HEALTH SELECT COMMISSION
Thursday 24 September 2026

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

Apologies for absence:- Apologies were received from Keenan, Fisher, Havard and Tarmey.

The following officers and partners were also in attendance:-

Ian Spicer, Executive Director of Adult Care, Housing and Public Health
Gilly Brenner, Public Health Consultant
Carole Foster, Moving Rotherham Programme Manager
Kathy Wakefield, Senior Programme and Commissioning Lead, North East and Yorkshire Office for Pan ICB Commissioning (OPIC)
Laura Brown, Public Health Officer for Rotherham, North East and Yorkshire Office for Pan ICB Commissioning

The following were also in attendance to observe:-

John Edwards, Chief Executive
Phillip Horsfield, Service Director of Legal Services
Cllr Steele, Chair of the Overview and Scrutiny Management Board

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

23. MINUTES OF THE PREVIOUS MEETING HELD ON 23 JULY 2026

Resolved:-

That the minutes of the meeting held on 23 July 2026 were approved as a true and correct record of the proceedings.

24. DECLARATIONS OF INTEREST

There were no declarations of interest.

25. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

26. 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.

27. PHYSICAL ACTIVITY FOR HEALTH (SPORT ENGLAND) MAIN BID AND PROGRESS UPDATE

The Chair welcomed Gilly Brenner, Public Health Consultant and Carole Foster, Moving Rotherham Programme Manager to the meeting and invited them to introduce the presentation.

The Commission received a detailed update regarding the progression of the Physical Activity for Health programme and the development of the main funding bid to Sport England. Members were advised that the programme had previously been presented to the Commission during its developmental phase and had now progressed to the stage of preparing a main award bid. It was emphasised that the preceding year had deliberately been structured as a development and learning period, with the primary purpose being to build understanding, strengthen partnerships, test approaches and gather evidence to inform future delivery rather than to focus solely on implementation.

The Commission heard that the programme had been developed in recognition of the wide-ranging benefits of physical activity, which extended beyond improvements to health and wellbeing. Physical activity was described as contributing to independence, healthy ageing, community cohesion, economic participation and wider sustainability objectives. It was explained that the work had sought to build upon existing strengths within Rotherham, including its extensive network of community spaces, country parks, rivers, lakes, canals, trails and green spaces, as well as its established sporting heritage through facilities such as the New York Stadium and Herringthorpe Stadium. Reference was also made to the borough's strong network of community and voluntary sector organisations, established sports clubs, activity providers and strategic partners, including the Yorkshire Sport Foundation, the National Centre for Sport and Exercise Medicine and Sport England.

Members were reminded that inequalities in physical activity participation remained significant and that opportunities to be active were not distributed equally across the population. Barriers included income, geography, poor health, disability, social circumstances and the design and safety of neighbourhoods, rather than a lack of motivation or personal choice. Consequently, the programme had focused on understanding how everyday movement could be embedded more effectively into daily life and how environmental and systemic barriers could be reduced.

During the development year, work had concentrated on establishing the foundations for a coordinated, place-based approach to physical activity.

A range of pilot initiatives and engagement activities had been undertaken to strengthen partnerships, test innovative approaches and improve understanding of the needs of inactive and underserved communities. Training and development opportunities had been provided for partner organisations, particularly to improve understanding of inclusion and the needs of people with disabilities and learning disabilities. Extensive engagement work had been undertaken through Voluntary Action Rotherham and its partners to explore barriers to the use of community and green spaces. Additional engagement had been carried out by the Yorkshire Sport Foundation with local community organisations to gain insight into local circumstances and challenges.

Members noted that substantial consultation activity had also taken place with children and young people. Surveys had been conducted with parents of Key Stage 1 children, alongside direct engagement with Key Stage 2 and Key Stage 3 pupils. This had been undertaken to better understand levels of participation, barriers to activity, preferences and aspirations. Further engagement had taken place through Rotherham United Community Trust, including work with young people outside mainstream educational settings and within faith-based settings.

Particular attention was drawn to the commissioning of the Every Move Counts service, which had served as a significant test-and-learn project during the development phase. The service had provided personalised coaching support for inactive individuals living with long-term health conditions. Participants had received one-to-one support to identify barriers to physical activity, develop confidence and explore practical ways to become more active. The service had sought to connect individuals with appropriate opportunities and support sustained behavioural change.

