HEALTH SELECT COMMISSION
Thursday 20 November 2025

Present:- Councillor Keenan (in the Chair); Councillors Ahmed, Baum-Dixon, Brent, Clarke, Duncan, Garnett, Harper, Tarmey and Harrison.

Apologies for absence:- Apologies were received from Yasseen, Thorp and Fisher.

The webcast of the Council Meeting can be viewed at:-
https://rotherham.public-i.tv/core/portal/home

33. MINUTES OF THE PREVIOUS MEETING HELD ON 2 OCTOBER 2025

Resolved:-

That the minutes of the meeting held on 2 October 2025 were approved as a true and correct record of the proceedings.

34. DECLARATIONS OF INTEREST

There were no declarations of interest.

35. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no questions from members of the public or the press.

36. EXCLUSION OF THE PRESS AND PUBLIC

There were no items on the agenda that required the exclusion of the press or members of the public.

37. DRAFT ADULT SOCIAL CARE MENTAL HEALTH STRATEGY 2026-2029

The Chair welcomed Scott Matthewman, Assistant Director of Strategic Commissioning and Holly Smith, Change Lead for Service Improvement and Governance to the meeting and invited them to introduce the draft Strategy and supporting presentation.

The Assistant Director of Strategic Commissioning explained that the purpose of the session was to provide members with an overview of the draft Strategy, its development, and its proposed priorities ahead of submission to Cabinet in December 2025.

They described that the strategy had been co-designed over an extended

period with a wide range of stakeholders to ensure it reflected local needs and aspirations. They confirmed that the document set out a clear strategic vision for adult mental health services in Rotherham and identified priorities for delivery over the next three years. The priorities included:

- Establishing a Mental Health Partnership Board to oversee implementation.
- Expanding the mental health enablement offer.
- Improving access to services and reducing waiting times.
- Enhancing support for carers and families.
- Strengthening crisis pathways.
- Developing the workforce to meet future needs.

They noted that a detailed action plan would accompany the Strategy to ensure accountability and measurable progress, with governance arrangements in place to monitor delivery.

The Change Lead for Service Improvement and Governance outlined the background and development process to the Strategy. They reported that Cabinet had approved recommendations from the Adult Social Care Mental Health Review in December 2023, which included the requirement to produce a co-designed borough-wide mental health Strategy. The draft Strategy aimed to achieve parity for mental health services across Rotherham and had been shaped by contributions from Public Health, Housing, NHS colleagues, and Voluntary and Community sector partners. They highlighted the critical role of Housing in Adult Social Care, supporting mental health recovery and continuity of care and acknowledged that mental ill health was a growing public health concern which ranged from everyday stresses to long term conditions and recognised that higher levels of wellbeing were linked to lower levels of illness.

The Strategy had been informed by robust data sources, including the Rotherham's Mental Health Needs Assessment (RHNA), loneliness engagement data, the Joint Strategic Needs Assessment (JSNA), and insights from the Rotherham Parent Carers Forum. To ensure the strategy reflected community priorities, a 12 week formal consultation had been undertaken between May and July 2025. This consultation involved 26 bespoke engagement events across the borough, delivered in partnership with organisations such as Voluntary Action Rotherham, South Yorkshire Housing, and Rotherham Ethnic Minority Alliance (REMA). Engagement activities included drop-in sessions at venues such as Wellgate Court and the Unity Centre, workshops with staff networks and cultural groups, and attendance at promotional events including Women of the World and Shared Lives. The consultation generated 227 responses, with 95 individuals supported to complete surveys. All findings were analysed and directly informed the strategy's vision, values, and priorities.

Feedback gathered throughout consultation was crucial to informing how this alignment with other strategies could be achieved. It was important to ensure that we referenced those existing areas of focus in order to capture views on how this strategy could support wider priorities and initiatives already in place within Rotherham's mental health services.

From consultation, the proposed vision was that residents experiencing mental health challenges should feel empowered, respected, and receive early support to prevent decline and maintain independence close to home. The core values identified were:

- People-focused (47%),
- Caring (39.6%), and
- Respectful (32.6%).

Key themes which emerged included improving mental health services, preventing crisis through early intervention, reducing waiting times, ensuring voices were heard, and providing consistent access to information and support.

The strategy set out phased priorities across its three-year span:

Year 1 - Voice, prevention, reducing delays, and access, including expansion of the mental health enablement service.

Year 2 - Service improvement and enhanced support for carers and families.

Year 3 - Partnership and integration, alongside workforce development.

