HEALTH SELECT COMMISSION
Thursday 23 July 2026

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

Apologies for absence:- Apologies were received from David Gill, Rotherham Speak Up and Professor Adam Layland, Yorkshire Ambulance Service.

The following officers and partners were also in attendance:-
Councillor Baker-Rogers, Cabinet Member for Adult Social Care and Health
Councillor Williams, Cabinet Member for Transport, Jobs and the Local Economy
Lorna Vertigan, Head of Regeneration
Gilly Brenner, Public Health Consultant
Emily Parry Harries, Link Officer and Director of Public Health
Kym Gleeson, Manager, Healthwatch Rotherham
Bob Kirton, Managing Director, The Rotherham NHS Foundation Trust (TRFT)
Simon Langmead, GP and Clinical Director of Rotherham Central North Primary Care Network
Jude Archer, Assistant Director of Transformation, South Yorkshire ICB
Claire Smith, Portfolio Director, Contracting & Commissioning and Place Relationship Lead for Rotherham, South Yorkshire ICB
Toby Lewis, Chief Executive of Rotherham, Doncaster and South Humber NHS Trust (RDaSH)

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

12. MINUTES OF THE PREVIOUS MEETING HELD ON 18 JUNE 2026

Resolved:-

That the minutes of the meeting held on 18 June 2026 were approved as a true and correct record of the proceedings.

13. 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	Partner's employment

14. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

15. 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.

16. HEALTH HUB PHASE 2

The Chair welcomed Councillor Williams, Cabinet Member for Transport, Jobs and the Local Economy, Lorna Vertigan, Head of Regeneration, Councillor Baker-Rogers, Cabinet Member for Adult Social Care and Health and Gilly Brenner, Public Health Consultant to the meeting and invited them to introduce the presentation in relation to Phase 2 proposals for the Health Hub development and wider strategic context.

The Cabinet Member for Transport, Jobs and the Local Economy explained that the project represented a significant opportunity to combine the Council's regeneration ambitions with health and wellbeing objectives in a way that would benefit both residents and the town centre. Members were reminded that Phase 1 was already underway and had involved the successful relocation of Abbey Pharmacy from the Markets complex into the former Boots building on Effingham Street as part of the wider Markets and Library regeneration scheme. Phase 2 was intended to build on this foundation by exploring a broader vision for the site as a town-centre-based health and wellbeing hub.

The proposal sought to improve access to primary health services, encourage greater integration between health providers, local government and the voluntary sector, address health inequalities and increase vibrancy and footfall within the town centre. The location was considered particularly advantageous due to its proximity to public transport links, the markets, the new library, parking facilities and other town centre amenities.

Members were advised that the Rotherham GP Federation had expressed a strong interest in relocating a number of borough-wide services into the hub, creating an opportunity to develop a more integrated and accessible model of service delivery. It was emphasised that proposals remained at an early stage and that significant engagement and business case development would be required before any formal decisions were taken.

The Head of Regeneration outlined the history and strategic importance of the former Boots building, which had been purchased by the Council several years earlier to prevent its conversion into storage space. Its prominent location opposite the markets and new library, close to the

Interchange, Tesco and Drummond Street car park, provided an opportunity to attract visitors into the town centre and support movement between neighbouring businesses and facilities.

Members heard that Phase 1 had been completed successfully, with Abbey Pharmacy now operating from the site and experiencing high levels of footfall and positive customer feedback. The vision for the next phase was to develop a central, accessible facility offering a range of health and wellbeing services through a collaborative approach involving public, private and voluntary sector partners. The project aimed to improve access to services, reduce health inequalities, contribute to town centre growth and create a more seamless patient experience through the co-location of pharmacy and clinical services. The proposal also aligned with the Council Plan and the Rotherham Together Partnership's ambitions to create vibrant town centres while improving health outcomes.

The Public Health Consultant provided an overview of the complex health commissioning landscape, explaining the respective roles of Integrated Care Boards, NHS England, the Department of Health and Social Care, the Local Authority and GP practices. Members were informed that the Local Authority retained responsibility for commissioning a range of public health services, including sexual health, substance misuse, smoking cessation, weight management, school nursing and NHS Health Checks, while other healthcare services were commissioned through the NHS structures described.

The presentation highlighted ongoing national reforms, including the transfer of some NHS England functions into the Department of Health and Social Care and structural changes affecting Integrated Care Boards. Members were advised that GP practices operated independently but increasingly collaborated through Primary Care Networks and that Rotherham's GP Federation delivered several borough-wide services and public health programmes on behalf of member practices.

