KING'S HEALTH PARTNERS

An Academic Health Sciences Centre for London

Pioneering better health for all

King's Health Partners

Strategic Outline Case:
creating a single academic healthcare organisation

July 2012

CONTENTS

EXECUTIVE SUMMARY

1. King's Health Partners, accredited by the Department of Health as an Academic Health Sciences Centre (AHSC) in 2009, is a partnership between King's College London (KCL) and three NHS Foundation Trusts: Guy's and St Thomas' (GStT), King's College Hospital (KCH) and South London and Maudsley (SLaM). In February 2012 the four partners agreed to look at the case for creating a single academic healthcare organisation. The partners are in a position of strength but the proposition is that the new organisation could achieve more and at greater pace, allowing King's Health Partners to respond to a changing world and the future needs of patients.

2. If the health challenge of the last century was the treatment of infectious disease, this century's challenge is dealing with long-term conditions. Diabetes rates, for example, are expected to grow by 60% over the next 20 years. Many more people have both physical and mental health challenges. This is particularly the case in the kind of deprived and diverse communities that King's Health Partners serves across south London, where levels of health inequalities are high.

3. But the health system has not kept up with these changes. It remains focussed on disease and illness rather than promoting health and wellbeing. The mind and the body are treated separately. Services are fragmented and not always patient-centred. Research and education can appear quite distant from the reality of healthcare problems. As an integrated organisation, King's Health Partners would be better able to develop a new model of healthcare to help meet this challenge and improve the quality of life for our patients.

4. The academic world is also changing. Global competition for the best students, research talent and resources is increasing. At the same time, medical research is becoming increasingly complex, which requires organisational scale and a broad range of expertise.

5. The wider economic context presents a further serious challenge. While demand for healthcare and the costs of healthcare are rising, NHS funding may, at best, be held steady for the next decade. This means the NHS needs innovative new models of healthcare that radically improve value for the patients and the system.

6. So although King's Health Partners has achieved a great deal in its current form, we believe we could respond better to this changing environment if we created a more integrated organisation. This would enable us to align our priorities, give us greater financial flexibility, make it easier to work with local partners, and give us the organisational scale to transform how we work. As a result, we could more effectively achieve our vision.

7. **Our vision for the new organisation is to be a leader, locally and globally, in improving health and wellbeing**. **We aspire to be one of the top ten global academic healthcare organisations and to bring these benefits to our local communities, patients and students.**

8. King's Health Partners is uniquely positioned to do this because it brings together three successful trusts, with mental health at the core, with a leading university, all serving one of the most diverse and challenged communities in the country.

9. Working closely with partners across the health and care system and beyond, we have six goals for the new organisation:

   - **Provide care around people's needs.** We will aim to work in partnership across the health and care system to integrate care around the patient, and to overcome traditional distinctions between mind and body (for example, through routine screening for depression, alcohol and dementia). Better understanding people's full care needs will enable us to provide better value care in more appropriate settings.
   - **Keep people well.** Intervening earlier and working with our partners, including patients themselves, we hope to develop new approaches to the main health challenges of our local population, such as alcohol and childhood obesity.
   - **Provide the best specialist care when it is needed.** By bringing together our specialist services we aim to improve patient outcomes for the most pressing health challenges our communities face and to enhance our research.
   - **Train the workforce of today and tomorrow.** Through better teaching and facilities, we hope to produce the highest quality graduates and develop our staff to their full potential. To help shape the healthcare workforce of the future, we will develop new ways of learning and new professional roles.
   - **Turn world-leading research into treatments as quickly as possible.** We aim to speed up translational research to create new drugs and treatments that benefit our local patients first. We will seek to develop new research opportunities by working with our diverse local population and by using the strengths across our university.
   - **Build prosperity for our local communities and the UK.** We aim to attract new commercial, fundraising and grant income, which will help contribute to the local economy through new jobs and investment. We will seek to improve the productivity of all our services, and reinvest these savings in better care.

10. **To achieve this vision we propose creating a single organisation through the merger of the three NHS Foundation Trusts (with mental health at its core), enhanced by closer integration with KCL and a stronger academic ethos**. **This would create the UK's most integrated and innovative academic healthcare organisation.**

11. We envisage that the new organisation would deliver benefits for our patients, public, staff, students, commissioners and other providers, including:

    Better health

    - **More integrated care**. Integrating care across the new organisation would help ensure patients' full mental and physical needs are met, for example by addressing the physical health needs of patients with serious mental illness, and through earlier identification and treatment of the 40% of hospital inpatients with dementia.
    - **Better patient experience**. A shared electronic patient record across the new organisation could help engage patients in their own care, avoid them having to repeat information unnecessarily, and improve patient safety.
    - **Better patient outcomes**. Consolidating certain specialist services could lead to better patient outcomes, because of the close relationship between quality and numbers of patients treated.

Better research and education

- **Higher quality research**. Locating academic and clinical staff and services together would encourage innovation in research and new medical breakthroughs that can swiftly be turned into improved patient care.
- **Better educational experience**. Better teaching, facilities and career opportunities would improve the educational experience and help King's Health Partners attract the best students and staff.

Better value

- **Better use of physical space**. Working more closely with community and mental health services would enable services to be brought closer to patients, and help the new organisation to make more efficient and creative use of its estate, which is made up of more than 225 locations across south London and beyond.
- **More efficient services.** The new organisation would enable us to improve value for money for patients and taxpayers across the health and care system. Estimates suggest 3-5% savings in non-clinical support functions alone could be achieved in the new organisation, which could be reinvested in better care for patients.
- **New jobs and investment**. The new organisation would help to attract new investment in our local communities from industry, fundraising, and grant-makers, helping create new jobs and encourage regeneration.

12. We recognise that an organisational change of this scale is a significant undertaking and that people will have a number concerns and questions, some of which are set out below.

- **Would merger lead to local services closing?** Core local health services would continue to be provided on multiple sites, for example, the two Accident and Emergency departments and two maternity units would remain in their current locations.
- **Would mental health issues be less prominent?** Mental health is central to the vision of the new organisation. We would aim to lead the UK in demonstrating equal treatment for mental and physical health at every level of the new organisation, and develop new ways of caring for patients with both mental and physical health needs.
- **Would academic issues be neglected?** A defining characteristic of King's Health Partners is academic excellence. This would be reflected in the organisational model at every level.
- **Would this change affect organisational performance?** We would put measures in place to try and minimise disruption to business as usual, including a dedicated transition team to oversee the merger planning and implementation.
- **Would the new organisation be too inflexible?** Organisational scale gives us the opportunity to transform the business, for example by developing delivery arms organised around patient pathways or population groups, which could be more autonomous and flexible in how they work.
- **How would cultural and staff issues of integration be handled?** If we proceed to the next stage of the process, engaging with staff to understand their priorities and concerns would be a high priority. We would work with them to build the culture and values of the new organisation, drawing on the best of the existing institutions.

13. Further detailed work would need to be undertaken at the next stage, but on the basis of the preliminary assessment undertaken in this paper we believe that the benefits of the new organisation outweigh the costs and risks. If the partner organisations decide to proceed on the path to establishing this new organisation, the next step would be to create a Full Business Case by early 2013. We estimate that the new organisation could be in place at the earliest by late 2014.

