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A

External Services Scrutiny Committee

Councillors on the Committee

Mary O'Connor (Chairman)
Michael White (Vice-Chairman)
Phoday Jarjussey (Labour Lead)
Judy Kelly
Peter Kemp

Date: **WEDNESDAY, 24 NOVEMBER 2010**

Time: **6.00 PM**

Venue: **COMMITTEE ROOM 6 - CIVIC CENTRE, HIGH STREET, UXBRIDGE UB8 1UW**

Meeting Details: Members of the Public and Press are welcome to attend this meeting

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Terms of Reference

1. To scrutinise local NHS organisations in line with the health powers conferred by the Health and Social Care Act 2001, including:

   (a) scrutiny of local NHS organisations by calling the relevant Chief Executive(s) to account for the work of their organisation(s) and undertaking a review into issues of concern;

   (b) consider NHS service reconfigurations which the Committee agree to be substantial, establishing a joint committee if the proposals affect more than one Overview and Scrutiny Committee area; and to refer contested major service configurations to the Independent Reconfiguration Panel (in accordance with the Health and Social Care Act); and

   (c) respond to any relevant NHS consultations.

2. To act as a Crime and Disorder Committee as defined in the Crime and Disorder (Overview and Scrutiny) Regulations 2009 and carry out the bi-annual scrutiny of decisions made, or other action taken, in connection with the discharge by the responsible authorities of their crime and disorder functions.

3. To scrutinise the work of non-Hillingdon Council agencies whose actions affect residents of the London Borough of Hillingdon.

4. To identify areas of concern to the community within their remit and instigate an appropriate review process.

Agenda

PART I - MEMBERS, PUBLIC AND PRESS

PART II - PRIVATE, MEMBERS ONLY

Minutes

EXTERNAL SERVICES SCRUTINY COMMITTEE

28 October 2010

HILLINGDON
LONDON

Meeting held at Committee Room 6 - Civic Centre, High Street, Uxbridge UB8 1UW

	Committee Members Present: Councillors Mary O'Connor (Chairman), Michael White (Vice-Chairman), Phoday Jarjussey, Judy Kelly and Peter Kemp **Witnesses Present**: Tom Pharaoh – Commissioning Support for London Sue Nunney – Hillingdon PCT Jacqueline Totterdell – The Hillingdon Hospital NHS Trust Richard Connett – Royal Brompton & Harefield NHS Foundation Trust Nicholas Hunt – Royal Brompton & Harefield NHS Foundation Trust Dr Mitch Garsin – Hillingdon LMC Andy Michaels – BMA / LMC Amanda Brady – Care Quality Commission (CQC) **Others Present**: Councillors John Hensley (in part) and Dominic Gilham Allan Edwards, Standards Committee Chairman Malcolm Ellis, Standards Committee Vice-Chairman **LBH Officers Present**: Linda Sanders, Ellis Friedman, Nav Johal and Nikki Stubbs **Public present:** 2	
13.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 4)* **RESOLVED: That all items be considered in public.**	**Action by**
14.	**HEALTH INEQUALITIES WORKING GROUP - DRAFT FINAL REPORT** *(Agenda Item 6)* Councillor John Hensley, Chairman of the Health Inequalities Working Group, introduced the Working Group's draft final report on the effect of overcrowding on educational attainment and children's development. Members were advised that the Working Group had been acutely aware that the effects of overcrowding had the greatest impact on the development of children under five. Councillor Hensley advised that his meeting with a young person whose attainment and development had been hindered by overcrowding had been very emotional. The report looked at the existing good practice already undertaken and proposed recommendations to build on this work. Dr Ellis Friedman was thanked for his considerable contribution to the Working Group meetings.	**Action by**

	It was noted that Councillor Phoday Jarjussey, who had been a Member of the Working Group, had not agreed with recommendation 6 in the draft final report. **RESOLVED: That the report of the Health Inequalities Working Group be agreed and submitted to Cabinet for consideration at its meeting on 18 November 2010.**	
15.	**PROVISION OF HEALTH SERVICES IN THE BOROUGH** *(Agenda Item 5)* The Chairman welcomed those present to the meeting. <u>Cardiovascular and Cancer Services</u> Mr Tom Pharaoh, Senior Project Officer at Commissioning Support for London, gave a presentation on the work that had been undertaken to develop models of care with regard to cancer and cardiovascular services across London. In developing the proposals for cancer services, consideration had been given to early diagnosis, common cancers/general care and rarer cancers/specialist care. These work areas had been investigated by a project board which had received evidence and information from an expert reference group for each work area, an overarching expert reference panel, a patient panel and experts from outside of London. Although there were areas of excellence in London in terms of mortality for all cancers, there were significant inequalities in access and outcomes. It was noted that later diagnosis had been a major factor in causing poorer relative survival rates. It had been suggested that specialist surgery be centralised and that common treatments and surgery be localised where possible. It was also suggested that organisational boundaries should not be a barrier to the strong commissioning that was required for high quality comprehensive care pathways. The following recommendations resulted from the work that was undertaken: • Early diagnosis: o Direct access to some diagnostic investigations from primary care o Increase the uptake rates of screening programmes o Understand and address inequalities to increase awareness and reduce late presentation • Common cancers/general care: o Centralisation of some surgical services and localisation of others o Standardised best practice (day case breast surgery, laparoscopic colorectal surgery, enhanced recovery programmes to minimise lengths of stay) o High quality, safe local delivery of chemotherapy o Acute oncology services in emergency departments o Complement traditional follow-up with bespoke follow-up	**Action by**

based on survivorship model

- Rarer cancers/specialist care:
  - Concentration of some rarer cancer services beyond minimum NICE requirements to help ensure high quality experience and outcomes
  - Minimum caseloads for specialist oncologists for each rarer tumour type to maintain their specialist expertise
  - Consider centralised commissioning of all radiotherapy (to include specialist radiotherapy) to ensure equal access to treatment for all Londoners

In developing proposals for cardiovascular services, the focus had been on emergency and complex hospital care in the following work areas: vascular surgery – surgery on veins and arteries; cardiac surgery – surgery on the heart; and cardiology – less invasive procedures on the heart. This project had been led by a clinical expert panel for each work area and a patient panel. It was noted that the proposals that came out of the investigation were in relation to how cardiac surgery was organised rather than where heart bypass surgery was provided.

