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the European Social Charter

submitted by

THE GOVERNMENT OF THE UNITED KINGDOM

(Articles 3, 12 and 13 for the period 01/01/2005 – 31/12/2007
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COUNCIL OF EUROPE

THE EUROPEAN SOCIAL CHARTER

THE UNITED KINGDOM'S TWENTY EIGHTH REPORT

OCTOBER 2008

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Article 3 – The right to safe and healthy working conditions

Article 3, Paragraph 1

United Kingdom

The general legal framework

1. The position remains generally as previously described. The Health and Safety at Work etc. Act (HSWA) 1974 is the primary piece of legislation covering occupational health and safety in the United Kingdom (UK). An up-to-date consolidated version of the Act can be viewed at the Ministry of Justice UK Statute Law Database via the following link:- http://www.statutelaw.gov.uk/. It is listed under the category of UK (Public Act General) as Chapter No. 37 of 1974.

2. Comprehensive information on Health and Safety legislation as it applies in Great Britain can be viewed at the Health and Safety Executive website at:- http://www.hse.gov.uk/legislation/. Similarly the legislation that applies in Northern Ireland can be viewed at the Northern Ireland Health and Safety Executive website at:- http://www.hseni.gov.uk/index/information_and_guidance/legislation.htm.

Great Britain

3. The Health and Safety Executive (HSE) is responsible for administering the Act and a number of other Acts and Statutory Instruments relevant to the working environment in Great Britain.

4. The HSWA applies to most workplaces, including offshore installations and nuclear installations, and to most people at work, including the self-employed. Domestic servants in private households are excluded. There are particular difficulties in respect to including domestic servants, in regard to the extent to which the state should interfere with the private home.

5. A number of other UK government bodies are responsible for occupational health and safety in some sectors:

- Railway safety – Office of Rail Regulation;
- Marine safety – Maritime and Coastguard Agency; and
- Aviation safety – Civil Aviation Authority.

6. The UK also implements health and safety legislation based on European directives and/or regulations. A key element is the health and safety Framework directive, primarily implemented in Britain by the Management of Health and Safety at Work Regulations 1999, which established broad based obligations for employers to evaluate, avoid and reduce workplace risks etc. A range of related and other directives, implemented through national regulations cover:

- the management of specific workplace risks (such as musculoskeletal disorders, noise, work at height or machinery);
- the protection of specific groups of workers (such as new or expectant mothers, young people and temporary workers);
- measures to complete and maintain the single market in the EU; or
- the protection of the environment.

A similar legal framework exists in Northern Ireland where the Health and Safety at Work (Northern Ireland) Order 1978 is the primary piece of legislation covering occupational health and safety.

Health and Safety Executive

7. On 1 April 2008, the Health and Safety Commission (HSC) and Health and Safety Executive (HSE) merged to form a single national regulatory body responsible for promoting the cause of better health and safety at work – the Health and Safety Executive. Before the merger, HSC was responsible for regulating health and safety in Great Britain. HSE (as was) and Local Authorities (LAs) are the enforcing authorities working in support of the Commission. LAs are responsible for regulation in offices, shops and other parts of the services sector. HSE regulates health and safety in nuclear installations, mines, factories, farms, hospitals, schools, offshore gas and oil installations, onshore chemical plants and the gas grid. Both regulators are responsible for many other aspects of the protection both of workers and the public. The Department for Work and Pensions (DWP) sponsors HSE.

8. The national occupational safety and health (OSH) policy is outlined in HSE's "Strategy for workplace health and safety in Great Britain to 2010 and beyond"[1].

9. The views of the social partners (including trade unions, such as the Trades Union Congress, and employers' organisations, such as the Confederation of British Industry) are routinely sought in the formulation, implementation and review of its national strategy for health and safety at work.

10. HSENI sets out its strategy for implementing the legal framework in Northern Ireland in its three year Corporate Plans; its current plan covering 2008 to 2011[2]. These plans are published only after consultation with all interested parties including employers' and workers' organisations.

In its Conclusions XVIII-2, the Committee asks whether setting up an inventory/register of buildings containing asbestos has been considered by the authorities.

11. The Control of Asbestos Regulations 2006 brings together three previous sets of regulations covering the prohibition of asbestos, the control of

[1] http://www.hse.gov.uk/aboutus/plans/index.htm
[2] http://www.hseni.gov.uk/27317_final_pdf.pdf

asbestos at work and asbestos licensing. The Regulations also prohibit the importation, supply and use of all forms of asbestos. Two Approved Codes of Practice providing guidance on complying with the Regulations were also published.

12. The UK's policy is to prevent people from being put at risk from asbestos in the first place. We have considered whether such an inventory/register would make a practical, affordable and proportionate contribution to the prevention or reduction of exposure to asbestos fibre, when considered alongside the current regulatory controls that were introduced in 2004.

13. In 2004 the UK introduced a duty to manage asbestos in non-domestic premises. Either a presumption must be made by the duty-holder that a building, or parts of it, contain asbestos or a survey must be done to identify where it is. The degree of detail required when surveying enables the individual locations of asbestos-containing materials in the building to be mapped, but there is no obligation to make this detail publicly available. The Regulations require only that that information must be made available to persons liable to disturb asbestos.

14. The inventory/register that the Committee is suggesting would simply indicate only whether buildings contain asbestos or not. The UK's view is that this would not add to the existing preventative structure, as detailed above.

15. The costs of setting up an online register, or any other form of list, would be very significant nationally as an estimated 500,000 or more buildings in England, Scotland and Wales are likely to contain asbestos. It would take considerable resources to compile and to keep up to date. It would be very difficult to do this practically. The UK preference, therefore, is to rely on the 'duty to manage' strategy.

The Committee asks also for the next report to provide information on any new measures taken in this area, as well as in respect of medical surveillance of temporary workers. Moreover, it would also like to know if non-permanent workers are entitled to representation at work in health and safety questions.

16. HSE produces and publishes guidance for agencies and employers on managing agency/temporary worker health and safety[1]. Guidance is also available from the HSE website pages[2]. Because it is not always clear who the employer of such workers is, the guidance emphasises the importance of clear liaison between the agency and the user business to ensure that, between them, they cover the range of health and safety protection measures that need to be taken to protect such workers, regardless of who

[1] http://www.businesslink.gov.uk/bdotg/action/printguide?r.l1=1073858799&r.l3=1077243939&topicId=1077243939&r.l2=1074409641

[2] http://www.hse.gov.uk/workers/agencyworkers.htm

their employer is. It describes how such liaison arrangements should work for specific issues like risk assessment, the provision of information, instruction and training, workforce consultation, the provision of equipment, such as personal protective equipment (PPE), health/medical surveillance and accident reporting.

17. Non-permanent workers do have consultation rights at work on health and safety issues under the Health and Safety (Consultation with Employees) Regulations 1996, and the Safety Representatives and Safety Committees Regulations 1977 as appropriate. Equivalent legislation exists in Northern Ireland and the HSE guidance published in 2006 for agencies and employers on managing agency/temporary worker health and safety is used here also.

18. In addition to publication of the guidance above, HSE has clarified for the main employment agency trade body (the Recruitment Employers Confederation) the legal position on charging for the provision of PPE to temporary/agency workers. It confirmed by letter in April 2007 that agency workers may not be charged for PPE provided for their use at work. This guidance is also available to the Gang-masters Licensing Authority (GLA), responsible for licensing labour providers in the agriculture and associated food processing sectors (including the setting of health and safety licence conditions).

19. Since the GLA was set up the HSE has had *ex officio* membership of the GLA Board and regularly discusses with it matters concerning the health and safety protection of temporary workers in relevant employment sectors.

Article 3, Paragraph 2

Great Britain

20. The position remains as previously described with the following update on statistics.

Accident Statistics:

	2006/07	2007/08p
Number of accidents at work, to employees:		
Reported under RIDDOR 95 [1]	143,388 Rate of 546.3 per 100,000 employees	N/a[3]
Annual estimate - LFS[2]	274,000 Rate of 1000 per 100,000 workers	N/a
Number of fatal accidents, to workers	247 Rate of 0.8 per 100,000 workers	228 Rate of 0.8 per 100,000 workers

[1] RIDDOR 95: The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995, under which fatal and non-fatal injuries to workers and members of the public arising from work activity are reported by employers and others, to either HSE or the local authority.

[2] LFS: The Labour Force Survey (LFS) is a national survey of households living at private addresses in the UK – consisting currently of about 52 000 responding households each quarter.

[3] Provisional non-fatal injury and enforcement statistics for 2007/08 will be available on 29 October 2008 following the publication of Health and Safety Statistics. These cannot be released earlier because of National Statistics guidelines. Such access is carefully controlled. Release into the public domain or any public comment on these statistics prior to official publication would undermine the integrity of official statistics. Fatal injury statistics were published on 30 June 2008, therefore provisional fatal injury statistics for 2007/08 are provided.

Enforcement Statistics:

	2006/07	2007/08p
Health and safety enforcement notices issued by HSE [1]	8,274	N/a
Health and safety enforcement notices issued by LAs	6,960	N/a

	2006/07	2007/08p
Prosecutions taken by HSE[2]	597 cases (566 convictions) 95% conviction rate	N/a
Prosecutions taken by LAs	149 cases (146 convictions) 98% conviction rate	N/a

21. Statistics on the number of inspection visits that HSE makes are not collated because (a) they are not required as part of our Public Service Agreement target with Central Government, (b) HSE measures the amount of time it spends on inspection activities not the numbers of inspections it makes, and (c) our interventions are recorded in a variety of ways meaning there is no one category of inspection visit for recording.

[1] Figures include those notices issued by HSE in 2006/07. The figures do not include the 23 improvement notices and 5 cessation of work activities issued by the Office of Rail Regulation (ORR) in 2006/07.

[2] Figures relate to prosecution cases concluded in 2006/07, and include those brought by HSE as well as cases initiated by HSE relating to the railway industry, now enforced by ORR.

Northern Ireland Statistics:

	2006/07	2007/08
Number of accidents at work, to employees:	3,505 Rate of 498 per 100,000 employees	3,257 Rate of 454 per 100,000 employees
Number of fatal accidents, to employees	10 Rate of 1.4 per 100,000 employees	6 Rate of 0.8 per 100,000 employees
Health and safety enforcement notices issued	366	408
Prosecutions taken	8	22
Number of inspections	13,676	13,132

Penalties for health and safety offences

22. Section 33 of the Health and Safety at Work Act 1974 sets out offences and maximum penalties and includes the following: Equivalent penalties exist in Northern Ireland under the Health and Safety at Work (Northern Ireland) Order 1978, Article 30.

Failing to comply with an improvement or prohibition notice, or a court remedy order (issued under the HSW Act S.s 21, 22 and 42 respectively):

Lower court maximum: GB£20,000 and/or 6 months' imprisonment
Higher court maximum: unlimited fine and/or 2 years' imprisonment

Breach of sections 2–6 of the HSW Act, which set out the general duties of employers, self-employed persons, manufacturers and suppliers to safeguard the health and safety of workers and members of the public who may be affected by work activities:

Lower court maximum: GB£20,000
Higher court maximum: unlimited fine

Other breaches of the HSW Act, and breaches of 'relevant statutory provisions' under the Act, which include all health and safety regulations. These impose both general and more specific requirements,

such as requirements to carry out a suitable and sufficient risk assessment or to provide suitable personal protective equipment:

Lower court maximum: GB£5,000
Higher court maximum: unlimited fine

Contravening licence requirements or provisions relating to explosives. Licensing requirements apply to nuclear installations, asbestos removal, and storage and manufacture of explosives. All entail serious hazards which must be rigorously controlled:

Lower court maximum: GB£5,000
Higher court maximum: unlimited fine and/or 2 years' imprisonment

On conviction of directors for indictable offences in connection with the management of a company (all of the above, by virtue of the HSW Act sections 36 and 37), the courts may also make a disqualification order (Company Directors Disqualification Act 1986, sections 1 and 2). The courts have exercised this power following health and safety convictions. Health and safety inspectors draw this power to the court's attention whenever appropriate:

Lower court maximum: 5 years' disqualification
Higher court maximum: 15 years' disqualification

In its Conclusions XVIII-2, the Committee asks the next report to provide the proportion of employees and companies covered by inspection visits, if such data is available.

23. Under UK law, all workplaces in the UK are subject to health and safety supervision either by the HSE/HSENI or the relevant local authority (except domestic employment). Therefore all employees are covered by visits in their workplaces as required (except domestic employees).

The Committee also observes that the number of prosecutions initiated by HSE shows a decreasing trend over the reference period (for example a decrease from 1,688 in 2003 to 982 in 2004) and asks for an explanation of this in the next report.

24. The decrease quoted in the observation compares two different measures of prosecution activity. The first figure, quoted for 2003, is the provisional number of Informations laid before the courts by HSE. Whereas the second figure, quoted for 2004, is the number of prosecution cases taken by HSE. Prosecution 'cases' consist of one or more Informations, hence the apparent large drop in the figures. The number of Informations laid by HSE actually rose to 1720 in 2003/04.

25. HSE remains committed to the appropriate use of enforcement to

improve standards and to hold failing duty holders to account. HSE places great importance on the proportionate and consistent use of enforcement action for both occupational safety and health instances. It has extensive procedures and policies in place to ensure it delivers firm but fair enforcement in practice. HSE's enforcement policies accord with the new statutory Compliance Code for UK Regulators and HSE audits its enforcement procedures to ensure that as an organisation it continues to take the right action at the right time.

26. HSE's enforcement policy drives proportionate and targeted interventions so the highest risks and most serious offences attract the firmest enforcement action. HSE does not measure its performance by the quantities of enforcement action it takes and does not set targets. Inspectors respond proportionately to the circumstances they find. The number of our enforcement actions will always vary from year to year.

Article 3, Paragraph 3

Consultation with employers' and workers' organisations

27. Consultation and involvement takes place through the Board of the HSE and Industry Advisory Committees. HSE issues consultation documents to gather views. The views of the social partners (including trade unions, such as the Trades Union Congress, and employers' organisations, such as the Confederation of British Industry) are routinely sought on a wide variety of health and safety issues, as well as in the formulation, implementation and review of the national strategy for health and safety at work.

28. The HSE Board is itself representative of employers and workers, and also has a legal duty to consult on proposals for regulations under HSWA. These consultations include consulting representations of employers and workers.

29. HSENI has similar arrangements in place for Northern Ireland.

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Article 3, Paragraph 1

32. The position remains as previously described.

Article 3, Paragraph 2

33. The position generally remains as previously described.

34. Occupational injuries reported to the Health and Safety at Work Inspectorate under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1985 as applied to the Island:

	2005	2006	2007
Cases of fatal injury	**1**	**0**	**0**
Major injuries	**16**	**11**	**21**
Over 3 day injuries	**130**	**163**	**159**
Dangerous occurrences	**9**	**12**	**18**
Disease	**1**	**1**	**1**

35. Enforcement action 2007:

- 21 Prohibition notices were served
- 5 Improvement notices were served

36. Advisory visits were carried out to follow up 98 officially recorded complaints, accidents and requests. In addition, 177 advisory and promotional meetings were recorded.

37. Routine Inspection visits were made to construction sites, factories, workshops, hazardous installations (gas and petroleum storage), farms and riding establishments, railways, the public sector operations (schools, hospitals, etc.), asbestos removals operations and quarry operations.

Article 3, Paragraph 3

38. The position remains as previously described.

ARTICLE 11, Paragraph 1 - Removal of the causes of ill-health

1. The position remains as previously described with the following developments.

Life expectancy and principal causes of mortality

2. Both cardio-vascular disease and diabetes as well as cancer give rise to the greatest public health problems and along with accidents are the principle causes of mortality in the UK.

3. The government published its National Service Framework (NSF) for Coronary Heart Disease (CHD) in 2000 to reduce premature mortality from CHD and other cardiovascular disease (CVD) by at least 40% by 2010. Latest data, as set out in the 2007 progress report *Building for the future*, shows that we have already met that target with a reduction of 40.3% from the 1995/97 baseline. We are also on track to meet the additional target of reducing inequalities in premature CVD mortality by 40% by the same date.

4. The Quality and Outcomes Framework of the new GP contract, introduced in 2004, provides an incentive for secondary prevention of CHD in primary care and practices are now achieving 98% of the points available. The percentage of heart attack victims given thrombolysis within 30 minutes of arrival at hospital, which was 38% in March 2000, reached 85% in 2007/08. A more challenging measure is now being used; percentage of patients treated within an hour of calling for help. This was 24% in 2000 and reached 71% in 2007/08. The feasibility of rolling out primary angioplasty as an alternative treatment for heart attack across England has been explored and will be the subject of a national policy document later in 2008. In 2007/08, 22% of patients had a primary angioplasty who would otherwise have had thrombolysis. Hospital waiting times have dropped dramatically: since March 2005 no-one should have waited more than three months for heart surgery and since the end of 2005, no one has waited more than six months for angiography.

5. In March 2005, the NSF was expanded with a new chapter that provides models of care and markers of quality for arrhythmias and sudden cardiac death.

Diabetes

6. The Government published the National Service Framework for Diabetes (NSF) in 2001, with a Delivery Strategy in 2003. This is a ten-year programme to raise the quality of care and reduce unacceptable variations in care for people with diabetes. The NSF places particular emphasis on both the early identification and management of diabetes as a national priority. It is essential to diagnose those with the condition as quickly as possible so they can access the support, advice and treatment they need to reduce their risk of developing the long-term vascular and cardiovascular complications associated with the condition.

7. Standard 2 of the NSF states: *'The NHS will develop, implement and monitor strategies to identify people who do not know they have diabetes.'* The introduction of the new Quality and Outcomes Framework (QOF) as part of the GP contract has led to an increase in the number of people diagnosed with diabetes. The QOF has also shown improvements in the key clinical indicators for people with diabetes, such as HbA1c (blood glucose), blood pressure and cholesterol levels.

8. Diabetes has a major impact on the health and wellbeing of those who develop it. Standard 3 of the NSF emphasises the importance of supporting people to enable them to manage their diabetes and empower them to be partners in their own care. To support this, the Government has published guidance in a range of areas designed to enable local services to meet the recommendations in the NSF.

9. In October 2005, the Department of Health (DH) and Diabetes UK published their report of the joint working group on patient education: 'Structured Patient Education in Diabetes.' The report contains guidance to help the NHS develop and deliver high-quality patient education programmes and highlights best practice.

10. This was followed in November 2006 by the joint DH and Diabetes UK publication 'Care Planning in Diabetes,'[1] which provides diabetes services with guidance and best practice models to ensure patients are empowered through quality care planning. It transforms the diabetes annual review into a proper dialogue between the healthcare professional and the person with diabetes and allows people with diabetes to become partners in their own care and decide, agree and own their condition to manage it, and its related complications, on a day-to-day basis.

11. The Year of Care approach also puts people with diabetes in the driving seat of their care and supports them to self-manage their condition. It describes the ongoing care a person with long-term condition should expect to receive in a year, including support for self-management. The Year of Care project is a partnership initiative between the DH, Diabetes UK, the Health Foundation and the National Diabetes Support Team, Three NHS pilot sites have been selected and these are currently exploring the feasibility of the Year of Care and what needs to happen to make it a reality.

12. Chronic Kidney Disease (CKD) is a long-term condition often progressive, which may involve damage or abnormality in both kidneys or loss of kidney function, with or without other evidence of kidney damage. It is estimated that between 3 and 5 million people in England have some degree of kidney impairment which often has no obvious symptoms, but leaves them at a greatly increased risk of heart attack or stroke. Only about 1% of those

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063081

with CKD go on to develop End Stage Renal Failure (ESRF). ESRF is an irreversible, long-term condition for which regular dialysis treatment of transplantation is required if the individual is to survive.

13. The demand for renal replacement therapy (RRT) (dialysis and transplantation) is increasing at 5% per annum until at least 2030 due to the ageing population, increasing incidence of diabetes and increased survival rates of patients requiring RRT.

14. *The National Service Framework for Renal Services* (the Renal NSF) covers the whole patient pathway from the identification of risk to end of life care. It was published in two parts in 2004 and 2005.

15. Part One, published in January 2004, sets five standards and identifies 30 markers of good practice in the areas of dialysis and transplantation, aimed at improving, fairness of access, patient choice about the type of treatment they receive and reducing variation in the quality of dialysis and kidney transplant services. These standards and markers of good practice will help the NHS and its partners manage the increasing demand for renal services.

16. Part Two, published in February 2005, sets four quality requirements and identifies 23 markers of good practice focusing on chronic kidney disease, acute renal failure and end of life care. These quality requirements and markers of good practice will help the NHS to reduce the development and progression of chronic kidney disease by better detection and management in primary care, minimise the impact of acute renal failure, and extend palliative care to kidney patients at the end of their lives.

17. *The National Service Framework for Renal Services: Working for Children and Young People* published in June 2006, sets out five standards, four quality requirements and markers of good practice from the Renal NSF and links them to the standards in the National Service Framework for Children, Young People and maternity Services (the Children's NSF).

18. Two progress reports on the implementation of the Renal NSF have been published so far. The first, *Delivering the National Service Framework for Renal Services*, was published in September 2005 and the second progress report in May 2007.

19. As a response to the inclusion of stroke in the Older People's National Service Framework and the publication of the 2005 National Audit Office Report, the National Stroke Strategy was launched in December 2007. Development of the strategy included six representative project groups and a formal consultation exercise. The strategy sets 20 "quality markers" which outline the features of a good service in the assessment and treatment of strokes, and those support services needed for stroke survivors to return to as full as possible a life in their community. The quality markers apply equally to those who care for stroke survivors.

20. As well as helping to improve existing stroke services, the Department is investing £20 million over five years (2005-2010) into the development of the UK Stroke Research Network.

21. In the beginning of 2008, the Prime Minister announced the Government's intention to shift the focus of the NHS towards empowering patients and preventing illness. As part of this, he set out his ambitions to dramatically extend the availability of 'predict and prevent' checks to give people information about their health, support lifestyle changes and, in some cases, offer earlier interventions.

22. Alan Johnson, Secretary of State for Health, launched the publication of 'Putting Prevention First' on 1st April 2008 which set out plans for the NHS to introduce a systematic and integrated programme of vascular risk assessment and management for those aged 40 and 74.

23. These checks will assess people's risk of heart disease, stroke, kidney disease and diabetes and be based on straightforward questions and measurements such as age, sex, family history, height, weight and blood pressure. They would also include a simple blood test to measure cholesterol.

24. A systematic, integrated programme of vascular checks has the potential to reduce health inequalities, as those in poor socioeconomic groups have significantly higher rates of overall cardiovascular risk, smoking rates and obesity.

25. We are working with stakeholders to ensure the vascular checks programme is delivered in a variety of settings and so are accessible to all sections of our population between the ages of 40 and 74. For example, as well as being provided in GP surgeries, they may also be available in community settings such as pharmacies.

26. Data for June 2008 shows that 90.3% of people with diabetes have been offered screening for diabetic retinopathy in the previous twelve months.

Mortality rates from diseases of the respiratory system

Pneumonia and Bronchitis

27. Tables on male death rates[1] and female death rates[2] by selected causes for the period 1996 to 2002 can be viewed at the NHS website. Death rates for Pneumonia and Bronchitis have fallen in England & Wales between 2003 and 2007 amongst men and women. The Committee will note from the following extract that deaths attributed to pneumonia, bronchitis and related diseases in the reference period are recorded as follows:

[1] http://www.performance.doh.gov.uk/HPSSS/TBL_A3.HTM
[2] http://www.performance.doh.gov.uk/HPSSS/TBL_A4.HTM

Death rates* for Pneumonia & bronchitis, emphysema and other COPD

England & Wales * Per miilion population

	Pneumonia		Bronchitis, emphysema and other COPD	
	Males	**Females**	**Males**	**Females**
2003	408	337	411	244
2004	360	296	364	214
2005	353	298	368	224
2006	320	261	343	213
2007	314	257	345	221

Source: Health Statistics Quarterly 39 p55

28. The Government would draw to the Committee's attention to the following. The UK has historically had high levels of respiratory disease. However some of the apparent excess of mortality may be related to the tendency of doctors in the UK to use the term 'bronchopneumonia', especially when certifying deaths of elderly people when no particular disease is apparent or predominant in the patient's pathology. Other countries favour the use of other diseases in these circumstances. For this reason, international comparisons should treat bronchopneumonia separately from other respiratory diseases.

