HEALTH SELECT COMMISSION

Date and Time:- **Thursday 18 June 2026 at 5.00 p.m.**

Venue:- **Rotherham Town Hall, The Crofts, Moorgate Street, Rotherham. S60 2TH**

Membership:- **Councillors Keenan (Chair), Yasseen (Vice-Chair), Ahmed, Baum-Dixon, Brent, Clarke, Duncan, Fisher, Garnett, Harper, Harrison, Havard, Ismail, Knight, Lelliott, Reynolds, Tarmey, Thorp and Gill.**

Co-opted Member David Gill representing Rotherham Speak Up.

This meeting will be webcast live and will be available to view via the Council's website. The items which will be discussed are described on the agenda below and there are reports attached which give more details**.**

Rotherham Council advocates openness and transparency as part of its democratic processes.

Anyone wishing to record (film or audio) the public parts of the meeting should inform the Chair or Governance Advisor of their intentions prior to the meeting.

AGENDA

1. Apologies for Absence

To receive the apologies of any Member who is unable to attend the meeting.

2. Minutes of the previous meeting held on 14 May 2026 (Pages 5 - 19)

To consider and approve the minutes of the previous meeting held on 14 May 2026 as a true and correct record of the proceedings and to be signed by the Chair.

3. Declarations of Interest

To receive declarations of interest from Members in respect of items listed on the agenda.

4. Questions from members of the public and the press

To receive questions relating to items of business on the agenda from members of the public or press who are present at the meeting.

5. Exclusion of the Press and Public

To consider whether the press and public should be excluded from the meeting during consideration of any part of the agenda.

For Discussion/Decision:-

6. Nominate Representative to Health, Safety and Welfare Panel (Pages 21 - 22)

This is item is for the Health Select Commission to nominate its representative to the Health, Safety and Welfare Panel for the 2026-27 municipal year.

7. Rotherham Women's Health Network Introduction and Overview (Pages 23 - 50)

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

8. Castle View Transition Plan (Pages 51 - 63)

This item is to consider 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.

9. Health Select Commission Work Programme - 2026/27 (Pages 65 - 66)

To consider the Health Select Commission's work programme for 2026/27.

For Information/Monitoring:-

To receive and note the contents of any reports routinely submitted to the Health Select Commission for information and awareness.

10. Health Select Commission Terms of Reference (Pages 67 - 68)

This item is for information only, and intended to ensure that new or returning members of the Health Select Commission are sighted on its Terms of Reference and that they are duly considered in relation to work programming and scrutiny activities conducted during the 2026-27 municipal year.

11. South Yorkshire, Derbyshire and Nottinghamshire Joint Health Overview and Scrutiny Committee

To receive and consider the minutes and recommendations of the South Yorkshire, Derbyshire and Nottinghamshire Joint Health Overview and Scrutiny Committee.

The minutes of the last 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 is expected to take place in October 2026, and discussions are underway regarding the agenda for that meeting. It is expected that Health Select Commission Members can be advised of agreed proposed agenda items and form dates by the next Health Select Commission Meeting, at which point Members will be invited to share any questions or comments they would like to be included in JHOSC's discussions regarding those agreed items for consideration.

12. Urgent Business

To consider any item(s) which the Chair is of the opinion should be considered as a matter of urgency.

JOHN EDWARDS,
Chief Executive.

The next meeting of the Health Select Commission will be held on Thursday 23 July 2026 commencing at 5.00 p.m. in Rotherham Town Hall.

This page is intentionally left blank

HEALTH SELECT COMMISSION
Thursday 14 May 2026

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

Co-optee, David Gill, Rotherham Speak-Up

Apologies for absence:- Apologies were received from Brent and Thorp.

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
Dania Pritchard, Assurance Lead for Professional Practice
Gilly Brenner, Public Health Consultant
Kym Gleeson, Manager, Healthwatch Rotherham
Bob Kirton, Managing Director, The Rotherham NHS Foundation Trust (TRFT)
Joanne Martin, Programme Lead, Transformation and Delivery at SY ICB (South Yorkshire Integrated Care Board)
Simon Langmead, Clinical Director for Rotherham Central and North Primary Care Network
Anthony Fitzgerald, Place Director for Rotherham at SY ICB

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

63. MINUTES OF THE PREVIOUS MEETING HELD ON 26 MARCH 2026

Resolved:-

That the minutes of the meeting held on 26 March 2026 were approved as a true and correct record of the proceedings.

64. DECLARATIONS OF INTEREST

There were no declarations of interest.

65. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

66. 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.

67. ADULT SOCIAL CARE CQC INSPECTION OUTCOME

This item was to receive an update from the Cabinet Member for Adult Social Care and Health and Adult Care, Housing and Public Health Service Officers in relation to the outcome of the CQC (Care Quality Commission) Inspection of the Council's Adult Social Care Services.

The Chair welcomed Dania Pritchard, Assurance Lead for Professional Practice, Ian Spicer, Executive Director of Adult Care, Housing and Public Health and Councillor Baker-Rogers, Cabinet Member for Adult Care and Health to the meeting and invited Councillor Baker-Rogers to introduce the report and presentation.

The Cabinet Member for Adult Social Care and Health advised the Commission that the CQC had inspected Adult Social Care services in July 2025 under new powers introduced by the Health and Care Act 2022. The final report was published on 20 March 2026 following a factual accuracy review process. The authority achieved an overall rating of 'good' with a score of 73 percent, placing it joint second in the Yorkshire and Humber region amongst published assessments, which was highlighted as a significant achievement. The Cabinet Member for Adult Social Care and Health expressed pride in the outcome of the assessment.

It was reported that the assessment framework considered four key areas and drew upon a wide range of evidence including service user feedback, and that the Council had undertaken extensive preparation through peer reviews and self-assessment activity ahead of inspection.

In outlining key highlights, the Cabinet Member emphasised the person-centred, strengths-based ethos underpinning service delivery, the range of access points for advice and support, and a strong preventative offer, including specialist provision such as the Complex Lives Team delivering trauma-informed support and the Supported Employment Team assisting neurodiverse residents. Reference was also made to transparent decision-making processes supported by advocacy, a diverse workforce promoting cultural competence, and clear strategic frameworks including equality, diversity, inclusion and digital inclusion.

The introduction further highlighted the Council's understanding of local need, effective alignment of services to demand, and robust partnership working, including co-location arrangements, multi-agency forums and data sharing approaches such as integrated discharge arrangements.

Strong links with the voluntary and community sector were noted, supported through grants, commissioning and social prescribing, alongside a clear focus on safety, governance and accountability, and a culture of learning and continuous improvement.

Concluding, the Cabinet Member reiterated that the assessment provided strong external assurance of the quality of Adult Social Care services and thanked staff for their contribution.
Dania Pritchard, Assurance Lead for Professional Practice delivered a detailed presentation which provided an overview of governance processes through which the CQC outcome had been considered prior to presentation to the Health Select Commission and onward reporting into Cabinet.

Members were appraised of the timeline of the assessment, including the onsite element in July 2025, receipt of the draft report in February 2026, a two-week factual accuracy process during which further evidence and clarifications were submitted, and publication of the final report on 20 March 2026. It was noted that this process had resulted in an improved final score of 73 per cent and that the scoring framework ranged from one, which reflected significant shortfalls, to four which denoted exceptional performance, with the majority of Rotherham's scores being three, representing a good standard of evidence and no scores at level one. The presentation illustrated how the overall rating sat firmly within the "good" range and confirmed the authority's joint second ranking within the region at the time of publication.

In summarising the findings, it was explained that the assessment drew heavily on lived experience, and that feedback had been largely positive, particularly in relation to access to information, communication, and the range of ways in which residents could engage with services. Whilst some feedback highlighted waiting times for assessments, it was reported that effective communication and risk-based prioritisation ensured individuals were supported safely while waiting, including through front-door services such as the Supporting Independence Team. Assessment practice was described as person-centred, with strong use of advocacy and a clear emphasis on working with individuals rather than doing things to them. Carers' needs were recognised and supported, although it was acknowledged that navigating available information could be challenging at times.

The presentation described the key strengths identified, reflecting the structure of the four CQC themes. It was highlighted that there was a broad and effective range of early intervention services, strong community-based support promoting independence, and a notable example of innovative practice in the Complex Lives Team, which adopted a holistic approach to supporting individuals facing multiple and complex challenges, including homelessness and substance misuse. Assessments were undertaken using a whole-family approach, and services were designed to ensure timely support based on risk. It was also noted that opportunities remained to strengthen co-production, although existing activity in this area was acknowledged.

Further strengths were identified in relation to partnership and commissioning arrangements, including effective oversight of providers,

strong relationships with the Voluntary and Community Sector, and the use of Section 75 agreements under the National Health Service Act 2006 to support integrated working.

In relation to safety, it was reported that safeguarding was embedded as ‘everyone’s business’, with clear processes, robust escalation arrangements and a well applied three-point test. Further positives included the availability of Occupational Therapy (OT) and Assistive Technology (AT) at the first point of contact, a wide range of feedback mechanisms, and a workforce reflective of the community it served.

Leadership was also described as a particular strength. The CQC noted that staff felt connected to leaders, understood the needs of the community, and operated within a culture that promoted learning, reflection and improvement. Governance arrangements were clear and effective, with stable leadership and strong strategic planning which supported service delivery.

Areas for development were also addressed, including reducing waiting times for assessments and certain complex equipment, strengthening support for seldom-heard groups and improving accessibility and digital inclusion.

It was noted that there was a need to increase carers’ access to services, ensure timeliness in safeguarding processes such as screening and completion of enquiries under Section 42 of the Care Act 2014, and further develop co-production and partnership communication arrangements. Officers advised that many of these areas were already recognised and were being addressed through existing programmes of work.

Members were informed of next steps, including reflection sessions held in March and April 2026 with senior and operational managers, the development of a structured improvement plan based on identified themes, and the organisation of a staff celebration event to recognise achievements whilst maintaining focus on continuous improvement.

The Executive Director of Adult Care, Housing and Public Health added that the assessment formed part of a national two-year baseline programme during which the CQC had undertaken approximately 150 inspections to establish comparative benchmarks. They emphasised that the assessment had been based on evidence from the preceding 12 months, meaning that emerging improvements not yet evidenced over that period were not reflected.

The Executive Director of Adult Care, Housing and Public Health reported that there had been no surprises in the findings due to the Council’s self-assessment and peer review activity, and that the inspection process itself had been positive, with staff demonstrating confidence and commitment in articulating their work. It was also noted that the final report was

considered an accurate and fair reflection of services, and that the authority had taken a pragmatic approach in finalising the report to ensure timely publication of the positive outcome.

The Chair expressed appreciation for the work undertaken and the positive impact of Adult Social Care services, and invited questions and comments from Members.

Councillor Ahmed queried the relatively low number of carers accessing ongoing support following assessment and sought clarity regarding what action would be taken to increase uptake.

In response, Officers explained that while the Council sought to increase carer involvement and uptake of assessments and support, barriers included accessibility and awareness of information, as well as individuals not identifying themselves as carers. It was noted that some carers elected only to receive advice or signposting rather than ongoing support, which affected the overall figures. Measures to improve access included the Borough That Cares Strategy, increased outreach activity, and the introduction of Carer Link officers at the ‘front door’.

Councillor Ahmed queried work around engagement with harder-to-reach communities, particularly the Roma community drawing on personal professional experience, and how impact and progress would be demonstrated in that area.

Officers advised that this remained an ongoing priority due to the evolving nature of the local population. Actions included the development of a new engagement strategy, use of Community Connectors, strengthened collaboration with the Voluntary and Community Sector, and improved access to multilingual and accessible information. It was also noted that commissioned services were increasingly being designed to reflect cultural preferences and community needs, whilst it was acknowledged that further work was required.

Councillor Harper raised concerns regarding performance in the ‘equity of experience’ domain given the prevalence of areas scored 2, and the use of 2011 Census data in drawing conclusions.

Officers clarified that the lower score reflected challenges experienced nationally in evidencing this area rather than a lack of activity, with many authorities having reported experiencing similar difficulties in relation to that domain. They explained that demonstrating outcomes required robust, non-anecdotal evidence, which remained a development area in that particular case. In relation to data, it was confirmed that the reference to 2011 Census Data was the CQC’s comparator which had been queried by the service with them. They were advised that its use reflected national data availability timelines and it was confirmed that more current local datasets were routinely used in practice by the Local Authority.