Delivery would be supported by the launch of a Mental Health Partnership Board in 2026, preceded by a working group to maintain momentum. A comprehensive delivery action plan with SMART objectives had been drafted and would accompany the Cabinet report to ensure effective implementation.

The Change Lead for Service Improvement and Governance concluded by confirming that the Strategy aligned with existing frameworks such as the Rotherham Health and Wellbeing Strategy and the Borough That Cares Strategy, ensuring coherence across local priorities. The draft Strategy also included practical information for residents on how to get involved, shape services, and raise safeguarding concerns.

The strategy was scheduled for presentation to Cabinet in December 2025, with publication planned for early 2026.

The Chair thanked the Officers for the presentation and invited questions and comments from Members.

Councillor Harper referred to data in the agenda pack which reflected that depression rates in Rotherham had risen from 8.8% to 17.3%, compared to a national average of 13.2%. They asked how the significant increase had influenced prioritisation within the strategy and what actions were planned to reduce the rate in line with the national average.

The Assistant Director of Strategic Commissioning explained that the strategy was intelligence-driven and triangulated performance data with lived experience feedback. They highlighted the role of the mental health enablement offer, which focused on early support and prevention, targeting individuals at the point of diagnosis to optimise wellbeing and prevent escalation. They described this approach as central to service design and delivery.

Councillor Keenan raised a related concern about homelessness and mental health. They noted that homelessness linked to mental health had increased from 15.9% to 39% in two years.

The Assistant Director of Strategic Commissioning acknowledged this was a critical issue and explained that the council's integrated approach, spanning Adult Social Care, Housing, and Public Health, enabled a broader understanding of resident needs and informed targeted service responses. They added that homelessness and mental health were often interlinked and that this recognition was shaping staff training and the development of rough sleeper and homelessness strategies to ensure appropriate clinical and social support.

Co-optee, David Gill, asked whether the strategy addressed autism and mental health, and sought reassurance as to how services would be made accessible to autistic individuals.

The Assistant Director of Strategic Commissioning confirmed that autism had been considered within the strategic framework. They noted that Rotherham had separate but connected strategies for learning disability, mental health, and autism and stressed the importance of synergy between those strategies, alongside a person-centred approach that recognised individual strengths and needs.

Councillor Clarke queried improvements to transition pathways for young people and the partnerships that would support that work.

The Assistant Director of Strategic Commissioning stated that significant work was already underway and that the strategy would act as a catalyst for reviewing current pathways, identifying gaps, and engaging both children's services and people with lived experience to drive improvements.

Councillor Clarke asked how integration with housing, voluntary organisations, and health partners would be operationalised and what role the voluntary sector would play.

The Assistant Director of Strategic Commissioning explained that the strategy had been co-designed with strong engagement from voluntary and community organisations and that the forthcoming Mental Health Partnership Board would formalise specific roles and responsibilities. They emphasised that delivery would be co-produced rather than prescriptive, drawing on the collective expertise of all partners.

Councillor Harrison wanted to understand how the strategy aligned with other key frameworks such as the Health and Wellbeing Strategy and the Borough That Cares Strategy, and how success against the vision of "empowered, respected and early support" would be measured.

The Assistant Director of Strategic Commissioning confirmed that alignment had been a conscious decision and that success measures would be co-designed with stakeholders, including people receiving services, alongside national indicators.

Councillor Harrison asked how individuals with mental health issues were identified when accessing other council services, such as housing, and whether this would fall under the remit of the partnership board.

The Assistant Director of Strategic Commissioning stressed the importance of holistic engagement and the principle of "making every contact count," intended to ensure referrals and advocacy for timely support.

Councillor Harrison asked about the role and authority of the Mental Health Partnership Board and how progress would be monitored.

The Assistant Director of Strategic Commissioning explained that the board would adopt governance principles similar to those used for the Learning Disability and Autism Partnership Board, reporting to the Health and Wellbeing Board and periodic updates to the Health Select Commission.

Councillor Brent queried what steps would be taken to remove barriers for underrepresented minority groups in accessing mental health services.

The Assistant Director of Strategic Commissioning reassured members that inclusivity was central to the strategy and that delivery would involve reviewing pathways, identifying gaps, and engaging communities to ensure interventions improved outcomes.

Councillor Brent asked if minority groups were or would be involved in co-production.

The Assistant Director of Strategic Commissioning confirmed that all community representations would be engaged.
Councillor Brent also queried whether there were any workforce gaps that

represented a risk to delivery.