1. BACKGROUND AND PURPOSE

1.1 King's Health Partners Academic Health Sciences Centre (AHSC) is a pioneering collaboration between King's College London (KCL) and three NHS Foundation Trusts (FTs): Guy's and St Thomas' (GStT), King's College Hospital (KCH) and South London and Maudsley (SLaM). King's Health Partners is one of only five accredited AHSCs in the UK and brings together an unrivalled range and depth of clinical and academic expertise, spanning both physical and mental health.

1.2 In February 2012 the four partner organisations unanimously endorsed a recommendation from the King's Health Partners Board to prepare a Strategic Outline Case (SOC) to assess the case for establishing a single academic healthcare organisation.

1.3 This recommendation followed two reviews commissioned by the King's Health Partners Board last year.[1] These reviews explored a number of organisational options for how King's Health Partners might accelerate its progress but concluded that creating a single academic healthcare organisation (i.e. merger of the three FTs and closer integration with KCL) was most likely to help us achieve our goals.

1.4 The partners, three successful Trusts and a leading university, are in a position of strength. Unlike many mergers this discussion is not being driven by the need for financial savings, although this could be a significant benefit. The proposition is that an integrated organisation could achieve more and at greater pace and that these benefits would translate directly into greater social value for the communities and patients that we serve.

1.5 This SOC is seeking to answer four questions:

- **What is the rationale for organisational integration?** (Sections 2 and 3)
- **What is the preferred organisational model?** (Section 4)
- **Do the benefits outweigh the costs and risks?** (Sections 5, 6 and 7)
- **What is the forward plan to achieve organisational integration?** (Section 8)

1.6 In the process of developing this SOC we have engaged a wide variety of groups and individuals to seek their views and to understand their concerns. They included staff, governors, commissioners, local authorities, MPs and other stakeholder groups. All have engaged in a thoughtful and constructive way. We hope this has helped us write a document that is clear about the benefits and addresses some of the concerns that have been voiced.

1.7 The next stage of the process would be accompanied by a broader and deeper engagement with all of our stakeholders, alongside a full public consultation at the appropriate stage. We hope to work in particular with our local partners in the health and care system to develop innovative ideas about how we might most effectively achieve our goals around integrated care and population health.

1.8 If the four partners agree to the recommendation of the SOC, we will proceed to the development of a Full Business Case. We recognise that further detailed work will need to be done at this stage, including quantifying the benefits and costs of the new organisation, and a detailed analysis and testing of the proposed organisational model.

2. CASE FOR CHANGE

Health needs are changing but healthcare systems are not keeping pace

2.1 If the health challenge of the last century was the treatment of infectious disease, this century's challenge is the prevention and management of long-term conditions. More than 15 million people in England have one or more such condition.[2] Rates of diabetes, for instance, are expected to grow by over 60% in the next 20 years. This challenge is particularly stark in the local communities that King's Health Partners serves, where one in four school children is already obese.[3]

2.2 The numbers of people with multiple long-term conditions ('multi-morbidity') is high and rising. More than one in three of this group have both physical and mental health challenges. New evidence suggests that the rates of people with multiple long-term conditions are highest in populations that are economically deprived such as Lambeth and Southwark.[4]

2.3 Multi-morbidity is particularly common amongst older people – and this population is growing fast. The number of people over 65 in the UK is set to increase to 20% by 2030 and the proportion of 85 year olds will double by 2032.[5]

2.4 Left unchecked, the likely cost to the system of these trends is extremely high – estimates suggest that around 70% of healthcare costs are already spent on people with long-term conditions.[6]

2.5 But healthcare systems around the world are not keeping pace. Health services are focussed on disease and illness rather than promoting health and wellbeing. They tend to be reactive and poor at planning ahead. The mind and the body are still treated quite separately.[7] In most healthcare systems, it often appears that the hospital rather than the patient is at the centre. One result of this is that care is not always provided in the best settings for patients. Services can be fragmented leading to worse outcomes and poorer experience for patients. This can have a particular impact on older people and those with long-term conditions who have to navigate this complex system.[8] Finally, research and education can appear quite distant from the reality of healthcare problems.

2.6 All of this points to the need for new models of healthcare delivery, including more integrated care, a new relationship between the patient and the system, changes to how the workforce is educated and trained (for example, considering the balance between generalist and specialist skills), and a more productive relationship between research and healthcare delivery. As an integrated organisation, King's Health Partners would be better able to develop a new model of healthcare to meet this challenge.

The academic world is becoming increasingly competitive

2.7 Competition for the best students and research talent is rising, as academia becomes a global market. The UK used to undertake 6% of clinical trial activity; the figure now stands at just 2%.[9] This has consequences for the country's overall economy and international standing in healthcare.

2.8 Universities increasingly need to demonstrate excellence to be able to compete. The upcoming Research Excellence Framework reinforces this trend – only the highest quality research will attract funding. It will also need to be able to demonstrate impact for social benefit. This offers a clear opportunity to organisations committed to translational research – as King's Health Partners is.

2.9 Meanwhile medical research is becoming more complex, as medicine continues to sub-specialise. One result of this is that is has become more difficult to sustain clinician-led research in traditional teaching hospitals.[10] This implies a need for greater organisational scale with larger academic facilities co-located with clinical services, supported by large scale specialist teams. It also raises the question of how organisations can undertake research in very different ways, including, for example, undertaking more research embedded in the communities we serve.

2.10 The demise of higher education block funding and the introduction of a new fees regime will further encourage competition for the best students. This is likely to raise student expectations about their experience which may take many forms – including demand for better teaching and better integration between academic learning and clinical placements. Successful universities will need to concentrate on delivering distinctive education and the best student experience.

2.11 Trends in teaching and courses suggest students are attracted to new ways of learning. This includes a greater number of inter-disciplinary courses, a greater emphasis on team working, problem solving and other general skills. AHSCs are well placed to benefit from these changes, by enhancing multi-professional elements within existing courses, and by developing new courses altogether that reflect emerging healthcare needs (for example, with management, humanities and informatics).

Economic and social pressures pose questions about how we work

2.12 The economic situation in the UK is an important part of the backdrop to the discussion about King's Health Partners' integration. Firstly, economic factors are closely related to health outcomes and health inequalities. In Lambeth and Southwark nearly 40% of children live in poverty, and the unemployment rate is above the national average.[11]

2.13 Second, with public finances under pressure, funding sources for health, education and research will inevitably be constrained. In particular, whilst the demand for and the costs of healthcare continue to rise significantly, NHS funding is likely to be, at best, held steady for the next ten years. This means the NHS needs innovative new ways of providing healthcare that radically improve productivity.[12] Organisations working in isolation will struggle to respond to this challenge.

2.14 Finally, the UK as a whole needs to find new sources of economic growth. As education, health and life sciences are among those industries in which the UK has a comparative advantage, there is a clear opportunity for King's Health Partners to contribute further to overall economic growth by realising the commercial potential of its business.[13] This in turn would contribute social value and employment opportunities to the south London economy (from which the majority of our workforce is drawn).