Suggestions for improvements included:

- Vascular surgery
  - All emergency and elective complex vascular surgery should be centralised into high volume hospitals
  - Local hospitals should continue to deliver the bulk of the vascular service: outpatients and diagnostics; varicose vein surgery
- Cardiac surgery
  - Concentrate the expertise of surgeons and teams performing mitral valve surgery
  - Improve urgent cardiac surgery by using electronic referral system and standardising the method of assessing the urgency of each patient
- Cardiology
  - Should patients not be directly transferred to heart attack centres they should be risk assessed at local A&E departments and high risk patients transferred to a centre for an angiogram with 24 hours
  - Hospitals organised into electrophysiology networks
  - Local hospitals should implant simple devices and link to specialist sites for complex care

Furthermore, the patient panel believed that improvements were required in order to improve quality, reduce deaths and give people better lives. It was suggested that improvements in the following areas would be beneficial to patients:

- Former patients being available for support
- Explanations of medical terms without prompting
- Continuity of care on wards
- Patients being discharged to their GPs with a care plan
- Consultants to have an interest in all aspects of patient care

The proposed models of care for cardiovascular and cancer care were published by Commissioning Support for London in August 2010. Although the formal consultation on the documents would end on 31 October 2010, Mr Pharaoh advised that consideration would be given to submissions after this date. It was noted that an online questionnaire soliciting feedback on the proposals was also available.

A financial analysis on the cost of implementing the proposals had been produced and published alongside the proposed models of care. Although it was anticipated that the proposals would increase the speed of cancer detection as well as the number of detections (and therefore the associated cost), it was believed that savings could be made elsewhere in the pathway.

Concern was expressed that the cancer services provided by the Mount Vernon cancer network had not been acknowledged in the proposals. These services were of a very high standard and there was a worry that their transfer to a hospital in central London would not be of benefit to Hillingdon residents or residents in the surrounding area.

Whilst, on the face of it, the proposals with regards to acute oncology, etc, appeared to be very positive, concern was expressed that there was very little detail. Those present were advised that an acute oncology pilot had been undertaken at Whittington Hospital and had resulted in significant savings.

With regard to the cardiovascular proposals, it was noted that additional work needed to be undertaken in relation to educating the public and raising awareness of heart attacks. Heart attack victims would often be driven to the nearest hospital by someone that was with them at the time of the attack. The public needed to be encouraged to dial 999 for heart attacks so that the victim could be taken by ambulance to the closest hospital that specialised in the type of care that the patient needed.

The centralisation of vascular services was generally supported but concern was expressed by Ms Jacqueline Totterdell, Chief Operating Officer at The Hillingdon Hospital NHS Trust (THH), that this could put additional financial pressure on THH. Patients were often admitted to one hospital for care and then transferred to another. In this circumstance, it was deemed important to ensure that the costs associated with a patient were shared between the two healthcare providers. Concern was also expressed that the lack of funding in the NHS could lead to a rationing of expensive operations such as implanting internal cardiac defibrillators.

On the whole, it was agreed that the evidence suggested that the proposals included within both reports were following the right direction of travel.

<u>Health White Paper</u>

Dr Mitch Garsin, Chairman of Hillingdon LMC, advised that, although the White Paper proposals had caused trepidation, the changes would offer real opportunity to improve care pathways. It was noted that there

was a lack of detail in the Paper which Dr Garsin suggested might have been done so that GP consortia developed the proposals themselves.

Members were advised that, although no decision had yet been finalised, it was likely that there would be one GP consortium created that was coterminous with the local authority boundaries. However, if this proved too small, the Hillingdon consortium would need to work with other consortia in the area.

It was noted that the Practice Based Commissioning (PBC) Board had expressed an interest in gaining pathfinder status which, if successful, would have funding attached. The Committee was supportive of the PBC Board applying for pathfinder status as it would take some uncertainty out of the system.

As well as concern about the limited funding that would be available over the next five years, Dr Garsin was concerned about the level of support that would be made available to the consortia. GPs were expected to take on a new role and the associated responsibilities at the same time as maintaining their regular surgeries and patient contact. It was anticipated that there would be some support provision from NHS personnel but that a more substantial support vehicle was needed.

Ms Sue Nunney, Director of Corporate Affairs at Hillingdon PCT, advised that, although a number of PCT staff would be moving to the national Board, the PCT hoped to provide support to the GP consortium. Concern was expressed that hard-working, knowledgeable and valued PCT staff would move away from the health sector as the PCTs wound down. It was noted that these staff had the option of creating a social enterprise which could then be used to support the GP consortium.

It was agreed that effective partnership working with the Trusts (particularly THH) and Hillingdon Council was key to ensuring that the proposals were implemented efficiently. The White Paper proposals had prompted an improvement in the communication between clinicians and it was noted that there had been more communication (in terms of both quality and volume) between GPs and Hillingdon Hospital over the last 2-3 months that there had been in the previous four years. This partnership working would enable different ways of working to be developed so that the health economy was able to cope with the anticipated increase in demand – working quicker, smarter, better.

Ms Nunney advised that Hillingdon, Ealing and Hounslow PCTs had formed a cluster which, it was anticipated, would deliver management cost savings. Although, there would only be one Chief Executive heading the cluster, there would continue to be three Boards representing each of the areas. Consultation was currently underway in the North West London sector for each cluster to create one management team and also streamline the cluster organisations. As far as non-executive appointments to the Board were concerned, it was possible that these posts would not be re-appointed to when their term of office ends and this was being discussed with the Appointments

Commission.

It was hoped that the changes that would come about from the White Paper would not have a negative impact on patients. To ensure this smooth transition, the GP consortium would need to ensure that it worked far more closely with the public than GPs had before. It was anticipated that members of the public and representatives from the local authority would be able to sit on the Board and additional media communication would need to be employed to raise public awareness of the changes. There would also be the possibility of being able to share the risk with other consortia.

Dr Garsin advised that he had been unaware of many of the 'Cinderella' services (such as the wheelchair service) and he was dependent on concerned residents or Councillors to ensure that these services did not slip through the net. The PCT would ensure that training was provided and events staged to ensure that the GPs were aware of all of the services that the consortium would need to provide.

Although there had been a change in the focus of the CQC, the Trusts were keen to ensure that the work they had undertaken to reduce waiting times was not overridden.