The Assistant Director of Strategic Commissioning acknowledged sector-wide challenges but noted that workforce engagement had been integral to strategy design and that issues would be addressed through business processes as they arose.

Councillor Clarke considered the issue of loneliness, asking which demographic/age-groups were most affected.

The Assistant Director of Strategic Commissioning did not have the data to hand but agreed to provide it at a later date.

Councillor Harper sought reassurance on how the strategy would address co-occurring issues such as mental health and substance misuse.

The Assistant Director of Strategic Commissioning reaffirmed the ambition of the strategy and explained that pathways across health and social care were being reviewed to ensure they were fit for purpose and responsive to complex needs. They confirmed that progress would be reported back to the Commission and Cabinet, with monitoring through the Health and Wellbeing Board.

Councillor Baum-Dixon asked whether the strategy accounted for differences between urban and rural areas, particularly regarding isolation and loneliness.

The Assistant Director of Strategic Commissioning confirmed that whilst the strategy set a universal vision, delivery would be tailored to local contexts, with targeted actions for specific communities as needed.

Councillor Brent raised a question concerning local suicide rates, noting national concerns about male suicide.

The Assistant Director of Strategic Commissioning did not have local gender-specific data but agreed to provide it at a later date. They outlined existing initiatives focused on early identification and support through the mental health enablement pathway, which aimed to introduce protective factors and prevent crisis.

Councillor Ahmed stressed the need to separate mental health from learning disability services based on professional experience. They highlighted cultural factors mental health and called for clearer expectations for providers, improved single points of access, and stronger collaboration with police and NHS partners.

The Assistant Director of Strategic Commissioning welcomed these points, stating that the strategy provided a framework for addressing such issues and that the detailed delivery plan would translate priorities into action.

Councillor Keenan asked what evidence supported the effectiveness of enablement and independence pathways in preventing crisis.

The Assistant Director of Strategic Commissioning described the enablement offer as a tailored 15-week programme which focused on early intervention and prevention, delivered in partnership with health colleagues to ensure continuity across pathways.

Councillor Keenan wanted to understand how the overarching strategy would guarantee responsiveness and flexibility of crisis support.

The Assistant Director of Strategic Commissioning reassured members that NHS partners were fully engaged in both strategy development and delivery, ensuring integration and person-centred care.

Resolved:-

That the Health Select Commission:

1. Supported the recommendation to Cabinet to approve the publication of the Adult Social Care Mental Health Strategy 2026-2029.

2. Requested that the Commission be provided with a copy of any delivery/action plan including any specific measurable targets or Key Performance Indicators (KPIs), against which progress would be assessed.

3. Requested a mid-point update on the delivery of the 2026-2029 Strategy (likely to take place in mid to late 2027).

4. Requested early involvement in consultation/co-production of the replacement Strategy when this iteration approaches conclusion, with a timeline for this to be agreed separately with the Chair and Governance Advisor.

5. Requested that the Service contacted co-optee, David Gill to take up the offer of support from Rotherham Speak Up in respect of lived experience.

6. Requested that the Service provide the more detailed data that underpinned the headline loneliness statistics, affording a more actionable data set that could be assessed over time.

7. Requested that the Service provide specific figures in respect of male suicide rates in Rotheram and outline how they compare with the national average.

38. ROTHERHAM PLACE PARTNERS WINTER PLAN 2025-26

The Chair welcomed Steph Watt, Portfolio Lead for Transformation and Delivery in Urgent and Community Care, SYICB, Jodie Roberts, Director of Operations and Bob Kirton, Managing Director, TRFT and Scott Matthewman, deputising for Emily Parry-Harries, Director of Public Health, RMBC to the meeting and invited Steph Watt to introduce the Place Partners Winter Plan presentation.

The Portfolio Lead for Transformation and Delivery began by emphasising that the Winter Plan was not only a national requirement but also a priority locally, reflecting Rotherham's long-standing commitment to robust winter planning. They explained that the plan had been developed collaboratively with all place partners including the Council, Primary Care Networks, The Rotherham NHS Foundation Trust (TRFT), Rotherham, Doncaster and South Humber NHS Trust (RDaSH), and Voluntary Action Rotherham.

The plan had undergone rigorous assurance processes and was formally signed off by the TRFT Board, the Place Board, and the South Yorkshire Integrated Care Board (SYICB). The plan had also been stress-tested through scenario planning at both regional and local levels and aligned with national urgent and emergency care standards, particularly the four-hour emergency department target, ambulance response times, and discharge delays.

