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EUROPEAN SOCIAL CHARTER

36th National Report on the implementation
of the European Social Charter

submitted by

THE GOVERNMENT OF THE UNITED KINGDOM

Articles 3, 11, 12, 13 and 14
for the period 01/01/2012 - 31/12/2015

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CYCLE XXI-2 (2017)

COUNCIL OF EUROPE

THE EUROPEAN SOCIAL CHARTER

THE UNITED KINGDOM'S THIRTY-SIXTH REPORT

JANUARY 2016

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General Questions from the Committee

Article 3

Statement of interpretation regarding Article 3

(Risk of work-related stress, aggression and violence)

The Health and Safety at Work Act (HSWA) 1974 and the Management of Health and Safety at Work Regulations 1999 establish a regime for the management of work place hazards, requiring risk assessments for all such hazards and, where risk is identified, action to remove, reduce or mitigate those risks as far as reasonably practicable. This includes the risk of work related stress, violence and aggression.

The flexibility within this process allows the risk assessment to be adapted to accommodate additional, temporary and new risks from the work, workplace, work environment and associated issues such as working patterns, etc.

HSE can take action under section 2 of HSWA where an employer has failed to assess the risk to their employers or have failed to take sufficient adequate measures to prevent injury to their employees. HSE also provides advice and guidance on measures that can be taken on both its violence website and in its guidance on lone working and vulnerable workers site.

Cases of work related violence which result in conditions that meet the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013 criteria (see: http://www.hse.gov.uk/riddor/reportable-incidents.htm) must be notified to the HSE. Stress is not RIDDOR reportable because it is not, of itself, a medical condition. HSE uses an annual survey of employees to gather data relating to the incidence and prevalence of work related stress. Its figures are supported by those of social partners (TUC and CIPD)

The HSE developed the Management Standards (MS) approach to tackling work related stress specifically to cope with the individual circumstances an employer may experience. The approach provides a mechanism for scoring organisational performance against a series of 6 Standards. These Standards identify 6 areas of work which, if not managed properly, are likely to result in pressure/stress. These were launched in 2004 and more information can be found at http://www.hse.gov.uk/stress/standards/index.htm .

The MS approach is an enhanced risk assessment tool that informs employers about the process of risk assessment but also:

- supplies guidance as to data sources for gathering evidence of the risk;
- provides a specific Indicator Survey tool of 35 questions designed to identify those individuals experiencing, or potentially experiencing, work related stress;
- Using the associated analysis tool employers can:

  - identify which elements of the work are potential stressors;
  - If demographic questions are used as part of survey, can identify where issues have arisen or may arise; and
  - Can provide performance marking against which performance can be assessed.
- Contains advice and guidance for analysing the results of the risk assessment; and
- Promotes co-operation and consultation between employers, employees and their representatives throughout the process.

HSE is reviewing its provision on work related stress, working directly with representative employers from Sectors of industry with statistically higher than average incidence rates for work related stress, to provide more data on levels of work related stress, gather more specific data on the stressors, review the relevance of the MS approach to these stressors and providing additional or specific guidance to these sectors: Education, Social Health and Central Government services (Prison Service and potentially Police Service).

With regard to provision for SMEs the HSE is in the process of developing an online version of the indicator questionnaire and analysis tool that will give real-time analysis for smaller numbers of employees and a tool providing size specific guidance for carrying out a risk assessment for work related stress which is more user friendly for smaller employees.

Statement of interpretation regarding Article 3, paragraph 2
(Scope of labour inspection)

The system of labour inspection in Britain continues to apply to all workplaces, as described in 'Regulation of Health and Safety at Work'. HSE's established enforcement policy statement accommodates the need for inspectors to target key risks and take proportionate action. This focuses enforcement action on serious risks and on those employers seeking an economic advantage from working with poor risk controls and not complying with the law. The UK's risk based approach has helped make it one of the safest places in the world to work.

The Government's reform of the health and safety system ("Good Health and Safety, Good for Everyone") introduced a new categorisation of non-major hazard industries in which inspection is concentrated on the higher risk industrial sectors. Lower risk sectors are not targeted for inspection, where it is considered to be less effective in terms of outcomes. However, employers in any sector who under-perform in health and safety may still be visited.

We identify workplaces where proactive inspection can be justified and target inspections based on risk profile. For example, around half of HSE's proactive inspection resources are devoted to the construction sector, and we have a number of planned inspections that specifically target risks to workers employed in industries involving exposure to dust.

Isle of Man

The identification of stress related ill-health (or factors which could contribute to such issues) is an important and embedded element of inspections and investigations undertaken by the Health and Safety at Work Inspectorate and this important issue is considered alongside other causes of work related ill health and fatigue.

Inspectors have been trained to identify the possible causes of stress - in addition to early signs of symptoms - and adopt the UK HSE's guidance when undertaking work place interventions.

The potential for health and safety implications as a consequence of work place aggression and violence is also considered during interventions by Inspectors.

The Isle of Man Government's Health and Safety Advisory unit has recently delivered a serious of presentations on the identification and management of stress related issues to managers and teams across all Departments and a programme of events on the value and importance of workplace well-being is currently being delivered to managers and nominated Departmental 'champions'.

Question on legal gender recognition practise

The Committee asks States Parties whether legal gender recognition for transgender persons requires (in law or in practice) that they undergo sterilisation or any other invasive medical treatment which could impair their health or physical integrity.

The Gender Recognition Act 2004 does not require individuals to undergo sterilisation or any other invasive medical treatment which could impair their health or physical integrity.

Isle of Man

The Isle of Man's legislation concerning the legal gender recognition for transgender persons, the Gender Recognition Act 2009 (of Tynwald), links directly to the UK's Gender Recognition Act 2004. Isle of Man residents can apply to the Gender Recognition Panel established under the UK's 2004 Act for a full gender recognition certificate. Persons who have been issued with such a certificate are legally recognised as their acquired gender under the Island's 2009 Act. The criteria for the legal gender recognition for transgender persons are therefore identical to those in the United Kingdom.

On the relationship between Article 12§1 and Article 13§1 (adequacy of benefits)

If the minimum level of income-replacement benefits under the social security system falls below a minimum guaranteed income threshold established by national law, will it be topped up with social assistance? If so, please provide details of any such threshold and the social assistance benefits that may be available in such a case.

There is no minimum level of income-replacement benefits in the UK. The benefit system is a mix of contribution and income related benefits, the latter are awarded on a means tested basis. The information provided in the body of this report under article 12 demonstrates the interaction of a series of contributory and income related benefits.

Isle of Man

The Isle of Man provides, subject to the satisfaction of certain qualifying criteria (in particular a residential qualification[1]), social assistance benefits to persons whose existing income – which may include earnings or income replacement benefits – is below a guaranteed minimum level.
Social assistance benefits include:

- employed person's allowance - for families and disabled persons who work but whose earnings are below the statutory income level – called the "applicable amount";
- income support – for certain groups of people who do not work or who work for less than 16 hours a week, and for whom there is no work-related conditionality- including people of state pension age, the sick, disabled and lone parents with a child under 12 years of age who have an income below their applicable amount ; and
- income-based jobseeker's allowance – for people who are unemployed, available for work and actively seeking work who have an income below their applicable amount.

The applicable amount in a particular case depends on the claimant's circumstances and that of their family (if they have one). The following factors will determine a person's applicable amount:

- their age;
- their family size;
- where they live and the amount of their housing costs or care home costs;
- whether they or any member of their family is disabled.

Consequently, applicable amounts vary considerably.

[1] Broadly speaking, to qualify for social assistance benefits a person must have been born in the Isle of Man or have lived in the Island for a continuous period of 5 years at any time, or be the spouse or civil partner of a person who was born in the Isle of Man or who has have lived in the Island for a continuous period of 5 years at any time

Statement of interpretation in regards to stateless persons

In the general introduction to the Conclusions XX-2 (2013) the Committee of Independent Experts stated on the personal scope of application of the European Social Charter and, in particular on the rights of stateless persons.

The UK Government points out that:

The European Social Charter does not apply to stateless persons. The appendix to the Charter (points 1 and 2) indicates that persons covered include:

- foreigners only insofar as they are nationals of other Contracting Parties lawfully resident or working regularly within the territory of the Contracting Party,
- refugees as defined in the Convention relating to the Status of Refugees, signed at Geneva on 28th July 1951, and lawfully staying in the territory of the Contracting Party.

The Revised European Social Charter applies (appendix to the revised Charter, points 1-3) to:

- foreigners only insofar as they are nationals of other Contracting Parties lawfully resident or working regularly within the territory of the Contracting Party,
- refugees as defined in the Convention relating to the Status of Refugees, signed at Geneva on 28 July 1951, and lawfully staying in the territory of the Contracting Party,
- stateless persons as defined in the Convention on the Status of Stateless Persons done in New York on 28 September 1954 and lawfully staying in the territory of the Contracting Party.

The UK is bound by the provisions of the European Social Charter.

Article 3 – The right to safe and healthy working conditions

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 and its Northern Ireland equivalent The Health and Safety at Work (Northern Ireland) Order 1978 are the primary pieces of legislation covering occupational health and safety in the United Kingdom. The legislation can be found on the government website http://www.legislation.gov.uk/

2. Comprehensive information on the Health and Safety legislation as it applies in Great Britain can be viewed at the Health and Safety Executive's website at http://www.hse.gov.uk/legislation/index.htm. Similarly the legislation that applies in Northern Ireland can be viewed at the Health and Safety Executive for Northern Ireland (HSENI) website at https://www.hseni.gov.uk/publications/list-primary-legislation

Great Britain

3. There have been several government reviews of health and safety in the last few years: Common Sense, Common Safety; Good Health and Safety Good for Everyone; and Reclaiming health and safety for all (see http://www.hse.gov.uk/aboutus/health-and-safety-reform/index.htm). These found that there was no case for radically altering legislation. HSE's goal-setting approach has stood the test of time and withstood close scrutiny. However, there was work to do around simplification and as a result, HSE has revoked and amended legislation to make the legal framework for health and safety clearer by removing unnecessary burdens, scrapping outdated legislation, cutting out duplication and removing regulatory requirements which offered little in terms of improving health and safety outcomes.

Northern Ireland

4. HSENI sets out its strategy for implementing the legal framework in Northern Ireland in its successive Corporate Plans. Its current plan which covers the four year period 2011 to 2015 has been extended to include 2015/16 and 2016/17 in line with other NICS Departments. The current plan stems from a joint strategy developed in partnership between HSENI and the district councils, which sets out the pathway for the better regulation of health and safety at work in Northern Ireland. HSENI is currently developing a new Corporate Plan which will be completed during the 2016/17 financial year.

Self-employed workers

5. In 2011, an independent review of health and safety regulation carried out by Professor Lofstedt recommended that those self-employed whose work activities pose no potential risk of harm to others should be exempt from health and safety law. This recommendation was accepted by Government.

6. As a result, from 01 October 2015, health and safety law in relation to the self-employed changed such that Section 3 (2) of the Health and Safety at Work etc. Act 1974 (HSWA) will not apply to the self- employed if their work activity poses no risk to the health and safety of others, including other workers and members of the public.

7. Section 1 of the Deregulation Act 2015 amended HSWA to limit the scope of Section 3 (2) so that only those self-employed persons who conduct an undertaking described in regulations will continue to have a duty under the provision.

8. The Health and Safety at Work etc. Act 1974 (General Duties of Self-Employed Persons) (Prescribed Undertakings) Regulations 2015 came into force on 01 October 2015 and set out the undertakings that Section 3 (2) continues to apply to. The Schedule to the regulations prescribe certain high risk work activities to ensure that self-employed people carrying out these activities will still have a duty to themselves and others. This is intended to include those activities where there are high numbers of self-employed persons and which statistically result in high numbers of fatalities or injuries. In addition, the Schedule also includes activities where EU requirements impose a specific duty on someone who is self-employed to protect themselves from risks to their own health and safety.

9. The high risk activities on the Schedule are:

- Work in agriculture, construction, gas or railways;
- Work with asbestos or genetically modified organisms

10. The Regulations also contain a risk-based provision such that those self-employed whose work activities do pose a risk of harm to others, continue to have duties under Section 3 (2) of HSWA.

11. Other new legislation is to implement new European Directives. All HSE owned and enforced legislation can be found at http://www.hse.gov.uk/legislation/index.htm

12. The Health and Safety Executive has a duty under the Health and Safety at Work etc. Act to consult others as appropriate on any proposals for regulations (section 50(3)) and Approved Codes of Practice (section 16(2)). The views of the social partners, including trade unions and employers' organisations are routinely sought in the formulation, implementation and review of national strategy for health and safety at work.

Paragraph 2

13. The position remains as previously described with the following update on statistics (please see the next page).

Accident Statistics:

Number of accidents at work, to employees:	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15 (p)	2015/16 (p)[3]
Reported injuries (RIDDOR[1])	138,431	133,282	122,799	116,686	111,299	80,368	78,671	76,054	n/a
of which; rate per 100,000 employees	545.6	522.6	490.4	464.4	442.6	318.4	307.4	292.9	n/a
Annual estimated cases - over-3-day injury (LFS)[2]	299,000	246,000	231,000	201,000	214,000	232,000	203,000	198,000	n/a
of which ; rate per 100,000 workers	1,050	870	830	700	750	800	690	660	n/a
Annual estimated cases - over-7-day injury (LFS)[2]	218,000	175,000	165,000	151,000	158,000	176,000	148,000	152,000	n/a
of which ; rate per 100,000 workers	760	610	590	530	550	610	500	500	n/a
Number of fatal accidents to workers (RIDDOR)	233	179	147	175	171	150	136	142(r)	144(p)
of which ; rate per 100,000 workers	0.8	0.6	0.5	0.6	0.58	0.5	0.45	0.46(r)	0.46(p)

Enforcement Statistics:

Enforcement statistics[4]	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15 (p)	2015/16 (p)
Enforcement notices issued by HSE[5]	7,758	8,077	9,727	11,038	9,908	8,807	10,119	9,446	n/a
Enforcement notices issued by LAs	6,010	6,340	6,110	7,270	6,045	4,693	3,671	2,984	n/a
Prosecution cases taken by HSE[6,7]	567	580	505	554	576	606	605	650	n/a
of which ; resulting in conviction for at least one offence	545	535	473	515	531	575	567	606	n/a
conviction rate for cases heard	96%	92%	94%	93%	92%	95%	94%	93%	n/a
Prosecution cases taken by LAs	155	145	117	129	98	109	92	78	n/a
of which ; resulting in conviction for at least one offence	152	142	114	125	95	104	89	76	n/a
conviction rate for cases heard	98%	98%	97%	97%	97%	95%	97%	97%	n/a

Notes:

[1]RIDDOR: The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (as amended), under which fatal and defined non-fatal injuries to workers and members of the public arising from work activity are reported by employers.
[2]LFS: The Labour Force Survey (LFS) is a national survey of households living at private addresses in the UK – consisting currently of over 50 000 responding households each quarter. Estimates for the period 2001/02-2013/14 were revised in October 2015. LFS data sets were reweighted to reflect new population estimates based on the 2011 Census. The impact of this change is recorded at http://www.hse.gov.uk/statistics/about/revisions/revision-log.htm.
[3]With the exception of fatal injury statistics (published in July 2016), provisional statistics for 2015/16 and revised statistics for 2014/15, are not currently available (marked as 'N/a' in the above tables). These shall be published for the first time in November 2016, but cannot be released earlier because of UK National Statistics guidelines.
[4]Since 1 April 2006 railway safety has been enforced by the Office of Rail Regulation (ORR). Such details are excluded here.
[5]Figures relate to enforcement notices issued in the relevant year.
[6]Figures relate to prosecution cases concluded in the relevant year.
[7]In Scotland, HSE and local authorities investigate potential offences but cannot institute legal proceedings. HSE and local authorities send a report to the Crown Office and Procurator Fiscal Service (COPFS). COPFS makes the final decision whether to institute legal proceedings and which offences are taken.
(p) Provisional
(r) Revised

Northern Ireland Statistics:

	2007/08 *	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16 (p)
Number of accidents at work, to employees		3,134	3,066	3,228	3,119	2,579	2,653	2,740	2,777
of which; rate per 100,000 employees		433	401	464	447	372	380	381	380
Number of fatal accidents to employees		9	3	4	7	3	3	7	-
of which; rate per 100,000 employees		1.24	0.39	0.6	1.0	0.43	0.43	0.97	-
Enforcement notices issued		382	367	412	285	315	254	203	254
Prosecutions taken		21	22	17	35	19	21	29	19
Number of inspections		12,572	15,124	17,306	13,755	15,084	13,922	10,516	13,223
Number of occupational diseases		72	51	29	32	11	17	14	37

Paragraph 3

Consultation with employers' and workers' organisations

14. The position remains as previously described. Consultation and involvement takes place through the Board of HSE and Industry Advisory Committees. HSE issues consultative 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 in the formulation, implementation and review of national strategy for health and safety at work.

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

Answers to the Committee's Conclusions XX-2 (2013)

The report indicates that in Northern Ireland there were 72 occupational diseases in 2008/2009, 51 in 2009/2010 and 29 in 2011/2012. The Committee notes the particularly low level of occupational diseases in Northern Ireland during the reference period. It asks that the next report indicates whether the above-mentioned level constitutes an indication of under-reporting. Should this be the case, the Committee asks to be informed on the measures taken to counteract this phenomenon.

16. It cannot be said with certainty if the perceived "low level of occupational diseases in Northern Ireland" is indicative of under-reporting. HSENI is aware that under reporting of occupational injuries and diseases can occur for many reasons. In the case of diseases it may result, for example, from a failure to make the link between exposure and disease. For some years now HSENI has focussed on occupational health as a priority topic. We have prioritised issues such as asbestos related ill health, silicosis, musculoskeletal disorders, and occupational asthmas etc. We have maintained a strong focus on these issues and have engaged with industry to raise awareness of the problems and to ensure solutions are put in place to minimise the risks. HSENI will maintain this proactive focus on occupational health issues through promotion and providing information through to enforcement action when required.

Answers to the ECSR's questions XX-2 (2013)

In its Conclusions 2013 on the UKs 32nd Social Charter Report, the Committee noted it understands that there are no developments with respect to the legal framework relating to the protection of temporary workers and asked that the next report provides full and updated information on this point.

There are no developments with respect to the legal framework relating to the protection of temporary workers. HSE has published revised guidance on this topic which addresses the most common issues, particularly where the responsibility lies for training and PPE requirements: http://www.hse.gov.uk/vulnerable-workers/agency-temporary-workers.htm

The Committee recall that all workplaces and all activities must be covered by occupational health and safety regulations. This also includes self-employed workers, home workers and domestic workers. The Committee asks that the next report indicates which are the categories of domestic workers covered by health and safety laws and regulations further to health and social workers; it also asks to

be informed on the steps taken to protect health and safety of domestic workers without interfering with private home".

Domestic workers employed in private households are not covered by UK health and safety law and other related legislation whilst other workers in a domestic setting (such as health and social care workers) are covered.

Domestic work describes work that takes place within private households, that is governed by an employment relationship (i.e. it does not cover work a family member might undertake) and covers occupations such as carers, cleaners, gardeners, secretaries or cooks. Domestic workers can live in the household they work in or away from their employer.

UK employment law provides comprehensive employment and social protection to domestic workers, and as a rule, domestic workers in the UK are entitled to the same employment rights as workers generally – such as paid annual leave, sick pay and anti-discrimination rights.

It would not be proportionate or practical to extend criminal health and safety law, including inspections, to private households employing domestic workers as this would impose disproportionate burdens and raise issues of privacy.

ISLE of MAN

Article 3, Paragraph 1

The Isle of Man's health and safety legislative framework is built upon the Health and Safety at Work etc Act 1974 (of the UK Parliament) (as applied to the Island) and the Management of Health and Safety at Work Regulations 2003. Both the Act and the Regulations are Isle of Man adaptations of existing UK legislation.

These two pieces of core legislation are supplemented by a range of risk and industry specific Acts and Regulations which are subject to regular review to ensure they provide the basis for delivery of proportionate risk management standards and enable the effective use of currently available equipment, materials and processes.

In 2012 two pieces of legislation; the Construction (Health and Safety) Regulations 1985 and the Construction (Head Protection) Regulations 1999 were revoked as they were contributing to unhelpful duel standards and confusion in the minds of those responsible for managing health and safety in work places.

Manx Health and Safety legislation is applicable to all employers, employees and contractors who operate on the Island including those who come to the Island from other jurisdictions.

The Health and Safety at Work Inspectorate (HSWI) is an Isle of Man Government organisation which is now based in the Department of Environment, Food and Agriculture (DEFA) following a move from the Department of Infrastructure (DOI) in July 2014. The move to DEFA was made to combine the Health and Safety at Work Inspectorate with the Islands Environmental Health team to ensure more effective delivery of health and safety across all sectors of the community.

Environmental Health Officers are now undertaking health and safety inspections in shops, offices, restaurants and some residential homes while Inspectors attached to the Health and Safety at Work Inspectorate cover health and safety in industrial, agricultural, construction and Government locations.

All occupational and community health and safety matters are now covered by the same group of professional inspectors and officers.

The new team, which comprises of 8 inspectors/officers and two managers, is now able to provide a single point of contact for all workplace and community health and safety enquiries and has also been able to provide more effective coverage of all premises for fewer regulatory visits.

Article 3, Paragraph 2

Inspectors are empowered to issue enforcement notices to stop work or ensure the introduction of improved standards, issue formal cautions and to recommend prosecution of duty holders and individuals in appropriate circumstances.

Appendix A contains the Departments report on health and safety inspection between 2012 and 2016. As it covers the period of transition from the Department of Infrastructure to the Department of Environment, Food and Agriculture, it refers mainly to the activities of the HSWI team – it does however include the input from Environmental Health Officers as they have commenced occupational health and safety activities.
Information on the numbers of reported incidents, investigations undertaken and sanctions applied between January 2012 and December 2015 is contained in Table 4.

Isle of Man Population Data

All data is taken from the Isle of Man Census undertaken in April 2011. Table 1 contains details of the numbers employed per sector.

Census data 2011	
Resident population	84,497
Economically Active	44,609
Working for one or more employers	37,034
Self-employed (employing others)	1,817

Please Note: The number used to calculate the Standardised Accident Rate (SAR) is the sum of the Industry sector totals (43134).

Table 1: Employed population 2011*

Employment in the Isle of Man by Sector	Industry Total	Males	Females	%
Agriculture, forestry and fishing	850	695	155	2
Manufacturing	2,295	1,775	520	5
Construction	3,352	3,188	164	8
Electricity, gas, other energy and water	878	744	134	2
Transport and communications	3,037	2,149	888	7
Wholesale distribution	821	607	214	2
Retail distribution	3,683	1,659	2,024	9
Insurance	1,931	871	1,060	4
Banking	2,927	1,177	1,750	7
Other financial institutions	1,695	848	847	4
Property owning and management	1,049	656	393	2
Other business services	1,842	844	998	4
Information and Communication Technology	609	457	152	1
Legal services	625	226	399	1
Accountancy services	958	487	471	2
Education	2,795	695	2,100	6
Medical and health services	3,539	787	2,752	8
Tourist accommodation	679	337	342	2
Other professional and technical services	1,000	659	341	2
Entertainment and catering	2,129	1,174	955	5
Miscellaneous services	3,382	1,359	2,023	8
Public administration	3,058	1,732	1,326	7
Total	43,134	23,126	20,008	100

Figures taken from the 2011Census Survey undertaken by, Economic Affairs Division, Isle of Man Treasury

Table 2 - HSWI Statistics March 2012 to December 2016

	12/13	13/14	14/15	15/16	Total 2012 to 2016
Total number of accidents reported	320	257	269	241	1087
Number of fatal accidents	1	1	0	0	2
Number of major accidents	64	51	51	22	188
Number of over 3 day accidents	126	118	146	148	538
Number of site interventions	382	432	370	386	1570

The total number of accidents reported includes school children and residents/patients in health care or residential establishments. The fatal, major and Over 3 day figures only include employees/workers.

The number of site interventions includes proactive inspections and investigations. The actual number of site visits is greater but follow up visits (for example to take statements following the initial investigation of incidents) have not been included. Attendance at emergency planning events, motorsport event safety meetings and educational and training events have not been included in the site intervention figures.

The data included in Table 2 does not include gas incident investigations, dangerous occurrences or complaints for which no site visit was made.

Table 3 – Standardised Accident Rates per 100,000 workers

	12/13	13/14	14/15	15/16
Employed population	43134	43134	43134	43134
Standardised accident rate per 100,000 workers - majors	148	118	118	51
Standardised accident rate – Over 3 days	292	273	338	343
Standardised accident rate – Over 3 day + majors	440	392	457	394

Table 4 - Enforcement Data 2012-2016

Sector	Improvement notice	Prohibition Notice	Formal Caution	Files presented to the Attorney General Chambers for consideration*
Construction (work at heights)	1	6		
Construction (asbestos)	1	4		1
Construction (demolition)		2		
Construction (vehicular, fabrication and machinery)	2	1		2
Construction (underground services)		2		
Construction (excavation)		1	1	1
Gas safety	1	2	2	2
Health services	3			3
Waste services	1	1		1
Entertainment	2	1	1	
Hospitality	1	2		1
Dangerous goods		1		
Transport/warehousing	2			
Fire safety		2		3
Agriculture/ arboriculture		1		
Totals	**14**	**26**	**4**	**14**

*of the 14 reports forwarded to the AG's department they considered that 11 should be prosecuted and in the other 3 cases alternative action should be taken by the inspectorate. Of the remaining 11 cases 3 are awaiting hearings. 8 cases have been heard 7 defendants have been found guilty and there was a not guilty verdict in the other case.

The number of companies and individuals covered by the DEFA regulatory team is currently being reviewed following the amalgamation of the HSWI with DEFA's Environmental Health team.

Article 3, Paragraph 3

In addition to the efficiency, effectiveness and consistency improvements created by the amalgamation of the health and safety and environmental health teams , the combined team delivers education and awareness events and works with Trade Unions, Trade

Associations and Professional bodies to review the priority risks and agree strategies to ensure appropriate control measures.

The Inspectorate has engaged with a wide range of sectors during the period covered by this review including manufacturing, food and drink, offices and shops, hotels, government departments, construction, utilities, fuel storage facilities, railways, motor sport interests, harbours and the airport.

During the period covered by this report DEFA inspectors and officers have investigate numerous fatalities and major injury incidents in health care and residential establishments. This has represented a significant proportion of the team's effort.

Motor sport events also require significant input from the team.

Examples of advisory and educational events held during the period include the following:

- Occupational safety on high speed roads
- Local authority health and safety awareness
- scaffold awareness
- gas safety
- health and safety in health care premises

These events attracted more than 230 people in total.

Numerous organisations and premises have received multiple visits during the 2012 / 2016 period.

A program to improve the work recording arrangements for the combined health and safety / environmental health unit is currently underway and the consequential improvement in intelligence collection and analysis will be used to influence the priority objectives of the team. The introduction of mobile working technology is also generating operational efficiency improvements during its trial period.

Article 11 – The right to protection of health

Paragraph 1

Life expectancy and principal causes of mortality

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

Cardiovascular Disease

2. The Cardiovascular Disease (CVD) Outcomes Strategy was published in March 2013 and set out 10 key actions that commissioners and providers of health care services could take to reduce mortality from CVD and improve patients' quality of life, their experience of care and safety of that care.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/217118/9387-2900853-CVD-Outcomes_web1.pdf

3. NHS England, which took over responsibility for the day to day running of the NHS in April 2013, hosts a CVD outcomes collaborative. This brings together the National Clinical Directors for Heart Disease, Stroke, CVD prevention and Obesity and Diabetes, the main relevant national charities, the National CVD Intelligence Network, Public Health England and the Department of Health. It coordinates delivery of the work which was initiated in the CVD Outcomes Strategy.

4. In 2015/16 and 2016/17, the Government made available £1m to make public access defibrillators and coronary pulmonary resuscitation (CPR) training more widely available in communities across England. The aim is to help improve survival from out of hospital cardiac arrest which was one of the recommendations of the CVD outcomes strategy.

5. Relevant NICE guidance and quality standards can be found at the following link:

https://www.nice.org.uk/guidance/conditions-and-diseases/cardiovascular-conditions

Diabetes

6. The prevalence of diabetes has been steadily increasing. Nearly 3 million people in England currently have the condition and on top of this, an estimated 940,000 have undiagnosed diabetes. Furthermore, 5 million people are at high risk of developing Type 2 diabetes. If nothing changes, by 2025 more than 4 million people in England will have diabetes.

7. Diabetes and its complications incur £5.61bn per year in direct costs to the NHS in England according to the Department of Health's latest estimates. In addition to the direct NHS costs, the annual social care costs associated with supporting people with diabetes are estimated to be £1.4 billion. This is expected to rise to £2.5 billion by 2030. Diabetes imposes substantial wider societal costs through increased mortality, sickness absence, presenteeism and informal care. This cost is expected to rise from £14bn per year in 2010/11 to £23bn per year in 2035/36.

8. The average reduction in life expectancy for Type 1 diabetes diagnosed in childhood is 12 years for males, and 14 years for females. The average reduction in life expectancy for people with Type 2 diabetes diagnosed at age 50 is 6 years, 3 of which are attributable to cardiovascular causes.

9. The National Audit Office report published in 2015 showed that the relative risk for a person with type 1 or type 2 diabetes developing a diabetes related complication has not changed or has fallen for most complications. This is in spite of the growing number of people with diabetes. However, there are still 22,000 people estimated to be dying each year from diabetes related causes that could potentially be avoided and the increase in the number of people with diabetes means that the absolute number of diabetes patients with complications is rising.

10. The Global Burden of Disease Study, a benchmarking study of 19 wealthy countries, published in 2013 indicated that, in 2010, the UK had the lowest rates of early death due to diabetes of all the countries included. This finding has now been reinforced by a more recent OECD study Cardiovascular Disease and Diabetes: Policies for Better Health and Quality of Care published in June 2015. This report notes that the UK has one of the lowest rates for avoidable, diabetes related hospital admissions and one of the highest consumption rates of cholesterol lowering and antidiabetic drugs; with levels over 40% and 20% higher than the OECD average, respectively.

11. The National Diabetes Audit (NDA) is the one of the largest annual clinical audits in the world, integrating data from both primary and secondary care sources. The latest report was published on 28 January 2016. It shows some encouraging trends, most notably the improvement in blood pressure management and recorded offers of structured education courses for people newly diagnosed with diabetes. These were both areas prioritised for improvement in earlier NDA reports. Less positively, variation in both the NICE care process and treatment target achievement remains a significant issue, while the previously stable percentage of people receiving all eight care processes has fallen.

12. The latest National Diabetes Inpatient Audit (NaDIA) was published in June 2016. It shows only 1.1 per cent of inpatients with diabetes developed a new foot lesion during their admission to hospital, a significant decrease from 2.2 per cent when inpatient auditing began in 2010. However, since 2010, these improvements have not been mirrored in the other two main hospital inpatient harms - severe hypoglycaemic episodes and diabetic ketoacidosis (DKA).

13. The new National Diabetes Foot Care Audit, a module of the National Diabetes Audit, aims to establish the extent to which national guidelines on the management of diabetic foot disease are being met. The audit provides local NHS teams with the evidence needed to tackle any identified differences in practice which will lead to an overall improvement in management and outcomes for patients. There has been an increase in the proportion of Trusts with multidisciplinary diabetic foot care teams, from around 60% in 2011 to over 70% in 2013.

14. NHS England has introduced the Clinical Commissioning Group Imporvment and Assessment Framework (CCG IAF) from 2016/17 onwards, to replace existing assurance processes. The CCG IAF draws together core performance metrics and diabetes is one of the 6 clinical priority areas it covers, , that will be overseen by an independent group. The diabetes indicators, are based on data from the National Diabetes Audit, together with

Public Health England's (PHE) Healthier Lives data and the Atlas of Variation. Current indicators for diabetes are:

- the percentage of diabetes patients that have achieved all 3 of the NICE recommended treatment targets (i.e. cholesterol, blood pressure and glucose control); and
- newly diagnosed diabetes patients referred to, or attending, a structured education course.

15. There is an enormous amount of data about diabetes which local health economies can use to compare services with each other e.g. PHE's public health profiles, the atlas of variation. However, data transparency alone won't deliver the step change in improvement needed in some areas. The NHS Right Care programme helps CCGs and other local partners make these improvements in diabetes care by providing hands on practical support for those areas which choose to use them. NHS England is investing in this programme to enable every health economy in England to embed the NHS Right Care approach at the heart of their transformation programmes.

16. NHS England, Public Health England and Diabetes UK have been working together on Healthier You: the NHS Diabetes Prevention Programme (NDPP), the first diabetes prevention programme of its kind to be delivered at scale, nationwide. In 2016, 27 sites covering nearly half of England will refer at least 10,000 people to an evidence based behaviour change intervention shown to reduce the risk of type 2 diabetes. Next year a second wave of the programme will reach a further 25% of the population and by 2020, the programme will be made available to up to 100,000 people at risk of diabetes each year across England. Those referred will get tailored, personalised help to reduce their risk including education on healthy eating and lifestyle and bespoke physical exercise programmes.

17. Building on the NDPP, NHS England is developing a diabetes management and care programme aimed at reducing variation and improving outcomes for people with diabetes. NHS England is making an additional £40m available from 2017/18 to support delivery of the programme which will focus on 4 areas:

- reducing variation in the achievement of the 3 NICE treatment targets,
- improving take up of structured education,
- improving access to multi-disciplinary foot care teams for people with diabetic foot disease, and
- improving access to specialist inpatient support.

18. The National Institute for Clinical Excellence (NICE) has published diabetes best practice clinical guidelines. There is a regular updating programme.

- Diabetes in pregnancy: management from preconception to the postnatal period (2016).
- Diabetes in pregnancy Quality standard (2016)

Renal

19. Since 1 April 2013, NHS England has commissioned specialist renal services for adults from adult specialist renal centres and adult renal transplant centres, and services for children from specialist paediatric renal centres. This includes services delivered on an outreach basis as part of a provider network. National commissioning supports equity of access to high quality renal care across the country,

20. Since the last update, the National Institute for Health and Care Excellence has published a guideline on Acute Kidney Injury (AKI), which sets out best practice on the prevention, detection and management of AKI. One in five patients who are emergency admissions to hospital will present with AKI, a condition that refers to the loss of kidney function over hours or days. However, despite the frequency of the condition, there are low levels of awareness and education among health professionals and the general public. Around 20 per cent of emergency cases of AKI are preventable which would save around 12,000 lives each year in England.

21. In addition, NICE has also published quality standards on AKI and renal replacement therapy services. Quality Standards set out the markers of high quality care, helping local NHS commissioners shape services for local populations by identifying the key standard that service should meet in the care they provide.