29. Bronchopneumonia is a terminal condition in someone who is already frail and immobile. Figures 1 a, b & c present age specific mortality rates for all respiratory deaths, all pneumonia and bronchopneumonia for the UK for males and females aged 65-74, 75-84 and over 85.

30. Variation in coding rules across countries also affects the number of deaths assigned to respiratory causes. In England and Wales there was a sharp fall in mortality rates from respiratory diseases between 1984 and 1992 because of the interpretation of the World Health Organisation selection rules for coding pneumonia as a cause of death. In 1993 this trend was reversed with the introduction of automatic cause coding software.

31. As part of the international implementation of the 10th revision of International Classification of Diseases (ICD-10), international rules for coding pneumonia were agreed. Following the introduction of ICD-10 in Scotland in 2000, and England and Wales in 2001, mortality rates from pneumonia in Scotland decreased by 46 per cent overall and in England and Wales by over 35 per cent for females and 40 per cent for males. Tables 2 a & b show age-standardised mortality rates for respiratory disease, all pneumonia and bronchopneumonia for the period 1991-2002 adjusted for the effect of ICD-10. Different countries have implemented ICD-10 for different data years so international comparisons of respiratory diseases during the late 1990s and the early 2000s should be treated with caution.

32. Annual rates of respiratory disease are also affected by other factors

such as flu epidemics.

Northern Ireland

33. The major contributors to ill-health in Northern Ireland, based on Social Security Statistics for long standing illness, were:

Groups	**August 2007**
Other	26.2%
musculo-skeletal conditions	33.4%
mental illness	24.8%
circulatory diseases	9.5%
respiratory diseases	4.2%
injury and poisoning	1.2%
cancers	0.8%
All illnesses	100.0%

Notes : (1) Long standing illness defined as an illness lasting one year or more
(2) Source: 100% DLA, AA ,IB and SDA databases provided by Dept. Social Development

34. During 2004 to 2006 the major causes of premature death (based upon those who survive infancy and die before 75 years of age), based on potential years of life lost were:

	% of total PYLL		
	2004	**2005**	**2006**
Circulatory Diseases	22.5%	20.2%	19.5%
Respiratory diseases	6.7%	5.7%	5.3%
Pneumonia	2.1%	1.9%	1.5%
Influenza	0.0%	0.0%	0.0%
Cancers	31.4%	29.2%	30.1%
External Causes (e.g. accidents, suicide, assault)	18.5%	24.2%	26.4%

35. Northern Ireland has a lower rate of overall mortality to Wales, and Scotland, but higher than England. Coronary heart disease, cancer and respiratory disease are the main causes of death among both sexes. They account for over 61% of all deaths in 2006.

36. Cancer deaths have been increasing and have overtaken heart disease as the main cause of death. In 2006 cancer contributed to over 27% of all deaths.

37. In considering Standardised Death Rates that are likely to vary between countries, there are variations for Northern Ireland relating to cancer, circulatory and respiratory diseases. Table 1 provides some examples by cause for Northern Ireland compared with EU Countries average (standardised for the age and sex of the population).

Table 1 Standardised Death Rates (per 1000,000 pop): Northern Ireland and 15 EU Countries

Cause	Northern Ireland	EU – 15 Countries
Malignant Neoplasms Female	57.6	63.6
Malignant Neoplasms Male	62.0	94.3
Diseases of the Circulatory System Female	23.6	26.8
Diseases of the Circulatory System Male	56.5	78.6
Diseases of the Respiratory System Female	9.2	5.8
Diseases of the Respiratory System Male	11.6	12.1

Source: Dept. Health, Social Services & Public Safety

38. Information from the Hospital Inpatients System can be used as a measure of morbidity. As indicated in Table 2 Coronary Heart Disease, Cancer, Diabetes and Renal Services together accounted for 16 per cent of the total inpatient activity in acute hospitals in Northern Ireland.

Table 2 Hospital Inpatient Activity: 2006/07

Activity Type	Proportion of Total Deaths and Discharges[1]
Coronary Heart Disease	2.5%
Cancer	8.0%
Diabetes	0.8%
Renal	17.4%

Source: Hospital Inpatient System, Hospital Information Branch

Access to National Health Services (NHS)

39. The position remains as previously described with the following developments.

40. Access to National Health Service (NHS) primary medical care is in the main provided by General Practitioners under contract to the NHS. Any person can approach any GP and ask to be registered as a patient. GPs are free to decide which patients they accept on their lists, in the same way that a patient can choose which GP they approach. GPs may use their discretion to accept any person as either registered NHS patients or as private fee-paying patients. The Government expects general practice to exercise this discretion with sensitivity and due regard for the circumstances of each case.

41. The NHS, in the form of its local organisations, the Primary Care Trusts, is under a duty to secure provision of primary medical services for everyone. Local Primary Care Trusts have the power to allocate individuals to a doctor's list if a person experiences difficulties in registering with a GP.

42. Emergencies and treatment that is immediately necessary (i.e. treatment that cannot reasonably be delayed), must be provided free of charge by a GP to a person regardless of whether the person is registered or not.

43. New services are being developed where individuals are able to access primary care services without having to be registered with a GP. These include NHS Direct, NHS Walk-in Centres and local drop-in clinics.

44. NHS Direct is a national clinical service staffed by highly experienced, trained teams of health advisors and nurses, which provides national 24/7 access to health information, advice and support via the telephone (0845 46 47) and internet (http://www.nhs.uk). NHS Direct also provides bespoke services to some PCTs (paid for by those PCTs), including:

- out-of-hours support for GP and dental services;
- telephone support for patients with long-term conditions;
- pre- and post-operative telephone assessment of patients;
- 24 hour response to health scares; and
- remote clinics via telephone.

45. NHS Walk-in Centres are a local facility where no appointment is necessary – offering quick access to at least a core range of NHS services, including advice, information and treatment for a range of minor injuries and illnesses. Walk-in centres are staffed by nurses, though an increasing number also now offer GP services. Patients do not however need to be registered with a GP to receive treatment. Most centres are open on a daily basis for extended hours.

46. NHS primary care generally acts as a gateway to NHS secondary (hospital) care with the GP in particular helping patients to get access to the services they need. The rules for entitlement to NHS hospital care are available at the Department of Health's website page for visitors, which describe also the general rules on entitlement[1].

Sexually transmitted infections (STIs)

47. Diagnosis and treatment of STIs and HIV is available from specialist genito-urinary medicine (GUM) clinics within the NHS. There are approximately 200 GUM clinics in England. Individuals can access any GUM clinic and no referral from a GP is needed. Diagnosis and treatment of STIs is also available from some family doctors, young people's clinics and some community contraceptive services. Testing for HIV is now routinely offered for

[1] www.doh.gov.uk/overseasvisitors.

all pregnant women as part of their ante-natal care.

Preventive measures

Immunisation

48. The position remains as previously described with the following developments.

a. Flu vaccine- In 2005 two additional groups were added to those recommended to receive flu immunisation (1) people with chronic liver disease, and (2) people who are the main carer for an elderly or disabled person whose welfare may be at risk if the carer falls ill.
b. BCG vaccine- In 2005 an improved targeted neonatal and other at risk based programme replaced the current schools' programme for older children.
c. Childhood immunisations- In 2006 the following changes were made to the childhood immunisation schedule.
d. Pneumococcal vaccine was introduced to the routine childhood immunisation programme, and the schedule for MenC and Hib vaccines was modified.
e. A pneumococcal vaccination catch-up programme was carried out for children aged under two years.
f. Hib vaccine- From 2007, a Hib booster was offered to young children who had not previously received one, so that these children are protected in line with older and younger children.
g. From 2008, HPV immunisation has been offered routinely to all 12- to 13-year-old girls (school year 8) to protect them against their future risk of cervical cancer. A catch up campaign is also underway for 17-18 year- olds.
h. In 2008, the MMR catch up campaign was launched in a bid to improve poor uptake rates, particularly in London.

Vaccination coverage

49. The Department of Health has introduced a new performance measure for the NHS called 'vital signs'. This will enable Strategic Health Authorities and the Department of Health to monitor immunisation rates and maintain high rates.

50. The Government would refer the Committee to its immunisation website[1] that gives comprehensive details of the UK immunisation resources and programme that operates in England and Wales. Children in Scotland are now protected through immunisation against many serious infectious diseases. Vaccination programmes aim both to protect the individual and to prevent the population from contracting these illnesses. As a public health measure, immunisations have been hugely effective in reducing the burden

[1] http://www.immunisation.org.uk

of disease. It is of public health concern when immunisation rates fall, as this increases the possibility of disease transmission, and hence complications arising from outbreaks of infectious diseases. The Scottish Executive has set a national target rate of 95% uptake among children aged 24 months for completed courses of the pre-school immunisations: diphtheria, tetanus, pertussis, polio, Hib, MenC, and measles, mumps and rubella (MMR). In Northern Ireland all parents receive invitations at the appropriate times to have their child immunised. Immunisation for young children usually takes place in the GP surgery or health centre. The immunisations given to 13 year olds and school leavers are usually given in school but parents and young people will be notified at the appropriate time by the school doctor/nurse.

Vaccination coverage rates against hepatitis

51. The UK has one of the lowest prevalence rates of hepatitis B in the world and the incidence of acute infection remains relatively stable and low. Therefore, hepatitis B immunisation is targeted at groups at increased risk of infection, e.g. babies born to infected mothers, injecting drug users, those at risk of sexual exposure and healthcare workers.

52. Neonatal Hepatitis B vaccine coverage for England 2007/08 remains strong. Quarterly estimates of three doses of hepatitis B vaccine at 12 months of age for the year 2007/08 ranged from 70-74% based on data received from 80% of English PCTs. Quarterly estimates of four doses of hepatitis B vaccine at 24 months of age for the same year ranged from 49% to 62% based on data received from 80% of English PCTs. Coverage at 24 months is known to be less complete and therefore represents an under-estimate of coverage at this age.

Mental health Services

53. The number of psychiatry hospitals is not available, as information is collected at trust level. A trust may contain several hospital sites, which are not counted. However, the Department does collect information on trusts that have NHS specialist Mental Health Services in respect of the Mental Health Minimum Data Set. For 2006-7, there are 70 Mental Health providers that the Information Centre collects information from. The number of beds available under mental health specialties is 29,200 in 2006-7. The modernisation in mental health services in England "The National Service Framework (NSF)" published in 1999 set out a comprehensive vision for mental health care in England. Part of the vision was to treat people with mental health illness in the community. As a result, in 2007/8, 106,300 home treatments were carried out by 344 Crisis Resolution Home Treatment teams; over 8,290 new patients diagnosed with first onset of psychosis were treated by 150 Early Intervention in Psychosis teams; and 19,930 patients were being seen by 249 Assertive Outreach teams at 31 March 2008.

Pharmacies

54. Statistical information on pharmacy provision in England and Wales can be found at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalhealthcare/DH_4086488

Health professionals and equipment

55. The Health and Personal Social Services Statistics[1] give full published information, in Sections D and E, on NHS workforce and expenditure include the following:

i). The population of England in 2006 was approximately 60,587,800. In September 2007 there were 127,645 doctors (excluding GP retainers) in the NHS. This included 33,674 consultants, 30,759 registrars, 16,024 doctors in training and 35,855 GPs. The number of doctors per 100,000 population is 210 (127,645/605).

ii). the number of qualified nurses (including practice nurses) per 100,000 population is 782.

iii) the number of dentists per 100,000 population as at the 31st March 2007 was 42.

iv). the number of beds available under mental health specialties in 2006-7 was 29,200. In addition, over 142,000 treatments to mental ill patients was carried out in the community in 2007/8.

v). the number of GP retainers as at 30 September 2007 was 565.

[1] http://www.performance.doh.gov.uk/HPSSS/INDEX.HTM

Northern Ireland

Table 1 – Staff information provided from HRMS for qualified nurses, unqualified nurses, midwives, hospital medical staff and hospital dental staff.

	Number of staff per 1,000 population			
Staff Groups	**30th September 2004**	**30th September 2005**	**30th September 2006**	**30th September 2007**
Qualified nurses	8.26	8.36	8.39	8.49
Unqualified nurses	2.70	2.75	2.70	2.74
Midwives	0.75	0.75	0.73	0.71
Hospital Medical Staff	1.88	1.94	2.03	2.08
Hospital Dental Staff	0.09	0.10	0.10	0.10

Source: HRMS. Figures exclude bank staff

Table 2 - Staff information provided from Central Services Agency for general medical practitioners and general dental practitioners

	Number of staff per 1,000 registered population at October each year			
Staff Groups	2004	2005	2006	2007
General medical practitioners	0.60	0.60	0.61	0.62
General dental practitioners*	0.81	0.84	0.86	0.90

Source: Central Services Agency

* Dental Practitioners are Principal Dentists, registered to provide Health Service dental treatment

Health Care Spending

56. Total Health Care spend in the UK

UK Health Spending as a percentage of GDP 1998-99 to 2007-08

Year		UK Public Spending (£bn)	Public Spending as a % of GDP	Private Spending as a % of GDP	Total Health Spending as a % of GDP
Accruals					
1998/99	outturn	46.9	5.4%	1.4%	6.8%
1999/00	outturn	49.4	5.3%	1.4%	6.7%
2000/01	outturn	54.2	5.6%	1.4%	7.0%
2001/02	outturn	59.8	5.9%	1.3%	7.2%
2002/03	outturn	66.2	6.2%	1.3%	7.6%
2003/04	outturn	74.9	6.6%	1.3%	7.9%
2004/05	outturn	82.9	6.9%	1.3%	8.2%
2005/06	outturn	89.7	7.2%	1.3%	8.5%
2006/07	outturn	94.5	7.1%	1.2%	8.3%
2007/08	estimated outturn	102.6	7.3%	1.2%	8.5%

Sources:

1. Public Spending - Public Expenditure Statistical Analyses (PESA) 2008

2. Private Spending - estimates based on published HMT data and analysis supplied by the "REFORM" think-tank

3. (money) GDP forecasts as shown in the Budget Report 2008 are rounded to nearest £ billion. These are the lower end of HM Treasury's forecast range and are consistent with the deliberately cautious assumption of trend growth used as the basis for forecasting public finances

Infant mortality

Infant and peri-natal mortality rates

57. The perinatal mortality rate in the UK rose to 8.5 (deaths per 1000 live & still births) in 2003 but then fell in each successive year to a level of 7.7 – based on provisional data - in 2007.

	United Kingdom	England & Wales	England
Infant mortality rate (Rate per thousand live births)			
1999	5.8	5.8	5.7
2000	5.6	5.6	5.6
2001	5.5	5.4	5.4
2002	5.3	5.2	5.2
2003	5.3	5.3	5.3
2004	5.1	5.0	5.0
2005	5.1	5.0	5.0
2006	5.0	5.0	5.0
2007	4.8p	4.8p	4.8p
Perinatal mortality rate (Rate per thousand live and still births)			
1999	8.2	8.2	8.2
2000	8.1	8.2	8.2
2001	8.0	8.0	8.0
2002	8.2	8.3	8.3
2003	8.5	8.6	8.6
2004	8.2	8.4	8.4
2005	8.0	8.0	8.0
2006	7.9	8.0	8.0
2007	7.7p	7.7p	7.7p

p= 2007 data are provisional
Source:Health Statistics Quarterly 39 p 44

58. The increase in the perinatal mortality rate in 2002 was largely due to an increase in the stillbirth rate in England and Wales. Investigation has shown the factors associated with this increase to be:

- being a single mother (but no increase at all among births outside marriage registered by both parents);
- singleton births - there were nine times more singleton births than multiples; and
- higher rates in spring and summer 2002.

59. Other factors examined include: birth weight; age of mother; gestation; sex; mother's country of birth; mother's region of residence; and cause of stillbirth. These provided no evidence of any other sub-group that might be associated with the increase in the stillbirth rate in England and Wales in 2002. After a further rise in 2003 the perinatal rate decreasing to record low of 2007.

60. Life expectancy at birth (2005) was 77 years of age for men and 81 for women.

Northern Ireland

In 2004 - 2006 the perinatal mortality rates and infant mortality rates in Northern Ireland were as given below:

	2004	2005	2006
Perinatal Deaths	8.0	8.1	6.9
Infant Deaths	5.3	6.1	5.1

Source: DHSSPS (PSAB)

Pregnant women, mothers and babies

61. The Department of Health convened an expert working group in order to provide advice on the most effective ways of caring for very sick or very premature newborn babies. The care of these very small or sick babies is extremely challenging, not least because the effects of care in these earliest days can be marked and long-lasting. For these babies, the Group has recommended that some concentration of expertise offers opportunities for the most effective delivery of services. One of the aims is to provide for local services for all babies, except those who need the most intensive care in designated units.

62. The report of the Expert Review Group on Neonatal Intensive Care was published in 2003. In line with the report, the Department has facilitated the development of 23 neonatal managed clinical networks across England to provide safe and effective services for mothers and babies. It has also established a Neonatal Taskforce to support the NHS to identify and deliver real improvements to neonatal services. The Taskforce work programme focuses on the key areas of data for commissioning, neonatal workforce, transport and surgery.

Maternal mortality

63. The Committee asked for an update on maternity mortality rates. The number of such deaths in 2007 was 47 – for a breakdown see Table 5.15 items O00-009 onwards on pages 174 to 176 in the Statistics that can be viewed at:
http://www.statistics.gov.uk/downloads/theme_health/DR2007/DR_07_2007.pdf

Maternity Services

64. The Department of Health is firmly committed to the principles of good quality woman-centred maternity services. Their aim is to ensure that women receive the highest quality maternity care by modernising all maternity units, increasing the number of midwives and giving women greater choice over childbirth.

65. Huge advances have been made in the last few years in changing the experience of women during pregnancy and childbirth. Not only is it much

safer to give birth but women are now able to make decisions about the care they receive rather than having to make do with what was decided by others. The ethos of putting women at the centre of service planning is now widely accepted.

Choice

66. Eight expert task and finish groups worked from different perspectives, to make recommendations for more responsive services. Maternity services were included. All were asked to address inequalities in both health services and health outcomes. They also asked groups to look at what information patients need in order to exercise choice. Organisations and individual views were taken during the recent choice consultation, which led to the publication of *Building on the Best – Choice, Responsiveness and Equity in the NHS* (December 2003).

The maternity standard of the Children's national service framework (NSF)

67. The Department of Health developed and published in September 2004, a children's national service framework (NSF) including maternity services to help set national standards of care which will cover antenatal, delivery (intrapartum) and post natal services. The maternity standard of the NSF sets out the vision for maternity care. The standard stresses the importance of the provision of flexible, individualised services designed to fit around the woman and her baby's journey through pregnancy and motherhood and makes maternity services more flexible, accessible and appropriate. It stresses the importance of contact with health services early in, and throughout pregnancy and aims to ensure more active follow-up of women who regularly fail to attend appointments and improvements in translation services. This will go a long way to address the inequality of access to services that face disadvantaged groups in society. The NSF is expected to be fully implemented by 2014.

68. Building on the maternity standard, the Department published *Maternity Matters: Choice, access and continuity of care in a safe service* in April 2007[1]. This is the strategy to deliver the Government's commitments for a modernised maternity service, placing safety, quality and improving standards at the very heart of its vision. This document introduces a new national choice guarantee for women. This means that by the end of 2009, all women will have choice in where and how they have their baby and what pain relief to use, depending on their individual circumstances. Women will also have choice over the type of antenatal care they receive and where they access postnatal care.

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073312

Antenatal care

69. The Department also commissioned the National Institute for Health and Clinical Excellence (NICE) to issue guidelines on antenatal care. The remit was "To develop clinical and service guidelines for the NHS in England and Wales for the delivery of routine antenatal care for all women including the number and timing of antenatal visits required and evidence based justification for the scope and content of each. This work drew upon the evidence based recommendations of the antenatal subgroup of the National Screening Committee". The guidelines, were issued in October 2003 and were revised and published in March 2008.

70. The provision of regular antenatal care is to check the wellbeing of both mother and baby and to ensure that any problems are picked up as early as possible. NICE, in its revised antenatal care guideline, suggested a recommended number of antenatal appointments, viz. 10 appointments for nulliparous women and 7 for parous women. The initial contact should be used as an opportunity to provide women with much of the information they need for pregnancy, with an opportunity to discuss issues and ask questions.

71. The Department of Health recognised that there is unequal access to and experience of services for socially excluded groups, with evidence that those at highest risk - around 16% of all pregnant women – are least likely to make early contact with maternity services. Some women delay until they are five or months pregnant, thus missing the crucial early days of maternity care and they and their babies have worse outcomes.

72. Therefore, through the "Better Quality for All" Public Service Agreements (PSA) announced in October 2007, the Department of Health developed a maternity indicator aimed at addressing early access so that all pregnant women will have seen a midwife or a maternity healthcare professional for a health and social care assessment of needs, risk and choices by 12 completed weeks of pregnancy.

NICE Guidelines

73. In order to improve the safety and wellbeing of mother and baby the Department commissioned the National Institute for Health and Clinical Excellence (NICE) to also issue clinical guidance on the following:

- **Use of electronic fetal monitoring May 2001**. The guideline helps to ensure that the technology is appropriately used and should result in a reduction in unnecessary Caesarean sections and instrumental deliveries. The guideline has been replaced by the Intrapartum Care Guideline issued in 2007.
- **Induction of labour June 2001, revised July 2008**. The guidelines help to provide clinicians in maternity units with recommendations for safe practice and reduce variations in clinical practice. It also provides women with evidence-based information about a range of key issues including the risks and benefits of induction, so they can make

informed decisions about what is right for them and their baby.

- **Anti-D prophylaxis May 2002, revised August 2008**. NICE recommends that pregnant rhesus negative women should be offered antenatal anti-D prophylaxis preventive treatment routinely (unless their blood already contains antibodies to the D antigen). This will help prevent Haemolytic disease of the newborn (HDN) which affects the fetus. HDN can range in severity from being detectable only in laboratory tests, through to stillbirth, birth of infants with severe handicaps or death of newborn children from anaemia and jaundice.
- **Routine antenatal care for the healthy pregnant woman October 2003, revised March 2008**. The guidelines provide national quality standards for the type, quantity and provision of antenatal care including screening programmes. All women should thus receive equitable care based on current best practice. These guidelines were revised and re-issued in March 2008 and contain new recommendations on antenatal information, gestational age assessment, preterm birth and the schedule of antenatal appointments, among others.
- **Caesarean Section April 2004**. This guideline has been developed to help ensure consistency of quality of care experienced by women having CS. It provides evidence based information for health care professionals and women about: the risks and benefits of CS; certain specific indications for CS; effective management strategies which avoid CS; anaesthetic and surgical aspects of care; interventions to reduce morbidity from CS and; aspects of organisation and environment which affect CS rates. It does not consider the effect these factors might have on other aspects of antenatal and intrapartum care.
- **Postnatal care July 2006**. The guideline sets the core care that should be available to women and babies who have uncomplicated care needs from the period immediately after birth to 8 weeks. It recommends that there should be personalised care plan for each woman, which takes account of her and her baby's individual needs.
- **Antenatal and Postnatal Mental Health February 2007**. These NICE guidelines make recommendations for the prediction, detection and treatment of mental disorders in women during pregnancy and the postnatal period (up to one year after delivery). They include advice on the care of women with an existing mental disorder who are planning a pregnancy, and on the organisation of mental health services.
- **Intrapartum Care September 2007** covering the care of healthy women in labour at term (37 – 42 weeks). It offers best practice advice on the care of healthy women and their babies. The guideline provides more information about the benefits and potential risks for each place of delivery to help women and their partners make more fully informed choices about what may suit them best according to their own needs. It also updates the 2001 guideline 'Use of electronic fetal monitoring'.
- **Diabetes in Pregnancy March 2008**. This guidance encompasses the management of diabetes and its complications from pre-conception to

the postnatal period.