The Portfolio Lead for Transformation and Delivery reflected on last year's approach, which had focused on expanding out-of-hospital pathways. Additional funding from the Better Care Fund and Section 75 agreements, alongside organisational investment, had supported several schemes. Learning from these initiatives had informed this year's plan, recognising that post-COVID demand remained consistently high throughout the year, with winter pressures exacerbated by flu and other infectious diseases.

They outlined significant developments over the past year, including the creation of a new medical Same Day Emergency Care (SDEC) unit, which had utilised £7 million national funding, and the establishment of a Transfer of Care Hub (ToCH). This hub brought together a multi-disciplinary team comprising Yorkshire Ambulance Service, health professionals, social care staff, and voluntary sector representatives. Its purpose was to co-locate specialists to manage referrals from both acute hospital and community settings, enabling real time decision making to avoid unnecessary admissions and ensure only those requiring hospital care were conveyed. They highlighted the benefits of co-location, which allowed immediate professional consultation and faster resolution of complex cases, particularly as patient acuity and complexity continued to rise.

Members heard that high impact activities had targeted frequent attenders with respiratory conditions, diabetes, and frailty. Capacity on the Virtual

Ward had been increased to support admission avoidance and discharge for high-acuity patients who would otherwise require hospital care. Led by nurse consultants and urgent care specialists, the Virtual Ward now included new pathways for heart failure, alongside existing frailty and respiratory pathways. Remote monitoring technology had also been introduced, enabling clinicians to observe patients at home using wearable devices, a development being tested with potential for future expansion.

The Portfolio Lead for Transformation and Delivery reported that service redesign within social care, particularly in enablement services, had significantly reduced waiting lists from a peak of 66 last winter to just nine in August, creating additional capacity. New targeted roles had been introduced, including a matron in the acute setting and a system flow coordinator to manage complex discharges. These changes had contributed to improved four-hour emergency department performance, which had risen steadily to over 70% since the end of last winter. Discharge metrics, including timely discharges and reductions in long-stay patients, compared favourably with regional benchmarks.

They described ongoing work to understand emergency department demand, supported by Healthwatch, which had conducted interviews during peak periods. Deep-dive data analysis was underway, with an action plan in development to address overrepresented and underrepresented groups.

They acknowledged persistent challenges, including sustained high demand, changing population expectations, and increased emergency department attendances which were regularly exceeding 300 compared to the previous modelled figure of 270. These pressures were impacting system flow and discharge pathways, with escalation beds remaining open year-round and 30 surge beds were activated in October. She confirmed that governance processes were in place to monitor and assure performance, reporting through regional and national structures.

In response to early and severe flu prevalence, planned activities had been accelerated. The Acute Respiratory Infection (ARI) Hub, providing additional primary care appointments, had opened early, and all Trust schemes were operational from the start of November. National priorities included improving vaccination uptake and reducing workforce sickness. The Portfolio Lead for Transformation and Delivery described coordinated efforts led by Public Health, primary care, the Trust, and the Council, including innovative approaches such as ward-based staff vaccinations, weekend clinics, and targeted outreach for vulnerable groups.

Other initiatives included:

- Enhanced primary care access through additional GP appointments and the respiratory hub.
- Proactive care pathways led by Primary Care Networks (PCNs), using

risk stratification and multi-disciplinary reviews for those most at risk of admission.
- A community geriatrician-led complex care pathway, combining clinical review with person-centred planning and medication checks.
- Collaboration with Yorkshire Ambulance Service to reduce avoidable conveyances, including a care home pathway and the community X-ray pilot, which enabled on-site imaging in care homes to prevent unnecessary hospital transfers.

They highlighted improvements in hospital flow through multi-agency events such as 'Every Minute Matters', which identified and addressed discharge delays. Community flow was also under review, with targeted actions based on delay metrics. Assurance processes included thrice-daily Trust discharge meetings and thrice-weekly place escalation meetings, which escalated to daily during peak pressures and involved executive-level representation.

Examples of new roles were shared, including Flow Capacity Managers coordinating complex cases across agencies and Care Home Trusted Assessors, who facilitated safe and timely discharges by liaising directly with care homes and families. Organisational development work supported these changes, with champion roles promoting new ways of working.

A comprehensive communications and engagement strategy underpinned the plan, aligned with national, regional, and local messaging. The Portfolio Lead for Transformation and Delivery concluded by outlining governance arrangements, winter resilience testing, and key risks, which included sustained demand, staff wellbeing, sickness absence, and industrial action. They reassured the Commission that robust, tested contingency plans were in place and continuously reviewed.

