HEALTH SELECT COMMISSION
Thursday 18 June 2026

Present:- Councillor Keenan (in the Chair); Councillors Yasseen, Ahmed, Baum-Dixon, Brent, Fisher, Harper, Harrison, Knight and Thorp.

Apologies for absence:- Apologies were received from Cllr Clarke, Duncan, Garnett, Ismail and Co-optee David Gill.

The following officers and partners were also in attendance:-
Councillor Baker-Rogers, Cabinet Member for Adult Care and Health
Ian Spicer, Executive Director of Adult Care, Housing and Public Health
Caroline Hine, Change Lead, Service Improvement and Governance
Gilly Brenner, Public Health Consultant (deputising for the Emily Parry Harries, Link Officer)
Kym Gleeson, Manager, Healthwatch Rotherham
Bob Kirton, Managing Director, The Rotherham NHS Foundation Trust (TRFT)
Nazreen Iqbal, Healthy Hospital Programme Manager at TRFT
Linda Strettle, GP Partner the Village Surgery
Radhika Gosakan, Consultant Obstetrician and Gynaecologist at TRFT

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

1. MINUTES OF THE PREVIOUS MEETING HELD ON 14 MAY 2026

Resolved:-

That the minutes of the meeting held on 14 May 2026 be approved as a true and correct record of the proceedings.

2. DECLARATIONS OF INTEREST

There were no declarations of interest.

3. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

4. 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.

5. NOMINATE REPRESENTATIVE TO HEALTH, SAFETY AND WELFARE PANEL

The Chair sought a representative from the Health Select Commission to sit as a member of the Health, Welfare and Safety Panel.

Resolved:-

That the Health Selection Commission appointed Councillor Brent as its representative on the Health, Welfare and Safety Panel for 2026/27.

6. ROTHERHAM WOMEN'S HEALTH NETWORK INTRODUCTION AND OVERVIEW

This item was to receive a report and presentation in relation to the formation and work of the Rotherham Women's Health Network.

The Chair welcomed Nazreen Iqbal, Healthy Hospital Programme Manager at The Rotherham NHS Foundation Trust (TRFT), Linda Strettle, GP Partner at the Village Surgery and Radhika Gosakan, Consultant Obstetrician and Gynaecologist at TRFT to the meeting and invited them to introduce the presentation.

The Healthy Hospital Programme Manager outlined the background to the establishment, development, and early outputs of the Rotherham Women's Health Network (RWHN), and provided an overview of the national policy context and an analysis of local service pressures and population health need via presentation.

Members were advised that the RWHN had been established in August 2025 as an organically developed, place-based partnership comprising female professionals from a wide range of sectors, including acute and primary healthcare, public health, the voluntary and community sector, and patient representation bodies such as Healthwatch.

It was emphasised that the Network had not been formally commissioned, nor formed part of any existing organisational structure, but had instead emerged as a result of shared professional concern that women's health lacked both coherent strategic focus and sufficient representation within local decision-making arrangements. The Network therefore sought to provide a collaborative forum through which partners could align priorities, share intelligence, and advocate for a more equitable and coordinated approach to women's health.

The Commission was informed that the core purpose of the Network had been to address health inequalities affecting women and girls in Rotherham, with a particular emphasis on ensuring that lived experience informed service design and delivery. In its initial period of operation, the Network had achieved a number of early outcomes, including establishing

cross-system relationships, improving communication between partner organisations, and increasing the visibility of women's health issues within local forums and decision-making processes.

It was further reported that the Network had begun to undertake a preliminary health needs assessment, drawing on available data and stakeholder insight to develop a clearer baseline understanding of women's health outcomes and inequalities within the borough. Although this work remained in progress, it had already begun to highlight a number of significant challenges requiring system-wide attention.

In setting the local context, the Healthy Hospital Programme Manager outlined the relevance of the national Women's Health Strategy for England (initially published in 2022 and subsequently refreshed), which had, for the first time, provided a comprehensive assessment of women's experiences across the health and care system. The Commission was advised that the Strategy had been informed by extensive national consultation and had identified consistent themes of women feeling unheard, dismissed, or inadequately supported when seeking care. Structural issues highlighted included fragmentation of services, prolonged diagnostic pathways, and insufficient inclusion of women in clinical research, all of which had contributed to inequitable outcomes. Whilst progress had been noted in certain areas, such as improved access to emergency contraception through community pharmacies, the development of digital care pathways relating to menopause and menstrual health, and a commitment from national research bodies to ensure sex-based inclusion in funded studies, it was stressed that many of the systemic barriers identified in the original Strategy persisted.