74. Guidelines in development are:

- **Care of pregnant women with complex social factors** – this guideline is expected to be published in 2010. It will cover the management of pregnant women who have complex social factors for example, children in care under Child Protection Orders, new migrants and drug users.

Antenatal Screening

75. One important aspect of antenatal care is screening. The National Health Service (NHS) Plan outlines the Department's commitment to establish effective and appropriate screening programmes for women and children. This will help modernise antenatal screening programmes following advice from the UK National Screening Committee (NSC)

76. As part of this advice, the NSC has set generic and specific programme standards for a comprehensive antenatal infrastructure to underpin antenatal screening programmes. Each disorder will has its own specific laboratory standards, implementation strategy, and information for healthcare workers and patients. Training is also underway to improve the technical knowledge, communication and counselling skills of staff involved. Special antenatal co-ordinators are in place to support this programme of work. This will ensure that women across the country receive the same standard of antenatal care and reduce variations in screening practice.

77. Work undertaken includes:

- universal provision of Down's Syndrome screening to ensure equity of access and higher quality services (Guidance for health professionals was published by the Department of Health on 11 November 2003, with updated guidance issued in May 2008); Down's syndrome screening is now offered in 98% of maternity units to women of all ages.

- antenatal screening programme for sickle cell and thalassaemia; screening is expected to be fully rolled out in all trusts by autumn 2008 and

- national programme standards for existing programmes for Hepatitis B, HIV, Syphilis and Rubella.

Further information on NICE is at: http://www.nice.org.uk
The NSF is at: http://www.doh.gov.uk/nsf/children.
NSC is at: http://www.nsc.nhs.uk

Investment in maternity services

78. In 2001 the Government announced a £100m capital investment over two years (2001-02 and 2002-03) to refurbish and modernise over 200 maternity units in England to improve the environment in which care is provided and better to meet the needs of women and their families. The £100m investment was spent on:

- New single room provision providing more privacy for families;
- More comfortable rooms with home comforts like televisions and telephones;
- Rooms provided for fathers to stay, especially where babies need special care;
- Better facilities for fathers and families as well as bereaved parents;
- New and replacement equipment like ultra sound scanners;
- Upgrading ante natal and delivery rooms; and
- Refurbishing amenities like toilets and showers.

79. Maternity expenditure in the NHS for 2007-08 was £1.78 billion. In 2008, the Department announced additional funds of £330 million over three years for maternity services. The extra funding will ensure that mothers get the best possible care and are guaranteed a full range of birthing choices. It supports the implementation of *Maternity Matters.*

The elderly

Immunisation

80. Older Adults are offered the following immunisation free of charge:

- **influenza immunisation** - Immunisation of high risk groups has been recommended in the UK since the late 1960s. In 2000, the policy was extended to include all people aged 65 and over and a much more proactive approach was taken to the influenza immunisation programme; and
- **pneumococcal immunisation** – In 2003, the policy of immunising high risk groups was extended to include all people aged 65 and over (this is being phased in over 3 years in England and Wales).

The National Service Framework for older people

81. The NSF for older people was published on 27th March 2001. It sets new national standards and service models of care across health and social services for all older people whether they live at home, in residential care or are being cared for in hospital.

82. The NSF is a ten-year programme of improvement supported by the Department of Health working closely with local health and social care partners, and national underpinning programmes to support implementation. Progress will be monitored through a series of milestones and performance measures, and will be overseen by the NHS Modernisation Board and the Older People's Taskforce which is chaired by the National Director for Older People's Services.

83. The NSF for Older People has 8 national standards:

Standard One:	Rooting out age discrimination
Standard Two:	Person-centred care
Standard Three:	Intermediate care
Standard Four:	General hospital care
Standard Five:	Stroke
Standard Six:	Falls
Standard Seven:	Mental health in older people
Standard Eight:	The promotion of health and active life in older age.

84. Main achievements of the NSF are:

- The NSF aims to root out age discrimination. An audit of written age-related policies has raised awareness of age discrimination and shown that only a very small number of policies are explicitly age discriminatory. The main focus now is on implicit, unwritten discrimination.
- There has been a significant increase in intermediate care services. As at March 2007, there were 34,339 intermediate care places, comprising 25,506 places in non-residential schemes and 8,833 intermediate care beds, benefiting over 404,000 people.
- The National Sentinel Stroke Audit published in 2007 states that in-patient specialist stroke care has made enormous progress with both an increase in the proportion of hospitals with a stroke unit (79% in 2004 to 91% in 2006) and an increase in the size of the units in England.
- Increased operations for older people - coronary artery bypass grafts operations rose by 18% in the last two years and cataract and knee replacement operations have increased by 23%.
- Over 98% of NHS trusts provide single-sex sleeping accommodation.
- The proportion of people of 75 or over being delayed in hospital fell from 4,691 in 2001 to 1,621 in 2007, a reduction of 65%.
- In 2007, the proportion of those supported to live intensively at home or in residential care reached over 35%.
- Direct payments – (payments in lieu of services provided by local councils) have increased in respect of older people, from 9733 in 2006, to 13184 in 2007.

Promoting the health of looked after children

85. Growing up as fit and well as possible is key to being able to benefit from educational and other life enhancing opportunities, yet the circumstances in which looked after children find themselves makes it harder for them to access a range of health services. Improving the health of looked after children is a multi-agency responsibility involving councils working closely with health agencies.

86. In November 2002 the Department of Health published detailed guidance on Promoting the Health of Looked After Children. The guidance, aimed at councils, Primary Care Trusts and Strategic Health Authorities, set out the revised legislative framework for safeguarding and promoting the health of looked after children. The key requirements are:

- Every LAC has their first health assessment when they enter into care, a health plan is set out stating how their health needs will be met, this is to be undertaken by an appropriately qualified registered medical practitioner;

- Review assessments may be carried out by an appropriately qualified nurse;

- The review health assessments for children under five are required twice yearly; and

- Notification is required to both the PCT in the area which the child is leaving and the PCT area to which the child is moving.

87. The Care Matters White Paper (June 2007) included a commitment to update the guidance and make it statutory for healthcare bodies as well as for local authorities. Revised guidance will be published in 2009.

88. The National Children's Bureau has developed a Healthy Care Programme as a practical means of improving the health and well-being of looked after children and young people, in line with the guidance. It supports local agencies to work in partnership to develop and provide healthy care environments, by using the National Healthy Care Standard to audit current practice and plan effective and child focused services. Most areas have set up a Healthy Care Partnership group with senior level involvement from key agencies.

Sexual Health & HIV

89. In 2001 the Government launched it first strategy on sexual health intended to develop an integrated approach to sexual and reproductive health, one that joins up health services, but also understands the importance of looking wider to put together a package of prevention. A review of this strategy was published in July 2008, and the government response to the review's

recommendations was due to be published in December 2008 and will be described in the UK's next Report.

90. The Sexual Health Strategy has the following key objectives, to:

• Reduce the transmission of STIs including HIV
• Reduce the prevalence of undiagnosed HIV and STIs
• Reduce unintended pregnancy rates
• Improve health and social care for people living with HIV and
• Reduce the stigma associated with HIV and STIs.

The key priorities include:

- Improving access to services, with particular consideration of the possible benefits of integrating services for reproductive health and STIs
- Spreading good practice in service delivery, including developing strong links between health services, families and schools.
- Developing programmes of professional training in sexual health to move away from a segregated approach.
- Adding value to public health campaigns by adopting a broader sexual health focus and encouraging a more mature attitude to sex.

Access to care

Hospital waiting times

91. Stage-of-treatment data

The first-outpatient standard of 13 weeks remains in place, 82 patients were waiting longer than 13 weeks for a first outpatient appointment at the end of December 2007.

An inpatient standard of 26 weeks is in place, 129 patients were waiting longer than 26 weeks for inpatient admission from the decision to admit at the end of December 2007.

92. 18 Weeks referral to Treatment

The NHS Improvement Plan (June 2004) set out an ambitious new aim. "*By the end of 2008 no one will have to wait longer than a maximum of 18 weeks from the time they are referred for a hospital operation by their GP until the time they have that operation"*.

93. The 18 week pathway builds on successive reductions in waiting times since the publication of the NHS Plan in 2000. It is different in two key ways:

- it measures the whole patient wait (including the 'hidden waits' for diagnostics and outpatient appointments after the first consultation) b) it covers all medical and surgical consultant-led treatment,

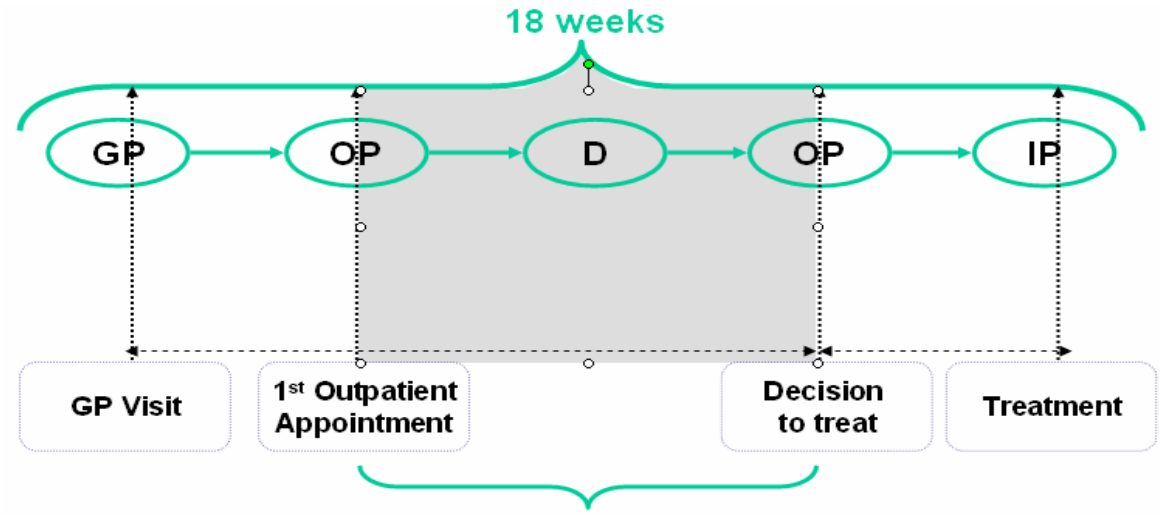
whereas previous elective care targets have focused on surgery.

- On 11 December 2006 the Department updated the existing rules defining the 18 week patient pathway previously set out in Annex A of the publication *'Tackling hospital waiting: the 18 week patient pathway. An implementation framework'.* The framework and updated rules, while not ruling out any particular treatments from the 18-week target, do exclude some services - for example, direct referrals to therapies, non-consultant–led mental health and audiology services. These are mainly accessed through primary care and the 18 weeks 'referral to treatment' target relates to hospital pathways.

94. The 18 Weeks Public Service Agreement (PSA) target is "To ensure that by the end of 2008 no one has to wait longer than 18 weeks from GP referral to hospital treatment". This is the most challenging waiting time target ever set in England, with the aim of removing hospital waiting as a concern for patients. Previous targets focused on reducing waits for particular stages of assessment or treatment (the wait to see a consultant in outpatients; the wait for hospital admission following a decision by a consultant that admission is required). The 18 Weeks target spans all the stages of care from referral through to the start of definitive treatment properly matching the total wait experienced by individual patients.

95. It is important to note that RTT times cannot be derived by adding together data on first outpatients, diagnostics and inpatients because many patients will have more than one diagnostic test, and the wait for subsequent outpatient appointments is not captured (see diagram).

Diagram showing how the RTT approach spans the stages of treatment
Time taken from the first outpatient appointment to decision to treat (or not to treat) which includes all diagnostics tests and subsequent outpatient appointments



was defined to cover pathways that involve or might involve medical and surgical consultant-led care. Thus, the receipt of some forms of treatment (e.g. hearing aids, physiotherapy) is covered by the target except when accessed directly from primary care without reference to a medical or surgical consultant-led service.

97. Treatment within 18 weeks will not be appropriate for a proportion of patients in three categories: i) those with genuinely complex cases or for whom the right treatment is not clear, ii) those who choose later appointments than those which would enable the hospital to treat them within 18 weeks, e.g. because they have a holiday booked, iii) those who do not comply with reasonable patient behaviour, e.g. by missing appointments. This gives rise to the need for a target 'tolerance', i.e. the percentage of patients for whom 18 Weeks is not expected to be met. To take account of this, an operational standard for delivery was set for the NHS of 95% for non-admitted patients and 90% for admitted by the end of December 2008.

98. Previous targets have measured at the end of each month how long patients have been waiting. This is administratively simple but does not reflect the full time that individual patients actually wait for treatment. The approach for 18 Weeks is to measure how long each individual patient actually waits or waited for treatment.

99. To assess how we are progressing towards delivering 18 weeks, the NHS needs to be able to measure referral to treatment time. This involves tracking a patient along their pathway. In particular, the NHS needs to be able to identify 18 week clock starts and clock stops and to measure the time between these dates.

100. During 2006, the Department of Health worked with eight pioneer sites from across the NHS to develop the format and content of the RTT data collection. Mandatory reporting of RTT times started in January 2007 for admitted pathways and in April 2007 for non-admitted pathways. The first publication of admitted RTT data was in March 2007, with non-admitted data published for the first time in August 2007.

101. While the target is for achievement by December 2008, milestones to be reached by March 2008 were set such that 85% of admitted patients and 90% of non-admitted patients should start their treatment within 18 weeks of referral.

102. When the NHS began measuring progress towards the maximum referral to treatment 18 week wait in January 2007:

- In March 2007, the first month admitted RTT figures were published, 48 per cent of patients whose treatment involved admission to hospital started their treatment within 18 weeks. By December 2007 this was 69 per cent.

- In August 2007, the first month non-admitted RTT figures were published, 76 per cent of patients whose treatment did not involve admission to hospital started their treatment within 18 weeks. By December 2007 this was 79 per cent.

103. The percentage of patients treated in December 2007 who waited more than 52 weeks between referral and start of treatment was 5.8 per cent, compared with 9.9 per cent in August 2007. This shows the NHS is successfully addressing the backlog of long waiters.

104. The NHS has already reduced the number of treated patients who waited more than a year from 90,354 in August 2007 to 59,631 in December 2007.

105. By the end of December 2008, any remaining waits over 18 weeks will be for patients who have chosen to wait longer than 18 weeks and/or where it is clinically appropriate for them to wait longer than 18 weeks. Most patients will wait much less time than this. The average waiting time for admitted patients in December 2007 was 11.4 weeks.

Bed Availability

106. There has been a decrease since 2003/04 in the number of general and acute beds in the NHS due to the development of care closer to home (for which there was near universal support in the responses to the National Beds Inquiry) which has meant that care is increasingly being delivered in new and more convenient settings.

107. Information Centre figures show there has been a long term downward trend in the average length of stay in hospital. It has decreased from 9.1 days in 1997/98 to 6.9 days in 2005/06.

108. In line with the drive to increase day case rates, day-only beds have expanded by 3,178 (45%) from 7,125 in 1997/98 to 10,303 in 2006/07.

109. The reduction in geriatric, mental illness and learning disability beds is consistent with the growth in care in the community and the NHS refocusing on the provision of medical services.

110. In the future, bed numbers may continue to fall as primary care and community services are enhanced. The White paper 'Our health, our care, our say' set out the Department's intention to accelerate the move to design services around the patient, rather than the needs of the patient being forced to fit around the service already provided.

Diagnostic Test Waiting Times Data

111. The NHS started reporting data on waiting times for diagnostic tests in April 2006.

112. December 2007 data for the 15 key diagnostic tests show that 83 per cent of patients waiting for one of the 15 key diagnostic tests we collect information on monthly were waiting less than 6 weeks compared with 49.4 per cent in April 2006.

113. The median wait for a diagnostic in December 2007 was around 3 weeks compared with 6.1 weeks in April 2006.

Management of Waiting Lists and Times

114. Decisions about how to configure and reconfigure services are for local bodies, and it is for PCTs, NHS trusts and NHS FTs to decide the way forward. This needs to be done in consultation with clinicians and other staff, the public and local stakeholders. Commissioners are expected to agree a realistic and affordable activity plan with providers, with clear assumptions and plans for resource utilisation which ensures that patients receive the most appropriate care in the most appropriate setting.

115. A framework to track local progress in reaching agreement will be established by the Department and SHAs to provide assurance around financial, activity and service plans.

Patient-reported waits

116. The ultimate test of the target is whether patients feel that 18 Weeks was achieved for them and whether hospital waiting is any longer a concern. To this end, PCTs are expected to undertake a local 18 week patient experience survey by the end of December 2008. We will look for assurance from SHAs that the results of the survey have been analysed and included in local PCT plans to deliver further improvements in patient's experience of 18 weeks pathways.

Wales

117. Tackling waiting times in Wales is a key priority of the Welsh Assembly Government. In March 2005, the First Minister and Minister for Health and Social Services announced a target of a maximum waiting time of 26 weeks from primary care referral to start of definitive treatment, including any wait for specified diagnostic tests, to be achieved by December 2009.

118. In the run up to December 2009, targets have been set within the Annual Operating Framework, to monitor progress towards the achievement of the target. The target to be achieved by March 2008 is that no one should wait over 22 weeks for first outpatient appointment and a further 22 weeks for inpatient or

daycase treatment. At the end of December 2007, the NHS in Wales was on course to deliver the target, with 6,300 inpatient/daycases and 13,200 outpatients waiting over 22 weeks. Detailed information on both numbers of beds and waiting times can be viewed at the Welsh Assembly's website[1].

Northern Ireland

119. In Northern Ireland, hospital waiting lists figures are collected on the basis of time band and, as a result, an average/median waiting time cannot be calculated. In 2005/06 a target was set to ensure that by 31st March 2006, no patients would be waiting more than 12 months for inpatient treatment. At the 31st March 2006 there were 13 patients waiting more than 12 months. The 2006/07 target reduced the maximum waiting time to 6 months, with one patient waiting longer than six months for treatment at 31st March 2008. A 2007/08 target of 21 weeks was set. At 31st March 2008, 55 patients were waiting more than 21 weeks for inpatient treatment.

120. A maximum waiting time target for a first outpatient appointment was also set for 2006/07, that no patient should wait more than 6 months for a first outpatient appointment. At 31st March 2007, there were 162 patients waiting longer than six months. The target reduced to a maximum waiting time of 13 weeks by 31st March 2008. On this date, there were 59 patients waiting more than 13 weeks for a first outpatient appointment.

Isle of Man

121. The previous report stated that the main hospital on the Isle of Man, Nobles Hospital, which opened in 2003, provides all standard General Hospital type services. However, it should be noted that it does not provide specialist services (such as cardiac surgery, neurosurgery and radiotherapy) which it is impossible to safely provide for an island community of 80,000 residents. Such services are provided by referral to NHS centres of excellence in the United Kingdom.

122. As reported previously, in terms of morbidity and mortality, diseases of the circulatory system (including coronary heart disease and cerebrovascular disease), cancers and diseases of the respiratory system continue to be the major public health concerns in the Isle of Man.

123. A Breast Cancer Screening Call and Recall Service has recently been established. It has tripled the rate of mammography but it is currently too early to assess the coverage of the target population. This will be assessed for the first time after one year of operation and annually thereafter.

124. The Island's cervical screening call and recall for women aged between 20 and 65 years has a high five-year coverage rate of eligible women (81.86% in 2007).

[1] http://www.wales.gov.uk/keypubstatisticsforwales/topicindex/topics.htm#waiting

125. The Island's vaccination programme is analogous to that in the United Kingdom. Seven of the Island's twelve GP practices achieved the 90% target for childhood immunisation in the quarter ended 31 March 2007, the remaining five practices achieving over 87%. The overall figure across the Island has risen from 89.37% (31 March 2006) to 92.48%.

126. As at 31 March 2007, every GP practice on the Island successfully achieved their target to be able to see patients within two working days.

127. The Isle of Man Government spends 7.8% of the Island's GDP on health care.

128. The figures for numbers of health professionals are currently as follows:

- Doctors (General Practitioners) per 1000 population – 0.58
- Dentists per 1000 population – 0.56
- Pharmacy practices per 1000 population – 0.3
- Optometry practices per 1000 population – 0.16
- Community Nurses per 1000 population – 0.95
- Midwives per 1000 population – 0.61

Article 11, paragraph 2 - advisory and educational facilities

Child Health Surveillance

129. The Child Health Promotion Programme, *Pregnancy & the First Five Years of Life* (CHPP)[1] is the universal preventive service that promotes the health and well-being of children. It is a core health service that begins in pregnancy and offers every family a schedule of screening tests, developmental surveillance, immunisation and vaccinations, health promotion and parenting support.

130. It includes services for families who have additional needs and risks, such as the Family Nurse Partnership programme.

131. Building on this, the Department of Health will also develop the school-age elements of the Child Health Promotion Programme and will set out a school age health offer in the way that has been done for 0-5 year olds. This will be published in 2009.

132. Purpose of the CHPP

- The publication updates Standard One of the National Service Framework for Children, Young People and Maternity Services (2004), in order to:
- Raise the profile of the CHPP and its role in delivering the new PSA indicators
- Promote a model of progressive universalism to reduce inequalities
- Provide additional technical detail on the content of the CHPP as set out in the NSF
- To promote the delivery of the CHPP through integrated children's services

133. Contribution to delivering government priorities

- The CHPP is a key service for delivering the 2008 -2011 Public Service Agreements for improving the health and well being of children, specifically the indicators for breastfeeding, obesity prevention and improving emotional health and wellbeing. By incorporating the PSA maternity indicator this updated CHPP recognises the important contribution made by maternity services to a child's future health and well-being.
- The CHPP makes a vital contribution to the *Every Child Matters* five outcomes. It feeds directly into the Children's Plan (2007) which includes strengthened support for all families during the formative early years of

1 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_083645?IdcService=GET_FILE&dID=

their children's lives and helps mothers and fathers ensure that children are ready for early years education, school and later life

134. New elements to the CHPP

- Strengthens the parenting support element of the CHPP, emphasising fathers
- It is based on a model of progressive universalism i.e. core programme for all and additional services for children who face disadvantages and risks
- Engages parents in early pregnancy
- Integrated services through Children's Centres and general practice
- Reflects changing public health priorities – obesity prevention, social and emotional development, breast feeding, accident prevention
- Focuses on the whole family

135. Family Nurse Partnership (FNP) and the CHPP

- The FNP forms one part of a progressive universal CHPP, for the most disadvantaged and at risk children and families. The Family Nurse Partnership programme (FNP) is a preventive programme for disadvantaged first time mothers and their families. It is an intensive and structured antenatal and infancy home visiting programme delivered by nurses

- FNP has three primary aims: to improve pregnancy outcomes, to improve child health and development and to improve parents' economic self-sufficiency.

- The FNP programme is evidence based, and rooted in theories of attachment, self-efficacy and human ecology. These are reflected in the materials and guidelines and the training programme for practitioners.

- Parents receive regular home visits from a specially trained nurse from early pregnancy until the child is two. Visits start ideally at around 14 – 16 weeks of pregnancy, although women may access the programme up to the 28th week of gestation. Visits can be weekly, fortnightly or monthly.

- We are now testing the FNP in England, through a two year formative evaluation by the University of London, Birkbeck and, from April 2009, through a randomised control trial.