Councillor Harper highlighted extreme outliers in waiting times, with the lengthiest wait approaching 1,400 days. Officers explained that such cases typically related to highly complex individuals or recording anomalies where cases remained open due to ongoing involvement. They emphasised that whilst transparency required inclusion of such data, systems were in place to review long waits, and the 'Waiting Well' approach ensured that risk was managed for those awaiting assessment.

Councillor Clarke sought further information on the role of 'Community Connectors', and outlined their belief that this role offered opportunities for enhanced outreach and intelligence across multiple areas or Council responsibility.

Officers explained that these roles acted as navigators rather than assessors, supporting residents to access services, providing early intervention, and maintaining links between communities and operational teams. It was also noted that relocating them to the 'front door' service as part of the Adult Contact Team had improved accessibility, enabling earlier engagement and short-term case support where needed. It was agreed that the Service would provide additional information regarding the role to aid Members' understanding.

Councillor Fisher wanted to understand how the Council intended to bridge the gap between local and national average wellbeing scores for carers, particularly around control over daily life and social contact.

Officers advised that annual survey data informed action planning and that a range of initiatives were in place, including Carers Week activity, contingency support, information events, and digital resources. They highlighted ongoing efforts to diversify support, including development of an online carers' platform to better meet the needs of younger and working carers, alongside continued engagement through the 'Borough That Cares' network and targeted events during Carer's Week.

Councillor Fisher commented on the report's reflection that co-production was 'not always meaningful' and asked how lived experience would meaningfully influence service design to improve that position.

Officers outlined ongoing work to strengthen co-production through early engagement on the forthcoming Adult Social Care Strategy 2027, wider community consultation, and expansion of the co-production board to better reflect the borough's demographics and increase participation from seldom-heard groups to deliver truly representative co-production.

Councillor Garnett asked about the impact of delays in Occupational Therapy and equipment provision.

Officers acknowledged the importance of timely intervention in maintaining independence and preventing hospital admissions. They outlined action taken which included increased investment in

Occupational Therapists and their earlier involvement in assessments, contract improvements for equipment provision, and exploration of digital and remote assessment approaches to improve efficiency.

Councillor Garnett queried whether the service understood fewer carers in Rotherham reported feeling safe versus the national average and asked what changes or action was planned to improve that position.

It was noted that further analysis of survey findings was required to determine underlying causes, with necessary caution regarding potential limitations in sample size and representation in order to truly understand the scale and depth of the problem, and to confirm if indeed there was one. Officers advised that this would form part of ongoing improvement work, supplemented by feedback from partners such as Healthwatch and continued engagement with carers.

Councillor Garnett also wanted to understand how the system ensured equity in safeguarding outcomes, particularly for adults with multiple disadvantages such as homelessness, s and mental health

Officers highlighted the role of the Complex Lives Team in providing trauma-informed, specialist support. They explained that safeguarding outcomes were monitored through detailed data analysis across demographics and that partnership arrangements, including the Safeguarding Adults Board, supported a coordinated response to complex need. Awareness raising activity such as Safeguarding Awareness Week further strengthened multi-agency working.

David Gill, Co-optee asked about co-production involvement opportunities for people with learning disabilities and autism.

Officers confirmed that participation was encouraged, including attendance at the co-production board and Mr Gill was invited to participate on behalf of Rotherham Speak-Up.

Councillor Yasseen raised concerns regarding delays in assessments, including Deprivation of Liberty Safeguards (DoLS) assessments, and queried whether additional resources would be required to address backlogs.

Officers acknowledged these pressures as a national issue, noting increasing demand and the scale of assessment activity, but advised that resources had been increased and prioritisation mechanisms applied. They confirmed that despite delays in some areas, waiting times between assessment and service provision were generally low, with strong market capacity in areas such as home care.

Councillor Yasseen challenged service to identify their top three priorities arising from the inspection feedback to promote focus on impact.

Officers reflected that these were some of the areas Members had questioned, and identified:

- Improving the carers' offer
- Addressing equity of experience and engagement with seldom-heard groups with additional emphasis on strengthening co-production and representation
- Reducing waiting times for assessments and reviews as the primary focus areas

Councillor Baum-Dixon raised questions regarding demographic change, rural access, data reliability, and long-term sustainability in the face of change, large scale building projects and an aging population.

Officers confirmed that they used a range of up-to-date data sources, including the Joint Strategic Needs Assessment (JSNA), to understand population trends, and outlined a preventative approach to managing demand. This included investment in early intervention, assistive technology, and employment support for working-age adults to promote independence. They also highlighted wider system collaboration with Place Partners, digital innovation, and ongoing efforts to maximise resources whilst maintaining service quality in the context of rising demand.

The Chair noted that there were a number of Members who had additional questions which was a testament to the importance of the subject matter. Due to time constraints, Members who had further questions that had not been addressed during the course of the meeting were requested to provide these in writing to the Governance Advisor would liaise with service in relation to obtaining responses which would in turn be shared during a subsequent Health Select Commission meeting. Service confirmed their consent to that approach.

The Chair thanked the Cabinet Members and Officers for their attendance on the insights in relation to the achievements and ongoing improvement work within Adult Social Care.

Resolved:-

That the Health Select Commission:

1. Noted the contents of the report including the areas of strength and the areas of focus, as detailed in the CQC assessment report.

2. Requested that the service provides the Health Select Commission with a copy of the 18 month action plan referred to under paragraph 5.1 of the report, upon this being developed.

3. Requested that service formalises arrangements, including the method of delivery and a suitable timeline, for reporting progress against CQC

improvement areas documented in the 18 month action plan to the Health Select Commission.

4. Requested that service provide the Health Select Commission with information regarding the role of 'Community Connectors' to aid their understanding.

68. NHS 10 YEAR PLAN; LOCAL IMPLICATIONS INCORPORATING NEIGHBOURHOOD HEALTH SERVICES

This item was to receive a presentation from Rotherham Place Partners in relation to how the NHS 10 Year Plan translates into the Rotherham context, including implications for Neighbourhood Health Services.

The Chair welcomed Joanne Martin, Programme Lead, Transformation and Delivery at SY ICB, Simon Langmead, Clinical Director for Rotherham Central North Primary Care Network, Bob Kirton, Managing Director of TRFT, Ian Spicer, Executive Director of Adult Care, Housing and Public Health in the absence of Emily Parry-Harries, Director of Public Health and Anthony Fitzgerald, Place Director for Rotherham at SY ICB (South Yorkshire Integrated Care Board) to the meeting and invited Joanne Martin to introduce the presentation.

The Programme Lead, Transformation and Delivery at SY ICB introduced the report, explaining that the neighbourhood health framework, published in March 2026, formed a central delivery mechanism for the Government's National Health Service (NHS) 10 Year Plan and set out a clear national expectation for how services should be delivered going forward.

It was emphasised that, for Rotherham, the approach did not represent a radical departure from existing practice in Rotherham, but instead built upon established place-based and locality working, including alignment with the Joint Strategic Needs Assessment (JSNA) and existing community insight work. However, the framework formalised expectations and introduced greater clarity regarding roles, governance and accountability, particularly for the Place Board and the Health and Wellbeing Board.

Members heard that Neighbourhood Health aimed to ensure that the majority of people's care needs were met closer to home through integrated, multidisciplinary teams operating across Primary Care, Community and Mental Health services, Adult Social Care, Public Health and the Community and Voluntary Sector, working collectively as a single system rather than in organisational silos.

It was clarified that this did not involve removing all hospital based care but instead sought to shift activity, where appropriate, towards community settings with a strong emphasis on prevention, early intervention and addressing the wider determinants of health. This approach was

described as particularly important in Rotherham given the prevalence of health inequalities, long-term conditions and pressures on Urgent and Emergency Care.

The presentation highlighted that Neighbourhood Health was now a mandated operating model rather than an optional approach, with systems expected to demonstrate delivery against five national minimum goals relating to:

- Outcomes
- Health Inequalities
- Patient Experience
- Urgent and Emergency Care performance
- Staff Experience

Whilst these goals were already familiar, it was noted that delivery at neighbourhood level would now be the primary mechanism for achieving them, requiring clearer alignment between local arrangements, performance reporting and governance structures.

Members were informed that the framework identified three priority areas for reform over the next three years:

- Improving access to routine care, particularly general practice and community services
- Strengthening proactive and preventative care through the use of population health data
- Developing alternatives to hospital care in order to reduce avoidable admissions

Although much of this work was already underway locally, the framework required a more consistent and coordinated approach at neighbourhood level, alongside clearer accountability for delivery and outcomes.

Implementation would be phased, with an initial focus in 2026–2027 on delivering tangible improvements within existing structures, followed by more formalised neighbourhood models, commissioning arrangements and funding approaches from 2027 onwards.

The Commission heard that the framework also introduced significant shifts in roles and responsibilities across the system. Integrated Care Boards (ICBs) would move away from detailed operational oversight towards a strategic commissioning role focused on population outcomes, investment decisions and system assurance, with greater emphasis on population health management and reducing health inequalities.

Local authorities were positioned as co-leaders of Neighbourhood Health, with an enhanced role in prevention and addressing wider determinants such as housing, employment and social inclusion, while Health and Wellbeing Boards would provide strategic leadership and democratic

accountability, ensuring alignment with the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

It was further reported that provider organisations would be expected to move away from delivering isolated services towards collective accountability for outcomes across neighbourhood populations, working as integrated teams and focusing on outcomes and experience rather than activity levels alone. In this context, provider leaders would play a key role in redesigning pathways, improving integration and ensuring that care was delivered in the most appropriate setting, with hospital care used only where necessary.

The role of the Rotherham Place Board was described as central to delivery, with responsibility for ensuring that Neighbourhood Teams were established, that organisations were working as a single system, and that barriers to integration were addressed. The Health and Wellbeing Board, by contrast, would focus on strategic oversight, ensuring that neighbourhood delivery aligned with local priorities and reduced health inequalities, whilst holding partners to account for outcomes rather than managing operational delivery. The importance of strong alignment, shared data and effective communication between these governance structures was emphasised to avoid duplication and ensure collective accountability.

It was reiterated that Neighbourhood Health represented a mandatory national direction of travel and a significant opportunity for Rotherham to build on its existing strengths in partnership working and locality based delivery, provided that governance, leadership and accountability arrangements continued to evolve to support improved outcomes for residents.

The Managing Director, TRFT added that in addition to the presentation delivered, supplementary slides had been provided to Members as part of the published agenda pack to illustrate work already undertaken in response to the NHS 10 Year Plan since its publication, noting that the detailed Neighbourhood Health guidance had only been issued recently.

The Chair thanked Officers for the comprehensive overview, welcomed the opportunity to build on existing good practice, and invited questions and comments from Members.

Councillor Harper queried why a small number of General Practice (GP) services were reflected as ‘amber’ within the data-sharing arrangements and sought reassurance that deprived areas would benefit from the new model, citing the impact of poor quality housing on health and wellbeing.

In response, Officers explained that all practices had already signed up in principle and the ‘amber’ status related only to a technical step in activating the system, which was believed to have been resolved since the presentation was prepare, with all practices now being ‘green’.

Officers emphasised that the new approach, based on defined neighbourhoods aligned to wards, would allow more targeted responses to local health inequalities, including issues such as poor housing conditions affecting health, by bringing together services to address the wider determinants of health.

Councillor Baum-Dixon sought clarity in relation to the alignment of neighbourhood boundaries, the challenges of rurality, and access to services across dispersed communities.

Officers advised that neighbourhoods had not yet been finalised and that this would be a complex process, requiring alignment across health, social care, housing and other services. It was confirmed that population health data would be analysed at ward and smaller geographic levels to reflect differing needs, including rural isolation and transport barriers, and that future models would need to account for these variations rather than applying a uniform approach.

Councillor Fisher asked how success would be measured and how assurance would be provided to Members, as well as how workforce capacity and cultural change would be managed.

Officers explained that a range of performance measures were being developed, covering demand, prevention, system flow, workforce wellbeing, and integration across services. It was emphasised that cultural change, integrated team working, and simplifying systems for residents would be central to success, alongside improving patient and staff experience. Officers also highlighted that success would ultimately be judged by improved outcomes and by how residents experienced more joined-up and accessible services.

Councillor Fisher queried how funding would be shifted from acute hospital care to community provision, maintaining accountability.

Officers acknowledged that no additional funding was available and that the programme required better use of existing resources. Examples were provided of initiatives already reducing demand on hospitals, such as ‘hospital at home’ services, virtual wards, and mobile diagnostic services, which avoided admissions and improved outcomes. It was further explained that current funding models did not always incentivise such approaches and that future commissioning arrangements would need to move towards pooled budgets and outcome based funding across organisations.