Particular attention was drawn to a number of clinical areas where inequalities remained pronounced. For example, the Commission noted that the average diagnostic delay for endometriosis was approximately nine years, illustrating the challenges faced by women in accessing timely investigation and treatment. Similarly, differences in the presentation and recognition of cardiovascular disease in women were reported to contribute to poorer outcomes, while persistent inequalities in maternity care, particularly affecting women from Black and South Asian backgrounds, continued to raise significant concern.

The Healthy Hospital Programme Manager also highlighted issues relating to menstrual health and gynaecological conditions more broadly, noting ongoing parliamentary scrutiny and national reviews in these areas. Although a refreshed national strategy had introduced a wide-ranging programme of actions, the absence of a detailed delivery plan and ring-fenced funding was identified as a significant risk to effective implementation at a local level.

The Commission's attention was drawn to a series of local population health indicators which illustrated the scale of the challenge in Rotherham. It was reported that, whilst overall female life expectancy

stood at approximately 81.7 years, women spent an average of 25.2 years in poor health, equating to around 31% of their lifespan.

Furthermore, healthy life expectancy had declined markedly over the preceding decade, falling from 58.5 years to 51.1 years. In later life, women in Rotherham experienced fewer years free from disability compared to the national average, with those aged 65 expected to spend approximately seven years in good health, compared to around ten years across England. These figures were presented as evidence of a widening gap not only in longevity, but in the quality of life experienced by women locally.

Wider determinants of health were also considered, and the Commission heard that women in Rotherham were disproportionately affected by socioeconomic pressures, including housing instability, financial insecurity, and food poverty. In particular, it was highlighted that 84% of lone parent households were female, increasing their exposure to economic vulnerability. Additionally, higher rates of chronic pain were reported among women compared to men, further contributing to reduced quality of life and increased demand for health services. These factors were considered interconnected drivers of inequality, reinforcing the need for a holistic, cross-sector approach.

To illustrate the lived experience underpinning the data, the Commission received a case study concerning a Rotherham woman who had engaged with local services via Healthwatch. The case demonstrated a recurring theme identified through the Network's engagement work, namely that women frequently felt their concerns were not fully heard or taken seriously within healthcare interactions. In this instance, the individual had also faced additional barriers linked to language and cultural differences, which had compounded difficulties in accessing appropriate care. The consequences were both clinical and socioeconomic, including deterioration in health, impact on mental wellbeing, and eventual loss of employment. It was noted that such experiences were not isolated, but reflective of broader systemic issues highlighted locally and nationally.

The GP Partner outlined a section of the presentation which detailed findings from a local audit of gynaecology referrals, undertaken to better understand patient flow and service demand. This analysis had reviewed consecutive referrals over a one-year period. It was reported that urgent suspected cancer referrals were being managed effectively, with patients seen promptly in line with national targets and a relatively high proportion of referrals resulting in confirmed diagnoses, indicating appropriate clinical thresholds for referral. Urgent non-cancer referrals were also processed within reasonable timescales, typically within two months. However, significant delays were identified in relation to routine referrals, where waiting times were substantially longer, with some patients waiting an average of 253 days for initial consultation. These delays were attributed to system-wide pressures, including workforce challenges and high levels of demand, rather than deficiencies in individual clinical performance. The

audit further demonstrated that a considerable proportion of patients referred routinely required ongoing specialist input, with only a small percentage discharged after an initial appointment.

Importantly, the audit identified a cohort of patients whose needs could potentially have been met outside of secondary care, particularly in relation to menopause management, menstrual disorders, and certain types of pelvic pain. It was suggested that the development of intermediate, community-based services, commonly referred to as women's health hubs, could enable more timely access to care while reducing pressure on hospital services. Evidence from comparator areas, including Oxford and Sheffield, was presented to demonstrate the potential effectiveness and impact of such models.