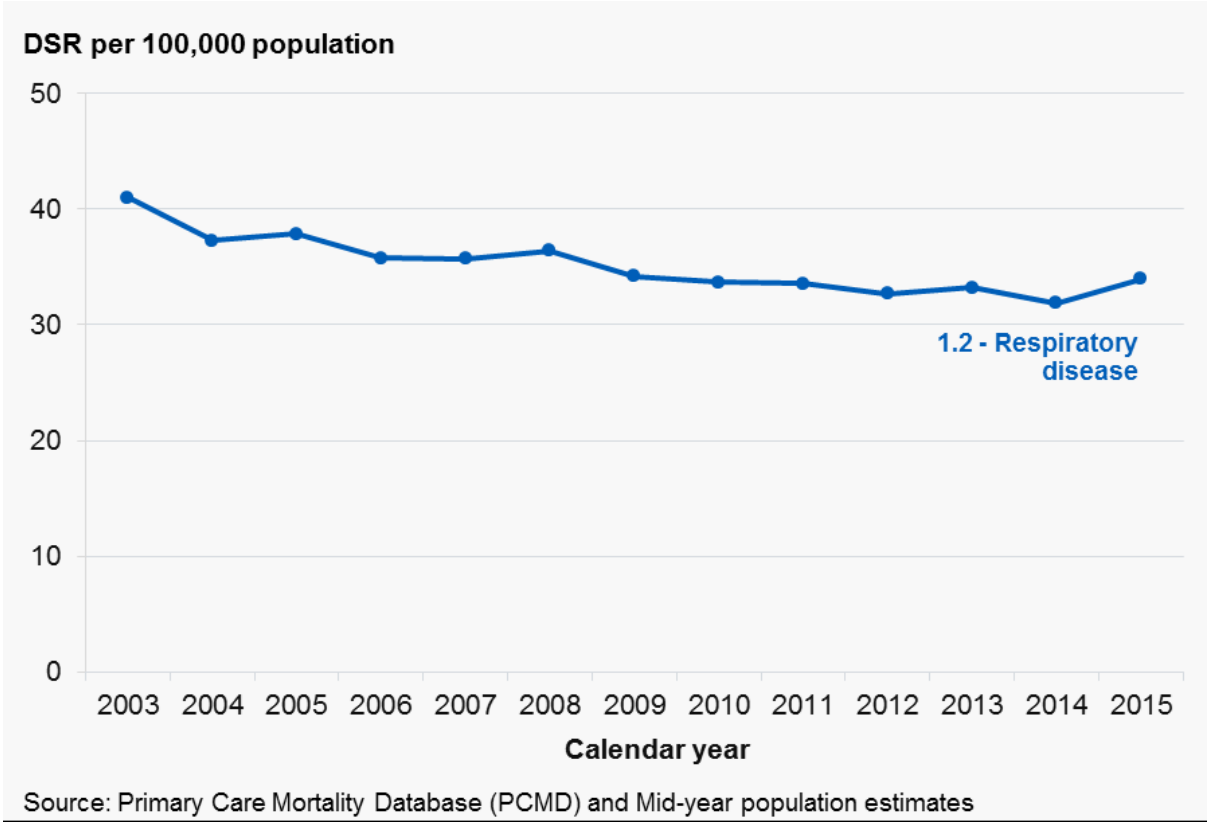
Respiratory

22. Respiratory illness affects one in five people in the UK, is responsible for around a million hospital admissions and is the third biggest cause of death in the UK. In 2010, the UK had a higher rate of respiratory deaths than any other country in the OECD and the highest prevalence of asthma in the world at around 9-10% of the adult population. The last update provided an explanation for this in terms of coding.

23. Currently, over 1 million people are diagnosed with chronic obstructive pulmonary disease (COPD) with an estimated further 1 million living with the condition while undiagnosed. COPD causes over 100,000 emergency admissions and 20,000 deaths each year. 10% of emergency admissions for COPD are in people whose condition is undiagnosed. There are around 1,000 asthma deaths a year in the UK - around 90% of which are avoidable. 5.4 million people are currently receiving treatment for asthma.

24. Whilst the graph below shows a significant reduction in deaths from respiratory disease since 2003, there was a significant increase for the first time in 2015. Chronic obstructive pulmonary diseases (COPD) such as bronchitis and emphysema were the biggest causes of death within the respiratory disease category in 2015 for individuals younger than 75 years old. The Office for National Statistics data for England and Wales show that there were 4,770 COPD deaths for males and 4,099 COPD deaths for females in this age group in 2015. This accounts for 53 per cent of the total deaths within the respiratory category for that year. The significant increase in deaths in this period could be a reflection of an increasingly aging and frail population more vulnerable to respiratory disease as well as an increase in the number of deaths from flu.

Under 75 mortality rate from respiratory disease by year 2003 to 2015



25. The 2016/17 mandate to NHS England contains objectives aimed at reducing premature mortality which includes respiratory illness. This is complemented by the NHS Outcomes Framework 2016/17 which sets out the Department's priority areas for the NHS and includes reducing deaths from respiratory disease as a key indicator. It also highlights the need to reduce unplanned hospital admissions due to asthma.

26. In July 2016, Public Health England launched a national campaign focusing on the key respiratory symptoms of a persistent cough and inappropriate breathlessness. The campaign encouraged people with these symptoms to see their doctor. As well as tackling premature mortality, earlier diagnosis can help with the management of conditions such as chronic obstructive pulmonary disease (COPD) thereby improving the quality of life for people living with them.

27. The National Institute for Health and Care Excellence (NICE) has published quality standards for both COPD (QS10, July 2011 which was updated February 2016) and asthma (QS25, February 2013) setting out the markers of high quality, cost effective care. Implementation of the NICE quality standards aim to raise the standard of care people with these conditions receive. NICE has also published quality standards on idiopathic pulmonary fibrosis (QS79, January 2015) and pneumonia (QS110, January 2016). It is also developing clinical guidelines on asthma diagnosis and monitoring, management of asthma and is due to review its COPD guideline in the near future.

Northern Ireland

28. During 2013 to 2015 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		
	2013	**2014**	**2015**
Circulatory Diseases	26.1%	25%	24%
Respiratory diseases	14.1%	14%	14%
Cancers	28.2%	29%	28%
External Causes (e.g. accidents, suicide, assault)	4.9%	5%	5%
Source : NISRA Website			

29. Northern Ireland has an overall mortality rate that is higher than that in England and Wales, but lower than in Scotland[2]. Circulatory disease, cancer and respiratory disease continue to be the main causes of death among both sexes. They accounted for almost three-quarters of all deaths in Northern Ireland in 2015*.

30. *NISRA Website

31. 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 29 per cent of the total deaths and discharges in acute hospitals in Northern Ireland.

32. Hospital Inpatient Activity: 2011/12 – 2014/15

Activity Type	**Proportion of Total Deaths and Discharges**			
	2011/12	**2012/13**	**2013/14**	**2014/15**
Coronary Heart disease	1.9%	2.1%	2.3%	2.1%
Cancer	8.4%	8.6%	8.7%	9.2%
Diabetes	0.6%	0.6%	0.3%	0.3%
Renal Failure	16.9%	17.0%	16.2%	15.3%

England

Cancer

33. Over 250,000 people in England are diagnosed with cancer every year and around 130,000 die from the disease. Currently, about 1.8 million people are living with and beyond a cancer diagnosis. Despite improvements in survival and mortality in recent decades, cancer outcomes in England remain poor when compared with the best outcomes in Europe. Although improvements have been made in the quality of cancer services, a significant gap remains in both survival and mortality rates. To put this in context, if England was to achieve cancer survival rates at the European average, then 5,000 lives would be saved every year. If England were to achieve cancer survival rates at the European best, then 10,000 lives would be saved every year.

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35. *Improving Outcomes: A Strategy for Cancer*[3], published on 12 January 2011, updated the *Cancer Reform Strategy* which was published in 2007. The Strategy set out actions to tackle preventable cancer incidence, improve the quality and efficiency of cancer services; improve patients' experience of care; improve quality of life for cancer survivors; and deliver outcomes that are comparable with the best in Europe.

36. The Strategy was backed with more than £750 million over the Spending Review period including over £450 million to achieve early diagnosis through:

- enabling improved GP access to key diagnostic tests;
- allowing for the increased testing and treatment costs in secondary care associated with more people being diagnosed;
- supporting campaigns aimed at raising awareness of the signs and symptoms of cancer and getting symptomatic patients to present earlier; and
- supporting GPs to diagnose cancer earlier, including support on when to commission and how to interpret diagnostic tests.

37. Other plans outlined in the Strategy include:

- improving the information available to patients and commissions;
- reducing regional variation in access to treatment;
- ensuring payments incentivise high quality, cost-effective services, including the development of tariffs for chemotherapy and radiotherapy;
- piloting a national cancer survivorship survey and data collection on the number of women with secondary breast cancer;
- implementing HPV testing as triage for women with mild or borderline cervical screening test results; and
- supporting cancer research through funding a policy research unit on Cancer Awareness, Screening and Early Diagnosis.

38. Progress on implementation of the cancer strategy is measured through the IOSC annual reports. The first annual report highlighted progress made, including:

- improvements in the data and analyses that support clinicians, commissioners, providers and patients;
- commencing the extension of the age range for bowel and breast cancer screening;
- progress in introducing a flexible sigmoidoscopy bowel screening programme;

3 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123394.pdf

- successful public awareness campaigns;
- surgical training programmes on laparoscopic colorectal cancer and low rectal cancer; and
- continued improvement in patient care pathways.

Access to Primary Medical Services

39. The Government is committed to improving access to GP services as part of our plan for a seven day NHS. Achieving improved access not only benefits patients but also has the potential to create more efficient ways of working, which benefits GPs and practice staff. GP Access Fund schemes are testing improved and innovative access to GP services. A wide variety of approaches are being tested through the Access Fund, including: longer opening times at evenings and weekends; better use of telecare and health apps; more innovative ways to access services by video call, email or telephone; and developing more integrated services with a single point of contact to co-ordinate patient services.

40. The GP contract agreement for 2014/15 brought in a measure allowing GP practices to register new patients from outside their traditional boundary areas without a duty to provide home visits for such patients, as they previously had to. This measure is designed to increase flexibility in the system and increase the freedom that patients have to choose a GP practice that suits them – for example, for commuters who may wish to register with a practice close to their work, as opposed to where they live, or to allow for continuity when patients move house. All NHS England regional teams have arrangements in place to ensure that those patients are able to access services in hours should they require primary medical care if they are unwell whilst at their home address.

41. 111 is a free telephone number for urgent healthcare needs. The NHS 111 service is available across England, with similar arrangements in the devolved administrations. NHS 111 health advisors assess people's symptoms, give them the healthcare advice they need or direct them to the local service that can help them best. NHS111 is available 24 hours a day, 365 days a year. In England, the Government is moving towards arrangements where an increasing number of patients will speak directly to a relevant healthcare professional during their initial call and NHS 111 advisors will be able to book appointments with some healthcare services directly for callers. An online NHS 111 service is also being developed, which will allow users to complete a clinical assessment online, and connect them to an appropriate healthcare service.

42. NHS Walk-in Centres and urgent care centres are local facilities where no appointment is necessary – offering quick access to a core range of NHS services, including advice, information and treatment for a range of minor injuries and illnesses. These are largely staffed by nurses, though a significant number also 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.

Scotland

43. The Scottish Government is committed to a vision of a modern Primary Care and GP service with more GPs working in Scotland as part of multi-disciplinary teams, alongside nurses, pharmacists, optometrists and other allied health professionals to support patients to live well in their communities, and allow them to access the right person at the right time.

44. The recent 2015/16 Health and Care Experience Survey has shown an overall positive picture for access to GPs. Over 90 per cent of General Practice patients said they were able to see or speak to a doctor or nurse within two working days of requesting an appointment, with an increase in the number of respondents happy with their GP opening hours.

45. However we recognise that there is more work to do to support GP services. In March this year the Cabinet Secretary announced a further £20 million package - in addition to the £85 million Primary Care Fund - to ease short term pressures on GPs and improve access over the next year.

46. Through the £6 million Digital Services Development Fund (part of the £85 million Primary Care Fund) we are supporting the uptake of technology to support access, such as greater online presence for booking appointments and scheduling repeat prescriptions, to free up time to allow GP's to treat patients.

Northern Ireland

47. In Northern Ireland the system is different. Patients can only receive treatment if they are registered with a GP and to be registered with a GP the patient must be 'ordinarily resident' in Northern Ireland. This means that to be registered as a patient they must reside here lawfully and on a continuous and settled basis with an identifiable purpose for their residency. The GP does not have discretion to register a patient. Checks on whether someone is 'ordinarily resident' are carried out by the Business Services Organisation.

48. Emergencies and treatment that is immediately necessary (i.e. treatment that cannot reasonably be delayed), will be provided free of charge by a GP to a person regardless of whether the person is registered or not. It should also be noted that neither NHS Direct nor NHS Walk-in centres exist in Northern Ireland.

Preventative Measures

Immunisation

49. The position remains largely as previously described.

50. Responsibility for delivery of national immunisation programmes rests with a number of organisation, as set out below:

- The Department of Health is responsible for national strategic oversight and policy
- Public Health England (PHE) is responsible for planning & implementation (including procurement of vaccines) and specialist advice
- NHS England is responsible for commissioning programmes under the terms of the Section 7A agreement

51. The vaccination programme in the UK is constantly evolving, and takes account of the recommendations of the Joint Committee on Vaccination & Immunisation (JCVI). Key developments over the past few years include:

- The MenACWY immunisation programme was introduced in August 2015 to immunise all teenagers in school years 9 to 13 before they complete academic year

13. This is being done by replacing the routine adolescent MenC booster given in years 9 or 10 with the MenACWY vaccine. There have also been a series of GP based catch-up campaigns targeting older teenagers attending higher or further education settings after leaving school as well a time-limited 'freshers' programme aimed at older students aged up to 25 in university.

- The introduction of the MenACWY vaccination programme for teenagers and adolescents was in response to the rising number of MenW cases.
- Since September 2015, Men B vaccine (Bexsero®) has been routinely offered to infants in the UK, following JCVI advice. The programme is a 3 dose course offered at 8 weeks (2 months) and 16 weeks (4 months) with a booster dose at 12 months. It is targeted at infants as they are at highest risk.
- The UK is the first – and so far only – country to have a national and publicly funded MenB vaccination programme using this vaccine.
- In 2012, the JCVI recommended that the seasonal flu immunisation programme be extended to include children between the age of 2-17 years, starting with the youngest children. In 2016/17 the vaccine will be offered to all children between the age of 2-7 years. The vaccine offers important protection not only to the child, but also prevents the child passing the virus on to their family and the wider community.

Vaccination coverage

52. Uptake of most vaccination programmes is high. The latest annual vaccination coverage statistics for England for 2015-16 is available at: http://content.digital.nhs.uk/catalogue/PUB21651

53. In relation to the childhood flu vaccination programme, data from pilot sites in 2014/15 show that the childhood live attenuated influenza vaccine (LAIV) nasal spray has been effective both in protecting the children themselves and their communities from flu.

54. NHS England and PHE work together to identify and reduce variation in uptake levels, and when appropriate local areas will commission targeted services for populations that are less able to access mainstream GP services.

Mental Health Services

55. NHS England stated that in 2014/15 mental illness was the single largest cause of disability in England, costing the economy roughly the same as the NHS[4]. 1 in 4 people are estimated to have a mental health condition. We are implementing an ambitious programme to transform mental health services.

[4] NHS Annual report – 2014-15.
[2] Closing the Gap: Priorities for essential change in mental health' https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf
[3] Better Access to Mental Health by 2020' https://www.gov.uk/government/publications/mental-health-services-achieving-better-access-by-2020
[4] Future in Mind – children and young people mental health' https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people
[5] Five Year Forward View for Mental Health' https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

56. In 2012 a cross-Government Suicide Prevention Strategy was launched, with "zero suicide" pilots to set a vision that suicide is not inevitable. The strategy will be developed further to meet Taskforce recommendations and reduce the national suicide rate by 10% by 20/21.

57. In 2014, 'Closing the Gap: Priorities for essential change in mental health'[2] set out 25 commitment for addressing gaps and inequalities in mental health, mostly achieved under the coalition government.

58. In 2014 'Better Access to Mental Health by 2020'[3] set out commitment to introduce first ever waiting times for mental health. The Improving access to Psychological Therapies target was met in April 2016. Also in 2014 the Crisis Care Concordat Set out commitment to work together to ensure that people experiencing a mental health crisis receive the right care and support. All local areas now have a local plan.

59. In 2015 'Future in Mind – children and young people mental health'[4] set out the strategy for improving children and young people's mental health.

60. In 2016, the 'Five Year Forward View for Mental Health'[5] by the Independent Mental health Taskforce set out visions for transforming mental health services by 2020/21 through 58 recommendations for improvement. The government welcomed the publication of the Five Year Forward View for Mental Health which will ensure additional investment of £1bn by 2020/21 and an extra 1m people have access to mental health services.

Scotland

61. The Scottish Government's Mental Health Strategy for Scotland: 2012-2015 set out a range of key commitments across the full spectrum of mental health improvement, services and recovery to ensure delivery of effective, quality care and treatment for people with a mental illness, their carers and families. Acknowledging that mental illness is one of the top public health challenges in Europe. This new Strategy brings our mental health improvement work and work to improve mental health services together for the first time in a single strategy. The strategy sets out plans to work together with our partners to respond to the ongoing challenge of improving mental health and wellbeing and ensuring improved services and outcomes for individuals and communities over the period to 2015.

62. The Strategy supports and adopts the 3 Quality Ambitions for Scotland that health and care is person centred, safe and effective. These are reflected in the 7 key themes applicable across the whole Strategy; and the 36 specific commitments to be delivered over the period to 2015 and which cover the full spectrum of mental health improvement, prevention, care, services, and recovery.

63. Progress updates on the Mental Health Strategy are available on the Scottish Government's website and the next Mental Health Strategy will build on the previous strategy and be the centrepiece for this Government's focus on improving Mental Health. We will publish the next Strategy later this year.

Wales

64. In November 2011 the Welsh Government issued *Together for Health*. This document sets out how the Government aims to improve health and health services for the

people of Wales through to 2016 and beyond, building on and complementing the actions set out in its *Programme for Government*.

65. Building on this, a number of major health condition delivery plans were published e.g. heart disease, cancer, diabetes, stroke, neurological conditions, respiratory, liver disease, critically ill and end-of-life care and are reported on annually. Six of these plans will be refreshed in 2016.

66. The national population bowel screening policy in Wales is based on advice from the UK National Screening Committee (UK NSC). The UK NSC provides independent advice to all UK Ministers on screening, advising that programmes are only offered where there is robust, high quality evidence that screening will do more good than harm

67. The national population screening programmes specifically targeted at all children in Wales include:

- Antenatal screening (screening for fetal anomalies, sickle cell disease, thalasseamia, hepatitis B, HIV and syphilis).
- Newborn and Infant Physical Examination (screening for congenital heart disease, congenital cataracts, congenital hip dysplasia and undescended testicles in newborn babies).
- Newborn Hearing screening (screening for moderate, severe and profound hearing impairment in newborn babies).
- Newborn Bloodspot screening (screening for rare but serious diseases - congenital hypothyroidism, cystic fibrosis, medium-chain acyl-CoA dehydrogenase deficiency, phenylketonuria, sickle cell disease, maple syrup urine disease, homocystinuria, glutaric aciduria type 1 and isovaleric acidaemia).
- Hearing impairment screening in school age children.
- Vision defects screening in school age children.
- Child measurement screening in school age children.
- Diabetic retinopathy screening in children with diabetes aged 12 and over.

68. The national population screening programmes specifically targeted at adults in Wales include:

- Breast cancer screening (screening for early signs of disease in women aged 50-70). Wales was the first fully digitalised service in the UK (completed in December 2012).
- Cervical cancer screening (screening for abnormalities in the cervix in women aged 25-64 years old).
- Bowel cancer screening (screening for early signs of disease in both men and women aged 60-74 years of age).
- Abdominal Aortic Aneurism screening (screening for aneurisms in men aged 65).
- Diabetic Retinopathy screening (screening for sight threatening retinopathy in all men and women with diabetes).

Health professionals

69. The health care workforce statistics are published as provisional experimental statistics by NHS Digital. These statistics are published bi-annually and the first set of data using the new methodology was published for Sept 2015.

	March 2016 FTE
Total NHS sector	1,186,226
Of which:	
HCHS staff in NHS Trusts and CCGs	1,027,100
HCHS staff in Support orgs and central bodies	33,774
General practice workforce (1)	125,352
Independent Healthcare workforce	41,573

Notes:

Source NHS Digital Healthcare Workforce statistics

(1) Totals include estimated figures for practices which did not provide a submission. The proportion of practices which did not provide a submission was 7.3% in March 2016

Scotland

70. The latest release of Statistical information on NHS staffing in Scotland as at 6 September 2016 has information on staff in post across all NHS staff groups. The statistics cover: Overall staff and Turnover; Medical and dental; Nursing and midwifery; Allied health professions; other therapeutic staff and personal social care; Healthcare science staff; and all other staff.
https://www.isdscotland.org/Health-Topics/Workforce/Publications/2016-09-06/2016-09-06-Workforce-Report.pdf

Northern Ireland

71. The population of Northern Ireland in 2015 was 1,851,621. In September 2015 there were 5,697 doctors/dentists (excluding GP retainers and GDPs) in the NHS. This included: 1,704 consultants; 520 SAS grade doctors, 1,363 registrars (including GP trainees); 547 other doctors in training; 1,274 GPs; and 289 other medical & dental staff.

72. The number of doctors/dentists (excluding GP retainers and GDPs per 100,000 of population is 308. The number of qualified nurses (including Trust employed practice nurses only) per 100,000 of population is 849. Please note that this is not comparable with England because of the integration of social services and health in Northern Ireland. The number of General Dental Practitioners per 100,000 of population at 2011 was 57.

Wales

73. Information on NHS staffing in Wales can be found at:
http://gov.wales/docs/statistics/2016/160330-staff-directly-employed-nhs-30september-2015-en.pdf

Pharmacies

74. Statistical information on pharmacy provision in England and Wales can be found at: https://www.gov.uk/government/statistics/general-pharmaceutical-services-20067-to-201516 (England)

75. Community Pharmacy in Wales:
http://gov.wales/statistics-and-research/community-pharmacy-services/?lang=en

Health Care Spending

76. Information on UK healthcare expenditure has been produced by the Office for National Statistics and covers the period 1997 to 2014 (released 19 May 2016). The data has been produced according to the System of Health Accounts 2011 (SHA 2011), which provides internationally standardised definitions both for total current healthcare expenditure and the analysis of this spending by financing scheme, function and provider organisation.

77. The SHA 2011 definitions have been developed by the Organisation for Economic Co-operation and Development (OECD), Eurostat – the statistical office of the European Union, and the World Health Organisation (WHO), and will be used to measure healthcare expenditure by almost all OECD and European Economic Area (EEA) member states from 2016. Full details are set out at https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/ukhealthaccounts/2014#appendix-2-data-from-the-expenditure-on-healthcare-in-the-uk-series-1997-to-2014

Northern Ireland

78. Table 1 – Staff information provided from HRPTS for qualified nurses, nurse support, midwives, hospital medical staff and hospital dental staff.

	Headcount of staff per 1,000 population			
Staff Groups	**30th September 2012**	**30th September 2013**	**30th September 2014**	**30th September 2015**
Qualified nurses	8.21	8.32	8.42	8.49
Nurse support	2.53	2.56	2.53	2.54
Midwives (Band 6+)	0.69	0.69	0.68	0.66
Hospital & Community Medical Staff	2.12	2.12	2.14	2.17
Hospital & Community Dental Staff (excluding general dental practitioners)	0.10	0.10	0.11	0.10

Source: HRMS. Figures exclude bank staff, staff on career breaks and staff with a whole-time equivalent less than or equal to 0.03 and GP Registrars.

79. Table 2 - Staff information sourced from Business Services Organisation for general medical practitioners and general dental practitioners

	Number of staff per 1,000 registered population at October each year			
Staff Groups	2012	2013	2014	2015
General medical practitioners	0.64	0.64	0.66	0.69
General dental practitioners	0.57	0.57	0.57	0.57

Source: Business Services Organisation

Infant mortality

80. The infant mortality rate in the United Kingdom has continued to fall, from 4.6 per 1,000 live births in 2008 to 3.7 in 2014.

Infant mortality rate (deaths per 1,000 live births)

Year	United Kingdom	England	Wales	Scotland	Northern Ireland
2008	**4.6**	**4.6**	**4.0**	**4.2**	**4.7**
2009	**4.5**	**4.5**	**4.7**	**4.0**	**5.1**
2010	**4.3**	**4.2**	**3.9**	**3.7**	**5.7**
2011	**4.2**	**4.2**	**3.7**	**4.1**	**4.3**
2012	**4.0**	**4.0**	**3.9**	**3.7**	**3.5**
2013	**3.8**	**3.8**	**3.6**	**3.3**	**4.6**
2014	**3.7**	**3.6**	**3.2**	**3.6**	**4.8**

Source: ONS Childhood, Infant and Perinatal Mortality Statistics

Perinatal mortality rate

81. The perinatal mortality rate has fallen gradually from 7.5 deaths per 1000 live & still births in 2008 to 6.6 in 2014.

Perinatal mortality rate (deaths per 1,000 total births)

Year	United Kingdom	England	Wales	Scotland	Northern Ireland
2008	**7.5**	**7.5**	**6.7**	**7.4**	**7.5**
2009	**7.6**	**7.5**	**7.5**	**7.4**	**8.0**
2010	**7.4**	**7.4**	**7.4**	**6.9**	**8.0**
2011	**7.4**	**7.5**	**6.6**	**6.9**	**6.4**
2012	**6.9**	**6.9**	**7.2**	**6.5**	**6.4**
2013	**6.7**	**6.7**	**6.2**	**5.8**	**7.5**
2014	**6.6**	**6.6**	**7.0**	**5.9**	**6.6**

Source: ONS Childhood, Infant and Perinatal Mortality Statistics

Pregnant women, mothers and babies

Maternal mortality

82. The maternal mortality rate in the United Kingdom has fallen from 13.95 deaths per 100,000 maternities in 2003-05 to 9.02 in 2011-13.

Maternal mortality rate (deaths per 100,000 maternities)

Year	United Kingdom	Direct Deaths	Indirect deaths
2003-05	**13.95**	**6.24**	**7.71**
2004-06	**12.56**	**5.45**	**7.11**
2005-07	**11.66**	**5.09**	**6.57**
2006-08	**11.39**	**4.67**	**6.72**

2007-09	**10.89**	**4.33**	**6.56**
2008-10	**11.03**	**3.76**	**7.27**
2009-11	**10.63**	**3.49**	**7.15**
2010-12	**10.12**	**3.25**	**6.87**
2011-13	**9.02**	**2.91**	**6.11**

Source: Saving Lives, Improving Mothers' Care 2015, MBRRACE-UK

83. The Department of Health has made improving the safety of maternity services a priority. In November 2015 the Secretary of State for Health announced the Government's national ambition to reduce the rates of stillbirths, neonatal deaths, maternal deaths and brain injuries that occur during or soon after birth by 50% by 2030; and 20% by 2020. The Government pledged to work with top consultants, midwives and other experts both across this country and internationally to ensure we apply the very best practice consistently across the NHS.

84. To support the NHS in achieving this stretching ambition, the Government also committed to invest:

- £1.4million to roll out training programmes to make sure staff have the skills and confidence they need to deliver world-leading safe care;
- £2.24 million to support trusts to buy monitoring or training equipment to improve safety in their maternity services; and
- £500,000 to develop a new standardised perinatal mortality review tool which will be used consistently across the NHS so staff can review and learn from every stillbirth and neonatal death.

85. The Government also committed to work with Sign up to Safety – a national patient safety campaign launched in 2014. In March 2016, a Sign up to Safety sub-brand 'Spotlight on Maternity' was launched. New guidance asked all organisations with maternity services to contribute towards achieving the Government's national ambition and improve maternity outcomes.

86. In February 2016, the independent National Maternity Review[5], led by Baroness Cumberlege published *Better Births* which made wide-ranging proposals to make care safer and give women greater control. The report's vision is for maternity services across England to become safer, more personalised, kinder, professional and more family friendly. The report's seven key priorities are:

- Personalised care which is centred on the woman, her baby and her family
- Ensuring continuity of carer
- Safer care, with professionals working together across boundaries and learning when things go wrong
- Better postnatal and perinatal mental health care
- Multi-professional working, breaking down barriers between midwives, obstetricians and others
- Increased working across geographical boundaries
- A reformed payment system

87. In July 2016, the Maternity Transformation Programme (MTP) was launched to deliver the vision and recommendations set out in *Better Births* and the national ambition.

[5] It was commissioned by NHS England to review maternity servies under the *NHS Five Year Forward View* (2014) www.england.nhs.uk/ourwork/futurenhs/

The MTP is led by NHS England and comprised of nine national work streams for England which are designed to facilitate local change – they are being led as follows:

(1) Supporting Local Transformation – NHS England
(2) Promoting good practice for safer care – Department of Health
(3) Increasing Choice and Personalisation – NHS England
(4) Improving access to perinatal mental health services – NHS England
(5) Transforming the workforce – Health Education England
(6) Sharing data and information - NHS England
(7) Harnessing digital technology – NHS Digital and NHS England
(8) Reforming the payment system – NHS England & NHS Improvement
(9) Improving prevention – Public Health England

88. A national Board oversees the MTP and is independently chaired by Sarah-Jane Marsh, CEO of Birmingham Children's Hospital and Birmingham Women's Hospital. A Stakeholder Council, led by Baroness Cumberlege, has been established to enable stakeholders to influence and contribute to the MTP by scrutinizing its work and providing advice and constructive challenge.

89. The Department of Health is leading work stream (2) - 'Promoting good practice for safer care' but responsibility will transfer to NHS Improvement in April 2017.

90. In October 2016 the Department of Health launched the *Safer Maternity Care Action Plan* with a further package of measures to help achieve the ambition. The Plan has actions for organisations, multi-disciplinary teams and individuals at every level of the health system, and they are specified for each of the five key drivers for delivering safer care that were set out in the guidance document 'Spotlight on Maternity' in March 2016:

- Creating strong leadership for maternity systems at every level
- Identifying and sharing best practice, and learning from investigations
- Prioritising and investing in the capability and skills of the maternity workforce
- Improving data collection
- Focusing on innovation

91. The plan details the actions needed at national and local levels that will build on the progress we have already made to improve the safety of maternity services. New initiatives include:

- An £8 million Maternity Safety Training Fund to support maternity services to drive improvements in safety. The funding can be used to pay for evidence-based multi-disciplinary training courses for local maternity teams. Health Education England has publishing a new national catalogue of approved Maternity Safety training programmes developed with partners and led by the Royal College of Obstetricians and Gynaecologists.
- A new £250,000 Maternity Safety Innovation Fund to support development and implementation of the best and the brightest ideas to drive improvements in maternity safety.
- Maternity ratings for clinical commissioning groups across England will be published to benchmark local areas, help identify those areas needing improvement and examples of the best practice
- A new national Maternity Safety Quality Improvement Programme that will regularly bring clinicians and commissioners together with national and international experts to work collaboratively to continuously learn, plan, test and assess steps to improve safety in maternity services.

- A consultation to develop a 'safe space' to allow clinicians to speak openly about things that go wrong without fear that information they disclose may be used against them in court or professional misconduct hearings
- The appointment of two National Maternity Safety Champions. They will lead the way by working across professional groups and system boundaries to maintain a continuous emphasis on high quality, safe maternity care for women and new-borns.
- The launch of the 'Our Chance' campaign in partnership. The campaign will support women and their families to have a healthy pregnancy and raise awareness of stillbirth, by giving information on warning signs to look out for and providing advice on immunisation, maternal mental health and when to get help from their midwife.

92. There will also be a consultation on a new rapid resolution and redress (RRR) scheme. The RRR scheme could investigate and learn lessons from more than 500 incidents a year. In cases where harm was avoidable this would offer timely access to financial support without the current obligation on families to launch a formal legal process. At present, the average time families have to wait for resolution of a case is 11.5 years. Eligible families would be given the option to join an alternative system of compensation that offers support and regular payments without the need to bring a claim through the courts and the scheme would ensure families receive personalised support including counselling, case management and legal advice. A similar scheme operating in Sweden has reduced serious avoidable birth injuries by around 50% in the last 6 to 7 years.

93. The Department has commissioned the National Institute for Health and Care Excellence (NICE) to issue clinical guidelines (evidence based recommendations on the appropriate treatment and care of people with specific diseases and conditions within the NHS) on the following:

- **Induction of labour June 2001, updated September 2016**. 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**. The guideline 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) to help prevent Haemolytic disease of the newborn, which in severe cases can result in stillbirth, severe handicap or neonatal death.
- **Routine antenatal care for the healthy pregnant woman March 2008 updated March 2016**. The guidelines provide national 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.
- **Caesarean Section April 2004 updated August 2012**. This guideline has been developed to enable healthcare professionals to give appropriate research-based advice to women and their families. This will enable women to make properly informed decisions. The guideline has not sought to define acceptable caesarean section rates.
- **Postnatal care July 2006 updated October 2016**. 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.
- **Antenatal and Postnatal Mental Health clinical management and service guidance December 2014 updated June 2015**. These 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 December 2014 updated November 2016.** This guideline provides best practice advice on the care of healthy women in labour at term (37 – 42 weeks) and their babies.
- **Diabetes in Pregnancy May 2011 updated November 2016**. This guidance encompasses the management of diabetes and its complications from pre-conception to the postnatal period.
- **Diabetes in pregnancy Quality standard updated January 2016** which covers managing diabetes and its complications in women (all females of childbearing potential) who are planning a pregnancy and women who are already pregnant. It also covers areas in which additional or different care should be offered to women with diabetes and their newborn babies.
- **Care of pregnant women with complex social factors updated November 2016.** This guideline covers the management of pregnant women who have complex social factors.
- **Multiple pregnancy November 2011 updated September 2016.** This guideline covers the management of twin and triplet pregnancies in the antenatal period. Multiple pregnancy is associated with higher risks for the mother and babies, with maternal mortality associated with multiple births being 2.5 times that for singleton births.

Choice

94. It is important for all women to be able to give birth in a safe, high quality environment that is best suited for them. Women have told us that choice of place of birth is one of the most important choices for them to make during their pregnancy. We want as many women as possible to give birth in a place of their choice and to have the best start to family life. We want to ensure that women make informed and safe choices about where they have their baby. Clinicians should discuss with women the various options available and any associated risks in order to help them make an informed choice. Women should always receive excellent maternity services, regardless of where they give birth.

95. The NHS England mandate includes an objective to work with its system partners to ensure that the NHS offers women the greatest possible choice of providers; ensures every woman has a named midwife who is responsible for ensuring she has personalised, one-to-one care throughout pregnancy, childbirth and during the postnatal period, including additional support for those who have a maternal health concern; and reduces the incidence and impact of postnatal depression through earlier diagnosis, and better intervention and support.

96. The DH-funded Birthplace in England study (2011) showed that for low risk pregnancies, babies born at midwife-led units or at home (for second or subsequent pregnancies) did as well as babies born in obstetric units, with fewer interventions. First-time mothers are advised to plan to give birth in a midwife-led unit or a consultant-led unit. The Birthplace Study found that for first-time low-risk pregnancies, home birth has a significantly increased risk of poor outcomes for the baby and transfer rates to hospital are high.