Councillor Clarke raised concerns about how prevention and community-based services would operate in areas where infrastructure was lacking, particularly where residents were unable to physically access local facilities.

Officers responded that the model would not rely solely on residents travelling to neighbourhood hubs, but would include flexible delivery tailored to individual needs, including services delivered in people's homes. It was emphasised that the approach would require more personalised responses and stronger multidisciplinary working to address practical barriers and ensure that vulnerable residents were not excluded.

Councillor Yasseen expressed concerns regarding the scale of the proposed reform given the lack of detailed implementation plans, unclear neighbourhood definitions, and the absence of additional funding. They acknowledged that the framework represented a major system change but that detailed implementation plans were still being developed following recent national guidance and whilst welcomed, required careful planning and execution.

Officers emphasised that the current position focused on direction of travel rather than finalised design, and that further detail, including neighbourhood mapping and delivery models, would be developed over time. They also recognised financial pressures across the system, noting that efficiencies would be required through reducing duplication and focusing investment on prevention rather than hospital care, which was considered both costly and less effective for long-term outcomes. It was also emphasised that the programme was at an early stage within a 10 Year Plan, and that a phased approach would be taken to avoid rushed implementation. Officers highlighted the importance of engaging with communities, testing models, and focusing initially on priority areas to establish effective approaches before wider rollout. It was also noted that strong partnership working across organisations in Rotherham placed the area in a favourable position to deliver the programme successfully, hence its inclusion in the 43 prioritised areas.

Councillor Yasseen raised broader points regarding accountability and the increased role of local governance, and expressed concerns that residents would look to Elected Members for resolution of issues arising from the Neighbourhood Health model and sought assurances around Member's being kept informed.

Officers acknowledged this and emphasised the need for clear governance arrangements, ongoing scrutiny, and continued Member engagement as the programme developed.

Councillor Baum-Dixon highlighted the importance of ensuring services reflected cross-boundary considerations, such as access to services outside the borough for those parts of the borough neighbouring other ICB footprints, and the need to ensure that patient voice and engagement, including representation of seldom-heard groups, remained central to the development of neighbourhood health services and encouraged Place partners to keep these issues in mind as work progressed.

The Chair thanked Officers for the presentation, considered responses and looked forward to progress being made.

Resolved:-

That the Health Select Commission:

1. Noted the contents of the presentation and the update provided.

2. Requested that, as with the roles of the Place Board and Health and Wellbeing Board, the role of Health Select Commission be clearly defined and agreed at the earliest opportunity to ensure that focussed outcome driven scrutiny can be appropriately framed and scheduled in line with delivery plans and timelines. The specific details and timeline for completion of this subsequent scrutiny activity would be agreed at a suitable stage once greater clarity was achieved.

3. Requested that the Commission be sighted on and included in any engagement, consultation and co-production work supporting the Neighbourhood Health transition, including considerations around neighbourhood footprints.

69. MENOPAUSE REVIEW REPORT

Members were invited to consider the Menopause Scrutiny Review Report. The report was the result of the workshop undertaken in 2025, subsequently re-framed as a spotlight review.

There were no questions or comments from members in relation to the report.

Resolved:-

That the Health Select Commission:

1. Noted the content of the Menopause Review Report.

2. Supported Option B as described in the report.

3. Supported the report being presented to OSMB, and subsequently Cabinet.

70. HEALTH SELECT COMMISSION WORK PROGRAMME - 2026/27

Members were presented with the proposed work programme for the 2026/27 municipal year and invited to advise the Chair and/or Governance Advisor of any comments or suggestions for topics to consider.

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.

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

Members were advised that the South Yorkshire, Derbyshire and Nottinghamshire Joint Health Overview and Scrutiny Committee (JHOSC) meeting scheduled to take place on 11 March 2026 was cancelled, and the calendar of meetings for the 2026/27 municipal year were not yet confirmed. Health Select Commission Members would be advised of proposed dates and topics for consideration once that information was made available.

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.

72. URGENT BUSINESS

The Chair wished to place on record that they considered it a privilege to have had the opportunity to work with Members of the Health Select Commission throughout the 2025/26 municipal year. They recognised the level of involvement and commitment that had been demonstrated by all concerned and offered their thanks to both Members and Officers who have supported the Commission's meetings for their valuable contributions.

This page is intentionally left blank

Agenda Item 6

Rotherham Metropolitan Borough Council

BRIEFING	TO:	Health Select Commission
	DATE:	18 June 2026
	TITLE:	Health, Safety and Welfare Panel Representation

1. Role of the Health, Safety & Welfare Panel

The Health, Welfare and Safety Panel provides a regular forum for the Council and its employees to consider matters relating to health, welfare and safety and to provide advice, guidance and recommendations to appropriate Committees or other Council bodies.

Objectives of the Panel include:-

- To promote a healthy and safe working environment for all members of staff employed by the Council and to protect the public from any risk of danger that may arise as a result of the Council's activities.
- To monitor the welfare arrangements (facilities for eating, drinking, first aid and toilets, etc) provided for employees.
- To provide a forum for consultation on proposals put forward by management and by the trade unions.
- To recommend changes to the way in which work is performed by the introduction of safe systems of work, procedures and arrangements, including those for the training of staff.
- To monitor statistics on accidents, incidents and illness and to recommend action to address key issues which may arise from that information.
- To promote greater awareness of health, welfare and safety policies to assist in facilitating improvement in Council performance.

2. Membership and Request for Member Representation from the Health Select Commission

The Panel comprises six Elected Members of the Council to be appointed annually, including Member(s) from:

- Cabinet - Member with responsibility for Health, Welfare and Safety.
- A member from the Overview and Scrutiny Management Board.
- One member from each of the Select Commissions (Scrutiny).
- A member from the Members' Training and Development Panel.

3. Membership and Request for Employee Representation from the Trade Unions

The Panel also has representation from the Employees' Side and includes:

- At least three teacher representatives (NASUWT and NEU Trades Unions).
- A maximum of seven representatives from all other areas of Council work e.g. UNISON, UNITE the Union, GMB.

4. Frequency of Meetings / Visits

The Panel normally meets four times per year. Additional meetings may be held if the business to be transacted is sufficiently urgent. The meetings scheduled for 2026/27 are:-

9 July 2026 at 2:00pm
15 October 2026 at 2:00pm
4 February 2027 at 2:00pm
22 April 2027 at 2:00pm

Inspection visits by the Panel shall be made on a quarterly basis to various locations throughout the borough. Visits of inspection are scheduled to take place on:-

17 June 2026 at 8:45am (from the Town Hall)
Other dates to be confirmed

Refreshments are available from 8:30am, prior to departure.

Rotherham Women's Health Network Report for the Health Select Committee June 2026

1. Context & Policy Framework

1.1 The Women's Health Strategy for England (2022)[1] was launched as the first comprehensive, system-wide plan to address longstanding inequalities in how women experience healthcare. It was driven by extensive public consultation, which revealed consistent themes: women often felt not listened to, dismissed, or poorly supported, and there were significant gaps in research, data, and service design tailored to women's needs.
At a high level, the 2022 strategy set out a 10-year ambition to improve health outcomes across the life course—from adolescence to menopause and ageing—by improving access, embedding a "listening to women" approach, increasing representation in research, and shifting more care into community settings.

1.2 Recently in April 2026, a Renewed Women's Health Strategy[2] was introduced because progress had been uneven and many of the original issues—such as long waits for diagnosis, fragmented services, and women feeling unheard—persisted. Reviews and parliamentary scrutiny highlighted gaps in implementation, workforce pressures, and insufficient prioritisation of areas like menstrual and gynaecological health.
The refreshed strategy is therefore intended not just to restate ambitions, but also to accelerate delivery and align women's health more closely with wider NHS reform, ensuring it becomes a core system priority rather than a standalone policy.

1.3 What is notably different in the 2026 refresh is its stronger focus on practical system change and accountability. It places women's voices at the centre of care in more concrete ways—for example, linking patient feedback to service improvement and potentially funding decisions, and introducing clearer care pathways and single points of referral to reduce delays. There is also greater emphasis on reducing waiting times, improving pain management standards, expanding menstrual health education, and redesigning clinical pathways for conditions like endometriosis and menopause.

1.4 The refreshed national Women's Health Strategy outlines:

- 117 actions and 4 core commitments over a 10-year horizon
- A focus on improving healthy life expectancy and reducing inequalities
- A long-term ambition to eliminate cervical cancer by 2040

Priority areas include:

- Endometriosis (delayed diagnosis)
- Cardiovascular disease (misdiagnosis risk in women)
- Mental health
- Maternity inequalities
- Osteoporosis and dementia

The strategy emphasises listening to women, improving access, and strengthening prevention and early intervention.

[1] Women's Health Strategy for England - GOV.UK
[2] The Renewed Women's Health Strategy for England

Lead Author: Nazreen Iqbal, Healthy Hospital Programme Manager.
Co-Author, Linda Strettle GP and Rachel Copley Public Health Practitioner.

1.5 84% of women report not being listened to by healthcare professionals, persistent inequalities and variation in care and cultural issues including bias and unequal treatment.

1.6 Overall, while the 2022 strategy established the vision and direction, the 2026 refresh represents a shift toward implementation, integration, and measurable change—with a stronger focus on tackling systemic biases, improving patient experience, and delivering faster, more joined-up care for women across the health system.

1.7 While the 2026 update to the Women's Health Strategy for England is broadly welcomed for maintaining focus on women's health and sharpening priorities, the absence of a detailed delivery plan and ring-fenced funding means that implementation is less certain. In practice, this shifts responsibility onto local systems—Integrated Care Boards (ICBs), NHS trusts, and local authorities—to decide how and whether to prioritise women's health alongside many competing demands. This reliance on local leadership creates both opportunity and risk.

2. Rotherham Women's Health Network (RWHN)

2.1 The Rotherham Women's Health Network (RWHN) was established in August 2025 by a group of committed women seeking to address health inequalities affecting women in Rotherham. Since its inception, the network has grown steadily and now includes representation from a broad range of stakeholders across the borough. It is important to note the network is made up of voluntary members, and some of the attendees attend in their own time, unpaid.

2.2 Membership spans key partners including Public Health, Primary Care, Secondary Care (Gynaecology and Sexual Health Services), Healthwatch, Voluntary Action Rotherham, and Rotherham Metropolitan Borough Council (RMBC). While the network is currently an all-female group, there is a clear commitment to engaging male allies to strengthen and support this work.

2.3 The network has established formal governance arrangements, including agreed Terms of Reference, and meets on a bimonthly basis to progress its priorities. Its overarching aim is to ensure that women's health remains a visible and prioritised agenda within Rotherham, to address inequalities, and to progress the ambition for a dedicated Women's Health Hub.

2.4 Despite being in its early stages, the network has already identified several key themes through shared discussion and insight. A priority emerging from this work is the need for a single, accessible and consistently maintained source of information on women's health services in the Rotherham area.

2.5 The network is increasingly recognised as a key forum for engagement, with partners proactively inviting the group to contribute to local events and initiatives. Membership continues to grow, including the involvement of academic partners such as the University of Sheffield, supporting greater opportunities for research engagement and ensuring that the voices of women in Rotherham inform future studies.

2.6 The network has begun to collate intelligence on key public health indicators relating to women's health and intends to strengthen this further by incorporating primary and secondary care data. In addition, collaboration with Healthwatch—who are currently undertaking a women's health survey—will provide valuable qualitative insight, which will be synthesised into a comprehensive report.

2.7 The RWHN has taken it's early findings to Rotherham Place board on the 20th May 2026. The presentation was well received and the following actions were agreed:

- SYICB to include women's health in their Target Operating Model.
- We have agreed to host a 'Protected Learning Time' session on women's health for GP's.
- We have requested funding to be able to host a conference on women's health; we are awaiting confirmation on this.
- A commitment to embedding women's health within the neighbourhood model going forward.
- Support to agree a referral proforma for Primary Care referrals into gynaecological secondary care.

2.8 Looking ahead, the network aims to share its early findings and raise the profile of women's health through a Rotherham-wide conference, complemented by interactive workshops. This will provide an opportunity for system partners to convene, align priorities, and make a collective commitment to advancing this agenda.

