anemia due to intrinsic factor deficiency
Iron-deficiency anaemia	D511	Vitamin B12 deficiency anemia due to selective vitamin B12 malabsorption with proteinuria
Iron-deficiency anaemia	D512	Transcobalamin II deficiency
Iron-deficiency anaemia	D513	Other dietary vitamin B12 deficiency anemia
Iron-deficiency anaemia	D518	Other vitamin B12 deficiency anemias
Iron-deficiency anaemia	D520	Dietary folate deficiency anemia
Iron-deficiency anaemia	D521	Drug-induced folate deficiency anemia
Iron-deficiency anaemia	D528	Other folate deficiency anemias
Iron-deficiency anaemia	D529	Folate deficiency anemia, unspecified
Iron-deficiency anaemia	D531	Other megaloblastic anemias, not elsewhere classified
Iron-deficiency anaemia	D571	Sickle-cell anemia without crisis
Iron-deficiency anaemia	D580	Hereditary spherocytosis
Iron-deficiency anaemia	D581	Hereditary elliptocytosis

Annex 2 (Continued)

Ambulatory care sensitive condition	ICD-10 code	Definition
Iron-deficiency anaemia	D590	Drug-induced autoimmune hemolytic anemia
Iron-deficiency anaemia	D591	Other autoimmune hemolytic anemias
Iron-deficiency anaemia	D592	Drug-induced non-autoimmune hemolytic anemia
Iron-deficiency anaemia	D599	Acquired hemolytic anemia, unspecified
Iron-deficiency anaemia	D601	Transient acquired pure red cell aplasia
Iron-deficiency anaemia	D608	Other acquired pure red cell aplasias
Iron-deficiency anaemia	D609	Acquired pure red cell aplasia, unspecified
Iron-deficiency anaemia	D610	Constitutional aplastic anemia
Iron-deficiency anaemia	D611	Drug-induced aplastic anemia
Iron-deficiency anaemia	D640	Hereditary sideroblastic anemia
Iron-deficiency anaemia	D641	Secondary sideroblastic anemia due to disease
Iron-deficiency anaemia	D642	Secondary sideroblastic anemia due to drugs and toxins
Iron-deficiency anaemia	D643	Other sideroblastic anemias
Iron-deficiency anaemia	D644	Congenital dyserythropoietic anemia
Iron-deficiency anaemia	D648	Other specified anemias
Migraine/acute headache	G43	Migraine
Migraine/acute headache	G440	Cluster headache syndrome
Migraine/acute headache	G441	Vascular headache, not elsewhere classified
Migraine/acute headache	G443	Chronic posttraumatic headache
Migraine/acute headache	G444	Drug-induced headache, not elsewhere classified
Migraine/acute headache	G448	Other specified headache syndromes
Migraine/acute headache	R51	Headache
Nutritional deficiency	E40	Kwashiorkor
Nutritional deficiency	E41	Nutritional marasmus
Nutritional deficiency	E42	Marasmic kwashiorkor
Nutritional deficiency	E43	Unspecified severe protein-energy malnutrition
Nutritional deficiency	E550	Rickets, active
Nutritional deficiency	E643	Sequelae of rickets
Other vaccine-preventable diseases	A35	Other tetanus
Other vaccine-preventable diseases	A36	Diphtheria
Other vaccine-preventable diseases	A37	Whooping cough
Other vaccine-preventable diseases	A80	Acute poliomyelitis
Other vaccine-preventable diseases	B05	Measles
Other vaccine-preventable diseases	B06	Rubella [German measles]
Other vaccine-preventable diseases	B161	Acute hepatitis B with delta-agent (coinfection) without hepatic coma
Other vaccine-preventable diseases	B169	Acute hepatitis B without delta-agent and without hepatic coma
Other vaccine-preventable diseases	B180	Chronic viral hepatitis B with delta-agent
Other vaccine-preventable diseases	B181	Chronic viral hepatitis B without delta-agent
Other vaccine-preventable diseases	B26	Mumps
Other vaccine-preventable diseases	G000	Hemophilus meningitis
Other vaccine-preventable diseases	M014	Rubella arthritis
Pelvic inflammatory disease	N70	Salpingitis and oophoritis
Pelvic inflammatory disease	N73	Other female pelvic inflammatory diseases
Pelvic inflammatory disease	N74	Female pelvic inflammatory disorders in diseases classified elsewhere
Perforated appendix	K350	Acute appendicitis with generalized peritonitis
Perforated appendix	K351	Acute appendicitis with peritoneal abscess
Perforated/bleeding ulcer	K20	Esophagitis
Perforated/bleeding ulcer	K210	Gastroesophageal reflux disease with esophagitis
Perforated/bleeding ulcer	K219	Gastroesophageal reflux disease without esophagitis
Perforated/bleeding ulcer	K221	Ulcer of esophagus
Perforated/bleeding ulcer	K226	Gastroesophageal laceration-hemorrhage syndrome
Perforated/bleeding ulcer	K250	Acute with hemorrhage
Perforated/bleeding ulcer	K251	Acute with perforation
Perforated/bleeding ulcer	K252	Acute with both hemorrhage and perforation
Perforated/bleeding ulcer	K254	Chronic or unspecified with hemorrhage
Perforated/bleeding ulcer	K255	Chronic or unspecified with perforation
Perforated/bleeding ulcer	K256	Chronic or unspecified with both hemorrhage and perforation
Perforated/bleeding ulcer	K260	Acute with hemorrhage
Perforated/bleeding ulcer	K261	Acute with perforation
Perforated/bleeding ulcer	K262	Acute with both hemorrhage and perforation
Perforated/bleeding ulcer	K264	Chronic or unspecified with hemorrhage
Perforated/bleeding ulcer	K265	Chronic or unspecified with perforation
Perforated/bleeding ulcer	K266	Chronic or unspecified with both hemorrhage and perforation
Perforated/bleeding ulcer	K270	Acute with hemorrhage

Ambulatory care sensitive condition	ICD-10 code	Definition
Perforated/bleeding ulcer	K271	Acute with perforation
Perforated/bleeding ulcer	K272	Acute with both hemorrhage and perforation
Perforated/bleeding ulcer	K274	Chronic or unspecified with hemorrhage
Perforated/bleeding ulcer	K275	Chronic or unspecified with perforation
Perforated/bleeding ulcer	K276	Chronic or unspecified with both hemorrhage and perforation
Perforated/bleeding ulcer	K280	Acute with hemorrhage
Perforated/bleeding ulcer	K281	Acute with perforation
Perforated/bleeding ulcer	K282	Acute with both hemorrhage and perforation
Perforated/bleeding ulcer	K284	Chronic or unspecified with hemorrhage
Perforated/bleeding ulcer	K285	Chronic or unspecified with perforation
Perforated/bleeding ulcer	K286	Chronic or unspecified with both hemorrhage and perforation
Perforated/bleeding ulcer	K920	Hematemesis
Perforated/bleeding ulcer	K921	Melena
Perforated/bleeding ulcer	K922	Gastrointestinal hemorrhage, unspecified
Peripheral vascular disease	I73	Other peripheral vascular diseases
Tuberculosis	A15	Respiratory tuberculosis, bacteriologically and histologically confirmed
Tuberculosis	A16	Respiratory tuberculosis, not confirmed bacteriologically or histologically
Tuberculosis	A17	Tuberculosis of nervous system
Tuberculosis	A18	Tuberculosis of other organs
Tuberculosis	A19	Miliary tuberculosis
Urinary infection	N10	Acute tubulo-interstitial nephritis
Urinary infection	N11	Chronic tubulo-interstitial nephritis
Urinary infection	N12	Tubulo-interstitial nephritis, not specified as acute or chronic
Urinary infection	N136	Pyonephrosis
Urinary infection	N151	Renal and perinephric abscess
Urinary infection	N159	Renal tubulo-interstitial disease, unspecified
Urinary infection	N30	Cystitis
Urinary infection	N390	Urinary tract infection, site not specified

The above table contains all conditions and codes listed in Purdy et al. (2009) tables 3 and 4 except the following:

- ‘Failure to thrive’ and ‘low birth weight’ are excluded as they are purely paediatric conditions.
- ‘Angina’ codes R073, R074, Z034, Z035 are generic chest pain codes which are unlikely to indicate ischaemic heart disease.
- E139 and E149 not included in ‘diabetes complications’ as both codes specify ‘...without complications’.
- Mental health admissions (with the exception of ‘dementia’) are excluded as they are not relevant to the evaluation sites that are collecting admission data. The excluded conditions are ‘deliberate self-harm’, ‘neuroses’ and ‘schizophrenia’. ‘Dementia’ is relevant to two pilot sites, and so is retained.
- ‘Stroke’ is excluded because of the substantial change seen in the admission criteria for stroke over the study period.
- O15 is excluded from ‘convulsions and epilepsy’ as the condition—eclampsia (a specific disorder of pregnancy)—is unrelated, except for the common symptom of fits.
- There are also some additional codes included:
- I129, I139, I132 and A082 are introduced by the process of converting the AHRQ codes from ICD-9CM to ICD-10.
- All cystitis codes (N30) are included in ‘urinary tract infection’, supplementing N300, N308 and N309.

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## **Appendix B: Details of quantitative methods**

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# 1. Staff questionnaires

Survey data were collected from health and social care staff in all 16 pilots using a questionnaire administered in Summer 2010 (early in the intervention) and Spring 2011 (towards the end of the intervention). The questionnaire consisted of 24 questions on: personal experience of the piloted activity (e.g. changes to role, activities and work practices); views of health and social care quality received by patients/service users; communication within and between participating organisations as well as with other health and social care staff; experiences of team working, job satisfaction and ability to deliver high quality care; as well as information on individual background and demographic characteristics

## 1.1 Sampling for staff questionnaire

The targeted sample was 50 members of staff per site, although some sites identified a slightly smaller number. Each pilot site had a designated project manager who assisted in identifying the sample of staff participating in their pilot, providing a list of two groups:

- (A) members of staff formally associated with the pilot (in administrative or direct contact roles with service users), including all new appointees to the project and staff formally seconded full time or part time to the pilot; and
- (B) members of staff not formally associated with the pilot but whose work might be influenced in some way by pilot activity, such as GPs, community nurses, or social workers.

Group A was expected to include between 5 and 15 staff members per site, while group B in some cases exceeded the targeted number of 50. In such cases we randomly sampled the relevant number of staff from the second group so as to make a total of 50 for distribution.

We followed the same staff cohort for the repeated distribution of the questionnaire in spring 2011. Any new staff who had joined group A were included in the second round though in practice there were few of these. We also noted any staff that changed between groups A and B between survey rounds, although again such changes were rare. Table A1 below provides the total numbers of completed questionnaires at different stages of staff survey and the response rates. The numbers of questionnaires returned from the sixteen sites were fairly similar, and analyses conducted with and without allowing for clustering of responses within sites suggested that the findings (e.g. particularly positive or negative ones) were not dominated by the results from any one site.

**Table A1. Summary of survey process and response rates to staff questionnaires**

Number of questionnaires sent in round 1	776
Number of questionnaires returned in round 1	510 (66%)
Number of questionnaires returned in round 2	354 (46%)
Number of questionnaires returned in both rounds	350 (45%)

## 1.2 Analysis of staff questionnaire data

We used SPSS v19 to analyse the data from the 'before' time point (Summer 2010) and 'after' time point (Spring 2011). We transformed the data into categorical variables for analysis to overcome the problem of low variation in some variables and dichotomised the response variables by coding the top response category (e.g. excellent or very good) or two top response categories as 1 and all other valid response items as 0.

Using STATA v12 we performed McNemar test to test for differences between paired proportions of staff members responding in a particular way in 'before' and 'after' rounds of the staff survey. As the number of staff responding from each site was small, we analysed the



data aggregated from all sites. We adjusted the standard errors of McNemar tests for clustering of patients within sites, though this made no difference to the conclusions.

## 2. Patient questionnaires

We created a survey instrument to assess the experience of patients/service users in 11 of the 16 pilots. For five pilot sites it was not appropriate to collect patient information using this questionnaire because of the nature of the intervention and/or the population group targeted by the intervention (e.g. some pilots were focusing on end of life care). These sites are excluded from this part of the evaluation.

Questionnaires were administered at two time points with one year in between: autumn 2009 and autumn 2010 (follow-up was repeated on the same sample of patients/service users). The questionnaire was developed using planned outcomes identified by pilot sites in their applications to join the scheme; a number of domains common to most pilots were included. The survey comprised 26 questions covering communication with primary care doctors and nurses; organisation and coordination of care; care planning; assessment of care from social services; arrangements following discharge from hospital; frequency of certain critical events (e.g. notes unavailable, test duplicated, wrong medication, wrong dose of medication, no follow-up arrangements after hospital discharge); and, type and frequency of recent health or social care provider.

Whenever possible we drew on existing validated instruments to select items to represent the identified domains. In particular, we took several questions from the English National GP Patient Survey, which is currently sent annually to 5.5 million randomly sampled patients ([www.gp-patient.co.uk](http://www.gp-patient.co.uk)) in order that we could control for secular changes in the response to these questions. Cognitive interviews with volunteer patients in Cambridge tested the questionnaire for construct validity before distribution.

### 2.1 Sampling for patient questionnaire

Sites identified a sample of up to 500 patients to ensure sufficiently large numbers to detect a large intervention effect. We planned to take a random sample in sites expecting more than 500, but the identified populations did not exceed this number in practice, and several small pilots identified 200 or fewer patients for inclusion. In these cases we sampled all patients who had received an intervention. For sites identifying patients/service based on their risk profile (rather than presence on a disease register), respondents were sampled sequentially until the target of 500 was reached or until 31 March 2010 (a priori endpoint for enrolment). Table A2 below provides the total numbers of completed questionnaires at different stages of survey and rates of response.

**Table A2. A summary of survey process and response rates to patient questionnaires**

Number of questionnaires sent in round 1	2995 (100%)
Number of questionnaires returned in round 1	1650 (55%)
Number of questionnaires returned in round 2	1231 (41%)
Number of questionnaires returned in both rounds	1197 (40%)
Number who returned both rounds of the questionnaire <u>AND</u> had received an intervention at least two months before the second survey	700 (23%)

We excluded patients who completed questionnaires but who had not received an intervention by the time of the second survey – i.e. they had been identified by sites as eligible patients for the first round but had not actually received an intervention by the time of the second survey. This led to a significant reduction in the number of responses available for analysis (see table). There were substantial differences in the numbers of responses from service users available for analysis from individual sites.

Unlike the staff questionnaire, patients/service users were asked in general about their care and not about the impact of the pilot as they may have been unaware of the existence of the

pilot. Therefore for patient/service user questionnaire results we report solely the responses of 700 service users who responded to both rounds of the survey and were documented by the sites as having received an intervention. For all patients/service users, the site identified the start date of its intervention.

Power calculations showed that detection of a small effect would require a sample of 2,500 patients and that small effects would therefore only be detected if we pooled data across sites. We therefore pre-specified sites with similar interventions where we planned to pool data. One subgroup analysis consisted of sites identifying patients at high risk of admission who received some sort of intensive case management (Church View, Cumbria, Nene, Norfolk, Northumbria and Principia). A second subgroup pooled these sites together with sites aimed at people with dementia who also received intensive case management (Bournemouth and Poole, and Newquay).

## **2.2 Analysis of patient questionnaire data**

We used SPSS v19 to analyse the data from the 'before' time point (Autumn 2009) and 'after' time point (Autumn 2010). We transformed the data into categorical variables for analysis to overcome the problem of low variation in some variables and dichotomised the response variables by coding the top response category (e.g. excellent or very good) as 1 and all other valid response items as 0. Using STATA v12 we performed McNemar tests to test for differences between paired proportions of patients responding in a particular way in 'before' and 'after' rounds of the patient survey. These analyses were performed on the whole dataset as well as subsets of sites that were pooled (as above). We also carried out separate analyses on subsets of patients whose self-reported health did not change between two rounds of survey and patients whose health changed (typically deteriorated) over the same period. We adjusted the standard errors of McNemar tests for clustering of patients within sites, though this made little difference to the conclusions.

There were relatively more patients from one site (Cumbria) than from other sites in the case management group: we therefore conducted analyses for case management sites with and without patients from Cumbria. These analyses are not included in this report, but they did not alter the overall conclusions. As part of sensitivity analyses, we also coded the top two response categories (e.g. very good and good) as 1 and then the rest as 0, but found the results were not in general sensitive to the method of coding.

A number of questions in the survey were taken from the national GP Patient Survey in order that we could compare changes in the Integrated Care Pilots to changes occurring more generally. These analyses were carried out for people over 65 completing the GP Patient Survey in 2008/09 and 2009/10, the most recent available datasets available to us. Mixed effect logistic regression was used to find the effect of a one-year change adjusting for the age, gender, ethnicity, self-rated health and deprivation of responders including a random effect for practice.

## 3. Secondary care utilisation

### 3.1 Individual patient level analysis

The following sections describe in more detail the approach used for data linkage, formation of control groups, and the difference-in-difference approach to the analysis of secondary care data.

#### Data linkage

We linked participants at the person level to data on inpatient, outpatient, and accident and emergency activity sourced from the Hospital Episode Statistics (HES), a national data warehouse for England.<sup>1</sup> A HES and Office of National Statistics (ONS)-linked mortality file provided data on all deaths occurring in and out of hospital for those patients tracked through HES, although such data were only available for the pre-intervention period. The data linkage was conducted by the NHS Information Centre for Health and Social Care, which acted as a trusted third party and was the only organisation involved with the ICP evaluation to have access to both patient identifiers and data on secondary care activity. The National Information Governance Board confirmed that individual patient consent was not required for the data linkage to take place, and the approach was also scrutinised by the Cambridgeshire ethics committee.

Integrated care pilot sites were asked to maintain a data management spreadsheet containing data for every person receiving one of their interventions, including the patient's NHS number, date of birth, gender, post code, the date that the patient started to receive an integrated care pilot intervention, and the code of the GP practice with which they are registered. The spreadsheets were encrypted and transferred to the NHS Information Centre for data linkage. Two HES data linkage algorithms were then applied. The first pass of the algorithm required exact matches on NHS number and gender and a partial match on date of birth. Patients who were not linked following the first pass were then subject to a second pass that required exact matches on gender, date of birth and post code. After the data linkage had been conducted, the NHS Information Centre provided the Nuffield Trust with the HES IDs required to select the relevant records of hospital data from the HES data sets, together with information regarding the year of birth, gender, geographical area, intervention start date and practice code. No identifiable information or NHS numbers were transferred to the research team at any point in the data linkage process.

Sites maintained their data management spreadsheets throughout the pilot period, and the linkage was conducted three times at six monthly intervals on cumulative lists, including patient recruited to date. This enabled feedback to be provided to sites about the quality of the data recorded and maximised the proportions of participants that could be linked to HES.

#### Formation of matched control groups

Although there are several methods of selecting controls, the principle is always to select, from a wider population of potential controls, a subgroup of matched controls that is sufficiently similar to the intervention group with respect to baseline variables observed for all individuals. The selection of variables to incorporate in this process has been the subject of much debate. One case study and two sets of simulations show that including a variable that is related to recruitment into the intervention, but not to the outcome under study, does not improve bias in the estimated intervention effect, but can worsen the precision of the estimates<sup>2 3</sup>. As a result we aimed to ensure that intervention and matched control patients were similar in terms of a set of variables that are known to predict future emergency hospital admissions.<sup>4</sup> This included age, gender, categories of prior hospital utilisation defined over a variety of time periods, number of outpatient specialties, the total number of chronic health conditions, area-level deprivation score (Index of Multiple Deprivation 2010<sup>5</sup>), and 16 markers of specific health conditions (anaemia, angina and ischemic heart disease, asthma, atrial fibrillation and flutter, cancer, cerebrovascular disease, congestive heart failure, COPD, diabetes, history of fractures, history of other falls, history of injury, hypertension, dementia, other mental health conditions, and renal failure). Health conditions were included regardless

of whether they were recorded as the primary, secondary or other diagnosis, but we conducted further checks that intervention and matched control patients were similar in terms of recorded primary diagnoses.

Note that a fundamental limitation of the observational techniques being applied is that participants and matched controls may differ systematically according to some other, unobserved variable. This is known as “residual confounding” and can only be avoided by a sufficiently large randomised trial. However the variables used for the matching include some strong predictors of future hospital use.

Of the methods used to select matched controls, propensity score methods are perhaps the most established. These collapse baseline variables to a single scalar quantity known as the propensity score, which is the estimated probability of an individual receiving the intervention conditional on observed baseline variables.<sup>6</sup> A control is then selected on the basis that it has a similar propensity score to the individual receiving the intervention. More recently, prognostic score methods have been developed using a different scalar quantity, which is the estimated probability of an individual receiving the outcome (here, an emergency hospital admission) in the absence of the intervention conditional on observed baseline variables.<sup>7</sup> We chose the prognostic approach because the mechanism by which individuals had been selected for the interventions was known to have varied over time and between individual districts. A propensity score would have therefore been difficult to estimate in practice. In addition, the prognostic approach weights variables by how predictive they are of future hospital admissions. Since we were most concerned to balance variables that are strongly predictive of future hospital admissions, the prognostic approach helped us prioritise variables in the matching.

The formation of controls was limited to patients who had been linked to HES and began to receive an intervention before 30 September 2010. This cut-off point was chosen to ensure that at least six months of follow-up data were available within the timelines allowed for the evaluation. Importantly, controls were selected before follow-up data was available to the research team, to ensure no bias on behalf of the team.

In theory, controls could be chosen from within the integrated care pilot sites, from within similar areas, or nationally. Selecting controls from within the pilot areas ensures consistency of contextual factors relating to the configuration of services or characteristics of areas. However, it poses a number of risks, including the limited availability of controls and the possibility for the hospital utilisation of controls to be influenced by other aspects of the pilots. Such an approach may also increase the possibility for control and intervention patients to differ in terms of characteristics that are not recorded in operational data sets, if patients with these characteristics were strongly associated with recruitment into the interventions. Instead, we chose to select controls from outside of the pilot sites, and specifically from a pool of individuals registered in England but not registered at one of the general practices supplying patients for the pilot interventions. This resulted in a large number of individuals, and a random subset of 1-2 million individuals was selected, stratified by age and area-level deprivation score to match the characteristics of pilot participants. This was the pool from which matched controls was selected.

Patients were recruited into the interventions over a period of time stretching from February 2009 to the cut-off point of September 2010. We wanted to ensure our predictive risk scores reflected all hospital activity occurring before the interventions began, and further that they reflected the same period of time for controls as intervention patients. We therefore developed an algorithm that operated on a monthly basis and summarised individual histories over a range of periods. For example, when matching patients who began an intervention in February 2009, individual histories were created that summarised patterns of hospital use and recorded diagnoses up until 28 February 2009. A predictive risk score was calculated at 28 February for the subset of intervention patients that began an intervention in that month, as well as for the entire set of 1-2 million potential controls. This predictive risk score was then used in the subsequent steps of our matching algorithm. Note that the choice to summarise histories to the end of the month of intervention, rather than to the beginning of the month, meant that a limited amount of post-intervention data was included in the calculation of the

risk scores. However, it meant that the predictive risk scores reflected all secondary care activity occurring before the start of the intervention. This was particularly important in some of the pilots such as Torbay where a substantial amount of activity was expected in the few days before intervention. In total the algorithm was run 18 times, as patients were not recruited in every month between February 2009 and September 2010.

Much of the data available on individual characteristics available for matching was sourced from hospital data. We therefore only aimed to construct matched controls for people with an inpatient or outpatient hospital contact within three years of the relative monthly end point. The same restriction was applied to the pool of potential controls. Although intervention patients without a contact in this time period were not matched to a control, their subsequent hospital utilisation was compared to national data on hospital use for patients who had not previously had a hospital contact, on an age and gender adjusted basis, to check that substantial reductions in hospital use were not being missed.

The primary variable that we required to be similar between pairs of control and intervention patient was the predictive risk score. Several predictive risk models are in routine use in the NHS, but they do not relate to the specific population subgroup that is being considered here, namely patients with an inpatient or outpatient contact within a three-year period. For example, the Patients At Risk of Re-hospitalisation (PARR) model<sup>4</sup> produces predictions for patients with a recent inpatient admission, and the Combined Predictive Model produces predictions for entire registered populations<sup>8</sup> We chose to create our own predictive model using a similar set of predictor variables to PARR, but calibrated to the patterns of care observed in the integrated care pilot sites for patients with an inpatient or outpatient contact within a three-year period. The models were rebuilt for every month of the algorithm using pooled data from all of the sites, so that 18 models were built in total. Intervention participants were excluded when fitting the predictive risk models in line with recent recommendations for prognostic matching.<sup>7</sup> A split-sample model development approach was adopted, so that the data set was split at random, with one half used to develop models that could be tested against the other half of the data set. A&E data were not available to use as predictor variables for the model. Having fit the models, risk scores were calculated for the intervention patients and potential controls. Matching was performed for one intervention patient at a time. The precise method was iterated until satisfactory balance was achieved between intervention and matched control patients on the set of variables described above. We measured balance by the standardised difference. This is defined as the difference in the sample means as a percentage of the square root of the average of the sample variances. While there is no clear consensus on the issue, some researchers have proposed that a standardised difference of greater than 10% denotes meaningful imbalance in the variable.<sup>9</sup> As the standardised difference only measures a difference in means, the other metrics including Q-Q plots were used to compare the distribution of covariates.

In the final version of the algorithm, the pool of potential controls was successively limited in a series of steps. To begin with, it was reduced to those of the same combination of discrete variables (for example, gender) as the intervention patient and with a similar predictive risk score, defined as a logit within 20% of a standard deviation<sup>6</sup>. Histories of hospital use and diagnoses of major disease groups were then recalculated for the intervention patient and the remaining set of potential controls using the precise date that the patient in question received the intervention. At this stage, individuals who had died before the intervention start date were also excluded from being a control. Matching was then performed simultaneously according to a key set of variables including the predictive risk score, age, area-level deprivation score, number of chronic health conditions, prior number of emergency admissions, elective admissions, outpatient attendances, and days in hospital. The five closest controls according to the Mahalanobis distance were retained.<sup>10</sup> Controls were selected without replacement so that the same individual could not act as a control to more than one intervention patient. Balance was assessed using the entire set of variables selected at the outset of the project.

The control matching was performed by the Nuffield Trust, and the final set of matched controls was discussed and agreed by the wider research team prior to the availability of follow-up data.

Across all sites, 10,744 patients were confirmed to have received an intervention before September 2010 and we identified matched controls for 8,691 of these (81%) with a total of 42,206 individually matched controls. Reasons that controls could not be found were:

1. Not linked to HES
2. No prior hospital use (therefore no data to use in the matching)
3. Well-matched controls could not found

The characteristics of cases and controls in all sites and in sites focusing on case management is shown in the following two tables (tables A3 and A4)

**Table A3. Characteristics of cases and controls (All sites, excluding Torbay)**

	<b>Control: Mean (sd)</b>	<b>Intervention: Mean (sd)</b>	<b>Standardised difference</b>
N	42,206	8,691	
Risk score	0.23 (0.19)	0.24 (0.21)	-6.3%
Age	71.9 (14.9)	71.2 (15.4)	4.9%
Female	54.3%	53.9%	0.7%
<b>Ethnicity</b>			
Black	3.3%	3.4%	-0.4%
Asian	14.0%	13.9%	0.2%
Unknown	13.1%	12.8%	0.7%
White	67.5%	67.7%	-0.5%
Other	2.2%	2.2%	-0.1%
<b>Index of multiple deprivation</b>			
1 <sup>st</sup> quartile (least deprived)	16.0%	17.9%	-5.2%
2 <sup>nd</sup> quartile	21.9%	22.2%	-0.9%
3 <sup>rd</sup> quartile	21.0%	19.3%	4.1%
4 <sup>th</sup> quartile (most deprived)	41.2%	40.5%	1.3%
<b>Hospital use (prior year)</b>			
Emergency admissions	1.1 (1.7)	1.3 (1.9)	-10.1%
Elective admissions	1.4 (3.0)	1.4 (3.3)	-1.9%
ACS admissions	0.5 (1.3)	0.5 (1.1)	-4.3%
Outpatient attendances	9.5 (11.0)	9.7 (11.5)	-2.1%
A&E visits	1.3 (2.0)	1.4 (2.0)	-6.1%
Length of stay	11.8 (19.7)	14.1 (22.5)	-11.1%
<b>Diagnoses on inpatient record (3 years)</b>			
Number of chronic conditions	1.2 (1.4)	1.2 (1.5)	-3.1%
Anaemia	7.8%	8.5%	-2.7%
Angina	9.3%	9.8%	-1.4%
Ischemic heart disease	14.5%	15.9%	-3.9%
Asthma	7.3%	6.8%	2.1%
Atrial fibrillation	11.5%	12.0%	-1.7%
Cancer	13.2%	13.9%	-2.1%
Cerebrovascular disease	7.0%	7.1%	-0.5%
Congestive heart failure	5.9%	6.7%	-3.2%
COPD	8.8%	9.8%	-3.1%
Diabetes	20.0%	21.0%	-2.5%
Falls	9.7%	10.0%	-1.1%
Injuries	17.5%	19.2%	-4.2%
Hypertension	36.8%	36.0%	1.6%
Mental health	8.6%	10.5%	-6.3%
Renal failure	4.0%	4.9%	-4.3%
<b>In-hospital death (6 months after start)</b>	2.5%	3.9%	



**Table A4. Characteristics of cases and controls (Case management sites)**

	<b>Control: Mean (sd)</b>	<b>Intervention: Mean (sd)</b>	<b>Standardised difference</b>
N	17,311	3,646	
Risk score	0.36 (0.20)	0.37 (0.21)	-8.5%
Age	80.7 (9.9)	79.6 (11.5)	10.7%
Female	59.2%	58.5%	1.6%
<b>Ethnicity</b>			
Black	0.2%	0.3%	-2.7%
Asian	0.5%	0.6%	-1.4%
Unknown	5.8%	5.8%	0.2%
White	93.2%	92.9%	0.9%
Other	0.4%	0.4%	-0.6%
<b>Index of multiple deprivation</b>			
1 <sup>st</sup> quartile (least deprived)	27.7%	32.2%	-9.7%
2 <sup>nd</sup> quartile	34.8%	36.3%	-3.0%
3 <sup>rd</sup> quartile	26.2%	25.6%	1.4%
4 <sup>th</sup> quartile (most deprived)	11.3%	6.0%	18.9%
<b>Hospital use (prior year)</b>			
Emergency admissions	1.9 (1.9)	2.1 (2.3)	-13.2%
Elective admissions	2.0 (4.1)	2.3 (4.8)	-6.4%
ACS admissions	0.8 (1.8)	0.8 (1.4)	-4.4%
Outpatient attendances	11.5 (12.0)	11.6 (12.2)	-1.0%
A&E visits	1.8 (2.3)	1.8 (2.2)	1.2%
Length of stay	20.0 (23.5)	24.9 (26.9)	-19.3%
<b>Diagnoses on inpatient record (3 years)</b>			
Number of chronic conditions	1.6 (1.5)	1.7 (1.6)	-2.7%
Anaemia	12.5%	13.5%	-3.0%
Angina	13.8%	14.5%	-2.1%
Ischemic heart disease	21.8%	22.1%	-0.7%
Asthma	9.9%	10.1%	-0.4%
Atrial fibrillation	20.5%	21.3%	-1.9%
Cancer	25.3%	26.4%	-2.5%
Cerebrovascular disease	11.6%	10.6%	3.1%
Congestive heart failure	11.3%	12.6%	-3.9%
COPD	16.8%	18.2%	-3.7%
Diabetes	15.0%	16.3%	-3.4%
Falls	15.8%	16.0%	-0.5%
Injuries	28.1%	30.4%	-5.0%
Hypertension	51.0%	48.5%	4.9%
Mental health	13.7%	14.9%	-3.5%
Renal failure	6.5%	8.5%	-7.5%
<b>In-hospital death (6 months after start)</b>	4.8%	8.4%	

## Comparison of endpoints

Analysis of inpatient activity was restricted to ordinary admissions, excluding transfers and regular attendances and maternity events (patient classifications 1 and 2 only). Admissions were classified further based on defined admission methods into emergency activity (codes 21-28) and elective activity (all other codes excluding transfers). Bed days included stays following emergency and elective admissions, with same day admissions and discharges assigned a length of 1 bed day. Outpatient activity was restricted to appointments that were attended (codes 5 and 6). Our set of ambulatory sensitive conditions was derived from AHRQ and Purdy et al<sup>11, 12</sup> and described in the published study protocol Ling et al<sup>13</sup>. Analysis of accident and emergency activity included all visits, regardless of subsequent inpatient admission, but was limited to April 2007 to March 2010 due to the available data. Since the HES-ONS linked mortality file was only available for the pre-intervention period, comparisons of mortality post intervention were restricted to analysis of deaths occurring within hospital only.

Notional costs of care were estimated from HES data by applying the set of mandatory and indicative tariffs used in England for the reimbursement of inpatient and outpatient care (2008/09 Payment by Results tariffs). These assume a stay of a certain number of days (the “trim point”), and allow hospitals to charge a pre-specified amount for each additional excess bed day. Costs were not adjusted for the regional costs of providing care, and so were effectively a weighted activity measure which allowed robust comparison of the magnitude of care received for control and participants. Activity not covered by the tariffs was costed using the National Reference Costs (NRC). If neither tariff nor NRC were available, the activity was costed as the average tariff for the speciality under which it was delivered.

Endpoints were compared using data that were pooled over several sites, according the pre-specified categorisation of interventions. A “difference-in-difference” analysis was conducted for each endpoint, which compared the two groups in terms of the differences between the numbers of admissions in the six months after the date of the intervention to the numbers in the six months before. This aimed to reduce the impact of any unobserved systematic differences between the groups.

Hospital use for individuals in the same site will tend to be correlated. This within-site homogeneity was accounted for in the analysis by constructing hierarchical difference-in-difference models which included random effects at the site level. The matched nature of the data was also taken account using a random effect for each “block”, consisting of an intervention patient and their matched controls.

### 3.1.1 Estimating the effect of an unobserved confounding variable

The increase in emergency admissions observed in pilot sites (and case management sites in particular) could have been due to imperfect matching between cases and controls, e.g. cases being sicker and hence more likely to be admitted. Although cases and controls were similar in terms of the predictor variables that we could observe, it is nevertheless possible that systematic unobserved differences existed between the groups. We have some evidence that this was the case because six month mortality was greater in cases than controls (8.4% vs 4.8% in case management sites), an effect that was unlikely to be caused by the interventions. In order to estimate the effect of incomplete matching, we performed an additional analysis by using a simulation technique outlined by Higashi et al<sup>14</sup>. This involved making assumptions about the strength of an omitted confounder variable, and then estimating what impact controlling for that variable would have had on the analysis of emergency admissions.

We simulated a continuous confounder based on a range of assumptions about the correlation with emergency admissions and recruitment into the intervention. In each scenario, the variable was simulated using a rejection sampling approach, generating triads of (U, T, Y) that met the following criteria:

1. Allocation into intervention,  $T \sim \text{Bernoulli}(0.5)$

2. Emergency admissions in the six months post intervention,  $Y \sim$  according to the observed marginal distribution
3. Unobserved confounder,  $U$  was a mixture of normal distributions

Correlation ( $U, T$ ) and correlation ( $U, Y$ ) as desired

We continued to generate these triads until  $T = t, Y = y$ , the values observed in the data. We then used OLS regression to estimate the effect of the intervention adjusting for the simulated values of the unobserved confounder.

Correlation with emergency admissions	Correlation with intervention receipt	Estimated treatment effect	Approx. 95% confidence interval	
0	0	0.14	0.14	0.14
0.2	0.2	0.06	0.05	0.07
0.2	0.4	-0.02	-0.04	0
0.2	0.6	-0.10	-0.13	-0.05
0.4	0.2	-0.01	-0.03	0
0.4	0.4	-0.14	-0.16	-0.12
0.3	0.6	-0.29	-0.32	-0.26
0.6	0.2	-0.06	-0.08	-0.04
0.6	0.3	-0.21	-0.23	-0.18
0.5	0.5	-0.39	-0.42	-0.37

**Table A5 Correlation of the potential omitted confounder with intervention receipt and emergency admissions that would be required to eliminate the observed relationship**

From the table, we selected correlation values to illustrate the magnitude of the correlations required to turn no effect into an increase of 9% in emergency admissions (as found in case management sites). It can be seen that, for a reduction in emergency admissions to have been masked, an unobserved confounder would have had to exist with correlations of 0.4 with both the intervention and with emergency admissions.

Finally, we considered how likely it was that such a confounder would exist. We know from our data that the strongest predictor of future emergency admission is a past history of emergency admission, which has a correlation of 0.25 with emergency admissions and 0.10 with intervention receipt. Therefore for a hypothetical confounder to turn even a very small reduction in admissions into a 9% increase would require a confounder correlated almost twice as strongly with the outcome as the strongest predictor we know to date. We consider this unlikely and therefore conclude that it is unlikely that a confounding variable masked a true reduction in emergency admissions over six months among patients in case management sites. While we cannot be certain the extent to which pilot interventions were associated with increased admissions in the intervention group, it is unlikely that the interventions reduced emergency admissions.

## 3.2 Practice level analysis

While the person-based analysis will give the most direct measure of the effectiveness of the interventions, it is still of interest to see if the effect of the intervention can be seen at the practice level. While practice based analyses are more robust to unmeasured covariates at individual patient level, any effect of the intervention is greatly diluted by individuals who are not exposed to the intervention.

In this analysis, we have separately used the number of elective admissions, the number of emergency admissions, the number of ambulatory care sensitive conditions, the number of outpatient attendances, and the number of A&E attendances recorded in HES aggregated at practice level. For each practice the data were aggregated into 14 age by gender groups (age groups 0-4, 5-14, 15-44, 45-64, 65-74, 75-84 and 85+). Practices which received an intervention as part of the ICP scheme were compared to a random selection of half of all other practices in England. This comparison was made for the two years following intervention (12 months from 1.4.09 and 12 months from 1.4.10), expecting a greater effect in the second year. Note that due to the unavailability of data, the A&E attendances analysed are only for 11 months in the final year.

The analysis performed was a longitudinal mixed effect Poisson regression using four years of data (two years prior to and two years following the intervention) employing a difference in differences methodology. The regression analysis controlled for the following covariates: list size for each year under study; patient age and gender profile; list size per FTE GP; mean IMD; patient ethnicity profile; QOF quality scores; QOF prevalence scores; mean years since qualification of GPs; the proportion of GPs who qualified in the UK; and the Low Income Scheme Index (LISI) score<sup>15</sup>. The random effects are included so that the underlying admission rate in each practice is accounted for and that this rate can change year on year. This is achieved by fitting an unstructured covariance matrix. An interaction term between year (following intervention) and intervention group allows us to assess the effect of the intervention in the two years following intervention. Practices with less than 1000 patients in any year were excluded from the analysis as were all data from individual practices prior to any practice list size changes of more than 10% in any one year.

### **3.3 Analysis of secondary care costs**

For secondary care utilisation comparing patients/service users with controls, notional costs of care were estimated from HES data by applying the set of mandatory and indicative tariffs used in England for the reimbursement of inpatient and outpatient care (2008/09 Payment by Results tariffs). These assume a stay of a certain number of days (the “trim point”), and allow hospitals to charge a pre-specified amount for each additional excess bed day. Costs were not adjusted for the regional costs of providing care, and so were effectively a weighted activity measure which allowed robust comparison of the magnitude of care received for control and participants. Activity not covered by the tariffs was costed using the National Reference Costs (NRC). If neither tariff nor NRC were available, the activity was costed as the average tariff for the specialty under which it was delivered.

## 4. Supplementary tables

Tables A6.i and A6.ii are expansions of table 5.7 in the main report to include absolute values and confidence intervals. Table A6.i shows the values for the individual patient analysis and table A6.ii for the practice based analysis for those practices included in the individual patient analysis. Table A6.iii shows the results for Torbay (which could not be included in the individual patient analysis), with an age breakdown of Torbay results in table A6.iv

	Relative difference	p-value	Absolute difference per head (95% CIs)
Emergency admissions	+2% (0.2%, 4%)	0.03	0.02 (0.00 to 0.04)
A&E attendance	-1% (-3%, +0.8%)	0.26	-0.01 (-0.03 to 0.01)
Elective admissions	-4% (-7%, -1%)	0.003	0.04 (-0.07 to -0.01)
Outpatient attendance	-20% (-28%, -12%)	<0.001	-0.2 (-0.28 to -0.12)

**Table 6.i. Individual patient analysis: changes in hospital utilisation comparing six months before with six months after an intervention**

		2007/8	2008/9	Year 1 post intervention 2009/10	Year 2 post intervention 2010/11	Rate ratio for year 2 (95% CIs)	p value
Emergency	Intervention	81	88	92	91	0.98 (0.95-1.01)	0.14
	Control	76	85	87	88		
A & E	Intervention	175	184	237	226	1.09 (0.91-1.30)	0.33
	Control	204	229	261	253		
Elective	Intervention	127	138	145	144	1.00 (0.98-1.03)	0.79
	Control	110	122	125	128		
ACSC*	Intervention	11	13	14	16	0.98 (0.74,1.30)	0.88
	Control	6	8	9	10		
Out Patient	Intervention	932	1002	1070	1099	0.95 (0.92-0.98)	<0.01
	Control	975	1091	1201	1249		

\* ACSC = Ambulatory care sensitive condition.

**Table 6.ii. Practice based analysis: mean number of admissions per 1000 patients per year for intervention practice (excluding Torbay) and control practices**

		2007/8	2008/9	Year 1 post intervention 2009/10	Year 2 post intervention 2010/11	Rate ratio for year 2* (95% CIs)	p value
Emergency	Intervention	82	86	86	88	0.93 (0.89,0.98)	0.02
	Control	77	85	87	89		
A & E	Intervention	306	323	342	319	0.83	0.19

	Control	201	226	259	250	(0.63,1.10)	
Elective	Intervention	136	149	145	149	0.93	<0.01
	Control	110	123	126	128	(0.89,0.97)	
ACSC*	Intervention	7	8	9	11	0.99	0.98
	Control	7	9	9	11	(0.57,1.72)	
Out Patient	Intervention	1113	1285	1318	1311	0.90	<0.01
	Control	972	1084	1194	1241	(0.86,0.94)	

**Table 6.iii. Practice based analysis: mean number of admissions per 1000 patients per year for Torbay and control practices**

\*There were also significant reductions in year 1 (2009/10)

Age band	Elective admissions*	Emergency admissions*	Ambulatory care sensitive admissions*	Out Patient attendance*
0-4	0.87 (0.81,0.93)	0.86 (0.79,0.93)	0.62 (0.31,1.23)	0.88 (0.84,0.93)
5-14	0.90 (0.82,0.97)	0.74 (0.70,0.79)	1.57 (0.83,2.93)	0.83 (0.80,0.87)
15-44	0.91 (0.86,0.96)	0.94 (0.90,0.99)	0.90 (0.50,1.62)	0.86 (0.82,0.90)
45-64	0.93 (0.88,0.98)	0.93 (0.89,0.98)	0.94 (0.53,1.66)	0.90 (0.86,0.94)
65-74	0.99 (0.93,1.04)	0.96 (0.92,1.01)	1.21 (0.69,2.14)	0.95 (0.91,0.99)
75-84	0.93 (0.88,0.98)	0.93 (0.89,0.98)	0.85 (0.48,1.50)	0.93 (0.89,0.98)
85+	0.93 (0.88,0.98)	0.96 (0.90,1.02)	1.34 (0.75,2.39)	0.94 (0.89,0.98)

**Table 6.iv. Changes in hospital utilisation in Torbay by age group.**

\* Figures in table 6.iv represent risk ratios. Example: a risk ratio of 0.9 is equivalent to a relative reduction of 10%

## 5. References

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# **Appendix C: Patient–service user questionnaire**



**GETTING YOUR VIEWS ABOUT YOUR CARE**

**Thank you for answering these questions about the care you have received from the NHS and from social services.**

**Health and social care staff in your area are trying to organise more joined-up care to meet people's needs better. Your answers will help them to improve the care they provide.**

**We would like to hear about your own views. However, if you prefer, you can ask a friend or relative to help you answer the questions. The questionnaire should take you between 10-15 minutes to complete.**

**Your answers to the questions are confidential.**

**Once you have completed the questionnaire, please return it in the envelope provided.**

**You don't need to put a stamp on the envelope.**

**Return address:**

## SECTION A. YOUR EXPERIENCE OF SEEING GPs

**Q1** How often do you see the GP you prefer at your GP surgery or health centre?  
*Please put "x" in one box only.*

- 1  Always or almost always
- 2  A lot of the time
- 3  Some of the time
- 4  Never or almost never
- 5  Not sure / not tried
- 6  There's usually only one doctor at my GP surgery or health centre
- 7  I don't have a particular GP I prefer to see

**Q2** Last time you saw a GP, how good was the doctor at each of the following?  
*Please put "x" in one box for each row.*

	Very Good	Good	Neither Good nor Poor	Poor	Very Poor	Doesn't Apply
a. Listening to you .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
b. Explaining tests and treatments...	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
c. Involving you in decisions about your care.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

## SECTION B. YOUR EXPERIENCE OF SEEING NURSES

For these questions, think about nurses who you might see at home as well as nurses you see in your GP surgery or health centre.

**Q3** How often do you see the nurse you prefer at your GP surgery or health centre?  
*Please put "x" in one box only.*

- 1  Always or almost always
- 2  A lot of the time
- 3  Some of the time
- 4  Never or almost never
- 5  Not sure / not tried
- 6  There's usually only one nurse at my GP surgery or health centre
- 7  I don't have a particular nurse I prefer to see

**Q4** Last time you saw a nurse, how good was the nurse at each of the following?

*Please put "x" in one box for each row.*

	Very Good	Good	Neither Good nor Poor	Poor	Very Poor	Doesn't Apply
a. Listening to you .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
b. Explaining tests and treatments.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
c. Involving you in decisions about your care.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

**SECTION C. PLANNING YOUR CARE**

**Q5** In the last six months, how much of the time have you been:

*Please put "x" in one box for each row.*

	Always	Often	Sometimes	Never	Don't Know / Doesn't Apply
a. Satisfied that your care was well organized.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. Helped to plan ahead so you could take care of your condition, even in difficult times .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c. Helped to look after yourself.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

**Q6** In the last six months, have any of the following happened?

*Please put "x" in one box for each row.*

	Yes	No	Don't Know / Doesn't Apply
a. Test results or your medical notes were not available at the time of your appointment .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. The doctor or nurse ordered a test that you felt was unnecessary because it had already been done .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c. You were given the wrong medicine or drug.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d. You were given the wrong dose of a medicine or drug.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

**Q7** Do you have any long-standing health problem, disability or infirmity? Please include anything that has troubled you over a period of time or that is likely to affect you over a period of time.

- 1  Yes ..... → Continue to next question
- 2  No ..... → Skip to Section D
- 3  Don't know / can't say..... → Skip to Section D

**Q8** Have you had discussions in the past 12 months with a doctor or nurse about how best to deal with your longstanding health problem(s), disability, or infirmity?

- 1  Yes ..... → Continue to next question
- 2  No ..... → Skip to Section D

**Q9** In these discussions...

*Please put "x" in one box for each row.*

	Yes	No	Don't know / Doesn't Apply
a. Did the doctor or nurse take notice of your views about how to deal with your health problem? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Did the doctor or nurse give you information about the things you might do to deal with your health problem? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c. Did the doctor or nurse give you a written document about the discussions you had about managing your health problem? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d. Did the doctor or nurse ever tell you that you had something called a 'care plan'?.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

**Q10** Do you think that having these discussions with your doctor or nurse has helped improve how you manage your health problem?

*Please put "x" in one box only.*

- 1  Yes, definitely
- 2  Yes, to some extent
- 3  No, not at all
- 4  Don't know / can't remember

**SECTION D. HELP FROM SOCIAL SERVICES**

**Q11** Have you had any help from social services in your home in the last six months, either providing care for you or helping you to arrange care?

