HEALTH SELECT COMMISSION
Thursday 26 March 2026

Present:- Councillor Keenan (in the Chair); Councillors Adair, Ahmed, Brent, Clarke, Garnett, Harper, Tarmey, Thorp, Fisher and Harrison.

Apologies for absence:- Apologies were received from Yasseen, Duncan, Havard and David Gill (Co-optee).

The following Officers and Partners were in attendance:

Kym Gleeson, Manager of Healthwatch Rotherham
Emily Parry-Harries, Director of Public Health/Health Select Commission Link Officer
Ian Spicer, Executive Director of Adult Care, Housing and Public Health
Bob Kirton, Managing Director, The Rotherham NHS Foundation Trust (TRFT)
Jodie Roberts, Operations Director, TRFT
Jo Evans, Improvement Director, Sheffield Teaching Hospitals
Richard Maxted, Operations Director, Sheffield Teaching Hospitals
Mark Tuckett, Chief Strategy Officer, Sheffield Teaching Hospitals
Julia Jessop, Managing Director, South Yorkshire and Bassetlaw Cancer Alliance

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

53. MINUTES OF THE PREVIOUS MEETING HELD ON 22 JANUARY 2026

Resolved:-

That the minutes of the meeting held on 22 January 2026 were approved as a true and correct record of the proceedings.

54. DECLARATIONS OF INTEREST

The following declarations of interest were made:-

Member	Agenda Item	Interest Type	Nature of Interest
Councillor Fisher	Agenda Item 7	Personal Interest	Partners employment within organisation.

55. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

56. 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.

57. SOUTH YORKSHIRE CANCER ALLIANCE LUNG CLINIC UPDATE

This item was to receive an update report and presentation in relation to the Non-Surgical Oncology Transformation Programme and resultant Joint Lung Clinic implementation serving both Rotherham and Barnsley patients from the Rotherham Hospital site.

Members had previously received information regarding the proposals for the Lung Clinic in May 2025, following a broader update provided to the South Yorkshire, Derbyshire and Nottinghamshire Joint Health Overview and Scrutiny Committee earlier that year. Consideration of this item was augmented by a site visit to the facility undertaken by members of the Health Select Commission, along with their counterparts from Barnsley Council on 19 March 2026. The Chair offered sincere thanks to all of the staff involved in supporting that valuable scrutiny activity.

The Chair welcomed Jo Evans, Improvement Director, Specialised Cancer Services at Sheffield Teaching Hospitals, Richard Maxted, Operations Director, Specialised Cancer Services at Sheffield Teaching Hospitals, Mark Tuckett, Chief Strategy Officer at Sheffield Teaching Hospitals and Julia Jessop, South Yorkshire and Bassetlaw Cancer Alliance Managing Director to the meeting and invited them to introduce the report and presentation.

The Chief Strategy Officer at Sheffield Teaching Hospitals explained that the purpose of the presentation was to report on progress since implementation of the Joint Lung Clinic, and noted their expectation that Members had had the opportunity to read and digest the report provided in the agenda pack ahead of the meeting, and noted that some members had visited the clinic.

They set out the intended flow of the presentation:

- Context
- What had been implemented
- How it was operating
- Next steps

The Improvement Director, Specialised Cancer Services at Sheffield Teaching Hospitals described their role in co-ordinating the work to open and embed the Joint Clinic.

They summarised the case for change which was a national shortage of Consultant Oncologists alongside rising demand driven by new

treatments and increasingly complex pathways, compounded by regional variation that created uneven patient experiences and inconsistent service resilience.

The Improvement Director explained that these pressures had led to the Non-Surgical Oncology (NSO) Transformation Programme. Although this had started with outpatient redesign, it had broadened to consider end-to-end pathways, including how outpatient assessment and decision-making shaped the onward patient journey.

They outlined the programme's aims which were:

- To improve clinical safety and reduce clinical risk
- Address inequalities in access and experience across the region
- Strengthen workforce sustainability by planning around known workforce constraints

They added that the programme had been organised into three phases and that the Joint Lung Clinic sat in Phase 1, the 'Stabilisation' phase.

