A before and after study of integrated training sessions for children's health and care services

ABSTRACT

Recent UK policy drivers such as the National Collaboration for Integrated Care and Support and Making Every Contact Count prioritise integrated care, an approach that seeks to provide more coordinated and seamless health and social care. In children's services, despite many partners, there are challenges around integrating care. A deprived borough of London ran short training and networking sessions for services supporting children and young people. This study examined whether intersectoral training would improve participants' knowledge of local services and joint working (including communication, navigation and confidence in collaboration). As part of a service evaluation, the study utilised a pre-post Likert scale survey design for each training session, a one month follow up survey, and telephone interviews with a sub sample of participants. The educational intervention was three sets of 1.5 hour educational workshops from December 2016 to February 2017. There were 302 attendances from 202 individuals from the health (n=99), education (n=145), social care (n=39) and voluntary (n=19) sectors. The pre- and post-surveys found significant increases in self-assessed knowledge of health/education/social care/voluntary services and in some elements of joint working. However, these increases were not sustained in any domain after one month of follow up. There was also no difference in self-assessments amongst those who attended three sessions compared to those who attended one or two. Telephone interviewees highlighted networking as being helpful and suggested that informative tasks and diverse attendance would be beneficial in future. To conclude, this study suggests that although short learning sessions may seem to improve immediate knowledge and some elements of joint working in the short term, any gains are not sustained in the long term. The cost effectiveness of such schemes is in doubt but may be improved by a more targeted delivery of content.

Key words: education, networking, community, children, young people

What is known about this topic

- Many existing studies have evaluated integrated learning schemes, mainly with a focus on the health sector

- These studies have found that such schemes can be beneficial for knowledge or team working
- Cochrane systematic reviews have recommended that further evidence is necessary to determine to what extent efficacy can be generalised

What this paper adds

- This educational training programme was not effective in improving participants' knowledge of local services or joint working after one month of follow up
- Attendees found the opportunity to network was helpful, and recommended improvements included more information on services and a greater diversity of attendance

INTRODUCTION

Integrated care is defined by the World Health Organisation as "a concept bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion."(Grone & Garcia-Barbero, 2001) Integration has recently been prioritised in United Kingdom (UK) national health policy - for example, the National Collaboration for Integrated Care and Support was established in 2013 to promote integration across health and other sectors. The collaboration defined integration as "the means to the end of achieving high quality, compassionate care resulting in better health and wellbeing and a better experience for patients and service users, their carers and families."(Department of Health, 2013) Similarly, the Making Every Contact Count initiative seeks to standardise learning and training of health care professionals such that families receive harmonious messages (Speller & Dewhurst, 2015).

These drives have occurred because it is perceived that integration produces better outcomes in certain domains, and some studies have found this to be the case (Bernabei et al., 1998; Janse, Huijsman, de Kuyper, & Fabbricotti, 2014; Titova, Steinshamn, Indredavik, & Henriksen, 2015). A review of systematic reviews concluded that integrated care programmes for the chronically ill seem to improve quality of patient care (Ouwens & Wollersheim, 2005). Although most integrated care projects focus on care for the elderly, many of whom have high health and social care needs, integration has also been recommended to improve children's services (Wolfe, 2016). In children's services a litany of organisations may be involved across the health, social care, education and voluntary sectors, and integrated care could be beneficial by decreasing the amount families have to repeat themselves, increasing efficiency, and encouraging coherent planning. However, little research has been undertaken firstly about the efficacy of integration across the variety of services working with children and young people, and secondly about ways in which to encourage integration in practice.

There are various methods whereby integration can be promoted, such as through formal integrated care pathways, new care models, and interdisciplinary approaches (Campbell, Hotchkiss, Bradshaw, & Porteous, 1998; Janse et al., 2014; Moore et al., 2017). One type of intervention is interprofessional education (IPE), whereby

practitioners from different services meet and are educated together, and ideally would form connections for future collaboration, with increased knowledge about the roles performed by other services. A 2013 Cochrane review of IPE reviewed 15 studies which compared the effectiveness of IPE versus no intervention (Reeves, Perrier, Goldman, Freeth, & Zwarenstein, 2013). They found that, of the 15 studies, seven studies reported positive outcomes from IPE, four mixed, and four no effect. The authors commented that due to the largely heterogeneous approach taken by most studies, it is difficult to underpin elements that make an IPE intervention successful or not. It should be noted that this review is now five years old and does not cover more recent research in the field.