Particular attention was given to Connect Healthcare CiC's interest in becoming a tenant within the proposed health hub. Members heard that Connect currently delivered borough-wide services from facilities in Rawmarsh but believed a town centre location would significantly improve accessibility for patients. Services currently provided by Connect included extended access appointments, same-day services, minor eye condition clinics, physiotherapy, NHS Health Checks, smoking cessation support and weight management programmes. Connect also regularly supported wider NHS priorities, including vaccination programmes and winter pressure responses. Because these services were available to residents across the borough rather than being linked to specific GP practice lists, a central location was considered especially beneficial.

The presentation set out the anticipated benefits of the scheme from both health and regeneration perspectives. Members were informed that locating services within the town centre would improve accessibility and

convenience, allowing residents to combine healthcare appointments with shopping and other activities. Evidence from similar schemes elsewhere suggested that people were more inclined to engage with health services when they were embedded within everyday community settings. Data presented showed that 23% of Rotherham households did not have access to a private vehicle, rising to as much as 62% in some more deprived communities. Approximately 60% of Rotherham's population would be able to reach the new town centre location within a 30-minute public transport journey, compared with only 30% for Connect Healthcare CiC's current Rawmarsh location, equating to around 80,000 additional residents enjoying easier access to services. The hub was therefore seen as a means of tackling barriers to healthcare, improving patient experience and supporting broader economic and social outcomes.

Members also heard that the project aligned closely with emerging NHS priorities, including the NHS 10-Year Plan and the neighbourhood health agenda, which promoted greater integration between healthcare, social care, public services and voluntary organisations. It was argued that co-locating services within a single building could provide earlier intervention, better signposting, more holistic support and improved efficiency. Officers highlighted the importance of addressing wider determinants of health, such as housing, employment and financial wellbeing, and suggested that a range of support services could potentially operate from the hub alongside clinical provision. The proposal was presented as a response to significant local challenges, including lower healthy life expectancy, higher levels of long-term health conditions, increasing demand for care services and an ageing population. Members were advised that delivering meaningful improvements would require new approaches and greater service integration.

The Commission was informed that officers had visited the Living Well Centre in Warrington to examine a successful example of a similar model. The Warrington facility combined physical premises in the town centre with outreach provision and digital signposting services. Members heard how the centre operated a welcoming, open-access environment featuring a central reception area, themed service days and opportunities for residents to access multiple forms of support during a single visit. Examples included themed events focused on families, children, women's health and healthy ageing. Officers considered aspects of this model highly relevant to Rotherham and were exploring opportunities to incorporate similar features. Interest had already been expressed by a range of Council services, including occupational therapy, adult social care, housing, youth justice and family services, which could potentially provide a regular presence within the building. Discussions had also taken place with NHS and voluntary sector partners regarding opportunities for future collaboration.

Detailed draft floorplans for the facility were presented. Members heard that the ground floor would include the existing pharmacy, a flexible community and wellbeing space, refreshment facilities, accessible toilet

provision including a Changing Places facility, clinical consultation rooms and a centrally positioned reception area designed to oversee both waiting areas and public spaces. The community area would support drop-in services, voluntary sector activity and informal advice and support. Upstairs, proposals included non-clinical assessment rooms, flexible training and meeting spaces, facilities for group activities and physical activity sessions, areas for occupational therapy and physiotherapy assessments, and a dedicated space capable of supporting future diagnostic or minor surgical services. Officers emphasised that flexibility had been built into the design to ensure the building could adapt to changing models of healthcare delivery over time.

In concluding the presentation, officers outlined the next steps for the project. Further refinements to the design work were being undertaken, and work was progressing on a memorandum of understanding with Connect Healthcare CiC to establish its commitment before significant Council investment was made.

Stakeholder engagement would continue with health partners, voluntary organisations and local businesses. Members were advised that concerns raised by businesses regarding the nature of services operating from the building would be addressed through ongoing communication and engagement. The project timetable had recently been revised, with the intention now being to progress the scheme to RIBA Stage 3 to provide greater design detail and cost certainty before seeking Cabinet approval in November 2026.

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

Councillor Garnett welcomed the proposals but queried how the project would demonstrate that it had reduced health inequalities rather than simply relocating existing services. She further questioned how officers would ensure that the hub benefited those residents with the greatest health needs rather than predominantly serving individuals who were already accessing healthcare services.

The Public Health Consultant explained that the town centre location itself would improve accessibility, particularly for residents without access to private transport and those living in more deprived communities. She advised that the proposed model went beyond clinical provision by creating opportunities to co-locate services addressing wider determinants of health, including housing, financial advice and other support services. She noted that current public health services such as weight management and smoking cessation already reached disproportionately high numbers of residents from deprived backgrounds and stated that officers intended to build upon this success through partnerships with voluntary and community sector organisations to engage groups that might otherwise be reluctant to access formal health services.

Councillor Garnett also wanted to understand what role the hub would play in improving population health and preventing ill health, beyond delivering clinical services, and sought clarification regarding the contribution of smoking cessation, weight management and NHS Health Checks to improving life expectancy in Rotherham.