97. **The NHS Choice Framework for 2016-17** sets out the choices of place of birth. When a woman gives birth they should have the choice to do so:

- at home, with the support of a midwife
- in a midwife-led facility (for example, a local midwife-led unit in a hospital or birth centre), with the support of a midwife
- in hospital with the support of a maternity team. This type of care will be the safest option for some women and their babies.

98. **NHS England is leading work stream (3) of the MTP 'Increasing Choice and Personalisation'**, which is working with Maternity Choice and Personalisation Pioneers to test new approaches to widen and deepen choices available for women.

99. In March 2016, CCGs were invited to express their interest in working with neighbouring CCGs to test ways of improving choice and personalisation for women accessing maternity services. A panel selected seven Maternity Choice and Personalisation Pioneers.

100. The Pioneers' scale, geographical spread, mix of urban and rural localities, and ambition – including their enthusiasm to work collaboratively both locally and nationally – provide a strong foundation for demonstrating how choice and personalisation can be improved for women accessing maternity services.

101. All of the Pioneers will seek to deepen and widen the choices available to women across CCG boundaries, by attracting new providers into their areas and by empowering women to take control in decisions about the care they receive to meet their needs and preferences. NHS England and other national partners will support and work with the Pioneers to develop and test new approaches, and promote their national adoption.

Early Access

102. Early access to antenatal care promotes greater choice for women and ensures they receive the right care at the right time, helps tackle the negative impact of health inequalities from the start of life and supports good health and well-being in mother and baby.

103. As soon as they know they are pregnant, women are encouraged to contact their maternity service for a full assessment of their health, risk factors and choices so that a personalised plan of care can be prepared. Women can choose to initially contact a midwife directly or their GP for advice about developing healthy lifestyles, exercise, and taking folic acid supplements. Women with complex social factors (e.g. teenagers and those form disadvantaged groups) do not always access maternity services early, or attend regularly for antenatal care and poorer outcomes are consequently reported for mother and baby - maternity services need to be proactive in engaging all women.

104. Pregnant women with complex social factors may need additional support to use antenatal care services. The NICE clinical guideline on 'Pregnancy and complex social factors' (2010) describes how access to care can be improved, how contact with antenatal carers can be maintained, the additional support and consultations that are required and the additional information that should be offered to pregnant women with complex social factors.

Sick and preterm babies

105. The care of 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. To provide safe and effectives care, neonatal services in England are organised within 23 neonatal managed clinical networks. Within each network, some hospitals are specially equipped to provide intensive care for the sickest and smallest babies, with other hospitals providing high dependency and special care as close to home as possible.

106. Two evidence-based documents have been published – the NHS *Toolkit for High Quality Neonatal Services* in 2009 and the NICE *Quality Standard for specialist neonatal care* published in 2012 and updated in January 2016 - to help health service commissioners and providers ensure they are providing safe, high quality care for sick and premature babies and their families.

Perinatal mental health

107. Perinatal mental illness is one of the leading causes of death for mothers during pregnancy and the year after birth. We know that between 10 and 20 per cent of women develop a mental illness during pregnancy or within the first year after giving birth, and four in every 1000 women will experience complex or severe perinatal mental illness requiring psychiatric in-patient care in a specialist mother and baby units.

108. There is widespread agreement about 'what good looks like' in perinatal mental health. We know what services are needed and how they should be organised. To ensure that these services are developed and women have access to the right care at the right time and close to home, the Government has committed to invest a total of £365 million from 2015/16 to 2020/21. NHS England has started work to expand perinatal mental health networks across the country.

109. These networks, recommended by the National Institute for Health and Care Excellence (NICE), play a key role in sharing good practice and identifying care pathways for women in a local area, supporting all health professionals involved in caring for women during pregnancy and after birth.

Investment in maternity services

110. NHS England has estimated that the total NHS cost for delivering maternity services in 2013/14 was £4.7bn, compared to £2.5 billion in 2010-11.

Wales

111. In Wales, annual maternity performance boards are held, chaired by the Chief Nursing Officer, to monitor progress on the actions from the strategy. National performance indicators and outcome measures have been set to aid performance improvement.

Access to care

Waiting times

112. An NHS Constitution establishes the principles and values of the NHS in England. It states that patients "have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible." The two waiting time rights, set out in the Handbook to the NHS Constitution, are:

- to start consultant-led treatment within a maximum of 18 weeks of referral for non-urgent conditions; and
- to be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected.

113. The NHS Constitution also commits that the NHS will "provide convenient, easy access to services within the waiting times set out in this Handbook to the NHS Constitution." Pledges set out what the NHS is committed to achieve, they are not legally binding and cannot be guaranteed for everyone all of the time. These waiting times pledges are described in the Handbook to the NHS Constitution and cover cancer, diagnostic tests, accident and emergency and ambulance response times.

114. Waiting time rights and pledges are not expected to be met for every NHS patient. At any one time, there will be patients that choose to delay their treatment, that do not co-operate by attending appointments they have agreed, or that it would be clinically inappropriate to treat within the maximum waiting time.

115. To account for this, NHS England publishes operational standards in the form of percentage thresholds that set an expected level of performance. These are the minimum performance levels that the NHS is expected to meet operationally in order to deliver its commitments to patients. The key standards are:

- 95% of patients to be admitted, transferred or discharged within four hours of arrival in all types of accident and emergency department
- 92% of patients waiting to start consultant-led treatment for non-urgent conditions to be waiting within 18 weeks
- 93% of patients to see a specialist for suspected cancer within two weeks from urgent GP referral
- 85% of patients to begin first definitive treatment for all cancers within 62 days from urgent GP referral
- 99% of patients to be waiting within six weeks from referral for a diagnostic test.

116. Rising demand from a growing and ageing population has made achievement of these standards more challenging in recent years. As at September 2016, the waiting time standards for four hour accident and emergency waits, 18 weeks from referral-to-treatment, 62 days to start of cancer treatment, and six weeks for diagnostic tests were being missed.

117. Compared to 2009-10, in 2015-16 there were:

- 22.9 million A&E attendances, an increase of 2.4 million or 11.8%
- 20.4 million GP and other referrals made to general and acute specialties, an increase of 3.8 million or 23.0%
- 8.2 million ordinary (i.e. overnight) elective and day case admissions, an increase of 1.3 million or 19.0%
- 59.1 million consultant-led outpatient attendances, an increase of 9.6 million or 19.4%

- 1.7 million patients referred to a specialist for suspected cancer, an increase of 822,000 or 90.9%
- 282,000 patients starting treatment for cancer, an increase of 20.9%

Northern Ireland

In-patients

118. In 2011/12 a target was set to ensure that by from 1st April 2011, at least 50% of inpatients and day cases were treated within 13 weeks and no patient should wait longer than 36 weeks for treatment. At 31st March 2012, 18,109 (35.6%) patients were waiting more than 13 weeks for inpatient and day case treatment and 775 patients were waiting longer than 36 weeks.

119. The 2012/13 target reduced the maximum waiting time to 30 weeks by 31st March 2013. At 31st March 2013 14,876 (31.2%) patients were waiting longer than 13 weeks for inpatient and day case treatment and 1,586 were waiting longer than 30 weeks.

120. The 2013/14 target stated that by March 2014, 80% of inpatient and day cases should be treated within 13 weeks, with the maximum waiting time dropping to 26 weeks for treatment. At 31st March 2014, 16,356 (33.1%) patients were waiting longer than 13 weeks for inpatient and day case treatment; with 4,312 of these patients waiting longer than 26 weeks.

121. The wording of the target was modified in 2014/15, so that from April 2014, at least 80% of patients should be treated within 13 weeks for inpatient and day case treatment, with no one waiting longer than 26 weeks. At 31st March 2015, 48.0% (27,780) of the total number waiting were waiting more than 13 weeks for inpatient and day case treatment, with 13,622 waiting longer than 26 weeks.

122. The target was changed in 2015/16 to state that from April 2015, at least 65% of inpatients and day cases should be treated within 13 weeks; and no patient should wait longer than 26 weeks for treatment. At 31st December 2015, 52.4% (35,113) of patients were waiting longer than 13 weeks for inpatient and day case treatment; with 21,413 of these patients waiting over 26 weeks.

Out-patients

123. In 2011/12 a target was set to ensure that by from 1st April 2011, at least 50% of patients wait no longer than 9 weeks for a first outpatient appointment and no patient should wait longer than 21 weeks. At 31st March 2012, 28,278 (27.4%) patients were waiting more than 9 weeks for a first outpatient appointment and 5,903 patients were waiting longer than 21 weeks.

124. The 2012/13 target reduced the maximum waiting time to 18 weeks by March 2013. At 31st March 2013 19,764 (19.8%) patients were waiting longer than 9 weeks for a first outpatient appointment and 1,670 were waiting longer than 18 weeks.

125. The 2013/14 target stated that by March 2014, 80% of patients should wait no longer than 9 weeks for a first outpatient appointment; with the maximum waiting time

dropping to 15 weeks. At 31st March 2014, 39,768 (31.3%) patients were waiting longer than 9 weeks for a first outpatient appointment; with 19,173 of these patients waiting longer than 15 weeks.

126. In 2014/15, the target was at least 80% of patients should be waiting not longer than 9 weeks; while the maximum waiting time element of the target was that no patient should wait longer than 15 weeks. At 31st March 2015, 56.3% (107,955) of the total number waiting were waiting more than 9 weeks for a first outpatient appointment, with 82,486 waiting longer than 15 weeks.

127. The target was changed in 2015/16 to state that from April 2015, at least 60% of patients should wait no longer than 9 weeks for a first outpatient appointment; and no patient should wait longer than 18 weeks. At 31st December 2015, 70.0% (164,638) of patients were waiting longer than 9 weeks for a first outpatient appointment; with 122,771 of these patients waiting over 18 weeks.

England

Bed availability

128. There were an average of 130,717 available beds open overnight in the first quarter of 2016-17, compared to 297,364 in 1987-88. The number of beds has shown a long term decreasing trend, as a result of progress in medical technology, shorter lengths of stays for routine operations, and an increase in the percentage of procedures done as day cases. Day cases now account for around 82% of all elective admissions. Occupancy rates have ranged between 84% and 89% in each quarter since 2010-11, with higher rates during the winter months of the fourth quarter.

Paragraph 2

Healthy Child Programme

129. The *Healthy Child Programme, Pregnancy and the first five years of life,* published in 2009[6], is the evidence based prevention and early intervention programme which sets out the good practice framework for the delivery of services to promote optimal health and wellbeing and reduce health inequalities.

130. In July 2011, the Department of Health and Department for Education jointly published *Supporting Families in the Foundation Years* (FitFY)[7] which set out the Government's vision for the system of services to support parents, children and families in the foundation years starting from pregnancy until a child's fifth birthday. It explains the role of different services that place parents and families at their heart to make this vision a reality.

131. In FitFY, the Government committed to increase the number of health visitors by 4,200 by 2015 to support the full and consistent implementation of the Healthy Child Programme across the country. In England, a four year programme to transform the health visiting service addressing recruitment and retention, professional development and commissioning for the health visiting profession concluded on 1 April 2015.

132. The programme increased the number of health visitors in post by almost 4,000 FTE (May 2010 - April 2015), growth of around 50%, leaving a workforce totalling just over 12,000 health visitors. This is thought to be the biggest percentage professional growth ever achieved in the NHS for such a timescale. In excess of 7000 nurses and midwives were trained to become health visitors, and health visitors were attracted back to practice.

133. The Healthy Child Programme offers every family a programme of screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices. Through the Healthy Child Programme, health visitors provide advice and support to help parents care better for their child.

134. In 2009 the Department of Health published the Healthy Child Programme From 5-19 years old. It extends the universal progressive model of child development which starts with the 0-5 Healthy Child Programme into later childhood and adolescence.

135. The good practice guidance sets out recommended framework of universal and progressive services for children and young people to promote optimal health and wellbeing. It brings together the wide range of recommended programmes and interventions for local areas to consider. The guidance outlines suggested roles and responsibilities to enable the progression of evidence based service innovation and improvement. Its implementation is designed to encourage the development of high-quality services that make a measurable contribution to the prevention of ill health and to the reduction on health inequalities.

136. To ensure the Healthy Child Programme, which was published in 2009, remains up to date with the latest evidence to assist Local Authorities, a review of the evidence base

[6] http://dera.ioe.ac.uk/11042/1/dh_107626.pdf

[7] https://www.education.gov.uk/publications/eOrderingDownload/supporting%20families%20in%20the%20foundation%20years.pdf

for the Healthy Child Programme was undertaken by Public Health England and published in March 2015[8].

137. The Family Nurse Partnership programme supports young first-time mothers and their babies through one-to-one support during pregnancy and the first two years of their baby's life. As of April 2016, there were 16,975 FNP places across England.

138. Responsibility for commissioning 0-5 children's public health services, including the Healthy Child and Family Nurse Partnership programmes, transferred from NHS England to Local Government on 1 October 2015. This joined it up with the commissioning for 5-19 year olds and wider public health functions which transferred to local government in April 2013.

Scotland

139. The Early Years have a profound impact on an individual's future experience of health and wellbeing. Health professionals, particularly health visitors, have a vital role to play in supporting children and families in the first few years of a child's life and in our communities, and they are at the core of delivering universal services. We are developing the Health Visiting Services over the next two years to introduce a consistent enhanced service to all families and grow the workforce to meet additional demands.

140. The Universal Health Visitor Pathway, published in October 2015, outlines a core home visiting programme as a minimum standard to be offered to all families with children 5 years of age and under. NHS Boards are being asked to implement this with the first health visitor visit in the pathway (the antenatal home visit) for all new families. The programme consists of a minimum of 11 contacts, ideally in the home, to all families. Eight of which are within the first year of life. There will also be 3 Child Health Review points at 13-15 month, 27-30 month and prior to starting to school to assess development and report formally on any issues or concerns.

141. The Scottish Government's investment in an additional 500 health visitors will ensure that NHS Scotland has the right levels of staff to provide visits and reviews for children in order that they can get the best possible start in life. The investment in health visitors is the first part of the work to fulfil the Government's vision to revolutionise children's services and make Scotland the best place to grow up.

Northern Ireland

142. The Department of Health published a five year Sexual Health Promotion Strategy and Action Plan 2008-2013. The Strategy aims to improve, protect and promote the sexual health and well-being of the population in Northern Ireland. The Strategy includes targets to delay first sexual intercourse; reduce the rate of births to teenage mothers; reduce the incidence of sexually transmitted infections, including HIV; and to improve access to genito-urinary medicine and sexual health services. Action to address teenage pregnancy is being integrated with the implementation of the Sexual Health Promotion Strategy's Action Plan. An addendum "Progress and Priorities" published in March 2014, updates and extends the lifespan of the Sexual Health Promotion Strategy and Action Plan (2008-2013) to improve, protect and promote sexual health and wellbeing within the population of Northern Ireland. It includes a revised Action Plan up to the end of December 2015.

[8] https://www.gov.uk/government/publications/healthy-child-programme-rapid-review-to-update-evidence .

Public Health

143. In November 2010, the Government published a White Paper on public health entitled Healthy Lives, Healthy People: our strategy for public health in England[1]. The White Paper set out wide-ranging reforms to how public health is organised in England, with the aim of empowering individuals and giving local communities the tools to address their particular needs, whilst ensuring that central government provides a robust and resilient response to health threats. The legislative changes necessary to create the new system are contained in the Health and Social Care Act 2012[2], and will come into force in April 2013. The key elements of the new system are set out below.

144. The Department of Health will continue to provide oversight of the system, setting strategy and promoting alliances to improve health. It has published a Public Health Outcomes Framework, which consists of a vision – "to improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest"; two high level outcomes, namely increased healthy life expectancy, and reduced differences in life expectancy and healthy life expectancy between communities; and 66 indicators spread across four domains. These domains are improving the wider determinants of health; health improvement; health protection and healthcare public health. The Outcomes Framework will enable the Government to track and publish progress right across public health.

145. The Department has also published a number of documents setting out ambitions for health in England covering drugs, tobacco, alcohol and physical activity.

146. In April 2013, the Government established Public Health England (PHE) as an executive agency of the Department of Health. PHE is an expert national body which plays a leading role in delivering the Secretary of State for Health's statutory duties to protect health and address health inequalities, and his power to take steps to improve the health and wellbeing of the nation. PHE supports local authorities (LAs) in England in taking forward their duty to improve the health of their populations, not least through providing the evidence base and advice on public health interventions. PHE also provides expertise on the population aspects of clinical commissioning and is the public health adviser to NHS England. A framework agreement between DH and PHE sets out the main elements of our relationship, including how accountability arrangements work in practice. PHE's three key functions will be to:

- deliver services including specialist public health services, and information and intelligence service (the range of activities needed to support, monitoring and evaluate public health activities) and support the commissioning and delivery of health and care services and public health programmes;
- lead for public health by encouraging transparency and accountability across the system and supporting public health policy development and building the evidence base; and

[1] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127424.pdf

[2] http://www.dh.gov.uk/health/2012/06/act-explained/

- develop the workforce by supporting the development of the specialist and wider public health workforce.

147. Since it was established, PHE has released a number of evidence-based publications, covering research and advice from scientific committees, along with peer reviewed research and advice on specific public health issues, including topics of high public interest such as shale gas extraction and sugar consumption.
PHE has established a global reputation and provided expert analysis and professional judgement to help government, the NHS and the people of England to protect and improve health, and has:

- developed a world-leading reputation on health protection. We have been able to depend on PHE to protect the nation's health through its expert response to the Ebola threat;
- helped drive progress in programmes locally, such as the NHS Health Check programme and on drug and alcohol recovery;
- put in place new arrangements for LAs to account for the public health grant, providing greater transparency and alignment with local needs than the previous, NHS-based, system; and
- informed national policy decisions, including through major reports on the public health impacts of alcohol, e-cigarettes and consumption of sugar and carbohydrates.

148. PHE will need to retain its world leading expertise so that it can continue to perform its vital role in protecting the UK and furthering its work with international partners to prevent and respond to health threats across the globe, including new infections and antimicrobial resistance. PHE is also working now to strengthen its influence on the development of key policies across Whitehall.

149. PHE has made a major contribution to health improvement activity, supporting LAs on local initiatives by providing the evidence, support tools, advice and through social marketing campaigns. In this challenging financial climate, it is vital that PHE can further evolve and embed its public health leadership role, including by helping local authorities understand the impact of their spending decisions, by highlighting geographic variations, and by drawing out and correlations between investment in particular services and relevant outcomes. It will also be important for PHE to continue working closely with delivery partners to support directors of public health and the NHS locally with the evidence base for health improvement activity.

150. There will be a new local leadership role for local government. Upper tier and unitary local authorities in England (152 in total) will have a duty to take appropriate steps to improve the health of their populations. How they choose to do this will largely be for local discretion, driven by the needs identified in the local Joint Strategic Needs Assessment (JSNA), and articulated in the Joint Health and Wellbeing Strategy which builds upon the JSNA.

151. There will be a small number of public health mandatory functions. Local authorities will be required to:

- Provide public health advice to local clinical commissioning groups, to ensure that clinical commissioners take into account the needs of the whole population.
- Take steps to ensure plans are in place to protect the local population.
- Commission comprehensive open access sexual health services.
- The NHS health checks programme.
- Commission the national child measurement programme.

152. There will be a continuing role for the NHS in improving and protecting the public's health, not least in using clinical contacts to encourage patients to make more healthy choices ("making every contact count"). The NHS Commissioning Board will also be asked to commission some public health services on Secretary of State's behalf. The services concerned are as follows:

- national immunisation programmes;
- cancer and non-cancer screening programmes;
- Children's public health services for 0-5 year olds (though responsibility for these will transfer to local authorities by 2015);
- Child Health Information Systems (CHIS);
- Public health services for offenders in custody; and
- Sexual Assault Referral Centres (SARCs) or Sexual Assault Services

153. The National Institute for Health and Clinical Excellence (NICE) public health 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. For example, NICE has published guidance on:

- Quitting smoking in pregnancy and following childbirth;
- Preventing type 2 diabetes – population and community interventions; and
- Promoting physical activity for children and young people

Wales

154. Following a Green Paper consultation in 2012 and a subsequent White Paper in 2014, a Public Health (Wales) Bill was introduced for consideration by the National Assembly for Wales in June 2015. The Bill sought to further improve and protect health and well-being in Wales through a series of actions in specific areas of public health policy. These included new measures relating to tobacco and nicotine products, regulation of 'special procedures' such as body piercing and tattooing, enhancing the public health role of community pharmacies, and improving the planning and provision of toilets for use by the public. The approach in the Bill complemented the overarching legislative approach of the Well-being of Future Generations (Wales) Act 2015, which provides that public bodies in Wales will need to align themselves to a series of national well-being goals, including "a healthier Wales."

155. The Public Health (Wales) Bill was not passed by the National Assembly but the Welsh Government has committed to reintroducing the Bill during the first year of the new Assembly term. The Bill will be a replica of the legislation as it was amended during the previous scrutiny process, but without the previous provisions restricting the use of nicotine inhaling devices in certain open places.

Paragraph 3

Infectious Diseases

156. The UK immunisation programme currently protects against 16 different diseases based on high quality independent expert advice from the Joint Committee on Vaccination & Immunisation (JCVI). The most recent additions to the programme are:

- Pertussis for pregnant women (2012)
- Rotavirus for infants (2013)
- Shingles for older people (2013)
- Meningococcal disease serogroup B for infants (2015)
- Meningococcal disease serogroups ACWY for adolescents (2015)

157. In addition, a seasonal flu programme for children was introduced in 2013. The programme will eventually extend to all children aged 2-16 but started with the youngest children first. In 2016/17 the vaccine was offered to all children aged 2-7 years old. Uptake for our immunisation programmes is good with more than 90% uptake of the target population for most childhood vaccines.'

Reduction of Environmental Risk

158. The position remains as previously described with the following updates.

Air Quality Strategy

159. No update from the previous report

Water Strategy – Future Water

160. The Government published a White Paper: Water for Life, in December 2011, setting out its approach to:

- sustainable delivery of secure water supplies;
- an improved and protected water environment;
- fair, affordable and cost-reflective water charges; and
- more sustainable and effective management of surface water

161. In 2014 the water industry agreed business plans with Ofwat which set out how they will deliver sustainable water supplies and their contribution to environmental protection and improvement at fair and affordable but cost-reflective charges. During the period the Environment Agency developed and consulted and published the second round of River Basin Management Plan which set out how all sectors will contribute to sustainable and effective manage and protection of surface and ground waters. These include areas specifically protected for raw water supply.

Contaminated Land

162. 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 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 contaminated land legislation comes into play.
- 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.

163. In April 2012 the Department for Rural Affairs (DEFRA) issues revised statutory guidance on contaminated land. It was refined in order to ive greater clarity to regulators as to how to decide when land is and is not actually contaminated land. It was made shorter, simpler and more focused towards achieving optimum results in terms of dealing with sites most in need of remediation.

164. In 2014, Defra published new contaminated land screening levels (Category 4 Screening Levels (C4SLs)). C4SLs are a screening tool to help local authorities and others when deciding to stop further assessment of a site, on the grounds it cannot be considered contaminated land under Part 2A. C4SLs are more pragmatic (whilst still strongly precautionary) compared to other generic screening levels describing a slightly higher level of risk but still 'low'. This work can be seen at: http://randd.defra.gov.uk/Default.aspx?Module=More&Location=None&ProjectID=18341

Noise

165. The Noise Policy Statement for England (NPSE)[9] sets out the Government's vision to "promote good health and a good quality of life through the effective management of noise within the context of Government policy on sustainable development". It covers the management of environmental, neighbour and neighbourhood noise and aims to:

- avoid significant adverse impacts on health and quality of life; mitigate and minimise adverse impacts on health and quality of life; and
- where possible, contribute to the improvement of health and quality of life.

Noise Mapping and Action Planning

166. The Environmental Noise (England) Regulations 2006 and Directive 2002/49/EC – more commonly known as the Environmental Noise Directive (END) – require periodic noise maps and action plans to be produced, consulted on and published.

167. These strategic noise maps estimate people's exposure to environmental noise from road, rail and aviation. They also encompass noise from industry inside

[9] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/69533/pb13750-noise-policy.pdf

agglomerations (large urban areas). The data underpinning the results of the most recent set of noise maps was published in 2015[10].

168. The Environmental Noise Directive also requires the creation of action plans based on the results of noise mapping. These provide a noise management framework that allows the relevant authorities to decide what action needs to be taken to tackle those areas worst affected by transport noise. The most recent set of Action Plans were published in 2014[11].

Food Safety

Creutzfeldt-Jakob Disease (CJD)

169. As at 23 November 2016, there have been 178 definite or probable cases of variant CJD in the United Kingdom, of whom none is still alive- see table below. A case of vCJD was diagnosed in 2016. This case was heterozygous at codon129 of the PRNP gene. 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. Continuing surveillance remains a priority.

170. Results of three major surveys of the prevalence of the abnormal prion protein associated with vCJD in archived appendix samples carried out to date all show prevalence of abnormal prion protein in the UK population to be around 1 in 2,000 – 1 in 5,000. It is not clear how many of those carrying the infection is ever likely to develop symptoms of vCJD: taken together, the evidence on prevalence of infection and the number of observed clinical cases suggest the majority of carriers may never do so.

171. Data collected by the UK's National CJD Research and Surveillance Unit suggest that in the UK vCJD deaths peaked in 2000 (28 deaths) and two deaths have been reported in the last five years. There are no known patients currently alive with variant-CJD.

172. There were no deaths from vCJD in 2012 or 2015, with one reported case per annum in 2013 and 2016.

173. The 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. The Government has taken the following supportive action.

Blood

174. 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, detected/diagnosed/reported in humans in 2003. The measures were tightened as

[10] https://www.gov.uk/government/publications/open-data-strategic-noise-mapping
[11] https://www.gov.uk/government/publications/noise-action-plans-large-urban-areas-roads-and-railways

evidence of transmission via blood began to emerge from animal studies, and following the first possible case of transfusion associated transmission, detected in humans in 2003, traced back to a transfusion in the 1990s. The measures in place include removing white blood cells from blood; this was introduced in 1999 and no known case of presumed vCJD transmission through a blood transfusion has occurred since.

Surgery/Dentistry

175. Advice has been published on the decontamination, quarantining and where appropriate 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 or single patient use only.

Alcohol

176. The Government launched a cross cutting Alcohol Strategy in 2012 to tackle alcohol as a driver of crime and support people to stay healthy, whilst cutting red tape for responsible businesses and supporting local pubs and continues to build on this initiative.

177. The strategy includes a package of health measures, building on the Public Health reforms to introduce a ring-fenced public health grant to Local Authorities and the introduction of Health and Wellbeing Boards. Alcohol-related hospital admissions are included as an indicator in the Public Health Outcomes Framework.

178. The strategy encourages Local Authorities to:

- Invest further in brief advice (extending activity such as that in the Health Check)
- Ensure Alcohol Liaison Nurses are working across NHS hospitals
- Provide effective alcohol treatment and recovery.

179. There has been an alcohol check within the NHS Health Check for adults from April 2013.

180. UK Chief Medical Officers' low risk drinking guidelines were published in January 2016 (https://www.gov.uk/government/publications/alcohol-consumption-advice-on-low-risk-drinking) and provide the public with the most up to date scientific information to help people make informed decisions about their own drinking. The guidelines have been tested through public consultation and market research to ensure the advice is as clear and useable as possible. The low risk drinking guidelines have been developed on the basis that people have a right to accurate information and clear advice about alcohol and its health risks. There is also a responsibility on government to ensure that this information is provided for people in an open way, so that they can make informed choices.

181. The new Change4Life campaign helps people check if they are drinking above the lower-risk guidelines or not and offers tips and tools to cut down.

182. Sales of alcohol below the level of duty plus VAT were banned in May 2014 to tackle the worst cases of very cheap and harmful alcohol, meaning it is no longer legal to sell a can of ordinary lager for less than around 40p, but introduction of a Minimum Unit Price for alcohol in England and Wales was put on hold while awaiting the outcome of a legal challenge against the policy in Scotland. The UK Government has noted the recent ruling of the Scottish Court in favour of the Scottish Government and will continue to monitor the impact of any implementation of minimum unit pricing in Scotland.

183. Effective alcohol education is also essential to help ensure that young people are equipped with the information that they need to make informed, healthy decisions to keep themselves safe. Alcohol and drug education is already a statutory part of the key stage 4 national curriculum for science and teaches children about the effects of recreational drugs, including alcohol, on behaviour, health and life processes. The Government's Drug Strategy confirms our commitment to provide accurate information to young people, and their parents/carers, about drugs and alcohol through education and the FRANK drug information and advice service.

184. We are also addressing other factors that can influence young people's attitude to alcohol:

- we have doubled the fine to shops for persistently selling alcohol to children;
- are closely monitoring the evidence for action around factors that can influence young people's attitude to alcohol, such as exposure to alcohol advertising and marketing; and
- we have given local authorities more than £8 billion in funding over three years so they can put the right services, including children's services, in place to help their communities.

185. We are now seeing a welcome decrease in the incidence of drinking amongst young people. Survey data on young people's drinking shows a steady decline, over recent years, in the proportion of 11-15 year olds who drink alcohol (falling from 61% in 2003 to 38% in 2014).

- Evidence suggests that alcohol consumption has increased over the long-term and alcohol-related harms are still increasing. Alcohol consumption overall has fallen recently, but long term consumption has risen and a significant minority of people misuse alcohol: over 10 million people say they drink above the UK CMOs'low risk drinking guidelines[12];
- 1.1 milliom hospital admissions are alcohol-related (7% of the total);
- alcohol is on of the fourth biggest behavioural risk factors for disease and death in the United Kingdom along with smoking, obesity and lack of physical activity;
- the estimated cost for the NHS around £3.5bn every year; and
- and over 6,800 deaths each year in England are thought to be caused by alcohol.

186. Detailed evidence on alcohol misuse and harm in England is set out as part of the Department of Health's evidence to the Health Committee's inquiry into the Alcohol Strategy[13].

Scotland

187. The Scottish Government has a comprehensive Alcohol Framework, introduced in 2009, to tackle alcohol misuse which contains over 40 measures which aim to help prevent problems arising in the first place, and ensuring support and treatment for those who are already experiencing problems. A progress report was published in 2012: http://www.gov.scot/Resource/0038/00388540.pdf and a refresh of the Alcohol Framework is currently in development.

188. A key measure in the Framework is minimum unit pricing. Legislation was passed in 2012: http://www.legislation.gov.uk/asp/2012/4/contents but has not yet been implemented due to a legal challenge from parts of the alcohol industry.

Wales

189. In 2008 the Welsh Government issued the *Substance Misuse Strategy for Wales: Working Together to Reduce Harm 2008-18.* The Strategy gives a high priority to tackling alcohol misuse. A new 2016-18 Substance Misuse Delivery Plan has been developed, following extensive consultation during 2015 and includes a range of specific actions specifically targeted at tackling alcohol related harms. As part of the Delivery Plan the

[12] Health Survey for England 2014, Health and Social Care Information Centre (HSCIC)
[13] Government's Alcohol Strategy: written evidence submitted by oral witnesses pages 14- 31 https://ww.parliament.uk/documents/commons-committees/Health/Writtenevidencebyoralwitnesses.pdf

Welsh Government is delivering a combination of both population and individual level interventions such as brief interventions to address the harm caused by alcohol.

190. As part of the Substance Misuse Delivery Plan, he have a number of programmes in place to support people to drink sensibly and raise awareness of the dangers of harmful drinking. This includes the "Change4Life" alcohol campaign, the "Have a Word" Brief Interventions programme and our Healthy Working Wales programme.

191. Alcohol Concern Cymru continue to support the delivery of the Substance Misuse Strategy and accompanying Delivery Plan for 12-15. Their roles includes raising awareness of alcohol misuse issues, monitoring and reporting on questionable alcohol labelling and promotions, leading on information campaigns, issuing good practice guidance and undertaking research.

192. Integrated Family Support Services (IFSS) provides intense support to children and families where the parents' primary presenting problem is alcohol or drug misuse. However many families using the service will have multiple problems including mental illness which can co-exist with substance misuse. The intervention techniques currently used by IFSS have shown to be particularly effective in creating change in families with substance misuse, which represent highest percentage of referrals for concern of a child's welfare. IFSS began its implementation in Wales in September 2010 and has been available across Wales since April 2014.

Obesity

193. Levels of overweight and obesity in England continue to remain high. 62% of adults, and 31% of children are either overweight or obese. This poses a serious threat to individual health, and impacts on the NHS and wider economy. The Government is committed to tackling this important public health challenge.

194. *Childhood Obesity: A Plan for Action*[14] was launched in August 2016. The plan focuses on actions that are likely to have the biggest impact on childhood obesity and maintaining a healthy diet. Key and bold measures in the plan include:

- Introducing the Soft Drinks Industry Levy alongside a sugar reduction programme
- Making food labelling clearer
- Making healthier options available in schools
- Helping children to enjoy an hour of physical activity every day and a healthy rating scheme for primary schools

195. The policies in the plan are informed by the latest research and evidence, including, the Scientific Advisory Committee on Nutrition report *Carbohydrates and Health*[15], Public Health England's evidence package on *Sugar reduction: the evidence for action*[16]*, and* various reports from key stakeholders.

196. The food and drink industry has a role to play in tackling obesity and has made progress in recent years. Billions of calories and tons of sugar have been removed from

[14] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/546588/Childhood_obesity_2016__2__acc.pdf
[15] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445503/SACN_Carbohydrates_and_Health.pdf
[16] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/470179/Sugar_reduction_The_evidence_for_action.pdf

products, and portion sizes have been reduced; some major confectionery manufacturers have committed to cap single serving confectionery at 250 calories. Alongside this, some retailers have also removed sweets from checkouts. The challenge to industry to make further substantial progress remains.

197. Change4Life was launched in 2009. Its aim has been to inspire a social movement, through which government, the National Health Service, local authorities, businesses, charities, schools, families and community leaders could all play a part in improving children's diets and activity levels.

198. Change4Life inspires families and children in England to eat well and move more. The campaign has enjoyed considerable success and unparalleled levels of engagement. Since launch more than 4 million people have signed up to Change4Life and it now has more than 200 national partners. There were more than 2 million downloads of the Sugar Smart app (launched in January 2016).

199. Start4Life, the 'sister' brand, helps pregnant mums-to-be and parents of babies aged 0-5 to adopt healthy behaviours that give their babies and young children the best start in life.

200. While is not possible to draw an exact correlation between Change4Life and reductions in childhood obesity, there is clear evidence to support the assumption that it plays a key role in raising awareness of the issues around obesity and improving the health behaviours of families, for example:

- A decrease in the purchase of sugary fizzy drinks of more than 8% during the January 2014 Sugar Swaps campaign period when compared with January 2013
- 38,000 more children getting 60 minutes exercise a day directly due to Change4Life sports clubs
- 104 million additional minutes of physical activity among those taking part in the 2014 Change4Life 10 Minute Shake Up with Disney campaign
- 78% of parents reported that their children did more activity as a result of the Change4Life 10 Minute Shake up with Disney 2015

Northern Ireland

201. A ten year strategy to prevent obesity, across the life course, was published in 2012: http://www.dhsspsni.gov.uk/fitter-future-for-all-outcomes-framework-2015-2019.pdf.

