Open Agenda

Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee

Wednesday 6 March 2013
7.00 pm
Ground Floor Meeting Room G02B - 160 Tooley Street, London SE1 2QH

Membership

Councillor Mark Williams (Chair)
Councillor David Noakes (Vice-Chair)
Councillor Denise Capstick
Councillor Norma Gibbes
Councillor Rebecca Lury
Councillor Eliza Mann
Councillor The Right Revd Emmanuel Oyewole

Reserves

Councillor Sunil Chopra
Councillor Neil Coyle
Councillor Rowenna Davis
Councillor Paul Kyriacou
Councillor Jonathan Mitchell

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Contact
Julie Timbrell on 020 7525 0514 or email: julie.timbrell@southwark.gov.uk
Webpage:

Members of the committee are summoned to attend this meeting
Eleanor Kelly
Chief Executive
Date: 26 February 2013

Southwark Council

Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee

Wednesday 6 March 2013
7.00 pm
Ground Floor Meeting Room G02B - 160 Tooley Street, London SE1 2QH

Order of Business

Item No.	Title	Page No.
	PART A - OPEN BUSINESS	
1.	**APOLOGIES**	
2.	**NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT** In special circumstances, an item of business may be added to an agenda within five clear working days of the meeting.	
3.	**DISCLOSURE OF INTERESTS AND DISPENSATIONS** Members to declare any interests and dispensations in respect of any item of business to be considered at this meeting.	
4.	**MINUTES**	
5.	**PERSONALISATION, SAFEGUARDING AND THE ASSOCIATED RISKS - REPORT**	
6.	**ANNUAL ADULT SAFEGUARDING REPORT AND INTERVIEW WITH THE INDEPENDENT CHAIR**	
7.	**MENTAL HEALTH OLDER ADULTS AND DEMENTIA - UPDATE**	1 - 42

SlaM's Mental Health Older Adults and Dementia - Clinical Academic Group (MHOAD) have provided the attached papers in response to the committees request for an update. The resolutions of the committee meeting of 18th September 2012 were as follows:

- The Equality Impact Assessment will be developed.
- An additional analysis of spare capacity will be provided.
- Supplementary information will be provided on the service offered to homeless older people with mental health needs.
- Additional information will be provided on the rise in acutely unwell people.
- An explanation will be provided for the lower number of users from both Southwark and Lambeth, compared with Croydon and Lewisham, and why there is a lower proportion of Southwark BME service users compared with Lambeth and Lewisham.
- Data and patient journey vignettes will be provided on medication levels used by the Home Treatment Team.

8. REVIEW : KING'S HEALTH PARTNER MERGER 43 - 104

Attached is a review of King's Health Partners' proposals for closer integration and merger by The King's Fund.

9. WORK-PLAN

DISCUSSION OF ANY OTHER OPEN ITEMS AS NOTIFIED AT THE START OF THE MEETING.

PART B - CLOSED BUSINESS

DISCUSSION OF ANY CLOSED ITEMS AS NOTIFIED AT THE START OF THE MEETING AND ACCEPTED BY THE CHAIR AS URGENT.

Date: 26 February 2013

Agenda Item 7

MHOA &D (CAG)

Cha Power
Deputy Director

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Monday 25th February 2013

Councillor Mark Williams
c/o Members Room
160 Tooley Street
London
SE1 2QH

Dear Councillor Williams

Re: Home Treatment Team and update for the Overview and Scrutiny Committee

As requested in the July meeting I attach an update on the Home Treatment Team outlining progress so far. Included are the statistics relating to numbers assessed by HTT as well as details on the number of people assessed across Southwark and Lambeth with ethnic and gender breakdown and details on the clinical outcomes.

The service is progressing satisfactorily.

Lewisham Commissioners have requested that SLAM expand the service to cover Lewisham from April 2013. There will be a formal evaluation of this process in September 2013 and I will ensure you get a copy of this.

The Reference group has not yet been able to identify a service user willing to come to an open council meeting but service user feedback is part of the overall evaluation. I include a number of vignettes to illustrate who the team is working with and the interventions offered. In both of these cases the most likely outcome would have been admission to an acute psychiatric bed if the team had not been able to offer a Home Treatment service

You requested how the increase in acutely unwell people would be managed. There has been no significant increase in referrals to community or inpatients services with the introduction of Home Treatment in either Lambeth or Southwark. The equivalent bed days activity of Home treatment would be measured as 8 beds in Southwark and 6 beds in Lambeth. This has so far managed our need for acute inpatient care. We have five available beds at

Chelsham House at the Bethlem Royal Hospital but to date we have not needed to use these.

There was a query on what the service would offer homeless older people with mental health problems. The Start Team is a multi-disciplinary team made up of social workers, nurses and psychiatrists that work with homeless people within the Borough outreaching to day centres and homeless hostels. They cover all age groups. They liaise with older adults where appropriate if a person requires admission or is known to Mental Health of Older Adults service.

In addition, in response to the concern regarding support to homeless older adults, the number of older adults that are homeless is very small. They are therefore more likely to be admitted after assessment as currently Home Treatment do not have access to alternative accommodation such as a hostel to place them in.

In addition, we have noted that there is a lower number of patients admitted from both Southwark and Lambeth compared to Croydon and Lewisham. On investigation it is clear that the reason for the level of admissions of Croydon residents is due to the fact that the elderly population of Croydon is larger than for Southwark, Lambeth and Lewisham and when this is adjusted there is no significant difference. Lewisham however, does have a similar over 65 population to Lambeth and Southwark and therefore the number of admission from this borough is higher. The reasons for this is being investigated but it is a factor that has persuaded Lewisham NHS Commissioners to invest in this model in this borough commencing in 2014/15.

In relation to access to the service by the local BME population we have identified that the Borough of Lambeth had marginally higher Caribbean and Asian numbers comparing both inpatient groups. This is an area we will continue to monitor but it should be noted that the numbers are of admissions from these groups are small.

I have forwarded a copy of the updated action plan in the Equality Impact Assessment which provides an update on progress to date

If you have any further queries please do not hesitate to contact me.

Yours sincerely

Cha Power
Deputy Director
Mental Health of Older Adults & Dementia
Clinical Academic Group

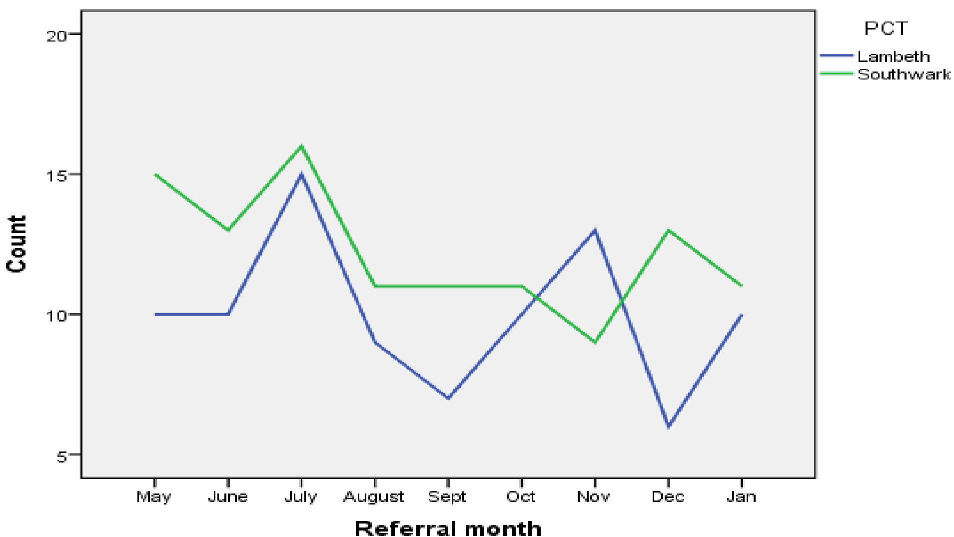
MHOAD Home treatment team pilot: progress report 3

1st May 2012 – 31st January 2013

1) Referrals/assessments

A total of 200 referrals were made to the team over this time period: 90 for Lambeth residents and 110 for Southwark residents. The figure below shows number of referrals by month: a mean of 10 for Lambeth residents and 12 for Southwark residents. Of these referrals, 103 were accepted for home treatment.

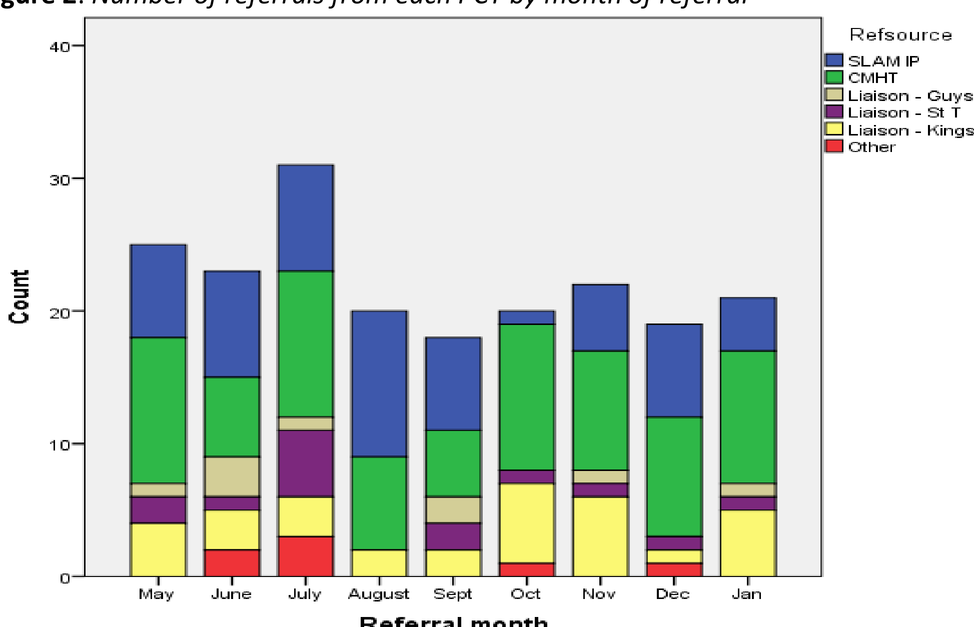
Figure 1: *Number of referrals from each PCT by month of referral*



2) Sources and nature (crisis versus facilitated early discharge) of referral

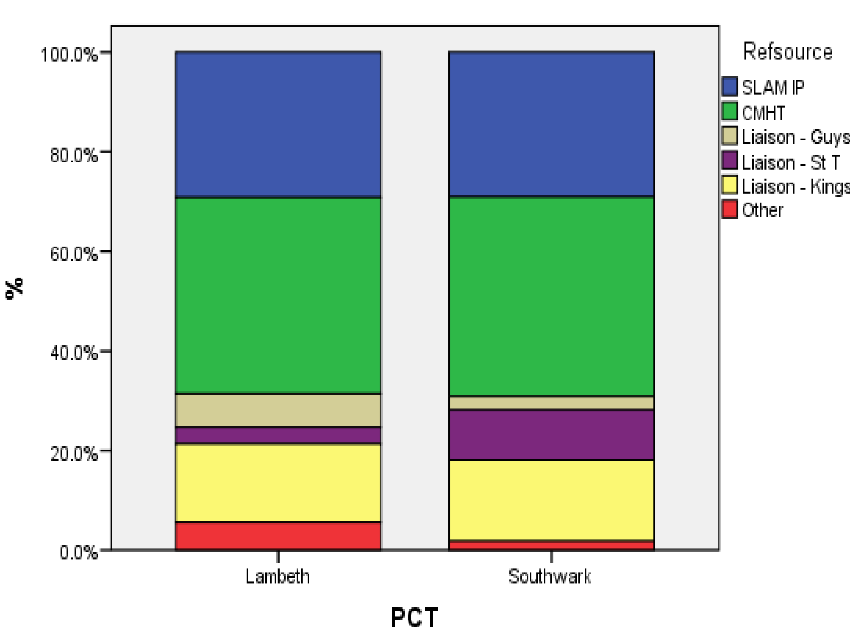
Data in figure 2 shows relatively fewer referrals from SLAM inpatient services and more from liaison in more recent months. This is considered a measure of a greater role for the home treatment team in gatekeeping referrals.

Figure 2: *Number of referrals from each PCT by month of referral*



Referral source by PCT is shown in the figure that follows. For reference, the category 'other' includes for example, referrals for service users who are resident within SLAM boroughs but in mental health beds outside of the trust.

Figure3: *Referral source by PCT*



Referrals from liaison services represent 28% (n=52) of referrals to home treatment. An analysis of these referrals showed that of these referrals 17 (33%) were new presentations (not known to MHOAD/SLAM mental health services) assessed by home treatment, demonstrating the value of this is team in gatekeeping for older adult inpatient and community services.

Nature of referral

The majority of referrals over this time period have been defined as crisis referrals: 72%. This did not differ statistically by borough (71% versus 73%, Lambeth and Southwark respectively).

Table 6: *Nature of referral to home treatment team by month of referral*

Nature of referral		Referral month									Total
		May	June	July	August	Sept	Oct	Nov	Dec	Jan	
	Crisis	18	18	24	9	11	18	18	11	17	144
	FED	7	5	7	11	7	3	4	8	4	56
Total		25	23	31	20	18	21	22	19	21	200

3) Characteristics of service users referred to home treatment

Home treatment team referrals have been for older adult service users across the age range but of note is the representation of referrals for the oldest age category. Figure 4 shows a breakdown of referrals by ethnicity in line with borough profiles.

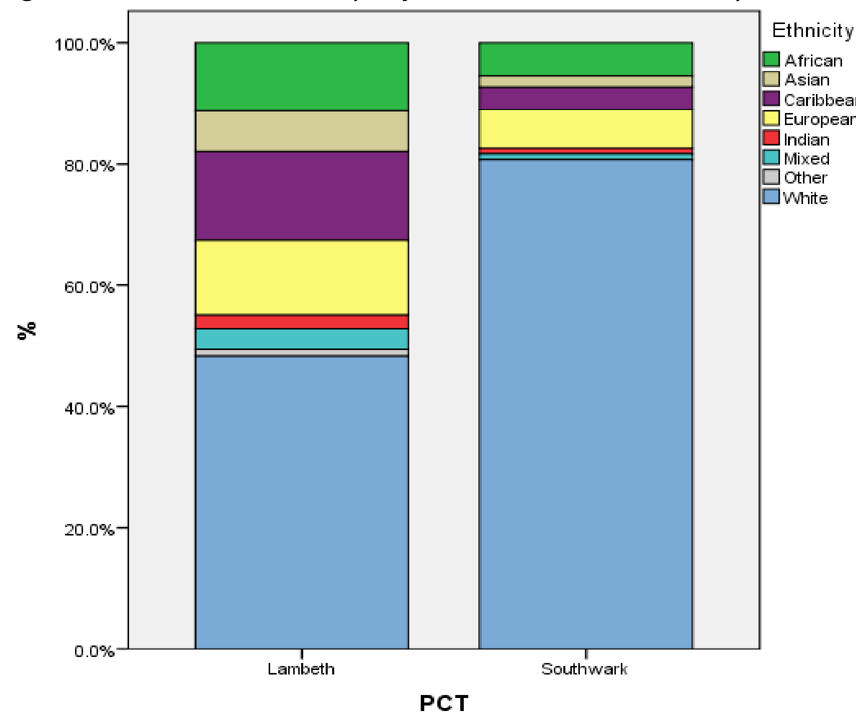
Table 1: Age group

		Frequency	Percent
Years	**60-69**	44	22.0
	70-79	105	52.5
	80-89	46	23
	90/+	5	2.5
	Total	200	100.0

Table 2: Gender

		Frequency	Percent
	Female	111	55.5
	Male	89	44.5
	Total	200	100.0

Figure 4: *Service user ethnicity: referrals to home treatment by PCT*



4) Diagnosis (SLAM) of referrals to home treatment

The majority of referrals for home treatment were for service users whose mental health difficulties were diagnosed as non-psychotic.

Table 3: *Referrals to HT by diagnostic grouping*

Diagnostic group		Frequency	Percent	Valid Percent
	Non-psychotic[1]	79	39.5	39.9
	Psychotic	56	28	28.3
	Organic	40	20	20.2
	Personality[2]	9	4.5	4.5
	Alc/drugs	8	4	4
	Physical	1	.5	.5
	Z code	4	2	2
	Learning diffs	1	.5	.5
	Total	198	99.0	100.0
	Missing	2	1.0	
Total		200	100.0	

[1] This number includes x8 with a diagnosis of bipolar affective disorder
[2] This number includes x4 referrals for each of two service users

5) Service users accepted for home treatment

Table 4 shows the numbers of referrals accepted for home treatment by referral month along with the outcomes of those referrals not taken on for home treatment.

Table 4: *Number of referrals accepted and destination of rejected referrals by month of referral*

Assessment outcome		Referral month									Total
		May	June	July	August	Sept	Oct	Nov	Dec	Jan	
	0 Accepted	16	10	17	11	11	8	10	6	10	103
	1 CMHT	2	3	5	4	1	2	5	5	2	29
	2 ward	5	9	9	5	5	8	6	2	6	55
	3 social care	0	1	0	0	0	2	0	1	0	4
	4 acute	1	0	0	0	0	0	1	0	0	2
	5 adult MH	0	0	0	0	1	1	0	1	1	4
	6 other	0	0	0	0	0	0	0	2	0	2
Total		24	23	31	20	18	21	22	19	21	199[1]

[1] Missing data for one episode (outcome)

More referrals for home treatment were rejected on the grounds of excessive risk or severity of symptomatology (too severe) than for any other reason shown in table 5. This is reflected in the higher numbers of rejected referrals remaining on or being admitted to a ward (Table 4). The category of 'not assessed' includes for example, telephone calls made to the team to discuss referral where it was clear referral was not appropriate.

Table 5: *Reasons for the rejected referrals by month of referral*

Reason not accepted	Referral month									Total
	May	June	July	August	Sept	Oct	Nov	Dec	Jan	
0 too severe	**3**	**8**	**8**	**4**	**4**	**8**	**4**	**3**	**6**	**48**
1 not in crisis	**2**	**2**	**2**	**4**	**0**	**1**	**3**	**1**	**0**	**15**
2 social	**0**	**2**	**3**	**0**	**0**	**2**	**0**	**1**	**0**	**8**
3 S/U refused	**2**	**1**	**1**	**1**	**1**	**0**	**2**	**2**	**1**	**11**
4 not assessed	**2**	**0**	**0**	**0**	**2**	**1**	**1**	**4**	**0**	**10**
5 out of area	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**	**2**
Total	**9**	**13**	**14**	**9**	**7**	**12**	**11**	**11**	**8**	**94**[1]

[1] Missing data for three episodes

- Borough of residence was not statistically associated with acceptance of home treatment with 57% (n=51) of Lambeth residences accepted for treatment and 47% (n =52) of Southwark residents accepted.

- There is a statistically significant difference between acceptance for home treatment and diagnosis of an organic disorder such that, whilst 57% of those with a functional mental health diagnosis were accepted for home treatment, this was the case for 33% of those with an organic diagnosis ($\chi^2(1)$ 7.7 p =.006).

- Although a higher percentage of FEDs were accepted for home treatment (61% n =34) versus crisis referrals (48% n = 69) this difference did not reach statistical significance.

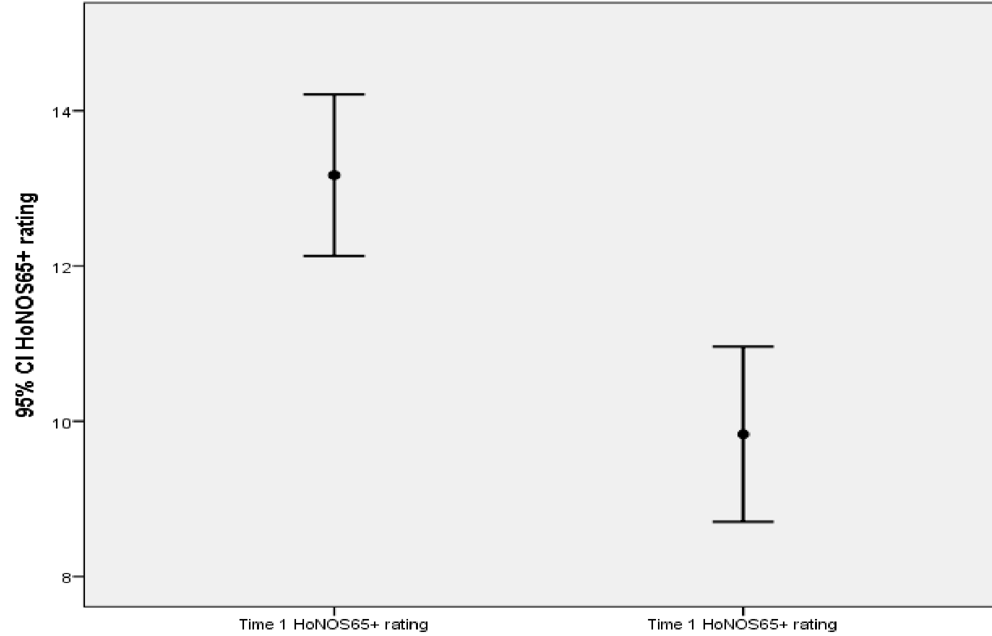
6) Duration of treatment and clinical outcome

The mean length of episode was 20 days (SD=12) the modal (most frequent duration) is 13 days.