The Commission was informed that the development year had generated a number of positive outcomes. Awareness of physical activity opportunities had increased among children, young people and communities. Stronger relationships had been established across sectors, and examples were provided of collaborative working emerging through the programme. One example highlighted how Yorkshire Cricket had worked with Rotherham United Community Trust to deliver cricket activities in communities where existing trusted relationships already existed. This was presented as an illustration of how partnership working could maximise opportunities and improve access.

The programme had also produced extensive consultation findings, supported by a detailed evaluation report containing over one hundred pages of evidence and insight. Analysis of that information had informed the development of a new physical activity strategy. In parallel, efforts had been made to build system capability, including supporting GP practices to become ‘active practices’ and encouraging healthcare professionals to treat physical inactivity as a significant health risk factor in the same way that they would address smoking or high blood pressure.

Members heard that several key themes had emerged consistently from community engagement and consultation. Cost and affordability had continued to be significant barriers to participation. Residents had expressed a strong preference for activities delivered close to home due to transport challenges and accessibility issues. Feedback had identified opportunities to make better use of existing community assets, including cycling infrastructure, while highlighting a lack of early years cycling provision and training. Communities had consistently reported that trusted local organisations and venues were the most effective means of delivering activities and that new initiatives should be integrated into established settings rather than introduced independently. Difficulties in accessing information about available activities had also been identified, alongside the need to improve inclusion and accessibility. Furthermore, consultation findings had reinforced the importance of long-term sustainability and the need to avoid short-term approaches to addressing inactivity.

In response to these findings, a new five-year physical activity strategy had been developed. The strategy sought to create the conditions that would enable people to move more frequently in ways that were enjoyable, meaningful and capable of improving health, wellbeing and quality of life. A set of partnership principles had been established to guide implementation. These principles included joining up activity across organisations, involving communities in decision-making, building confidence and capability, encouraging innovation and learning, focusing on long-term sustainability and ensuring that equality, diversity and inclusion remained central to all activity.

The Commission noted that delivery would continue through an established partnership structure comprising a broad active network, specialist working groups, core system leaders and the Moving Rotherham Board, which would maintain strategic oversight and report through the Health and Wellbeing Board and the Cultural Partnership Board.

The strategy identified three priority audiences for focused action over the next five years. These were children and young people, people living with long-term health conditions and disabilities, and communities experiencing the lowest activity levels due to wider inequalities. Alongside these priorities, the strategy would focus on three cross-cutting themes: communication, inclusion, and placemaking/system change. Communication would seek to improve awareness of opportunities and activities. Inclusion would address inequalities and accessibility issues, while placemaking and system change would focus on embedding physical activity considerations into wider planning, development and environmental decision-making.

Looking ahead, Members were advised that the main bid to Sport England would seek investment to deliver activity aligned with the

strategy. Proposed initiatives included work with schools to strengthen links between educational settings and community-based opportunities, expanded cycling provision for children, continuation and refinement of the successful Every Move Counts health coaching programme, and targeted investment through the voluntary sector to support hyper-local interventions within communities experiencing the greatest barriers to physical activity. Additional funding would support communications and marketing capacity, inclusion-focused training for providers, wider workforce development, celebratory awards activity to showcase success across the borough, and comprehensive evaluation arrangements to measure and communicate the long-term impact of the programme.

The presentation concluded with an invitation for interested parties to participate in the borough-wide active network.

The Chair thanked officers for the presentations and invited questions and comments.

Cllr Thorp questioned how the programme would engage residents who were not already connected to sports clubs, community groups or organised activities, noting that many residents in their ward did not participate in such networks and therefore might never encounter the opportunities being promoted.

In response, the Public Health Consultant explained that many of the programme's partners were not traditional physical activity organisations but community-based groups already working with residents in local neighbourhoods. They advised that delivery would initially focus on people already engaged with community and voluntary organisations but who remained physically inactive, as this was where the programme could achieve the greatest impact. Alongside this targeted work, wider communications and marketing campaigns would seek to reach residents who were not connected to established organisations. It was emphasised that local communities themselves would help shape the messaging and approach to ensure that activity opportunities reflected local identities and needs rather than having externally designed initiatives imposed upon communities. The Chair further clarified that the geographical focus of much of the work was determined by Sport England funding criteria and guidance.

Cllr Thorp asked where within the borough the programme would be focused.

