HILLINGDON CCG UPDATE

Relevant Board Member(s)	Dr Ian Goodman
Organisation	Hillingdon Clinical Commissioning Group (HCCG)
Report author	Caroline Morison; Rebecca Whitworth; Melanie Foody; Joe Nguyen - HCCG
Papers with report	None

1. HEADLINE INFORMATION

Summary	This paper provides an update to the Health and Wellbeing Board on key areas of CCG work. The paper encompasses: • North West London (NWL) Health and Care Partnership refresh • Finance update • QIPP delivery • Wood Report: Child Death Overview Panel
Contribution to plans and strategies	The items above relate to the HCCG's: • 5 year strategic plan • Out of hospital (local services) strategy • Financial strategy • Joint Health and Wellbeing Strategy • Better Care Fund
Financial Cost	Not applicable to this paper.
Relevant Policy Overview and Scrutiny Committee	External Services Select Committee
Ward(s) affected	All

2. RECOMMENDATION

That the Health and Wellbeing Board notes the update.

3. INFORMATION

The following section summarises key areas of work the CCG wishes to bring to the attention of the Health and Wellbeing Board.

3.1 NW London Health and Care Partnership

The North West London Sustainability and Transformation Plan (STP) was published in October 2016. It set out how health and care organisations would work together to improve care and services for people across North West London (NWL). In Hillingdon, the locally articulated priorities have been incorporated into our joint Health and Wellbeing Strategy.

Good progress has been made in many areas, but with the publication of the Long Term Plan and the new clinical strategy being developed for London, it feels right that we refresh our strategy. A midpoint review of our 5 year plan gives us an opportunity to 'take stock and refresh' where needed, so as to ensure we continue to prioritise the right areas.

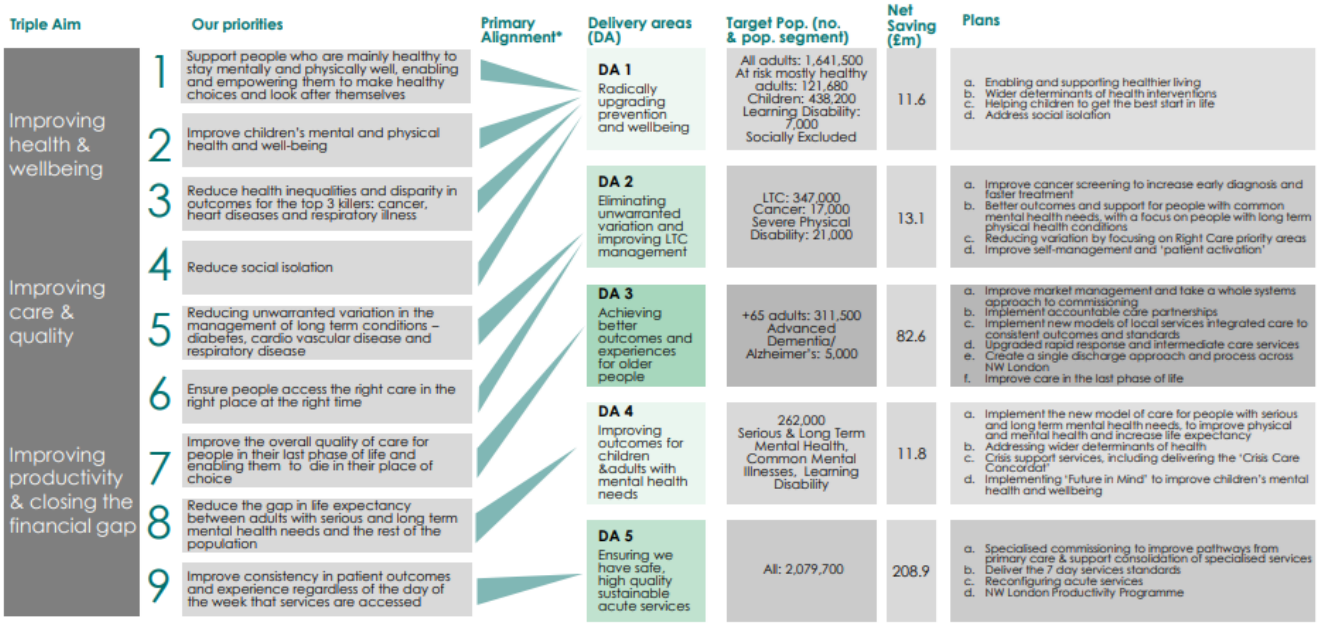
The refresh includes:

- reviewing existing priority areas and proposing new priority areas in light of national strategy and priorities, and active engagement with our communities and clinicians;
- reviewing existing programmes of work and identifying key programmes that will deliver above;
- working with our NW London 'Clinical and Quality Leadership Group' to articulate a clear set of outcomes; and
- building on our existing governance process to ensure it remains timely and facilitative – programme area governance will be established (where it is not already meeting).

The intention is to share a final version of the refresh with partners via the North West London Health and Care Partnership's governance process in March 2019.

Progress to date

Our 2016 NW London Sustainability and Transformation Plan vision was for everyone to have the opportunity to 'be well and live well' and the proposed models of care would see patients take more control and be supported by an integrated system proactively managing care in areas as close to people's homes as possible. The vision and models of care were further defined into the following 9 priorities and were delivered within 5 Delivery Areas.



** Many of our emerging priorities will map across to several delivery areas. But we have sought to highlight where the main focus of these Delivery Areas are in this diagram*

Good progress has been made in many of the above areas, including: demonstrating how we can successfully work as a health and care system to improve residents' care and experience; increased use of digital technology to enable people to find the right services for their health needs as well as helping people with long-term conditions manage their care better; and availability of GP appointments seven days a week, 8am-8pm. Additionally: over 3,000 people have been discharged from hospital through Homefirst, reducing the time they have needed to be in hospital; a 24/7 single point of access for adults in a mental health crisis has been successfully launched; and active work with care homes to improve training for staff and enable more residents to be cared for at home; as well as the redesign of outpatient services in a number of key specialities. This work has provided a better experience for patients and improved cost effectiveness for the system. These, and a range of other programmes, provide a strong springboard on which to build going forward.

Our refreshed plan

The *refreshed* vision for NW London, '*create one integrated health and care system working together to maximise benefits to residents and staff',* embodies the '*live well, be well, age well'* principles. It is to be underpinned by three aims which will be delivered through seven Interconnected Areas and five enablers. Intelligence which has been used to inform the refresh and the proposed priority areas has been forthcoming from senior health and care partners across NW London, clinical, managerial and lay member representative leads working on existing priority programmes of work, colleagues working to support enabler functions such as estates, IT and workforce and national intelligence including Rightcare. The following is a summary plan:

The next few pages detail the emerging priority programmes for each of the seven Interconnected Areas.

Proposed Priority Programmes for the *Refreshed* NW London Health andCare Partnership Plan to 2020/21

Interconnected Area	Aim	*Proposed* priority programmes and projects
1) Healthy communities and prevention	**Aim:** to support people to support themselves and others, to live full and active lives in their community	**1.1) Promoting Self Care** **1.1a) Digital Self-Care** - *improving access* **1.1b) Personalised self-care** - *increased and personalised use of Patient Activation Measurement (PAM)* **1.1c) Social Prescribing** - *easier access and vibrant communities* **1.2) Promoting Healthy Lifestyles** **1.2a) Childhood Obesity** – *increased healthier choices* **1.2b) Alcohol Misuse** – *adopting best care management*
2) Maternity, children and young people (CYP)	**Aim:** to develop our Health and Care System offer for Children and Young People which looks beyond illness **Aim:** to improve safety, continuity and personalisation of maternity care	**2.1) Children and Young People (CYP)** **2.1a) Dental -** *improving dental care* **2.1b) Asthma Children with Long Term Conditions –** *adopt best care across NWL* **2.1c) Complex Care needs of Children** – *improving what matters to CYP* **2.1d) Starting well and staying well -** *promoting a better start in life* **2.2) Maternity 'Better Births'** **2.2a) Personalised care and choice** – *improving women-centre care and choice* **2.2b) Continuity of carer** – *increasing continuity of maternity team* **2.2c) Safer care –** *increasing quality and safety of care* **2.2d) Starting well and staying well -** *Improving links with CYP programme to work jointly on prevention initiatives which focus on first 1000 days of life , (includes a focus for Neonatology)*