The Improvement Director explained that the model for Barnsley and Rotherham patients had been shaped by patient, public and staff feedback. There was the need to consolidate the number of sites providing face-to-face appointments, as the system did not have sufficient consultant capacity to run multiple separate clinics with the required resilience.

They explained that the change was expected to:

- Increase consultant cover and senior oversight so clinics were less vulnerable to single-handed working and vulnerabilities through absence
- To standardise pathways and reduce unwarranted variation so care felt consistent regardless of postcode
- To minimise unnecessary travel and, where possible, offer appointments closer to home for patients needing face-to-face review.

The presentation then turned to Lung Outpatients specifically, describing that the service had historically relied on a single consultant providing outpatient support with one located in Barnsley and one in Rotherham. That separate clinic model left little resilience. They explained that initially, telephone appointments had been increased where clinically appropriate, but when face-to-face review was required Barnsley patients had often travelled to Weston Park Cancer Centre, creating a level of travel that was inconsistent with arrangements elsewhere.

They described the Joint Lung Clinic as a measure intended to reduce variation and create a more robust outpatient model and outlined how an options appraisal had recommended locating the joint clinic in Rotherham, building on the existing Rotherham Clinic and consolidating Barnsley

patients and the Barnsley consultant into a single combined service.

They outlined the establishment of a multidisciplinary working group that comprised of clinical and non-clinical colleagues from Sheffield, Barnsley and Rotherham that met weekly to prepare for launch ahead of the implementation and noted that the Sheffield involvement reflected the wider referral relationship with Weston Park Cancer Centre even though the outpatient clinic delivery for this cohort took place in Rotherham.

They confirmed that the Joint Clinic had gone live on 27 November 2025. Operational readiness had centred on clear communication and standardisation. Patient information leaflets had been designed and tested with a patient group and refined for clarity, and staff were supported with jointly developed Standard Operating Procedures and documentation to ensure consistent ways of working.

Reflecting on the early position since 'go-live', the Improvement Director noted that experiences shared indicated improved patient and clinical safety through increased resilience and senior cover, with a combined team in one location providing oversight if one consultant was unavailable, supporting continuity and reducing the risk of service disruption.

They clarified that the change related to Outpatient Clinics and that treatment continued to be delivered locally for both Barnsley and Rotherham patients, and added that the practical impact on Rotherham patients had been limited in terms of appointment day, location and process, whilst the system monitored whether the combined model created any detriment for either population.

They explained that an evaluation framework had been agreed drawing on patient engagement which focussed on what mattered to patients, staff engagement which focussed on workforce and operational issues, alongside feedback from forums such as the Health Select Commission which focussed on assurance and impact.

As the Joint Clinic had only operated since 27 November 2025, it was acknowledged that there were limitations to the available evaluation data, the offer to return after a 12-month evaluation to allow more robust assessment of trends and outcomes was reiterated. Nonetheless, it was noted that in that context early months showed a reduction in Barnsley referrals, which the team had reviewed and interpreted as likely natural variation influenced by fluctuation and seasonal effects which had reinforced the need for longer-term evaluation to validate assumptions made.

The Improvement Director summarised the information gleaned from the patient questionnaire. 52 patients had responded when the presentation was prepared, which had risen to 79 on the day of the meeting, but noted that the additional responses had not changed the themes identified in the

report.

Feedback was largely positive about the care received at Rotherham, including staff interactions, reception welcome and the clinic environment with 93% of respondents said they had been informed about the change, although one person reported not feeling informed and had needed to ring for clarity.

They explained that there had been issues with appointment letters from the Sheffield side, but these were largely resolved. It was reported that the most consistent negative theme was parking at the Rotherham Hospital site. The Improvement Director indicated that the question had been included deliberately because transport and travel had formed part of the considerations that had led to the identification of Rotherham Hospital as the preferred Joint Clinic site. They confirmed that they had made TRFT aware of the feedback, whilst noting it was not within Sheffield Teaching Hospitals' or the Cancer Alliance's direct control to remedy.

The Improvement Director also outlined staff feedback, which reflected that the Clinic set-up and jointly developed SOPs had supported clearer expectations and more consistent processes. They identified IT and specifically Wi-Fi connectivity as an ongoing operational challenge that was being addressed in conjunction with the relevant TRFT staff. They particularly highlighted a positive cultural impact in that the Barnsley team had felt incredibly welcomed by Rotherham colleagues and in day-to-day practice, staff had worked cohesively, such that organisational boundaries were barely distinguishable.