The Public Health Consultant reported that smoking remained the single most significant contributor to health inequalities and highlighted newly received national data showing that Rotherham's Stop Smoking Service ranked amongst the most successful nationally, with the highest participation levels since 2016. They explained that NHS Health Checks enabled earlier identification and treatment of cardiovascular disease and provided opportunities to support healthier lifestyles and emphasised the role of the hub in tackling loneliness, strengthening mental wellbeing and creating opportunities for peer support through links with community and voluntary organisations.

The Cabinet Member for Adult Social Care and Health added that the hub's central location would significantly increase access to healthcare for residents who did not have access to a car, making services easier to reach through public transport and reducing barriers faced by some of the borough's most disadvantaged residents.

Councillor Brent asked whether services located within the new hub would integrate with the NHS App and other digital access routes.

The Public Health Consultant advised that most clinical appointments would continue to be accessed through existing referral pathways, predominantly via individual GP practices. They explained that online booking arrangements already existed for some services and that Connect Healthcare was receptive to exploring greater digital integration in the future. She also highlighted opportunities arising from the development of the new Gizmo platform, which could improve signposting and navigation through health services. Officers further explained that, based on experiences elsewhere, themed service days and a welcoming drop-in environment could encourage residents to seek advice and access a wider range of support services beyond their original reason for attending. The Director of Public Health added that normalising health as part of everyday life was a key objective, enabling residents to seek help and advice in a more informal and accessible environment.

Councillor Brent also questioned the apparent prioritisation of regeneration benefits over health benefits within the presentation's summary of 'win-win' outcomes. They noted that increased footfall and regeneration appeared to feature more prominently than health outcomes and sought reassurance that improving health remained the principal focus.

The Cabinet Member for Transport, Jobs and the Local Economy responded that no ranking had been intended and that all benefits should be viewed as complementary. They explained that whilst the project was regeneration-led, it had been developed specifically to deliver meaningful health and wellbeing improvements alongside town centre renewal. The Cabinet Member for Adult Social Care and Health agreed that the items listed were not presented in priority order and reiterated that both improved healthcare access and increased town centre vitality were integral objectives. The Public Health Consultant emphasised that extensive public health involvement had shaped the project and that maximising health and wellbeing outcomes remained central to its development.

Councillor Brent acknowledged the explanation and commented that he viewed the initiative as primarily health-led rather than regeneration-led.

Councillor Clarke highlighted concerns regarding women's health outcomes and referenced the Commission's reviews into menopause and access to contraception, alongside the recent input from the Rotherham Women's Health Network in relation to women's health inequalities In Rotherham. They asked whether the hub would include provision relating to menopause, contraception, menstrual health and gynaecological services given the recommendations made and position outlined.

The Public Health Consultant confirmed that active discussions were underway regarding women's health provision and advised that the flexible design of the building would support a variety of future services and initiatives. They referenced successful models elsewhere, including dedicated women's health themed sessions, and stated that officers were exploring opportunities to co-locate clinical services with wider support and advice. They further confirmed that Public Health commissioned sexual health services and intended to explore how those services might be incorporated into the wider health hub offer.

Councillor Clarke also raised concerns regarding accessibility for residents in outlying communities such as Dinnington and asked whether officers would analyse geographical usage data to ensure all parts of the borough were benefiting equally.

The Public Health Consultant reported that Public Health was already undertaking wider work on healthcare access across the borough and intended to use service data to identify patterns of access and any emerging inequalities. They advised that patient data would enable monitoring of where service users originated and would support ongoing evaluation of the model's effectiveness. They further noted that wider discussions regarding health estates across the borough were ongoing and emphasised that the Health Hub should be viewed as one part of a broader approach rather than a solution to every accessibility challenge.

Councillor Harper wanted to understand how success would be measured in both the short and long term and sought details regarding monitoring arrangements.

The Public Health Consultant explained that a range of measures would be used, including patient feedback, footfall data, efficiency measures and healthcare outcomes. They described examples from Warrington, where co-location of services had enabled more effective referrals and improved health outcomes. The Director of Public Health also stressed that whilst quantitative measures were important, qualitative evidence and personal experiences were equally valuable. They argued that residents' stories and experiences would help demonstrate whether the project was genuinely improving lives and achieving the intended outcomes.

Councillor Fisher asked how priorities were or would be determined for the health hub and whether decisions were driven by data and evidence.

The Public Health Consultant explained that priorities would be shaped to a certain extent by commissioning arrangements alongside service opportunities, patient need and the potential benefits of co-locating services. They reiterated that flexibility had been deliberately built into the design, enabling the service mix to evolve over time in response to feedback, changing needs and health commissioning priorities and opportunities. The Director of Public Health added that the proximity of services would create important opportunities for immediate referrals and early intervention, allowing patients to receive timely support at the point of need.