Members were advised that the THH management had been in discussions with MONITOR over the last month with regard to the Hospital's application for Foundation Trust status. THH had now written to MONITOR to formally agree that the historic due diligence work would commence in December 2010 with a view to completing the process by April 2011 at the earliest.

Dr Garsin stated that there was a desire to redesign the urgent care service and that plans would be drawn up sometime in the next year.

Consideration was given to the Royal Brompton & Harefield (RBH) NHS Foundation Trust Clinical Quality Report for the period ending 30 September 2010 which had been considered by the Trust Board on 27 October 2010. The report included the MONITOR declaration for quarter 2 and advised that the Trust was now fully compliant with all 16 of the Care Quality Commission essential standards of quality and safety.

It was noted that the Trust's target for number of operations cancelled had again not been met. Members were advised that, according to the CQC target definition, an operation was classed as cancelled if it was cancelled on the day of the scheduled start time. Because the Trust made every effort possible to ensure that the maximum number of operations were performed, it was inevitable that some cancellations would happen on the day of operation. Mr Nicholas Hunt, Director of Service Development at the Trust, advised that the team would continue to operate in this manner as patient care carried the higher priority.

Although the number of complaints received by the Trust was not a national target, RBH reported these statistics to its Trust Board and

	Commissioners to ensure transparency, and to make sure that focus is maintained on this important measure of quality. Care Quality Commission (CQC) Ms Amanda Brady, from CQC, advised that, since 1 April 2010, the CQCs relationship with the NHS had changed so that it was now a legal relationship. The CQC no longer produced the commissioning report and had instead moved into monitoring and compliance. Stroke Ms Totterdell circulated information in relation to the North West London Stroke Unit length of stay and activity to Members. She advised that, although the length of stay at Hillingdon Hospital seemed to be long, it appeared that there might be some shorter stay patients that were being cared for at Northwick Park rather than being sent back to Hillingdon Hospital. This would have a significant effect on the THH average length of stay. Ms Totterdell stated that North West London NHS had been asked to look at the home address postcodes of these patients to make sure that they were being cared for in the correct Stroke Unit. Hillingdon Hospital Site Visit It was noted that Members of the Committee had visited Hillingdon Hospital on Monday 11 October 2010 and were joined by representatives from Age UK. The purpose of the visit was to witness the procedures that had been put in place to ensure that patients' nutritional intake was monitored. The Members had split up and visited three different wards: surgical, medical and stroke. Overall, the Members had been very impressed with the procedures that had been put in place. Councillor O'Connor advised that Ms Totterdell had gained a promotion and would be leaving THH and, as such, this would be the last time that she attended an External Services Scrutiny Committee meeting. The Members thanked her for the work that she had undertaken whilst at THH and wished her well in her new position. **RESOLVED: That:** **1. the report be noted; and** **2. the presentation from Commissioning Support for London on cardiovascular and cancer services be noted.**	
16.	**MINUTES OF THE PREVIOUS MEETING - 14 JULY 2010** *(Agenda Item 3)* **RESOLVED: That the minutes of the meeting held on 14 July 2010 be agreed as a correct record.**	**Action by**
17.	**WORK PROGRAMME** *(Agenda Item 7)* 24 November 2010 It was noted that Councillor White would not be present at the Committee's next meeting on 24 November 2010 and that, should he have any questions in advance of the meeting for the witnesses	**Action by**

	attending, these would be forwarded to Democratic Services. <u>Children's Self-Harm Working Group</u> It was agreed that the scrutiny review on children's self-harm would focus on children/young people up to the age of 18 and vulnerable young people up to the age of 25. It was anticipated that, although the review would primarily consider physical self-mutilation, it would also touch on other related issues such as anorexia and drug and alcohol abuse. A Health Visitor from Hillingdon Hospital would be invited to attend the first witness session. Other potential witnesses included representatives from Relate, YMCA, Mind, Metropolitan Police Service, Social Services. Officers would contact BBC Radio 4 to establish whether it would be possible to obtain a transcript from an item on children's self-harm that had been broadcast in the last three months. It was agreed that the Working Group would include Councillors O'Connor and Kemp. The appointment of the remaining membership would be delegated to Councillor O'Connor in consultation with the Chief Whips. The dates of the Working Group meetings would be agreed with Councillor O'Connor in advance of the Committee's next meeting. **RESOLVED: That:** **1. Councillor White's apologies be noted for the meeting on 24 November 2010;** **2. officers contact BBC Radio 4 to obtain a transcript of the item on children's self-harm;** **3. the appointment of the remaining membership of the Children's Self Harm Working Group be delegated to Councillor O'Connor in consultation with the Chief Whips;** **4. the dates of the Children's Self Harm Working Group meetings be agreed with Councillor O'Connor in advance of the Committee's next meeting; and** **5. the Work Programme be agreed subject to the above amendments.**	Nav Johal / Nikki Stubbs Nav Johal / Nikki Stubbs
	The meeting, which commenced at 4.30 pm, closed at 6.32 pm.	

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki Stubbs on 01895 250472. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.

PROVIDER SERVICES REPORT

Officer Contact	Nav Johal and Nikki Stubbs, Deputy Chief Executive's Office
Papers with report	None

REASON FOR ITEM

To enable the Committee to examine Hillingdon PCT's provider services, specifically:

a. End of Life Care;
b. Children's Speech and Language Therapies;
c. Tuberculosis;
d. Community Dental Service;
e. Physiotherapy; and
f. Vertical integration.

OPTIONS AVAILABLE TO THE COMMITTEE

1. Receive the presentations from the witnesses

2. Question the witnesses on their presentations

3. Make recommendations as appropriate

4. Decide what further action is required

INFORMATION

Background

1. Primary Care Trusts (PCTs) are at the centre of the NHS and control approximately 80% of the NHS budget. PCTs spend this money in two ways: firstly, they commission services for their local residents (e.g., from hospital and mental health trusts); and secondly, provide a range of healthcare services themselves. These are known as 'provider services' and include services usually provided in the community such as community nursing, health visitors and podiatry.

2. Government policy has sought to refocus the role of PCTs onto the commissioning of services from other providers and move away from providing services themselves. In 2005, the Government indicated its view that PCTs should divest themselves of provider services and only commission services. This was controversial and the requirement was then changed so that, at the very least, PCTs must create new governance arrangements for their provider services that maintain an internal separation from the commissioning function.