- 1  Yes ..... → Continue to next question
- 2  No ..... → Skip to Section E

**Q12** Do you feel that your opinions and preferences are taken into account by social services or your care workers when decisions are taken about what services are provided to you?  
*Please put "x" in one box only.*

- 1  Always
- 2  Usually
- 3  Sometimes
- 4  Never
- 5  This question doesn't apply to me

**Q13** At the present time, do care workers visit you as often as you need?  
*Please put "x" in one box only.*

- 1  Yes, the frequency is about right
- 2  No, I need less visits
- 3  No, I need more visits
- 4  This does not apply to me

**Q14** At the present time, when care workers visit you do they spend the right amount of time with you?  
*Please put "x" in one box only.*

- 1  Yes, the duration of the visit is about right
- 2  No, I need a little more time
- 3  No, I need a lot more time
- 4  No, I have more time than I need
- 5  This does not apply to me

**SECTION E. BEING ADMITTED TO HOSPITAL**

**Q15** Have you been admitted to hospital in the last six months?

- 1  Yes ..... → Continue to next question
- 2  No ..... → Skip to Section F

**Q16** Thinking about when you came out of hospital:  
*Please put "x" in one box for each row.*

	Yes	No	Didn't Apply	Can't Remember
a. Did you have clear follow-up arrangements?.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b. Did you know who to contact with questions about your treatment after you had left hospital?.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

## SECTION F. QUESTIONS ON USING THE NHS AND SOCIAL SERVICES

**Q17** In the last three months, have you seen any of these professionals or carers in person?  
*Please put "x" in one box for each row.*

	Don't Know / Not Sure	No	Yes	Approximately how many visits?
a. GP in the surgery or health centre .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	_____ Number of visits
b. GP at home .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	_____ Number of visits
c. GP out of hours service .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	_____ Number of visits
d. Nurse in the surgery or health centre .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	_____ Number of visits
e. Practice nurse or district nurse at home .	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	_____ Number of visits
f. Community matron at home .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	_____ Number of visits
g. Physiotherapist .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	_____ Number of visits
i. Social worker or care manager .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	_____ Number of visits
j. Home carer / home help .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	_____ Number of visits

## SECTION G. COORDINATION OF YOUR CARE

**Q18** Thinking about all the health and/or social services you have used in the last 6 months, has your care been well coordinated? (For example, the way different doctors, nurses, and organisations work together).  
*Please put "x" in one box only.*

- 1  Very good
- 2  Good
- 3  Neither good nor poor
- 4  Poor
- 5  Very poor
- 6  Doesn't apply

## SECTION H. FINALLY, SOME QUESTIONS ABOUT YOURSELF

**Q19** Are you male or female?

- 1  Male
- 2  Female

**Q20** How old are you?

- 1  34 or younger
- 2  35 – 54
- 3  55 - 64
- 4  65 – 74
- 5  75 - 84
- 6  85 or over

**Q21** In general would you say your health is:  
*Please put "x" in one box only.*

- 1  Excellent
- 2  Very good
- 3  Good
- 4  Fair
- 5  Poor

**Q22** Which of the following statements best describes how much control you have over your daily life at the present time? *By 'control over daily life', we mean you have the choice to do what you want, when you want - for example having meals, going to bed and getting up, going out etc.*  
*Please put "x" in one box only.*

- 1  I feel in control of my daily life
- 2  With help, I feel in control of my daily life
- 3  I have some control over my daily life, but not enough
- 4  I have no control over my daily life

**Q23** What is your ethnic group?  
*Please put "x" in one box only.*

- 1  **White** (British, Irish or any other White background)
- 2  **Mixed** (White and Black Caribbean, White and Black African, White and Asian or any other mixed background)
- 3  **Asian or Asian British** (Indian, Pakistani, Bangladeshi or any other Asian background)
- 4  **Black or Black British** (Caribbean African or any other Black background)
- 5  **Chinese**
- 6  **Any other ethnic group**

**Q24** Finally, did you fill in this questionnaire by yourself or did you have help from someone else?  
*Please put "x" in one box only.*

- 1  I filled it in by myself
- 2  I filled it in with help from a friend or family member
- 3  I filled it in with help from a care worker

**Q25** We would like to talk to a small number of people in more detail about how their care is coordinated and planned. If you would be happy for us to contact you for a telephone or face to face conversation, could you please tick this box?

- 1  Yes, I am willing to be contacted for further information

**We appreciate your willingness to help but we will not be able to contact people in all areas.**

**Q26** If you would like to add any other comments about your care you can write them here or include another sheet of paper.

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***Thank you very much.  
Please return the questionnaire in the stamped addressed envelope.***



**Integrated Care Pilots evaluation: final report**

# **Appendix D: Staff questionnaire**

**GETTING YOUR VIEWS ABOUT THE INTEGRATED CARE PILOTS**

You are working in one of the areas selected by the NHS to be an 'Integrated Care Pilot'. These were launched by the Department of Health in April 2009. As part of the national evaluation of the pilots, we are interested in your views about the pilot in your area. Integrated care pilots are part of a broader reform effort that aims to improve health care and social care through better coordination.

Your answers to the questions are confidential, and will not be shared in identifiable form with anyone in your locality or elsewhere. We will however, be feeding back the overall results of the survey to the people running the pilot in your area. All the responses will be anonymised, and if you make additional comments that cannot easily be anonymised, we will not feed them back.

**SECTION A. ABOUT YOUR INTEGRATED CARE PILOT**

You have been sent this questionnaire because you are working in one of the NHS 'Integrated Care Pilot' areas.

Please write your job title here \_\_\_\_\_

**1. Do you know that you are working in an area that is part of an 'Integrated Care Pilot'?**

- |                      |                          |   |                                |
|----------------------|--------------------------|---|--------------------------------|
| Yes                  | <input type="checkbox"/> | 1 | Continue to next question      |
| Don't know/ not sure | <input type="checkbox"/> | 2 | Continue to next question      |
| No                   | <input type="checkbox"/> | 3 | Skip to section B (Question 9) |

**2. How has your job changed since the introduction of the Integrated Care Pilot?**

Please put "x" in the box which describes you best.

- |   |                          |   |                                |
|---|--------------------------|---|--------------------------------|
| I am a new appointment to the Integrated Care Pilot   | <input type="checkbox"/> | 1 | Continue to next question      |
| I have been seconded to work full-time on the Integrated Care Pilot (i.e. direct face-to-face with Integrated Care Pilot patients and/or associated administrative tasks) | <input type="checkbox"/> | 2 | Continue to next question      |
| I have been seconded to work part-time on the Integrated Care Pilot (i.e. direct face-to-face with Integrated Care Pilot patients and/or associated administrative tasks) | <input type="checkbox"/> | 3 | Continue to next question      |
| There have been some changes to my job, though I am not formally employed to work on the Integrated Care Pilot  | <input type="checkbox"/> | 4 | Continue to next question      |
| My job has not changed since the introduction of the Integrated Care Pilot  | <input type="checkbox"/> | 5 | Skip to section B (Question 9) |

**3. This question is about how your job has changed since the Integrated Care Pilot. Please indicate your level of agreement to each reason.**

Please put "x" in one box for each row.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Not applicable to me
a. The depth of my job has increased (e.g. through extending my skills)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
b. The breadth of my job has been expanded (e.g. wider range of tasks, and/or working with more organisations)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
c. I now delegate more responsibility to others	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
d. I now have more responsibility delegated to me	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>

**4. How much of your daily work relates to the Integrated Care Pilot?**

Please put "x" in one box only.

None specifically	<input type="checkbox"/> <sub>1</sub>
Some of my daily work	<input type="checkbox"/> <sub>2</sub>
All of my daily work	<input type="checkbox"/> <sub>3</sub>
Not sure / can't say	<input type="checkbox"/> <sub>4</sub>

**5. These questions ask about how much time you spend personally working on the Integrated Care Pilot. The time could be extra hours or substitutes for what you normally do.**

Please put a best approximate number in the box for each row.

On average, how many <u>hours</u> a week do you work specifically on the Integrated Care Pilot? Consider the last 4 weeks.	<u>        </u> <sup>1,2</sup> (hours)	Not Applicable <input type="checkbox"/> <sub>9</sub>
What is the <u>maximum</u> number of <u>hours</u> you have spent in a week specifically working on the Integrated Care Pilot? Consider the last 4 weeks.	<u>        </u> <sup>3,4</sup> (hours)	Not Applicable <input type="checkbox"/> <sub>10</sub>
What is the <u>minimum</u> number of <u>hours</u> you have spent in a week specifically working on the Integrated Care Pilot? Consider the last 4 weeks.	<u>        </u> <sup>5,6</sup> (hours)	Not Applicable <input type="checkbox"/> <sub>11</sub>
In the last 4 weeks, how many <u>weeks</u> have you worked over the expected working hours and this 'overtime' was specifically because of the Integrated Care Pilot?	<u>        </u> <sup>7,8</sup> (weeks)	Not Applicable <input type="checkbox"/> <sub>12</sub>

**6. This question is about the effect of the Integrated Care Pilot on the organisation you work in (e.g. PCT; GP practice; local authority)**

Please put "x" in one box for each row.

	Better than before the integrated care pilot started	No change	Worse than before the integrated care pilot started	Not sure
Support for training in my area of work	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Clarity of accountability structures in my work (e.g. I know what the lines of management are and who I report to)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Communication between different parts of my organisation	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
Communication with other organisations	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

**If communication has changed, please describe in what way and for which organisations.**

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**7. How have these aspects of your job changed since the Integrated Care Pilot started?**

Please put "x" in one box for each row.

	Better than before the integrated care pilot started	No change	Worse than before the integrated care pilot started
Having clear planned goals and objectives for my job	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Having an interesting job	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Developing my role	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Having adequate resources to do my job (e.g. skills, staff, IT, time, etc)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>

**If you think any of these aspects of your job have changed, please tell us how.**

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**8. Do you participate in a steering group or board of your Integrated Care Pilot?**

Yes	<input type="checkbox"/>	1	Continue to next question
No	<input type="checkbox"/>	2	Continue to next question

**SECTION B. YOUR VIEWS ON HEALTH AND SOCIAL CARE QUALITY**

**9. These questions are about changes to the care your patients/service users receive.**

*Please put "x" in one box only.*

	Got better	Not changed	Got worse	Not sure
In the last year, has the overall care your patients/ service users receive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Please put "x" in one box only.*

	Yes	No	Too early to tell	Not sure
Have you seen improvements in care as a result of the Integrated Care Pilot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If you have seen changes in care for patients / service users either in the last year or as a result of the Integrated Care Pilot, please provide further detail here (there is also more space at the end).**

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**These questions are about working in a team, and relate to the group of people you work with most closely.**

**10. Do you work in a team?**

Yes	<input type="checkbox"/>	1	Continue to next question
No	<input type="checkbox"/>	2	Skip to section C (Question 12)

**11. These questions are about how working with your team has changed since the Integrated Care Pilot started.**

Please put "x" in one box for each row.

	Better than before the integrated care pilot started	No change	Worse than before the integrated care pilot started
Having clear team objectives	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Working closely with other team members	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Meeting regularly to discuss how care can be improved	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Having clear lines of accountability	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Having new electronic communication systems	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>

**SECTION C. SOME MORE QUESTIONS ABOUT YOUR JOB**

**12. Do you have face to face contacts with patients/ service users as part of your job?**

Yes, frequently	<input type="checkbox"/> <sub>1</sub>	Continue to next question
Yes, occasionally	<input type="checkbox"/> <sub>2</sub>	Continue to next question
No	<input type="checkbox"/> <sub>3</sub>	Skip to section D (Question 17)

**13. The next questions are about the contribution you personally make.**

Please put "x" in one box for each row.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Not applicable to me
I am satisfied with the quality of care I give to patients / service users	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
I feel my role makes a positive difference to patients / service users	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
I am able to do my job to a standard I am personally pleased with	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
I can manage all the conflicting demands on my time at work	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>

**14. The next questions are about how well the care for your patients/service users is integrated.**

Please put "x" in one box for each row.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Not applicable to me
People providing care for my patients/service users work well together	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
A 'seamless service' is a good description for the care my patients service users receive	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
There is good communication with other organisations providing care for my patients/service users	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>

**15. How frequently do you communicate with people in the following groups?**

This could be about patients / service users, or about services in general.

Please put "x" in one box for each row.

	Never	Rarely	Occasionally	Often	Constantly
<b>Hospital doctors</b>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
<b>GPs</b>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
<b>Hospital nurses</b>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
<b>Community nurses</b> (incl. community matrons and community psychiatric nurses)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
<b>Pharmacists</b>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
<b>NHS-employed therapists</b> (incl. physiotherapists, therapy assistants, health and well-being trainer)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
<b>Social Care Professionals</b> (incl. GSCC-registered social workers, occupational therapists, case managers, assistant practitioners)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
<b>Paid care workers/ care assistants/ residential workers/ child and family workers</b>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
<b>Third or voluntary sector</b>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
<b>Administrators/Managers</b>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

**16. Do you manage staff as part of your job?**

Yes	<input type="checkbox"/> <sub>1</sub>
No	<input type="checkbox"/> <sub>2</sub>

Now we would like to ask you some questions about yourself so that we can compare the responses of different groups of staff.

**SECTION D. SOME QUESTIONS ABOUT YOURSELF**

**17. What is your age group?**

16-30	<input type="checkbox"/>	1
31-50	<input type="checkbox"/>	2
51-65	<input type="checkbox"/>	3
66+	<input type="checkbox"/>	4

**18. What is your occupational group?**

Put "x" in the box that comes closest to your current job.

<b>Medical</b> (incl. consultant, registrar and GP)	<input type="checkbox"/>	1
<b>Nurse or midwife</b> (incl. specialist nurse, community nurse, practice nurse, or health visitor)	<input type="checkbox"/>	2
<b>Community Matron</b>	<input type="checkbox"/>	3
<b>Community psychiatric nurse or community mental health worker</b>	<input type="checkbox"/>	4
<b>Pharmacist</b>	<input type="checkbox"/>	5
<b>NHS-employed therapist</b> (incl. physiotherapist, therapy assistant, health and well-being trainer)	<input type="checkbox"/>	6
<b>Social Care Professional</b> (incl. GSCC-registered social worker, occupational therapist, case manager, assistant practitioner)	<input type="checkbox"/>	7
<b>Paid care worker/ care assistant/ residential worker/ child and family worker</b>	<input type="checkbox"/>	8
<b>NHS administrative staff</b> (incl. receptionist/clerical)	<input type="checkbox"/>	9
<b>Social service administrative staff</b> (incl. receptionist/clerical)	<input type="checkbox"/>	10
<b>NHS general management</b> (if not included in categories above)	<input type="checkbox"/>	11
<b>Social service general management</b> (if not included in categories above)	<input type="checkbox"/>	12
<b>Third or voluntary sector</b> (if not included in categories above)	<input type="checkbox"/>	13
<b>Other</b>	<input type="checkbox"/>	14



19. How long have you worked in your current job?

Less than a year	<input type="checkbox"/>	1
1-2 years	<input type="checkbox"/>	2
3-5 years	<input type="checkbox"/>	3
6-10 years	<input type="checkbox"/>	4
11-15 years	<input type="checkbox"/>	5
More than 15 years	<input type="checkbox"/>	6

20. Are you male or female?

Male	<input type="checkbox"/>	1
Female	<input type="checkbox"/>	2

21. Do you have a certain number of contracted hours to work?

Yes	<input type="checkbox"/>	1	Continue to next question
No	<input type="checkbox"/>	2	Skip to Question 23

22. If yes, how many hours a week are you contracted to work?

<sub>1</sub>  <sub>2</sub> Hours

Now go to Question 23.

**23. Please tick the box corresponding to the pay range you are currently on.**  
This information is to help with our economic analysis of the Integrated Care Pilots.  
Your answer will be confidential, but please skip this question if you prefer not to answer.

£10,000 to £14,999 annually	<input type="checkbox"/> <sub>1</sub>
£15,000 to £19,999 annually	<input type="checkbox"/> <sub>2</sub>
£20,000 to £24,999 annually	<input type="checkbox"/> <sub>3</sub>
£25,000 to £29,999 annually	<input type="checkbox"/> <sub>4</sub>
£30,000 to £34,999 annually	<input type="checkbox"/> <sub>5</sub>
£35,000 to £39,999 annually	<input type="checkbox"/> <sub>6</sub>
£40,000 to £44,999 annually	<input type="checkbox"/> <sub>7</sub>
£45,000 to £49,999 annually	<input type="checkbox"/> <sub>8</sub>
£50,000 to £59,999 annually	<input type="checkbox"/> <sub>9</sub>
£60,000 to £69,999 annually	<input type="checkbox"/> <sub>10</sub>
£70,000 to £79,999 annually	<input type="checkbox"/> <sub>11</sub>
£80,000 to £99,999 annually	<input type="checkbox"/> <sub>12</sub>
More than £100,000 annually	<input type="checkbox"/> <sub>13</sub>

**24. Please write any other comments you may have about the Integrated Care Pilot. There is more space if needed on the back of this questionnaire.**

We are particularly interested in your views on the following:

- how the Integrated Care Pilot has helped to improve care for patients
- the things which have helped or got in the way of providing better care
- whether health professionals are more engaged in improving care
- whether managers are more engaged in improving care
- whether the voluntary sector is more engaged in improving care

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**Integrated Care Pilots evaluation: final report**

# **Appendix E: Template for collecting data from sites**

We are aiming to obtain the total added labour costs for your ICP over the course of 12 months of operation (serving patients). Please complete the chart below using actual cost data, and where unavailable, give your best estimate.

Question 1: This chart asks about direct labour costs over the ICP's first 12 months of operation.\*

Here we are interested in new staff hired specifically for ICP purposes before or during first 12 months of operation. Please list all long-term staff hired with intention of involvement in the ICP (full- and part-time).

New staff											(For individual respondents)			
New staff member title/role	Please explain role(s), if unclear from title given	Estimated number of hours worked per day (ICP and non-ICP)	Estimated number of <u>overtime</u> hours worked per day (Includes ICP and non-ICP work)		Length of employment in months (out of first 12)**	Annual salary or hourly wage	If applicable, average hourly overtime wage	Work time devoted solely to ICP		Overtime work hours devoted solely to ICP			Notes	On a scale of 1-7, how confident are you about each of these figures?
			Paid	Unpaid				Percentage of regular work hours (assumed 8 per day)	If varied, please give range or percentage variation per week	Percentage of <u>paid</u> overtime work hours (devoted to ICP)	Percentage of <u>unpaid</u> overtime work hours (devoted to ICP)	Percentage of <u>unpaid</u> overtime work hours		
<i>(Add in as many rows as needed)</i>														1 = not at all confident 7 = absolutely confident or based on raw data

\* Please use your official start date but factor in any direct labour costs related to ICP set-up and planning that took place after that date.

\*\* This is included in case new staff were only contracted for a number of months out of the year or otherwise left the pilot early. If employee has been with pilot longer than first 12 months, please still state 12.

Question 2: This chart asks about direct labour costs over the ICP's first 12 months of operation.\* Here we are interested in existing staff who now participate in ICP activity.

Please send chart to all participating organisations.

Participating organisations: please list all staff members with any involvement in the ICP (full- and part-time).

Existing staff											(For individual respondents)			
Staff member role or title	Please explain role if unclear from title	Estimated number of hours worked per day (ICP and non-ICP)	Estimated number <u>overtime</u> hours per day (ICP and non-ICP)		Annual salary or hourly wage	If applicable, hourly overtime wage	Work time devoted solely to ICP			Overtime work hours devoted solely to ICP			Notes	On a scale of 1-7, how confident are you about each of these figures?
			Paid	Unpaid			Percentage of regular work hours (assumed 8 per day)	If varied, please give range or percentage variation per week	What percentage of this time has replaced (or substituted for) time that would have previously been spent on other activity?	Percentage of overtime work hours	Percentage of <u>paid</u> overtime work hours (devoted to ICP)	Percentage of <u>unpaid</u> overtime work hours (devoted to ICP)		
<i>Add in rows for each member of staff (or staff category if many people have same role). If using categories, please give averages for requested data.</i>														1 = not at all confident 7 = absolutely confident or based on raw data

\* Please use your official start date but factor in any direct labour costs related to ICP set-up and planning that took place after that date.

\*\* We ask for an average here just in case responsibilities have changed or people left the pilot throughout the year. If you find that numbers of a particular staff category varied greatly throughout the year, please make note in the Notes section.

**Question 3: This chart asks about the 'set-up' or fixed costs (e.g. buildings, equipment etc) necessary for your pilot to operate.**

Here we are interested in one-off costs required to start the ICP and the initial intentions with these purchases. Please include one-off purchases that were made after pilot began operation if you consider them integral to the 'platform' or foundation of the pilot.

New costs					
	Was this purchase intended solely for use with ICP? If yes, what was the total cost (GBP)?	If purchase was intended to be shared with non-ICP services, please answer the following:		Brief explanation	On a scale of 1-7, how confident are you about each of these figures?
		Estimated total cost (GBP)	Average % use for ICP		1 = not at all confident 7 = absolutely confident or based on raw data
New building(s), down-payments for rent, renovations or refurbishments					
New equipment (medical or non-medical) or furniture etc.					
New computer systems or add-on hard/soft-ware					
New transport (cars, vans etc)					
One-time staffing-related expenses (non-labour), eg. initial recruitment and training					
Professional and other fees					
Other (please list and explain)					

**Question 4: This chart asks about any products/services required to start the ICP that were carried over from previously existing NHS or social care.**

Costs of products/services carried over from existing care					
	Can you estimate the value/cost of the segment given to ICP (GBP)?	If not, please answer the two questions below.		Brief explanation	On a scale of 1-7, how confident are you about each of these figures?
		Current total value/cost of asset/service (per month if applicable)	Average % of total asset/service used for ICP (per month)		1 = not at all confident 7 = absolutely confident or based on raw data
Building(s)					
Equipment (medical or non-medical) or furniture					
Computer systems or add-on hard/soft-ware					
Transport (eg. rented or purchased cars, vans, ambulances)					
Staffing-related expenses (non-labour), eg. initial recruitment and training					
Professional and other fees					
Other (please list and explain)					

Question 5: This chart asks about additional running ('recurrent') costs that occur on a regular basis to keep the project resourced.

Recurring costs							
	Is this service/facility used exclusively by the ICP? If yes, please give average total cost per month (GBP)	If service/facility is shared with non-ICP care, please answer the questions below.			Do these costs vary monthly? If yes, please give a range of costs or a percentage.	Brief explanation	On a scale of 1-7, how confident are you about each of these estimates?
		<i>What is the average total cost per month (ICP plus non-ICP costs)?</i>	<i>Can you estimate the percentage of use that is exclusively for ICP purposes?</i>	<i>Can you estimate the average monthly cost of ICP usage?</i>			<i>1 = not at all confident 7 = absolutely confident or based on raw data</i>
Staff travel							
Training							
Other (non-salary) staff costs							
Rent and rates of buildings and equipment							
Heating, lighting and other fuel costs							
Maintenance & repair; computer upgrades							
Other regular contractual arrangements							
Consumables (eg. drugs, dressings)							
Marketing and communications							
Clinical audit/service level research and ongoing							
Other							

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# **Appendix F: Summary of local metrics**



# Appendix F. Summary of local metrics provided by sites

Integrated care pilot sites participated in the national evaluation, but also provided local metrics which were designed to complement the national evaluation data with measures which sites had identified as being particularly relevant to their pilot. Sites' proposals for local metrics had been discussed with the evaluation team and the Department of Health at the start of the project.

Although most sites provided some information, the information provided was patchy, with some sites not being able to collect the data they had originally planned. It was never intended that local metrics would provide a comprehensive assessment of the pilot's success, but rather that the data provided would complement that from the national evaluation. We do not therefore attempt to draw detailed conclusions from the local evaluations on their own. Indeed, the partial nature of the data submitted provided makes it impossible to do this. However, the following table draws out some of the headlines from local evaluations. More detailed results from individual pilots are available from the evaluation team

The table shows mixed success in achieving the goals which the pilots set out at the start of the programme. In general, pilots were much more successful in demonstrating improvements in the process of care than in showing improvements in outcome. This may be partly because it is much harder to show changes in outcomes, but partly because in some pilots, the interventions were only rolled out towards the end of the evaluation period. We make further comment on some of the results in the main body of the report.

<p>Process measures improved as planned</p>	<p>Percentage of people expressing a choice on place of death increased from 3% to 22% (Cambridge)</p> <p>Medication reviews completed within a week of hospital discharge increased from 8% to 80% (Nene).</p> <p>Number of people on dementia registers increased from 131 to 230 between April 09 and March11 (Newquay).</p> <p>94% of actions recommended by falls clinic carried out, e.g. onward referral (North Tyneside).</p> <p>65% of patients with severe COPD are on correct treatment compared to 49% in control practices (Northumbria)</p> <p>Percentage of diabetic patients with care plans increased from 2.2% to 72.2% (Tower Hamlets)</p> <p>Percentage of carers of people receiving a community based service who received specific carer's service / advice / information increased from 24/6% to 42.1% (Norfolk)</p> <p>In the first six months, 163 people were referred to the 'Hot Spot' scheme to advise vulnerable people on keeping warm. (Durham Dales).</p>
<p>Process measures: inconclusive evidence</p>	<p>Change in number of referrals and waiting time to see a therapist: data recorded but site advises the data are unreliable (North Cornwall)</p> <p>COPD patients generally very satisfied with their care, Two thirds of patients thought that the</p>

	<p>service had improved in the previous 12 months, with most comments related to changes in medication. However there were no clear trends showing improvement during the course of the pilot (Northumbria).</p> <p>Patient satisfaction very high with falls service – no clear ‘before and after’ data as this was evaluation of a new service (North Tyneside)</p> <p>More patients on CVD register in pilot than control districts (16.5% vs 13.6% of 40-74 year olds), but time of assessment and nature of controls unclear (Tameside and Glossop).</p> <p>Significant event audits carried out, though any actions followed from learning points not specified (Church View, Newquay)</p>
<p>Process measures not improved</p>	<p>Changes in the management of community services meant that the agreed staffing model was not implemented (Cumbria)</p>
<p>Outcome measures improved</p>	<p>Percentage of people from nursing homes dying in hospital reduced (Cambridge, 12.5%, 11.1%, 8.7%, 8.2% in successive six month periods)</p> <p>Percentage of patients with controlled HbA1 and controlled blood pressure increased from 24% to 28% (Tower Hamlets).</p> <p>‘Referral bounce’ – i.e. referrals being rejected by one organisation with a recommendation to refer to another – reduced by 90%. (North Cornwall)</p> <p>1.8% rise in emergency admissions compared to 7.4% rise in control district. Length of stay for older people reduced by 11.6% in pilot compared to a reduction of 7.1% in a control district (Torbay)</p>
<p>Outcome measures: inconclusive evidence</p>	<p>Fewer patients with dementia admitted to hospital inappropriately (Newquay), but site unable to collect data from other areas as planned. Documentation of changes to care that may have reduced admissions</p> <p>Trend towards fewer admissions, though with very small numbers (too small for statistical analysis), North Cornwall</p> <p>COPD patients more likely to be getting correct treatment and to have fewer exacerbations compared to similar patients from other areas. Pilot patients with key workers in Northumbria 50% less likely to be admitted. These differences may be due to differences in case mix and will be examined in more detail in the main evaluation (Northumbria)</p> <p>CPN sickness rates reduced by 57% – not an original aim and not clear how this was related to the intervention (North Cornwall)</p> <p>Audit of 150 non-elective admissions identified which were potentially avoidable. Although not specifically designed to identify admissions which had been avoided, the audit identified a number of patients where the pilot intervention (e.g. community nurse specialist) was thought to have avoided admissions (Principia)</p> <p>A range of methods to establish patient views were intended to be carried out in Bournemouth and Poole, Church View, Principia, Tameside and Glossop. These were never completed.</p> <p>Emergency admissions to one hospital reduced, though main change predated pilot: 2007/8 1688, 2008/9 1279, 2009/10 1226, 2010/11 1103 (Cumbria)</p>

	<p>Mixed response (from positive to negative) to two surveys of patients referred to the 'Hot Spot' scheme. It was not possible to draw clear conclusions as the numbers were very small.</p>
<p>Outcome measures showing no improvement or marginal improvement</p>	<p>Percentage of people dying at home unchanged (38.9%, 36.8%, 38.1%, 34.5% in successive 6 month periods). This was partly because community based services were not initiated as planned, and partly because many patients' choice was to die in hospital (Cambridge)</p> <p>Percentage of people dying at home unchanged from 20.2% to 20.9% – partly because community based end-of-life care services were not initiated until near the end of the pilot study (Nene).</p> <p>Recovery rate unchanged using Improving Access to Physiological Therapies measure: 2009 46%, 2010 47%. (North Cornwall)</p> <p>National Social Services measure NI136: number of people supported to live independently through social services increased from 3,666 to only 3,737 (Norfolk)</p>

# ANNEX: Further details of local evaluations.

A summary of the results from individual sites follow. In a number of cases data are incomplete or unclear. This was either because data were not collected as planned, or because the site was unable to respond to queries from the evaluation team despite numerous requests.

## Bournemouth and Poole

The two local metrics are

1. Number of people seen in the period by Specialist Intermediate Care Team and Dementia Advisor. This was to be measured by recording and collecting the data relating to the number of referrals to each service.
2. Are service users valued and supported. This was to be collected by an audit of patient and service users' records for evidence in care plans of relevant discussions, exploring their wishes, views, interests and ethnic and religious needs

Metric 1. The following data were provided:

	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11
Number of Referrals	21	19	45	34	24	25	20	23	14	31	23
Not suitable	9	4	16	4	8	10	2	6	10	26	6
Net Referrals	12	15	29	30	16	15	18	17	4	5	17

Metric 2. The site provided a blank 'Life Diary/Emergency Plan' which patients / service users were invited to complete. The Life Diary would form the basis of assessing the extent to which patients were valued and supported. This contains basic information about care (e.g. contact details for professionals), details about things they do / would like to do, a diary space, space for professional carers to record visits, and space for advance directives. It's a substantial document which has been received by 119 patients judged able to complete it. No analysis was provided of this document by the site, and no additional data were provided to demonstrate how service users were 'valued and supported'.

## Cambridge

The local metrics are:

1. Number of patients expressing choice of place of death, as a percentage of all patients in the pilot practices
2. Percentage of people who express a choice of place of death dying in that place of choice (overall target for pilot 50%)
3. Number of people dying at home as a percentage of all deaths in the pilot
4. Number of admissions in the year prior to death in the target population compared with numbers identified in a retrospective audit.

5. Number of people dying in hospital admitted from nursing homes as a percentage of all deaths among nursing home residents dying in the pilot.

The following data were provided for Cambridge:

	Oct-09	Apr-10	Oct-10	Apr-11
Population covered	170897	171226	175033	175375
Live patients on Eol register	96	169	176	173
No. deaths since 1/1/09	970	1548	2158	2818
<b>Deaths in previous 6 months</b>				
No death with place recorded	522	626	551	621
No. of live patients on EOL expressing their choice re place of care / death. <i>(The numbers relate to those who are still alive &amp; on the EOL register &amp; have expressed a preference to where they want to be cared for – so do not relate directly to metric 1 which relates to those who have died).</i>	7	26	30	75
metric 1 ( % patients who have died, who had expressed a place of death / care)	3.0%	7.2%	14.1%	22.4%
metric 2 ( % dying in their chosen place of death who expressed a choice)	53.3%	83.3%	82.2%	76.7%
metric 3 ( % of patients dying at home)	38.9%	36.8%	38.1%	34.5%
metric 5 ( % of deaths from nursing home in hospital)	12.5%	11.1%	8.7%	8.2%

Although the numbers are small, they indicate that raising awareness via an EOL Education package can lead to an improvement in the number of patients with a recorded preferred place of death and the number of patients dying in that preferred place of death.

It is notable, and was not expected, that the majority of patients who expressed a preference wanted to die in hospital. Hence increasing the number who expressed a preference would not necessarily lead to an increase in deaths at home. Therefore metric 3 (% of patients dying at home) turned out not necessarily to be an appropriate one.

Metric 5 shows a decrease in the percentage of nursing home patients who were admitted to hospital before death. This could have been related to the increased training provided in the pilot which included, for example, training in the use of 'just in case' boxes (where a range of drugs for emergency use is left with the patient).

## **Church View**

The local metrics are:

1. Number of care plans completed and shared across primary and secondary care (process)
2. Significant event audit of people admitted to hospital who are being actively case managed (intermediate outcome)
3. Qualitative analysis of patient/user experience (separate funding application through the local Knowledge Transfer Partnership)

Data provided in April 2011 indicated:

61 patients took part in virtual ward rounds; 15 died and 152 summary assessment reviews took place. Assuming a 'summary assessment review' is taken as the same thing as a 'care plan', then this is the figure for metric 1

One case history and three clinical significant event audits were provided (metric 2). These included the following learning points:

- An 82 year old died after six admissions and 42 outpatient appointments in the last year of life. This included many discussions on the virtual ward. The patient repeatedly expressed a wish to be treated as aggressively as possible: she wanted to take advantage of everything the hospital might have to offer. This underlines that increasing patient choice will not always reduce resource use (c.f. the high proportion of Cambridge patients who chose to die in hospital).
- Patient with COPD at end of life admitted inappropriately. Need for better communication with urgent care team and ambulance service about patients at the end of life.
- Patient with pulmonary embolism anti-coagulated. Difficulty maintaining control: eventually stopped as being unsafe. Difficulty initially in getting all professionals involved in 'singing from the same hymn sheet'. Issues could be resolved once there was consistent input from all professionals.

The pilot did not succeed in obtaining funding for metric 3.

It is not possible to draw any general conclusions about the success of the pilot from data provided by Church View.

## **Cumbria**

The local metrics are:

1. Review discharges and A&E attendances of patients age 70+ and diabetics, and record avoidable factors.
2. Inpatient resource allocation audit. Application of a method of attributing unnecessary inpatient costs to the services for which patients are waiting before they can be discharged

Metric 1.

Neither of these metrics were reported by the site. The site comments that changes in the management of community services, as dictated by the 'Transforming Community Services' process, have meant that the agreed staffing model was not implemented. It was therefore not possible to gather the data as planned

Data were provided on bed usage in the 'step down' Cockermonth Community Hospital, which showed increased bed occupancy and reduced length of stay:

	2008/09	2009/10	2010/11
Bed occupancy	66.9%	79.7%	80.1%
Length of stay	14.7 days	10.8 days	10.4 days

No explanations were given for these changes. Other data provided for Cockermonth General Hospital show a reduction in the numbers of emergency admissions, but this was a change which predated the pilot (2007/8 1688, 2008/9 1279, 2009/10 1226, 2010/11 1103). No comments are made about how these relate to the availability of services more generally, e.g. other hospitals (this will be examined in more detail in the main evaluation).

We received a file analysing admissions from Maryport in June 2010 with a comment that there have been delays with data from Cockermonth. The file contained some quantitative data on timing of admissions, the route of admissions and the clinical diagnosis, and a substantial amount of descriptive information on the sorts of things that might help to avoid admission. A table is also provided of the costs of admissions to Cockermonth Hospital, broken down by diagnostic group. No consistent trends were evident over the pilot period.

#### **Durham Dales.**

The local metrics are:

1. The number of referrals to the 'Hot Spot' scheme in Durham Dales compared to referrals from the rest of County Durham. 'Hot Spot' is a new scheme for giving advice to vulnerable people on keeping warm etc.
2. Reviewing recommendations which had been made for a sample of people who had been referred to the Hot Spot scheme, and contacting the people to see how many of the recommendations had actually been carried out.

The following data were provided for metric 1 in June 2010:

District	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Total
Dales	4	6	6	6	5	0	16	43
Sedgefield	6	7	8	3	2	2	7	35
Durham	0	3	4	3	2	1	11	24
Chester-le-Street	0	5	2	3	0	1	3	14
Derwentside	3	3	6	0	1	1	8	22
Easington	6	7	4	0	3	0	5	25
Total	19	31	30	15	13	5	50	163

Metric 2 was assessed by a telephone administered questionnaire to people who had been referred to the HotSpot scheme. Ten people were able to provide information. Seven of the ten respondents reported that they kept their heating on for longer than the previous winter, and six that they kept their thermostat at a higher temperature. Five said that they had changed their behaviour or attitude towards the cold as a result of the pilot scheme. All ten said they would take part in the scheme again, and general comments indicated a high level of satisfaction.

These results were more positive than a previous survey reported by the site in which six out of 53 patients who had been referred to the HotSpots scheme between December 2009 and January 2011 responded to a survey. Of these, all had reported that the scheme was not useful (five scoring 1 and one scoring 2 on a scale from 1 (not useful) to 6 (very useful)). On that questionnaire, only two patients had changed behaviour to 'save energy or keep warm'. None had changed energy tariff, been referred for cavity wall insulation or been referred for benefit entitlement. Three patients had received emergency funds, but these were not among the patients who could be contacted.

These two surveys appear to have asked different questions, and it is not clear when they were carried out.

Overall, there was some evidence that the 'hotspot referral' had been effective, though this conclusion is based on a very small sample of responses.

### **Nene**

The local metrics are:

1. Percentage of complex patients receiving medication review (clinical and compliance based) within one week of hospital discharge
2. Percentage of people dying at home increased (target from 21% to 26.5%)

Metric 1. A baseline audit was undertaken showing that 8% of target patients were receiving a medication review within one week of hospital discharge. A pilot was then subsequently undertaken to increase the percentage of medication reviews following discharge. Following completion of the pilot, the scope was widened to increase coverage (including all patients aged 65+ and discharged from hospital on 4 or more medications). Subsequent audit shows that of 76 patients within the scope of the pilot, 80% (61 patients) had a medication review within one week of discharge. This shows that the medicines management pilot has been successful in increasing the percentage of patients receiving a medication review within one week of discharge

Metric 2. The percentage of deaths at home for all recorded deaths in Northamptonshire are shown in the following table:

Year	2008	2009	2010
Deaths at home (%)	20.2%	19.9%	20.9%

The Pro-active Care Case Management Model provides a facility whereby patients at the end of life can be supported to die in their place of preference. Of the 3065 patients who have been in Pro-active Care between July 2008 and January 2011, 601 patients have died with 48% (286) of these dying at home

The End of Life Community Services has been live since December 2010. The services include a Rapid Response Community Nursing Team, Care Coordination Centre, End of Life Link Nurses to expedite discharges for patients wishing to die in a non-hospital setting and access to low level social support through Age Concern.



The 2 year goal for this metric has not been achieved as a consequence of the End of Life Services only going live in December 2010. With the new End of Life Services now operational, more patients at the end of life will be fully supported in meeting their place of death preferences.

However, against this, Cambridge's experience that many people don't want to die at home needs to be considered. Meeting people's choice about place of death will not necessarily lead to an increase in deaths at home.

## Newquay

The local metrics are:

1. Number of people on QOF dementia registers.
2. Reports of significant event audits of people on register admitted to hospital, especially acute hospital and Cove Ward.

Metric 1. The number of people on dementia registers in the pilot practices increased from 131 in April 2009 to 230 in February 2011, with most of the increase occurring between July 2009 and November 2009 (226 were recorded in November 2009). The site comments that these data are based on the number of people on QOF dementia registers and some of the rapid increase in 2009 may have been due to re-coding. The site also comments that the match between practice QOF dementia registers and adult social care provider / mental health provider records are very incomplete (up to 42% mismatch). They comment that 'effective liaison is not yet embedded within Newquay'.

Metric 2. 132 significant event proformas were completed over the course of the pilot. These identified a range of learning points, e.g. identifying patterns in falls in one care home and remedying this by changing flooring surfaces. Significant events included admissions which the pilot defined as inappropriate and avoidable ('red' and to a lesser extent 'amber'). 13 out of the 18 'amber' admissions and three out of the five 'red' admissions took place in the first half of the data recording period.

	Green	Amber	Red	Not Known	Total
Sep-09	2	1	0	9	12
Oct-09	2	0	1	3	6
Nov-09	0	0	1	5	6
Dec-09	1	2	0	13	16
Jan-10	9	4	0	1	14
Feb-10	11	2	1	2	16
Mar-10	3	2	0	0	5
Apr-10	8	0	0	1	9
May-10	8	2	0	0	10
Jun-10	10	0	0	0	10
Jul-10	4	1	1	0	6
Aug-10	6	1	1	0	8
Sep-10	8	0	0	1	9
Oct-10	6	1	0	0	7

Nov-10	4	1	0	5	10
Dec-10	3	0	0	2	5
Jan-11	5	1	0	6	12
Feb-11	4	0	0	8	12
Total	94	18	5	56	173

The pilot suggests that this demonstrates a small but progressive reduction in inappropriate and avoidable admissions since the pilot started (see table, 'red' and 'amber'). They comment that they do not have a robust system in place to compare these figures with countywide admissions data or with other local admissions data. This is largely due to data collection issues which have been a challenge across the life time of the pilot, with no data available for the mental health provider on admissions to their in-patient wards.

### Norfolk

Local metrics are:

1. National Social Services measure NI135 - Carers who have been assessed and in receipt of services
2. National Social Services measure NI136 - People supported to live independently through social services

### Results

	NI135	NI136
2009-10	24.6%	3,666
2010-11	42.1%	3,737

### Site's comments on results:

<b>NI 135: Carers receiving needs assessment or review and a specific carer's service, or advice and information</b>	
The percentage of carers whose needs were assessed or reviewed by the council in a year who received a specific carer's service, or advice and information in the same year as a percentage of people receiving a community based service in the year. (High is good)	
Numerator	The number of carers receiving a 'carer's break' or other specific carers service, or advice or information, during the year following a carer's assessment or review.
Denominator	The number of adults receiving a community- based service during the year.
Conclusions	This is a positive result and shows that there have been more carers' assessments in the community.

NI 136: People supported to live independently through social services (all adults)	
This indicator will measure the number of adults all ages per 100,000 population that are assisted directly through social services assessed/care planned, funded support to live independently, plus those supported through organisations that receive social services grant funded services. (High is good)	
Numerator	Adults and older people helped to live at home at 31 March plus Adults and older people receiving grant funded services during a sample week
Denominator	Population figures are based on the latest mid year population estimates from ONS.
Conclusions	The result is a positive one, showing that more service users have been supported to live independently in Norfolk.

Comment: Although the site reports these as positive outcomes, the improvement in the second one is marginal.

### North Cornwall

The local metrics are:

1. Change in number of referrals and waiting time to see a therapist assessed by: a) number of referrals, and b) mean and median waiting time from referral to time of first appointment.
2. IATP (Improving Access to Physiological Therapies) measure of recovery rate, using IATP standardised questionnaire. Client scores will be compared before and after treatment, and compared to national data that are being captured as part of the IATP programme.

The following data were provided:

	Median waiting time		Recovery rate	
	Oct 09 – Dec 09	Oct 10 – Dec 10	Oct 09 – Dec 09	Oct 10 – Dec 10
Boscastle	106	21	67%	45%
Camelford N	108	22	60%	Not enough data
Camelford G	106	29	20%	Not enough data
Wadebridge	86	15	60%	73%
Port Isaac	121	32	25%	42%
Bude	95	21	43%	40%
Stratton	101	12	23%	55%
Carnewater	125	29	60%	45%
Stillmoor	102	35	86%	29%
Lostwithiel	85	48	67%	Not enough data
<b>All</b>	<b>106 days</b>	<b>27 days</b>	<b>46%</b>	<b>47%</b>

The site comments on the two metrics as follows:

#### Metric 1

Although at first glance the figures for referral waiting times show a significant improvement, they cannot be reliably attributed to “integrated care”. The site reported that the referral process which was improved by the integrated care approach for a patient was a small part of the overall waiting time experienced by patients. Although it could be argued that “integrated problem solving” resulting from the project’s integrated approach led to single organisation process initiatives which are the main cause of the significant reduction in waiting times, the site does not believe that they can be fully attributed to patient pathways resulting from “integrated care”.

## Metric 2

The Recovery Rate measure was selected as it was already a national IAPT (Improving Access to Psychological Therapies) measure. This measure shows high levels of variance and IAPT is now redefining this measure to reflect a move along the questionnaire scale being used rather than a change from above a cut off line to below the cut off line (some patients start above the cut off line and improve but remain above the cut off and therefore are not deemed to be recovering, whilst other patients start below the cut off line and make improvements but are not included in the measure).

The site also reports improvement in the following measures:

### Referral bounce

A key issue at the start of the project was that of “Referral Bounce” (GPs who found referrals being rejected by one organisation with a recommendation to refer to another organisation only to have that organisation recommend referral back to the original provider). This bouncing between organisations was frustrating for all concerned and obviously did not help the service user at the centre of the issue. The North Cornwall PBC Working Group estimates a 90% reduction in referral bounce.

### Admissions

The site reports a trend towards fewer admissions, though with very small numbers (too small for statistical analysis)

### Sickness Rates.

At the start of the pilot project CPN sickness rates were highlighted as being a problem. The new way of working in the pilot has seen a reduction in sickness days from 51 days to 22 days, a reduction of 57% over comparable 6 month periods for the eight North Cornwall CPNs.

### Case histories

- Case histories presented which show how:
- regular communication with CPN’s, Psychiatrists and GP’s ensured a patient was seen, assessed and treated quickly, avoiding an acute crisis.
- immediate same day communication made between the counsellor, GP and CPN certainly prevented a possible suicide attempt
- GP’s can now able to regularly liaise with the CMHT and Community Alcohol Team about a difficult and complex chronic alcoholic, providing more support for GP.
- Young lady whom had previously suffered with severe self harming behaviour following childhood difficulties and abuse was rapidly assessed and seen by a CPN and the CMHT took over her case very effectively.

Evaluator's comment: not clear what these case histories show over and above care from a standard community mental health team approach (although the site did not have an effective team before the pilot).

### North Tyneside

The local metrics are:

1. Follow up in the GP patient records to check recommended referrals have been made after attendance at the falls assessment clinic
2. Patient questionnaire, using a modification of one they are already using in the hospital outpatient falls service

Metric 1.

A review of 464 patients attending the service was updated in April 2011. All recommendations regarding onward referrals to primary care organisations and Age UK were being appropriately referred to those organisations. Practices referred 94% of patients to secondary care when recommended by the falls prevention service.

Detailed results are as follows:

Recommendation	Total	% referred
Patients invited to the service	464	
Unwilling to attend/DNA	134	
Patients attending the service	330	
Information given/medication review	147	
Patients to be referred	183	
Referrals to primary care only		
Age Concern gait & balance classes	78	100
Jubilee Day Hospital/Community physio	17	100
Referrals to secondary care		
Dexa scan	31	97
Falls & syncope	44	95
Cardiology	7	100
ENT	6	50

The six patients who were not referred to secondary care arose either due to:-

- Patient did not wish to be referred (2)
- GP did not believe recommendation was appropriate (1)
- Clerical error (1)
- Not yet referred (2)

These data indicate that local primary care services are being highly effective in carrying through recommendations for further specialist referral.

#### Metric 2 (Patient questionnaire)

A patient survey was sent in March 2010 to 243 patients seen at the Falls Prevention Clinic in the four months ending 28 February 2010. The questionnaire included 23 questions requiring the patient to indicate whether the service was Excellent, Good, Fair or Poor. In addition a section was included for patient comments or suggestions. All surveys were sent with a covering letter requesting completion and return in a stamped addressed envelope. Patient response was very good with a response rate of slightly over 75% with 183 replies being received. Each question within the survey has been scored 4 for Excellent, 3 for Good, 2 for Fair and 1 for Poor.

Question	Mean score
Improved Access & Waiting	
Amount of information received before your appointment	3.04
Usefulness of the information you received prior to your appointment	2.98
Directions to Albion Road Resource Centre	3.37
Ease of changing your appointment	3.38
Registration process at reception on arrival at the clinic	3.32
Waiting time in the clinic	3.17
Building Closer Relationships	
Attitude of reception staff	3.54
Attitude of the health care assistant/physiotherapist	3.79
Attitude of the doctor at the clinic	3.85
More information, more choice	
Information relating to any delays	3.18
Information given to you in the clinic regarding your condition or treatment	3.47
Opportunities you had to discuss your care and express any concerns	3.53
Willingness of staff to answer questions fully	3.61
Safe, high quality, coordinated care	
Concern and care shown to you	3.61
Courtesy and respect shown to you	3.68
Privacy in the consulting area	3.70
History, examination and test you received	
Physiotherapist	3.60
Medical assessment	3.64

ECG/blood pressure and other test performed by Health care assistant	3.67
Was your care plan explained to you	3.45
Did you receive written information about the result of your visit	3.28
Overall impression	
Did you have a comprehensive assessment regarding your problems	3.49
Would you recommend this service to others	3.59

The survey results show

- That patients rate the service very highly with a score of over 3.5, i.e. between 'Good' and 'Excellent' when asked if patients would recommend the service to others.
- Patients also believe the clinicians and the service to be very helpful with many comments as to the help it has given them and the high quality of care and also evidence of improvement in their health.
- All categories rated above 3.00 i.e. 'Good'
- The one area which, whilst still being rated 'Good', scored lower than other areas was that of Patient Information prior to attendance at the clinics. This area is currently being reviewed to identify how improvements can be made.

### Northumbria

The local metrics are:

1. Patients with FEV1 <60% on triple combination therapy with Tiotropium, ICS and LABA (best measure)
2. Patients with Oxygen Stats <92% that have had an LTOT assessment
3. Patient questionnaire results

Metric 1. The percentage of patients meeting this criterion by practice ranged from 29% to 100% in February 2010, with four practices above 90% (all 100%). In an audit completed in September 2010, seven practices had achieved 100% on this measure, though there were some incomplete data. 65% of patients with severe COPD are reported as being on correct treatment compared to 49% in control practices

Metric 2. The percentage of patients with oxygen saturation recorded increased. However, practices were not recording referral for long term oxygen therapy (LTOT) so it was not possible to assess metric 2.

Metric 3: Patient questionnaires. 110 questionnaires were mailed to patients, with between 52 and 92 replies. The questionnaires had 47 questions and were sent over a period of eight months in April 2010, July 2010, November 2010 and April 2011, so provide some opportunity to look at change over time. The survey results show the following. Percentages relate to the four time periods: there are not generally discernable trends over this period.

- 88-90% of patients knew who their key worker was and 88-90% knew how to contact him /her. 89-91% were 'very satisfied' with their key worker.
- 85-88% knew what to do if their symptoms got worse, and 78-82% knew what medications to take if their symptoms got worse. 84-87% felt confident in taking 'rescue medicines' on their own. There was no marked trend towards improvement in any of these responses.