Interconnected Area	Aim	*Proposed* priority **programmes** and projects
3) Primary, social and community care	**Aim:** to improve community based care so as to support people closer to home and prevent deterioration in their health and wellbeing	**3.1) Supporting *Primary Care* at Scale** Projects will increase investment and support for GPs and their teams to provide more access, proactive and co-ordinated care for their local communities **3.2) Supporting people with *Frailty*** Projects will develop and deliver proactive and co-ordinated health and social care services supporting people with Frailty in their own homes, communities and in and out of hospital **3.3) Supporting people with *Dementia*** Project will develop and deliver proactive and co-ordinated health and social care services supporting people with Dementia in their own homes, communities and in and out of hospital **3.4) Supporting people in *Last Phase of Life*** Projects will make sure health and care staff are aware of and respect people's wishes during their last phase of life **3.5) Supporting people with *Diabetes*** **3.6) Supporting people with *Muscular/skeletal conditions*** **3.7 Supporting People with *Coronary Vascular Disease*** Projects will seek to identify and support people with increasing needs and work to prevent deterioration in conditions

Interconnected Area	Aim	*Proposed* priority **programmes** and projects
4) Urgent and emergency care	**Aim:** to ensure Urgent and Emergency care is delivering the right care in the right place (i.e. home, community or hospital) first time	**4.1) People find the right service in a crisis** **4.1a) New model of Integrated Urgent care inc 111 online** - *improve access, efficiency and increase public confidence* **4.1b) Older people supported in crisis –** *improving Multi-Disciplinary Teams, pathways and quality* **4.1c) Enhance alternative pathways and demand management –** *improve ways of working and quality of care* **4.2) Patients admitted to hospital only when need it** **4.2a) Enhanced front door pathways inc. Frailty, Ambulatory Emergency Care (AEC) and streaming/redirection** – *improving Multi-Disciplinary Teams , pathways and quality* **4,2b) Standardise Urgent Treatment Centre service provision** – *improved and consistent high quality* ***4.2c)* Ambulance handovers** - *adopt best practice* **4.3) Patients go home as soon as they are fit to leave** ***4.3a* improving patient journey and collaborative care** – *adopt best practice* ***4.3b* Specialist support services 7days a week** *-improved continuity and quality* ***4.3c* Discharge to assess** – *improved Multi-Disciplinary Teams ways of working*
5) Mental Health	**Aim:** to improve outcomes for children and adults with mental health, learning disability and autism needs, and enable them to live well through timely access to community based and high quality of care no matter where they live.	**5.1) Prevention and Early Intervention** **5.1a) *Common Mental Health Needs*** – *improve access and quality of care* ***5.1b) Early Intervention Psychosis -*** *improve access and quality of care* **5.2) Focused Interventions for targeted populations** **5.2a) *Adults with Serious and Long Term Mental Health Needs -*** *improve access and quality of care* **5.2b) *Learning Disability and Autism -*** *improve access and quality of care* ***5.2c) Children and Young People's Mental Health Needs -*** *improve access and quality of care*

Interconnected Area	Aim	*Proposed* priority **programmes** and projects
6) Cancer	**Aim:** to enhance screening and on-going Multi-Disciplinary Team care which enables people to live as independently as possible with, and beyond, cancer	**6.1) Cancer '*early identification*'** **6.1a) Increasing earlier diagnosis and improving 1, 5 and 10 year survival rates –** *improving earlier identification and diagnosis of stages 1 and 2 cancers and patient centred care management* **6.2) Cancer '*rapid treatment*'** **6.2a) Collaboration of service delivery -** *advancing pathway co-ordination with continued investment in quicker, clinical pathways* **6.2b) Improving productivity through efficient diagnostic utilisation and workforce initiatives –** *Delivering unified care with our network of providers and specialists* **6.3) Cancer '*living with and beyond*'** **6.3a) Realising and embedding Quality of Life standard for our populations –** *improving survival rates and universal long-term outcomes*
7) Hospital care	**Aim:** to implement good quality, sustainable acute care in the most appropriate places as close to people's home as possible **Aim:** for NHS Providers to work together to improve value and patient experience whilst increasing quality and reducing costs	**7.1) SaHF Implementation and Assurance** **7.1a) Overseeing implementation of SaHF out of hospital reconfiguration.** Ensure out of hospital reconfiguration (including hubs) is implemented according to the approved Strategic Outline Case 1 (SOC1) plans and deliver the associated benefits **7.1b) Overseeing implementation of SaHF acute hospital reconfiguration.** Ensure that the acute hospital reconfiguration in outer NW London is implemented according to Strategic Outline Case 1 plans and deliver the associated benefits Develop, support and assure strategic developments for inner NW London Strategic Outline Case 2 (SOC2) **7.1c) Regulator assurance** Manage relationships with regulators to ensure business cases for Shaping a Healthier Future (SaHF) delivery are best placed to be approved **7.2) NHS providers *working together*** **7.2a) Outpatients Transformation** – *right place, right time and right information* **7.2b) Radiology Network** – *image sharing* **7.2c) Workforce** – *increasing the value* **7.2d) Procurement Alliance** – *smartly buying together*