The Chair thanked the Portfolio Lead for Transformation and Delivery for the comprehensive presentation and invited questions and comments from Members.

Councillor Brent highlighted the complexity of the report and the heavy use of abbreviations and acronyms. They explained that as a lay person their understanding had been limited by unfamiliar terminology used. They suggested that future reports should either include a glossary or define acronyms at first use.

Officers acknowledged this concern and agreed to provide that explanatory detail in future reports and presentations. The Chair also advised that a Health Select Commission glossary had been produced previously and would be re-circulated to all members.

Councillor Tarmey asked how recent changes to the GP contract might affect emergency department demand during winter, questioning whether it would improve, remain static, or increase pressures.

The Deputy Director of Place for Rotherham, SYICB, Claire Smith responded that while national challenges existed, Rotherham GPs were highly engaged with health and ICB colleagues. They noted that all practices remained open until 6:30 pm and that online access was being monitored. Overall, minimal impact was anticipated. The Managing Director, TRFT reinforced this point, citing strong local relationships and described that GP clinical directors had visited the Urgent and Emergency Care Centre (UECC) and the new Same Day Emergency Care Centre (SDEC) to understand how they could work together to improve patient care. They explained that these visits had included discussions about out-of-hours care and integration with urgent pathways.

Councillor Tarmey queried whether recent rounds of industrial action had had a significant impact locally. The Managing Director, TRFT confirmed that Rotherham had experienced similar patterns to the national picture, with approximately 50% of resident doctors participating in strikes. This was lower than previous periods. The Portfolio Lead for Transformation and Delivery explained that senior doctors largely continued working, which allowed the Trust to maintain most elective activity and deliver 90% of planned procedures. However, they stressed that this did not diminish the level of planning and disruption required to maintain safe care.

Councillor Harper raised concerns about ambulance wait times and handover delays, referencing national targets of 30 minutes for Category 2 response and 45 minutes for handovers. They asked whether these targets were realistic and how they interacted, noting that delays in handover could prevent ambulances from responding to urgent calls.

The Managing Director, TRFT explained that the 30-minute target for Category 2 calls was a national standard, whilst the 15-minute handover target had long been unachievable nationally. The new 45-minute threshold aimed to drive improvement. They described that Rotherham had excelled, achieving an average handover time of 14 minutes, better than the national ask of 15 minutes and ranking as the best performer in Yorkshire and Humber. They attributed this success to a whole hospital approach and system wide co-ordination, noting that only six ambulances had breached the 45-minute threshold so far in 2025, compared to much higher figures elsewhere.

Councillor Harper asked whether the impact of early flu peaks would affect performance in that area.

The Portfolio Lead for Transformation and Delivery acknowledged that performance might deteriorate slightly during peak periods due to infection control constraints but noted that early preparation and robust measures were in place. They added that the expected flu peak in mid-December, rather than post-Christmas, might actually be beneficial for planning.

Councillor Harper also queried the reference to “Southern Hemisphere” in planning assumptions.

The Portfolio Lead for Transformation and Delivery explained that flu predictions and vaccine development were based on patterns observed in countries such as Australia and New Zealand, which had experienced a severe season. They confirmed that early indications suggested the current vaccine strain was well-matched, which should mitigate severity.

Councillor Harrison asked how scenario testing and escalation processes would be monitored during winter.

The Managing Director, TRFT described regular scenario exercises within the Trust and across the wider place, supported by dynamic bed management and robust governance through the Urgent and Emergency Care Delivery Group. They emphasised the importance of cultural alignment and multi-agency collaboration during high-pressure periods. They also noted that cyber security risks were now a major concern, perhaps more so than traditional winter pressures.

Councillor Harrison wanted to understand which risks were rated highest and what mitigations were in place.

The Portfolio Lead for Transformation and Delivery and the Operations Director, TRFT identified demand, staffing, and industrial action as the key risks, with scenario plans covering illness, holiday periods, and vaccination uptake. Admission avoidance pathways had been embedded ahead of winter to minimise disruption, and staffing plans accounted for seasonal leave and sickness.

Councillor Clarke sought assurance on capacity within community pathways and enablement services to prevent discharge delays, and asked how the Transfer of Care Hub would improve flow.