2.15 Alongside changes in the economy we will see significant social changes. In the future, we can expect a more informed and less deferential population. This offers healthcare providers the opportunity to develop a new, less paternalistic relationship with patients and service users. Technology could play a significant role in enabling this change. Technological advance in the last 20 years has been extraordinarily rapid, influencing many aspects of our lives. The rate of advance looks set to continue - with continuing growth in computing power and social media and a move towards ubiquitous access. Yet healthcare has been slow to benefit from these advances. King's Health Partners has the opportunity to tap into new technological opportunities to transform the care it provides (for example tele-medical monitoring for cardiac patients after surgery) and to encourage new research opportunities.

King's Health Partners has achieved much but there are further opportunities

2.16 King's Health Partners has achieved a lot in its current organisational form, for example:

- We have established 21 Clinical Academic Groups (CAGs) to help integrate patient care, research and education across the partners. The CAGs are driving service and academic improvement in a range of areas, including consolidating Bone Marrow Transplantation, Vascular Surgery and Stroke services.
- We are making progress on finding new ways to tackle local health challenges. In partnership with our local health and social care partners, the Lambeth and Southwark Integrated Care Programme is redesigning local systems of care to fit around the needs of patients, starting with care for older people.
- We are innovating in 'whole person care'. For example, the Psychological Medicine CAG is working with the Cardiovascular CAG implementing joint clinics for patients with chest pain as part of the King's Health Partners IMPARTS (Integrating Mental and Physical Healthcare: Research, Training and Services) programme.
- King's Health Partners is at the forefront of pioneering new medical techniques; for example, we host one of the largest Transcatheter Aortic Valve Implantation (TAVI) programmes in the world.
- We have put in place the building blocks for groundbreaking research. For example, the Department of Heath reaccredited our two National Institute for Health Research (NIHR) Biomedical Research Centres (BRCs) and established a new Biomedical Research Unit for Dementia, pledging over £112 million of funding over five years.
- King's Health Partners has established an Education Academy which successfully oversees the education and training activities of the four organisations to ensure consistent standards of excellence. In April 2012, all three Trusts were appointed lead providers to deliver £77 million worth of postgraduate training programmes to higher speciality trainees across south London in 15 different specialties, from renal medicine to forensic psychiatry. With local partners, we are leading the development of the South London Local Education and Training Board.
- We have created a single King's Health Partners fundraising team to join up the efforts across the four organisations.

2.17 However, current organisational arrangements are not allowing us to make progress towards achieving our vision at sufficient pace, not least because the financial incentives are not fully aligned.

2.18 The result is that we are slowed down or in some cases missing opportunities altogether. This has affected the Clinical Academic Groups, progress on bringing together corporate functions such as IT, and in some instances hindered the development of external partnerships.

2.19 Our Clinical Academic Groups are now telling us that a more integrated organisation would allow them to achieve more and at greater pace.

An integrated King's Health Partners would make it easier to achieve our goals

2.20 A more integrated organisation would offer a number of advantages that would help King's Health Partners overcome current organisational barriers, respond more effectively to the external opportunities described above, and help achieve our academic and healthcare goals.

- **Align priorities and decision-making.** A single organisation would help align organisational priorities. For example, King's Health Partners would be able to articulate a clearer set of healthcare and academic priorities to potential philanthropic donors.
- **More financial flexibility.** An organisation with a single balance sheet would enable greater resource flexibility, for example investing more in mental health interventions such as liaison psychiatry that can help reduce hospital length of stay. As a single organisation we could also make better use of our combined assets (£1.3billion across the three FTs) to release funds for investment in new models of healthcare.
- **Make it easier to work with external partners.** An integrated organisation would simplify relationships with external partners. For example, we could streamline our processes to reduce bureaucracy for referring GPs. With our external partners, King's Health Partners could help develop a shared electronic patient record that covered the whole health and care system.
- **Organisational scale to transform how we work and improve efficiency.** An integrated organisation would offer economies of scope and scale. For example, we might consider consolidating elective care for a number of specialties in a single centre, thereby improving patient experience, outcomes and efficiency.

3. VISION FOR THE NEW ORGANISATION

3.1 An integrated organisation would allow us to extend our vision – in particular to achieve a greater focus on physical and mental health integration; on prevention and population health; and on the academic opportunities associated with these two major challenges.

3.2 **Our vision for the new organisation is to be a leader, locally and globally, in improving health and wellbeing**. **We aspire to be one of the top ten global academic healthcare organisations and to bring these benefits to our local communities, patients and students.**

3.3 In pursuit of this vision, we aim to overcome some traditional distinctions. We hope that our local and global ambitions can reinforce each other: our large and diverse local population can help us make a global impact, and our global reach can help us improve the health of our local population. We hope to excel academically and provide consistently high quality care for all our patients. We hope that we can address both the mental and physical health needs of our patients. We hope we can provide system leadership, not just provide services.

3.4 King's Health Partners is uniquely positioned to do this because it brings together three successful Trusts, with mental health at the core, with a leading university, all serving one of the most diverse and challenged communities in the country.

3.5 Working in partnership with others in the health and care system and beyond, we have six goals for the new organisation:

i) Provide care around people's needs

3.6 By bringing together acute, community and mental health services the new organisation can provide more integrated care for our patients. But to be most effective we will need to work in partnership across the health and care system with providers and commissioners. Building on the work of the Integrated Care Programme, we hope to develop a new relationship with primary care and social care, overcoming the barriers that have existed since the NHS was formed. A key enabler of this will be developing a shared electronic patient record - helping King's Health Partners, our partners and our patients to work in fundamentally new ways with each other.

3.7 Providing more integrated care also has implications for how we educate and conduct research. We will consider what the future workforce might look like and what its educational needs might be, for example the balance between generalists and specialists in hospitals.[14] We will also look at how we can use our partnerships with others in the health and care system to change how we do research, for example by extending more trials into the community, and by investing more in understanding how to improve the delivery of healthcare. Our recent creation of King's Improvement Science, which seeks to find new solutions to real world problems in healthcare, is a key step in this direction.

3.8 By bringing together a mental health Trust with two acute care Trusts and community services in Lambeth and Southwark, the new organisation will help us

overcome traditional distinctions between mind and body, helping position King's Health Partners as a world leader on whole person care.

3.9 At present, patients with mental illness, particularly those with serious mental illness do not receive adequate physical care – these patients live on average 10 to 15 years less than expected – often rivalling the years of life lost to many major medical illnesses (such as breast cancer or heart disease).[15] Improving the physical health of the seriously mentally ill will require a joined-up approach across the healthcare spectrum and specific programmes, clinics and professional development to deal with this issue. King's Health Partners aims to be the national leader in the development, implementation and evaluation of these programmes.