The seven Interconnected Areas have identified some high level priority programmes of work in conjunction with discussions with colleagues across NW London. These include; local authority, clinical, managerial and lay member representatives. Engagement in the refresh is ongoing.

3.2 Finance update

Overall, at Month 9, the CCG is reporting it is on target against its YTD in-year surplus of £0.1m and forecasting achievement of its £0.2m planned in-year surplus by year end. The CCG's financial position remains extremely tight at M09, with significant adverse variances within Acute and Continuing Care. These have been balanced by releasing the contingency reserve and underspends within Primary Care and Prescribing.

The CCG's 2018/19 exit underlying position (ULP) at M09 is a £3.4m surplus (£6.9m plan), which represents a deterioration of £3.5m from plan. The shortfall from the planned ULP is balanced by a combination of in-year non-recurrent underspends, slippage on investment and additional allocations (net).

The main areas of pressure include acute overspends (£3m YTD) in relation to Royal Brompton and Harefield, Chelsea and Westminster, Imperial, Barts and the London, Guys and St Thomas', and West Herts and Continuing Care (£1.9m YTD) in relation to Learning Disabilities, Section 117s, Elderly Frail and Physical Disabilities. The Continuing Care pressures are partially offset by an anticipated underspend within Funded Nursing Care and Children's Complex Placements.

The overall Prescribing position is currently a YTD underspend of £1m and Forecast Outturn (FOT) underspend of £1.4m. The YTD and FOT position is reported based on the 2018/19 PPA profile.

The overall Primary Care position is currently a YTD underspend £1.1m and FOT underspend £1.7m which is largely in relation to underspends within delegated budgets.

Overall Position – Executive Summary Month 9 YTD and FOT

Table 1

PROGRAMME BUDGETS		Year to Date Position			Forecast Outturn Position		
	Final Budgets (£000)	YTD Budget (£000)	YTD Actual (£000)	Variance Sur/(deficit) (£000)	FOT Actual (£000)	FOT Variance Sur/(deficit) (£000)	FOT QIPP Variance (£000)
Commissioning of Healthcare							
Acute Contracts	220,067	165,730	168,030	(2,300)	222,425	(2,358)	(315)
Acute/QIPP Risk Reserve	(2,984)	(696)	0	(696)	(1,688)	(1,296)	(892)
Other Acute Commissioning	13,624	9,525	9,469	56	13,636	(12)	0
Mental Health Commissioning	26,581	19,815	19,955	(140)	26,888	(307)	(61)
Continuing Care	24,702	18,449	20,350	(1,900)	27,080	(2,378)	(620)
Community	34,078	25,516	25,021	495	33,399	679	(116)
Prescribing	35,400	26,462	25,413	1,049	34,036	1,364	464
Primary Care	46,773	33,891	32,775	1,116	45,058	1,715	0
Sub-total	**398,241**	**298,692**	**301,013**	**(2,320)**	**400,834**	**(2,593)**	**(1,539)**
Corporate & Estates	4,899	3,615	3,211	405	4,378	521	0
TOTAL	**403,140**	**302,308**	**304,223**	**(1,915)**	**405,212**	**(2,073)**	**(1,539)**
Reserves & Contingency							
Contingency	1,859	1,742	0	1,742	0	1,859	0
2017/18 Balance Sheet Pressures	0	0	166	(166)	166	(166)	0
RESERVES Total:	**1,859**	**1,742**	**166**	**1,575**	**166**	**1,693**	**0**
Total 2018/19 Programme Budgets	**404,999**	**304,050**	**304,389**	**(340)**	**405,379**	**(380)**	**(1,539)**
Total Programme	**404,999**	**304,050**	**304,389**	**(340)**	**405,379**	**(380)**	**(1,539)**
RUNNING COSTS							
Running Costs	**5,613**	**4,173**	**3,833**	**340**	**5,233**	**380**	**111**
CCG Total Expenditure	**410,612**	**308,223**	**308,222**	**0**	**410,612**	**0**	**(1,428)**
In-Year Surplus/(Deficit)	**179**	**134**	**0**	**134**	**0**	**179**	**0**
MEMORANDUM NOTE							
Historic Surplus/(Deficit)	**7,663**	**5,747**	**0**	**5,747**	**0**	**7,663**	**0**
TOTAL	**418,454**	**314,104**	**308,222**	**5,882**	**410,612**	**7,842**	**(1,428)**