In 2016, the London borough of Newham tested an IPE intervention which aimed to support integrated working amongst services for children. Newham is one of the most ethnically diverse and economically challenged boroughs in the UK (Centre on Dynamics of Ethnicity, 2013). The programme aimed to provide integrated training across the health, education, social care and voluntary sectors for professionals working for children and young people's services. The programme was based on the principle that learning together might engender integrated practice, and thus integrated care. The programme was facilitated by the Early Help Partnership, an organisation that advises schools on statutory responsibilities regarding safeguarding and providing early support to children and families (Newham London, 2014). Whilst research has examined integrated learning within health, especially medical education (Briffa & Porter, 2013; Fatchett & Taylor, 2013), few studies have looked at the impact across multiple sectors, such as health, education, voluntary and social care sectors together. This approach was undertaken as it was hoped this would maximise impact by covering all services working to care for an individual child, rather than a select few solely within health.

The aim of this service evaluation study was therefore to assess the efficacy of an intersectoral educational intervention across children's services for:

- improving participants' knowledge of local services
- improving participants' joint working (including communication, navigation and confidence in collaboration).

METHODS

The intervention

The programme included three training workshops, with each workshop being delivered in four different localities within Newham to make a total of 12 training events. The first set of training workshops occurred in December 2016, the next set in January 2017 and the final set in February 2017.

Each of the three workshops covered a different aspect of early help, communication, resources and building capacity. Early help is defined as "the principle of providing at an early point, support to children, young people and families to maximise their life and prevent more complex problems emerging further down the line."(Newham London, 2014) The sessions involved a mixture of activities including group discussions, presentations and team bonding tasks. Participants were placed on tables with representatives from different sectors. Session facilitators were mostly Early Help Partnership staff with some additional facilitators from local children's organisations. The third workshop included speakers from Children and Adolescent Mental Health Services (CAMHS) and Health Visiting. The Health Visiting service provides community-based nurses for health checks and health promotion services either at local centres or through home visits to children aged 0-5 years.

Practitioners from 22 separate organisations or services, spread across the health, education, social care and voluntary sectors were invited to attend by the Early Help practitioners. These organisations were selected as they were identified as being locally significant by the Early Help practitioners and involved in multidisciplinary work within children's services. There were no exclusion criteria for attendees and any practitioner from the respective organisations could attend. Participants could attend the whole series of workshops (all three in their locality) if desired, or only one or two sessions.

Data collection

The two core outcomes of interest were whether the workshops a) improved self-reported knowledge about local services, b) affected joint working between services.

The evaluation utilised mixed (quantitative and qualitative) methods. The quantitative data comprised of surveys completed before and after each workshop. All attendees were invited to complete a survey before each session and another survey after each session. They were informed as to the purpose of the survey and that by completing the survey they were giving consent for their responses to be used in the service evaluation and study, and no separate formal consent was gained. The surveys were a 10-question Likert scale with questions designed in line with the objectives for the workshops. Question responses were on a scale of 1-4, with 1 indicating Strongly Disagree and 4 indicating Strongly Agree. Questionnaires were anonymised in order to encourage candidness. All attendees were emailed an anonymous follow-up survey after one month containing the same 10 Likert scale questions. The survey was devised by the authors and revised in order to ensure a neutral wording focused on the objectives. The same version was then used throughout the evaluation process.

To collect qualitative feedback, 30 attendees, 10 from each session, completed a structured telephone interview, with questions devised by the authors, lasting approximately 15 minutes. A sample of 30 is a standard number used when planning for saturation across a small sample (Guest, Bunce, & Johnson, 2006; Morse, 2000). Approximately two weeks after each session, attendees were numbered and then a random number generator was used to invite individuals to participate by email until the acceptance rate reached 10 after each session. Participants were informed by email of the purpose of the interview, and confirmed consent by responding to schedule an interview. Questions were standardised and the topics matched the aims of the workshop, for example '*Did you learn more about local pathways and services from the workshop*'? Full questions are available on request. Responses were recorded, transcribed and then coded by a researcher independent of the scheme, using the constant comparative method to derive common themes using a grounded theory approach. The grounded theory approach was chosen because the aim was not to test a pre-existing theory, but to deductively identify themes arising from the words of the participants themselves (Foley & Timonen, 2015). The interviews were conducted in order to identify elements of the programme that participants felt were most efficacious as well as possible barriers to implementation of learning from the workshops and/or retention of knowledge.