3.10 At the same time, patients with long-term physical conditions receive sub-optimal mental health care: nearly 30% of people with long-term conditions have depression; half of all referrals to specialist services have 'medically unexplained symptoms' many of which are linked to psychiatric diagnoses.[16] King's Health Partners will seek to lead the way in developing innovative services and models of care (such as routine depression, alcohol and dementia screening) which lead to improved outcomes and lower costs of care.[17]

3.11 We recognise that the physical-mental integration is often held back by the lack of appropriate funding incentives. By bringing all these services within a single organisation, King's Health Partners will develop internal incentives to drive this integration.

ii) Keep people well

3.12 Through the scale of the new organisation and its academic strengths we will seek to develop new approaches to population health to address the stark healthcare challenges our populations face, such as alcohol and childhood obesity. We will do this in partnership with others in the healthcare system, local government, industry and the voluntary sector. We will aim to intervene earlier and avoid unplanned care where possible, for example through earlier interventions for people with long-term conditions such as Chronic Obstructive Pulmonary Disease (COPD) to avoid unnecessary hospital admissions.

3.13 We will seek to support people to manage their own health, for example by using telehealth to support self-care at home rather than in the hospital.[18] By offering patients greater access to their own health records we hope to empower them to better manage their own health. To this end, we will build on SLaM's MyHealthLocker, which is the first patient-held electronic health record in the field of mental health. Opening up a two-way flow of information between patients and their clinicians this represents a shift in the status of the patient from a passive recipient to active participant in their care.

3.14 To find new ways of addressing these public health challenges, we will draw on the strengths across the university. For example, cultural anthropologists and social geographers can shed light on 'lifestyle diseases' by better understanding the cultural context of people's lives. KCL's recent creation of a new Department of Social Science, Health and Medicine demonstrates our commitment to this issue.

3.15 We aim to do more to help our staff improve their own health. This is because they represent a significant proportion of the local population in their own right, and because we know that healthier staff provide better care. We are putting in place a range of measures to help our staff become healthier, for example through smoking cessation classes and mental health interventions to support their wellbeing. Through this and other measures we would like to support and encourage our staff to be effective advocates for health and wellbeing in the local community.

iii) Provide the best specialist care when it is needed

3.16 Our patients deserve excellent local services, but we believe that they also deserve excellent specialist services. We know that treating higher numbers of patients is associated with better outcomes in certain specialist services. So to improve the quality of care we provide, we will consider consolidating some of our specialist services across our sites. Our proposals may include co-locating these services with academic facilities to accelerate the translation of research into new drugs and treatments and to encourage further research innovation. This is relevant for some of the most pressing health challenges in our area, such as HIV and sexual health, sickle cell disease and alcohol-related liver disease.

3.17 In those specialist areas where we excel, we will continue to strengthen and expand our clinical networks. Based on clear protocols, data and pathways, these networks will help us to improve the quality of care across the country. We will consider how the greater use of technology can support our specialist networks, thereby enabling patients to be cared for safely and effectively closer to home.

iv) Train the workforce of today and tomorrow

3.18 Our ranking in the National Student Survey suggests we need to do more to improve student experience.[19] Closer integration between the university and the Trusts should help us improve teaching, student experience and the quality of graduates. Our ambition is that all King's Health Partners award-bearing education will be consistently high quality, and should take a common approach to quality assurance, training of teachers, performance management and student feedback. We will seek to improve the quality of our teaching through more efficient use of clinical time and better recognition of clinicians who make an academic contribution.

3.19 Greater flexibility in investment decisions will allow us to improve educational facilities across the King's Health Partners campuses, for example by creating a 'virtual learning environment' that enables students and staff to access all learning resources from all King's Health Partners sites.

3.20 Healthcare is changing and the new organisation will prepare the current and future workforce accordingly. We aim to do this by offering students and healthcare professionals a greater diversity of applied educational and research opportunities (including primary, community and mental health settings). Alongside this, we will extend the opportunity for students to undertake more joint or intercalated degrees with other academic disciplines. We will consider how to support new professional roles, such as integrated care practitioners, who work across physical and mental health, and social care. We will also offer more 'inter-professional' education (between doctors, nurses, mental health professionals) – professionals who work together should have the opportunity to train together.

3.21 Through the new organisation, we hope to offer enhanced career opportunities to our students and staff. Currently only about 20% of our clinical students end up working at King's Health Partners' healthcare providers. This is inefficient and a poor way of managing talent. We will work towards a point where the majority of our students are employed in King's Health Partners and see us as their natural employer. This will have benefits for the quality of healthcare that we provide by ensuring a more consistent level of training to future employees.

v) Turn world leading research into treatments as quickly as possible

3.22 Bringing together clinical and academic services will increase sub-specialisation in research, and encourage innovation between clinicians and academics. This should help speed up translational research. We will also aim to make research easier to conduct by improving the research infrastructure (such as bio-banking). An important dimension of this will be encouraging a greater number and range of healthcare professionals to get involved in research. This will both improve the quality of the research itself and help encourage a culture of improvement across King's Health Partners.

3.23 As a single organisation we will seek to make the most of our large and diverse local population with its global research implications. We will aim to make better use of patient data for research through a new electronic record. Leveraging our scale, we will seek to establish a larger number of patient trials addressing the health issues that matter to our local population. We will do this in partnership with others through the Academic Health Science Network we hope to develop across south London.

3.24 Closer working with the university can help us draw on the academic strengths across KCL's Schools. For example, researchers in the humanities and health might collaborate to better understand the different cultural experiences of pain.

vi) Build prosperity for our local communities and the UK

3.25 A single organisation will help us to generate new income through our own business and attract new commercial, fundraising and grant income. For example, closer integration with the university would allow us to commercialise better the value of our research and create more commercial spin-outs.

3.26 Attracting new income and investment will enable us to contribute to the local economy, helping regenerate some of the most deprived areas of the country. This will occur directly (e.g. by creating new jobs and developing new products) and indirectly (e.g. through building new facilities and offering new training opportunities to local people).

3.27 Our new organisation will also accelerate efforts to position the UK and London as one of the top global centres for life sciences, competing with places like Boston, San Francisco and Singapore.[20] Our organisational scale, increased patient base and improved administrative systems will make King's Health Partners an attractive partner to commercial and other research organisations.

4. ORGANISATIONAL MODEL

4.1 We are proposing that King's Health Partners AHSC should be embodied as the partnership of a single NHSFT formed through the merger of the three FTs, and closer integration with KCL. Full integration between an NHS organisation and a university is not feasible under the current statutory arrangements. Nevertheless, a partnership on the lines we envisage would enable us to create the UK's most integrated and innovative academic healthcare organisation. In taking it forward, we would:

- Honour and build on the strength and depth of the heritage and prestige of our current institutions and the strategic advantages of our current main hospital sites.
- Strengthen the links between KCL and the clinical-service delivery arms of the NHS organisation, so that all clinical services are supported by the strength in teaching and research that only an AHSC can provide.
- Put mental health at the centre of the mission and practice of the new partnership at all levels, and reflect this in the leadership (executive and non-executive) of the AHSC and its delivery arms.