3. Hillingdon PCT reformed its governance structure for provider services in order to meet Government requirements. Senior officers from the PCT will be attending the meeting to outline the service that they provide in relation to: end of life care, children's speech and language therapy, tuberculosis, community dental services and physiotherapy. Members will also receive an update on the progress of the vertical integration.

End of Life Care

4. The Community Palliative Care Team's main care activities are**:** symptom surveillance, care planning, including anticipatory symptom control, acute symptom control, emotional support, support for the carer, referral to appropriate services, eliciting Preferred Place of Care (patient's and carer's), and making arrangements (out of hours service referrals, anticipatory medication, information for patient and carer) to enable patients to achieve their preferences, liaising with other clinicians, initiating admission to appropriate services when necessary and preventing inappropriate hospital admissions.

5. The measurable forms of the Team's activity are telephone calls, direct patient contacts (home visits, outpatient clinics and clinical input at the Enhanced Care Beds) and education sessions. The service delivered 6,210 direct patient contacts and 6,959 telephone contacts between April 2009 and March 2010. During this period, there were 394 deaths under the care of the Community Team - 293 (74%) of these died at their Preferred Place of Care (PPC).

6. Twenty Enhanced Care Beds were available in Hayes Cottage Nursing Home and in the Northwood and Pinner Community Unit in Mount Vernon Hospital. Care concentrated on end of life care, for patients in the last (estimated) 3 months of their life. For these patients, an advanced care plan was available, together with priority access to the Out-of-Hours Medical Service and with access to anticipatory medication. From the summer of 2009, the ten beds in the Northwood & Pinner Community Unit were no longer available.

7. Following an identified need to enhance the care given to residents in care homes, and a successful bid to Macmillan Cancer Relief for an additional funded post to support the work, the Team set up a care home project. To date, 355 patients have been identified as having a limited prognosis and a management plan which reflects their wishes for care. 270 of these have died - 260 of which died in the nursing homes, as was their wish.

8. The Team has completed 2 audits (Preferred Place of Care and Hospital Deaths of Nursing Home Residents) and produced 3 basic guidelines for use in the community (Admission to the ECB, Anticipatory Therapy for opioid-naïve patients, and guidance on use of Fentanyl Patches). An information sheet was developed for patients and carers concerning home care and out of hours' services. 36 formal education sessions were organised and were attended by 546 individuals.

9. For the third year in a row the team received a PCT award for exceptional contribution to patient care.

Children's Speech and Language Therapies

10. Prime responsibility for the provision of Speech and Language Therapy (SLT) services to children has rested with the NHS since 1974. The NHS is not under a statutory duty to provide SLT. A joint Department of Children Schools and Families (DCSF)/Department of Health working group on provision of speech and language therapy services to children with SEN was established in November 1998 and reported in November 2000. This report made a number of recommendations to improve SLT provision.

11. The Speech and Language Therapy Department (SaLT) based at the Hillingdon Hospital provides a service for patients with communication, cognitive, voice or swallowing difficulties

due to stroke, brain injury, progressive neurological diseases and other medical conditions. The SaLT team, experienced in all aspects of assessment and treatment, work with the multidisciplinary team to achieve the best possible outcome for each patient.

12. Speech and language disorders can include the following:
    - Speech may be slurred due to difficulty producing sounds clearly in words because the tongue or other facial muscles are slow-moving and discoordinated.
    - Voice disorders may be caused by a variety of health problems (e.g., asthma, stroke, road traffic accidents, cancer, degenerative disorders) and vocal strain that may impact vocal cord closure, affect pitch, volume or quality of voice and distracts listeners from what is being said. Voice disorders may also cause pain or discomfort for the person speaking.
    - Language disorders may be receptive or expressive in nature, or both. Receptive language disorders refer to difficulties understanding language, whether written or spoken. Expressive language disorders include difficult putting words together, difficulty accessing vocabulary, or difficulty formulating sentences to convey ideas such as wants, needs, choices or opinions.
    - Cognitive problems (higher level thinking problems) include difficulty with attention, memory, organisation, problem solving, reasoning, judgement and the ability to integrate all of these skills to function independently and safely in everyday life.
    - Swallowing disorders may result from brain injury, stroke or other medical conditions and involve difficulty on holding food in the mouth, chewing or swallowing. Chest infection, malnutrition or dehydration can occur if these problems are not addressed.

13. Patients with swallowing problems will need a referral from a medic, consultant or GP, whereas patients with communication and cognition difficulties can self refer by telephoning the department directly.

Tuberculosis (TB)

14. Hillingdon had the 11th highest rate of tuberculosis diagnoses in the country for 2004/06. It is thought that this might have been a reflection of the local population, which may have a high percentage of persons in at risk groups, such as people who have recently emigrated from countries with high rates of TB.

15. TB is a bacterial infection which is spread by inhaling tiny droplets of saliva from the coughs or sneezes of an infected person. Mycobacterium tuberculosis (the bacteria responsible for TB) are very slow moving, so a person may not experience any symptoms for many months, or even years, after becoming infected.

16. Although TB primarily affects the lungs (pulmonary TB), the infection is capable of spreading to many different parts of the body, such as the bones or nervous system. Typical symptoms of TB include a persistent cough, weight loss and night sweats.

17. There are three possibilities that can occur after becoming infected by TB:
    - Your immune system kills the bacteria, and you experience no further symptoms - this is what happens in the majority of cases.
    - Your immune system cannot kill the bacteria, but manages to build a defensive barrier around the infection - this means that you will not experience any symptoms, but the bacteria will remain in your body and is know as latent TB. There is the possibility that a

latent TB infection could develop into an active TB infection at a later date, particularly if your immune system becomes weakened.
- Your immune system fails to kill or contain the infection and it slowly spreads to your lungs - this is known as active TB.

18. Before antibiotics were introduced, TB used to be a major health problem in England. Nowadays, the condition is much less common, although in recent years TB cases have been increasing, particularly among ethnic minority communities originating from places where TB is widespread. The number of tuberculosis cases in the UK reached a 30-year high in 2009 when 9,040 new cases were identified - the highest figure since 1979 when there were 9,266 cases in England and Wales alone. Furthermore, the number of TB cases resistant to first-line treatment has almost doubled in the past decade, according to data from the Health Protection Agency (HPA).

19. The number of drug-resistant cases went from 206 in 2000, to 389 cases in 2009. Of these, the proportion resistant to treatment with multiple types of antibiotics remains low (1.2%) but has still seen a rise over the last decade. In 2000, there were 28 multi-drug resistant cases of TB, rising to 58 cases in 2009.