3. Population Health Data

3.1 Women in Rotherham are experiencing declining rates of health with healthy life expectancy registering lower than it did a decade ago at just 55.1 years compared to 58.5 years in 2011-2013.[3]

3.2 Healthy life expectancy at birth for females in Rotherham is significantly lower than the England average of 61.3 years and is also lower than the corresponding estimate for males in Rotherham (55.6 years).[4]

3.3 Concerningly these figures highlight that the average woman in Rotherham now spends over 30% of their life in poor health. This is exacerbated further in the most deprived areas of Rotherham, specifically around the Central wards and Maltby East.

3.4 At age 65, women in Rotherham can expect to live an average of 7.3 years free from disability, compared to 9.9 years for women in England, a gap of 2.6 years. For men, the corresponding figures are 8.2 years in Rotherham and 9.8 years nationally. This highlights a wider inequality for women in Rotherham, who experience a larger gap in disability-free life expectancy (2.6 years) compared to men (1.6 years).[5]

3.5 Entrenched local deprivation, high unemployment rates and poorer physical health in Rotherham compound several inequalities for women and girls. Rising rates of violence against women and girls, both nationally and locally, contribute to long-lasting trauma and poorer mental and physical health outcomes. Nationally, 3.3% of women aged 16 and over

[3]Office for Health Improvement and Disparities. Public Health Outcomes Framework: Life expectancy and health indicators for Rotherham [Internet]. London (UK): Department of Health and Social Care; 2025 [cited 2025 Nov 4]. Available from: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/4/gid/1000049/pat/15/par/E92000001/ati/502/are/E08000018/iid/90362/age/1/sex/2/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1

[4] Public Health England. Health Inequalities Dashboard: statistical commentary, March 2020 [Internet]. London (UK): GOV.UK; 2020 Mar 3 [cited 2025 Nov 4]. Available from: https://www.gov.uk/government/statistics/health-inequalities-dashboard-march-2020-data-update/health-inequalities-dashboard-statistical-commentary-march-2020

[5] Office for National Statistics. Sexual offences in England and Wales overview: year ending March 2022 [Internet]. Newport: ONS; 2023 Mar 23 [cited 2025 Nov 12]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/sexualoffencesinenglandandwalesoverview/march2022 [ons.gov.uk]

reported experiencing sexual assault in the year ending 2022, while 7.7% of women reported having experienced rape or attempted rape at some point in their lifetime.[6]

3.6 Women provide significantly more unpaid care than men.[7] In Rotherham, limited childcare availability and wider socio-economic challenges are associated with lower household incomes and restricted employment opportunities for women. This is evident despite girls in Rotherham generally outperforming boys in educational attainment across school years.[8]

3.7 Rotherham women suffer higher rates of chronic pain, self-harm episodes and physical inactivity than both their male Rotherham counterparts and women nationally[9]. Male prevalence of back pain in Rotherham is 14.3% compared to the female prevalence of 22.0%.[10] This physical health gender disparity is replicated for musculoskeletal pain.

3.8 Women in Rotherham experience higher rates of non-communicable diseases compared to the national average. For example, cardiovascular disease mortality among women in Rotherham is 207.2 per 100,000, compared to 181.2 per 100,000 in England[11]. A similar pattern can be seen across other conditions, including Alzheimer's disease and cancer as well as in all-cause mortality, where rates among women in Rotherham are consistently worse than the national average.[12]

3.9 Girls in Rotherham show concerning trends in responses to the school lifestyle survey. Around 22% report experiencing chronic loneliness, 42.5% have experienced bullying, and 28.2% report a recent decline in their mental health.[13] All of these figures are higher than those reported by boys, indicating poorer wellbeing outcomes for girls.

4. Lived Experience & Patient Voice

4.1 Healthwatch are a key stakeholder in the Rotherham women's Network and we are working closely together. They currently have a survey out to gather local intelligence and lived experience from women around their experiences of healthcare services locally.

4.2 Healthwatch gather feedback from local residents and Elena's story highlights the impact on individuals that are systematically not being heard.

4.3 Elena arrived in England 6 years ago with her family and was initially placed in a hostel in the Midlands. After moving to Rotherham, Elena reported a very positive experience with her

---

[6] Office for National Statistics. Sexual offences in England and Wales overview: year ending March 2022 [Internet]. Newport: ONS; 2023 Mar 23 [cited 2025 Nov 12]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/sexualoffencesinenglandandwalesoverview/march2022 [ons.gov.uk]

[7] Office for National Statistics. Unpaid care by age, sex and deprivation, England and Wales: Census 2021 [Internet]. London: ONS; 2023 [cited 2025 Nov 4]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles/unpaidcarebyagesexanddeprivationenglandandwales/census2021

[8] Office for National Statistics. Childcare accessibility by neighbourhood: 2024 [Internet]. London: ONS; 2024 Jun 4 [cited 2025 Nov 4]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/educationandchildcare/articles/childcareaccessibilitybyneighbourhood/2024-06-04

[9] Office for Health Improvement & Disparities. Public Health Profiles [Internet]. London: Department of Health and Social Care; 2025 [cited 2025 Nov 7]. Available from: Fingertips | Department of Health and Social Care

[10] Versus Arthritis. Back pain in Rotherham [Internet]. London: Versus Arthritis; [cited 2025 Nov 18]. Available from: https://www.arthritis-uk.org/media/13233/rotherham-back-pain.pdf

[11] Office for Health Improvement & Disparities. Public Health Profiles [Internet]. London: Department of Health and Social Care; 2025 [cited 2025 Nov 7]. Available from: https://fingertips.phe.org.uk/search/cardio.

[12] Office for Health Improvement & Disparities. Public Health Profiles [Internet]. London: Department of Health and Social Care; 2025 [cited 2025 Nov 7]. Available from: https://fingertips.phe.org.uk/search/dementia.

Lead Author: Nazreen Iqbal, Healthy Hospital Programme Manager.
Co-Author, Linda Strettle GP and Rachel Copley Public Health Practitioner.

first GP surgery, describing staff as caring, patient, and supportive of both her physical and mental health needs.

4.4 Following another house move, Elena had to register with a different GP surgery, where her experience changed significantly. For the past 4 years, Elena has experienced recurrent urinary infections causing severe pain and distress.

4.5 Despite repeated contact with her GP surgery, Elena felt her concerns were dismissed and that staff did not listen to her requests for further investigation. Elena reported being repeatedly directed to pharmacies and prescribed antibiotics, despite wanting the underlying cause of her condition investigated. The repeated use of antibiotics caused additional side effects, which Elena also felt were dismissed by healthcare staff. Elena described reception staff as rude and felt communication lacked empathy and understanding.
She felt she was treated differently to English patients and perceived less friendly and supportive interactions from staff due to her nationality.

4.6 Elena stated she felt the need to change the way she spoke to healthcare professionals in order to be taken seriously. Requests to see doctors she felt comfortable with were not accommodated, leading to inconsistent care and frustration.

4.7 The ongoing health issues significantly affected Elena's daily life, employment, sleep, relationships, and mental wellbeing. Elena eventually left her job due to the impact of her health condition and repeated flare-ups. She described experiencing severe emotional distress and feelings of hopelessness due to the lack of support and ongoing pain. After years of advocating for herself, Elena was finally referred for a scan and further investigation.
Elena's case highlights the impact of patients feeling unheard within healthcare services, particularly regarding communication, continuity of care, and culturally sensitive support.

5. Audit of Gynaecology Referrals (TRFT)

5.1 An audit of gynaecology referrals highlights significant challenges, including long waiting times, variation in referral quality, and opportunities to strengthen community-based care.

An audit of 100 consecutive outpatient records (January 2025) identified:

- Urgent suspected cancer: 27%
- Urgent referrals: 15%
- Routine referrals: 58%

5.2 Source of Referrals

- Majority originate from primary care across all categories
- Smaller proportion from secondary care

5.3 Waiting Times

- Urgent suspected cancer: 12 days
- Urgent: 64 days
- Routine: **253 days**

➞ Key issue: Significant delays for routine cases.

5.4 Referral Outcomes

- Two-week wait: 60% discharged at first appointment
- Urgent referrals: 47% discharged at first appointment
- Routine referrals: 12% discharged at first appointment

5.5 Community/Hub-Based Model

Potential benefits include:

- Pre-screening and triage of referrals
- Delivery of interventions closer to home
- Reduced demand on secondary care
- Improved patient experience

Examples from other systems show:

- Rapid triage (within 72 hours)
- Use of telephone and face-to-face models
- Reduced referral volumes

5.6 Pathway and Process Improvements

- Introduction of referral proformas to ensure appropriate pre-referral testing
- Development of specific pathways (e.g. ovarian cysts)
- Enhanced clinical training in primary care

6. Recommendations

6.1 Make women's health a core local priority – Embed women's health within Place plans, neighbourhood models, and system strategies to address worsening outcomes and inequalities for women in Rotherham.

6.2 Invest in a community-based Women's Health Hub – Deliver integrated, accessible care closer to home to reduce long waits, improve early intervention, and enhance patient experience.

6.3 Support a Rotherham Women's Health Conference – Enable system-wide collaboration across health, local authority, and community partners to share learning, align priorities, and act as a catalyst for sustainable change in women's health outcomes.

6.4 Improve access, pathways, and patient experience – Reduce gynaecology waits, standardise referral processes, and ensure services actively listen to and respond to women's voices.

7. References

1. Women's Health Strategy for England - GOV.UK (2022) Available from: https://assets.publishing.service.gov.uk/media/6a0dcebffaac4bc0b0e906f4/withdrawn-womens-health-strategy-for-england-easy-read.pdf
2. The Renewed Women's Health Strategy for England. GOV.UK (2026) Available from: The Renewed Women's Health Strategy for England
3. Office for Health Improvement and Disparities. Public Health Outcomes Framework: Life expectancy and health indicators for Rotherham [Internet]. London (UK): Department of Health and Social Care; 2025 [cited 2025 Nov 4]. Available from: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/4/gid/1000049/pat/15/par/E92000001/ati/502/are/E08000018/iid/90362/age/1/sex/2/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1
4. Public Health England. Health Inequalities Dashboard: statistical commentary, March 2020 [Internet]. London (UK): GOV.UK; 2020 Mar 3 [cited 2025 Nov 4]. Available from: https://www.gov.uk/government/statistics/health-inequalities-dashboard-march-2020-data-update/health-inequalities-dashboard-statistical-commentary-march-2020
5. Office for National Statistics. Sexual offences in England and Wales overview: year ending March 2022 [Internet]. Newport: ONS; 2023 Mar 23 [cited 2025 Nov 12]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/sexualoffencesinenglandandwalesoverview/march2022 [ons.gov.uk]
6. Office for National Statistics. Sexual offences in England and Wales overview: year ending March 2022 [Internet]. Newport: ONS; 2023 Mar 23 [cited 2025 Nov 12]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/sexualoffencesinenglandandwalesoverview/march2022 [ons.gov.uk]
7. Office for National Statistics. Unpaid care by age, sex and deprivation, England and Wales: Census 2021 [Internet]. London: ONS; 2023 [cited 2025 Nov 4]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles/unpaidcarebyagesexanddeprivationenglandandwales/census2021
8. Office for National Statistics. Childcare accessibility by neighbourhood: 2024 [Internet]. London: ONS; 2024 Jun 4 [cited 2025 Nov 4]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/educationandchildcare/articles/childcareaccessibilitybyneighbourhood/2024-06-04
9. Office for Health Improvement & Disparities. Public Health Profiles [Internet]. London: Department of Health and Social Care; 2025 [cited 2025 Nov 7]. Available from: Fingertips | Department of Health and Social Care
10. Versus Arthritis. Back pain in Rotherham [Internet]. London: Versus Arthritis; [cited 2025 Nov 18]. Available from: https://www.arthritis-uk.org/media/13233/rotherham-back-pain.pdf
11. 39. Office for Health Improvement & Disparities. Public Health Profiles [Internet]. London: Department of Health and Social Care; 2025 [cited 2025 Nov 7]. Available from: https://fingertips.phe.org.uk/search/cardio.
12. Office for Health Improvement & Disparities. Public Health Profiles [Internet]. London: Department of Health and Social Care; 2025 [cited 2025 Nov 7]. Available from: https://fingertips.phe.org.uk/search/dementia.

This page is intentionally left blank

Rotherham Women's Health Network

Nazreen Iqbal Healthy Hospital Programme Manager TRFT
Linda Strettle GP Partner at Village Surgery
Radhika Gosakan Consultant Obstetrician and Gynaecologist TRFT

Rotherham Women's Health Network

The Rotherham Women's Health Network (RWHN) **brings together stakeholders** across health, social care, community, and voluntary sectors to **improve women's health and wellbeing within Rotherham Place**. The RWHN is a partnership network aiming to address **health inequalities**, strengthen **service coordination**, and ensure **women's voices inform local decision-making**.