The Chair invited questions and comments from members in relation to the report and presentation.

Councillor Brent queried the adequacy and reliability of communication methods with patients along the cancer pathway. They wanted to understand how standard communications operated before and after appointments or treatments, and how the service accounted for communication failures, particularly given increasing reliance on electronic patient records and the risks that poor communication could delay diagnosis or treatment.

Richard Maxted, Operations Director for Specialised Cancer Services at Sheffield Teaching Hospitals explained that once a referral was received, the patient's details were logged into the electronic patient record (EPR) and the patient was contacted by telephone to arrange an appointment. This phone call was used to ensure the patient had heard and understood the appointment details, which significantly increased attendance reliability. A written confirmation letter was then issued. Following appointments, letters summarising outcomes and next steps were issued both to patients and, where appropriate, clinicians and GPs.

They also described how communication failures were identified and explained that all cancer pathway patients were ‘tracked’ which meant their progress was monitored at every stage. If a patient failed to attend an appointment, the service contacted them to explore reasons. Sometimes this was because of outdated contact details and sometimes due to disengagement related to the emotional burden of diagnosis. In the latter case, Clinical Nurse Specialists often telephoned patients to check on wellbeing and encourage re-engagement.

Councillor Brent raised sought reassurances regarding oncologist shortages particularly in the context of staffing gaps contributing to diagnosis and treatment delays.

The Operations Director provided broader context and clarified that the shortage stemmed partly from workforce planning issues arising from a reduced number of junior doctors choosing oncology, and partly from consultants retiring earlier than predicted during the pandemic. They noted a longstanding disparity between the north and south of England with respect to consultant numbers, with the north having fewer oncologists relative to population need but reassured members that significant efforts had been made to improve that position with recent indications of an improved position as a result of successful recruitment campaigns and other innovative approaches to retaining talent beyond training rotations. Those approaches included a focus on improving the appeal of the workplace, enhancing specialist registrar experiences to encourage them to stay, and workforce diversification. To qualify that they explained that whilst consultants remained essential for initial treatment planning, ongoing monitoring could often be conducted by advanced practitioners, junior doctors, and other staff. They described a shift to ‘consultant-led and team-delivered’ model which provided resilience amid both rising demand and workforce shortages.

Councillor Harper enquired about service resilience in the Joint Clinic, specifically, the response when one of the two consultants were absent.

The Operations Director explained that historically, lone consultants prepared their teams in advance of leave however, the new joint working arrangement ensured that one senior consultant would always be present, as the two consultants coordinated leave. In cases of long-term absence, the service would seek locum support or redistribution of consultant cover across the region. Training junior and advanced staff to work across both consultants’ teams had further improved service resilience.

Councillor Harrison wanted to understand whether there were any factors under the Joint Clinic model that could compromise safe cover.

The Operations Director reiterated that planned leave was carefully coordinated, and whilst there was always the possibility of unexpected medium or long-term sickness, this would be mitigated through redeployment within the wider regional consultant pool or use of locums if

required. No other factors were expressed as being considered to have the potential to compromise safe cover.

Councillor Harper wanted to understand long-term succession planning given recruitment difficulties cited.

The Operations Director explained the training pathway from medical school through foundation years and into specialty training. They described how early interests developed and how Sheffield sought to create positive experiences for trainees entering oncology to encourage retention. The service monitored expected CCT (Certificate of Completion of Training) dates to anticipate future gaps and influence training rotations. The Chief Strategy Officer added that although recruitment remained challenging, the situation had improved compared with three or four years earlier, and highlighted recent successful consultant appointments where other centres had failed to recruit.

Councillor Clarke referred to concerns about transport and parking reflected in patient feedback. They welcomed efforts to review transport, particularly given that 13% of patients relied on taxis which represented an unwelcome additional financial burden that had the potential to further disadvantage cancer patients who may already be exposed to financial vulnerabilities. Of further concern was the low satisfaction rate with car parking at the hospital site and the effect of stress and anxiety caused by overcrowded and often dangerous parking conditions on cancer patients and their families who were undoubtedly already managing challenging personal circumstances.