The study was undertaken in the context of routine service evaluation, and was conducted in accordance with Health Research Authority guidance. In the UK, a 'service evaluation' is an evaluation of the processes and/or impacts of a service or programme. Under the rules of the National Health Service (NHS) Research Ethics process, these evaluations do not require formal research ethics approval. The Health Research Authority decision tool was used to confirm that Research Ethical Committee approval was not required (Health Research Authority, 2017). The study did not seek patients' views or utilise individually attributable data.

Data analysis

Analysis of quantitative data used Mann Whitney U as questionnaires were anonymised and non-normally distributed. All analyses were conducted using IBM SPSS Version 24. Mann Whitney U tests were conducted to assess the significance of any changes in agreement for each statement across all participants a) when comparing pre- and post-session surveys; b) when comparing at one month follow up to final session pre-session scores; c) when comparing those who attended all three sessions versus one or two sessions. The Bonferroni correction was completed to correct for multiple testing, and the level of significance was thus set at the 98.3% level of confidence. Normal distribution of data was assessed using Shapiro-Wilk. The change in percentage figures presented were adjusted given that 1 was the minimum possible score.

RESULTS

Participant characteristics

Practitioners from 22 separate organisations or services, spread across the health, education, social care and voluntary sectors, attended the training sessions. Practitioner organisations included general practice, health visiting, school health (5-19), community nursing, paediatric services, CAMHS, HeadStart (a preventative Mental Health and resilience project), Family Nurse Partnership (a voluntary home visiting programme for first time young mums, aged 19 years or under), local schools, Best Start in Life staff, Families First (Troubled Families agenda), Early Help Partnership, Children's Social Care, 0-25 Special Educational Needs and Disabilities (SEND), voluntary sector organisations, Safer Schools policing, youth offending service, and community nursing neighbourhood teams. Fig. 1 graphically illustrates

the number of training places filled by each organisation, with each label being proportional to number of training places. Health Visiting were the most represented group, with n=61 training places; this compares to n=20 from Families First.

In total, there were 202 unique attendees across the three workshops; 126 of these (62%) attended just one session, 52 (26%) attended two and 24 (12%) attended three. This meant a total of 302 training places were filled. Within this total, 145 places (48%) were taken by the education sector, 99 (33%) by the health sector, 39 (13%) by social care/local authority professionals and 19 (6%) by the voluntary sector. The cost for the whole scheme was £29,998.50 in 2017 for a cost of £71.08 per training place filled and £107.51 per unique participant.

The pre- and post-questionnaires were collected and collated from all three workshops, with a total of 254 pre-questionnaires completed (84% response rate across 302 attendances) and 220 post-questionnaires (73% response rate). The one month follow-up questionnaire was completed by 65 people (32% response rate).

For the phone interviews, a total of 84 invitations were sent to achieve the target sample, a response rate of 36%. Other than the 30 participants, three individuals declined to participate and the remainder did not respond. Of the 30 participants, 17 were from the Education sector, five from the Health sector, six from the Social Care sector, and two from the voluntary sector.

Impact on knowledge of local services

The pre- and post-questionnaire scores shown in Table 1 and Fig. 2 suggest that attending the workshops resulted in significant increases, in the short term, in mean self-assessed knowledge of health (+13.3%), social care (+9.0), and voluntary services (+11.0%). There was also a significant increase in self-assessed knowledge of other professionals' roles (+13.3%). For each of these, the p-value was $p<0.001$. After the Bonferroni correction for multiple testing, there was no significant increase in mean self-assessed knowledge of education services. There was no significant difference in self-assessed knowledge when comparing those who attended one or two workshops with those who attended all three, as shown in Table 1.

However, one month later, there was no significant difference relative to the scores before the final session. This suggests that the immediate change in knowledge was not sustained one month later.

Some telephone interviewees were positive about the impact of the workshops on their knowledge. Three quarters said that they had learned more about local pathways and services from the workshops (77%), and the remainder said they had not.

