**SHA Central Council, Cardiff, 30 March 2019**

**Present:** Alex Scott-Samuel (ASS), Alison Scouller (AS), Tony Beddow (TB), Tony Jewell (TJ), Carol Ackroyd (CA), John Lipetz (JL), Diane Jones (DJ), Coral Jones (CJ), Brian Fisher (BF), Andy Thompson (AT), Vivien Walsh (VW), Mike Roberts (MR), Nicholas Csergo (NC), Vivien Giladi (VG), Caroline Bedale (CB), Irene Leonard (IL), Mark Ladbrooke (ML), Norma Dudley (ND), Brian Gibbons (BG), Gurinder Singh Josan (GSJ)

**Observers:** Darren Williams, Sophie Williams, Peter Jenkins, June Clark

**Apologies:** Jean Hardiman Smith, Catharine Grundy Glew, Corrie Lowry, David Llewellyn Davies, David Mattocks, David Wrigley, James Williamson, Jessica Ormerod, Jos Bell, Kathrin Thomas, Katrina Murray, Peter Mayer, Steve Bedser, Jon Schaffer, James Gill, Abdul Rahman?

**1 Guest speaker**

The guest speaker was Julie Morgan, Deputy Minister for Health and Social Services in the Welsh Government. She was introduced by AS

Key points from her talk: Priorities are maintaining the NHS as health service provider, tackling health inequalities, maintaining free prescriptions in Wales. Public Health measures include the wide banning of smoking, maintaining free school breakfasts, starting to ban physical punishments of children (a measure unwelcomed by some Christian Institutes) – it’s a programme in need of much supportive information for parents. There’s no purchaser /provider split in Wales, both Primary and Secondary health care are all NHS and no services are performance targeted. As social care was split before devolution, this is still so. The Welsh organ donation scheme is very successful. Waiting times are challenging but figures for these and discharge are better than in England. Social care operates in co-production and is person-centred, concentrating on the individual’s objectives – ‘doing with’ rather than ‘doing to.’ In England, 1000 Sure Start Centres have closed since 2009, whilst Wales is still investing in early years, although more is required so schemes can become more widespread. 1:1 support is provided for vulnerable women, particularly if the woman’s already had a child taken into care. Austerity has had devastating impacts on child poverty- on both relative and absolute poverty. The Assembly is trying to be more innovative and is supportive of a social care levy through its tax raising powers. Front line care workers are amongst the worst paid staff but the aim is to have good quality care throughout Wales and a CPD programme for social work is being considered. It is hoped to re-balance social care, but currently, most provision is private. 12% of social care is in Local Authority control, this could rise and co-operative provision is another possibility. Investment in the workforce is necessary, and collective bargaining might help achieve this. The numbers of children in care have doubled each year, with many taken miles away from their birth families.

MR asked how Wales was doing with ‘left behind’ communities since inequalities and poverty are increasing every year, rickets is back and the working poor are becoming poorer. Julie replied that Early Years investment has tripled, and with the understanding that high quality care and education are crucial at this stage, Wales has adopted European and Scandinavian models. CA commented that in England there was a strong lobby by the disabled and about the inadequacy of children’s services; state provision was not trusted. Julie responded that this was not so in Wales. ND asked how user-led co-operatives could be sure of surviving. Julie said regional partnership boards incorporating health, social, education and housing forums have been set up to ensure similar services are maintained across geographical boundaries. A Future Generation Act considers long term matters and is taking Wales forward as part of the global world.

**Note:** The Central Council meeting was in 2 sections, before and after the invited speaker to fit in with her commitments, but for continuity, the speaker’s presentation has been given first

2 **Notes of Central Council meeting, 19.1.19**

Tony Jewell had sent apologies

**3 Treasurer**

ASS reported that Tom Fitzgerald has resigned as Treasurer with immediate effect, but has offered to help if explanations or other help is needed. Diane Jones has offered to act as Acting Interim Treasurer. Tom was thanked for his valuable contribution to the SHA, and Diane for stepping up to take his place.