- 61-64% had a care plan (61% April, 62% July, 64% November, 63% April). Most (65-71%) had shared the care plan with the GP; few had shared it with other professionals.
- Most patients thought that the service had improved in the previous 12 months (70% April, 71% July, 64% November, 64% April). Most comments related to changes in medication (including provision of 'rescue medication'), better communication, key worker contact, increased confidence, and better information
- In response to a question about whether they were as involved as they wanted to be in decisions about their care, between 71 and 74% replied 'yes definitely' and 24-27% 'Yes, to some extent')

Additional comment by the pilot on local evaluation:

- Coding continues to improve, which is excellent although some pilot practices still need to improve further. Coding is better in the pilot practices when compared with the non-pilot practices, but some are just not coding.
- The known prevalence rates still remain variable and the rates for the pilot practices seems to be greater
- Several areas suggest that the pilot patients are getting better outcomes and higher quality of care. There is significant variation in the practice's hospital admission rates. The admission rates for pilot patients with key workers are about half the rate for the non-pilot target patients, with rates of 0.66 admissions per patients for patients with key workers compared with 1.32 for those without.

Comment by evaluation team: Patients made many positive comments in the questionnaire, with two thirds reporting improvements in care in the preceding 12 months, mostly relating to medication changes.

The number of respondents increased from the beginning to the end of the survey period which, taken with the pilot's comment that prevalence increased in intervention practices suggests that 'milder' cases might have been being recruited to pilot practices though the site states that these groups were of comparable severity, The main evaluation will independently evaluate changes in admission pattern, with detailed case mix adjustment to allow for differences in case mix between practices.

## Principia

The local metrics are:

1. Audit of people who are being case managed in the community wards and who are none the less admitted to hospital as emergencies.
2. 'Patient diaries' for people with COPD

Metric 1. Audit report provided of non-elective admissions (April 2010). 369 non-elective admissions were included in the audit and 150 discussed in detail (108 patients). Six patients (5.6%) were considered to have had admissions which were potentially avoidable. The avoidable factors identified were: poor discharge planning, patient discharged too early, and patient could have been treated in the community. A comment was made in the report that the low numbers of potential avoidable admissions was not surprising as by the time a patient reached that stage there was often little that could be done in the short term. The important issue was to work to anticipate problems for patients. Although not specifically designed to identify admissions which had been avoided, the audit identified a number of patients where the pilot intervention (e.g. community nurse specialist) was thought to have avoided admissions.

The audit was planned be repeated later in 2010, but no further data were available from the site.



Metric 2. Information from the site was that the diary scheme was not implemented.

### **Tameside and Glossop**

The local metrics are:

1. Increase in the number of patients on CVD risk registers greater than in non-ICP practices
2. Patient questionnaire to measure improvement of patient's perception of care (open-ended questionnaire to be completed 15 months from the development of care plan).

Metric 1.

The following data were provided, indicating an increased number of patients aged 40-74 on CVD related risk registers

	Population (40-74 year old)	On register (20% Risk)	On register as a percentage of total 40-74 year old pop (%)	Rate per 1000
ICP	20332	3360	16.5	165.3
Non ICP	79049	10738	13.6	135.8

The timing of this assessment and the nature of the controls was unclear.

Metric 2.

The questionnaire survey was not conducted by the site as originally planned.

### **Torbay.**

The agreed local metrics were:

Metric 1. Reduction in average length of stay of TCT patients aged 65+ in Torbay Hospital, using South Devon as the control.

Metric 2. Increase in the number of patients (or carers) advising that they felt involved in discharge planning.

The site did not provide data for the second metric. However, data were provided with detailed spreadsheets relating to a range of aspects of the pilot's activity. In particular, these focused on assessments of the impact of providing a same day Rapid Assessment Service run by acute physicians as an alternative to the previous three times weekly clinic run by Care of the Elderly consultants. In addition, Care of the Elderly consultants provided a telephone hotline for GPs to use to explore alternatives to admission.

The site compared data from Torbay with that from South Devon, where neither of these two interventions took place. They acknowledge that the control comparison is imperfect because of other changes occurring across the health care system. Nevertheless, the results suggest the following:

Rates of emergency admission

Number of >65 non-elective admissions	2008/09	2009/10	2010/11	Overall change over period
Torbay	6090	6186	6201	+ 1.8%
South Devon	5475	5548	5885	+ 7.4%

These data are compatible with the pilot interventions limiting the rise in emergency admissions in Torbay.

The site also reports a reduction in patients over 65 attending A&E or the admissions unit of 330, compared to an increase in South Devon of 367. This is consistent with the interventions diverting patients from A&E, though some of these may still have involved consultations, e.g. in an assessment clinic rather than A&E.

#### Length of stay

Data from the site also point to a change in the pattern of length of stay of elderly people in Torbay, with a rise in the proportion with a 0/1 day length of stay and a reduction in the proportion of 2 day length of stay. The site interprets these data as indicating that patients were rapidly diagnosed, stabilised and sent home. However, these data are complex to interpret, partly because there were additional aspects of the pilot focused specifically on discharge planning. In addition, some changes in these indicators also occurred in the control South Devon area.

Average length of stay for >65s	2008/09	2009/10	2010/11	Overall change over period
Torbay	8.6	8.2	7.6	-11.6%
South Devon	8.4	8.1	7.8	-7.1%

From these data, we conclude that there is some evidence that the pilot intervention was associated with a reduction in length of stay for older people.

In neither case were statistical analyses of these data provided.

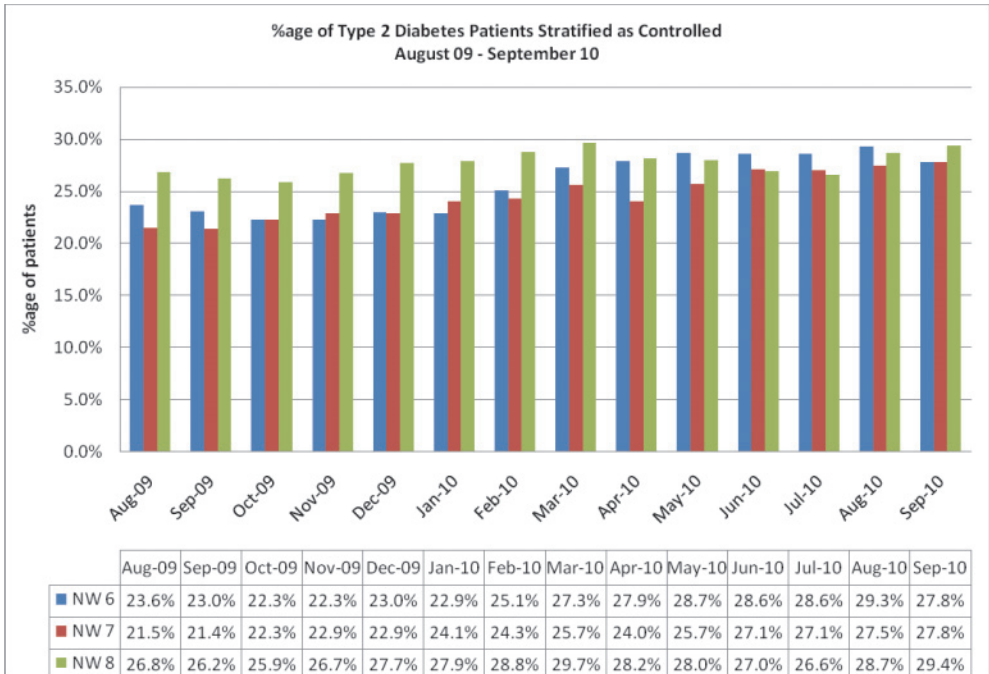
#### Tower Hamlets

The local metrics are:

1. Percentage and patients in the controlled stratification (for blood pressure, cholesterol and HbA1c)
2. Document of care planning consultations that have been completed.

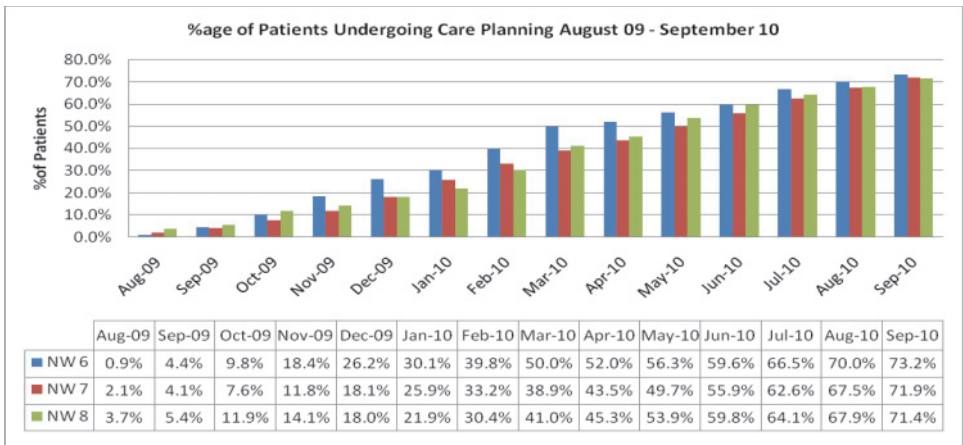
#### Metric 1.

This metric assesses patients who fulfil all three of the following clinical indicators: blood pressure less than 140/80, HbA1C less than 7.5, and cholesterol less than 4.5 mmol. The number of patients identified as controlled has increased across all networks by an average of 4.4% since reporting on the intervention rising from an average of 24% in August 2009 to 28.4% by September 2010.



Metric 2.

The number of patients with care plans increased from an average of 2.2% in August 2009 to 72.2% by September 2010.



**Wakefield**

The metrics are:

1. Output of their balanced scorecard.
2. Patient questionnaires

Metric 1. Data from a balanced scorecard were provided in April 2010

Metric 2. Report on a survey of service users was provided in April 2010.

Information on some performance metrics and the results of a patient/client survey were provided in April 2010. However, since the intervention which was originally planned had not been implemented by the end of the pilot (April 2011), there was no 'after' data, hence no 'before and after' metrics are available.

**Integrated Care Pilots evaluation: final report**

## **Appendix G: Site overviews**

# Appendix G. Overview of Integrated Care Pilot sites

Completed activities to date refer to March 2011 except where otherwise noted and are reported as presented by the pilots to the national evaluation team.

## **Bournemouth and Poole**

Theme/focus:

New model for delivering care for older people with dementia

**Aims:** To improve early intervention and signposting of services for people with memory loss and support for people with diagnosed dementia

Intervention/service change:

- Low-level case finding for people with early memory loss: provision of information (e.g. available local services), earlier 'signposting' to alert people of symptoms, enabling access to earlier intervention
- Integrated 'intermediate care' community team providing:
  - Single point of access (to multiple diagnostic services)
  - Holistic assessment of health and social care needs
  - Decision support through Life Diaries - offered to all patients who are medically fit and under the care of the integrated team
  - Team members with access to each other's information systems (agreed data sharing protocol)

### **Partnerships/governance structure:**

Site describes the ICO as a "GP-led model." Collaboration between GPs, public sector organisations and third-sector services: NHS Bournemouth & Poole, Borough of Poole Council, Alzheimer's Society, Faithworks, Dorset Healthcare Foundation Trust, Poole Hospital Foundation Trust

Single line management is provided by Bournemouth and Poole Community Health Services for community based team, participating staff are employed by B&P CHS, Borough of Poole, Alzheimer's and Poole Hospital Foundation Trust

Intervention start date: 1 September 2009

Activity to date (March 2011)

- The Specialist Intermediate Care Team is currently seeing between 20 to 30 referrals each month
- Dementia Support Worker has been seconded to the team from the Alzheimer's Society
- Training has been delivered to third sector organizations, such as banks, solicitors and hairdressers to help their staff better recognize and support customers with memory problems / dementia
- Case finding taking place from Poole Hospital's admission list, emailed to integrated team daily, although primary source of referrals comes from the community: memory cafes, leaflets, low-level support groups
- Memory cafes are run twice a month with 25 attendees on average
- "Singing for the Brain" sessions (informal group singing sessions) are running, very popular, with 50+ attendees – this has generated local media attention
- "Life diaries" support offered to all patients who are medically fit and under the care of the integrated team
- Ongoing communications events with GPs and community stakeholders

Facilitators to success

- Flexibility in designated roles and responsibilities of integrated care team, enabling them to try various ways of connected with hard-to-engage patients
- Widespread community and stakeholder engagement (public as well as third sector and local business support)
- The 'Transforming Community Services' agenda is encouraging better integration between services
- Time invested in building relationships between partner organisations
- Regular communication between partner organisations

#### Barriers and challenges

- Working with the two local unitary authorities and their anomalies one local authority is engaged and contributes but the other has withdrawn. Both local authorities work to different eligibilities and criteria's and the borough of Bournemouth decided not to engage with this project
- The original intention was to use a care record system owned by Borough of Poole, but the records and reporting system turned out not to meet needs of the integrated care team, so could not be used. Local authority staff developed their own internal record for the project.
- Space issues were time consuming. Originally the pilot was going to be based at a GP surgery. However the initial room proposed by one GP was not supported by other GPs in the practice. Negotiations to lease affordable alternative premises were protracted and complex.
- Financial constraints for all partners.
  - Bournemouth Social Services meant they were unable to provide a dedicated social worker for community team as planned.
  - Worsening financial position of the PCT - if the project is to be rolled out to further locations, the design of the teams will have to be modified to make it more affordable, and it will have to be funded by cost savings elsewhere.

#### Cambridge

##### Theme/focus:

Coordination of end-of-life care to enable people to be cared for and die in the place they choose

##### Aims:

To identify patients who are in the last year of their life, improve the use of End of Life tools to proactively plan the patients care, ensuring their preferences for care are met through actively involving all stakeholders in the appropriate use of these tools. To improve the services that are required in the community to support patients nearing the end of their life

The key objective of the pilot for 50% of patients who know they are dying, to die in the place of their choice by the end of the pilot period. (EOE SHA has set a target for all its PCTs to achieve 90% of patients dying in their preferred place by March 2012). Integrated care activity hoped to lead to:

- Improved care
- Improved care co-ordination
- Improved use of resources
- Innovation and sustainable change

"The ambition is to provide more services as an ICO e.g. Out of Hospital Care and Long Term Conditions, as well as formalising the structure arrangements between the organisations to become a legal entity."

##### Partnerships/governance structure:

- Project led by Assura Cambridge LLP and NHS Cambridgeshire (PCT) End of Life Steering Group described as a "provider-driven partnership"
- Pilot Project Management Board (PMB) manages implementation of seven work streams
- Provider partners include: Cambridge University Hospitals NHS Foundation Trust; Assura Cambridge LLP; Assura Medical Ltd (now majority owned by Virgin Healthcare); Cambridgeshire Community Services (NHS Cambridgeshire provider arm)

##### Intervention/service change:

Key interventions delivered by the ICO:

- Development of a unique tool to identify patients who have expressed a preference of where they wish to die and the means to capture whether this was achieved
- Development of a peer to peer educational package on managing patients at the end of their life for GPs and their teams. This included training on ensuring all patients have access to appropriate medications and implementing existing end of life care tools.

Intervention start date: October 2009

### **Activity to date (March 2011)**

The pilot initially planned a formalised partnership between organisations to deliver end-of-life care but was unable to achieve this. However, the work has demonstrated that integration is not just about merging organisations but about bringing teams and services together, which has been done. Integration at service level did not occur partly because it was not possible to make the service change without change in organisational structure. The ICO continues to work with NHS Cambridgeshire to support delivery of some of the wider, whole systems changes e.g. the expansion of Hospice at Home.

- Developed good relationships between local providers of End of life (EOL) care
- Identified gaps in service provision
- EOL registers established at participating GP practices
- Developed MIQUEST search tool to identify patients in last year of life and promote the use existing tools effectively
- Generic training on use of tools (and the coding/data capture required to record this) has occurred in:
  - all GP practices with GPs, Practice Nurses and District nurses
  - with key clinical groups at Addenbrooke's – including GP Liaison Group, Joint Clinical & Corporate Group, Executive Forum, DME Service Delivery Unit, Oncology Service Delivery Unit
- Made a case for the roll-out of 'Just in case' bags (JICBs) to improve patient/carer experience and reduce hospital admissions with subsequent cost reductions.
- Developed a template which will support the prescribing of JICBs
- Hospice at Home model agreed and referral criteria drafted.
- Benchmarked hospice at home services to inform the further development of the service in this area
- An initial education package was delivered to practices during the autumn of 2009 with a second undertaken from January to mid-March 2011

Facilitators to success

- Good relationships between the individuals and organisations involved to start with, and further developed throughout pilot period
- Commitment to integrated working across partner organisations
- Clinical leadership and ownership of the pilot
- Support of other stakeholders including the SHA and the DH
- Staff training
- Pilot funding – enabled site to provide backfill for the clinicians to enable them to take the work forward

Barriers and challenges

- As a provider-driven partnership, the ICO has had to move at the pace of commissioners, specifically with the phases of the Marie Curie Delivering Choice Programme. It has not been possible to implement the enhancements and/or changes to community services which were originally planned.
- Key strategic changes within the individual organisations led to some senior distraction from the ICO e.g. CCS was focused on attaining Trust status and Virgin bought AssuraMedical from the Assura Group during the course of the pilot.
- Having to go through conventional organisational channels for approvals, etc. because integrated management was not in place
- Lack of IT integration across participating organisations



- Risk of getting sidetracked from ICO objectives due to the multitude of wider work and events taking place around end of life care

## Church View

### Theme/focus:

Management of elderly patients with high frequency or predicted high frequency of hospital admission. Provision of integrated primary and secondary care services to enable holistic care rather than treatments from a range of individual clinicians.

### Aims:

- To integrate and co-ordinate care for elderly patients who are frequently admitted to hospital or who are seeming to become frequent users, in order to prevent avoidable admissions and help prevent re-admission
- To remove current organisational barriers in order to provide seamless and personal services
- To improve communication between primary and secondary care and explore new models of working
- To ensure full utilisation of the resources available across primary and secondary care
- To improve patient experience

### Partnerships/governance structure:

Church View Medical Practice, City Hospitals Sunderland, South of Tyne & Wear PCT Commissioner and Provider arms (community nursing teams) and Sunderland City Council (social services). There is a representative from the practice patients' forum on the Project Board.

Before the pilot, the only effective relationship that existed was between the GP practice and its patient forum. The other relationships were based on ad hoc interactions.

### Intervention/service change:

- Organisational integration of one GP Practice and the Foundation Trust (separate locations maintained)
- Virtual ward rounds with integrated team including consultant, GP, community nursing and social services
- Individual care planning for patients involving summary care records, shared with team
- Combined predictive model used to identify patients for virtual ward, focusing on those who are at risk of being admitted to hospital, as well as current frequent users of services
- There are systems in place to flag if a patient involved in the pilot is admitted to hospital (the GP practice will be notified and the clinicians in secondary care will be aware that a care plan is in place).

### Intervention start date:

1 April 2010

### Activity to date (May 2011)

- Organisational integration between the GP practice and the Foundation Trust – PMS contract and all staff TUPE transferred (Transfer of Undertakings - Protection of Employment) April 2010. Practice staff, including GPs are now employees of City Hospitals Sunderland
- Establishment of virtual ward round running since April 2010– held every 2 weeks
- Improved awareness between teams involved in virtual ward round regarding each other's services and pathways

### Facilitators to success

- Involvement of Department of Health added to the credibility of project and helped build attention and interest
- Concept of the Pilot drew interested parties together

- Clinical and managerial commitment and strong leadership of the Pilot (management time dedicated to organizational integration has been considerable from hospital and PCT)
- PCT recognition that some hospital activity needs to be moved to the community to develop future capacity of the service

#### Barriers and challenges

- Challenges with IT, specifically sharing care plan/record across teams – this has not been possible electronically
- Organisational integration hindered until transfer of PMS contract was possible. Delays due to a number of issues; PCT processes, consideration by Co-operation and Competition Panel, and referral by the Overview and Scrutiny Committee to Secretary of State and Independent Reconfiguration Panel. In addition, practical challenges such as agreements for premises and discussions with solicitors and HR over TUPE processes
- “Putting national policy into practice is extremely difficult when faced with local context i.e. vertical integration and integration of services. Operationalising vertical integration requires considerations such as compliance with Principles and Rules for Co-operation and Competition, notifications to the Co-operation and Competition Panel, local primary care contracting processes etc.”

## Cumbria

### Theme/focus:

System change through bringing together general practice and community services to deliver higher quality of care to all residents. The project covered three workstream sites: Cockermouth, Maryport and South Lakeland.

### Aims:

- Reduce inappropriate hospital admissions by providing high quality care in the community – particularly for the older population and for those with long term conditions
- Provide an emphasis on self care and preventative care in partnership with other agencies
- Ensure the delivery of elective care in the most appropriate setting

### Partnerships/governance structure:

The South Lakeland workstream was ultimately enhanced to become the Collaborative Board, which took on commissioning responsibility for 50% of the PCT budget. Maryport and Cockermouth both have their own workstream but are also led by the Allerdale locality board, which, like South Lakeland, has commissioning responsibility for 50% of the PCT budget.

### *Cockermouth*

Three GP practices, existing community nursing teams, Cockermouth clinic (the outpatient clinic for visiting consultants), community hospital, therapy teams (physiotherapy, speech and language, chiropody, occupational therapy).

### Maryport

Maryport Group GP Practice, PCT provider staff and Social Services, as well as close links with third sector organisations

### South Lakeland

GP practices and community services, secondary care providers (acute and mental health care) and social services.

### Intervention/service change planned:

The project plan is to devolve budgets from the PCT to each of the three pilot sites to enable them to commission and provide effective integrated services that are tailored to meet the needs of the community. Primary care, community and rehabilitation services will be fully integrated to deliver a comprehensive support service closer to home.

### Cockermouth

- New premises to be designed specifically for the ICO to provide out a range of services, including: a children's centre, NHS dentistry, diagnostic centre (with point of care laboratory, X-ray US CT MRI), co-located voluntary services (e.g. Age Concern, Alzheimer's), community hospital beds and a teaching centre.
- Merging of three GP practices to form one integrated primary care practice to operate from the new premises ('one stop shop')
- Staff to be directly employed by the ICO (e.g. all existing GP employed staff) or seconded from the PCT (all community staff).
- Virtual wards to enhance case management of patients at high risk of admission.
- Enhancement of self-care, increased support and information for people with long term conditions.

### Maryport

- Provision of various integrated services through planned ICO management take-over of Maryport Group GP Practice, PCT provider staff, and Social Services.

- Increased and improved provision of services 'closer to home' with a particular focus on the elderly at risk of unscheduled admission.
- Development of a rehabilitation centre for elderly people.

#### South Lakeland

- Formation of a GP commissioning collaborative that brings together all primary care practices under one umbrella. Original plan was to bring together the GPs along with community nursing and therapy services within a social enterprise structure. This was deemed to breach competition regulations as commissioners and providers would have been in the same organisation.
- Provision of a range of integrated services through virtual, horizontal integration of GPs and community services and GPs with shared objectives, vision and values, with an integrated clinical information system.
- Focus on providing integrated services for older people
- Integration of hospital minor injuries unit with GP out of hours service Not achieved because of difficulty liaising with contract holder for out of hours care

Intervention start date:

1 April 2010

Activity to date (May 2011)

#### Cockermouth

- Planned new building has not yet been realised (first stage of planning permission may be gained in summer 2011)
- Fitz Road and South Street GP practices merged on 01/04/2011; the third practice in the town is actively engaged in the project.
- Following enforcement of Transforming Community Services (TCS) at short notice, PCT provider staff have moved under employment of Cumbria Partnership Foundation Trust (01/04/2011) formerly a mental health trust
- All GP practices now using EMIS records system; community and hospital staff will share the EMIS Web system with rollout planned for September 2011. This will allow GP, community and community hospital staff to share appointments, patient records and care planning.
- Implementation of anticoagulation clinic, elderly screening, drug and alcohol, dressings clinic and minor surgery clinic has been delayed by the move of Derwent House Surgery back to their old premises in the short-term.
- Reduction in average length of stay at Cockermouth hospital from 39.7 days (2006) to 12.7 days (June 2009) to 10.4 days (March 2011) – now hospital with lowest average length of stay in Cumbria (Additional note: Use of hospital as an NHS nursing home has ceased. Hospital has changed to a community hub and rehabilitation unit, throughput changed following increase in medical cover, clinical leadership and provision of rehabilitation therapists and assistants.)
- Intensive home support for patients via virtual ward

#### Maryport

- GP practice in Maryport took over the direct management of District Nursing staff, community Hospital staff and Community Therapy Team staff with effect from July 2009, via the Practice Manager holding an honorary contract with the PCT. *This came to an end when all PCT provider staff transferred to Cumbria Partnership Foundation Trust (CPFT) during the Q4 of 2010/11.*
- The site's aim to establish Community Interest Companies as potential vehicles for delivering APMS services under 'any qualified provider' has proved impractical to date; PCT has been reluctant to support this move during recent reorganisations. However, the commissioning groups remain committed to the development of CICs.
- Rehabilitation Centre opened for two days a week in November 2010, led by the Community Therapy Team with the input of statutory and non-statutory organizations, working closely with Age UK West Cumbria.
- Development of new service for people with alcohol problems
- Establishment of a Short Term Intervention Team (STINT) within Community Therapy Team
- Already existing community based services regularly audited and evaluated e.g. vasectomy, dermatology.
- Minor injuries unit at hospital extended opening hours

- Induction processes developed to enable community staff to work in the hospital and vice versa
- ICO in charge of around half healthcare budget for Maryport (given devolved responsibility for approximately half the local health budget)
- Development of Maryport-based evening District Nursing service (*Prior to the pilot the evening District Nursing service covered the whole of Allerdale. During the course of the pilot each sub-locality in Allerdale (i.e. more than just the two pilot sites in the area) made the decision to make the service sub-locality-based in order to provide improved integration during the evening period.*)
- Home care practitioners established (staff trained to provide low-level care, e.g. getting up/dressed/toileting/feeding in order to prevent unnecessary admission or facilitate earlier discharge from acute settings).
- GPs with special interests (GPwSI) have set up dermatology and surgical services in Maryport, and additional surgical services have been developed over the course of the pilot (e.g. carpal tunnel service and complex skin surgery)
- Improved working with third sector organizations (e.g. site used their input into developing Rehabilitation Centre that opened in November 2010)

#### South Lakeland

- Virtual ward set up
- Single point of access introduced – one point of access for most health services
- Liaison nurse post established - employed in community but working in the hospital to support discharge planning
- Launch of diabetes service in the community: diabetologist and specialist nurse now employed by PCT
- Establishment of the Westmorland Primary Care Collaborative (WPCC) with 20 out of 21 practices and all 14 community teams
- Shared clinical information system established with electronic records shared across GP practices and community teams
- Management of 51-bed community ward at Westmorland General taken over by WPCC, providing step up and step down care
- Short Term Intervention Team (STINT) and community respiratory team under single management structure

#### Facilitators to success

#### Cockermouth

- Reconfiguration of social services to match localities of pilot
- Community hospital and community nursing teams highly valued in community
- Recent funding arrangements which mandate better cooperation between health and social care (Health now shares co-terminus boundaries with social services. Recent funding allocations for enablement and service transformation have been given to NHS, but can only be spent in collaboration with social services.)

#### Maryport

- History of working in an integrated way in Maryport
- Practice and hospital being located next door to each other
- Financial backing to Maryport (£100k from 'spend to save scheme')
- Support and ethos of NHS Cumbria
- Move towards GP commissioning is facilitating development of integration
- Shared IT system between practice, community hospital, community staff and outpatients (There is a single electronic patient record used across the GP practice, Community Hospital, Community Teams (District Nurses/Community Therapy Team), and Outpatient Department).

#### South Lakeland

- Strong clinical leadership
- Very supportive PCT
- Good relationships with local authorities
- 'Can do' attitude of ICO encouraged staff to want to work with it.
- Development of national GP commissioning role ('support around this that far exceeds any support from the pilot')

- Having staff working for a single employer improves service integration
- Proactive PBC group
- Good relationships with specialist providers, social care, local council and third sector
- When some members Primary Care Collaborative held up progress, others have made clear they want to drive it forward
- Shared vision from senior leadership across separate organisations
- Single shared information system makes a big difference
- Approach generated external interest (although unrelated to Pilot involvement)

#### Barriers and challenges

Cumbria was one of six PCTs that had been given permission to continue to employ provider side staff following a change of policy at the DH, but a need for clear separation between commissioning and providing was still required. This created a significant problem that has been overcome through the imminent transfer of provider staff to Cumbria Partnership Mental Health Foundation Trust. Progress in the Cumbria pilots was significantly slowed down for six months while an alternative arrangement for the provider side was made.

#### Cockermouth

- Union grievance regarding terms and conditions and pension rights of staff who might transfer from PCT employment
- Current re-configuration of health service threatens progress and is a disruption to the pilot. (The loss of budgetary and managerial control of community and hospital staff has added a layer of bureaucracy to the system. Furthermore current funding arrangements leave to cost of service change with one organisation and the benefits with another.)
- Flooding in the town meant the speed of some activities was slowed as focus was on flood recovery
- Delays in obtaining approval for new building, conditional stage one approval for the building currently anticipated
- Negotiation with three separate surgeries was a challenge, also in sites separate from community teams
- Social services reluctant to adopt population-centred approach of the pilot (Closer working, retirements and reconfiguration of the social work department now enables us to pursue locality based social services)
- National changes to GP commissioning are a challenge, conflicting the drivers of each organisation (e.g. Acute trust is maximising PbR, Partnership Trust (community staff) facing cost of shift to community care while commissioners reap benefit. The separation of commissioner and providing may facilitate transparency, but it has slowed the process of service change.)

#### Maryport

- Difficult to maintain input from Cumbria Partnership Foundation Trust
- Lack of information regarding budgets
- Lack of accurate and timely admissions and referral data
- Delays in recruitment to therapy post
- Some cynicism from staff due to delays in implementing some areas of work
- Process has uncovered long standing tensions between individuals within the provider teams (An unforeseen consequence of the pilot was that long standing tensions between individuals, some of them quite complex, were forced to the surface now that they were under one employer, and had to be managed/dealt with)
- Cumbria PCT did have dispensation from the DH (as part of the Transforming Community Services agenda) for the planned changes in governance, but this was overturned by the Coalition Government. This shifted people's work away from ICO activity
- Lack of clarity as to who within the PCT can permit changes to be made
- Unions had grievance with PCT (over changes of personnel and their conditions of employment).
- Larger organisational change occurring impeding progress (This refers to organisational change going on across Cumbria, in the way that locality working was being developed during the pilot.)
- Financial challenges affecting social workers meaning social workers no longer based at Maryport

#### South Lakeland

- A major barrier was shift in Department of Health policy, which meant plans to commission and provide services from within one organisation (which were a key part of the pilots plans) had to be scrapped. This change meant that much of the pilot's progress to a 'Kaiser-like' model had to be reversed.
- Change of national focus from integrated care to GP commissioning. Pilot seemed 'increasingly irrelevant'.
- Lack of support for being a pilot. Financial support (£90k) small in relation to budget (£80m).
- GP out of hours service provider reluctant to integrate with minor injury/primary care assessment unit
- Employment issues, such as pensions meant staff had to stay employed by PCT
- Relationship with Acute Trust under pressure due to financial challenges – current payment system for hospitals is a disincentive to them keeping people out of hospital



## Durham Dales

Theme/focus:

Ensuring local communities have effective health services targeted to the needs of all of the community. Workstreams target a range of service users and conditions

Aims:

- Prevention of disease
- Reduced emergency admissions and accident and emergency attendees
- Improved access for patients in rural areas
- Reduction in health inequalities
- Greater patient involvement
- More cost effective services

Intervention/service change:

The Durham Dales ICO planned eight workstreams.

The first two workstreams relate to the downgrading of Bishop Auckland General Hospital in 2009 so that it would no longer have acute consultant beds:

- *Urgent Care* – GP practice-based unit providing immediate triage and onward referral. Consultant led Rapid Access Medical Assessment Clinic
- *GP Beds at Auckland General Hospital* - creation of a GP ward operated by GPs with nurse-led medical cover
- *Care Closer to Home* - shifting services out of hospital to a community-based setting,
- *Transport* - provision of transport to access acute and community based services to improve access to services to those living in rural areas
- *Fuel Poverty* – identification of those at risk of fuel poverty, referrals to 'HotSpots' advice centres and appropriate support including 'Energy on Prescription' (to contribute to fuel bills for particularly vulnerable patients). The budget came from Public Health budgets.
- *Older Peoples' Mental Health*- project to increase clinician awareness and identification of dementia
- *Vascular Screening* - promotion of a screening programme across Durham Dales – subsequently extended to include other chronic diseases.
- *Rural Mental Health* - creation of a service directory, and improved case management

Partnerships/governance structure:

The model is described as a 'managed provider network'. Partners are: Durham Dales Practice Based Commissioning Cluster (lead), NHS County Durham and Darlington, Tees Esk and Wear Valley NHS Foundation Trust (TEWV), County Durham and Darlington NHS Foundation Trust, NHS County Durham and Darlington Community Health Services Trust, Durham County Council, North East Ambulance Service, and third-sector organisations. Each workstream has a GP clinical lead.

Intervention start date:

Early 2010

Activity to date (March 2011):

Urgent care

- GP led Urgent Care Clinic running since 2009, including provision of iv antibiotics
- Consultant led Rapid Access Medical Assessment Clinic provides a same day alternative to emergency hospital admission.
- Integration with GP surgeries commenced in August 2010 with several Urgent Care Centre GPs holding half-day surgeries at Bishop Auckland practices. (Added benefit is that GPs from Urgent

Care get the opportunity to see and treat more day to day complaints/illnesses which allows them to keep more up-to-date with their skills.)

- 111 number piloted for urgent but non '999' calls
- GP beds at Bishop Auckland General Hospital

- Small number of patients admitted to GP beds
  - Ongoing discussions about the viability of a GP led ward
- Care Closer to Home workstream

- Gynaecology and pain management clinics at Richardson Hospital have now commenced
- Consultant-led community diabetes specification is complete but not yet implemented. This work continues under leadership of GP Commissioning.

Transport workstream

- Baseline data received from NEAS (North East Ambulance Service) and now being provided on a monthly basis
- Volunteer driver scheme in place for GP practices in Crook, Butterknowle and Willington
- GP practices using the Transport Resource Centre (run by the Local Authority) to help patients book transport to appointments at acute and community hospitals
- Local survey showed that practice DNAs ("Did not attend") were mainly related to patients forgetting their appointment and not due to transport problems

Fuel poverty workstream

- Hot Spots scheme advice scheme established
- MacMillan cancer has joined the partnership to assist with HotSpot plans for cancer patients
- Patients have been identified for 'Energy on Prescription' these patients' bills have been paid (full 6 months worth)
- Protocol and referral forms agreed with the Fire and Rescue Service (A referral form has been developed and given to all partners for use when a staff member from a participating organization visits a patient's home and thinks there might be an opportunity for a visit from the fire service (i.e. no smoke alarms, chip pans etc.)
- Welfare Rights project being piloted at Willington GP Practice

Older Peoples' Mental Health

- Dementia screening tool has been chosen and made available, with training, to staff in GP practices
- Practices provided with information brochure for newly diagnosed dementia patients and their carers.
- Ongoing work on developing a care planning programme with two of the Dales practices
- Ongoing work on a care home pilot, particularly in understanding staff training needs and confidence in managing dementia

Vascular Screening

- Now aims extended to include a broader range of chronic diseases
- Screening programme implemented as originally planned
- Analysis of training needs undertaken for primary care staff for diabetes, COPD and risk assessment in atrial fibrillation
- Breathe Easy peer support group started in November 2010
- Community Pulmonary Exercise Programme started in March 11
- Met Office alert project – 500 patients recruited. Project ended on the 31 March 2011

Rural Mental Health workstream

- Rural mental health pathways have been reviewed and revised and this will be rolled out to all clinical staff in June 2011

Facilitators to success

- Strong pre-existing relationships between Dales GPs
- Sustained strong GP relationships through PbC management
- Commitment and enthusiasm of GPs, lay members and the managers and clinicians from partner organisations

- Substantial third sector involvement
- Regular meetings between GPs and workstream groups
- Strong project management (“an effective and hard working support team”)

#### Barriers and challenges

- Changes in NHS Structures and resultant job losses; particularly changes in staff involved in ICO
- Conflicts of interest / occasional incompatible expectations between partner organisations
- Insufficient staff time to dedicate to the project
- Lack of administrative support from partner organisations to support workstream leads
- Lack of funding for some workstreams due to unforeseen financial constraints within the PCT
- Bureaucracy surrounding decision making involving multiple organisations
- Inadequate information/data or delays in information availability – including sharing of information between partner organisations, confidentiality and data protection
- Priorities of participating organisations change when faced with external influences such as NHS and social service reform, seasonal work pressures, and swine flu. “The ICO has moved down the agenda” [of participating organisations]
- Lack of sustainability: “Most workstreams have come to an end now although there are a number of pieces of work that we will continue to work on until they have either become main stream or come to a natural end”

## **Nene**

### **Theme/focus:**

Multiple programme work streams with different condition/service focuses - mostly for people with chronic conditions, elderly, those at risk of hospital admission

### **Aims:**

The aims of the project focus on patients at risk of hospital admission in order to:

- Improve the quality of patient care
- Improve patient experience
- Reduce emergency admissions

The original aims have expanded to include:

- Reducing the demand on institutional care

Partnerships/governance structure:

Originally a collaboration between the local PbC group (Nene Commissioning, lead organisation) and PCT Provider Services, the Northamptonshire Integrated Care Partnership (NICP) is now an enterprise including patient representation, Northamptonshire County Council (NCC) social services, Kettering General Hospital Foundation Trust (KGH), Northampton General Hospital Trust (NGH), Northamptonshire Healthcare Foundation Trust (NHFT), East Midlands Ambulance Trust (EMAS), Age Concern, Northamptonshire Out of Hours service and PCT

### **Intervention/service change:**

#### **Six work streams:**

*Pro Active Care (PAC):* Identification of patients at high risk of hospital admission, case management and tracking through 'virtual wards'. Personalised care plans to reduce admission risk and provide more choice in end-of-life care.

*Medicines Management:* For ProActive Care patients who have been discharged after an emergency admission to review medication and remove duplication. Subsequently extended to all patients aged over 65 and on four or more medicines.

*Wellbeing/Depression Management for patients with LTCs:* Patients already case managed and identified with LTCs to be assessed for anxiety and/or depression and signposted accordingly.

*End of life care:* Rapid access services and a care coordination centre for patients at the end of life and their carers. Integration of specialist palliative nursing support and lower level social support to provide a rapid, responsive service for patients and carers in their own home.

*Urgent Care:* A range of schemes aimed at reducing the number of emergency admissions.

*Personal Health Budgets:* Site awarded national pilot status. Aim is to give more choice and control over money spent on meeting health and well being needs.

### **Intervention start date:**

29 June 2009

### **Activity to date (March 2011)**

#### **Pro Active Care (PAC)**

- As of November 2010, 57 out of the 75 practices involved in the Nene consortium had identified and enrolled patients to ProActive care and delivered the program, covering a population of

567,000. As at April 2011 PAC moved from pilot status to become mainstream business as usual and is now included in formal contractual arrangements with the provider.

- Hospital discharge teams and social workers became able to refer to Pro Active Care
- As of February 2011 3,191 individual patients had been managed under Pro Active Care; all have personalised care plans. The target of 6,000 patients per year supported under PAC is being achieved and exceeded.
- Following internal deep dive evaluation of 1,000 patients it showed that there had been a 39% reduction in emergency admissions for patients in PAC
- Carers of patients in PAC are systematically receiving an assessment of need and ongoing support from the carer support workers.

#### Medicines Management

- Medicines management work stream pilot was extended and widened to capture more patients and is supported with additional funding for increased pharmacist capacity.
- Medication reviews for patients living in 75 out of 84 care homes. 379 patients living in a care home have received a medication review since December 08. A total of 1373 suggestions for change were made to GPs and of these 90% were accepted. The service has become mainstream.
- Following a pilot showing potential cost savings, the 'Medication on Discharge' review scheme was extended. Included 61 patients by November 2010.

#### Wellbeing/Depression Management for patients with LTCs

- Training for community nurses in use of Depression and Anxiety screening tool completed.
- #### End of Life Services:

- End of Life Link Nurse pilot ran from Sept 09 to Jan 10 in one acute hospital
- Contract signed between PCT and new provider November 2010
- Information Sharing Agreements were signed with main stakeholders
- The new Service went live on 6<sup>th</sup> December 2010 and includes the following:
  - Care Coordination service 24/7
  - Rapid response service
  - Primary care link nurse in acute hospitals
- As at the 31<sup>st</sup> March 118 patients have been referred to the Primary Care Link Nurses in KGH & NGH. Of these 80% were cared for at the end of their life in a place of their preference and of those patients 85% experienced a supported discharge by the Link Nurse into the community.
- From 1<sup>st</sup> April an additional 250 hours of personal care support is now being provided by Age Concern under the EOL Contract resulting in a total of 550 hours per week now available to support patients and their families.

#### Urgent Care

- GP in A&E (scheme withdrawn Sept 09)
- EMAS Primary Care Protocol developed to improve communication between primary care and the ambulance service to reduce the need for hospital transit. Recognised as Best Practice and rolled out across East Midlands SHA.
- Business case developed and agreed during 2010 for Integrated Community Elderly Care Service to support elderly people in specialist care centres, care homes and their own homes.
- Service targeted to support elderly, frail patients commenced in December 2010 and consists of the following:
  - Additional 40 new Intermediate Care Staff
  - Additional Consultant Geriatricians and Consultant Psycho-geriatricians working in A&E with Intermediate Care staff
  - Consultant Geriatricians and Consultant Psycho-geriatricians working with Intermediate Care staff and Hospital Discharge Teams to facilitate early safe discharge
  - Comprehensive Geriatric Assessments (CGA) and Comprehensive Mental Assessments (CMA) undertaken by Consultants.
  - 18 beds in Specialist Care Centres commissioned by health from NCC social services
  - Funding for beds ring-fenced by NCC to deliver additional Social Care Managers and Rehabilitation Services in the Community
  - Introduced IT systems to link between A&E, ICT and SCCs that now produce one single patient health record held in the Community.

- Results to 31<sup>st</sup> March 2011
  - Confirmation of 505 prevented admissions from December 10 to 31<sup>st</sup> March 11 for CECS acute/community. This is 59 prevented admissions above plan.
  - During the period from December 10 to end of March 11 124 CGAs have been delivered by Consultant Geriatricians. Conversion rate is 90% of patients receiving a CGA are not admitted to a hospital inpatient bed.
  - During the period from December 10 to end of March 11 78 CMAs delivered by Consultant Psycho-geriatrician. The new service has reduced the wait for Psychological assessment for patients with dementia admitted to hospital from 3 weeks to zero days.
  - Average Length of Stay in Specialist Care Centres have decreased from 60 days to 7 days due to improved flow through the whole system
  - Emergency admissions, ALOS and Excess Bed Days for patients aged >75 are lower in the period December 10 to February 11 than in the same period last year against an increasing national trend
  - CECS service became mainstream from April 11 due to the exceptional performance of the service

#### Personal Health Budgets

- NICE became a Personal Health Budget Pilot in April 2009
- A project manager was recruited in January 2010
- Patient cohorts offered personal budgets are:
  - Mental Health
  - CHC
  - Long Term Neurological Condition
- To date 63 patients consented to Personal Health Budgets Pilot
- National recruitment deadline extended to June 11 due to challenges faced by pilots
- National policy based on findings of pilots. National Policy roll out planned for October 2012

#### Facilitators to success

- Identification and successful engagement of key stakeholders and their belief that the intended system changes will improve quality of and access to services.
- Extensive involvement by NHS and social care managers and clinicians
- Strong clinical leadership to drive through change both at Board level and on the front line
- The 'high profile' or priority given to the work of the NICE by all participating organisations
- National policy focuses on reducing demand for urgent care across the system and the QIPP agenda
- Increased responsibility and accountability of Nene commissioning through PbC and GP commissioning policies

#### Barriers and challenges

- Difficulties with data sharing between organisations
- Delays in gaining CQC registration for End of Life Services provider which delayed implementation
- Unprecedented increases in demand for urgent care (with a reduced resource base)
- Delays in PCT decision-making
- Economic downturn and 'flat cash' situation for the NHS preventing integrated care staff deployment
- Introduction of 'Transforming Community Services' and due diligence restricted the growth of services
- Uncertainty created by the change in government and current reforms to health and social care systems

## Newquay Integrated Care Pilot

Theme/focus:

The project intends to develop a scalable and replicable **integrated care pathway for dementia** in Newquay. The pilot will de-couple dementia from the traditional silo of secondary care based "Older People's Mental Health Services." Dementia will be treated as a long-term condition best managed through integrated and preventative case management in primary care.

The pilot will lead to the development of a **virtual dementia team** of key staff, drawn from a range of health and social care organisations and anchored around GP practices, to provide and directly commission care to all patients registered on a local GP's dementia register.

Aims:

- Improve access to early assessment, diagnosis and support and increase the number of people receiving a diagnosis of dementia;
- Increase choice of services and support available to people with dementia and their carers;
- Strengthen care and support for people with dementia and their carers;
- Develop a new model of community dementia services, based on a philosophy of care that sees dementia as a long term condition requiring continuity of care from diagnosis until end of life
- Create additional capacity through efficiency and productivity gains

Intervention/service change:

- Increased GP knowledge and awareness of dementia diagnosis and care services
- Increased ability and confidence in GP dementia detection and diagnosis
- Integrated 'virtual teams' based at GP surgeries, drawn from a range of health and social care partner organisations. Services are for both dementia patients and their carers.
- Specialist community memory clinic providing an accessible assessment and diagnostic service in a non Mental Health environment
- Provision of specialist dementia liaison service to community hospital and dementia registered care homes
- Delivery of service model based on the principles of case management of long term conditions

The first phase of the pilot focused on developing partnership working between the GPs and Memory Nurses, developed from the existing CPN role, at the centre of the virtual team. Phase 2 of the pilot has sought to bring the Community Health Services and Adult Care and Support Teams into the partnership.

Partnerships/governance structure:

NHS Cornwall and Isles of Scilly PCT (Community Health Services Team, District Nurses and the Community Hospital), Newquay Practice Based Commissioning Group and 3 GP Practices, Cornwall Partnership NHS Trust (Community Mental Health Team (CMHT) includes, Team manager, Consultant Psychiatrist, memory nurses, mental health occupational therapists, Health Care Assistants, Community Psychiatric Nurse a Dementia Liaison Nurse, dedicated administration support), Cornwall Council (Directorate of Adult Care and Support).

A project board includes leaders from all organisations. Currently no formal shared systems, governance or contractual arrangements exist, but these are intended to be developed in the form of a service specification for GP consortia.

Intervention start date:

April 2009

Activity to date (March 2011):

- All Community Health Services Staff have undertaken Dementia Awareness Training

- Dementia Link Nurses have been established within the District Nursing and Community Hospital Teams.
- Job description for Memory Nurses developed and banded
- A Lead GP and Memory Nurse have been identified for each GP Practice. The original plan to co-locate Memory Nurses in GP practices proved not to be possible in two practices, though regular liaison takes place and the Memory Nurse works one day per week at the GP Practice site.
- Distribution of Dementia Resource Packs to virtual teams
- Training Needs Analysis has been undertaken for the CMHT and a training programme is underway to deliver training in healthcare monitoring and Long Term Conditions Management (to support their improved understanding, skills development and capacity to support the physical health needs of individuals with dementia)
- Backfill secured for Dementia Liaison Practitioner
- Originally, a joint Commissioning Plan for Dementia Services was created between PCT and County Council
- Since April 2010, all individuals with dementia have been provided with individualized care plans and are supported in the development of these plans.
- Specialist local memory assessment service
- Menu of services available to individuals and carers has been expanded to include Cognitive Stimulation Therapy (CST), OT Assessment and interventions and the SWAPS (Shared Lives Respite Service).
- Regular Case Management Meetings held at GP Practices
- Regular Newquay based Team and MDT Meetings to enable effective team working within CFT (CMHT, Consultant, Dementia Liaison Practitioner)
- Training for the CMHT to use Adult Care & Support Needs Assessment Systems
- Regular liaison between the CMHT and Community Nursing teams to discuss the needs of individuals on the case list
- Virtual team meetings held regularly
- Development of a set of guidance documents and tools to clarify the model of care and clinical roles required to deliver it;
- GP training to increase their involvement with, and support to, individuals with dementia and their carers;
- Implementation of Community Mental Health Team case management processes with 'Memory Nurses' managing case lists and coordinate access to support and services;
- Cross team liaison and communication processes in place
- Provision of physical health monitoring equipment to CMHT staff
- Assistive technology kits made available for assessment
- CST maintenance groups run by Age Concern
- Development of Memory Cafe

#### Facilitators to success

- Project alignment with other policies: National Dementia Strategy; QIPP programme, Transforming Community Services, and individual care plans/budgets
- Roll-out of the Health and Social Care Hubs and the implementation of new dementia service specifications
- Support from key individuals locally
- Strong project management to lead delivery and manage risks as they arise
- Development of other dementia models in other GP practices (Pool, Lostwithiel and Falmouth) have encouraged an element of friendly competition

#### Barriers and challenges

- Lack of GP confidence and ability to diagnose dementia
- Increased sickness of key CMHT members at key times during pilot ,
- Staffing change including Dementia Liaison Nurse impacting on the consistency of approach and support for virtual team partners within the Community Hospital and Community Health Teams
- Difficulties around data collection and integrating IT systems of participating organisations
- Changes in project management; reduced project office resource to deliver the pilot evaluation
- Adult Care and Support undergoing major reorganization and budget review, loss of representation on the project board for a protracted period



- Staff anxiety over health and social care reforms; including concern about the impact of new models of dementia care are being developed that sit outside of the specialist CMHT services- GP commissioning consortia will have more choice for commissioning dementia services as the provider market continues to be stimulated.
- Clinical staff were under pressure from administrative and reporting requirements
- Initial confusion in the role of Trusts local operational managers (though associated with ownership of project by GPs and commissioners)
- The support required to develop memory nurse capacity for case management was underestimated by the pilot, with team members finding it extremely difficult to adopt responsibilities that sit outside their original roles, while continuing to perform their previous roles.
- Concerns from some professional groups arising from concern about the impact the new model of care may have on existing roles, responsibilities and governance , e.g. transferring responsibility for some assessment/diagnosis away from Mental Health Professionals towards GPs
- Lack of perceived engagement from clinicians at the outset which resulted in a feeling of increased work load and misunderstanding of the shared vision of the care model
- Lack of inclusion at onset of planning and development of the model of key clinicians, which resulted in many of the above reported barriers and challenges.