HoNOS65+ ratings are available for 69% of all referrals made and assessed during this time period. The mean rating at assessment is 13.7 (SD=5.1) which is line with severity expected for service users of inpatient and thus home treatment care (see at http://wdst.amhocn.org/ for benchmarked data).

Paired HoNOS65+ ratings are available for 81% (n=83) of those who were accepted for and received home treatment intervention. The graph below shows the ratings for these service users at assessment and at discharge.

Figure 5: *Mean HoNOS65+ ratings at assessment and discharge*



An analysis using a paired sample t-test showed a statistically significant mean improvement from start to finish of home treatment episode of care (t = 5.28(82), p = .000).

Data prepared and analysed by Dr Alice Mills (Clinical Psychologist, Outcomes Lead MHOAD)

alice.mills@slam.nhs.uk

(18.02.13)

Equality Impact Assessment Guidance

What is an Equality Impact Assessment?
An equality impact assessment (EIA) is a systematic way of analysing a policy, function or proposed service change / development to check its potential or actual impact on equality of treatment or outcomes. The EIA process is in two parts; an initial screening and a full assessment. The screening should start as soon as planning is under way, as this will inform and strengthen your planning.

Why carry out Equality Impact Assessments?
EIAs are a method for individuals and teams to use to think about the likely impact of their work and to make sure that, as far as possible, any negative outcomes for disadvantaged groups are eliminated or minimised and that opportunities for promoting equality are maximised. It is a process that will help to identify groups who may be receiving differential treatment or outcomes that are discriminatory or unfair.

The Equality Act 2010 requires public authorities such as SLaM to have due regard [which means an adequate evidence base for decision making] to the need to:

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

These three aims apply to the following 'protected characteristics:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion / belief
- Sex
- Sexual orientation
- Marriage and civil partnership [but only in regards to the first aim – eliminating discrimination and harassment]

SLaM is legally required to conduct analysis of the effects on equality of new or revised policies or service changes/developments. To conduct this analysis policy reviewers/authors and leads for service change/developments should conduct an Equality Impact Assessments to show this has been taken into consideration in all decisions, policies and practices. 'Policies and practices' covers all proposed and current activities which the authority carries out.

An initial screening is carried out to decide if any part of the policy or service change/development is likely to have an impact on equality for any group or groups; that is to identify where differential treatment or outcomes that are discriminatory or unfair may exist. Where it is likely that the proposed policy or service change/development may have a

negative impact it is important to remove or minimise as far as possible any disadvantages suffered by people due to their protected characteristics and to take steps to meet the needs of people from protected groups (often referred to as protected characteristics) where these are different to the needs of other people.

Where required to implement a decision over which the Trust has no control an equality impact assessment should still be conducted, and where there is a likely impact to consider mitigating measures or alternative ways of doing things to minimise the impact and to meet our legal requirements as outlined in the public sector duty.

What equality groups need to be considered?
The EIA process should cover the following areas:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion / belief
- Sex
- Sexual orientation
- Marriage and civil partnership [but only in regards to the first aim – eliminating discrimination and harassment]

THE PROCESS:
When should an EIA be carried out?
The process of conducting an equality impact assessment should not be an after-thought, but part of the 'day to day' work, and the initial screening used as early as possible in:

- the development of new policies and procedures
- the review of current policies
- the development of a business case
- the planning stage of all new services changes/developments/projects

The full EIA assessment should be conducted for:

- All policies, functions and service developments where an adverse or negative impact on equality group(s) has been identified during the initial screening process.

Who should conduct the EIA?
It is important that the process is conducted by those working and planning the policy, function or service change/development. They will have expertise in that particular area as well as a thorough understanding of the main aim, objectives and intended outcomes.

Part 1 – the initial screening
The initial screening prompts, through a series of questions, an assessment of negative impact or gaps in knowledge about likely impact. It should be a relatively short process which uses a range of information, such as:

- personal knowledge and experience
- relevant research and reports
- previous consultation results
- analysis of complaints, comments, surveys or audits
- demographic data and other statistics including census results
- Trust equality monitoring data
- specialist advice (internal and external)

The information collected during the initial screening should be analysed to decide whether the policy, function or service change/development could potentially affect different groups of people/protected characteristics, and whether any of these differences are likely to result in a negative impact. As well as a negative impact, the screening process may highlight a neutral impact, a positive impact or a differential impact (where the impact on one or more protected characteristic may be greater than for another).

Neutral impact
There may well be some policies that are assessed as having no specific impact or relevance to equalities. This will become evident during the initial screening process and, where there is a neutral impact, the full assessment is not required although it is important to always set out the evidence for this decision.

Positive impact
The assessment may show a positive impact for one or more protected characteristics, or an improvement in relationships between people who share protected characteristics. This impact may be differential, where the impact on one group is greater than for another group.

Negative impact
A negative impact is where the way the policy, function or service change/development is implemented or provided may, often unintentionally, result in inequalities or discrimination being experienced. This disadvantage may also be *differential*, where the negative impact on one protected characteristic is likely to be greater than for another.

The process and findings of a screening need to be recorded, even when it highlights that a positive or neutral impact is likely.

Part 2 – the full impact assessment
If the initial screening shows that a negative impact seems likely a full assessment should be conducted to establish the extent of the impact and to make recommendations aimed at minimising any negative differential in outcomes.

As with the screening stage it is important to be clear of the aims, objectives and specific outcomes you hope to achieve from the proposed policy, function or service development.

Using the evidence
Which of the protected characteristics is likely to be affected? Consider the evidence, what does the data show? Is quantitative and qualitative information available in-house and externally from relevant community groups or networks? Is there strong evidence, some evidence with considerable gaps or is it anecdotal? Does the information need to be supplemented through new consultation exercises to fill the gaps?

Consultation and involvement
Internal and external consultation is an important and on-going part of the process. Identify and consult people from relevant groups who are likely to be affected, tailoring the methods used to best reach the various groups, e.g. using existing networks, consultation meetings, focus groups, reference groups and survey questionnaires. Local SLaM diversity groups will also be a helpful resource (CAG Equality Leads[1] will be able to provide details on these groups and also on local service user networks). Externally, identify relevant stakeholders who are interested in promoting equality from individuals to community groups.

[1] Each clinical academic group has at least one Service Equality Lead. If you are not sure who this person is, contact kay.harwood@slam.nhs.uk or phone 020 3228 2157 for guidance.

Remember to circulate results of any consultation and feed them back into your planning and decision making processes.

Assessing the evidence
This involves making a reasonable judgment on the evidence you have drawn together as to whether there is likely to be a negative impact on some protected characteristics. It may be that the evidence indicates both positive and negative impact is likely for some, and if this is the case you will need to balance these when making a decision about the likely overall effect of implementing the policy, function or service development.

The following questions may be useful when assessing the likely impact:

- Do you need to make changes in response to concerns raised by interested groups and relevant stakeholders, or issues raised during any consultation that has been conducted for the assessment process?

- Is there is potential for the policy, function or service change/development to be directly or indirectly discriminatory? If there is, you should find another way to meet the aims. If it is indirectly discriminatory and there is no alternative way can you justify the decision to proceed as it is?

- If the policy, function or service change/development is not directly or indirectly discriminatory is there still potential for some groups to experience a negative impact on equality of opportunity or good community relations? If a negative impact is likely can it be justified because of the overall objectives of the policy, function or service change/development, or can it be adapted so that it compensates for any adverse effects?

- Could other measures be taken to reduce or remove the negative impact without affecting the overall aim of the policy, function or service change/development?

- Will any changes to the policy, function or service development be significant and will you need to consult about them?

What should be published?
Results of all EIAs should be published. Even if the screening process shows that there is no negative impact, this should be published so that groups and individuals can see how this conclusion was reached and enable them to respond if they feel it is inaccurate. This is another reason why it is important to support your decisions with appropriate evidence. In order that is clear why a particular service development or policy has been assessed as having a neutral; positive or negative impact. Decisions on any changes made as a result of the assessment should also be noted.

Remember to feed back results to everyone who has contributed to the assessment and ensure that the information is available to all interested parties.

Where the full assessment is very detailed a summary of the assessment may be published, however, the complete documentation should be made available to anyone who requests it. Your CAG Equality Lead or Kay Harwood will provide advice on this, and they will also arrange for the assessments to be placed on the Trust website.

External verification

Once completed, EIA's relating to service developments may require external verification. Your CAG Equality Lead in consultation with the CAG Service Director/CAG Executive will advise if the process you have used is sufficient, or if external scrutiny of the assessment should take place, via a relevant group or groups, such as a local Partnership Board or Overview and Scrutiny Committee. If external scrutiny is required the CAG Service Director/Equality Lead will make the necessary arrangements.

Further advice

If you have any questions when working through the assessment contact your CAG Equality Lead or Kay Harwood by emailing: kay.harwood@slam.nhs.uk or phone: 020 3228 2157

EQUALITY IMPACT ASSESSMENT
PART 1 – INITIAL SCREENING

SLaM wants to ensure that we provide accessible and equitable services that meet the needs of our diverse community and to meet the first principle of the NHS constitution – to provide comprehensive services available to all, paying particular attention to marginalised groups who are not keeping pace with the rest of society.

Under the Equality Act 2010 we are all protected from less favourable treatment or discrimination based on age; disability; pregnancy and maternity; gender reassignment; race; religion / belief; sex; sexual orientation; marriage and civil partnership [but only in regards to the first aim – eliminating discrimination and harassment]. As an organisation we are legally obliged to consciously think about equality as part of the decision making process in the design, delivery and evaluation of our services and policy development/review. This is why we ask you to begin / conduct the EIA at the planning stage and in a group, using the screening tool as a prompt to the necessary conversations about the impact of your work on equality. (See guidance for further information)

1. Name of the policy / function / service development being assessed?

Establishment of a Home Treatment Team as part of the Mental Health for Older Adults and Dementia (MHOAD CAG)

2. Name of **Lead** person responsible for carrying out the assessment? (where there is a service change, this should be the individual with responsibility for implementing the change) *[The EIA should, wherever possible, be completed and considered in a group]*

Lead: David Norman/Cha Power

Others involved:

Staff in the Mental Health of Older Adults Service including nurses, psychiatrists, psychologists and researcher; users and carers; Local Authority representatives from LB Lambeth and Southwark, voluntary sector organisations and NHS Commissioners from Lambeth and Southwark.

This EIA draws on the views of staff, service users, carers and those who work with older people in Lambeth and Southwark.3. Describe the main aim, objective and intended outcomes of the service change?

Aim
SLAM is seeking to *redesign* services in order to avoid unnecessary admissions to hospital based services. The primary motivation in doing so is the need to provide more appropriate, effective, efficient and patient centred 'crisis' care.
There is significant evidence (see elsewhere in this assessment) to suggest that
1) the majority of patients would prefer to be supported and 'treated' in their own home;
2) prolonged periods spent in hospital can have a detrimental impact on an individual's ability to recover from a 'crisis'.

Objective –
These proposals will enable the MHOAD to better meet the needs of those who experience 'crisis' incidents, provide quicker, more effective interventions within the home. It is important to underline that reference to 'home' include all relevant types of residence, including an individual's house or flat, or sheltered accommodation.
The basic proposal is for MHOAD develop a new Home Treatment Team (HTT) to provide early interventions for people experiencing or at risk of 'crisis' in their own homes. As a result of reduced admissions over time there may be a reduction in bed numbers.

The Lambeth and Southwark Older Adults Home Treatment Team will provide comprehensive and accessible crisis resolution and home-based care and treatment to people in the acute phase of mental illness which, in the absence of the team, would result in admission to hospital. It will be a multidisciplinary service offering crisis assessment , home treatment and onward referral for the residents of Lambeth and Southwark.

The team will:

- Gatekeep all Lambeth and Southwark admissions to the MHOA&D CAG inpatient beds.
- Oversee the allocation of the MHOA&D CAG inpatient beds.
- Offer an assessment service for residents of Lambeth and Southwark who, immediately prior to the team's involvement; have been assessed as requiring admission to hospital.
- Provide intensive home-based treatment to patients in the acute phase of mental illness, thus diminishing the need for hospital admission.
- Facilitate early discharge from hospital
- Secure appropriate follow-up care for the patient once the alleviation of the acute phase of mental illness has occurred.
- Be fully integrated into the Lambeth and Southwark mental health systems and the community as a whole.

Principles of the Service

The team will:

- Provide a safe and effective home based alternative to hospital admission for residents of the area defined as Lambeth and Southwark.
- Provide rapid assessment and intensive planned care 7 days a week.
- Oversee the allocation of inpatient beds for the MHOA&D CAG. All patients living in Lambeth and Southwark who are deemed to require more intensive input will be assessed by the HTT prior to any allocation of an inpatient bed. All patients living in Lewisham and Croydon will not be assessed by the HTT.

- Act as gatekeeper to all Lambeth and Southwark MHOA & D beds by ensuring that each patient referred for inpatient care receives a comprehensive assessment before a final decision is reached as to eventual treatment location.

- Facilitate early discharge for inpatients and providing high intensity support in the community.

- Work co-operatively and collaboratively with patients, their families and carers, primarily in their place of residence, and encourage them to take an active part in the decision-making process regarding the care they receive.

- Recognise the pivotal role of family and carers and aim to provide them with or signpost them to the relevant support.

- Acknowledge the importance of a patient's current and potential support system which can include the community as a whole as well as voluntary and statutory agencies. The team will engage and work within the patient's support system when conducting assessments, providing ongoing care and when planning a patient's discharge and aftercare from the service.

- Recognise that Lambeth and Southwark have a richly diverse population. The Team's aim will be to provide care that is constantly sensitive and appropriate to the patients' circumstances, gender, ethnicity, language and culture. Patients will be assisted in accessing specific services relevant to themselves and their individual needs.

- Remain relevant to both patients of the service and the Lambeth and Southwark mental health system for older adults as a whole. For this reason, the team will encourage ongoing dialogue and feedback with individuals and organisations which will assist in shaping the team's operation and activity.

4 (a). What evidence do you have and how has this been collected? *[Please list the main sources of data, research and other sources of evidence reviewed to determine the impact on the equality groups, sometimes referred to as protected characteristics. Your data can include demographic data, access data, national research, surveys, reports; focus groups; information from your service?]*

Evidence suggests that SLAM currently provides a greater number of hospital beds per head of the local population(s) as compared with the national average and has higher admission rates than other similar urban areas, including other London boroughs (see main assessment). There is also emerging internal evidence which suggests that patients experience longer stays on existing SLAM wards that those in other similar units. The proposed service development of Home Treatment Team as part of the wider Mental Health of Older Adults and Dementia Clinical Academic Group, (MHOAD) is an attempt to redress a historical over reliance upon in-hospital services. This will achieved by developing and delivering improved home based interventions, including during periods outside current service hours.

We have used data relating to local population, service use and service evaluations from both the Trust and other MH units. This data covers a number of the equality protected grounds, however there are gaps in terms of current data collection (for example in relation to disability) and these are addressed in the action plan which accompanies this EIA.

4 (b). Is there reason to believe that the policy / function / service development could have a negative impact on a group or groups?

YES

Which equality groups may be disadvantaged / experience negative impact? *[please base your answers on available evidence which can include for example key themes from the general feedback you receive via patient experience data (such as patient surveys; PEDIC); carer experience; complaints; PALS; comments; audits; specialist information - your personal knowledge and experience]*

Age	YES
Disability	YES
Gender reassignment	YES
Pregnancy and maternity	NO
Race	YES
Religion / Belief	Yes
Sex	YES
Sexual orientation	YES
Marriage and civil partnership	YES

Others [that your service / policy is specifically aimed at (e.g. refugees, behavioural difficulties)
Group NO

5. Have you explained your policy / function / service development to people who might be affected by it? *(Please let us know who you have spoken to and the results of these conversations and what actions/ developments/ changes have come out of them)*

Yes

If 'yes' please give details of who you involved and what happened as a result.

- Staff consultation - Staff consultations were held in February 2012. Staff were given the opportunity to be seconded into the Home Treatment Team for the duration of the pilot.
- User consultation – The "Being Involved" Group – which is effectively our current Service user and Carer Advisory Group in MHOAD CAG, received three presentations on the proposals to develop the Home Treatment Service – they gave constructive and useful feedback which shaped the development of the service. This group is made up of service users, carers and ex-carers. Many ex-carers expressed the view that they would have welcomed the existence of a HTT when they were caring for their loved ones.

The start of the pilot in June 2012 will see managers increasingly consulting with local agencies, discussing ways in which the service can be delivered and improved. A Service user and carer participation group has been established which will also guide the development of the pilot in the coming months.

- Carers consultation - Carers groups supported by the Alzheimers Society were consulted on the development of the Home Treatment Service. The proposal received a positive response. The CAG has Advisory Groups in each of the four boroughs it serves. Notification of the development of the Home Treatment Team was brought to both Southwark and Lambeth meetings. Both have asked to be kept informed. Feedback from these meetings informed the development of the pilot.

6. If the policy / function / service development positively promotes equality please explain how?
The proposals will lead to the provision of enhanced 'out of hours' services, which will effectively ensure that older people can access the same levels of service currently available to working age adults.
Community Mental Health Teams currently operate Monday to Friday (office hours). The new service would represent a significant extension of provision, with the Home Treatment Team (HTT) operating seven day a week, 365 days a year between the hours of 9am and 8pm. This means that the proportion of the week during which the HTT can provide 'crisis' care will be significantly increased. The following EIA includes proposed measures to enable MHOAD to cover the remaining periods (outside HTT's operating hours).

Disability – Our service users include people with dementia, learning disability, physical disability/health issues. Our service will support them by treating them in their own home, thus preventing hospital admission, unless the crisis cannot be treated at home. The emphasis in the work of the HTT will be to keep people in their lives, and in their communities as far as possible.
Age – this change brings services for older people into line with those for people in other age ranges.
Ethnicity – opportunity to ensure services are culturally appropriate and responsive to the needs of services users from different ethnic groups. The HTT will liaise with local BME groups to ensure they know about their service and can receive referrals – links will also be established with the BME volunteer programme in SLAM to seek support from BME volunteers to support people – such as accompanying people to lunch clubs, or church.

7. From the screening process do you consider the policy / function / service development will have a positive or negative impact on equality groups? Please rate the level of impact and summarise the reason for your decision.

Positive:	High (highly likely to promote equality of opportunity and good relations)	Medium (moderately likely to promote equality of opportunity and good relations)	Low (unlikely to promote equality of opportunity and good relations)
Negative:	High	Medium	Low

(highly likely to have a negative impact) (moderately likely to have a negative impact) (probably will not have a negative impact)

Neutral: High (highly likely)

Reason for your decision: The nature of the services which are provided means that this development is clearly relevant to the equality duty. It is important therefore to ensure that the service development does not lead to any unintended consequences for particular groups and communities and that these service changes are properly assessed so that we can identify any potential problems at the earliest possible stage and put in place measures to remove any potential discriminatory or inequality of access and outcome.

Date completed: 22nd February 2013

Signed ………………………………………. Print name …………………………………..

If the screening process has shown potential for a high negative impact you will need to carry out a full equality impact assessment

Given that there is the potential for this policy to affect different groups differentially, it has been decided that the policy would benefit from a full equality impact assessment. This will enable us to identify gaps in current approach/systems and identify additional support for particular groups and communities. This will ultimately strengthen the policy overall.

PART 2 – FULL EQUALITY IMPACT ASSESSMENT

1. Name of the policy / function / service development?

Establishment of a Home Treatment Team as part of the Mental Health Older Adults and Dementia (MHOAD).

2. From the initial screening process, which groups may experience negative impact?

Age	YES
Disability	YES
Gender reassignment	YES
Pregnancy and maternity	NO
Race	YES
Religion / Belief	YES
Sex	YES
Sexual orientation	YES
Marriage and Civil partnership	YES

Others [that your service / policy is specifically aimed at (e.g. refugees, behavioural difficulties)

Group:…………………………… NO

It is important to underscore that as we are dealing with mental health services (which clearly fall within the definition of disability for the purposes of the Equality Act 2010, thus all significant changes to these services are deemed relevant to the duty.

Introduction
This proposal is in line with significant policy and academic thinking regarding the most effective interventions for older people with mental health issues.

This now substantial literature underscores the importance of
1) early, community and home based interventions which avoid unnecessary admissions,
2) early, appropriate and non-delayed discharge.

The literature is explored in greater detail below. This literature includes JRF, 2011, Older People and High Support http://www.jrf.org.uk/sites/files/jrf/older-people-and-high-support-needs-full.pdf), McGlynn, P (ed) (2006) **Crisis Resolution and Home Treatment: A practical guide, The Sainsbury Centre for Mental Health 2006** http://www.centreformentalhealth.org.uk/pdfs/Crisis_resolution_and_home_treatment_guide.pdf and http://www.centreformentalhealth.org.uk/pdfs/crisis_resolution_mh_topics.pdf and Pinner, G et al (2011), In-patient care for older people within mental health services, Faculty of the Psychiatry of Old Age of the Royal College of Psychiatrists. The latter notes that:

'Significant numbers of mental health beds have been reportedly occupied by people whose discharge has been delayed: 13.3% of functional mental illness beds and 28.6% of organic assessment beds in a national survey by the Faculty of Psychiatry of Old Age (Barker & Bullock, 2005). More recent findings by the Mental Welfare Commission for Scotland (2010) show very similar results, reporting that on average 2.5 patients on dementia assessment wards and 0.75 patients on functional assessment wards are there because of delayed discharges at any one time, the main delay being patients waiting to move into a care home.'