Stakeholders

Public Health	Primary Care	Gynaecology
RMBC	TRFT	ICB
Screening Team	Voluntary Action Rotherham	Healthwatch

Better Representation and coordination	**Sharing of Information**	**Health Needs Assessment**	Outcomes

Refreshed Women's Health Strategy

117 Actions

4 Commitments

10 year Horizon

2040 Cervical Cancer Elimination

1. Reverse Decline in healthy life expectancy

2. Raise healthy life expectancy in the poorest regions

3. Reduce time women spend in poor health as a share of their lives

Conditions in Focus

Endometriosis
Diagnosis takes avg. **9y 4mo**.
Dedicated NHS Online pathway & community 1st design

Osteoporosis
1 in 3 women will fracture.
20 new DEXA scanners; FLS nation wide by 2030

Cardiovascular
Women are **50% more likely to be misdiagnosed**. New CVD modern service framework 2026

Dementia
Leading cause of female death (16% in 2024) Barbra Windsor Dementia Goals Programme

Mental Health
1 in 4 women affected
Vs 1 in 7 men.
915000 to complete NHS Talking Therapies by 2029

Maternity
Black maternal mortality 3 x higher Amos investigation and gap closure target

Renewed Women's Health Strategy for England - GOV.UK

Acting on Women's Voices and Choices

→ Women's Voices Partnership established by 2027

→PREMS & PROMS for Gynaecology outpatients.

→ NHS trust funding tied to women's feedback ("patient power payments")

→ Pain standards mandated for procedures like hysteroscopy

→ Free emergency contraception in all pharmacies, now

Transforming NHS Performance

→ Single access point for all gynaecology referrals

→ Menopause and menstrual health among the first 9 pathways on NHS Online (2027)

→ Explicit target to close the Black and Asian maternal mortality gap

→ 20 new DEXA scanners; fracture liaison services nationwide by 203

Acting on Women's Voices and Choices Supporting Healthy Prosperous Lives

→ Cervical cancer elimination target: 2040

→ HPV home testing kits and pharmacy vaccination from this year

→ BRCA1/2 and Lynch syndrome genomic testing expanded

→ Employers with 250+ staff must publish menopause action plans from 2027

Research and Innovation for Women

→ NIHR will no longer fund research that ignores sex-based differences

→ £1.5m FemTech healthcare challenge

→ Female founders accelerator via NIHR

→ AI Ethics Initiative: diversity standards for health AI datasets

Renewed Women's Health Strategy for England - GOV.UK

Key Takeaways

84% of women report not being listened to by healthcare professionals.

Systematic **failure to listen** to women

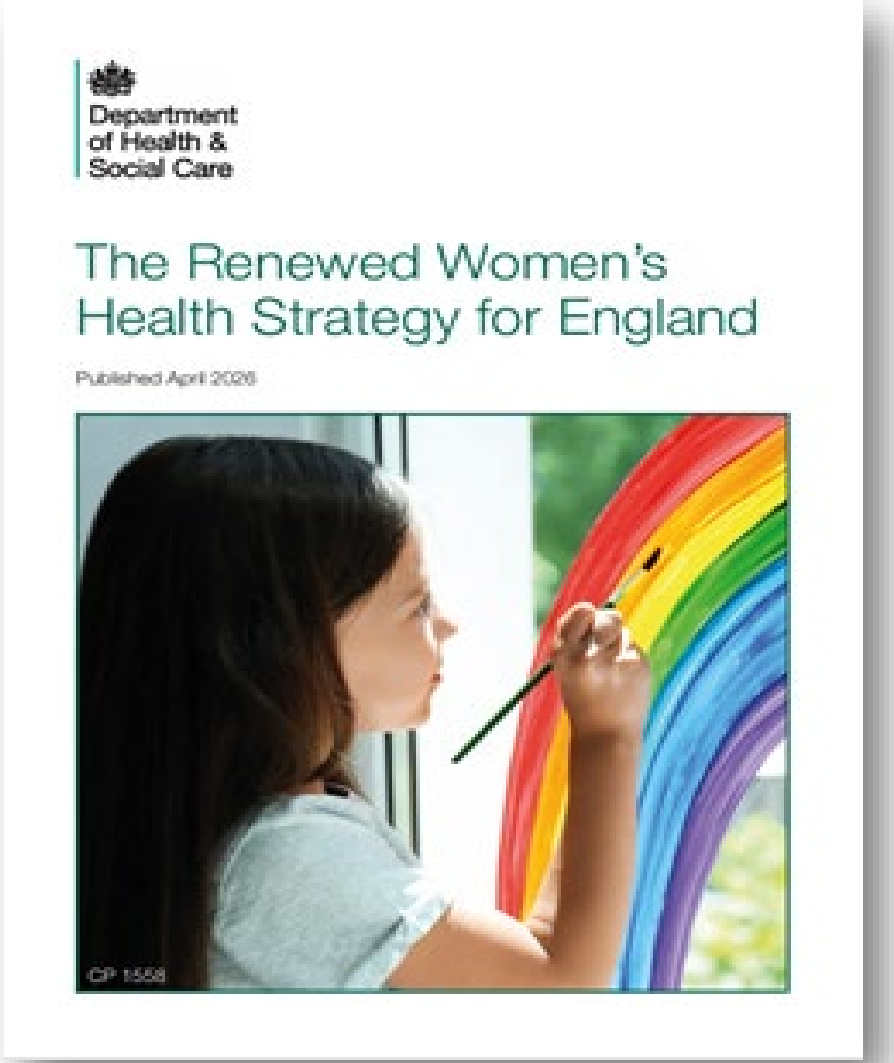
Culture of **unequal treatment**, and to tackle **unconscious bias** and **medical misogyny**.

Women's Health HUBS named

Disparity continues…

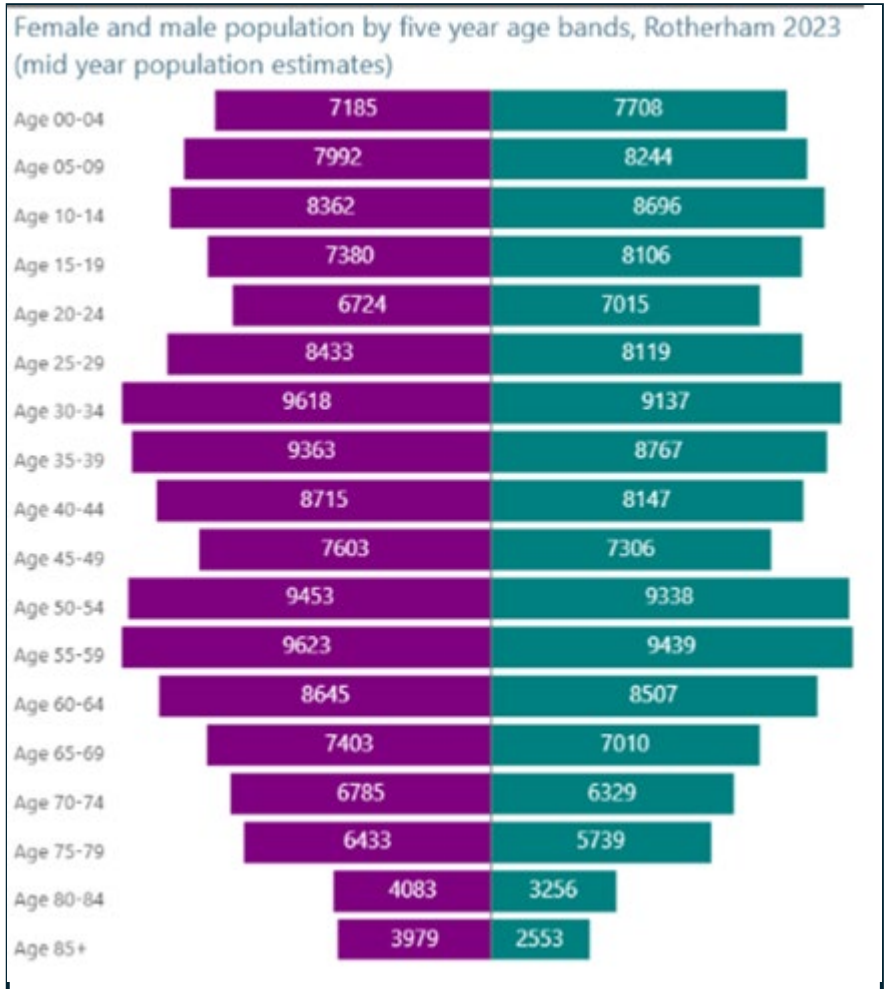
£1 million to improved education around period.
1.5 mill women's fem tech innovation.

(£6.3 offered for men's mental health.)

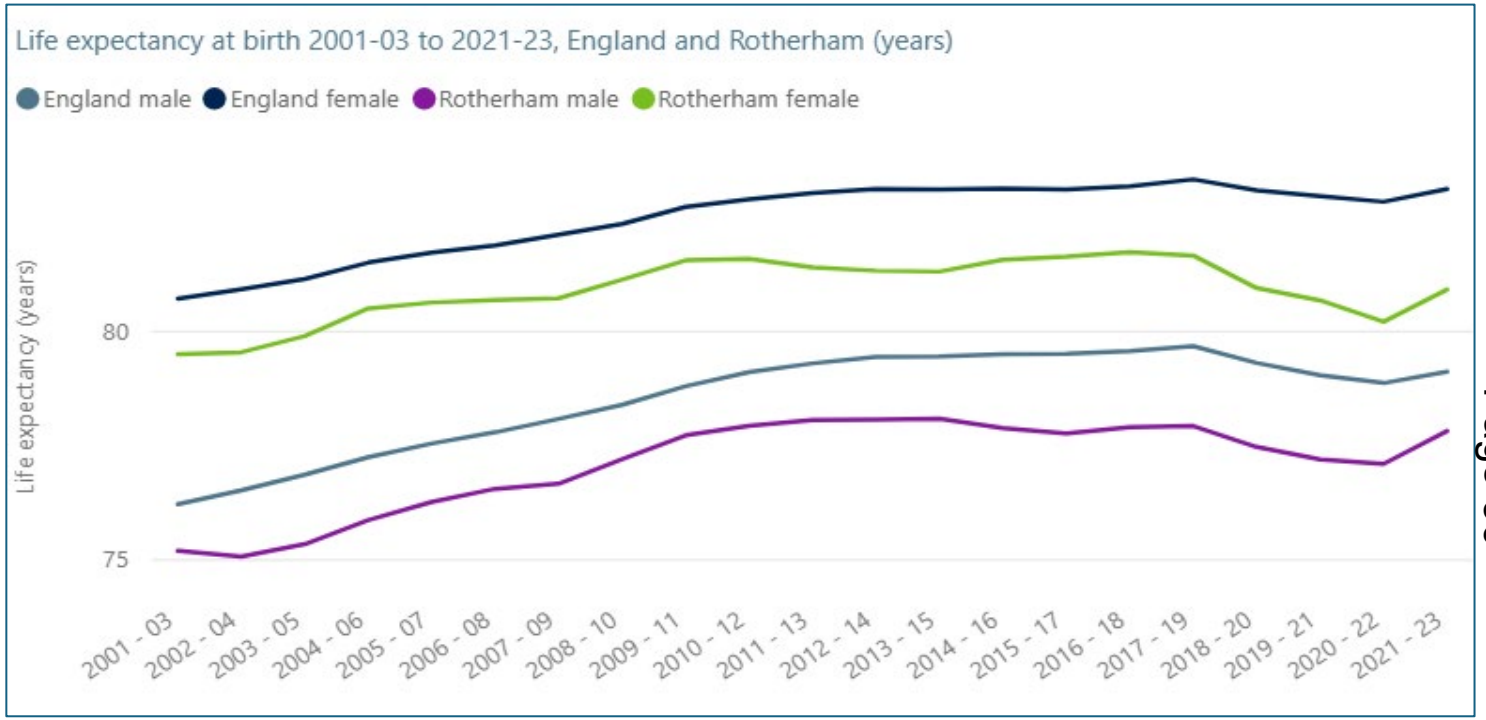


Renewed Women's Health Strategy for England - GOV.UK

Rotherham Women's Data



- 137,779 females in Rotherham (1)
- All age groups over 25 have more females than males