A Safeguarding lead said: "*Definitely about local pathways – it's been quite a grey area for us, the referral system and exactly how to do it, and that was clarified a lot more through the training*." A Voluntary sector worker said: "*It was good to hear about the pathways and how you can move a client through the system (…) it's given me a better picture in terms of who to refer to.*" A Social Worker said: "*Yes, moreso how the services work, especially with health and the school nurses – what we can and can't ask them to do."*

Some who did not respond positively highlighted that the workshops did not cover new material. A Family Support Worker said: "*I think I knew most of them that existed anyway (…) I've attended so many previous workshops so I already knew a lot of stuff that was delivered at the workshop.*" A Special Educational Needs Coordinator said: "*No not really, because I've been attending different courses already."*

Impact on joint working (communication, navigating local services, and confidence in collaboration)

Impact on navigating local services

There was a significant increase between the pre- and post-questionnaire scores in participants who agreed that they knew how patients/clients can access most other relevant services in Newham (+14.7%, $p<0.001$). However, one month later, there was no significant difference relative to the scores before the final session. This suggests that the impact of the workshops in this domain was not sustained over time. There was no significant difference in this domain amongst those who attended one or two sessions compared to those who attended three sessions.

There was no significant difference in pre- and post-test scores regarding whether participants were confident in calling or talking to someone from another service when they had a question about a patient or client. Likewise there was no significant difference after one month of follow-up, or between attendees who attended a greater or lesser number of sessions.

Impact on communication

There was no significant difference in perceived inter-service communication after workshops (see Table 2 and Figure 3). At one month follow-up, participants were not more likely to say they had worked closely with other services to help patients/clients or had met with professionals from other services in the last three and six months respectively. There was no difference in average follow-up scores between participants who attended all three sessions and those who attended one or two.

In telephone interviews, about half of participants said that their communication with other professionals in the locality changed since attending the workshop (47%), with some mentioning they had improved contacts. An Education Welfare Officer said: "*I found it useful sitting on a table with someone from Families First who I had emailed and not met, so when an issue came up for that service I had a very good contact, and it made the whole process much smoother*."

Conversely, a Families First practitioner said: "*I already have quite a good professional network – my communication techniques haven't changed."* A Learning

Mentor said: *"One of the things with integrated services – it's good in principle, but like we discovered in the workshop, not everyone buys into the same system. If there's one central database you can access all the information on, but another 10 schools have bought into a different system, they're not connected."*

Impact on confidence in collaboration

There was a significant increase between the pre- and post-questionnaire scores in participants who agreed that health, social care and education services in Newham work well together (+12.7%, $p<0.001$). However, there was no longer a significant difference after one month of follow-up. There was no significant difference in trends amongst those who had attended one or two compared to three sessions.

Potential impact on practice

When asked whether they had done anything differently since attending the workshops, 40% of telephone interviewees said yes and 47% said no. A Family Support Worker said: "*I've broadened my contacts, so I've been able to liaise with different sectors - for example I didn't have a linked health visitor before and I managed to get one.*" Other examples of changes to practice reported after attending workshops included using contacts gained during workshops, use of an Early Help Record tool, improved awareness of resources, more appropriate use of resources, and providing information to colleagues who had not attended. A Service Delivery Manager said: "*I've spoken about it to my manager and other colleagues about how we can work together*." Conversely, an Education Welfare Officer said: "*Not particularly, because we were kind of working in that framework anyway*." A Families First Practitioner said: "*Nothing different, it just cemented a few things*."

About two fifths of telephone interviewees thought that the things they had learned at workshops had impacted on people using services or helped them provide better services (37%). One fifth did not think this was the case (20%) and the rest were uncertain. A child psychologist said: "*Not as yet, it may have an impact indirectly due to networking so there's greater access and greater understanding of our services*."

Learning points

When asked what was the most helpful part of the workshop, 70% of participants said networking; 30% said knowledge of other organisations, and 17% said learning about new developments in the area. A Sports Development Officer said: "*The networking part was very good – an opportunity to understand what everyone else does in their industry, we didn't really work previously with mental health or understand what social care does.*" A Family Support Worker said: "*Sharing good practice with the rest of the people in the group*."