The Portfolio Lead for Transformation and Delivery explained that the hub provided real time co-ordination across services, prioritising home based care where safe and appropriate, supported by a tiered approach from voluntary sector ‘settling in’ services to high-acuity virtual wards. They gave an example of Age UK’s hospital aftercare service, which could bridge short term gaps by supporting patients between discharge and the start of formal care packages. Where home pathways lacked capacity, commissioned beds were used as alternatives. The hub ensured accountability for individual cases and facilitated rapid escalation to the correct pathway.

Councillor Clarke asked about delays caused by hospital dispensing, which they noted they had raised previously with the Trust via the Health Select Commission.

The Managing Director TRFT acknowledged past challenges but reported improvements, including a pharmacist embedded in the discharge lounge, extended weekend hours, and Age UK support for medication delivery to patient homes following discharge. They added that electronic referral systems had also been streamlined to replace multiple forms with a single, dynamic form covering all pathways, reducing duplication and improving information quality.

Councillor Harper asked a question concerning staff vaccinations, noting changes to COVID eligibility.

The Managing Director, TRFT confirmed that COVID vaccinations were no longer provided by the Trust and were now accessed via GPs for those who qualified, but flu vaccination uptake among staff had reached a record 56%, supported by ward-based delivery and outreach to ambulance and GP federation staff. They emphasised that flu posed a greater risk than COVID in terms of hospitalisation, with current COVID-related admissions averaging one patient per week compared to much higher flu-related admissions.

Councillor Harper queried the rationale for moving to a single referral form and the impact that this had realised.

The Portfolio Lead for Transformation and Delivery explained that while a single form had existed for acute discharges, it had been redesigned as an electronic system with conditional drop-down menus, simplifying completion and improving data quality. This change reduced duplication and ensured individuals only needed to share their information once, improving continuity across organisational boundaries.

Councillor Clarke posed a broader public health question, citing research from a national care home chain showing that changing meal timings had significantly reduced slips and trips. They asked whether similar principles could inform community nutrition initiatives, such as reintroducing Meals on Wheels.

The Assistant Director of Strategic Commissioning acknowledged the importance of person-centred planning and close collaboration with independent providers. The Portfolio Lead for Transformation and Delivery expressed interest in reviewing the evidence and sharing best practice regarding the findings Councillor Clarke had referred to through care home and home care forums.

Resolved:-

That the Health Select Commission:

1. Noted the contents of the Rotherham Place Partner's Winter Plan 2025-26.

2. Requested that when presenting the 2026-27 Winter Plan, elements of success from previous years, or elements implemented and deemed unsuccessful from 2025/26 or otherwise not replicated be highlighted and information provided regarding the rationale for those decisions.

3. Requested that where risks were presented in the context of the Winter Plan, the associated grading was detailed to clearly illustrate the greatest areas of concern to Health Select Commission members.

4. Requested that when referring to acronyms or abbreviations connected with technical health issues, report authors include the full term on first use or provide a glossary to aid members' understanding.

5. Requested that Councillor Clarke liaise with the Portfolio Lead for Transformation and Delivery at the ICB to support the sharing of best practise in relation to the impact or mealtime variation on trips and falls.

39. HEALTH SELECT COMMISSION WORK PROGRAMME - 2025/26

Members were advised that the start time of the 22 January 2026 Health Select Commission meeting had been brough forward to 4.00 pm to accommodate the addition of anticipated Adult Social Care CQC inspection feedback.

Resolved:-

That the Health Select Commission:

1. Approved the work programme.

2. Agreed that the Governance Advisor was authorised to make any required changes to the work programme in consultation with the Chair/Vice Chair and report any such changes back to the next meeting.

40. SOUTH YORKSHIRE, DERBYSHIRE AND NOTTINGHAMSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

At the Chair's request, the Governance Advisor shared that the South Yorkshire, Derbyshire and Nottinghamshire Joint Health Overview and Scrutiny Committee (JHOSC) had taken place on 21 October 2025, and noted that Stroke Emergency Care and Aftercare had been added to the Committees work programme following suggestion by the Rotherham Member with support from the Barnsley Member.

Members were advised that the next JHOSC meeting was due to take place on 7 January 2026, and that the minutes of the previous meeting would be shared with members once available.

The Chair requested that members reviewed the agenda for the January 2026 meeting once published, and contacted the Chair and Governance Advisor regarding any questions or comments to be raised during that meeting.

41. HEALTH AND WELLBEING BOARD ANNUAL REPORT

The Chair requested that Health Select Commission Members who had comments, queries or questions they would like to discuss further in relation to the Health and Wellbeing Board Annual Report channel these via the Chair and Governance Advisor.

42. URGENT BUSINESS

There was no urgent business to discuss.