Month 9 Year to Date Position – Acute Contracts and Continuing Care

Table 2

Acute Contracts

		Month 9 Position		
	Final Budgets (£000)	YTD Budget (£000)	YTD Actual (£000)	Variance Sur/(deficit) (£000)
In Sector SLAs				
Chelsea And Westminster Hospital NHS Foundation Trust	2,411	1,813	2,074	(262)
Imperial College Healthcare NHS Trust	13,383	10,061	10,512	(450)
London North West Hospitals NHS Trust	18,378	13,827	13,770	57
Royal Brompton And Harefield NHS Foundation Trust	7,198	5,415	5,936	(521)
The Hillingdon Hospitals NHS Foundation Trust	143,545	108,223	108,315	(91)
Sub-total - In Sector SLAs	**184,915**	**139,340**	**140,607**	**(1,267)**
Sub-total - Out of Sector SLAs	**33,368**	**25,051**	**25,825**	**(774)**
Sub-total - Non NHS SLAs	**1,784**	**1,340**	**1,598**	**(259)**
Total - Acute SLAs	**220,067**	**165,730**	**168,030**	**(2,300)**
Sub-total - Acute/QIPP Risk Reserve	**(2,984)**	**(696)**	**0**	**(696)**
Total Acute Contracts & Acute Reserves	**217,082**	**165,034**	**168,030**	**(2,996)**

Continuing Care

		Month 9 Position		
	Final Budgets (£000)	YTD Budget (£000)	YTD Actual (£000)	Variance Sur/(deficit) (£000)
Mental Health EMI (Over 65) - Residential	2,530	1,898	1,829	69
Mental Health EMI (Over 65) - Domiciliary	339	255	168	86
Physical Disabilities (Under 65) - Residential	3,005	2,254	2,328	(74)
Physical Disabilities (Under 65) - Domiciliary	2,092	1,569	2,126	(557)
Elderly Frail (Over 65) - Residential	2,604	1,953	2,008	(55)
Elderly Frail (Over 65) - Domiciliary	296	222	616	(394)
Palliative Care - Residential	540	405	489	(84)
Palliative Care - Domiciliary	713	535	425	110
Sub-total - CHC Adult Fully Funded	**12,120**	**9,090**	**9,989**	**(900)**
Sub-total - Funded Nursing Care	**3,095**	**2,322**	**1,982**	**339**
Sub-total - CHC Children	**2,398**	**1,798**	**1,718**	**80**
Sub-total - CHC Other	**1,669**	**1,174**	**1,863**	**(688)**
Sub-total - CHC Learning Disabilities	**5,420**	**4,065**	**4,797**	**(731)**
Total - Continuing Care	**24,702**	**18,449**	**20,350**	**(1,900)**