- Healthy life expectancy for Rotherham females is 56.5 (2)
- Healthy life expectancy for England females is 61.9
- Life expectancy at birth in Rotherham is 81.7 so the number of years lived in poor health is 25.2 (31%)

Rotherham Women's Data

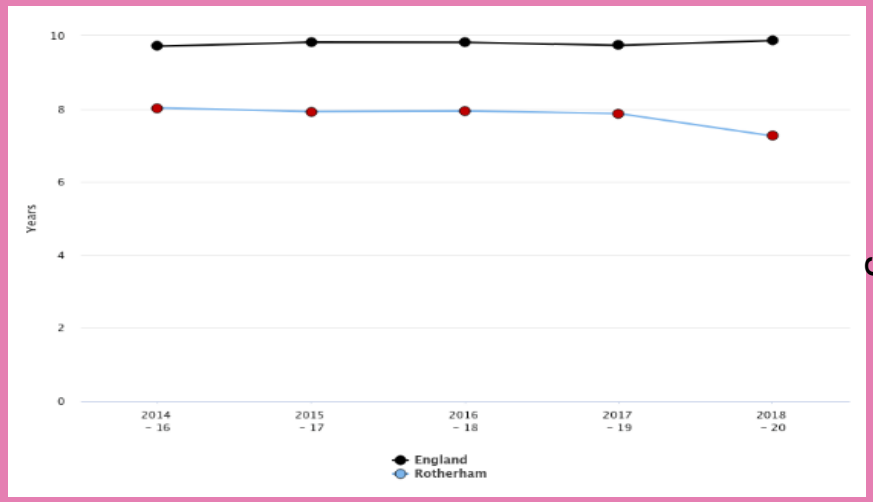
Housing

- Women spend 43% of earnings on rent vs. men at 28%. (3)
- Housing costs are 12 times women's annual earnings vs. 8 times for men (4)
- Only 8% of first-time buyers are single women compared to 18% being men

Food insecurity

- 40.8% of Rotherham's population live in areas at highest risk of food insecurity
- Lone parent households are most affected, and with 84% being led by women, this creates a disproportionate impact

Disability-free LE at 65 – Females



Chronic Pain
22% of females, 14.3% of males

‘Female A’s’ Journey – “I Shouldn’t Have to Beg”

A Positive Start: ‘Female A’ arrived in England 6 years ago and initially received compassionate, supportive healthcare in Rotherham. Staff communicated well, showed patience, and supported her mental health.

The Struggle to Be Heard: After moving and changing GP surgeries, Female A’s experience changed dramatically.
For 4 years, she suffered repeated urinary infections and severe pain. Despite repeated requests, she felt dismissed and unheard:

- Told repeatedly to “go to the pharmacy”. Requests for scans and investigation ignored.
- Concerns about side effects from antibiotics dismissed

Feeling Judged & Ignored:
Female A felt treated differently because of her nationality. She changed the way she spoke to healthcare workers in hopes of being listened to:
“Why do I have to try to be someone else?”

Impact on Her Life: Pain affected her sleep, work, relationships, and mental health. She eventually left her job due to ongoing illness. Felt hopeless and unsupported during her worst moments.

“I just want people to understand me and give me more time… I shouldn’t have to beg to be helped.”

Key Themes & Learning Points

What Went Wrong?

- Lack of listening and empathy
- Failure to investigate ongoing symptoms
- Poor continuity of care
- Communication barriers and perceived discrimination
- Over-reliance on repeat antibiotics instead of root-cause investigation

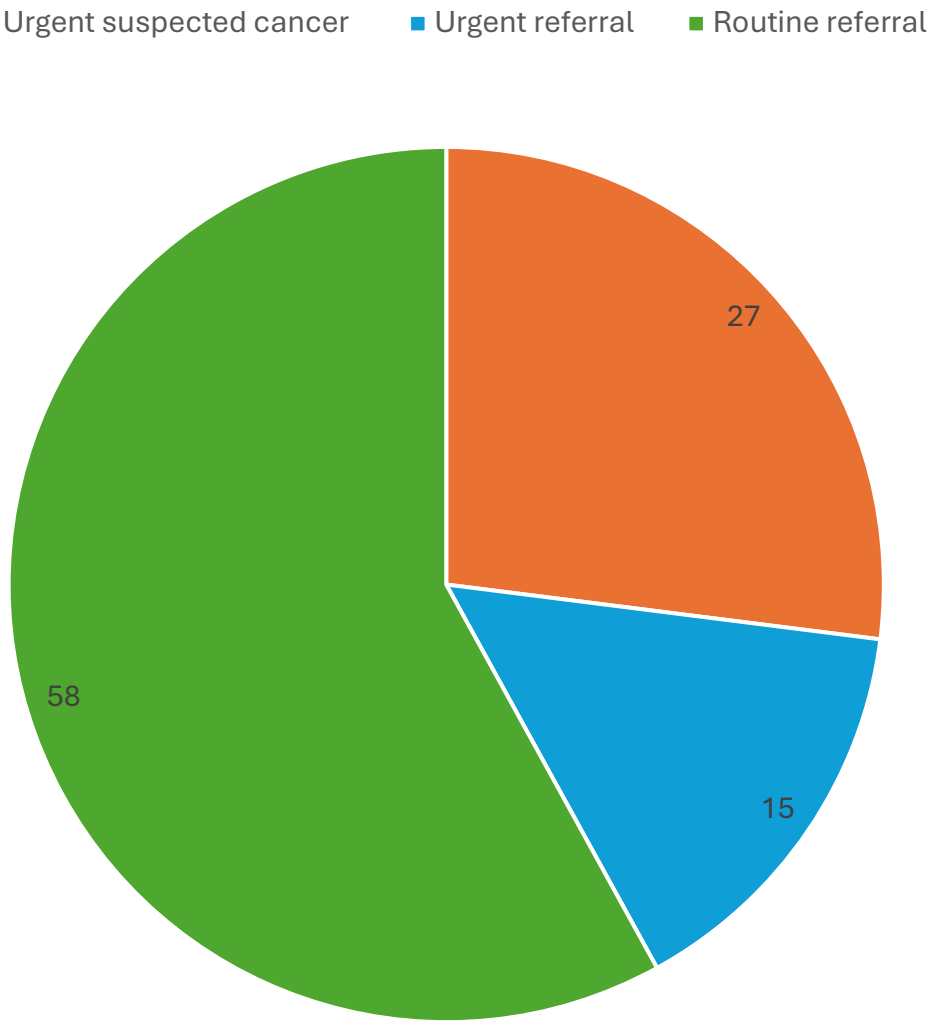
Lessons for Healthcare Professionals

- Listen to patients' lived experiences
- Build trust through empathy and continuity
- Avoid assumptions or dismissive responses
- Ensure culturally sensitive and equitable care
- Patients should never feel they must "fight" to be heard

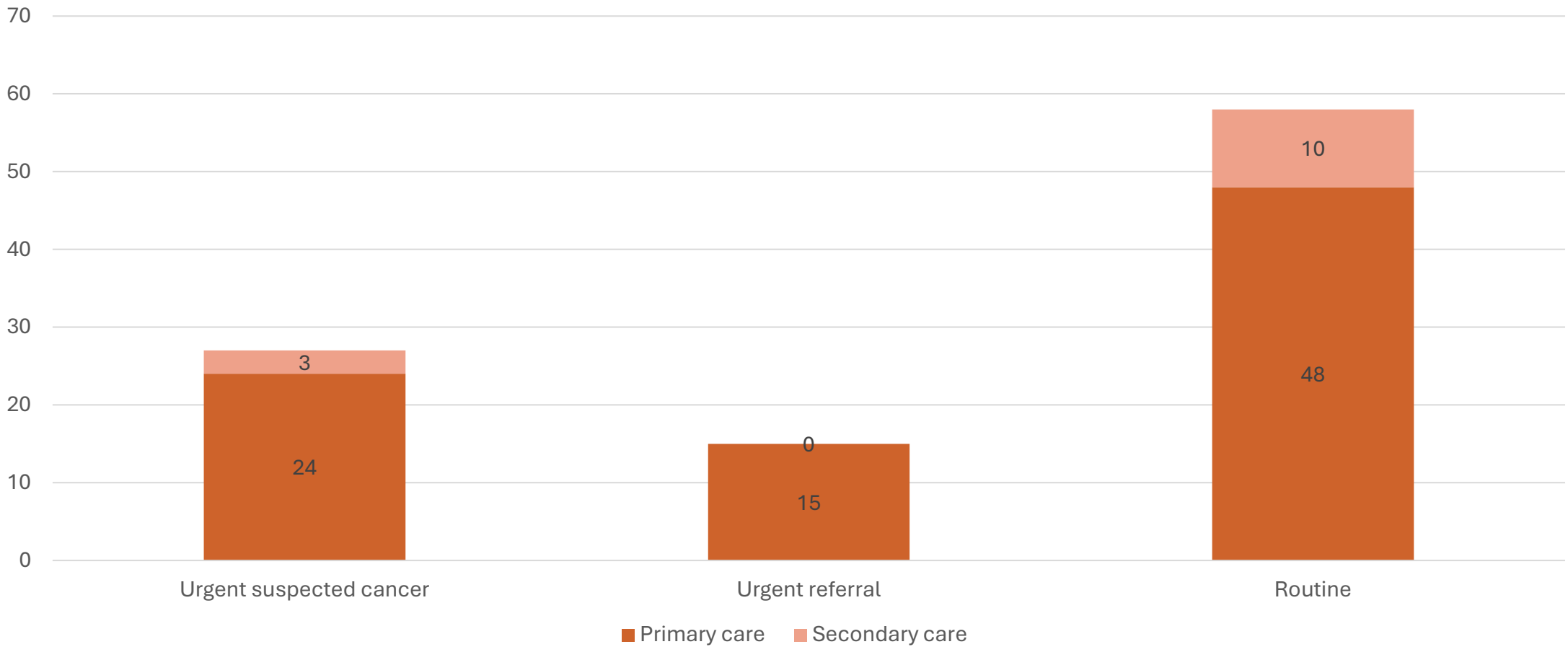
When patients feel unheard, the impact is not only physical — it affects dignity, trust, mental health, and quality of life.

Audit

- 100 records from consecutive Gynaecology outpatient appointments Jan 2025 (reviewed Jan 2026)



Origin of referral – primary/secondary care



Reasons for referral

Urgent suspected cancer referrals

- Imaging suggestive of cancer and/or raised Ca125 (ovarian cancer marker)
- Wait time 12 days

Urgent referrals

- Menorrhagia and abnormal bleeding
- Wait time 64 days

Routine referrals

- Menorrhagia, pelvic pain, endometriosis, abnormal bleeding patterns
- Wait time 253 days

Outcomes

Two Week Wait - 60% discharged at first appt (mainly PMB)
Abnormal imaging/Ca125 not discharged
3 cancers diagnosed (1 endometrial, 1 ovarian, 1renal)
4 ongoing monitoring of ovarian cysts

Urgent referrals - 47% discharged at first appt

Routine referrals - 12% discharged at first appt

Routine referral outcomes n=58

- 56% needed secondary care input and referral,
  - Secondary care input needed with imaging, treatments such as GnRH analogues, follow up of ovarian cysts and surgery such as laparoscopy/hysterectomy among other outcomes
- 19 patients could have had actions in primary care/hub setting prior to referral.

Number of patients	Other options at referral
2	HRT queries - could have been dealt with via A&G rather than a referral
9	Bleeding problems or pain – treated with Mirena coil or contraception - ?could have been done in a community hub
8	Bleeding problems or pain & had not had an ultrasound scan, swabs or blood tests prior to their secondary care gynecology appointment.