## Norfolk Integrated Care Pilot (NICP)

**Theme/focus:** Coordinated care for older people and vulnerable groups; Thetford only - sexual health and falls prevention

**Aims:** The aim of the Norfolk ICP is to provide cohesive, pro-active and personalised care for vulnerable and older people.

Norfolk Integrated Care Network consists of six 'sub-pilots' across Norfolk, however, only three of these are part of the national evaluation. The purpose of running multiple sub-pilot projects was to enable each to design their services around the needs of their local communities.

Intervention/service change:

- Integrated health and social care teams developed within each sub-pilot area, comprising GPs, community health and adult social care staff
  - Teams identify target populations through use of a predictive risk tool
  - Joint assessment processes
  - Patients and service users provided with a 'key worker' or case manager as a primary contact point.
  - In some patients are on a joint caseload
  - A few teams have an integrated care 'liaison' officer who is provided with access to multiple IT systems containing patient data and referrals, and who can relay this information quickly to relevant health and social care colleagues.
  - "Live" unplanned acute admissions data from two hospitals now issued directly to participating practices and their integrated teams
- Multi-disciplinary team (MDT) meetings at GP practices are held between weekly and monthly
- In one area social workers spend half a day to one day a week in GP surgeries
- Health and social care teams are co-located in a few places, and discussions are ongoing about further co-location.
- A few sub-pilots include Rapid Response teams—groups of health and social care clinicians who are taught generic care skills in order to respond to patients within four hours and aim to avoid hospital admission.

Partnerships/governance structure:

Norfolk Integrated Care Network is jointly funded by, and involves joint working between, Norfolk PCT and Norfolk County Council, and voluntary sector partners in some sub-pilots.

Intervention start date:

Each patient has an individual start date. Interventions started in each pilot in April 2010. Patient lists are "live" with patients being added to lists as they are identified via hospital admission data and/or professional judgment.

Activity to date (March 2011):

- All six sub-pilots (in two separate waves) had integrated teams in operation by late 2010
- Patients are continuously identified and placed on integrated care lists, and are now receiving team responses within pilot sites
- Mid Norfolk, North Norfolk, Thetford, King's Lynn Rural West and Norwich social care and community staff have now been aligned to the GP surgeries in the locality - each surgery has named staff to work with. This was in place by summer 2010.
- Social workers are physically based at all North Norfolk site practices at least 0.5 days per week and are included on the practice booking system so that patients and service users can book appointments to see the social worker.
- NHS Norfolk Out of Hospital Care and PbC Commissioners have begun integrating with the Community Services Adult Social Care Commissioners - should be finalised by 31 May 2011
- Decision-making tool created to assist with when a case should be referred to health or to social care.

- A 6-month long joint Integrated Care Leadership and Management programme has been designed and implemented for managers from Social Care, NCH&C and PbC. The first cohort of 15 completed the course in October 2010.
- Integrated Care Liaison Officer posts created in two sub-pilots and more recently, three further ICLOs have been appointed. All sites have integrated care liaison staff/coordinators appropriate to the scale of the site.
- Norfolk County Council Integrated Care Coordinator staff appointed in Autumn 2010 to support the integrated teams (Nine posts across Norfolk)
- Teams co-located at Mid-Norfolk and plans to do so at North-Norfolk (Thetford and Norwich also considering it)
- The ICP has influenced development of a bid to establish a social work pilot social enterprise. Their statement of intent includes service delivery according to the principles of the Norfolk ICP project.
- Memorandum of Understanding between organizations published, making integration 'the norm' is in draft form and yet to be finalised.

#### Facilitators to success

- Effective project-related training and development (e.g. Integrated Care Leadership and Management course)
- Formal arrangements for integration give individuals a platform for strengthening and building on existing relationships
- Operational management group crucial for joint decisions and overall ICO strategy
- Strong project and clinical leadership (in areas where it exists)
- Co-location of health and social care teams (where applicable)
- Widespread support for integrated care (conceptually) and for individual projects: "Unsurprisingly we have found that where engagement is greatest, most progress has been made."
- Being given the opportunity to make changes: "We've also found that engagement has increased once people have begun to experience integrated care and witnessing that colleagues elsewhere are making progress."
- Core team meetings and events at which sub-pilots could share knowledge
- Some see financial constraints as making integration even more of a necessity

#### Barriers and challenges

- The large number of participants across several organisations has made it difficult to progress as quickly as intended. The largest site proved the most difficult to get going.
- Lack of GP engagement in some areas
- Some initial disagreement and uncertainty within sub-pilots regarding what 'integration' would look like, relating to groups never having worked together before.
- Changes within participating organisations (e.g. Transforming Community Services, local government, staff changes within third-sector partners)
- Lack of continuous, widespread clinical and managerial leadership
- Staff hesitancy/nervousness around implementation activities, and uncertainty about what they are allowed to do: "Do we really have permission to do this?". Delays in getting approval to implement changes
- GPs generally prefer to use professional judgment than PARR tool to identify at-risk patients. The "live" unplanned admissions data has been very well received by primary care and the integrated team members.
- Slow pace of change (bureaucracy of multiple participating organisations), time spent reporting progress to multiple organisations
- Some difficulty building motivation/convincing staff to take on more work now for potential benefit later
- Historical lack of understanding/respect among differing professions
- Feelings of loss of professional identity (regarding integrated teams and generic worker roles)
- Too much work already to take on new tasks associated with ICP
- Lack of integrated IT and patient record systems
- Historically, there has been general lack of communication between professionals and organisations; although Improved communication and trust between health and social care professionals has been a real achievement of the pilot.
- Confusion surrounding ICP geographical boundaries when the Pilots first started, due to revised team structures in all organisations (Primary Care, NCH&C and Norfolk County Council)

- Impact on project team resources with additional work required to support wider Norfolk roll-out planning activities

## North Cornwall

Theme/focus:

Integrated adult (18+) mental healthcare for patients of the 10 GP practices within the North Cornwall PBC group

Aims:

- To improve access and choice to mental health services through increasing the availability of information about the services available and making it clear where self referrals are applicable
- To deliver clinical benefits and improved social functioning for patients
- To improve process efficiency to reduce waiting times and enable faster recovery

Intervention/service change:

The project integrates the mental health services delivered by the affiliated GP practices, Cornwall Foundation Trust (secondary mental health and social services provider), Outlook South West (primary care Improving Access to Psychological Therapies provider) and third sector organisations. The integration is achieved primarily through forming “virtual” teams involving these organisations, based at GP surgeries, and with a single agreed care pathway across organisations from prevention through to treatment and discharge. User and carer involvement is expected to be an important part of developing new services.

Partnerships/governance structure:

The core sponsoring organisations are North Cornwall PBC group, NHS Cornwall and Isles of Scilly (PCT), Outlook South West and Cornwall Foundation Trust. Formal organisational structures for integrated decision making do not exist outside of the project “steering group.” The management of the virtual teams is carried out at the practice level with Practice Managers ensuring that monthly meetings are arranged.

The agreed way of working is documented for each practice. This includes the core “golden principles” which the sponsoring organisations have agreed to and have been approved with service user involvement.

Intervention start date:

7 September 2009

Activity to date (March 2011):

- Virtual teams based around all 10 GP practices
- Referral criteria agreed between core mental health provider organisations
- Effective service user involvement
- Service delivery gaps identified with follow up commissioning work in progress
- Accreditation of 3<sup>rd</sup> sector organisations
- Searchable provider services database developed ([www.cornwallmentalhealth.com](http://www.cornwallmentalhealth.com))
- Key stakeholder events held, improving awareness and establishing working links between organisations
- Initiation of roll out of virtual team approach across whole of Cornwall

Facilitators to success

- A shared belief and value base that the changes proposed are best for patient care
- Awareness that service user representative input is central to the entire process
- The key people involved in the project believe in its aims and continue to strive to achieve the goals of the project whilst doing their day job
- Increased communication between all providers

Barriers and challenges

- Time required by individuals and organisations to meet the project plan resulting in slower than expected progress. “The need to use internal staff who are already committed to full time jobs is a key inhibiting factor for delivering any change in the NHS.”
- The understanding between partners of what each organisation was commissioned to deliver was slower than expected, as was awareness, understanding and trust of third sector organisations.
- PCT restructuring resulted in the loss of dedicated project support. Proposal for replacement staff was originally rejected by the PCT but with continued pressure, support was returned.
- At the point of formal written agreement, differences arise in understanding, even when there have been previous discussions with apparent agreement.
- GPs have widely differing approaches and levels of engagement. Even GPs who volunteer as representatives for their practice(s) do not necessarily promote the change they advocate to other GPs.
- The time taken to build relationships and trust and the wider “blame” culture within the NHS which inhibits open discussion both within the NHS and across organisations.
- Formal organisational structures for integrated decision making outside of the project steering group proved difficult to create, and no forum currently exists to include all stakeholders. Progress relies on a small core of key individuals to push things forward.
- Confidentiality issues – ensuring the partners are able to share patient data as necessary
- Consensus on terminology – e.g. “care plan” was initially clear to everyone and not questioned, but it was found that different groups had specific interpretations, which led to different views on what a care plan should be.
- Lack of experience in project management

## North Tyneside

Theme/focus:

The project focuses on improving the quality of life for patients at risk of falling, reducing the incidence of falls, and hence reducing the number of those patients who will have an unplanned admission to hospital.

The pilot services are available to the population of North Tyneside over the age of 59 (although initially limited to those GP practices willing to participate in the pilot). During the two years of the pilot patients were seen from practices with a registered patient list of 65,000 representing 34% of the PCT population.

The service continues to run beyond the pilot phase and now receives support from both GP commissioning groups in North Tyneside enabling patients from all practices in North Tyneside to benefit from the service in the coming years.

Aims:

The aims of the project are:

- Establish case finding for people at risk of falls and syncope, with referral to a multi-disciplinary assessment clinic,
- To improve the quality of patient care, and reduce the individual and health economic burden of falls and syncope in the community

Intervention/service change:

Establishment of a comprehensive rapid-access falls and syncope assessment service in the community

The pilot has two main phases namely:

1. Identification of high risk patients
2. Provision of community based assessment clinics and a network of community-centred, targeted strength and balance training classes in partnership with the voluntary sector

Phase 1: Identifying high risk patients

This comprises practice-based audit of medical records identifying patients over the age of 59 with one or more of the following indicators of falls and blackout risk: Patients on four or more medications (especially antihypertensives, antianginals and hypnotics); fragility fractures, facial injuries or hand injuries; recurrent falls ( $\geq 2$  per NICE guidance); or blackouts. Because all local commissioning groups and hence all GP practices have signed up to services, self referral is no longer necessary.

Phase 2: Community based falls prevention clinics in North Tyneside, with associated strength and balance training

Patients identified in Phase 1 as at risk of falls are referred by their GP to the service. Patients receive a targeted medical and physiotherapy assessment including: ECG, assessment for postural hypotension, osteoporosis risk assessment, gait and balance measures, blood tests as needed. After being seen by our service, a report is sent to the patient's GP with a copy given to the patient. Immediate treatment would then be instituted in tandem with primary care colleagues, while directing patients for further investigation as needed.

*Community centre-based targeted strength and balance training exercise classes.* These classes are organised and run by Age UK North Tyneside with input from the clinical assessment team

Partnerships/governance structure:

The six partners in the pilot were:

- Norprime Ltd - a GP owned primary care based organisation formed to deliver change in the scope and quality of medical services available in the community.
- Newcastle upon Tyne Hospitals FT – currently the provider of specialist falls and syncope services to the region.
- Age UK North Tyneside – a 3<sup>rd</sup> sector provider of care to the over 50s
- NHS North of Tyne – the commissioner for all health care services in North Tyneside
- North East Ambulance Service (NEAS) – provider of ambulance services in North Tyneside
- North Tyneside Local Authority Social Services
- STARS – a third sector organisation championing and supporting patients with blackouts

Intervention start date:

September 2009

Activity to date (March 2011):

Phase 1: Identification of existing high risk patients

- Initial audit of patient records and telephone triage by pilot practices completed by December 2009, but ongoing at a rate to ensure no significant clinical risk to high-risk patients. The service is likely to take approx four years to complete for all patients in North Tyneside.

The pilot was initially designed to perform the audit throughout only the PCT area, followed by clinical assessments. The site quickly realised that the audit would identify a large number of patients who were in need of the service but would have to wait in some cases for several years before being seen by the service due to clinical capacity constraints. Accordingly, phase 2 started immediately after phase 1 was completed for the first practice.

Phase 2: A community based falls prevention clinics with associated community-Based strength and balance training

- Commencement of service - September 2009
- Commencement of balance classes - October 2009
- 1000 people seen by Sept 2010 1600 to date
- Commencement of direct referral from North East Ambulance Service - April 2011

Facilitators to success

- Strong management team: willing and able to react to concerns of organisations and individuals
- Pre-existing relationships between lead individuals
- Determination, perseverance and willingness of the team
- The knowledge that the pilot has DH support continues to benefit the pathway
- Fall prevention and reductions in preventable hospital admissions are national and local priorities
- The change towards GP commissioning has benefitted the service raising awareness, giving added weight to requests for ongoing funding.
- Clinical outcomes are increasingly convincing GP practices who were initially uncertain regarding the pilot

Barriers and challenges

- The traditional barriers between primary and secondary care can hinder the implementation of integration activities. Traditionally, contact between primary and secondary care clinicians resulted out of individual patient needs. Subsequently both groups are wary of their roles within integrated care and the design of new service. This has been accentuated by the national tariff whereby money follows the patient with consequent changes to income flows to provider organisations.
- The number of practices/patients seen in the pilot were constrained by the number of clinical sessions being limited to 5 per week, and the higher than expected DNA rate of approx 25%.
- The novelty of the service can lead to uncertainty in primary care.
- The additional cost of the service which by its nature is preventative and therefore the benefits are not immediately quantifiable.



- The ongoing inertia and cynicism within certain areas of primary care have resulted in much more time being devoted to convincing clinicians of the benefits of the service.
- Delay in providing an SLA from the PCT delayed Norprime's ability to provide SLAs to service providers causing some uncertainty between each organisation in the partnership.
- The lack of activity invoice payments has caused significant problems to Norprime. This continues while bureaucracy reigns supreme.
- Issues with the engagement of some GPs and problems with IT systems not being compatible
- Information governance rules in all organisations have resulted in significant delays in the transfer of patient data between organisations.
- Financial pressures within the NHS. Current economic constraints cast doubt over the sustainability of a *preventative* pathway at a time of immediate cash savings.
- Political uncertainties sometimes used as a reason for 'not doing anything just now'.

## Northumbria

Theme/focus:

Community implementation of an agreed best-practice care pathway for patients with Chronic Obstructive Pulmonary Disease (COPD), involving care planning and increased self management support

Aims:

The aims are to improve patient experience and satisfaction, improve health related quality of life, and to reduce hospital admissions and A&E attendances.

Intervention/service change:

A shift of specialist care into primary/community care settings, involving:

- use of a named primary or community key worker (community or practice nurse) for each patient
- key workers undertaking two initial visits for care planning plus proactive, regular follow-up and reactive contacts following exacerbations or hospital attendances/admissions
- a single standardised assessment of disease severity and review of therapy
- individualised care planning with tailored self-management plans
- use of patient-held records and a single care plan by all care providers—including out-of-hours, secondary and social care

Integration here is seen by site in the sense of “links” into reablement services through key workers and to wider social care through generic workers trained specifically to support COPD patients.

There is focus on identifying and treating the most vulnerable patients as opposed to those most visible to secondary care; in particular this includes the housebound who have not always received proactive care for their long term conditions.

Partnerships/governance structure:

Organisations involved:

Northumbria Healthcare NHS Foundation Trust is the lead agency and takes responsibility for overall running of the project. Other partners include: North Tyneside North West PbC Group (GP practices and GP Commissioning), British Lung Foundation North of England (aids in developing care plans plus expert resource on patient engagement and experience issues), NHS Newcastle & North Tyneside Community Health (community nursing provider pre-TCS), North Tyneside Council (adult social care / reablement services), NHS North of Tyne (PCT) and Northern Doctors Urgent Care (out-of-hours provider).

Intervention start date:

Patients were invited for assessment from 1 July 2009

Activity to date (March 2011):

- Recruitment of 14 GP practices (open to 29 in locality), ongoing phone / email contact with all participating practices
- 140 patients enrolled
- Standardised assessment including completion of St George’s Questionnaires
- Comprehensive tiered pulmonary rehabilitation programme offered to all enrolled patients
- Standardised patient information based on British Lung Foundation booklets

- Two full programmes of key worker education completed on diagnosis and management of COPD plus care planning (however, site cannot comment on key worker care activity to date)
- Regular performance reports sent to practices
- Regular newsletters
- Analysis of patient questionnaires on two occasions
- Delivery of engagement training to members of steering group
- Dissemination of model through attendance at local and national events and submission of model to various interested parties

#### Facilitators to success

- Strong, well established relationships between key participants
- Strong clinical and managerial leadership
- Senior buy-in and support (e.g. from Trust Chief Executives)
- Clear model based on evidence-based best practice with primary/community workers as core to service delivery.

#### Barriers and challenges

- Beyond the project manager, no staff have been employed specifically for the pilot, and participating staff therefore had to absorb pilot activity 'on top of' existing workload – however, it is viewed as a change to best practice as opposed to new work per se
- 'Transforming Community Services' (national policy) and local Community Nursing Review led to key worker staff changes during the course of the project which affected continuity of care
- Challenges in communication between primary and secondary care
- Difficulty establishing GP engagement and support in some areas.
- Lack of GP support within some pilot practices affected key workers' ability to proactively engage
- Considerable training needs for community staff in developing confidence as well as required competencies
- Practice based key workers were not always able to attend training events

The pilot feels that work to date has proved the viability of a relatively low cost model using existing primary and community staff, aimed at enhancing and standardising care of patients with COPD through a care planning approach. They report that local evaluation has demonstrated improved compliance with best practice treatment regimes, reduced A&E attendances, and reduced admissions. They also report some early evidence of a possible reduction in exacerbations. The pilot is now being rolled out as part of an integrated COPD care programme across Northumberland and North Tyneside.

### **Principia Partners in Health**

Theme/focus:

Management of high risk patients with long-term conditions

Aims:

The Principia ICP aims to:

- Inform and empower patients
- Improve coordination of care
- Increase patient satisfaction
- Reduce avoidable hospital admissions

#### **Intervention/service change:**

The ICP encompasses two projects – creation of virtual 'Community Wards', integrating care between community organisations (horizontal integration) and integrated clinical pathway for people with severe Chronic Obstructive Pulmonary Disease (vertical integration).

#### *Community Wards*

The service is provided to patients registered with Principia GPs who are aged over 18 years and are at risk of hospitalisation, or have complex chronic care needs. Primary interventions are cross-provider communication and collaboration through discussion of patients at regular MDT meetings, case management, and proactive care planning

### *Chronic Obstructive Pulmonary Disease (COPD)*

Implementation of the county-wide pathway, including establishment of community specialist team. Primary aim of the specialist team is to prevent unnecessary recurrent hospital admissions of patients with COPD by identifying patients who will benefit from a case management approach. This involves intensive assessment followed by close monitoring and pro-active management of a patient's condition in order to prevent deterioration and exacerbation. This is done through nursing interventions and pulmonary rehabilitation. Integration with secondary care takes the form of shared identification of patients appropriate for case management in primary care, and support for early discharge.

### **Partnerships/governance structure:**

Principia Partners in Health is a social enterprise organization, founded in 2006. It designs and delivers local health services in Rushcliffe, a borough of Nottinghamshire, on behalf of the NHS. The company brings together 16 General Practices, community health staff, patients and the public to ensure local health services are designed around the specific needs of the local population. It works in partnership with East Midlands Ambulance Service, Nottinghamshire County Council Adult Health and Social Care, Nottingham University Hospitals NHS Trust, Nottingham Emergency Medical Service (GP out-of-hours provider), Community Health Partnerships (DH-owned investment and management company), and NHS Nottinghamshire County.

Principia partners is run by a board made up of representatives of local GPs, community-based service providers (e.g. district nurses), and patients. This is supported by a Clinical Commissioning Forum and a Patient Reference Group. In collaboration with Nottinghamshire Healthcare Trust, the ICO board formed a new alliance called Community Health Partnerships which successfully bid in 2011 to provide community health services.

### **Intervention start date:**

1 September 2009

### **Activity to date (March 2011):**

#### ***Community Wards***

3 wards launched covering the whole cluster – north, south and central. All 16 practices belong to one of these wards (in addition PCT now made decision to roll the scheme out county wide)

Community Service Advisor (virtual ward clerk) posts designed and recruited

Practice based multi-disciplinary team meetings established and ongoing

PARR++ software installed in all practices

Baseline audit of admissions completed

Data sharing agreements established

Clinical nurse specialist for drug and alcohol recruited

Engagement with wider clinical teams

Ward rounds established in two out of three wards, feeding into practice MDTs.

The average rate of emergency admissions for all ACS conditions for Principia registered patients has reduced since the pilot started, before the pilot it was 10.2% below the national average, during the pilot it has been 14.4% below the national average.

## **COPD**

Specialist COPD Team established

Acute consultant community clinic started

Self-care toolkit distributed and reviewed with patients

Remodelling of the delivery of pulmonary rehabilitation service to significantly reduce waiting list – patients can be referred by both primary care and hospital services which makes this a proactive and locally accessible service provided by the specialist community team who patients already know

Provision of exercise therapy for patients who have completed pulmonary rehabilitation

Wellbeing psychological group established

Met Office COPD Forecast alert for bad weather and high virus count – patients followed up by GP practice

Pharmacy industry sponsored nurse to work with practices on prevalence, case finding and better management of COPD patients

In the first 12 months of the pilot compared to the previous 12 months £37,828 less was spent on emergency admissions for COPD.

### *Still in progress (COPD):*

Direct access beds - navigator cards to direct patients to the appropriate wards avoiding unnecessary time spent in A&E or MAU.

Community Oxygen Service

Telehealthcare

### *Both interventions:*

Urgent Care Support Service has started providing rapid response health and social care for patients to be able to remain at home rather than be admitted in hospital or a social care home when it is not clinically indicated or required.

### *Still in progress (Community Wards):*

Creation of community geriatrician posts

## **Facilitators to success**

- Prior to the Pilot, organisational commitment to integration
- Good and long-standing clinical relationships, especially between GPs, who were connected through earlier partnerships
- Financial incentives for 16 practices to participate through the Principia Success Scheme
- Reaching agreements with practices and reassuring them regarding safety of data sharing
- A strong shared vision of the Pilot across Principia
- Continued commitment and enthusiasm of people to 'make it work' with a shared goal to provide better patient care
- Strong clinical and managerial leadership

- Other organisations wanting to be part of the community ward (e.g. mental health, drug and alcohol services)
- Profile of being a national Pilot
- Adaptability (especially in the face of altered situations, such as financial climate)

#### Barriers and challenges

- Perception of considerable bureaucracy involved in being part of the national Pilot scheme – not materialised
- Some early GP resistance to data sharing
- Different views in some GP practices about how multi-disciplinary team meetings should be run, led to inconsistency and difficulties for community staff attending
- Lack of interest from some GP practices in the Met Office Forecast alert service, and one practice not engaged with refreshing PARR data
- Organisational change and uncertainty within PCT provider services (particularly regarding the national roll out of 'Transforming Community Services')
- Different information systems used across organisations
- Needing to work with other GP commissioner groups at a county level for COPD pathway, which slowed progress at times
- Staffing issues – staff leaving key roles and problems with recruiting posts early in the pilot
- Issue around nursing home patients not being admitted to community ward due to community services specification - it has been agreed that those patients that require specialist input from a specialist clinician, e.g. falls specialist, COPD nurse, and heart failure nurse, will provide support to patients as clinically indicated. This will enable such patients to be managed on the community ward where indicated
- Financial climate and impact of this on staff and jobs, great impact on community ward where key posts were lost (six community matrons reduced to three, three Community Service Advisors (ward clerks) reduced to one)
- For COPD pilot – lack of 'step up' beds these were aspirational more than expected
- Financial climate means tendency to view projects as 'successful' if they reduce costs, risking less focus on improving clinical outcomes
- Engagement with a wide range of colleagues within the acute partner

#### **NHS Tameside and Glossop**

##### **Theme/focus:**

Behaviour change in people at risk of cardiovascular disease (CVD)

##### **Aims:**

Aims are to change behaviour in people at risk of developing CVD; reduce morbidity and mortality for people with established CVD; improve patient experience; reduce visits to outpatient clinics and reduce emergency admissions.

##### **Intervention/service change:**

The pilot involves implementation of two new services, one for primary CVD prevention and one for secondary CVD prevention.

***The Primary Prevention Service aims to provide a seamless path for those patients who are identified by information on GP systems as being at 20% or greater risk of developing CVD.***

Data held in practices is used to send out invitations to patients who can then book an appointment for an assessment at their practice or a local pharmacy. They are supported in agreeing to a personal action plan, which is delivered through a range of health interventions including smoking cessation advice, weight management and exercise programmes (booked by Health Call). Health Call supports patients for 6 months, after which the patient is encouraged to have a reassessment of their risk status. GP practice systems are updated to provide a single record of key data.

***The Secondary Prevention Service aims to reduce mortality and morbidity, increase and improve self care and optimise management, for people with diagnosed CVD or other conditions where patients are likely to develop premature CVD.***

This involves patient identification using GP registers shared with other clinicians to enable opportunistic assessment of patients to ensure their management is fully optimised. Patients are also supported through personal action plans as above, patient information sessions, and medicine use reviews at pharmacies.

#### **Partnerships/governance structure:**

The piloted projects are a collaboration between NHS Tameside and Glossop (lead), local GPs and pharmacists, patients, commissioners, Local Authority, PCT provider arm, Collaboration for Leadership Applied Health Research and Care (CLAHRC Manchester), and Tameside Hospital NHS Foundation Trust.

#### **Intervention start date:**

- Primary Prevention Service: First patients invited March 2009
  - Secondary Prevention Service: Identification and segmentation of patients from December 2010 onwards; assessment of patients March 2011 onwards
- Activity to date (March 2011):

#### *Primary Prevention Service*

- 1038 patient invited for Primary Prevention assessment, 99 attended of which 82 were eligible for lifestyle support and 28 of these opted to receive support
- The remaining 1144 eligible patients will be invited through the NHS Health Checks process
- The model was revised from assessments only being available in pharmacies to include GP practice in an attempt to increase uptake and following further review the assessments will only be available in GP practices in the future
- The ongoing lifestyle support has been embedded into a NHS Health Checks Local Enhanced Service
- Service design and development was GP lead and involved a range of clinical professionals

#### *Secondary Prevention Service*

- Practice CVD Registers have been validated and READ codes allocated to support more proactive management of patients
- 60 patients who are on the community nursing team caseload had assessments scheduled in March 2011
- Agreed proformas are supporting the updating of GP held patient records from community assessments
- The community nursing team hope to extend the opportunistic assessment wider than the pilot practices
- Long Term Conditions Group responsible for ongoing service development
- GPs, Consultants and senior nursing staff have been actively engaged in the process of developing the secondary prevention model

#### *General activity noted*

- Increased knowledge base in locality regarding both CVD and health and social care finances
- Improved joint working is increasingly part of the 'day job' and therefore being picked up as part of commissioners' and others' work programs
- "The service delivery has not progressed as planned and so the real benefit to the patients is not evident."
- Robust cost modeling has enabled return on investments to be calculated
- Communication is taking place with GPs to highlight the cost benefits of the services
- Identification of targets for each practice to achieve cost savings

#### **Facilitators**

- Where existing working practices were in place it has been easier to build on these
- Leadership and strong partnership working in the past has helped deliver the work to date; dedicated team of people at the PCT
- Designing services has enabled stakeholders to have a visible influence on local provision and joint conversations have strengthened the sense of integration
- Regular communication, mainly via e-mail
- People not being afraid to question specific issues that are identified
- A general respect for each others' contribution, knowledge and general experience
- External consultant input: Chris Ham
- The pilot project structures (governance, workstreams) have helped provide opportunities and discipline for thinking and have provided permission to step away from day job.

#### Barriers

- Partner organisations put precedence over other priorities, e.g. PCT's reform agenda
- "The project has lacked strong leadership internally as well as amongst the partner organizations." Which lead to difficulties in progressing work to agreed timescales
- Implementing 'Transforming Community Services' and the development of consortia/clusters changed the PCT's priorities leading to a reduction in resources. This hampered the development of the pilot.
- Key staff moved to new posts outside the PCT
- Lack of project dedicated staff made it difficult to prioritize the project management and workstreams
- Changes in staff at SRO and workstream leads caused breaks in progress and changes in direction
- "Sometimes it feels as though we move from one meeting to another with not much happening in between."
- Very poor uptake of intervention, mainly because the review by a pharmacist appeared was unpopular with patients. Scheme later redesigned to offer choice of review at GP surgery.
- Lack of clarity around governance over some decision-making: "Not clear why clinical pathways were changed and by whom, when none of the clinicians had seen changes presented to them until late in the day. This creates distrust."
- Significant effort has been put into inviting involvement and informing patients, but little marketing of the project internally: "It needs branding, it needs communication and creation of a real sense of local ownership"
- Communication with some partners was poor and this was seen as the fault of the pilot rather than communication within organisations involved in the pilot.



## **Torbay Integrated Care Pilot**

### **Theme/focus:**

Multiple linked interventions to provide seamless care for older people with complex co-morbidities

### **Aims:**

- Develop a range of community health and social care services to enable people to remain independent at home for as long as possible
- Reduce emergency admissions and length of stay by providing coordinated support for patients when acutely ill, and enhancing discharge planning
- Maximise collective expertise and resources to reduce the number of hand-offs between organisations
- Increase the early identification of dementia and support self management
- Ensure that palliative services are resourced appropriately and administered to maximise effect

### **Planned interventions/service changes:**

1. *'Immediate intervention'* - Incorporating redesign of Rapid Access to Care for the Elderly (RACE) clinics and development of community based geriatrician service
2. *Acute workstream* - A&E multidisciplinary team pilot adding hospital discharge co-ordinator and community physiotherapist to existing multidisciplinary team to help provide a more holistic assessment of patient needs as they enter A&E and to redirect to community services if appropriate
3. *Care of the elderly pathway* - Improving the interface between primary and secondary care through 'hotline' for GPs to contact consultants directly, and consultants working 2 days a week in community clinics.
4. *Palliative care workstream* - Improving end of life care with a specific focus on COPD, CCF and people with dementia in care homes
5. *Reablement* - Optimising use of community hospitals and intermediate care facilities
6. *Preventative workstream* - Telecare services for patients with COPD, dementia-focused Memory café, interventions to prevent fragility fractures

### **Partnerships/governance structure:**

Torbay Care Trust (TCT), Torbay Council, South Devon Healthcare NHS Foundation Trust, Devon Partnership Trust

Provider network/partnership between these four primary partner organizations. Each workstream is headed by a clinician and executive lead. The workstreams report to the Steering Board which meets monthly. Budgets were not pooled but they have attempted to utilise primary care resources in secondary care settings and vice versa.

### **Intervention start date:**

April 2010

### **Activity to date (March 2011):**

#### *Immediate intervention*

- Board approved funding for 1WTE community based care of the elderly consultant in February 2010

*There was a net increase in acute physicians, which in turn freed up some COTE consultant sessions to be carried out in the community, to develop the COTE hotline M-F 09:00-17:00, and also to increase the Rapid Assessment Clinics from 3 days a week by COTE to 5 days a week by Aps.*

- From July 2010 acute physicians took over Rapid Assessment Clinics in the Emergency Assessment Unit. Similar clinics (RACE) were previously run by care of the elderly consultants, who were then freed up for the Care of the Elderly pathway (see below)

Acute workstream- A&E multidisciplinary team pilot

- Discharge co-ordinators rolled out to 7 wards at DGH, plus A&E and a ward in Paignton's Community Hospital (from March 2010).
- Community physiotherapist and discharge coordinator joined existing multidisciplinary team working in A&E (from April 2010)

Care of the elderly pathway

- Care of the Elderly hotline established for all practices
- Care of the elderly consultants working in the community for two sessions per week from July 2010

Palliative care workstream

- Designed a three-phase training plan for all nursing homes in Torbay, with a particular focus on patients with non-cancer conditions such as COPD, CCF and dementia.
- Training due to be completed during 2011

Reablement

- Review of the medical model of the two community hospitals completed
- St Edmunds intermediate care facility closed and review currently taking place on rehabilitation needs of orthopaedic patients

Preventative workstream

- Specialist nurses currently being recruited so that they are trained and ready to begin in April 2011.
- Very limited number of falls patients picked up by emergency care practitioners as originally planned. Falls management instead addressed by developing a Falls Liaison Service to identify and manage first fragility fractures (to commence April 2011)
- Telehealth services now provided to COPD patients from all 21 GP practices - 75 patients over a 9-month period
- Four Memory Cafés introduced in Torbay
- Psychiatric Liaison Service introduced in Torbay Hospital to provide additional support in A&E and the community for people presenting with psychiatric problems

Facilitators to success

- A strong 'can-do' culture in Torbay, encouraged by the former Chief Executive of the Care Trust
- Autonomy and motivation of frontline staff; they feel involved in changing the services
- Unwavering commitment from four partner organisations
- High profile clinical and executive leads for each workstream
- Interest and engagement from care of the elderly consultants
- Financial pressures and consequential need to release funding from each organisation through QIPP has driven clinicians to take on the challenge of integration and to look at different ways of providing care
- Creation of a group called Transforming Integrated Care, which holds monthly meetings and has representatives of managers from all four partner organisations.
- Discipline of monthly progress reports to the ICP board ensured the momentum to develop throughout the programme

Barriers and challenges

- Some delay in implementation due to changes in key personnel
- Because exec and clinical leads are so high profile, significant forward planning is needed to ensure engagement with monthly Integrated Care Steering Board meetings

- Time and effort needed to get clinicians from primary and secondary care settings engaged on a scale wide enough to effect change, and to think about challenges from a whole system perspective without automatically defaulting to requesting additional resources, or to seeing the initiatives as 'extra' rather than 'different/smarter' ways of working
- Varying degrees of engagement with GPs and intermediate care teams in the five zones: 'wholesale change of mindset' (by both specialists and GPs) required to fully develop role of community geriatricians
- Working within the parameters of tariff and PbR prevent partners from establishing a 'whole system of care'
- Community services do not always have the resources to support care 'closer to home'.

## **NHS Tower Hamlets**

Theme/focus:

Helping patients with long-term conditions to manage their own care, through integrated health and social care

Aims:

The pilot aims to improve health and well-being for patients with long-term conditions, increase uptake of services within targeted hard-to-reach groups, and reduce increases in local incidence of long-term conditions.

Intervention/service change:

The integrated care programme in Tower Hamlets is made up of six work programmes, three of which form the DH ICP pilot. The ICP forms part of a much larger overall Primary Care Investment Programme, which preceded Tower Hamlets being awarded DH pilot status.

- Primary Care Investment Programme (PCIP)
  - Eight geographically defined provider networks consisting of a variety of health and social care functions (within primary care)
  - Development and implementation of care packages for long term conditions, specifically diabetes (*NB: only diabetes intervention is included in the national evaluation's quantitative analysis*)
- Integrated Health and Social Care Programme
  - Formalizing working arrangements between the PCT and London Borough of Tower Hamlets (LBHT) through the re-design of adult health and social care service provision:
    - A single point of access to district nursing and social care
    - Joint prevention and early intervention services
    - Jointly provided reablement services and longer-term support
- Long-term conditions (LTC)
  - This workstream concentrates on higher-level planning and development of the PCIP care packages described above, and wider strategy for local commissioning of joint health and social care services for various long-term conditions.

### **Partnerships/governance structure:**

- NHS Tower Hamlets (Primary Care Trust, lead organisation)
- Local Authority (London Borough of Tower Hamlets)
- Tower Hamlets Community Health Services (PCT provider)
- LMC representatives
- Acute clinical leads
- Patients/ service users
- GPs
- Other stakeholders include third sector organisations (e.g. THINK and other local patient and public involvement groups)

A joint governance structure was established with workstreams driven by the commissioners from the NHS Tower Hamlets and the London Borough of Tower Hamlets. Each of the three ICP programmes has its own governance structure reporting to the IC Board, with ownership has distributed across senior management across organizations to ensure joint accountability

### **Intervention start date:**

01/09/2009 (when diabetes project went live)

### **Activity to date (March 2011):**

*PCIP and Long-term conditions programmes:*

- Care packages:

- Diabetes-Type II (phased roll-out starting in Sept 09)
- Childhood Immunisation & Vaccinations (rolled out across all networks in Dec 09)
- NHS Health Checks (phased roll-out starting April 10)
- Hypertension (phased roll-out Oct 10)
- CVD Secondary Prevention (planned roll out 2011-2012)
- Chronic Obstructive Pulmonary Disease (planned roll out 2011)
- All eight provider networks have been established, providing a single point of access to a number of services. Work is now concentrating on using the network model to bring together a broader range of clinical and non clinical stakeholders (e.g. pharmacists, third sector organisations etc.)
- Care packages currently being delivered for diabetes, childhood immunisation, NHS health checks and hypertension
- The recruitment toolkit and logo is being made available to practices to use at their discretion.
- Networks now delivering bespoke Organisational Development (OD) plans following a borough wide programme. Assessment of OD needs for networks has been completed for 2010/11

*Integrated Health & Social Care Programme:*

The proposals for this programme have been expanded to include a range of services covering early intervention, prevention, assessment, reablement and longer-term support. Key activity to date:

- A high level project plan has been developed following the successful completion of the two staff workshop events held in May. The plan looks at how the identified quick wins in shaping the service can be implemented.
- Options for joint working and Short Term Intervention Service have been outlined. The focus is on creating the information sharing, ICT infrastructure and joint working practices that will deliver improved outcomes on the front line.
- A short term ICT programme is being established to deliver to on priority information needs. Plans are underway to pilot in September a dual touchdown facility in 4 different locations
- Establishment of a pilot to have Social Worker involvement in MDT meetings to be piloted at a network level.

**Facilitators to success**

- Involvement of key representatives at Board level in driving forward the ICP and overseeing the workstreams
- Shared vision amongst all partnership organisations
- Robust infrastructure across all eight provider networks
- Strong clinical leadership
- Close working between primary and secondary care clinicians
- Focus on organisational development
- Progress with information technology solutions:
  - Achievement Dashboards providing practice- and overall network-level performance data
  - Call/Recall: software allowing networks to centralise processes which previously had to be replicated by multiple people at practice level; standardised approach to ensuring all patients receive a care plan; live patient lists; and links process to performance and targets (snapshots of how many patients require a care plan)
- Profile of being a national Pilot

**Barriers and challenges**

- Changes within organisations slowed the pace of change
- Complexity of ICP has meant it has been hard to communicate, and there has been some lack of understanding of what the programme is trying to achieve.
- Complexity of programme interdependencies is a challenge

## **Wakefield**

### **Theme/focus**

Integrated care pathway for those with substance abuse

### **Aims**

The pilot builds on longstanding collaboration between the NHS, third sector and other stakeholders, to integrate care for substance misuse. The aim is to make measurable improvements in the care experience for substance misusers, creating integrated pathways that are both personalised and cost efficient.

The pilot includes five work streams: Information, Management and Technology; Communications and Social Marketing; Enhanced Shared Care; and a Balanced Scorecard to provide feedback on the performance of the various contributors to the care of this vulnerable population.

### **Partnerships/governance structure**

Wakefield Integrated Substance Misuse Services (WISMS) is a partnership between NHS, local government, third sector and private sector (Schering Plough) organisations, as well as wider stakeholders in the management of substance misuse and social re-integration.

### **Intervention/service change**

Within the timescale of the Integrated Care Pilot, the main new intervention is development of a 'balanced scorecard'. The score card represents "a commitment to the development of a shared basket of outcomes which when combined would define an exemplar service for service users, commissioners and providers."

### **Intervention start date**

*Intervention (as defined by Balanced Scorecard) has not yet begun (May 2011)*

### **Activity to date (May 2011)**

- Service user engagement is high with attendance at all Board meetings
- The project has become firmly embedded within 'Transforming Community Services' with one partner completing the process of Right to Request for social enterprise as a first wave site (Right to request was a DH policy allowing PCTs to continue to provide services as a social enterprise as opposed to a formal NHS provider).
- Development of a Practitioners' Forum to enable practitioners to develop a shared understanding of the key drivers for integrated care.
- Practitioners' Forum has delivered safeguarding training to a range of organisations
- Development and implementation of a local service user questionnaire, with a high percentage of completed returns.
- Enhanced Share Care –
  - Piloting of a one stop shop approach to housing and tenancy issues, employment and well being
  - Increased numbers accessing shared care through greater engagement with a practice offering holistic care in a super output area of the PCT
  - Access to user led recovery groups from the enhanced shared care site ( SMART recovery)

### **Facilitators for success**

- Strong governance and programme management consistent since the pilot's inception
- Good administrative support
- Commitment of workstream leads and key partners to the pilot's aims and objectives
- Strategic fit of the pilot to national agendas and policies (Transforming Community Services and World Class Commissioning).