The Operations Director acknowledged those concerns, and recognised the challenge across many hospital sites. They described a potential role for Western Park Cancer Charity, which operated minibus routes from several locations, although demand from Rotherham had been limited to date. There was the possibility of creating a combined Barnsley to Rotherham route, but only where sufficient patient demand emerged.

Bob Kirton, Managing Director of Rotherham Hospital acknowledged the parking issues at Rotherham Hospital. They outlined recent steps taking to improve parking organisation and availability which had included:

- Creating 200 new staff parking spaces to free patient spaces
- Implementing ANPR
- Plans to introduce enforcement to address unsafe parking behaviours

They described that a new estates strategy was under development, with the potential to revisit a previous application for a multi-storey car park at the hospital site. They further noted ongoing discussions with the Council and South Yorkshire Transport, and in turn SYMCA (South Yorkshire Mayoral Combined Authority) about improving public transport access.

Councillor Tarmey commented that issues with parking at the hospital was

a frequent cause of complaint to Ward Members, but emphasised the need to balance the enforcement response with the need for compassion carefully to not cause further distress. They suggested that the relevant Council Service could consider the sufficiency of the roads infrastructure and enforcement around the hospital site to consider whether anything could be done to help TRFT manage the issue given its impact on Rotherham residents.

The Chair agreed that a recommendation could be made to explore Councillor Tarmey's suggestion.

The Councillor Clarke was concerned that the patient survey, notwithstanding the increased number or responses at the time of discussion, was too short-term and small to be considered a representative sample yielding meaningful data for analysis and asked whether there was scope to extend beyond the planned conclusion in March 2026.

The Improvement Director confirmed survey uptake was strong and aided by the simple in clinic delivery approach, and gave an undertaking to continue collecting responses as part of the 12-month evaluation.

Councillor Fisher queried whether there had been any unintended consequences, either positive or negative, from the establishment of the Joint Clinic.

The Improvement Director noted that staff had initially been apprehensive but found unexpected benefits, such as strong teamworking and a welcoming environment at Rotherham. A survey of staff experiences would be included in the evaluation which would seek to capture more detail regarding similar unintended consequences.

Councillor Brent wanted to know whether lessons learned from the experience of establishing the Joint Clinic and from the patient survey would be shared with TRFT, to allow dissemination of good practice and to further harness the power of collaborative working within the system. The Improvement Director confirmed that this was already being explored, as Rotherham Hospital had expressed interest in applying the insights elsewhere within the hospital's operations.

Councillor Harrison was keen to understand whether the Joint Clinic had generated any efficiency savings and who would be responsible for commissioning a permanent solution for Non-Surgical Oncology in Rotherham.

The Operations Director confirmed that the Joint Clinic was cost-neutral excepting for travel expenses for Barnsley staff. The South Yorkshire and Bassetlaw Cancer Alliance Managing Director clarified that outpatient redesign was the responsibility of the Integrated Care Board, whilst specialised commissioning involved NHS England. They clarified that the

aim of establishment of the Joint Clinic was improved patient experience and outcomes rather than cost reduction.

Councillor Thorp was concerned about the ratio of face-to-face versus telephone appointments, and in particular the variation between Clinics.

The Operations Director explained that distance and patient preference were key factors, particularly in the context of appointments in Sheffield. First appointments were usually face-to-face, but follow-up clinical checks could be conducted via phone where appropriate. The Improvement Director added that Barnsley numbers reflected a temporary backlog of telephone consultations due to earlier space constraints, and potentially a familiarity and comfort with the approach taken regarding telephone appointments prior to the Joint Clinic's implementation. The expectation remained that there would be gradual return to more balanced provision.

Councillor Harper reflected on the practical challenges experienced by clinicians, raising concerns shared with Members during the site visit in relation to the reliability of Wi-Fi connectivity in clinical spaces. The Improvement Director advised that they understood that this was a longstanding issue in that part of the hospital building and did not affect Joint Clinic staff in isolation. They were working with staff at TRFT to address the issue, with wired connectivity in clinical spaces one proposed solution. The matter was due for further review at the working group's final meeting.