Councillor Fisher also wanted to understand whether the relocation of Connect Healthcare CiC services represented the creation of additional capacity or solely the transfer of existing provision.

The Public Health Consultant explained that the current proposal involved relocating existing services into a more accessible and integrated setting rather than creating new capacity. However, they noted that some community-based clinics would continue to operate in local settings where there were clear benefits to doing so. They emphasised that the intention was to improve accessibility and service integration while maintaining the ability to deliver outreach services across the borough where required in the context of the financial constraints across the wider NHS infrastructure.

Councillor Harrison asked officers to identify the greatest risks to delivery and sought assurances regarding contingency planning should partner involvement fail to materialise.

The Public Health Consultant described the project as an ambitious partnership initiative requiring commitment from multiple organisations and flexibility to adapt to changing service models over time. They highlighted the importance of creating a high-quality environment and

ensuring long-term sustainability. The Head of Regeneration identified funding as the most significant project risk, noting that no capital budget had yet been formally allocated and that funding arrangements would need to be resolved as part of the project's progression toward Cabinet consideration in November 2026.

Councillor Thorp questioned whether the project would genuinely increase healthcare provision and access or simply concentrate existing services in the town centre. Whilst welcoming the proposed location, they expressed concern that some communities might lose locally accessible services and questioned whether the strong emphasis on footfall risked overshadowing healthcare objectives.

The Public Health Consultant acknowledged that the proposal did not presently include funding for significant new services but argued that the benefits arose from delivering services in a fundamentally different way. They stated that co-location would improve patient experience, make navigation through the health system easier and strengthen links between healthcare, community support and preventative services. The Cabinet Member for Adult Social Care and Health acknowledged that some services would become slightly less convenient for Rawmarsh residents already access the Connect Healthcare CiC services outlined, but argued that a town centre location offered significantly better access for the wider borough. The Director of Public Health emphasised that the health hub should not be viewed as simply relocating services but rather as creating a different and more effective delivery model, capable of reaching people who may not otherwise have engaged.

Councillor Yasseen expressed support for the overall vision and the benefits of integrated, preventative healthcare. They sought clarification regarding the timeline presented within the report, observing that Cabinet approval appeared scheduled before completion of consultation and business case development. The Head of Regeneration clarified that the timetable had since been revised from what was included in the presentation and that Cabinet would not be asked to make decisions until the outline business case, designs and associated costs had been completed.

Councillor Yasseen sought assurances regarding stakeholder engagement and community consultation, questioning the extent to which local residents and future service users could genuinely influence the proposals.

The Public Health Consultant confirmed that a programme of public, stakeholder and voluntary sector engagement was planned and would continue beyond the hub's opening. They emphasised that the flexible nature of the building design would allow future users and partners to influence the evolving service offer. They also noted that Healthwatch had offered to support engagement activities.

Councillor Yasseen also queried how health outcomes would be measured and how the project would demonstrate tangible improvements beyond increased footfall and regeneration benefits.

The Public Health Consultant advised that discussions were ongoing regarding the inclusion of clear outcome measures and social value commitments within future agreements with health partners. They suggested that specific targets and monitoring arrangements would form part of future contractual and governance arrangements.

Councillor Yasseen also highlighted potential community cohesion issues resulting from increased use of the town centre by a wider range of residents and encouraged proactive consideration of these matters.

The Public Health Consultant acknowledged both the risks and the opportunities associated with bringing different communities together, stating that the shared spaces within the hub could help foster interaction, engagement and a stronger sense of community cohesion.

The Chair thanked officers, Cabinet Members and Commission members for their contributions and welcomed the enthusiasm shown for the emerging proposals, noting the Commission's strong interest in the continued development of the Town Centre Health Hub project.

Resolved:-

That the Health Select Commission:

1. Noted the contents of the presentation received.

2. Requested that the relevant Council Services and health partners including the ICB, TRFT, RDasH, YAS and any relevant voluntary and community sector organisations engage in discussions to consider and develop firm proposals for services to operate from the Health Hub with the greatest potential of positive impact for Rotherham residents and service providers.

3. Requested that the Health Select Commission be advised of the anticipated timeline for final proposals and be sighted on them once agreed.

4. Requested that a further update be provided to the Health Select Commission at one, three and five year intervals post implementation to allow the Commission to scrutinise service delivery and assess whether the targeted impact of the Health Hub in terms of health inequalities, healthy life expectancy and general population health was being delivered.

17. PRIMARY CARE NETWORK (PCN) DEVELOPMENT

The Chair Welcomed Simon Langmead, Clinical Director of Rotherham Central North Primary Care Network, and Jude Archer, Assistant Director of Transformation at the South Yorkshire Integrated Care Board to the meeting and invited them to introduce the presentation relating to the role of PCNs in delivering healthcare services across the borough and their future contribution to neighbourhood-based models of care.