20. People can suffer drug-resistant TB either from catching a drug resistant strain or due to inappropriate or incomplete treatment. Those without a drug-resistant strain need a six month course of multiple antibiotics, but those with multi-drug resistant TB may need to be treated for 18 months or longer.

21. Globally, in 2007, there were 9.2 million new cases of TB, and 1.7 million deaths resulting from the condition. It is also estimated that one-third of the world's population is infected with latent TB. Countries with high numbers of HIV cases also often have high numbers of TB cases. This is because HIV weakens a person's immune system, which means that they are more likely to develop a TB infection.

22. Left untreated, an active TB infection can be potentially fatal because it can damage the lungs to such an extent that a person becomes unable to breathe properly. With treatment, a TB infection can usually be cured. Most people will need to take a long-term course of antibiotics, usually lasting for at least six months.

23. It is thought that between 70-80% of people who are given the Bacillus Calmette-Guérin (BCG) vaccine are protected against TB. However, BCG vaccinations are not routinely given as part of the childhood immunisation schedule, unless a baby is thought to have an increased risk of coming into contact with TB compared to the general population. For example, babies born in areas of inner-city London, where TB rates are higher than in the rest of the country, will probably be given the BCG vaccination. Vaccinations may also be recommended for people who have an increased risk of developing a TB infection; for example, health workers, people who have recently arrived from countries with high levels of TB and people who have come into close contact with somebody infected with TB.

Community Dental Service

24. Specialist community dentistry services are provided from Uxbridge Health Centre and Ickenham Health Centre and covered orthodontics, periodontics, endodontics, adult special needs, prosthetics and paediatrics. These services were transferred to Hillingdon PCT from

Hammersmith and Fulham PCT in 2007 with a subsequent reduction in waiting times from 24 months to 4-10 months.

25. Although Ward Councillors had received reports from Residents that had been unable to register with an NHS dentist, there was an underspend by the PCT on "units of dental activity" in 2008/2009. This appeared to be a communication issue in that Residents were finding it hard to get an NHS dentist even though the NHS dentists had spare capacity.

26. In 2008/2009, access levels were at 68%, with a target of 72% for 2009/2010 and 75% for the year after. To address this gap, additional promotion of services was undertaken and Residents experiencing problems with accessing an NHS dentist are encouraged to contact the PCT dental advisors. Information on this service and the emergency contact number were distributed to all Councillors for use in their ward surgeries.

27. At the meeting on 15 July 2009, it was agreed that further investigation would be undertaken into the concern regarding a two tier approach used by some NHS dentists, i.e., some would not accept patients that were in receipt of benefits.

28. It is thought that the provision of dental services to those with special needs has improved, but legislation has reduced options in that dentists are no longer permitted to administer a general anaesthetic as they don't have back up facilities.

Physiotherapy

29. Physiotherapists help and treat people of all ages with physical problems caused by illness, accident or ageing. They work autonomously, most often as a member of a team with other health or social care professionals. Physiotherapy is a healthcare profession which sees human movement as central to the health and well-being of individuals. They identify and maximise movement potential through health promotion, preventative healthcare, treatment and rehabilitation.

30. The core skills used by physiotherapists include manual therapy, therapeutic exercise and the application of electro-physical modalities. They also have an appreciation of psychological, cultural and social factors which influence their patients. Physiotherapists try to bring the patients into an active role to help make the best of independence and function.

31. At the Committee's meeting on 15 July 2009, Members were advised that the physiotherapy service was being expanded further and it was hoped that patient waiting times would be reduced to a maximum of two weeks from receipt of referral. This would be achieved through measures such as the introduction of Saturday clinics and an additional site which was currently in the planning process.

32. As there were no pulmonary nurses in the Borough, physiotherapists had been dealing with the low number of referrals received for chronic obstructive diseases.

Vertical Integration

33. On 30 March 2010, the Board of NHS Hillingdon endorsed a recommendation from the Community Services Externalisation Assessment Panel to vertically integrate Hillingdon Community Health with CNWL (Central & North West London Foundation Trust).

34. 'Vertical integration' is the term applied in healthcare to describe the integration of services across hospital and community boundaries. It is widely accepted that vertical integration has the potential to provide significant patient care whilst making economic sense. This separation of provider services from the commissioning arm of PCTs is designed to ensure that each part of the organisation will be able to focus exclusively on its core business.

35. At its meeting on 16 June 2010, the External Services Scrutiny Committee was advised that the internal separation of the commissioning and provider functions had taken place 18 months previously and was working well. It was noted that the external separation would need to be managed carefully to ensure that Residents were aware that there would not be a reduction in services or a change in access points (unless the commissioners decommissioned the service).

36. CNWL is the successful NHS organisation chosen from those short-listed as it is perceived that CNWL will bring benefits centred around improving outcomes and quality, the ease of service integration, clinical sustainability, financial stability and whole system fit.

37. The Joint Integration Commission (JIC) was in place to oversee the integration and ensure that patients received the best quality and outcomes and that tax payers received the best value for money. Membership of the JIC included NHS Hillingdon, HCH, CNWL, HCH Staff Side, LINks, GPs (Practice-based Commissioning (PbC)) and the Council.

38. Members were advised that the proposals would be the subject of a communications and engagement plan which would be considered by the staff and would be the subject of weekly written briefings, face-to-face meetings and posted on the Intranet. Engagement was also undertaken with PbC/GPs, the LINk (and other patient/public groups) as well as the Council.

39. The next step of the process is to produce a due diligence report and an integrated business plan. These will then need to be approved by the Cooperation and Competition Panel (CCP), Monitor, Hillingdon PCT and CNWL's Board and then full approval will then be given by the NHS London Board. The due diligence process requires that key criteria be met, such as improved pathways to the community. These criteria have been borne in mind throughout the whole process to date. The due diligence process will culminate in the production of one report which will include background information (reports on accounts, estates, clinical service, etc) and will illustrate that the proposal to appoint CNWL is appropriate. This information will be checked by Monitor.

40. It is anticipated that the transfer will take place on 1 April 2011 at the latest (although January 2011 is preferred). Following the completion of the transfer, Hillingdon PCT will take on a contract management role with regard to the provider services in Hillingdon.