- The formative evaluation is assessing the feasibility of implementing the FNP in ten sites in England. It will also offer some initial findings on short term impacts and costs. The

Randomised Control Trial will measure impact more rigorously.

- A randomised control trial will take place from 2009 in 17 FNP sites. The aim of the trial is to find out what impact the FNP has compared to usual services.

136. The NHS Plan set out a commitment to introduce by 2004 new and effective screening programmes for women and children. A number of national screening programmes have been rolled out, including screening for Down's Syndrome, now offered in 98% of all maternity units to women of all ages, Newborn Hearing, screening offered to all babies and 99% of newborn babies are screened, cystic fibrosis screening, available to all newborns in November 2007, newborn sickle cell, offered to all newborns in October 2006 and Medium Chain Acyl-CoA Dehydrogenase Deficiency expected to be fully rolled out in March 2009.

Public Health

137. The National Institute for Health and Clinical Excellence (NICE) produces Public health programme guidance deals with broader action for the promotion of good health and the prevention of ill-health. This guidance may focus on a topic, such as smoking, or on a particular population, such as young people, or on a particular setting, for example, the workplace.

138. NICE public health guidance aims to help public health professionals and practitioners in local government and NHS organisations achieve the targets set out in the 2004 white paper 'Choosing Health: making healthy choices easier´.

139. Examples of programmes are:
- National or regional smoking cessation strategies; and
- Strategies to improve the diet and nutrition of mothers and infants.

140. NICE produces two types on guidance on public health:

- **Public health intervention guidance** makes recommendations on clear activities (interventions) to promote a healthy lifestyle or reduce the risk of developing a disease or condition. For example, giving advice in GP's offices to encourage exercise
- **Public health programme guidance** deals with broader activities for promoting good health and preventing ill health. This guidance may focus on a topic (such as smoking), particular population (such as young people) or a particular setting (such as the workplace). For example: strategies to improve the diet and nutrition of mothers and infants.

Northern Ireland

141. Blood samples are taken from pregnant women and screened for Hepatitis B, Syphilis and HIV infection as well as Rubella immunity. If the tests for infection are positive then appropriate follow up steps are taken both in regard to the woman and the subsequent baby. In particular regard to babies a new neonatal hearing screening programme has been implemented from October 2005.

142. There is a full childhood immunisation programme in place in Northern Ireland. In addition, an HPV immunisation programme, aimed to protect young girls from a future risk of developing cervical cancer, is currently in the planning stages for implementation in September

Encouragement of individual responsibility- unprotected sex

Sexually Transmitted Diseases (STDs)

Sexual health a priority

143. Sexual Health is a priority area for the NHS and has been identified as a priority area in the 2008/9 Operating Framework. This includes maintaining the existing commitments on 48-hour access to GUM services and rollout of the chlamydia screening programme.

144. The High Quality Care for All: NHS Next Stage Review Final has identified sexual health as one of six priority areas for PCTs to commission comprehensive wellbeing and prevention services to meet the needs of their local population. This may be viewed at:
http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_085825

STIs and the National Chlamydia Screening Programme

GUM

145. Our target has been to offer everyone who needs it an appointment at a GUM clinic within 48 hours by March 2008**.** The figures for March 2008 show that 98.9% of first attendees were offered an appointment within 48 hours, which means that the vast majority of Primary Care Trusts have delivered on this target which is a considerable achievement.

146. Overall, the number of STIs is increasing and we are seeing more people coming forward for screening. In England there was a 16% increase in screens in 2007. In 2006 38% of those screened tested positive for an STI. In 2007 this reduced to 35%.

147. Chlamydia is the most common STI. We set new targets for the NHS to screen 15-24 year olds for chlamydia to ensure high screening volumes and reduce prevalence via the National Chlamydia Screening Programme.

To the end of December 2007 we have seen over 540,000 screens performed.

HIV

148. The UK remains a low prevalence country for HIV as a result of sustained public education campaigns since the 1980s, including needle exchange schemes for injecting drug users, and open access genito-urinary medicine services The Government remains committed to keeping HIV on the public agenda and in 2001 the first ever National Strategy for Sexual Health and HIV was published by the Department of Health in England. This has just been reviewed and the Government's response will be in December 2008.

149. A key goal for the Department on HIV is to reduce the level of undiagnosed HIV in the population, which remains at approximately 30% of the total number of people estimated to be living with HIV in England.

150. HIV health promotion remains a strategic priority. Government funded health promotion work is research based, reflects latest epidemiology and is rigorously evaluated. Health promotion materials produced under Department of Health contracts use a range of approaches to convey information in an appealing, sensitive and non-stigmatising way. Materials are targeted towards the two groups most at risk from HIV in the UK, namely gay men and African communities living in England.

151. We have increased our investment by £1m a year (2006/07, 2007/08 and 2008/09) in our targeted HIV health promotion for gay men and African communities. This is additional to sustained investment over the last 10 years in work done throughout England led by the Terrence Higgins Trust and the African HIV Policy Network.

152. In addition, HIV is included along with other STIs in the Department of Health's adult sexual health campaign, Condom Essential Wear. This was launched in November 2006 to raise awareness of the invisibility of STIs and promote condom use amongst sexually active 18-24 year olds. Campaign tracking is starting to indicate initial stages of behaviour change within the target audience and evidence suggests a shift in condom purchasing behaviour towards the target 18-24 age group.

153. DoH also funds:

- the Sexual Health Line which provides information and advice on STIs (including HIV prevention) 24 hours daily, every day of the year; and

- the African AIDS Helpline provided by the NGO, the Black Health Agency; and contributes to Terrence Higgins Trust Direct, which offers specialist advice and information on HIV.

Northern Ireland

Contraception and Abortion

154. A £26.8million investment for 2008/09 has been invested to improve women's knowledge of and access to all forms of contraception and to help reduce the number of teenage conceptions, abortions and repeat abortions. This will include a new targeted campaign to highlight long acting reversible methods of contraception. The funding is concurrent for 2009/2010 and 2010/2011.

155. There has been significant investment to improve early access to abortion services. In 2007, 90% of all abortions were carried out at under 13 weeks gestation and 70% were at under 10 weeks.

Teenage Pregnancy

156. Between 1998 (the baseline year for the Teenage Pregnancy Strategy) and 2006 (latest year for which data are available) the under-18 conception rate has fallen by 12.9%, to its lowest level for over 20 years. The under-16 rate has fallen by 12.6% over the same period.

Isle of Man

157. The position in relation to general public health policy is largely as previously described and the provision of health care continues to be a high priority for the Isle of Man Government.

158. The first Isle of Man General Population Health and Lifestyle Survey was carried out in April 2005. This survey was aimed at the most important health status determinant – lifestyle – and it examined patterns of smoking, diet and physical exercise and alcohol in the adult population.

Article 11, Paragraph 3 - the prevention of diseases

Infectious Diseases

159. The first infectious disease strategy for England, *Getting Ahead of the Curve*[1], was published in December 2002 and is being implemented. A new Health Protection Agency was established in April 2003. Strategies already exist for antimicrobial resistance and sexual health. New Action Plans are in development for Healthcare associated infection, tuberculosis, antimicrobial resistance. A cross-government 'National Framework for responding to an influenza pandemic' was issued November 2007 and is supported by detailed operational and infection control guidance contingency plans are in place to deal with a range of diseases, particularly zoonotic diseases that require a multidisciplinary approach such as West Nile Virus, SARS and rabies.

160. The childhood immunisation programme continues to maintain high levels of vaccine coverage. Influenza and pneumococcal vaccination programmes are also carried out to immunise high risk groups which include older people. The HPV vaccine is being offered routinely to all 12 to 13 year-old girls (school year 8) to protect them against their future risk of cervical cancer. A catch up campaign is also underway for girls up to age 18.

161. Various information materials are produced for both the child and adult immunisation programmes, the former are designed in response to research which tracks parental attitudes to the childhood immunisation programme.

162. National Surveillance systems are in place to monitor the impact of vaccination programmes, identify new and emerging diseases, and monitor emerging problems such as antimicrobial resistance.

163. A comprehensive strategy to tackle infections in our hospitals is in place. NHS organisations must comply with a statutory *Code of Practice for the Prevention and Control of Healthcare Associated Infections*, with compliance monitored by the independent Healthcare Commission. A target to halve the numbers of meticillin resistant *Staphylococcus aureus* (MRSA) bloodstream infections was set in 2004 and was achieved as planned by the quarter ending June 2008. A new target has been set to cut *Clostridium difficile* infections by 30% by 2010-11 compared with 2007-08.

Reduction of Environmental Risk

164. The position remains as previously described with the following update on developments.

[1] www.doh.gov.uk/cmo/idstrategy/idstrategy2002.pdf

Air Quality Strategy

165. The UK Government and the devolved administrations published the latest Air Quality Strategy for England, Scotland, Wales and Northern Ireland on 17 July 2007 (Cmd paper No 7169).

166. The Strategy can be accessed via the UK Defra Environment Protection web pages[1] and it:

- sets out a way forward for work and planning on air quality issues;
- sets out the air quality standards and objectives to be achieved;
- introduces a new policy framework for tackling fine particles; and
- identifies potential new national policy measures which modelling indicates could give further health benefits and move closer towards meeting the Strategy's objectives.

Water strategy - Future Water

167. The Government launched its new water strategy for England, Future Water on 7 February 2008. The strategy sets out a framework for water management in England. This includes:

- sustainable delivery of secure water supplies;
- an improved and protected water environment;
- fair, affordable and cost-reflective water charges;
- reduced water sector greenhouse gas emissions; and
- more sustainable and effective management of surface water.

168. Accompanying the strategy is a full public consultation on draft statutory Social and Environmental Guidance to Ofwat, which will be one of the ways of delivering the strategy, and consultations on surface water drainage and phosphates.

Northern Ireland

169. In general, the policy on prevention of water pollution in Northern Ireland is reflective of that applicable across the rest of the UK.

170. Under the terms of the Water (Northern Ireland) Order 1999 No. 662 (NI 6), the Department of the Environment in Northern Ireland has a duty to promote the conservation of the water resources of Northern Ireland and the cleanliness of water in waterways and underground strata. The Department can undertake a range of enforcement options including prosecution and the use of a range of notices, enforceable through a court order, to ensure specific actions are undertaken to prevent pollution or remedy it.

171. New arrangements for the delivery of water and sewerage services

[1] http://www.defra.gov.uk/environment/airquality/strategy/index.htm

came into operation on 1 April 2007. The Water and Sewerage Services (NI) Order 2006 came into effect providing for an "undertaker" to run the services. A company - Northern Ireland Water - has been appointed as sole water and sewerage undertaker for Northern Ireland. The company is 100% owned by the Government through the Department for Regional Development (DRD).

172. Along with the transfer of responsibility for delivery of water and sewerage services to Northern Ireland Water, a new independent, regulatory regime has been established to oversee the water industry. The main regulator is the Northern Ireland Authority for Utility Regulation which also oversees the gas and electricity utilities. Environmental regulation is carried out by the Northern Ireland Environment Agency and water quality monitoring by the Drinking Water Inspectorate. DRD also has a regulatory role. The Consumer Council for Northern Ireland has a statutory role as consumer representative.

173. The legislation introduces new rights and protections for consumers as well as providing for full environmental enforcement in the water and sewerage area for the first time as a result of the removal of Crown immunity.

174. All discharges to waterways or to underground stratum from both domestic and industrial sources are regulated by means of a discharge consent. A consent to discharge under the Water Order specifies maximum daily limits, and the location of the discharge. When an application is made for a discharge to a waterway, the consent parameters are determined by the Department and are based on the environmental needs of the receiving water. The discharge is modelled or assessed in a manner that ensures that there is no deterioration in water quality, thus ensuring the long-term sustainability of the waterway.

175. On 1 January 2007 the Nitrates Action Programme Regulations (Northern Ireland) 2006 (the NAP Regulations) and the Phosphorus (Use in Agriculture) Regulations (Northern Ireland) 2006 (Phosphorus Regulations) came into operation. Both sets of Regulations apply to all farmers across Northern Ireland and seek to improve the use of nutrients on farms and as a result improve water quality. Monitoring and enforcement of the NAP and Phosphorus Regulations is carried out by staff of the Northern Ireland Environment Agency (NIEA). The Nitrates Directive (transposed by the NAP Regulations) is one of the Statutory Management Requirements under Cross Compliance.

176. The Water Supply (Water Quality) Regulations (Northern Ireland) 2007 (No. 147) partially transpose Directive 98/83/EC, the objective of which is to protect human health from the adverse effects of any contamination of water intended for drinking or food preparation by ensuring that it is wholesome and fit for human consumption. These Regulations, which are concerned with water supplied in Northern Ireland for drinking, washing, cooking and food preparation and production, include high levels of monitoring by the water undertaker.

177. The Department of Agriculture and Rural Development publishes "The Code of Good Agricultural Practice for the Prevention of Pollution of Water, Air and Soil". The Code gives practical advice on management practices that can be implemented on farm and underpins the Department's advisory services.

Land and soil contamination

Soil Action Plan

178. The First Soil Action Plan for England (2004-2006) provided a good foundation but much remains to be done to improve the management of soils to deliver a wide range of benefits to society and to improve the measures used to achieve this. A draft Soil Strategy for England is currently out for public consultation, to succeed the First Action Plan.

179. The draft Soil Strategy for England takes stock of progress under the Action Plan, as well as taking forward emerging priorities for soil protection on maintaining soil carbon and the recycling of organic wastes to land. Defra issued a public consultation on the draft Soil Strategy for England on 31 March 2008. The consultation sought to obtain views on Defra's proposals. Full details on this together with details on research, monitoring and indicators on all aspects of soil and contaminated land can be accessed via the Defra website pages[1].

Contaminated land

180. The Government's long-term aim is to work towards a future where all the contaminated land in England has been identified and dealt with. The scale of the task means this is likely to take decades to achieve. There is a a wide range of policies to tackle land contamination, falling into two broad areas:

Sites where there is a "voluntary" solution. Often land is remediated as it is being redeveloped under the planning system, or because land owners want to increase the utility and value of their land. Wherever possible, the Government encourages voluntary remediation (as opposed to compulsory remediation under contaminated land legislation). Policy in this area is overseen primarily by the Department for Communities and Local Government (CLG).

Sites where there is unlikely to be a voluntary solution. This includes contaminated sites which have been developed without being cleaned-up; sites where remediation would be prohibitively expensive; and sites where the person who polluted the land, and/or the current owner, is unwilling to deal with the problem voluntarily. It is mainly on these types of site that

[1] http://www.defra.gov.uk/environment/land/soil/research/index.htm

contaminated land legislation comes into play.

181. Defra's interest in contaminated land lies primarily in sites where there is no voluntary solution. In particular, Defra oversees contaminated land legislation (Part 2A of the Environmental Protection Act 1990), which was introduced to require action in the absence of a voluntary solution.

182. In July 2008 new guidance was produced on improvements to contaminated land entitled "Outcome of the "Way Forward" exercise on soil guideline values" that can be viewed via the following link:

http://www.defra.gov.uk/environment/land/contaminated/pdf/wayforward080722.pdf

Asbestos

183. The Government's response above in respect of Article 3, Paragraph 1 and the Committee's Conclusions XVIII-2, describes the position as far as the duty to manage asbestos in non-domestic premises is concerned. In October 2004 Defra wrote to all Local Authorities[1] re-issuing its existing guidance on the management of asbestos waste from domestic property to remind local authorities of their powers and duties with regard to the collection and disposal of this material[2].

Radiation

184. The UK has accumulated a substantial legacy of radioactive waste from a variety of different nuclear programmes, both civil and defence-related. Some of this waste is already in storage, but most will only become waste over several decades as existing nuclear facilities are decommissioned.

185. The government is committed to finding a safe solution for the management of higher activity radioactive waste that:

- ensures the long term protection of people and the environment;
- does this in an open and transparent way;
- is based on sound science; and
- uses public monies effectively .

186. The Government and the devolved administrations for Wales and Northern Ireland carried out a public consultation on "A Framework for Implementing Geological Disposal"[3], which ran from June to November 2007. Following careful consideration of the responses to the Consultation, the Government then published the White Paper - "Managing Radioactive Waste Safely: A Framework for Implementing Geological Disposal" on 12 June 2008.

[1] http://www.defra.gov.uk/Environment/waste/localauth/pdf/asbestos-domesticletter.pdf
[2] http://www.defra.gov.uk/Environment/waste/localauth/pdf/asbestos-domestic.pdf
[3] http://www.defra.gov.uk/corporate/consult/radwaste-framework/index.htm

This sets out Government's detailed policy and plans for the long-term management of higher activity wastes. The White Paper can be viewed via the following link:

http://www.defra.gov.uk/environment/radioactivity/mrws/pdf/white-paper-final.pdf

187. Following the thorough review the experts have advised that geological disposal, coupled with safe and secure interim storage, is the best option. Geological disposal is internationally recognised as the preferred approach for the long-term management of higher activity radioactive waste.

188. The construction and operation of a geological disposal facility will be a multi-billion pound, high technology project that will provide skilled employment for hundreds of people over many decades. In addition, there may be other benefits for a host community that might be agreed through discussions with government.

189. The government has invited communities to express an interest in beginning discussions, without commitment, on the possibility of hosting a geological disposal facility at some point in the future.

Noise

Neighbourhood Noise Strategy

190. 84 per cent of respondents to the 'Towards a National Ambient Noise Strategy' consultation supported more action to tackle neighbourhood noise. Following the consultation on the Government's strategy to tackle ambient noise, Defra has undertaken the development of a Neighbourhood Noise Strategy[1].

191. The Neighbourhood Noise Strategy is being developed in consultation with a steering group. The steering group involves three groups of participants: a stakeholder group with experience of noise issues and campaigning; an expert group familiar with the enforcement and technical issues; and a Government group, with knowledge of legislation and Government policy affecting noise issues.

192. The Neighbourhood Noise Strategy will look at ways to improve neighbourhood and neighbour noise management at national, regional and local level by, among other things:

193. Measuring the incidence and impact of neighbourhood and neighbour noise problems;

- To commission, oversee, review and guide the implementation of the outcomes of research into neighbourhood and neighbour noise;

[1] http://www.defra.gov.uk/environment/noise/neighbour.htm

- Reviewing existing statutory provisions;
- Considering the need for new statutory provisions;
- Developing new statutory provisions where gaps are identified;
- Identifying and developing existing and new non-statutory initiatives and programmes; and
- Reviewing the neighbourhood noise enforcement practices and performance of the relevant authorities in England and Wales, and to identify opportunities and mechanisms for improvement.

Noise Mapping

194. Noise maps, which can be viewed at the Defra website, provide an overview of the ambient noise climate (unwanted or harmful outdoor sound created by human activities, including that created by transportation, such as road, rail and air traffic, and from industrial activity) in cities and major transportation sources in England.

195. The maps account for the number of people affected by different levels of ambient noise, the source of that noise (i.e. road, rail, air or industry) and the locations of the people affected.

196. The mapping was carried out during 2006-07 in line with the Department's work to implement the EU's Environmental Noise Directive. They incorporate the noise maps produced for the 18 English airports.

Regulations

197. These noise maps have been produced to meet the requirements of the Environmental Noise (England) Regulations 2006 and Directive 2002/49/EC – more commonly known as the Environmental Noise Directive (END) – and are intended to inform the production of noise action plans, which are to be developed on a five year rolling programme.

198. The action plans will seek to manage noise issues and effects including noise reduction if necessary, based on the results obtained through the mapping process. The next stage of the Defra's work to implement the directive will be to develop action plans. This will include a public consultation.

National Ambient Noise Strategy

199. Work is currently underway to develop a combined National Noise Strategy covering both environmental and neighbourhood noise, which will be launched in due course.

In its Conclusions XVII-2 the Committee asks for information on action taken under the Anti Social Behaviour Act 2003, amending the Noise Act 1996.

200. In September 2006, Defra and the Chartered Institute for Environmental Health produced a joint publication "Neighbourhood Noise Policies and Practice for Local Authorities – a Management Guide"[1] for all local authorities and includes guidance reflecting the amendment to the legislation. Typical case study examples of the exercise of the powers can be viewed via the following links:
http://www.respect.gov.uk/members/case-studies/article.aspx?id=8716
http://www.respect.gov.uk/members/case-studies/article.aspx?id=12162

Food Hygiene

Food Standards Agency

201. The Food Standards Agency (FSA) is an independent Government department set up by an Act of Parliament in 2000 to protect the public's health and consumer interests in relation to food. The FSA carries out a range of work to make sure food is safe to eat, including funding research on chemical, microbiological and radiological safety, as well as food hygiene and allergy. FSA reports to parliament with those parts established in Scotland, Northern Ireland and Wales reporting also to the respective national assemblies.

202. The details of FSA's day-to-day work on safety and hygiene, including policy, business and research programmes are set out in the FSA website pages at: http://www.food.gov.uk/aboutus/

Northern Ireland and Ireland

203. The Food Safety Promotion Board (FSPB) is an implementation Body established under the terms of the Belfast Agreement on 8 March 1999. The FSPB headquarters are located in Cork, employing 30 members of staff, with a sub-office located in Dublin. FSPB is jointly sponsored by the Department of Health, Social Services and Public Safety in Northern Ireland and the Department of Health and Children in Dublin under the auspices of the North/South Ministerial Council. Funding is split on the basis of 70% (DOHC) and 30 % (DHSSPSNI). The total funding for the Boards operations in 2007 (calendar year) is €9,700,000.

[1] http://www.defra.gov.uk/environment/noise/guidance/pdf/noisemanagement-localauthorities.pdf

United Kingdom

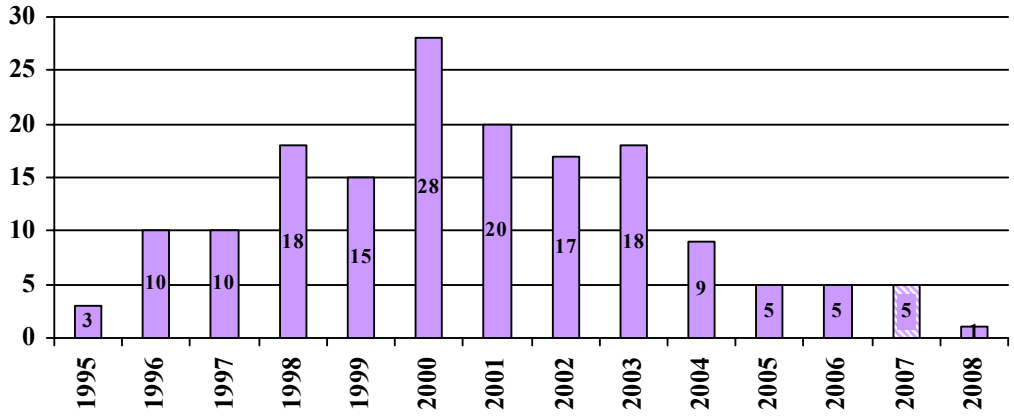
Creutzfeld-Jakob Disease - BSE

204. As at 21 October 2008, there have been 167 definite and probable cases of vCJD in the UK, of whom three are still alive – see table below. It is thought that most of these cases arose from exposure to Bovine Spongiform Encephalopathy (BSE) infectivity in bovine meat products in the 1980s and early 1990s, before wide-ranging measures minimising potential exposure were introduced. Three cases were probably a result of secondary transmission via non-leucodepleted blood from donors who themselves later developed vCJD.

205. Estimates of the number of people currently incubating vCJD in the UK have been made based on modelling and vary widely. One published estimate identified 3 affected samples out of 12, 674 tested, which would suggest a prevalence of about 1 in 4,000 (with a statistical confidence interval of between 1 in 1,400 and 1 in 20,000). However all such estimates are very uncertain, for example, the samples used in this study primarily came from an age group that may have been at relatively high exposure to BSE, so lower figures could apply to the population in general. It is also not clear how many of those carrying the infection are likely to develop symptoms of vCJD: given the small number of cases actually seen so far, the majority of carriers may never do so.