202. An update report was issued on the first set of short-term outcomes, and this contains an update on relevant indicators: https://www.health-ni.gov.uk/publications/obesity-prevention-framework-and-reports.

Answers to the ECSR's questions XX-2 (2013)

Any person can approach any GP in the area they live 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 a registered NHS patient or a temporary registered patient (because their permanent home is elsewhere). The Government expects general practice to exercise this discretion with sensitivity and due regard for the circumstances of each case but with an expectation that legally resident individuals within the UK should be appropriately registered with a GP and entitled to receive NHS primary medical care services. The Committee asks to be kept informed on the implementation of this system.

The reference to legally resident individuals is incorrect. Registration with a GP in England is not based on residency (we do not, currently, ask GP practices to check status of patients applying to join their list). The procedure for registration is set out in the legislation governing the contracts between NHS England and individual providers of primary medical services. The arrangements have been in place since 2004 and are currently set out in the NHS (General Medical Services Contracts) Regulations 2015 (SI2015 No. 1862) and the NHS (Personal Medical Services Agreements) Regulations 2015 (SI2015 No. 1879).

Scotland

The Scottish Government is committed to a vision of a modern Primary Care and GP service with more GPs working in Scotland as part of multi-disciplinary teams, alongside nurses, pharmacists, optometrists and other allied health professionals to support patients to live well in their communities, and allow them to access the right person at the right time.

The recent 2015/16 Health and Care Experience Survey has shown an overall positive picture for access to GPs. Over 90 per cent of General Practice patients said they were able to see or speak to a doctor or nurse within two working days of requesting an appointment, with an increase in the number of respondents happy with their GP opening hours.

However we recognise that there is more work to do to support GP services. In March this year the Cabinet Secretary announced a further £20 million package - in addition to the £85 million Primary Care Fund - to ease short term pressures on GPs and improve access over the next year.

Concerning hospital waiting times, since 1 January 2009, the standard in England is that no-one should wait more than 18 weeks from GP referral to the start of hospital treatment or other clinically appropriate outcome unless they choose to do so, or it is clinically appropriate that they wait longer. The Committee asks the next report to indicate how this operational standard is being met in practice.

An NHS Constitution establishes the principles and values of the NHS in England. It states that patients "have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible." The two waiting time rights, set out in the Handbook to the NHS Constitution, are:

1. to start consultant-led treatment within a maximum of 18 weeks of referral for non-urgent conditions; and
2. to be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected.
3. The NHS Constitution also commits that the NHS will "provide convenient, easy access to services within the waiting times set out in this Handbook to the NHS Constitution." Pledges set out what the NHS is committed to achieve, they are not legally binding and cannot be guaranteed for everyone all of the time. These waiting times pledges are described in the Handbook to the NHS Constitution and cover cancer, diagnostic tests, accident and emergency and ambulance response times.
4. Waiting time rights and pledges are not expected to be met for every NHS patient. At any one time, there will be patients that choose to delay their treatment, that do not co-operate by attending appointments they have agreed, or that it would be clinically inappropriate to treat within the maximum waiting time.
5. To account for this, NHS England publishes operational standards in the form of percentage thresholds that set an expected level of performance. These are the minimum performance levels that the NHS is expected to meet operationally in order to deliver its commitments to patients. The key standards are:

    a. 92% of patients waiting to start consultant-led treatment for non-urgent conditions to be waiting within 18 weeks
    b. 95% of patients to be admitted, transferred or discharged within four hours of arrival in all types of accident and emergency department
    c.
    d. 93% of patients to see a specialist for suspected cancer within two weeks from urgent GP referral
    e. 85% of patients to begin first definitive treatment for all cancers within 62 days from urgent GP referral
    f. 99% of patients to be waiting within six weeks from referral for a diagnostic test.

The Committee asks the next report to include examples of concrete activities and campaigns undertaken by public health services, or other bodies, to promote health and prevent diseases.

Public Health England (PHE) has seven key priorities for the next five to ten years to help people live as well as possible, for as long as possible. The seven priorities are:

- Tackling obesity, particularly among children
- Reducing smoking and stopping children starting
- Reducing harmful drinking and alcohol-related hospital admissions
- Ensuring every child has the best start in life
- Reducing the risk of dementia, its incidence and prevalence in 65-75 year olds
- Tackling the growth in antimicrobial resistance
- Achieving a year-on-year decline in the incidence of tuberculosis

These are important factors for determining health, and also share many of the same risk factors.

PHE delivers its objectives and programmes in partnership with a wide coalition of stakeholders including the commercial and voluntary sectors, charities, local government

and other government departments to enhance reach and impact. We provide public health advice to the National Health Service (NHS).

As part of our role we have a range of national campaigns to improve the public's health, including health protection (for example flu vaccination), health improvement (for example, young people's health and wellbeing (Rise Above); Talk to Frank about drugs advice; and seasonal campaigns such as flu). These are undertaken in partnership at national and local levels to increase impact, including with the NHS, local authorities and the voluntary and community sector.

In addition, PHE publishes a wide range of evidence based advice and information to support commissioners of public health and care services to improve effectiveness of prevention and health improvement campaigns. These resources are all freely available and accessible through the Government's web portal. We will promote these resources through our local partners.

Social Marketing

Public Health England (PHE) uses social marketing campaigns as a key tool for helping people to change their behaviour and make it easier for them to live healthier for longer. PHE's evidence-based and rigorously evaluated marketing programmes employ impactful messaging and tools designed to complement the way people live their lives; notably capitalising on digital technologies to deliver successful interventions at scale and cost efficiently.

Marketing activities are aligned around three life stages: Starting Well, which supports two of PHE's strategic priorities: ensuring every child has the best start in life and reducing childhood obesity, and includes the flagship Change4Life campaign; Living Well, which uses the One You brand to inspire and help adults to lead healthier lives and supports smoking cessation; and Ageing Well, which encourages people to act on a range of signs and symptoms of diseases like cancer, to facilitate earlier diagnosis and help increase survival rates.

PHE's priorities include action across the life course and for specific conditions, such as dementia risk reduction. We have a number of prevention programmes targeted at drugs, alcohol, tobacco, HIV prevention, diet and obesity, work and worklessness.

We also have a major programme targetting cardio-vascular disease prevention, including the NHS Health Checks which is offered to people aged 40-75 on a 5 year rolling basis.

Maternity and early years

The Best Start in Life Programme aims to drive improvements and reduce health inequalities in health outcomes in pregnancy and the early weeks through embedding prevention in maternity pathways, to improve the proportion of children ready to learn at age two years and the increase the proportion of children ready for school at age five years. PHE is leading a system wide approach with other government departments, arm's length bodies and Local Authorities priorities are: reducing smoking in pregnancy, improving perinatal mental health, improving oral health, reducing inequalities in speech, Language and communication, reducing harm from accidents.

School Nursing

School nurses, as leaders of the Healthy Child Programme, deliver a number of programmes and services, these include; immunisation programmes, sexual health, healthy eating, hand washing and more recently programmes relating to Antimicrobial Resistance (AMR) and becoming antibiotic guardians.

School nurses also provide support in terms of mental health, Female Genital Mutilation prevention, and keeping safe – including sexual exploitation. School nurses also support children with additional health needs including those with diabetes, asthma and more complex health needs. School nurses provide health promotion, advice, sign posting and referrals to specialist services

Scotland

The public health system in Scotland, involving both Scottish Government and the National Health Service, undertakes a range of activities to prevent communicable diseases of significance in Scotland. In addition to core preventative activities such as vaccination, this includes focussed activity on tuberculosis and E.coli. Scotland has also developed and implemented a world-leading approach to viral hepatitis, which has informed the World Health Organization's Global Hepatitis Programme. Scotland has a mature health protection system with effectives systems of surveillance to readily detect and respond to emerging threats from communicable disease. Public health agencies are empowered via primary legislation – the Public Health (Scotland) Act 2008 – to investigate and control threats. Health Protection Scotland is Scotland's national health protection organisation, and its website (http://www.hps.scot.nhs.uk/) provides further information on the various activities to prevent communicable disease.

The nature of the constitutional settlement means many aspects of the tackling of non-communicable diseases are devolved to Scotland and the Scottish strategies on these and other key public health issues are detailed at:
http://www.gov.scot/Topics/Health/Services

Numerous other campaigns taking place across the UK are referenced in the body of the report above.

The Committee asks the next report to provide updated information on health education in schools in England, namely whether it is a statutory obligation, how it is included in school curricula (as a separate subject or integrated into other subjects), and the content of health education.

Change4Life makes resources available to schools to support a whole school approach to maintaining a healthy weight including materials to encourage daily physical activity and healthy eating. PHE published What works in schools and colleges to increase physical activity in November 2015. The Childhood Obesity Action Plan states that a Healthy Schools Rating Scheme will be developed for primary schools from 2017/18 onwards and this will cover physical activity, healthy eating and emotional health and wellbeing. An Ofsted Thematic Review will support this scheme.

The Committee asks what concrete medical checks are carried out through the period of schooling (including their frequency, their objectives, and the proportion of pupils covered).

The National child measurement programme (NCMP) measures the height and weight of all children in state schools age 5-6 and 10-11. The measurements taken in the 2015/16 academic year covered 95% of all pupils. The original purpose of the NCMP was as a surveillance tool to determine the obesity prevalence of primary school aged children but it is now used as a method of screening and offering support to children who are not a healthy weight.

Similar programmes operate (with the same purpose and frequency) throughout the UK, such as the Child Measurement Programme for Wales and Scottish Child Health Programme.

The Committee asks the next report to provide information on the levels of air pollution, contamination of drinking water and food intoxication during the reference period, namely whether trends in such levels increased or decreased.

The UK is currently required to report air quality data to the European Commission on an annual basis under the following European Directives:

1. The Council Directive on ambient air quality and cleaner air for Europe (2008/50/EC).
2. The Fourth Daughter Directive (2004/107/EC) under the Air Quality Framework Directive (1996/62/EC).

Reports covering the period 2003 to 2015 can be accessed on the UK Air Website, section 4.3 provides detailed information on air pollution trends:
https://uk-air.defra.gov.uk/library/annualreport/index

The Drinking Water Inspectorate publishes annual reports on the quality of drinking water. In the UK our drinking water is of the highest standard, at a record level of quality and among the best in the world. They reports can be found at:
http://www.dwi.gov.uk/about/annual-report/index.htm

In 2014 the Food Standards Agency published research on how many people suffer from food poisoning in the UK every year providing public officials with the most detailed picture yet of this problem. The findings are important as official data for food poisoning cases

significantly under-estimates how big the problem is, as only the most serious cases get reported. The data from this study, coupled with data from official statistics, refines our previous estimates of the real burden of foodborne disease and so will help focus efforts to reduce levels of food poisoning in the UK. Due to the unreliability of data trends in levels of food intoxication are not possible to reliably determine. More information on the study and its findings can be found at:
https://www.food.gov.uk/science/research/foodborneillness/b14programme/b14projlist/b18021

Scotland

Scottish Ministers established Food Standards Scotland (FSS) in April 2015 as an independent public body to ensure that its citizens rights to the protection of health are met in so far as they relate to the safety of the foods they consume. FSS provides all functions that were previously provided by the Food Standards Agency in Scotland. FSS's strategic direction for the 2016-2021 and its three-year corporate plan were published in August 2016 and set out how the organisation plans to achieve its vision to create a food and drink environment in Scotland that benefits, protects and is trusted by consumers: http://www.foodstandards.gov.scot/sites/default/files/FSS%20Strategy%20Doc%20Final.pdf

The body has the role of ensuring that all of the relevant EU legislation on food safety, hygiene and standards is given effect through Scottish law as this is a fully devolved matter in the UK. As well as its legislative policy role, FSS has a function of providing transparent, independent advice to the citizens of Scotland on matters of food safety. It also ensures, on behalf of Scottish Ministers, that all competent authorities, including local authorities, involved in the enforcement of EU food law are discharging their functions appropriately.

Concerning alcohol, the report mentions a Government Alcohol Strategy (March 2012) which sets out how local and national government, the alcohol industry and people themselves can combat irresponsible drinking. The Committee asks to be kept informed on the implementation of this strategy.

Going forward, we will continue to build on the Alcohol Strategy launched in 2012 to tackle alcohol as a driver of crime and support people to stay healthy, whilst cutting red tape for responsible businesses and supporting local pubs.

As regards alcohol consumption, overall it has fallen recently, but long term consumption has risen and a significant minority of people misuse alcohol (over 9 million people say they drink above the guidelines). The Committee asks the next report to also include trends on tobacco consumption.

England

Smoking rates in England are at their lowest ever levels – down to 16.9% for adults and 8% for 15 year olds. However, there are considerable regional differences and around 7.7 million people in England still smoke.

Smoking remains one of the UK Government's most significant public health challenges and we have committed to a new tobacco control plan to continue to drive down smoking rates. The harmful effects of tobacco fall most heavily on disadvantaged communities and this is something the new plan will focus on.

Scotland

The Scottish Government is ambitious in its determination to improve health and reduce inequalities. Smoking makes a significant contribution to Scotland's unfair and unjust health inequalities, with smoking rates ranging from 39% in Scotland's most deprived communities to 11% in its least deprived.

Despite a drop in the number of people smoking in Scotland tobacco remains the biggest cause of preventable death. We want to create a tobacco-free generation by 2034 by creating an environment where young people do not want to smoke whilst reducing the prevalence among the adult population to five per cent or lower.

Legislative Framework

The Government have implemented the Tobacco and Primary Medical Services (Scotland) Act 2010. This brought into force the ban on the sale of tobacco from automatic vending machines and the display of tobacco and smoke-related products in large shops in April 2013. A ban on the display of tobacco and smoking related products in other shops came into force in April 2015.

During 2015 we took legislation through Parliament to ban the sale of tobacco and Nicotine Vapour Products (NVPs) by under 18s and to introduce a statutory age-verification scheme to help combat under-age tobacco and NVP purchases. These will be implemented in 2017 and include a ban on NVP advertising, promotion and sponsorship as well as restrictions on smoking in hospital grounds.

The Smoking Prohibition (Children in Motor Vehicles) (Scotland) Act 2016 was passed by the Scottish Parliament in 2015. It will become an offence for an adult to smoke in a vehicle with a child (under the age of 18) on board, subject to limited exceptions. This will become law in December 2016.

Measures taken:

- We launched CREATING A TOBACCO-FREE GENERATION – A Tobacco Control Strategy for Scotland, in 2013. This aims to reduce the harm caused by tobacco and sets out 46 measures. It sets out the government's target of reducing smoking prevalence in Scotland to 5% or lower by 2034 though a range of actions based on Prevention, Protection and Cessation.
- In 2014 Scottish Ministers launched the campaign Take it Right Outside to raise awareness of the dangers of second-hand smoke to children. Along with this we announced a new target to reduce the number of children exposed to second-hand smoke in the home from 12% to six per cent by 2020. This target aims to spare 50,000 children from exposure to second-hand smoke. The campaign was re-run in 2015.
- Record investment in NHS smoking cessation services is helping hundreds of thousands of people to attempt to quit smoking. The Scottish Government allocates around £11million annually to NHS Boards to support the delivery of local stop smoking services in a range of settings including hospital settings.

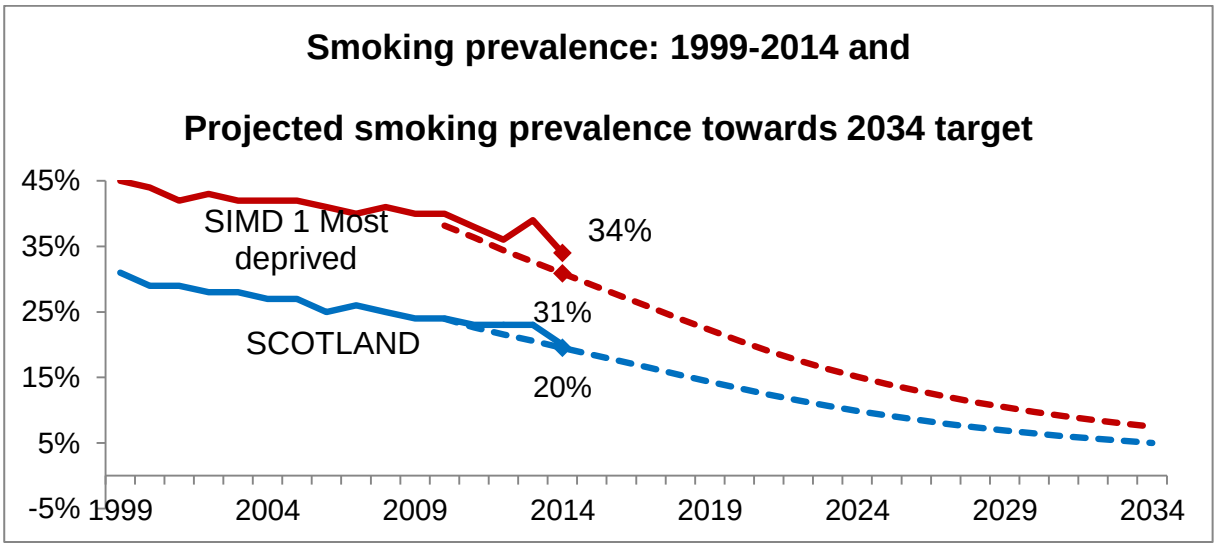
Statistics

There are over 10,000 smoking-related deaths a year in Scotland and approximately 128,000 smoking-related hospital admissions.

Scottish Public Health Observatory (ScotPHO). [2015]. ScotPHO Online Profiles Tool. Available from: www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool

Smoking related illnesses cost around £300m per year to the healthcare system. If smoking were reduced by one percentage point the estimated potential reduction in expenditure is £13.4m.

Scottish Public Health Observatory (ScotPHO). 2012. ScotPHO Smoking Ready Reckoner - 2011 Edition. Available from: http://www.scotpho.org.uk/downloads/scotphoreports/scotpho120626_smokingreadyrec



Northern Ireland

The Public Health Agency published a detailed report on the use of Tobacco in Northern Ireland and its effect on public health in December 2015, which can be found at: http://www.publichealthagency.org/sites/default/files/Tobacco%20Control%20Northern%20Ireland%202015.pdf

Wales

The Tobacco Control Action Plan for Wales can be found at: http://gov.wales/docs/phhs/publications/120202planen.pdf

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Article 11, Paragraph 1

Access to comprehensive medical care (including maternity, early years and health improvement/prevention programmes) is provided free at the point of delivery through community, primary and secondary care services. Tertiary care is commissioned from appropriate specialist centres in England.

The Public Health function is located within the Department of Health and Social Care and oversees health protection (vaccination, immunization, communicable disease control and population screening programmes); public health surveillance and intelligence; health improvement; and healthcare public health. Cross-government work is underway to improve health and wellbeing by addressing the wider determinants of health.

The Department of Health and Social Care has published a five year strategy (available at: https://www.gov.im/media/1349186/health-and-social-care-in-the-isle-of-man-the-next-five-years-gdno20150052.pdf). The strategy focuses on prevention; early intervention and delivery of care closer to home in order improve health and wellbeing and deliver a sustainable health and social care service for future years.

Current priorities for improving public health are the reduction of lifestyle risk factors at population level. These include smoking; overweight and obesity; drug and alcohol misuse; and sexual health. The approach to each risk factor is based on cross-government and community engagement; needs assessment and evidence led strategy development. This will lead to review and revision of some of the existing programmes.

Universal maternity and child health services are provided. The content of these programmes is reviewed to ensure they are responding to current health challenges. For example, breast feeding and nutrition and exercise for the under 5s are being reviewed in response to current high levels of childhood obesity (26% of reception class children were overweight/obese at school entry in September 2015).

Three adult cancer screening programmes are delivered – breast, bowel and cervical. Introduction of abdominal aortic aneurysm screening is under review. Mortality from aortic aneurysm is low on island and screening may not, therefore, be appropriate.

A comprehensive dataset of health indicators is currently in production, the first phase of the Indicator set should be ready November 2016

Article 11, Paragraph 2

Encouraging and facilitating individual responsibility for matters of health is a key objective of the DHSC five-year strategy (referenced above). Programmes to reduce the prevalence of lifestyle risk factors (referenced above) include components appropriate for all stages of the life course (children, working age adults, older adults) and settings (schools, workplaces, communities). Health Visitors deliver a comprehensive programme of early years support to young children and families.

A comprehensive programme of ‘personal, health, social and economic’ education is delivered by teachers in schools. The PHSE programme is overseen by the Department of Education and Children. There is also a comprehensive programme to support

emotional wellbeing and resilience in children and young people being developed between DHSC and DEC.

- Breast screening programme uptake (age 50-70) 2013/14: 74%
- Cervical screening programme uptake 2014/15: 79.66%
- Bowel screening programme uptake: indicator not currently available

Article 11, Paragraph 3

Communicable Disease Control is delivered on Island by local staff but with formal links for specialist expertise and professional development with Health Protection Scotland. Environmental hazards are covered by the Health Protection team within DHSC, working with Environmental Health. There is a link with Public Health England Centre for Radiation, Chemical and Environmental Hazards for specialist advice when required.

There are three adult cancer screening programmes as described above.

Comprehensive immunization programmes are delivered by community, public health and primary care staff.

The Health Protection Committee (a sub-committee of the DHSC Board) provides oversight and governance for all communicable disease control, environmental hazards, immunization and screening programmes. The committee membership is cross-government.

The 'Social Attitudes Survey, 2016' reported smoking prevalence at 15% - however, this was based on small sample size. A more robust estimate should be available from the forthcoming health and lifestyle survey in 2017.

Vaccination uptake:

- Five-in-one childhood vaccination 2014/15: 95.7%
- MMR 2014/15: 92.09%
- Meningitis C (Q1-3, 2015): 92.89%

Article 12 – The right to social security

Paragraph 1

United Kingdom

1. Separate, but corresponding, schemes of Social Security operate in Great Britain and Northern Ireland. Reciprocal arrangements between the two ensure that the schemes effectively operate as a single system. The law governing Social Security in Great Britain was amended during the reference period by the measures listed below. Corresponding legislation came into effect in Northern Ireland as listed after the GB measures. Benefit levels are maintained in parity with Great Britain and all rates quoted therefore apply equally.

2. Copies of the original text of Acts, Regulations and Orders can be viewed at the Government's website[17]. 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[18]. 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 Communities website[19].

3. 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 2011 to 31 May 2016, is attached as **Appendix B**. A corresponding Report on the European Code of Social Security covering the same period was submitted to the Council of Europe and is attached as **Appendix C**. A copy of the biannual Report of 2016, updating the UK's position on the application of the Code of Social Security, is attached as **Appendix D**.

4. The scope and coverage of the UK's social security system remains generally as previously described, taking into account developments as set out in the reports referred to above together with the changes and proposals described in this report.

5. The Department for Work and Pensions Annual Report and Accounts for 2015/16 gives a detailed overview of its current operation, funding and expenditure on benefits and their administration.

New Style Jobseekers Allowance (JSA)

6. New Style JSA was introduced in 2013, supporting the principle that people should be able to access financial help after paying into the National Insurance Contributions scheme. The new style JSA consists of a contribution-based element only meaning it can be paid regardless of whether a claimant is also entitled to Universal Credit (UC) or not. New style JSA is also payable where a claimant does not qualify for Universal Credit but satisfies the conditions of entitlement for contribution based benefit.

[17] http://www.opsi.gov.uk/legislation/index.htm
[18] http://www.dwp.gov.uk/publications/specialist-guides/law-volumes/the-law-relating-to-social-security/
[19] https://www.communities-ni.gov.uk/services/law-relating-social-security

7. Someone who is claiming new style JSA, and has been awarded it, will also be credited with a Class 1 National Insurance credit. This will also be credited when a claimant meets the entitlement conditions for a new style award but no benefit is being paid.

8. The contribution conditions that a claimant needs to satisfy to be entitled to new style JSA are exactly the same as for old style JSA. The conditionality structure of new style JSA differs slightly from old style JSA and is similar to UC. New Style JSA claimants are required to be available for work and search for work for up to 35 hours a week.

9. A claimant can choose to claim new style JSA on its own, whether or not they would be entitled to UC. A claimant must accept a claimant commitment, some exceptions apply, which explains what the claimant must do to meet their work related requirements and the consequences of not doing so.

10. Failure to follow the work related requirements will result in a benefit sanction. Sanctions for new style JSA are similar to those for UC. New style JSA sanctions do not apply to claimants who are also claiming UC as the UC sanctions will apply instead.

11. A dual claim is where UC and new style JSA are claimed, and paid, alongside each other. In dual claims UC conditionality applies and the work-related requirements are managed through a claimant commitment.

12. New style JSA is taken into account as unearned income in UC and their award is amended to take into account the 'adjusted gross award' of new style JSA.

The New State Pension

13. The new State Pension has been introduced for people reaching state pension age on or after 6 April 2016.

14. The new State Pension is the biggest reform to the UK's State Pension system for a generation. The Government is modernising the complicated State Pension system to provide clarity around what people can expect from the State and offers a solid foundation for personal retirement saving

.

15. The full amount will be over £8,000 a year - so people can build their own savings on top. From April 2016 onwards, everyone will build their State Pension at the same rate; and because it will be above the basic means-tested level, it will not penalise or discourage personal saving. The full rate is set above the level of the basic means test in Pension Credit, helping to support private saving.

16. It works alongside Automatic Enrolment, enabling millions more to save in a workplace pension. The reforms of state and workplace pensions, along with reviews of the State Pension age, are designed to form the main elements of a sustainable basis of retirement income in the decades to come.

17. Around three-quarters of people who reach State Pension age under the new system in the first fifteen years will have a notionally higher State Pension than they would have had under the old system (over 75% of females and around 70% of males gain). By 2030, over 3 million women stand to gain an average of £550 extra per year as a result of these changes

18. The cost will be no more than the current system, up until the 2040s, at which point it is projected to cost less. In addition, the UK's Office for Budget Responsibility estimated in 2014 that projected State Pension age changes will reduce national debt by 17% of GDP in the longer-term.

19. The Government is encouraging people – especially those aged 50 and over – to check their own State Pension (and understand what the changes mean for them) by using our new online State Pension estimation service, called Check your State Pension. Over 1.4 million State Pension forecasts have now been viewed using Check your State Pension since it was introduced in February 2016.

20. This service not only provides the individual with a personalised forecast of their State Pension, and the earliest they can get it, but also flags if they can improve their State Pension further by filling gaps in their National Insurance contributions record.

Great Britain

Industrial Injury Benefit

21. The Welfare Reform Act 2012 simplified the way industrial injuries benefits are claimed. Several old schemes specifically for claims for accidents and disease which occurred before 1948, and an analogous industrial injuries scheme for unemployed claimants and those on work based training were abolished, and all remaining claimants on those schemes were moved to the existing Industrial Injuries Disablement Benefit (IIDB) scheme. This change removed potential confusion and error for claimants, and established a single claiming option for all claimants.

Northern Ireland

22. Osteoarthritis of the knee as it relates to certain carpet fitters and floor layers was added to the list of prescribed diseases that may qualify a person for industrial injuries benefit; and employment as a coke oven worker was added as an occupation in relation to which primary carcinoma of the lung is a prescribed disease.

DWP Benefit Expenditure and Caseload Tables

23. The benefit expenditure and caseload tables are typically a biannual source (coinciding with fiscal events) for historic and current outturns and future estimates of benefit caseload and expenditure (in both real and nominal terms). They provide figures for all GB benefits, divided up by claimant group and locality.

DWP Benefit Rate Statistics

24. More detailed information on benefits rates generally is accessible from the following sources:

- A schedule of rates of Social Security Benefits from April 2016 are set out in Benefit and pension rates: April 2016.
- Information on the average amounts of benefits in payment can be obtained from the DWP Statistics Tabulation Tool or Stat-Xplore Tool. Options include the caseload for each benefit (in thousands) and average amount of benefit paid.

- Information on rates of benefit administered by HM Revenue & Customs (Child Benefit, Guardian's Allowance and Tax Credits) can be found at Rates and allowances: tax credits, Child Benefit and Guardian's Allowance.

Northern Ireland Statistics

25. Comparable statistics published for Northern Ireland can be viewed at the Department for Communities Benefit Statistics page.

Answers to the ECSR's questions XX-2 (2013)

The Committee notes that these legislative developments (the Welfare Reform Act and the State Pension Reform) are outside the reference period. Therefore, it asks the next report to indicate how these have affected the personal coverage of social security risks – i.e. the percentage of the covered persons out of the total active population as well as the minimum levels of income-replacement benefits (unemployment, sickness, maternity and old-age).

State Pension Reform remains outside the reference period having being implemented in April 2016.

The Welfare Reform Act (which falls primarily under Article 13 as it concerns mainly social assistance) has not affected the personal coverage of social security risks. The existing system of contributory benefits remains as explained above. The one way in which the minimum levels of income-replacement benefits have been affected is through the benefit cap.

From April 2013 the Government introduced a cap on the total amount of benefit that working-age people can receive. The cap was set at £26,000 per year or £500 per week for a couple (with or without children) and single parent households; and equivalised at 67%, or £350 per week (after rounding), for single adult households without children.

The Welfare Reform and Work Act 2016 included changes to the benefit cap. Starting in November 2016 total household benefit payments for working-age claimants will be capped so that workless households will no longer be entitled to receive more than £20,000 in benefit (£13,400 for single adults with no children) and £23,000 (£15,410 for single adults with no children) in Greater London. There are a number of exemptions including households receiving disability benefits. From November 2016 new exemptions have been added for households entitled to Carer's Allowance, the Carer's element in Universal Credit or Guardian's Allowance.

An evaluation of the current £26,000 benefit cap showed capped households were 41% more likely to enter work than comparable households not affected by the benefit cap, and the greater the amount by which benefit receipt was reduced by the cap, the greater the proportion moving into employment.

The new lower, tiered cap strengthens work incentives, achieves fairness for taxpayers and ensures there is a reasonable safety net of support for the most vulnerable. It recognises that many hard working families earn less than median earnings – a lower cap provides a strong work incentive. The tiered approach recognises that almost half of all households currently capped are living in London, in contrast only 3% of capped households live in the North East. The tiered cap would see a more equitable distribution of capped cases, with around 22% in London.

A higher cap tier of £23,000 in London takes account of the higher household costs in London including housing. For example, average private rents are around three times

more expensive in London than in the North East. Average Housing Benefit payments in London are around £3,000per year higher than those outside London. A tiered cap will mean that the distribution of capped households will be more broadly in line with the geographical distribution of Housing Benefit claimants. This will ensure that the work incentive effects are better felt across all of the country.

The level of the tiered caps is fair and reflects the broader economic situation – for instance, alongside the differences in housing costs, around 4 out of 10 households earn less than £23,000in London, whilst around 4 out of 10 households in GB (excluding London) earn less than£20,000.

People who move into specified levels of work are not affected by the cap – creating a clear incentive to move into employment. People who are entitled to Working Tax Credit, or who meet/exceed the earnings threshold in Universal Credit are exempt from the benefit cap.

An updated impact assessment has been published for the new, lower, tiered cap: Impact Assessment

The Committee asks the next report to explain, in the context of the reforms implemented in 2012 and also in the light of the observation of the Committee of Ministers, what are the eligibility conditions for ESA benefit and invalidity benefit and what is their duration and their minimum level.

The entitlement conditions for ESA as are follows:

A claimant may be entitled to ESA if:

- they are at least 16 years of age and under state pension age.
- have an illness, health condition or disability which limits their ability to work – this applies regardless of their normal employment status, i.e. whether they are normally employed, self-employed or unemployed; and
- are not entitled to Statutory Sick Pay (SSP), or their entitlement to SSP has ended.
- ESA can be awarded on the basis of either National Insurance (NI) contributions (contributory ESA (ESA(C)) or low income (income-related ESA (ESA (IR)). Both elements can be paid at the same time.

Income-related ESA

- A claimant may be entitled to income-related ESA regardless of how much they have paid by way of NI contributions, if they satisfy the conditions relating to their financial position. They must have savings of less than £16,000 and, if they have a partner or civil partner, the partner must work for less than 24 hours per week on average.

Contributory ESA

- Normally, to be entitled to contributory ESA, a claimant has to satisfy two conditions:
- To have paid enough NI contributions in the two tax years prior to claiming ESA for at least 26 weeks; and

- To have either paid, or been credited with enough, NI contributions in two tax years prior to claiming ESA that is at least 50 times the minimum threshold.
- A time limit of one year was introduced from 1 May 2012 for people in the work-related activity group (WRAG) to be entitled to contributory ESA. This underlines the principle that, with appropriate support, claimants are expected to return to work. It is more consistent with the rules for receiving contributory Jobseeker's Allowance (JSA), which has a time-limit of six months, whilst recognising the different nature of ESA recipients and the purpose of the benefit.

Time-limiting contributory ESA

- From 1 May 2012 the Welfare Reform Act 2012 introduced a one year time limit to contributory ESA for those in the work-related activity group. Before 1 May 2012, people could qualify for many years of benefit on the basis of National Insurance contributions made over a relatively short period of time.
- People in the Support Group will not have their benefit time limited because they have the most severe health conditions or disabilities and are the least likely to move into work.
- People receiving income-related ESA will not have their benefit time-limited.
- People moving off contributory ESA as a result of the time limit will be able to apply for income-related ESA if they are eligible.

ESA Rates

- ESA is paid at different rates depending on an individual's circumstances and the stage of the claim process. The benefit rates are intended to cover normal day-to-day living expenses such as food, normal replacement of clothing and local travel.
- Flat rate premiums may be paid for groups recognised as having additional needs – e.g. carers, severely disabled people and people aged over 60.
- The higher rates are paid from the 14th week of the award, compared to the 52nd week of an Income Support award under the previous system.
- People in the Support Group are automatically entitled to the Enhanced Disability Premium if they are entitled to income-related ESA. This provides a minimum income guarantee of £123.70 for a single person compared to £101.15 for a person in the work-related activity group.
- In addition, claimants may qualify for additional support such as Personal Independence Payment, Housing Benefit, Child Tax Credits, or Child Benefit.

Current ESA rates

The current rates of benefit (usually reviewed annually)

Assessment Phase	**2016/2017**
ESA (for a single person) under 25*	£57.90
ESA (for a single person) 25 or over	£73.10
Main Phase	
Work-related activity component	£29.05 Removed for new claims from 3 April 2017
Support component	£36.20
Enhanced Disability Premium (income-related only)	£15.75

The Committee asks what is the personal coverage of healthcare – i.e. the percentage of persons covered out of the total population.

100% of the permanent population are covered by the residency based system of healthcare provided through the NHS.