Conclusions

Long wait times for routine gynecology appointments

- 250 days.
- Proforma for referrals could help ensure appropriate tests done pre-referral eg swabs, scans etc
- CASES or community hub could help screen and review referrals and triage/appoint in a hub setting

Conclusions

Community/hub clinics

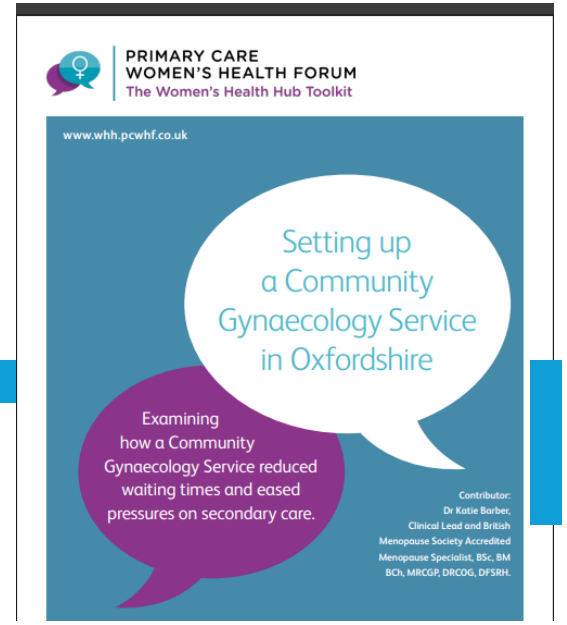
- Prescreening of referrals and triage to appropriate services/ tests
- Access to contraceptive, HRT and Mirena coils e.g. community gynecology clinics which is similar to other areas.
- Education for women for the treatment options eg coils
- Change in bleeding pattern over the age of 45 – community clinic or LES for endometrial pipelle prior to coil fit could avoid secondary care referrals.

There were potentially training needs for clinicians regarding recognizing cervical polyps, side effects of flushes on Depo-Provera and examining patients prior to 2ww for PMB for patients with a hysterectomy

There is a potential role for an ovarian cyst pathway - several patients had multiple ongoing reviews in secondary care following up ovarian cysts.

How could it work?

Oxford – referrals reviewed within 72hrs, appts at hubs/GP surgeries for 20-30min telephone/f2f, 25 clinical sessions/week (1/5th f2f, rest 50:50 triage/telephone)



Referrals

It was originally anticipated the community service would see 20% of the patients, with the remaining 80% still going to secondary care. However, the Community Hubs are managing between 45-55% of patients with approximately 45-55% being referred on to secondary care[1].

For example, an average month this year saw 650 referrals, 285 telephone contacts and 100 face to face consultations.

Examples of referral include:

- A 32-year-old with a dermoid cyst increasing in size – referred on to gynae. This model ensures that routine referrals with high cancer risk can be expedited on to secondary care gynae services.
- A patient whose HRT was not alleviating symptoms. Through simple EMIS record sharing, it was established that the solution would be to increase the dose, with a note sent to the GP to request this.

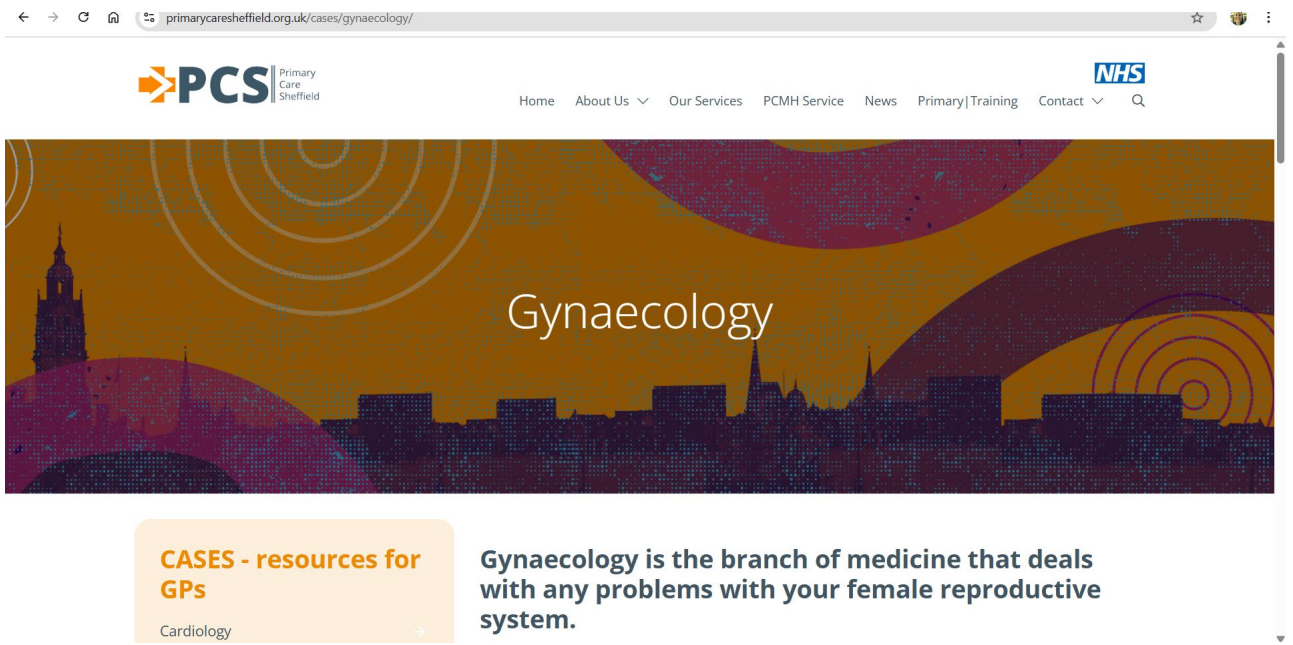
Appointments include face to face appointments and telephone consultations. Using laptops and telephone triage, GPs can work from home, their own surgeries or office based at one of the sites.

On average 6-8 cases are seen per hour by GP triage, if necessary, this can be flexed to suit the individual GP and patient requirements.

https://www.pcwhs.co.uk/_userfiles/pages/files/whh%20toolkit/settingupacommunitygynaecologyserviceinoxfordshire.pdf

Disparity across SY

- CASES in Sheffield
- ‘Overall CASES has resulted in an average 23.7% reduction in referrals across all specialties. ‘



https://primarycaresheffield.org.uk/wp-content/uploads/2023/02/Case-studies-brochure-7.pdf

Call To Action from the Rotherham Women's Network

Mainstream NHS spend + reprioritisation needed

Requires leadership focus on women's health

Commitment to specialist women's health centres in every region.
Expansion of community diagnostic centres (e.g. scans, tests for gynaecology)

Support for the expansion of the Rotherham Women's Health Network

(Admin support/Funding for a conference)

Creation of a women's Health HUB in Rotherham

References

1. Office for National Statistics. *Estimates of the population for England and Wales: mid-2023, local authority boundaries edition* [Internet]. Newport (UK): ONS; 2024 Jul 15 [cited 2025 Nov 4]. Available from: https://www.ons.gov.uk/file?uri=/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/estimatesofthepopulationforenglandandwales/mid20232023localauthorityboundarieseditionofthisdataset/mye23tablesew.xlsx

2. Office for Health Improvement and Disparities. *Public Health Outcomes Framework: Life expectancy and health indicators for Rotherham* [Internet]. London (UK): Department of Health and Social Care; 2025 [cited 2025 Nov 4]. Available from: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/4/gid/1000049/pat/15/par/E92000001/ati/502/are/E08000018/iid/90362/age/1/sex/2/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1

3. Women's Budget Group. Housing and gender: Spring Budget 2022 Pre-Budget Briefing [Internet]. London: WBG; 2022 Mar [cited 2025 Nov 6]. Available from: https://wbg.org.uk/wp-content/uploads/2022/03/Housing-and-gender-PBB-Spring-2022.pdf

4. Department for Communities and Local Government. English Housing Survey: First-time buyers, 2015–16 [Internet]. London: DCLG; 2018 [cited 2025 Nov 11]. Available from: https://assets.publishing.service.gov.uk/media/5a82461bed915d74e6236b5d/First_Time_Buyers_report.pdf

5. Office for Health Improvement & Disparities. Public Health Profiles [Internet]. London: Department of Health and Social Care; 2025 [cited 2025 Nov 4]. Available from: https://fingertips.phe.org.uk/search/food%20insecurity#page/1/gid/1/pat/6/ati/502/are/E08000018/iid/93864/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

6. Office for National Statistics. Families and households in the UK: 2022 [Internet]. Newport (UK): ONS; 2023 May 18 [cited 2025 Nov 4]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/families/bulletins/familiesandhouseholds/2022

7. Office for Health Improvement & Disparities. Public Health Profiles [Internet]. Fingertips; 2025 [cited 2025 Nov 7]. Available from: https://fingertips.phe.org.uk

8. Versus Arthritis. Back pain in Rotherham [Internet]. London: Versus Arthritis; [cited 2025 Nov 18]. Available from: https://www.arthritis-uk.org/media/13233/rotherham-back-pain.pdf

Agenda Item 8

Rotherham Metropolitan Borough Council

Public Report
Health Select Commission

Committee Name and Date of Committee Meeting
Health Select Commission – 18 June 2026

Report Title
Castle View Day Centre Transition Plan

Is this a Key Decision and has it been included on the Forward Plan?
No

Executive Director Approving Submission of the Report
Ian Spicer, Executive Director of Adult Care, Housing and Public Health

Report Author(s)
Helen Fisher, Head of Specialist Services, Adult Care
helen.fisher@rotherham.gov.uk

Caroline Hine, Change Lead, Adult Care
caroline.hine@rotherham.gov.uk

Ward(s) Affected
Borough-Wide

Report Summary
This report provides an update on the transition into the Castle View Day Centre from the existing two sites at Maple Avenue, Maltby and Elliot Centre, Herringthorpe.

The transition progressed well with strong engagement from customers, carers and staff, and a structured and phased approach. Transition to the Day Centre from the existing two sites began week commencing 11 May 2026 and completed week commencing 26 May 2026.

Recommendations

1. That Health Select Commission receive the update on the phased Castle View transition.

List of Appendices Included

None

Background Papers

1. Cabinet Report December 2021 - Proposals for the REACH Service
2. Cabinet Report update October 2022

Consideration by any other Council Committee, Scrutiny or Advisory Panel
None

Council Approval Required

No

Exempt from the Press and Public
No

Castle View Day Centre Transition Plan

1. Background

1.1 Castle View is a new purpose-built day support service for adults with Autism and Learning Disabilities.

1.2 It brings the service together into one operational building, rather than operating over two sites as has been the case for several years.

1.3 The transition programme has been designed to support delivery of modern, person-centered services in a timeframe that suits the individuals and their needs.

1.4 The service was previously known as REACH Day Services and has now been renamed to Castle View.

1.5 In total there are 38 customers who attend the service, of these 4 are fully funded by Health.

1.6 There are 35 members of staff plus 1 admin and 3 managers.

2. Key Issues

2.1 Customers have received reviews of their needs, completed by Adult Social Care, prior to any move taking place.

2.2 Transitions have been timetabled based on the needs of each individual to ensure they have the correct support.

2.3 Staff consultation took place between 12 November 2026 and 12 December 2026 to engage with the team around the new operating model.

3. Options considered and recommended proposal

3.1 Options considered around the transition were:

1. Move all customers and staff in from a specific date

2. Stagger the transition to allow a phased approach to occupation

3.2 The recommended option was a phased transition, operating over three sites for a period of three weeks.

3.3 This ensured all staff and customers were able to safely transition and it was done with care and compassion, giving people the time they needed to adjust to a new setting.

3.4 Handing back the previous buildings took place on Monday 1 June 2026.

4. Consultation on proposal

4.1 The initial consultation period took place between 31 January 2022 and 30 April 2022. This was a 90 day public consultation to establish the views and needs of users of the REACH Day Service, their families, and carers and younger people preparing for adulthood, regarding the new service offer.

4.2 The outcomes were presented to Cabinet in October 2022, the approved option was for the Service to operate from one large newbuild centrally located building, complimented by community outreach support across the borough to support access to local communities.

4.3 Staff were consulted on the new operating model in conjunction with colleagues from HR.

4.4 Customers and their families / carers were kept updated with details of the build as it progressed and timelines for reviews and transition dates. This was done via newsletters and regular Parents and Carers meetings.

5. Timetable and Accountability for Implementing this Decision

5.1 Transition into Castle View Day Centre transition began w/c 11 May 2026 with this due to be complete by w/c 1 June 2026.

5.2 Completion took place earlier than expected due to customers asking to transition sooner than planned:

5.3 13 – 15 May 2026 the number of customers each day was between 6/8 with the support of 6/7 staff

5.4 18 – 22 May 2026 the number of customers each day was between 14 & 17 with the support of 6/9 staff

5.5 25 – 29 May the number of customers each day was between 22 & 30 with the support of 15/16 staff

Total of customers transitioned by weeks

5.6 Week 1 – 7 customers
Week 2 – 25 customers
Week 3 – (end of) All fully transitioned

Accountable Officer(s)
Helen Fisher, Head of Specialist Services
Caroline Hine, Change Lead

Report Author:

Helen Fisher, Head of Specialist Services, Adult Care
helen.fisher@rotherham.gov.uk

Caroline Hine
caroline.hine@rotherham.gov.uk

This page is intentionally left blank

Castle View Day Centre

Health Select Commission

18 June 2026

Castle View Day Centre - Canklow

Castle View Day Centre Overview

Purpose-built centre delivering high-quality, person-Centred day opportunities for adults with autism and learning disabilities.