206. Data collected by the UK's National CJD Surveillance Unit suggest that in the UK vCJD deaths peaked in 2000 (28 deaths) and have since fallen to five each in 2005, 2006 and 2007, and one to date in 2008.

Number of deaths per annum from vCJD in the UK



207. The Health Department's key priority is to ensure that measures are in place to minimise the potential for secondary spread of vCJD through blood/blood products or through surgery including dentistry. Supporting this the UK has taken action including:

- *Blood* - Shortly after vCJD was first identified, the possibility of human-to-human transmission through blood was considered, and precautionary measures were implemented to reduce what was, at that time, a theoretical risk. The measures were tightened as evidence of transmission via blood began to emerge from animal studies, and following the first possible case of transfusion associated transmission in humans in 2003. These measures included removing white blood cells from blood, and importing blood products from countries unaffected by vCJD. An important additional step, introduced in March 2004, was to exclude from blood donation all those who had received a blood transfusion since January 1980.
- *Surgery/Dentistry* – advice has been published on the decontamination, quarantining and where appropriate use as single use only of surgical equipment (including endoscopes), and on the assessment of patients before surgery to identify patients with, or at risk of, CJD. Advice has been issued to all dentists in the UK to use endodontic reamers and files as single use only.

Smoking, alcoholism and drug addiction

208. A comprehensive set of statistics on drug, alcohol and tobacco misuse can be found at http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalpublichealth/DH_4032542

Alcohol

209. The Government strategy to tackle alcohol misuse, especially among young people, can be found at the following link. http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH_085386

Smoking

210. For the past decade, eliminating premature death and disease caused by tobacco use has been a foremost public health priority for the Government. Smoking prevalence continues to decline. Smoking remains the main cause of preventable morbidity and premature death in the United Kingdom, accounting for over 100,000 deaths each year in the United Kingdom. According to the National Institute for Health and Clinical Excellence (NICE), tobacco use is the primary reason for the gap in healthy life expectancy between rich and poor.

211. Ten years after the publication of the *Smoking Kills* White Paper in 1998, the UK has developed a reputation as a leader in Europe and across the world in effective tobacco control. In 2007, an independent academic survey of tobacco control activity across 30 European countries ranked the UK' as being most effective.

212. Over the past decade, the Government has delivered an ambitious programme of tobacco control, with achievements including:

- introducing laws to provide protection from the harm caused by exposure to secondhand smoke in enclosed work and public places;
- comprehensively banning advertising of tobacco in print, on billboards and on the internet;
- limiting tobacco advertising at the point of sale to a maximum space of an A5 sheet of paper;
- As of 1st October 2007 it became illegal to sell tobacco products to anyone under the age of 18 (an increase from 16) in England and Wales. The change in law also came into effect in Scotland from the same date. Products affected include cigarettes, cigars, and hand rolling tobacco and papers.
- introducing legislation into Parliament to substantially increase sanctions for retailers who persistently sell tobacco to people under the age of 18;
- passing laws to require hard-hitting pictorial health warnings on all tobacco products produced for the UK market from October 2008;
- setting up an extensive network of local NHS Stop Smoking Services in communities across the country to support smokers who want to quit. Today, smokers who quit with the support of the NHS are up to four times more likely to quit long term than are smokers who try to quit by going 'cold turkey';
- continuing high levels of investment in the NHS Stop Smoking Services means that we have the most comprehensive and fully resourced smoking cessation support programme in the world;
- making pharmaceutical stop smoking aids more widely available, including on prescription from the NHS;
- running a world class marketing and communications programme that has reached out to millions of smokers with information on and support in quitting.

213. The Department of Health and the NHS will continue to develop a range of evidence-based policies and support options to help smokers from all sections of the community to quit, particularly with the help of the NHS. Smokers who quit with NHS support are up to four times more likely to succeed, compared to smokers why try to quit by going "cold turkey". We will continue to promote the benefits of quitting, and the most effective quit

strategies using our award-winning communication campaigns, which are based on sound social marketing principles.

214. The Government has announced a commitment to develop a new national tobacco control strategy to build on our achievements and further reduce smoking rates. The Department of Health has recently consulted on the future of tobacco control as the first step in developing a national strategy, with the consultation focusing on the following four areas:

- **Further action to reduce smoking rates and health inequalities caused by smoking:** including new targets for a reduction in smoking prevalence, regional differences and health inequalities, and ways to tackle the supply of cheap illegal tobacco in our communities.

- **Protecting children and young people from smoking:** reducing young people's access to tobacco, reducing exposure to tobacco promotion, and protecting children from secondhand smoke.

- **Helping smokers to quit:** including NHS stop smoking support, increasing access to and take-up of quit services among high smoking prevalence groups, supporting young smokers to quit, supporting pregnant smokers to quit and how best practice can be best shared.

- **Helping those who cannot quit:** considering the potential of a harm reduction approach in tobacco control to help people whose addiction to nicotine makes it extremely difficult to quit altogether.

Key metrics:

215. Among adults aged 16 and over in England in 2006:

- Results from the General Household Survey show, overall smoking prevalence has decreased. In 2006, 22% of adults reported smoking, compared to 24% in 2005 and 39% in 1980 (see chart below).

- Those aged 20 to 24 and 25 to 34 reported the highest prevalence of cigarette smoking (31% and 29% respectively) while those aged 60 and over reported the lowest prevalence of smoking (12%)

- As with previous years, smoking was higher among men than women (23% and 21% respectively) although this gap is narrowing

- Those in the routine and manual groups reported the highest prevalence of smoking (29%).

- Two-thirds of current smokers and ex smokers who had smoked regularly at some point in their lives started smoking before they were 18.

Smoking among children

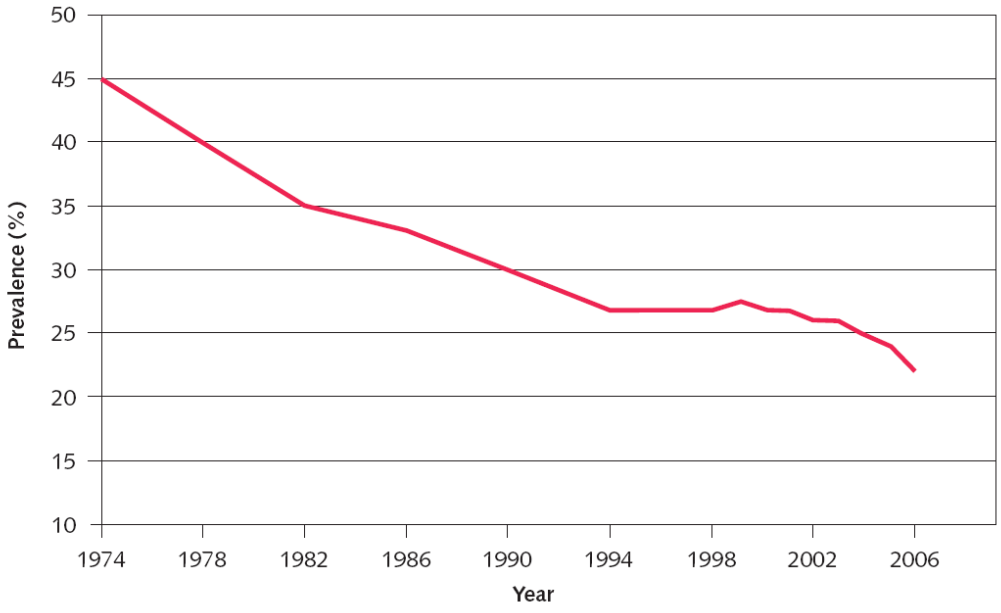
216. Among pupils aged 11 to 15 in England in 2007:

- Two-thirds of pupils reported they had never smoked. The proportion who had never smoked had rose from 47% in 1982 to 67% in 2007
- Six per cent of children reported that they were regular smokers (smoked at least once a week), down from 9% in 2006.
- Since 1990 there has been an increase in the number of pupils being refused cigarettes at point of sale, from 37% in 1990 to 53% in 2006.

Behaviour and attitudes to smoking

217. Among adults in Great Britain in 2007:

- Almost three-quarters of current smokers reported wanting to give up smoking
- Two-thirds (67%) of adults report that they do not allow smoking at all in their home, an increase from 61% in 2006
- Four in five people agree with the smokefree legislation in place throughout the UK since 2007.



Prevalence of smoking in Great Britain (1974-2006),
from General Household Survey 2006

Drug abuse

218. Data published by the National Treatment Agency in September 2008 showed that there were 202,000 people in drug treatment in 2007/08, a 130% increase on the 1998 baseline when the Government launched its previous Drug Strategy. At the same time 83% of those in drug treatment were recorded as having an effective treatment episode that has had a long term positive impact on their addiction. This increase in the availability of effective treatment has led to demonstrable benefits such as a reduction in drug related crime and a halting in the sharp increases in drug related deaths that were identified in the 1990's. These improvements have been supported by substantial Government investment with the Pooled Drug Treatment Budget now at a level of £398m annually and this with mainstream investment means that it is estimated that over £600m is being spent in England every year on drug treatment.

219. In February 2008 the Government launched its new drug strategy, *Drugs: Protecting Families and Communities* which builds on the previous drug strategy. It sets out a 10-year vision and a raft of new measures to enforce, educate and intervene on drugs, and support those who need it into treatment.

220. The new strategy emphasises the importance of treatment as a key plank of government policy, and sets out the following priorities for the next 3 years:

- greater emphasis on treatment outcomes, completion and planned exit
- more individually tailored care packages, rather than one size fits all;
- reducing the negative impact of parental drug use on families;
- more user friendly treatment for parents and other groups who are under-represented in treatment; and
- the need for drug misusers to contribute to society through work, helped by better support to access training and employment

221. In terms of measuring treatment outcomes we have committed to building on the progress already made by increasing the number of Problematical Drug Users (Crack and/or Heroin) in effective treatment by 3% by 2011. This is in addition to a number of commitments within the Drug Strategy such as the programme of work to support those drug users who are benefits as a result of their dependence to tackle their addiction so that they are able to come off benefits and back into work.

Northern Ireland

Smoking

222. The Department of Health, Social Services and Public Safety (DHSSPS) published a five year Tobacco Action Plan in 2003. The Plan, which provides a framework for collaborative working across Government

Departments, the statutory and voluntary sectors, as well as within business and local communities, identified three key target groups – children and young people, disadvantaged adults who smoke and pregnant women who smoke.. The Plan will be reviewed in 2008/09 and is likely to be rolled forward for a further five years. Comprehensive legislative controls on smoking in enclosed public places and workplaces, which came into effect on 30 April 2007, have been well received across Northern Ireland. The Department has funded the appointment of additional environmental health officers to assist with the enforcement of the legislation. The Department continues to fund a range of tobacco control initiatives including major public information campaigns and the provision of smoking cessation services across Northern Ireland. A dedicated telephone helpline service for smokers has been available since 2003.

Alcohol and Drug Abuse

223. In 2002 it was agreed that there should be a Review of the two strategies and the Joint Implementation Model in 2004 in order to assess their current role and effectiveness. In May 2004 this was formulated as the New Way Forward which described a two-strand process which saw the Review as Part One and the development of a New Strategic Direction for alcohol and drugs as Part Two. It was later agreed that the New Strategic Direction would be launched in May 2006, with implementation starting in October 2006.

- The development of this began in April 2005 and followed a six-stage approach to develop a fully integrated, inclusive and co-ordinated strategic direction for addressing alcohol and drug misuse in Northern Ireland over the next five years. The intention was to combine a clear regional vision with local and community aspirations. The New Strategic Direction for Alcohol and Drugs (NSD) was launched in May 2006 with full implementation beginning in October 2006. It is based on the logic model approach with a mix of short, medium and long-term outcomes at both the regional and local level, delivering on a number of Key Priorities.

- Under the NSD there is a New Strategic Direction (for Alcohol and Drugs) Steering Group (NSDSG) chaired by the Permanent Secretary, DHSSPS, with the primary role to maintain an overview of the NSD, in particular progress on work to achieve its outcomes. The NSDSG will in turn report to the current Ministerial Group on Public Health (MGPH) which consists of senior civil servants from a wide range of Government Departments together with the NIO whose business areas impact on public health and the determinants of health. It is currently chaired by the Minister with responsibility for Health.

- Within the DHSSPS, the policy lead for alcohol and drugs is with the Health Development Policy Branch (HDPB). In addition there are four Advisory Groups:

- Children, Young People and Families
- Treatment and Support
- Law and Criminal Justice
- 'Binge Drinking'

Their role is to:
- advise the NSDSG in respect of the particular issue;
- comment on current work towards the outcomes in the NSD; and
- make recommendations as to future work and direction.

- The four local Drugs and Alcohol Co-ordination Teams have continued, and in support of the NSD's Key Priorities they have developed their own local action plans, with a focus on outcomes. These outcomes have formed the basis of a tendering process through which they are being delivered.

- In addition to the above there is a Liaison Group consisting of Chairs and Senior Co-ordinators of the local Alcohol and Drugs Co-ordination Teams, HDPB, DAIRU and Chairs of the four advisory groups. They meet on a regular basis to monitor overall progress on the NSD.

- The annual budget in respect of the local action plans and supportive regional work is £5.4m

Isle of Man

224. A cross agency strategy to prepare for a future outbreak of pandemic flu is being developed. In 2007 the Department of Health and Social Security published two public information documents entitled "Pandemic Flu – The Facts" (a short leaflet) and "What is Pandemic Flu?" (a detailed booklet).

225. In April 2005 the Chief Minister's Updated Drugs and Alcohol Strategy for 2005 onwards was launched. The aim of the strategy is to achieve a balance between harm reduction, demand reduction and supply reduction measures to reduce the harmful effects of drugs in the Isle of Man community. The strategy promotes partnerships between health, law enforcement and education agencies, drug users, people affected by drug-related harm, community-based organisations and industry to reduce drug-related harm in the Island.

226. The Public Health (Tobacco) Act 2006 was brought into fully into force in June 2007. This Act introduced provisions to control tobacco advertising and it gave the Department of Local Government and Environment the power to make Regulations to prohibit and control smoking in public places. A copy of the Act can be found on the Government website at : http://www.gov.im/lib/docs/infocentre/acts/publichealth.pdf.

227. The No-Smoking Regulations 2007 which were laid before Tynwald

(the Island's parliament) in June 2007 prohibited smoking in almost all enclosed public places; the Regulations come into operation on 30th March 2008. A copy of the Regulations can be found at: http://www.gov.im/lib/docs/dlge/enviro/nosmokingpremisesregs2007.pdf.

228. The Isle of Man has updated its food hygiene legislation. The European Communities (Food Hygiene Laws) (Application) Order 2007 applied with appropriate modifications a number of EC food hygiene regulations, including EC Regulations 852/2004, 853/2004 and 854/2004, as part of the law of the Island. The purpose of these EC Regulations is to protect public health, safeguard the interests of consumers in relation to food, and are of a nature that food business operators take responsibility for producing food safely, whilst ensuring controls are proportionate to risk and not burdensome to enforcement bodies or food businesses. Implementation of the applied measures is through the Food Hygiene Regulations 2007 which came into operation in July 2007. Copies of the Order and Regulations can be found at:
http://www.gov.im/lib/docs/dlge/enviro/foodhygieneecapplnordersd5.pdf and
http://www.gov.im/lib/docs/dlge/enviro/foodhygieneregulationssd59407.pdf
respectively.

229. Legislation to deal with the issue of noise pollution has been enacted. The Noise Act 2006 came into force on 1st January 2007. A copy of the Act can be found at: http://www.gov.im/lib/docs/infocentre/acts/noise.pdf.

ARTICLE 12, Paragraph 1

United Kingdom

1. The United Kingdom has ratified both ILO Convention No.102 on Social Security (Minimum Standards) and the Council of Europe's European Code of Social Security. A copy of the UK's last submitted Report on Convention No. 102, for the period 1 June 2001 to 31 May 2006, is attached as **Appendix 12A**. During the reference period the UK also submitted its 39th and 40th annual Reports on ratified parts of the European Code of Social Security and copies of those reports are attached as **Appendices 12B and 12C**.

2. The general scope and coverage of the UK's social security system remains as previously described and as set out in the reports referred to above.

3. Separate, but corresponding, schemes of Social Security are operated in Great Britain and Northern Ireland. Reciprocal arrangements between the two ensure that the schemes effectively operate as a single system with contributions and benefit rates and dates of commencement maintained in parity.

4. The complete Law on Social Security, as it currently applies in Great Britain, as amended and updated, is published as the "Blue Volumes" and is now available on line via the Department for Work and Pensions' website[1]. Guidance on how to navigate the respective volumes is also available there. Corresponding Social Security legislation that has effect in Northern Ireland can be viewed at the Department for Social Development in Northern Ireland website[2].

Great Britain

5. The Department for Work and Pensions Annual Report for 2008 gives a detailed overview of its current operation, funding and expenditure on benefits and their administration. The Report for 2008 can downloaded in full in .pdf format at:

http://www.dwp.gov.uk/publications/dwp/2008/dr08/Fullreport.pdf

It can also be accessed via the Department's website where it is broken down to its component parts in smaller more manageable .pdf files at: http://www.dwp.gov.uk/publications/dwp/2008/dr08/.

[1] **http://www.dwp.gov.uk/advisers/docs/lawvols/bluevol/**
[2] **http://www.dsdni.gov.uk/law_relating_to_social_security**

Welfare Reform

6. The Government is committed to building an inclusive and fair society, and a prosperous economy, where everyone has the opportunity to fulfill their potential. Full employment is at the heart of the strategy. The Government has a long-term aim of an employment rate of 80 per cent. It will help to combat poverty and ensure the UK is well placed to respond to economic change, and reap the benefits.

7. The Welfare Reform Act 2007 introduces a key element of the Government's Welfare Reform proposals - the creation of the new Employment and Support Allowance (ESA), which replaces Incapacity Benefit and Income Support payable on the basis of incapacity for new customers from 27th October 2008 and which is outside the reporting period. The implementation of the new benefit will be described in full in the UK's next report.

8. The Government wants as many people as possible to share in the rewards of work. They believe that paid work is the best route to independence, health and well-being for most people. Significant progress has already been made with the introduction of a series of radical reforms to improve the opportunities for people to work. But more needs to be done.

9. On 21 July 2008 "No one written off: reforming welfare to reward responsibility"[1] was published and sets out a range of options to:

- provide a more personalised service to help jobseekers to access the support and skills they need to help themselves;
- deliver a simpler system of two working age benefits which means we can focus on equipping those who can work with the skills they need to find jobs while also providing the right support at the right time to those who need it most;
- empower disabled people as they are given greater control of the support they get from government;
- ensure that many more parents will be able to access the skills and training they need to find employment and improve their children's life chances. Reforms to the child maintenance system combined with support to help lone parents with older children into work will lift up to 200,000 children out of poverty; and
- strengthen local partnerships, creating more opportunities for back-to-work providers to deliver greater local flexibility and help to jobseekers so that they can access jobs within the local labour market.

The consultation closed on 22 October 2008 and the results will feed into a Bill in the next session of Parliament.

[1] http://www.dwp.gov.uk/welfarereform/noonewrittenoff/

Pension Reforms – 2010 Onwards

10. The Government is also undertaking a landmark reform of the UK pensions system. This follows extensive work to identify the problems facing the pensions system. Then a proposed package of measures, designed to deliver increased financial security for an ageing population, underwent an unprecedented national consultation process in order to build a genuine, broad based consensus around the way forward.

11. This work culminated in two White Papers**:**

"Security in Retirement" on 25th May 2006 – for more detail see:

http://www.dwp.gov.uk/pensionsreform/towards.asp

"Personal Accounts: a new way to save" on 12 December 2006 – see

http://www.dwp.gov.uk/pensionsreform/new_way.asp

12. The first phase of the reforms was completed with the Pensions Act becoming law in July 2007. The second phase, in the Pensions Bill, was introduced to Parliament on 5 December 2007.

The Pensions Act 2007

13. In July 2007 The Pensions Act legislated for the reforms to the State Pension system set out in the first of these White Papers. Measures in the Act will, over the coming years, make the state system more generous, fairer to women and carers, and more widely available. The Act also created the Personal Accounts Delivery Authority to advise on the introduction of a new, simple and low cost pensions savings vehicle.

National Statistics – DWP Social Security Statistics

14. National Statistics is the official source for authoritative accurate and relevant information on the economy and society. It brings together a vast range of statistical information overseen by the National Statistician.

15. The Department for Work and Pensions has made major changes to the National Statistics which it publishes, both in the data sources employed and methods of delivery. In October 2005, DWP began releasing aggregate statistics using a new Internet tabulation tool. The Work and Pensions Longitudinal Study is now the source for benefit and employment scheme statistics. Access to the National Statistics via the Tabulation Tool is available via the following link - http://www.dwp.gov.uk/asd/statistics.asp.

16. The Tabulation Tool (Tabtool) (http://dwp.gov.uk/asd/tabtool.asp) allows users to download bespoke information designed to their needs. Other

statistics which are not part of the Tabulation Tool can be accessed via the above statistics link. There is also a guide to statistics - (http://dwp.gov.uk/asd/data_guide.asp).

17. The best statistics to use are sourced from the newly published Work and Pensions Longitudinal Study (WPLS). These data are based on 100% of claimants and cover information such as age and gender of claimant, duration of their spell on benefit and geographical locations of claimants.

18. For more detailed breakdowns specific to one benefit (for example type of Jobseeker's Allowance in payment) the 5% sample data has more detail but less comprehensive coverage.

19. WPLS data should be used first and the samples only accessed if the data needed is not available on the WPLS. DWP recommends that, where the detail is only available on the 5% sample data, the proportions derived should be applied to the overall 100% total for the benefit. The Guide to Sources document lists which information is available from each data source and provides more detail.

Quarterly Summary Statistics

20. Information on the numbers of benefit claimants, employment programme, labour market decision and vacancies produced by Department for Work and Pensions are released through a Quarterly Summary (see link below for the May 2008 Release). Not all DWP National Statistics are covered by this release. Some statistics have their own first releases but links to these are given throughout.
http://www.dwp.gov.uk/asd/asd1/stats_summary/Stats_Summary_may_2008.pdf

Northern Ireland Statistics

21. Comparable statistics published for Northern Ireland can be viewed at the Department for Social Development Research and Statistics website pages via the following link.

http://www.dsdni.gov.uk/index/stats_and_research/stats-publications/stats-benefit-publications.htm

Conclusions XVIII-1

In Conclusions XVIII-1, the Committee concludes that the situation in the United Kingdom is not in conformity with Article 12§1 of the Charter on the grounds that at least for single persons the level of the Statutory Sick Pay, the Short-Term Incapacity Benefit, and the contributory JSA are manifestly inadequate.

22. The Government would like to draw the Committee's attention to the

fact that benefits in the UK are usually increased annually in line with prices. Thus year on year the purchasing value of the benefits remains the same. On the other hand, in a stable economy earnings tend to increase by more than prices and people in work generally see their standard of living improve year by year. To avoid benefit dependency, the Government believes that increasing benefits for people of working age in line with prices is the fairest approach.

23. For those who find that their benefit is not sufficient for their needs the UK has a range of means tested social assistance benefits that can be paid additionally. Thus no one should be forced to live in poverty.

24. The Government would draw the Committee's attention to the UK's published Abstract of Statistics, which is an annual reference source for information on the main aspects of Benefits, Contributions and Indices of Prices and Earnings. The Abstract for 2007 provides data in answer to the following types of questions:

(a) How do the values of state benefits compare to prices?
(b) Are state benefits today, worth more or less in terms of Average Earnings than in previous years?
(c) How does the income of an unemployed person compare with Average Earnings?
(d) How much is spent on benefits?
(e) How do the rates of benefits compare with one another?