Response to the ECSR's Conclusion of non-conformity

The Committee concludes that the situation in the United Kingdom is not in conformity with Article 12§1 of the Charter on the ground that:

- **the minimum levels of short-term and long-term incapacity benefit is manifestly inadequate;**
- **the minimum level of state pension in manifestly inadequate;**
- **the minimum level of job seeker's allowance are manifestly inadequate.**

The UK government disagrees with the methodology used by the ESCR in that they consider the benefit rates in isolation and do not take into account the safety net of other UK benefits and credits available.

In the United Kingdom there are a range of benefits available to people dependent on whether they have paid sufficient National Insurance to qualify for a particular contingency such as retirement, sickness, or unemployment. These contributory benefits can be supplemented by means-tested benefits (which are defined as social assistance not social security) such as income-related Employment and Support Allowance and income-based Jobseeker's Allowance. In addition Housing Benefit is available to help with the costs of rent, and extra costs benefits such as Attendance Allowance, Disability Living Allowance and Personal Independence Payment can help with care and/or mobility needs. Many people therefore receive a combination of benefits to replace earnings when they are unable to work and it is the aggregate of these benefits which reflects the level of support provided by the UK Government and not just contributory benefits alone.

Contribution-based Jobseeker's Allowance (JSA(C)) is an earnings replacement benefit for unemployed people. It is awarded to support claimants whilst looking for work in acknowledgment of their recent work history and their contribution of paying National Insurance Contributions in the most recent two complete tax years. It is a short term benefit paid for up to 182 days. People with low income can also claim income-based JSA. They may also claim other benefits such as Housing Benefit to help with the rent, and Child Benefit and Child Tax Credits if they have children.

Contribution–based Employment and Support Allowance is an earnings replacement benefit for people below state pension age who are unable to work because of a health condition or disability. It is limited to 365 days for people in the work-related activity group but is unlimited for people in the support group. People with a low income can also claim income-related ESA. They may also claim other benefits such as Housing Benefit to help with the rent, and Child Benefit and Child Tax Credits if they have children. They may also claim Personal Independence Payment to help with care and mobility needs.

It is the focus of the benefits system in the United Kingdom to support those who have low income and capital. Although some individuals will only receive JSA(C) or ESA(C) and have no entitlement to other benefits, they generally have other resources available to them within the benefit unit[20] such as capital and/or partner earnings. Alternatively, these benefit units may be entitled to income-related benefits but do not claim them.

However, the majority of those who are claiming JSA(C) (62%) and most of those claiming ESA(C) (91%) are also claiming other benefits such as Housing Benefit, Personal Independence Payment or Child Benefit. The proportion of those in receipt of ESA(C) and JSA(C) who are also in receipt of other benefits is summarised in Table 1 below:

Table 1: Proportion of benefit units receiving contribution-based JSA or ESA that are also in receipt of other key benefits, United Kingdom, 2013/14

	JSA(C)		ESA(C)	
2013/14	Benefit Units	Proportion of total	Benefit Units	Proportion of total
Total	160,000	100%	700,000	100%
Of which				
Eligible for any benefits in group 1	80,000	51%	550,000	79%
Eligible for any benefits in groups 1-2	90,000	52%	630,000	90%
Eligible for any benefits in groups 1-3	100,000	62%	640,000	91%

The benefit groups referred to are:

1. Income related ESA or JSA, Housing Benefit, Working Tax Credits and Council Tax Support[21]

[20] A benefit unit is defined to be a single adult or a married or cohabiting couple and any dependent children; since January 2006 same-sex partners (civil partners and cohabitees) have been included in the same benefit unit.

[21] Northern Ireland has a system of rates rather than council tax. Therefore in this analysis, for benefit units in Northern Ireland, Council Tax Support is replaced by Rates Relief and Rates Housing Benefit.

2. Disability Living Allowance, Personal Independence Payment, Severe Disablement Allowance, Carer's Allowance and Statutory Maternity Pay
3. Child Benefit and Child Tax Credits

Source: Policy Simulation Model (see **annex A** for the full methodology)

Notes:

1. Figures are rounded to the nearest 10,000 benefit units
2. Figures may not sum due to rounding

Many other benefits are also available which are not included in this table. Please refer to the table of DWP benefit and pension rates[22] or the table of HMRC benefit rates[23] for more information on these benefits. In addition, passported benefits such as free school meals for children or free NHS prescriptions are also available to some claimants.

The UK benefits system is based on circumstances of families / benefit units and targeted at those most in need. Therefore the overall income of households should be taken into account when assessing adequacy of benefits. It is estimated that 88% of adults in families/benefit units in receipt of contribution-based ESA or JSA in the UK are in households with equivalised incomes above 40% of median income in 2014/15. This is based on the Households Below Average Income datasets. Possible reasons why households may be in receipt of less than 40% of median income could be possession of large sums of capital or not taking up their entitlements to income-related benefits.

Old age benefits similarly comprise a mixture of contribution and income based benefits. The examples below have been compiled to illustrate the range of pensioner benefits in addition to the State Pension. Some benefits like the State Pension are dependent on your Social Security contributions (contributory benefit), benefits like Pension Credit are means-tested, benefits like the Winter Fuel Payment are available to all that claim them (non-contributory benefit), and benefits like free prescriptions are age dependent but universal.

Scenario A - Someone on average state pension (£138.42 – Feb 2016, GB)

Entitlement	**Amount**
State Pension	**£138.42**
Guarantee Credit	£17.18
Savings Credit	£2.76
Total Pension Credit	**£19.94**
Total Income	**£158.36**
Housing benefit	(Up to) **£168.70** depending on circumstances
Other entitlements* *Some benefits may only be available if you're also in	Winter fuel payment - £200 Christmas bonus - £10 Free prescriptions Free dental treatment

[22] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/524117/benefit-and-pension-rates-from-6-april-2016.pdf
[23] https://www.gov.uk/government/publications/tax-and-tax-credit-rates-and-thresholds-for-2016-17/tax-and-tax-credit-rates-and-thresholds-for-2016-17

receipt of means-tested benefits i.e. Pension Credit	Free sight test *Cold weather payment - £25 per week of cold weather *Warm home discount scheme - £140 electricity bill discount *Vouchers for glasses/ lenses *Fares to receive NHS treatment *Free wigs/fabric supports *Help with housing costs *Sure Start maternity grant *Funeral expenses payment *Budgeting loans

Scenario B - Someone on average state pension with caring responsibilities for a severely physically disabled person

Entitlement	**Amount**
State Pension	**£138.42**
Guarantee credit	£51.78
Savings Credit	£2.76
Total Pension Credit	**£54.54**
Total Income	**£192.96**
Housing benefit	(Up to) **£168.70** depending on circumstances
Additional Amounts taken into account in guaranteed credit entitlement	**Carer's Additional Amount** - £34.60
Other entitlements* *Some benefits may only be available if you're also in receipt of means-tested benefits i.e. Pension Credit	Carer's allowance entitlement Winter fuel payment - £200 Christmas bonus - £10 Free prescriptions Free dental treatment Free sight test *Cold weather payment - £25 per week of cold weather *Warm home discount scheme - £140 electricity bill discount *Vouchers for glasses/ lenses *Fares to receive NHS treatment *Free wigs/fabric supports *Help with housing costs *Sure Start maternity grant *Funeral expenses payment *Budgeting loans

Scenario C - Someone on average state pension who is severely physically disabled person

Entitlement	**Amount**
State Pension	**£138.42**
Guarantee credit	£79.03
Savings Credit	£2.76
Total Pension Credit	**£81.79**
Attendance Allowance –	**£82.30**

Higher Rate	
Total Income	**£302.51**
Housing benefit	(Up to) **£168.70** depending on circumstances
Additional Amounts taken into account in guaranteed credit entitlement	**Severe Disability Additional Amount** - £61.85
Other entitlements* *Some benefits may only be available if you're also in receipt of means-tested benefits i.e. Pension Credit	Winter fuel payment - £200 Christmas bonus - £10 Free prescriptions Free dental treatment Free sight test *Cold weather payment - £25 per week of cold weather *Warm home discount scheme - £140 electricity bill discount *Vouchers for glasses/ lenses *Fares to receive NHS treatment *Free wigs/fabric supports *Help with housing costs *Sure Start maternity grant *Funeral expenses payment *Budgeting loans

The UK government maintains that its welfare system provides comprehensive and adequate cover, spending £258 billion on welfare in the year 2014/2015[24].

Our objective is to ensure that work always pays more than a life on benefits; that support is focused on the most vulnerable; and crucially, that the system is fair to those who pay for it, as well as those who benefit from it.

In assessing the UK's benefit system it is important for the Committee to take into account the dynamic effects of our policies and benefit rates, which are designed to ensure that people are always better off in work and do not become trapped on welfare. Our approach is working with the UK employment rate at a record high of 74.5%[25].

[24] http://visual.ons.gov.uk/welfare-spending/
[25] http://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/uklabourmarket/october2016

ISLE of MAN

Article 12, Paragraph 1

Please Note: Responsibility for social security matters was transferred from the (former) Department of Social Care to the Treasury with effect from 1st April 2014.

The following changes have occurred within the Island's social security programme since our last report in August 2012.

LEGISLATION

No Acts of the United Kingdom Parliament relating to welfare or pensions (or parts thereof) have been applied to the Island since the last report.

However, numerous Statutory Instruments of the United Kingdom Parliament have been applied to the Island.

The fundamental changes made by these and other secondary social security legislation made in the Island are detailed below.

STATE RETIREMENT PENSIONS

There were no changes to the entitlement conditions between the last report and 31st December 2015.

UNEMPLOYMENT BENEFITS

Previously Jobseeker's Allowance (JSA) was not payable to jobseekers who worked for 16 or more hours in a week. Furthermore income-based JSA was not payable to jobseekers whose partners worked for 24 or more hours in a week. From 9th August 2015 the limit on the number of hours a jobseeker – or their partner- can work was abolished. However, the amount a jobseeker earned, or for income-based JSA the amount they or their partner earned, over £30 a week continued to affect the amount of JSA payable to them.

From 1st November 2015 the following changes were made to **income-based** JSA -

- The amounts of personal allowances for jobseekers who do not have housing costs were generally reduced by around 27% from their previous levels.

- Personal allowances are reduced once a person has been claiming JSA for 6 months. They are reduced by 20% once they have been entitled to JSA for at least 6 months; by a further 10% after 9 months of JSA and by a further 10% after 12 months of JSA. So, a jobseeker who has been claiming JSA for at least 12 months will receive only 60% of the personal allowance of a jobseeker who has been claiming JSA for less than 6 months. These reductions apply irrespective of whether the jobseeker has housing costs. However, the allowances for any dependent children, housing costs and premiums are not affected.

- The maximum amount a jobseeker may earn before the amount of JSA paid to them is affected has been reduced - from £30 to £10 per week.

Members of the reserve forces claiming a jobseeker's allowance are now treated as available for and actively seeking work while they are undergoing their annual continuous training.

The availability and suitability of childcare must be taken into account when considering whether a jobseeker's caring responsibilities for a child make it unreasonable for that jobseeker to undertake a particular employment or to carry out a jobseeker's direction and whether a jobseeker has just cause for leaving their employment.

Any caring responsibilities for a child or necessary child care expenses which represent an unreasonable amount of a jobseeker's earnings must be taken into account in determining whether a jobseeker has just cause for leaving employment.

A single jobseeker who is responsible for a child may be treated as a person in hardship if their child would suffer hardship unless a jobseeker's allowance is paid to them.

SICKNESS AND INVALIDITY BENEFITS

There have been no changes since the last report.

The Island has not introduced employment & support allowance (introduced in Great Brain from October 2008 for new claimants) and currently has plans to do so.

INDUSTRIAL INJURY BENEFITS

The description of prescribed disease D10 (primary carcinoma of the lung) in the Social Security (Industrial Injuries) (Prescribed Diseases) Regulations 1985 has been amended in order to include employment wholly or mainly as a coke oven worker.

Bronchiolitis obliterans and nasal carcinoma have also been added to the list of prescribed diseases for industrial injury disablement benefit purposes.

DISABILITY BENEFITS

A claimant of **attendance allowance or disability living allowance** is now required to have been resident in the Isle of Man or the United Kingdom for at least 104 out of the 156 weeks immediately preceding the date of their claim. Previously they had to have been so resident for at least 52 out of the 104 weeks immediately preceding the date of their claim.

From 6th December 2018 (when men's and women's state pension ages will be equalised), the upper age limit for claiming **disability living allowance** (which is currently 65 years) will be the same as pensionable age for state pension purposes.

Disability living allowance and attendance allowance may now only be paid for up to 13 weeks of temporary absence abroad, or for up to 26 weeks if the temporary absence is for medical treatment. Previously it was paid for up to 26 weeks of temporary absence (ordinarily), or for an indefinite period if the temporary absence is for medical treatment.

The rates of **attendance allowance** and **disability living allowance** payable in the Isle of Man are now generally around 8% lower than in Great Britain.

CARER'S BENEFITS

A claimant of **carer's allowance** is now required to have been resident in the Isle of Man or the United Kingdom for at least 104 out of the 156 weeks immediately preceding the date of their claim. Previously they had to have been so resident for at least 52 out of the 104 weeks immediately preceding the date of their claim.

The rate of c**arer's allowance** in the Isle of Man was significantly increased from April 2015 – from £61.35 to £112.10 per week. The weekly rate in Great Britain from April 2015 was £62.10.

Since 1st April 2013 carer's allowance has been funded out of National Insurance contributions, whereas previously it was funded from general taxation.

BENEFITS TO MEET CARE COSTS

There have been no changes to the entitlement conditions since the last report.

However, the rate of the **nursing care contribution** has been increased. As at 31st December 2015 the weekly rate was £112.10.

BENEFITS DURING PREGNANCY AND CHILDBIRTH

There have been no changes to the entitlement conditions since the last report.

FAMILY BENEFITS

The lone parent increase of **chid benefit** was abolished in April 2013.

A family income test for **child benefit** was introduced in April 2014, and subsequently modified from April 2015. Broadly –

- If family income is less than £50,001 a year the maximum rate of child benefit is payable;
- If family income is between £50,001 and £60,000 a year 75% of the maximum rate of child benefit is payable;
- If family income is between £60,001 and £70,000 a year 50% of the maximum rate of child benefit is payable;
- If family income is between £70,001 and £80,000 a year 25% of the maximum rate of child benefit is payable; and
- If family income is greater than £80,000 a year no child benefit is payable.

"Family income" means for a lone parent their income and for a couple their combined income.

For more information see https://www.gov.im/categories/benefits-and-financial-support/social-security-benefits/child-benefit/

INCOME-RELATED BENEFITS

Income Support

Premiums applicable to the elderly, disabled, long-term sick and carers were significantly revised from April 2013. Transitional protection was given to existing beneficiaries.

"Transitional additions" have been discontinued.

Only lone parents who have at least one child **under the age of 12** are now eligible to claim income support solely on the basis that they are a lone parent.

Lone parents whose youngest child is aged 5 or over may now have to attend work-focused interviews (unless the lone parent is under age 18 or is aged 60 or over).

Income-based jobseeker's allowance

See "UNEMPLOYMENT BENEFITS" above.

Employed Person's Allowance (EPA)

EPA was introduced from 31st January 2012 and replaced both Family Income Supplement and Disability Working Allowance. This was largely "re-branding".

The provisions for EPA are broadly the same as for its predecessors.

See https://www.gov.im/categories/benefits-and-financial-support/social-security-benefits/employed-persons-allowance for more information.

Maternity Payment and Additional Funeral Payment

There have been no changes to the entitlement conditions since the last report.

Exceptional Needs Grants and Budgeting loans

The entitlement criteria for budgeting loans have been tightened. Subject to their satisfying the other qualifying conditions, a claimant can now only be awarded a budgeting loan if they have not received another budgeting loan within the previous two-year period. Furthermore, a claimant may only be given a budgeting loan on account of their having lost cash or had it stolen once in a lifetime.

A claimant may now qualify for an exceptional needs grant by satisfying the domestic violence condition if they have to move to a new home because of an act of domestic violence **or due to a fear of a future act** of domestic violence.

A budgeting loan may be paid to help certain disabled people with meeting an initial lump-sum payment when leasing a vehicle under the *Motability* Scheme. A budgeting loan for this purpose is disregarded when considering an application for a budgeting loan for any other item.

A grant or loan (as appropriate) may now be paid for a freezer or fridge-freezer.

Loans may now be awarded in relation to repairs to furniture or household equipment and central heating boilers.

Repayment of a budgeting loan from ongoing benefits is now at the standard rate of £12.50 per week. Deductions may also now be made from ongoing payments of child benefit and guardian's allowance by way of repayment of a budgeting loan.

See https://www.gov.im/categories/benefits-and-financial-support/social-security-benefits/budgeting-loans-and-exceptional-needs-grants for more information.

Winter Bonus

Income-based jobseeker's allowance ceased to be a qualifying benefit for the Winter Bonus from 1st November 2012.

There have been no other changes to the entitlement conditions since the last report.

MISCELLANEOUS

Income-based jobseeker's allowance ceased to be a qualifying benefit for the **Christmas Bonus** from 1st November 2012.

The categories of persons "engaged in caring" in a week who are entitled to a National Insurance credit for that week has been extended to include persons who would otherwise have been awarded child benefit for a week in respect of a child under the age of 12 but for the fact that their family income for child benefit purposes exceeds the upper income threshold (currently £80,000).

Benefit Claims in Payment & Annual Budgets at the beginning and end of the Reporting Period

Benefit/Pension	1 January 2012 No.	2011/12 Expenditure £,000	31 Dec 2015 No.	2015/16 Expenditure£,000
Retirement Pension	18,396	108,885	18,991	133,288
Old Person's Pension	43	122	42	147
Age Addition	(3,848)	426	(3,990)	444
Retirement Pension Premium	(3,178)	1,714	(3,005)	1,594
Pension Supplement	(13,715)	32,042	(14,225)	36,862
Christmas Bonus	(23,075)	1,894	(23,929)	943
Nursing Care Contribution	325	1,105	368	2,278
Child Benefit	10,075}		8,470}	
No. of children	(17,179)}	19,615	(14,315)}	10,887
Guardians Allowance	0	0	0	0
Contributory Jobseeker's Allowance	214	501	191	388
Incapacity Benefit (Short Term)	405	2,609	868	2,326
Incapacity Benefit (Long Term)	1,565	7,119	1,634	8,188
Maternity Allowance	556	4,102	444	3,943
Paternity Allowance	25	88	29	80
Adoption Allowance	3	15	2	17
Bereavement Allowance (incl. lump-sum payment)	121}		121}	
Widowed Parent's Allowance	8}	639	1}	746
Widow's Pension	52	243	28	115
Funeral Payments	(782)	195	(756)	207
Attendance Allowance	1,222	3,974	1,076	3,676
Disability Living Allowance	2,182	7,912	2,364	9,215
Severe Disablement Allowance	171	624	139	587
Industrial Disablement Benefit	261	493	235	321
Family Income Supplement}		5,994		-
Disability Working Allowance}		96	-	-
Employed Person's Allowance}	1,002	566	1,213	9,578
Carer's Allowance	265	778	316	2,027
Income Support[1]				
- Pensioners	1,718}		1,559}	
- Working age	2,199}	32,092	2,341}	34,445
Income-related Jobseeker's	951	3,948	691	4,072
Total no. of claims/expenditure/budget	41,759	237,791	41,123	266,374

[1] Includes Winter Bonus, Maternity Payments, Exceptional Needs Grants and TV Licence Payments

BENEFIT RATES
1. NATIONAL INSURANCE BENEFITS

(weekly rates)	2012/13	2015/16
Retirement Pension (R.P.)	**£**	**£**
Basic R.P. - own insurance	107.45	115.95
- on spouse's insurance	64.40	69.50
Old Person's Pension	64.40	69.50
Age Addition to R.P.	2.00	2.00
Retirement Pension Premium (maximum rate)	15.20	16.15
Pension Supplement (maximum rate)	52.45	53.75
Incapacity Benefit		
Short-term Incapacity Benefit		
over pension age	95.15	101.10
under pension age - lower rate	74.80	79.45
- higher rate	88.55	94.05
Long-term Incapacity Benefit		
standard rate	99.15	105.35
age addition - higher rate	11.70	11.15
- lower rate	5.90	6.20
Bereavement Benefits		
Lump-sum Payment	2,000.00	2,000.00
Bereavement Allowance	105.95	112.55
Widowed Parent's Allowance	105.95	112.55
Widow's Pension (transitional cases only)	105.95	112.55
Contribution-Based Jobseeker's Allowance		
Under 25	56.25	57.90
Aged 25 or over	71.00	73.10
Maternity Allowance		
Employed earners maximum rate	179.85	179.85
Self-employed rate	135.45	139.58
earnings threshold	30.00	30.00
Paternity Allowance		
Maximum rate	179.85	179.85
Adoption Allowance		
Maximum rate	179.85	179.85
earnings threshold	30.00	30.00

Industrial Injuries Disablement Benefit

100%	158.10	168.00
20%	31.62	33.60

Dependants Additions

Spouse (or person looking after children)		
with R.P. (protected cases only)	61.85	65.70
with Long-term Incapacity Benefit	57.60	61.20
with Short-term Incapacity Benefit	44.85	47.65
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 (protected cases only)	11.35	11.35

2. NON-CONTRIBUTORY BENEFITS

(weekly rates)	2012/13 £	2015/16 £
Child Benefit		
first child or qualifying young person	20.40	20.40
second or subsequent child or qualifying young person	13.50	13.50
increase for lone parent (protected cases only)	6.95	0.00
Carer's Allowance	58.45	112.10
Severe Disablement Allowance (S.D.A.) (protected cases only)		
Basic rate	69.00	74.65
Age related additions:-		
higher rate	11.70	11.15
middle rate	5.90	6.20
lower rate	5.90	6.20
Attendance Allowance (A.A.)		
higher rate	73.60	75.65
lower rate	49.30	50.70
Disability Living Allowance (D.L.A.)		
Care Component		
higher rate	73.60	75.65
middle rate	49.30	50.70
lower rate	19.55	20.10
Mobility Component		
higher rate	51.40	54.80
lower rate	19.55	20.10
Dependency Additions		
Spouse (or person looking after children) -		
with Carer's Allowance (protected cases only)	34.40	36.55
with S.D.A.	34.60	36.75
Children - with I.C.A., S.D.A (protected cases only)	11.35	11.35

3. INCOME-RELATED BENEFITS
INCOME SUPPORT

(weekly rates)	2012/13	2015/16
Personal Allowances	**£**	**£**
Couple, both members aged 18 or over	149.60	152.60
Couple, one member aged 18 or over, one aged 16 or 17	119.65	122.05
Couple, both members aged 16 or 17		
- in respect of whom housing costs are applicable	119.65	122.05
- in respect of whom housing costs are not applicable	89.80	91.60
Single claimant aged not less than 25	98.05	100.05
Single claimant aged between 18 and 24	78.40	80.00
Single claimant aged 16 or 17		
- in respect of whom housing costs are applicable	78.40	80.00
- in respect of whom housing costs are not applicable	58.85	60.05
Lone parent aged 18 or over	98.05	100.05
Lone parent aged 16 or 17	78.40	80.00
First qualifying young person or child	32.65	33.35
Second and subsequent qualifying young person or child	39.55	40.35
Modifications in Special Cases		
(a) Board and Lodging Cases		
Meals Allowances (per day) :-		
- Breakfast	2.55	2.65
- Lunch	3.70	3.80
- Dinner	3.70	3.80
Maximum allowance for board and lodgings, including any additions for meals not included :-		
- Single claimant	157.30	160.45
- Couple	233.35	238.05
Personal Expenses :-		
- Single claimant	32.30	32.95
- Couple	64.60	65.90
Addition for each qualifying young person or child		
First qualifying young person or child	32.65	33.35
Second and subsequent qualifying young person or child	39.55	40.35

(b) Residential and Nursing Home Cases

Maximum allowances for accommodation charges :-		
- Residential care home managed by DHSC	432.32	441.00
- Commercial, voluntary or charitable residential care home	432.32	441.00
- Nursing Home	697.13	711.20
Allowances for personal expenses	32.30	32.95
(c) Hospital In-patients (transfer from care homes only)	32.30	32.95
(d) Lone parents - Childminding costs		
- Lower rate	158.00	160.00
- Higher rate	233.00	235.00

Premiums

Lone parent :-	16.70	-
Pensioner :-		
Awards commencing on or after 8/4/2013:-		
- single	-	62.60
- couple	-	95.75
Transitionally protected cases (awards pre 8/4/2013):-		
- Single, aged 60-74	64.65	64.65
- Couple, one or both aged 60-74	71.75	95.75
- Single, aged 75 or over	90.45	95.75
- Couple, one aged 75 or over	90.45	95.75
- Couple, both aged 75 or over	98.85	98.85
Incapacity :-		
Awards commencing on or after 8/4/2013:-		
- single	-	25.50
- couple	-	38.25
Transitionally protected cases (awards pre 8/4/2013):-		
- single	35.60	35.60
- couple	50.70	50.70
Disability premium		
Awards commencing on or after 8/4/2013:-	-	53.15
- single	-	79.75
- couple		
Transitionally protected cases (awards pre 8/4/2013):-		
- single	16.50	16.50

- couple	23.80	23.80
Higher Disability Premium (awards pre 8/4/2013 only)		
- single	52.10	52.10
- couple	74.45	74.45
Blindness premium (awards pre 8/4/2013 only)		
- claimant or partner	31.50	31.50
- dependent child or young person	14.80	14.80
Mobility Premium		
Awards commencing on or after 8/4/2013:-		
- single	-	26.20
- couple	-	39.30
- lower	-	6.00
Transitionally protected cases (awards pre 8/4/2013):-		
- higher	51.40	51.40
- lower	31.85	31.85
Carer premium		
- single	35.10	62.60
- couple	70.20	95.75
Higher carer premium (awards pre 8/4/2013 only)	62.30	62.30
Attendance premium		
- highest rate	73.60	75.65
- middle rate	49.30	50.70
- lowest premium	19.55	20.10
Disabled child premium	39.80	40.60
Shared care premium	24.20	24.70

Housing Costs

Maxima towards rent, loan interest, rates, service charges etc . :-

Single claimant or couple		
- with no children	116.00	116.00
- with one dependent child	150.00	153.00
- with two dependent children	162.00	165.00
- with three or more dependent children	178.00	182.00
Maintenance and insurance	12.95	13.25
Deductions for inclusive utilities :-		
- heating	18.25	18.65
- lighting	1.55	1.55
- cooking	2.30	2.30
- hot water	2.30	2.30
Reductions in amounts for non-dependent occupants :-		
- in receipt of income support or income-based jobseeker's allowance	14.50	14.80
- in any other case	51.10	52.10

Income-Based Jobseeker's Allowance

Rates of personal allowances, premiums and housing costs are the same as for Income Support with the following exceptions :-

- No provision is made for a pensioner premium in respect of a single claimant aged 75 or over;
- No provision is made for a pensioner premium in respect of a couple where both members of the couple are aged 75 or over; and
- No provision is made for an incapacity premium in respect of a single claimant.

EMPLOYED PERSON'S ALLOWANCE (EPA)

	2012/13	2015/16
(weekly rates)		
Prescribed Amounts	**£**	**£**
Single claimant who is a disabled worker	216.15	220.50
Lone parent who is not a disabled worker	268.05	273.45
Lone parent who is a disabled worker	322.20	328.65
Couple neither of which is a disabled worker	268.05	273.45
Couple which includes a disabled worker	322.20	328.65
For the first or only child or qualifying young person	20.80	21.20
Increase for each additional child or qualifying young person	60.05	61.25
Disabled Child's Allowance	39.20	40.00
24 hours or more per week work addition	32.10	32.70
Housing costs :-		
Maxima towards rent, loan interest, rates, service charges etc . :-		
Single claimant or couple		
- with no children	116.00	116.00
- with one dependent child	150.00	153.00
- with two dependent children	162.00	165.00
- with three or more dependent children	178.00	182.00
Maintenance and insurance	12.95	13.25
Deductions for inclusive utilities :-		
- heating	18.25	18.65
- lighting	1.55	1.55
- cooking	2.30	2.30
- hot water	2.30	2.30
Reductions in amounts for non-dependent occupants :-	26.05	26.55
Non-householder's contribution	14.50	14.80
Maximum childminding costs :-		
- less than 24 hours work per week		
- 1 child	110.00	111.00
- more than 1 child	177.00	179.00
- 24 hours or more work per week		
- 1 child	158.00	160.00
- more than 1 child	233.00	235.00
Maintenance disregard	23.70	24.20

LUMP SUM PAYMENTS

	2012/13 £	2015/16 £
Christmas Bonus (annual)	82.50	40.00
Winter Bonus (annual)		
Standard rate per claim (reduced rate for shared households)	300.00	300.00
Bereavement Payment (one-off)	2,000.00	2,000.00
Funeral Payment (one-off, not means-tested)		
standard rate	210.00	210.00
enhanced rate	350.00	350.00
Maternity Payment (one-off)		
Standard rate for each child (reduced rate for repeat claims within 3 years)	500.00	500.00

Article 13 – The right to social and medical assistance

Paragraph 1

Great Britain

Social Assistance

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

Legislation

The Welfare Reform Act 2012

2. The Welfare Reform Act 2012 received Royal Assent on 8 March 2012 and has effect in Great Britain. The Welfare Reform (Northern Ireland) Order 2015 broadly corresponds to the Welfare Reform Act 2012, with some flexibilities agreed between the Northern Ireland Executive and the UK Government.

3. The Act's main provisions summarised in our previous report are updated as follows:

Universal Credit

4. Universal Credit aims to make work pay by ensuring claimants are better off in work than on benefits, promoting personal responsibility to actively seek work and increase earnings, while continuing to provide support for those who need it most. The Government wants to move to a higher wage, lower welfare, lower tax society and Universal Credit is a key part of this change. Universal Credit is a single payment that includes help for people in many different circumstances including, single people, couples, people with health problems or disabilities, people with caring responsibilities, people with children (including extra support for children with disabilities), and people with childcare or housing costs. Evidence shows that Universal Credit is working[26].

5. Universal Credit replaces income-based Jobseeker's Allowance, income-related Employment and Support Allowance, Income Support, Working Tax Credit, Child Tax Credit and Housing Benefit.

6. Universal Credit has been successfully rolled out across the country to new single jobseekers and is now available in all jobcentres. We are continuing our successful rollout of the universal credit full service for all new claimants. As of November 2016, over 420,000 claimants are receiving UC, and are being supported to build better futures for themselves. The plans have been announced through to completion of the rollout in September 2018. At which stage the vast majority of people will no longer be able to make a claim to income-based jobseeker's allowance and employment and support allowance, income support, housing benefit or tax credits.

7. The Government considers it right to ask those who are able to work to do more in return for receiving benefits while protecting those who are not able to work. Under

[26] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/483029/universal-credit-at-work-december-2015.pdf

Universal Credit, the requirements claimants will have to meet will be set according to individual capability and circumstance.

Disability Living Allowance Reform /Personal Independence Payment

8. A key element of the Government's welfare reforms is the replacement of Disability Living Allowance (DLA) for people aged 16-64 with Personal Independence Payment (PIP). By reforming DLA[27], the Government wants to create a fairer, more transparent and sustainable system of financial support for disabled people who face the greatest barriers to participating in society.

9. PIP is designed to have a more objective assessment process, with new entitlement criteria and a face-to-face consultation for most people that enables a more accurate and consistent assessment of individual need. The assessment treats people as individuals, considering the impact of their impairment or health condition on their everyday life. The assessment also takes account of the fact that many people have complex support needs and more than one impairment or health condition and gives greater parity of esteem to both mental and physical health conditions, which was not the case in DLA.

10. Throughout the development of PIP, the Department consulted extensively with disabled people, organisations of and for disabled people, carers and experts in health, disability and social care. Those consultations led to the Government introducing a number of significant improvements to PIP, including amending Regulations[28] to:

- ensure that consideration must be given to whether individuals can complete the assessment activities "safely, to an acceptable standard, repeatedly and in a reasonable time period";
- broaden the approach to aids and appliances so that they include non-specialist aids (such as electric can openers);
- divide the previously proposed communicating activity into two, to take account of verbal communication and reading and understanding signs, symbols and words;
- increase the amount of time allowed for a temporary absence abroad; and
- allow claimants to request further time to complete forms.

11. PIP was introduced for new claimants on 8 April 2013 in a limited geographic area in the North of England before being rolled out across Great Britain (GB) from 10 June 2013 (PIP was introduced from 20 June 2016 in Northern Ireland). From October 2013 the Government started inviting existing claimants of DLA to claim PIP when: they reached age 16; a change of circumstances is reported; the existing award of DLA is ending; or where they voluntarily claim. These arrangements were phased in on a post code basis between October 2013 and July 2015 and now apply across GB. From July 2015 the Government also started inviting claimants in receipt of longer or indefinite awards of DLA to claim PIP, initially in a limited area and with limited numbers before extending this activity across GB from October 2015.

12. PIP is currently (at 31 July 2016) being received by around 932,000 claimants, of whom 339,000 were previously in receipt of DLA[29]. In line with the intention that PIP should be focused on those with the greatest needs, 24% of those currently in receipt are

[27] The Government initially consulted on the reform of Disability Living Allowance between December 2010 and February 2011: https://www.gov.uk/government/consultations/disability-living-allowance-reform
[28] http://www.legislation.gov.uk/uksi/2013/377/contents
[29] PIP claimant statistics can be extracted from Stat-Xplore: https://stat-xplore.dwp.gov.uk/

receiving both the enhanced rates[30] (totaling £139.75 a week) compared to 15% of working age claimants receiving the highest rates under DLA.

13. The Government acknowledges that in the early days following PIP's introduction there were delays to claims being processed. The Government, together with the assessment providers, introduced a range of improvements to bring down the time claims are dealt in. On average, claims are currently being processed in 11 weeks[31] from the point of claim to the decision, including the time given for claimants to complete and return a questionnaire and to arrange and conduct a face-to-face consultation where required. Claims are now being cleared at over four times the rate they were in January 2014. Between January 2014 and July 2016 the number of claims cleared increased from 16,000 a month to around 80,000. Claims cleared have been steadily increasing quarter on quarter since summer 2015, as we invite more people to claim PIP, and the Government and its providers are now operating well within the levels aimed for.

14. The operation of the PIP assessment is subject to two, statutory reviews within four years of its introduction. The first review was conducted by Paul Gray CB and reported its findings to the Government on 17 December 2014[32]. It considered how the assessment process was working from the perspectives of claimants, health professionals, and operational colleagues involved in delivery. The initial government response was published in February 2015[33] and addressed all the short term recommendations which were identified. The second government response was published in November 2015[34] addressing the medium and long-term recommendations made in the review.

15. On 6 July 2016 Paul Gray CB was appointed to lead the second independent review of the PIP assessment. This review will consider how effectively further evidence is being used to assist the correct claim decision and the speed and effectiveness of information-gathering as well as building on recommendations from the first review[35]. The second review will be published by April 2017.

Fraud and Error

16. The administrative penalty as an alternative to prosecution for benefit fraud was toughened in May 2012. The changes introduced a minimum administrative penalty of £350, or 50 per cent of the amount overpaid whichever is the greater, up to a maximum of £2,000. The maximum penalty was increased in April 2015 to £5,000.