In these areas, referral triage systems and integrated primary and secondary care services had enabled a significant proportion of patients, up to 50% in some cases, to be managed without requiring hospital-based intervention. The absence of an equivalent model within Rotherham was noted, alongside concerns regarding inconsistency of provision across the wider South Yorkshire Integrated Care System footprint.

The GP Partner also highlighted a number of operational challenges within existing pathways, including variability in referral quality and evidence that some patients had not undergone appropriate preliminary investigations prior to referral. This was linked, in part, to limitations in interoperability between primary and secondary care IT systems, as well as potential gaps in clinical guidance and education. Opportunities were therefore identified to improve pathway efficiency through enhanced communication, education for primary care practitioners, and the introduction of triage or advisory functions within referral processes.

In concluding, The Healthy Hospital Programme Manager reiterated the Network's support for the national strategic direction of travel but emphasised that, without clear delivery mechanisms and dedicated resources, the ambition for improved women's health outcomes risked remaining unrealised. They stressed the importance of collective leadership across the local system, involving the Council, NHS partners, and the voluntary sector, in order to translate national policy into meaningful local change. They described the Rotherham Women's Health Network as an emerging vehicle through which such collaboration could be facilitated but acknowledged that its longer-term role, governance arrangements, and resourcing remained to be defined. The Commission was invited to note the report, the progress made to date and the significant challenges that remained, particularly the risk that, in the absence of coordinated action, existing inequalities in women's health would persist or widen further.

The Chair thanked the Rotherham Women's Health Network for their insightful report and presentation, and invited questions and comments from members.

Councillor Harrison wanted to understand whether any funding had been secured locally in the absence of ring-fenced national funding, and what risks existed to both the Network's priorities and sustainability given its reliance on voluntary participation.

The Healthy Hospital Programme Manager advised that, although no dedicated funding had been secured, there had been encouraging strong engagement from system partners, including the Rotherham Place Board, which had shown interest in the RWHN's work and had committed to incorporating women's health within its planning. They further reported that the Council's Public Health team had offered administrative support. However, it was acknowledged that much of the work continued to rely on individuals contributing beyond their core roles, and cautioned that, without additional resource, the momentum and impact of the Network could not be sustained at scale. The GP Partner reinforced this concern, noting competing clinical and organisational responsibilities within primary care, and emphasised the need to access emerging funding opportunities to support future delivery.

Councillor Harrison also queried, given that one of the recommendations of the report provided was the establishment of a women's health hub, what the business case, funding model, and timeline were for establishing such a facility, and how equitable access would be ensured, particularly for those in rural locations or with transport barriers.

The GP partner confirmed that no formal business case or secured funding model currently existed and that financial constraints across the NHS presented a significant challenge to developing such a facility. They referenced examples from other areas, particularly Oxford, where hub services were distributed across communities to maximise accessibility. The Consultant Obstetrician and Gynaecologist added that the development of a business case and identification of funding sources would be essential next steps if the model were to progress and achieve sustainability in the long term.

Councillor Fisher wanted to understand how commitments made at Place Board level would be translated into tangible system-wide improvements rather than isolated actions.

The Healthy Hospital Programme Manager explained that, whilst the Network remained at an early stage, it had already succeeded in convening key partners across the system. The GP Partner emphasised that the intended system-wide improvement lay in placing women at the centre of care, enabling earlier intervention and reducing lengthy waits. They also highlighted frustration amongst primary care clinicians where patients could not be progressed through the system efficiently, suggesting that improved integration, potentially through a hub model, would strengthen communication and service delivery across organisational boundaries.

Councillor Fisher also queried how variation in referral quality and pre-referral testing in primary care would be addressed, and what underlying drivers of inconsistency had been identified. Councillor Fisher noted that a postcode lottery had been observed in relation to access to Long Acting Reversible Contraception (LARC) options within the Access to Contraception Review, and wanted to understand whether there was the potential to engineer this out through collaborative service design at local level.

The GP Partner outlined plans to improve education and standardisation through regular training sessions for general practitioners. They also described proposals for structured referral templates to ensure that appropriate investigations were undertaken prior to referral. Additional initiatives, including a potential local women's health conference and broader stakeholder engagement, were identified as opportunities to improve shared understanding and reduce variation in care, thereby promoting greater equity.