Forecast Outturn (FOT) Position - Acute Contracts and Continuing Care

Table 3

Acute Contracts

	Month 9 Position		Forecast Outturn Position		
	YTD Actual (£000)	Variance Sur/(deficit) (£000)	FOT Actual (£000)	FOT Variance Sur/(deficit) (£000)	FOT QIPP Variance (£000)
In Sector SLAs					
Chelsea And Westminster Hospital NHS Foundation Trust	2,074	(262)	2,655	(243)	(1)
Imperial College Healthcare NHS Trust	10,512	(450)	13,969	(587)	(170)
London North West Hospitals NHS Trust	13,770	57	18,132	246	(394)
Royal Brompton And Harefield NHS Foundation Trust	5,936	(521)	7,904	(707)	(70)
The Hillingdon Hospitals NHS Foundation Trust	108,315	(91)	143,541	4	162
Sub-total - In Sector SLAs	**140,607**	**(1,267)**	**186,201**	**(1,286)**	**(472)**
Sub-total - Out of Sector SLAs	**25,825**	**(774)**	**34,093**	**(725)**	**128**
Sub-total - Non NHS SLAs	**1,598**	**(259)**	**2,130**	**(346)**	**29**
Total - Acute SLAs	**168,030**	**(2,300)**	**222,425**	**(2,358)**	**(315)**
Sub-total - Acute/QIPP Risk Reserve	**0**	**(696)**	**(1,688)**	**(1,296)**	**(892)**
Total Acute Contracts & Acute Reserves	**168,030**	**(2,996)**	**220,737**	**(3,654)**	**(1,207)**

Continuing Care

	Month 9 Position		Forecast Outturn Position		
	YTD Actual (£000)	Variance Sur/(deficit) (£000)	FOT Actual (£000)	FOT Variance Sur/(deficit) (£000)	FOT QIPP Variance (£000)
Mental Health EMI (Over 65) - Residential	1,829	69	2,332	198	
Mental Health EMI (Over 65) - Domiciliary	168	86	233	107	
Physical Disabilities (Under 65) - Residential	2,328	(74)	3,104	(99)	
Physical Disabilities (Under 65) - Domiciliary	2,126	(557)	2,809	(716)	
Elderly Frail (Over 65) - Residential	2,008	(55)	2,732	(129)	
Elderly Frail (Over 65) - Domiciliary	616	(394)	836	(540)	
Palliative Care - Residential	489	(84)	581	(41)	
Palliative Care - Domiciliary	425	110	628	85	
Sub-total - CHC Adult Fully Funded	**9,989**	**(900)**	**13,255**	**(1,135)**	**0**
Sub-total - Funded Nursing Care	**1,982**	**339**	**2,573**	**523**	**0**
Sub-total - CHC Children	**1,718**	**80**	**2,255**	**143**	**0**
Sub-total - CHC Other	**1,863**	**(688)**	**2,633**	**(964)**	**(455)**
Sub-total - CHC Learning Disabilities	**4,797**	**(731)**	**6,365**	**(945)**	**(165)**
Total - Continuing Care	**20,350**	**(1,900)**	**27,080**	**(2,378)**	**(620)**

3.3 QIPP update

The 2018/19 QIPP target is £12.4m, or 3% of the CCG allocation. The CCG is £1,406k behind target for M9, achieving £7,033k of £8,440k YTD plan or 83% delivery. A recovery plan has been developed which returns QIPP delivery to 90% by year end.

There has been slippage against some of our programmes in the following areas: Planned Care, Mental Health, Older People and End of Life (EoL).

Planned care

Gastroenterology, neuro-community service:
One of the key objectives related to transformation in these planned care services is for specific activity and health conditions to be managed in a community setting and for some of the clinics to be run by Clinical Nurse Specialists. The delays in transformation in these areas relate to recruitment of nursing staffing. However, the following Clinical Nurse Specialist (CNS) posts have now been appointed into: Community Parkinson's, Community Epilepsy and Irritable Bowel Syndrome/Irritable Bowel Disease. These schemes will continue into 2019/20.

Ophthalmology and gynaecology
The Gynaecology community Clinical Assessment and Treatment Service (CATS) has not delivered the planned levels of activity to shift activity out of hospital into the community service. The CCG is undertaking a review of the service model which is linked into the NWL Out-patient Transformation Programme that has commenced in 2019.

For Ophthalmology, the CCG is also working with partners to review and develop the service in a similar way to the Integrated MSK service with a single point of access that will triage patients to the most appropriate point of care first time.

Follow-up Variation THH contract
The schemes relates to reducing variation in terms of number of follow-ups in specific specialities to bring in line with national average. There has been some partial delivery and more work will continue in 2019/20 to refresh the benchmarking ratios data.