Resolved:

That the Health Select Commission:

1. Noted the implementation and initial appraisal of the NSO joint Lung Clinic for Rotherham and Barnsley patients.

2. Noted that a formal clinic evaluation would be undertaken 12-months post go-live, which would enable more meaningful data analysis to influence recommendations for future service provision.

3. Requested that South Yorkshire and Bassetlaw Cancer Alliance provide the data and metrics requested by the Health Select Commission following the briefing received in May 2025 be provided following conclusion of the planned clinic evaluation, given that it had not been possible to provide the full detail at the time of the meeting. The means via which this would be provided were to be agreed outside of the meeting.

4. Requested that South Yorkshire and Bassetlaw Cancer Alliance considered the public and community transport needs, including the availability and infrastructure of onsite parking in conjunction with The Rotherham NHS Foundation Trust (TRFT), following the planned clinic evaluation.

5. Requested that relevant Council Officers consider the roads network and transport infrastructure in the hospital's immediate vicinity, including car parking restrictions and enforcement to seek to ensure that this supports traffic flow and actively contributes to reducing travel and parking frustrations for Rotherham residents accessing the hospital site.

58. SDEC (SAME DAY EMERGENCY CARE) CENTRE IMPLEMENTATION UPDATE

This item was to receive an update in relation to the success and impact of the Same Day Emergency Care (SDEC) Centre since implementation. This followed the initial proposal regarding the SDEC being presented to the Health Select Commission in March 2025.

The Chair welcomed Bob Kirton, Managing Director of TRFT (The Rotherham NHS Foundation Trust) and Jodie Roberts, Director of Operations at TRFT to the meeting and invited them to introduce the presentation.

The Director of Operations delivered a presentation regarding TRFT's development and implementation of the new Same Day Emergency Care (SDEC) Centre, and set out the pressures that had driven the change, the capital funding that had enabled it, and the early impact on flow, performance and both patient and staff experience.

They explained that Emergency Department (referred to as UECC, the Urgent and Emergency Care Centre) demand had been rising year on year and that attendances had increased by 12% from the previous year into the current financial year, which had contributed to crowding, limited assessment space, longer waits and a poorer experience for patients and staff.

In response, the Trust had pursued a time-limited NHS England capital opportunity, had prepared a business case at short notice, and secured £7 million in funding. They emphasised that this funding had supported a broader programme of enabling works and service moves, not just the SDEC in isolation.

The Director of Operations outlined the delivery timeline, from bid to opening and the considerations taken at each stage. The Trust had then designed new 'front door' services with the intent that patients could be seen in the right place, at the right time, by the right clinicians. The new build had increased the Emergency Department footprint, eased overcrowding, created more clinical spaces and improved waiting times, whilst also enabling the creation of an urgent Primary Care area and relocating the Minor Injuries Unit into the new SDEC footprint to free

additional space in the UECC.

She described the wider reconfiguration required to unlock the space:

- The Fracture Clinic had moved from the front of the hospital, with the new location expected to open toward the end of 2026
- Sexual Health had moved out to create the necessary Fracture Clinic space, with its revised front-of-hospital location due to open within the next few months
- Pre-operative assessment had moved to allow Sexual Health to relocate, with pre-op assessment now based at the back of the hospital

The Director of Operations noted that several services had therefore benefited from improved accommodation, but that delivering this had required significant organisational operational and logistical effort, which had included moving around 600 staff whilst retaining focus on the wider benefits despite understandable sensitivities around change and disruption.

They described that a former corridor and room layout had been knocked through and rebuilt into the dedicated SDEC environment with individual cubicles, seating areas, two waiting rooms and multiple clinical spaces, including rooms supporting minor injuries as patients entered the service.

Turning to access and pathways, the Director of Operations described a key enhancement introduced after opening: a direct access pathway that had not been available when the unit opened in July, enabling Yorkshire Ambulance Service (YAS) crews to bring suitable patients straight into SDEC and avoid attendance at the UECC. From August 2025, local GPs had also been able to refer directly into SDEC, and they reported positive feedback from Primary Care and other professionals.