The Clinical Director of Rotherham Central North Primary Care Network outlined his role as a practising GP in Rotherham, Clinical Director of one of the borough's six Primary Care Networks, Chair of the Clinical Directors Group and lead for neighbourhood health development across primary care. They explained that the presentation was intended to provide an overview of the development of the Primary Care Networks in Rotherham, their current structure, the work they were undertaking and their anticipated role within future neighbourhood health arrangements.

Members heard that Primary Care Networks had been established nationally in 2019 following publication of the NHS Long Term Plan and the associated five-year framework. Their creation had represented a significant change in the organisation of general practice by encouraging and requiring GP practices to collaborate more closely in delivering services for defined populations. Previously, GP practices had largely operated as individual businesses with limited joint responsibility for service delivery. The introduction of PCNs was therefore described as a major cultural and operational shift, supported by targeted funding intended to strengthen collaborative working and expand the scope of primary care provision.

The Commission was advised that Rotherham's PCNs had evolved from the former Clinical Commissioning Group locality structures. Whilst the previous arrangements had primarily supported communication and peer support between practices, the formation of PCNs brought greater responsibility for joint working and service delivery. Six Primary Care Networks had subsequently been established across the borough, each serving populations ranging from approximately 35,000 to 55,000 residents. The networks had largely developed from pre-existing relationships between practices and therefore did not always align with clear geographic boundaries.

Detailed information was provided regarding the composition of each network. Health Village and Dearne PCN covered practices within central Rotherham and parts of the northern borough. Maltby and Wickersley PCN served practices based largely around the Maltby and Wickersley geography. Raven PCN consisted of a cluster of practices serving a broad central and southern area. Rother Valley South PCN represented the most geographically coherent network, covering communities including Dinnington, Thurcroft, Swallownest and surrounding areas. Central North PCN served central and western parts of the borough, including

Kimberworth and Greasbrough. Wentworth 1 PCN covered a large area across the northern borough, Parkgate, Rawmarsh and parts of central Rotherham. Members were shown a map illustrating the extent of each network and were advised that significant overlap existed between many PCN boundaries, particularly within central parts of the borough.

The wider organisational structure of primary care within Rotherham was then explained. Members heard that the borough contained 28 GP practices, which collectively formed the six Primary Care Networks. Above this structure sat Connect Healthcare CiC, the borough-wide GP Federation, which comprised all practices and provided services at scale across Rotherham. This arrangement enabled services to be delivered collaboratively where a borough-wide approach was more effective than individual practice or network provision.

The Commission received a detailed explanation of the principal functions undertaken by Primary Care Networks through the Direct Enhanced Service (DES) contract. Members were informed that the DES framework was designed to support, connect and expand primary care provision, with nationally allocated funding used to deliver agreed priorities and service improvements.

Particular attention was given to the Additional Roles Reimbursement Scheme (ARRS), which represented the largest element of PCN funding. The Clinical Director of Rotherham Central North Primary Care Network explained that the scheme had been created during a period of significant workforce shortages in general practice and was intended to diversify the primary care workforce by funding a wide range of additional professional roles. These included pharmacists, physiotherapists, mental health practitioners, care coordinators, social prescribing link workers, physician associates and other specialist practitioners. More recently, funding criteria had been extended to include GPs and practice nurses. Networks were able to determine which roles would best meet the needs of their populations, enabling them to tailor workforce development according to local priorities. The scheme had increased capacity, broadened expertise within primary care and enhanced service provision for patients.

Members also heard about the Enhanced Health in Care Homes programme, an area in which Rotherham had been a national pioneer. Prior to the introduction of the scheme, residents in care homes often remained registered with multiple GP practices, resulting in fragmented healthcare arrangements and inefficiencies. Rotherham had proactively aligned individual care homes with specific GP practices before the national PCN arrangements were introduced. This model had subsequently been adopted nationally and incorporated into the PCN framework. As a result, every care home for older people in Rotherham was aligned with one or, in some cases, two GP practices. Regular ward rounds, vaccination programmes, care planning and proactive healthcare management were now delivered in a more coordinated manner, improving continuity of care and strengthening relationships between

healthcare professionals, residents and care home staff.

The presentation also covered Enhanced Access arrangements, under which Primary Care Networks were required to provide appointments outside standard weekday opening hours. Members were advised that five of the six PCNs delivered these services collaboratively through Connect Healthcare CiC, allowing evening and weekend appointments to be provided efficiently through shared hubs. This joint approach enabled more appointments to be offered than the minimum national requirement. Rother Valley South PCN had instead developed its own local model to meet the needs of its communities.

Further information was provided regarding the Investment and Impact Fund, through which PCNs received funding linked to achievement of specific national priorities. Current priorities included increasing uptake of annual health checks for people with learning disabilities and improving colorectal cancer screening pathways through the use of faecal immunochemical testing (FIT). The Clinical Director of Rotherham Central North Primary Care Network explained that these initiatives helped support earlier diagnosis, better targeting of specialist services and improved patient outcomes.