Councillor Harper asked whether there was sufficient intelligence at this early stage to identify gaps in outcomes relating to ethnicity, deprivation, or other inequalities, particularly given the anticipated abolition of Healthwatch.

The Healthwatch Rotherham Manager, Kym Gleeson, responded that analysis of relevant data was ongoing and that findings would be reported to the Rotherham Women's Health Network in due course.

Councillor Harper asked how the Network was addressing wider determinants of health, and whether it had established links with other Council Services that were able to provide support and assistance around the wider determinants of health.

The Healthy Hospital Programme Manager confirmed that the Network recognised that women's health outcomes were intrinsically linked to broader socioeconomic factors, including housing, employment, and childcare, and that discussions were already taking place with Public Health colleagues and other partners to ensure a coordinated, system-wide response.

Councillor Thorp sought clarity regarding the described model operating in Sheffield. They questioned whether reduced referrals might result in patients receiving less care in practice.

The GP Partner explained that the Sheffield model involved triaging referrals and providing advice back to General Practitioners where appropriate, ensuring that patients were seen by the most suitable clinician without unnecessary delay. They stated that evidence suggested this approach had reduced unnecessary referrals without negatively impacting patient outcomes, but acknowledged that ongoing evaluation

would be required.

Councillor Thorp probed referral and discharge data, and asked whether the intention of proposed changes was to reduce the number of patients reaching consultant appointments unnecessarily.

In response, the GP Partner explained that some discharges were unavoidable due to national referral requirements, particularly for suspected cancer pathways. However, they noted that delays and inefficiencies could arise where patients attended specialist appointments without having undergone appropriate initial investigations. The Consultant Obstetrician and Gynaecologist added that work was ongoing within the Trust to improve referral pathways and outpatient performance, whilst also highlighting the importance of encouraging earlier patient presentation through public health interventions.

Councillor Thorp also raised concerns about the potential loss of Healthwatch and the implications for patient insight. The Healthy Hospital Programme Manager acknowledged the value of Healthwatch in capturing lived experiences and confirmed that the Network would continue to advocate for its role, while also exploring alternative data sources across NHS services and research functions. The Managing Director of TRFT (The Rotherham NHS Foundation Trust) reinforced this point, emphasising that Healthwatch provided a unique and valuable perspective that complemented formal service data.

Councillor Thorp asked which single recommendation of the four referred to in the RWHN's report would be most critical if only one could be progressed.

The GP Partner stated that the establishment of a women's health hub would have the greatest impact, citing strong support from General Practitioners and evidence from other areas that such models improved access, patient empowerment, and system efficiency.

Councillor Yasseen provided a reflective contribution rather than a direct question, highlighting the scale of women's health inequalities and the historical underrepresentation of such issues. They welcomed the report as a compelling case for action and emphasised the importance of political advocacy, partnership working, and practical support, including the potential development of a conference to bring together stakeholders and expertise.

The presenters collectively expressed appreciation for this support and reiterated the importance of collective action to progress the agenda.

A question submitted by Councillor Clarke relating to food insecurity was then raised in their absence by the Chair. They queried how the issue manifested locally and what actions were being taken in response.

The Healthy Hospital Programme Manager explained that food insecurity was a recognised public health issue addressed through existing partnership arrangements but emphasised that women, particularly single parents, were disproportionately affected. They reflected that this reinforced its relevance within the wider women's health agenda. Public Health representatives added that coordinated work was underway through local food networks to address these challenges.

Councillor Harper questioned why declining healthy life expectancy among women had not been more prominently addressed previously.

The Healthy Hospital Programme Manager responded that these issues were longstanding but had often been overlooked, with women living longer but spending more years in poor health. The GP Partner and other contributors added that whilst there had been notable improvements in areas such as screening and maternity care, significant challenges remained, including mental health needs and systemic biases in healthcare delivery.

The Chair thanked the representatives of the RWHN for the report, presentation and insightful answers to members' queries.

Resolved:-

That the Health Select Commission:

1. Noted the contents of the report, recommendations and presentation received.

2. Agreed to prepare a formal report recommending that the Rotherham Women's Health Network be invited to sit as a Co-optee on the Health Select Commission, to be formally considered by the Commission at its next meeting and referred to OSMB to confirm the appointment in line with the Council's Constitution.