They described that the model had also supported planned next-day returns for follow-up treatment and had enabled community ‘in-reach’ meaning that so where safe and appropriate, patients could be treated and returned home and unnecessary admissions avoided. The Director of Operations explained how the team had made SDEC clearer for patients through a plain-language infographic which explained that whilst many people expected care to fit the four-hour emergency standard, SDEC was designed for patients likely to need longer assessment and treatment without requiring admission, typically up to around eight hours. The infographic was supported by QR codes and paper leaflets that set out the core elements of the pathway.

They shared early activity and performance observations, noting that SDEC attendances had increased markedly in 2025, and contrasting this with 2024 when the previous medical SDEC area had sometimes been used for inpatient bedding over winter and emphasised that the new facility had been designed specifically to prevent beds being placed there,

protecting same-day capacity and reinforcing the principle that people were generally better at home when admission was not necessary.

The Director of Operations linked the programme to wider improvements in four-hour performance, whist acknowledging multiple contributory initiatives, but highlighting that the extra clinical space had helped patients be assessed and reviewed by medical teams in a more timely manner.

They closed with examples of positive patient feedback gathered through a variety of feedback routes including the Friends and Family Test and direct emails, and noted how encouraging it had been when patients referred to staff by name and recognised the multidisciplinary team's contribution.

The Chair thanked the Director of Operations for the presentation and invited questions and comments from Members in relation to the update provided.

Councillor Thorp offered thanks for both presentation and preceding visit to the facility. They explained that prior to attending, they had imagined the facility might feel like a collection of isolated areas where patients waited without understanding their place in the process. However, after first-hand experience, they had observed a system that worked smoothly and created a positive, calm patient experience. Councillor Thorp queried the rising attendance figures from 2024 to 2025. They wanted to understand whether the figures were linked to what used to be Ward B6 and whether the sharp increase had caused any difficulties.

The Director of Operations explained that although attendance had risen significantly, this was what the team had anticipated and wanted. They explained that Ward B6 had not been an environment suitable for expansion, as its configuration previously included beds which restricted patient flow. In the new SDEC Centre, the space had been purposely designed to cope with growing demand. It was acknowledged that attendance had recently reached more than 70 patients in a single day, alongside high UECC volumes, but confirmed that the workforce structure remained adequate, whilst adding that the team continued to monitor capacity closely.

Councillor Thorp asked what had become of Ward B6 following the opening of the SDEC.

The Director of Operations explained that Ward B6 had been repurposed as a 'decamp' ward to support temporary moves during ward refurbishments, including the current Haematology Ward project. They noted that B6 had originally been built during COVID as a high-specification critical-care overspill area, making it valuable for inpatient or day-service use as and when required.

Councillor Rajmund Brent wanted to know if the Trust understood why

there had been a 12% year-on-year increase in attendance.

The Director of Operations advised that this was difficult to pinpoint but reflected rising patient acuity, increased walk-in presentations, and a notable upturn in working-age adults using the UECC. The system was exploring ways to ensure patients accessed the most appropriate services rather than defaulting to emergency care.

Councillor Brent observed that as awareness of the new facility grew, demand would likely continue to increase, creating the risk of future overcrowding. He expressed concern that the calm, comfortable environment could be compromised if that trend continued unabated.

The Director of Operations assured Members that the unit had been built with future adaptability and growth in mind. The clinic-room capacity exceeded current demand, and the layout could be reconfigured quickly to respond as care models evolved. They added that long-term sustainability would depend on strong collaborative work with Primary Care and Yorkshire Ambulance Service to ensure patients were directed to the best setting from the outset.

TRFT's Managing Director offered a broader perspective, praising the clinical and operational teams for managing what had been an extremely challenging winter. They described how SDEC provided an essential pathway for patients whose needs had been assessed by clinicians and who required same-day intervention without the delays associated with traditional Emergency Department delays. They further explained that Rotherham had become one of the few areas in Yorkshire and the Humber able to 'pull' patients directly from ambulance workloads into SDEC, easing system pressure and emphasised that although the model had strong potential, significant cultural change across the public and partner organisations would be required to address uncontrolled growth in emergency care attendances.

Councillor Harper then reflected on experiences of Ward B6, and commented that the new facility was incomparable in terms of quality of the environment. They wanted to understand whether the SDEC was an enhanced version of Ward B6 or a fundamentally different service, and whether it had directly improved waiting times in A&E.