17. Administrative penalties may be offered at the Department's discretion to people as an alternative to a prosecution in certain cases where there has been benefit fraud or attempted benefit fraud. Where a person accepts the offer of an administrative penalty, they will not be prosecuted in respect of that offence. As before May 2012 the person will have to repay any overpayment and is also liable for a 4 weeks loss of benefit. The

[30] PIP is comprised of two components, both paid at either a standard or enhanced rate: the daily living component; and the mobility component. Further details on PIP can be found here: www.gov.uk/pip
[31] https://www.gov.uk/government/collections/personal-independence-payment-statistics
[32] https://www.gov.uk/government/publications/personal-independence-payment-pip-assessments-first-independent-review
[33] https://www.gov.uk/government/publications/personal-independence-payment-pip-assessments-first-independent-review-government-response
[34] https://www.gov.uk/government/publications/personal-independence-payment-pip-assessments-first-independent-review-second-government-response
[35] https://www.gov.uk/government/publications/personal-independence-payment-pip-assessment-second-independent-review

administrative penalty changes were not retrospective, meaning that the offence on which the tougher administrative penalty can be offered must occur wholly on or after 8 May 2012. Because the change is not retrospective the tougher administrative penalty will take some time to work through and apply to all cases where an administrative penalty is offered.

18. The loss of benefit penalty is designed to be a deterrent against abuses of the benefit system by applying a penalty to those who are convicted, or who have accepted an administrative penalty or caution for a benefit fraud offence. The loss of benefit penalty was toughened in April 2013:

- A 13 week loss of benefit penalty for a first conviction (previously 4 weeks)
- Loss of benefit periods of 26 weeks and 3 years (previously 13 weeks) apply where an offender is convicted of a benefit fraud offence and had previously committed one or more benefit offences within a specified period
- For serious organised and identity fraud cases the penalty is an immediate 3 year loss of benefit after a single offence
- Following Welfare Reform Act 2012 the loss of benefit penalty for those accepting an administrative penalty remained at 4 weeks

19. The fraud loss of benefit penalty changes were not retrospective, meaning that the benefit fraud offence on which the tougher loss of benefit penalty can apply must be committed wholly on or after 1 April 2013, as a result the number of cases where the tougher loss of benefit penalty can apply is low but will ramp up in future years.

20. The £50 civil penalty was introduced in October 2012 as a minor flat rate penalty to help tackle claimant error. A DWP internal 3 year review on the operation of the civil penalty was carried out in 2016 and found the penalty is operating as intended.

21. Around 222,000 claimant error overpayments had a civil penalty imposed between October 2012 and September 2015 which represents 43% of all considered overpayments. DWP considers the full circumstances of each overpayment above £65 including any further information supplied by the claimant against the penalty criteria and guidance. This ensures civil penalties are only given on appropriate cases and has led to a much lower level of appeals against the penalty (2%) than was anticipated in the business case. DWP recognises and appreciates that there are different reasons why someone might make a mistake in giving information about their claim. Not all of them mean that a claimant is at fault or deserves a civil penalty and we understand this. Similarly, we know that some people may have a reasonable excuse for their failure to do something and the provisions allow us not to impose a penalty where this is the case.

22. In the first 3 years only 3% of claimants with a civil penalty had two or more civil penalties imposed. There was a 7% drop in the number of civil penalties in Year 3 (October 14 - September 15) and at the same time the number of overpayments dropped by 2%. These numbers are encouraging but it is too early to treat them as an indication that the civil penalty is achieving its policy aim of reducing claimant error.

23. The Welfare Reform Act 2012 enabled the creation of a Single Fraud Investigation Service which brought together Department for Work and Pensions (DWP), Her Majesty's Revenue and Customs and Local Authority fraud investigators to operate as a single organisation within DWP's Fraud and Error service. The new service allows each individual fraud investigator to identify the totality of welfare benefit and tax credit fraud in

each investigation. The Single Fraud Investigation Service project has successfully integrated the investigators from these areas, work continues on sharing data and how we manage cases in a single service. The last people joined DWP in March 2016.

24. Bringing our investigation services into one command ensures that we can deliver a consistent approach in terms of, value for money, effectiveness, professionalism and customer service while offering long term sustainability.

25. Having a single approach enables DWP's Fraud and Error service to investigate and punish welfare benefit fraud, delivering cross-Government savings whilst enhancing Government's reputation for tackling fraud. They can now investigate fraud effectively through better application of the existing fraud investigation resources and provide an integrated investigation capability which equips DWP to deal with fraud challenges presented by the introduction of Universal Credit, Personal Independence Payments and future digitalisation. The current Penalties Policy in respect of social security fraud and error is publicly available[36].

Sanctions & Hardship

26. The Bill introduced a tougher set of sanctions to more effectively encourage claimants to meet their responsibilities. This includes a new three year sanction for jobseekers who repeatedly fail to meet the most important job seeking conditions such as refusing an offer of employment.

27. The hardship system has undergone reform so that only those claimants in greatest need receive payments.

Housing Benefit/Local Housing Allowance

28. The Act sets out powers to restrict the increase in Local Housing Allowance rates to the Consumer Prices Index. This will enable greater control over the growth of Housing Benefit in the private rented sector and ensure future support for claimants will be kept at a more reasonable and realistic level. It also introduces a measure to ensure that Housing Benefit for working-age tenants in the social rented sector takes account of whether they under occupy their property.

29. The Removal of the Spare Room Subsidy is in operation within Housing Benefit for the social rented sector which was introduced from April 2013 through secondary legislation and Welfare Reform Act 2012.

Employment and Support Allowance

30. The Act introduced a one year time limit to the receipt of contributory Employment and Support Allowance (ESA) for people who are able to prepare for work and are in the Work Related Activity Group. This measure does not affect people in the Support Group who have the most severe health conditions or impairments and are the least likely to move into work, or those receiving income-related ESA. Claimants with low or no other sources of income may either become entitled to income-related ESA or an increased amount of income-related ESA once their contributory ESA has ended.

[36] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/398189/penalties-policy.pdf

31. This measure underlined the principle that ESA was never intended to be a benefit for the long term for claimants who are able to move towards employment. It ensures that financial support for disabled people and people with health conditions is well targeted.

Abolishing Employment and Support Allowance (Youth) Provisions

32. The Act abolished the 'youth' provisions, which allowed certain young people to qualify for contributory ESA without having to pay National Insurance contributions. This brought those claiming ESA 'youth' in line with other groups, and simplified the benefit system in advance of the introduction of Universal Credit.

Benefit cap

33. The benefit cap was introduced in 2013. A key aim of the benefit cap is to influence a change in attitudes by encouraging people to take up work or increase the hours they work, to reduce long term dependency on benefits. A review of the first year has been published[37].

34. Evaluation of the current cap[38] has shown that capped claimants are 41% more likely to move into work than similar uncapped claimants. The latest published statistics are here: https://www.gov.uk/government/statistics/benefit-cap-number-of-households-capped-to-may-2016

Social Fund Reforms

35. The Act abolished the discretionary Social Fund and amended payments on account legislation in order to replace Crisis Loan alignment payments and Budgeting Loans with a new national payment on account scheme. New local provision replaced Community Care Grants and Crisis Loans for general living expenses. The new provision is the responsibility of local authorities in England and the Scottish and Welsh Governments.

The Social Fund

36. The Social Fund is administered by the Department for Work and Pensions and provides interest free loans, grants and payments through both a regulated and a cash limited discretionary scheme. It provides additional funds to people on top of benefits in a range of circumstances.

37. The Social Fund scheme includes a regulated scheme made up of Maternity, Funeral, Cold Weather and Winter Fuel Payments; and a discretionary scheme comprising repayable Budgeting Loans.

38. The Welfare Reform Act 2012 abolished parts of the discretionary Social Fund, introduced payments on account to replace Crisis Loan alignment payments and eventually Budgeting Loans; and paved the way for the delivery of new local provision to replace Community Care Grants and Crisis Loans for general living expenses from April 2013.

39. The new local provision ensures that support is available for those in the greatest need as Local Authorities are better placed to determine and support the needs of local vulnerable people than the previous centralised system which was more remote.

[37] ' The benefit cap: a review of the first year '.
[38] https://www.gov.uk/government/publications/benefit-cap-evaluation

40. The Government published a review of Local Welfare Provision in November 2014 that found that Local Authorities were best placed to help vulnerable people locally and provide a timely and better targeted service. Local Authorities are working with a range of different stakeholders and partners in their local areas and have a good understanding of their local community.

41. In the Government response to the Work and Pension Select Committee inquiry on future funding of Local Welfare Provision £129.6 million was identified in the 2015-16 local government finance settlement relating to local welfare provision. The Government will continue to provide support to local authorities as part of its commitment to reduce ring-fencing and end top-down Whitehall control.

42. The Social Fund Annual Report for 2015/16 can be found at:
https://www.gov.uk/government/publications/social-fund-annual-report-2015-to-2016

Child Support Maintenance Reforms

43. The Welfare Reform Act 2012 enabled reforms to the child maintenance system to encourage separated parents to work together to make their own family-based arrangements where possible. As part of these reforms, application fees and collection charges were introduced in June 2014 and are designed to make parents think about their maintenance arrangements before defaulting to the statutory scheme, which remains available for those who need it.

44. The Act also provides a requirement that the Department conduct a review of the impact of charging 30 months after its introduction. The 30 month review is currently on-going and is due to be completed by the end of December 2016 and policy response and analytical summary published in early 2017.

Simplification of the Industrial Injuries Disablement Benefit

45. Measures were included to rationalise, simplify and deregulate the Industrial Injuries Disablement Benefit scheme. The changes allowed the removal of old and redundant legislation. The new arrangements were designed so that nobody loses any money. The changes did not affect large numbers of customers.

46. Changes introduced in 2012 have simplified the claims process for the Industrial Injuries Disablement Benefit Scheme. Today, individuals no longer need to consider which of several schemes to claim against, and instead are presented with clear information about a single scheme from the gov.uk portal. Claimants, regardless of age, are now paid the same rate of benefit. No significant reforms to the Scheme have been undertaken since 2012.

Lone Parents

Conditionality changes for parents

47. From April 2017, responsible carers (both lone parents and partners) claiming Universal Credit will be expected to look for work when their youngest child turns 3, and to prepare for work when their youngest child turns 5. Responsible carers with a child aged 1 remain subject to work focused interviews only. Responsible carers with a child under age 1 are not required to undertake work-related activities as a condition of receiving benefit.

Tailoring conditionality

48. We will ensure that any work related requirements will be tailored to individual circumstances and compatible with child care responsibilities. The flexibilities and support available to parents claiming UC are there to help ensure that any requirements imposed on them are not disproportionate**.** The number of hours that we will "expect" a responsible carer to look for work will vary dependent on childcare availability and any other particular needs that a child may have.

49. A parent who decides, with good reason, to look after their children themselves, rather than use the Department for Education (DfE) childcare offer (or where it is not available) will have requirements appropriately tailored to their circumstances. Requirements will be continually reviewed when circumstances change.

Partner conditionality

50. All UC claimants will be allocated to one of 4 legal conditionality groups depending on individual and household information, characteristics and earnings. This includes both partners in a household claim.

51. The conditionality framework has been developed on the expectation that claimants will transition between groups - determined by an increase or decrease in earnings (including household earnings) or a change in circumstances e.g. birth of a child or recovery from a health condition. Regardless of which conditionality group a claimant is allocated to, they will be expected to accept a Claimant Commitment which sets out their responsibilities in return for receiving UC.

52. Impact analysis of previous changes to lone parent conditionality for those with children aged 7 and over, where lone parents moved from Income Support to Jobseeker's Allowance, showed that over 10% more lone parents were in work after conditionality than before. This has fed into our assumption in extending the policy to parents with children aged 3 and 4.

53. Evidence shows that one of the biggest drivers of child poverty is long-term worklessness and low earnings; 12% of all children live in workless households; 38% of those in workless households are in persistent poverty. This measure is about parental employment, but the majority affected will be women – 91% of lone parents are female.

Addressing Financial Exclusion – Credit Union Reform

54. Financial exclusion imposes real costs on individuals and their families - often the most vulnerable people in our society. Credit unions offer a real alternative for people on low incomes - they are part of the more diverse financial service sector that Government wishes to see. The Department for Work and Pensions is looking at ways to modernise and expand.

55. The DWP Growth Fund increased access to affordable credit through credit unions and other contracted third sector financial suppliers from August 2006 until March 2012. On a £500 loan provided through the Growth Fund the average borrower saved an average of £401 in interest charges when compared to the same loan being provided by a high cost lender.

56. More needs to be done to secure credit union expansion and modernisation to the point where each has the opportunity to become sustainable. The DWP coordinated a feasibility study to examine the scope and the options for the modernisation and expansion of credit unions. The feasibility study has been published and informal views received.

57. On 27th June 2012 the Government announced that it will take forward the study's findings and make a further investment of up to £38 million in credit unions to support growth, modernisation and sustainability of that sector. The investment has to date helped a number of credit unions to benefit from a new banking platform, access to an Automated Lending and Decision system, and benefit from marketing and business planning tools. The investment is being delivered through the Credit Union Expansion Project that ends in December 2016 with benefits being realised over a longer period.

Social Reform

58. The Government has made a commitment to building a country that works for everyone – not just the privileged few. As the Prime Minister has made clear, tackling poverty and disadvantage, and delivering real social reform, will be a key Government priority. A new Cabinet Committee, chaired by the Prime Minister, has been set up to oversee this agenda. It will oversee and agree social policy reforms and lead the government's work to increase social mobility, deliver social justice and make Britain a country that works for everyone. Further detail on this agenda will be set out in due course.

Legislation

The Welfare Reform and Work Act 2016

59. The Welfare Reform and Work Act 2016 builds on the important welfare reforms we have made since 2010. It will deliver a system that ensures that work always pays more than a life on benefits; that support is focused on the most vulnerable; that the system is fair to those who pay for it, as well as those who benefit from it. The Act received Royal Assent on 16 March 2016 and has effect in Great Britain.

60. The Act's main provisions are summarised as follows:

The Benefit Cap

61. The benefit cap is about incentivising work, and thereby transforming families' life chances, consistent evidence across a number of reports indicates that the current cap is working. Capped households are 41% more likely to go into work than similar uncapped households. Our analysis has found that the greater the amount of benefit that is capped, the greater the proportion of those moving into work. Since its introduction, around 56,000 households that were previously capped are no longer capped. Of those, 41% have gone into work, over 11% are no longer claiming housing benefit and 10% have reduced their housing benefit.

62. We want to continue the success of our reforms to help reduce welfare dependency and make sure that work is always the best route out of poverty. That is why in the Summer Budget 2015 the Government announced a lower, tiered cap to £20,000 nationally (£13,400 for single people without children), with the exception of £23,000 in Greater London (£15,410 for single people without children) and these were passed in the Welfare Reform and Work Act 2016 and are planned to be implemented from November

2016. A revised Benefit Cap Impact Assessment of these changes was published on 25th August 2016[39].

63. In order to protect the most vulnerable, households are exempt from the benefit cap if someone is in receipt of certain benefits. For example, households in which a member is entitled to an extra-costs disability benefit, such as Disability Living Allowance (DLA) or Personal Independence Payment (PIP), are exempt from the cap. New exemptions for households entitled to Carer's Allowance, carer-related costs in Universal Credit, and Guardian's Allowance are also being brought forward in the autumn. In addition, Housing Benefit paid to households in Supported Accommodation is also disregarded from the benefit cap. In order to incentivise work, households which include a member who is entitled to Working Tax Credit or in receipt of Universal Credit and earns £430 or more a month are also exempt from the cap. For cases where claimants need further financial support, Local Authorities can provide additional support through Discretionary Housing Payments (DHP). The UK Government will provide £870 million funding for the DHP scheme over the next 5 years. £40 million of DHPs have been allocated to the benefit cap for 2016/17 – a £15 million increase since last year.

The Benefits Up-rating Freeze

64. Between 2008 and 2015, Average Weekly Earnings have risen by 12%, whereas the rates of most working-age out-of-work benefits, such as Jobseeker's Allowance (JSA), have risen by 21%. It is not fair that the amount people receive on benefits should increase by a faster rate than the amount working people receive from employment. The freeze will help reverse this trend, helping earnings to grow faster than benefits.

65. This is also an important part of the Government's welfare reforms that, together with the freeze of Local Housing Allowance rates in Housing Benefit, contribute £3.5 billion of savings per year by 2019-20. These savings are a necessary part of the Government's economic plan to restore the nation's finances. Our approach provides the appropriate balance between incentivising work for those who can move closer to the labour market, while protecting benefits in order to protect the most vulnerable. That is why we have made many important exemptions to the freeze, including DLA, PIP, disability premiums in JSA, ESA, Income Support and Housing Benefit, Attendance Allowance, the support group component in ESA, the Limited Capability for Work and Work-Related Activity amounts in Universal Credit, the disability elements of working tax credit and the disabled and severely disabled child elements of Child Tax Credit.

Changes to ESA

66. This Government recognises that the gap between the employment rates of disabled people and non-disabled people remains too large. That is why we are committed to halving it, as set out in this Government's election manifesto. Most people with disabilities and health conditions want to work, including the majority of ESA claimants (61% of the work-related activity group) and there is a large body of evidence showing that work is generally good for physical and mental wellbeing.

67. The recent record employment levels have benefitted many but have yet to reach those on ESA. It is important to remember that while over 50% of JSA claimants leave the benefits within 3 months, only 1 in 100 of those who have been placed in the Work Related

[39] https://www.gov.uk/government/publications/welfare-reform-and-work-act-impact-assessment-for-the-benefit-cap

Activity Group following their Work Capability Assessment leave the benefit each month. In addition to providing financial security for individuals, work often has a profound effect on people's life chances and it is right that this Government does everything it can to provide better support to get people into work. The work-related activity component, which was originally designed to act as an incentive to encourage people to participate in work-related activity and therefore return to work more quickly, isn't working as intended and is failing claimants. Accordingly from April 2017, the work-related activity component will not be paid to new ESA claimants only. Existing ESA claimants and those in the support group will not be affected by this measure. This change will ensure people have the right support and incentives to move towards work, and enables us to recycle money that will make a significant difference to the life chances of those in the work-related activity group. This new funding will be worth £60 million a year in 2017/18 rising to £100 million in 2020/21 and will support those with limited capability for work to move towards and into suitable employment.

Changes to the Measures of Child Poverty

68. The Welfare Reform and Work Act 2016 made significant amendments to the Child Poverty Act 2010 (now referred to as the Life Chances Act 2010), including removing the duty on the Secretary of State to meet income related targets and the duty to prepare a child poverty strategy setting out how the Secretary of State was to meet those targets and to ensure children in the UK did not experience socio-economic disadvantage. The Act also renamed the Social Mobility and Child Poverty Commission as the Social Mobility Commission, redefined and strengthened its role and widened its remit. There is no longer a requirement for the Commission to comment in its annual report on the progress made towards implementing a child poverty strategy. Instead the Commission's report must now set out its views on the progress made towards improving social mobility in the UK.

69. The Government has made a clear commitment to tackling poverty and disadvantage, and delivering real social reform. This means a continued focus on tackling the root causes – not the symptoms – of poverty. This is why provisions in the Welfare Reform and Work Act 2016 introduced two new two new statutory measures that will drive real action on workless households and educational attainment. These are the two areas that we know can make the biggest difference to disadvantaged children and their families.

70. This Government has already made real progress in this area. The number of children living in workless households is at a record low. Around 557, 000 fewer children are living in workless households compared with 2010. There is the highest employment rate on record with 2.7 million more people in work since 2010. These figures show that this Government's approach – growing the economy, creating jobs, and ensuring that work will pay – has transformed the lives of some of the most vulnerable in our society.

71. We continue to have in place a strong safety net, with around £90 billion a year spent on working-age benefits to support those in need. Furthermore, spending to support people with disabilities and health conditions will be higher in real terms in every year to 2020 than in 2010, and spending on main disability benefits actually went up by £3 billion in real terms between 2010 and 2015. We continue to spend around £50 billion every year on benefits to support people with disabilities or health conditions and this represents over 6 per cent of all Government spending.

Northern Ireland

72. In the European Social Charter UK 32nd Report in relation to Article 12 Paragraph 1 there was an explanation given that the Northern Ireland Assembly is currently considering measures corresponding to the Welfare Reform Act 2012 (see paragraph 25). The changes outlined for Great Britain in Article 12, Paragraph 1 in paragraphs 8 to 24 and Article13, Paragraph 1 in paragraphs 4 to 26 relating to the Welfare Reform Act 2012 are now in the process of being implemented for Northern Ireland (see Annex for list).

73. The introduction of the welfare reforms contained in the Welfare Reform Act 2012 proved controversial in Northern Ireland and the relevant Bill was delayed in its passage through the Assembly. In November 2015, as a result of *A Fresh Start: The Stormont Agreement and Implementation Plan*[40], it was agreed that the Westminster Government would legislate for welfare reform in Northern Ireland.

74. The decisions on welfare reform taken in 2015 resulted in the Welfare Reform (Northern Ireland) Order 2015[41] being made on 9th December 2015. The Order included the reforms made in Great Britain by the Welfare Reform Act 2012 along with the flexibilities and top-up payments agreed in the Fresh Start Agreement. The regulations to implement the changes contained in this Order have been made but fall outside the reference period of this report as they are operational from 2016 onwards.

75. The main changes being introduced include:

- The introduction of Universal Credit
- Changes to conditionality and sanctions
- A move from Disability Living Allowance to the new Personal Independence Payment
- A Benefit Cap on households
- Social Fund Reforms
- Changes to Employment and Support Allowance (ESA), in particular time limiting claims to 365 days and changes to youth provisions
- Housing Benefit changes, in particular under occupancy
- Strengthening of the penalty regime around Fraud and error
- Introducing Entitlement to Work as a Condition for Contributory Benefits
- Introducing changes to Income Support entitlement conditions so that lone parents whose youngest child is five years old or over will need to claim either Jobseeker's Allowance, if they are capable of work, or Employment and Support Allowance, if they have limited capability for work or a health condition,
- Child Support Maintenance Reforms
- Simplification of the Industrial Injuries Disablement Benefit
- Reform of Appeals Process

76. The Welfare Reform (NI) Order 2015 will ensure that the welfare reforms enabled by the Welfare Reform Act 2012 in Great Britain are delivered in NI.

[40] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/479116/A_Fresh_Start_-_The_Stormont_Agreement_and_Implementation_Plan_-_Final_Version_20_Nov_2015_for_PDF.pdf

[41] http://www.legislation.gov.uk/nisi/2015/2006/contents

Universal Credit

77. Universal Credit will provide a new single system of means-tested support for working-age people, whether in or out of work. Support for housing costs, children and childcare costs will be integrated in the new benefit. It will also provide additions for disabled people and carers.

78. Once introduced in Northern Ireland in 2017, the new Universal Credit will, over time, replace the following existing means-tested benefits: income-based Jobseeker's Allowance; income-related Employment and Support Allowance; Income Support; Working Tax Credit; Child Tax Credit; and Housing Benefit.

79. The system will be simpler and more efficient and people will no longer need to be 'benefits experts' to find out what benefits they can get. This will lead to an increased take-up of benefit and reductions in poverty. For those in work, financial support will be withdrawn at a single transparent rate as earnings increase to ensure that work always pays and is seen to pay.

80. It is considered right to ask those who are able to work to do more in return for receiving benefits while protecting those who are not able to work. Under Universal Credit, the requirements claimants will have to meet will be set according to individual capability and circumstance.

Disability Living Allowance Reform

81. The Welfare Reform (Northern Ireland) Order 2015 ("the Order") provides for Disability Living Allowance to be replaced in Northern Ireland by a new non-means-tested benefit for extra costs. This is called Personal Independence Payment and will be introduced in 2016. This will contribute to the extra costs of overcoming the challenges faced by some disabled people to enable them to lead full, active and independent lives.

82. Personal Independence Payment will include two components: a 'Mobility' component based on the individual's ability to get around; and a 'Daily Living' component based on their ability to carry out everyday activities. The Order also introduces a new individualised and objective assessment to identify those who face the greatest barriers and reviews will ensure that awards continue to reflect claimants' needs.

Simplification of the Industrial Injuries Disablement Benefit

83. The Welfare Reform (Northern Ireland) Order 2015 includes measures to rationalise, simplify and deregulate the Industrial Injuries Disablement Benefit scheme. The changes will allow the removal of old and redundant legislation. The new arrangements are designed so that nobody will lose any money. The changes do not affect large numbers of claimants.

Reform of Appeals Process

84. The Welfare Reform (Northern Ireland) Order 2015 introduces changes to the appeals process so claimants must seek a revision of the disputed decision before making an appeal. These measures aim to ensure timely, proportionate and more efficient dispute resolution.

Statistics

Social Assistance Statistics

85. Summary of Households Below Average Income (HBAI) Data Set

86. Average incomes have recovered from the recession and in 2014/15 are the highest on record. Annual median income growth was the highest seen since 2001/02.

87. Compared to 2013/14, there have been falls in absolute low income for most groups.

88. Relative low income has increased slightly overall (1%), with children seeing the largest rise (2%).

- Relative and absolute low income levels are lower than in 2009/10, with absolute low income being the lowest level on record.
- In 2014/15 relative low income for working-age adults BHC was unchanged on 2013/14 at 15%.
- Absolute low income BHC fell 1ppt to 14% compared to 2013/14
- Those with higher levels of employment have fared better. For adults in working families in 2014/15, relative low income BHC is unchanged at 10%. For adults in workless families, there has been a 2ppt increase since 2013/14 to 39% Working-age adults with children have fared slightly less well. Working-age adults with children have seen a 1ppt increase in relative low income BHC and AHC
- The proportion of working-age adults in relative low income BHC that are living in working families has increased in 2014/15 by 1ppt to 56% note - (not statistically significant). This is the highest on record. The number of people in poverty and in working families is also at a record high.

89. Children - overall

- In 2014/15 relative low income level is slightly lower than in 2009/10. Absolute low income is lower than in 2009/10 and is the lowest level on record.
- Relative low income Before Housing Costs (BHC) increased by 2ppt in 2014/15 to 19% (increase of 200,000 children, In total there are now 2.5 million children living in low income households BHC.
- The number of children in absolute low income BHC was flat at 17% (2.3 million).
- The number of children in combined low income and material deprivation remained flat since 2013/14 at 13% (1.7 million).
- Relative low income After Housing Costs (AHC) increased in 2014/15 by 1ppt to 29% (increase of 200,000 children. In total there are 3.9 million children living in low income households AHC.
- Children in households where all adults were in work fared better, with employment growth increasing their earnings. Relative low income was unchanged at 8% BHC.

- Children in workless households fared least well with a rise of 8ppt to 47% BHC, as did larger families (3+ children) with increases of 3ppt to 25% BHC.

90. Children – lone parent families

- In 2014/15, relative and absolute low income levels are slightly lower than in 2009/10 .
- Between 2013/14 and 2014/15, relative low income for children in lone parent families Before Housing Costs (BHC) increased by 5ppt to 25%.
- Relative low income After Housing Costs (AHC) increased by 4ppt to 44% .
- Absolute low income BHC rose 2ppt to 22%, but is still one of the lowest rates on record (AHC was unchanged at 42%).
- Children of lone parents with higher levels of employment fared better although all groups saw increases in low income. Children of lone parents in full-time work saw a 2ppt increase to 11% BHC children of lone parents in part-time work saw a 3ppt increase to 19% , while children in workless lone parent families saw rises of 10ppt to 37%.

91. Pensioners

- Relative low income for pensioners After Housing Costs (AHC) was unchanged between 2013/14 and 2014/15 at 14%.
- Absolute low income AHC fell 2ppt to 13% - the lowest on record .
- The rate of pensioners aged 65yrs and over in material deprivation fell by 1ppt to 8% .
- Helped by triple lock protection of the Basic State Pension (cash rise of 2.7%), the poorest pensioners received increased state support in real terms in 2014/15. This can be compared with most working-age benefits where cash rises were capped at 1%. Inflation as measured by the Consumer Prices Index (CPI) over 14/15 stood at 1.1%

92. The tables in the full release are at:
http://statistics.dwp.gov.uk/asd/index.php?page=hbai_arc

Statistical Summaries

93. The DWP Statistical Summary brings together key National Statistics on DWP administered benefits and JSA (Jobseeker's Allowance) sanctions and vacancies. To provide a more complete picture of DWP responsibility, statistics on Housing Benefit and Council Tax Benefit (administered by Local Authorities) and the Child Support Agency are also included. The August 2012 release is at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/560554/dwp-stats-summary-october-2016.pdf

94. Previous releases in the time series are at:
https://www.gov.uk/government/collections/dwp-statistical-summaries

Tax Credits and Statistics

95. A full description of Child Tax Credits and Working Tax Credits and HMRC published rates, method of calculation and related statistics are set here:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/519572/cwtc-main-Apr16.pdf

96. Information on both is also provided in the responses to Part VII in the European Code of Social Security reports set out in **Appendices C & D.**

Paragraph 2

97. The position remains as previously described.

Paragraph 3

98. The position remains as previously described

Paragraph 4

99. The position remains as previously described with the following update.

Primary health care

100. Primary care continues to be free to all, other than statutory charges that apply to all patients (unless they qualify for an exemption).

Secondary care

101. Entitlement to free NHS hospital treatment is based on whether the person seeking treatment is "ordinarily resident" in the UK. This broadly means that the person is living here on a lawful, voluntary and properly settled basis for the time being. From April 2015, non-EEA nationals must also have the immigration status of indefinite leave to remain.

102. Those people who are not ordinarily resident here are deemed overseas visitors and are subject to the NHS (Charges to Overseas Visitors) Regulations 2015, as amended, which place a legal duty on NHS hospitals to identify those patients who are overseas visitors and to make and recover the charge for their treatment unless they are covered by an exemption from charge category listed within these regulations. One category of exemption is for an overseas visitor who is a national of a state which is a contracting party to the European Social Charter, where they are lawfully present in the UK and without sufficient resources to pay the charge. This is limited only to treatment the need for which arises during their visit to the UK.

103. Furthermore, from April 2015, an immigration health surcharge is payable by non-EEA nationals who apply for a visa to enter or remain in the UK for more than six months.

104. Some groups of unlawfully present foreign nationals are exempt from charges. These comprise those whose applications for asylum, temporary protection or humanitarian protection are still being considered, including appeals; those being supported by the Home Office with section 95 support; failed asylum seekers receiving section 4(2) HO support or support by a local authority under section 21 of the National Assistance Act 1948 or Part 1 of the Care Act 2014; those who are victims, or suspected victims, of modern slavery or human trafficking; children in the care of a Local Authority and those receiving compulsory psychiatric treatment or treatment imposed by a court

order. Other unlawfully present foreign nationals are chargeable for all hospital services they receive unless the service itself is exempt from charge. These services are emergency treatment given within an Accident & Emergency Unit or elsewhere at a hospital until the point of admission or as an outpatient (not further emergency treatment); family planning services (not including termination of pregnancy); treatment for most infectious diseases, including sexually transmitted infections; and treatment required for a physical or mental condition caused by torture, female genital mutilation, domestic violence or sexual violence (this does not apply if the patient has travelled to the UK for the purpose of seeking that treatment.

105. 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 make and recover charges from the person liable to pay but can decide not to actively pursue for debt when the person is genuinely without funds if not considered cost effective to do so.

106. Immigration Rules came into force on 31 October 2011 that allow a person with an outstanding debt to the NHS of £1000 or more to be refused a future immigration application to enter to remain in the UK. Since April 2016 the level of outstanding debt before which this can apply has been lowered to £500 or more.

107. As regards primary care, General Practitioners have a measure of discretion as to who they accept as NHS patients on their lists and provide with free primary medical services. They can only turn down an application to join their list of patients if they have a reasonable reason for doing so which would not include a person's immigration status. Any primary care treatment which a health professional considers to be immediately necessary would be provided regardless of registration.

108. In December 2015 a consultation exercise was launched which primarily considered the extension of the Charging Regulations into areas of NHS care that are not currently within their scope, eg primary medical services and A&E treatment. The consultation closed in March 2016 and no decisions have yet been taken on the way forward.

Medical Assistance Statistics

109. Spending on health in the UK
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/datasets/healthcareexpenditureintheukalltables

Health and Lifestyles

110. http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles

Hospital care

111. http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care

Mental Health

112. http://www.ic.nhs.uk/statistics-and-data-collections/mental-health

Population

113. http://www.ic.nhs.uk/statistics-and-data-collections/population-and-geography

Primary-care

114. http://www.ic.nhs.uk/statistics-and-data-collections/primary-care

Screening

115. http://www.ic.nhs.uk/statistics-and-data-collections/screening

Workforce

116. http://www.ic.nhs.uk/statistics-and-data-collections/workforce

Answers to the ECSR's questions XX-2 (2013)

The report describes in detail the reforms in the field of social assistance planned to enter into force in 2012-2013, in particular through the adoption of the Welfare Reform Act 2012; as these measures fall outside the reference period, the Committee will assess their impact in its next supervision cycle of Article 13 and asks the next report to provide information in this respect.

Since 2010 the Government has published cumulative analysis of the impacts of its tax, welfare and public spending policies on households. The most recent assessment was published by Her Majesties' Treasury (HMT) at Budget 2016[42]. It showed that the proportion of spending received by households in each quintile of the income distribution has remained similar since 2010-11, with half of all welfare and public services spending going to the poorest 40% of households in 2019-20.

This cumulative distributional analysis is the most comprehensive available, covering not only the effects of direct cash transfers between households and government, but also the effects of frontline public service provision. Welfare spending is not the only way to help; the introduction of the National Living Wage, extending childcare for working parents and increases to the Personal Tax Allowance are important enablers to the removal of barriers to participation. The HMT analysis includes these wider impacts.

The Committee previously noted, in 2000 and 2003 (Conclusions XV-1 and XVI-1) that sanctions can be appealed and that payment can be maintained, although at a lower rate, in cases of hardship. It notes from the report that under the new Welfare Reform Act 2012 the sanctions will be strengthened and the hardship payments will be granted only to those claimants in greatest need; it asks the next report to clarify what criteria will be applied in practice to ensure that, in conformity with the Charter, a person will not be deprived of his/her means of subsistence.

If a claimant demonstrates they cannot meet their immediate and most essential needs, including accommodation, heating, food and hygiene, as a result of their sanction, they can apply for a hardship payment. Claimants who are sanctioned can apply for hardship payments equivalent to 60% of their normal benefit payment. JSA claimants who are seriously ill or pregnant can receive 80% if they qualify for hardship payments. Universal Credit claimants can apply for hardship payments as soon as they receive a payment reduced by a sanction. All ESA claimants who meet the criteria for hardship can receive payments from day one of their sanction, as can JSA claimants categorised as 'vulnerable'. We improved the clarity of the JSA and ESA hardship application process and made improvements to the payment process to ensure that payments are made within 3 days.