The Moving Rotherham Programme Manager explained that activity would be concentrated within a number of priority neighbourhoods identified through deprivation measures and inactivity data, including Rawmarsh East, Greasbrough, East Herringthorpe, East Dene, Brampton, Clifton, Thrybergh, Hooton Roberts, Kimberworth Park, Eastwood, Masbrough, Maltby East, Maltby and Rotherham Central. Members were advised that these locations had been identified primarily through

deprivation indicators and Sport England data, with Hooton Roberts included because it had been identified as one of the most inactive areas in the borough. Whilst children and young people and residents with long-term health conditions would be supported borough-wide, officers reiterated that the place-based investment had to follow the conditions attached to the external funding. Members were also assured that the wider objective was to develop sustainable systems and partnerships that would ultimately benefit the whole borough beyond the lifetime of the funding programme.

Cllr Paul Thorp subsequently asked how success would be measured.

In response, the Moving Rotherham Programme Manager advised that comprehensive evaluation arrangements would be implemented, including baseline consultation, journey tracking, performance monitoring against agreed targets and the use of public health datasets and dashboards. They highlighted that significant evaluation work had already been completed during the development phase, including engagement with more than 2,000 young people, which had generated valuable evidence regarding barriers to participation and future opportunities for intervention. Progress would be monitored through action plans overseen by the Moving Rotherham Board, with accountability also provided through wider partnership governance arrangements.

Cllr Clarke sought assurance regarding the programme's relationship with food insecurity and healthy eating initiatives, questioning how financial barriers to participation would be addressed and whether data would be available on the socio-economic profile of participants.

The Public Health Consultant responded that evaluation work undertaken to date had demonstrated strong engagement from residents registered with some of the borough's most deprived GP practices. They explained that the programme deliberately sought to remove cost barriers by promoting free or low-cost opportunities such as health walks and local activities. Members heard examples of existing interventions, including discounted leisure provision for residents with long-term health conditions and the successful provision of free swimming opportunities during the school holidays, which had significantly increased participation levels among children and young people. Officers acknowledged the continuing impact of poverty and the cost-of-living pressures and confirmed that affordability would remain a key consideration during implementation.

Cllr Clarke raised concerns regarding transport accessibility, particularly for residents living in more rural communities.

The Public Health Consultant acknowledged that transport represented a significant public health challenge extending beyond physical activity provision. Members were informed that work was underway to assess transport accessibility across the borough, including access to health facilities, leisure centres and public services. Findings would be used to

inform discussions with the South Yorkshire Mayoral Combined Authority regarding opportunities to improve connectivity, particularly within rural communities.

Cllr Harper questioned how officers would demonstrate that inequalities in physical activity levels had genuinely narrowed between the most and least active communities rather than simply reporting increased participation numbers.

The Public Health Consultant explained that the programme would utilise data from the national Active Lives Survey alongside local monitoring information. Whilst recognising limitations in ward-level sample sizes, they stated that officers expected to see positive trends in priority communities over time. They also emphasised that much of the desired behaviour change related to informal, everyday activity that was difficult to quantify directly. Consequently, qualitative evidence, case studies and stories gathered through community organisations and services such as Every Move Counts would supplement quantitative measures to provide a fuller assessment of impact.

Cllr Harper asked about sustainability once the existing funding period ended.

The Public Health Consultant advised that Sport England funding was currently secured until 2028 and that indications from the organisation suggested a desire to continue and expand place-based investment. Nonetheless, officers were deliberately designing interventions that would create sustainable capacity rather than temporary programmes. Training initiatives had therefore adopted a train-the-trainer approach, whilst longer-term services such as Every Move Counts were being evaluated to identify future funding opportunities and demonstrate their wider benefits to the health system.

Cllr Brent asked what evidence officers would expect to present in five years' time to demonstrate that the programme had improved population health and reduced health inequalities.

The Public Health Consultant acknowledged the complexity of attributing long-term public health outcomes to a single intervention but advised that a range of evidence would be assembled to demonstrate impact. Members heard that some benefits, such as improvements in falls prevention, could become evident relatively quickly, whilst wider health and wellbeing outcomes would likely emerge over a longer period. Officers intended to draw together multiple strands of evidence to demonstrate meaningful change.

Cllr Rajmund Brent asked how communication and marketing activity would address residents' difficulties in locating information about available opportunities.