- Partners committed to outcome-focused and personalisation agenda
- Common desire to strengthen collaborative working in tough economic times
- Co-location of recovery and treatment, drug and alcohol staff teams
- Local commissioners supportive of interventions that promote health and well-being needs as well as those that promote local QuIPP (Quest for Quality and Improved Performance) objectives
- Recent emphasis from government on outcome-focused commissioning and service integration have strengthened the pilot's legitimacy

#### Barriers and challenges

- Information governance sharing issues for the Balanced Scored Card project which have prevented the roll out of the Balanced Scorecard as originally planned. Sharing of data between the NHS and Social Services has presented obstacles that proved insuperable.
- Spectrum Community Health CIC was established on April 1st and the ICO was a facilitator
- The economic downturn has brought about the following challenges: Distracting Board members and creating challenges for the involvement of some representatives; Slowing down of critical recruitment; and Decrease in budget spend available per client for drug treatment
- Uncertainties resulting from changing political environment and policies leading to a reluctance to develop new ideas
- Changes to board membership throughout the life of the pilot and appearance of competing priorities for some senior members of the board.
- Increasing difficulties in obtaining required sense of equality of commitment and resource contribution from partners to make the partnership work
- External factors such as pandemic flu impacted on the pilot's activities by placing a significant burden on providers to respond to other national priorities

**Integrated Care Pilots evaluation: final report**

# **Appendix H: Detailed results of patient and staff survey**



**ALL SITES**

**Results for patient population defined by (1) presence in both rounds of survey and (2) taking part in the pilot, and (3) start date at least 2 months before second round of patient survey**

restriction of start date constitutes a control over the length of exposure to intervention

results controlled for clustering at the level of site

\* the outcome of interest is always coded as 'one' (1)

\*\* cutoff point for significance is 0.05

N=700		Descriptives 1 (binary coding with first category contrasted with the 'rest')					Results (conditional logistics=McNemar's) (binary coding with first category contrasted with the 'rest')					
		Round 1 (#)	Round 1 (prop.)	Round 2 (~)	Round 2 (prop.)	Difference (R2-R1)	Odds Ratio	SE	Z	P> z	Sign	
<b>Q1</b>	<b>How often do you see the GP you prefer at your GP surgery or health centre?</b>											
	Always or almost always	258	0.58	232	0.524	-0.056	0.653	0.174	-1.6	0.11	ns	
<b>Q2</b>	<b>Last time you saw a GP, how good was the doctor at</b>											
a	Listening to you											
	Very Good	347	0.681	335	0.658	-0.023	0.83	0.173	-0.91	0.36	ns	
b	Explaining tests and treatments											
	Very Good	264	0.613	248	0.576	-0.037	0.775	0.147	-1.34	0.18	ns	
c	Involving you in decision about your care											
	Very Good	235	0.594	213	0.539	-0.055	0.681	0.12	-2.17	0.03	S	fewer patients think that a doctor was very good at involving them into decisions about care
<b>Q3</b>	<b>How often do you see the nurse you prefer at your GP surgery or health centre?</b>											
	Always or almost always	131	0.5137	108	0.423	-0.0907	0.5	0.0794	-4.19	0.000	S	fewer patients see the nurse that they prefer
<b>Q4</b>	<b>Last time you saw a nurse how good was the nurse at</b>											
a	Listening to you											
	Very Good	313	0.68	306	0.665	-0.015	0.9	0.089	-1.06	0.289	ns	
b	Explaining tests and treatments											
	Very Good	247	0.608	236	0.581	-0.027	0.825	0.161	-0.98	0.327	ns	
c	Involving you in decision about your care											
	Very Good	206	0.598	195	0.5668	-0.0312	0.8	0.0836	-2.13	0.033	S	fewer patients think that a nurse was very good at involving them into decisions about care
<b>Q5</b>	<b>In the last six months, how much of the time have you been</b>											
a	Satisfied that your care was well organized											
	Always	265	0.672	268	0.68	0.008	1.0625	0.211	0.3	0.76	ns	
b	Helped to plan ahead so you could take care of you condition even in difficult times											
	Always	178	0.582	172	0.562	-0.02	0.88	0.159	-0.68	0.497	ns	
c	Helped to look after yourself											
	Always	161	0.565	168	0.589	0.024	1.166	0.219	0.82	0.412	ns	
<b>Q6</b>	<b>In the last six months, have any of the following happened</b>											
a	Test results of your medical notes were not available at the time of your appointment											
	Yes	52	0.161	52	0.161	0.00	1	0.18	0	1	ns	
	The doctor or nurse ordered a test that you felt was unnecessary because it had been already done											
	Yes	15	0.048	20	0.063	0.015	1.357	0.386	1.07	0.284	ns	
c	You were given the wrong medicine or a drug											
	Yes	11	0.0307	6	0.0167	-0.014	0.5	0.244	-1.41	0.157	ns	
d	You were given the wrong dose of a medicine or drug											
	Yes	10	0.0276	6	0.0165	-0.0111	0.33	0.272	-1.35	0.178	ns	

Q7	<b>Do you have any long-standing health problem, disability or infirmity?</b> Yes	413	0.875	427	0.905	0.03	2	0.321	4.31	0.00	S	more patients have disability in Round 2 compared to Round 1
Q8	<b>Have you had discussion in the past 12 months with a doctor or nurse about how best to deal with your longstanding health problems</b> Yes	343	0.861	346	0.869	0.008	1.1	0.15	0.7	0.485	ns	
Q9	<b>In these discussions</b>											
a	Did the doctor or nurse take notice of your views about how to deal with your health problem Yes	280	0.942	284	0.956	0.014	1.67	0.75	1.13	0.257	ns	
b	Did the doctor or nurse give you information about the things you might do to deal with your health problem Yes	269	0.896	273	0.91	0.014	1.25	0.19	1.46	0.143	ns	
c	Did the doctor or nurse give you a written document about the discussions you had about managing your health condition Yes	91	0.338	102	0.379	0.041	1.344	0.418	0.95	0.342	ns	
d	Did the doctor or nurse ever tell you that you had something called a care plan Yes	64	0.264	82	0.338	0.074	2.125	0.652	2.46	0.014	S	more patients have care plan
Q10	<b>Do you think that having these discussions with your doctor or nurse has helped improve how you manage your health problem</b> Yes, definitely	166	0.5155	166	0.5155	0	1	0.106	0	1	ns	
Q11	<b>Have you had any help from social services in your home in the last six months</b> Yes	151	0.304	124	0.25	-0.054	0.55	0.169	-1.94	0.052	ns	
Q12	<b>Do you feel that your opinions and preferences are taken into account by social services of your care workers when decisions are taken about what services are provided to you</b> Always	57	0.533	41	0.383	-0.15	0.4667	0.148	-2.4	0.017	S	fewer patients think that their preferences are always taken into account
Q13	<b>At the present time, do care workers visit you as often as you need</b> Yes	72	0.878	73	0.89	0.012	1.167	0.703	0.26	0.798	ns	
Q14	<b>At the present time, when care workers visit you do they spend the right amount of time with you</b> Yes	71	0.866	74	0.9	0.034	1.75	1.587	0.62	0.537	ns	

<b>Q15</b>	<b>Have you been admitted to hospital in the last six months</b>													
	Yes	195	0.38	136	0.26	-0.12	0.539	0.164	-2.02	0.043	S	fewer admissions in Round 2		
<b>Q16</b>	<b>Thinking about when you came out of hospital</b>													
a	Did you have clear follow up arrangements													
	Yes	45	0.67	51	0.76	0.09	2.5	1.17	1.95	0.051	ns			
b	Did you know who to contact with questions about your treatment after you had left hospital													
	Yes	47	0.71	53	0.8	0.09	2	0.632	2.19	0.028	S	more patients knew who to contact post hospitalisation		
<b>Q17</b>	<b>In the last 3 months, have you seen any of these professionals or carers <u>in person</u>?</b>													
a	GP in the surgery or health centre	305	0.704	312	0.721	0.017	1.13	0.157	0.91	0.363	ns			
b	GP at home	99	0.257	87	0.2265	-0.031	0.76	0.158	-1.32	0.188	ns			
c	GP out of hours service	26	0.076	29	0.085	0.009	1.15	0.312	0.51	0.607	ns			
d	Nurse in the surgery or health centre	224	0.604	220	0.593	-0.011	0.931	0.297	-0.22	0.823	ns			
e	Practice nurse or district nurse at home	132	0.352	115	0.306	-0.046	0.667	0.171	-1.58	0.114	ns			
f	Community matron at home	13	0.0379	12	0.0349	-0.003	0.857	0.523	-0.25	0.801	ns			
g	Physiotherapist	51	0.143	35	0.098	-0.045	0.567	0.125	-2.55	0.011	S	fewer patients see physiotherapists		
i	Social worker or care manager	56	0.154	55	0.151	-0.003	0.974	0.105	-0.25	0.806	ns			
j	Home carer/home help	60	0.1676	61	0.17	0.0024	1.0625	0.261	0.25	0.806	ns			
<b>Q18</b>	<b>Thinking about all the health and/or social services you have used in the last 6 month, has your care been well coordinated</b>													
	Very good	200	0.494	192	0.474	-0.02	0.881	0.137	-0.81	0.416	ns			
<b>Q21</b>	<b>In general would you say your health is</b>													
	Excellent	7	0.0133	7	0.0133	0	1	0.233	0	1	ns			
<b>Q22</b>	<b>Which of the following statements best describes how much control you have over your daily life at the present ime</b>													
	I feel in control of my daily life	257	0.489	225	0.4285	-0.0605	0.573	0.062	-5.09	0	S	fewer patients feel in control of their lives		
<b>Q24</b>	<b>Did you fill in this questionnaire by yourself or did you have help from someone else</b>													
	I filled it in by myself	350	0.65	344	0.639	-0.011	0.857	0.152	-0.87	0.387	ns			

**POOL 1: Case management sites: Church View, Cumbria, Nene, Norfolk, Northumbria, Principia**

**Results for patient population defined by (1) presence in both rounds of survey and (2) taking part in the pilot, and (3) start date at least 2 months before second round of patient survey**

restriction of start date constitutes a control over the length of exposure to intervention

results controlled for clustering at the level of site

\* the outcome of interest is always coded as 'one' (1)

\*\* cutoff point for significance is 0.05

N=460		Descriptives 1 (binary coding with first category contrasted with the 'rest')					Results (conditional logistics=McNemar's) (binary coding with first category contrasted with the 'rest')					
		Round 1 (#)	Round 1 (prop.)	Round 2 (~)	Round 2 (prop.)	Difference (R2-R1)	Odds Ratio	SE	Z	P> z	Sign	
Q1	How often do you see the GP you prefer at your GP surgery or health centre? Always or almost always	201	0.618	171	0.526	-0.092	0.491	0.038	-9.17	0.000	S	fewer patients see the doctor that they prefer
Q2	Last time you saw a GP, how good was the doctor at											
a	Listening to you Very Good	268	0.714	249	0.664	-0.05	0.63	0.0867	-3.37	0.001	S	fewer patients think that a doctor was very good at listening to them
b	Explaining tests and treatments Very Good	204	0.642	185	0.582	-0.06	0.667	0.168	-1.61	0.108	ns	
c	Involving you in decision about your care Very Good	178	0.618	158	0.339	-0.279	0.615	0.122	-2.44	0.015	S	fewer patients think that a doctor was very good at involving them into decisions about care
Q3	How often do you see the nurse you prefer at your GP surgery or health centre? Always or almost always	97	0.524	83	0.448	-0.076	0.6	0.088	-3.55	0.000	S	fewer patients see the nurse that they prefer
Q4	Last time you saw a nurse how good was the nurse at											
a	Listening to you Very Good	235	0.689	227	0.666	-0.023	0.843	0.055	-2.59	0.01	S	fewer patients think that a nurse was very good at listening to them
b	Explaining tests and treatments Very Good	184	0.617	177	0.593	-0.024	0.851	0.1919	-0.72	0.474	ns	
c	Involving you in decision about your care Very Good	153	0.614	145	0.582	-0.032	0.794	0.0916	-1.99	0.047	S	fewer patients think that a nurse was very good at involving them into decisions about care
Q5	In the last six months, how much of the time have you been											
a	Satisfied that you care was well organized Always	202	0.719	198	0.705	-0.014	0.897	0.205	-0.47	0.637	ns	
b	Helped to plan ahead so you could take care of you condition even in difficult times Always	139	0.631	130	0.59	-0.041	0.769	0.18	-1.12	0.263	ns	
c	Helped to look after yourself Always	129	0.638	125	0.619	-0.019	0.882	0.057	-1.91	0.056	ns	

<b>Q6</b>	<b>In the last six months, have any of the following happened</b>											
a	Test results of your medical notes were not available at the time of your appointment											
	Yes	38	0.161	38	0.161	0	1	0.244	0	1	ns	
b	The doctor or nurse ordered a test that you felt was unnecessary because it had been already done											
	Yes	7	0.029	12	0.05	0.021	1.71	0.655	1.41	0.159	ns	
c	You were given the wrong medicine or a drug											
	Yes	10	0.037	4	0.015	-0.022	0.333	0.171	-2.14	0.032	S	fewer patients have been given the wrong medicine
d	You were given the wrong dose of a medicine or drug											
	Yes	7	0.0189	3	0.011	-0.0079	0.2	0.252	-1.27	0.203	ns	
<b>Q7</b>	<b>Do you have any long-standing health problem, disability or infirmity?</b>											
	Yes	319	0.927	326	0.947	0.02	2.167	0.584	2.87	0.004	S	more patients have disability in Round 2 compared to Round 1
<b>Q8</b>	<b>Have you had discussion in the past 12 months with a doctor or nurse about how best to deal with your longstanding health problems</b>											
	Yes	269	0.873	269	0.873	0.00	1	0.161	0	1	ns	
<b>Q9</b>	<b>In these discussions</b>											
a	Did the doctor or nurse take notice of your views about how to deal with your health problem											
	Yes	223	0.945	226	0.957	0.012	2	1.527	0.91	0.364	ns	
b	Did the doctor or nurse give you information about the things you might do to deal with your health problem											
	Yes	213	0.895	215	0.903	0.008	1.15	0.146	1.13	0.26	ns	
c	Did the doctor or nurse give you a written document about the discussions you had about managing your health condition											
	Yes	64	0.294	79	0.362	0.068	1.789	0.717	1.45	0.146	ns	
d	Did the doctor or nurse ever tell you that you had something called a care plan											
	Yes	45	0.228	60	0.305	0.077	2.363	0.776	2.62	0.009	S	more patients have care plan
<b>Q10</b>	<b>Do you think that having these discussions with your doctor or nurse has helped improve how you manage your health problem</b>											
	Yes, definitely	129	0.502	129	0.502	0	1	0.079	0	1	ns	
<b>Q11</b>	<b>Have you had any help from social services in your home in the last six months</b>											
	Yes	116	0.318	85	0.233	-0.085	0.39	0.056	-6.49	0.00	S	less patients have help from social services
<b>Q12</b>	<b>Do you feel that your opinions and preferences are taken into account by social services of your care workers when decisions are taken about what services are provided to you</b>											
	Always	44	0.536	33	0.402	-0.134	0.476	0.164	-2.15	0.032	S	less patients think that their preferences are always taken into account
<b>Q13</b>	<b>At the present time, do care workers visit you as often as you need</b>											
	Yes	52	0.89	50	0.86	-0.03	0.667	0.421	-0.64	0.521	ns	
<b>Q14</b>	<b>At the present time, when care workers visit you do they spend the right amount of time with you</b>											
	Yes	51	0.864	56	0.949	0.085	6	10	1.08	0.282	ns	

Q15	<b>Have you been admitted to hospital in the last six months</b> Yes	177	0.468	109	0.288	-0.18	0.403	0.0709	-5.16	0.00	S	less admissions in Round 2
Q16	<b>Thinking about when you came out of hospital</b>											
a	Did you have clear follow up arrangements Yes	41	0.66	48	0.77	0.11	3.33	2	2.01	0.045	S	more patients had clear arrangements
b	Did you know who to contact with questions about your treatment after you had left hospital Yes	43	0.705	50	0.819	0.114	2.4	0.675	3.11	0.002	S	more patients knew who to contact post hospitalisation
Q17	<b>In the last 3 months, have you seen any of these professionals or carers in person?</b>											
a	GP in the surgery or health centre	226	0.724	223	0.715	-0.009	0.918	0.074	-1.05	0.295	ns	
b	GP at home	90	0.313	77	0.268	-0.045	0.723	0.181	-1.3	0.195	ns	
c	GP out of hours service	22	0.0905	22	0.0905	0.000	1	0.296	0	1	ns	
d	Nurse in the surgery or health centre	160	0.618	159	0.588	-0.030	0.976	0.392	-0.06	0.953	ns	
e	Practice nurse or district nurse at home	118	0.4244	101	0.363	-0.061	0.613	0.188	-1.59	0.112	ns	
f	Community matron at home	8	0.032	8	0.032	0.000	1	0.619	0	1	ns	
g	Physiotherapist	46	0.176	30	0.115	-0.061	0.515	0.123	-2.77	0.006	S	less patients saw physiotherapist
i	Social worker or care manager	41	0.156	40	0.151	-0.005	0.964	0.114	-0.31	0.76	ns	
j	Home carer/home help	45	0.169	47	0.177	0.008	1.167	0.293	0.61	0.54	ns	
Q18	<b>Thinking about all the health and/or social services you have used in the last 6 month, has your care been well coordinated</b> Very good	158	0.523	153	0.507	-0.0164	0.895	0.173	-0.57	0.569	ns	
Q21	<b>In general would you say your health is</b> Excellent	3	0.0077	3	0.0077	0	ESTIMATION FAILED					
Q22	<b>Which of the following statements best describes how much control you have over your daily life at the present time</b> I feel in control of my daily life	186	0.478	167	0.429	-0.049	0.634	0.086	-3.32	0.001	S	less patients feel in control of their lives
Q24	<b>Did you fill in this questionnaire by yourself or did you have help from someone else</b> I filled it in by myself	273	0.68	272	0.678	-0.002	0.965	0.163	-0.21	0.836	ns	

ALL SITES

Results for patient population defined by (1) presence in both rounds of survey , (2) taking part in the pilot, (3) start date at least 2 months before second round of patient survey, and 4) UNCHANGING health status (defined by unchanging answers to Q7, Q21 and Q22)

restriction of start date constitutes a control over the length of exposure to intervention  
 results controlled for clustering at the level of site

\* the outcome of interest is always coded as 'one' (1)

\*\* cutoff point for significance is 0.05

N=307	Descriptives 1 (binary coding with first category contrasted with the 'rest')					Results (conditional logistics=McNemar's) (binary coding with first category contrasted with the 'rest')									
	Round 1 (#)	Round 1 (prop.)	Round 2 (~)	Round 2 (prop.)	Difference (R2-R1)	Odds Ratio	SE	Z	P> z	Sign					
<b>Q1</b>	<b>How often do you see the GP you prefer at your GP surgery or health centre?</b>														
	Always or almost always					147	0.604	143	0.588	-0.016	0.889	0.263	-0.4	0.691	ns
<b>Q2</b>	<b>Last time you saw a GP, how good was the doctor at</b>														
a	Listening to you					200	0.69	192	0.66	-0.03	0.78	0.166	-1.15	0.25	ns
b	Explaining tests and treatments					149	0.62	138	0.57	-0.05	0.7027	0.206	-1.2	0.229	ns
c	Involving you in decision about your care					132	0.59	116	0.52	-0.07	0.567	0.163	-1.97	0.049	S
	Very Good														fewer patients think that a doctor was very good at involving them into decisions about care
<b>Q3</b>	<b>How often do you see the nurse you prefer at your GP surgery or health centre?</b>														
	Always or almost always					75	0.55	56	0.41	-0.14	0.4	0.0932	-3.94	0.000	S
															fewer patients see the nurse that they prefer
<b>Q4</b>	<b>Last time you saw a nurse how good was the nurse at</b>														
a	Listening to you					193	0.73	184	0.7	-0.03	0.763	0.229	-0.9	0.369	ns
b	Explaining tests and treatments					148	0.65	141	0.62	-0.03	0.787	0.342	-0.55	0.583	ns
c	Involving you in decision about your care					124	0.63	117	0.6	-0.03	0.774	0.176	-1.12	0.261	ns
	Very Good														
<b>Q5</b>	<b>In the last six months, how much of the time have you been</b>														
a	Satisfied that you care was well organized					160	0.69	162	0.7	0.01	1.07	0.243	0.31	0.753	ns
	Always														
b	Helped to plan ahead so you could take care of you condition even in difficult times					108	0.603	103	0.58	-0.023	0.838	0.221	-0.67	0.506	ns
	Always														
c	Helped to look after yourself					88	0.55	98	0.62	0.07	1.526	0.301	2.15	0.032	S
	Always														more patients are always helped to look after themselves
<b>Q6</b>	<b>In the last six months, have any of the following happened</b>														
a	Test results of your medical notes were not available at the time of your appointment					29	0.152	29	0.152	0	1	0.267	0	1	ns
	Yes														
b	The doctor or nurse ordered a test that you felt was unnecessary because it had been already done					11	0.058	10	0.0534	-0.0046	0.9	0.324	-0.29	0.77	ns
	Yes														
c	You were given the wrong medicine or a drug					6	0.0285	4	0.019	-0.0095	0.6	0.309	-0.99	0.323	ns
	Yes														
d	You were given the wrong dose of a medicine or drug					8	0.0375	5	0.0234	-0.0141	0.25	0.3125	-1.11	0.267	ns
	Yes														

Q7	Do you have any long-standing health problem, disability or infirmity? Yes					IRRELEVANT-SELECTION VARIABLE						
Q8	Have you had discussion in the past 12 months with a doctor or nurse about how best to deal with your longstanding health problems Yes	229	0.867	228	0.86	-0.007	0.95	0.34	-0.14	0.886	ns	
Q9	In these discussions											
a	Did the doctor or nurse take notice of your views about how to deal with your health problem Yes	186	0.95	187	0.95	0	1.25	0.942	0.3	0.767	ns	
b	Did the doctor or nurse give you information about the things you might do to deal with your health problem Yes	178	0.9	176	0.89	-0.01	0.846	0.231	-0.61	0.541	ns	
c	Did the doctor or nurse give you a written document about the discussions you had about managing your health condition Yes	53	0.302	69	0.39	0.088	2	0.876	1.58	0.114	ns	
d	Did the doctor or nurse ever tell you that you had something called a care plan Yes	43	0.275	56	0.358	0.083	2.44	1.01	2.16	0.031	S	more patients have care plan
Q10	Do you think that having these discussions with your doctor or nurse has helped improve how you manage your health problem Yes, definitely	101	0.49	111	0.54	0.05	1.357	0.199	2.08	0.038	S	more patients think that discussions are helpful
Q11	Have you had any help from social services in your home in the last six months Yes	88	0.301	81	0.277	-0.024	0.767	0.242	-0.84	0.4	ns	
Q12	Do you feel that your opinions and preferences are taken into account by social services of your care workers when decisions are taken about what services are provided to you Always	34	0.53	26	0.4	-0.13	0.555	0.196	-1.66	0.097	ns	
Q13	At the present time, do care workers visit you as often as you need Yes	47	0.88	49	0.92	0.04	2	1.58	0.88	0.381	ns	
Q14	At the present time, when care workers visit you do they spend the right amount of time with you Yes	44	0.846	46	0.88	0.034	1.667	1.805	0.47	0.637	ns	
Q15	Have you been admitted to hospital in the last six months Yes	119	0.399	73	0.244	-0.155	0.439	0.177	-2.04	0.042	S	fewer admissions in Round 2 (n.b. regression to mean)
Q16	Thinking about when you came out of hospital											
a	Did you have clear follow up arrangements Yes	24	0.71	27	0.79	0.08	2	1.33	1.04	0.298	ns	
b	Did you know who to contact with questions about your treatment after you had left hospital Yes	29	0.78	30	0.81	0.03	1.25	0.496	0.56	0.574	ns	



<b>Q17</b>	<b>In the last 3 months, have you seen any of these professionals or carers <u>in person</u>?</b>										
a	GP in the surgery or health centre	179	0.7	178	0.69	-0.01	0.967	0.226	-0.14	0.888	ns
b	GP at home	65	0.28	53	0.23	-0.050	0.612	0.14	-2.14	0.032	S fewer patients saw GP at home
c	GP out of hours service	20	0.097	16	0.078	-0.019	0.733	0.178	-1.27	0.202	ns
d	Nurse in the surgery or health centre	136	0.604	134	0.59	-0.014	0.9375	0.452	-0.13	0.894	ns
e	Practice nurse or district nurse at home	90	0.4	74	0.33	-0.07	0.483	0.14	-2.36	0.018	S fewer patients see practice nurse at home
f	Community matron at home	9	0.0445	9	0.0445	0	1	0.67	0	1	ns
g	Physiotherapist	36	0.167	26	0.12	-0.047	0.615	0.201	-1.48	0.138	ns
i	Social worker or care manager	38	0.175	36	0.165	-0.01	0.925	0.155	-0.46	0.647	ns
j	Home carer/home help	39	0.183	36	0.169	-0.014	0.7	0.176	-1.42	0.156	ns
<b>Q18</b>	<b>Thinking about all the health and/or social services you have used in the last 6 month, has your care been well coordinated</b>										
	Very good	116	0.49	115	0.49	0	0.973	0.223	-0.12	0.905	ns
<b>Q21</b>	<b>In general would you say your health is</b>										
	Excellent				0		IRRELEVANT-SELECTION VARIABLE				
<b>Q22</b>	<b>Which of the following statements best describes how much control you have over your daily life at the present ime</b>										
	I feel in control of my daily life				0		IRRELEVANT-SELECTION VARIABLE				
<b>Q24</b>	<b>Did you fill in this questionnaire by yourself or did you have help from someone else</b>										
	I filled it in by myself	184	0.615	180	0.602	-0.013	0.75	0.329	-0.65	0.513	ns

**POOL 1: Church View, Cumbria, Nene, Norfolk, Northumbria, Principia**

**Results for patient population defined by (1) presence in both rounds of survey and (2) taking part in the pilot, and (3) start date at least 2 months before second round of patient survey and 4) UNCHANGING health status (defined by unchanging answers to Q7, Q21 and Q22)**

restriction of start date constitutes a control over the length of exposure to intervention  
 results controlled for clustering at the level of site

\* the outcome of interest is always coded as 'one' (1)

\*\* cutoff point for significance is 0.05

N=319	Descriptives 1 (binary coding with first category contrasted with the 'rest')					Results (conditional logistics=McNemar's) (binary coding with first category contrasted with the 'rest')									
	Round 1 (#)	Round 1 (prop.)	Round 2 (~)	Round 2 (prop.)	Difference (R2-R1)	Odds Ratio	SE	Z	P> z	Sign					
<b>Q1</b>	<b>How often do you see the GP you prefer at your GP surgery or health centre?</b>														
	Always or almost always					128	0.607	102	0.483	-0.123	0.395	0.040	-9.100	0.000	S
<b>Q2</b>	<b>Last time you saw a GP, how good was the doctor at</b>														
a	Listening to you														
	Very Good					170	0.702	154	0.636	-0.066	0.579	0.111	-2.842	0.004	S
b	Explaining tests and treatments														
	Very Good					130	0.631	118	0.573	-0.058	0.700	0.245	-1.020	0.308	NS
c	Involving you in decision about your care														
	Very Good					116	0.611	102	0.537	-0.074	0.622	0.150	-1.966	0.049	S
<b>Q3</b>	<b>How often do you see the nurse you prefer at your GP surgery or health centre?</b>														
	Always or almost always					61	0.500	56	0.459	-0.041	0.750	0.149	-1.446	0.148	NS
<b>Q4</b>	<b>Last time you saw a nurse how good was the nurse at</b>														
a	Listening to you														
	Very Good					147	0.668	138	0.627	-0.041	0.735	0.131	-1.720	0.085	NS
b	Explaining tests and treatments														
	Very Good					108	0.551	107	0.546	-0.005	0.966	0.168	-0.201	0.841	NS
c	Involving you in decision about your care														
	Very Good					94	0.570	92	0.558	-0.012	0.917	0.220	-0.363	0.717	NS
<b>Q5</b>	<b>In the last six months, how much of the time have you been</b>														
a	Satisfied that you care was well organized														
	Always					122	0.685	123	0.691	0.006	1.038	0.272	0.144	0.885	NS
b	Helped to plan ahead so you could take care of you condition even in difficult times														
	Always					90	0.625	84	0.583	-0.042	0.769	0.273	-0.739	0.460	NS
c	Helped to look after yourself														
	Always					87	0.640	85	0.625	-0.015	0.909	0.111	-0.783	0.434	NS

<b>Q6</b>	<b>In the last six months, have any of the following happened</b>										
a	Test results of your medical notes were not available at the time of your appointment										
	Yes	29	0.197	27	0.184	-0.014	0.882	0.231	-0.477	0.633	NS
b	The doctor or nurse ordered a test that you felt was unnecessary because it had been done before										
	Yes	6	0.042	9	0.063	0.021	1.500	0.764	0.796	0.426	NS
c	You were given the wrong medicine or a drug										
	Yes	10	0.062	3	0.019	-0.043	0.222	0.119	-2.802	0.005	S
d	You were given the wrong dose of a medicine or drug										
	Yes	5	0.030	3	0.018	-0.012	0.333	0.509	-0.719	0.472	NS
<b>Q7</b>	<b>Do you have any long-standing health problem, disability or infirmity?</b>										
	Yes	188	0.908	195	0.942	0.034	2.167	0.584	2.867	0.004	S
<b>Q8</b>	<b>Have you had discussion in the past 12 months with a doctor or nurse about how to deal with your health?</b>										
	Yes	160	0.865	164	0.886	0.022	1.364	0.294	1.439	0.150	NS
<b>Q9</b>	<b>In these discussions</b>										
a	Did the doctor or nurse take notice of your views about how to deal with your health?										
	Yes	131	0.923	133	0.937	0.014	1.667	1.262	0.675	0.500	NS
b	Did the doctor or nurse give you information about the things you might do to deal with your health?										
	Yes	125	0.874	128	0.895	0.021	1.375	0.133	3.303	0.001	S
c	Did the doctor or nurse give you a written document about the discussions you had?										
	Yes	39	0.298	43	0.328	0.031	1.286	0.528	0.612	0.540	NS
d	Did the doctor or nurse ever tell you that you had something called a care plan?										
	Yes	26	0.213	34	0.279	0.066	2.000	0.625	2.218	0.027	S
<b>Q10</b>	<b>Do you think that having these discussions with your doctor or nurse has helped you deal with your health?</b>										
	Yes, definitely	81	0.516	73	0.465	-0.051	0.714	0.163	-1.475	0.140	NS
<b>Q11</b>	<b>Have you had any help from social services in your home in the last six months?</b>										
	Yes	83	0.356	62	0.266	-0.090	0.417	0.050	-7.229	0.000	S
<b>Q12</b>	<b>Do you feel that your opinions and preferences are taken into account by social workers?</b>										
	Always	29	0.537	22	0.407	-0.130	0.462	0.176	-2.030	0.042	S
<b>Q13</b>	<b>At the present time, do care workers visit you as often as you need?</b>										
	Yes	33	0.846	32	0.821	-0.026	0.800	0.452	-0.395	0.693	NS
<b>Q14</b>	<b>At the present time, when care workers visit you do they spend the right amount of time with you?</b>										
	Yes	37	0.881	39	0.929	0.048	3.000	4.000	0.824	0.410	NS
<b>Q15</b>	<b>Have you been admitted to hospital in the last six months?</b>										
	Yes	120	0.488	73	0.297	-0.191	0.390	0.073	-5.036	0.000	S

<b>Q16</b>	<b>Thinking about when you came out of hospital</b>										
a	Did you have clear follow up arrangements										
	Yes	26	0.605	33	0.767	0.163					
b	Did you know who to contact with questions about your treatment after you had left										
	Yes	27	0.675	33	0.825	0.150	7.000	4.000	3.405	0.001	S
	<b>In the last 3 months, have you seen any of these professionals or carers in person?</b>										
<b>Q17</b>											
a	GP in the surgery or health centre	144	0.713	143	0.708	-0.005	0.958	0.145	-0.280	0.779	NS
b	GP at home	57	0.308	55	0.297	-0.011	0.938	0.225	-0.268	0.788	NS
c	GP out of hours service	14	0.089	16	0.102	0.013	1.200	0.459	0.476	0.634	NS
d	Nurse in the surgery or health centre	100	0.575	94	0.540	-0.034	0.818	0.256	-0.643	0.520	NS
e	Practice nurse or district nurse at home	81	0.445	73	0.401	-0.044	0.733	0.222	-1.024	0.306	NS
f	Community matron at home	6	0.037	5	0.030	-0.006	0.750	0.530	-0.407	0.684	NS
g	Physiotherapist	32	0.187	20	0.117	-0.070	0.455	0.178	-2.012	0.044	S
i	Social worker or care manager	26	0.150	28	0.162	0.012	1.111	0.217	0.540	0.589	NS
j	Home carer/home help	32	0.184	37	0.213	0.029	1.625	0.278	2.834	0.005	S
	<b>Thinking about all the health and/or social services you have used in the last 6 month, has your care been well coordinated</b>										
<b>Q18</b>	Very good	101	0.515	101	0.515	0.000	1.000	0.233	0.000	1.000	NS
	<b>In general would you say your health is</b>										
<b>Q21</b>	Excellent	3	0.012	3	0.012	0.000					
	<b>Which of the following statements best describes how much control you have over your daily life at the present ime</b>										
<b>Q22</b>	I feel in control of my daily life	120	0.478	101	0.402	-0.076	0.635	0.087	-3.317	0.001	S
	<b>Did you fill in this questionnaire by yourself or did you have help from someone else</b>										
<b>Q24</b>	I filled it in by myself	177	0.668	178	0.672	0.004	1.042	0.154	0.277	0.782	NS

## Frequencies

## Staff Questionnaire Round 1 All

**Q1\_R1 Do you know you are working in an Integrated Care Pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	454	79.1	89.5	89.5
	2 DK	15	2.6	3.0	92.5
	3 No	38	6.6	7.5	100.0
	Total	507	88.3	100.0	
Missing	System	67	11.7		
Total		574	100.0		

**Q2\_R1 How has your job changed since the introduction**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 New appointment	50	8.7	10.6	10.6
	2 Seconded to work full time	19	3.3	4.0	14.7
	3 Seconded to work part time	53	9.2	11.3	26.0
	4 Some changes, but not formally on pilot	143	24.9	30.4	56.4
	5 Not changed	205	35.7	43.6	100.0
Total		470	81.9	100.0	
Missing	System	104	18.1		
Total		574	100.0		

**Q3a\_R1 The depth of my job has increased**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	13	2.3	4.6	4.6
	2 Disagree	36	6.3	12.6	17.2
	3 Neither	65	11.3	22.8	40.0
	4 Agree	109	19.0	38.2	78.2
	5 Strongly agree	28	4.9	9.8	88.1
	6 Not applicable	34	5.9	11.9	100.0
Total		285	49.7	100.0	
Missing	System	289	50.3		
Total		574	100.0		

**Q3b\_R1 The breadth of my job has been expanded**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	7	1.2	2.4	2.4
	2 Disagree	18	3.1	6.2	8.6
	3 Neither	40	7.0	13.8	22.4
	4 Agree	134	23.3	46.2	68.6
	5 Strongly agree	65	11.3	22.4	91.0
	6 Not applicable	26	4.5	9.0	100.0
	Total	290	50.5	100.0	
Missing	System	284	49.5		
Total		574	100.0		

**Q3c\_R1 I now delegate more responsibility to others**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	25	4.4	8.9	8.9
	2 Disagree	61	10.6	21.8	30.7
	3 Neither	89	15.5	31.8	62.5
	4 Agree	59	10.3	21.1	83.6
	5 Strongly agree	10	1.7	3.6	87.1
	6 Not applicable	36	6.3	12.9	100.0
	Total	280	48.8	100.0	
Missing	System	294	51.2		
Total		574	100.0		

**Q3d\_R1 I now have more responsibility delegated to me**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	10	1.7	3.4	3.4
	2 Disagree	39	6.8	13.4	16.9
	3 Neither	55	9.6	19.0	35.9
	4 Agree	115	20.0	39.7	75.5
	5 Strongly agree	40	7.0	13.8	89.3
	6 Not applicable	31	5.4	10.7	100.0
	Total	290	50.5	100.0	
Missing	System	284	49.5		
Total		574	100.0		

**Q4\_R1 How much of your daily work relates to the pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 None specifically	65	11.3	21.4	21.4
	2 Some	186	32.4	61.2	82.6
	3 All	38	6.6	12.5	95.1
	4 Not sure	15	2.6	4.9	100.0
	Total	304	53.0	100.0	
Missing	System	270	47.0		
Total		574	100.0		

**Q5\_hours\_1\_R1 Average hours per week**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	7	1.2	2.9	2.9
	.20	2	.3	.8	3.7
	.50	16	2.8	6.6	10.2
	1.00	32	5.6	13.1	23.4
	1.50	3	.5	1.2	24.6
	2.00	37	6.4	15.2	39.8
	2.50	1	.2	.4	40.2
	3.00	12	2.1	4.9	45.1
	3.50	1	.2	.4	45.5
	4.00	22	3.8	9.0	54.5
	4.50	1	.2	.4	54.9
	5.00	4	.7	1.6	56.6
	5.50	1	.2	.4	57.0
	6.00	11	1.9	4.5	61.5
	6.50	1	.2	.4	61.9
	7.00	4	.7	1.6	63.5
	7.50	2	.3	.8	64.3
	8.00	10	1.7	4.1	68.4
	10.00	7	1.2	2.9	71.3
	12.00	2	.3	.8	72.1
	15.00	3	.5	1.2	73.4
	16.00	4	.7	1.6	75.0
	17.00	1	.2	.4	75.4
	17.50	1	.2	.4	75.8
	18.00	2	.3	.8	76.6
	18.50	1	.2	.4	77.0
	18.75	1	.2	.4	77.5
	19.00	1	.2	.4	77.9
	20.00	10	1.7	4.1	82.0
	21.00	1	.2	.4	82.4
	22.50	2	.3	.8	83.2
	25.00	3	.5	1.2	84.4
	26.25	1	.2	.4	84.8
30.00	11	1.9	4.5	89.3	
32.00	1	.2	.4	89.8	
35.00	2	.3	.8	90.6	
37.00	5	.9	2.0	92.6	
37.50	9	1.6	3.7	96.3	
40.00	6	1.0	2.5	98.8	
48.00	1	.2	.4	99.2	
50.00	2	.3	.8	100.0	
Total		244	42.5	100.0	
Missing	System	330	57.5		
Total		574	100.0		

**Q5\_NA\_1\_R1 Not applicable**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	52	9.1	100.0	100.0
Missing	System	522	90.9		
Total		574	100.0		

**Q5\_hours\_2\_R1 Maximum hours per week**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	4	.7	1.7	1.7
	.50	4	.7	1.7	3.3
	1.00	12	2.1	5.0	8.4
	1.50	1	.2	.4	8.8
	2.00	21	3.7	8.8	17.6
	2.50	1	.2	.4	18.0
	3.00	21	3.7	8.8	26.8
	3.50	1	.2	.4	27.2
	4.00	32	5.6	13.4	40.6
	5.00	6	1.0	2.5	43.1
	6.00	16	2.8	6.7	49.8
	7.00	5	.9	2.1	51.9
	7.50	1	.2	.4	52.3
	8.00	16	2.8	6.7	59.0
	9.00	1	.2	.4	59.4
	10.00	8	1.4	3.3	62.8
	12.00	5	.9	2.1	64.9
	14.00	1	.2	.4	65.3
	15.00	6	1.0	2.5	67.8
	16.00	7	1.2	2.9	70.7
	18.00	2	.3	.8	71.5
	18.75	1	.2	.4	72.0
	20.00	8	1.4	3.3	75.3
	22.00	2	.3	.8	76.2
	24.00	2	.3	.8	77.0
	25.00	5	.9	2.1	79.1
	26.25	1	.2	.4	79.5
	27.00	1	.2	.4	79.9
	30.00	12	2.1	5.0	84.9
	32.00	1	.2	.4	85.4
	35.00	2	.3	.8	86.2
	37.00	5	.9	2.1	88.3
	37.50	11	1.9	4.6	92.9
	39.00	1	.2	.4	93.3
	40.00	5	.9	2.1	95.4
	42.00	1	.2	.4	95.8
	42.50	1	.2	.4	96.2
	45.00	3	.5	1.3	97.5
	50.00	2	.3	.8	98.3
	60.00	4	.7	1.7	100.0
Total		239	41.6	100.0	
Missing	System	335	58.4		
Total		574	100.0		



**Q5\_NA\_2\_R1 Not applicable**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	51	8.9	100.0	100.0
Missing	System	523	91.1		
Total		574	100.0		

**Q5\_hours\_3\_R1 Minumum hours per week**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	52	9.1	22.5	22.5
	.50	13	2.3	5.6	28.1
	.75	1	.2	.4	28.6
	1.00	41	7.1	17.7	46.3
	2.00	24	4.2	10.4	56.7
	3.00	13	2.3	5.6	62.3
	4.00	10	1.7	4.3	66.7
	5.00	3	.5	1.3	68.0
	5.50	1	.2	.4	68.4
	6.00	5	.9	2.2	70.6
	7.00	1	.2	.4	71.0
	7.50	2	.3	.9	71.9
	8.00	6	1.0	2.6	74.5
	10.00	5	.9	2.2	76.6
	15.00	7	1.2	3.0	79.7
	16.00	4	.7	1.7	81.4
	18.00	1	.2	.4	81.8
	18.75	2	.3	.9	82.7
	20.00	3	.5	1.3	84.0
	22.50	1	.2	.4	84.4
	24.00	1	.2	.4	84.8
	25.00	4	.7	1.7	86.6
	28.00	2	.3	.9	87.4
	30.00	8	1.4	3.5	90.9
	32.00	1	.2	.4	91.3
	35.00	2	.3	.9	92.2
	37.00	6	1.0	2.6	94.8
	37.50	8	1.4	3.5	98.3
	40.00	3	.5	1.3	99.6
	45.00	1	.2	.4	100.0
Total		231	40.2	100.0	
Missing	System	343	59.8		
Total		574	100.0		

**Q5\_NA\_3\_R1 Not applicable**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	58	10.1	100.0	100.0
Missing	System	516	89.9		
Total		574	100.0		

**Q5\_hours\_4\_R1 Number of weeks worked overtime because of pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	94	16.4	55.3	55.3
	.30	1	.2	.6	55.9
	1.00	18	3.1	10.6	66.5
	2.00	14	2.4	8.2	74.7
	3.00	7	1.2	4.1	78.8
	4.00	30	5.2	17.6	96.5
	8.00	1	.2	.6	97.1
	10.00	1	.2	.6	97.6
	12.00	1	.2	.6	98.2
	15.00	1	.2	.6	98.8
	16.00	1	.2	.6	99.4
	120.00	1	.2	.6	100.0
Total		170	29.6	100.0	
Missing	System	404	70.4		
Total		574	100.0		

**Q5\_NA\_4\_R1 Not applicable**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	113	19.7	100.0	100.0
Missing	System	461	80.3		
Total		574	100.0		

**Q6a\_R1 Support for training in my area of work**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	72	12.5	23.6	23.6
	2 No change	201	35.0	65.9	89.5
	3 Worse than before	4	.7	1.3	90.8
	4 Not sure	28	4.9	9.2	100.0
Total		305	53.1	100.0	
Missing	System	269	46.9		
Total		574	100.0		

**Q6b\_R1 Clarity of accountability structures in my work**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	60	10.5	19.9	19.9
	2 No change	200	34.8	66.4	86.4
	3 Worse than before	18	3.1	6.0	92.4
	4 Not sure	23	4.0	7.6	100.0
	Total	301	52.4	100.0	
Missing	System	273	47.6		
Total		574	100.0		

**Q6c\_R1 Communication between different parts of my organisation**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	133	23.2	43.8	43.8
	2 No change	140	24.4	46.1	89.8
	3 Worse than before	13	2.3	4.3	94.1
	4 Not sure	18	3.1	5.9	100.0
	Total	304	53.0	100.0	
Missing	System	270	47.0		
Total		574	100.0		

**Q6d\_R1 Communication with other organisations**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	182	31.7	59.9	59.9
	2 No change	100	17.4	32.9	92.8
	3 Worse than before	9	1.6	3.0	95.7
	4 Not sure	13	2.3	4.3	100.0
	Total	304	53.0	100.0	
Missing	System	270	47.0		
Total		574	100.0		

**Q7a\_R1 Having clear planned goals and objectives**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	71	12.4	23.7	23.7
	2 No change	209	36.4	69.7	93.3
	3 Worse than before	20	3.5	6.7	100.0
	Total	300	52.3	100.0	
Missing	System	274	47.7		
Total		574	100.0		

**Q7b\_R1 Having an interesting job**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	119	20.7	39.8	39.8
	2 No change	174	30.3	58.2	98.0
	3 Worse than before	6	1.0	2.0	100.0
	Total	299	52.1	100.0	
Missing	System	275	47.9		
Total		574	100.0		

**Q7c\_R1 Developing my role**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	131	22.8	43.8	43.8
	2 No change	163	28.4	54.5	98.3
	3 Worse than before	5	.9	1.7	100.0
	Total	299	52.1	100.0	
Missing	System	275	47.9		
Total		574	100.0		

**Q7d\_R1 Having adequate resources**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	53	9.2	17.8	17.8
	2 No change	189	32.9	63.4	81.2
	3 Worse than before	56	9.8	18.8	100.0
	Total	298	51.9	100.0	
Missing	System	276	48.1		
Total		574	100.0		

**Q8\_R1 Participate in steering group or board**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	173	30.1	56.5	56.5
	2 No	133	23.2	43.5	100.0
	Total	306	53.3	100.0	
Missing	System	268	46.7		
Total		574	100.0		

**Q9a\_R1 Has overall care patients receive ...**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Got better	242	42.2	48.4	48.4
	2 Not changed	158	27.5	31.6	80.0
	3 Got worse	11	1.9	2.2	82.2
	4 Not sure	89	15.5	17.8	100.0
	Total	500	87.1	100.0	
Missing	System	74	12.9		
Total		574	100.0		

**Q9b\_R1 Seen improvements in care as result of pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	185	32.2	37.2	37.2
	2 No	53	9.2	10.7	47.9
	3 Too early to tell	178	31.0	35.8	83.7
	4 Not sure	80	13.9	16.1	99.8
	9 2 or more ticked	1	.2	.2	100.0
	Total	497	86.6	100.0	
Missing	System	77	13.4		
Total		574	100.0		

**Q10\_R1 Work in a team**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	451	78.6	89.3	89.3
	2 No	53	9.2	10.5	99.8
	9 2 or more ticked	1	.2	.2	100.0
	Total	505	88.0	100.0	
Missing	System	69	12.0		
Total		574	100.0		

**Q11a\_R1 Having clear team objectives**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	125	21.8	28.4	28.4
	2 No change	296	51.6	67.3	95.7
	3 Worse than before	19	3.3	4.3	100.0
	Total	440	76.7	100.0	
Missing	System	134	23.3		
Total		574	100.0		

**Q11b\_R1 Working closely with other team members**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	172	30.0	38.7	38.7
	2 No change	267	46.5	60.1	98.9
	3 Worse than before	5	.9	1.1	100.0
	Total	444	77.4	100.0	
Missing	System	130	22.6		
Total		574	100.0		

**Q11c\_R1 Meeting regularly to discuss how care can be improved**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	192	33.4	43.3	43.3
	2 No change	242	42.2	54.6	98.0
	3 Worse than before	9	1.6	2.0	100.0
	Total	443	77.2	100.0	
Missing	System	131	22.8		
Total		574	100.0		

**Q11d\_R1 Having clear lines of accountability**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	83	14.5	18.9	18.9
	2 No change	333	58.0	75.9	94.8
	3 Worse than before	22	3.8	5.0	99.8
	9 2 or more ticked	1	.2	.2	100.0
	Total	439	76.5	100.0	
Missing	System	135	23.5		
Total		574	100.0		

**Q11e\_R1 Having new electronic communication systems**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	75	13.1	17.3	17.3
	2 No change	352	61.3	81.3	98.6
	3 Worse than before	6	1.0	1.4	100.0
	Total	433	75.4	100.0	
Missing	System	141	24.6		
Total		574	100.0		

**Q12\_R1 Have face-to-face contact with patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes, frequently	304	53.0	59.8	59.8
	2 Yes, occasionally	67	11.7	13.2	73.0
	3 No	137	23.9	27.0	100.0
	Total	508	88.5	100.0	
Missing	System	66	11.5		
Total		574	100.0		

**Q13a\_R1 I am satisfied with the quality of care I give to patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	6	1.0	1.6	1.6
	2 Disagree	12	2.1	3.1	4.7
	3 Neither	19	3.3	4.9	9.6
	4 Agree	185	32.2	48.1	57.7
	5 Strongly agree	129	22.5	33.5	91.2
	6 Not applicable	34	5.9	8.8	100.0
	Total	385	67.1	100.0	
Missing	System	189	32.9		
Total		574	100.0		

**Q13b\_R1 I feel my role makes a positive difference to patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	5	.9	1.3	1.3
	3 Neither	22	3.8	5.7	7.0
	4 Agree	199	34.7	51.6	58.5
	5 Strongly agree	155	27.0	40.2	98.7
	6 Not applicable	5	.9	1.3	100.0
	Total	386	67.2	100.0	
Missing	System	188	32.8		
Total		574	100.0		

**Q13c\_R1 I am able to do my job to a standard I am personally pleased with**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	10	1.7	2.6	2.6
	2 Disagree	31	5.4	8.0	10.6
	3 Neither	29	5.1	7.5	18.1
	4 Agree	200	34.8	51.8	69.9
	5 Strongly agree	111	19.3	28.8	98.7
	6 Not applicable	5	.9	1.3	100.0
	Total	386	67.2	100.0	
Missing	System	188	32.8		
Total		574	100.0		

**Q13d\_R1 I can manage all the conflicting demands on my time**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	17	3.0	4.4	4.4
	2 Disagree	86	15.0	22.3	26.7
	3 Neither	76	13.2	19.7	46.4
	4 Agree	155	27.0	40.2	86.5
	5 Strongly agree	45	7.8	11.7	98.2
	6 Not applicable	5	.9	1.3	99.5
	9 2 or more ticked	2	.3	.5	100.0
	Total	386	67.2	100.0	
Missing	System	188	32.8		
Total		574	100.0		

**Q14a\_R1 People providing care for my patients work well together**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	4	.7	1.0	1.0
	2 Disagree	38	6.6	9.8	10.9
	3 Neither	74	12.9	19.2	30.1
	4 Agree	205	35.7	53.1	83.2
	5 Strongly agree	42	7.3	10.9	94.0
	6 Not applicable	23	4.0	6.0	100.0
	Total	386	67.2	100.0	
Missing	System	188	32.8		
Total		574	100.0		

**Q14b\_R1 A seamless service is a good description for the care my patients receive**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	11	1.9	2.9	2.9
	2 Disagree	84	14.6	21.8	24.7
	3 Neither	127	22.1	33.0	57.7
	4 Agree	120	20.9	31.2	88.8
	5 Strongly agree	18	3.1	4.7	93.5
	6 Not applicable	25	4.4	6.5	100.0
	Total	385	67.1	100.0	
Missing	System	189	32.9		
Total		574	100.0		

**Q14c\_R1 There is good communication with other organisations providing care for my patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	8	1.4	2.1	2.1
	2 Disagree	60	10.5	15.5	17.6
	3 Neither	108	18.8	28.0	45.6
	4 Agree	157	27.4	40.7	86.3
	5 Strongly agree	33	5.7	8.5	94.8
	6 Not applicable	20	3.5	5.2	100.0
	Total	386	67.2	100.0	
Missing	System	188	32.8		
Total		574	100.0		

**Q15a\_R1 Communicate with hospital doctors**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	38	6.6	9.9	9.9
	2 Rarely	71	12.4	18.5	28.4
	3 Occasionally	118	20.6	30.7	59.1
	4 Often	104	18.1	27.1	86.2
	5 Constantly	53	9.2	13.8	100.0
	Total	384	66.9	100.0	
Missing	System	190	33.1		
Total		574	100.0		

**Q15b\_R1 Communicate with GPs**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	9	1.6	2.3	2.3
	2 Rarely	20	3.5	5.2	7.5
	3 Occasionally	60	10.5	15.6	23.1
	4 Often	150	26.1	39.0	62.1
	5 Constantly	143	24.9	37.1	99.2
	9 2 or more ticked	3	.5	.8	100.0
	Total	385	67.1	100.0	
Missing	System	189	32.9		
Total		574	100.0		

**Q15c\_R1 Communicate with hospital nurses**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	42	7.3	11.0	11.0
	2 Rarely	80	13.9	20.9	31.9
	3 Occasionally	153	26.7	39.9	71.8
	4 Often	70	12.2	18.3	90.1
	5 Constantly	36	6.3	9.4	99.5
	9 2 or more ticked	2	.3	.5	100.0
	Total	383	66.7	100.0	
Missing	System	191	33.3		
Total		574	100.0		



**Q15d\_R1 Communicate with community nurses**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	24	4.2	6.3	6.3
	2 Rarely	33	5.7	8.6	14.9
	3 Occasionally	83	14.5	21.7	36.6
	4 Often	161	28.0	42.1	78.8
	5 Constantly	81	14.1	21.2	100.0
	Total	382	66.6	100.0	
Missing	System	192	33.4		
Total		574	100.0		

**Q15e\_R1 Communicate with pharmacists**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	34	5.9	9.0	9.0
	2 Rarely	65	11.3	17.2	26.3
	3 Occasionally	120	20.9	31.8	58.1
	4 Often	122	21.3	32.4	90.5
	5 Constantly	36	6.3	9.5	100.0
	Total	377	65.7	100.0	
Missing	System	197	34.3		
Total		574	100.0		

**Q15f\_R1 Communicate with NHS employed therapists**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	30	5.2	7.9	7.9
	2 Rarely	65	11.3	17.0	24.9
	3 Occasionally	118	20.6	30.9	55.8
	4 Often	113	19.7	29.6	85.3
	5 Constantly	56	9.8	14.7	100.0
	Total	382	66.6	100.0	
Missing	System	192	33.4		
Total		574	100.0		

**Q15g\_R1 Communicate with social care professionals**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	32	5.6	8.3	8.3
	2 Rarely	62	10.8	16.1	24.5
	3 Occasionally	123	21.4	32.0	56.5
	4 Often	114	19.9	29.7	86.2
	5 Constantly	53	9.2	13.8	100.0
	Total	384	66.9	100.0	
Missing	System	190	33.1		
Total		574	100.0		

**Q15h\_R1 Communicate with paid care workers**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	41	7.1	10.7	10.7
	2 Rarely	97	16.9	25.3	36.0
	3 Occasionally	125	21.8	32.6	68.7
	4 Often	90	15.7	23.5	92.2
	5 Constantly	30	5.2	7.8	100.0
	Total	383	66.7	100.0	
Missing	System	191	33.3		
Total		574	100.0		

**Q15i\_R1 Communicate with third or voluntary sector**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	39	6.8	10.2	10.2
	2 Rarely	126	22.0	32.9	43.1
	3 Occasionally	121	21.1	31.6	74.7
	4 Often	66	11.5	17.2	91.9
	5 Constantly	31	5.4	8.1	100.0
	Total	383	66.7	100.0	
Missing	System	191	33.3		
Total		574	100.0		

**Q15j\_R1 Communicate with administrators/managers**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	17	3.0	4.4	4.4
	2 Rarely	45	7.8	11.7	16.2
	3 Occasionally	85	14.8	22.2	38.4
	4 Often	133	23.2	34.7	73.1
	5 Constantly	103	17.9	26.9	100.0
	Total	383	66.7	100.0	
Missing	System	191	33.3		
Total		574	100.0		

**Q16\_R1 Manage staff**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	226	39.4	58.2	58.2
	2 No	162	28.2	41.8	100.0
	Total	388	67.6	100.0	
Missing	System	186	32.4		
Total		574	100.0		