[42] https://www.gov.uk/government/publications/budget-2016-documents

Other claimants who meet the criteria for hardship can receive payments from day 15. In addition to hardship payments, claimants who are not eligible or do not have day one access are signposted to local authorities where they can receive immediate assistance. Each local authority will tailor their support to meet the needs of their communities.

The Committee notes that there have been no changes to the situation which was previously found to be in conformity with the Charter. It notes however from the report that, due to a substantial increase in the number of appeals, the waiting times for appeals to be heard have increased. In order to ensure timely, proportionate and more efficient dispute resolution the authorities are planning to reform the appeal procedure, so that claimants must seek a revision of the disputed decision before making an appeal to the First-tier tribunal. The Committee asks the next report to provide information on the impact of the reform.

Mandatory Reconsideration (MR), the process that requires claimants to seek a revision of a decision before being able to appeal, was introduced for Universal Credit and Personal Independence Payment in April 2013 and for all other benefits from Oct 2014.

Listed below is all the relevant statistical information the department has published to date:

- https://www.gov.uk/government/statistics/mandatory-reconsiderations-of-dwp-benefit-decisions-data-to-october-2014
- https://www.gov.uk/government/statistics/jobseekers-allowance-and-employment-and-support-allowance-sanctions-decisions-made-to-march-2016 (Tables 1.8 & 2.6)
- https://www.gov.uk/government/statistics/esa-work-capability-assessment-mandatory-reconsiderations-data-to-april-2016
- https://www.gov.uk/government/statistics/tribunals-and-gender-recognition-certificate-statistics-quarterly-april-to-june-2016] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/529079/pip-statistics-to-apr-2016.pdf
- https://www.gov.uk/government/statistics/esa-outcomes-of-work-capability-assessments-including-mandatory-reconsiderations-and-appeals-september-2016

Table 1. This ad hoc information was published following concerns about the lack of information in relation to the time taken to clear applications - there is no statutory time limit to decide an application. There was focus on ESA because the introduction of MR meant that those ESA claimants found fit for work could no longer remain on ESA pending appeal. Even if they applied for MR they needed to claim Jobseeker's Allowance whilst the MR was considered. If the MR was unsuccessful then they could appeal and go back onto ESA. This was controversial and meant that clearance times were critical. As the statistics show, the median average was 13 days with over 70% cleared within 30 days. Table 6 shows the latest clearance time for ESA and it is now a median average of around nine days.

Table 4, which has appeal statistics, is included because this shows, at table SSCS.3, the significant drop in appeals, particularly in ESA, since the introduction of MR. MR is not the sole reason for the reduction but it has played an important role.
Tables 3, 5 & 6 include information for ESA and PIP, about the number of applications and their outcome i.e. whether the decision was revised or not. They show that the vast majority of decisions are unchanged. Table 6, see Table 17 therein, also shows that for ESA only a small percentage of those whose MR did not succeed then appeal.

Mandatory Reconsideration is a key component of the decision making process which if done properly benefits both claimants and the department. That this is accepted was confirmed when the Department's Social Security Advisory Committee (SSAC) decided to research the effectiveness of its introduction, focusing on ESA. In its recently published Report, whilst it approved the policy, it made a number of recommendations around the process. Even though the statistics suggest that MR is working in that claimants are being given the opportunity to present new evidence and very few go on to appeal, the department recognises the need for the improvements recommended by SSAC e.g. how it gathers key information from claimants at the MR stage, rather than have this produced only on appeal, and will be addressing these over the coming months.

In the light of the explanations and case-law examples provided, the Committee holds that the "habitual residence" test, as applied in the United Kingdom is in conformity with the Charter. It asks nevertheless to be kept informed of any legislative or other development in this area, as well as of any relevant data concerning the applications accepted and rejected, in relation with the entitlement to social and medical assistance benefits.

European Economic Area (EEA) migrants have, under the European Treaties and Directives, a right to live in another Member State as long as they are exercising a qualifying 'right to reside'; this means an EEA national who has a 'right to reside' as somebody who is either a worker or a self-employed person, a jobseeker, a self-sufficient person or a student.

Since December 2013, the UK has introduced a number of measures which affect the right to access means-tested, tax-funded benefits by EEA migrants. These are dependent on type of 'right to reside' in the UK being exercised by EEA nationals and the benefit claimed. These reforms are designed to ensure that only those who come to the UK to work, and have a realistic chance of finding work, are able to access the benefits system.

Strengthened Habitual Residence Test

In December 2013 a more robust Habitual Residence Test was introduced and used for face to face interviews with migrants and returning UK nationals claiming benefits.

The strengthened test, which included an improved question set supported by intelligent IT, is intended to help benefit decision makers to make more consistent decisions on benefit entitlement.

Three month residence requirement for income-based Jobseeker's Allowance

Since 1 January 2014, newly arrived jobseekers have been unable to claim income-based Jobseeker's Allowance until they have been living in the UK for a period of three months. This is in addition to the requirement to demonstrate that they are habitually resident. This measure also applies to UK nationals returning to the UK after an extended absence abroad.

Six month time-limited access to income-based Jobseeker's Allowance

Since 1 January 2014, immigration regulations only allow EEA nationals to reside in the UK as a jobseeker or as a person who 'retains' worker status for a maximum of six

months, unless they have genuine chance of getting work. A 'Genuine Prospect of Work' assessment is applied after six months to EEA nationals claiming income-based Jobseeker's Allowance.

The 'Genuine Prospect of Work' assessment considers whether the claimant has an imminent job start or has had a change of circumstances leading to a potential job offer. If compelling evidence not provided, the EEA national's right to reside in UK ends and entitlement to income-based Jobseeker's Allowance stops. If evidence of a job offer is provided, payment of this benefit will be extended to the date of the job start.

Removal of access to Housing Benefit for EEA jobseekers

Since 1 April 2014, EEA migrants with a right to reside as a jobseeker are unable to access Housing Benefit.

Three month time limit review for EEA jobseekers claiming income-based Jobseeker's Allowance

Since 10 November 2014, income-based Jobseeker's Allowance has only been payable for 3 months to recently arrived EEA national jobseekers, unless there they have a genuine chance of getting a job. The Genuine Prospect of Work assessment is applied after benefit has been in payment for 3 months. If there is no compelling evidence of a job offer, entitlement to income-based Jobseeker's Allowance will end. EEA nationals who had worked but lost their job ('retained worker') are subject to a 'Genuine Prospect of Work' assessment after they have received income-based Jobseeker's Allowance for 6 months.

Restricting EEA Jobseekers' access to Universal Credit

Since 10 June 2015, new EEA migrants with a right to reside as a jobseeker are unable to access Universal Credit.

Statistics/data

Data was published[43] on 25 August 2016 relating to some of the above measures to restrict migrants' access to benefit introduced between December 2013 and February 2015.

Relevant CJEU case law

In June 2010, the European Commission signalled that it intended to infract the UK about its 'right to reside' test as applied both to means-tested out-of-work benefits as well as to 'family benefits' such as Child Benefit and Child Tax Credit. However, following a CJEU ruling in September 2013 in an Austrian case called Brey (C-140/12) concerning entitlement to a 'social assistance' benefit, where the right to reside was at issue, the European Commission filed its application against the UK at the CJEU in June 2014 only in relation to Child Benefit and Child Tax Credit. The Commission argued that the application of the 'right to reside' test in UK domestic legislation was discriminatory and contravened free movement principles.

[43] https://www.gov.uk/government/statistics/analysis-of-eea-migrants-access-to-income-related-benefits-measures

In its ruling[44] of 14 June 2016, the CJEU dismissed the European Commission's action against the UK and made clear that Member States are free to ensure that "social benefits" are paid only to EU citizens who are exercising free movement rights lawfully in compliance with the requirements of EU law on rights of residence. Although these rules amount to indirect discrimination against EEA migrants, the Court ruled that they were justified by the need to protect the host Member State's public finances.

[44] http://curia.europa.eu/juris/liste.jsf?num=C-308/14

ISLE of MAN

Article 13, Paragraph 1

There is no change to the information previously provided, but please see the information supplied under Article 12(1) in relation to changes to the social security benefits programme.

Article 13, Paragraph 2

The position remains as previously described. Persons in the Isle of Man who are in receipt of social or medical assistance do not have diminished political or social rights.

Article 13, Paragraph 3

The position remains as previously described.

Article 13, Paragraph 4

The Isle of Man and the United Kingdom renewed their Reciprocal Health Agreement in 2010. Non-UK nationals taking up residence in the Isle of Man are entitled to receive healthcare on the same basis as a resident from the moment they arrive. Non-UK visitors requiring treatment will be treated but may be required to meet all or some of the costs.

Article 14 – The right to benefit from social welfare services

Paragraph 1

1. The Department of Health works to define policy and guidance for delivering a social care system that provides care equally for all, while enabling people to retain their independence, control and dignity. Full details of the range of policy areas covered can be viewed at:
http://www.dh.gov.uk/health/category/policy-areas/social-care/

The Care Quality Commission

2. The Care Quality Commission oversees national standards and checks whether hospitals, care homes and care services, including care in the home, comply with those standards. Its findings are shared with the public and full details can be viewed at: http://www.cqc.org.uk/

Social Care for Older People

3. Until April 2015 the social care system in England had remained unchanged since 1948. It was complicated, out of date and not fit for the 21st century. The Government committed to reform it to ensure it is sustainable, promotes wellbeing and provides more choice and control to older people and their carers. Following the passage of the Care Act 2014 there is a new care system in place in England from April 2015 that prioritises independence and wellbeing at an early stage and throughout an older person's care journey.

4. The measures set out in the Care Act will support better access, quality and sustainability. In particular they will:

- support people to stay independent for as long as possible, thereby improving outcomes and ensuring the long-term sustainability of the health and care system;
- introduce greater national consistency in access to care and support and help people better understand and navigate the care system;
- provide better information to help people plan ahead and to make effective choices;
- give people more control over their care;
- ensure carers have the same rights as care users with regard to access to assessments and support;
- improve the quality of care and support including through user and carer feedback;
- help build and sustain a care workforce able to meet increased demand and higher expectations of high quality, personalised care; and
- improve integration between health and care services and other local public services.

5. Further background at https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets

6. Included in the Care Act are details of how people will pay for their social care in the future. These rules will be implemented from April 2020.

7. While it is too early to judge the effect of the Care Act, but we are starting to see it have a profound impact on the way the care system works, the responsibilities of local

government and partners, and the rights, outcomes and experience of people who need care.

Scotland

8. The Scottish Government works in partnership with service users, carers, local authorities, the NHS, the Care Inspectorate as well as the voluntary and independent sectors to improve community care services across Scotland. Full details of the range of the support, protection and services provided can be viewed at:
http://www.scotland.gov.uk/Topics/Health/Support-Social-Care

Regulating Care

The Care Inspectorate (CI)

9. The CI will inspect, regulate and support improvement of social care and social work services across Scotland. At the request of Scottish Ministers, the Care Inspectorate is leading joint inspections of services for children and young people across Scotland. These inspections look at the difference services are making to the lives of children, young people and families. They take account of the full range of work with children, young people and families within a community planning partnership area.

Healthcare Improvement Scotland (HIS)

10. HIS takes over the regulation of independent healthcare services, previously carried out by the Care Commission. It will also take over the work of NHS Quality.

Northern Ireland

Personal Social Services in Northern Ireland

11. Northern Ireland has a population of 1,851,621 people; of whom 383,800 are aged under 16 and 285,900 are of pensionable age (2014). By 2035, it is predicted that the number of people of pensionable age (i.e. age 65 and over) will have risen to 498500[45]. The number of children under the age of 16 is projected to decline steadily from 383,800 in 2014 to 371,864 by 2035. There will also be a further significant increase in the number of people aged 85 years and over from 34,400 in 2014 to 88,600 by 2035. This projected growth of the ageing population is likely to have important implications for the future financing and delivery of long term care services.

12. A comprehensive picture of social services expenditure and provision across the five Health and Social Care trusts which provide personal social services in Northern Ireland, and across all major Programmes of Care, can be found at:
https://www.health-ni.gov.uk/topics/social-services

Wales

13. The debate about paying for care in Wales is part of the Welsh Government's wider reform for social care, as set out in its strategic direction 'Fulfilled Lives, Supportive

[45] http://www.nisra.gov.uk/demography/default.asp20.htm

Communities' (June 2008). That established the principle of local authority social services supporting individuals to live independently as possible, wherever possible at home.

14. Like England, the Welsh Government has in recent years looked to reform current arrangements for the funding of care and support which charge individuals for the care they receive. It published a Green Paper in 2009 following consultation with the care sector setting out the arguments on this complex issue. In 2010 it took an approach similar to the proposal to cap an individual's lifetime contribution to the cost of their care contained in the recommendations of the Commission on Funding of Care and Support in England. It did this by introducing then a national weekly maximum charge for the non-residential care a person receives. This was initially set at £50 per week but is now £60 per week.

15. More fundamental reform of the arrangements in Wales is awaiting the detail of the reform expected to take place in England from 2020. This is for two reasons. Firstly, some of that potential reform may impinge on any consequential funding that may come to Wales as a result of those reforms taking place and affect the Welsh Government's ability to introduce reforms in Wales. Secondly, the UK Government's welfare reform agenda continues to unfold and has the potential to affect some of the income those receiving care and support have to pay for their care. Both of these restrict the ability to make informed decisions at present on the nature longer term reform in Wales should take.

16. In the meantime, the Welsh Government is to increase the level of the capital limit as it is applied to charging for residential care from its current level of £24,000 to £50,000. This is to enable care home residents to retain more of their capital without this having to be used to pay for their care.

Statistical Information

England

17. http://content.digital.nhs.uk/socialcarecollections2016

Scotland

18. Health and Community Care statistics:
http://www.scotland.gov.uk/Topics/Statistics/Browse/Health

19. Social Services Workforce Statistics:
http://data.sssc.uk.com/data-publications/22-workforce-data-report

Northern Ireland

20. The table below shows the breakdown of expenditure in Northern Ireland by Programme of Care (PoC).

TABLE TOTAL (NET) PSS EXPENDITURE (£UK) BY PoC 2014/15

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	207,742	0	207,742	21.47
Elderly Care	553,462	108,367	445,094	45.99
Mental Health	65,667	19,157	46,510	4.81
Learning Disability	215,139	12,549	202,590	20.93
Physical & Sensory Disability	67,832	2,461	65,372	6.75
Health Promotion & Disease Prevention	0	0	0	
Primary Health & Adult Community	496	0	496	0.05
Total	1,110,338	142,535	967,803	100.00

1 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 (–2011 - 2015) [1, 2, 3, 4, 5, 6]

PSS Activity	2011	2012	2013	2014	2015
Places in residential homes	5,992	5,491	5,347	5,192	5,212
Places in nursing homes	9,833	10,876	10,872	10,846	10,854
Residential home care packages	4,207	4,097	3,965	3,902	3,679
Nursing home care packages	8,149	8,167	8,407	8,587	8,581
Clients receiving domiciliary care	23,522	24,134	25,330	24,189	23,260
Number of direct payments paid including one-off and payments which ceased during quarter	2,134	2,484	2,594	2,840	3,043
Persons receiving meals services	4,245	3,269	3,066	3,101	2,800
Persons registered at statutory day centres	8,260	8,081	8,203	8,254	8,194

1 Information on places in residential and nursing homes was provided by the RQIA for the position as at June 30th. Residential places in nursing homes are included under places in residential homes.

2 Information on residential and nursing home care packages refers to the position as at 30 June

3 Information on the number of clients receiving domiciliary care services refers to those receiving care during a survey week in September each year.

4 Information on direct payments refers to the quarter ending 30 June each year.

5 Information on persons receiving meals on wheels refers to the position as at 31 March and includes those receiving frozen meals.

6 Information on persons registered at statutory day care facilities refers to the position as at 31 March

Sources: Community Information Branch, DoH

Table - Places in Residential Homes, by Client Group (31 March 2011 – 2015)[1]

Client Group	2011	2012	2013	2014	2015
Children[2]	365	362	354	352	346
Elderly	3,513	3,598	2,862	2,685	2,768
Mentally Ill[3]	356	377	331	-	-
Learning Disabled	539	551	615	652	650
Physically Disabled / Sensory Impaired	12	12	12	12	12

1 Figures relate to the position as at 31 March unless otherwise stated.

2 Information on the number of places in residential homes for children was provided by the RQIA. Figures relate to the position as at 30 June.

3 Information collection for places in residential homes solely for persons designated mentally ill was discontinued in February 2014.

Sources: Community Information Branch, DoH

Social Services Personnel

21. The figures below are taken from the Human Resource, Payroll, Travel & Subsistence system as at 30th September 2015. This data excludes staff with a whole-time equivalent (WTE) less than or equal to 0.03 and staff on career breaks. Domiciliary care/home help staff have not been included due to a reporting issue with the whole-time equivalent.

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

	Full-Time	Part-Time		Total	
	Head count	Head count	WTE	Head count	WTE
Social Worker Band 5	119	41	26.6	160	145.6
Social Worker Band 6	1581	558	369.3	2139	1950.3
Social Worker Band 7	961	147	100.4	1108	1061.4
Social Worker Band 8A/8B/8C	297	23	14.8	320	311.8
AYE Social Worker Band 5	0	0	0	23	22.5
Social Work Placement Student (non AFC)	4	0	0.00	4	4
Social Work Support/Social Care Band 2	57	350	247.7	407	304.7
Social Work Support/Social Care Band 3	650	1155	809	1805	1459
Social Work Support/Social Care Band 4	300	161	105.8 93.59	4613 86	405.83 35.59
Social Work Support/Social Care Band 5	766	452	319.7	1218	1085.7
Social Work Support/Social Care Band 6	38	17	12.4	55	50.4
Social Work Support/Social Care Band 7/8A/8B/8C	48	8	6.2	56	54.2
Total				7756	6855.4

Safeguarding Vulnerable Groups

22. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It is responsible for:

- processing requests for criminal records checks and
- maintaining lists of those barred from defined sets of activity which involve working with children or vulnerable adults known as “regulated activity”.

23. The DBS replaced both the Criminal Records Bureau (CRB) and the Independent Safeguarding Authority (ISA) in 2012. This followed a process of review aimed at improving the efficiency of the disclosure and barring arrangements and making them more proportionate. In particular, the scope of regulated activity from which people can be barred was changed to focus on activity which involves working closely and unsupervised with children or vulnerable adults. These changes were introduced through the Protection of Freedoms Act 2012.

24. Standard DBS checks are available for roles that are excepted from the Rehabilitation of Offenders Act 1974. These checks show convictions and cautions incurred by the person concerned, whether or not such convictions are "spent" under the terms of that legislation. The most sensitive of these roles (such as working in schools, hospitals etc) are eligible for enhanced DBS checks. As well as spent and unspent convictions, enhanced checks show any additional information (such as intelligence) which is held by the police and which they reasonably believe to be relevant. Further changes were introduced in 2013 so that some old and relatively minor cautions and convictions are now filtered out from checks after defined periods of time.

25. Those who have committed one of a list of the most serious violent or sexual offences will be barred automatically by the DBS. Once someone is barred it is illegal for them to work in regulated activity or for someone to employ them in such activity knowing they are barred. Committing one of a secondary set of offences will result in barring subject to the person being allowed to make representations. Barring can also be considered where information arises in the course of dealing with an application for a DBS check or where information is passed on by an organisation that has a legal duty or power to do so. Typically there is a duty on employers to make a referral to the DBS when they have dismissed or removed an employee from working in regulated activity, following harm to a child or vulnerable adult or where there is a risk of harm. The DBS also has discretion to accept referrals from members of the public.

26. The DBS plays a central role in safeguarding the vulnerable, both by facilitating access to criminal records and by barring those who are unsuitable to work in regulated activity. Changes since 2012 have brought these functions together in one organisation and enhanced the proportionality of the whole system.

Looked After Children

Residential Care

27. In 2014, the Department for Education reformed the care planning and children's homes regulations to improve the safety of children in residential care. This included strengthening safeguards when children are placed out-of-area and when children go missing from care.

28. The following measures came into force in 2014. (Those that appeared in the Children's Homes Regulations were subsequently included in the new regulatory framework for children's homes that came into force in April 2015):

- Homes' managers and providers of new homes to annually assess the location of the home to better protect children living there.

- Strengthened arrangements for monthly unannounced independent monitoring visits of children's homes (Regulation 44 visits), so that children are better safeguarded.
- The Director of Children's Services has oversight of all decisions to place a child in a distant placement.
- Local authorities to consult with the local area where they are placing the child, to assure themselves that the placement will meet the child's needs.
- Homes to notify the local authority in which the home is located of the admission and discharge of children from the home.
- All homes to ensure that they have clear policies for preventing children from going missing; and to respond when children do go missing, in line with local police protocols on 'missing'.

29. The Department for Education published advice in July 2014 to support implementation of these changes[46].

30. In April 2015, we introduced new regulations and Quality Standards for children's homes[47] with accompanying guidance[48] for providers of residential homes for vulnerable children. These specify the outcomes that children must be supported to achieve while living in children's homes, followed by a clear set of underpinning requirements for achieving the standard. They challenge children's homes to apply their skills and professional judgment to provide high quality, better tailored care, have high aspirations and achieve positive outcomes for each and every child that they care for.

31. The revised regulations give a clear platform for providers and the regulator (Ofsted) to focus explicitly on the progress and experiences of children and young people and less on process. The revised regulations introduced nine quality standards:

- Quality and purpose of care;
- Children's wishes and feelings;
- Education;
- Enjoyment and achievement;
- Health and well-being;
- Positive relationships;
- Protection of children;
- Leadership and management; and
- Care planning.

32. In 2015 Sir Martin Narey was commissioned to lead an independent review into residential care, which set out the role of residential care within the wider care system and made recommendations about how outcomes for children who are currently placed in residential care can be improved. This was published in July 2016[49]. The review covered all residential care settings, including those settings not regulated by Ofsted and will inform the government's future program of work.

[46] https://www.gov.uk/government/publications/childrens-homes-regulations-amendments-2014
[47] http://www.legislation.gov.uk/uksi/2015/541/contents/made
[48] https://www.gov.uk/government/publications/childrens-homes-regulations-including-quality-standards-guide

[49] https://www.gov.uk/government/publications/childrens-residential-care-in-england

Care Leaver Strategy

33. The first cross-government care leaver strategy was published in 2013[50] which recognised the need to work coherently across government to address care leavers' needs and introduced a number of changes to policies and practices so that care leavers were better supported. A progress update was published in 2014 to ensure that support for care leavers is embedded in all relevant departmental policies.[51]

34. In 2015 the government undertook to publish a refreshed care leaver strategy for care leavers in 2016. This was published in July 2016, and contains five key outcomes that the government is seeking to achieve for care leavers.[52]

The Children and Families Act 2014[53]

35. The Children and Families Act takes forward the government's commitments to improve services for vulnerable children and support strong families. It underpins wider reforms to ensure that all children and young people can succeed, no matter what their background. The Act reforms the systems for adoption, looked after children, family justice and special educational needs and introduced changes to support the welfare of children.

36. The Children and Families Act includes the following provisions:

- Consolidating legislation relating to the rights and support for young carers and parent carers, and extend their rights to assessment;
- Staying put: this requires local authorities to support young people to remain with their former foster carers to age 21 where both the young person and carer want the arrangement to continue – allowing those young people to enjoy continuity in their care arrangements and a more gradual transition to adulthood.
- Putting the role of Virtual School Head on a statutory footing by requiring local authorities in England to appoint an officer for the purpose of discharging the authority's duty to promote the educational achievement of the children they look after;
- Supporting the reform of children's homes, particularly by enabling the development of a regulation and inspection framework that sets high standards for children in residential care and offers them the support required to achieve positive outcomes.

Innovation Programme

37. The government announced the Children's Social Care Innovation Programme in October 2013. The Innovation Programme seeks to support the development, testing and sharing of effective ways of supporting children who need help from children's social care services. It was set up to provide tailored and substantial support – more than £100 million over two years - to support improvements to the quality of services so that children who need help from the social care system have better chances in life.

[50] https://www.gov.uk/government/publications/care-leaver-strategy
[51] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/368235/Care_Leavers_Strategy_update.pdf
[52] https://www.gov.uk/government/publications/keep-on-caring-supporting-young-people-from-care-to-independence
[53] http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted

Pupil Premium Plus

38. The pupil premium provides schools with additional money to raise the attainment of disadvantaged pupils of all abilities. In April 2014 the government introduced the pupil premium plus for looked-after children and extended the number of children looked after who attract this funding from those who have been in care for at least six months or more to those who have been looked after for just one day. In 2014-15 the pupil premium unit of funding for looked-after children was £1900, more than double the £900 it was in 2013.

Putting Children First

39. In 2015 the government undertook work to set out a strategy for improving children's social care. 'Putting Children First' was published in 2016 and sets out some of the steps the government is taking to ensure that looked after children and care leavers are able to achieve positive outcomes[54]. In our strategy we committed to undertake a national stocktake of foster care to better understand current provision, how needs are matched with skills, where this works really well, and what can be learned nationally from good practice.

Guidance

40. The Department of Education has issued and updated a range of statutory guidance to promote the welfare of children, providing help and support to vulnerable children and their families and protection to children who have suffered, or are at risk of suffering, harm. This includes:

The Children Act 1989 guidance and regulations. Volume 2: care planning, placement and case review[55] (Updated June 2015)

41. This guidance updates and consolidates The Children Act 1989 Guidance and Regulations, Volume 2: Care Planning, Placement and Case Review documents published in March 2010.

42. It now includes information contained in the following updates and supplements:

- Delegation of Authority: Amendments to the Children Act 1989 Guidance and Regulations (July 2013)
- Looked-after children: contact with siblings – February 2014
- Looked-after children and youth justice: Application of the Care Planning, Placement and Case Review (England) Regulations 2010 to looked-after children in contact with youth justice services – April 2014
- Early permanence placements and approval of prospective adopters as foster carers: Statutory guidance for local authorities and adoption agencies – July 2014
- Out of authority placements of looked-after children – July 2014
- Permanence, long-term foster placements and ceasing to look after a child – March 2015

[54] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/554573/Putting_children_first_delivering_vision_excellent_childrens_social_care.pdf
[55] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/441643/Children_Act_Guidance_2015.pdf

Working together to safeguard children (March 2015)[56]

43. This is guidance on inter-agency working to safeguard and promote the welfare of children. This includes protection of children from maltreatment, preventing impairment of children's health or development, ensuring that children grow up in circumstances consistent with the provision of safe and effective care, and taking action to enable all children to have the best outcomes. This guidance replaces 'Working together to safeguard children' (2013).

Boarding schools: an opportunity to improve outcomes for vulnerable children (November 2014)[57]

44. This paper encourages education professionals, local authorities and social workers to consider a boarding place for vulnerable children. It provides information about the benefits of a boarding environment and meeting the costs of boarding provision.

Social care: guide to the 0-25 SEND code of practice (September 2014)[58]

45. This guide is for social care professionals and is designed to help social care practitioners and commissioners understand their statutory duties under the special educational needs and disability reforms in the Children and Families Act 2014. It should be read alongside the 'Special education needs and disability code of practice: 0-25' (June 2014)59.

Care of unaccompanied and trafficked children (July 2014)[60]

46. This statutory guidance sets out the steps local authorities should take to plan for the provision of support for looked after children who are unaccompanied asylum seeking children and child victims of trafficking. It does not provide detailed guidance on steps that local authorities should take, in partnership with other agencies, to identify and protect trafficked children before they become looked after. This is described in practice guidance "Safeguarding children who may have been trafficked"61, published by the Department for Education and Home Office in 2011.

Promoting the education of looked-after children (July 2014)[62]

47. This guidance sets the framework through which local authorities discharge their statutory duty under 22(3A) of the Children Act 1989 to promote the educational

[56] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf
[57] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/379050/Boarding_schools_improve_outcomes_for_vulnerable_children.pdf
[58] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/348928/Social_care__guide_to_the_0_to_25_SEND_code_of_practice.pdf
[59] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/398815/SEND_Code_of_Practice_January_2015.pdf
[60] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/330787/Care_of_unaccompanied_and_trafficked_children.pdf
[61] https://www.gov.uk/government/publications/safeguarding-children-who-may-have-been-trafficked-practiceguidance
[62] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/335964/Promoting_the_educational_achievement_of_looked_after_children_Final_23-....pdf

achievement of looked after children. That includes those children placed out-of-authority. This guidance replaces Promoting the Educational Achievement of Looked After Children published in March 2010.

Statutory guidance on children who run away or go missing from home or care (January 2014)[63]

48. This guidance sets out the steps local authorities and their partners should take to prevent children from going missing and to protect them when they do go missing. It replaces the statutory guidance issued in 2009, in line with changes in evidence, policy and the statutory framework covering looked after children

Statistics

49. Of the 69,540 children looked after at 31 March 2015[64]:

- 55% were male, 45% were female
- 73% were of White British ethnic origin
- 2,630 were unaccompanied asylum seeking children
- 61% were looked after due to abuse or neglect
- 330 of the 15,130 females aged 12 years and over were mothers
- 75% were in foster placements, 5% placed for adoption, 5% placed with parents, 3% in other placements in the community, 9% in secure units, children's homes and hostels, 2% in other residential settings and 1% in residential schools.
- 60% were looked after under a care order and 29% under a voluntary agreement.

50. Educational attainment and outcomes for children who were looked after continuously for at least 12 months[65:]

- In 2015, 61% of children looked after had a special educational need, compared to 50% of children in need and 15% of all children.
- At key stage 1, 73% of looked after children achieved level 2 or above in mathematics, 71% achieved level 2 or above in reading, and 63% achieved level 2 or above in writing.
- At key stage 2, 52% of looked after children achieved level 4 or above in reading, writing and mathematics.
- At key stage 4, 14% of looked after children achieved 5 or more A* - C GCSEs or equivalent, including English and mathematics.

Scotland

51. Residential care homes offer young people (usually of secondary school age) a safe place to live away from their families. Residents live alongside a number of other young people in the home, cared for by staff who do not live on site.

[63] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307867/Statutory_Guidance_-_Missing_from_care__3_.pdf

[64] https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2014-to-2015

[65] https://www.gov.uk/government/statistics/outcomes-for-children-looked-after-by-las-31-march-2015

52. These establishments provide accommodation, support and in some cases education. Most are run by local authorities, but the voluntary and independent sectors provide a range of residential services (in particular residential schools). All residential care establishments are inspected by the Care Inspectorate[66] to ensure they meet national standards.

53. Most young people who live in a residential establishment will have been assessed as needing to be cared for away from home by the local authority. Young people are placed in residential care on the recommendation of a Children's Hearing Panel, or on an emergency (short-term) basis to guarantee their safety.

54. Young people living in residential establishments are usually educated in schools nearby, with the exception of being for young people living in residential schools and secure accommodation, where education is provided on site.

Scotland – Statistics

55. Child safety and wellbeing statistics can be found at the following links: http://www.scotland.gov.uk/Topics/Statistics/Browse/Children

- Child Protection
- Children Looked After
- Care Leavers
- Attendance and Looked After Children
- Exclusions and Looked After Children
- Average Tariff Scores and Looked After Children
- Destinations and Looked After Children
- Secure Accommodation

Northern Ireland

56. The Department of Health strategy to address the needs of 'Looked After Children', *Care Matters in Northern Ireland* (2007), outlines the strategic vision for wide ranging improvements in services to children and young people in and on the edge of care.

- The strategy aims to increase support for vulnerable children and to improve outcomes for care-experienced young people by:
- increasing preventative services and support to help vulnerable families stay together;
- improving the range, quality and stability of placement options for children who cannot live at home;
- ensuring that Health and Social Care Trusts have the necessary arrangements in place to act as effective corporate parents for children in care;
- improving educational opportunities for children in care;
- providing children in care with opportunities to take part in activities outside school and care; and
- strengthening support to young people leaving care as they make the transition to adulthood.

[66] http://www.scswis.com/

The Children and Young People's Strategic Partnership (CYPSP)

57. The Health and Social Care Board established the Children and Young People's Strategic Partnership (CYPSP) in January 2011. CYPSP is a multi-agency partnership of senior representation of Statutory/Voluntary/Community organisations, Councils and Government Departments involved in delivering services to children and families. A single partnership covers all of Northern

58. The statutory basis for CYPSP is set out in The Children (1995 Order) (Amendment) (Children's Services Planning) Order 1998.

59. The purpose of CYPSP is to develop and maintain arrangements for integrated planning and commissioning across agencies and sectors, with the aim of improving the wellbeing of children and families in the context of the high level outcomes for children set out in the Children's strategy. CYPSP is committed to the realization of children's rights.

60. CYPSP has developed a multi-agency Outcomes Based Accountability information system. The CYPSP Information Team provides information management and support to the CYPSP working groups. Much work had already taken place in measuring the outcomes for children and young people. Previously, alongside OFMDFM, a set of Core Indicators have been chosen which link to each Outcome, within the Northern Ireland Children's Strategy, with information collated from across a range of agencies. The information has been collected over time, which provides information on whether children's lives are improving or not. This allows CYPSP to identify issues which need to be addressed, and then stimulate debate about the supports and services required to drive change and improvement. The information is linked to the ten year strategy for children and young people in Northern Ireland; that every child or young person should be:

- healthy;
- enjoying, learning and achieving;
- living in safety and with stability;
- experiencing economic and environmental well-being;
- contributing positively to community and society and
- living in a society which respects their rights.

61. The Children's Services Planning order "Requires every Health and Social Services Board to prepare and publish plans for the provision of children's services within its area and to keep those plans under review. In preparing or updating its plans, a Health and Social Services Board is required to consult Health and Social Services trusts, education and library boards, district councils, certain voluntary organisations, the Northern Ireland Housing Executive, the Probation Board for Northern Ireland, the police and other relevant bodies".

62. The purpose of a Children's Services plan is to:

- Promote integrated provision of service and effective use of available resources
- Clarify objectives in relation to services
- Promote integrated provision of services and effective use of available resources
- Ensure consistency of approach to planning by (HSCB) and (HSC Trusts)

- Promote a high degree of coordination and collaboration between (HSCB) and (HSC Trusts) and between social care and health services
- Promote a high degree of coordination and collaboration between (HSCB) and (HSC Trusts) and other agencies and organizations which have a contribution to make to effective provision of local services
- Facilitate joint commissioning by agencies when it is seen as appropriate to meet the needs of children

63. The current CYPSPO plan covers the period 2014-2017. CYPSP has established **5 Outcomes Groups** focussing on need in specific geographic areas (currently co-terminus with the Health and Social Care Trusts). The purpose of Outcomes Groups is to act as coordination and planning space for early intervention developments in their area linking with other planning partnerships to avoid duplication. They provide support to a network of Family Support Hubs and Locality Groups.