Governance

4.2 In this form, King's Health Partners would consist of a partnership of two legal entities – KCL and the new NHSFT – which would nevertheless present to the world as a unified entity. This would be expressed through:

- **Merger of the three FTs**. We propose bringing together physical and mental healthcare in equal partnership in a single FT, with specific provisions to ensure adherence to the guiding principle that there should be parity between mental and physical healthcare. This should enhance the distinct national standing of SLaM and the Institute of Psychiatry (IoP), which is part of KCL. Such provisions should include ensuring that the overall balance of the Board and leadership of the new organisation appropriately reflect the parity between mental and physical health. This might include non-executive (for example, chair / vice chair), executive, clinical and academic leadership. Similarly, attention to the prominence and approach of mental health services should be reflected in the wider corporate structure.
- **Establishing a new King's Health Partners Board**. The Board would focus on the strategy and investment in order to deliver the AHSC vision. It would seek to embody the partnership values that have characterised King's Health Partners to date, including the parity accorded to mental and physical health. Membership would be drawn from the executives and non-executives of the NHSFT and KCL. Additional non-executives would be appointed to the Board, in order to bring in external perspectives and enhance the academic ethos of the organisation.
- **Establishing a new King's Health Partners Executive**. The objective of the Executive would be to ensure delivery of the King's Health Partners strategy and to reconcile any competing priorities between NHSFT and KCL. It would be led by the Executive Director of King's Health Partners, comprise key executives from the two partners (including the CEO of the NHSFT), and reflect the parity between mental and physical health.

4.3 Other governance arrangements would be considered to help cement the partnership, for example, reciprocal executive and non-executive representation between the NHSFT, KCL and the King's Health Partners Boards.

Organisation and operating model

4.4 We are conscious that in following this model of partnership, we would be proposing the creation of an NHSFT twice as big as any that exists at present. Indeed, Guy's and St Thomas' is already the largest FT by turnover in England. The relationship with KCL creates an even larger entity. We have been clear from the outset that this undertaking would be unacceptable – and would fail – if it resulted in a remote, centralised organisation which attempted to replicate the conventional NHS Trust governance, management and service arrangements at this scale. It would have to operate in a very different way to be effective.

Clinical academic delivery arms

4.5 Our proposed model for the organisation of the new NHSFT is that it would operate in a group structure, in which responsibility for delivery of the objectives of the AHSC would be devolved to a small number of clinical academic delivery arms which would:

- be of sufficient scale to have their own character, leadership and devolved budgets;
- nevertheless represent an opportunity to bring delivery of clinical services even closer to the patients and communities that they serve;
- be accountable for the quality of services for which they are responsible, and take responsibility for engaging with regulators, commissioners and other stakeholders;
- be coterminous with the relevant KCL Schools to more effectively support the AHSC goals; and
- take responsibility for progressing the research and teaching objectives of the AHSC within their area to support and enhance the clinical services that they lead.

4.6 These clinical academic delivery arms would be directly accountable to the NHSFT Board for NHS performance issues, for which the FT would be statutorily accountable. They would also have accountability to KCL through the relevant academic Schools for performance on academic issues, for which KCL is statutorily accountable, in a manner comparable to the way the IoP and SLaM currently interact. This will ensure that the operational issues have a clear line of accountability and can be swiftly resolved. Finally, the clinical academic delivery arms would report to the King's Health Partners Board for the shared agenda of the tripartite mission. This dialogue would focus on setting strategy and agreeing an integrated business plan, including budgets, against which they would be monitored. The SLaM-IoP relationship is the nearest existing analogue to how we envisage the clinical academic delivery arms working.

4.7 Each of these clinical academic delivery arms would have a management board, which would involve non-executive representation and a role for FT Governors. The

Board's leadership structure would respect the shared academic and healthcare goals of King's Health Partners, including the commitment to reflect the central role of mental health across the leadership of the organisation.

4.8 The number and composition of these clinical academic delivery arms have yet to be decided; and of course, they would evolve over time as the health system changes and new models of care drive different service delivery arrangements. However, the aim would be to begin building the new structure on the foundation of the current CAGs. So for example, at the point of launch of the merged organisation, it is possible to envisage cancer services, children's services and dentistry all operating as separate, single service delivery arms with their own character, leadership and budgets. Over time, other clinical service areas might also be grouped to a greater extent around patient pathways and population groups than they are under our current arrangements. However, we also recognise the importance of continuity over the transition period, in particular to ensure operational performance is maintained.

4.9 As part of our commitment to encourage a greater academic ethos, we would look in particular at how we develop our workforce. For example, the majority of future consultant appointments to the new NHSFT will simultaneously be given honorary academic appointments at KCL, helping support the development of an 'integrated faculty' across King's Health Partners.

Cross-cutting functions

4.10 The NHSFT Board will bring together the management of a number of central and support functions that appropriately sit at the corporate level. These functions might include, for example, finance, estates, human resources, IT and facilities management. While each of the separate clinical academic delivery arms may have some of its own support functions, these would operate under clear rules of discretion established by the FT Board.

4.11 There is also scope for establishing a number of cross-cutting functions across both the NHSFT and KCL, as is already the case with fundraising which is run by KCL. For example, we would leverage KCL's expertise in education and research management to lead the development of comprehensive frameworks for education and for research; and to coordinate our activities in these two areas, most urgently in relation to medical education.

Benefits of the new organisation

4.12 The new organisational model would help King's Health Partners deliver the vision in a number of ways, in particular by:

- aligning the interests of the separate organisations;
- bringing physical and mental health services together into a single organisation;
- simplifying the academic and healthcare relationship – KCL will have only one FT to work with;
- creating the organisational scale to help deliver the vision.

Transition to the new organisation

4.13 The full details of the operating model would be developed as part of the Full Business Case. While that is being compiled, we would also carry out further reviews of the ambitions of the current CAGs – particularly those in priority areas for the AHSC – which might impact on the emerging operating model for the AHSC.

4.14 Our transition to the new organisation would be evolutionary where possible, in order to ensure that performance against key operational measures is maintained where appropriate and improved wherever necessary. This will be essential for ensuring that we maintain the confidence and support of patients as well as the wider population and stakeholders.

4.15 As we develop the new organisation, we would like to engage further with our local commissioners, and our partners in primary care, to discuss how we might most effectively achieve our goals around encouraging more integrated care and strengthening community services. We genuinely believe that there is scope for innovation in this area, to the benefit of patients. But we recognise that if there is to be further integration involving primary care, it has to be on the basis of real partnership.

5. BENEFITS

Improving health

5.1 **Improving care outcomes.** The special emphasis on linking physical and mental healthcare would lead to an immediate improvement of care provided to patients – and would in time lead to better long-term outcomes (for example by decreasing years of life lost to schizophrenia). Consolidating our specialist services would lead to better patient outcomes because for many specialties quality is directly related to how many cases a centre does. For example, specialist endovascular aneurysm repair has lower mortality and shorter length of stay than open surgery but requires doctors to be doing a large number of cases to be proficient. Creating integrated clinical services could also help 'level up' performance across different services by putting in place the most effective practice.[21]

5.2 **Quicker access to new drugs and therapeutics.** We would be able to speed up access to new drugs and treatments through more effective research, supported by clinical and academic co-location; through more opportunities for patients to take part in trials as commercial partners are attracted to our larger patient base; and through investment in cutting edge technologies (for example, robotic surgery for complex mitral valve surgery), which may be unaffordable as separate organisations.