It concludes:

'Community services must be developed to allow proper alternatives to in-patient care to avoid unnecessary admission. Services such as crisis intervention and home treatment are all too often exclusive to adult mental health services, but arrangements should be made within trusts to provide equally relevant services for older people. This is an area which is clearly age discriminating and contravenes the Age Discrimination Act that will be enforceable by 2012.'

The proposed service change will enhance access and therefore improve service provision for groups across the broad equality agenda. Key improvements will include:

(i) Extending service provision
(ii) Equalising services for all age groups
(iii) Greater opportunities to develop and deliver integrated care packages.
(iv) More bespoke support for individual service users, their families and carers.
(v) Reducing disruption for individuals, their families and carers.

Current provision
MHOAD currently provides 81 acute beds across the trust. This is significantly higher than for other comparable parts of London. The pilot will demonstrate if there is a possibility of reducing bed numbers in order to reconfigure services to be more bespoke and cost effective.

Bed numbers in Neighbouring Trusts

June 7th 2012

TRUST	BED NUMBERS	AGE GROUP	HOME SERVICE	FUNCTIONAL/ORGANIC SPLIT
Oxleas	73	65	No	Yes
South West	41	75	Yes	No

and St Georges				
CNWL	31	65	Yes	No
East London and City	70	65	No but specialist Dementia Teams	Yes
West London NHS Trust	48	65	No	No

3) What evidence do you have? Please give details.

a) Strong evidence

There is a strong national and local evidence base for the proposed changes. This draws on local service level data, service reviews and audit, DH/NICE guidance and advice and independent research by think tanks and academics. This has been supplemented with findings from recent consultation exercises with MHOAD patients, carers and staff (2010 and 2011/2012

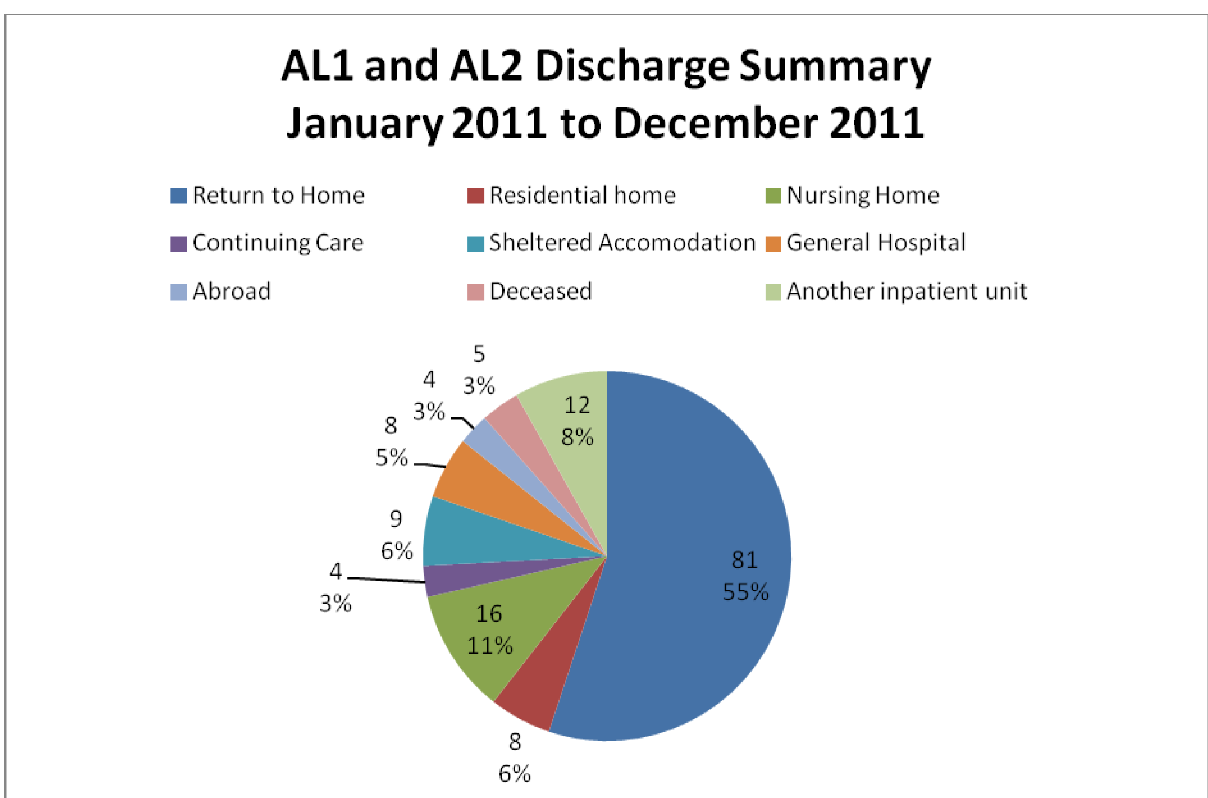
In addition, the Home Treatment pilot will be evaluated through a Programme Board consisting of representatives from NHS and Social Services commissioners, Social Services managers, clinicians from the MHOA service, and representatives from Kings and St Thomas's hospitals and the voluntary sector.
There will be a separate service user and carers reference group which will provide input into the development of the pilot and any subsequent recommendations. The draft terms of reference for these groups are attached. This group will support further engagement exercises between August 2012 – March 2013.

Action: A draft version of this EIA and/or a summary version will be circulated to both stakeholder groups.

MHOAD in-Patient activity
(i) Historic and current over provision of in-hospital services within SLAM
There is evidence to suggest that SLAM has historically retained and used a greater number of beds (per head of the population) than other comparable (location, social mix and population size) areas/boroughs. Internal records show the following:

	MAY 2011	JUN 2011	JUL 2011	AUG 2011	SEP 2011	OCT 2011	NOV 2011	DEC 2011	JAN 2012	FEB 2012	MAR 2012	APR 2012	Last 12 Months
AL1	33	28	24	40	49	34	51	47	45	39	46	0	**40**
AL2	45	46	33	60	27	65	39	23	35	35	34	28	**39**
Chelsham	66	40	51	35	33	49	32	45	42	29	32	20	**40**
Hayworth	45	43	27	59	46	21	43	45	44	34	73	62	**45**

(ii) A substantial proportion of those leaving AL1 and AL2 'go home'
Table two shows that 81% of those discharged (or leaving AL1 & AL2) during 2011 returned 'home' (using the broad definition outlined above of home being a person's residence). Just 8% went directly to another inpatient mental health service, with a further 5% entering into general hospital care.



This data underlines the importance of continuity of care and importance of the 'home' environment in the provision of on-going long-term care. It also prompts the question of whether it would be more appropriate to try and keep people in their own homes and provide on-going interventions in these and other community based settings.

Academic and policy evidence to support a move towards home based care
There is now a considerable body of evidence to support a shift away from traditional hospital based care for older people with mental health diagnosis. This literature which dates back to 2001 and beyond, argues that more effective outcomes can be achieved by a combination of early, home based interventions and a focus on ensuring timely, non-delayed discharge from hospital settings (in appropriate cases). This literature includes academic, think tank and service provider evidence.

Commission for Social Care Inspection (2006) stated that service users who have made the transition to older people's service noted the inequality of provision

Kings Fund and Centre for Mental Health (2010) : to meet current financial challenges strengthen home treatment and crisis especially in older adults where provision is "patchy"

"Mental Health and the Productivity Challenge: Improving quality and value for money"
(Naylor, C. & Bell, A (2010), Mental health and the productivity challenge
Improving quality and value for money, Kings Fund, London
http://www.kingsfund.org.uk/publications/mental_health_and.html) which says that improving value for money can often be achieved by also improving the quality of services.

The report's three key messages about the way that older people's mental health services can contribute to improving productivity are that:

- *Delivering services to care homes can reduce the use of primary and secondary health services, and can also reduce unnecessary prescribing of antipsychotic drugs, which are currently estimated to be overprescribed to the value of £14 million per year*
- *Mental health liaison services can help increase productivity in acute hospitals by improving older people's clinical outcomes while reducing length of stay and re-admission rates*

Perhaps most importantly in the context of this assessment, the Kings Fund report quotes Anderson et al (2009) which suggests that:

Provision of specialist older people's CRHT services can reduce hospital admission rates by up to 31 per cent, as well as reducing length of stay and admission to care homes (Anderson et al 2009).

This forms a major part of the rationale for the current service proposal. It is not simply that more effective home based interventions can reduce hospital stays and readmissions, but rather it can wholly avoid unnecessary admissions in the first place by facilitating earlier interventions, which prevent individuals entering full blown crisis.

The most exhaustive analysis of the evidence base for home based interventions has been provided by Dr Sara Turner (2011). The following section provides an overview of this analysis.

The notion of introducing models of crisis intervention which is built around home treatment teams is not a new one. The NHS National Service Framework for Mental Health (published in 1999) proposed that such arrangements should be at the heart of future mental health provision.

However, take up and implementation during the intervening period has been somewhat patchy, although by 2005, 243 CRHTTs had been established (Turner, S, Reviewing models of crisis and home treatment teams to aid planning a better community service). In relation to provision for older people the picture was much starker – just 9% of areas had introduced specialist services for older people, and in many of these the services were available for shorter periods than comparable services for the wider population (Turner & Healthcare Commission). An earlier Healthcare Commission review of older people's services found that:

The out-of-hours services for psychiatric advice and crisis management for older people were much less developed, and older people who had made the transition between these services when they reached age 65 said there were noticeable differences such as poorer quality, fewer services and less support. (Healthcare Commission)

Action: It is clearly important that the service provision offered by HTT matches that of comparable services for other age groups, in order to ensure equality of service and provision under the Equality Act 2010.

Hospital stays can have a longer term detrimental impact on an individual's longer term health prospects. As Turner underlines:

The main reasons that people with functional problems are admitted to hospital are because of risk of suicide or self-harm (may be psychotic or non-psychotic) or because of an acute psychotic episode. The unintended consequence of admission to hospital is that there is a loss of independence and there can be difficulties for both the person and the support system in re-establishing the previous level of acceptable/adaptive functioning. The loss of confidence from an admission can often make it difficult to achieve discharge without substantial packages of support. The philosophy behind crisis and home treatment teams has been to put short term intensive treatment and support into the community setting to maintain all of the links that the person has. When admission is unavoidable, such a team can also provide intensive input to promote earlier discharge and rebuild confidence.

As Turner shows a number of localities have already adopted the home based care model and there are further examples which underline the growing importance of this approach for the care of older people with mental health diagnoses. The proposed approach has already been explored and adopted in other London boroughs.
Islington is pursuing this approach having identified that ineffective community based interventions have historically led to an over reliance on hospital based services. It noted:

'weaknesses in community based services can lead to avoidable admissions to acute hospital care, while over reliance on residential care diverts money away from community services, reducing their capacity.' (Islington, Joint Commissioning Strategy - http://www.ncl.nhs.uk/media/43939/120511-joint-commissioning-strategy.pdf)

The current proposal will allow SLAM to redress this imbalance.

A further example is provided by West Sussex NHS which recently commissioned a review of its acute bed provision for older people which recommended a move toward home based care (NHS West Sussex),
(http://www.westsussex.nhs.uk/domains/westsussex.nhs.uk/local/media//publications/consultations/improving-mental-health-services/Sussex_Older_Peoples_Mental_Health_Services_Review_of_Acute_Bed_Provision.pdf)

The proposals for the establishment of a HTT is clearly in line with the wider national agenda of a move away from traditional hospital based treatment to more responsive, individualised and effective home based care services.

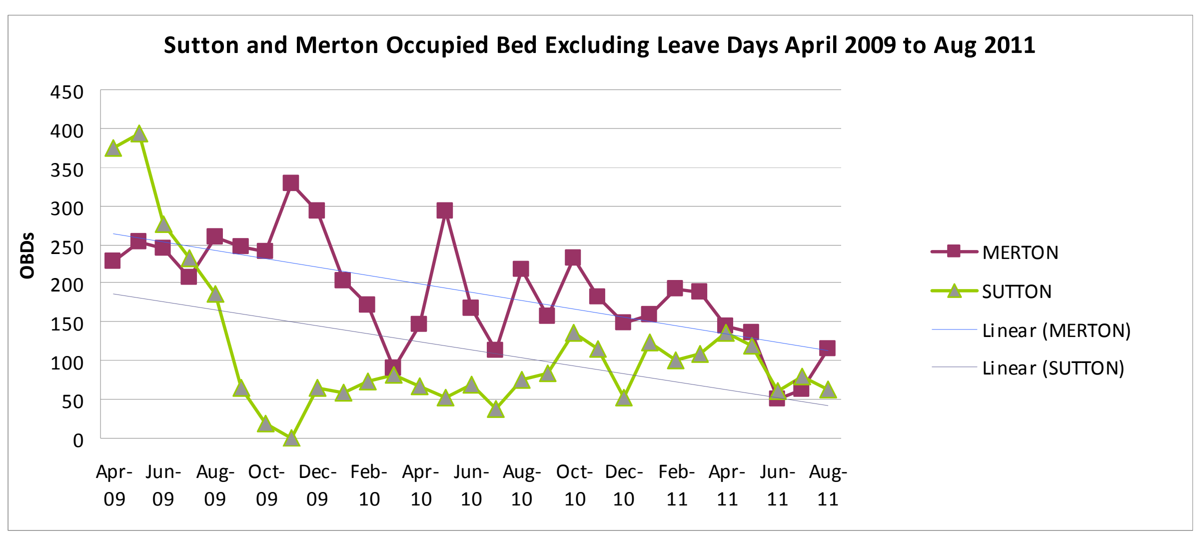
Evidence of more effective interventions
Turner's review of a range of older people's HTTs found that their development led to improved outcomes for service users and a reduced reliance on in-hospital services. A review of a HTT in Sheffield found *'no re-admissions within 28 days and a reduced rate of re-admissions over a period up to a year'* (Turner, 2011).
Turner notes that there are *'clear suggestions that the establishment of Specialist Older People's Teams has had an effect on admissions and discharges however the evaluations have again not been robust so results also have to be treated with caution'* (Turner, 2011).

Turner concludes:

'The evidence presented so far in this report supports the view that older people can frequently be maintained in their own homes if timely, intensive input is offered to them. Those services which previously reported pressure on beds no longer report this and those which have reduced bed numbers have reported success. The evidence is not hard research evidence from controlled research trials but it is consistent. The reports of service users, carers and professionals have been almost universally positive with any concerns about

having several people involved in the care of an individual not being borne out in practice' (Turner, 2011)

A review of Sutton's Intensive Home Treatment Team (pilot) which was established in 2009 found that a significant decrease in the number of hospital beds used (comparison with neighbouring Merton) following the establishment of the IHTT.



Sutton OPMH services have seen fewer inpatient admissions over this period than the other Borough Services:
As a result, Sutton had far lower hospital admissions compared to its neighbouring boroughs –

In developing the pilot the following questions were considered.

Do we have the correct hours of service?
The establishment of the HTT would see some service users move from 24/7 to home based services. This raises the question of whether the HTT should operate 24/7. Evidence from other similar HTTs suggests that 24/7 is not the norm. Turner's review found that no existing service provides an around the clock service and just one providing telephone support at night. Most services appear to operate extended hours, usually 7am – 10-11pm (Turner, 2011).

One review paper wrote of night time admissions found:

"Overnight presentations requiring immediate admission are rare in the over-65 age group. The Generic Home Treatment Team was the only service we visited that was fully operational on a 24/7 basis and saw an average of just two older people presenting at night per month. Our own local audit of acute psychiatric admissions found that fewer than 8% of older adults admitted over a one-year period had presented in crisis overnight (between 8pm and 8am), and three quarters of these night time admissions were under the Mental Health Act, suggesting that home treatment was probably inappropriate at that point in time."

It is important that we think about this gap and consider the options on the basis that HTT will provide a core between 9am and 8pm.

As outlined above, the Home Treatment pilot will be evaluated through a Programme Board consisting of representatives from NHS and Social Services commissioners, Social Services

managers, clinicians from the MHOA service, and representatives from Kings and St Thomas's hospitals and the voluntary sector. In addition, there will be a separate service user and carers reference group which will provide input into the development of the pilot and any subsequent recommendations. They will support the managers to consider gaps throughout 2012/13.

Service user, relative and carer feedback will be obtained.

Complete and reliable information and outcome measures will be obtained from
HoNOS65+/MHCT: at assessment and discharge
Zarit Burden Interview: at assessment and discharge

Staff and team well-being will be assessed.

It is hoped that the development of the HTT will inform the evidence base for home treatment for older people.

Role of the HTT

It is proposed that the HTT will provide a range of services and interventions:

- Handle staged discharge of those leaving hospital and establish care packages to help avoid readmissions
- Provide home visits
- Work with relevant providers to identify service users at risk of crisis
- Be the first point of contact for services experiencing or on the verge of a crisis.
- Act as 'gatekeepers' to relevant key services
- Work with hospital based colleagues to ensure continuity of treatment and wider provision
- Facilitate access to psychological services.
- Ensure continuity of provision between services.
- Signpost service users and carers to other relevant services

Currently the team is co-located on the MHOAD CAG Aubrey Lewis 2 Ward. The team operates from 9am-9pm Monday- Friday and 10.am-6pm at weekends and will be available 365 days a year. Current staffing is provided by existing ward and community staff with one new appointee (HTT Manager) on secondment. This is in order to see if the HTT model is effective, efficient and provides good value for money.

It is important to note that the establishment of HTT does not mean that those service users who use the HTT will not be able to access in-hospital services if they are required. HTT members will be able to fast-track those service users who need in-hospital treatment and will have the skills and capacity required to handle the most complex cases.

Continued availability of hospital provision for those who need it
It is also important to underline that in-hospital and other residential alternatives will still be available to those for require, including those for whom their home circumstances are at the root of their mental ill health.

Action: Set out protocols for admission to in-hospital services.

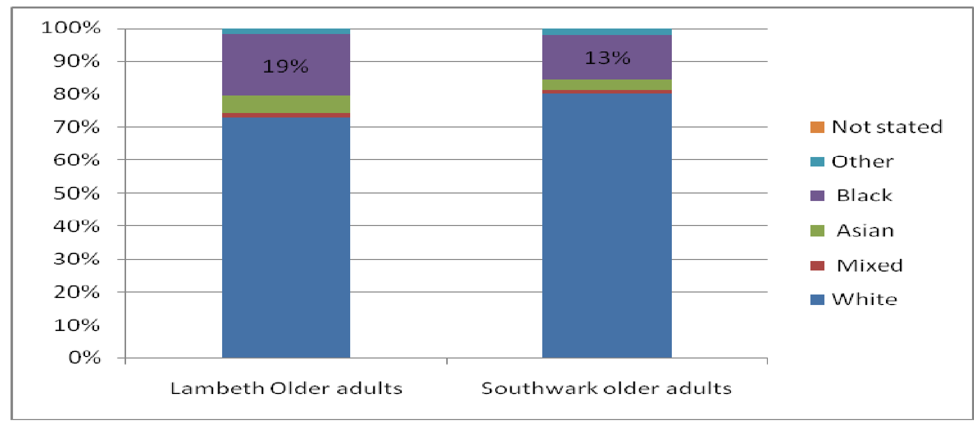
Action: Training for HTT members on hospital referrals. This is already being implemented as in the current pilot the team is located on the ward, working directly with ward staff on admissions and discharge. This is being explored as a model for future work.

Analysis of equality data

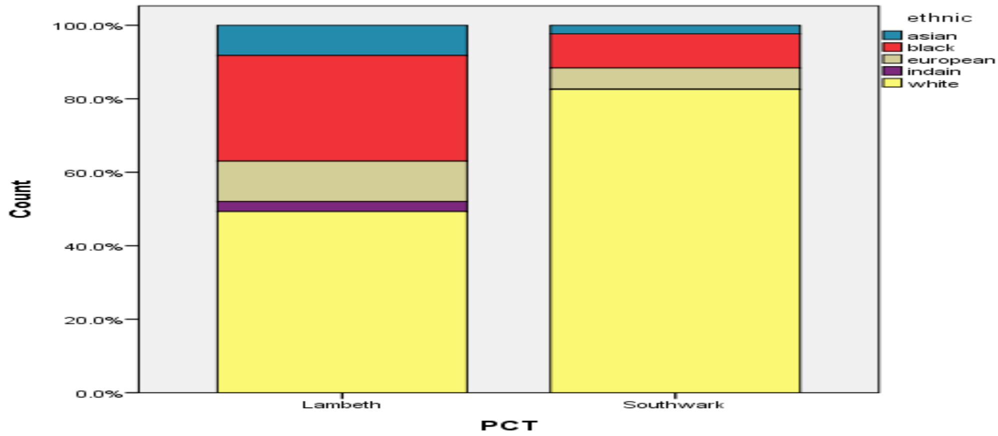
(1) Ethnicity

The HTT use the initial assessment undertaken with new service users to establish whether they have any specific needs or requirements arising from their ethnicity and what the HTT needs to do address these needs. An example of this can be the provision of interpreters. Data on ethnicity is recorded on ePJS.