The Public Health Consultant explained that a blended communications approach would be required, recognising that different population groups accessed information through different channels. Proposed activity included wider publicity campaigns, hyper-local communications, school-based engagement, digital channels and integration with the developing Gizmo information platform. Members were advised that trusted local networks and word-of-mouth communication remained particularly important. Cllr Rajmund Brent suggested that parish councils could play a valuable role in dissemination, a point that was welcomed by officers. The Moving Rotherham Programme Manager further advised that community-based events would be organised within target areas to showcase local opportunities and connect residents with activity providers.

Cllr Duncan focused on work with children and young people and asked how the programme would ensure activities reached children from deprived communities who were least likely to participate in sport.

In response, the Public Health Consultant explained that the programme would build on the work of the School Games network, which had evolved significantly beyond traditional competitive sport. Teachers were already being supported to identify disengaged children and introduce them to a wider range of activities including BMX cycling, parkour and other non-traditional options. The intention was to provide sustained engagement rather than isolated experiences and to broaden young people's exposure to activities they may not otherwise encounter.

Cllr Duncan expressed concern regarding how ongoing participation would be sustained after initial engagement.

The Moving Rotherham Programme Manager explained that cycling equipment, physical activity resources and related assets would be placed permanently within community venues such as libraries and other settings, enabling continued access beyond the duration of specific projects. The Public Health Consultant also reiterated the substantial cultural shift that had occurred within the School Games approach nationally and locally, with a stronger focus now directed towards inactive children and young people.

Returning to the discussion on cycling, Cllr Harper asked what the proposed cycling interventions would look like in practice and whether schools remained active partners in cycle training.

The Public Health Consultant advised that traditional cycling proficiency training was now delivered through the Bikeability programme, although officers wished to strengthen local influence over delivery to ensure consistent access across all schools. Additional investment was proposed to support children before they reached formal Bikeability training, particularly those who had not yet developed basic cycling skills. Officers also highlighted opportunities to promote active school environments through the Creating Active Schools framework.

Cllr Harrison questioned how governance arrangements would avoid duplication and ensure accountability.

The Moving Rotherham Programme Manager explained that all activities would be aligned to a common action plan overseen by the Moving Rotherham Board. They further advised that revised governance structures were being developed to incorporate lived experience, ensuring that residents and participants would help shape and scrutinise delivery. In response to a supplementary question, officers confirmed that organisations such as Scouts, Cubs, Squirrels and Guides would continue to be engaged through the wider active network and local community events.

Cllr Ismail raised concerns regarding language barriers within some communities and enquired whether funding would support interpretation and culturally appropriate engagement.

The Moving Rotherham Programme Manager advised that flexible local funding allocations would allow communities to determine the support they required, including translation and interpretation services where appropriate. They further explained that work was underway with a range of faith organisations, including mosques, churches and other faith settings, to integrate physical activity within existing activities and educational programmes and to provide training and equipment that would support sustainable local delivery.

Cllr Baum-Dixon encouraged officers to consider wider environmental measures that might encourage informal physical activity, including improvements to parks, lighting, CCTV and recreational infrastructure.

The Moving Rotherham Programme Manager advised that small-scale community capital funding would be available to address local issues and that larger infrastructure improvements would be considered through the planned sports and built facilities strategy. They also emphasised the importance of collaboration with parish councils and elected members in identifying local priorities and funding opportunities.

Cllr Baum-Dixon asked whether sufficient effort had been made to understand how people first became active.

The Moving Rotherham Programme Manager explained that extensive consultation involving around 2,000 children and young people had already explored motivations, barriers and participation patterns. The findings had demonstrated a strong preference amongst many children for individual activities rather than organised team sports, helping shape the future programme design.

The Chair reflected on the importance of ensuring that learning from the programme influenced wider policy decisions, particularly around

neighbourhood infrastructure and public spaces. They also highlighted walking as one of the most accessible and cost-effective forms of physical activity and questioned why it had not featured more prominently within the presentation.

The Public Health Consultant responded that walking remained a core element of the overall strategy but had not featured heavily within the funding proposal because substantial provision already existed through initiatives supported by Voluntary Action Rotherham and the Ramblers Association. Officers intended to build upon this existing provision through community-based work rather than create duplicate services.

The Chair reiterated their view that walking should remain central to efforts to promote physical activity across the borough.

Resolved:-

That the Health Select Commission:

1. Noted the contents of the presentation received.

2. Requested that the Health Select Commission be provided with the detail of any metrics agreed upon against which progress or success will be measured, clearly identifying how those metrics support tackling health inequalities and general population health, along with progress reports in line with those metrics at relevant intervals.