When asked what could have improved the workshop, 16% asked for more information on services; 11% asked for greater Social Care input; 11% asked for exemplar referral plans. Other themes raised by a minority included housing guidance, a greater diversity of attendees, dissemination of contact details, and more new information. A Voluntary Sector worker said: "*I think if we had the opportunity to have a slot where each individual service could give a brief overview of what they deliver, referral pathways, contact details, that would have been really helpful*." A Families First practitioner said: "*I feel that it would have been helpful to have someone from social services at the meeting because they are the bit at the middle where everyone goes to*." A Sports Development Officer said: "*There was not enough time to network – it was like, rush rush rush, everything was quite quick*."

DISCUSSION

Main findings of this study

This study found that a short series of workshops produced short-term increases in self-reported knowledge of local services and some elements of joint working, but this impact was not sustained after one month of follow up. Those who attended three workshops were no more likely to have increases in self-reported knowledge or joint working than those who attended one or two.

The implication of this study is that short workshops of this type are not sufficient to create a sustained change to knowledge or practice. Feedback from the 30 telephone interviews suggested that workshops helped participants learn more about local pathways and services and that professionals particularly valued the opportunity for

networking with colleagues across sectors, and offered some suggestions for elements that were more helpful than others.

What is already known on this topic

There is already a breadth of evidence investigating the value of integrated learning schemes, although such evidence has mainly focused on the health sector (Fraser, Symonds, & Cullen, 2005; Zanotti, Sartor, & Canova, 2015). Such schemes are rarely intersectoral in addition to being interprofessional.

Regarding the impact on professional practice, individual studies have concluded that such schemes can be beneficial for practitioner knowledge or team-working (J. C. Campbell et al., 2001; Morey et al., 2002). However, a Cochrane systematic review concluded that further evidence is necessary about the generalisability of the benefits of such schemes (Reeves et al., 2013).

In the context of the increased drive towards integrated care, an Integrated Care Pioneers Programme was established in 2013, with first results from pilot programmes reported in 2014 (NHS England, 2015a). It was reported that many pioneer programmes found that integration of care resulted in improved patient satisfaction. Other studies have reported that integrated care results in improved patient satisfaction, but this was not formally assessed in this study (Mastellos et al., 2014; Siegel, Stößel, & Wilhelm, 2016).

What this study adds

This study is notable due to its multisectoral nature, encompassing not only the health sector but also the education, social care and voluntary sectors. New care models are increasingly encouraging community-centred models that see the voluntary and community sectors as key partners in care (NHS England, 2015b). However, despite the broad and inclusive model of the programme, this study found that the workshops did not produce any sustained benefits.

There has been an increased strategic drive for integrated care in health (Department of Health, 2013). Monitor has a role in enabling integrated care following the reforms of the Health and Social Care Act 2012 (Monitor, 2015). Many commissioned

schemes aiming to promote integration involve formal changes such as joint assessments, joint services or budget pooling, rather than exploring integration that may arise organically as a result of collaboration (National Audit Office, 2017). Our study feeds into this policy debate by suggesting that this sort of short workshop series does not help professionals to connect and integrate in the longer term.

Additionally, it can be expensive to bring people together in such a way. The workshops in this study cost £108 per unique participant. Questions could be raised about whether this is a cost-effective use of resources given the lack of long term benefit detected by this study. This is an important consideration for others running intersectoral or multiprofessional events, as without proper planning and follow-up the events may not have a lasting impact on practice. The opportunity cost of the event for participants' individual organisations should also be a financial consideration. Schemes of this sort may frequently be approved without strong evidence as to their efficacy, given the complexity and expense that comes with evaluating them (Walsh, Reeves, & Maloney, 2014).

There is learning from this study about ways to increase the impact of future schemes. Future schemes that prioritise particular elements, such as individual service presentations and more time for networking, may produce greater benefits and be more cost-effective, given that these are elements that were reported by interviewees to be valued and useful to a greater degree. It may also be advisable to advertise content in advance so training places are not wasted on those who are already familiar with the content. Additionally, future schemes may benefit from more diverse attendance, as raised in the phone interviews, as in this programme there was lower proportional representation from the social care and voluntary sectors. Participants fed back that greater social care involvement would have been useful.