The chart below shows the ethnicity profile of older adults in Lambeth and Southwark using Office for National Statistics Table PEEGC309: LAD 2009 Single Year of Age by Ethnic Group, mid-2009



The chart below shows the ethnicity profile of referrals to the HTT for Lambeth and Southwark between 1st May and 28th November 2012



This data suggests that there are a disproportionately low number of Black older adults being referred to the HTT in Southwark. It will be important for the HTT in Southwark to address this under-representation by raising awareness among Black older adults in Southwark as well as their families and carers and relevant VCS organisations with the aim of increasing referrals. The HTT will regularly review the ethnicity profile of HTT service users to monitor progress in achieving this aim. The previously mentioned review by NHS

Islington argued that a greater emphasis on community based interventions can help improve services and outcomes for particular groups and communities:

'With poor experiences and outcomes obtained in psychiatric hospitals, alternative services for the black and ethnic minority population present a new and innovative way of providing acute mental health care. Such services have taken due consideration of cultural needs and the problems experienced by these communities. Our indications are that such considerations are welcome but that the problems of working with marginalised communities may lie not singularly in providing culturally specific services but in working with staff to enhance cultural understanding and further consideration of patient-centred care provision.' (Islington, Joint Commissioning Strategy - http://www.ncl.nhs.uk/media/43939/120511-joint-commissioning-strategy.pdf)

Therefore addressing any under-representation by BME older adults in the HTT is likely to have a positive impact and this will help SLaM to deliver improved race equality outcomes.

2) Disability

We are aware that most service users accessing our services have long term mental health conditions and therefore meet the definition of disabled. The decision as to who receives our service is principally based on the severity and complexity of the mental health condition, which could be a depressive illness, an anxiety disorder, a personality disorder, dementia, or any other mental disorder such as bi-polar affective disorder, but diagnosis per se is not a criterion for acceptance or exclusion from services.

The HTT use the initial assessment undertaken with new service users to identify whether or not they are disabled; whether they have any specific needs of requirements arising from this disability and what the HTT needs to do to put in place reasonable adjustments to enable it to be accessible to the service user. Reasonable adjustments can relate to physical access to SLaM buildings, the provision of information in alternative formats; the provision of BSL interpreter and hearing loops as well as making other reasonable adjustments in way the service is delivered.

Data on disability is recorded as part of the narrative recording of the 'patient journey'.

3) Gender

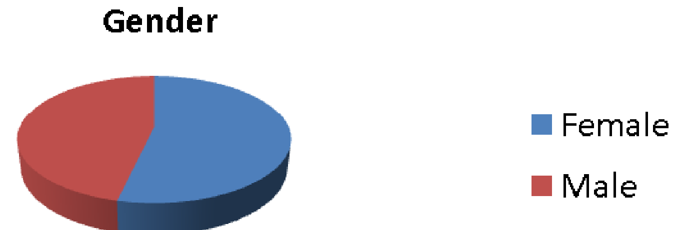
The HTT use the initial assessment undertaken with new service users to establish whether they have any specific needs or requirements arising from their gender and what the HTT needs to do address these needs. Data on gender is recorded on ePJS.

Data from http://www.poppi.org.uk/ shows the following estimated gender profile of older adults in Lambeth and Southwark in 2012:

	Lambeth	Southwark
Females	55%	56%
Males	45%	43%

The following table shows current service use by gender and borough for the last twelve months

	Female	Male	Total
Croydon	1007	568	1575
Lambeth	573	373	946
Lewisham	548	323	871
Other Borough	6	4	10
Southwark	399	235	634



4) Sexual Orientation/ Gender re-assignment/transgender
The HTT use the initial assessment undertaken with new service users to establish whether they have any specific needs or requirements arising from their sexual orientation and what the HTT needs to do address these needs. Data on sexual orientation is recorded as part of the narrative recording of the 'patient journey'.
Evidence from research and internal discussions has helped us increase our understanding of potential impacts on sexual orientation equality. In particular, we are aware that we need to be mindful of invisibility and assumed heterosexuality as well as exposure to stigma and discrimination. We are also aware that our LGBT Service users may anticipate negative treatment given their possible negative past experiences of services offered. The age group we are offering a service to grew up in a time when homosexuality was perceived as a mental disorder (removed from the Diagnostic and Statistical Manual of Mental Disorders in 1973) so they may not be confident in disclosing their sexual preferences.
In recognition that staff attitudes and organisational culture need to support gay, lesbian, bisexual and transgender people, all HTT staff have undertaken equality training. The Trust also regularly runs a training day on 'gender concerns in mental health and anti-discriminatory practice'. This programme is co-presented by the Trust's Equality and Diversity trainer and a transgender member of staff.

5) Age
The development of a Home Treatment Team for older people has significant potential to help eliminate age discrimination by creating a service that can deliver better outcomes for older people where no such service existed before.

HTT use the initial assessment undertaken with new service users to establish whether they have any specific needs or requirements arising from their age and what the HTT needs to do address these needs. Data on age is recorded on ePJS.

6) Religion and belief
The HTT use the initial assessment undertaken with new service users to establish whether they have any specific needs or requirements arising from their religion or belief and what the HTT needs to do address these needs. Data on religion or belief is recorded as part of the narrative recording of the 'patient journey'.

Supervision of staff provides a focus for the delivery of a service that is sensitive to religious beliefs. Clients are able to access the Trust multi-faith spiritual and pastoral care service.

4.. Please outline steps taken during the EIA process to raise awareness and consult/involve interested parties and those who may be affected by the policy / function / service development

Staff consultation- Staff consultations were held in February 2012. Staff were given the opportunity to be seconded into the Home Treatment Team for the duration of the pilot. User consultation – The "Being Involved" Group – which is effectively our current Service user and Carer Advisory Group in MHOAD CAG, received three presentations on the proposals to develop the Home Treatment Service – they gave constructive and useful feedback which shaped the development of the service. This group is made up of service users, carers and ex-carers. Many ex-carers expressed the view that they would have welcomed the existence of a HTT when they were caring for their loved ones.
The start of the pilot in June 2012 will see managers increasingly consulting with local agencies, discussing ways in which the service can be delivered and improved. A Service user and carer participation group has been established which will also guide the development of the pilot in the coming months. Carers consultation - Carers groups supported by the Alzheimers Society were consulted in the development of the Home Treatment Service. The proposal received a positive response. The CAG has Advisory Groups in each of the four boroughs it serves. Notification of the development of the Home Treatment Team was brought to both Southwark and Lambeth meetings. Both have asked to be kept informed. Feedback from these meetings informed the development of the pilot. We will ensure that we use this engagement and consultation to help address any gaps in our understanding of potential impacts experienced by people with protected characteristics. We have informed local stakeholders about the development.

5. What does available evidence / results of consultation show?
The results of the engagement exercises to date indicate that local communities are interested in the development of the HTT and wish to remain informed and involved. This is why a Programme Board for the pilot as well as the user and carer Reference Group has been established. As outlined above the pilot is an important contribution to national knowledge on the effectiveness or otherwise of a Home Treatment Service for older adults.

In practice during the pilot both of these groups have been successful so they are being merged as they discuss the same issues. Feedback on this approach can be provided at the end of the pilot.

Further in depth consultation is planned with service users in March and April 2013.

6. If you have not been able to conduct consultation how do you intend to test out your findings and recommended actions?
This is a pilot. Consultation and engagement has commenced and will continue throughout the period of the pilot we will ensure that this includes a focus on equality to help improve our understanding of the potential equality impacts and what HTT do to maximise any

positive impacts and mitigate any negative impacts. Further in depth consultation is planned with service users in March and April 2013

7. What changes or practical measures would reduce the negative impact on particular groups? (Think what a successful outcome would look like and what can be done to bring about this outcome)

See attached action plan.

If changes are required please complete the action plan template overleaf

8. What are the main conclusions of the assessment?
The main conclusions of the assessment are that it is correct to have a pilot phase of the Home Treatment Service in order to be sure that it meets the requirements of our local communities.
It is necessary and important to seek the support and partnership of our local stakeholders in this programme of work.

9. Has a monitoring process been established to measure/review the effects of the policy, function or service development? (This may include statistical analysis of monitoring data, satisfaction surveys or use of networks)

A senior psychologist is leading on measuring the effects of the pilot.

Date completed: …………25th February 2013…………………………..

Signed …………Cha Power Deputy Manager MHOAD CAG …………………………..
Print name …………………………………..

Please send an electronic copy of the completed assessment, action plan (if required), any relevant monitoring reports used and a summary of replies received from people you have consulted, to:

1. Kay.harwood@slam.nhs.uk
2. Your CAG Equality Lead

ACTION PLANNING

Agree actions and insert into action plan

The following action plan should summarise the proposed actions, setting out the timescale, lead individual and include details of any monitoring needed in the future to check that desired outcomes are reached.

Issue / Adverse impact identified	Proposed actions	Responsible/ lead person	Timescale	Progress
Important to ensure service users and stakeholders are aware of considerations and thinking in terms of the development of the HTT.	A draft version of this EIA and/or a summary version will be circulated to stakeholders as part of this process.	Durand Darougar – Clinical Services Manager	June 2012- June 2013	Draft EIA being developed. **Key agencies locally have been invited to attend the User and Carer Participation Group** - this group now merging with the managers reference group.
Important that the service provision offered by HTT matches that of comparable services for other age groups, in order to help eliminate age discrimination in the provision of SLaM services.	Establishment of the HTT for older adults that enables older people to remain in their homes and get the mental health services they need. .	Cha Power	June 2012	Pilot has begun alongside ongoing equality impact assessment
How do we know that the HTT service hours are the right ones?	Review service hours.	Cha Power	October 2012	Service hours under review as part of the pilot. **No changes following review in October**
How will we cover those periods outside HTT operating hours?	Produce clear communication resources explaining out of	Cha Power	July 2012	Operational policy developed

	hours arrangements.			
How can we be sure that the service will improve outcomes for service users?	Put in place data collection systems and monitor admissions and outcomes for HTT service users	Cha Power Alice Mills	July 2012	Data collection in place. Initial analysis undertaken Ongoing review of EIA planned **See reports that have been compiled**.
Will the HTT have strong enough relationships with local organisations which provide residential care for service users?	Continue to develop links and contacts with residential care providers, housing associations specialising in supported housing and mainstream health and social care providers.	Cha Power		Ongoing – HTT WMHD event had service users and carers and a number of agencies in attendance. HTT team had a stall at Copelestone event. HTT refers to local agencies such as Alzheimers Project and Dulwich Helpline.
Some service users, carers and other stakeholders may be concerned that service users will not be referred to in-hospital services, when and where appropriate. This is particularly important for service users for whom their home environment is a contributory factor in their condition.	Set out protocols for admission to in-hospital services and provide reassurances regarding access to appropriate services.	Cha Power	July 2012	Operational Policy
Will staff know	Training for HTT	Cha Power	July 2012	Staff in HTT

when services should be referred for in-hospital treatment?	members on hospital referrals.			are trained mental health practitioners. There is joint working with the wards.
Ensure current ethnic monitoring categories are comparable with the Census 2011 categories.	Review ethnic monitoring categories to ensure comparability with Census 2011.	Cha Power	March 2013	SLAM Ethnic monitoring is in accordance with census 2011
Do we have a complete picture of the ethnic profile of all service users?	Map all relevant service use by ethnicity.	Cha Power	December 2012	The ethnicity of service users is recorded on Electronic Patient Journey (ePJS)
Do individual service users have particular language support needs?	Review service user records to determine whether any service users require language support or other additional needs.	Cha Power	July 2012	Part of the operational policy – Interpreters are used as required – provided by the Trust.
Will staff have the knowledge and skills needed to deliver services to a range of communities?	Ensure that all HTT members receive comprehensive equalities training.	Cha Power	July 2012	Staff have received Equalities Training
How can the HTT ensure that it provides appropriate services, interventions and solutions for different communities – including signposting to wider services?	HTT to make contact and build working relationships with local community organisations which work in particular with older adults	Cha Power	Sept - 2012	Relations are being established across Lambeth and Southwark. Service users are referred to agencies depending on their needs as identified in care planning. Particular attention will be given to increasing

				referrals from Black older adults in Southwark
How will the HTT ensure that it can provides services which are appropriate to different communities and groups?	HTT management should consider diversity profile of the team and ensure that all staff are properly trained to deal with different communities and groups.	Cha Power	Recruitment policy Training programme	The team composition reflects the local population
It is not yet clear whether female and male services have different expectations and needs.	Consultation and discussions with service users and carers should seek to determine whether female and male users have different service needs.	Cha Power	During the pilot	Services are provided on a needs led basis. If a specific service is required based on gender then it is provided.
Ensuring we understand the disability profile of service users and any potential positive and negative impacts in relation to disability	Record disability in ePJS case notes Consider use of PEDIC can help improve understanding of potential impacts of HTT in relation to disability	Cha Power	Ongoing Consider use of PEDIC in the pilot – with proviso that numbers are small	HTT developed prompt to consider disability in initial assessments with service users. Disability recorded in narrative of ePJS case notes
Is information available and delivered in different formats	Ensure that all communication (verbal and written) is available and delivered in appropriate formats. Identify appropriate sources of communication support. Ensure consistency	Cha Power Laura Broadley	Ongoing	All requests for information in different formats are met.

	across all related services.			
Should the HTT service collect and analyse data relating to the sexual orientation; religion and belief of service users?	Record sexual orientation and religion and belief in ePJS case notes Consider where consultation and use of PEDIC can help improve understanding of potential impacts of HTT in relation to sexual orientation and religion and belief	Cha Power	Ongoing	HTT developed prompt to consider sexual orientation and religion and belief in initial assessments with service users. Sexual orientation and religion and belief recorded in ePJS case notes
Are all relevant, current policies and practices appropriate in terms of sexual orientation?	See above	Cha Power	Ongoing	
Do staff and managers have the knowledge and skills to deal with service users on issues relating to sexual orientation?	Ensure that staff equality training includes a sexual orientation and age component.	Cha Power		Staff have received Equalities training
Need to consider how the service development will be perceived by wider communities. Need to ensure that the changes are communicated clearly in order to avoid any misconceptions.	Develop communications strategy explaining rationale and evidence for changes and ensure transparency about plans.	Cha Power	Ongoing	Leaflet has been produced. Staff held a WMHD event. Staff have attended local events they were invited to. HTT has also received positive feedback

				from partner agencies.
How will we ensure that the projected impacts are correct and that the policy does not have any unintended consequences?	In addition to on-going monitoring and appropriate remedial action, there will be further review of all equality data and assessment of impact of the work of the HTT after twelve months.	Cha Power	Autumn 2013	This is being monitored as the pilot progresses.

Please send an electronic copy of your completed assessment to:

1. Kay.harwood@slam.nhs.uk
2. Your Service Equality Lead

The national annual admission rate thus derived is 343/100,000 people aged 65+. The admission rate for Sussex overall 2008/09
FYE based upon Q1-Q3 admissions) was calculated to be 426/100,000 based on the ONS population .

http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1304-075_V01.pdf

Vignettes – November 2012

Pt known to SL CMHT, with a diagnosis of dementia

The family contacted the CMHT with concerns that their father's condition had deteriorated he was expressing delusional beliefs that his wife had been seeing other men. He was experiencing some visual and auditory hallucinations, seeing images and shadows, which he believed were men trying to get into his house and hearing noises which he thought were men's voices.

Due to these experiences CM was not allowing his wife out of his sight, he was following her around the house where ever she went, she was not allowed to leave the house, he was locking the bedroom door at night, and one night when she got up to go to the toilet he tried to prevent her from leaving the room by putting his hands around her neck, resulting in an incident where she fell down the stairs. It was at this point that the family alerted mental health services.

The patient was seen by the Community Psychiatrist and a member of the home treatment team to facilitate a joint assessment. The outcome of the assessment was to accept the patient for home treatment.

The patient's children were staying with their mother and father during this period.

HTT Interventions

1. A urine sample was taken to eliminate a urinary infection, which could have been the cause for a marked change in the patient's mental health.
2. An ECG was undertaken at Kings College Hospital prior to the introduction of an anti psychotic medicine to ensure that this would be a safe option.
3. An anti psychotic, risperadone was introduced, taken in the evenings. The HTT over saw the administration of this, to monitor compliance, improvements and/or any side effects.
4. HTT were visiting both morning and evening to monitor the patient's mental state and risk to his wife and others.
5. The HTT supported the family and the patient's wife, offering reassurance, and psycho educational information regarding the patient's mental health and experiences.
6. An OT assessment was undertaken and handrails were fitted in the hallway to ensure safe use of the stairs and the ground floor toilet. No other adaptations were necessary.
7. Weekly reviews were held with community consultant and or care co-orindator, HTT patient and his wife and family members to review his recovery.
8. Twice daily visits were reduced to once a day as the patients started to improve.
9. Administration of medication was handed over to the family, the patient was accepting this with no difficulties and since it's introduction there had been significant improvement. The patient no longer saw shadows or heard voices, he no longer thought that his wife was seeing other men, he stopped following her around the

home, locking the bedroom door and she could go out alone without him trying to stop her.

10. HTT visits were reduced further to every other day and then to every third, the patient was discharged back to the Community Mental Health Team after a period of 4 weeks with the HTT.

Vignettes – November 2012

Mary

Pt known to North Southwark CMHT since December 2011. She was given a diagnosis of 'Acute & transient psychotic disorder'. Prior to referral to the HTT in October 2012 this was not treated with any anti psychotic medication.

The CMHT referred Mary to the HTT as her mental state had been deteriorating and she was expressing persecutory delusional beliefs about the 'neighbour' who lived above her. She believed he was 'trying to harm her', that he was intentionally making noise above her bedroom at night to disturb her sleep and that 'men' were going to come into her flat at night and harm her. Mary had acted upon her delusions, and on numerous occasions she had been up stairs to challenge the neighbour. Each night she was pushing a fridge freezer against the door to prevent 'the men' coming into her flat. These symptoms were similar to Mary's presentation in December 2011 which resulted with Mary being admitted to hospital under a Section 2 of the Mental Health Act 1983, 2007.

The patient was seen by the Community Psychiatrist and a member of the home treatment team to facilitate a joint assessment. The outcome of the assessment was to accept the patient for home treatment.

Mary has complex needs. She has poor mobility and the physical strength required to push the fridge freezer against the door put her at 'high risk' of falls, she was putting herself at risk from others by challenging the neighbors about her delusions.

During the spell of home treatment Mary's daughter was living with her. She was also in receipt of a care package through an Agency which was being delivered by her daughter.

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HTT Interventions

1. An anti psychotic, Amisulpride 25mgs mane was introduced, taken in the evenings. The HTT over saw the administration of this, to monitor compliance, improvements and/or any side effects.
2. The HTT were visiting both morning and evening to monitor the patient's mental state and assess the care being provided.
3. The HTT raised safe guarding concerns regarding Mary's care package, due to her daughter on a number of occasions neglecting her Mother, not tending to her personal care nor prompting her for her physical health medication.
4. Mary's care package was reviewed by Social Services and new carer was allocated.
5. The HTT liaised with Mary's children through out the treatment spell, to keep them informed of her progress.

6. An OT assessment was undertaken. Mary's front door was unsafe, she was unable to close and lock this, the Housing Association were contacted and this was fixed. A key safe was fitted to allow carers access. Mary was agreeable to have a pendent alarm because she was a high falls risk and home alone most of the day. Mary was provided with a specialist chair with adjustable legs and high back which was easy for her to get in and out of.
7. Weekly reviews were held with community consultant and or care co-ordinator and family members to review her recovery.
8. Mary's medication was increased to 50mgs of Amisulphride as the psychotic symptoms persisted and were under treated.
9. Mary's visits were increased to three times a day to manage her safely and support her daughter who was experiencing carer stress. These were reduced after 3 days to twice daily visits as Mary's mental state improved.
10. Administration of medication was handed over to the carer's as Mary was accepting this with no difficulties and since the increase there had been significant improvement. She no longer preoccupied by her neighbour or disturbed by him, she had stopped pushing the fridge freezer against her door at night to prevent 'men' from coming into the flat to harm her.
11. HTT visits were reduced further to every other day and then to every third, the patient was discharged back to the Community Mental Health Team after a period of 7 weeks.

The King's Fund

Ideas that change health care

A review of King's Health Partners' proposals for closer integration and merger by The King's Fund

December 2012

Foreword

In response to the demands wrought by an aging population, developments in medicine and technology, and a period of severe resource constraint, hospitals all over the country (and world) are rethinking the configuration of their services and the shape of their organisation. The King's Fund was asked to undertake a rapid, independent review of one such reorganisation; the proposed merger of Guy's and St Thomas' Hospitals, King's College Hospital, and South London and the Maudsley and their closer integration with King's College London, currently working together as King's Health Partners (KHP). The proposed merger builds on established collaboration between these organisations and if it proceeds will result in the creation of by far and away the biggest NHS Foundation Trust in England.

This report draws on the views of a cross section of stakeholders, an analysis of the evidence on mergers, and the experience of the Fund's staff to explore the challenges that arise in taking forward the proposed merger. As well as rehearsing the opportunities and risks involved, the report identifies six key issues that require careful and sustained attention to realise the opportunities and manage the risks. The Fund's work elsewhere in the NHS leaves us under no illusion about the difficulties in bringing this off while also containing valuable learning on how to overcome the challenges that have been highlighted in the literature on mergers. Of critical importance will be investment in leadership and organisation development on a scale commensurate with the ambition of the organisations involved.

There are no easy options, whatever the eventual decision on the proposed merger. As my colleagues make clear, if the decision is not to proceed then the status quo may be unsustainable as the pressures on the NHS increase, requiring other options to be considered. Given these complexities, we hope this report offers a timely and helpful contribution to a debate that has implications not only for south London but for the NHS as a whole. The focus within the report on the practical steps that need to be taken to turn aspirations into reality highlights the importance of planning now for the complex but essential challenges of implementation and execution that change on this scale entails.