**4 Policy Development**

TB commented that SHA now had draft policies on Integrated Care, and on Maternity Care. Mental Health was underway. As yet, there was nothing on Carers or Children and Young People

(i) Integrated Care

TB outlined his precirculated paper. Integrated Care was about what a National Care service should look like, and rebuilding a public NHS. Section 1 defines a socialist care system. Integration has never included privatisation in Wales, it means delivery of health services for which it is necessary (a) to identify a language to which all can agree which provides a health gain to the Welsh population. ASS asked for comments and responses within a week

NC suggested we build on links with Composite 8 (Labour Party motion 2017). CB agreed this is a useful starting point. Social gain needs to be quantified, to take account of quality and the burden on informal (unpaid) carers needs to be relieved too. She suggested there were 5 discrete service areas, although some people have complex needs not addressed within a single area. Does this next bit in italics make sense? Equal pay for equal work should prevail. BG suggested we need to make sense of the various discussion points and return with motions to the next meeting There was general agreement to ASS’s suggestion that this be a second draft. BF does not want any attempt to integrate Health and Social Care into a single issue as Social Care is really important. GSJ commented that some members were underwhelmed by the conten;t, there were concerns about accountability, and people need to have confidence in the evidence. Presentations seem to be at an early stage and mainly academic currently. CA had found the contributions helpful particularly around the boundaries of Health and Social Care. She liked NC’s suggestion about the re-instatement and composite 8. SC suggested a separate look at social care, particularly where there’s an interface. What are the crucial issues, where individual budgets are contentious, the scope of what people should discuss bearing in mind that people value user-led services, and diversity of input, especially younger people in receipt of social care? There was a plea for no more separate legal identities, no more re-structuring or concerns about just securing one’s own job. We need a common framework for employment recalling that many teams have worked successfully for years across health and social care. ML said we needed a third set of national terms to integrate pay and conditions. The Lansley ‘reforms’ (2012) were all about privatisation and these will have to be reversed. Some people like budgets but this is not the way to deliver public services. We need properly trained staff, given proper benefits, sick pay, holidays etc...

June Clark (observer) suggested we were digging a hole for ourselves in using the term ‘social care’. Care is about interactions between people; it’s personal, maybe intimate, needing proper regulation and basic nursing care. It seems the preventive aspect seems to have been lost from true social care. Referring to the ‘Agenda for Care’ programme, it’s necessary to get the language sorted. What can we learn from the Scottish system? Suitable arrangements are specified in public services; partnerships under 1 provider helps build a new common culture. IL commented that social and clinical needs should both be addressed – and that doesn’t happen with an insurance based system. There is similarity between this and the current Tesco situation in which baby foods are no longer stocked because they’re being stolen.

TB commented that it was impossible to get good care through the market system. Health gains mean adding years to life and life to years – is this itself an adequate definition of social gain? The 5 service areas are where there’s best potential for greatest co-operation already between health and social care. Who is accountable and for what? What about access rates? Needs should be assessed by someone other than the individual. A national political framework would detail speed of access, range of services, some body should determine how best to deliver what an individual is entitled to. Maybe we need a new definition of social care, to include co-production, citizens rights etc.. The Health and Social Care Act has changed the whole mind set of what professionals are expected to do, and that’s all consistent with breaking up national plans in order to ration and prioritising budget over needs. The government ducks these issues consistently.

(ii) Maternity policy

ASintroduced the draft policy. AT suggested an addition to item 9, that partners of pregnant women should have a legal right to take time off in the event of problems developing during the pregnancy. Para 1 – Is 6 weeks too limiting given Marmot’s reference to the importance of the first 5 years? BG referred to the first 1000 days –maybe link it with the successful ‘flying start’ programme in Wales - equivalent to Sure Start in England. ND said health visiting needed more investment, particularly to help those with very restrictive budgets. TB said special help was needed where the mother and baby services were poor. A more pro-active approach is needed to smoking. AS said the paper was general, maybe needed complete revision in a year’s time. ASS commented on the good work done by Maternity Action with asylum seekers and other marginalised groups in England. BG said docs not cops provided successful action.