3. Agreed to ensure that the desire for a Women's Heath Hub and the provision of relevant associated women's health services be included in considerations in relation to the Town Centre Health Hub Phase 2 as part of the consultation process and the Commission's formal pre-decision scrutiny scheduled to take place later in the municipal year.

7. CASTLE VIEW TRANSITION PLAN

This item was to receive a report and presentation in relation to transition into the Castle View Day Centre from the existing two sites at Maple Avenue, Maltby and Elliot Centre, Herringthorpe.

The Chair welcomed Carolie Hine, Change Lead, Service Improvement and Governance, Ian Spicer, Executive Director of Adult Care, Housing and Public Health and Cllr Baker-Rogers, Cabinet Member for Adult Care and Health to the meeting and invited Cllr Baker-Rodgers to introduce the report and presentation.

The Cabinet Member for Adult Care and Health introduced the report, providing both contextual background and an overview of the transition process, they emphasised the significance of the development within the wider transformation of learning disability services in the borough.

Members were informed that the Castle View Day Centre had been designed specifically to meet the needs of adults with autism and learning disabilities, including individuals with complex and high-level support requirements. The facility was described as an exemplar of accessible and inclusive design, with all aspects of the building carefully considered to support service users. This included the layout and flow of the building, accessible drop-off arrangements, wide corridors and doorways, adaptable and partitionable internal spaces, and the use of colour schemes to support navigation and sensory comfort. External areas, including a purpose-designed sensory garden, were also highlighted as providing a calm, therapeutic environment for those accessing the service. The Centre was reported to support 38 individuals, including four fully health-funded placements, and was staffed by approximately 35 frontline workers alongside management and administrative support.

The Commission were advised that the development of Castle View formed part of the Council's wider strategic ambition to modernise services and ensure that provision was aligned with both current and future needs. It was emphasised that this was not simply a replacement of outdated facilities, but a transformation to a modern, person-centred service model, enabling improved outcomes, enhanced user experience, and greater dignity and independence for those accessing support. The Centre now operated as the continuation of the former 'Reach' day services under a redesigned model of care.

In relation to the transition process itself, Members were advised that this had been subject to extensive planning and delivered through a deliberately phased approach. It was reported that, prior to any relocation, all individuals accessing the service had undergone reviews through Adult Social Care, and individualised transition plans had been developed to reflect each person's specific needs, preferences, and readiness to move. The overarching aim of this approach had been to minimise anxiety, support emotional wellbeing, and ensure continuity of care throughout the process. It was explicitly noted that a single-day transition had been considered but rejected, as it would not have been appropriate for individuals with complex needs, despite being operationally more straightforward from a service delivery perspective.

The Cabinet Member for Adult Care and Health stressed that comprehensive engagement had taken place with all relevant stakeholders. Staff had been formally consulted on the new operating model, with support from Human Resources, including consideration of changes to working patterns and environments. Families, carers, and service users had been engaged throughout the process via newsletters, meetings, and visits to the new facility, ensuring transparency and opportunities for feedback. This inclusive and communicative approach was reported to have contributed significantly to the success of the transition and the high levels of acceptance and enthusiasm observed.

It was reported that the physical transition commenced in the week beginning 11 May and had been completed by the end of May, earlier than initially anticipated. Members were informed that this accelerated timeline had been driven by service users themselves, many of whom chose to move sooner than planned after visiting the new facility and experiencing the improved environment. The phased transition had allowed numbers to increase incrementally over a three-week period, ensuring that staffing arrangements and support levels were continuously adjusted to maintain safety and quality of care. By the end of the transition, all individuals had successfully relocated to Castle View, and the previous facilities had been vacated and formally handed back on 1 June 2026.

Officers emphasised that the transition had been underpinned at all times by a focus on customer safety and individual need. It was recognised that service users presented with a diverse range of needs and levels of understanding, and therefore required tailored and responsive support. The ability to adapt the transition pace, particularly in response to users' eagerness to move earlier, was highlighted as evidence of a flexible, person-centred approach. The Committee was advised that this adaptability, combined with strong coordination and communication between officers, staff, families and carers, had ensured a smooth and successful transition process.