Chris Ham
Chief Executive

Executive Summary

This report sets out the conclusions of a rapid independent review by The King's Fund, for King's Health Partners' Academic Health Science Centre (AHSC), of the merger proposed by the three founding NHS foundation trusts – Guy's and St Thomas' Hospitals (GSTT), King's College Hospital (KCH) and South London and Maudsley (SLaM) and their closer integration with King's College London (KCL). The review aims to provide constructive challenge to the integration process. The review draws on interviews and engagement with local and external stakeholders, as well as the current evidence on mergers across all sectors. It contains no financial analysis or assessment of the proposed merger. It does not judge whether merger is the 'right' decision – that decision can only be taken by the KHP Board and the four partners.

King's Health Partners has been working since 2008 to deliver world-class services, education and research that can compete globally as well as bring benefits to the local community. The proposed merger aims to build on this established partnership and support the full realisation of this vision through:

- further integrating academic medicine with service specialties, both to improve the quality of research and to translate its findings faster into treatment
- reconfiguring specialist services, both on service grounds and to support that integration
- deriving benefits from bringing mental and physical health more closely together
- developing a new model of integrated care, across two dimensions – between health and social care and between primary and community care and the hospitals.

The opportunities for specialist services presented by the merger have been well articulated by KHP and are well understood by local and external stakeholders. The opportunities offered by bringing mental and physical health together are appreciated intellectually, but so far proposals lack detail about what this will mean in practice. The opportunity for KHP to do something radically different for the local population and develop a model of integrated care driven by population health needs, as well to bring leading edge research into the routine care of patients in the local community, are core elements of the vision for many of the KHP Board. They require significantly better articulation, however, for local stakeholders to feel confident they will be achieved.

Those we spoke to articulated six key areas of risk from the proposed merger.

- The history of mergers in all industries and in all sectors, private and public, is poor. The benefits anticipated from merger are frequently overstated and not realised.

- There is a risk that mental health services become the Cinderella services in the merged organisation. The separation of mental health services into specialist trusts (now the norm) came from their poor experience in jointly managed organisations. Will history repeat itself?
- The proposed merged organisation will require significant leadership and management capacity /skills at all levels of the organisation. Will these be in place?
- Mergers can be a significant management distraction. Will this threaten the delivery of the core business in the short/medium term?
- There are significant cultural differences to be overcome, and the new culture needs to avoid the worst of the current organisational cultures.
- The merged organisation may become remote, unaccountable and monolithic, divorced from the local community and its staff.

In addition, the proposed merger would be undertaken at a time of significant structural and regulatory upheaval and at a time when competition law in health care being strengthened. Competition rules present a potentially significant regulatory barrier to the proposed merger. Another important factor will be the final outcome of the review being undertaken by the Trust Special Administrator of South London Healthcare Trust. The proposed merger between King's College Hospital and Princess Royal Bromley not only affects the dynamics of the proposed KHP merger but may also influence any review of the impact on local competition.

If the three foundation trusts overcome the necessary regulatory barriers and then decide to proceed with merger, there are six key areas that will require careful attention if the merger is to succeed.

1. **Create clear shared goals**

- the diversity of the goals for the merger needs to be acknowledged and the potential synergies between the merger's many components needs to be better articulated
- the potential synergies between the merger's many components need to be explored, developed and articulated
- public consultation needs to focus all the aspects of the merger and not emphasise different elements in different settings.

2. **Establish a clear structure for decision-making authority**

- the Partnership Board needs to identify where rights for making key decisions will lie and what degrees of freedom leaders in the structures below board level will have
- in particular, the Board will need to both vest authority in and create processes for operating budget control, capital allocation, and staff recruiting, promotion, incentives, and discipline.

3. **Design an operational architecture aligned to the goals of the merged organisation**

Careful planning will be required to identify:

- the units' structures and scope of activities, and where unit boundaries will lay
- the structure of shared services
- the processes for managing the flow of patients and of information among the units.

4. **Ensure leadership capability**

- carefully evaluate the leadership capabilities of those clinical and non-clinical leaders currently in post
- where willing and able candidates are not already in place, recruit clinical leaders
- establish a leadership and management development strategy.

5. **Harmonise the culture and preserve identities**

- The Board must give clear messages and back these messages with consistent actions, including appropriate incentives and performance management, as an essential part of creating a unified culture.

6. **Develop a sophisticated system for assessing and rewarding performance**

- The merged entity will need to develop a nuanced, outcome- and value-focused measurement and reporting system (ie, balanced scorecard) and a nuanced professional reward system for staff who take on multiple roles in teaching, clinical care and research.

A decision to merge by the boards of KHP and three foundation trusts is just the beginning. There are regulatory hurdles to be overcome. There is a need to obtain active support from commissioners and other key community stakeholders. The implementation challenge is clearly large and will require commitment from clinicians and senior and mid-level managers, with the way it is done being a far more important determinant of the ultimate success than the early conception and positioning. Mergers frequently fail, and this is in large part because boards fail to recognise the extent of the change management task and the rigour required in post merger implementation. The complexity and scale of the proposed merger makes it all the more important for KHP to pay close attention to these issues. The likelihood of success can be increased by effective and early planning and preparation for meeting these implementation challenges, particularly in the areas of: making the case for the merger to staff and the community, supporting operational diversity, and identifying and developing effective clinical and non-clinical mid-level leaders.

Introduction

King's Health Partners (KHP) was formed in 2008 as one of the UK's first Academic Health Science Centres, to pursue a tripartite mission of excellence in clinical services, research and education. The founding partners of King's Health Partners are three NHS foundation trusts – Guy's and St Thomas' Hospitals (GSTT), King's College Hospital (KCH) and South London and Maudsley (SLaM) – and a university, King's College London (KCL).

A Strategic Outline Case (SOC) has been produced by KHP setting out the case for the merger of the three NHS foundation trusts. Full integration between an NHS organisation and a university is not legally feasible and is not being pursued by the partners. The SOC concludes that the benefits of merger/closer integration of KCL outweigh the risks of a change in organisational form. This conclusion has been accepted by the KHP Board and the recommendation to proceed to the next stage has been accepted by the governing bodies of the four partners. To move to merger, the four partners need to create a Full Business Case (FBC) for consideration by the KHP Board and the boards of the individual four partners. The aim is to produce the FBC by April 2013.

This report contains the findings of arapid, independent review by The King's Fund that will feed into the thinking of the KHP Board. The aim of this review is to provide constructive input and challenge to the integration process that KHP is engaged in. The review does not judge whether merger is the 'right' decision – that decision can only be taken by the KHP Board and the four partners. The aim is to inject into the process some external challenge and in particular to gather and to feed in the perspective of external stakeholders about the opportunities, challenges and risks presented by the potential merger. The review makes no assessment of the financial model underpinning the business case. The full terms of reference and the detailed methodology for the review are provided in Appendix A, pp 34-35.

Methodology

This review is informed by four sources of evidence and input.

The first is nearly 30 interviews undertaken with a range of internal and external stakeholders. This did not include Lambeth and Southwark MPs, who we understand have significant reservations about the proposed merger and are currently in a separate dialogue with KHP about these concerns. We hope they and other local stakeholders will find this report useful.

The second is a high-level review of the literature on organisational merger. The key findings are included in this document and the full review is provided in Appendix E, pp 41-57.

The third is the reflections and advice from senior members of The King's Fund Leadership faculty and some senior external stakeholders who know KHP but are not involved in its day-to-day activities. This group met to consider early findings and their views have informed this report.

- Professor Keith Peters, University of Cambridge
- Dr Claire Gerada, President, RCGP, and local GP
- Professor Peter Jones, University of Cambridge
- Professor Chris Ham, Chief Executive, The King's Fund
- Professor Richard Bohmer, Harvard Business School, Visiting Senior Fellow, The King's Fund
- Nick Timmins, Senior Fellow, The King's Fund

Finally, we have drawn on output from other related work including:

- the McKee Review (September 2011), which aimed to see what steps are needed to most effectively realise the ambitions for the AHSC
- a review of the academic opportunities and challenges faced by KHP – the 'Scott' report (June 2012)
- 'Exploring our Futures' – a piece of work that looked at what health and care in Lambeth and Southwark might be like in 2030 and a report that considered its implications for KHP (The King's Fund, May 2012).

Structure of this report

The structure of this report is as follows:

- the rationale for merger and the tripartite vision for AHSC
- the tripartite mission context – service, education and research
- the opportunities presented by the merger – the external stakeholder perspective
- the challenges presented by the merger – the external stakeholder perspective
- the evidence on mergers – what the literature says
- what the merging partners in KHP need to get right if they are to succeed

- a case study from The King's Fund: working alongside foundation trusts as they move towards merger
- if the three foundation trusts decide not to merge, what are the alternatives and what are the risks?
- conclusion.

Where relevant, throughout this document, we draw out key issues that in our view need to be considered and addressed by the KHP Board as they develop their proposals for closer integration and merger.

The rationale for merger

King's Health Partners aims to deliver world-class services, education and research that can compete globally as well as bring benefits to the local community. The proposed merger aims to expedite the realisation of this vision.

The overarching aim of KHP is, in its own words*, to create a centre where world-class research, teaching and clinical practice are brought together for the benefit of patients. We want to make sure that the lessons from research are used more swiftly, effectively and systematically to improve healthcare services for people with physical and mental health care problems. This is about providing a world-class service.*

At the same time as competing on the international stage, our focus remains on providing local people with the very best that the NHS has to offer. King's Health Partners will bring real and lasting benefits to the communities of south London. Local people will continue to benefit from access to world-leading healthcare experts and clinical services which are underpinned by the latest research knowledge. There will also be benefits for the local area in regeneration, education, jobs and economic growth.
Source: http://www.kingshealthpartners.org/info/about-us

KHP see the above two goals as mutually reinforcing, clinical care underpinned by excellent research bringing significant benefits to the local population.
"we want to create a system in which the residents of these boroughs will be able to call upon the very best expertise and ....that that brings real benefits to the individuals within the community and their improved health goes hand in hand with the improved quality of the research and teaching from the academic point of view." KHP Partner

The Strategic Outline Case for the merger sets six goals for the 'new' organisation

1. providing care around people's needs

2. keeping people well through earlier intervention
3. providing the best possible specialist care where it is needed
4. training the workforce of today and tomorrow
5. turning world-leading research into treatments as quickly as possible
6. building prosperity for our local communities and the UK.

But, as one KHP stakeholder told us:

It is designed to raise quality. That is what it is about. There is no other driver. There is no-one I know in this whole equation who is mad enough to say 'oh, let's have a great big reorganisation, that is what we need.' I promise you.

This overarching ambition to raise quality and the six goals for the 'new organisation' are essentially built on four platforms:

- further integrating academic medicine with service specialties, both to improve the quality of research and to translate its findings faster into treatment
- reconfiguring specialist services, both on service grounds and to support the first platform
- deriving benefits from bringing mental and physical health more closely together
- developing integrated care, across two dimensions – between health and social care and between primary and community care and the hospitals.

A major impetus for the proposed merger comes from Clinical Academic Groups established across KHP who feel that current structures stand in the way of them delivering on the platforms described above, particularly the first two. There are currently 21 Clinical Academic Groups, summarised in Appendix C, p 39. While CAGs have achieved some changes, for example, reconfiguring bone marrow and vascular surgery services, it has taken a long time.

… forever … extremely inefficient and slow … heck of a lot of money wasted in the delay.

The CAGs have strong sense of *responsibility without power*, in large part because proposals for service change have to go through two boards, sometimes three and conceivably four. Each organisation has their 'bottom line' to protect. KHP argues that without merger some changes – eg, to dental, cardiac and children's services – are not possible because the financial impact on one or other of the current foundation trusts is too great. KHP argues that single balance sheet across three foundation trusts would solve that.

We are not going to be as successful as we could be in achieving the purposes of the AHSCs through the CAGs if the CAGs have to report up three or four

separate reporting lines. That is all it is. I don't see it as anything more than that … But if you are not going to do that by merger, what other way are you going to do it?
(KHP partner)

The lack of a single leadership, lack of a single budget, the implications for other services that come out mean you have an environment for debate which allows people to play off different parts of the system incredibly effectively.
(KHP partner)

People like me for instance, very much saw the downside of merger in terms of diversion and something we wanted to resist … but such has been the groundswell initially [from the CAGs] that we could miss a historic opportunity … it has driven us to the conclusion that we have to get rid of those fault lines in some way or other, and do it quickly before austerity means it gets too difficult.
(KHP partner)

There is considerable enthusiasm for the merger from the academic partner in KHP, King's College London.
"Crucially, from the college's point of view, the vision of greater integration, which has emerged in the strategic outline case, contains significant aspects of academic integration, as well as the clinical side. The mandate given to the college to coordinate research and also award teaching right across KHP in much the same way as we are already doing for fund raising. Those are the most positive aspects and those are big positives."

A number of those we spoke to identified the bringing together of mental health with physical health as the *unique selling point* of the proposed merger.

Our USP is mental health. It is a crown jewel.
(KHP partner)

A further rationale is the ambition to deliver more integrated care, particularly with the community, although stakeholders within KHP acknowledge that ambition has not been as well articulated as the other goals.

I think we pulled our punches on that [integrated care], partly because we're scared of looking like we're trying to take over primary care. Whereas actually, I'd put it the other way round. We want primary care to come in, be equal partner … because that is, I think, genuinely one if its [the merger's] potentially game-changing opportunities.
(KHP partner)

Integrating primary and secondary care 'is arguably the highest impact thing we can do' [as a result of a merger].

(KHP partner)

The lack of clarity in the strategic outline case about how that is to be achieved was picked up widely by the external stakeholders that we spoke to.
The benefits for local services to the communities in Lambeth and Southwark not well spelt out … does not explain well enough how that would happen – where care would be delivered, and how, out in the community.
(Local stakeholder)

What is the real narrative about pathways? Are we going to get the commitment of a huge monolith to be responsive to localities…
(Local stakeholder)

There is a need to get across the type of vision discussed at the dinner held earlier in the year to discuss the proposals. At the dinner, the model of integrated care combined with an AHSC was identified as the unique opportunity for KHP. In America these two models tend to be separate. There are either examples of "end to end" care or strong translational research. It was argued that in the context of the NHS one ought to be able to do both for the whole population.

"If you can get into understanding how to manage population health then you are on to something special."
"Can this be a step into something really big and bold, integrated care for chronic disease, an exportable model?"
"If we want to make a serious difference to people - then we need to recast the relationship with professionals and not get hung up on organisational issues."
Participants at KHP Dinner

The opportunity for KHP to do something radically different and develop a model of integrated care driven by population health needs is central to the vision of many of the KHP board. They see the scale of the merger as a real asset in this regard, providing the opportunity to redesign a whole system of care. In particular they view the merger as an opportunity to realise one of the core missions of an academic health science centre; to bring leading edge research into the routine care of patients in the local community.

Context

The context in which merger and closer integration is being pursued could have a significant impact on the outcome. In this section we consider the national and local drivers for KHP services, education and research. We begin with some key facts and figures about the constituent organisations of KHP.

King’s Health Partners – constituent organisations

In 2012 the three NHS foundation trusts have a combined income of just under £2.13 billion. The summary analysis in Appendix B (pp 36–38) shows that the three NHS trusts bring different levels of income into the partnership, have different service profiles and different percentages of activity arising from the local community in Lambeth and Southwark. This analysis is important because it could influence the power dynamic in the partnership as merger is pursued and the priority placed on services, such as community, in the merged organisation.

The local community

The local community served by KHP - Lambeth, Southwark and surrounding boroughs, has some significant health and social care challenges. There are stark inequalities. For example, in Lambeth and Southwark nearly 40 per cent of children and just over 33 per cent of adults live in income-deprived households. There are high rates of alcohol and drug misuse, and associated violent crime. The high ethnic diversity is a source of cultural richness but also brings vulnerability to chronic disease and socio-economic challenges. Half of young black men in the two boroughs are unemployed, and the poor economic environment could worsen this position. However, as the work done in ‘Exploring Our Futures’ (www.exploringourfutures.org) identified, there is a well-developed sense of community and some emerging innovative partnerships between statutory and voluntary sectors, including primary care.

In addition, rates of chronic disease such as diabetes are expected to grow by over 60 per cent in the next 20 years. Rates of multi-morbidity in those with chronic disease are high (over 40 per cent), and, as highlighted by Barnett *et al* (2012), higher still in populations that are economically deprived. As we see later in this report, local stakeholders feel strongly that KHP needs to demonstrate how it will respond to these local needs. The conclusion from ‘Exploring our Futures’ was the need for integration and co-ordination across health and social care services, statutory and voluntary and a much stronger focus on prevention and wellbeing.

And we want ....to know how [the merger] is going to benefit Southwark’s residents, and improve the outcomes, and help with health inequalities …
(Local stakeholder)

I don’t think they have articulated the benefits for local people … how the merger will improve local people’s experience.
(Local stakeholder)

National service context

The national context for NHS services is challenging. The NHS is at the beginning of the longest period of financial austerity in its history. The Nicholson Challenge of £20 billion productivity savings by 2014/15 may well extend to £50 billion by 2021 (Appleby 2012). At the same time the NHS is likely to face significant growth in demand. For example, the number of people over 85 is expected to double by 2032 and the number of people with multiple chronic conditions to grow from 1.9 million to more than 2.9 million between 2008 and 2018. New information and medical technologies may exacerbate immediate cost pressures but could also provide new and more effective means to address demand.

…the outside world is changing at a pace that is much faster than ever before with a demography of health and the expectations of society, the rapidly changing science base, the need for health care industries to be profitable etc…
(External stakeholder)

Several argued that the financial context created a strong imperative for merger and merger at pace before it was driven by necessity – for example, if the three foundation trusts started failing financially – rather than volition, as it is currently.

The NHS is also in a period of significant structural and regulatory upheaval. There is a new commissioning framework, strategic health authorities (SHAs) and primary care trusts (PCTs) have been abolished and replaced by the NHS Commissioning Board, clinical commissioning groups and local authorities (who have taken on significant elements of public health budgets). Many of those we interviewed were acutely aware of this context and the challenges ahead.

Given the NHS restructure – CCGs, commissioning board, NHS London going, half the expertise lost from local PCT, any qualified provider, South London Healthcare, and then the proposal for the merger on top – it just feel there is an awful lot going on at the moment. Perhaps this is a bridge too far?
(Local stakeholder)

Monitor's role is changing to that of economic regulator, and competition law is expected to have a greater role in shaping the configuration of services. A key issue for the proposed merger will be the need to satisfy Monitor and the Office for Fair Trading (OFT) that the proposed merger will be in the best interests of patients and not anti-competitive. This is a significant hurdle for the partner foundation trusts, and it is by no means certain that it will be overcome.

The new framework for specialised commissioning also has particular significance for KHP. The current assumption is that a significant proportion of KHP's services – more than half on most estimates – will be commissioned by

the NHS Commissioning Board via their London Local Area Team (LAT), who will potentially have a 'controlling interest' over KHP's services. One stakeholder suggested that the NHS Commissioning Board may be a stronger commissioner of specialist services and drive faster reconfiguration of specialist services.

Going back to the national commissioning board and the impact that will have, I think that will potentially enable much swifter change to be required, in terms of how many services you might accredit and so there could be a much greater call from commissioners to change the pattern and portfolio of services, so I think there's something about this as an opportunity for the partners locally to take that into their own hands rather than waiting for commissioners to tell them – and do that in a way that potentially reflects more what local people would need. (Local stakeholder)

Under the new commissioning arrangements, the NHS Commissioning Board will have a significant influence on the proposed new entity. This will happen regardless of a merger. Estimates we were given were that they will commission 60 to 70 per cent of GST's activity, perhaps half of King's College Hospitals', though an appreciably smaller element of SLaM's. This makes it likely that over half of the merged entity's activity will be bought by the NHS Commissioning Board, whose prime interest is specialist services.

It is not clear whether the NHS Commissioning Board and its local area teams would therefore support actions needed for the effective development of community-based and integrated services, for example, the development of new local currencies outside the standard tariff. The three foundation trusts already pull in activity from well outside their local area. But without the active and practical support for the vision from the key purchasers by volume – the NHS Commissioning Board and the local CCGs – there is much less chance of the wider goals of the merger, beyond reconfiguring specialist services and gaining better academic inputs into them – being realised.