Members were also reminded of the pivotal role Primary Care Networks had played during the COVID-19 pandemic. From December 2020 onwards, PCNs had been central to the organisation and delivery of the vaccination programme across Rotherham. The programme had required unprecedented collaboration between GP practices and had demonstrated the effectiveness of network-based working. The Clinical Director of Rotherham Central North Primary Care Network described the vaccination programme as a significant early test of the new PCN model, which ultimately strengthened relationships and collaborative working across the borough.

The Commission heard about a current programme of proactive care being developed through the networks. This work focused on prevention and earlier intervention for cohorts of patients at greater risk of poor health outcomes. One strand targeted younger adults aged 18–39 who experienced both mental health conditions and physical long-term health conditions, recognising that physical health needs were often overlooked within this group. Another strand focused on residents experiencing complex frailty, with the aim of identifying needs earlier, preventing deterioration, supporting independence and improving quality of life. The programme sought to reduce avoidable demand on acute services through more proactive community-based support.

Looking ahead, the Clinical Director of Rotherham Central North Primary Care Network explained how Primary Care Networks were expected to contribute to the developing neighbourhood health model previously considered by the Commission. They suggested that PCNs had already provided a blueprint for neighbourhood working by demonstrating how

different professionals and organisations could collaborate around shared population needs. However, they acknowledged that the current PCN geography in Rotherham presented challenges due to overlapping boundaries and differing population distributions. As a result, significant work had been undertaken to reconsider local geography and align services more effectively with emerging neighbourhood arrangements.

Members were informed that Rotherham was involved in the National Neighbourhood Health Implementation Programme, providing an opportunity to test and shape new approaches to integrated local care. The Clinical Director of Rotherham Central North Primary Care Network outlined emerging national proposals for future health service contracting arrangements, including potential neighbourhood provider models and integrated health organisations. These developments were intended to bring services together around local communities, promote prevention, improve access to care closer to home and make greater use of technology.

The presentation concluded with an update on local neighbourhood development. The Rotherham Place Board had recently agreed to implement four shadow neighbourhood areas over a twelve-month period to test new collaborative arrangements. These emerging neighbourhoods would bring together multiple Primary Care Networks alongside community health teams, voluntary sector organisations and other partners. Initial priorities would focus on supporting residents with complex frailty through integrated neighbourhood teams, with the objective of improving quality of life, reducing avoidable hospital admissions and enabling more care to be delivered within community settings closer to people's homes.

Councillor Garnett welcomed the presentation and asked how equitable access to services was being achieved across the borough given the overlap between Primary Care Networks and the varying geographical coverage shown within the report.

The Clinical Director of Rotherham Central North Primary Care Network explained that each PCN had been designed to respond to the specific needs of its local population and had developed bespoke workforces and services accordingly. They noted that this was particularly evident within the Additional Roles Reimbursement Scheme, where individual networks had chosen different combinations of professionals to reflect local requirements. They further explained that this localised approach was balanced by the borough-wide role of Connect Healthcare CiC, through which all practices worked collaboratively to provide services available to the whole population. They advised that it was the combination of tailored local provision and borough-wide services that helped ensure equitable access for residents.

Councillor Garnett referred to the emerging neighbourhood health agenda and asked what shortcomings existed within the current PCN

arrangements that neighbourhood reforms represented an opportunity to address, and what practical improvements residents would experience as a result.

The Clinical Director of Rotherham Central North Primary Care Network explained that the original PCN structures had been established around existing relationships between GP practices rather than around communities or geography. Whilst this had helped create effective working relationships during the early stages of implementation, it had also resulted in significant geographical overlap and inefficiencies. They advised that as Rotherham's population had become older, frailer and more complex, there had been increasing recognition that services needed to be organised around neighbourhoods and communities rather than historic organisational structures. They stated that neighbourhood working would allow professionals to better understand local communities, reduce duplication, improve coordination and enable care to be delivered closer to where people lived. They noted that the proposed reforms sought to retain the collaborative strengths of PCNs whilst addressing geographical inefficiencies and improving outcomes for residents.

Councillor Fisher asked how the six Primary Care Networks identified and prioritised local health inequalities and whether any data or evidence existed regarding variations in health outcomes between populations served by different PCNs.

The Clinical Director of Rotherham Central North Primary Care Network explained that a growing range of data sources was available to PCNs, supplemented by increasing collaboration with public health colleagues. They advised that, historically, much of the decision-making had been driven by the knowledge and experience of local GPs who understood the needs of their registered populations. However, more sophisticated datasets were now available, including prevalence data, screening uptake information and broader population health intelligence. They noted that inequalities manifested themselves in different ways across different communities and that PCNs increasingly used such information to guide workforce planning and service investment, particularly where disparities were identified in areas such as cancer screening and preventative health activity.