The Committee further heard that the co-location of services within Castle View had generated a number of operational and social benefits. These included the integration of previously separate cohorts, enabling greater social interaction and community-building among service users, as well as improved access to high-quality equipment and purpose-built facilities, including sensory rooms and therapeutic external spaces. Staff were reported to have responded positively to the new working environment, and service users were described as engaged, content, and benefiting significantly from the improved setting.

In providing additional context, officers advised that the opening of Castle View represented the culmination of a long-term transformation programme for learning disability services, spanning approximately a decade. This programme had been underpinned by a strategic commitment from the Council to retain direct operational responsibility for

supporting those with the highest level of need, including individuals requiring one-to-one or two-to-one care. The development of Castle View was therefore positioned not only as a service improvement, but as the final component in fulfilling this commitment.

Members were reminded that the facility served individuals who often had the least ability to advocate for themselves, and that the investment in such a high-quality, inclusive environment demonstrated a commitment to equality, equity, and inclusion in service provision.

During the discussion, members expressed strong support for the development and the outcomes achieved. Feedback provided from a member who had visited the facility, describing it as 'absolutely amazing' and highlighting the quality of the environment, including the sensory spaces and overall design. It was acknowledged that the investment represented value for money in delivering appropriate, high-quality care for individuals with complex needs. A minor observation was made regarding the use of the term 'customers' to describe service users, with a preference expressed for more person-centred terminology; however, this did not detract from the overall positive reception of the report.

In conclusion, the Commission were asked to note that the transition to Castle View had been delivered successfully, ahead of schedule, and in a manner that prioritised the needs, experiences, and wellbeing of service users. The Cabinet Member for Adult Care and Health recognised the development as a significant milestone in the transformation of learning disability services in Rotherham, delivering a modern, inclusive, and high-quality environment that supported improved outcomes for some of the borough's most vulnerable residents.

The Chair thanked the Cabinet Member and officers for the report and presentation and invited questions and comments from members.

Councillor Thorp raised a concern he had received regarding accessibility within associated residential accommodation, specifically relating to wheelchair access and the need for additional aids to enable entry and exit. He asked whether more proactive planning could be undertaken to ensure that appropriate adaptations were in place prior to residents moving in.

In response, the Executive Director of Adult Care, Housing and Public Health clarified that the issue related not to the Castle View Day Centre itself, but to separate housing provision, which formed part of the Council's general housing stock rather than the day centre service. They explained that whilst properties had been designed to a higher baseline level of accessibility than standard housing, it was not possible to anticipate every individual requirement in advance. He acknowledged that, in the specific case referenced, more proactive planning could potentially have been undertaken where sufficient time allowed, but noted that individual needs could vary significantly and sometimes required

adaptation post-occupation. The Cabinet Member for Adult Care and Health added that the Council remained committed to ensuring that homes met the needs of residents with disabilities and that ongoing work would be undertaken to address any identified issues.

Councillor Harper asked about capacity within the new facility, specifically whether the figure of 38 represented full capacity and how the service would be future-proofed. They also queried whether there was scope for additional provision should demand increase.

The Executive Director of Adult Care, Housing and Public Health responded that capacity was not a fixed figure in the traditional sense, as the service sought to adopt a more flexible operating model, including the potential for extended opening hours and increased days of operation. This approach would enable greater utilisation of the building without necessarily increasing physical capacity. They also explained that whilst there was physical space to accommodate more individuals, the determining factor would be the complexity of individual needs and ensuring compatibility and safe staffing ratios. The Change Lead, Service Improvement and Governance added that the referral process remained active and that there was some current capacity within existing operating hours, although precise ‘vacancy’ figures were not immediately available.

Councillor Harper wanted to understand how individuals accessed the service and whether referrals could be made directly by General Practitioners.

The Executive Director of Adult Care, Housing and Public Health explained that, given the high level of need among those supported, individuals were typically already known to Adult Social Care and would access the service via a social worker referral. Whilst General Practitioners could make referrals, these were ordinarily channelled through social care to ensure that eligibility criteria were met and that those with the highest support needs were prioritised appropriately.

Councillor Harrison queried how the service intended to move from describing benefits as ‘intangible and unmeasurable’ to demonstrating clear, measurable outcomes, particularly in relation to areas such as mental health, independence, and social inclusion.