South London Context

The Regime for Unsustainable NHS Providers was enacted in July 2012 to find a financially sustainable solution for South London Healthcare NHS Trust (SLHT) and the south-east London health system as a whole. At that time SLHT was spending around £1 million per week more than it had[1]. South London Healthcare (SLHT) includes three main hospital sites (Queen Elizabeth Greenwich, Princess Royal Bromley and Queen Mary's Sidcup (see Figure 2 below)). The Trust Special Administrator (TSA), appointed to review the future

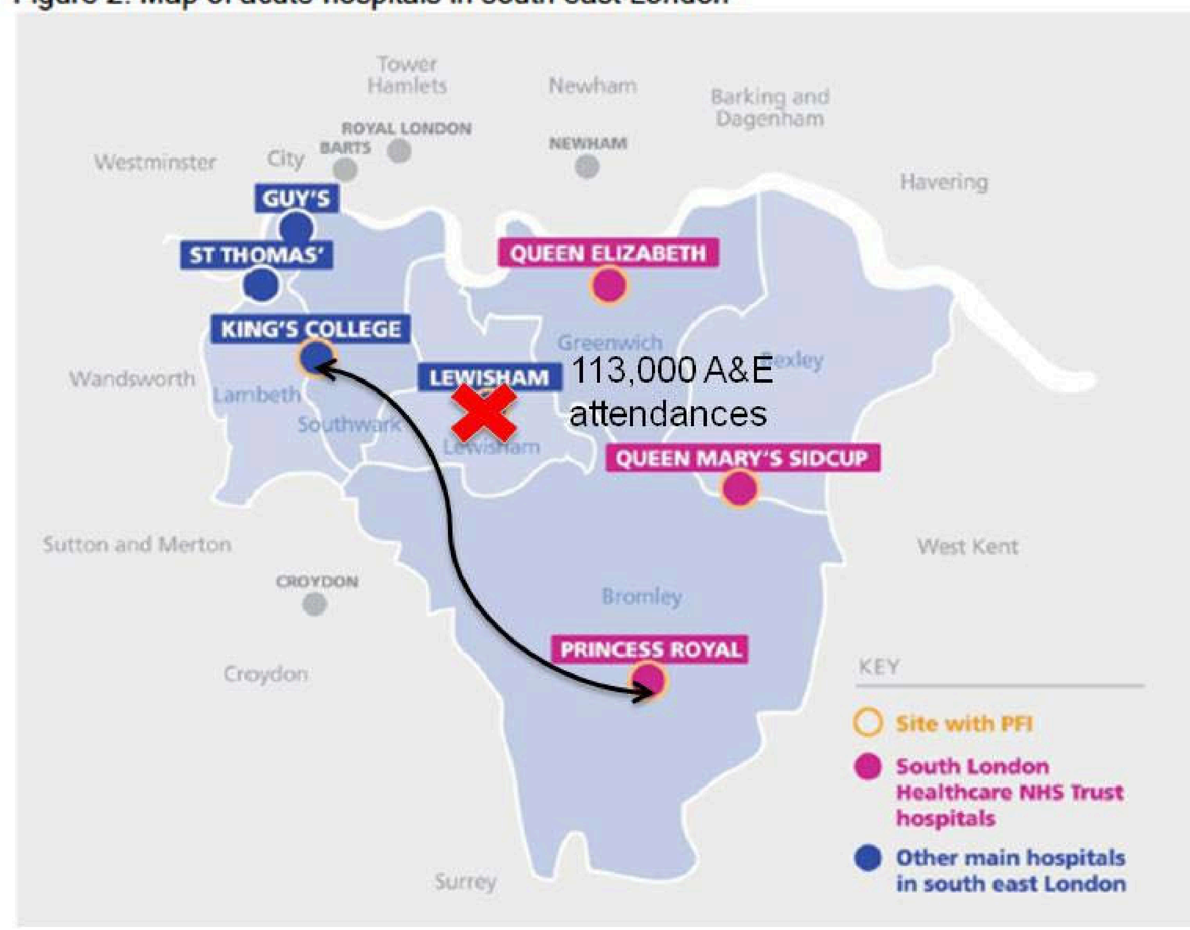
[1] Source: Draft Report - Securing sustainable NHS services: Consultation on the Trust Special Administrator's draft report for South London Healthcare NHS Trust and the NHS in south east London. October 2012

of SLHT will deliver his final recommendations to the Secretary of State on 7 January 2013, who will make his decision by Friday 1 February 2013.

The TSA has made a number of recommendations in his draft report that have implications for King's Health Partners and the proposed merger. The first recommendation is that King's College Hospital, on behalf of King's Health Partners (KHP), is the TSA's preferred provider to run Bromley's Princess Royal University Hospital (PRUH). King's has expressed an interest in running the PRUH, and is currently looking at the proposals in more detail. In a press release issued by KCH, Tim Smart, Chief Executive of King's College Hospital, said*: We are fully supportive of the TSA's plans to establish a solution for South East London. We believe that this process will strengthen the hospitals that make up SLHT and benefit the populations they serve. It also reinforces the momentum to develop King's Health Partners as an integrated academic health sciences centre, which remains our goal.* If this does not happen, the option would be a full tender process to identify other organisations with an interest in running the PRUH.

The second recommendation with significant implications for KHP is that Lewisham Hospital will cease to provide care for the most critically unwell patients who require admission after attending A&E. The current A&E at Lewisham has more than 113,000 A&E attendances per annum. This will have consequences for the future service and income profile of KHP.

Figure 2: Map of acute hospitals in south east London



Source: Map Office Trust Special Administrator Draft Report October 2012
(with The King's Fund's annotations: X - Lewisham A&E -> Urgent Care Centre, Proposed merger King's College Hospital and Princess Royal University Hospital, Bromley)

Stakeholder views about the impact and consequences of the South London proposals varied. In general there was anxiety about the impact of the new patient flows resulting from the proposed changes at Lewisham, a suspicion that many more patients could flow into central London than are anticipated in the TSA's analysis, and a lack of clarity about how the proposals for the merger of King's and Princess Royal fitted with the KHP merger and vision. There was anxiety that the merger between KCH and PRUH could undermine the viability of the proposed elective centre at Lewisham and thus services at Lewisham more generally. There was also concern that an extension of King's role further out into South London may make it more difficult to get regulatory approval.

The SLH issue – again unknown and quite de-stabilising at the moment.

If King's takes over Bromley, will that worry competition regulators more?

As this report explores, merger is a resource-intensive process, and there are important questions about the feasibility of King's pursuing a merger with

Princess Royal at the same time as the merger within KHP. It is important to note that at this stage King's has not undertaken a full due diligence review of the PRUH and until this is complete it will not be clear that a merger between King's and PRUH is a financially viable and sustainable path.

Context – Research and Education

In May 2012 KHP commissioned an external assessment of the current drivers of change in academia, both research and education, and the consequent challenges and opportunities for KHP. The report was written by Cherill Scott (some key extracts are provided in Appendix D, p 40). The report described the pressures on teaching and research to become 'more professionalised' with demonstrable outcomes on delivery. In some organisations these pressures have resulted in an increasing separation of service, teaching and academic roles not their closer integration, as envisaged by the vision for Academic Health Science Centres. Cherill Scott said in her report:

We have touched on other trends which could threaten the cohesion of the 'tripartite' enterprise: the increasing professionalisation and regulation of research and educational activities, the time and expertise which they require, and the imperatives for KCL to preserve its standards of excellence across all its academic schools, not just those concerned with healthcare.

It is an argument that is not entirely bought by King's College.

"Yes, I see the argument. I'm not sure that I buy it, because what does professionalisation of research mean in practice? It means that we've got to submit high quality work to the research excellence framework if we want to get funding for it or grants from the national institute of health research, so yes, we need that level of performance from the NHS people who are taking part in research, but after all that's an accepted standard of quality - of course we have to facilitate that and that's part of the logic of this greater coordination of research across KHP that I was referring to before. On the teaching side, the greater professionalisation of teaching - that's true of measuring it through the national student's survey and so on, but were not necessarily looking here for teaching wizardry! We're looking for people who are reliably delivering high quality, caring clinical teaching to our undergraduates - there's nothing new in that." KHP Partner

The opportunities presented by the merger – the external stakeholder perspective

Overall, our interviews, with the proviso that they were only with a limited number of local stakeholders, picked up little outright hostility to the merger proposal. Many, however, raised concerns about the risks. We explore these concerns in the next section.

It is fundamentally a good idea. But it is a profound managerial challenge. I would want to be sure that they have understood the scale of that challenge and have the people who are up to doing it. (External stakeholder)

Many we spoke to understood and appreciated the potential benefits to specialist services.

The benefits for research and specialist care have been well explained, which is brilliant and we don't want to stop that …
(Local stakeholder)

We are in favour of bringing academic research to frontline medicine if it can be made to work and from the work KHP have done so far then it seems like it is, then brilliant.
(Local stakeholder)

There was also enthusiasm for bringing mental and physical health closer together.

Every professional fibre in my body says that they should be aligned … putting them together is both symbolic – it would be a very important national message that this can happen with such a high- profile trust – but it also speaks to what we're beginning to understand about the biology of these conditions – biology doesn't really recognise the neck.
(External stakeholder)

Another stakeholder told us that given the rising tide of mental health issues among the elderly and the interaction with physical care: *to handle that as three separate trusts not talking to one another is no longer a runner*.

The opportunity to drive efficiencies was raised by a number of people.

I think it simplifies, speeds up, creates more scale for providers to deliver whole scale changes that result in cost saving.
(Local stakeholder)

Informatics and IT were also flagged as an area of opportunity.

I think IT, the use of bio informatics, IT to drive research and clinical care, that must be a huge potential win of a joint organisation.
(External stakeholder)

The challenges and risks presented by the merger – the external stakeholder perspective

Despite a widespread recognition of the potential benefits of the merger, most of those we interviewed are concerned about the potential risks.

- The history of mergers in all industries and in all sectors, private and public is poor. The benefits anticipated from a merger are frequently overstated and not realised (see also the next section on the evidence on mergers).
- There is a risk that mental health services become the Cinderella services in the merged organisation. The separation of mental health services into specialists trusts (now the norm) came from their poor experience in jointly managed organisations. Will history repeat itself?
- The proposed merged organisation will require significant leadership and management capacity /skills at all levels of the organisation. Will these be in place?
- Mergers can be a significant management distraction. Will this threaten the delivery of the core business in the short/medium term?
- There are significant cultural differences to be overcome, and the new culture needs to avoid the worst of the current organisational cultures.
- The merged organisation may become remote, unaccountable and monolithic, divorced from the local community and its staff?

There are also significant regulatory barriers to be overcome before the merger can proceed. Are partners fully aware of and prepared to overcome these barriers? One stakeholder suggested that risks should be put into two 'buckets'.

So, I would think about the issues and risks in 2 buckets – 1 is the bucket of deciding it's the right thing to do and getting it 'approved', then a separate bucket which is about assuming you get it approved, where do the risks lie – which I think are around implementation planning, people risks, losing talent, getting the financial model wrong, losing control, not delivering to the time frame. (External stakeholder)

Mergers – a poor track record of success

While there are successful examples of mergers, and the factors leading to success are well understood, mergers generally have a poor track record (see the next section on the evidence from the literature). This poor track record was a significant source of concern for a number of those we spoke to.

My worry about potential negatives is that for mergers of this size there is hardly any evidence that they succeed, in the commercial world or the public sector. So that is obviously a worry. That you would be creating something so large, without precedent, that there would be failures – particularly at a time when the NHS is under strain financially and in terms of reorganisation.
(Local stakeholder)

Risks to mental health services

Mental health services present some of the greatest opportunities to the merger but also face some of the most significant risks. People we interviewed were very mindful of the history of mental health services becoming the poor relation when managed together with acute services.

The lessons from history are that when you put mental health and physical health together mental health does come off worse.
(Local stakeholder)

The issue that led to the development of specialist mental health trust is that mental health gets lost.
(External stakeholder)

The stakes for mental health services are thought to be particularly high given the current high standing of SLaM and the Institute of Psychiatry.

Our mental health partner is, by general agreement, the leading NHS mental health trust and arguably one of the best mental health providers in the world.
(KHP partner)

It is worth emphasising, however, that senior figures within KHP repeatedly emphasised the view, and indeed volunteered it, that SLaM and the Institute of Psychiatry are seen as 'a jewel in the crown' of both KHP and King's College, whose successful integration as an equal partner in the new entity is seen as central to the proposition.

The most distinguished bit of King's Health Partners, probably, is mental health – SlaM and the Institute of Psychiatry. And what kind of idiot would jeopardise that?
(KHP partner)

Cultural challenges

As the literature shows (see next section), culture plays a significant part in determining the success or otherwise of a merger. Many we spoke to felt that there are significant cultural differences between the partners that could present a major barrier to a successful merger outcome. Many were mindful of the experience of Guy's and St Thomas' merger and tensions that created.

[There are] hundreds of years of conflict and tension between GSTT and King's. Will it mean some bloody fights between acute trusts?
(Local stakeholder)

Leadership and management capacity

To create an organisation with a turnover of more than £2 billion and to merge three large organisations with long histories and different cultures is a significant leadership challenge and managerial undertaking. Several stakeholders expressed concern about whether that capacity was present currently or could be easily obtained.

My other worry is whether the NHS has got the management skills, the staff, the leadership to manage an enterprise on this scale? There is a real danger, for example, that those relatively rare people who are top managers in the NHS – and being a top manager in the NHS is one of the most demanding jobs I have ever seen in my life – are you going to get them to want to be in a subsidiary position of being the site manager of St Thomas's, or the site manager of the Maudsley?
(External stakeholder)

Risks to performance and delivery

Organisations going through merger frequently experience dips in their performance, both during and immediately after merger, as the merger distracts from core business. Several we spoke to were worried about this.

The most immediate risk is its going to absorb a huge amount of management time. Even the full business case looks like it's going to be quite expensive, but it is a diversion of management time – probably for the next two years, the earliest date seems to be early 2015 that this would be finalised – that is a little worrying.
(Local stakeholder)

[A key risk?] Well just the diversion of energy from the business of making people better and improving.
(External view)

Quality of response to patients will get worse before it gets better if it ever gets better.

(Local stakeholder)

Creating a remote, unaccountable and monolithic organisation
The scale of the merged organisation was seen to be a significant risk – would it become remote, unaccountable and monolithic?

It's all to do with disempowerment of staff, becoming part of a gigantic enterprise and not feeling they're in charge of their day-to-day lives.
(External stakeholder)

You create a monolith, which is very difficult to govern internally, but is also very difficult to work with.
(Local stakeholder)

If you just go and talk to anybody for five minutes at St Mary's hospital or Charing Cross, the sense of feeling disempowered by their mergers into bigger systems is large.
(External stakeholder speaking about hospital consultants' views)

Mergers – what the evidence tells us

Mergers carry significant risks and often fail because the nature of those risks are not fully appreciated and as a result are inadequately mitigated. Despite many examples of failure, successful mergers do take place across all industries and the literature provides examples of them. Below we summarise some of the key messages from the literature on mergers across all industries, including health care.

Quantifying and realising the benefits
A frequent problem in mergers is a failure to clarify objectives and how they will be achieved. There is also a tendency to be unduly optimistic about the financial and non-financial benefits. In health care there is a particular tendency to have both stated and unstated objectives that may conflict with each other. All benefits and the means by which a merger will help their achievement should be articulated.

Risks to performance
In all industries, mergers can present a significant risk to organisational performance and result in planning blight that delays necessary service developments. Contributory factors include incompatible management and governance systems and confusion during merger around roles and responsibilities. Strong performance management and governance will be critical to achieving a merger's objectives, before, during and after the merger.

Planning

Mergers frequently fail because of inadequate preparation and planning, including investment in robust due diligence. It is critical that a merger has sufficient support to address the scale of the change management task. Planning is also needed at all levels of the organisation, in the case of health care, from board to ward.

Managing human resources

There are many people challenges created by a merger including difficulties in integrating working practices, loss of morale, fear of job loss and employee stress. It is very important that these aspects of merging are addressed. Strategies that can help include undertaking 'human' due diligence; timely and robust appointment processes; investment in staff development activities including team building. In health care, clinical engagement is critical to a merger's success.

Culture and communication

Addressing issues of culture and communication are critical to the successful outcome from a merger. The evidence is that while culture and communications are frequently identified as a key concern, they are rarely allocated sufficient resources. A key challenge is to address early concerns about jobs and benefits to ensure that staff can focus on organisational performance.

Conclusion

The chances that mergers will be successful are considerably enhanced if boards and their organisations follow best practice. This includes:

- clear and quantifiable objectives
- effective due diligence
- adequate resourcing
- good pre- and post-implementation planning
- significant attention to the human agenda, including cultural issues
- in health care specifically, clinical engagement and leadership is critical.

What KHP and the merging trusts will need to get right if they are to succeed

In consideration of the views expressed by internal and external stakeholders, and insights from the literature on mergers in and outside the health care sectors, the following six issues have been identified as important determinants of the merger's success should it go ahead. In effect these are areas that

require careful planning even in advance of the formal execution of the merger. Put simply, a merger agreement at the level of the Partnership Board and the signing of contracts is only the beginning of a merger. The success of the merger will depend on what comes afterwards. That is, a merger is a process not an event.

The other thing I noticed [in my previous experience with a merger] was that it's very easy for the process of merger to become the business – once the merger is achieved there needs to be some prior planning about what's effectively a huge gear change from achieving the merger to actually getting the new organisation running sweetly. These two things have to operate in parallel – they're two projects I think.
(External stakeholder)

1. Create clear shared goals

The proposed merger is multifaceted. It is intended to create scale for research, improve the quality and efficiency of inpatient specialist services by centralising and rationalising them, and support the development of community-led integrated care. However, the diversity of these goals carries the potential for conflict both among the goals and in the mechanisms by which they may be achieved. For example, specialist services need to focus on increasing concentration and rationalisation while integrated care needs to focus on increasing the links to the community and the geographical spread of services. Moreover, Academic Health Science Centres have a tripartite mission: research, teaching and clinical care. By their nature these organisations are prone to an internal tussle between the resource needs of these three missions. The three missions are often treated as if they require trade-offs among them, for example, investments in research being seen as taking money from clinical teaching. Less often are these three missions seen as complementary. Finally, the proposed merger combines horizontal and vertical integration—the former combining the inpatient specialist units, and the latter combining tertiary secondary, primary and community care—with the risk that one crowds the other out.

In our interviews different stakeholders emphasised different elements of the merger. Each focused on, and was attracted to or rejected, a subset of the proposal's elements. For example, most CAG leaders framed the merger in terms of inpatient services while those from SLaM emphasised the community care issues.

Both the literature on mergers and some of those interviewed emphasise the importance of clear, unambiguous and measureable goals. Clarity about the proposed merger's goals is needed not only to reduce the anxiety and uncertainty for those individuals and organisations likely to be affected by the

merger but also so that an appropriate approach to the merger and its execution can be developed.

You need very clear and specific gains to be made clear for all parties. Everything so far from KHP has been far too conceptual and aspirational and not gritty and specific enough. You need these gritty objectives to help get through what is bound to be a very difficult and challenging process. (Local stakeholder)

In the strategic outline case other opportunities were included as well [beyond the research benefits of an academic health science centre], but for me – I start to worry that you're trying to address lots of different issues - you need to look at one issue you're trying to address and then create the structure that supports that, otherwise you'll be trying to create a model that's solving different problems and I would worry that that might not work.
(Local stakeholder)

The diversity of perspectives and potential goal conflict places a burden on the Partnership Board, which must ensure that the goals of the merger, and the mechanisms by which these goals are to be realised, are clearly articulated, transparent and public.

In practice this means several things:

- the diversity of the goals needs to be acknowledged,
- the potential synergies between the merger's many components needs to be explored, developed and articulated
- public consultation needs to focus all the aspects of the merger and not emphasise different elements in different settings.

2. Establish a clear a structure for decision-making authority

One of the key motivators for the merger, particularly in the minds of the current CAG leadership, is the complexity of decision-making processes in the partnership. Currently, service reconfigurations need to be approved by at a minimum of two, but more often three or even four, different organisations. Although there is a clear case that centralising volume for complex patient groups or procedures is a prerequisite of quality improvement, sub-specialisation and clinical research, in practice this has been hard to achieve across the entire partnership. CAG leaders believe that one of the proposed merger's main advantages would be to reduce the number of decision-making bodies to which they would need to take their proposals for service reconfiguration.

The question we are all asking ourselves is [if] what's being proposed is a different governance model – [and] if we ask what the governance model is – the answer we get is 'well we haven't really thought about that yet …'
(Local stakeholder)

If simpler and more expeditious decision-making is one of the merger's goals then the question of in whom and at what levels in the new organisation's decision-making authority is vested merits careful consideration. A thoughtful balance needs to be struck between central integration and direction-setting and decentralised control. If control is too centralised it risks defeating this goal of the merger. But if it is too decentralised it risks replacing one set of silos with another or dissipating accountability.

The governance mishaps we have been having recently in any big organisation seem to be that the people at the top say 'we didn't know what was going on down below.' So if you have this massive organisation in this very centralised model you'll either get a model [in which] too much will have to go to the top, and that'll be very slow, or if you devolve things then those at the top don't really know what's going on ….
(Local stakeholder)

Moreover, to realise improvement in the integration of care across the primary–secondary interface will require careful planning of the allocation of decision rights.

This means that:

- the Partnership Board needs to identify where decision rights for key decisions will lie and what degrees of freedom leaders in important subunits will have
- in particular, the Board will need to both vest authority in and create processes for operating budget control, capital allocation, and staff recruiting, promotion, incentives, and discipline.

3. Design a complementary operational architecture

The merged entity's diversity, described above, relates not only to its goals but also to its operations. The merged entity will provide community care, community-level inpatient care, care for complex patients and rare conditions as well as undertaking basic and clinical research and teaching. The operating models for each of these activities differ, comprising, for example:

- high-volume surgical centre undertaking repeatable elective procedures
- hospital-based disease/condition integrated practice units (the 'institutes' model)
- community-based integrated care organisations configured around populations and needs (eg., end-of-life, frail elderly).