3. Requested that a mechanism via which Elected Members can be updated on the activities being undertaken in their wards connected with the programme and its associated funding so that they can support raising awareness in their local communities, alongside the wider communications and marketing strategy, be agreed and implemented.

4. Agreed that a further update on the progress and impact of the programme be provided at the halfway point of the strategy, in late 2028.

28. IMMUNISATION PROGRAMME COMMISSIONING CHANGES

The Chair welcomed Kathy Wakefield, Senior Programme and Commissioning Lead, North East and Yorkshire Office for Pan ICB Commissioning (OPIC), Laura Brown, Public Health Officer for Rotherham, North East and Yorkshire Office for Pan ICB Commissioning and Gilly Brenner, Public Health Consultant deputising in the absence of Denise Cornwall, Health Protection Principal to the meeting and invited them to introduce the presentation.

The Commission heard that to support the transition, a new Office for Pan-ICB Commissioning (OPIC) was being established. The role of OPIC would be to provide specialist commissioning support to Integrated Care Boards in fulfilling their responsibilities for national screening and immunisation programmes.

Members were advised that the North East and Yorkshire OPIC footprint would cover the North East and North Cumbria Integrated Care Board, Humber and North Yorkshire Integrated Care Board, West Yorkshire Integrated Care Board and South Yorkshire Integrated Care Board. It was explained that these arrangements aligned with the Government's Ten-Year Health Plan and the wider objective of strengthening the role of Integrated Care Boards as strategic commissioners of health services. Officers reported that significant work was already underway to redesign operating models, strengthen governance arrangements and build closer working relationships with Integrated Care Board partners to ensure a smooth transition.

Members were informed that screening and immunisation represented only one component of OPIC's responsibilities, but nevertheless constituted a substantial and complex programme of work. The Commission heard that responsibility covered a wide range of vaccination and screening programmes delivered across all age groups, from childhood immunisations through to adult vaccination programmes and cancer screening services. In addition to routine commissioning functions, officers advised that the team also played a key role in responding to outbreaks and public health incidents through multi-agency incident management arrangements involving the United Kingdom Health Security Agency (UKHSA), local authorities, Integrated Care Boards and healthcare providers.

The presentation highlighted the key commissioning priorities underpinning all immunisation and screening programmes. Members heard that improving uptake and coverage across vaccination and screening programmes remained a primary objective, alongside a strong focus on reducing health inequalities and narrowing the gap between areas, services and populations with the highest and lowest levels of uptake. These objectives informed both local and national commissioning plans and were central to the commissioning intentions for 2026/27.

The Commission was advised that a number of significant service developments were currently being implemented. These included the continued expansion of community pharmacy provision, which already delivered influenza (flu), Coronavirus Disease 2019 (COVID-19) and childhood flu vaccinations. Under proposals aligned to the Government's Ten-Year Health Plan, community pharmacies would also become involved in the delivery of adolescent Human Papillomavirus (HPV) vaccinations, with planning and implementation work currently underway. Members also noted the successful rollout of what was described as the world's first gonorrhoea vaccination programme, using the Meningococcal

Group B (MenB) vaccine and targeting identified high-risk cohorts through sexual health services.

Further developments within screening programmes were outlined. The Commission heard that the threshold for bowel cancer screening had been lowered to support earlier detection, with positive early indications being reported. Members were also informed that Human Papillomavirus self-testing had recently been introduced at the end of August, representing an important step towards achieving cervical cancer elimination objectives by improving access and encouraging greater participation in screening. Additionally, several national workstreams were exploring the use of automated technologies and artificial intelligence (AI) within screening pathways, both to enhance service delivery and to support workforce capacity challenges.

In relation to pre-school immunisation programmes, officers reported that improving uptake among children aged under five remained a priority, particularly with regard to measles-containing vaccines. The Commission was advised that measles continued to present ongoing concerns nationally, with occasional outbreaks and clusters of cases still occurring. Members noted that changes introduced to the childhood vaccination schedule earlier in the year had incorporated chickenpox vaccination into the combined Measles, Mumps, Rubella and Varicella (MMRV) programme, which had been positively received. It was further reported that a targeted MMRV catch-up programme would commence in November and continue until March 2028, focusing on children aged over six years who had not previously received a chickenpox vaccination or contracted the disease.