There are 38 customers who regularly attend. They are supported by 35 members of staff, plus 1 admin officer and 3 managers.

The new high-tech building offers level access throughout, access to outside spaces and a high-tech sensory room. The building is air conditioned to ensure a regulated temperature at all times.

There are flexible spaces which can be tailored to suit the needs of those using the service. There is a light and airy feel throughout with a high standard of fit out.

Compassionate Change Management – The approach emphasized delivering change with care, compassion, and respect for each person's unique circumstances.

Transition and Consolidation – Summary of service change rationale and progress moving customers and staff from 2 previous sites into one location.

Engagement and Outcomes – Highlights consultation activities, key milestones, and compassionate implementation ensuring strong stakeholder engagement.

Public consultation

Public Consultation Process

Initial public consultation shaped service direction and confirmed support for modernization, this took place between January and April 2022. This was a 90 day public consultation to establish the views and needs of users of the REACH Day Service, their families, and carers and younger people preparing for adulthood, regarding the new service offer.

The outcomes were presented to Cabinet in October 2022, the approved option was for the Service to operate from one large newbuild centrally located building, complimented by community outreach support across the borough to support access to local communities.

Staff Engagement

Staff and Human Resources collaborated on the new operating model and working arrangements in November and December 2025.

Customer and Family Communication

Regular updates were provided to customers and families during the build and transition phases via newsletters and face to face information sessions.

There were some conversations with families around the transition planning and use of transport. Some families were concerned about the limited level of input they had to the new building.

Building Trust and Managing Expectations

Ongoing engagement helped address concerns promptly and built trust with stakeholders.

Options Considered

Single Date Transition

Moving all customers and staff on one specified date was quicker but posed higher risks of anxiety and disruption. Some customers have specific equipment which needed to be transferred between sites.

There could have been the potential for service disruption as equipment would need testing prior to use following the move.

Transport options could have been a simple switch from drop-off and collection at the same venue.

Phased Transition Approach (option chosen)

A staggered, phased transition allowed gradual adjustment, supporting individuals and reducing operational risks. The service closed for two days, to allow removals of equipment to take place in a safe environment.

Transport options posed challenges as they were asked to operate via three sites, which caused some updating of timetables for the management team responsible.

Staffing levels were not affected by running over three sites due to careful rota management and customer placements within the transition scheduling.

Person-Centred Values

The recommended phased approach aligned with compassionate, flexible, person-Centred service values. It gave the greatest benefit for all customers and staff.

Transition Programme

Successful Site Consolidation

Transition from two sites, The Elliott Centre in Herringthorpe (NHS owned building and site) and Maple Avenue in Maltby (RMBC owned) , into one modern facility progressed well with strong engagement from customers, carers, and staff.

Phased Approach Benefits

A phased approach was deliberately chosen to minimise anxiety, manage risk, and allow individuals to move at a pace that suited their needs.

Transition activity began in the week commencing **11 May 2026** and was completed earlier than anticipated due to positive customer readiness and confidence week commencing **26 May 2026**.

Transitions were scheduled to occur when individuals felt ready, reducing anxiety and boosting confidence.

Staff were given time to familiarize themselves gradually with new environments, routines, and operating models.

Focus on Safety and Dignity

Throughout the transition, safety, dignity, and person-Centred practice were prioritized to ensure positive outcomes.

The programme focused on individual needs through detailed reviews conducted by Adult Social Care prior to transition.

Transition Timeline

Structured Transition Timeline

The transition was planned from 11 May to 1 June 2026, allowing gradual attendance and staffing growth.

Accelerated Progress

Transition advanced faster as customers were ready earlier, showing flexibility in the plan.

Effective Preparation and Support

Early completion highlights strong preparation, communication, and ongoing support during transition.

Week One

Week one had 6 to 8 daily customers with 6 to 7 staff, establishing routines and environment.

Week Two

Customer attendance increased to 14-17 daily with staff levels adjusted to support growth.

Week Three

Attendance reached 22-30 customers daily with 15 to 16 staff, fully transitioning all customers.

Staged Scaling Success

The staged increase in customers and staff ensured safe and effective scaling of activity and support.

Key Issues

Customer Experience Safety

Ensuring customers had a safe, positive move with minimal disruption was a primary focus during transition.

Staff Consultation and Engagement

Consulting staff about the new operating model helped build understanding and readiness for change. Staff were able to visit the site prior to opening to familiarize themselves with the new layout and receive training on new high-tech equipment.

Continuity of Care

Maintaining seamless care across old and new sites was critical to ensure ongoing support during the transition.

Proactive Transition Management

Careful planning, clear communication, and flexibility ensured smooth progress and stakeholder confidence.

Benefit Delivery

It is expected that the transition into Castle View from two separate, dated and unsuitable buildings will have a positive impact on the wellbeing of all users.

The change of building feeling is an intangible and unmeasurable benefit to all customers, staff and families.

The modern equipment and level access facilities, the light and airy feel, the ability to move freely and access to external areas is something they have not always had at previous settings.

Customers and staff have all commented on how big the building feels, on how nice it is and how much it will improve lives.

Operational Delivery

Maintaining Care Standards

Focus was on maintaining high standards of care while gradually increasing activity in the new centre during transition.

Staffing and Support Alignment

Staffing levels were aligned to customer numbers and needs, ensuring appropriate support and supervision daily.

Effective Coordination and Communication

Leadership managed clear coordination and communication between old and new sites during the transition period.

Smooth Handover Process

Staff familiarised with new building, equipment, and routines while delivering consistent care for a smooth handover.

Successful Transition

All customers moved into the new Castle View Day Centre, marking a significant achievement in service relocation.

Previous buildings were formally handed back on 1 June 2026.

Positive Stakeholder Feedback

Feedback from customers, families, and staff shows strong engagement and growing confidence in the new environment.

Milestone in Service Delivery

The transition completion marks progress in delivering person-Centred, modern services across the borough.

Safe and Compassionate Change

The programme showed that careful planning and engagement enabled safe, compassionate large-scale service change.

This page is intentionally left blank

Health Select Commission – Work Programme 2026-2027

Chair: Cllr Keenan **Vice-Chair: Cllr Yasseer**
Governance Advisor: Kerry Grinsill-Clinton **Link Officer: Emily Parry-Harries**

The following principles were endorsed by OSMB at its meeting of 5 July 2023 as criteria to long/short list each of the commission's respective priorities:

Establish as a starting point:
- What are the key issues?
- What is the desired outcome?

Agree principles for longlisting:
- Can scrutiny add value or influence?
- Is this being looked at elsewhere?
- Is this a priority for the council or community?

Developing a consistent shortlisting criteria e.g.
- T: Time: is it the tight time, enough resources?
- O: Others: is this duplicating the work of another body?
- P: Performance: can scrutiny make a difference
- I: Interest: what is the interest to the public?
- C: Contribution to the corporate plan

Meeting Date	Responsible Officer	Agenda Item
18-Jun-26	Cllr Baker-Rogers, Caroline Hine and Helen Fisher Nasreen Iqbal, Dr Linda Strettle Governance Advisor	Castle View Transition Plan Rotherham Women's Health Network Introduction and Overview Nominate Representative to Health, Safety and Welfare Panel
23-Jul-26	Denise Littlewood Simon Langmead	Immunisation Programme Commissioning Changes Primary Care Network (PCN) Development
24-Sep-26	Cllr Baker-Rogers, Gilly Brenner, Carole Foster Cllr Williams, Simon Moss, Cllr Baker-Rogers, Gilly Brenner	Physical Activity for Health (Sport England Main Bid and progress update) Health Hub Development Phase 2
19-Nov-26	Steph Watt, Emily Parry-Harries, Bob Kirton Jackie Scantlebury, Moira Wilson, Sally Morris- Shaw and Cllr Baker-Rogers Cllr Baker-Rogers	Place Partners Winter Plan 26/27 Rotherham Safeguarding Adults Board Annual Report and 2025-2028 Strategic Plan Delivery Updat Health and Wellbeing Board Annual Report (For Information Only)
21-Jan-27	Bob Kirton, Helen Dobson, Jodie Roberts Cllr Baker-Rogers, Kirsty Littlewood, Dania Pritchard Emily Parry-Harries	TRFT Annual Report Adult Social Care Strategy 2027-2032 (Pre-Decision Scrutiny)?? Director of Public Health's Annual Report (For Information Only)
18-Mar-27	Garry Parvin Cllr Baker-Rogers, Kirsty Littlewood	All Age Autism Strategy Pre-Decision Scrutiny Castle View 6 Month Post Implementation Update
13-May-27	Vacant Slot Vacant Slot	Vacant Slot Vacant Slot

Substantive Items for Scheduling

Reviews for Scheduling

2026/27 municipal year		Access to NHS Dentistry Review

Items to be Considered by Other Means (e.g. off-agenda briefing, workshop etc)

Sep-26	Garry Parvin	Consultation/Co-production enagagement with HSC re All Age Autism Strategy Refresh
April/May 2027	Kerry Grinsill-Clinton, Cllr Keenan	Quality Accounts

Items for Future Consideration

TBC	Bob Kirton	ERCP Reintroduction at TRFT
Mid-Late 2027	Cllr Baker-Rogers, Holly Smith, Scott Matthewman	Adult Social Care Mental Health Strategy - Mid point review of delivery
TBC	TBC	RDaSH Neurodiversity Waiting Times Reduction Strategy
TBC	TBC	RDaSH Workforce Culture and Safety Strategy
TBC	TBC	TRFT Learning from Incidents and Impact on Front-Line Service Delivery
TBC	TBC	TRFT's Understanding of and Action in Respone to the Impact of Health Inequalities on Day-to-Day Operations
TBC	TBC	System Pressures Affecting Frail and End of Life Patients Across Place Partners, and How to Addre These

The Health Select Commission Terms of Reference - Revised 2025

All Scrutiny Commissions Functions

1. To carry out the annual overview and scrutiny work programme as agreed for each select commission with OSMB.

2. To submit reports to OSMB with recommendations on matters that affect the borough or the inhabitants of the borough.

3. Within their terms of reference, each Select Commission may:

    a. scrutinise and review the performance of the Council in relation to its policy objectives, performance targets and/or particular service areas;

    b. question Cabinet Members and Chief Officers about their decisions and performance, in relation to particular decisions, initiatives or projects;

    c. make recommendations to the Cabinet and appropriate Committee and/or Council arising from the outcome of the scrutiny process;

    d. review and scrutinise the performance of other partners and public bodies in the area and invite reports from them by requesting them to address the Committee and local people about their activities;

    e. conduct research, community and other consultation in the analysis of policy issues and possible options;

    f. question and gather evidence from any person (with their consent); and in liaison with OSMB, appoint non-voting co-optees to the Select Commissions and/or Task and Finish Groups.

Health Select Commission Specific Functions

1. To discharge the local authority's powers of review and scrutiny on such health related matters as designated within the Health and Social Care Act 2012, Statutory Instrument No. 218/2013 - The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 and associated Department of Health Guidance.

2. The Health Select Commission is tasked with carrying out in-depth overview and scrutiny as directed by the OSMB, including scrutinising:

    a. Adult Social Services including adult safeguarding, services for older people, a range of services to meet the needs of people with learning disabilities, support

for people with mental health issues and dementia, and services to support people with physical disabilities

b. Arrangements from childhood to adulthood for people with complex needs (with Improving Lives)

c. Partnerships and commissioning arrangements in relation to health and well-being and their governance arrangements and the integration of health and social care services, including prevention/early intervention activity

d. Measures for achieving health improvements and the promotion of wellbeing for Rotherham's adults and children;

e. Measures designed to address health inequalities; Revised May 2026

f. Scrutinising public health arrangements;

g. Issues referred to the select commission by the Healthwatch Rotherham (or any successor body).

3. The Health Select Commission is appointed to be part of the South Yorkshire, Derbyshire and Nottinghamshire Joint Health Overview and Scrutiny Committee under Regulation 30 of the Local Authority (Public Health, Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218. The joint committee is authorised to discharge the following health overview and scrutiny functions of the authority (in accordance with regulations issued under Section 244 National Health Service Act 2006) in relation to health service reconfigurations or any health service related issues covering this geographical footprint.