The literature on operations performance in health care suggests that these are best viewed as distinct operations. As Skinner wrote in 1974 'a factory that focuses on a narrow product mix and for a particular market niche will outperform the conventional plant, which attempts a broader mission'. In effect this merger would, to a greater extent than the constituent organisations already are, be the combination of a community care service, a primary care clinic, a district general hospital, a tertiary / quaternary hospital, a laboratory and a university—effectively a 'plant-within-a-plant' model. Moreover, the existing CAG structure may need to evolve as medicine and health care change and the needs of frail elderly and patients with multiple concurrent co-morbidities dominate the work of all health care institutions.

… the crunch will come in how we carve up this monster, because one thing that must not happen is that we end up with a 2.3 [billion pound] … megatrust, which is slow. Now there are two challenges in that. One is that … it is actually quite difficult to create boundaries which are sufficiently robust…. and porous … [so] that you can actually expect those to run as business units pretty autonomously.
(KHP partner)

Success of a merger will depend in part on creating a coherent operating design that does two things. First, it must accommodate the differing needs of different patient segments and create a system to manage the flow of patients among subunits. In particular, and in the light of community concerns that the merger risks focusing more on academic medicine than community-based integrated care and the needs of the community, a well-developed operational model of integrated care spanning general practice, community services, hospital outpatient clinics and short-stay facilities will be important. Second, it will have to create a clear demarcation between shared services—such as capital budgeting processes, procurement, human resources, and information systems—and specialist units. For example, each specialist unit will doubtless make demands for its own information system, yet the specialised care units and the research function will both benefit from data that can be shared.

The immediate implication for the Partnership Board is that some careful planning will be required to identify the ideal ultimate operating structure:

- the units' structures and scopes of activities, and where unit boundaries will lay
- the structure of shared services
- the processes for managing the flow of patients and information among the units.

4. Ensure leadership capability

Complex operations, diverse goals and distributed control all put a premium on board, senior and mid-level leadership. The size and complexity of the merged enterprise will clearly be a challenge for the incoming board, although many large corporations and government agencies successfully manage enterprises of equivalent size and complexity. Some of the important early decisions will revolve around the reconfiguration of services within the merged organisation: which specialist services will be concentrated on which sites and therefore which will lose a service. KHP will still not be a fully integrated organisation. It will still consist of the board of King's College and the board for the three foundation trusts. In other words, for some changes the approval of two boards will still be required, as opposed to, potentially, four at present. That will still leave hard decisions and potential trade-offs to be made. Our interviewees told us that the KHP Board has yet to take any really hard decisions. Indeed, one cited the inability at the time of the interviews to agree a relatively simple land swap between King's College, London, and GST as an example of a potential inability to do that in the longer term.

The leadership capabilities of mid-level clinical leaders will also be particularly important in this merger. Realising the merger's goals will depend to a large degree on effective partnerships between local administrative and clinical leaders and managers. The need for mid-level leadership capability arises from the nature of the change management work that will be necessary to make the merger work at the 'front line.' Such leadership will be critical to negotiating the relocation of specialist services; brokering effective partnerships between primary and inpatient care services; integrating physical, mental and social services; managing clinician performance to assure both quality and efficiency; and balancing the needs of the university with those of the care units.

We had exactly the right leader to lead the process of merging, but that person was not necessarily the right leader to drive the new organisation …. We used to think of it as one process to get everyone into the same big tent but actually it's quite different to then look at everyone who's in the tent and think, well, do we need you all in the new organisation? You want everyone in to begin with but then one has to be quite brutal about what the new organisation needs.
(External stakeholder)

These tasks will be necessary in each specialty service and each geographical region, meaning that a large group of capable mid-level leaders will be needed. And they will be made easier if there is a clear message, sense of direction and set of goals coming from the board (Recommendation 1, above).

Hence the board will have to have a plan to:

- carefully evaluate the leadership capabilities of those clinical and non-clinical leaders currently in post

- recruit clinical leaders where willing and able candidates are not already in place
- establish a leadership and management development strategy.

5. Harmonise the culture and preserve identities

An organisation's culture is defined by employees' underlying beliefs about the organisation's purpose and 'how we do things here.' Senior leaders play an important role in shaping these beliefs. The existing organisations have strong identities and cultures, making it challenging to create unity. Moreover, one of the potential partners (SLaM), essential to the merged entity's value proposition, risks losing its unique identity if it becomes a small (annual revenue £364 million) component of a lager (annual revenue £2.1 billion+) organisation.

I think the cultural issue is a real one because there [was] a huge difference between the three sites always historically in cultural terms … In a funny sort of way … King's has always found its identify in not being Guy's and St Thomas.
(KHP partner)

Hence how the goals of the merger are developed and how senior leaders communicate, and more importantly act, will be important in shaping the culture of the future organisation. Troublingly, community stakeholders are already reporting that they hear a story of the proposed merger that is weighted to the merger's academic aspirations, regardless of the message intended by the Partnership Board.

Creating a unified culture will require sophisticated and strong leadership that reinforces the desired behaviours through all the organisational incentives and structures.

You need to understand what cultures you want in an organisation and how far everyone is from being there. You need to properly understand the starting position and the 'distance between the parties'. KHP recognises that there are differences but they have not really got underneath them. For example – what matters in this organisation; what is rewarded what gets promotions; where is actual power here; who makes what decisions; how much delegation really; what do frontline team think about support services; is this a listening organisation or a bit of sham bottom up vs top down; what do people fear; how is poor performance managed? A cultural audit is needed to get underneath these.
(Local stakeholder)

The board must give clear messages and back these messages with consistent actions, including appropriate incentives and performance management, as an essential part of creating a unified culture.

6. Develop a sophisticated system for assessing and rewarding performance

Again related to Recommendation 1, how the merged organisation defines and measures success will be very important. In particular, how fixed costs are allocated and financial and quality performance defined exerts a powerful influence over behaviour within an organisation. If care integration is successful at reducing unnecessary admissions and the consolidated specialist services attract complex patients both nationally and internationally, then the inpatient costs per patient are likely to rise, something for which the specialist services must not be penalised. Conversely, integrated care programmes may increase the primary care spending per patient and thus look financially less viable compared to specialist services, which cannot be allowed to starve these programmes of vital investment.

In such an operationally diverse institution each component of a merged entity contributes something different to the whole, and the performance of each needs to be measured differently as appropriate, for example, repeatable procedures by cost-per-case, complex patients by re-admission rate, end-of-life care by quality of life, etc. Without this, some units may be viewed as underperforming when they are in fact optimising a different dimension of care. Such sophisticated reporting and performance management systems will require the integration of information systems across the merged entity to allow analysis of the unified enterprise.

A similar issue arises in the job descriptions and reward systems for those staff who work in multiple areas in the merged entity. Poorly designed reward systems can penalise those who contribute to multiple organisational goals simultaneously, thus creating a disincentive to combine teaching research and care. A sophisticated measurement and assessment will also be required at the level of individual staff.

The trusts … need to be encouraging job plans that allow adequate time for high-quality substantial inputs into teaching and/or research.
(KHP partner)

The merged entity will need to develop a nuanced, outcome- and value-focused measurement and reporting system (ie, balanced scorecard) and a nuanced

professional reward system for staff who take on multiple roles in teaching, clinical care and research.

A case study from The King's Fund: Working alongside foundation trusts as they move towards merger

Our 'on the ground' experience of organisation change is that 'culture eats strategy for breakfast '. Consequently, it is very important for organisations to identify what is good in their existing cultures, as a basis of creating a unique vision that is supported by all. A methodology such as Appreciative Inquiry can allow staff from all disciplines, sites, and grades to engage in purposeful conversations across the merging organisations to share their stories about what makes their existing organisation good, and about their hopes for the new organisation. A representative team of internal change agents (formal and informal leaders across the organisations who have taken up the opportunity to influence the future) have proved a powerful means of driving change. Small (pairs) and big (100 plus) conversations can create a dynamic and energy in both organisations and an opportunity for staff (including non-executive directors and governors) to get involved in the merger process. This is about both managing the legacy of each organisation and shaping the culture of the new.

The behaviour of the board is critical. Staff continue to look to their current leaders and watch for signs that they are confident in the fairness and transparency of processes and in the rationale for the merger. Engaging early in the development of the new board allows members to begin to articulate the vision and strategy of the new organisation, to discuss unified governance arrangements and to identify benefits of the merger that can be realised and signalled to staff in the first six to twelve months (the early wins that will maintain the momentum). Medical engagement is crucial; benchmarking levels of engagement in both organisations through the Medical Engagement Survey (MES) gives all medical staff an opportunity to influence the medical engagement strategy for the merged organisation and provides a baseline from which to work and an indication of where to focus. Other essential work streams include talent management and leadership development, with a focus on retaining the talent and developing leaders at all levels with the ambition and skills to succeed.

All of these activities are aspects of an integrated organisational development plan. The plan will be a guide to action; senior leaders will continue to make sense of and address cultural challenges as the merger journey unfolds.

Irene Hewitt and Katy Steward, The King's Fund Leadership Faculty

What are the alternatives to merger and what are the risks?

Potentially, there are a wide range of alternatives to a full merger, none of which are risk free. For example, the two acute trusts could merge, leaving SLaM as a freestanding foundation trust. It is doubtful that would be any easier to get through the regulatory hurdles than a full-blown merger. It would still leave the cross-funding difficulties that CAG leaders have identified as a key driver for merger, although on a smaller scale, affecting chiefly the goal of integrating physical and mental health, both in hospital and the community. It would reduce the four boards involved in KHP decision-making to three. It is not obviously a better solution than either the status quo or a full merger of the foundation trusts.

Those we spoke to identified two main alternatives to full-blown merger as a means to realise the partnership goals. The first is to try and realise the stated merger goals within the current partnership structure. For example:

- develop community services comprising hospital-based specialists working part time in the community with a coalition of NGOs and GPs
- second psychiatry to acute medical services as is already happening
- agree on 'service swaps' among existing partners (brokered by Partnership Board).

That approach broadly amounts to the status quo, but driven harder. As one KHP partner put it to us:

It is not that we can't do what we want to do. I think we can. It is just that it is extremely inefficient, and slow. There are all sorts of impediments. So the language I use is that we can go further faster. That is the hypothesis. At the moment we are kind of living with the worst of all worlds. We are sort of behaving like a single organisation. We are trying to. But we are falling over repeatedly because we are not. And that itself consumes a certain amount of time and energy.

The second is to create new 'joint venture' structures for specific purposes, each stopping short of full merger. These could include:

- jointly owned new provider organisations to provide integrated community services that purchase specialist services from the partners
- specialist services included in an independent, jointly owned 'special purpose vehicle.'

The way I think about it there are three models, there's the SOC (strategic outline case) which is the fully leaded merger, there is SOC minus which is the SPV [special purpose vehicle] holding company model and there is SOC plus which is vertical integration in my mind. The question is, do you achieve 70 per cent, 80 per cent, 100 per cent, of the benefits in any of those models and at what cost and what risk?
(KHP partner)

Exploring precisely what joint ventures might be created, and in what form, is beyond the scope of this paper. Each would require a significant business case in its own right. And the big risk from such an approach is that it would create even more 'businesses' and silos than the current structure, each of which would be tempted to look after its own interest at the expense of the whole. Such approaches can work well when providing a service across organisations – HR, IT support, laboratory services, for example. It is much less clear it would work well when these joint ventures were operating as discrete entities in an organisation within which the boundaries between specialities are likely to be fluid over time.

The risks if the NHS partners do not merge

It is not clear that status quo is stable. The NHS partner organisations in KHP may either have to move on to closer integration or see it move back – particularly as the spending squeeze gets tighter.

As that happens, some of those we spoke to within KHP believe the requirement for the three foundation trusts to protect their bottom line will get stronger. As a result, trade-offs to support service reconfiguration such as took place for bone marrow and vascular services would get harder. The argument is that a single, larger, organisation would be better placed to cope with austerity to come.

We will be better placed to deal with that [the financial challenge] if we've already gone through the pain of merger – and there will be pain – because we will be a bigger organisation, better able to run through that.
(KHP partner)

The downside will be if we haven't done it. I would worry that the pressures of more and more financial challenge would begin to peel us apart and it would be a sort of dog eat dog mentality that would exist at that point. So we might then in ten years' time be like Imperial, merging three failing trusts.
(KHP partner)

Conclusion

There is a little bit of a danger of 'group think' that the three boards have been progressing down a path ... and you think you've got the answer already, and it doesn't really matter what comes out of the full business case, you're still going to do what you thought you were going to do? I don't think I'd have the knowledge to say, well you mustn't do it, for a certain set of reasons, but it just worries me that they're going down a path and they can't stop themselves now. The train has left the station. (Local stakeholder)

This report aims to help KHP avoid 'group think'. It lays out the significant risks presented by the merger, as well as the opportunities. Both the opportunities and risks are potentially magnified by the proposed merger taking place at a time of great organisational upheaval, both locally and nationally and with the spectre of continuing financial austerity for at least five, possibly ten, years.

The opportunities for specialist services presented by the merger have been well articulated by KHP and are well understood. The opportunities offered by bringing mental and physical health together are appreciated intellectually, but so far proposals lack detail on what this will mean in practice. The opportunities afforded by new ways of working with primary and community care require significantly better articulation by KHP for local stakeholders to feel confident in them.

The risks of the proposed merger rest in large part in four areas.

First, the degree to which there is clear buy-in from a significant number of the many clinicians who will be involved across the three organisations, and not just from their leaders. One of the potential advantages of this proposal over many other past NHS mergers is that the proposed merger is a voluntary one. It is not, at this stage, being forced by financial distress or quality issues. But to raise the chances of success, an understanding of the advantages that it could bring is needed deep into the organisation and not just limited to the board and the CAG leaders.

Second, it clearly requires active support from the key commissioners, including the NHS Commissioning Board, which will have a significant influence over the future of three foundation trusts, whether or not they merge. Local stakeholders, including the health and wellbeing boards and scrutiny committees, need to believe there is gain in this if the project is not to be mired in controversy.

We are less bothered about the organisational form, we are very bothered about outcomes and in particular trying to take a value-based approach to the delivery

of those outcomes. Therefore, the organisational form that best assures the delivery of that would be the one that would be most welcome.
(Local commissioner)

Third, as well as support from commissioners the organisation needs to work collaboratively and well with other key stakeholders in the community, including the relevant health and wellbeing boards and other local political representatives. Key to these relationships will be a credible and robust plan for the future of local community services and their closer integration with hospital and specialist services.

Fourth, before a decision to merge is made, the board needs to be clear that it has addressed the implementation issues outlined above and has effective answers to them. A decision to merge is just the beginning. The implementation challenge is clearly large and will require commitment from clinicians and senior and mid-level managers, with the way it is done being a far more important determinant of the ultimate success than the early conception and positioning. The likelihood for success can be increased by effective, early planning and preparation for meeting these implementation challenges, particularly in the areas of: making the case for the merger to staff and the community, supporting operational diversity, and identifying and developing effective clinical and non-clinical mid-level leaders.

Professor Richard Bohmer
Nick Timmins
Candace Imison

December 2012

The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

Appendix A

Terms of Reference for The King's Fund Review

The King's Fund is to lead a short, independent and objective review of the thinking that has gone into the SOC to date. The objective is to provide constructive input to the integration process KHP is engaged in. The review will not judge whether merger is the 'right' decision – that decision can only be taken by the KHP Partners Board and the four partners, but it will critically appraise the opportunities, challenges and risks of such a merger.

The King's Fund would establish a small panel to examine the thinking to date, focusing on the following questions:

- What are the potential benefits from establishing a single Academic Healthcare organisation, in particular benefits to local people as well as a contribution towards the excellence of the NHS generally? What are the anticipated means by which these benefits will be realised?
- Are there alternative ways that might realise the same goals and benefits?
- What are the key risks presented by the proposed merger? In particular, what organisational challenges are presented by the merger, including leadership and cultural issues?

The review will make no assessment of the financial model underpinning the business case.

Membership of The King's Fund Panel

- Professor Keith Peters, University of Cambridge
- Dr Claire Gerada, President, RCGP, and local GP
- Professor Peter Jones, University of Cambridge
- Professor Chris Ham, Chief Executive, The King's Fund
- Professor Richard Bohmer, Harvard Business School, Visiting Senior Fellow, The King's Fund
- Nick Timmins, Senior Fellow, The King's Fund.

The panel was supported by Candace Imison, Deputy Director of Policy, The King's Fund.

Methodology

The review is informed by five streams of evidence:

- reflections of the challenge group, who were interviewed individually and then met as a group to consider early findings

- more than 25 separate interviews undertaken with internal and external stakeholders, including:
    - challenge panel (3)
    - KHP stakeholders, including King's College (7)
    - CAG leads (3)
    - trust governors (3)
    - local authority – officers and OSCs (3)
    - local commissioners, including CCGs (3)
    - community rep (1)
    - GSTT Charity (1)
    - BLT merger lead (1)

  We have also met with CAG leaders as a group.

- expert advice from The King's Fund's leadership faculty

- a high-level review of the literature on organisational merger: key findings are included in this document and the full review is provided in Appendix E (pp 37 – 51)

- output from other related work including
    - the McKee Review (September 2011), which aimed to see what steps are needed to most effectively realise the ambitions for the AHSC
    - a review of the academic opportunities and challenges faced by KHP (June 2012)
    - a review of the local strategic issues in Lambeth and Southwark – 'Exploring our Futures' and its implications for KHP (May 2012).

Appendix B

King's Health Partners – Key Facts and Figures

Source: King's Health Partners

Table 1: Summary of NHS trusts' income, income type and sources

	GSTT	**KCH**	**SLaM**
Total income 2012	£1.136 billion	£629 million	£364 million
Trusts combined income (%)	53	30	17
Acute (%)	65	84	0
Mental health (%)	0	0	88
Other (%)	27	16	12
Community (%)	8	0	0
Clinical income from Lambeth & Southwark (%)	19	30	41
Staff	11,063	6,823	4,934
Property assets	£736 million	£293 million	£243 million

The breakdown of the combined NHS trust income by service type is:

- acute services –£1.27 billion (60 per cent)
- other (which includes training and R&D) – £450 million(21 per cent)
- mental health – £322 million (15 per cent)
- community services – £89 million (4 per cent).

In 2012/13 the predicted income for King's College London is £571 million.

Appendix C

KHP – Current Partners Board, Executive and Clinical Academic Groups – An overview

Source: http://www.kingshealthpartners.org/info/clinical-academic-groups

Appendix D

Some key findings from the report written by Cherill Scott, June 2012 (Discussion Document: academic opportunities and challenges)

> The professionalisation of research practice in universities that has been stimulated by the effects of successive Research Assessment Exercises (RAEs), increasing competition for research funding, rivalry between 'world-class' universities and, of course, the internal dynamics of many bio-medical science disciplines as specialties and sub-specialities have proliferated. The growing dominance of large and specialised research teams has made it more difficult to sustain traditional patterns of MD-led research. This has been reflecting in the declining proportion of NHS-employed clinicians involved in frontline research (at any rate, as represented by being entered in RAEs)(p7).
>
> A similar, although less intense, process of professionalisation has also taken with regard to university teaching. The growing sophistication of teaching programme structures, and increasing emphases on more formal approaches to student feedback, patterns of assessment and quality assurance, have tended to encourage the growth of learning-and-teaching specialists in universities. At the same time, pressure has grown for more higher education teachers to be 'trained'. The introduction of the National Student Survey (NSS) – and, in particular, its impact on university league tables – has intensified the cycle of feedback and scrutiny. As with research, the effect has probably been to discourage practising clinicians from engaging in teaching (p8).
>
> ....The 'weak link', therefore, in AHSCs (as it also tends to be in Academic Health Centres in the United States and similar arrangements in the rest of Europe) is likely to arise from the difficulty academic partners may face in reconciling the more generic imperatives arising from the development of higher education systems and the more specific demands arising from the need to build closer links with their service partners. These generic imperatives and specific demands, of course, are not inevitably in conflict. With creative responses and careful management their latent synergies can be developed. However, these synergies cannot be taken for granted (p8).

Appendix E

Mergers – what is the evidence?
A high-level review of the literature on mergers

Introduction

This paper sets out some of the key messages from a brief high-level review of the literature on mergers (drawing on more than 50 sources) including studies of the NHS, health care internationally, and the commercial sector. The largest body of literature relates to the commercial sector but much of it has relevance to the NHS.

Mergers are large, complex projects that require fast results, innovative thinking and collaboration. Most boards radically underestimate the time, disruption and effort that a merger will take. As a result, mergers frequently fail to realise their stated benefits, in both the health and the commercial sector. This paper explores some of the key risks associated with merger and the areas that the evidence suggests would help manage these risks and realise the anticipated benefits.

The paper covers:

- quantifying and realising the benefits from merger
- risks to performance from merger

and strategies to realise the benefits from merger

- well-resourced and detailed planning
- managing human resources
- culture and communication.

Quantifying and realising the benefits

This section explores some of the underlying issues associated with quantifying and realising the benefits – particularly in health care. This includes:

- setting out clear and measurable objectives – including at business unit level
- expressing optimism bias – particularly about economies of scale, and quality benefits in health care
- the risks presented by mandated mergers.

Setting out clear and measurable objectives

A common issue in failed mergers is a decision to merge taken at speed without sufficient clarity as to what the key objectives were or how they were to be achieved (Sirower 1997; Epstein 2005). In business sectors, defining value is easier and can normally be expressed in terms of shareholder value; however, this is more complex in health care. There is a tendency, particularly in NHS mergers, to have both stated and unstated drivers for a merger (Fulop *et al* 2005). Fulop warns that organisations can be left with unclear objectives where there is a conflict between unstated and stated drivers. Most of the business literature highlights the need to have a clear understanding of the true rationale for the transaction in order to fully define the approach (Christensen *et al* 2011). It is therefore particularly important in a health service context to have clear objectives in order to reduce stakeholder anxiety, minimise drift in the process and allow for effective evaluation (Ferguson and Goddard 1997; Fulop *et al* 2002; Gaynor *et al* 2012; Dranove 1998; Epstein 2005).