5.3 **Less wasted time for patients.** Greater separation of acute and elective services could prevent the admission of emergency patients from disrupting planned activity – reducing inconvenience for patients and improving efficiency of services.[22] For example, consolidation of fractured neck of femur surgery for elderly patients could reduce waiting times for theatres. Likewise, creating a single elective joint replacement centre would reduce cancelled operations and the length of stay in hospital.

5.4 **More integrated care.** More joined up working across acute, community and mental health services could improve patient care and experience. For example, an estimated 40% of inpatients in King's, Guy's and St. Thomas' hospitals have dementia, but recognition of dementia in secondary care is poor. The inclusion of dementia specialists in Accident & Emergency departments could lead to earlier diagnosis and more effective treatment.

5.5 **More convenient care**. A large proportion of King's Health Partners' 225 sites are based in the community. These could be used more effectively and creatively to support care closer to home.

5.6 **Better use of information technology**. Creating shared platforms such as a shared electronic patient record across King's Health Partners and our local partners could lower the risk of medical error, reduce outpatient appointment time, and improve patient experience by avoiding asking people to repeat basic information. At Brigham & Women's hospital (Boston, USA), e-prescribing and access to an electronic patient record including medical history decreased the incidence of preventable adverse drug events by more than 17%.[23]

Better research

5.7 **Quality of research.** First, bringing together academic and clinical services in specialties would encourage innovation and improve access to clinical trials. Second, the integrated organisation could improve access to and data about the vast patient population that the three healthcare providers serve, by developing a shared electronic record that is accessible to research, building on existing models like the Clinical Record Interactive Search (CRIS). For researchers aspiring to generate research with global applicability this is particularly important. Third, the scale and reach of the new organisation would offer new research opportunities, such as finding solutions to the problems of healthcare delivery through 'Improvement Science', or by linking physical and mental health research to better understand 'medically unexplained symptoms'.

5.8 **Making research easier**. The new organisation would be able to improve research infrastructure (including laboratories, IT, trial co-ordination, bioinformatics, data management and bio-banking). This would make it easier to conduct major clinical trials either for our own research or in conjunction with the pharmaceutical industry. New processes would encourage clinical and patient participation in research (for example by taking a consistent approach to obtaining patient consent) and reduce bureaucracy (such as by creating a single research approvals process).

5.9 **Attracting research talent and funding.** Closer links to the new NHSFT would help KCL demonstrate impact (a critical factor in how university research is assessed). New funding partners (whether commercial, not-for-profit or government) would find it more attractive and easier to do business with the new organisation. The enhanced scale, performance, and reputation of the organisation would help attract the best talent and resources, competing against the world-leading AHSCs.

Better education and training

5.10 **Improved student experience.** The new organisation would be able to improve the student experience (particularly for clinical undergraduates), for example through better coordination of clinical teaching, co-location of clinical and academic facilities, and improved student services.

5.11 **Greater opportunities for applied learning**. The new organisation would offer a wide range of applied educational opportunities for health and non-health students. It could do this through joint degrees, a wide range of real world learning opportunities (for example across community and mental health settings), and greater employment opportunities upon graduation. This would give students a more rounded education and KCL a comparative advantage in attracting the best students.

5.12 **Improved resources and facilities for students and staff**. Greater flexibility in investment decisions would allow us to improve educational and training facilities across the King's Health Partners campuses. All King's Health Partners students and staff would have access to common support services and facilities, such as the libraries.

5.13 **Attract the best students**. Enhanced experience, facilities, learning and employment opportunities would help King's Health Partners attract the best students in the UK and internationally.

Better value

5.14 **More efficient healthcare economy.** The new organisation would enable us to improve value for money for patients and taxpayers across the health and care system. Estimates suggest 3-5% of savings could be achieved from savings in non-clinical support functions alone in the new organisation.[24] We think significant further savings could be achieved through improved productivity across much of our business which will have benefits for the whole healthcare economy. For example, we could consolidate services where they are duplicated. A single heart attack centre could enable all patients to receive 24/7 care by combining the workforce and implementing a single on call rota. Likewise, a single diabetes service would enable King's Health Partners to reduce the number of specialist services and move more care closer to home. The Full Business Case will examine in detail the full range of productivity opportunities.

5.15 **Better use of assets.** The new organisation has the potential to make better use of its extensive estate, which comprises 225 sites with a combined value of over £1.8 billion. An integrated organisation could unlock more value from this estate, for example by rationalising facilities, freeing up space for re-use or reinvesting the capital in front line services. The Charitable Trusts associated with our organisations have combined assets of well over £600 million which could be used to greater effect if joined up.

5.16 **New jobs and prosperity.** The new organisation has the potential to generate new income by extending the geographic reach of its specialist services and by attracting new investment (commercial and not for profit). For example, we would aim to develop further initiatives such as the Cell Therapy Catapult centre at Guy's Hospital, the objective of which is to bridge the gap between academic invention and real life commercial products. This kind of development has the potential to create new employment opportunities and prosperity in the local economy.

6. FINANCIALS

The four partners are in financial good health but have challenging future plans

6.1 The finances of the three NHS Foundation Trusts reveal a combined organisation with an income of £2.1 billion and expenditure of £2.0 billion. KCL has total income of £532 million and expenditure of £507 million, of which around 45% is King's Health Partners related.

6.2 In their most recent annual accounts, each of the three FTs and KCL reported a financial surplus. Over the next three years, growth projections for both income and expenditure are approximately 1% across the three FTs. KCL is projecting around 5% growth in both income and expenditure. Collectively the FTs plan to find annual cost savings of approximately £200 million by 2015. Of this approximately half will be from pay costs, reflecting about 8% of the pay cost base.

6.3 Capital investment plans for each partner are significant. The FTs are planning approximately £480 million of capital expenditure over the next three years. KCL is midway through a £635 million ten-year capital programme (of which ca. 30% is at the three health campuses). The FTs' funding plans for their capital programmes are derived from a combination of existing cash reserves, additional borrowing and from future surpluses. Shortfalls in projected levels of cost savings or margin from income growth would threaten the ability to fund these capital plans in full. The projected drawdown on loans at the FTs will total £207 million over the next three years.

6.4 The combined property footprint of all four organisations comprises over 800,000 square metres across more than 225 sites, at a value of around £1.8 billion. Of the health sites, around one quarter is leasehold. The majority of KCL property is freehold.

6.5 The Charitable Trusts associated with our organisations have combined net assets of approximately £636 million. Whilst they will not be directly integrated with the FTs, a full merger of the FTs might necessitate a merger of the three Charitable Trusts.

The benefits of integration could be significant but are not fully quantified

6.6 We recognise that savings anticipated in advance of mergers are not always realised post-merger. Accordingly, we need to ensure that any merger savings identified are supported by robust and detailed plans in order to ensure the anticipated value of savings is realised. These detailed plans will be drawn up as part of the Full Business Case process. With this caveat in mind, our assessment is that across the FTs there is opportunity to achieve between 3-5% of cost savings from organisational synergies in some non-clinical support functions. These benchmark estimates will need to be supported by bottom-up analysis before being confirmed.