The presentation also addressed school-aged and adolescent vaccination programmes. Members heard that efforts continued to restore uptake levels to those experienced prior to the COVID-19 pandemic, with a particular focus on Human Papillomavirus vaccination because of its role in preventing cervical cancer. School immunisation providers were increasingly using the national Mavis reporting system, which improved parental communication, consent processes, data management and information sharing with General Practitioner (GP) practices. The Commission was also advised of the recent implementation of a time-limited MenB catch-up vaccination programme for higher-risk groups, including university entrants and young people entering residential further education settings. Officers reported that this programme had been positively received by educational providers, vaccination services and the wider public. Members were additionally informed that the Joint Committee on Vaccination and Immunisation (JCVI) had recommended the introduction of a routine adolescent MenB vaccination programme following outbreaks earlier in the year, although ministerial approval was still awaited.

Updates were also provided regarding adult immunisation programmes. Particular emphasis was placed on the Respiratory Syncytial Virus (RSV)

vaccination programme, which had been expanded to include all adults aged over 80 and residents of older persons' care homes regardless of age. Further eligibility extensions had subsequently been introduced for people aged 65 to 74 with specified clinical risk factors, including respiratory conditions and immunosuppression. Members also heard that efforts continued to improve uptake of seasonal vaccination programmes such as flu and COVID-19 vaccines. A particular focus had been placed on increasing access for people experiencing homelessness, with close partnership working taking place between health services and local authority inclusion health teams. Vaccination against pneumococcal disease had also been extended to this cohort to maximise opportunities for co-administration alongside other vaccines.

The Commission noted additional expansion of community pharmacy delivery within the seasonal flu programme. From October, pharmacies would be able to vaccinate at-risk children up to the age of 17, whilst from December they would also be able to offer vaccination to school-aged children who had missed their school vaccination sessions and associated catch-up opportunities. This approach was intended to improve convenience and maximise overall uptake. Officers reported that a trajectory of improvement targets had been established over the next three years to support continued progress across all vaccination programmes.

Following the national update, the Public Health Consultant outlined the contribution of the Council's Public Health Service to immunisation and screening efforts. Members heard that the authority's health protection function played an important role in community outreach and engagement, utilising established relationships with local communities, faith groups and community leaders to promote accurate health information and improve trust in vaccination programmes. This approach had built upon successful methods developed during the COVID-19 pandemic, where trusted local messengers had been particularly effective in reaching communities that health services could otherwise find difficult to engage.

The Commission was informed that Public Health teams also routinely analysed immunisation data to identify areas of lower uptake and emerging concerns. Where gaps were identified, targeted interventions were developed to address local challenges. Examples included providing vaccination opportunities through schools or community settings in particular neighbourhoods where childhood vaccination rates were below expected levels. Public Health also supported practical delivery arrangements through communications campaigns, provision of venues and the establishment of temporary vaccination sites where appropriate.

Members further received an update on the Pathfinder Childhood Immunisation Pilot, an NHS England initiative designed to improve vaccination uptake among children aged 0 to 5 years. The pilot utilised health visiting services commissioned by Public Health to identify children

who had missed vaccinations and offer alternative opportunities to receive them. Officers explained that the programme was particularly supporting families who had experienced barriers to accessing routine vaccination pathways, including General Practitioner registration issues, language barriers, childcare commitments and other practical obstacles. Vaccinations could therefore be offered during routine health visiting contacts, creating a more flexible and accessible route into the programme. Whilst the pilot remained at an early stage, Members were advised that it would continue for a further twelve months, allowing more comprehensive data and outcomes to be gathered.

In conclusion, officers reiterated the significant organisational changes that were taking place nationally, the ongoing focus on improving vaccination and screening uptake, and the extensive partnership work being undertaken locally to address inequalities, improve access and support population health through effective immunisation programmes.

The Chair thanked officer for the presentation and invited questions and comments from members.

Cllr Duncan opened the discussion by asking about the principal risks associated with the planned transfer of commissioning responsibilities to Integrated Care Boards and how local health needs would continue to influence commissioning decisions within the new Office for Pan-ICB Commissioning arrangements. Particular concern was expressed regarding whether local priorities, including efforts to improve uptake of the Measles, Mumps and Rubella (MMR) vaccine and Human Papillomavirus (HPV) vaccinations, might be diluted within a larger geographical footprint.