Councillor Fisher wanted to understand whether evidence existed that the Additional Roles Reimbursement Scheme had successfully expanded primary care capacity and how the performance of these additional roles was measured.

The Clinical Director of Rotherham Central North Primary Care Network explained that the introduction of new professional roles had originally been intended to increase capacity at a time when additional GP recruitment had proved difficult nationally. They acknowledged that both patients and practices had required time to adapt to a more diverse workforce, as many residents had traditionally expected all healthcare

needs to be addressed by a GP. They advised that staff funded through the scheme were now closely monitored through appointment activity data and performance reporting. They further stated that whilst the scheme had clearly increased appointment capacity, it had also enhanced the quality of services available. Examples included clinical pharmacists undertaking specialist medication reviews, social prescribing link workers addressing wider social needs and dedicated dementia support roles. Although some of these benefits were not easily quantifiable through performance metrics alone, they reported that they were widely recognised by both patients and healthcare professionals.

Councillor Thorp raised concerns about the geographical configuration of the networks, questioning how arrangements could operate efficiently when practices in distant and seemingly unrelated communities were grouped together.

The Clinical Director of Rotherham Central North Primary Care Network acknowledged the limitations of the current geography and explained that, when PCNs were established, the priority had been to build on existing working relationships between practices rather than strict geographical alignment. They reiterated that requiring independent GP practices to collaborate represented a significant cultural change and that grouping practices with existing relationships had been a pragmatic approach. They added that the current neighbourhood health reforms were partly intended to address these geographical challenges by creating structures that reflected communities more accurately.

Councillor Thorp asked what practical benefits patients experienced as a result of GP practices being organised into Primary Care Networks and sought confirmation that all practices within the borough were members of a PCN.

The Clinical Director of Rotherham Central North Primary Care Network confirmed that all 28 GP practices in Rotherham belonged to one of the six networks. They explained that the greatest benefits had come through workforce expansion and service diversification. Patients were now routinely able to access professionals such as physiotherapists, pharmacists and social prescribing workers through their own GP practices, often without realising those services were funded through the PCN structure. This had increased appointment availability, improved access to specialist expertise and strengthened links between primary care and wider community support. The ICB Portfolio Director, Contracting & Commissioning and Place Relationship Lead for Rotherham added that PCNs also enabled practices to learn from one another and share examples of best practice, leading to continuous improvement across the borough.

Councillor Harrison observed that the presentation focused primarily on structures and programmes rather than outcomes and asked what performance indicators were used to assess the effectiveness of PCNs

and how residents were informed in respect of PCN performance.

The Clinical Director of Rotherham Central North Primary Care Network acknowledged the point made and advised that PCNs were subject to several forms of performance monitoring. The Investment and Impact Fund formed the principal national performance framework and included measures such as annual health checks for people with learning disabilities and the use of faecal immunochemical testing within colorectal cancer screening pathways. In addition, appointment activity across the various Additional Roles Reimbursement Scheme workforces was closely monitored and reported to commissioners. They explained that wider practice and network performance data was regularly reviewed. In relation to public awareness, they noted that efforts had initially been made to explain the purpose of PCNs to residents, but over time the additional services had become embedded within everyday general practice, resulting in many patients being unaware that the services they were receiving originated from the PCN model. They suggested that this integration itself reflected the success of the approach.

Councillor Harper asked whether the enhanced access services delivered by PCNs had reduced pressure on accident and emergency departments and what further work was planned if such benefits had not yet materialised.

The Clinical Director of Rotherham Central North Primary Care Network explained that the use of shared evening and weekend hubs allowed primary care to deploy resources more efficiently than if every practice attempted to open independently outside normal hours. They stated that the shared model freed resources for clinical activity and enabled more appointments to be offered than national requirements stipulated. Whilst there was a reasonable expectation that these services should help reduce pressure on urgent and emergency care, he acknowledged that attendance at accident and emergency departments continued to increase nationally and locally. They highlighted examples of collaborative initiatives with Rotherham Hospital, including acute respiratory infection hubs, where patients presenting at hospital could be redirected into primary care services where appropriate. They advised that ongoing discussions were taking place between primary care, The Rotherham NHS Foundation Trust (TRFT) and wider partners regarding how urgent demand could be better managed across the whole system.

Councillor Yasseen reflected that the subject matter had been difficult to scrutinise due to the highly structured national policy framework underpinning Primary Care Networks. Referring to documentation produced when PCNs were first established in 2019, she questioned whether earlier aspirations to align PCN boundaries with the Council's neighbourhood model had ever been implemented and whether they could now be revisited given the ongoing evolution of neighbourhood healthcare arrangements.