6.7 It is expected that there are further financial benefits, still to be assessed, which would only be realised through more transformational changes arising from integration. For example, the Integrated Care Programme is implementing a new model of healthcare delivery for older adults which could free up 16,000 bed days per annum (about 2% of the King's Health Partners' total).

6.8 A detailed analysis of the asset base would determine the extent to which capital could be released. To give an illustration of the order-of-magnitude, land and building assets across the FTs have a value of £1.3 billion. Increasing utilisation to release 5% would therefore free up £65 million of additional capital. Alternatively, the freed-up estate could be used for additional sources of rental income.

The costs are not yet fully assessed – particularly longer term restructuring costs

6.9 The detailed cost estimates of transition would be developed alongside the integration plans as part of the Full Business Case process. The main cost categories are described below.

- *Transitional costs.* The Full Business Case itself would require investment funding from the partners. A separate paper will develop robust costings including the cost of the project team and other costs (such as legal advice). In addition, project management resources would be required to both plan transition to the new organisation and subsequently to run post merger integration.
- *Restructuring costs*. There would be a need for both short-term and longer-term restructuring costs. For example, investment in systems would be required to help integrate the organisations. This might include short- term investment such as common payroll platforms, or longer term investment in IT systems such as e-prescribing.
- *Transformational costs*. The SOC has not sought to calculate longer term transformational costs such as the development of entirely new clinical or academic facilities. Where these developments are integral to the new organisation, they would be included in the Full Business Case.

The financial dynamics of the new organisation may need to adapt

6.10 The new organisation would need to build capability to succeed in a changing environment, including the possibility of new funding models in the future, such as capitation payments or personal health budgets. These new funding models may pose financial challenges but could also deliver significant productivity by stimulating innovation in healthcare delivery.

7. CONCERNS AND QUESTIONS

7.1 A number of concerns and questions associated with the proposed organisational change have emerged as we have developed the SOC, in part through discussions with our staff and stakeholders. We seek to address these below.

Would merger lead to closure of local services?

7.2 Core local services would continue to be provided on multiple sites. For example, the two Accident and Emergency departments and two maternity units would remain in their current locations. Rather than closing existing local services, the new organisation would seek to develop new local models of care with our partners to deliver more services, closer to patients' homes.

Would mental health issues be less prominent in the new organisation?

7.3 Mental health is key to the vision of the new organisation and would have a central place in it. The unique place of mental health and its parity of esteem would be enshrined in the principles of the new NHSFT. Specific provisions would be made in the Council of Governors of the NHSFT so that those with mental illnesses could be involved and engaged in this new organisation. In addition, specific provisions would be made to the governance and management model to reflect the centrality of mental health to the new organisation. This might include the creation of specific non-executive, executive and professional leadership roles in the new organisation. The experience of mental health systems would significantly inform the overall model of care of the new organisation, as mental health systems have pioneered the move from hospitalised care to the community. In addition, there is a body of evidence that suggests investment in mental health interventions can reduce demand for acute services.[25]

Would academic issues be neglected in the new organisation?

7.4 A defining characteristic of King's Health Partners is academic excellence. This would be reflected in the new organisational model at every level. A range of mechanisms would be considered to cement the partnership between the NHSFT and KCL, including joint appointments and reciprocal non-executive representation between NHSFT and KCL. The new organisation would commit to flourishing academic campuses at Guy's, St Thomas', King's College Hospital and SLaM/IoP. The new organisation would seek to make the most of the university's wide range of academic strengths (across culture, security, health and beyond), reinforcing KCL's position as a world leading centre for translational research in these areas.

How would operational performance be maintained during this process?

7.5 We recognise that a merger of this scale is a significant undertaking with many associated risks, particularly in the transitional period. To help ensure merger causes little disruption to business as usual, or result in a loss of operational focus, a dedicated transition team would be put in place to operate in parallel to everyday business. This team would ensure robust programme management of the pre- and post-merger activities as well as the active management of both internal and external stakeholders. We would structure and manage our new organisation so there is clear accountability for achieving NHS performance standards (such as

access times) and KCL's key performance measures (such as the National Student Survey and the Research Excellence Framework).

How would the cultural and staff challenges of integration be handled?

7.6 We recognise we would need to put significant investment into developing a strong organisational culture for the new organisation. This would draw on the best of each of the existing organisations. Working with staff to develop this culture and values would be a high priority if we proceed to the next stage of the process.

7.7 There would be significant career and development opportunities for staff in the new organisation. For example, we plan to develop new professional roles as we develop new models of healthcare that cut across existing boundaries. We would support staff with appropriate training as required, for example to better understand the needs of mental health patients in hospital settings.

7.8 In addition, we hope the new organisation would be able to offer better facilities and support services (such as ICT, library access and leisure facilities). Where it is necessary, we would make it easy for staff to work across locations, through improved transport, ICT, and through new ways of working.

Would merger create an inflexible or remote organisation?

7.9 Organisational scale gives us the opportunity to transform the organisation altogether, and make it more responsive, for example by developing new pathway or population based delivery arms. The NHSFT would devolve significant decision-making powers to these delivery arms, creating more autonomous and flexible units that allow the organisation to maintain its agility.

Would merger undermine local accountability through Governors?

7.10 The Council of Governors is a key part of the accountability structure of a Foundation Trust. Making sure that governance works is important to maintaining the independence and accountability of an FT. Governors may have concerns that the sheer size of the merged organisation would make it more difficult for them to fulfil their duties. The Full Business Case must address an appropriate structure for the new Council of Governors that enables the Governors to represent their communities of interest and to hold the Board to account.

Would merger lead to reconfiguration of services?

7.11 Some of the benefits of a new merged organisation may only be realised by changing or reconfiguring services. However, no decision has yet been made about what changes might be appropriate. Although some changes are put forward as examples in this SOC, it is recognised that these proposals would require engagement and/or consultation with stakeholders, including commissioners, public and patients and consideration of the guidance and law.

How will the costs of restructuring the organisation be managed?

7.12 In the Full Business Case resources would be dedicated to detailing costs of restructuring the new organisation and ways to manage these, such as pay differential between the end organisations. Transformation of the organisation would have costs but we believe these would be outweighed by the clinical and

academic benefits, would be offset by the savings that are achieved and would not all be immediate. Moreover, the new organisation would have greater financial flexibility than the individual organisations currently do to invest for the long term.

Would creating a single organisation affect the investment plans of the partners?

7.13 Each of the four partners has significant investment plans. Organisational integration cannot and should not impede future investment. However, the Full Business Case process would need to ensure that these investments are fully aligned with the shared goals for King's Health Partners. It may turn out that joint investments in the new organisation would be a more efficient way of delivering some of these plans (for example, to procure new IT systems).

Would organisational integration reduce patient choice and competition?