Witnesses

41. Representatives of the health service providers in the Borough will be attending and are likely to include:

- Maura St George: Clinical Service Lead for End of Life, Hillingdon PCT
- Freda O'Driscoll: Head of Children's Therapies, Hillingdon PCT
- Hannah Kaur: Senior Nurse Specialist (TB), Hillingdon PCT
- Alan Taylor: Clinical Lead for Specialist Community Dental Service, Hillingdon PCT
- Jill Dady: MSK Clinical Lead (physiotherapy services), Hillingdon PCT

- Maria O'Brien: Managing Director, Provider Services, Hillingdon PCT
- John Vaughan: Director of Strategic Planning and Partnerships, Central & North West London NHS Foundation Trust

SUGGESTED SCRUTINY ACTIVITY

Members to question representatives from the Hillingdon PCT, Central & North West London NHS Foundation Trust and Hillingdon Hospital on the developments to provider services and decide whether to take any further action.

BACKGROUND REPORTS

Hillingdon Community Specialist Palliative Care Team – Annual Review April 2009/ March 2010

SUGGESTED KEY QUESTIONS/LINES OF ENQUIRY

End of Life Care

1. During 2009/2010, 74% of the Community Team's patients died in their Preferred Place of Care – how does this compare to other areas and what action is being taken to increase this figure?
2. How has the withdrawal of the 10 enhanced care beds at the Northwood and Pinner Community Unit impacted on the service provided?
3. How long will the funding provided by Macmillan Cancer Relief be available for the care home project? Are there any plans to extend this project?

Children's Speech and Language Therapy

1. Does the number of therapists in Hillingdon currently meet the demand for the service?

Tuberculosis

1. What action is being taken to reduce the number of TB diagnoses in Hillingdon?
2. Is there any publicity or education planned in a bid to reduce the number of TB cases?

Community Dental Services

1. What are the current waiting times for community dentistry services?
2. What were the access levels in 2009/2010 (the target was 72%)?
3. What action has been taken to address concerns raised about a two tier approach used by some NHS dentists?
4. Are there currently any areas of Hillingdon where demand for NHS dental services outstrips supply? Are there any areas where supply outstrips demand?
5. How is the PCT working to promote oral good health e.g. through health promotion activities, working with partners?
6. How is the PCT proposing to allocate funding for dentistry since the three year ring fencing ended in March 2009? Has the level of funding for NHS dental services increased or decreased since March 2009?

Physiotherapy

1. What are the current patient waiting times and have these been reduced since July 2009?
2. What progress has been made with regard to the introduction of Saturday clinics and an additional site?
3. Are physiotherapists continuing to deal with referral for chronic obstructive diseases (as a result of having no pulmonary nurses in the Borough)? If so, how does this impact on their workload?

Vertical integration

1. What was learnt from (and what actions were taken as a result of) the consultation with staff on the communications and engagement plan?
2. What progress has been made with regard to the due diligence process?
3. Have services been affected by the proposed changes?

WORK PROGRAMME

Officer Contact	Nav Johal and Nikki Stubbs, Deputy Chief Executive's Office
Papers with report	Appendix A: Work Programme 2010/2011 Appendix B: Draft Scoping Report: Children's Self Harm Working Group

REASON FOR REPORT

To enable the Committee to track the progress of its work in accordance with good project management practice.

OPTIONS OPEN TO THE COMMITTEE

1. Note the proposed Work Programme.

2. To make suggestions for/amendments to future working practices and/or reviews.

INFORMATION

1. At its last meeting, the Committee agreed the attached Work Programme. Pale shading indicates completed meetings.

2. At the Committee's last meeting, Members agreed that the Committee will scrutinise the Council's arrangements for addressing Children's self harm. A Working Group will need to be set up. The scoping report for this review is attached to this report at Appendix B.

3. It had been agreed at the Committee's meeting on 14 July 2010 that the meeting scheduled for 11 January 2011 would be used as an opportunity to speak to GPs about the implications of the Health White Paper.

SUGGESTED SCRUTINY ACTIVITY

1. Members note the Work Programme and make any amendments as appropriate.

2. Ensure Members are clear on the work coming before the Committee

BACKGROUND DOCUMENTS

None.

APPENDIX A

EXTERNAL SERVICES SCRUTINY COMMITTEE

2010/11 WORK PROGRAMME

NB – all meetings start at 6pm in the Civic Centre unless otherwise indicated.

Shading indicates completed meetings

Meeting Date	Agenda Item
9 June 2010	**Community Cohesion Review** The review the achievements of the following organisations since April 2009 with regards to Community Cohesion: • Metropolitan Police • London Fire Brigade • University of Brunel • Union of Brunel Students • Hillingdon Primary Care Trust • Strong & Active Communities • Hillingdon Inter Faith Network • Hillingdon Association of Voluntary Services
16 June 2010	**LINk** To receive a report on the progress of LINk in the Borough since the last update received by the Committee in June 2009.
	Provider Services Detailed scrutiny of provider services, with particular reference to vertical integration and the proposed appointment of Central & North West London NHS Foundation Trust.
14 July 2010	**Safer Transport** To scrutinise the issue of safety with regards to transport in the Borough (Safer Neighbourhoods Team, Metropolitan Police Service and British Transport).
22 September 2010	**CANCELLED**
28 October 2010 - 4.30pm	**NHS & GPs** Performance updates and update on significant issues: • NHS • GPs

Meeting Date	Agenda Item
24 November 2010	**Provider Services** Review of effectiveness of provider services (with particular reference to end of life care, TB, children's speech and language therapy, physiotherapy and specialist community dentistry) and of the progress of the vertical integration: • CNWL • PCT • London Ambulance Service
11 January 2011	**Health White Paper** Review the implications and proposals contained within the Health White Paper published on 12 July 2010. Invitees would potentially include: • Dr Mitch Garsin (Chairman of Hillingdon LMC) • Dr Tony Grewal (Medical Director of the Londonwide LMCs) • the Chairman of Practice-Based Commissioning • GPs
23 February 2011	**Crime & Disorder** • Metropolitan Police Service • Safer Neighbourhoods Team • Metropolitan Police Authority • PCT • London Fire Brigade • Probation Service • British Transport Police • Safer Transport Team
30 March 2011 – 5pm	**Community Cohesion Review** The review the achievements of the following organisations since June 2010 with regards to Community Cohesion: • Metropolitan Police Service • London Fire Brigade • University of Brunel • Union of Brunel Students • Hillingdon Primary Care Trust • Strong & Active Communities • Hillingdon Inter Faith Network • Hillingdon Association of Voluntary Services