In response, The Senior Programme and Commissioning Lead advised that officers regarded the transition principally as an opportunity rather than a risk. It was explained that the new arrangements would strengthen relationships with Integrated Care Boards and primary care providers and would bring screening and immunisation commissioning into closer alignment with wider health system planning. Although the new commissioning footprint would cover a larger geographical area across the North East and Yorkshire, Members were assured that a strong local presence would be retained. Dedicated South Yorkshire screening and immunisation teams would continue to operate, supported by place-based leads maintaining local relationships with authorities and partners. Officers acknowledged that there were some short-term risks arising from reduced staffing capacity following a recent voluntary redundancy programme. However, recruitment activity was underway to address vacancies and officers stated that essential work, particularly around reducing inequalities and supporting priority programmes, continued to be delivered through close collaboration between local authorities, Integrated Care Boards and wider system partners. It was emphasised that the longer-term effect of the changes was expected to be beneficial because of the stronger integration with local health commissioning structures.

Cllr Duncan subsequently clarified that their concern had related primarily to the risks during the transfer process itself and noted the reassurance provided regarding recruitment and workforce planning.

Cllr Thorp questioned why uptake of influenza and Coronavirus Disease 2019 (COVID-19) vaccinations had declined amongst care home residents and those aged over 65 despite overall improvements in uptake.

The Senior Programme and Commissioning Lead advised that no single cause had been identified. Officers were working closely with local authority partners and infection prevention and control teams to improve understanding of eligibility criteria and increase awareness amongst care home residents, relatives, carers and managers. Members were informed that joint communications were issued by Integrated Care Boards and local authorities to reinforce programme eligibility and the importance of vaccination. Officers also highlighted practical challenges associated with obtaining consent for residents lacking mental capacity, which frequently involved discussions with family members and the application of best-interest decision-making processes. Additional work was taking place with hospital providers to ensure eligible patients were vaccinated prior to discharge into care home settings.

Cllr Thorp queried whether declining uptake might be linked to increasing public scepticism regarding vaccination following the COVID-19 pandemic.

The Senior Programme and Commissioning Lead advised that no evidence had emerged to support such a conclusion and therefore officers had not identified this as a significant contributory factor.

Cllr Harrison sought clarification regarding the effectiveness of community engagement campaigns and pop-up vaccination services, asking whether outreach activity generated sustained improvements in vaccination uptake or simply resulted in temporary increases in attendance.

The Senior Programme and Commissioning Lead explained that all outreach schemes were subject to comprehensive business cases and robust evaluation processes. Evidence gathered through projects funded during the COVID-19 pandemic, particularly those aimed at improving access and reducing inequalities, suggested that outreach activity could successfully vaccinate people who might not otherwise engage with services; however, overall increases in uptake were generally relatively modest compared with the scale of effort involved. Whilst the evidence did not demonstrate substantial increases in vaccination coverage attributable solely to outreach activity, officers remained committed to supporting community-based provision because of its value in reaching vulnerable populations and addressing barriers to access. Members heard that future work would continue to explore neighbourhood-based vaccination models targeted at communities with persistently low uptake.

Cllr Ahmed asked why vaccination uptake remained comparatively low within certain communities and sought assurances regarding actions being taken to tackle these disparities.

The Senior Programme and Commissioning Lead explained that the causes were multifactorial and varied between localities and population groups. Deprivation, cultural factors, language barriers and literacy levels all contributed to lower uptake in some communities. Members were advised that, in certain areas, perceptions of the National Health Service itself could also influence engagement. Officers described ongoing work with community leaders, faith leaders and local partners to better understand local concerns and tailor interventions accordingly. The importance of place-based intelligence and trusted relationships within communities was emphasised as a key mechanism for addressing inequalities and improving uptake.

Cllr Ahmed asked whether a large-scale public campaign similar to that adopted during the COVID-19 pandemic should be introduced to encourage greater uptake of routine vaccinations.

Officers explained that the pandemic response had been delivered under exceptional circumstances and had benefited from substantial resources and emergency arrangements that would not be sustainable within routine vaccination programmes. Whilst efforts were continuing to expand delivery routes through community pharmacies, health visiting services and healthcare providers, evidence suggested that increasing the number of providers principally improved accessibility and flexibility rather than significantly increasing uptake. Members heard that more targeted approaches would therefore continue to be used, with mass vaccination models deployed only where significant outbreaks or specific public health risks justified such action. Officers also suggested that public understanding of vaccine-preventable diseases had diminished because many of those diseases were now rarely encountered. Consequently, future communications would place greater emphasis on explaining the serious consequences of illnesses such as diphtheria and tetanus and highlighting the protections afforded by vaccination.