Community hernia repair service
The community Hernia service did not commence in August 2018 as planned due to challenges finding a GP host practice to deliver the service. This has now been secured and the service will commence in February 2019.

Mental health

Mental Health schemes relating to Section 117 continue to place a significant cost pressure for the HCCG due to increase in referral numbers with spend over budget.

Complex care
For complex cases work (Section 117 and CHC), the CCG has used additional senior resource seconded into role for six months that commenced on 15 October 2018. The review has identified strategic opportunities and operational actions to improve the quality of care and generate efficacies. A series of deep dive meetings have been established to inform Phase 2 of the work.

HCCG has commissioned support from a consultancy, Unified Health Care, who are scoping potential benefits from CCG CHC standard cases for Q4 and to inform our work in 2019/20.

We are drafting a new Hillingdon s117 policy that details entry and exit arrangements into s117 aftercare and incorporates a new cost sharing tool to determine the funding split for all s117 cases. We are working with the Council to complete an audit of 20 cases to inform the choice of a tool that is fair and ensures both parties are operating in line with national policy.

Older people

Older People transformation schemes relate to the work of the Care Connection Team (CCT) and Accountable Care Partnership (ACP). Both QIPP schemes are based on admission avoidance scheme for patients over 65 years.

More recent analysis of CCT work has showed the positive impact they have made to reduce A&E and Non-Elective (NEL) activity for the patients on their caseload. In addition, an evaluation of the impact of the CCT work is been undertaken by Hillingdon Health Care Partners that will be shared with HCCG in late February 2019 that will inform future development of the service.

The ACP scheme relates to a reduction in activity for North East London (NEL) at West Herts and London North West (LNWHT) and providers working more efficiently across the system to reduce activity in other local trusts through the better management of older people in their usual place of residence and in the community. The refreshed plan is to further understand the overall increase in NEL across all ages and providers. A deep dive of those GP practices with high NEL activity at the former provider trusts is underway. The analysis will be shared with ACP colleagues and clinicians to understand the types of patients accessing these services and how we can bring them into our commissioned ACP pathways.

End of Life

The EoL programme has been slow to commence due to challenges in recruiting posts for the Palliative Overnight Sitters Service (PONS) for the Single Point of Access (SPA). However, recruitment has now been successful, the SPA went live on 11 September 2018 and is receiving referrals.

3.4 Child Death Overview Panel

In 2016, the Wood Review of local safeguarding children boards recommended changes to the way the Child Death Overview Panel (CDOP) function is delivered so that the panels cover larger areas where trends and patterns can be assessed and learning disseminated across a wider area.

Currently, across North West London (NWL), there are 6 Child Death Overview Panels (CDOPs) to oversee the review of child death across the 8 NWL boroughs. A successful bid for funding to the Department for Education (DfE) was made by Harrow on behalf of the 8 boroughs and NWL is now an Early Adopter Site for developing new arrangements. Our bid was based upon the following key objectives across NWL:

- Rationalising the Child Death Overview Panel (CDOP) process across eight local authority/eight CCG areas in line with the updated guidance.
- Implementation of eCDOP - a secure web-based record keeping system - we (Hillingdon) are using eCDOP - first meeting held mid-February.
- Development of an agreed Child Death Rapid Response process and support structure.
- Development of the key worker function for families in response to child death.

The project is currently being mobilised with a view to having the new models agreed in February in order to begin mobilisation across the CCGs prior to April 2019. The proposal for Hillingdon is to work together across Ealing, Hillingdon and Hounslow which will provide a more appropriate scale for reviewing trends as well as aligning with the police configuration for West London.

Next steps to deliver the changes include:

- Consultation undertaken on 4 Models - closed 12 February 2019.
- Models designed are based on statutory requirements and responsibilities of CDR partners and using a best-fit approach for NWL. Models include costs.
- Hillingdon's preferred model matches the Police Borough Command Unit (Ealing, Hillingdon, Hounslow) and local hospitals. The outcomes (learning, themes, etc) of the work will then feed into the NWL forum.
- Further engagement planned following results of the consultation and prior to proposed model approval from the NWL CCGs and local authorities.

4. FINANCIAL IMPLICATIONS

None in relation to this update paper.

5. LEGAL IMPLICATIONS

None in relation to this update paper.

6. BACKGROUND PAPERS

NIL.