The Director of Operations clarified that the new facility was not an extension of B6 but a purpose-built facility informed by national best practice. They confirmed that it had contributed to improved performance in areas such as ambulance handover times, time-to-clinician, and four-hour targets, though she emphasised that multiple initiatives across the Trust had also contributed to those improvements.

Councillor Harrison asked how success would be measured for the new facility and how success measures had been developed.

The Director of Operations explained that the evaluation model aligned with national Emergency Care Access Standards, assessing how efficiently patients were seen, treated, discharged, or admitted. Low readmission rates suggested safe decision-making, while staff satisfaction, boosted by the predictable midnight closing time and improved working environment, was also a key indicator. A comprehensive analysis would take place after a full year of operation.

Councillor Ahmed echoed the positive impressions but raised concerns about public awareness regarding the facility, and reflected that many residents still defaulted to A&E even for minor concerns. They also noted that residential and care homes frequently called 999 to transfer responsibility to the hospital when other means of accessing care were more appropriate. They asked how cultural change could be encouraged and enquired whether a sensory room could be incorporated into the SDEC footprint for patients with learning disabilities.

The Director of Operations confirmed that a sensory room existed within the SDEC but had not yet been fully equipped due to budget constraints. The hospital charity had undertaken fundraising to allow its completion. They agreed that culture change would require strong system-wide communication and collaboration. TRFT's Managing Director reinforced this, noting that differences even between care homes in their 999 call rates demonstrated the scale of the cultural challenge. They highlighted that many frequent attenders at UECC had social, housing, or wellbeing needs rather than medical ones, stressing the importance of multi-agency work to address systemic stressors.

Councillor Ahmed suggested more community-based engagement, including with groups such as REMA (Rotherham Ethnic Minority Alliance) and VAR (Voluntary Action Rotherham, and encouraged the Trust to adopt a firmer stance when redirecting people to more appropriate services.

Councillor Adair shared their personal positive experience of SDEC praising the speed and reassurances taken from the service received.

Councillor Brent reiterated others' views regarding the quality of the environment and noted the visible LGBTQ+ positive signage, lanyards, and badges. They asked whether similar visibility could be introduced for neurodiversity and learning disabilities, and whether this was indicative of local leadership within the SDEC or part of a wider Trust policy around overt inclusivity.

The Director of Operations confirmed that no equivalent materials for neurodiversity or learning disabilities currently existed but committed to take the suggestion forward. They explained that the organisation aimed to be open and welcoming for all, and that inclusivity was embedded in the Trust's philosophy. The Managing Director added that although some areas were delivering excellent inclusive practice, consistency across all

patient-facing areas remained a development goal.

Resolved:

That the Health Select Commission:

1. Noted the update in relation to the SDEC and its impact on patient care.

2. Requested that TRFT provided further data regarding the impact on waiting times, ambulance handover, staff and patient satisfaction following 12 months of operation or following a suitable period of adoption of direct referral routes to all partners for whom this was intended to assist members to fully understand the impact of the SDEC for Rotherham residents. The means via which the data would be provided, along with any specific considerations around metrics and a finite timeline would be agreed with TRFT in due course.

59. HEALTH SELECT COMMISSION WORK PROGRAMME - 2025/26

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.

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

The Chair advised Members that the most recent JHOSC meeting took place on 7 January 2025 as the meeting scheduled to take place on 11 March 2026 was cancelled. The minutes of this January meeting were circulated to members upon publication, and a link to them was provided in the agenda pack for this meeting.

The next JHOSC meeting date was to be confirmed and would be shared with Health Select Commission members as soon as arrangements were in place. It was anticipated there would be no further meetings in the 2025/26 municipal year.

The Chair requested that Health Select Commission Members who had comments, queries or questions they would like raised regarding the 7 January JHOSC 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 Governance Advisor at the earliest opportunity so these could be addressed accordingly.

61. SUPPLEMENTARY PUBLIC HEALTH GRANTS FOR 2026/27 - CABINET REPORT

The Chair requested that Health Select Commission Members who had comments, queries topics they would like to suggest for consideration by the Health Select Commission arising from the Supplementary Public Health Grants for 2026/27 Cabinet Report channel these via the Chair or Governance Advisor.

62. URGENT BUSINESS

There was no urgent business to consider.