**Q17\_R1 Age**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 16-30	31	5.4	6.1	6.1
	2 31-50	319	55.6	63.0	69.2
	3 51-65	151	26.3	29.8	99.0
	4 66+	5	.9	1.0	100.0
	Total	506	88.2	100.0	
Missing	System	68	11.8		
Total		574	100.0		

**Q18\_R1 Occupational group**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Medical	138	24.0	27.3	27.3
	2 Nurse or midwife	63	11.0	12.5	39.7
	3 Community matron	17	3.0	3.4	43.1
	4 Community psychiatric nurse	6	1.0	1.2	44.3
	5 Pharmacist	3	.5	.6	44.9
	6 NHS-employed therapist	17	3.0	3.4	48.2
	7 Social care professional	14	2.4	2.8	51.0
	8 Paid care worker	10	1.7	2.0	53.0
	9 NHS admin staff	48	8.4	9.5	62.5
	10 Social service admin staff	4	.7	.8	63.2
	11 NHS general management	108	18.8	21.3	84.6
	12 Social service general management	8	1.4	1.6	86.2
	13 Third or voluntary sector	32	5.6	6.3	92.5
	14 Other	33	5.7	6.5	99.0
	99 2 or more ticked	5	.9	1.0	100.0
	Total	506	88.2	100.0	
Missing	System	68	11.8		
	Total	574	100.0		

**Q19\_R1 How long in current job**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Less than 1 year	73	12.7	14.4	14.4
	2 1-2 years	103	17.9	20.4	34.8
	3 3-5 years	112	19.5	22.1	56.9
	4 6-10 years	84	14.6	16.6	73.5
	5 11-15 years	52	9.1	10.3	83.8
	6 More than 15 years	81	14.1	16.0	99.8
	9 2 or more ticked	1	.2	.2	100.0
	Total	506	88.2	100.0	
Missing	System	68	11.8		
Total		574	100.0		

**Q20\_R1 Gender**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 male	174	30.3	34.4	34.4
	2 Female	332	57.8	65.6	100.0
	Total	506	88.2	100.0	
Missing	System	68	11.8		
Total		574	100.0		

**Q21\_R1 Certain number of contracted hours**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	400	69.7	80.0	80.0
	2 No	100	17.4	20.0	100.0
	Total	500	87.1	100.0	
Missing	System	74	12.9		
Total		574	100.0		

Q22\_R1 Number of hours

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	6.00	2	.3	.5	.5
	7.00	2	.3	.5	1.0
	10.00	4	.7	1.0	2.0
	12.00	2	.3	.5	2.6
	15.00	3	.5	.8	3.3
	16.00	1	.2	.3	3.6
	17.00	2	.3	.5	4.1
	18.00	4	.7	1.0	5.1
	18.50	1	.2	.3	5.4
	18.75	3	.5	.8	6.1
	18.77	1	.2	.3	6.4
	20.00	4	.7	1.0	7.4
	21.00	3	.5	.8	8.2
	22.00	3	.5	.8	8.9
	23.00	1	.2	.3	9.2
	24.00	7	1.2	1.8	11.0
	25.00	9	1.6	2.3	13.3
	26.00	3	.5	.8	14.0
	27.00	5	.9	1.3	15.3
	28.00	4	.7	1.0	16.3
	29.00	1	.2	.3	16.6
	30.00	30	5.2	7.7	24.2
	31.00	1	.2	.3	24.5
	31.50	1	.2	.3	24.7
	32.00	8	1.4	2.0	26.8
	32.50	1	.2	.3	27.0
	33.00	1	.2	.3	27.3
	34.00	4	.7	1.0	28.3
	35.00	3	.5	.8	29.1
	36.00	6	1.0	1.5	30.6
	37.00	139	24.2	35.5	66.1
	37.25	1	.2	.3	66.3
	37.50	83	14.5	21.2	87.5
	38.00	13	2.3	3.3	90.8
	40.00	16	2.8	4.1	94.9
	44.00	4	.7	1.0	95.9
	45.00	2	.3	.5	96.4
	46.00	1	.2	.3	96.7
	47.00	1	.2	.3	96.9
	48.00	7	1.2	1.8	98.7
	50.00	3	.5	.8	99.5
	52.00	1	.2	.3	99.7
	56.00	1	.2	.3	100.0
	Total	392	68.3	100.0	
Missing	System	182	31.7		
Total		574	100.0		

Q23\_R1 Pay range

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 £10,000 to £14,999	29	5.1	7.0	7.0
	2 £15,000 to £19,999	41	7.1	9.9	16.9
	3 £20,000 to £24,999	29	5.1	7.0	23.9
	4 £25,000 to £29,999	32	5.6	7.7	31.6
	5 £30,000 to £34,999	35	6.1	8.5	40.1
	6 £35,000 to £39,999	41	7.1	9.9	50.0
	7 £40,000 to £44,999	31	5.4	7.5	57.5
	8 £45,000 to £49,999	27	4.7	6.5	64.0
	9 £50,000 to £59,999	31	5.4	7.5	71.5
	10 £60,000 to £69,999	16	2.8	3.9	75.4
	11 £70,000 to £79,999	19	3.3	4.6	80.0
	12 £80,000 to £99,999	31	5.4	7.5	87.4
	13 More than £100,000	50	8.7	12.1	99.5
	99 2 or more ticked	2	.3	.5	100.0
	Total	414	72.1	100.0	
Missing	System	160	27.9		
	Total	574	100.0		

## Frequencies

## Staff questionnaire Round 1 Group A

**Q1\_R1 Do you know you are working in an Integrated Care Pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	133	85.3	97.8	97.8
	2 DK	1	.6	.7	98.5
	3 No	2	1.3	1.5	100.0
	Total	136	87.2	100.0	
Missing	System	20	12.8		
Total		156	100.0		

**Q2\_R1 How has your job changed since the introduction**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 New appointment	27	17.3	20.1	20.1
	2 Seconded to work full time	13	8.3	9.7	29.9
	3 Seconded to work part time	23	14.7	17.2	47.0
	4 Some changes, but not formally on pilot	35	22.4	26.1	73.1
	5 Not changed	36	23.1	26.9	100.0
	Total	134	85.9	100.0	
Missing	System	22	14.1		
Total		156	100.0		

**Q3a\_R1 The depth of my job has increased**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	4	2.6	4.0	4.0
	2 Disagree	8	5.1	7.9	11.9
	3 Neither	18	11.5	17.8	29.7
	4 Agree	46	29.5	45.5	75.2
	5 Strongly agree	16	10.3	15.8	91.1
	6 Not applicable	9	5.8	8.9	100.0
	Total	101	64.7	100.0	
Missing	System	55	35.3		
Total		156	100.0		

**Q3b\_R1 The breadth of my job has been expanded**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	2	1.3	1.9	1.9
	2 Disagree	2	1.3	1.9	3.8
	3 Neither	9	5.8	8.7	12.5
	4 Agree	48	30.8	46.2	58.7
	5 Strongly agree	35	22.4	33.7	92.3
	6 Not applicable	8	5.1	7.7	100.0
	Total	104	66.7	100.0	
Missing	System	52	33.3		
Total		156	100.0		

**Q3c\_R1 I now delegate more responsibility to others**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	7	4.5	7.0	7.0
	2 Disagree	20	12.8	20.0	27.0
	3 Neither	32	20.5	32.0	59.0
	4 Agree	23	14.7	23.0	82.0
	5 Strongly agree	4	2.6	4.0	86.0
	6 Not applicable	14	9.0	14.0	100.0
	Total	100	64.1	100.0	
Missing	System	56	35.9		
Total		156	100.0		

**Q3d\_R1 I now have more responsibility delegated to me**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	3	1.9	2.9	2.9
	2 Disagree	9	5.8	8.7	11.7
	3 Neither	18	11.5	17.5	29.1
	4 Agree	45	28.8	43.7	72.8
	5 Strongly agree	17	10.9	16.5	89.3
	6 Not applicable	11	7.1	10.7	100.0
	Total	103	66.0	100.0	
Missing	System	53	34.0		
Total		156	100.0		



**Q4\_R1 How much of your daily work relates to the pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 None specifically	10	6.4	9.3	9.3
	2 Some	66	42.3	61.1	70.4
	3 All	30	19.2	27.8	98.1
	4 Not sure	2	1.3	1.9	100.0
	Total	108	69.2	100.0	
Missing	System	48	30.8		
Total		156	100.0		

**Q5\_hours\_1\_R1 Average hours per week**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	1	.6	1.0	1.0
	.20	1	.6	1.0	2.0
	1.00	11	7.1	11.1	13.1
	1.50	1	.6	1.0	14.1
	2.00	12	7.7	12.1	26.3
	3.00	3	1.9	3.0	29.3
	4.00	7	4.5	7.1	36.4
	6.00	1	.6	1.0	37.4
	6.50	1	.6	1.0	38.4
	7.00	3	1.9	3.0	41.4
	8.00	7	4.5	7.1	48.5
	10.00	4	2.6	4.0	52.5
	12.00	1	.6	1.0	53.5
	15.00	3	1.9	3.0	56.6
	16.00	3	1.9	3.0	59.6
	17.00	1	.6	1.0	60.6
	18.00	2	1.3	2.0	62.6
	18.75	1	.6	1.0	63.6
	19.00	1	.6	1.0	64.6
	20.00	5	3.2	5.1	69.7
	22.50	1	.6	1.0	70.7
	25.00	3	1.9	3.0	73.7
	26.25	1	.6	1.0	74.7
	30.00	5	3.2	5.1	79.8
	35.00	2	1.3	2.0	81.8
	37.00	4	2.6	4.0	85.9
	37.50	5	3.2	5.1	90.9
40.00	6	3.8	6.1	97.0	
48.00	1	.6	1.0	98.0	
50.00	2	1.3	2.0	100.0	
Total		99	63.5	100.0	
Missing	System	57	36.5		
Total		156	100.0		

**Q5\_NA\_1\_R1 Not applicable**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	8	5.1	100.0	100.0
Missing	System	148	94.9		
Total		156	100.0		

**Q5\_hours\_2\_R1 Maximum hours per week**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	3	1.9	3.1	3.1
	2.00	2	1.3	2.0	5.1
	3.00	7	4.5	7.1	12.2
	4.00	11	7.1	11.2	23.5
	5.00	2	1.3	2.0	25.5
	6.00	4	2.6	4.1	29.6
	7.00	2	1.3	2.0	31.6
	8.00	2	1.3	2.0	33.7
	10.00	5	3.2	5.1	38.8
	12.00	3	1.9	3.1	41.8
	14.00	1	.6	1.0	42.9
	15.00	4	2.6	4.1	46.9
	16.00	5	3.2	5.1	52.0
	18.00	2	1.3	2.0	54.1
	18.75	1	.6	1.0	55.1
	20.00	5	3.2	5.1	60.2
	22.00	1	.6	1.0	61.2
	24.00	1	.6	1.0	62.2
	25.00	4	2.6	4.1	66.3
	26.25	1	.6	1.0	67.3
	27.00	1	.6	1.0	68.4
	30.00	6	3.8	6.1	74.5
	35.00	1	.6	1.0	75.5
	37.00	3	1.9	3.1	78.6
	37.50	8	5.1	8.2	86.7
	40.00	3	1.9	3.1	89.8
	42.00	1	.6	1.0	90.8
	45.00	3	1.9	3.1	93.9
	50.00	2	1.3	2.0	95.9
	60.00	4	2.6	4.1	100.0
Total		98	62.8	100.0	
Missing	System	58	37.2		
Total		156	100.0		

**Q5\_NA\_2\_R1 Not applicable**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	7	4.5	100.0	100.0
Missing	System	149	95.5		
Total		156	100.0		

**Q5\_hours\_3\_R1 Minumum hours per week**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	14	9.0	14.7	14.7
	.50	3	1.9	3.2	17.9
	1.00	12	7.7	12.6	30.5
	2.00	7	4.5	7.4	37.9
	3.00	3	1.9	3.2	41.1
	4.00	5	3.2	5.3	46.3
	5.00	3	1.9	3.2	49.5
	6.00	2	1.3	2.1	51.6
	7.00	1	.6	1.1	52.6
	8.00	4	2.6	4.2	56.8
	10.00	1	.6	1.1	57.9
	15.00	3	1.9	3.2	61.1
	16.00	3	1.9	3.2	64.2
	18.00	1	.6	1.1	65.3
	18.75	2	1.3	2.1	67.4
	20.00	3	1.9	3.2	70.5
	22.50	1	.6	1.1	71.6
	24.00	1	.6	1.1	72.6
	25.00	3	1.9	3.2	75.8
	28.00	2	1.3	2.1	77.9
	30.00	3	1.9	3.2	81.1
	32.00	1	.6	1.1	82.1
	35.00	2	1.3	2.1	84.2
	37.00	5	3.2	5.3	89.5
	37.50	6	3.8	6.3	95.8
	40.00	3	1.9	3.2	98.9
	45.00	1	.6	1.1	100.0
	Total	95	60.9	100.0	
Missing	System	61	39.1		
Total		156	100.0		

**Q5\_NA\_3\_R1 Not applicable**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	9	5.8	100.0	100.0
Missing	System	147	94.2		
Total		156	100.0		

**Q5\_hours\_4\_R1 Number of weeks worked overtime because of pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	36	23.1	46.8	46.8
	1.00	8	5.1	10.4	57.1
	2.00	7	4.5	9.1	66.2
	3.00	7	4.5	9.1	75.3
	4.00	17	10.9	22.1	97.4
	10.00	1	.6	1.3	98.7
	120.00	1	.6	1.3	100.0
	Total	77	49.4	100.0	
Missing	System	79	50.6		
Total		156	100.0		

**Q5\_NA\_4\_R1 Not applicable**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	25	16.0	100.0	100.0
Missing	System	131	84.0		
Total		156	100.0		

**Q6a\_R1 Support for training in my area of work**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	30	19.2	27.5	27.5
	2 No change	62	39.7	56.9	84.4
	3 Worse than before	1	.6	.9	85.3
	4 Not sure	16	10.3	14.7	100.0
	Total	109	69.9	100.0	
Missing	System	47	30.1		
Total		156	100.0		

**Q6b\_R1 Clarity of accountability structures in my work**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	28	17.9	25.7	25.7
	2 No change	64	41.0	58.7	84.4
	3 Worse than before	8	5.1	7.3	91.7
	4 Not sure	9	5.8	8.3	100.0
	Total	109	69.9	100.0	
Missing	System	47	30.1		
Total		156	100.0		

**Q6c\_R1 Communication between different parts of my organisation**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	54	34.6	49.1	49.1
	2 No change	47	30.1	42.7	91.8
	3 Worse than before	3	1.9	2.7	94.5
	4 Not sure	6	3.8	5.5	100.0
	Total	110	70.5	100.0	
Missing	System	46	29.5		
Total		156	100.0		

**Q6d\_R1 Communication with other organisations**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	73	46.8	66.4	66.4
	2 No change	30	19.2	27.3	93.6
	3 Worse than before	3	1.9	2.7	96.4
	4 Not sure	4	2.6	3.6	100.0
	Total	110	70.5	100.0	
Missing	System	46	29.5		
Total		156	100.0		

**Q7a\_R1 Having clear planned goals and objectives**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	37	23.7	34.9	34.9
	2 No change	64	41.0	60.4	95.3
	3 Worse than before	5	3.2	4.7	100.0
	Total	106	67.9	100.0	
Missing	System	50	32.1		
Total		156	100.0		

**Q7b\_R1 Having an interesting job**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	66	42.3	62.3	62.3
	2 No change	39	25.0	36.8	99.1
	3 Worse than before	1	.6	.9	100.0
	Total	106	67.9	100.0	
Missing	System	50	32.1		
Total		156	100.0		

**Q7c\_R1 Developing my role**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	68	43.6	63.6	63.6
	2 No change	38	24.4	35.5	99.1
	3 Worse than before	1	.6	.9	100.0
	Total	107	68.6	100.0	
Missing	System	49	31.4		
Total		156	100.0		

**Q7d\_R1 Having adequate resources**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	31	19.9	29.5	29.5
	2 No change	56	35.9	53.3	82.9
	3 Worse than before	18	11.5	17.1	100.0
	Total	105	67.3	100.0	
Missing	System	51	32.7		
Total		156	100.0		

**Q8\_R1 Participate in steering group or board**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	84	53.8	75.7	75.7
	2 No	27	17.3	24.3	100.0
	Total	111	71.2	100.0	
Missing	System	45	28.8		
Total		156	100.0		

**Q9a\_R1 Has overall care patients receive ...**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Got better	75	48.1	56.4	56.4
	2 Not changed	36	23.1	27.1	83.5
	3 Got worse	2	1.3	1.5	85.0
	4 Not sure	20	12.8	15.0	100.0
	Total	133	85.3	100.0	
Missing	System	23	14.7		
Total		156	100.0		

**Q9b\_R1 Seen improvements in care as result of pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	69	44.2	51.9	51.9
	2 No	8	5.1	6.0	57.9
	3 Too early to tell	46	29.5	34.6	92.5
	4 Not sure	10	6.4	7.5	100.0
	Total	133	85.3	100.0	
Missing	System	23	14.7		
Total		156	100.0		

**Q10\_R1 Work in a team**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	122	78.2	90.4	90.4
	2 No	13	8.3	9.6	100.0
	Total	135	86.5	100.0	
Missing	System	21	13.5		
Total		156	100.0		

**Q11a\_R1 Having clear team objectives**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	57	36.5	48.7	48.7
	2 No change	57	36.5	48.7	97.4
	3 Worse than before	3	1.9	2.6	100.0
	Total	117	75.0	100.0	
Missing	System	39	25.0		
Total		156	100.0		

**Q11b\_R1 Working closely with other team members**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	72	46.2	61.0	61.0
	2 No change	46	29.5	39.0	100.0
	Total	118	75.6	100.0	
Missing	System	38	24.4		
Total		156	100.0		

**Q11c\_R1 Meeting regularly to discuss how care can be improved**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	76	48.7	63.9	63.9
	2 No change	41	26.3	34.5	98.3
	3 Worse than before	2	1.3	1.7	100.0
	Total	119	76.3	100.0	
Missing	System	37	23.7		
Total		156	100.0		

**Q11d\_R1 Having clear lines of accountability**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	41	26.3	35.0	35.0
	2 No change	70	44.9	59.8	94.9
	3 Worse than before	6	3.8	5.1	100.0
	Total	117	75.0	100.0	
Missing	System	39	25.0		
Total		156	100.0		

**Q11e\_R1 Having new electronic communication systems**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	33	21.2	28.4	28.4
	2 No change	81	51.9	69.8	98.3
	3 Worse than before	2	1.3	1.7	100.0
	Total	116	74.4	100.0	
Missing	System	40	25.6		
Total		156	100.0		

**Q12\_R1 Have face-to-face contact with patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes, frequently	58	37.2	42.6	42.6
	2 Yes, occasionally	22	14.1	16.2	58.8
	3 No	56	35.9	41.2	100.0
	Total	136	87.2	100.0	
Missing	System	20	12.8		
Total		156	100.0		

**Q13a\_R1 I am satisfied with the quality of care I give to patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	2	1.3	2.2	2.2
	2 Disagree	3	1.9	3.4	5.6
	3 Neither	5	3.2	5.6	11.2
	4 Agree	40	25.6	44.9	56.2
	5 Strongly agree	25	16.0	28.1	84.3
	6 Not applicable	14	9.0	15.7	100.0
	Total	89	57.1	100.0	
Missing	System	67	42.9		
Total		156	100.0		

**Q13b\_R1 I feel my role makes a positive difference to patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	3	1.9	3.4	3.4
	3 Neither	6	3.8	6.7	10.1
	4 Agree	42	26.9	47.2	57.3
	5 Strongly agree	37	23.7	41.6	98.9
	6 Not applicable	1	.6	1.1	100.0
	Total	89	57.1	100.0	
Missing	System	67	42.9		
Total		156	100.0		



**Q13c\_R1 I am able to do my job to a standard I am personally pleased with**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	2	1.3	2.3	2.3
	2 Disagree	7	4.5	8.0	10.2
	3 Neither	8	5.1	9.1	19.3
	4 Agree	42	26.9	47.7	67.0
	5 Strongly agree	28	17.9	31.8	98.9
	6 Not applicable	1	.6	1.1	100.0
	Total	88	56.4	100.0	
Missing	System	68	43.6		
Total		156	100.0		

**Q13d\_R1 I can manage all the conflicting demands on my time**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	4	2.6	4.5	4.5
	2 Disagree	19	12.2	21.6	26.1
	3 Neither	15	9.6	17.0	43.2
	4 Agree	34	21.8	38.6	81.8
	5 Strongly agree	15	9.6	17.0	98.9
	6 Not applicable	1	.6	1.1	100.0
	Total	88	56.4	100.0	
Missing	System	68	43.6		
Total		156	100.0		

**Q14a\_R1 People providing care for my patients work well together**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	2	1.3	2.2	2.2
	2 Disagree	7	4.5	7.9	10.1
	3 Neither	18	11.5	20.2	30.3
	4 Agree	39	25.0	43.8	74.2
	5 Strongly agree	14	9.0	15.7	89.9
	6 Not applicable	9	5.8	10.1	100.0
	Total	89	57.1	100.0	
Missing	System	67	42.9		
Total		156	100.0		

**Q14b\_R1 A seamless service is a good description for the care my patients receive**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	5	3.2	5.6	5.6
	2 Disagree	18	11.5	20.0	25.6
	3 Neither	25	16.0	27.8	53.3
	4 Agree	24	15.4	26.7	80.0
	5 Strongly agree	7	4.5	7.8	87.8
	6 Not applicable	11	7.1	12.2	100.0
	Total	90	57.7	100.0	
Missing	System	66	42.3		
Total		156	100.0		

**Q14c\_R1 There is good communication with other organisations providing care for my patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	3	1.9	3.4	3.4
	2 Disagree	14	9.0	15.7	19.1
	3 Neither	22	14.1	24.7	43.8
	4 Agree	31	19.9	34.8	78.7
	5 Strongly agree	10	6.4	11.2	89.9
	6 Not applicable	9	5.8	10.1	100.0
	Total	89	57.1	100.0	
Missing	System	67	42.9		
Total		156	100.0		

**Q15a\_R1 Communicate with hospital doctors**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	9	5.8	10.0	10.0
	2 Rarely	17	10.9	18.9	28.9
	3 Occasionally	31	19.9	34.4	63.3
	4 Often	21	13.5	23.3	86.7
	5 Constantly	12	7.7	13.3	100.0
	Total	90	57.7	100.0	
Missing	System	66	42.3		
Total		156	100.0		

**Q15b\_R1 Communicate with GPs**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	4	2.6	4.4	4.4
	2 Rarely	4	2.6	4.4	8.9
	3 Occasionally	18	11.5	20.0	28.9
	4 Often	30	19.2	33.3	62.2
	5 Constantly	33	21.2	36.7	98.9
	9 2 or more ticked	1	.6	1.1	100.0
	Total	90	57.7	100.0	
Missing	System	66	42.3		
Total		156	100.0		

**Q15c\_R1 Communicate with hospital nurses**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	8	5.1	8.9	8.9
	2 Rarely	19	12.2	21.1	30.0
	3 Occasionally	39	25.0	43.3	73.3
	4 Often	14	9.0	15.6	88.9
	5 Constantly	9	5.8	10.0	98.9
	9 2 or more ticked	1	.6	1.1	100.0
	Total	90	57.7	100.0	
Missing	System	66	42.3		
Total		156	100.0		

**Q15d\_R1 Communicate with community nurses**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	6	3.8	6.8	6.8
	2 Rarely	7	4.5	8.0	14.8
	3 Occasionally	14	9.0	15.9	30.7
	4 Often	43	27.6	48.9	79.5
	5 Constantly	18	11.5	20.5	100.0
	Total	88	56.4	100.0	
Missing	System	68	43.6		
Total		156	100.0		

**Q15e\_R1 Communicate with pharmacists**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	14	9.0	15.7	15.7
	2 Rarely	15	9.6	16.9	32.6
	3 Occasionally	31	19.9	34.8	67.4
	4 Often	23	14.7	25.8	93.3
	5 Constantly	6	3.8	6.7	100.0
	Total	89	57.1	100.0	
Missing	System	67	42.9		
Total		156	100.0		

**Q15f\_R1 Communicate with NHS employed therapists**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	3	1.9	3.4	3.4
	2 Rarely	15	9.6	16.9	20.2
	3 Occasionally	29	18.6	32.6	52.8
	4 Often	24	15.4	27.0	79.8
	5 Constantly	18	11.5	20.2	100.0
	Total	89	57.1	100.0	
Missing	System	67	42.9		
Total		156	100.0		

**Q15g\_R1 Communicate with social care professionals**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	8	5.1	8.9	8.9
	2 Rarely	11	7.1	12.2	21.1
	3 Occasionally	27	17.3	30.0	51.1
	4 Often	26	16.7	28.9	80.0
	5 Constantly	18	11.5	20.0	100.0
	Total	90	57.7	100.0	
Missing	System	66	42.3		
Total		156	100.0		

**Q15h\_R1 Communicate with paid care workers**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	13	8.3	14.6	14.6
	2 Rarely	23	14.7	25.8	40.4
	3 Occasionally	30	19.2	33.7	74.2
	4 Often	14	9.0	15.7	89.9
	5 Constantly	9	5.8	10.1	100.0
	Total	89	57.1	100.0	
Missing	System	67	42.9		
Total		156	100.0		

**Q15i\_R1 Communicate with third or voluntary sector**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	5	3.2	5.6	5.6
	2 Rarely	27	17.3	30.0	35.6
	3 Occasionally	30	19.2	33.3	68.9
	4 Often	19	12.2	21.1	90.0
	5 Constantly	9	5.8	10.0	100.0
	Total	90	57.7	100.0	
Missing	System	66	42.3		
Total		156	100.0		

**Q15j\_R1 Communicate with administrators/managers**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	1	.6	1.1	1.1
	2 Rarely	5	3.2	5.6	6.7
	3 Occasionally	17	10.9	18.9	25.6
	4 Often	40	25.6	44.4	70.0
	5 Constantly	27	17.3	30.0	100.0
	Total	90	57.7	100.0	
Missing	System	66	42.3		
Total		156	100.0		

**Q16\_R1 Manage staff**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	66	42.3	72.5	72.5
	2 No	25	16.0	27.5	100.0
	Total	91	58.3	100.0	
Missing	System	65	41.7		
Total		156	100.0		

**Q17\_R1 Age**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 16-30	13	8.3	9.6	9.6
	2 31-50	80	51.3	58.8	68.4
	3 51-65	43	27.6	31.6	100.0
	Total	136	87.2	100.0	
Missing	System	20	12.8		
Total		156	100.0		

**Q18\_R1 Occupational group**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Medical	25	16.0	18.4	18.4
	2 Nurse or midwife	9	5.8	6.6	25.0
	3 Community matron	4	2.6	2.9	27.9
	4 Community psychiatric nurse	3	1.9	2.2	30.1
	6 NHS-employed therapist	5	3.2	3.7	33.8
	7 Social care professional	4	2.6	2.9	36.8
	8 Paid care worker	5	3.2	3.7	40.4
	9 NHS admin staff	11	7.1	8.1	48.5
	11 NHS general management	45	28.8	33.1	81.6
	12 Social service general management	2	1.3	1.5	83.1
	13 Third or voluntary sector	9	5.8	6.6	89.7
	14 Other	13	8.3	9.6	99.3
	99 2 or more ticked	1	.6	.7	100.0
	Total	136	87.2	100.0	
Missing	System	20	12.8		
Total		156	100.0		

**Q19\_R1 How long in current job**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Less than 1 year	32	20.5	23.7	23.7
	2 1-2 years	33	21.2	24.4	48.1
	3 3-5 years	28	17.9	20.7	68.9
	4 6-10 years	18	11.5	13.3	82.2
	5 11-15 years	6	3.8	4.4	86.7
	6 More than 15 years	18	11.5	13.3	100.0
Total	135	86.5	100.0		
Missing	System	21	13.5		
Total		156	100.0		

**Q20\_R1 Gender**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 male	41	26.3	30.1	30.1
	2 Female	95	60.9	69.9	100.0
	Total	136	87.2	100.0	
Missing	System	20	12.8		
Total		156	100.0		

**Q21\_R1 Certain number of contracted hours**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	112	71.8	84.8	84.8
	2 No	20	12.8	15.2	100.0
	Total	132	84.6	100.0	
Missing	System	24	15.4		
Total		156	100.0		

**Q22\_R1 Number of hours**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	6.00	1	.6	.9	.9
	7.00	1	.6	.9	1.8
	18.75	2	1.3	1.8	3.5
	18.77	1	.6	.9	4.4
	20.00	1	.6	.9	5.3
	22.00	1	.6	.9	6.2
	25.00	2	1.3	1.8	8.0
	27.00	1	.6	.9	8.8
	30.00	9	5.8	8.0	16.8
	32.00	2	1.3	1.8	18.6
	34.00	2	1.3	1.8	20.4
	35.00	2	1.3	1.8	22.1
	36.00	1	.6	.9	23.0
	37.00	47	30.1	41.6	64.6
	37.25	1	.6	.9	65.5
	37.50	25	16.0	22.1	87.6
	38.00	5	3.2	4.4	92.0
	40.00	7	4.5	6.2	98.2
	44.00	1	.6	.9	99.1
	45.00	1	.6	.9	100.0
Total		113	72.4	100.0	
Missing	System	43	27.6		
Total		156	100.0		

Q23\_R1 Pay range

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 £10,000 to £14,999	5	3.2	4.3	4.3
	2 £15,000 to £19,999	12	7.7	10.3	14.5
	3 £20,000 to £24,999	10	6.4	8.5	23.1
	4 £25,000 to £29,999	3	1.9	2.6	25.6
	5 £30,000 to £34,999	10	6.4	8.5	34.2
	6 £35,000 to £39,999	11	7.1	9.4	43.6
	7 £40,000 to £44,999	11	7.1	9.4	53.0
	8 £45,000 to £49,999	13	8.3	11.1	64.1
	9 £50,000 to £59,999	10	6.4	8.5	72.6
	10 £60,000 to £69,999	4	2.6	3.4	76.1
	11 £70,000 to £79,999	6	3.8	5.1	81.2
	12 £80,000 to £99,999	11	7.1	9.4	90.6
	13 More than £100,000	11	7.1	9.4	100.0
	Total	117	75.0	100.0	
Missing	System	39	25.0		
Total		156	100.0		

## Frequencies

## Staff Questionnaire Round 1 Group B

**Q1\_R1 Do you know you are working in an Integrated Care Pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	256	78.8	89.2	89.2
	2 DK	12	3.7	4.2	93.4
	3 No	19	5.8	6.6	100.0
	Total	287	88.3	100.0	
Missing	System	38	11.7		
Total		325	100.0		

**Q2\_R1 How has your job changed since the introduction**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 New appointment	11	3.4	4.1	4.1
	2 Seconded to work full time	5	1.5	1.9	6.0
	3 Seconded to work part time	16	4.9	6.0	11.9
	4 Some changes, but not formally on pilot	95	29.2	35.4	47.4
	5 Not changed	141	43.4	52.6	100.0
	Total	268	82.5	100.0	
Missing	System	57	17.5		
Total		325	100.0		

**Q3a\_R1 The depth of my job has increased**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	8	2.5	5.7	5.7
	2 Disagree	25	7.7	17.7	23.4
	3 Neither	39	12.0	27.7	51.1
	4 Agree	46	14.2	32.6	83.7
	5 Strongly agree	5	1.5	3.5	87.2
	6 Not applicable	18	5.5	12.8	100.0
	Total	141	43.4	100.0	
Missing	System	184	56.6		
Total		325	100.0		



**Q3b\_R1 The breadth of my job has been expanded**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	4	1.2	2.8	2.8
	2 Disagree	14	4.3	9.9	12.7
	3 Neither	25	7.7	17.6	30.3
	4 Agree	69	21.2	48.6	78.9
	5 Strongly agree	18	5.5	12.7	91.5
	6 Not applicable	12	3.7	8.5	100.0
	Total	142	43.7	100.0	
Missing	System	183	56.3		
Total		325	100.0		

**Q3c\_R1 I now delegate more responsibility to others**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	15	4.6	10.9	10.9
	2 Disagree	33	10.2	23.9	34.8
	3 Neither	43	13.2	31.2	65.9
	4 Agree	29	8.9	21.0	87.0
	5 Strongly agree	4	1.2	2.9	89.9
	6 Not applicable	14	4.3	10.1	100.0
	Total	138	42.5	100.0	
Missing	System	187	57.5		
Total		325	100.0		

**Q3d\_R1 I now have more responsibility delegated to me**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	6	1.8	4.2	4.2
	2 Disagree	27	8.3	18.9	23.1
	3 Neither	29	8.9	20.3	43.4
	4 Agree	52	16.0	36.4	79.7
	5 Strongly agree	16	4.9	11.2	90.9
	6 Not applicable	13	4.0	9.1	100.0
	Total	143	44.0	100.0	
Missing	System	182	56.0		
Total		325	100.0		

**Q4\_R1 How much of your daily work relates to the pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 None specifically	45	13.8	30.0	30.0
	2 Some	93	28.6	62.0	92.0
	3 All	3	.9	2.0	94.0
	4 Not sure	9	2.8	6.0	100.0
	Total	150	46.2	100.0	
Missing	System	175	53.8		
Total		325	100.0		

**Q5\_hours\_1\_R1 Average hours per week**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	5	1.5	4.5	4.5
	.20	1	.3	.9	5.4
	.50	14	4.3	12.6	18.0
	1.00	20	6.2	18.0	36.0
	1.50	2	.6	1.8	37.8
	2.00	21	6.5	18.9	56.8
	2.50	1	.3	.9	57.7
	3.00	9	2.8	8.1	65.8
	3.50	1	.3	.9	66.7
	4.00	11	3.4	9.9	76.6
	4.50	1	.3	.9	77.5
	5.00	1	.3	.9	78.4
	5.50	1	.3	.9	79.3
	6.00	8	2.5	7.2	86.5
	7.50	2	.6	1.8	88.3
	8.00	1	.3	.9	89.2
	10.00	1	.3	.9	90.1
	12.00	1	.3	.9	91.0
	18.50	1	.3	.9	91.9
	20.00	2	.6	1.8	93.7
	30.00	4	1.2	3.6	97.3
	32.00	1	.3	.9	98.2
	37.50	2	.6	1.8	100.0
	Total	111	34.2	100.0	
Missing	System	214	65.8		
Total		325	100.0		

**Q5\_NA\_1\_R1 Not applicable**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	33	10.2	100.0	100.0
Missing	System	292	89.8		
Total		325	100.0		

**Q5\_hours\_2\_R1 Maximum hours per week**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	4	1.2	3.7	3.7
	.50	4	1.2	3.7	7.5
	1.00	9	2.8	8.4	15.9
	1.50	1	.3	.9	16.8
	2.00	16	4.9	15.0	31.8
	2.50	1	.3	.9	32.7
	3.00	14	4.3	13.1	45.8
	3.50	1	.3	.9	46.7
	4.00	18	5.5	16.8	63.6
	5.00	3	.9	2.8	66.4
	6.00	8	2.5	7.5	73.8
	7.00	2	.6	1.9	75.7
	7.50	1	.3	.9	76.6
	8.00	8	2.5	7.5	84.1
	9.00	1	.3	.9	85.0
	10.00	2	.6	1.9	86.9
	15.00	1	.3	.9	87.9
	22.00	1	.3	.9	88.8
	24.00	1	.3	.9	89.7
	25.00	1	.3	.9	90.7
	30.00	4	1.2	3.7	94.4
	32.00	1	.3	.9	95.3
	35.00	1	.3	.9	96.3
	37.50	2	.6	1.9	98.1
	40.00	2	.6	1.9	100.0
	Total	107	32.9	100.0	
Missing	System	218	67.1		
Total		325	100.0		

**Q5\_NA\_2\_R1 Not applicable**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	32	9.8	100.0	100.0
Missing	System	293	90.2		
Total		325	100.0		

**Q5\_hours\_3\_R1 Minimum hours per week**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	34	10.5	33.3	33.3
	.50	9	2.8	8.8	42.2
	.75	1	.3	1.0	43.1
	1.00	24	7.4	23.5	66.7
	2.00	10	3.1	9.8	76.5
	3.00	7	2.2	6.9	83.3
	4.00	4	1.2	3.9	87.3
	5.50	1	.3	1.0	88.2
	6.00	2	.6	2.0	90.2
	7.50	2	.6	2.0	92.2
	10.00	3	.9	2.9	95.1
	25.00	1	.3	1.0	96.1
	30.00	3	.9	2.9	99.0
	37.50	1	.3	1.0	100.0
	Total	102	31.4	100.0	
Missing	System	223	68.6		
Total		325	100.0		

**Q5\_NA\_3\_R1 Not applicable**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	37	11.4	100.0	100.0
Missing	System	288	88.6		
Total		325	100.0		

**Q5\_hours\_4\_R1 Number of weeks worked overtime because of pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	46	14.2	63.0	63.0
	.30	1	.3	1.4	64.4
	1.00	7	2.2	9.6	74.0
	2.00	6	1.8	8.2	82.2
	4.00	10	3.1	13.7	95.9
	12.00	1	.3	1.4	97.3
	15.00	1	.3	1.4	98.6
	16.00	1	.3	1.4	100.0
	Total	73	22.5	100.0	
Missing	System	252	77.5		
Total		325	100.0		

**Q5\_NA\_4\_R1 Not applicable**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	63	19.4	100.0	100.0
Missing	System	262	80.6		
Total		325	100.0		

**Q6a\_R1 Support for training in my area of work**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	33	10.2	21.9	21.9
	2 No change	107	32.9	70.9	92.7
	3 Worse than before	3	.9	2.0	94.7
	4 Not sure	8	2.5	5.3	100.0
	Total	151	46.5	100.0	
Missing	System	174	53.5		
Total		325	100.0		

**Q6b\_R1 Clarity of accountability structures in my work**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	21	6.5	14.2	14.2
	2 No change	107	32.9	72.3	86.5
	3 Worse than before	8	2.5	5.4	91.9
	4 Not sure	12	3.7	8.1	100.0
	Total	148	45.5	100.0	
Missing	System	177	54.5		
Total		325	100.0		

**Q6c\_R1 Communication between different parts of my organisation**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	58	17.8	38.9	38.9
	2 No change	75	23.1	50.3	89.3
	3 Worse than before	8	2.5	5.4	94.6
	4 Not sure	8	2.5	5.4	100.0
	Total	149	45.8	100.0	
Missing	System	176	54.2		
Total		325	100.0		

**Q6d\_R1 Communication with other organisations**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	80	24.6	53.7	53.7
	2 No change	58	17.8	38.9	92.6
	3 Worse than before	5	1.5	3.4	96.0
	4 Not sure	6	1.8	4.0	100.0
	Total	149	45.8	100.0	
Missing	System	176	54.2		
Total		325	100.0		

**Q7a\_R1 Having clear planned goals and objectives**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	20	6.2	13.3	13.3
	2 No change	118	36.3	78.7	92.0
	3 Worse than before	12	3.7	8.0	100.0
	Total	150	46.2	100.0	
Missing	System	175	53.8		
Total		325	100.0		

**Q7b\_R1 Having an interesting job**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	35	10.8	23.5	23.5
	2 No change	110	33.8	73.8	97.3
	3 Worse than before	4	1.2	2.7	100.0
	Total	149	45.8	100.0	
Missing	System	176	54.2		
Total		325	100.0		

**Q7c\_R1 Developing my role**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	44	13.5	29.7	29.7
	2 No change	101	31.1	68.2	98.0
	3 Worse than before	3	.9	2.0	100.0
	Total	148	45.5	100.0	
Missing	System	177	54.5		
Total		325	100.0		

**Q7d\_R1 Having adequate resources**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	13	4.0	8.7	8.7
	2 No change	103	31.7	69.1	77.9
	3 Worse than before	33	10.2	22.1	100.0
	Total	149	45.8	100.0	
Missing	System	176	54.2		
Total		325	100.0		

**Q8\_R1 Participate in steering group or board**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	61	18.8	40.9	40.9
	2 No	88	27.1	59.1	100.0
	Total	149	45.8	100.0	
Missing	System	176	54.2		
Total		325	100.0		

**Q9a\_R1 Has overall care patients receive ...**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Got better	127	39.1	44.7	44.7
	2 Not changed	100	30.8	35.2	79.9
	3 Got worse	6	1.8	2.1	82.0
	4 Not sure	51	15.7	18.0	100.0
	Total	284	87.4	100.0	
Missing	System	41	12.6		
Total		325	100.0		

**Q9b\_R1 Seen improvements in care as result of pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	89	27.4	31.6	31.6
	2 No	32	9.8	11.3	42.9
	3 Too early to tell	111	34.2	39.4	82.3
	4 Not sure	49	15.1	17.4	99.6
	9 2 or more ticked	1	.3	.4	100.0
	Total	282	86.8	100.0	
Missing	System	43	13.2		
Total		325	100.0		

**Q10\_R1 Work in a team**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	250	76.9	87.4	87.4
	2 No	35	10.8	12.2	99.7
	9 2 or more ticked	1	.3	.3	100.0
	Total	286	88.0	100.0	
Missing	System	39	12.0		
Total		325	100.0		

**Q11a\_R1 Having clear team objectives**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	49	15.1	19.8	19.8
	2 No change	189	58.2	76.5	96.4
	3 Worse than before	9	2.8	3.6	100.0
	Total	247	76.0	100.0	
Missing	System	78	24.0		
Total		325	100.0		

**Q11b\_R1 Working closely with other team members**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	73	22.5	29.2	29.2
	2 No change	173	53.2	69.2	98.4
	3 Worse than before	4	1.2	1.6	100.0
	Total	250	76.9	100.0	
Missing	System	75	23.1		
Total		325	100.0		

**Q11c\_R1 Meeting regularly to discuss how care can be improved**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	84	25.8	33.9	33.9
	2 No change	160	49.2	64.5	98.4
	3 Worse than before	4	1.2	1.6	100.0
	Total	248	76.3	100.0	
Missing	System	77	23.7		
Total		325	100.0		

**Q11d\_R1 Having clear lines of accountability**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	28	8.6	11.4	11.4
	2 No change	204	62.8	82.9	94.3
	3 Worse than before	13	4.0	5.3	99.6
	9 2 or more ticked	1	.3	.4	100.0
	Total	246	75.7	100.0	
Missing	System	79	24.3		
Total		325	100.0		

**Q11e\_R1 Having new electronic communication systems**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	30	9.2	12.4	12.4
	2 No change	208	64.0	86.3	98.8
	3 Worse than before	3	.9	1.2	100.0
	Total	241	74.2	100.0	
Missing	System	84	25.8		
Total		325	100.0		

**Q12\_R1 Have face-to-face contact with patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes, frequently	190	58.5	66.0	66.0
	2 Yes, occasionally	34	10.5	11.8	77.8
	3 No	64	19.7	22.2	100.0
	Total	288	88.6	100.0	
Missing	System	37	11.4		
Total		325	100.0		

**Q13a\_R1 I am satisfied with the quality of care I give to patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	2	.6	.9	.9
	2 Disagree	7	2.2	3.1	3.9
	3 Neither	10	3.1	4.4	8.3
	4 Agree	113	34.8	49.6	57.9
	5 Strongly agree	82	25.2	36.0	93.9
	6 Not applicable	14	4.3	6.1	100.0
Total		228	70.2	100.0	
Missing	System	97	29.8		
Total		325	100.0		





**Q13b\_R1 I feel my role makes a positive difference to patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	1	.3	.4	.4
	3 Neither	10	3.1	4.4	4.8
	4 Agree	121	37.2	52.8	57.6
	5 Strongly agree	94	28.9	41.0	98.7
	6 Not applicable	3	.9	1.3	100.0
	Total	229	70.5	100.0	
Missing	System	96	29.5		
Total		325	100.0		

**Q13c\_R1 I am able to do my job to a standard I am personally pleased with**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	4	1.2	1.7	1.7
	2 Disagree	18	5.5	7.8	9.6
	3 Neither	15	4.6	6.5	16.1
	4 Agree	125	38.5	54.3	70.4
	5 Strongly agree	65	20.0	28.3	98.7
	6 Not applicable	3	.9	1.3	100.0
	Total	230	70.8	100.0	
Missing	System	95	29.2		
Total		325	100.0		

**Q13d\_R1 I can manage all the conflicting demands on my time**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	10	3.1	4.3	4.3
	2 Disagree	58	17.8	25.2	29.6
	3 Neither	48	14.8	20.9	50.4
	4 Agree	88	27.1	38.3	88.7
	5 Strongly agree	22	6.8	9.6	98.3
	6 Not applicable	3	.9	1.3	99.6
	9 2 or more ticked	1	.3	.4	100.0
	Total	230	70.8	100.0	
Missing	System	95	29.2		
Total		325	100.0		

**Q14a\_R1 People providing care for my patients work well together**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	1	.3	.4	.4
	2 Disagree	27	8.3	11.8	12.2
	3 Neither	44	13.5	19.2	31.4
	4 Agree	126	38.8	55.0	86.5
	5 Strongly agree	20	6.2	8.7	95.2
	6 Not applicable	11	3.4	4.8	100.0
	Total	229	70.5	100.0	
Missing	System	96	29.5		
Total		325	100.0		

**Q14b\_R1 A seamless service is a good description for the care my patients receive**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	5	1.5	2.2	2.2
	2 Disagree	54	16.6	23.8	26.0
	3 Neither	81	24.9	35.7	61.7
	4 Agree	71	21.8	31.3	93.0
	5 Strongly agree	6	1.8	2.6	95.6
	6 Not applicable	10	3.1	4.4	100.0
	Total	227	69.8	100.0	
Missing	System	98	30.2		
Total		325	100.0		

**Q14c\_R1 There is good communication with other organisations providing care for my patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	4	1.2	1.7	1.7
	2 Disagree	39	12.0	17.0	18.8
	3 Neither	69	21.2	30.1	48.9
	4 Agree	93	28.6	40.6	89.5
	5 Strongly agree	16	4.9	7.0	96.5
	6 Not applicable	8	2.5	3.5	100.0
	Total	229	70.5	100.0	
Missing	System	96	29.5		
Total		325	100.0		

**Q15a\_R1 Communicate with hospital doctors**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	20	6.2	8.8	8.8
	2 Rarely	33	10.2	14.5	23.2
	3 Occasionally	64	19.7	28.1	51.3
	4 Often	71	21.8	31.1	82.5
	5 Constantly	40	12.3	17.5	100.0
	Total	228	70.2	100.0	
Missing	System	97	29.8		
Total		325	100.0		

**Q15b\_R1 Communicate with GPs**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	3	.9	1.3	1.3
	2 Rarely	9	2.8	3.9	5.3
	3 Occasionally	30	9.2	13.2	18.4
	4 Often	89	27.4	39.0	57.5
	5 Constantly	97	29.8	42.5	100.0
	Total	228	70.2	100.0	
Missing	System	97	29.8		
Total		325	100.0		

**Q15c\_R1 Communicate with hospital nurses**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	25	7.7	11.0	11.0
	2 Rarely	40	12.3	17.6	28.6
	3 Occasionally	87	26.8	38.3	67.0
	4 Often	47	14.5	20.7	87.7
	5 Constantly	27	8.3	11.9	99.6
	9 2 or more ticked	1	.3	.4	100.0
	Total	227	69.8	100.0	
Missing	System	98	30.2		
Total		325	100.0		

**Q15d\_R1 Communicate with community nurses**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	12	3.7	5.3	5.3
	2 Rarely	14	4.3	6.2	11.5
	3 Occasionally	51	15.7	22.5	33.9
	4 Often	96	29.5	42.3	76.2
	5 Constantly	54	16.6	23.8	100.0
	Total	227	69.8	100.0	
Missing	System	98	30.2		
Total		325	100.0		

**Q15e\_R1 Communicate with pharmacists**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	12	3.7	5.4	5.4
	2 Rarely	35	10.8	15.7	21.1
	3 Occasionally	72	22.2	32.3	53.4
	4 Often	80	24.6	35.9	89.2
	5 Constantly	24	7.4	10.8	100.0
	Total	223	68.6	100.0	
Missing	System	102	31.4		
Total		325	100.0		

**Q15f\_R1 Communicate with NHS employed therapists**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	18	5.5	7.9	7.9
	2 Rarely	30	9.2	13.2	21.1
	3 Occasionally	71	21.8	31.3	52.4
	4 Often	74	22.8	32.6	85.0
	5 Constantly	34	10.5	15.0	100.0
	Total	227	69.8	100.0	
Missing	System	98	30.2		
Total		325	100.0		

**Q15g\_R1 Communicate with social care professionals**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	14	4.3	6.1	6.1
	2 Rarely	43	13.2	18.9	25.0
	3 Occasionally	70	21.5	30.7	55.7
	4 Often	68	20.9	29.8	85.5
	5 Constantly	33	10.2	14.5	100.0
	Total	228	70.2	100.0	
Missing	System	97	29.8		
Total		325	100.0		

**Q15h\_R1 Communicate with paid care workers**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	19	5.8	8.3	8.3
	2 Rarely	60	18.5	26.3	34.6
	3 Occasionally	69	21.2	30.3	64.9
	4 Often	59	18.2	25.9	90.8
	5 Constantly	21	6.5	9.2	100.0
	Total	228	70.2	100.0	
Missing	System	97	29.8		
Total		325	100.0		