It can be viewed at:
http://www.dwp.gov.uk/asd/asd1/abstract/Abstract2007.pdf

Isle of Man

ARTICLE 12, Paragraph 1

25. There is no substantial change to the information previously provided, with the exception the updated/additional information set out in the following paragraphs.

State Retirement Pension

26. From 6th April 2005 the position of those who decided to defer their award of State Retirement Pension was improved by allowing them to choose to receive a lump sum payment rather than an increase in the rate of their weekly pension when they eventually claim their pension, to compensate them for not doing so earlier.

Pregnancy and Childbirth

27. The maximum period for which **Maternity Allowance** may be awarded was extended from 26 weeks to 39 weeks for babies due on or after 24th June 2007.

Family Benefits

28. Eligibility for **Child Benefit** was extended to young persons under the age of 20 who are still in full time education or approved training of more than 12 hours per week and studying for a qualification up to GCE "A" level standard or equivalent from April 2006

29. The maximum period of award of **Adoption Allowance** was increased from 26 weeks to 39 weeks in line with Maternity Allowance.

Civil Partnerships

30. The provisions of the United Kingdom's Civil Partnerships Act 2004 which relate to social security matters were applied to the Island with effect from 5th December 2005. The effect of this on the benefit entitlement of Isle of Man residents who have entered into a civil partnership in the UK (at present there is no legal provision to enter into such a partnership in the Island) is explained below.

Contributory Benefits

31. Where a civil partnership is formed, the following benefits are payable to both parties of a civil partnership in the same way as married couples. Those living together as if they were civil partners, but who have not registered their partnership, will be in a similar position to unmarried opposite-sex partners, and may not be eligible for certain benefits. The effect on individual benefits is described in the following paragraphs.

Bereavement Benefits

32. Surviving civil partners will be entitled to bereavement benefits in exactly the same way as surviving spouses. The rules which terminate entitlement to Bereavement Allowance and Widowed Parent's Allowance on remarriage, and suspend payment during cohabitation, are extended to same sex couples who form a civil partnership or otherwise live together as if they are civil partners.

Incapacity Benefit

33. Civil partners can claim an Adult Dependency increase for their partner in the same way as men and women can claim for their spouse now (this only applies where a civil partnership has been registered).

State Pension

34. Civil partners will not receive full rights (in relation to, for example,

Category B pensions and Adult Dependency Increase) until married men gain equal treatment in 2010.

35. Where rights were equal between men and women, civil partners gained these rights from 5th December 2005 (for example, substitution of partner's contribution record on divorce/dissolution of civil partnership or death of partner).

Gender Recognition

36. The provisions of the United Kingdom Gender Recognition Act 2004 which relate to social security were applied to the Island with effect from April 2005. From that date a transsexual man or transsexual woman who has been issued with a full Gender Recognition Certificate (by the U.K. Gender Recognition Panel) will be legally recognised in their acquired gender for Social Security and National Insurance purposes only.

37. National Insurance contributions are paid on the basis of the acquired gender, for example a transsexual woman aged under 60 will pay NI contributions up to the State Pension age for women and a transsexual man aged under 60 will pay NI contributions up to the State Pension age for men.

38. The main benefits affected are

- State pensions
- Contracted-out occupational pensions
- War Disablement Pensions and War Widows Pension
- Bereavement Benefits and Widow's Benefits
- Incapacity Benefits

State Pension

39. Following a successful application for a full Gender Recognition Certificate State Pension can be claimed at the age appropriate to the acquired gender.

Bereavement Benefits/Widows Benefits

40. When a transsexual man gets a full Gender Recognition certificate entitlement to Widow's Pension and Widowed Mother's Allowance will stop.

41. Widowed Parent's Allowance and Bereavement Allowance are not affected.

Incapacity Benefit

42. Incapacity Benefit is affected by the age of the person claiming the

benefit. If a transsexual woman is receiving Incapacity Benefit it will cease at age 60 and at age 65 for a transsexual man.

Hospital In-Patients

43. The United Kingdom Hospital In-Patients Regulations 2005 were applied to the Island in April 2006. These Regulations amend other regulations so that, except in specified cases, a person's benefit is no longer adjusted when a person has been receiving free medical treatment as a hospital in-patient for 52 weeks.

Isle of Man - Benefit Claims in Payment & Annual Budgets

Benefit/Pension	Jan '05 No.	2005/06 Budget £,000	Dec '07 No.	2007/08 Budget £,000
Retirement Pension	15,908	70,198	16,941	83,051
Old Person's Pension	71	182	62	190
Age Addition	(3,667)	399	(3,739)	410
Retirement Pension	(4,281)	2,169	(3,847)	2,101
Premium	(10,955)	23,370	(11,803)	23,759
Pension Supplement	9,434	17,696	9,820	17,734
Child Benefit	(16,360)	-	(16,754)	-
No. of children	(520)		(313)	
Lone Parent Increase	2	1	2	6
Guardians Allowance	242	382	107	516
Contributory Jobseeker's Allowance	85	201	63	211
Enhanced Jobseeker's Allowance	604	1,915	405	1,968
	1,333	5,266	1,390	5,666
	216	2152	354	4,743
Incapacity Benefit (Short Term)	2	86	3	73
	2	17	2	9
Incapacity Benefit (Long Term)	74}		74}	
Maternity Allowance	38}	548	23}	411
Paternity Allowance	149	793	91	519
Adoption Allowance	1,320	3,310	1,238	3,474
Bereavement Allowance	1,991	6,023	2,048	6,281
Widowed Parent's Allowance	220	455	195	607
Widow's Pension	227	416	217	439

Isle of Man – Benefit Rates

(rates are weekly unless otherwise stated)

			2005/06	**2007/08**
RETIREMENT PENSION (R.P.)			**GB£**	**£**
Basic R.P. -	own insurance		82.05	87.30
	- on spouse's insurance		49.15	52.30
Old Person's Pension			49.15	52.30
Age Addition to R.P.			2.00	2.00
Retirement Pension Premium			12.05	12.85
Pension Supplement			41.03	43.65
INCAPACITY BENEFIT				
Short-term Incapacity Benefit				
over pension age			73.35	78.05
under pension age	-	lower rate	57.65	61.35
	-	higher rate	68.20	72.55
Long-term Incapacity Benefit				
standard rate			76.45	81.35
age addition	-	higher rate	16.05	17.10
	-	lower rate	8.05	8.55
BEREAVEMENT BENEFITS				
Bereavement Payment (lump sum)			2,000.00	2,000.00
Bereavement Allowance			82.05	87.30
Widowed Parent's Allowance			82.05	87.30
Widow's Pension (transitional cases only)			82.05	87.30
CONTRIBUTION-BASED JOBSEEKER'S ALLOWANCE				
Aged 16 or 17			33.85	35.65
Aged 18 or over but under 25			44.50	46.85
Aged 25 or over			56.20	59.15
MATERNITY ALLOWANCE (M.A.)				
Employed earners maximum rate			169.25	156.10
Self-employed rate			106.00	112.75
earnings threshold			30.00	30.00

PATERNITY ALLOWANCE		
Maximum rate	169.25	180.40
ADOPTION ALLOWANCE		
Maximum rate	169.25	156.10
earnings threshold	30.00	30.00
INDUSTRIAL INJURIES DISABLEMENT BENEFIT		
100%	123.80	131.70
20%	24.76	26.34
CHRISTMAS BONUS (LUMP SUM)	80.00	82.50
FUNERAL PAYMENTS (LUMP SUM)		
standard rate	205.00	210.00
enhanced rate	340.00	350.00
DEPENDANTS ADDITIONS		
Spouse (or person looking after children)		
with R.P.	49.15	52.30
with Long-term Incapacity Benefit	45.70	48.65
with M.A. or Short-term Incapacity Benefit	35.65	37.90
Children - with R.P., W.B., Incapacity Benefit (Long-term and higher rate short-term) and, if beneficiary over pension age, with Short-term Incapacity Benefit	11.35	11.35

Article 13 – The right to social and medical assistance

Article 13, Paragraph 1

1. "Directgov"[1] is the UK Government website that brings together information and online services for the public. It provides information from across government departments and elsewhere and includes comprehensive information and guidance on all social and medical assistance aspects in the pages on Tax, Money and Benefits[2] and Health and Wellbeing[3] .

Medical Assistance

2. The position remains as previously described with the following developments.

Radical reform – putting the patient in the driving seat

3. The NHS is continuing to change the way it works to personalise services around the individual needs, aspirations and circumstances of patients, carers and the public – patients should not have to fit around institutions. The expression of this through patient choice has continued to grow: 'Free Choice' for all 9m+ patients a year requiring elective referrals to hospital was introduced from 1 April 2008. Under this initiative patients referred for elective procedures will be able to choose from any hospital in England which meets NHS standards and price (tariff).

4. The Government is committed to introducing choice of setting, treatment and provider for the c.15m patients with long-term conditions over 2008-2010 and we are building on the successful launch of the NHS Choices public information service to both better inform choice of services, and provide people with the information and support they need to stay healthy or manage their conditions. In January 2008, the Prime Minister announced the development of a 'Patient Prospectus' (provided through NHS Choices) to encourage and support self-care, the first phase of which will be launched in the autumn of 2008.

5. The number of NHS Foundation Trusts has grown and there is increasing evidence of the potential of FTs to deliver increased efficiency and improved services. The Department of Health (DH) has also continued to introduce a wider range of providers from the independent and not-for-profit sectors to provide healthcare to NHS patients, including primary care. During the past year there has been a substantial growth in patients using the Extended Choice Network, allowing them to choose to be treated at participating independent sector hospitals.

6. The two new independent inspectorates are working and we are

[1] http://www.direct.gov.uk/en/index.htm
[2] http://www.direct.gov.uk/en/MoneyTaxAndBenefits/index.htm
[3] http://www.direct.gov.uk/en/HealthAndWellBeing/HealthServices/PractitionersAndServices/index.htm

preparing for the creation of a single regulator - subject to the outcome of legislation.

7. Looking to the future, the Government will continue to invest heavily in information technology to enable the NHS to deliver faster, safer and more convenient care. This includes public-facing information services such as "NHS Choices" which was launched in June 2007 and now provides a wide range of information on how to stay healthy, specific conditions, and health services – including a growing number of indicators of service quality, increasing transparency and accountability for quality.

8. These changes are underpinned by a reaffirmation of the basic values of the NHS – the intention to provide services, equally, to everyone regardless of their circumstances and their ability to pay..

Creating a Patient-led NHS – Delivering the NHS Improvement Plan

9. In December 2005 DH published the document *Health Reform in England: Update and Next Steps*. The document describes the elements of reforms to the healthcare system and how they are expected to interact, leading to better patient services and value for the taxpayer's money. It sets out a framework for reform and:

- explains how the reforms are intended to be mutually reinforcing;
- re-states the rationale for reform;
- summarises the initiatives already announced; and
- lays out a programme of further policy development.

10. During 2007/08, the focus has continued to be on strengthening and raising the standards of commissioning, particularly through the new World Class Commissioning programme, which sets out – for the first time – a clear vision, competencies and standards for commissioners. DH has also – again for the first time – developed clear policy and mechanisms for managing choice and competition (published in the *Principles and Rules for Cooperation and Competition* in December 2007, alongside a standard national contract for hospital services; further guidance will be published during 2008/09, as well as establishing an independent Cooperation and Competition Panel to deal with competition disputes which cannot be resolved at local level). DH consulted on future arrangements for regulation - a key role in assuring patient safety.

11. As services improve and capacity grows, the NHS is offering patients more choice and more personalised services. The Government is committed to introducing choice of setting, treatment and provider for the some 15m patients with long-term conditions over 2008-2010. Choice of maternity services is to be introduced by December 2009.

12. Keys themes of the current Next Stage Review of the NHS, and its interim report, have been how to introduce greater personalisation of the services funded by the NHS, increase patient and carer choice and control, encourage and enable self- and shared-care, and secure greater consistency and quality of services. This work is being informed by an unprecedented programme of engaging clinicians, managers and patients.

Social Assistance

13. The position remains as previously described with the following developments.

14. The Department for Work and Pensions Annual Report for 2008 gives a detailed overview of its current operation, funding and expenditure on benefits and their administration. The Report for 2008 can downloaded in full in .pdf format at:
http://www.dwp.gov.uk/publications/dwp/2008/dr08/Fullreport.pdf
It can also be accessed via the Department's website where it is broken down to its component parts in smaller more manageable .pdf files at:
http://www.dwp.gov.uk/publications/dwp/2008/dr08/.

Housing Benefit

15. A more straightforward and transparent way of calculating entitlement to Housing Benefit in the private rented sector, the Local Housing Allowance (LHA), was implemented nationally from 7th April 2008 (see further detailed information at the "Directgov" website link below[1].)

16. Additionally, significant improvements and simplifications to Housing Benefit and Council Tax Benefit that have made a real difference include: additional funds amounting to over £180 million paid to local authorities from 2003 to 2006 through the Standards Fund and free consultancy through the Performance Development Team.

17. The Government continues to look at ways of simplifying the system by bringing the Housing Benefit and Council Tax Benefit rules into line with Pension Credit and New Tax Credits wherever possible.

18. The average time taken to process new Housing Benefit and Council Tax Benefit claims has been halved from 55 calendar days in 2002/03 to 26 days in 2007/08, surpassing the set PSA target of 48 days.

19. Housing Benefit is paid to over 4 million tenants – 2.5 million people of working age and 1.5 million pensioners (data available to August 2007). Total spending on Housing Benefit was around £15.7 billion for the year 2007/08

[1] http://www.direct.gov.uk/en/MoneyTaxAndBenefits/BenefitsTaxCreditsAndOtherSupport/On_a_low_income/DG_10018928

with an estimated 32% (£5.1billion) being spent on the elderly and 68% (£10.7 billion) on working age claimants.

20. There has been a significant 75% reduction in the number of complaints to the Local Government Ombudsmen on Housing Benefit, down from 4,028 in 2000/01 to 997 in 2006/07.

Tax Credits

21. The UK operates a system of Tax Credits, administered by Her Majesty's Revenue and Customs (HMRC). Tax Credits are payments made by the Government and are mainly income related in-work benefits for a variety of personal circumstances. Child Tax Credit (CTC) and Working Tax Credit (WTC) replaced Working Families' Tax Credit, Disabled Person's Tax Credit and Children's Tax Credit in April 2003. CTC is available to families with children aged up to 16, or up to 20 and in full-time non-advanced education or certain forms of training. WTC is available to people working for at least 16 hours a week if they have children, or have an illness or disability which puts them at a disadvantage in getting a job. Certain other adults also qualify - for example, if they are aged at least 25 and work for at least 30 hours a week.

22. Information on Tax Credits is available on the Directgov website pages and they are also described in detail on the HMRC website at http://www.hmrc.gov.uk/taxcredits/introduction.htm

23. HMRC also publish an Independent Taxation Manual IN1300+ that sets out guidance on Child Tax Credit[1].

24. A detailed example of how Tax Credit entitlement is calculated is set out below for information.

Example of Tax Credit calculation:

The entitlement for 2007-2008 has been calculated using the following circumstances:

- Standard beneficiary with gross annual family income of £17,420.00 (£335 per week).
- a joint claim with one partner working at least 30 hours per week
- two children under the age of 16

The award period is for 366 days from 6 April 2007 to 5 April 2008
The maximum tax credit for each element for 366 days is as follows:

[1] http://www.hmrc.gov.uk/manuals/Inmanual/html/1incont/01_0095_INCONT33.htm

WTC - Work Elements

Basic	£1,731.18
Second adult	£1,701.90
30 hour	£706.38
Total maximum work elements =	**£4,139.46**

CTC - Child/Young Person Elements

Children under 16	£3,696.60
Total maximum child/young person elements =	**£3,696.60**

CTC – Family Elements

Family	£545.34
Total maximum family elements	**£545.34**
The total maximum elements are	**£4,139.46 WTC**
	£4,241.94 CTC

The amount of the award will be reduced when the household income exceeds the income limits. In this example the income limit is £5,220.00 as the claimants are entitled to the WTC work elements.

As the income of £17,420.00 is greater than the income limit of £5,220.00 the difference of £12,200.00 is used to reduce the value of the award due. This is done in the following order in this example using taper rates for 2007-2008:

- WTC work elements at the taper rate of 37%
- CTC individual elements at a rate of 37%
- CTC family element at a rate of 6.67%

As the total income of £17,420.00 is more than the income limit of £5,220.00 the WTC work element is calculated as follows:

a) total income		£17,420.00
minus WTC taper start point		£5,220.00
	=	£12,200.00
b) 37% of (a)		£4,514.00
c) maximum work elements of WTC (£4,139.46) minus (b)	=	£0.00
Amount of work elements of WTC payable	**=**	**£0.00**

As WTC elements are reduced to nil and there is no child care element, CTC individual elements are worked out as follows:

a) The CTC taper point is:

$$\frac{\text{Total WTC elements}}{0.37} + \text{WTC taper start point}$$

$$\frac{£4,139.46}{0.37} + £5,220.00 = \textbf{£16,407.73}$$

Total income – CTC taper point = £17,420.00 - £16,407.43 = £1,012.27
b) 37% of (a) (£1,012.27) = £374.53
c) Maximum child elements of CTC – (b) = £3,696.60 - £374.53 = £3,277.07

Amount of child elements of CTC payable = £3,277.07

The CTC family element has a minimum income threshold of £50,000.00 (£50k). If the income is less than the income threshold the maximum amount of the entitlement is due**.** Therefore, as the income in this example is £17,420.00 and below the £50k threshold the claimants are entitled to the full amount of the CTC family element of £545.34.

Summary

Total WTC payable £00.00
Total CTC payable £3,867.41

National Statistics – DWP Social Security Statistics

25. National Statistics is the official source for authoritative accurate and relevant information on the economy and society. It brings together a vast range of statistical information overseen by the National Statistician.

26. The Department for Work and Pensions has made major changes to the National Statistics which it publishes, both in the data sources employed and methods of delivery. In October 2005, DWP began releasing aggregate statistics using a new Internet tabulation tool. The Work and Pensions Longitudinal Study is now the source for benefit and employment scheme statistics. Access to the National Statistics via the Tabulation Tool is available via the following link - http://www.dwp.gov.uk/asd/statistics.asp.

27. The Tabulation Tool (Tabtool) (http://dwp.gov.uk/asd/tabtool.asp) allows users to download bespoke information designed to their needs. Other statistics which are not part of the Tabulation Tool can be accessed via the above statistics link. There is also a guide to statistics - (http://dwp.gov.uk/asd/data_guide.asp).

28. The best statistics to use are sourced from the newly published Work and Pensions Longitudinal Study (WPLS). These data are based on 100% of claimants and cover information such as age and gender of claimant, duration of their spell on benefit and geographical locations of claimants.

29. For more detailed breakdowns specific to one benefit (for example type of Jobseeker's Allowance in payment) the 5% sample data has more detail but less comprehensive coverage.

30. WPLS data should be used first and the samples only accessed if the data needed is not available on the WPLS. DWP recommends that, where the detail is only available on the 5% sample data, the proportions derived should be applied to the overall 100% total for the benefit. The Guide to Sources document lists which information is available from each data source and provides more detail.

Social Assistance Benefit Expenditure Statistics

31. Income-related benefit expenditure including a breakdown of certain Benefits by type of recipient for the period 1991/92 to 2010/11, in nominal and real terms, at 2008/09 prices is set put in the tables that can be viewed at: http://www.dwp.gov.uk/asd/asd4/Table7.xls?x=1

Tax Credit Statistics

32. HMRC published statistics on Tax Credits can be viewed at:

http://www.hmrc.gov.uk/stats/personal-tax-credits/cwtc-quarterly-stats.htm

Medical Assistance

33. **Spending on health in the UK**

UK Health Spending as a percentage of GDP 1998-99 to 2007-08

Year Accruals		UK Public Spending (£bn)	Public Spending as a % of GDP	Private Spending as a % of GDP	Total Health Spending as a % of GDP
1998/99	outturn	46.9	5.4%	1.4%	6.8%
1999/00	outturn	49.4	5.3%	1.4%	6.7%
2000/01	outturn	54.2	5.6%	1.4%	7.0%
2001/02	outturn	59.8	5.9%	1.3%	7.2%
2002/03	outturn	66.2	6.2%	1.3%	7.6%
2003/04	outturn	74.9	6.6%	1.3%	7.9%
2004/05	outturn	82.9	6.9%	1.3%	8.2%
2005/06	outturn	89.7	7.2%	1.3%	8.5%
2006/07	outturn	94.5	7.1%	1.2%	8.3%
2007/08	estimated outturn	102.6	7.3%	1.2%	8.5%

Sources:

1. Public Spending - Public Expenditure Statistical Analyses (PESA) 2008

2. Private Spending - estimates based on published HMT data and analysis supplied by the "REFORM" think-tank

3. (money) GDP forecasts as shown in the Budget Report 2008 are rounded to nearest £ billion. These are the lower end of HM Treasury's forecast range and are consistent with the deliberately cautious assumption of trend growth used as the basis for forecasting public finances

34. Further information on total UK health expenditure can be viewed at the Office for National Statistics (ONS) website[1].

[1] http://www.statistics.gov.uk/healthaccounts/experimental.asp

Article 13, Paragraph 2

35. The position remains as previously described.

Article 13, Paragraph 3

36. The position remains as previously described.

Article 13, Paragraph 4

37. The position remains as previously described.

The Committee, in its previous Conclusions concluded that the situation regarding general social services, which are mainly a local government responsibility, is in conformity with Article 14§1 of the Charter and asks whether it is possible from existing statistical data on social services to identify staff specifically responsible for advice and assistance to prevent, remove and alleviate want, the corresponding expenditure and the number of applicants for and recipients of these services.

38. Unfortunately the information cannot be provided as it is not collated centrally.

The Committee asks also whether unlawfully present foreign nationals, including persons whose applications for refugee or stateless person status have been rejected, are eligible for social and medical assistance in case of need, where necessary until they are repatriated.

39. The National Asylum Support Service (NASS) provides support to persons who are not lawfully present in the UK, such as failed asylum-seekers, to prevent them becoming destitute pending their repatriation. Section 4 of the Immigration and Asylum Act 1999 Ch. 33[1], as amended by the Immigration and Asylum (Treatment of Claimants, Etc.) Act 2004, and the Immigration and Asylum (Provision of Accommodation to Failed Asylum-Seekers) Regulations 2005 (SI 2005 No.930)[2] make provision for this. The Explanatory Memorandum that accompanied the 2005 Regulations when presented to Parliamentary explains some background to this and can be viewed via the following link.
http://www.opsi.gov.uk/si/em2005/uksiem_20050930_en.pdf .

40. It is a general condition of entitlement to free NHS hospital treatment that the person seeking treatment must be "ordinarily resident" in the UK. This broadly means that the person is living here on a lawful, voluntary and settled basis. Those people who are not ordinarily resident here are deemed

[1] http://www.statutelaw.gov.uk/legResults.aspx?LegType=Act+(UK+Public+General)&
[2] www.opsi.gov.uk/si/si**2005**/**2005**0930.htm -

overseas visitors and are subject to the NHS (Charges to Overseas Visitors) Regulations 1989, as amended, which place a legal duty on NHS hospitals to identify those patients who are overseas visitors and to make a charge for their treatment unless they are covered by an exemption from charge category listed within these regulations.

41. Unlawfully present foreign nationals, including unlawfully present persons whose applications for refugee or stateless person status have been rejected, are not an exempt from charge group, so would be chargeable for all non-exempt services they receive. However, exempt services they do have access to include treatment given within an Accident & Emergency Unit of a hospital, compulsory psychiatric treatment, family planning services, treatment within, or as a referral from, a sexually transmitted diseases clinic, and treatment for certain other contagious diseases. HIV treatment is not an exempt service but the diagnostic test and associated counselling is free to all.