Meeting Date	Agenda Item
26 April 2011	**Quality Accounts & CQC Evidence Gathering** • Hillingdon Primary Care Trust (PCT) • The Hillingdon Hospital NHS Trust • Royal Brompton & Harefield NHS Foundation Trust • Central & North West London NHS Foundation Trust • London Ambulance Service • Care Quality Commission (CQC)

Themes	Future Work to be Undertaken
Health Inequalities Working Group Comprising Councillors: • John Hensley (Chairman) • Beulah East • Phoday Jarjussey • Judy Kelly • John Major • Carol Melvin • Mary O'Connor • Michael White	Detailed review of the impact of housing overcrowding on educational attainment and children's development. Working Group Meeting dates: • 3 August 2010 • 31 August 2010 • 22 September 2010 • 19 October 2010 Witnesses • To be agreed
Children's Self Harm Working Group Comprising Councillors: • Mary O'Connor • Peter Kemp • John Hensley • Shirley Harper-O'Neill	Detailed review of children's self harm. Working Group Meeting dates: • To be agreed Witnesses • To be agreed

London Borough of Hillingdon

EXTERNAL SERVICES SCRUTINY COMMITTEE

2010/2011

DRAFT SCOPING REPORT

Proposed review title:

CHILDREN'S SELF HARM WORKING GROUP

Aim of review

To recommend, review, improve and formalise the Council's arrangements for addressing children's self harm in the Borough.

Draft Terms of Reference

1. **To consider existing Council services and procedures which address children's suicide and self harm and any improvements that could be made;**
2. **To review whether the Council's processes in tackling this are timely, effective and cost efficient;**
3. **To review the guidance and support that is currently available from the Council to these children and their parents/carers;**
4. **To assess ways of measuring the number of cases of children's self harm and the accuracy of these methods;**
5. **To seek out the views on this subject from Residents and partner organisations using a variety of existing and contemporary consultation mechanisms;**
6. **To examine best practice elsewhere through case studies, policy ideas, witness sessions and visits; and**
7. **After due consideration of the above, to bring forward strategic, innovative and practical recommendations to the Cabinet in relation to the Council's procedure in dealing with cases of children's self harm.**

Background and importance

Self-harm (also known as self injury or self mutilation) means deliberately injuring ourselves. Often this leaves a mark, a scar, draws blood or leaves a bruise. The most common ways of doing this are cutting, burning, biting, scratching or pricking to draw blood, burning, picking at old wounds, punching or head-banging a wall. Other ways to self-harm include self-poisoning, pulling your hair out, hitting yourself against objects, taking a drug overdose, and swallowing and putting things inside yourself. Behaviours associated with substance abuse, neglecting yourself and eating disorders can also be considered to some extent as self-harm.

Self-harm is more common than is generally realised. It is impossible to say exactly how many people self-harm because many young people hurt themselves secretly before finding the courage to tell someone and many of them never ask for counselling or medical help. There is no 'typical' person who self harms. It can be anyone. An individual who self harms cannot be stereotyped; they can be of all ages, any sex, sexuality or ethnicity and of different employment status etc.

Most people who self-harm have been through difficult experiences as a child or young adult. These experiences may include, separation from someone, being bullied, assaulted or isolated, being put under pressure, homelessness, going into care, bad relationships, hospital or other institutions, neglect, physical violence, emotional abuse or sexual abuse.

They may feel bad about themselves. As pressure builds up, self harm can feel the only way of dealing with it. Sometimes a physical pain provides a relief to the feelings in their head. They may want to punish themselves because they feel guilty or worthless. Or they may feel the cutting acts like a pressure valve, allowing them to relax. It can also be a way to physically express feelings and emotions when individuals struggle to communicate with others. In the majority of cases self harm is a very private act and individuals can go to great lengths to hide scars and bruises and will often try to address physical injuries themselves rather than seek medical treatment.

Although suicide is not the intention of self-harm, the relationship between self-harm and suicide is complex, as self-harming behaviour may be potentially life-threatening. There is also an increased risk of suicide in individuals who self-harm to the extent that self-harm is found in 40–60% of suicides.

Some facts about self-harm:

- All kinds of people self-harm, but it's most common among girls age 15-19 and men aged 20-24. It's not known exactly how many people self-harm, as it's often hidden.
- Every 30 minutes a teenager deliberately cuts, burns or scalds themselves.
- It is estimated that between 1 in every 12 and 1 in 15 children and young people deliberately self-harm.
- 6.2% of 16-24 year olds have attempted suicide in their lifetime.
- 8.9% of 16-24 year olds have self harmed in their lifetime.
- 64 males per million of the population and 17 females per million died through intentional self harm in 2008.
- In 2004, there were 277 suicides amongst children and young people aged between five and 24-years-old in England and Wales.
- In 2005 28 children under the age of 14, (10 girls and 18 boys) took their own lives.

- More than 24,000 teenagers are admitted to hospital in the UK each year due to the severity of their injuries after deliberately harming themselves. Most have taken overdoses or cut themselves.

- The UK has one of the highest rates of self harm in Europe at 400 per 100,000 population.

Reasons for the review

This review will focus on children/young people up to the age of 18 years old and vulnerable adults up the age of 25 years old. It will look at what the Council is doing currently and also at the extent of children's self harm in the Borough. Physical self-mutilation will be the primary focus of the review, but it will also touch on other related issues such as anorexia and drug and alcohol abuse.

Current procedures need to be reviewed to ensure that sufferers are not overlooked

Work is currently being undertaken by various departments within the Council to address the issue of children who self harm.

To ensure that Borough Residents receive the best possible service, children who self harm and their parents/carers should be made aware of procedures to and advice that is available to help them. This would go some way to making sure that those Residents who want and need help are not overlooked.

Awareness raising

This is a sensitive subject and sufferers are often unwilling to speak openly about their situation for a variety of reasons including fear and embarrassment. Raising awareness of children's self harm (and the help and advice that is available to them) may help them to speak up and gain support in dealing with the matter.

Current measures in place

Hillingdon Local Safeguarding Children Board

The Local Safeguarding Children Board (LSCB) evolved from the Area Child Protection Committees as a requirement from the Children's Act 2004. The LSCB is the key statutory mechanism for agreeing how the relevant organisations in Hillingdon will co-operate to safeguard and promote the welfare of children, and ensure our effectiveness.