7.14 In nearly every other part of the country outside London, it is the norm that only a single teaching hospital would serve the size of population that King's Health Partners does. Nonetheless, it may be the case that the proposed integration of the NHS Trusts is deemed to require consideration by the relevant competition authorities. However, a preliminary review of evidence indicates that for acute services in this sector of London, significant choice and competition would remain. Some of the key arguments to support this assessment are laid out below.

- *Access to services would not be reduced.* Core local services such as maternity and Accident and Emergency departments would remain on the existing two sites. Due to the size of the units there is not a risk that services will be closed or reconfigured at a later date.
- *Many alternative providers would remain for routine services.* There are numerous other providers in the local area. King's College Hospital and Guy's and St Thomas' are two of 25 acute trusts in London. For non elective services there are significant alternatives. Within 30 minutes drive time (~6miles) 44% of the population have a choice of 2-5 Accident and Emergency departments. For elective service such as a knee replacement there are a number of alternative providers, all of whom conduct significant numbers of procedures.
- *Specialist services must be considered on a regional or national base*. For example, 68% of patients receiving Coronary Artery Bypass Grafts (CABG) are regional or national referrals and in this market there are a large number of other providers.
- *Any reduction of choice and competition would be outweighed by improvements in the quality of care.* The benefits case is detailed in section 5 of this document. A single organisation would improve patient care and experience in a number of ways. Without merger, the realisation of these benefits may not occur or would be much slower.

Would merger impede King's Health Partners' ability to respond to the external environment?

7.15 Significant changes are underway in the healthcare system (for example, the developments around the future of South London Healthcare Trust), in the academic world and in the wider economy. Part of the justification for organisational integration is to better equip King's Health Partners to respond to this changing environment. However, if we proceed with integration we would ensure that we do not become too inward focussed in the short term. For example, we would continue

to jointly lead the development of an Academic Health Sciences Network for south London, to help spread innovations in healthcare across the whole sector. Organisational integration would also better prepare us to deal with the challenging economic environment that all NHS organisations will be facing. This would help protect the interests of local patients.

What would be the risks of not proceeding?

7.16 There are also risks if the partners do not proceed to form a single academic healthcare organisation including the creation of one NHS Foundation Trust more closely integrated with KCL. First, King's Health Partners may need to adjust its ambition and/or the expectations about the pace of delivery. Second, King's Health Partners would be in a poorer position to respond to future trends in healthcare, the economy and the academic world. Third, not proceeding may itself require organisational restructuring to CAGs. Finally, alternative processes might need to be found to deliver financial savings in years to come.

8. FORWARD PLAN

8.1 There are five core sets of activities on the forward path to approval:

- creating a Full Business Case and integrated business plan for the new organisation (including detailed set of financials);
- designing the organisational and operating model;
- gaining approval from the regulatory and competition authorities;
- working with commissioners, engaging formally with the public and our members, and broader communications with our staff and stakeholders;
- planning for the transition to and implementation of the new organisation, including the appointments process and integration plans.

8.2 These activities would be managed as a programme separate from the 'business as usual' of both the King's Health Partners Executive and the various partner organisations. It would be led and managed by a Programme Management Office (PMO) and accountable to the King's Health Partners Board for designing and managing the work and co-ordinating the interactions with the key stakeholder groups. The PMO would be led by members of the King's Health Partners Board supported by a full-time Programme Director and team. It would report regularly to the King's Health Partners Board and a subset of this board between board meetings as required.

Regulatory and competition process

8.3 The current estimated path to regulatory approval runs to April 2014. During this period, the core milestones on this path are engaging with commissioners and stakeholders, the start of formal public consultation and formal engagement with Monitor and the competition authorities (beginning with pre-notification discussions in April 2013). The latter requires the five-year integrated business plan to be complete.

8.4 There are two key external uncertainties around this timeline which could potentially impact the timing by a year or more:

- the detailed implications of the recent Health and Social Care Act, including the licensing regime;
- the impact of the appointment of a Trust Special Administrator in respect of South London Healthcare Trust (SLHT) – a process in which the FT partners are keen to play a constructive part.

8.5 An important step following approval of this Strategic Outline Case by Partner boards and the KCL Council would be to seek further guidance from various authorities around these uncertainties.

Communications and engagement

8.6 Ahead of a public consultation and in conjunction with the development of a Full Business Case, we would need to communicate the positive case for a new

organisation, demonstrating to staff, members, governors, patients and stakeholders the benefits and explaining how we would manage the risks.

8.7 To achieve this communication, we would continue to use face-to-face methods and to use the media and our own publications, but we would also significantly increase our use of digital media channels and look to foster debates in other environments.

8.8 We would hold a further series of broad staff engagement events as well as with specific staff groups, both clinical and non clinical. We would produce communications materials to clearly outline the benefits of a new organisation and explain the proposals to our staff and stakeholders. We would continue to meet with local health scrutiny teams, MPs, commissioners, clinicians, patients and patient groups to understand their views, and we would work closely with regulators (including HEFCE and Monitor) and the Department of Health on the proposal.

8.9 It is recognised that some of the proposals in this document will require engagement and/or consultation with stakeholders. At the appropriate time, engagement and consultation, following best practice, will be undertaken. It is important that, at this stage, no decision has yet been made about what changes (if any) might be appropriate.

8.10 Each of the partners in King's Health Partners understands their obligations under the Equality Act 2010 and, in working through the detailed issues arising from this SOC and the development of any case for organisational change, will properly analyse and take into account the impact of any equality issues in order to meet the three main aims of the general equality duty.

9. CONCLUSION

9.1 The analysis undertaken in this SOC helps answer the four questions that were posed.

What is the rationale for organisational integration?

9.2 There are a number of significant external drivers for King's Health Partners to consider changing its organisational form - healthcare, academic, economic and social.

9.3 The internal driver for change is the King's Health Partners mission. The proposition is that a more integrated King's Health Partners could deliver more and at greater pace. A single organisation would achieve this through closer alignment of priorities, greater financial flexibility, simplifying partnership working, and organisational scale.

9.4 An integrated academic healthcare organisation could thereby help King's Health Partners realise an enhanced vision, with a particular focus on physical and mental health integration and on the challenges of population health.

What is the preferred organisational model?

9.5 Merger of the three Foundation Trusts and closer integration with KCL has been identified as the preferred organisational model.

Do the benefits outweigh the costs and risks of integration?

9.6 A number of clear benefits have been identified from organisational integration, including improved care for patients, enhanced academic performance and increased economic value. The costs of integration will include transitional costs and short and longer-term restructuring costs. Neither the costs nor benefits of integration have been fully assessed at this stage. The risks of organisational integration are significant, but we believe these could be managed. The Full Business Case would undertake a more detailed (and quantitative) analysis of the full benefits and costs of integration.

What is the forward plan?

9.7 If the Boards of the partner organisations decide to proceed, the next step is to assess fully the costs and benefits in a Full Business Case. We believe this could be completed by early 2013.

9.8 Depending on the regulatory process, the organisation could legally come into form by late 2014.

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King's Health Partners
Ground Floor
Counting House
Guy's Hospital
London SE1 9RT

T 020 7188 4058
F 020 7188 9330
E kingshealthpartners@kcl.ac.uk

www.kingshealthpartners.org

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