Plan at the business unit level

As part of the merger process, high-level plans at the business unit level are recommended, setting out the future mission, values, strategies and objectives for at least the first year, so that momentum can be quickly established and maintained (Ashkenas *et al* 2011). Hendel (1998) in a review of the merger of two obstetric divisions emphasised the importance of planning ahead, involving all partners from the early stages, extensive dialogue among colleagues and strong nursing leadership as key elements for a smooth transition. From the

outset, there is a need to set clear, quantifiable objectives for business units that can be directly attributable to the merger and can be monitored by senior management/board.

Optimism bias

Literature from the commercial sector highlights the tendency of leadership teams to express an optimism bias when setting out the benefits for merger (Braithwaite *et al* 2005). Fulop *et al* (2005) make similar observations with specific regard to health care transactions. There is a strong body of evidence that while mergers typically make savings in the form of reduction in managerial posts and back office functions, these are often overstated at the outset (Ferguson and Goddard 1997; Fulop *et al* 2002; Gaynor *et al* 2012). They can also be difficult to realise if sites continue to operate independently (Dranove and Lindrooth 2003).

Mixed evidence about economies of scale in health care

While mergers offer theoretical opportunities to lower costs by achieving economies of scale, several studies have noted that health care mergers often raise costs (Vogt and Town 2006; Kjekshus and Hagen 2007; Ahgren 2008). As Burns and Pauly noted 'economies of scale do not automatically flow from hospital size and merger' (p 132, 2002). There are a number of opposing factors concurrently affecting unit costs, which mean that economies of scale are not always realised in health care, for example:

- larger hospitals may have lower management costs per patient
- larger hospitals provide more specialist (potentially more expensive) services
- larger hospitals attract more complex cases from a wider area (NIHR Service Delivery and Organisation 2010). While this may reduce the unit costs of the specialist work, the specialist infrastructure may increase the unit cost of the more generalist work delivered in that setting
- larger hospital systems experience greater remoteness from leadership, reducing capacity to react and make decisions swiftly (Fulop *et al* 2005).

To fully realise benefits, a focus on wider clinical re-configuration is required

(Dranove and Lindrooth 2003; Dranove 1998; Kjekshus and Hagen 2007). Sloan *et al* (2003) argue that the most successful health care consolidations (in terms of cost savings) have occurred when one or more facility is closed and virtually all inpatient services are provided on one site.

Limited evidence about the impact on the quality of care from health care mergers

Clinical quality improvements are regularly stated drivers for hospital consolidation (Fulop *et al* 2005); however, there is a lack of conclusive evidence that mergers alone have a positive impact on clinical outcomes and some evidence of reductions in quality as a result of merger (Fulop *et al* 2002; Fulop *et al* 2005; Gaynor *et al* 2012; Ho and Hamilton 2000). A recent case study (KPMG 2011) of the merger of University Hospitals Birmingham provides an example of a merger that resulted in an organisation that post-merger has been able to deliver high-quality performance.

The risks presented by mandated mergers

KPMG (2011), using data from a survey that they undertook of health care providers, provide evidence to suggest that mandated mergers, that is those that are driven by stakeholders external to the organisations merging, are somewhat less likely to have successful outcomes and operate at a slower pace. They also showed that they were less likely to have undertaken due diligence as part of the merger process.

Key messages

Quantifying and realising the benefits – common problems:

- insufficient clarity about objectives and how they will be achieved
- boards have a tendency to express optimism bias with respect to expected benefits.

In health care there is a tendency:

- to overstate the benefits related to economies of scale
- to expect mergers to produce an increase in clinical quality – which are not always realised
- to overstate back office savings.

Risks to performance

There are a number of risks to performance through a merger process:

- service delivery decline
- loss of key staff and reductions in morale
- planning blight
- weak governance and supporting systems

Service delivery decline

The literature across all sectors highlights risks to organisational performance as a result of a merger (Dranove and Lindrooth 2003; Spang *et al* 2001; Digeorgio 2003; Christensen *et al* 2011; Sirower 1997). Gaynor *et al* (2012) found evidence of longer waiting times and poorer outcomes (such as mortality and readmission rates) for some specialities for up to several years after merger. The falls in service performance have been linked to lack of clarity around roles and responsibilities, poor and delayed decision-making as well as issues arising from cultural differences (Ashkenas *et al* 2011). Fulop *et al* (2002) highlighted the risks in health care mergers of managerial attention turning inwards, and focusing on issues such as restructuring rather than core service delivery. Cortvriend (2004) argue that deteriorating performance can be the result of

damage to the psychological contract which in turn induces staff to exit or state an intention to leave.

Loss of key staff and reductions in morale

Mergers can have a significant adverse impact on staff and their morale. In health care, nurses have been shown to experience loss of morale, stress anxiety, absenteeism and lower motivation to provide a high quality of care (NIHR 2010). Brown *et al* (2006) found that some nurses were affected up to 12 months after a merger and reported lower participation and decreased coping effectiveness.

Planning blight

Fulop *et al* (2002) found that service developments could be delayed by merger, some for at least 18 months. Fulop's later work (2005) attributed this to a loss of management control and lack of clarity about decision-making responsibilities. In commercial mergers planning blight is also problem. Strategies to address this include ensuring clear lines of managerial accountability, building and sustaining momentum for post-merger integration and good pre-merger planning (DiGeorgio 2003; Harris 2010; Kanter 2009; Epstein 2005).

Weak governance and supporting systems

Merged organisations seek to realise new efficiencies through integrated systems functions and procedures. However, both Gerds *et al* (2012) and Fletcher (2001) highlight the risks when core business processes and their interdependencies are not systematically thought through. Blackstone and Fuhr (2003) note difficulties in co-ordinating information technology as a significant problem for many hospital mergers. Transition costs of putting hospitals onto the same IT platform are often significantly underestimated, and Blackstone and Fuhr cite the case of a US hospital merger where the IT integration budget requirement went from $25m to $126m.

Key messages

Key performance risks

- efficiency drop
- staff dissatisfaction and loss of key staff
- weakness in corporate governance – incompatibility of supporting systems and confusion around roles and responsibilities
- planning blight.

Management strategies

- create a clear decision-making process
- close monitoring and management of performance
- clarify roles and responsibilities
- effective resource planning
- ensure the impact of merger is assessed and mitigate w.r.t. supporting systems (IT, waiting list management, outpatient appointments etc)

Well-resourced and detailed planning

The analyses of mergers in all sectors reinforce the importance of well-resourced and detailed planning. This should include:

- undertaking robust due diligence
- adequate pre- merger and post-merger planning – including the first 100 days
- putting in place the necessary skills and capacity to support the merger process.

Undertaking robust due diligence

Monitor define due diligence as the process by which parties disclose all material statements/information which may influence the outcome of the proposed transaction. In a merger, they recommend this would encompass financial, legal, strategy, real estate, pensions and technical considerations. In this paper we also explore the benefits of a human due diligence audit (see human resources section).

The need to undertake due diligence is highlighted as a key issue – especially in the commercial literature where its absence or a superficial approach is cited a significant contributory factor to failure in many mergers (Harvey and Lusch 1995; Stahl and Mendenhall 2005; DiGeorgio 2003). Research by A T Kearney (1998) found that inadequate due diligence was the primary cause of at least 11 per cent of bank merger failures in the USA. This figure was likely to be as much as 35 per cent if failure to examine cultural factors is taken into consideration.

For NHS trusts there are specific documents on the due diligence process issued by Monitor (Monitor/Department of Health 2009) and NHS London (2010) which include detailed recommendations of the issues to assess and consider.

Sample scope for due diligence

- Legal due diligence
- Financial due diligence
- *Overview, including revenue and profitability analysis, historical trends by hospital unit, seasonality, fixed assets, liabilities, cashflow review*
- Commercial due diligence
- *Demand*
- *Competition*
- *Business plan*
- Operations due diligence
- IT due diligence
- Taxation due diligence
- HR and pensions due diligence
- Estates/property due diligence
- Environmental due diligence

Adapted from (Monitor / Department of Health 2009, pp 193–202)

Pre- and post-merger planning

A majority of those involved in health care mergers have felt they were not sufficiently prepared for the transaction, resulting in problems and loss in productivity post-merger (KPMG 2011; Fulop *et al* 2002). The planning process should take account of the fact that post-merger integration will not be 'business as usual'. As Fulop *et al* found (2005), NHS merger processes can lack clear time

boundaries, with issues continuing into the third year beyond a transaction. In fact, most commercial boards also radically underestimate the time, disruption and effort a merger will take (Epstein 2005).

Gaining early momentum – the first 100 days

The initial period following merger is an opportunity to set tone, signal direction and deliver energy to the organisation (DiGeorgio 2003; De Camara and Renjen 2004). In health care, momentum has often been lost through delays in management decisions, appointments and failure to adequately clarify objectives and the means to achieve them (Fulop *et al* 2005; Katzenbach *et al* 2012) emphasise the importance of making a small number of changes early on that will provide the organisational unit with clear signals of the values and culture of the new organisation. In health care those are most likely to be in relation to the treatment and interaction with patients. A number of authors, DiGiorgio (2003) and Perry and Herd (2004) highlight the importance of identifying some quick wins in the immediate post-merger period to facilitate momentum and build enthusiasm for the new organisation.

Necessary skills and capacity

A critical role for the board is to ensure that the organisation has the necessary skills and capacity to take forward and implement the merger (De Camara and Renjen 2004; Marks and Mirvis 1998; DiGeorgio 2002, 2003). Although there has been limited evaluation of NHS mergers, there is a recognition that managerial experience of mergers is low (KPMG 2011) and there appears to be a tendency to underestimate the level of resource required to support a successful transaction. For example, organisations may lack the necessary programme management and change management expertise including softer skills around communication and partnership working (Ashkenas *et al* 2011). However, Ashkenas *et al* (2011) drawing on the examples of successful mergers in the commercial sector caution that relying on external expertise rather than developing in-house staff, could lead to a dependency on support.

Building the integration team

Building a well-resourced, multi-skilled and cross-organisational integration team is considered key to a successful merger process (Harris 2010; Epstein 2005; Harding and Rouse 2007). A number of authors recommend that roles and responsibilities of the integration team, along with organisational structures, should be established and agreed ahead of any integration announcement (Epstein 2005). Ideally the team should be made up of staff from both organisations, across a number of functional areas and with clear roles and responsibilities (Epstein 2005). Many successful corporate mergers have also taken senior leadership out of day to day roles to focus on planning and implementation (De Camara and Renjen 2004).

Key messages

- Ensure a robust process of due diligence.
- Identify the skills and capacity required to support the merger – ensure that enough support is available to address the scale of the change management task. Identify and address any gaps in capability – for all stages of the merger process – before, during, and after.
- Support organisational level plans with plans at the business unit level – including setting out future mission, values, strategies and objectives for the first year.
- Be clear that post-merger integration is not business as usual. Post-merger integration should begin with proper pre-merger planning.
- The first 100 days after a major change sets the tone, signals the direction of the organisation and its vitality – plan to deliver early wins to build momentum and establish the culture of the organisation.

Managing human resources

There is a tendency to focus on the systems and processes of a merger and neglect the human effect. There are many people challenges created by merger including difficulties in integrating working practices, loss of morale, fear of job loss and employee stress (Ferguson and Goddard 1997; McClennan and Howard 1999). In this section we look at the strategies that can help address these issues including:

- undertaking human due diligence
- the appointment process for senior and middle management
- securing clinical engagement and leadership
- clear process and timelines
- investment in team building.

The importance of human due diligence

A number of authors recommend a detailed assessment of human factors before and during merger. Epstein (2005) recommends that a detailed evaluation of organisational fit and human resource capabilities should form part of the due diligence process. A human due diligence audit can minimise the risks of merger. In one study, Harding and Rouse (2007) found that close to 90 per cent of successful mergers had undergone a task of identifying key employees and targeting them for retention, whilst only one-third of unsuccessful transactions had gone through this process. To gather intelligence on the human side of integration in a systematic comprehensive way, Harding and Rouse recommend a mixture of methods and tools (see Table 1)

<table>
<tr><th colspan="2"><u>Integration decisions enabled by human due diligence</u></th></tr>
<tr><td colspan="2">Determining the structure of the organisation and resolving conflicts in decision-making processes.</td></tr>
<tr><td colspan="2">Setting the tone for the combined culture and establishing a process for migrating to a new culture.</td></tr>
<tr><td colspan="2">Filling the top jobs quickly and deciding how to retain other key talent.</td></tr>
<tr><td colspan="2">Implementing programs aimed at winning the hearts and minds of employees in the target organisation.</td></tr>
<tr><th colspan="2"><u>Methods and tools</u></th></tr>
<tr><th><u>Fact-based assessment</u></th><th><u>Qualitative tools</u></th></tr>
<tr><td>Organisation charts</td><td>Interviews with key staff</td></tr>
<tr><td>Compensation and promotion processes</td><td rowspan="2">Role plays and simulations to determine patterns of response to situations</td></tr>
<tr><td>Job descriptions and responsibilities</td></tr>
<tr><td>Employee turnover rates</td><td rowspan="2">Review of management handling of prior situations</td></tr>
<tr><td>Culture audits</td></tr>
<tr><td>360 feedback</td><td rowspan="2">Interviews with customers and other stakeholders</td></tr>
<tr><td>Satisfaction surveys</td></tr>
<tr><td>Staff loyalty</td><td>Interviews with suppliers</td></tr>
</table>

Human due diligence methods and tools, adapted from Harding and Rouse (2007)

Appointment process for senior leadership in the new organisation

Many sources emphasise the influence of the appointment process for senior managers on the merger outcome (Schmidt 2002; Marks and Mirvis 1998; DiGeorgio 2003; Harding and Rouse 2007; Harris 2010). While it is important that appointments are made rapidly, the process must also be robust (Epstein 2005). There are risks if the outcome of the appointments process is that one organisation is perceived to be dominant over the other. A timely, transparent appointments process, rooted in meritocracy, can minimise this risk (Ashkenas *et al* 2011).

Fulop *et al* (2005) also highlight the importance of the process of recruiting to middle management posts. Delays in middle management appointments were identified as a key contributor to overall delays in organisational and service developments as a consequence of merger.

Securing clinical engagement and leadership

The importance of clinical engagement in health care organisations is well documented (Ham and Dickinson 2008). The full benefits of mergers are unlikely to be met without effective clinical integration (Fulop *et al* 2005; Corrigan *et al* 2012). Hirschfield and Moss (2011) stress the importance in mergers of identifying clinical leaders for the new organisation at an early stage. Delay in identifying key medical leadership can contribute to delays in key projects to help realise the integration benefits (Fulop *et al* 2002). The case study of the University Hospitals Birmingham merger (KPMG 2011) also highlights the benefits of close clinical engagement in the merger process.

Clear process and timelines

Most of the business literature emphasises the importance of a clear process with milestones for staff as a means of reducing the adverse impact of merger on morale (Epstein 2005; Katzenbach *et al* 2012; Harris, 2010). There is evidence from health care mergers that a lack of a clear timeline can undermine leadership credibility and extend post-merger disruption (Fulop *et al* 2005).

Investment in team building

Team building, at all levels of the organisation, should be done early to clarify roles and responsibilities and reinforce expectations and set standards. However, this shouldn't be considered a one off activity (DiGeorgio 2003).

Key messages

- Recognise that the 'human agenda' is critical.
- Deciding who gets what job and the organisational structure are central activities to both the process of merger and subsequent benefits realisation
- Have a clear process for creating the new structure with a realistic timetable – that is adhered to.
- Use the merger to access staff competencies. If people don't develop/display leadership skills during a merger, they are unlikely to do so when things return to 'normal'. Test staff by giving them stretch assignments and rotating them through new and challenging roles.
- Undertake team building early on to clarify roles and responsibilities.
- Communicate and reinforce expectations, and set standards. This needs to be seen as part of the long term integration process, it is not a 'one off' activity.

Culture and communication

Addressing issues of culture and communication are critical to a successful outcome from a merger. The evidence from corporate mergers and transactions is that, while culture and communications are frequently identified as a key concern, they are rarely allocated sufficient resources (KPMG 2011; McKinsey 2010; Katzenbach 2012). Most executives with merger experience say they would spend more time and resource on culture and communication if given the chance again (KPMG 2011).

Culture

A lack of cultural integration can be a significant barrier to a successful outcome from merger in all sectors (Pikula 1999; Kanter 2009; Blackstone and Fuhr 2003). The major consultancies advocate systematic tools for assessing and approaching cultural factors and argue that a cultural assessment should be a core part of any merger process (McKinsey & Company, 2010; KPMG 2011a; KPMG 2011b; Deloitte 2010). Cultural issues are particularly important in health

care because of the complex dynamics at play within and between different professional groups (Braithwaite *et al* 2005; Fulop *et al* 2002).

Many merger processes, in the commercial and health care sectors, are projected as mergers of equals, but may be perceived as takeover by one of the parties (Fulop *et al* 2005; DiGeorgio 2003). This can cause resentment and impair organisational effectiveness for a number of years. Marks and Mirvis (1998) and DiGeorgio (2003) noted that this was more likely if the appointments process is not transparent (as we discussed in the section Board Leadership). Harding and Rouse (2007) argue that although many companies describe a merger of equals, there is always a financial and cultural acquirer. An example of how this thinking has been applied is the 1997 merger of Boeing and McDonnell Douglas. Each business was seen to be the cultural acquirer in the sectors where they were previously dominant so the merged organisation explicitly set out to adopt McDonnell's approach to the military sector and Boeing's to the commercial operation (Harding and Rouse 2007).

Other authors argue that imposition of culture on another organisation carries a high risk of failure and that a more successful approach draws on the successes and strengths of both organisations in order to foster a new joint culture (Katzenbach *et al* 2012). A cluster of the human resource and cultural literature argues for building upon the human strengths of both organisations, whilst recognising their limitations (Kanter 2009; Harris 2010; Katzenbach *et al* 2012; De Camara and Renjen 2004). Kanter (2009) found that the most successful mergers were those that focused on the qualities of both organisations and counsels against an acquiring firm acting like conqueror. This is particularly salient in a health care setting, where many professional groups do not identify strictly with their provider organisations, but as part of the wider NHS. Deloitte have articulated the advantages of the wider NHS identity and an opportunity for its leverage in health care transformation and restructure (Deloitte 2010).

Communications

An effective communication strategy is a key priority for any merger (Epstein 2005; KPMG 2011; McKinsey & Company 2010). The general view is that it is far better to 'over' than 'under' communicate (McKinsey & Company, 2010;

Hirschfield and Moss 2011). There should be active internal and external stakeholder communication from the early strategy phase through to implementation (De Camara and Renjen 2004).

The communications strategy needs to help people understand the rationale for merger, its prospective benefits and the impact on them as individuals (Marks and Mirvis, 1998). Successful corporate mergers define and communicate a motivating vision about how the combined organisation can perform more effectively in its market place, and are not just focused on cost-cutting strategies (De Camara and Renjen 2004; DiGeorgio 2003; Katzenbach *et al* 2012). De Camara and Renjen (2004) also recommend addressing early concerns about jobs and benefits, to ensure staff can focus on organisational performance. Effective communication has been found to moderate some of the negative impact on morale felt by nursing staff (Burke 2004).

An example of the scale of what is required can be seen in the successful HP–Comapq's 2002 merger (De Camara and Renjen 2004):

- pre-merger – 1000 of the firms' top leaders were given communications training
- all employees received information for customers to answer their questions
- the organisation held more than 17 000 team meetings across the world to present the new organisation roles and responsibilities.

Several authors emphasise the importance of effective two-way communication at multiple levels in the two organisations which helps staff feel involved in the process while executives have a better sense of the organisation's response to major change (Marks and Mirvis 1998; DiGeorgio 2003). Some case studies of successful mergers have emphasised the importance of a communications function embedded in the integration team itself (De Camara and Renjen 2004).

Key messages

- Cultural differences can act as a major barrier to integration. Be clear at the outset that culture is a key issue in determining the success (or failure) of a merger.
- A strong focus on creating a common culture is critical and needs to be a central part of the communications strategy. This should be an integral part of the implementation plan...not an afterthought
- Aim for the culture and work methods of the two organisations based on relative strengths.
- Celebrate strengths and develop staff from both organisations to avoid a perception of 'takeover'.
- Communications need to address a key concern of individuals –what will this mean to me?

Conclusion

This brief review of the literature on merger demonstrates that many of the risks and opportunities presented by merger are common across all sectors. The chances that merger will be successful are considerably enhanced if boards and their organisations follow best practice. The literature is essentially unambiguous as to what that consists of:

- clear and quantifiable objectives
- effective due diligence
- adequate resourcing
- good pre- and post-implementation planning
- significant attention to the human agenda including cultural issues
- in health care specifically, clinical engagement and leadership is critical.

The literature supports the view that a merger can be the right organisational response to the issues facing two organisations. Successful mergers do take place across all industries, and the literature provides examples of them. However, mergers carry significant risks and often fail because the nature of those risks are not fully appreciated and as a result are inadequately mitigated. The literature review suggests some of the practical actions that will increase the chances of success.

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