42. Treatment which a clinician considers to be immediately necessary, or urgent enough not to be able to wait until the patient has returned to their home country, will always be given regardless of whether or not a chargeable patient has paid in advance or will be able to do so. This does not mean that the treatment is then free; hospitals must take reasonable steps to recover any debts, or to write them off if it is not reasonable to pursue them.

43. A Judicial Review ruling in April 2008 found that failed asylum seekers can, in certain circumstances, be considered to be ordinarily resident. In order for this to be so they must first have the immigration status of "temporary admission/release" which the judge found equated to lawful presence. Most failed asylum seekers retain this status. They must also be considered to meet the other requirements of the ordinary residence test. An appeal against the judgment in this case was heard on 17/18 November 2008 but the final outcome is not yet reported.

44. As regards primary care, General Practitioners have discretion as to who they accept as NHS patients on their lists and provide with free primary medical services. Any primary care treatment which a health professional considers to be immediately necessary would be provided without charge.

45. A joint Department of Health and Home Office review of access to the NHS by foreign nationals is currently ongoing. This is in relation to both primary and secondary care and is considering issues such as asylum. A full public consultation exercise is due in early 2009.

ARTICLE 14

Article 14, Paragraph 1

Great Britain

1. The National Health Service (NHS) Information Centre publishes a large number of statistics and surveys which can be accessed via its website[1]. Statistical information on Health and Personal Services including statistics on Personal Social Services for England by category, workforce and expenditure can also be found at the Office for national Statistics - Department of Health site[2]. Social Services statistics for Wales can be viewed at the ONS Wales website page[3]. Information on health and social care in Scotland can be viewed at the Scottish Executive website[4].

Putting People First

2. The Government launched Putting People First (PPF) on 10 December 2007. Signed by six government departments and a wide range of external stakeholders and agencies, the concordat supports the commitment to independent living for all adults and sets out the need for the state to empower citizens to shape their own lives and the services that they receive. It is unique in establishing a collaborative approach between central and local government, the sector's professional leadership, providers and the regulator.

3. It articulates the common aims and values that will guide all the participants in modernising adult social care. It signals the recognition across the sector of the need to work across shared agendas with users and carers to transform people's experience of local support and services.

4. PPF describes four interdependent elements:

- **Universal services** – ensure people have the right housing options, routes into employment, easy access to advice and information, access to good quality health services and a street scene that ensures easy movement and good transport for people who use wheelchairs or have other mobility needs.
- **Preventive services** - enable people to be as independent as possible, without relying on social care, where other means of support can ensure better outcomes. Good preventative services, jointly commissioned, are the best way of reducing the risks of financial pressures arising for the demographic and other challenges.
- **Choice and control** – ensure that people receiving services and their carers have both choice over the services they receive and some control over the process. To do this, people who use services, or their advocates, should understand the amount of money that is available to spend on their support.

[1] http://www.ic.nhs.uk/
[2] http://www.performance.doh.gov.uk/HPSSS/INDEX.HTM#sectionc
[3] http://www.wales.gov.uk/keypubstatisticsforwalesheadline/content/health/2003/hdw20030529-e.htm
[4] http://www.scotland.gov.uk/Topics/Health/care

- **Social capital –** ensure that services operate in a way that builds on the social capital available within families and communities.

Individual Budgets

5. Individual budgets (IBs) are intended to enable people needing social care and associated services to design their support and to give them the power to decide the nature of the services they need. Key features include:

- A transparent allocation of resources, giving individuals a clear cash or notional sum for them to use on their care or support package;
- A streamlined assessment process across agencies, meaning less time spent giving information;
- Bringing together a variety of streams of support and/or funding, from more than one agency;
- Giving individuals the ability to use the budget in a way that best suits their own particular requirements; and
- Support from a broker or advocate, family or friends, as the individual desires.

The Government stated its commitment to piloting IBs in the White Paper "Our Health, Our Care, Our Say" published in January 2006[1], with a view to rolling them out nationally by 2009/10, should they prove successful.

Dignity

6. The Department of Health (DH) launched the Dignity in Care Campaign in November 2006. It set out to stimulate a national debate in England about dignity in care. It aimed to get staff and the public talking about what dignity in care means for people using care services and to inspire them to take action.

7. Through the campaign, DH wants to end tolerance of care services that do not respect the dignity of those using them. To date the campaign has primarily focused on older people but it has always been the intention to extend the campaign at some point to all client groups. Since May 2008, there has been increased media coverage of the campaign and the number of Dignity Champions (local people who are signing up committed to take action) has doubled to over 3,000.

8. Dignity features in key performance frameworks including the NHS Operating Framework and the national indicator set. We have embedded Dignity in key national and local health and social care policies and strategies.

1 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4127552

Carers

9. The New Deal for Carers[1] includes additional monies that councils can use to provide emergency cover for carers; the development of a helpline and an expert carers programme and a review of the 1999 Prime Minister's Carers Strategy.

10. DH published the revised National Carers Strategy on 11th June 2008[2]. Key components of the new strategy will ensure that carers have increased choice and control, and are empowered to have a life outside caring. The Government is investing over £255m to ensure implementation of the new strategy.

The strategy includes:

- access to information for every carer;
- an additional £150m over 2 years for breaks from caring;
- pilots to look at how the NHS can better support carers;
- annual health check pilots for carers;
- up to £38m to enable carers to be better able to combine paid employment with caring;
- over £6m in increased support for young carers;
- training for professionals to provide better support for carers;
- training for carers; and
- £1.2m to help develop capacity in the voluntary sector.

11. The strategy is not just about support for carers that costs money. It is also about health and social care agencies finding flexible ways to deliver existing services and about how employers can be more flexible about the way they support carers.

Carers' information service/helpline

12. New Deal for Carers is made up of four constituent parts, of which the strategy described above is the centrepiece. The other components are:

- **Comprehensive national information service** that meets the many and diverse needs and concerns of carers. The service will provide, via a single telephone number and a website, access to the information needed by carers. The service will either offer direct assistance to carers or refer onto support that is more appropriate. The service, for which we are making £2.775 million per year available, will be in place in spring 2009.

- **Emergency care cover.** £25 million additional funding per year was made available from October 2007 to local authorities – to enable them

[1] http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Carers/NewDealforCarers/index.htm
[2] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085345

to develop plans with carers to provide cover when the carer experiences an emergency that prevents them from caring.

- **Standing Commission on Carers.** The Commission has a long-term remit, which includes a key role in the implementation of the strategy as well as a responsibility to advise the Government on matters it feels are relevant to carers in the longer term

The Social Care Institute for Excellence (SCIE)

13. The SCIE (www.scie.org.uk) identifies and spreads knowledge about good practice to the large and diverse social care workforce to support the delivery of transformed, personalised social care services. It also reaches and influences practitioners, managers and the sector leadership who have responsibility for service delivery in adults' and children's services. It is an increasingly influential and authoritative voice, recognised by the Government, opinion formers and the public so that when people want to know what already works in social care, and what might work in the future, SCIE is their first port of call.

14. The Care Quality Commission will take over from the Commission for Social Care Inspection, the Healthcare Commission, and the Mental Health Act Commission on 1 April 2009. From April 2010 the new Commission will move to a common system of registration for all providers of regulated health and adult social care.

15. The Department recently carried out a twelve week consultation on the scope of regulation (ie which activities will require providers to register with the new Commission before they can provide them) and what the essential requirements of safety and quality of care should be that providers have to meet in order to maintain their registration. The consultation closed on 17 June 2008. The responses to the consultation are currently being analysed and the Government's response will be published in due course. The consultation document (*A consultation on the framework for the registration of health and adult social care providers*)[1] can be viewed at the website.

Safeguarding Vulnerable Groups

16. The Government is providing for a new Vetting and Barring Scheme to operate in England and Wales. (Northern Ireland will have a similar scheme and Scotland will have a complementary scheme introduced through its own legislation)

17. The Vetting and Barring Scheme will build on and replace the existing barring schemes for children and vulnerable adults and will draw on information from police, workforce regulators, service inspectors, local authorities and employers to provide a comprehensive and consistent

[1] www.dh.gov.uk/en/Consultations/Closedconsultations/DH_083625

measure of protection for vulnerable groups.

18. The new scheme will apply to health, social care, education, supported housing, sports and leisure facilities for children and vulnerable adults whether provided by the state or by the private or independent sectors. The new scheme will be proactive, with vetting taking place on an individual's first application to work with children or vulnerable adults. This will make it far more difficult for abusers to gain access to the most vulnerable groups in our society.

19. The scheme will start to receive applications from 12 October 2009. When used in conjunction with criminal records bureau checks, the Vetting and Barring Scheme will provide employers with the most comprehensive vetting service on offer anywhere in the world.

Qualifications

20. The Social Work degree replaced the Social Work Diploma in 2003. It ensures that theory and research directly informs and supports practice. Training providers are required to enter into arrangements with stakeholders, particularly service users and employers, to ensure that they are involved with the programme design and the selection process of students. Any students studying for the Social Work Degree, who are not being supported by their employer, may be eligible for a bursary of up to £4,975. Numbers of students beginning training are around 37 percent more than five years ago. The new Post Qualifying Framework for social workers came into force in September 2007, and there are 171 courses delivering training in across 5 areas of specialism.

21. The department provides funding via the National Training Strategy Grant (£107.859 million for each year in 2006/07 and 2007/08) and the Human Resources Development Strategy Grant (£49.750 million for each year in 2006/07 and 2007/08) to support employers, of both adults and children's services, meet the National Minimum Standards, used by the National Care Standards Commission to regulate care services. The grants are paid to local councils who should ensure that appropriate resources are made available to develop both their own staff and those in the private and voluntary organisations providing social care services on their behalf.

The Fair Access to Care Services

22. Fair Access to Care Services (FACS) is a centrally produced framework to help local government, councils, to set eligibility criteria for provision of services. Developed in 2001 the intention is to assist councils in achieving national consistency in the way in which eligibility criteria are set.

23. The Fair Access to Care Services (FACS) framework addresses individuals' needs, associated risk to independence, and includes the four eligibility bands; critical, substantial, moderate and low. When considering

individuals in relation to these bands, guidance stresses that councils should not only identify immediate needs, but also needs that would worsen for lack of timely help.

24. Councils apply the principles set out in FACS to check that people are eligible for services. We understand that some local authorities might focus on those groups with the highest needs, which is why the English government is developing a Green Paper to look at options for the reform of the care and support system. The Green Paper 'The case for change - why England needs a new care and support system' can be found on the DH website: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084725

25. The Government is concerned that the application of eligibility criteria should not result in denying people the care that they need. The Commission for Social Care inspection (CSCI) has therefore been asked to undertake a review of the criteria for FACS, their application by councils with social care responsibilities and their impact on people. The report is due back to Government in the autumn.

The Mental Capacity Act 2005

26. The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who lack capacity to make some decisions for themselves. The Act makes clear who can take decisions on behalf of others in which situations and how they should go about this. It covers major decisions in relation to property and affairs, healthcare treatment and accommodation, as well as everyday decisions about personal care.

27. The Act received Royal Assent in April 2005 and was fully implemented in October 2007 by a cross government implementation programme consisting of the Ministry of Justice (MoJ), Welsh Assembly Government (WAG) and the Office of the Public Guardian (OPG) in a cross government implementation programme.

Deprivation of Liberty Safeguards

28. The Mental Capacity Act 2005 sets out Deprivation of Liberty Safeguards (MCA DOLS) covering the lawful deprivation of liberty of those people who:

- lack capacity to consent to arrangements made for their care or treatment in either a hospital or care home; and who

- need to be deprived of liberty in their own best interests to protect them from harm.

29. MCA DOLS are a response to a European Court of Human Rights' judgment in October 2004 in the "Bournewood" case (HL v the UK). The Court

found that an autistic man with a learning disability, who lacked the capacity to decide about his residence and medical treatment and who had been admitted informally to Bournewood Hospital, was unlawfully deprived of his liberty in breach of Article 5 of the European Convention on Human Rights (ECHR).

30. The MCA DOLS introduce a requirement for hospitals and care homes ('managing authorities') to seek authorisation from their PCT or local authority ('supervisory bodies') if they believe they can only care for a person in circumstances that amount to a deprivation of liberty.

31. Before depriving someone of liberty, a managing authority must obtain a deprivation of liberty 'authorisation'. There are two types of authorisation: urgent and standard:

- A managing authority must apply to a supervisory body to obtain a standard authorisation. This can only be issued if a series of six statutory assessments indicates the need to do so.

- A managing authority can issue itself an urgent authorisation in rare circumstances where it becomes apparent that there is a need to deprive someone of their liberty immediately, in their own best interests. It lasts for seven days during which an assessment for a standard authorisation must be completed

32. The MCA DOLS also include provision for:

- people deprived of liberty to challenge their deprivation in the Court of Protection; and

- a statutory requirement for all people deprived of liberty to have a representative who acts on their behalf on all matters relating to the deprivation of liberty.

Scotland

Free Personal and Nursing Care in Scotland

33. Free personal and nursing care (FPNC) was introduced in Scotland on 1 July 2002. Prior to that date, people could be charged for personal care services provided in their own home and many residents in Care Homes had to fully fund their care from their own income and savings.

34. On 26 August 2008 Scotland's Chief Statistician published Personal and Nursing Care Statistics for 2006-2007[1] which give a picture of the number of people benefiting from free personal and nursing care in Scotland, as well as how much is being spent on the policy.

[1] http://www.scotland.gov.uk/Publications/2008/08/25160542/18

35. Some of the notable statistics included in the report are:

Care Homes

- Self-funders in Care Homes who are assessed as requiring Free Personal and Nursing Care receive £145 per week for Free Personal Care and/or £65 per week for Free Nursing Care. There were around 9,400 people receiving Free Personal Care at the end of 2006-07, of which around two-thirds also received the Free Nursing Care payment.

- Between 2005-06 and 2006-07, Local Authority expenditure on Free Personal and Nursing Care for self-funding residents in care homes increased from £95.0 million to £97.4 million, a rise of 2.6%. This is in line with increasing numbers of self-funding residents in Care Homes.

Home Care

- People aged 65 and over who are assessed as requiring personal care services can no longer be charged for these services provided in their own home. There were nearly 41,000 people in Scotland receiving personal care services at the end of 2006-07.

- Expenditure on personal care services increased from £185 million in 2005-06 to £224 million in 2006-07, an increase of 21 per cent.

- Reasons for the increase in expenditure on personal care at home include a shift in the balance of care towards larger packages of care at home and an increasing proportion of home care clients requiring personal care services. In addition, the introduction of equal pay provision in local authorities has led to higher wage costs and in some areas the reimbursement of charges for meal preparation has led to higher costs for this year only.

36. Since the introduction of Free Personal Care in July 2002:

- People aged 65 or over who live in care homes and are assessed as self-funders now receive a weekly payment of £145 towards their personal care, and a further £65 if nursing care is also required. The remainder of the care homes fees - the 'hotel' costs - they still fund themselves. People aged under 65 can also receive £65 towards nursing care.

- People aged 65 and over can no longer be charged for personal care services provided in their own home. They can however be charged for domestic services such as help with shopping or housework but any charge would be subject to a financial assessment.

37. This data had previously been published annually since the introduction of Free Personal Care in 2002. The current version is the first to

have been published as National Statistics. This reflects better quality and consistency across local authorities for this latest data.

Carers

38. Under the Community Care and Health (Scotland) Act 2002, NHS Boards are required to develop and implement Carer Information Strategies. These strategies, which have been in place since May 2007, should improve carer identification, information and training to help carers continue in their caring role. A total of £9 million over the next three years will be provided to support NHS Boards in implementing these strategies and the Scottish Government is also investing a further £280,000 over two years to pilot carer training and help carers, particular new carers, to gain the knowledge and skills they need to care effectively while looking after their own health.

39. The Scottish Government's approach to young carers aims to ensure that their interests are addressed in mainstream support. This is particularly appropriate for supporting children living in drug misusing households who almost inevitably have some caring responsibilities. Such carers are often hidden from the services designed to help them, and their mental, physical and emotional health suffers as a result. We are investing £183,000 (spread over two years) in the development of a national young carer forum, which will give young carers a national voice and raise their profile within Scottish society. If this initial event is successful, funding will continue to make this forum an annual event.

40. Further Information on health and social care in Scotland can be found at the Scottish Government website at
http://www.scotland.gov.uk/Topics/Health/care

41. Scottish Community Care Statistics can be viewed at the Scottish Government website http://www.scotland.gov.uk/Topics/Statistics/17672/9460

Tackling Health Inequalities in Scotland

42. In June 2008 the report of the cross-cutting ministerial task force on health inequalities, *Equally Well* [1] was launched. The report highlights the £1.78 billion being spent on tackling health inequalities over the next three years and recommends that this resource can deliver better outcomes by re-designing public services.

43. This is backed by £15 million of new money to achieve this aim. The Convention of Scottish Local Authorities (COSLA) - which represents Scotland's local authorities who are responsible for delivering key services such as housing, education and social work - have been fully involved in, and are fully supportive of, the task force's work. *Equally Well* puts particular emphasis on the early years as that is when opportunities are greatest to create health by forging appropriate behaviour patterns and the ability to

[1] http://www.scotland.gov.uk/Publications/2008/06/09160103/0

relate well to other people.

44. The report signifies a shift from placing the emphasis on dealing with the consequences of health inequalities to tackling the underlying causes. Key proposals in the Report include:

- Working with NHS Lothian to implement the Nurse Family Partnership approach to provide intensive support for young mothers. This is an intensive programme of home visits by highly trained nurses which aims to improve pregnancy outcomes, children's health and development. It will also aim to improve families' economic self sufficiency by encouraging young mothers to aspire to improving their lives by, for instance, finding work.

- Working with four NHS boards to strengthen school nursing and the wider school health resource, especially in the most deprived areas. Work has already begun and £7 million of new funding is available over the next three years to take this forward.

- £4 million funding available for Lloyds TSB Foundation's Inspiring Scotland programme to improve play opportunities for children most in need, recognising the importance of physical and social environments on health and wellbeing.

- Engaging with employers and the business community to open up job opportunities for people claiming health-related benefits who are able to move into work.

- The expansion of Keep Well checks to identify and support people with depression and anxiety. Development of a framework for regular health assessments for people with learning disabilities across Scotland.

45. An implementation plan will be published before the end of 2008 which will give further details about how Equally Well will be taken forward. A number of test sites will be set up, in which clusters of public services will be redesigned, to demonstrate how change can improve people's health and wellbeing. The test sites will see public services working together with input from residents and frontline staff to gain an understanding of how people's interactions with services affect their health.

Free Bus Travel

46. The Scottish Government has introduced a Scotland-wide free bus scheme from 1st April 2006. Anyone aged 60 or over, and eligible disabled people, are entitled to free bus travel anywhere in Scotland provided they have applied for, and received, the new National Entitlement card.

Northern Ireland

Personal Social Services in Northern Ireland

47. Northern Ireland has a population of 1,759,148 people; of whom 431,867 are aged under 18 and 243,305 are of pensionable age (2007). By 2026, it is predicted that the number of people of pensionable age will have risen to 383,000[1]. The number of children under the age of 16 is projected to decline steadily from 406,437 in 2007 to 391,000 by 2026. There will also be a further significant increase in the number of people aged 85 years and over from 27,278 in 2007 to 59,000 by 2026[2]. This projected growth of the ageing population is likely to have important implications for the future financing and delivery of long term care services.

48. Northern Ireland has higher levels of social and economic disadvantage than other parts of the United Kingdom and is emerging from 30 years of conflict. These factors have implications for the demand and costs of personal social services.

49. Health and personal social services are provided under the Health and Personal Social Services (Northern Ireland) Order 1972. The Order places a duty on the Department of Health, Social Services and Public Safety to provide or secure the provision of integrated services to promote the physical and mental health of the people of Northern Ireland and to provide or secure the provision of personal social services designed to promote their social welfare.

People and their needs

50. Personal social services are provided for large numbers of people - they address a wide range of needs and seek to promote the well being of people who are very often vulnerable.

51. The range of services provided, includes care and support for:

- older people;
- people with dementia;
- people with a physical or sensory disability;
- people with a learning disability;
- people with mental health problems;
- people with drug or alcohol abuse problems;
- families, particularly where parents are experiencing difficulty in discharging their parental responsibilities;
- children who are looked after i.e. in public care;
- children in need, including children with disability; and
- carers.

[1] http://www.nisra.gov.uk/archive/demography/population/projections/ni/wni06singyear.xls
[2] http://www.nisra.gov.uk/archive/demography/population/projections/ni/wni06singyear.xls

The need for social services will always be considerable. Health & Social Services Boards and HSS Trusts (now referred to as Health & Social Care Trusts), therefore, have to assess the needs of the communities they serve and prioritise their efforts to ensure maximum support to those in most need.

Organisation and Management

52. The organisation and management of health and social services, like the rest of public service administration in Northern Ireland, is currently undergoing far reaching reform and modernisation. The section following describes current roles and responsibilities of organisations.

The Department of Health, Social Services and Public Safety (DHSSPS)

53. The DHSSPS was established by the Department's (NI) Order 1999. The department has three main business responsibilities:

- Health and Personal Social Services, which includes policy and legislation for hospitals, family practitioner services and community health and personal social services;
- Public Health, which covers policy, legislation and administrative action to promote and protect the health and well-being of the population; and
- Public Safety, which includes responsibility for the policy and legislation for the Fire Services and emergency planning.

54. The Department's mission is to improve everyone's health and social well-being. It does so by ensuring the provision of appropriate health and social care services free at the point of delivery both in clinical settings, such as hospitals and GP's surgeries, as well as in the community, through nursing, social work and other professional services. It also supports programmes of health promotion and education to encourage the community to adopt activities, behaviours and attitudes that will lead to better health and well-being.

Health and Social Services Boards (HSS Boards)

55. At present, there are four HSS Boards in Northern Ireland - they are agents of the DHSSPS and are responsible for assessing the needs of their resident population and planning, commissioning and purchasing health and social services to meet these needs.

56. In 2001 – 2004, a commitment was made to replace the GP Fundholding Scheme with fairer, less bureaucratic arrangements designed to strengthen structures for delivering high quality primary care services in local communities. Local Health and Social Care Groups (LHSCGs) were consequently established, with effect from 1 April 2002.

57. Local Health and Social Care Groups were formally stood down on 30

September 2006 as part of the implementation of the Review of Public Administration. Under the current proposals for the reform of the health and social care system in Northern Ireland there will, from April 2009, be Local Commissioning Groups which will have an important role in implementing innovative approaches to improve public health and reduce health inequalities by addressing the wider determinants of health and social well-being. The establishment of LCGs will be an important development in taking forward the development of a primary care centred service.

Health and Social Care Trusts (HSC Trusts)

58. There are 6 HSS Trusts in Northern Ireland, 5 of which provide health and social services. The 6th is the Northern Ireland Ambulance Service Trust. Although managerially independent of HSS Boards, who commission services from them under Service Level Agreements to meet the needs of their resident population, HSC Trusts are responsible to the HSS Boards for discharge of functions and are accountable to the DHSSPS.

59. Northern Ireland is the only part of the United Kingdom which, because of the integrated nature of health and social services, has HSC Trusts delivering community health and social services. HSC Trusts provide a wide range of personal social services, either directly or by purchasing services from the independent sector.

The Regulation and Quality Improvement Authority

60. The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, created the enabling legal framework for raising the quality of health and social care services in Northern Ireland, and extended regulation and quality improvement to a wider range of services. In April 2005, the Regulation and Quality Improvement Authority (RQIA) was established as a non-departmental public body of the DHSSPS. RQIA is an independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services. The RQIA's main functions are:

- to inspect the quality of health and social care services provided by Health and Personal Social Services (HPSS) bodies in Northern Ireland through reviews of clinical and social care governance arrangements within these bodies; and
- to regulate (register and inspect) a wide range of health and social care services delivered by HPSS bodies and by the independent sector. The regulation of services is based on new minimum care standards to ensure that service users know what quality of services they can expect to receive, and service providers have a benchmark against which to measure their quality.