(iii) Public Health

TJ reported on the Public Health policy group. It had been active with lots of e-mail and phone contributions. They had produced policies in short succinct statements with accompanying explanations; they now needed grouping, and checking for consistency. There were 5 sections: global health, environment, inequalities, investing and protecting public health, all to comply with state and international standards. Currently, only 5% investment in the NHS was spent in prevention. He would like detailed comments by e-mail but would take general feed back now. Comments included which were the priorities and why? MR (a co-author) said the document aimed at cross-cutting rather than developing silos. Councils were being taken to Court because they didn’t have comprehensive policies and actions to combat pollution. VG said the focus on water, obesity and sugary drinks was right. Should LAs provide water fountains and public toilets again? CB said mental health was not strong enough and needs integrating into Public Health. Attention to places of work, hazard campaigns, ‘decent jobs and decent lives’, an end to de-regulation, and Health and Safety measures re-introduced via Trade Unions were also required. ML spoke in support of a living wage, dealing with poverty, life expectation inequalities, poor housing, exploitative landlords and aiming to drive ‘cheapskates’ out of business. A National Occupational Health Service was proposed; it was important to challenge the mis-understanding of less state funding when the whole fabric of society is being damaged as private businesses collapse with very cruel consequences. All utilities in England are now foreign owned. Currently we have abandoned progressive taxation; Chief Execs have vast salaries and pay low taxes as in the US, whilst in Scandinavia this is reversed, Chief Execs have lower salaries and pay higher taxes. GSJ raised the matter of knife crime and drugs, advocating the public health approach adopted in Glasgow by analysing the data, getting early diagnosis, examining emergency admissions and linking these figures with ambulance calls and night club licenses

**5 Labour Party Women’s Conference**

CJ gave a report on the Women’s Conference, 23-24 February, Telford International Centre – the first stand alone women’s conference in 25 years. 600 delegates attended + additional visitors, and was an enlivening experience for all. Eight policy areas were raised with time to discuss each, giving many women the chance to speak for the first time at Conference. Coral proposed the decriminalisation of abortion, and this was composited with social care at the selection debate. The 2 motions chosen to go forward to the main conference are: migrant women (lots of personal experience present in the hall) and Universal Credit. Dawn Butler, Diane Abbott and Jeremy Corbyn all put in an appearance

**6 Social Care**

Social Care Model Resolution: CA said the Reclaim the Social Care group had provided a very good summary with some critical demands. Current Labour Party policy was dire. Many local campaigners were raising the same issues ie: for provision of a full range of social care free to enable people to live meaningful fulfilled lives. The resolution was agreed unanimously.

7 **Governance Review**

TB reported that 15 of the Clarke recommendations have been reviewed around principles, aims and values. The emerging proposals are that SHA should become a Company Limited by Guarantee. It seemed there could be £25000 /year to spend on staff (1 or more). SHA would change its legal status. ASS wondered if we were adequately informed, and in any case, as only about 50% of Central Council were present, VG suggested we delayed making a decision. AT said that the AGM would need to take this key constitutional decision. CA asked for a single sheet summary of the information. BF said the current situation was unsustainable. He referred the review group to the informative CIC site, and suggested maybe Society of Labour Lawyers might offer support with further advice. GSJ said SHA didn’t feel like a limited company to him.

**8 Secretary’s Report**

Jean's report had been precirculated. AT, replying to GSJ’s question about what was wrong with the database, said that many of the records set up by the former SHA director were not workable in practice. There were many issues with new members where nothing had been entered, so it was unclear who was a member and who just a contact; who was in which CLP, addresses and post codes and other specifications didn’t match either. There was now a small technical working group consisting of Ken Smith, Kal Ross and a colleague of Brian Fisher.

**9 Finance Report**

A brief report had been circulated.TB commented that the income stream was similar to last year’s, the books balance, and auditors are free to examine all finances, ask questions etc.. BF said the figures looked healthy and he’d like a prediction of costs and balances at the next meeting to clarify what we can afford. VG asked about membership, losses and gains. The Secretary has reported membership rising - about 1200 full members, of which around 400 are concessionary. SHA’s finances run January - December. The costs of the Disciplinary Hearing have not been included as bills have not yet been detailed, but ASS said legal costs were around £2200 + a settlement to the former director without prejudice of £3000 – a sum misrepresented in social media as if it were an admission of wrong-doing by SHA. The costs of a Tribunal would have been much greater and this payment consequently was therefore expeditious. AT commented that the payment was NOT compensation, but a compromise payment to draw a line under the negotiations and bring them to an end. DJ said the former director had alleged untruthfully on social media that he’d been compensated for unfair dismissal. TJ asked about Stark Murray Trust Funds which used to be available to SHA and whether SHA could benefit from legacies. Does SHA have Trustees? These last matters are referred to the Governance group. MR commented that recent disputes had adversely affected the SHA’s reputation, though it’s now recove**ring fast.**

**10 Dates of next / future meetings**

To be notified