Limitations of this study

There are a number of limitations to this study. A key limitation is that the Likert questionnaires relied on participants' self-assessments, rather than any objective measure, and so may be unrepresentative of the actual impact of the scheme. The study is also liable to attrition bias, firstly due to attendees who did not complete pre- and/or post-questionnaires, and also the one month follow-up survey. The high

proportion of non-responders to invitations to a phone interview, and the disproportionate representation of the Education sector in this group, mean that these responses may be subject to bias. Follow-up did not extend beyond one month after the completion of the final workshop. We sought to combat these limitations through triangulation and mixed methods, but we recognise generalisability may be affected. Another limitation comes from the choice of the Mann Whitney U test for assessment of statistical significance, a test that is useful for ordinal data, such as a Likert scale, and for non-normal data, which was confirmed in our data using Shapiro Wilk. It normally assumes independence between groups, which was not the case in this study due to the pre-post design, but as participants completed questionnaires anonymously, it was not possible to match them. There was no control or comparator group. Finally, this study also did not assess any impact of the scheme on service users, which ought to be a long-term aim of such schemes.

Conclusion

Within the context of the increased drive for integrated care, it seems theoretically worthwhile to bring professionals from different sectors together to network and learn together. However, we found that short integrated workshops alone were ineffective in leading to improvements in knowledge and joint working, although they were well received and served a networking function. They may thus act as a first step in informing ways to build capacity for integrated training and interprofessional practice.

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Tables and Figures

Statement	Mean (Pre)	Mean (Post)	Change (%)	Mann Whitney U	Mean (1 or 2 Sessions)	Mean (3 Sessions)	Change (%)	95% Confidence Interval	Mean (Session 3 Pre)	Mean (One Month Follow Up)	Change (%)	95% Confidence Interval
I know a lot about health services in Newham	2.63	3.03	+0.40 (13.3%)	**p<0.001**	2.71	2.83	+0.12 (4.0%)	p=0.397	2.84	2.75	-0.09 (-3.0%)	p=0.212
I know a lot about education services in Newham	2.84	3.02	+0.18 (6.0%)	p=0.018	2.95	3.30	+0.35 (11.7%)	p=0.078	2.95	3.08	+0.13 (4.3%)	p=0.120
I know a lot about social care services in Newham	2.70	2.97	+0.27 (9.0%)	**p<0.001**	2.80	2.91	+0.11 (3.7%)	p=0.582	2.83	2.84	+0.01 (0.03%)	p=0.900
I know a lot about voluntary services in Newham	2.29	2.62	+0.33 (11.0%)	**p<0.001**	2.27	2.65	+0.38 (12.7%)	p=0.055	2.31	2.41	-0.09 (-3.0%)	p=0.130
I know what professionals in other services do	2.61	3.01	+0.40 (13.3%)	**p<0.001**	2.80	3.17	+0.37 (12.3%)	p=0.035	2.80	2.94	-0.09 (-3.0%)	p=0.047

Table 1

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Statement	Mean (Pre)	Mean (Post)	Change (%)	Mann Whitney U	Mean (1 or 2 Sessions)	Mean (3 Sessions)	Change (%)	Mann Whitney U	Mean (Session 3 Pre)	Mean at One Month Follow Up	Change (%)	Mann Whitney U
I am confident in calling or talking to someone from another service when I have a question about a patient or client	3.27	3.37	+0.10 (3.3%)	p=0.187	3.40	3.65	+0.25 (8.3%)	p=0.191	3.42	3.49	+0.07 (2.3%)	p=0.282
I know how patients/clients can access most other relevant services in Newham	2.65	3.08	+0.44 (14.7%)	**p<0.001**	2.88	3.09	+0.21 (7.0%)	p=0.289	2.88	2.95	+0.07 (2.3%)	p=0.291
In the last three months I have worked closely with other services to help patients/clients	3.09	3.22	+0.13 (4.3%)	p=0.122	3.32	3.59	+0.27 (9.0%)	p=0.208	3.32	3.41	+0.09 (3.0%)	p=0.192
In the last six months I have met with professionals from other services	3.25	3.29	+0.04 (1.3%)	p=0.887	3.41	3.68	+0.27 (9.0%)	p=0.136	3.37	3.51	+0.14 (4.7%)	p=0.105
I think the health, social care and education services in Newham work well together	2.55	2.93	+0.38 (12.7%)	**p<0.001**	2.63	2.68	+0.06 (2.0%)	p=0.584	2.65	2.65	0.00 (0.0%)	p=0.969

590 Table 2

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