The Executive Director of Adult Care, Housing and Public Health explained that outcomes were monitored at an individual level through person-centred support plans, which identified each individual’s interests, goals, and areas for development. Progress was reviewed regularly as part of statutory processes, with adjustments made as necessary. They noted that outcomes might include increased participation in activities, reduced anxiety, or improvements in wellbeing, depending on the individual. The Cabinet Member for Adult Care and Health supplemented this by emphasising the importance of qualitative outcomes, such as individuals’ enjoyment and willingness to attend. The Change Lead,

Service Improvement and Governance added that the service was developing case studies, with appropriate consent, to capture personal experiences and demonstrate impact in a more qualitative and accessible way. The Executive Director of Adult Care, Housing and Public Health also highlighted the importance of feedback from families and carers as an additional measure of service effectiveness, noting that their perceptions of wellbeing and behaviour changes were a key indicator of success.

Councillor Yasseen reflected on the historical context of the service and noted that the original proposals had been subject to significant public concern and prolonged campaigning. They asked whether those individuals and families who had previously opposed the changes were now engaging with and benefitting from the new service, and whether trust had been rebuilt.

The Executive Director of Adult Care, Housing and Public Health acknowledged the complexity of the issue, explaining that change could be particularly difficult for families who had long advocated for existing provision and may have been cautious about losing established services. They emphasised that whilst the new provision had been positively received by many, it would not be appropriate to assume that all concerns had been resolved, and that rebuilding trust was an ongoing process. They also noted, however, that the continuity of staff and the quality of the new environment had contributed to positive experiences for many service users and their families.

Councillor Yasseen asked whether there was scope for the building to be utilised more widely, for example to provide additional short-break provision for families outside of standard operating hours.

The Executive Director of Adult Care, Housing and Public Health confirmed that the Council would be open to exploring additional uses for the facility, including evenings and weekends, provided that the primary function of the service, which was supporting individuals with the highest level of need, remained safeguarded. They noted that any expansion of use would require further consideration of funding and staffing implications.

Councillor Yasseen encouraged the maximisation of the value of the investment and emphasised their assertion that the building should not remain underutilised during periods when it was not in core use. They also asked for clarification regarding the date of the official opening event and highlighted communication issues which had resulted in some members not being informed of the revised date. Officers acknowledged this issue and offered to arrange further visits for Members who had not yet had the opportunity to attend.

The Chair thanked the Cabinet Member and officers for the report , presentation and considered responses to members' questions.

Resolved:-

That the Health Select Commission:

1. Noted the update provided in relation to the Castle View transition.

2. Requested that a further update in relation to the performance of Castle View in relation to patient experience and outcomes in line with metrics to be agreed with the service, be presented to the Commission following the 6 month post implementation evaluation, at it's 18 March 2027 meeting.

3. Requested that arrangements be made for Health Select Commission Members who have not yet had the benefit of visiting the site be afforded a tour of Castle View to inform and enhance its scrutiny of the scheduled post implementation update in March 2027.

8. HEALTH SELECT COMMISSION WORK PROGRAMME - 2026/27

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.

9. HEALTH SELECT COMMISSION TERMS OF REFERENCE

The Chair outlined that the Health Select Commission's Terms of Reference were included in the agenda pack to ensure that new and returning members were sighted on the Commission's responsibilities and that they be duly considered in relation to work programming and scrutiny activities conducted during the 2026-27 municipal year.

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

Members were advised that the minutes of the last South Yorkshire, Derbyshire and Nottinghamshire Joint Health Overview and Scrutiny Committee (JHOSC) meeting held 7 January 2026 were shared with members as soon as they became available and via the 14 May Health Select Commission meeting agenda pack.

The next JHOSC meeting was expected to take place in October 2026, and discussions were underway regarding the agenda for that meeting. Health Select Commission Members were expected to be advised of agreed proposed agenda items and agreed dates by the next Health Select Commission Meeting in July 2026.

The Chair requested that Health Select Commission Members who had comments, queries or questions they would like to be raised regarding the most recent minutes, or any suggestions of items for consideration by JHOSC in the 2026/27 municipal year refer these to the Health Select Commission Chair and/or Governance Advisor at the earliest opportunity so these can be addressed accordingly.

11. URGENT BUSINESS

There was no urgent business to consider.