The Clinical Director of Rotherham Central North Primary Care Network explained that they were not involved at the time the original decisions had been made but acknowledged that the current geography created challenges and inefficiencies. They stated that the emerging neighbourhood model sought to address many of those concerns by aligning healthcare delivery more closely with recognisable communities and ward-based geographies. The ICB Portfolio Director, Contracting & Commissioning and Place Relationship Lead for Rotherham added that the four neighbourhood model currently under development represented a twelve-month exploratory phase rather than a final destination. They stated that the intention was to test new approaches, strengthen collaboration between organisations and identify opportunities for improved alignment in future years.

Councillor Yasseen sought clarification on whether the existing central area arrangements, involving multiple overlapping PCNs, would eventually change under neighbourhood working arrangements.

The Clinical Director of Rotherham Central North Primary Care Network explained that the transition was complex because PCNs were not standalone organisations but collaborations of independent GP practices, each with its own staffing arrangements, premises and regulatory responsibilities. They advised that neighbourhood development was therefore focused initially on aligning organisations around common geographies whilst maintaining existing structures during the transition period. All partners, including primary care, community health services, social care, local government and the voluntary sector, had agreed to work within the four new neighbourhood footprints for twelve months, after which progress would be reviewed and future developments considered.

The Managing Director, TRFT supplemented the discussion by acknowledging the complexities involved in coordinating independently operated GP practices. They praised the significant achievements already made through the Primary Care Network model and explained that neighbourhood working represented the next stage of development. They informed Members that partners across primary care, community health services, mental health services, social care, voluntary organisations and the Council's neighbourhood teams were now working collectively to establish common neighbourhood arrangements. They stressed that the current model should be viewed as a starting point rather than a final solution and that the primary objective was to demonstrate that greater collaboration could deliver improved outcomes for residents before any longer-term structural changes were considered.

The discussion concluded with Members noting both the progress achieved through the Primary Care Network model and the opportunities presented by neighbourhood health approaches to improve integration, reduce inefficiencies and strengthen community based healthcare delivery across Rotherham.

Resolved:-

That the Health Select Commission:

1. Noted the contents of the presentation received.

2. Be furnished with data which quantifies the performance of each respective PCN serving the Rotherham borough.

3. Receive updates, via an appropriate method and at appropriate intervals to be determined, in relation to how the Primary Care Network in Rotherham continues to develop to support the National Neighbourhood Health Implementation Programme.

18. ROTHERHAM WOMEN'S HEALTH NETWORK CO-OPTEE PROPOSAL REPORT

The content of the report included in the agenda pack was outlined by the Governance Advisor at the Chairs request, as was the process which would follow if the Commission elected to support the recommendations therein.

Resolved:

That the Health Select Commission:

1. Seek approval from the Overview and Scrutiny Management Board (OSMB) to appoint a non-voting Co-optee seat from the Rotherham Women's Health Network (RWHN) to the Commission's membership.

2. Seek approval from OSMB that the RWHN non-voting co-optee seat on the Health Select Commission shall remain in place until such time as it is deemed no longer necessary or appropriate by the Commission.

19. HEALTH SELECT COMMISSION WORK PROGRAMME - 2026/2027

Members were advised that the work programme had been updated to reflect items for consideration as potential reviews, and it was noted that a scoping, scoring and prioritisation session would be convened in due course to consider those topics and make relevant determinations as to future scrutiny activity.

Resolved:-

That the Health Select Commission:

1. Approved the proposed work programme.

2. Agreed that the Governance Advisor be authorised to make any required changes to the work programme in consultation with the Chair/Vice Chair and reporting any such changes back at the next meeting for endorsement.

20. HEALTHWATCH ROTHERHAM ANNUAL REPORT

Members received a copy of the Healthwatch Rotherham Annual Report 2025/26. This was shared to ensure the Health Select Commission were sighted on the work conducted by Healthwatch Rotherham the relevant period of time, and the outcomes achieved for Rotherham residents.

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

Members were advised that the next JHOSC meeting remains expected to take place in October 2026, with final arrangements are still to be confirmed.

Health Select Commission members were informed that they would be updated regarding the agreed agenda items and meeting date once confirmed, at which point Members were invited to share any questions or comments on the agenda items.

22. URGENT BUSINESS

Members were advised that arising from its recent response to the Yorkshire Ambulance Service (YAS) Quality Account, the Health Select Commission had been invited to participate in the YAS Critical Friends Network (CFN) to facilitate a two way dialogue and provide additional context and opportunity for feedback and proactivity in relation to Quality Accounts relevant workstreams and progress.

Members were advised that the Chair attended the meeting that took place on 22 July 2026 and was keen to offer the opportunity to the Commission's membership to represent the Health Select Commission in that environment. Members were asked to make contact with the Chair and/or Governance Advisor if they wanted further information about the CFN, or were interested in attending.