**Q15i\_R1 Communicate with third or voluntary sector**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	25	7.7	11.1	11.1
	2 Rarely	79	24.3	35.0	46.0
	3 Occasionally	75	23.1	33.2	79.2
	4 Often	34	10.5	15.0	94.2
	5 Constantly	13	4.0	5.8	100.0
	Total	226	69.5	100.0	
Missing	System	99	30.5		
Total		325	100.0		

**Q15j\_R1 Communicate with administrators/managers**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	11	3.4	4.8	4.8
	2 Rarely	34	10.5	15.0	19.8
	3 Occasionally	56	17.2	24.7	44.5
	4 Often	70	21.5	30.8	75.3
	5 Constantly	56	17.2	24.7	100.0
	Total	227	69.8	100.0	
Missing	System	98	30.2		
Total		325	100.0		

**Q16\_R1 Manage staff**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	139	42.8	60.4	60.4
	2 No	91	28.0	39.6	100.0
	Total	230	70.8	100.0	
Missing	System	95	29.2		
Total		325	100.0		

**Q17\_R1 Age**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 16-30	14	4.3	4.9	4.9
	2 31-50	188	57.8	65.5	70.4
	3 51-65	81	24.9	28.2	98.6
	4 66+	4	1.2	1.4	100.0
	Total	287	88.3	100.0	
Missing	System	38	11.7		
Total		325	100.0		

**Q18\_R1 Occupational group**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Medical	96	29.5	33.4	33.4
	2 Nurse or midwife	46	14.2	16.0	49.5
	3 Community matron	12	3.7	4.2	53.7
	4 Community psychiatric nurse	3	.9	1.0	54.7
	5 Pharmacist	3	.9	1.0	55.7
	6 NHS-employed therapist	7	2.2	2.4	58.2
	7 Social care professional	10	3.1	3.5	61.7
	8 Paid care worker	2	.6	.7	62.4
	9 NHS admin staff	23	7.1	8.0	70.4
	10 Social service admin staff	1	.3	.3	70.7
	11 NHS general management	51	15.7	17.8	88.5
	12 Social service general management	6	1.8	2.1	90.6
	13 Third or voluntary sector	11	3.4	3.8	94.4
	14 Other	13	4.0	4.5	99.0
	99 2 or more ticked	3	.9	1.0	100.0
Total	287	88.3	100.0		
Missing	System	38	11.7		
Total		325	100.0		

**Q19\_R1 How long in current job**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Less than 1 year	27	8.3	9.4	9.4
	2 1-2 years	50	15.4	17.4	26.8
	3 3-5 years	65	20.0	22.6	49.5
	4 6-10 years	50	15.4	17.4	66.9
	5 11-15 years	39	12.0	13.6	80.5
	6 More than 15 years	55	16.9	19.2	99.7
	9 2 or more ticked	1	.3	.3	100.0
	Total	287	88.3	100.0	
Missing	System	38	11.7		
Total		325	100.0		

**Q20\_R1 Gender**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 male	101	31.1	35.3	35.3
	2 Female	185	56.9	64.7	100.0
	Total	286	88.0	100.0	
Missing	System	39	12.0		
Total		325	100.0		

**Q21\_R1 Certain number of contracted hours**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	217	66.8	76.1	76.1
	2 No	68	20.9	23.9	100.0
	Total	285	87.7	100.0	
Missing	System	40	12.3		
Total		325	100.0		

Q22\_R1 Number of hours

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	7.00	1	.3	.5	.5
	10.00	1	.3	.5	1.0
	12.00	1	.3	.5	1.4
	15.00	3	.9	1.4	2.9
	16.00	1	.3	.5	3.3
	17.00	2	.6	1.0	4.3
	18.00	3	.9	1.4	5.7
	18.50	1	.3	.5	6.2
	20.00	1	.3	.5	6.7
	21.00	2	.6	1.0	7.7
	23.00	1	.3	.5	8.1
	24.00	6	1.8	2.9	11.0
	25.00	5	1.5	2.4	13.4
	26.00	3	.9	1.4	14.8
	27.00	3	.9	1.4	16.3
	28.00	4	1.2	1.9	18.2
	30.00	16	4.9	7.7	25.8
	31.00	1	.3	.5	26.3
	31.50	1	.3	.5	26.8
	32.00	5	1.5	2.4	29.2
	32.50	1	.3	.5	29.7
	33.00	1	.3	.5	30.1
	34.00	2	.6	1.0	31.1
	35.00	1	.3	.5	31.6
	36.00	5	1.5	2.4	34.0
	37.00	65	20.0	31.1	65.1
	37.50	45	13.8	21.5	86.6
	38.00	5	1.5	2.4	89.0
	40.00	6	1.8	2.9	91.9
	44.00	3	.9	1.4	93.3
	46.00	1	.3	.5	93.8
	47.00	1	.3	.5	94.3
	48.00	7	2.2	3.3	97.6
	50.00	3	.9	1.4	99.0
	52.00	1	.3	.5	99.5
	56.00	1	.3	.5	100.0
	Total	209	64.3	100.0	
Missing	System	116	35.7		
Total		325	100.0		



Q23\_R1 Pay range

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 £10,000 to £14,999	14	4.3	6.2	6.2
	2 £15,000 to £19,999	12	3.7	5.3	11.5
	3 £20,000 to £24,999	12	3.7	5.3	16.8
	4 £25,000 to £29,999	24	7.4	10.6	27.4
	5 £30,000 to £34,999	22	6.8	9.7	37.2
	6 £35,000 to £39,999	24	7.4	10.6	47.8
	7 £40,000 to £44,999	15	4.6	6.6	54.4
	8 £45,000 to £49,999	12	3.7	5.3	59.7
	9 £50,000 to £59,999	20	6.2	8.8	68.6
	10 £60,000 to £69,999	10	3.1	4.4	73.0
	11 £70,000 to £79,999	11	3.4	4.9	77.9
	12 £80,000 to £99,999	16	4.9	7.1	85.0
	13 More than £100,000	32	9.8	14.2	99.1
	99 2 or more ticked	2	.6	.9	100.0
	Total	226	69.5	100.0	
Missing	System	99	30.5		
Total		325	100.0		

## Frequencies, Staff questionnaire, Round 2, All responses

**Q1\_R1 Do you know you are working in an Integrated Care Pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	262	74.4	92.3	92.3
	2 DK	9	2.6	3.2	95.4
	3 No	13	3.7	4.6	100.0
	Total	284	80.7	100.0	
Missing	System	68	19.3		
Total		352	100.0		

**Q2\_R1 How has your job changed since the introduction**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 New appointment	28	8.0	10.3	10.3
	2 Seconded to work full time	9	2.6	3.3	13.7
	3 Seconded to work part time	32	9.1	11.8	25.5
	4 Some changes, but not formally on pilot	84	23.9	31.0	56.5
	5 Not changed	118	33.5	43.5	100.0
	Total	271	77.0	100.0	
Missing	System	81	23.0		
Total		352	100.0		

**Q3a\_R1 The depth of my job has increased**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	5	1.4	3.0	3.0
	2 Disagree	21	6.0	12.7	15.8
	3 Neither	36	10.2	21.8	37.6
	4 Agree	67	19.0	40.6	78.2
	5 Strongly agree	18	5.1	10.9	89.1
	6 Not applicable	18	5.1	10.9	100.0
	Total	165	46.9	100.0	
Missing	System	187	53.1		
Total		352	100.0		

**Q3b\_R1 The breadth of my job has been expanded**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	4	1.1	2.4	2.4
	2 Disagree	8	2.3	4.8	7.2
	3 Neither	19	5.4	11.4	18.6
	4 Agree	84	23.9	50.3	68.9
	5 Strongly agree	38	10.8	22.8	91.6
	6 Not applicable	14	4.0	8.4	100.0
	Total	167	47.4	100.0	
Missing	System	185	52.6		
Total		352	100.0		

**Q3c\_R1 I now delegate more responsibility to others**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	13	3.7	8.1	8.1
	2 Disagree	34	9.7	21.3	29.4
	3 Neither	53	15.1	33.1	62.5
	4 Agree	37	10.5	23.1	85.6
	5 Strongly agree	6	1.7	3.8	89.4
	6 Not applicable	17	4.8	10.6	100.0
	Total	160	45.5	100.0	
Missing	System	192	54.5		
Total		352	100.0		

**Q3d\_R1 I now have more responsibility delegated to me**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	5	1.4	3.0	3.0
	2 Disagree	21	6.0	12.7	15.8
	3 Neither	33	9.4	20.0	35.8
	4 Agree	70	19.9	42.4	78.2
	5 Strongly agree	23	6.5	13.9	92.1
	6 Not applicable	13	3.7	7.9	100.0
	Total	165	46.9	100.0	
Missing	System	187	53.1		
Total		352	100.0		

**Q4\_R1 How much of your daily work relates to the pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 None specifically	32	9.1	18.5	18.5
	2 Some	112	31.8	64.7	83.2
	3 All	23	6.5	13.3	96.5
	4 Not sure	6	1.7	3.5	100.0
	Total	173	49.1	100.0	
Missing	System	179	50.9		
Total		352	100.0		

**Q5\_hours\_1\_R1 Average hours per week**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	5	1.4	3.4	3.4
	.20	1	.3	.7	4.1
	.50	6	1.7	4.1	8.3
	1.00	21	6.0	14.5	22.8
	1.50	2	.6	1.4	24.1
	2.00	23	6.5	15.9	40.0
	3.00	9	2.6	6.2	46.2
	3.50	1	.3	.7	46.9
	4.00	11	3.1	7.6	54.5
	4.50	1	.3	.7	55.2
	5.00	2	.6	1.4	56.6
	5.50	1	.3	.7	57.2
	6.00	8	2.3	5.5	62.8
	6.50	1	.3	.7	63.4
	7.00	1	.3	.7	64.1
	7.50	2	.6	1.4	65.5
	8.00	5	1.4	3.4	69.0
	10.00	4	1.1	2.8	71.7
	12.00	1	.3	.7	72.4
	15.00	3	.9	2.1	74.5
	16.00	3	.9	2.1	76.6
	17.50	1	.3	.7	77.2
	18.00	2	.6	1.4	78.6
	20.00	5	1.4	3.4	82.1
	22.50	1	.3	.7	82.8
	25.00	2	.6	1.4	84.1
	26.25	1	.3	.7	84.8
	30.00	4	1.1	2.8	87.6
	32.00	1	.3	.7	88.3
	35.00	2	.6	1.4	89.7
	37.00	2	.6	1.4	91.0
	37.50	7	2.0	4.8	95.9
	40.00	5	1.4	3.4	99.3
50.00	1	.3	.7	100.0	
Total		145	41.2	100.0	
Missing	System	207	58.8		
Total		352	100.0		

**Q5\_NA\_1\_R1 Not applicable**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	23	6.5	100.0	100.0
Missing	System	329	93.5		
Total		352	100.0		

**Q5\_hours\_2\_R1 Maximum hours per week**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	3	.9	2.1	2.1
	.50	2	.6	1.4	3.5
	1.00	7	2.0	5.0	8.5
	1.50	1	.3	.7	9.2
	2.00	9	2.6	6.4	15.6
	3.00	15	4.3	10.6	26.2
	3.50	1	.3	.7	27.0
	4.00	18	5.1	12.8	39.7
	5.00	3	.9	2.1	41.8
	6.00	11	3.1	7.8	49.6
	7.00	4	1.1	2.8	52.5
	7.50	1	.3	.7	53.2
	8.00	9	2.6	6.4	59.6
	9.00	1	.3	.7	60.3
	10.00	4	1.1	2.8	63.1
	12.00	3	.9	2.1	65.2
	15.00	4	1.1	2.8	68.1
	16.00	2	.6	1.4	69.5
	18.00	1	.3	.7	70.2
	20.00	6	1.7	4.3	74.5
	22.00	1	.3	.7	75.2
	24.00	2	.6	1.4	76.6
	25.00	2	.6	1.4	78.0
	26.25	1	.3	.7	78.7
	27.00	1	.3	.7	79.4
	30.00	6	1.7	4.3	83.7
	32.00	1	.3	.7	84.4
	35.00	2	.6	1.4	85.8
	37.00	2	.6	1.4	87.2
	37.50	9	2.6	6.4	93.6
	40.00	3	.9	2.1	95.7
	42.00	1	.3	.7	96.5
	45.00	2	.6	1.4	97.9
	50.00	2	.6	1.4	99.3
	60.00	1	.3	.7	100.0
	Total	141	40.1	100.0	
Missing	System	211	59.9		
Total		352	100.0		

**Q5\_NA\_2\_R1 Not applicable**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	23	6.5	100.0	100.0
Missing	System	329	93.5		
Total		352	100.0		

**Q5\_hours\_3\_R1 Mininum hours per week**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	28	8.0	20.6	20.6
	.50	10	2.8	7.4	27.9
	1.00	28	8.0	20.6	48.5
	2.00	13	3.7	9.6	58.1
	3.00	6	1.7	4.4	62.5
	4.00	7	2.0	5.1	67.6
	5.00	2	.6	1.5	69.1
	6.00	2	.6	1.5	70.6
	7.50	1	.3	.7	71.3
	8.00	4	1.1	2.9	74.3
	10.00	3	.9	2.2	76.5
	15.00	2	.6	1.5	77.9
	16.00	3	.9	2.2	80.1
	18.00	1	.3	.7	80.9
	18.75	1	.3	.7	81.6
	20.00	2	.6	1.5	83.1
	22.50	1	.3	.7	83.8
	25.00	3	.9	2.2	86.0
	28.00	2	.6	1.5	87.5
	30.00	3	.9	2.2	89.7
	35.00	2	.6	1.5	91.2
	37.00	3	.9	2.2	93.4
	37.50	7	2.0	5.1	98.5
	40.00	2	.6	1.5	100.0
Total		136	38.6	100.0	
Missing	System	216	61.4		
Total		352	100.0		

**Q5\_NA\_3\_R1 Not applicable**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	28	8.0	100.0	100.0
Missing	System	324	92.0		
Total		352	100.0		

**Q5\_hours\_4\_R1 Number of weeks worked overtime because of pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	52	14.8	52.0	52.0
	.30	1	.3	1.0	53.0
	1.00	13	3.7	13.0	66.0
	2.00	8	2.3	8.0	74.0
	3.00	4	1.1	4.0	78.0
	4.00	20	5.7	20.0	98.0
	15.00	1	.3	1.0	99.0
	16.00	1	.3	1.0	100.0
	Total	100	28.4	100.0	
Missing	System	252	71.6		
Total		352	100.0		

**Q5\_NA\_4\_R1 Not applicable**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	57	16.2	100.0	100.0
Missing	System	295	83.8		
Total		352	100.0		

**Q6a\_R1 Support for training in my area of work**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	50	14.2	28.9	28.9
	2 No change	104	29.5	60.1	89.0
	3 Worse than before	1	.3	.6	89.6
	4 Not sure	18	5.1	10.4	100.0
	Total	173	49.1	100.0	
Missing	System	179	50.9		
Total		352	100.0		

**Q6b\_R1 Clarity of accountability structures in my work**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	40	11.4	23.4	23.4
	2 No change	112	31.8	65.5	88.9
	3 Worse than before	7	2.0	4.1	93.0
	4 Not sure	12	3.4	7.0	100.0
	Total	171	48.6	100.0	
Missing	System	181	51.4		
Total		352	100.0		

**Q6c\_R1 Communication between different parts of my organisation**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	79	22.4	45.7	45.7
	2 No change	81	23.0	46.8	92.5
	3 Worse than before	4	1.1	2.3	94.8
	4 Not sure	9	2.6	5.2	100.0
	Total	173	49.1	100.0	
Missing	System	179	50.9		
Total		352	100.0		

**Q6d\_R1 Communication with other organisations**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	110	31.3	63.6	63.6
	2 No change	52	14.8	30.1	93.6
	3 Worse than before	4	1.1	2.3	96.0
	4 Not sure	7	2.0	4.0	100.0
	Total	173	49.1	100.0	
Missing	System	179	50.9		
Total		352	100.0		

**Q7a\_R1 Having clear planned goals and objectives**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	44	12.5	25.9	25.9
	2 No change	117	33.2	68.8	94.7
	3 Worse than before	9	2.6	5.3	100.0
	Total	170	48.3	100.0	
Missing	System	182	51.7		
Total		352	100.0		

**Q7b\_R1 Having an interesting job**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	73	20.7	42.9	42.9
	2 No change	95	27.0	55.9	98.8
	3 Worse than before	2	.6	1.2	100.0
	Total	170	48.3	100.0	
Missing	System	182	51.7		
Total		352	100.0		

**Q7c\_R1 Developing my role**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	81	23.0	47.6	47.6
	2 No change	87	24.7	51.2	98.8
	3 Worse than before	2	.6	1.2	100.0
	Total	170	48.3	100.0	
Missing	System	182	51.7		
Total		352	100.0		



**Q7d\_R1 Having adequate resources**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	35	9.9	20.7	20.7
	2 No change	100	28.4	59.2	79.9
	3 Worse than before	34	9.7	20.1	100.0
	Total	169	48.0	100.0	
Missing	System	183	52.0		
Total		352	100.0		

**Q8\_R1 Participate in steering group or board**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	107	30.4	61.8	61.8
	2 No	66	18.8	38.2	100.0
	Total	173	49.1	100.0	
Missing	System	179	50.9		
Total		352	100.0		

**Q9a\_R1 Has overall care patients receive ...**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Got better	144	40.9	51.1	51.1
	2 Not changed	85	24.1	30.1	81.2
	3 Got worse	5	1.4	1.8	83.0
	4 Not sure	48	13.6	17.0	100.0
	Total	282	80.1	100.0	
Missing	System	70	19.9		
Total		352	100.0		

**Q9b\_R1 Seen improvements in care as result of pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	115	32.7	41.2	41.2
	2 No	23	6.5	8.2	49.5
	3 Too early to tell	103	29.3	36.9	86.4
	4 Not sure	38	10.8	13.6	100.0
	Total	279	79.3	100.0	
Missing	System	73	20.7		
Total		352	100.0		

**Q10\_R1 Work in a team**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	249	70.7	88.0	88.0
	2 No	33	9.4	11.7	99.6
	9 2 or more ticked	1	.3	.4	100.0
	Total	283	80.4	100.0	
Missing	System	69	19.6		
Total		352	100.0		

**Q11a\_R1 Having clear team objectives**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	79	22.4	32.6	32.6
	2 No change	155	44.0	64.0	96.7
	3 Worse than before	8	2.3	3.3	100.0
	Total	242	68.8	100.0	
Missing	System	110	31.3		
Total		352	100.0		

**Q11b\_R1 Working closely with other team members**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	109	31.0	44.5	44.5
	2 No change	134	38.1	54.7	99.2
	3 Worse than before	2	.6	.8	100.0
	Total	245	69.6	100.0	
Missing	System	107	30.4		
Total		352	100.0		

**Q11c\_R1 Meeting regularly to discuss how care can be improved**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	116	33.0	47.3	47.3
	2 No change	126	35.8	51.4	98.8
	3 Worse than before	3	.9	1.2	100.0
	Total	245	69.6	100.0	
Missing	System	107	30.4		
Total		352	100.0		

**Q11d\_R1 Having clear lines of accountability**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	54	15.3	22.4	22.4
	2 No change	177	50.3	73.4	95.9
	3 Worse than before	9	2.6	3.7	99.6
	9 2 or more ticked	1	.3	.4	100.0
	Total	241	68.5	100.0	
Missing	System	111	31.5		
Total		352	100.0		

**Q11e\_R1 Having new electronic communication systems**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	42	11.9	17.6	17.6
	2 No change	194	55.1	81.2	98.7
	3 Worse than before	3	.9	1.3	100.0
	Total	239	67.9	100.0	
Missing	System	113	32.1		
Total		352	100.0		

**Q12\_R1 Have face-to-face contact with patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes, frequently	163	46.3	57.4	57.4
	2 Yes, occasionally	40	11.4	14.1	71.5
	3 No	81	23.0	28.5	100.0
	Total	284	80.7	100.0	
Missing	System	68	19.3		
Total		352	100.0		

**Q13a\_R1 I am satisfied with the quality of care I give to patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	3	.9	1.4	1.4
	2 Disagree	5	1.4	2.3	3.7
	3 Neither	11	3.1	5.1	8.9
	4 Agree	109	31.0	50.9	59.8
	5 Strongly agree	70	19.9	32.7	92.5
	6 Not applicable	16	4.5	7.5	100.0
	Total	214	60.8	100.0	
Missing	System	138	39.2		
Total		352	100.0		

**Q13b\_R1 I feel my role makes a positive difference to patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	3	.9	1.4	1.4
	3 Neither	11	3.1	5.1	6.5
	4 Agree	109	31.0	50.9	57.5
	5 Strongly agree	89	25.3	41.6	99.1
	6 Not applicable	2	.6	.9	100.0
	Total	214	60.8	100.0	
Missing	System	138	39.2		
Total		352	100.0		

**Q13c\_R1 I am able to do my job to a standard I am personally pleased with**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	4	1.1	1.9	1.9
	2 Disagree	11	3.1	5.2	7.0
	3 Neither	17	4.8	8.0	15.0
	4 Agree	120	34.1	56.3	71.4
	5 Strongly agree	59	16.8	27.7	99.1
	6 Not applicable	2	.6	.9	100.0
Total	213	60.5	100.0		
Missing	System	139	39.5		
Total		352	100.0		

**Q13d\_R1 I can manage all the conflicting demands on my time**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	12	3.4	5.6	5.6
	2 Disagree	45	12.8	21.1	26.8
	3 Neither	45	12.8	21.1	47.9
	4 Agree	83	23.6	39.0	86.9
	5 Strongly agree	25	7.1	11.7	98.6
	6 Not applicable	2	.6	.9	99.5
	9 2 or more ticked	1	.3	.5	100.0
	Total	213	60.5	100.0	
Missing	System	139	39.5		
Total		352	100.0		

**Q14a\_R1 People providing care for my patients work well together**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	2	.6	.9	.9
	2 Disagree	18	5.1	8.5	9.4
	3 Neither	48	13.6	22.6	32.1
	4 Agree	109	31.0	51.4	83.5
	5 Strongly agree	24	6.8	11.3	94.8
	6 Not applicable	11	3.1	5.2	100.0
	Total	212	60.2	100.0	
Missing	System	140	39.8		
Total		352	100.0		

**Q14b\_R1 A seamless service is a good description for the care my patients receive**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	6	1.7	2.8	2.8
	2 Disagree	50	14.2	23.6	26.4
	3 Neither	70	19.9	33.0	59.4
	4 Agree	66	18.8	31.1	90.6
	5 Strongly agree	8	2.3	3.8	94.3
	6 Not applicable	12	3.4	5.7	100.0
	Total	212	60.2	100.0	
Missing	System	140	39.8		
Total		352	100.0		

**Q14c\_R1 There is good communication with other organisations providing care for my patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	2	.6	.9	.9
	2 Disagree	35	9.9	16.5	17.5
	3 Neither	66	18.8	31.1	48.6
	4 Agree	80	22.7	37.7	86.3
	5 Strongly agree	19	5.4	9.0	95.3
	6 Not applicable	10	2.8	4.7	100.0
	Total	212	60.2	100.0	
Missing	System	140	39.8		
Total		352	100.0		

**Q15a\_R1 Communicate with hospital doctors**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	18	5.1	8.5	8.5
	2 Rarely	34	9.7	16.0	24.5
	3 Occasionally	68	19.3	32.1	56.6
	4 Often	59	16.8	27.8	84.4
	5 Constantly	33	9.4	15.6	100.0
	Total	212	60.2	100.0	
Missing	System	140	39.8		
Total		352	100.0		

**Q15b\_R1 Communicate with GPs**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	5	1.4	2.3	2.3
	2 Rarely	9	2.6	4.2	6.6
	3 Occasionally	31	8.8	14.6	21.1
	4 Often	73	20.7	34.3	55.4
	5 Constantly	94	26.7	44.1	99.5
	9 2 or more ticked	1	.3	.5	100.0
	Total	213	60.5	100.0	
Missing	System	139	39.5		
Total		352	100.0		

**Q15c\_R1 Communicate with hospital nurses**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	20	5.7	9.5	9.5
	2 Rarely	37	10.5	17.5	27.0
	3 Occasionally	88	25.0	41.7	68.7
	4 Often	42	11.9	19.9	88.6
	5 Constantly	22	6.3	10.4	99.1
	9 2 or more ticked	2	.6	.9	100.0
	Total	211	59.9	100.0	
Missing	System	141	40.1		
Total		352	100.0		

**Q15d\_R1 Communicate with community nurses**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	11	3.1	5.2	5.2
	2 Rarely	14	4.0	6.7	11.9
	3 Occasionally	41	11.6	19.5	31.4
	4 Often	91	25.9	43.3	74.8
	5 Constantly	53	15.1	25.2	100.0
	Total	210	59.7	100.0	
Missing	System	142	40.3		
Total		352	100.0		

**Q15e\_R1 Communicate with pharmacists**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	16	4.5	7.7	7.7
	2 Rarely	34	9.7	16.3	24.0
	3 Occasionally	64	18.2	30.8	54.8
	4 Often	74	21.0	35.6	90.4
	5 Constantly	20	5.7	9.6	100.0
	Total	208	59.1	100.0	
Missing	System	144	40.9		
Total		352	100.0		

**Q15f\_R1 Communicate with NHS employed therapists**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	12	3.4	5.7	5.7
	2 Rarely	32	9.1	15.1	20.8
	3 Occasionally	66	18.8	31.1	51.9
	4 Often	63	17.9	29.7	81.6
	5 Constantly	39	11.1	18.4	100.0
	Total	212	60.2	100.0	
Missing	System	140	39.8		
Total		352	100.0		

**Q15g\_R1 Communicate with social care professionals**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	12	3.4	5.7	5.7
	2 Rarely	32	9.1	15.1	20.8
	3 Occasionally	72	20.5	34.0	54.7
	4 Often	59	16.8	27.8	82.5
	5 Constantly	37	10.5	17.5	100.0
	Total	212	60.2	100.0	
Missing	System	140	39.8		
Total		352	100.0		

**Q15h\_R1 Communicate with paid care workers**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	21	6.0	10.0	10.0
	2 Rarely	51	14.5	24.2	34.1
	3 Occasionally	77	21.9	36.5	70.6
	4 Often	44	12.5	20.9	91.5
	5 Constantly	18	5.1	8.5	100.0
	Total	211	59.9	100.0	
Missing	System	141	40.1		
Total		352	100.0		

**Q15i\_R1 Communicate with third or voluntary sector**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	18	5.1	8.5	8.5
	2 Rarely	65	18.5	30.8	39.3
	3 Occasionally	72	20.5	34.1	73.5
	4 Often	34	9.7	16.1	89.6
	5 Constantly	22	6.3	10.4	100.0
	Total	211	59.9	100.0	
Missing	System	141	40.1		
Total		352	100.0		

**Q15j\_R1 Communicate with administrators/managers**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	7	2.0	3.3	3.3
	2 Rarely	26	7.4	12.3	15.6
	3 Occasionally	42	11.9	19.8	35.4
	4 Often	77	21.9	36.3	71.7
	5 Constantly	60	17.0	28.3	100.0
	Total	212	60.2	100.0	
Missing	System	140	39.8		
Total		352	100.0		

**Q16\_R1 Manage staff**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	141	40.1	65.6	65.6
	2 No	74	21.0	34.4	100.0
	Total	215	61.1	100.0	
Missing	System	137	38.9		
Total		352	100.0		

**Q17\_R1 Age**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 16-30	20	5.7	7.1	7.1
	2 31-50	174	49.4	61.5	68.6
	3 51-65	88	25.0	31.1	99.6
	4 66+	1	.3	.4	100.0
	Total	283	80.4	100.0	
Missing	System	69	19.6		
Total		352	100.0		

**Q18\_R1 Occupational group**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Medical	83	23.6	29.3	29.3
	2 Nurse or midwife	35	9.9	12.4	41.7
	3 Community matron	13	3.7	4.6	46.3
	4 Community psychiatric nurse	4	1.1	1.4	47.7
	5 Pharmacist	1	.3	.4	48.1
	6 NHS-employed therapist	7	2.0	2.5	50.5
	7 Social care professional	8	2.3	2.8	53.4
	8 Paid care worker	6	1.7	2.1	55.5
	9 NHS admin staff	30	8.5	10.6	66.1
	11 NHS general management	63	17.9	22.3	88.3
	12 Social service general management	4	1.1	1.4	89.8
	13 Third or voluntary sector	13	3.7	4.6	94.3
	14 Other	15	4.3	5.3	99.6
	99 2 or more ticked	1	.3	.4	100.0
	Total	283	80.4	100.0	
Missing	System	69	19.6		
Total		352	100.0		

**Q19\_R1 How long in current job**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Less than 1 year	41	11.6	14.5	14.5
	2 1-2 years	56	15.9	19.9	34.4
	3 3-5 years	60	17.0	21.3	55.7
	4 6-10 years	42	11.9	14.9	70.6
	5 11-15 years	33	9.4	11.7	82.3
	6 More than 15 years	49	13.9	17.4	99.6
	9 2 or more ticked	1	.3	.4	100.0
	Total	282	80.1	100.0	
Missing	System	70	19.9		
Total		352	100.0		

**Q20\_R1 Gender**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 male	92	26.1	32.6	32.6
	2 Female	190	54.0	67.4	100.0
	Total	282	80.1	100.0	
Missing	System	70	19.9		
Total		352	100.0		



**Q21\_R1 Certain number of contracted hours**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	223	63.4	80.2	80.2
	2 No	55	15.6	19.8	100.0
	Total	278	79.0	100.0	
Missing	System	74	21.0		
Total		352	100.0		

**Q22\_R1 Number of hours**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	7.00	2	.6	.9	.9
	10.00	1	.3	.5	1.4
	12.00	1	.3	.5	1.8
	15.00	2	.6	.9	2.7
	17.00	1	.3	.5	3.2
	18.00	2	.6	.9	4.1
	18.75	1	.3	.5	4.6
	18.77	1	.3	.5	5.0
	20.00	2	.6	.9	5.9
	21.00	1	.3	.5	6.4
	22.00	1	.3	.5	6.8
	23.00	1	.3	.5	7.3
	24.00	3	.9	1.4	8.7
	25.00	4	1.1	1.8	10.5
	26.00	3	.9	1.4	11.9
	27.00	4	1.1	1.8	13.7
	28.00	3	.9	1.4	15.1
	30.00	14	4.0	6.4	21.5
	31.00	1	.3	.5	21.9
	31.50	1	.3	.5	22.4
	32.00	3	.9	1.4	23.7
	32.50	1	.3	.5	24.2
	33.00	1	.3	.5	24.7
	34.00	3	.9	1.4	26.0
	35.00	3	.9	1.4	27.4
	36.00	4	1.1	1.8	29.2
	37.00	76	21.6	34.7	63.9
	37.25	1	.3	.5	64.4
	37.50	49	13.9	22.4	86.8
	38.00	7	2.0	3.2	90.0
	40.00	7	2.0	3.2	93.2
	44.00	4	1.1	1.8	95.0
	45.00	2	.6	.9	95.9
47.00	1	.3	.5	96.3	
48.00	5	1.4	2.3	98.6	
50.00	1	.3	.5	99.1	
52.00	1	.3	.5	99.5	
56.00	1	.3	.5	100.0	
Total		219	62.2	100.0	
Missing	System	133	37.8		
Total		352	100.0		



Q23\_R1 Pay range

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 £10,000 to £14,999	14	4.0	6.0	6.0
	2 £15,000 to £19,999	17	4.8	7.2	13.2
	3 £20,000 to £24,999	12	3.4	5.1	18.3
	4 £25,000 to £29,999	23	6.5	9.8	28.1
	5 £30,000 to £34,999	25	7.1	10.6	38.7
	6 £35,000 to £39,999	16	4.5	6.8	45.5
	7 £40,000 to £44,999	19	5.4	8.1	53.6
	8 £45,000 to £49,999	16	4.5	6.8	60.4
	9 £50,000 to £59,999	21	6.0	8.9	69.4
	10 £60,000 to £69,999	7	2.0	3.0	72.3
	11 £70,000 to £79,999	13	3.7	5.5	77.9
	12 £80,000 to £99,999	15	4.3	6.4	84.3
	13 More than £100,000	35	9.9	14.9	99.1
	99 2 or more ticked	2	.6	.9	100.0
	Total	235	66.8	100.0	
Missing	System	117	33.2		
Total		352	100.0		

**Frequencies**

**Staff questionnaire Round 2 Group A**

**Q1\_R1 Do you know you are working in an Integrated Care Pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	91	81.3	98.9	98.9
	3 No	1	.9	1.1	100.0
	Total	92	82.1	100.0	
Missing	System	20	17.9		
Total		112	100.0		

**Q2\_R1 How has your job changed since the introduction**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 New appointment	20	17.9	22.0	22.0
	2 Seconded to work full time	6	5.4	6.6	28.6
	3 Seconded to work part time	18	16.1	19.8	48.4
	4 Some changes, but not formally on pilot	20	17.9	22.0	70.3
	5 Not changed	27	24.1	29.7	100.0
	Total	91	81.3	100.0	
Missing	System	21	18.8		
Total		112	100.0		

**Q3a\_R1 The depth of my job has increased**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	2	1.8	2.9	2.9
	2 Disagree	6	5.4	8.7	11.6
	3 Neither	14	12.5	20.3	31.9
	4 Agree	30	26.8	43.5	75.4
	5 Strongly agree	13	11.6	18.8	94.2
	6 Not applicable	4	3.6	5.8	100.0
	Total	69	61.6	100.0	
Missing	System	43	38.4		
Total		112	100.0		

**Q3b\_R1 The breadth of my job has been expanded**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	2	1.8	2.9	2.9
	2 Disagree	1	.9	1.4	4.3
	3 Neither	4	3.6	5.7	10.0
	4 Agree	34	30.4	48.6	58.6
	5 Strongly agree	25	22.3	35.7	94.3
	6 Not applicable	4	3.6	5.7	100.0
	Total	70	62.5	100.0	
Missing	System	42	37.5		
Total		112	100.0		

**Q3c\_R1 I now delegate more responsibility to others**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	4	3.6	6.1	6.1
	2 Disagree	16	14.3	24.2	30.3
	3 Neither	23	20.5	34.8	65.2
	4 Agree	12	10.7	18.2	83.3
	5 Strongly agree	4	3.6	6.1	89.4
	6 Not applicable	7	6.3	10.6	100.0
	Total	66	58.9	100.0	
Missing	System	46	41.1		
Total		112	100.0		

**Q3d\_R1 I now have more responsibility delegated to me**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	2	1.8	2.9	2.9
	2 Disagree	5	4.5	7.2	10.1
	3 Neither	14	12.5	20.3	30.4
	4 Agree	33	29.5	47.8	78.3
	5 Strongly agree	11	9.8	15.9	94.2
	6 Not applicable	4	3.6	5.8	100.0
	Total	69	61.6	100.0	
Missing	System	43	38.4		
Total		112	100.0		

**Q4\_R1 How much of your daily work relates to the pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 None specifically	4	3.6	5.5	5.5
	2 Some	47	42.0	64.4	69.9
	3 All	21	18.8	28.8	98.6
	4 Not sure	1	.9	1.4	100.0
	Total	73	65.2	100.0	
Missing	System	39	34.8		
Total		112	100.0		

**Q5\_hours\_1\_R1 Average hours per week**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	1	.9	1.5	1.5
	1.00	6	5.4	9.1	10.6
	2.00	7	6.3	10.6	21.2
	3.00	2	1.8	3.0	24.2
	4.00	6	5.4	9.1	33.3
	6.00	1	.9	1.5	34.8
	6.50	1	.9	1.5	36.4
	7.00	1	.9	1.5	37.9
	8.00	4	3.6	6.1	43.9
	10.00	4	3.6	6.1	50.0
	12.00	1	.9	1.5	51.5
	15.00	3	2.7	4.5	56.1
	16.00	3	2.7	4.5	60.6
	18.00	2	1.8	3.0	63.6
	20.00	3	2.7	4.5	68.2
	22.50	1	.9	1.5	69.7
	25.00	2	1.8	3.0	72.7
	26.25	1	.9	1.5	74.2
	30.00	2	1.8	3.0	77.3
	35.00	2	1.8	3.0	80.3
	37.00	2	1.8	3.0	83.3
	37.50	5	4.5	7.6	90.9
	40.00	5	4.5	7.6	98.5
50.00	1	.9	1.5	100.0	
Total		66	58.9	100.0	
Missing	System	46	41.1		
Total		112	100.0		

**Q5\_NA\_1\_R1 Not applicable**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1	6	5.4	100.0	100.0
Missing System	106	94.6		
Total	112	100.0		

**Q5\_hours\_2\_R1 Maximum hours per week**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1.00	1	.9	1.5	1.5
2.00	1	.9	1.5	3.0
3.00	6	5.4	9.1	12.1
4.00	6	5.4	9.1	21.2
5.00	1	.9	1.5	22.7
6.00	3	2.7	4.5	27.3
7.00	2	1.8	3.0	30.3
8.00	2	1.8	3.0	33.3
10.00	2	1.8	3.0	36.4
12.00	3	2.7	4.5	40.9
15.00	3	2.7	4.5	45.5
16.00	2	1.8	3.0	48.5
18.00	1	.9	1.5	50.0
20.00	5	4.5	7.6	57.6
22.00	1	.9	1.5	59.1
24.00	1	.9	1.5	60.6
25.00	2	1.8	3.0	63.6
26.25	1	.9	1.5	65.2
27.00	1	.9	1.5	66.7
30.00	4	3.6	6.1	72.7
35.00	1	.9	1.5	74.2
37.00	2	1.8	3.0	77.3
37.50	7	6.3	10.6	87.9
40.00	2	1.8	3.0	90.9
42.00	1	.9	1.5	92.4
45.00	2	1.8	3.0	95.5
50.00	2	1.8	3.0	98.5
60.00	1	.9	1.5	100.0
Total	66	58.9	100.0	
Missing System	46	41.1		
Total	112	100.0		

**Q5\_NA\_2\_R1 Not applicable**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1	5	4.5	100.0	100.0
Missing System	107	95.5		
Total	112	100.0		

**Q5\_hours\_3\_R1 Minumum hours per week**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid .00	6	5.4	9.5	9.5
.50	2	1.8	3.2	12.7
1.00	9	8.0	14.3	27.0
2.00	6	5.4	9.5	36.5
3.00	1	.9	1.6	38.1
4.00	3	2.7	4.8	42.9
5.00	2	1.8	3.2	46.0
6.00	1	.9	1.6	47.6
8.00	4	3.6	6.3	54.0
15.00	2	1.8	3.2	57.1
16.00	3	2.7	4.8	61.9
18.00	1	.9	1.6	63.5
18.75	1	.9	1.6	65.1
20.00	2	1.8	3.2	68.3
22.50	1	.9	1.6	69.8
25.00	3	2.7	4.8	74.6
28.00	2	1.8	3.2	77.8
30.00	1	.9	1.6	79.4
35.00	2	1.8	3.2	82.5
37.00	3	2.7	4.8	87.3
37.50	6	5.4	9.5	96.8
40.00	2	1.8	3.2	100.0
Total	63	56.3	100.0	
Missing System	49	43.8		
Total	112	100.0		

**Q5\_NA\_3\_R1 Not applicable**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1	7	6.3	100.0	100.0
Missing System	105	93.8		
Total	112	100.0		



**Q5\_hours\_4\_R1 Number of weeks worked overtime because of pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	26	23.2	51.0	51.0
	1.00	6	5.4	11.8	62.7
	2.00	4	3.6	7.8	70.6
	3.00	4	3.6	7.8	78.4
	4.00	11	9.8	21.6	100.0
	Total	51	45.5	100.0	
Missing	System	61	54.5		
Total		112	100.0		

**Q5\_NA\_4\_R1 Not applicable**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	17	15.2	100.0	100.0
Missing	System	95	84.8		
Total		112	100.0		

**Q6a\_R1 Support for training in my area of work**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	22	19.6	30.1	30.1
	2 No change	41	36.6	56.2	86.3
	4 Not sure	10	8.9	13.7	100.0
	Total	73	65.2	100.0	
Missing	System	39	34.8		
Total		112	100.0		

**Q6b\_R1 Clarity of accountability structures in my work**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	21	18.8	28.8	28.8
	2 No change	43	38.4	58.9	87.7
	3 Worse than before	4	3.6	5.5	93.2
	4 Not sure	5	4.5	6.8	100.0
	Total	73	65.2	100.0	
Missing	System	39	34.8		
Total		112	100.0		

**Q6c\_R1 Communication between different parts of my organisation**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	38	33.9	51.4	51.4
	2 No change	31	27.7	41.9	93.2
	3 Worse than before	1	.9	1.4	94.6
	4 Not sure	4	3.6	5.4	100.0
	Total	74	66.1	100.0	
Missing	System	38	33.9		
Total		112	100.0		

**Q6d\_R1 Communication with other organisations**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	53	47.3	71.6	71.6
	2 No change	17	15.2	23.0	94.6
	3 Worse than before	1	.9	1.4	95.9
	4 Not sure	3	2.7	4.1	100.0
	Total	74	66.1	100.0	
Missing	System	38	33.9		
Total		112	100.0		

**Q7a\_R1 Having clear planned goals and objectives**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	29	25.9	40.8	40.8
	2 No change	40	35.7	56.3	97.2
	3 Worse than before	2	1.8	2.8	100.0
	Total	71	63.4	100.0	
Missing	System	41	36.6		
Total		112	100.0		

**Q7b\_R1 Having an interesting job**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	45	40.2	63.4	63.4
	2 No change	26	23.2	36.6	100.0
	Total	71	63.4	100.0	
Missing	System	41	36.6		
Total		112	100.0		

**Q7c\_R1 Developing my role**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	46	41.1	63.9	63.9
	2 No change	26	23.2	36.1	100.0
	Total	72	64.3	100.0	
Missing	System	40	35.7		
Total		112	100.0		

**Q7d\_R1 Having adequate resources**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	23	20.5	32.9	32.9
	2 No change	37	33.0	52.9	85.7
	3 Worse than before	10	8.9	14.3	100.0
	Total	70	62.5	100.0	
Missing	System	42	37.5		
Total		112	100.0		

**Q8\_R1 Participate in steering group or board**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	57	50.9	77.0	77.0
	2 No	17	15.2	23.0	100.0
	Total	74	66.1	100.0	
Missing	System	38	33.9		
Total		112	100.0		

**Q9a\_R1 Has overall care patients receive ...**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Got better	50	44.6	54.3	54.3
	2 Not changed	26	23.2	28.3	82.6
	3 Got worse	1	.9	1.1	83.7
	4 Not sure	15	13.4	16.3	100.0
	Total	92	82.1	100.0	
Missing	System	20	17.9		
Total		112	100.0		

**Q9b\_R1 Seen improvements in care as result of pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	46	41.1	50.0	50.0
	2 No	6	5.4	6.5	56.5
	3 Too early to tell	34	30.4	37.0	93.5
	4 Not sure	6	5.4	6.5	100.0
	Total	92	82.1	100.0	
Missing	System	20	17.9		
Total		112	100.0		

**Q10\_R1 Work in a team**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	85	75.9	92.4	92.4
	2 No	7	6.3	7.6	100.0
	Total	92	82.1	100.0	
Missing	System	20	17.9		
Total		112	100.0		

**Q11a\_R1 Having clear team objectives**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	41	36.6	50.6	50.6
	2 No change	38	33.9	46.9	97.5
	3 Worse than before	2	1.8	2.5	100.0
	Total	81	72.3	100.0	
Missing	System	31	27.7		
Total		112	100.0		

**Q11b\_R1 Working closely with other team members**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	49	43.8	59.8	59.8
	2 No change	33	29.5	40.2	100.0
	Total	82	73.2	100.0	
Missing	System	30	26.8		
Total		112	100.0		

**Q11c\_R1 Meeting regularly to discuss how care can be improved**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	52	46.4	62.7	62.7
	2 No change	30	26.8	36.1	98.8
	3 Worse than before	1	.9	1.2	100.0
	Total	83	74.1	100.0	
Missing	System	29	25.9		
Total		112	100.0		

**Q11d\_R1 Having clear lines of accountability**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	30	26.8	37.0	37.0
	2 No change	48	42.9	59.3	96.3
	3 Worse than before	3	2.7	3.7	100.0
	Total	81	72.3	100.0	
Missing	System	31	27.7		
Total		112	100.0		

**Q11e\_R1 Having new electronic communication systems**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	21	18.8	25.9	25.9
	2 No change	59	52.7	72.8	98.8
	3 Worse than before	1	.9	1.2	100.0
	Total	81	72.3	100.0	
Missing	System	31	27.7		
Total		112	100.0		

**Q12\_R1 Have face-to-face contact with patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes, frequently	44	39.3	47.8	47.8
	2 Yes, occasionally	14	12.5	15.2	63.0
	3 No	34	30.4	37.0	100.0
	Total	92	82.1	100.0	
Missing	System	20	17.9		
Total		112	100.0		

**Q13a\_R1 I am satisfied with the quality of care I give to patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	1	.9	1.5	1.5
	2 Disagree	2	1.8	3.1	4.6
	3 Neither	5	4.5	7.7	12.3
	4 Agree	32	28.6	49.2	61.5
	5 Strongly agree	18	16.1	27.7	89.2
	6 Not applicable	7	6.3	10.8	100.0
	Total	65	58.0	100.0	
Missing	System	47	42.0		
Total		112	100.0		

**Q13b\_R1 I feel my role makes a positive difference to patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	2	1.8	3.1	3.1
	3 Neither	5	4.5	7.7	10.8
	4 Agree	30	26.8	46.2	56.9
	5 Strongly agree	28	25.0	43.1	100.0
	Total	65	58.0	100.0	
Missing	System	47	42.0		
Total		112	100.0		

**Q13c\_R1 I am able to do my job to a standard I am personally pleased with**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	1	.9	1.6	1.6
	2 Disagree	4	3.6	6.3	7.8
	3 Neither	7	6.3	10.9	18.8
	4 Agree	33	29.5	51.6	70.3
	5 Strongly agree	19	17.0	29.7	100.0
	Total	64	57.1	100.0	
Missing	System	48	42.9		
Total		112	100.0		

**Q13d\_R1 I can manage all the conflicting demands on my time**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	3	2.7	4.7	4.7
	2 Disagree	14	12.5	21.9	26.6
	3 Neither	8	7.1	12.5	39.1
	4 Agree	28	25.0	43.8	82.8
	5 Strongly agree	11	9.8	17.2	100.0
	Total	64	57.1	100.0	
Missing	System	48	42.9		
Total		112	100.0		

**Q14a\_R1 People providing care for my patients work well together**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	1	.9	1.6	1.6
	2 Disagree	3	2.7	4.7	6.3
	3 Neither	14	12.5	21.9	28.1
	4 Agree	31	27.7	48.4	76.6
	5 Strongly agree	10	8.9	15.6	92.2
	6 Not applicable	5	4.5	7.8	100.0
	Total	64	57.1	100.0	
Missing	System	48	42.9		
Total		112	100.0		

**Q14b\_R1 A seamless service is a good description for the care my patients receive**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	3	2.7	4.6	4.6
	2 Disagree	12	10.7	18.5	23.1
	3 Neither	19	17.0	29.2	52.3
	4 Agree	19	17.0	29.2	81.5
	5 Strongly agree	4	3.6	6.2	87.7
	6 Not applicable	8	7.1	12.3	100.0
	Total	65	58.0	100.0	
Missing	System	47	42.0		
Total		112	100.0		

**Q14c\_R1 There is good communication with other organisations providing care for my patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2 Disagree	9	8.0	14.1	14.1
	3 Neither	18	16.1	28.1	42.2
	4 Agree	24	21.4	37.5	79.7
	5 Strongly agree	7	6.3	10.9	90.6
	6 Not applicable	6	5.4	9.4	100.0
	Total	64	57.1	100.0	
Missing	System	48	42.9		
Total		112	100.0		

**Q15a\_R1 Communicate with hospital doctors**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	8	7.1	12.3	12.3
	2 Rarely	13	11.6	20.0	32.3
	3 Occasionally	24	21.4	36.9	69.2
	4 Often	11	9.8	16.9	86.2
	5 Constantly	9	8.0	13.8	100.0
Total	65	58.0	100.0		
Missing	System	47	42.0		
Total		112	100.0		

**Q15b\_R1 Communicate with GPs**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	3	2.7	4.6	4.6
	2 Rarely	3	2.7	4.6	9.2
	3 Occasionally	14	12.5	21.5	30.8
	4 Often	18	16.1	27.7	58.5
	5 Constantly	26	23.2	40.0	98.5
	9 2 or more ticked	1	.9	1.5	100.0
	Total	65	58.0	100.0	
Missing	System	47	42.0		
Total		112	100.0		

**Q15c\_R1 Communicate with hospital nurses**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	6	5.4	9.2	9.2
	2 Rarely	14	12.5	21.5	30.8
	3 Occasionally	27	24.1	41.5	72.3
	4 Often	11	9.8	16.9	89.2
	5 Constantly	6	5.4	9.2	98.5
	9 2 or more ticked	1	.9	1.5	100.0
	Total	65	58.0	100.0	
Missing	System	47	42.0		
Total		112	100.0		