Health and Social Services Councils

61. Health and Social Services Councils are independent organisations which represent the views and opinions of the general public in all areas of health and social services. There are 4 HSS Councils in Northern Ireland - one in each HSS Board area. HSS Councils:

- provide information and advice on health and social services issues;
- offer advice, information and help to people who want to complain about a service;
- monitor the quality of local services;
- work with local groups to help them give their opinions on health and social services;
- act for the public to improve the range, type and quality of services; and
- represent the public's interests in responding to consultation about health and social services.

Health and Social Care Reform and Modernisation

64. The Health and Social Care (Reform) Bill is the vehicle to give legal effect to the proposals to reform the health and social care system in Northern Ireland. These reform proposals include:

- a much smaller and more focused Department of Health, Social Services and Public Safety;
- a single Regional Health and Social Care Board to replace the existing four Health and Social Services Boards that will focus on commissioning, resource management and performance management and improvement;
- a Regional Agency for Public Health and Social Well-being that will incorporate and build on the work of the Health Promotion Agency but will have much wider responsibility for health protection, health improvement and development to address existing health inequalities and public health issues for all the people of Northern Ireland;
- a Regional Support Services Organisation to provide a range of support functions for the whole of health and social care system. The Central Services Agency will be dissolved and the majority of its services will be undertaken by the new organisation;
- a single Patient and Client Council to replace the current Health and Social Services Councils with five local offices operating in the same geographical areas as the existing Trusts, to provide a strong voice for patients, clients and carers;
- the NI Regional Medical Physics Agency will be merged with the Belfast Health and Social Care Trust; and

- the functions of the Mental Health Commission will transfer to the Regulation and Quality Improvement Authority.

Access to Services

65. In Northern Ireland, Health and Social Care (HSC) Trusts are responsible for assessing an individual's social care needs and for deciding what services to provide. HSC Trusts have a duty to give a community care assessment to anyone who, in their view, might be in need of services. The specifics of an individual's assessment are a matter for the Trust concerned and it is for them to decide how best to assess the needs of their local population. Eligibility criteria vary according to the service being assessed for, but typically factors such as frailty, disability, social isolation or exclusion and vulnerability are used to determine need. Presently complaints about the outcome of an assessment are directed initially to the Trust carrying out the assessment. Each Trust has in place arrangements to facilitate such appeals, and details of how to do this will be provided to the client when the assessment is being carried out. If it is not possible to resolve the issue at this level, the client has the right to ask for further investigation, initially at HSS Board level, and then by the Office of the Ombudsman for Northern Ireland. From 1 April 2009 the 2nd stage Independent Review will be removed, meaning that complainants will have access to the Ombudsman earlier (that is following local resolution investigation by the Trust).

Personal Social Services Activity in Northern Ireland

66. A comprehensive picture of social services expenditure and provision across the four HSS Boards and eleven HSS Trusts, which provide personal social services, in Northern Ireland and across all major Programmes of Care can be found at:
www.dhsspsni.gov.uk/hss/ssi/index.html

Statistical information relating to health and social care in Northern Ireland.

67. The Table below shows the breakdown of expenditure in Northern Ireland by Programme of Care.

TABLE TOTAL (NET) PSS EXPENDITURE BY POC 2006/07

PoC	PSS £'000	Less Client contrib. £'000	Net Total PSS Expend. £'000	% of Total Expend.
Acute	0	0	0	
Maternity & Child Health	0	0	0	
Family & Child Care	150,737	164	150,573	20.49
Elderly Care	422,471	66,581	355,890	48.42
Mental Health	52,376	4,895	47,481	6.46
Learning Disability	130,610	5,752	124,857	16.99
Physical & Sensory Disability	57,925	4,035	53,890	7.33
Health Promotion & Disease Prevention				
Primary Health & Adult Community	2,258	0	2,258	0.31
Total	816,377	81,427	734,950	100.00

68. In Northern Ireland there is an integrated Health and Personal Social Service system. The integrated Programme of Care definitions are specific to Northern Ireland and are not necessarily comparable with similar headings in other parts of the UK. For example Dementia services are part of the elderly programme of care in NI whereas they fall within Mental Health in other parts of the UK. The way children and elderly people with other special needs are classified can also be different.

Table - Personal Social Services Activity (31 March 1999 - 2008) [1, 2]

PSS Activity	1999	2001	2003	2005	2007	2008
Places in residential homes	6,913	6,701	6,830	6,556	5,558	5,405
Places in nursing homes	9,788	9,375	9,189	9,301	9,571	9,799
Residential home care packages	3,344	3,877	4,511	4,453	4,526	4,497
Nursing home care packages	5,106	5,882	7,382	7,567	7,768	7,728
Domiciliary care packages	6,306	6,828	7,110	8,184	8,429	9,608
Persons receiving finance for direct payments for care	12	33	81	248	660	879
Persons receiving home help/home care	28,115	28,182	26,339	26,066	23,913	22,599
Persons receiving meals services	4,374	4,092	4,657	6,284	6,670	5,755
Persons registered at statutory day centres	9,464	10,487	10,403	10,281	9,366	9,163

[1] Information on places in residential and nursing homes was provided by the RQIA from 31 March 2007 to present. Information provided by the RQIA for 2007 and 2008 refers to places registered in these homes at 30 June.

[2] Information on residential, nursing home and domiciliary care packages presented for 2008 refers to 30 June 2007, the latest date for which information is available.

[3] Information on persons receiving meals on wheels includes frozen meals provided from 2004/05 to present.

Sources: Community Information Branch, DHSSPS

Table - Places in Residential Homes, by Client Group (31 March 1999 – 2008)

Client Group	1999	2001	2003	2005	2007	2008
Children [1]	323	293	320	392	403	-
Elderly	4,689	4,579	4,706	4,492	3,945	3,706
Mentally Ill	651	604	637	548	602	595
Learning Disabled	1,173	1,180	1,120	1,070	1,005	898
Physically Disabled / Sensory Impaired	70	45	47	44	64	65

[1] Information on the number of places in residential homes for children was provided by the RQIA for 31 March 2007, whilst information for 31 March 2008 is not available at this time.

Sources: Community Information Branch, DHSSPS

Social Services Personnel

69. The figures below are taken from the Human Resource Management System as at 30th June 2008. This data excludes home helps and any other staff with a whole-time equivalent (WTE) of less than or equal to 0.03. A payroll Quarterly Cost Analysis, as at June 2008, shows an additional home help staff of 5,341 (headcount).

Table - Social Services staff by grade type, full-time, part-time and Whole Time Equivalent (WTE)

Social Care Staff Group	Full-Time	Part-Time		Total	
	Headcount	Headcount	WTE	Headcount	WTE
Social Worker Band 5	321	63	39.98	384	360.98
Social Worker Band 6	1372	510	332.81	1882	1704.81
Social Worker Band 7	741	135	93.16	876	834.16
Social Worker Band 8a/8b/8c	183	7	4.71	190	187.71
Playgroup Specialist/Worker Band 3-5	11	6	3.56	17	14.56
Social Work Support Bands 1-2	315	1177	833.31	1492	1148.31
Social Work Support Band 3	252	369	251.85	621	503.85
Social Work Support Band 4	293	168	107.05	461	400.05
Social Work Support Band 5	658	402	279.91	1060	937.91
Other Qualified/Senior Management Social Work	53	5	3.15	58	56.15
Trainee Social Work	152	0	0	152	152
Other Support Staff	57	19	11.76	76	68.76
TOTAL	4408	2861	1961.25	7269	6369.25

Isle of Man

62. The Social Services Division of the Department of Health and Social Security is responsible for the provision of social welfare services. The specific policies of the Division continue to be as reported in the previous reference period.

63. The Division is divided into three service areas: Adults; Children and Families; and Mental Health.

64. The expenditure of the Social Services Division in 2006/2007 was:

Area	**Expenditure £GB**
Adult Service Area	19,963,787
Children's Service Area	16,938,832
Mental Health Service Area	11,091,596
Central & Support Services	4,114,166
Total	**52,108,381**

65. The number of staff employed by Social Services Division as at 30 September 2007 was 873.50 [whole time equivalents (wte)] and of these 60.5 (wte) were Social Workers and 449.3 (wte) were Social Care Workers (including Residential Domiciliary and Day Care Services).

66. Eligibility Criteria were developed (introduced in March 2008) based on the guidance given in England and Wales for "Equal Access to Service Users". Their use is to ensure that all citizens have equal access to services based on their assessed needs. The criteria are publicly available so that the process is open and transparent. At the time of writing a review of the use of the criteria is being undertaken.

67. The Government encourages all existing social work and social care staff to register with the English General Social Care Council and all new staff must be registered as a condition of employment. Legislation is currently being drafted to ensure that all staff are required to be registered.

Children and Families

68. The legislative basis of the provision of social work services to children and their families is the Children and Young Persons Act 2001.

69. Social Services, whenever possible, aims to provide welfare services to enable children to be cared for by their own parents in their own homes. To help parents develop appropriate child care skills, we provide the following services:

- 24 social work staff (all qualified);
- Three family centres to help parents develop budgeting, housekeeping

and child care skills;

- Family Advisors (5.5) who visit families in their own homes to help them develop effective child care and budgeting skills;
- Supported day care to take pressure off families;
- Outreach support from care providers to provide support and therapeutic services to children, young people and their families, to help children and their families lead well adjusted lives;
- Two eight-place respite care units for children with disabilities which provide respite, outreach and day care;
- A therapeutic team of three specifically trained social workers who specialise in working with young people with emotional and behavioural problems;
- A Child and Adolescent Mental Health Service has been established to provide mental health services to those under the age of 16. This is led by a consultant psychiatrist and has four other professionals in the team providing psychological and therapeutic services;
- A juvenile youth justice team, jointly funded by Social Services, Health, Probation and the Police has been established to deal with youth crime.

70. Where children can no longer live within their families, efforts are made to provide care within a substitute family situation, either through a fostering placement or by supporting a family member to care for the child.

71. The following range of residential provision is in place:

- Two five-bed residential units for young people;
- A secure unit with five places which can accommodate young people who are a danger to themselves or other people and who have continually run away from open units has now been completed. It can also accommodate young people who have committed a criminal offence punishable in the case of an adult with over 10 years in prison and where all other community-based options have been tried and failed. Secure remand is also available in certain prescribed situations. Admission to this unit is essentially through the courts;
- A range of smaller units has been developed which accommodate young people in an ordinary house in an ordinary street with a staff team of at least two staff members looking after them at any one time; and
- A Leaving Care scheme has been developed with a new unit established providing a leaving care project with outreach community support.

72. At present much energy is being devoted to providing Integrated

Services for children and young people across Isle of Man Government Departments. There is a Tynwald Strategy for Children and Young People as well as an Integrated Children's Plan.

Adult Services

73. The legal basis for the provision of services to adults is contained in the National Assistance Act 1951 and the Chronically Sick and Disabled Persons Act 1983. The following services are provided:

- 225 beds for older people in four resource centres located in major centres of population. Provision includes long term care, day care, hospital to home care, and respite care;
- Planning is taking place to provide multi disciplinary community teams for community health and social care staff; for example, physiotherapy, occupational therapy, social work, mental health, home care etc, to provide care to people living at home with a pilot project commencing in the south of the Island;
- Home Care services have been developed from providing a traditional housekeeping service to a personal care service. More intensive care packages are now provided to more dependent people. The aim of this service is to enable older people and those with disabilities to remain at home;
- For an overall population of 80,000 people during 2007/2008 services provided for Adults (mostly for Older People) include 5,500 meals each month from Meals on Wheels. During the same period 570 people were in receipt of a Home Care Service;
- Building has commenced for a 32 place residential EMI unit in the Douglas area to enable all continuing care beds within the hospital to be closed and residents transferred to community-based settings;
- The Disability Employment Service has increased its range of operations and has managed to place some 19 per cent of the Island's people living with a learning disability into some form of employment;
- The provision of care in the community for older people and those with a disability is also undertaken through contracts with voluntary organisations. The range and terms of the contracts have continued to increase and improve the support given to older people and those with disabilities in their own homes; and
- A Carers Strategy has been developed which seeks to improve the help given to carers.

Mental Health

74. The legislation covering services to people with mental health problems is contained in the Mental Health Act 1998. The following

developments have taken place in the reporting period:

- Provision of 21 Acute Beds for those with mental health problems. Day treatment services are being developed to enable a significant number of people with mental health problems to remain at home during their illness but receive appropriate treatment as a day patient;
- A purpose built drug and alcohol-detoxification and treatment unit is ready to be opened. Community based services include a community support team for older people with a mental health problem living at home; and
- A community drug and alcohol team which is led by a consultant psychiatrist and comprises a psychologist, physician, social worker, probation officer, specialist nurses, a health education worker and education representative. Community based treatments are being provided such as supervised methadone treatment, drug arrest referral scheme, home detoxification and a co-ordinated approach is being taken to ensure effective treatment and prevention.

Article 14, Paragraph 2

Public participation in the establishment and maintenance of social welfare services - access to services provided by Third Sector Organisations (TSOs)

75. The Department of Health (DH) recognises that third sector and Social Enterprise organisations play a vital role in delivering high-quality, user-focused services across health and social care. Third sector organisations have a valuable understanding of clients' needs and are often better placed to respond more flexibly to those needs with innovative services and interventions.

76. Government reform promotes a greater plurality of provision (including service providers from the third sector) to increase capacity, encourage innovation, improve user responsiveness and ultimately improve health and reduce health inequalities. A great deal of work has been undertaken to remove barriers to third sector organisations entering the market and ensuring that there is a fairer playing field.

The Department of Health (DH) - Third sector and Social Enterprise programme

77. The DH Third sector and Social Enterprise programme was set up to improve relationships and communications between the DH and third sector. We manage it through a Delivery Board, which has representatives from the NHS and social care and third sector organisations.

78. The Delivery Board draws upon an external Sounding Board, which provides an independent reality-check and ensures that the Department's Third Sector and Social Enterprise programme is rooted within the wider third sector partnership agenda. It has a wide membership from across the third sector together with members from the NHS and social care.

Funding

79. *Section 64* of the Health and Public Services Act 1968 gives the Secretary of State for Health the power to make grants to voluntary organisations in England whose activities support the Department of Health's policy priorities. The total budget for 2007-08 was £17.2 million including continuing grants agreed in previous years. The Department awarded 132 new grants in 2007-08 funding round out of over 1,109 applications received. The average grant in 2007-08 was around £50,000 a year.

80. The DH introduced the *Opportunities for Volunteering (OFV) Scheme* in 1982. It provides grants to local health and social care organisations in England. The OFV scheme aims to enable organisations to expand volunteering involvement and opportunities in the fields of health and social care. A focus for the scheme is to provide opportunities for socially excluded

people / individuals to undertake voluntary work. In 2007-08 approximately £6.7 million was distributed to over 311 local projects which used their grants to enable over 19,467 volunteers to provide a wide range of health and social care services. The work of volunteers benefited many thousands of services users as well as their families, friends and local communities. OFV grants range from £2,000 to £35,000.

81. Following a Third Sector Funding & Investment Review, completed earlier this summer, we are introducing new third sector funding arrangements aimed at increasing transparency and effectiveness. Two new funding schemes from 2009-10 will replace the Section 64 General Scheme of Grants:

- *The Strategic Partner Programme* will recruit up to 10 national organisations (or consortia) in the first year to act as Strategic Partners from the third sector. These partners will receive funding to work at a strategic level informing and advocating for the third sector more widely, making the sure the views of third sector organisations are represented to the Department, communicating departmental policies effectively to the third sector and supporting the development and capacity of other third sector organisations.

- *The Innovation, Excellence and Service Development Fund* will support projects with the potential for national impact in line with the DH's objectives of better health and well-being and better care for all. Organisations will be able to apply individually, or in partnership with other third sector organisations.

82. The final shape of a volunteering investment fund will draw upon the responses to the four-month volunteering strategy consultation, 'Towards a strategy to support volunteering in health and social care', launched in June 2008.

Northern Ireland

70. The position continues to be that, Voluntary and private organisations and community groups make a significant contribution to many aspects of life in Northern Ireland. Increasing confidence in the voluntary sector's contribution and its potential is demonstrated by the number of innovative and exciting new partnerships with public, private and other charitable bodies

71. The private sector continues to make a major contribution to residential and nursing home care and is beginning to diversify its activity into the provision of domiciliary and day care.

The Committee observed in its previous Conclusions that supervision of non-state providers is carried out by the same agencies as for public providers and asks for the next report to indicate the conditions voluntary and private providers must fulfil to become social service

providers; it also asks how, in accordance with the above interpretation of Article 14§2, effective and equal access to social services provided by the independent sector is guaranteed.

83. The Commission for Social Care Inspection (CSCI)[1] is responsible for the regulation of all social care providers in England. It is a national, independent, Non-Departmental Public Body, established by the Government under the Health and Social Care Act 2001. Full details of is remit and operation are set out in its website and can be viewed via the link given below. It became fully operational in April 2004, taking over from the previous regulator for England, the National Care Standards Commission. CSCI has other important roles, which are to help raise standards across the country, to report to the Government on the quality of services and to help users by providing them with clear information about services and how to make complaints.

84. A new regulator, the Care Quality Commission (CQC), is expected to take over CSCI's work on the regulation of social care services in April 2009. CQC will also take over the regulation of healthcare from the Healthcare Commission.

85. The Government is pragmatic about who should provide care services. The important thing is not who provides a service, but that the service is high quality, responsive to users' needs and wishes, and delivers the best possible value for money. Local authorities are expected to commission care services that deliver Best Value. Best Value is the key element in our agenda to improve the quality of all local authority services, including social services, and the efficiency and economy with which they are delivered. Best Value will ensure that local authorities commission social care fairly and openly on the basis of a full consideration of costs, quality and outcomes for users. Currently, over 80% of social care is provided by private and voluntary sector providers.

Scotland

The Scottish Commission for the Regulation of Care (the Care Commission[2]) was set up in April 2002 under the Regulation of Care (Scotland) Act 2001 to regulate all adult, child and independent healthcare services in Scotland.
The Care Commission ensures that care service providers meet the Scottish Government's National Care Standards and works to improve the quality of care.

To do this, the Commission has 582 employees, including 328 Care Commission officers who inspect services, and an annual operating budget of around £30 million.

[1] http://www.carestandards.org.uk/
[2] http://www.carecommission.com

Wales

86. The Care and Social Services Inspectorate in Wales (CSSIW) has a new integrated structure comprising a national office, which has a strategic, all-Wales advisory role, and four regions, which ensure that regulatory decision making is taken at a local level. Over 6,000 services are regulated and inspected by CSSIW using the regulations and national minimum standards set by the Welsh Assembly Government. CSSIW works with other inspectorates and regulatory bodies in carrying out its work. Together with the Wales Audit Office it conducts joint reviews of local authority social services. Further information on its remit and operation can be viewed at http://www.cssiw.org.uk/.

Northern Ireland

87. The Regulation and Quality Improvement Authority (RQIA) is responsible for registering, inspecting and encouraging improvement in a range of health and social care services delivered by statutory and independent providers, in accordance with The Health and Personal Social Services (Quality, Improvement and Regulation)(Northern Ireland) Order 2003 and its supporting regulations.

88. The services RQIA regulates include residential care homes; nursing homes; children's homes; independent health care providers; nursing agencies; adult placement agencies; domiciliary care agencies; residential family centres; day care settings; and boarding schools.

89. Any person who carries on or manages such an establishment or care service must make an application to RQIA, and once granted, RQIA issues a certificate of registration to the applicant. RQIA maintains a register of all approved establishments and care services.

90. Within Northern Ireland there are four health and social services boards who plan, commission and purchase services. Five health and social care trusts are the providers of service, managing staff, services and budgets.

The Committee asks also for information on the protection of the right to privacy of clients

91. Social care employers are required to have written policies and procedures in place to enable social care workers to meet the General Social Care Council's Code of Practice for Social Care Workers[1]. This includes: "Implementing and monitoring written policies on: confidentiality; equal opportunities; risk assessment; substance abuse; record keeping; and the acceptance of money or personal gifts from service users or carers;".

92. The Code for Social Care workers also includes the following

[1] http://www.gscc.org.uk/NR/rdonlyres/8E693C62-9B17-48E1-A806-3F6F280354FD/0/CodesofPractice.doc

guidance:

"As a social care worker, you must strive to establish and maintain the trust and confidence of service users and carers.
This includes:
Being honest and trustworthy;
Communicating in an appropriate, open, accurate and straightforward way;
Respecting confidential information and clearly explaining agency policies about confidentiality to service users and carers;".

Scotland

93. The Scottish Social Services Council (SSSC) also publishes Codes of Practice for Social Service Workers and Employers. These are standards of conduct and practice which all social service workers and their employers must follow. The Codes of Practice were produced in consultation with service users, lawyers and the Plain English Campaign and can be viewed via the SSSC website pages at http://www.sssc.uk.com/Homepage.htm

Wales

94. The Care Council for Wales publishes its own codes setting out agreed professional standards which apply to all employers and those working in the social care profession regardless of where they work. Signing up to the Codes of Practice is a condition of acceptance on to the social care register.

95. The Code for Workers[1] sets down the standards of conduct expected of social care workers. It will ensure that workers know what is expected of them and that the public know what standards of conduct they can expect from care workers.

96. All social care workers are expected to meet the code and any serious failure to do so will be dealt with by employers. In the case of people who are registered may lead to investigation and action by the Care Council. The Care Council will operate in a manner that recognises the rights and responsibilities of employers and avoids duplication of processes or procedures. It will normally only deal with cases when employers have concluded complaints and disciplinary procedures and removal from the register or the setting of additional conditions on registration need to be considered.

97. There is also a Code of Practice for Employers of Social Care Workers[2], which applies to all employers across the social care sector regardless of whether they are public, private or statutory organisations. The Code for employers sets out how employers should meet their responsibilities for managing and supporting their staff and ensuring that they do their jobs well. The enforcement of the Codes for employers is a matter for the Care

[1] http://www.ccwales.org.uk/eng/conduct/pdf/final_codes_workers.pdf
[2] http://www.ccwales.org.uk/eng/conduct/pdf/information_for_employers.pdf

Standards Inspectorate for Wales.

Northern Ireland

98. The Northern Ireland Social Care Commission (NISCC)[1] is the regulatory body for the Northern Ireland social care workforce. NISCC is an independent public body, established to increase public protection by improving and regulating standards of training and practice for social care workers. NISCC has its own Code of Practice for Social Workers and Employers of Social Workers[2]

Isle of Man

99. Voluntary organisations are an essential part of the provision of social welfare services in the Isle of Man and a Council for Voluntary Services has been established. It is a specific policy of the Department of Health and Social Security to seek to work with the voluntary sector (and where appropriate with the private sector) in delivering services in partnerships with these organisations. Approximately one third of Social Services' budget is provided as direct grant aid to voluntary and independent organisations to provide welfare services. Voluntary organisations are consulted in the development of services for all groups of service users.

100. In partnership with the Voluntary and Statutory Sector the Isle of Man Government has a range of initiatives designed to help those who are homeless or in transitory accommodation including: the establishment of a registered charity, Kemmyrk, for the homeless; provision of emergency accommodation; and a "Night Stop" scheme for homeless young people.

101. Those using services and their carers are increasingly involved in service development and delivery. An example of this is the Service User Network in Mental Health Services which is involved in contributing to activities from policy making to staff interviews.

[1] http://www.niscc.info/home-1.aspx
[2] http://www.niscc.info/content/uploads/downloads/registration/Codes_of_Practice.pdf