The work of LSCB is part of the wider context of children's trust arrangements that aims to improve the overall wellbeing (i.e. the five Every Child Matters outcomes) of all children in the local area. Whilst the work of LSCB contributes to the wider goals of improving the wellbeing of all children, it has a particular focus on aspects of the 'staying safe' outcome.

The relevant area for LSCB is the Every Child Matters (ECM) Outcome 'Staying Safe', with a focus on the Protection & Prevention from harm and Promotion of the welfare of all children in the Local Authority. LSCB aims to improve the wellbeing of all children in the local area.

It is the responsibility of the LSCB to ensure that training on safeguarding and promoting welfare is provided to meet the local need.

Hillingdon Local Safeguarding Children Board (HSCB) develops local arrangements for safeguarding children and ensures that partners are working effectively together to achieve objectives. The Local Safeguarding Children Board is a multi-agency board from all agencies within the Borough, both statutory and from the private and voluntary sector, working together to safeguard and promote the welfare of our children and young people. The Hillingdon Safeguarding Children's Board has adopted the Government Department for Children, Schools and Families (DCSF) guidelines on sharing information, which should ensure that key information is properly shared to protect children and enable professionals to carry out their role having full access to relevant information.

Hillingdon Local Safeguarding Children Board Business Plan 2008-11 states 'Prevention' as a Priority. This Priority includes: self harm and suicidal behaviour for children and young people. A Community Engagement, Education and Prevention sub-group was to be set up to take a lead on this priority. An aim is to increase awareness and improve identification and access to services for children and young people who self harm. This group was tasked with auditing schools, colleges, Child and Adolescent Mental Health Services and hospitals to determine the source of the problem. The Community Engagement, Education and Prevention sub-group meets around every 6 weeks.

The multi-agency LSCB training sub-group is responsible for identifying training needs, managing and delivering the training programme to local staff within Hillingdon. This includes the statutory, voluntary and independent sectors.

The multi-agency training programme supports the HSCB business plan and priorities by providing a range of courses to equip local staff with the skills and knowledge to effectively safeguard and promote the welfare of children and young people.

Resources available

There are currently no additional resources available within the Council to devote to identifying and tackling children's self harm. As such, any work undertaken as a result of this review would have to be fulfilled within the current budgetary constraints and subsumed within the workloads of existing officers.

Consideration will need to be given to how additional resources can be identified to deal with the anticipated increase in reports of abuse that would result from the recommendations of this review.

Equalities

The Council needs to ensure that procedures for dealing with children who self harm are applied equitably to all community groups, races and ethnicities, enhances community cohesion and adequately meets the needs of a diverse borough.

Who is this review covering?

1. All people living in Hillingdon.

2. Hillingdon Safeguarding Children Board, Youth Service, Parent Partnership, Access and Inclusion Team, Children Services, Mental Health Service.

3. External partners e.g. Metropolitan Police and GPs.

Key issues

1. Are Residents' expectations and concerns about children's self harm reflected in the Council's service standards?

2. How are instances currently identified and dealt with across the Council and how can this be improved and standardised?

3. How have other councils successfully dealt with the issue of children's self harm?

4. Training of staff to property detect and assess cases.

5. Balance of the 'nanny state' versus an individual's freedom.

Methodology

1. The Children's Self Harm Working Group will be set up to examine background documents and receive evidence at its public and private meetings from officers and external witnesses.

2. The Committee may also make visits to sites and/or to other Councils with best practice examples.

Relevant Documents

To be provided as the review progresses.

Witnesses/evidence providers

Possible witnesses include: Health Visitor from Hillingdon Hospital, representatives from Hillingdon's Safeguarding Children Board (including Community Engagement, Education and Prevention sub-group), representatives from Relate, YMCA, Mind, Metropolitan Police Service,

Social Services, London Borough of Hillingdon's Youth Service, GPs, Centre for North West London Mental Health, and Children and Adolescent Mental Health Services (CAMHS).

There may need to be some further prioritisation within this list in order to make the review manageable and ensure that it is complete within the prescribed timescale.

Stakeholders and Consultation Plan

1. Partner agencies will be invited to make submissions to the Review.

2. The stakeholders are:
    - Parent Support Service (LBH)
    - Children and Families Service (including Youth Service, Parent Partnership, Referral and Assessment Team and the Access and Inclusion team) (LBH)
    - Hillingdon Safeguarding Children's Board (LBH)
    - Children Services (LBH)
    - GPs
    - Hillingdon PCT
    - Central and North West London NHS (CNWL)
    - Children and Adolescent Mental Health Services (CAMHS)

3. Consultation plan: representatives of stakeholders will be invited as witnesses. The review could be publicised in Hillingdon People and on the Council website and written contributions invited.

Connected work (recently completed, planned or ongoing)

Recent statistics from Hillingdon Hospital show the number of children and young people arriving at A&E with injuries caused by self-harm broken down by whether these were admitted or not.

		Apr'09-Jun'09	Jul'09-Sep'09	Oct'09-Dec'09	Jan'10-Mar'10	Total
Self-Harm	Admitted	0	0	2	5	7
	Non Admitted	1	0	1	3	5
Self-Harm Total		**1**	**0**	**3**	**8**	**12**

The Council are finalising an agreement to get this data at postcode level from Hillingdon Hospital. So it may soon be possible to carry out some area analysis.

Outcome

The Committee's recommendations will go to the Cabinet and the Council's partners for approval.

Proposed timeframe & milestones

- **Meeting 1:** Xpm, XXXXXXday XX December 2010 (Committee Room X) – To agree Terms of Reference and 1st Witness Session (X witnesses)
- **Meeting 2:** Xpm, XXXXXXday XX January 2011 (Committee Room X) – 2nd Witness Session (X witnesses)
- **Meeting 3:** Xpm, XXXXXXday XX February 2011 (Committee Room X) – 3rd Witness Session (X witnesses)
- **Meeting 4:** Xpm, XXXXXXday XX March 2011 (Committee Room X) – Finalise report for consideration by Cabinet on 14 April 2011 (if the report is ready in time, the report to be considered by the parent Committee at its meeting on 30 March 2011)

Risk Assessment

The review needs to be resourced and to stay focused on its terms of reference in order to meet its deadline.

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