**Q15d\_R1 Communicate with community nurses**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	5	4.5	7.8	7.8
	2 Rarely	5	4.5	7.8	15.6
	3 Occasionally	10	8.9	15.6	31.3
	4 Often	32	28.6	50.0	81.3
	5 Constantly	12	10.7	18.8	100.0
	Total	64	57.1	100.0	
Missing	System	48	42.9		
Total		112	100.0		

**Q15e\_R1 Communicate with pharmacists**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	9	8.0	14.1	14.1
	2 Rarely	11	9.8	17.2	31.3
	3 Occasionally	20	17.9	31.3	62.5
	4 Often	20	17.9	31.3	93.8
	5 Constantly	4	3.6	6.3	100.0
	Total	64	57.1	100.0	
Missing	System	48	42.9		
Total		112	100.0		



**Q15f\_R1 Communicate with NHS employed therapists**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	3	2.7	4.6	4.6
	2 Rarely	8	7.1	12.3	16.9
	3 Occasionally	21	18.8	32.3	49.2
	4 Often	21	18.8	32.3	81.5
	5 Constantly	12	10.7	18.5	100.0
	Total	65	58.0	100.0	
Missing	System	47	42.0		
Total		112	100.0		

**Q15g\_R1 Communicate with social care professionals**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	6	5.4	9.2	9.2
	2 Rarely	4	3.6	6.2	15.4
	3 Occasionally	21	18.8	32.3	47.7
	4 Often	20	17.9	30.8	78.5
	5 Constantly	14	12.5	21.5	100.0
	Total	65	58.0	100.0	
Missing	System	47	42.0		
Total		112	100.0		

**Q15h\_R1 Communicate with paid care workers**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	8	7.1	12.5	12.5
	2 Rarely	14	12.5	21.9	34.4
	3 Occasionally	25	22.3	39.1	73.4
	4 Often	11	9.8	17.2	90.6
	5 Constantly	6	5.4	9.4	100.0
	Total	64	57.1	100.0	
Missing	System	48	42.9		
Total		112	100.0		

**Q15i\_R1 Communicate with third or voluntary sector**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	4	3.6	6.2	6.2
	2 Rarely	19	17.0	29.2	35.4
	3 Occasionally	22	19.6	33.8	69.2
	4 Often	11	9.8	16.9	86.2
	5 Constantly	9	8.0	13.8	100.0
	Total	65	58.0	100.0	
Missing	System	47	42.0		
Total		112	100.0		

**Q15j\_R1 Communicate with administrators/managers**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	1	.9	1.5	1.5
	2 Rarely	3	2.7	4.6	6.2
	3 Occasionally	12	10.7	18.5	24.6
	4 Often	28	25.0	43.1	67.7
	5 Constantly	21	18.8	32.3	100.0
	Total	65	58.0	100.0	
Missing	System	47	42.0		
Total		112	100.0		

**Q16\_R1 Manage staff**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	47	42.0	72.3	72.3
	2 No	18	16.1	27.7	100.0
	Total	65	58.0	100.0	
Missing	System	47	42.0		
Total		112	100.0		

**Q17\_R1 Age**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 16-30	10	8.9	10.9	10.9
	2 31-50	52	46.4	56.5	67.4
	3 51-65	30	26.8	32.6	100.0
	Total	92	82.1	100.0	
Missing	System	20	17.9		
Total		112	100.0		

**Q18\_R1 Occupational group**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Medical	20	17.9	21.7	21.7
	2 Nurse or midwife	7	6.3	7.6	29.3
	3 Community matron	3	2.7	3.3	32.6
	4 Community psychiatric nurse	2	1.8	2.2	34.8
	6 NHS-employed therapist	3	2.7	3.3	38.0
	7 Social care professional	3	2.7	3.3	41.3
	8 Paid care worker	5	4.5	5.4	46.7
	9 NHS admin staff	9	8.0	9.8	56.5
	11 NHS general management	27	24.1	29.3	85.9
	13 Third or voluntary sector	6	5.4	6.5	92.4
	14 Other	6	5.4	6.5	98.9
	99 2 or more ticked	1	.9	1.1	100.0
	Total	92	82.1	100.0	
	Missing	System	20	17.9	
Total		112	100.0		

**Q19\_R1 How long in current job**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Less than 1 year	21	18.8	23.1	23.1
	2 1-2 years	23	20.5	25.3	48.4
	3 3-5 years	18	16.1	19.8	68.1
	4 6-10 years	10	8.9	11.0	79.1
	5 11-15 years	5	4.5	5.5	84.6
	6 More than 15 years	14	12.5	15.4	100.0
	Total	91	81.3	100.0	
Missing	System	21	18.8		
Total		112	100.0		

**Q20\_R1 Gender**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 male	26	23.2	28.3	28.3
	2 Female	66	58.9	71.7	100.0
	Total	92	82.1	100.0	
Missing	System	20	17.9		
Total		112	100.0		

**Q21\_R1 Certain number of contracted hours**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	75	67.0	84.3	84.3
	2 No	14	12.5	15.7	100.0
	Total	89	79.5	100.0	
Missing	System	23	20.5		
Total		112	100.0		

**Q22\_R1 Number of hours**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	7.00	1	.9	1.3	1.3
	18.75	1	.9	1.3	2.6
	18.77	1	.9	1.3	3.9
	20.00	1	.9	1.3	5.3
	22.00	1	.9	1.3	6.6
	25.00	1	.9	1.3	7.9
	27.00	1	.9	1.3	9.2
	30.00	6	5.4	7.9	17.1
	32.00	1	.9	1.3	18.4
	34.00	2	1.8	2.6	21.1
	35.00	2	1.8	2.6	23.7
	36.00	1	.9	1.3	25.0
	37.00	30	26.8	39.5	64.5
	37.25	1	.9	1.3	65.8
	37.50	17	15.2	22.4	88.2
	38.00	3	2.7	3.9	92.1
	40.00	4	3.6	5.3	97.4
	44.00	1	.9	1.3	98.7
	45.00	1	.9	1.3	100.0
	Total	76	67.9	100.0	
Missing	System	36	32.1		
Total		112	100.0		

Q23\_R1 Pay range

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 £10,000 to £14,999	4	3.6	5.0	5.0
	2 £15,000 to £19,999	11	9.8	13.8	18.8
	3 £20,000 to £24,999	4	3.6	5.0	23.8
	4 £25,000 to £29,999	3	2.7	3.8	27.5
	5 £30,000 to £34,999	9	8.0	11.3	38.8
	6 £35,000 to £39,999	6	5.4	7.5	46.3
	7 £40,000 to £44,999	6	5.4	7.5	53.8
	8 £45,000 to £49,999	8	7.1	10.0	63.8
	9 £50,000 to £59,999	8	7.1	10.0	73.8
	10 £60,000 to £69,999	1	.9	1.3	75.0
	11 £70,000 to £79,999	5	4.5	6.3	81.3
	12 £80,000 to £99,999	5	4.5	6.3	87.5
	13 More than £100,000	10	8.9	12.5	100.0
	Total	80	71.4	100.0	
Missing	System	32	28.6		
Total		112	100.0		

**Frequency Table**

**Staff questionnaire, round 2, group B**

**Q1\_R1 Do you know you are working in an Integrated Care Pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	161	73.5	88.5	88.5
	2 DK	9	4.1	4.9	93.4
	3 No	12	5.5	6.6	100.0
	Total	182	83.1	100.0	
Missing	System	37	16.9		
Total		219	100.0		

**Q2\_R1 How has your job changed since the introduction**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 New appointment	6	2.7	3.5	3.5
	2 Seconded to work full time	3	1.4	1.8	5.3
	3 Seconded to work part time	10	4.6	5.9	11.2
	4 Some changes, but not formally on pilot	62	28.3	36.5	47.6
	5 Not changed	89	40.6	52.4	100.0
	Total	170	77.6	100.0	
Missing	System	49	22.4		
Total		219	100.0		

**Q3a\_R1 The depth of my job has increased**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	3	1.4	3.4	3.4
	2 Disagree	14	6.4	15.9	19.3
	3 Neither	22	10.0	25.0	44.3
	4 Agree	32	14.6	36.4	80.7
	5 Strongly agree	4	1.8	4.5	85.2
	6 Not applicable	13	5.9	14.8	100.0
	Total	88	40.2	100.0	
Missing	System	131	59.8		
Total		219	100.0		

**Q3b\_R1 The breadth of my job has been expanded**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	2	.9	2.2	2.2
	2 Disagree	7	3.2	7.9	10.1
	3 Neither	15	6.8	16.9	27.0
	4 Agree	47	21.5	52.8	79.8
	5 Strongly agree	9	4.1	10.1	89.9
	6 Not applicable	9	4.1	10.1	100.0
	Total	89	40.6	100.0	
Missing	System	130	59.4		
Total		219	100.0		

**Q3c\_R1 I now delegate more responsibility to others**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	9	4.1	10.5	10.5
	2 Disagree	18	8.2	20.9	31.4
	3 Neither	26	11.9	30.2	61.6
	4 Agree	23	10.5	26.7	88.4
	5 Strongly agree	1	.5	1.2	89.5
	6 Not applicable	9	4.1	10.5	100.0
	Total	86	39.3	100.0	
Missing	System	133	60.7		
Total		219	100.0		

**Q3d\_R1 I now have more responsibility delegated to me**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	3	1.4	3.4	3.4
	2 Disagree	16	7.3	18.2	21.6
	3 Neither	18	8.2	20.5	42.0
	4 Agree	33	15.1	37.5	79.5
	5 Strongly agree	10	4.6	11.4	90.9
	6 Not applicable	8	3.7	9.1	100.0
	Total	88	40.2	100.0	
Missing	System	131	59.8		
Total		219	100.0		

**Q4\_R1 How much of your daily work relates to the pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 None specifically	27	12.3	29.3	29.3
	2 Some	59	26.9	64.1	93.5
	3 All	1	.5	1.1	94.6
	4 Not sure	5	2.3	5.4	100.0
	Total	92	42.0	100.0	
Missing	System	127	58.0		
Total		219	100.0		

**Q5\_hours\_1\_R1 Average hours per week**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	4	1.8	5.6	5.6
	.20	1	.5	1.4	7.0
	.50	6	2.7	8.5	15.5
	1.00	14	6.4	19.7	35.2
	1.50	2	.9	2.8	38.0
	2.00	14	6.4	19.7	57.7
	3.00	7	3.2	9.9	67.6
	3.50	1	.5	1.4	69.0
	4.00	5	2.3	7.0	76.1
	4.50	1	.5	1.4	77.5
	5.00	1	.5	1.4	78.9
	5.50	1	.5	1.4	80.3
	6.00	6	2.7	8.5	88.7
	7.50	2	.9	2.8	91.5
	8.00	1	.5	1.4	93.0
	20.00	2	.9	2.8	95.8
	30.00	1	.5	1.4	97.2
	32.00	1	.5	1.4	98.6
	37.50	1	.5	1.4	100.0
	Total	71	32.4	100.0	
Missing	System	148	67.6		
Total		219	100.0		

**Q5\_NA\_1\_R1 Not applicable**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	17	7.8	100.0	100.0
Missing	System	202	92.2		
Total		219	100.0		

**Q5\_hours\_2\_R1 Maximum hours per week**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	3	1.4	4.4	4.4
	.50	2	.9	2.9	7.4
	1.00	6	2.7	8.8	16.2
	1.50	1	.5	1.5	17.6
	2.00	8	3.7	11.8	29.4
	3.00	9	4.1	13.2	42.6
	3.50	1	.5	1.5	44.1
	4.00	10	4.6	14.7	58.8
	5.00	2	.9	2.9	61.8
	6.00	7	3.2	10.3	72.1
	7.00	2	.9	2.9	75.0
	7.50	1	.5	1.5	76.5
	8.00	5	2.3	7.4	83.8
	9.00	1	.5	1.5	85.3
	10.00	2	.9	2.9	88.2
	15.00	1	.5	1.5	89.7
	24.00	1	.5	1.5	91.2
	30.00	2	.9	2.9	94.1
	32.00	1	.5	1.5	95.6
	35.00	1	.5	1.5	97.1
	37.50	1	.5	1.5	98.5
	40.00	1	.5	1.5	100.0
Total		68	31.1	100.0	
Missing	System	151	68.9		
Total		219	100.0		

**Q5\_NA\_2\_R1 Not applicable**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	17	7.8	100.0	100.0
Missing	System	202	92.2		
Total		219	100.0		



**Q5\_hours\_3\_R1 Minumum hours per week**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	21	9.6	31.8	31.8
	.50	8	3.7	12.1	43.9
	1.00	17	7.8	25.8	69.7
	2.00	7	3.2	10.6	80.3
	3.00	3	1.4	4.5	84.8
	4.00	4	1.8	6.1	90.9
	6.00	1	.5	1.5	92.4
	7.50	1	.5	1.5	93.9
	10.00	2	.9	3.0	97.0
	30.00	1	.5	1.5	98.5
	37.50	1	.5	1.5	100.0
	Total	66	30.1	100.0	
Missing	System	153	69.9		
Total		219	100.0		

**Q5\_NA\_3\_R1 Not applicable**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	20	9.1	100.0	100.0
Missing	System	199	90.9		
Total		219	100.0		

**Q5\_hours\_4\_R1 Number of weeks worked overtime because of pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	25	11.4	55.6	55.6
	.30	1	.5	2.2	57.8
	1.00	5	2.3	11.1	68.9
	2.00	4	1.8	8.9	77.8
	4.00	8	3.7	17.8	95.6
	15.00	1	.5	2.2	97.8
	16.00	1	.5	2.2	100.0
	Total	45	20.5	100.0	
Missing	System	174	79.5		
Total		219	100.0		

**Q5\_NA\_4\_R1 Not applicable**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1	37	16.9	100.0	100.0
Missing System	182	83.1		
Total	219	100.0		

**Q6a\_R1 Support for training in my area of work**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 Better than before	23	10.5	25.0	25.0
2 No change	61	27.9	66.3	91.3
3 Worse than before	1	.5	1.1	92.4
4 Not sure	7	3.2	7.6	100.0
Total	92	42.0	100.0	
Missing System	127	58.0		
Total	219	100.0		

**Q6b\_R1 Clarity of accountability structures in my work**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 Better than before	15	6.8	16.7	16.7
2 No change	65	29.7	72.2	88.9
3 Worse than before	3	1.4	3.3	92.2
4 Not sure	7	3.2	7.8	100.0
Total	90	41.1	100.0	
Missing System	129	58.9		
Total	219	100.0		

**Q6c\_R1 Communication between different parts of my organisation**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 Better than before	34	15.5	37.4	37.4
2 No change	49	22.4	53.8	91.2
3 Worse than before	3	1.4	3.3	94.5
4 Not sure	5	2.3	5.5	100.0
Total	91	41.6	100.0	
Missing System	128	58.4		
Total	219	100.0		

**Q6d\_R1 Communication with other organisations**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	49	22.4	53.8	53.8
	2 No change	35	16.0	38.5	92.3
	3 Worse than before	3	1.4	3.3	95.6
	4 Not sure	4	1.8	4.4	100.0
	Total	91	41.6	100.0	
Missing	System	128	58.4		
Total		219	100.0		

**Q7a\_R1 Having clear planned goals and objectives**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	13	5.9	14.1	14.1
	2 No change	72	32.9	78.3	92.4
	3 Worse than before	7	3.2	7.6	100.0
	Total	92	42.0	100.0	
Missing	System	127	58.0		
Total		219	100.0		

**Q7b\_R1 Having an interesting job**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	23	10.5	25.0	25.0
	2 No change	67	30.6	72.8	97.8
	3 Worse than before	2	.9	2.2	100.0
	Total	92	42.0	100.0	
Missing	System	127	58.0		
Total		219	100.0		

**Q7c\_R1 Developing my role**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	30	13.7	33.0	33.0
	2 No change	59	26.9	64.8	97.8
	3 Worse than before	2	.9	2.2	100.0
	Total	91	41.6	100.0	
Missing	System	128	58.4		
Total		219	100.0		

**Q7d\_R1 Having adequate resources**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	8	3.7	8.7	8.7
	2 No change	62	28.3	67.4	76.1
	3 Worse than before	22	10.0	23.9	100.0
	Total	92	42.0	100.0	
Missing	System	127	58.0		
Total		219	100.0		

**Q8\_R1 Participate in steering group or board**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	43	19.6	47.3	47.3
	2 No	48	21.9	52.7	100.0
	Total	91	41.6	100.0	
Missing	System	128	58.4		
Total		219	100.0		

**Q9a\_R1 Has overall care patients receive ...**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Got better	88	40.2	48.9	48.9
	2 Not changed	58	26.5	32.2	81.1
	3 Got worse	4	1.8	2.2	83.3
	4 Not sure	30	13.7	16.7	100.0
	Total	180	82.2	100.0	
Missing	System	39	17.8		
Total		219	100.0		

**Q9b\_R1 Seen improvements in care as result of pilot**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	63	28.8	35.4	35.4
	2 No	17	7.8	9.6	44.9
	3 Too early to tell	67	30.6	37.6	82.6
	4 Not sure	31	14.2	17.4	100.0
	Total	178	81.3	100.0	
Missing	System	41	18.7		
Total		219	100.0		

**Q10\_R1 Work in a team**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	155	70.8	85.6	85.6
	2 No	25	11.4	13.8	99.4
	9 2 or more ticked	1	.5	.6	100.0
	Total	181	82.6	100.0	
Missing	System	38	17.4		
Total		219	100.0		

**Q11a\_R1 Having clear team objectives**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	33	15.1	21.6	21.6
	2 No change	114	52.1	74.5	96.1
	3 Worse than before	6	2.7	3.9	100.0
	Total	153	69.9	100.0	
Missing	System	66	30.1		
Total		219	100.0		

**Q11b\_R1 Working closely with other team members**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	54	24.7	34.8	34.8
	2 No change	99	45.2	63.9	98.7
	3 Worse than before	2	.9	1.3	100.0
	Total	155	70.8	100.0	
Missing	System	64	29.2		
Total		219	100.0		

**Q11c\_R1 Meeting regularly to discuss how care can be improved**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	58	26.5	37.7	37.7
	2 No change	94	42.9	61.0	98.7
	3 Worse than before	2	.9	1.3	100.0
	Total	154	70.3	100.0	
Missing	System	65	29.7		
Total		219	100.0		

**Q11d\_R1 Having clear lines of accountability**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	20	9.1	13.2	13.2
	2 No change	125	57.1	82.2	95.4
	3 Worse than before	6	2.7	3.9	99.3
	9 2 or more ticked	1	.5	.7	100.0
	Total	152	69.4	100.0	
Missing	System	67	30.6		
Total		219	100.0		

**Q11e\_R1 Having new electronic communication systems**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Better than before	20	9.1	13.3	13.3
	2 No change	128	58.4	85.3	98.7
	3 Worse than before	2	.9	1.3	100.0
	Total	150	68.5	100.0	
Missing	System	69	31.5		
Total		219	100.0		

**Q12\_R1 Have face-to-face contact with patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes, frequently	113	51.6	62.1	62.1
	2 Yes, occasionally	25	11.4	13.7	75.8
	3 No	44	20.1	24.2	100.0
	Total	182	83.1	100.0	
Missing	System	37	16.9		
Total		219	100.0		

**Q13a\_R1 I am satisfied with the quality of care I give to patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	2	.9	1.4	1.4
	2 Disagree	3	1.4	2.1	3.5
	3 Neither	6	2.7	4.2	7.7
	4 Agree	73	33.3	51.4	59.2
	5 Strongly agree	49	22.4	34.5	93.7
	6 Not applicable	9	4.1	6.3	100.0
	Total	142	64.8	100.0	
Missing	System	77	35.2		
Total		219	100.0		

**Q13b\_R1 I feel my role makes a positive difference to patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	1	.5	.7	.7
	3 Neither	6	2.7	4.2	4.9
	4 Agree	74	33.8	52.1	57.0
	5 Strongly agree	59	26.9	41.5	98.6
	6 Not applicable	2	.9	1.4	100.0
	Total	142	64.8	100.0	
Missing	System	77	35.2		
Total		219	100.0		

**Q13c\_R1 I am able to do my job to a standard I am personally pleased with**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	3	1.4	2.1	2.1
	2 Disagree	7	3.2	4.9	7.0
	3 Neither	9	4.1	6.3	13.4
	4 Agree	83	37.9	58.5	71.8
	5 Strongly agree	38	17.4	26.8	98.6
	6 Not applicable	2	.9	1.4	100.0
	Total	142	64.8	100.0	
Missing	System	77	35.2		
Total		219	100.0		

**Q13d\_R1 I can manage all the conflicting demands on my time**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	9	4.1	6.3	6.3
	2 Disagree	31	14.2	21.8	28.2
	3 Neither	35	16.0	24.6	52.8
	4 Agree	51	23.3	35.9	88.7
	5 Strongly agree	13	5.9	9.2	97.9
	6 Not applicable	2	.9	1.4	99.3
	9 2 or more ticked	1	.5	.7	100.0
	Total	142	64.8	100.0	
Missing	System	77	35.2		
Total		219	100.0		

**Q14a\_R1 People providing care for my patients work well together**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	1	.5	.7	.7
	2 Disagree	15	6.8	10.6	11.3
	3 Neither	32	14.6	22.7	34.0
	4 Agree	74	33.8	52.5	86.5
	5 Strongly agree	13	5.9	9.2	95.7
	6 Not applicable	6	2.7	4.3	100.0
	Total	141	64.4	100.0	
Missing	System	78	35.6		
Total		219	100.0		

**Q14b\_R1 A seamless service is a good description for the care my patients receive**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	3	1.4	2.1	2.1
	2 Disagree	36	16.4	25.7	27.9
	3 Neither	50	22.8	35.7	63.6
	4 Agree	43	19.6	30.7	94.3
	5 Strongly agree	4	1.8	2.9	97.1
	6 Not applicable	4	1.8	2.9	100.0
	Total	140	63.9	100.0	
Missing	System	79	36.1		
Total		219	100.0		

**Q14c\_R1 There is good communication with other organisations providing care for my patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly disagree	2	.9	1.4	1.4
	2 Disagree	25	11.4	17.7	19.1
	3 Neither	47	21.5	33.3	52.5
	4 Agree	52	23.7	36.9	89.4
	5 Strongly agree	11	5.0	7.8	97.2
	6 Not applicable	4	1.8	2.8	100.0
	Total	141	64.4	100.0	
Missing	System	78	35.6		
Total		219	100.0		



**Q15a\_R1 Communicate with hospital doctors**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	10	4.6	7.1	7.1
	2 Rarely	19	8.7	13.6	20.7
	3 Occasionally	43	19.6	30.7	51.4
	4 Often	45	20.5	32.1	83.6
	5 Constantly	23	10.5	16.4	100.0
	Total	140	63.9	100.0	
Missing	System	79	36.1		
Total		219	100.0		

**Q15b\_R1 Communicate with GPs**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	2	.9	1.4	1.4
	2 Rarely	6	2.7	4.3	5.7
	3 Occasionally	17	7.8	12.1	17.7
	4 Often	54	24.7	38.3	56.0
	5 Constantly	62	28.3	44.0	100.0
	Total	141	64.4	100.0	
Missing	System	78	35.6		
Total		219	100.0		

**Q15c\_R1 Communicate with hospital nurses**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	14	6.4	10.1	10.1
	2 Rarely	20	9.1	14.4	24.5
	3 Occasionally	58	26.5	41.7	66.2
	4 Often	30	13.7	21.6	87.8
	5 Constantly	16	7.3	11.5	99.3
	9 2 or more ticked	1	.5	.7	100.0
	Total	139	63.5	100.0	
Missing	System	80	36.5		
Total		219	100.0		

**Q15d\_R1 Communicate with community nurses**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	6	2.7	4.3	4.3
	2 Rarely	9	4.1	6.5	10.8
	3 Occasionally	28	12.8	20.1	30.9
	4 Often	57	26.0	41.0	71.9
	5 Constantly	39	17.8	28.1	100.0
	Total	139	63.5	100.0	
Missing	System	80	36.5		
Total		219	100.0		

**Q15e\_R1 Communicate with pharmacists**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	7	3.2	5.1	5.1
	2 Rarely	23	10.5	16.8	21.9
	3 Occasionally	41	18.7	29.9	51.8
	4 Often	51	23.3	37.2	89.1
	5 Constantly	15	6.8	10.9	100.0
	Total	137	62.6	100.0	
Missing	System	82	37.4		
Total		219	100.0		

**Q15f\_R1 Communicate with NHS employed therapists**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	9	4.1	6.4	6.4
	2 Rarely	21	9.6	15.0	21.4
	3 Occasionally	43	19.6	30.7	52.1
	4 Often	41	18.7	29.3	81.4
	5 Constantly	26	11.9	18.6	100.0
	Total	140	63.9	100.0	
Missing	System	79	36.1		
Total		219	100.0		

**Q15g\_R1 Communicate with social care professionals**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	6	2.7	4.3	4.3
	2 Rarely	26	11.9	18.6	22.9
	3 Occasionally	47	21.5	33.6	56.4
	4 Often	38	17.4	27.1	83.6
	5 Constantly	23	10.5	16.4	100.0
	Total	140	63.9	100.0	
Missing	System	79	36.1		
Total		219	100.0		

**Q15h\_R1 Communicate with paid care workers**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	13	5.9	9.3	9.3
	2 Rarely	35	16.0	25.0	34.3
	3 Occasionally	47	21.5	33.6	67.9
	4 Often	33	15.1	23.6	91.4
	5 Constantly	12	5.5	8.6	100.0
	Total	140	63.9	100.0	
Missing	System	79	36.1		
Total		219	100.0		

**Q15i\_R1 Communicate with third or voluntary sector**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	14	6.4	10.1	10.1
	2 Rarely	42	19.2	30.2	40.3
	3 Occasionally	49	22.4	35.3	75.5
	4 Often	22	10.0	15.8	91.4
	5 Constantly	12	5.5	8.6	100.0
	Total	139	63.5	100.0	
Missing	System	80	36.5		
Total		219	100.0		

**Q15j\_R1 Communicate with administrators/managers**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Never	6	2.7	4.3	4.3
	2 Rarely	22	10.0	15.7	20.0
	3 Occasionally	30	13.7	21.4	41.4
	4 Often	47	21.5	33.6	75.0
	5 Constantly	35	16.0	25.0	100.0
	Total	140	63.9	100.0	
Missing	System	79	36.1		
Total		219	100.0		

**Q16\_R1 Manage staff**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	93	42.5	65.0	65.0
	2 No	50	22.8	35.0	100.0
	Total	143	65.3	100.0	
Missing	System	76	34.7		
Total		219	100.0		

**Q17\_R1 Age**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 16-30	10	4.6	5.5	5.5
	2 31-50	116	53.0	64.1	69.6
	3 51-65	54	24.7	29.8	99.4
	4 66+	1	.5	.6	100.0
	Total	181	82.6	100.0	
Missing	System	38	17.4		
Total		219	100.0		

**Q18\_R1 Occupational group**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Medical	59	26.9	32.6	32.6
	2 Nurse or midwife	28	12.8	15.5	48.1
	3 Community matron	10	4.6	5.5	53.6
	4 Community psychiatric nurse	2	.9	1.1	54.7
	5 Pharmacist	1	.5	.6	55.2
	6 NHS-employed therapist	4	1.8	2.2	57.5
	7 Social care professional	5	2.3	2.8	60.2
	8 Paid care worker	1	.5	.6	60.8
	9 NHS admin staff	19	8.7	10.5	71.3
	11 NHS general management	33	15.1	18.2	89.5
	12 Social service general management	4	1.8	2.2	91.7
	13 Third or voluntary sector	7	3.2	3.9	95.6
	14 Other	8	3.7	4.4	100.0
	Total	181	82.6	100.0	
Missing	System	38	17.4		
Total		219	100.0		

**Q19\_R1 How long in current job**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Less than 1 year	18	8.2	9.9	9.9
	2 1-2 years	31	14.2	17.1	27.1
	3 3-5 years	41	18.7	22.7	49.7
	4 6-10 years	29	13.2	16.0	65.7
	5 11-15 years	28	12.8	15.5	81.2
	6 More than 15 years	33	15.1	18.2	99.4
	9 2 or more ticked	1	.5	.6	100.0
	Total	181	82.6	100.0	
Missing	System	38	17.4		
Total		219	100.0		

**Q20\_R1 Gender**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 male	60	27.4	33.3	33.3
	2 Female	120	54.8	66.7	100.0
	Total	180	82.2	100.0	
Missing	System	39	17.8		
Total		219	100.0		

**Q21\_R1 Certain number of contracted hours**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes	140	63.9	78.2	78.2
	2 No	39	17.8	21.8	100.0
	Total	179	81.7	100.0	
Missing	System	40	18.3		
Total		219	100.0		

Q22\_R1 Number of hours

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	7.00	1	.5	.7	.7
	10.00	1	.5	.7	1.5
	12.00	1	.5	.7	2.2
	15.00	2	.9	1.5	3.7
	17.00	1	.5	.7	4.4
	18.00	2	.9	1.5	5.9
	20.00	1	.5	.7	6.6
	21.00	1	.5	.7	7.4
	23.00	1	.5	.7	8.1
	24.00	3	1.4	2.2	10.3
	25.00	3	1.4	2.2	12.5
	26.00	3	1.4	2.2	14.7
	27.00	3	1.4	2.2	16.9
	28.00	3	1.4	2.2	19.1
	30.00	8	3.7	5.9	25.0
	31.00	1	.5	.7	25.7
	31.50	1	.5	.7	26.5
	32.00	2	.9	1.5	27.9
	32.50	1	.5	.7	28.7
	33.00	1	.5	.7	29.4
	34.00	1	.5	.7	30.1
	35.00	1	.5	.7	30.9
	36.00	3	1.4	2.2	33.1
	37.00	43	19.6	31.6	64.7
	37.50	31	14.2	22.8	87.5
	38.00	3	1.4	2.2	89.7
	40.00	2	.9	1.5	91.2
	44.00	3	1.4	2.2	93.4
	47.00	1	.5	.7	94.1
	48.00	5	2.3	3.7	97.8
	50.00	1	.5	.7	98.5
	52.00	1	.5	.7	99.3
	56.00	1	.5	.7	100.0
	Total	136	62.1	100.0	
Missing	System	83	37.9		
Total		219	100.0		

**Q23\_R1 Pay range**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 £10,000 to £14,999	10	4.6	6.8	6.8
	2 £15,000 to £19,999	5	2.3	3.4	10.3
	3 £20,000 to £24,999	8	3.7	5.5	15.8
	4 £25,000 to £29,999	18	8.2	12.3	28.1
	5 £30,000 to £34,999	15	6.8	10.3	38.4
	6 £35,000 to £39,999	10	4.6	6.8	45.2
	7 £40,000 to £44,999	12	5.5	8.2	53.4
	8 £45,000 to £49,999	8	3.7	5.5	58.9
	9 £50,000 to £59,999	13	5.9	8.9	67.8
	10 £60,000 to £69,999	6	2.7	4.1	71.9
	11 £70,000 to £79,999	8	3.7	5.5	77.4
	12 £80,000 to £99,999	9	4.1	6.2	83.6
	13 More than £100,000	22	10.0	15.1	98.6
	99 2 or more ticked	2	.9	1.4	100.0
	Total	146	66.7	100.0	
Missing	System	73	33.3		
Total		219	100.0		

## STAFF QUESTIONNAIRE ANALYSIS ALL SITES

Results for staff population defined by presence in BOTH rounds of survey

results controlled for clustering at the level of site

\* the outcome of interest is always coded as 'one' (1)

\*\* cutoff point for significance is 0.05

N=350	Descriptives 1					Results (conditional logistics=McNemar's)									
	Round 1 (#)	Round 1 (prop.)	Round 2 (~)	Round 2 (prop.)	Difference (R2-R1)	Odds Ratio	SE	Z	P> z	Sign					
<b>Q3</b>	<b>This question is about how your job has changed since the ICP. Please indicate your level of agreement to each reason.</b>														
a	The depth of my job increased (eg through extending my skills) Agree+Strongly Agree					71	0.67	69	0.66	-0.01	0.833	0.4	-0.38	0.704	ns
b	The breadth of my job has been expanded (eg wider range of tasks) Agree+Strongly Agree					96	0.85	95	0.84	-0.01	0.875	0.387	-0.3	0.763	ns
c	I now delegate more responsibility to others Agree+Strongly Agree					28	0.28	38	0.38	0.1	2.25	0.88	2.07	0.039	S
d	I now have more responsibility delegated to me Agree+Strongly Agree					74	0.67	73	0.66	-0.01	0.928	0.323	-0.21	0.832	ns
<b>Q6</b>	<b>This question is about the effect of the ICP on the organisation yo work in (eg OCT, GP practice, local authority)</b>														
a	Support for training in my area of work Better than before ICP started					41	0.29	43	0.31	0.02	1.17	0.494	0.36	0.72	ns
b	Clarity of accountability structures in my work (eg I know what the lines of management are and who I report to) Better than before ICP started					31	0.23	31	0.23	0	1	0.194	0	1	ns
c	Communication between different parts of my organisation Better than before ICP started					66	0.48	80	0.58	0.1	1.875	0.738	1.6	0.11	ns
d	Communication with other organisations Better than before ICP started					91	0.66	94	0.68	0.02	1.176	0.434	0.44	0.66	ns
<b>Q7</b>	<b>How have these aspects of your job changed since the ICP started?</b>														
a	Having clear planned goals and objectives for my job Better than before ICP started					35	0.27	33	0.25	-0.02	0.875	0.429	-0.27	0.785	ns
b	Having an interesting job Better than before ICP started					63	0.48	60	0.45	-0.03	0.842	0.235	-0.61	0.539	ns
c	Developing my role Better than before ICP started					71	0.55	70	0.54	-0.01	0.941	0.501	-0.11	0.909	ns
d	Having adequate resources to do my job (eg skills, staff , IT, time) Better than before ICP started					28	0.22	21	0.16	-0.06	0.5	0.255	-1.36	0.175	ns
<b>Q9</b>	<b>These questions are about changes to the care your patients receive</b>														
a	In the last year, have the overall care your patient receive? Got better					143	0.51	159	0.57	0.06	1.432	0.471	1.09	0.275	ns
b-V1	Have you seen improvements in care as a result of the ICP? Yes (vs No+Too early to tell)					114	0.41	155	0.56	0.15	3.277	0.941	4.13	0	S
b-V2	Have you seen improvements in care as a result of the ICP? Yes (vs No)					107	0.69	111	0.71	0.02	1.36	0.619	0.68	0.495	ns

staff delegates more responsibility to others

greater proportion of staff report report improvements in care



These questions are about how working with your team has changed since the ICP started													
Q11	a	Having clear team objectives Better than before ICP started	73	0.33	66	0.3	-0.03	0.787	0.267	-0.7	0.483	ns	
	b	Working closely with other team members Better than before ICP started	98	0.45	100	0.45	0	1.058	0.238	0.25	0.8	ns	
	c	Meeting regularly to discuss how care can be improved Better than before ICP started	102	0.47	106	0.48	0.01	1.117	0.251	0.49	0.621	ns	
	d	Having clear lines of accountability Better than before ICP started	51	0.24	59	0.28	0.04	1.47	0.533	1.06	0.288	ns	
	e	Having new electronic communication systems Better than before ICP started	38	0.18	40	0.19	0.01	1.105	0.389	0.28	0.776	ns	
Q13	The next questions are about the contribution you personally make												
	a	I am satisfied with the quality of care I give to patients Strongly Agree	68	0.38	54	0.3	-0.08	0.621	0.154	-1.91	0.056	ns	
	b	I feel my role makes positive difference to patients Strongly Agree	87	0.46	79	0.42	-0.04	0.764	0.231	-0.89	0.375	ns	
	c	I am able to do my job to a standard I am personally pleased with Strongly Agree	55	0.29	48	0.25	-0.04	0.75	0.199	-1.08	0.279	ns	
	d	I can manage all the conflicting demands on my time at work Strongly Agree	23	0.12	17	0.099	-0.021	0.647	0.249	-1.13	0.259	ns	
Q14	The next questions are about how well the care for your patients is integrated												
	a	People providing care for my patients work well together Agree+Strongly Agree	121	0.68	137	0.77	0.09	1.888	0.557	2.16	0.031	S	people work better together
	b	A 'seamless' service is a good description for the care my patients receive Agree+Strongly Agree	68	0.38	75	0.42	0.04	1.269	0.252	1.2	0.23	ns	
	c	There is good communication with other organisations providing care for my patients Agree+Strongly Agree	87	0.48	100	0.55	0.07	1.54	0.479	1.39	0.164	ns	
Q15	How frequently do you communicate with people in the following groups? This could be about patients, or about services in general.												
	a	Hospital doctors Often+Constantly	85	0.45	89	0.47	0.02	1.2	0.391	0.56	0.576	ns	
	b	GPs Often+Constantly	151	0.8	154	0.82	0.02	1.25	0.487	0.57	0.567	ns	
	c	Hospital nurses Often+Constantly	61	0.32	67	0.35	0.03	1.46	0.496	1.12	0.264	ns	
	d	Community nurses (inc. Matrons and psychiatric nurses) Often+Constantly	131	0.71	132	0.71	0	1.055	0.316	0.18	0.857	ns	
	e	Pharmacists Often+Constantly	88	0.48	92	0.5	0.02	1.17	0.344	0.55	0.585	ns	
	f	NHS-employed therapists (inc. Physiotherapists, therapy assistants, health and well-being trainer) Often+Constantly	95	0.5	102	0.53	0.03	1.36	0.383	1.12	0.263	ns	
	g	Social Care Professionals Often+Constantly	88	0.46	93	0.49	0.03	1.33	0.455	0.84	0.400	ns	
	h	Paid care workers/care Often+Constantly	60	0.32	67	0.35	0.03	1.388	0.429	1.06	0.289	ns	
	i	Third or voluntary sector Often+Constantly	50	0.27	45	0.24	-0.03	0.737	0.259	-0.87	0.386	ns	
	j	Administrators/Managers Often+Constantly	120	0.63	113	0.59	-0.04	0.764	0.212	-0.96	0.338	ns	

Integrated Care Pilots evaluation: final report

## **Appendix I: Costs reported by sites**

Site	Programme grant from DH	Set up costs (Prior to first 12 months of operation)				Running costs (Labour, 12 months)				Running costs (Non-labour, 12 months)				Estimate of total added cost for 12 months
		Labour		Non-labour		New Staff		Existing Staff		Value of goods/services carried over		Other		(Set-up plus 12 months operation)
Bournemouth and Poole	£80,000	£14,124.75	Locality Manager - 5 months Business Manager - 4 months Dep. Dir. of Community Health Services - 5 months Info and performance analyst - 3 months	£63,095.00	Includes rent & service charge, refurbishments, insurance & rates, furniture & fittings, legal fees (solicitors) for lease agreement, recruitment and CRB checks	£301,752.62	Includes cost of two CPNs. Although they could not find them to recruit within first 12 mos., it was an intended cost.	£29,797.78	Locality Manager Business Manager Deputy Director of Community Health Services	£0	£61,996.65	Staff travel, in-house training, mobile/blackberry costs, leaflet drop (printing & stationery costs), uniforms, medical & surgical supplies, cleaning, electricity, gas, water, depreciation, capital interest, professional subscriptions	£470,767	
Cambridge	£92,000	£62,500.00	Project Management and clinical time, reimbursement of lead GPs for their time, bidding costs (clinical time, bid writing, financial support)	£4,700.00	IT costs	£3,844.00	Time spent on ICP activities varied from 10% to 80% over a given week	£21,629.83	Total labour cost given stands at £43,870pa, but most replaces previous activity by 100% so not included in calculations	£0	£960.00	Average travel cost per months is reported at £80 with a confidence level of 5; Range of costs: £864-£1,056	£93,634	
Church View	£160,000	£146,095.00	Data evaluation, management, backfill for meetings	£40,750.00	Includes: Renovations and refurbishments, recruitment of pilot lead, auditor fee for advice on annual account reporting for ICP, legal fees attached to pilot and contract	£18,922.00	Project manager cost only. ICP represents only part of PM's total work time.	£0.00	All previously existing staff time given to ICP noted to replace previous work by 100%, so not included in calculations. If included, labour comes to £85,372 for 12 months.	£0	£3,600.00	Staff travel, patient surveys and communications	£209,367	
Cumbria - Cockermouth	£180,000		Site feels it is impossible to quantify set-up costs - some staff probably gave time as overtime, some making time for it by working more efficiently.	£16,800.00	Room to bring staff together, IT equipment, training and off-workshops	£99,636.00		£0.00	If including primary/community care labour costs: £1,673,000 (but this "ICP" work is classed as replacing previous work so is not included here)	£0	£0	Nothing listed, again because nothing considered to have changed	£116,436	
Cumbria - Maryport			None provided in cost template or LDs	£1,000.00	IT equipment	£75,300.00	General Manager Admin manager Admin support	£0.00	If including primary/community care labour costs: £1,865,000 (but this "ICP" work is classed as replacing previous work so is not included here)	£0	£0	Same as above	£76,300	
Cumbria - 5 Lakes			None provided in cost template or LDs	£97,700.00	Refurbishment of working facilities to enhance joined up working, IT equipment, Training/information dissemination/ workshops/ collaborative meetings Integration of IT Systems	£135,000.00	Clinical Lead ICO Manager ICO Admin	£0.00	If including primary/community care labour: £7,119,722 (but this "ICP" work is classed as replacing previous work so is not included here, same as above)	£0	£0	Same as above	£232,700	
Durham Dales	£150,000		None provided in cost template or LDs	£3,500.00	Costs on one-time staffing-related expenses other than labour (£1,000pa) are reported at a level of confidence 1; Range of costs: £3,250-£3,750	£66,200.00	Programme Manager Support Officer PA/Administrator	£0.00	Existing labour costs of £251,300pa reported, but site unable to estimate ICP time substitution so 100% (zero added cost) is assumed; confidence varies from 3 to 7	£0	£2,640.00	Annual travel and training for new staff  Range of costs: £2,376-£2,904	£72,340	
Nene (Northamptonshire)	£147,000	£2,300.00	Sign-on fee for administrative staff member	£11,004.00	Deposit for new offices, furniture, IT equipment, sign-on fee for new post	£137,651.49	NICP Programme Director Health Information Manager Admin Support Officer	£915,006.38	Includes payments to GPs for participation and to PCT provider services for upgrading community matrons to do Advanced Nurse Practitioner work  Site notes some unpaid overtime for salaried staff	£0	£341,328.72	Staff travel, training (one-off management training cost), nursing supplies, one off cost - evaluation of PAC by external group.  Also, 12 months of Age Concern's "Little Help" program	£1,407,291	
Newquay	£100,000	£2,000.00	Recruitment of project manager	£6,363.00	Lap tops, printers, basic physical health check tools, recruitment costs, training, external meeting facilitation, PR support	£67,771.00	Time spent on ICP activities by a new support worker (£16,000pa) varies from 50% to 100% per week; the project manager is reported to work an average of 1.5 hours (unpaid) overtime per day	£201,578.00	As the time spent by GPs, General manager and Clinical lead completely substitutes for previous non-ICP activity, their costs are not included. The number reported here reflects the costs related to the remaining staff: Clinical Lead, admin support, team leader, nurses (including dementia liaison), healthcare assistants, OT, service improvement lead, adult social care manager, social worker, case co-ordinator	£0	£14,736.00	Travel, training, venue hire/ refreshments, stationary, telephone, GP incentives for patient assessments  Costs reported at a confidence level of 5 and below; mode of 5; Range of costs: £11,953-£17,519	£292,448	
Norfolk	£110,000	£0	None reported due to difficulty in separating set-up and implementation periods	£88,786.89	Meeting room. Room given in-kind, but value included in estimation.	£125,862.71	Programme Director (part time) Senior Project Manager Project Manager Project Officer Project Officer (part time)	£51,519.50	All previously existing staff time noted to be 100% replacing previous work, so not included in calculations, this number represents backfill payments to GPs for attending core group meetings.	£2,368.00	Meeting room rental for core groups (4 meetings per year, for multiple groups)	£12,798.00	Staff travel £500 Training £66.50 (Site notes this is a low figure in the first year due to staff taking advantage of courses offered for free, e.g. Health Intelligence for Commissioning, Excel.) Marketing and communications £500 (including stationary/usage of 'Integrating Care in Norfolk Logo)	£278,967

Site	Programme grant from DH	Set up costs (Prior to first 12 months of operation)				Running costs (Labour, 12 months)				Running costs (Non-labour, 12 months)				Estimate of total added cost for 12 months
		Labour		Non-labour		New Staff		Existing Staff		Value of goods/services carried over		Other		(Set-up plus 12 months operation)
Northumbria	£95,000		None provided in cost template or LDs	£396.00	Pulse Oximeter for community staff, site not confident on percentage ICP use of machine.	£17,873.00	Project manager	£38,900.00	Information Manager Lead GP Specialist Respiratory Nurse (backfill) Practice Nurse (backfill)	£0		£26,088.00	Staff travel, training, and literature printing, noted to vary by 100% per month	£83,257
North Cornwall	£100,000	£2,000.00	Recruitment of project manager	£47,236.95	IT, recruitment, accreditation of commissioned 3rd sector organisations and marketing analysis and capture of information for provider database	£56,972.00	Project manager	£0.00	All previously existing staff time noted to be 100% replacing previous work, so not included in calculations.	£0		£61,771.36	Travel for therapists and CPNs practices, mobile phone costs for therapists and CPN staff working out of practices, database and website maintenance, and reprinting of booklets	£167,980
North Tyneside	£100,000	£25,000.00	Living Document 3 says £40,000: "This is solely staff time. The design of the pathway, negotiation with numerous groups and PCT committees in connection with all parts of the pathway has been very time consuming and expensive."	£15,863.00	Range of costs: £14,277-£17,449  Portable ECG machine CNPAT Beat to Beat Blood Pressure Monitor	£19,150.00	Administrative assistant and healthcare assistant  Assumed 20 working days per month; cost for health care assistance reported at a confidence level of 5; Range of costs: £18,435-£19,865	£42,000.00	100% substitution of staff ICP time includes: Consultant falls & syncope specialist, Physiotherapist - falls trained  Costs provided here include: Backfill payment for clinicians involved in running of project (£20,000pa); and 40% of project manager time (£22,000pa)	£7,200.00		£39,360.00	Various intervention-specific payments to providers	£141,373
Principia	£130,000	Principia ICP reported costs totalling £1.12m for the first 12 months of operation. Of this, £980k was within existing budgets; £125k was in set up costs; and £55k was new investment in service delivery.												
Tameside and Glossop	£115,000	£26,334.00	0.3 WTE Band 8B (Project Manager) 0.5 WTE Band 8A (Evaluation Lead) 0.9 WTE Band 5 (Project Support Officer) 0.5 WTE Band 5 (Ass PH Analyst) estimate 10 months	£22,537.00	New buildings and equipment, Assessment form & record cards, pharmacy risk assessment & prescribing of statins, telephone consultation to mobile numbers Costs reported at confidence levels 3 and 5; Range of costs: £18,904-£26,171	£0		£0	Site states substitution of non-ICP by ICP hours is 100%; confidence in reported values varies from 5 to 7; costs reported are based on 20 working days a month. Costs are in the range: £128,100-£142,590 (average £135,345).	£0		£5,844.00	Staff travel, training, "CLAHRC engagement in integrated care pilot" Costs reported at confidence levels varying from 3 to 7; Range of costs: £5,360-£6,328	£54,715
Torbay	£156,000	£15,000.00	GP locum fees	£0		£54,000.00	Programme Manager	£172,200.00	Total added labour costs of two staff members £22,200pa (Range: £19,980-£24,440), plus 150,000 to commission sessions for Care of the Elderly Consultants to carry out some sessions specifically out in the community, to run a Mon-Fri 09:00-17:00 hotline between GPs and consultants and also to extend Rapid Assessment Clinics from 3 days a week to 5 days a week.	£0		£0		£241,200
Tower Hamlets	£150,000		Labour costs given for first 12 months include both set up and ongoing maintenance of the initiative (because of later start date, previous 12 months included much evolving 'set-up')	£1,491,000.00	Costs included items such as recruitment, organisational development (assessment to assess GP network strengths and challenges, and a programme to support network through changes), legal advisors, evaluation, and a contingency for any further consultant fees as needed.	£1,184,700.00	Costs include CRG and Program backfill costs (£5,000pa) and Network development costs (£896,700pa)	£860,800.00	This includes £821,800 of participation payments to wave 1 GP practices for provision of diabetes care package.	£0		£0		£3,536,500
Wakefield	£79,000	£30,000.00	This cost covers six months of labour time for steering and sub-group meetings in order to develop metrics for the Balance Score Cards.  However, unable to completely disentangle set-up from recurring labour costs as integrated substance misuse team existed before the ICO and intervention objectives/activities are constantly evolving.	£25,773.00	IT: Shared servers and SharePoint development	£167,880.00	Interim Project Manager Information Consultant IT Consultant	£19,814.00	Total labour costs of £162,513pa reported but all existing staff time devoted to ICP assumed to be a 100% replacement of previous work (still to check with site), so not included in calculation. Unpaid overtime of 10% and 20% is reported for the clinical director of substance misuse and project manager, respectively.	£10,990.00	some staffing/IT	£11,500.00	staff travel and communications	£254,967