Cllr Harper questioned the rationale for the significant expansion of community pharmacy vaccination services and asked how the approach would support residents in rural or harder-to-reach areas.

In response, the Senior Programme and Commissioning Lead explained that community pharmacy provision was intended primarily to increase accessibility and convenience. Examples were provided of children who missed vaccinations through school-based programmes due to illness or practical difficulties and who could instead receive vaccinations through local pharmacies. Similarly, pharmacies provided additional opportunities for parents already accessing other healthcare services. Whilst expanded provision did not automatically result in significantly higher uptake rates,

officers considered that offering residents greater flexibility and choice increased the likelihood of participation over time and therefore remained an important element of the overall strategy.

Cllr Thorp sought further detail regarding the Pathfinder Childhood Immunisation Pilot. Referring to the reported investment in the programme, he questioned whether the initial increase in vaccinations appeared proportionate to the resources committed and asked whether the programme had been targeted appropriately at areas of low uptake.

The Public Health Officer for Rotherham explained that the Pathfinder programme formed part of a national Government initiative designed to test how health visiting teams could support immunisation delivery in the future. The intention was not simply to count vaccinations delivered but to evaluate different service models and establish sustainable approaches for long-term implementation. Members were advised that extensive preparatory work had been required, including workforce training, record management systems, referral pathways and engagement with General Practitioner practices. Within Rotherham, the programme had initially been delivered through a single trained health visitor, with additional staff currently being trained. Officers reported that referrals had expanded beyond the first participating practice and that the programme was gathering momentum. Particular emphasis was placed on supporting highly vulnerable families who were unlikely to engage through conventional routes. Members also heard that the programme's benefits extended beyond vaccination delivery itself. Health visitors undertaking home visits had identified additional health and welfare concerns, including unmet dental needs and safeguarding issues, demonstrating wider public health benefits beyond immunisation outcomes alone. Officers also highlighted engagement activity undertaken at community events, including the Rotherham Show, where thousands of residents had received information and positive conversations about vaccination.

Cllr Baum-Dixon observed that future reports would benefit from additional benchmarking information to provide greater national context and enable Members to assess the effectiveness of initiatives against national trends and comparable areas.

The Senior Programme and Commissioning Lead confirmed that officers routinely compared local performance against regional and national data, including published England averages, and agreed that the inclusion of additional contextual benchmarking information would assist Members in their scrutiny of performance.

Cllr Baum-Dixon reiterated the value of presenting such comparative information within future reports.

The Chair commented that it would be beneficial to consider the drivers of the significant improvement in vaccination uptake amongst pregnant women, noting that the increase appeared to provide valuable learning

opportunities. They also sought assurance regarding local governance and accountability arrangements during the transfer of commissioning responsibilities.

In response, the Senior Programme and Commissioning Lead explained that extensive governance arrangements were already in place, including internal senior management oversight, monthly programme monitoring and the establishment of a dedicated Office for Pan-ICB Commissioning leadership group involving executive representatives from Integrated Care Boards. At the local level, Members were advised that assurance and oversight were provided through the Health Protection Board, which received regular updates and monitored progress and risks associated with the transition.

Resolved:-

That the Health Select Commission:

1. Noted the contents of the presentation received.

2. Requested that local performance reports in relation to vaccination uptake be provided to the Commission at appropriate intervals to facilitate ongoing monitoring of support offered to wards, schools and GP practices. These reports should include benchmarking against national vaccination uptake data to enable comparison of local performance with national trends. Delivery method and timeline TBC.

3. Requested an update at an appropriate stage on the overall impact of the Pathfinder programme in Rotherham. Delivery method and timeline TBC.

29. HEALTH SELECT COMMISSION WORK PROGRAMME - 2026/27

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.

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

The minutes of the last JHOSC meeting held 7 January 2026 were shared with members as soon as they became available and via the 14 May Health Select Commission meeting agenda pack.

The next JHOSC meeting remains expected to take place in October 2026, and final arrangements are underway regarding the agenda for that meeting.

Health Select Commission members will be updated regarding the agreed agenda items and meeting date once confirmed, at which point Members will be invited to share any questions or comments they would like to be included in JHOSC's discussions regarding those agreed items for consideration.

31. URGENT BUSINESS

There was no urgent business to discuss.