64. The Outcome Groups in turn support 29 **Locality planning groups** focusing on need at local community level with a specific role in engaging communities in discussion about how organisations can work together to more effectively address need at a local level. Locality planning groups do not cross the new council boundaries. They focus on:

- Raising awareness of family support service and building a local constituency of support
- Linking communities, politicians with local services
- Embedding outcomes based planning in local communities
- Dialogue with community about service planning and development

65. The Outcome Groups also support a network of **29 Family Support Hubs** covering all of Northern Ireland supported by CYPSP. A Family Support Hub is a multi-agency network of statutory, voluntary and community organizations that either provide early intervention services or work with families who need early intervention services. The network accepts referrals of families who need early intervention family support and uses their knowledge of local service providers to signpost families with specific needs to appropriate services. Between March 2015 and December 2015 3015 families were referred to the Hubs for help. In the previous year 2,635 families had been referred over 700 services are networked through the Hubs.

66. CYPSP has also established **10 regional subgroups** focussing on need for specific vulnerable groups of children and young people. These are ‘task and finish’ groups with a clearly directed mandate from CYPSP where member organisations more explicitly agree to focus collectively on certain vulnerable groups. The collective focus will aim to improve the quality of work with vulnerable children, young people and families and improve outcomes for:

- young carers;
- Black and Minority Ethnic Children and Young People;
- Children and Young People with Disabilities;
- Children and Young People Offending
- Children and Young People with Emotional and Behavioural Difficulties
- LAC, 16+ and Young Homeless
- Domestic and Sexual Violence (with RSG)

- Think Family (with HSCB)
- LGBT Young People (with PHA)
- Children and Young People with Emotional and Behavioural Difficulties

Regional Group on the Health Needs of Looked After Children

67. The Public Health Agency has established a Health Needs of Looked After Children Inter-agency and cross-professional working group. The Group is currently working towards finalising an action plan to address the health needs of Looked After Children

68. The health needs of Looked After Children have been considered and will be incorporated within one of the standards proposed for the Children and Young People's Service Framework. A dedicated Looked After Children nurse position is being established in Health and Social Care Trust areas.

Wales

69. The Social Services and Well-being (Wales) Act 2014 Act strengthens existing safeguarding arrangements for children by placing on relevant partners a new "duty to report" where they have reasonable cause to suspect that a child is at risk. Partners including Health, Police, Probation and youth offending teams will be required to inform the local authority where they have reasonable cause to believe a child to be at risk.

70. The Act introduces parallel provisions for relevant partners to report to the local authority someone suspected to be an adult at risk of abuse . This is supplemented by a new duty for the local authority to make enquires to determine whether any action is required to safeguard vulnerable people

71. The Act introduces a new Adult Support and Protection Order to enable an authorised officer with the requisite skills and experience to secure entry to premises in order to speak in private with an adult suspected of being at risk to determine whether they are making decisions freely; whether they are at risk and decide what, if any, action should be taken'.

72. The Act establishes a National Independent Safeguarding Board which will work with Safeguarding Children Boards and Safeguarding Adult Boards to drive improvement; to report on the adequacy and effectiveness of arrangements to safeguard children and adults and make recommendations to Ministers about how arrangements could be improved.

73. The Act provides for the establishment of Safeguarding Children Boards and Safeguarding Adult Boards. The Safeguarding Children Boards will replace the existing Local Safeguarding Children Boards in Wales.

Paragraph 2

Role of the voluntary sector in the development and maintenance of services

74. The Department of Health's vision for health and social care strongly supports the wider aspirations of the Government to build a society which will draw on the strength and capabilities of active individuals and voluntary organisations that are independent of state.

75. The Department of Health recognises the vital role they play in supporting the lives of vulnerable people, such as the elderly and those experiencing mental health problems, to enable them to live their life in the community. That is why the Department of Health continues to look at ways to influence the environment to enable more people to be able to give their time, more often and in ways that fit in with their lives, to bring health and wellbeing benefits for themselves and others.

76. At the same time, the Department of Health continues to encourage leaders and decision makers in health, public health and social care to work together and consider more strategically where and how volunteering and the voluntary sector can help them to meet their respective priorities and improve the quality, equity and outcomes of statutory services. To that end, the Department of Health (working with others) has produced several reports and introduced new initiatives and legislation that help to promote the engagement between statutory bodies and the voluntary sector so that services are improved and /or better designed based on insight into clients' needs.

77. For example *Caring for our future: reforming care and support* (2012) sets out the Department of Health's commitment to make it easier for people to contribute to their communities through volunteering schemes and support the growth and development of neighbourhood support models that help people share time, talents and skills with others in their community. It also sets out the Department's commitment to "develop, in a number of trailblazer areas, new ways of investing in services that help people to stay active and independent, such as Social Impact Bonds. We will explore whether Social Impact Bonds can be used in care and support to help people live independent lives." As a result, almost £2m was awarded to eight projects looking into using Social Impact Bonds. Some of these have since been commissioned locally through local authorities and Clinical Commissioning Groups, delivering services mainly through the voluntary sector: Manchester Multi-dimensional Treatment Foster Care programme; Newcastle Ways to Wellness social prescribing project; Shared Lives adult foster care services in both Manchester and Lambeth; Thames Reach London Homelessness; Worcester elderly isolation reduction. The London School of Hygiene and Tropical Medicine is carrying out an independent evaluation of these Social Impact Bonds, due to report in June 2017.

78. *Time to Change* (the review into how a new national framework of support might be delivered locally to allow the growth of community provision required to move people out of inappropriate care) recommended using social investment to build capacity in community-based services to enable alternative support. The Department of Health has commissioned Social Finance to provide support and brokerage to areas interested in exploring the potential for using innovative models of finance, with a particular focus on leveraging investment from the full range of potential investors.

79. The Care Act (2014) places a duty on local authorities to provide or arrange services or facilities to prevent or delay the need for care and support. This Act also states that local authorities must promote the efficient and effective operation of a sustainable

market in services for meeting care and support needs and ensure that there is a meaningful choice of providers who, when taken together, provide a variety of services. This could be independent private providers, third sector, and voluntary and community based organisations, including user-led, mutual and small businesses.

80. The report *Helping in Hospitals: a guide to high impact volunteering in hospitals (2016)* provides a framework, supported by detailed advice, checklists, tools to help hospital trusts take a more strategic approach towards volunteering and how to measure the impact of volunteering through rigorous evaluation.

81. NHS England are building on this work and have awarded grants to three voluntary organisations one of which is the National Association of Voluntary Service Managers (an organisation exclusively supporting and leading voluntary services managers in England working within the NHS), to work together to implement the toolkit and consider the recommendations from the market research.

82. The Department of Health, in partnership with NHS England, Public Health England and representatives from the voluntary sector, has co-produced a review of its work with the voluntary sector. The review had two elements:

- the competed grant funding to the sector from the Department of Health;
- wider funding and partnerships between health and care agencies and the voluntary sector across England, focussing specifically on:
    - Defining, achieving and demonstrating impact
    - Building capacity and staying sustainable
    - Promoting equality and address health inequalities.

83. The final report Joint review of partnerships and investment in voluntary, community and social enterprise organisations in the health and care sector was published on 19th May 2016 and contains 28 recommendations for the Department, wider system and the voluntary sector. The recommendations cover a range of issues including co-production of services, social value, commissioning, funding and transparency, and are aimed ultimately at improving integrated working between voluntary and statutory sectors.

84. Supporting active and inclusive communities, and encouraging people to use their skills and talents to build new friendships and connections, are central elements to the Government's vision to improve the nation's health and wellbeing, reduce health inequalities and transform our care and support services so that they are one of the best in the world. The voluntary sector remains fundamental to the Government realising its ambition.

Northern Ireland

85. 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.

86. The RQIA regulates facilities including residential care homes; nursing homes; children's homes; independent health care providers; nursing agencies; adult placement agencies; domiciliary care agencies; residential family centres; and day care settings. RQIA also inspects schools providing accommodation.

87. Any person who carries on or manages such an establishment or agency must make an application to RQIA, and once granted, RQIA issues a certificate of registration to the applicant. RQIA maintains a register of all regulated establishments and agencies.

88. Within Northern Ireland there is a Health and Social Care Board who plans, commissions and purchases services. Five health and social care trusts are the providers of service, managing staff, services and budgets.

89. The Northern Ireland Social Care Council (NISCC)[67] is the regulatory body for the social care workforce in Northern Ireland. NISCC is a non-departmental public body, established to increase public protection by regulating the social care workforce and professional training courses for social workers. The standards of professional practice and conduct required of social care workers are set down in the NISCC Code of Practice for Social Care Workers. The NISCC Code of Practice for Employers of Social Care Workers sets down the responsibilities of employers in the regulation of social care workers[68]. The enforcement of the Codes for employers is a matter for the Regulation and Quality Improvement Authority which regulates registered services in Northern Ireland.

Answers to the ECSR's questions XX-2 (2013)

Besides the White Paper, the Government has also published a draft Care and Support Bill that will enable social care professionals to undertake their role more effectively and empower people who use care and support, their families and carers by supporting them to understand what help is available and how they can best access and navigate care and support. The Committee wishes the next report to provide further information on this reform

The Care Act 2014 provides the legislative framework for the Adult Social Care system. It defines the way the system works, the responsibilities of local government and their partners, and the rights, outcomes and experience of people who need care, carers and their families.

The Act is an historic piece of legislation, and represents the most significant and far-reaching programme of reform in adult social care undertaken in over 65 years.

The Act creates a 'well-being principle' to underpin the care and support system, meaning that people's well-being, and the outcomes which matter to them will be at the heart of every decision that is made – this applies equally to carers.

Regarding the relations with civil society, the Committee notes from the report that the Department of Health is implementing The Compact, an agreement which governs relations between the Government and civil society organisations, such as charities, in England. This Department aims at encouraging successful partnership between the Government and civil society organisations to ensure better outcomes for citizens and communities. The Committee asks the next report to provide further information on the implementation of this agreement.

The Compact lays the foundation for effective, mutually beneficial partnership working

[67] http://www.niscc.info/
[68] http://www.niscc.info/registration-standards/standards-of-conduct-and-practice

between the Government and Civil Society Organisations (CSOs). It is a longstanding agreement that sets out shared commitments from both the Government and CSOs. It includes areas such as promoting CSO's involvement in policy design, service design and delivery, funding arrangements, promoting equality and strengthening independence.

In 2010 The Compact was renewed and updated to be more streamlined, focused, and attuned to the Coalition's and Civil Society Organisations' priorities. It performs a crucial role in improving the partnership between the Government and civil society organisations, for the benefit of citizens and communities.

The Office for Civil Society in the Department for Culture Media and Sport is responsible for overseeing the Compact across Government and works with departments to support its implementation.

The government remains supportive of the principles of the Compact and will take a decision about re-signing it in due course.

In the absence of information concerning the issue of discrimination, the Committee wishes to know whether and how the Government ensures that services managed by the private sector are effective and are accessible on an equal footing to all, without discrimination at least on grounds of race, ethnic origin, religion, disability, age, sexual orientation and political opinion.

The Equality Act 2010 requires equal treatment in access to private and public services, regardless of the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, race, religion or belief, sex, and sexual orientation. Civil cases can be brought against those in violation of the Act.

The Committee wishes the next report to indicate the total budget for grants from the Department of Health to the voluntary sector.

Total budget on grants to voluntary sector organisations in 2015/16 was £66,420,935.

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Article 14, Paragraph 1

Responsibility for Social and Mental Care was transferred from the former Department of Social Care to the newly formed Department of Health and Social Care from 1st April 2014.

The Social Care Division is divided into three service areas: Adults, Children and Families, and Mental Health.

Expenditure across the service areas in 2015/16 was:

Division	Expenditure (GB£)
Adult Social Care	25,063,000
Children & Families	14,350,000
Mental Health	18,046,000
Corporate Services	1,826,000

Adult Social Care

The specific policies of adult social care continue to be as reported in the previous reference period.

The number of staff employed by Adult Social Care as of August 2016 was 520.9 [whole time equivalents (wte) against an establishment of 595.39 wte].

A Fair Access to Care Services Eligibility Criteria was introduced in December 2013. The need to have a transparent and robust assessment framework is supported by the introduction of the Social Services Act 2011. The Act places a duty on the Department to be clear in the way that it assesses those eligible for support and enables charges to be made for the provision of social care services to meet assessed needs. The criteria are publicly available so that the process is open and transparent.

As a requirement of the Regulation of Care Act 2013 all social work staff must be registered with the Health Care Professionals Council (HCPC), or equivalent regulatory body.

The legal basis for the provision of services to adults is contained in the Social Services Act 2011 and the Chronically Sick and Disabled Persons Act 1981 which provides a legal framework for the assessment and provision of support to those people deemed eligible for Social care services. The Social Services Act 2011 also places the requirement to provide an assessment to a carer, on a legal footing. The following services are provided:

- 169 beds for older people in three resource centres located in major centres of population. Provision includes long term care, day care and respite care.
- Reablement Service Established, supporting people to regain and relearn skills for daily living, allowing them to remain in the community longer.
- 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.

- Dementia Care Team set up with 11 service users currently receiving support.
- More intensive care packages provided.
- 6448 Meals on Wheels provided in March 2016.
- 185 Service users receiving home care, 11 Dementia Care and 120 receiving domestic services via our contract in the past year 329 people have benefitted from the reablement service.
- Building completed on a 16 (14 long term and 2 respite) place residential unit for people living with dementia in Ramsey. This unit has opened and is being utilised fully.
- The Disability Employment Service has continued 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; alongside the creation of a Social Firm that employs 30+ adults with a Learning Disability.
- 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.
- The right of carers to receive an assessment is written into the Social Services Act.
- Work has continued on reviewing services provided for people with Learning Disabilities. Day Services are currently in the process of reconfiguring services that will result in a new purpose built facility that will improve access for people with complex needs, increase employment opportunities and in doing so generate a greater community presence. . Supported Living and Housing options are being explored with the aim of developing supported housing options in order to offer people with learning disabilities greater independence and choice. To further develop and increase the current supported living scheme. Respite Care is currently in the process of reconfiguring services that will see the development of improved facilities that will improve access for people with complex needs. .

Children & Families

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

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:

- The children and family service has been restructured and retains the same number of social workers, a team of specialist family support workers [6 and a manager] and has re-commissioned services to replace the family centres but to provide a flexible range of support services.
- Family Advisors 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.
- A centre to support contact between children and significant adults in their lives.
- Outreach support from care providers to provide support and therapeutic services to children, young people and their families and provide targeted support to vulnerable families.

- Two eight-place respite care units for children with disabilities which provide respite, outreach and day care.
- A play therapist and behavioural therapist to provide support for young people with emotional and behavioural problems.
- A juvenile youth justice team, jointly funded by Social Services, Health, Probation and the Police has been established to deal with youth crime.

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. The Department also commissions an Adoption Service to find and support adoptive placements and support birth parents of children who have been or are being adopted.

In addition the following range of residential provision is in place:

- Two six-bed, four 4-bed, four 3-bed and one 2-bed residential units for young people.
- 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.
- A secure unit 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
- A 6-bed semi-independent accommodation for care leavers.
- An 8-bed supported housing scheme for vulnerable young people and young adults
- 3 beds in specialist accommodation for young people with Autism.

Significant work and resources have been invested since 2010 in the full range of Children and Families services to raise and maintain high standards of care and practice.

Mental Health

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

- Strategy in place 2015-2020 for the development of Mental Health and Wellbeing services supported by increased funding.
- In 2015 we commissioned a new build flexible use facility that will provide for 14 acute adults and 12 older people.
- 2015 redesigned the day service provision to provide dedicated resource to ‘at home ‘ support and enhanced day service provision to allow for early discharge and admission avoidance – opening 2016. This provides low to high intensity workers in home based placements
- Community based services include a community support team for older people with a mental health problem living at home alongside Primary Care support service
- A Child and Adolescent Mental Health Service provides 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 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, take home Naloxone, drug arrest referral scheme, home detoxification and a co-ordinated approach is being taken to ensure effective treatment and prevention.
- 2015 further redesign of provision to forensic and psychiatric intensive care.

Article 14, Paragraph 2.

Voluntary organisations are an essential part of the provision of social welfare services in the Isle of Man and a Council for Voluntary Services is well established. The Department of Health and Social Care seeks 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 the Social Care budget is provided as direct grant aid or contracts to voluntary and independent organisations to provide welfare services.

Voluntary organisations are consulted in the development of services for all groups of service users and those using services and their carers are increasingly involved in service development and delivery.

APPENDIX A

Report of the Health and Safety at Work Inspectorate

for

1 April 2012 – 31 August 2016

Isle of Man Government

Reiltys Ellan Vannin

August 2016

Foreword

Hon Richard Ronan, Minister of Environment, Food and Agriculture

The Isle of Man Health and Safety at Work Inspectorate (HSWI) has been through a number of changes over the past four years. A new team was formed following the retirement of two long serving inspectors, some outdated legislation has been revoked and the Inspectorate was amalgamated with the Island's Environmental Health team within the Department of Environment, Food and Agriculture.

These have been positive changes which have increased the number of qualified Inspectors available to carry out inspections and improved the consistency of health and safety regulation across all workplaces in the Isle of Man.

The removal of some outdated and prescriptive regulations has allowed the development of a more risk based approach to health and safety which encourages employers to identify the risks specific to their own undertakings and introduce proportionate measures to control them. This has been welcomed by employees and employers alike.

During the period covered by this report the Inspectorate has developed and maintained a well-informed balance between working with businesses and organisations to promote this preventative approach and taking enforcement action when appropriate.

It is an effective strategy which is helping employers and members of the public to become 'risk aware' rather than 'risk averse' and, as a consequence, they are identifying for themselves that investing in sensible health and safety is more cost effective than reacting to incidents after they have occurred.

I would encourage all businesses and organisations to adopt this realistic approach to the important topic of health and safety.

Richard Ronan

Introduction

This report covers the period from 1 April 2012 to the 31 August 2016.

The report explains the role of the Inspectorate and covers the work undertaken by Inspectors including inspections, investigation of incidents and complaints, enforcement, advice and educational events. The report also includes statistical information on

accidents and injuries and the time lost from the work place as a consequence of such incidents.

The Health and Safety at Work Inspectorate – Who We Are and What We Do

The Inspectorate is part of the Department of Environment, Food and Agriculture (DEFA), with the political responsibility for ensuring that the Inspectorate can contribute to the effective delivery of health and safety resting with the Minister of the Department.

All decisions on when enforcement action is taken (and the type of enforcement action which is most appropriate) however, are made within the Inspectorate.

Management and Staffing

The Inspectorate structure currently comprises one Senior Inspector of Health and Safety post and two Inspector posts. The team is managed by the Director of Environment, Safety and Health whose remit also includes managing the Environmental Health Team and the Environmental Health Protection Unit. The Director reports to the Departmental Chief Executive Officer and is generally focused on the strategic management of the Inspectorate rather than day to day operational activities.

The Department has a statutory duty to ensure that it has a sufficient number of appropriately qualified and experienced Inspectors who can work across a wide range of industries. Where possible the Department strives to support and encourage the development of these qualifications and skills at a local level, ensuring a mix of experience and grades which will allow for effective succession planning.

The HSWI team is supported in the delivery of health and safety by a team of six Environmental Health Officers who, in combination with their own objectives, ensure that legislative standards in offices, shops, restaurants, public houses and residential homes are maintained.

Work of the Inspectorate

The primary function of the Health and Safety at Work Inspectorate is to ensure compliance with legislation passed by Tynwald aimed at protecting workers and members of the public whose safety and health may be put at risk by work activities. This responsibility covers all public and private sector workplaces, including Government, with the exception of the licensing of petrol filling stations and firework retail outlets which are undertaken by the Office of Fair Trading.

The Inspectorate has wide ranging powers which allow it to inspect premises/sites where work activities are taking place and to require, by way of a legal Notice, an employer to make specific improvements to their operations within a given time frame (an Improvement Notice), or indeed if the activity is judged to be immediately hazardous, to cease it immediately (a Prohibition Notice).

Workplace Engagement

The Inspectorate recognizes that the effective application of health and safety legislation is best achieved through constructive engagement with employers, encouraging best practice, providing advice, guidance and education by way of seminars/events,

publications etc. as well as undertaking a proactive and planned inspection regime across the public and industry sectors. Such advisory/educational activities do not present a conflict of interests with the primary role of the Inspectorate as an enforcement body, if managed correctly and, as this annual report shows, there has been increasing engagement with employers and other stakeholders throughout this period.

At the commencement of 2016 the Inspectorate began the process of proactively visiting smaller construction sites and activities. Historical records show that the Inspectorate has focused its proactive resources on larger construction companies and construction projects. In the first half of 2016, between 1st January and 1st July, proactive and advisory visits have been undertaken, a majority of these involving smaller construction companies and sites.

Enforcement

Details of enforcement notices and prosecutions for health and safety offences are also included in this report. The Inspectorate presents reports to the Attorney General's Chambers in cases where it considers that serious breaches of the law have taken place. The Attorney General's Chambers makes the decision as to whether or not prosecution is sought.

Licensing

In addition to the general framework of health and safety legislation, the Inspectorate has a number of licensing responsibilities, building upon the fact that the legal duty to manage risk lies with the organisation that creates them. The Inspectorate is responsible for carrying out the annual safety reviews associated with issue of licences required for the operation of the Island's petroleum spirit and liquefied petroleum gas (LPG) storage depots.

Railway operators also have to be assessed annually (see below).

The Princess Alexandra Pier LPG storage facility operated by Manx Gas Limited is also now being assessed by UK Health and Safety Executive specialists to the standards specified in the UK's Control of Major Accident Hazards (COMAH) regulations, despite the fact that these regulations are not part of Isle of Man legislation. This development was at the request of Manx Gas Limited who wished to ensure that all of their major hazard sites were inspected under the same regime. This policy was implemented with the support of the HSWI. Other sites are inspected under the Isle of Man Dangerous Goods Act licensing regime by HSWI inspectors. There are 13 licensed sites/premises.

The Island's health and safety legislation also requires that all gas work (as defined) operatives are registered with Gas Safe Register and the HSWI works closely with this body to ensure that any unsafe or illegal work activities are investigated. The Island currently has approximately 85 registered gas companies with around 250 competent engineers/operatives. Gas Safe Register undertakes to inspect each business to ensure minimum standards are being achieved.

Certain horse riding establishments are required to hold licences. Although this licensing is not part of health and safety legislation inspectors provide assistance to DEFA's Agriculture and Veterinary division to report on health and safety matters at these

premises to determine if it is appropriate to issue an annual licence. There are currently 7 licenced horse riding establishments.

Asbestos contractors working with materials containing the more hazardous types of asbestos are required to hold an asbestos removal licence. This is administered through HSE Northern Ireland. Inspectors in the Island carry out random and proactive visits to premises where removal work is taking place. This information is fed back to HSE NI and provides invaluable evidence when it comes to the issuing of licences.

Until recently two Licensed Asbestos Removal Contractors (LARCS) were based on the Island, however, one of these companies recently relinquished its licence leaving only one current LARC. UK LARCS do occasionally operate in the Isle of Man.

Railways

The Isle of Man has three heritage railways which are owned and operated by the Isle of Man Government's Department of Infrastructure and three privately operated railways. There is a legislative requirement for the HSWI to conduct an annual safety inspection of all railways to ensure they are safe for use. Inspections are undertaken by Health and Safety Inspectors. Day to day health and safety regulation is also undertaken by the Inspectorate.

Inter-Agency Working

The Inspectorate also works collaboratively on a regular basis with other agencies and individuals in the course of their duties, including the Office of Fair Trading, the Police, the Coroner of Inquests, the Fire Service and Planning and Building Control.

How the work of the Inspectorate is delivered

Inspections

Inspection is the process carried out by warranted (HSWI) inspectors which involves observing site conditions, standards and practices where work activities are carried out under the duty-holder's control. Its purpose is to ensure compliance with legal requirements for which the Inspectorate is the enforcing authority and to promote standards of health and safety which are proportionate to the risks specific to the organization being inspected.

During the period covered by this Report inspectors visited a variety of different premises and activities including construction sites, factories, agricultural premises, the airport, heritage railways, power stations, offices and shops, hotels, highly flammable storage facilities, fairgrounds, hospital and care homes and premises where gas installation and repair work had been undertaken. In fact most types of premises where occupational activities were being undertaken.

Examples of where routine inspections have prompted further action are listed below:

- During a routine inspection of a construction site it was discovered that the undertaking was allowing its site staff to work within and close to a deep excavation sited immediately adjacent to a 4 storey property during the course of renovation

work. The risk that the adjacent building might collapse was felt to be significant and a Prohibition Notice was issued requiring work to cease immediately and not to recommence until safe systems of work were employed. The same company was issued with a Formal Caution.

- During a routine inspection of a horse riding establishment, the inspector noted that the fire extinguishers were in a poor/untidy condition and brought this to the attention of the operator. The inspector was informed that the firefighting equipment had recently been inspected and serviced. The work of the service company was investigated and a number of unsafe extinguishers were identified. The service engineer was subsequently prohibited from working on fire extinguishers and was later prosecuted by the Office of Fair Trading following a combined investigation.

- Proactive interventions with construction companies have resulted in a number of prohibition notices being served on companies operating on sites where it was identified that scaffold structures had been erected in a dangerous manner and in other cases where no safe systems of working at height had been adopted.

Investigations

Investigation is a reactive process which includes all those activities carried out in response to an incident or a complaint. Investigations are carried out to:

- gather and establish the facts relating to incidents,
- identify immediate and underlying causes and the lessons to be learned,
- prevent recurrence,
- detect breaches of legislation for which HSWI is the enforcing authority,
- identify the most appropriate course of action which might include formal enforcement.

An investigation may range from an enquiry by a single inspector about a minor incident or a complaint to a large enquiry involving a number of inspectors.

A complaint is a concern, originating from outside the HSWI, in relation to a work activity that is sufficiently specific to enable identification of the issue and the duty holder and/or location and that either:

- has caused or has potential to cause significant harm, or alleges the denial of basic employee welfare facilities, or
- appears to constitute a significant breach of law.

In total approximately 200 complaints are dealt with by the Inspectorate each year and a further 254 (average received per year from the previous 4 years) accident reports are received through incident reporting legislation adopted in the Isle of Man - the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2003 (RIDDOR). A few examples of where investigations have been undertaken resulting in significant enforcement action include:

- Following a report of a dangerous occurrence at a boating lake where a boat capsized leading to the amputation of a finger, the inspectorate served a Prohibition

Notice on the undertaking to prevent further use of the equipment until safety measures had improved. An improvement notice to direct the operator to review their safe systems of work including making improvements to work equipment where it was determined that moving parts of machinery were not fully guarded was also issued.

- The inspectorate received reports that work carried out by itinerant workers undertaking roofing works was being carried on in a dangerous manner. Investigations found, on a number of sites under their control, that the duty holder was not employing safe methods of working at height. On another premises it was discovered that the company was removing asbestos components without adequate safety precautions in place. The inspector issued Prohibition Notices on the company for each contravention.

- A complaint was received from a tenant in rented accommodation alleging that the gas boiler was unsafe. The subsequent HSWI investigation identified that both a registered and a non-registered gas installer had operated in breach of the relevant legislation. Prohibition Notices for each of the gas installers were served and one of the gas installers was prosecuted for offences concerned with dangerous gas work. It was concluded that the flue was dangerous and could easily has led to building occupants being exposed to carbon monoxide.

Enforcement

Enforcement means all dealings with duty holders that result in the serving of notices; the withdrawing of approvals; the varying of licences, conditions or exemptions; the issuing of formal cautions; or prosecution and the providing of information or advice, verbally or in writing. During the period of this report, **14** Improvement Notices, **26** Prohibition Notices and **4** Formal Cautions were issued.

Prosecution is the taking of punitive action against a duty holder following a decision-making process which is impartial, justified and procedurally correct. During the period covered by this report **14** cases were referred to the Attorney General's Chambers by the Health and Safety at Work Inspectorate.

A number of these cases are summarized below;

- A site engineer died from crush injuries when a large steel and fiberglass assembly toppled onto him. The subsequent investigation determined that one of the companies in control of the work failed to comply with section 3 of the Health and Safety at Work etc. Act 1974 as applied to the Isle of Man. This is the duty on an employer to take reasonably practicable steps to avoid exposing persons other than his or her employees to risks. The company later entered a guilty plea and were fined and ordered to pay costs.

- A site worker died from crush injuries when a dry-stone wall collapsed onto him. Investigations found that the laborer had been instructed to excavate a shallow trench alongside the length of the wall. The excavation work de-stabilised the wall causing it to fall onto him. Subsequent investigations determined that the organisation concerned failed to produce a specific risk assessment for this task. They pleaded guilty and were later prosecuted for breaches of health and safety legislation.

- A motorcyclist died in a collision on the public highway when he collided with a stationary refuse collection vehicle operating on the TT course during the TT festival. The refuse collection company involved was subsequently prosecuted for failing to carry out a suitable and sufficient risk assessment of the route and the operation of the vehicle during the TT period.

Data Collection

As part of its work the Inspectorate collects and monitors data on reportable work place accidents and injuries. The Appendices include data on the economically active population of the Isle of Man as of the last census in 2011. The figures include percentage of reported accidents per head of population and are also divided into reported accidents from the public sector and non-public sector. The figures cover types and causes of injuries and the amount of time spent off work, illustrating the impact of preventable accidents on both a personal and an economic level. It will undoubtedly be the case that, although required by law, not every significant workplace accident or near miss will be reported to the Inspectorate and therefore there will be under-reporting in these figures, although it is not possible to say to what extent this will be the case. Work continues to develop and improve the data management systems used by the HSWI.
Data collected by the HSWI is used to form an understanding of any developing accident and ill health trends and inform pro-active health and safety work with the community.

Other Work

Assisting other Agencies

Throughout the reporting period the Inspectorate continued to provide expertise and assistance to a number of agencies including the Police, Coroner's Office, Attorney General's Chambers, Fire Service, Building Control and Environmental Health. This work has included the investigation of 3 suicides in a mental health unit, a house fire at a domestic property and the investigation of the sudden death of a very young child to rule out accidental poisoning.

Educational Promotional

The Inspectorate is in constant contact with government and non-government agencies and inspectors are always willing to provide industry updates where appropriate. A gas safety seminar was provided to registered gas installers. The Head of Health and Safety provides an annual Inspectorate update to the IOSH conference. Other events have included a Legionella presentation to the health care sector and several work at height/scaffolding seminars. Following a fatal road traffic collision, the Inspectorate invited local authorities to a seminar to discuss requirements for those employing staff and contractors involved with work on or near the road.

Appendix I

Isle of Man Population Data

Census data 2011

Resident population 84,497
Economically Active 44,609
Working for one or more employers 37,034
Self-employed (employing others) 1,817

RESIDENT EMPLOYED POPULATION BY SEX AND INDUSTRY 2011*

Employment in the Isle of Man by Sector	Industry Total	Males	Females	%
Agriculture, forestry and fishing	850	695	155	**2**
Manufacturing	2,295	1,775	520	**5**
Construction	3,352	3,188	164	**8**
Electricity, gas, other energy and water	878	744	134	**2**
Transport and communications	3,037	2,149	888	**7**
Wholesale distribution	821	607	214	**2**
Retail distribution	3,683	1,659	2,024	**9**
Insurance	1,931	871	1,060	**4**
Banking	2,927	1,177	1,750	**7**
Other financial institutions	1,695	848	847	**4**
Property owning and management	1,049	656	393	**2**
Other business services	1,842	844	998	**4**
Information and Communication Technology	609	457	152	**1**
Legal services	625	226	399	**1**
Accountancy services	958	487	471	**2**
Education	2,795	695	2,100	**6**
Medical and health services	3,539	787	2,752	**8**
Tourist accommodation	679	337	342	**2**
Other professional and technical services	1,000	659	341	**2**
Entertainment and catering	2,129	1,174	955	**5**
Miscellaneous services	3,382	1,359	2,023	**8**
Public administration	3,058	1,732	1,326	**7**
Total	**43,134**	**23,126**	**20,008**	**100**

**Figures taken from the 2011 Census*

% of Reported Accidents by Population Type 2015/16	Total Number of accidents reported 170	%
All types of accidents, by total resident population	84,497	0.2
All types of accidents, by economically active	44,609	0.38

All types of accidents occurring in non-public industry sector	80	47
All types of accidents occurring in public sectors*	90	53

% of Reported Accidents by Population Type 2014/15	Total Number of accidents reported 269	%
All types of accidents, by total resident population	84,497	0.3
All types of accidents, by economically active	44,609	0.6
All types of accidents occurring in non-public industry sector	118	44
All types of accidents occurring in public sectors*	151	56

% of Reported Accidents by Population Type 2013/14	Total Number of accidents reported 257	%
All types of accidents, by total resident population	84,497	0.3
All types of accidents, by economically active	44,609	0.6
All types of accidents occurring in non-public industry sector	112	44
All types of accidents occurring in public sectors*	145	56

% of Reported Accidents by Population Type 2012/13	Total Number of accidents reported 320	%
All types of accidents, by total resident population	84,497	0.38
All types of accidents, by economically active	44,609	0.72
All types of accidents occurring in non-public industry sector	154	48
All types of accidents occurring in public sectors*	166	52

**Public sector includes all Government Departments, Statutory Boards, Offices, schools, health services and Local Government.*

Comparisons with UK accident rates

The UK Health and Safety Executive produce an annual report on accident statistics, using the same reporting framework as the IOM (RIDDOR). The most recent figures available for the UK are from 2014/15; comparisons show that the Isle of Man rates differ slightly from the UK, but the massive differences in populations and work activities make it difficult to provide a realistic comparison. There were no fatal accidents to IOM workers in 2014/15 and 2015/16 although there was one prosecution of an employer in respect of a fatal accident, which had occurred in 2013/14.

The UK figures are based on an accident rate per 100,000 employees and, as the economic population of the IOM is 44,609 the figures have been adjusted accordingly.

***UK mandatory reporting is triggered following 7 days absence from work this is reflected in the greater number of reported injuries following absence from work in IOM.

2015/16

	IOM		**UK**	
	Actual Number	Estimate Per 100,000	Actual Number	Per 100,000
Fatal Injuries to Workers*	0	0	144	0.46
Major Injuries	22	49.0	**	**
Reported Injuries causing 3 days or more absence from work***	148	332.0	**	**

***figures not yet released*

2014/15

	IOM		**UK**	
	Actual Number	Estimate Per 100,000	Actual Number	Per 100,000
Fatal Injuries to Workers*	0	0	142	0.46
Major Injuries	51	114	18084	70.3
Reported Injuries causing 3 days or more absence from work***	146	327	57970	222.7

2013/14

	IOM		**UK**	
	Actual Number	Estimate Per 100,000	Actual Number	Per 100,000
Fatal Injuries to Workers*	1	2	133	0.44
Major Injuries	51	114	19118	73.7
Reported Injuries causing 3 days or more absence from work***	118	264	59553	233.3

2012/13

	IOM		**UK**	
	Actual Number	Estimate Per 100,000	Actual Number	Per 100,000
Fatal Injuries to Workers*	1	2	150	0.51
Major Injuries	64	143	20214	80
Reported Injuries causing 3 days or more absence from work***	126	282	60154	238

Appendix II

Enforcement Data 2012-2016

Sector	**Improvement notice**	**Prohibition Notice**	**Formal Caution**	**Files presented to the Attorney General Chambers for consideration***

Construction (work at heights)	1	6		
Construction (asbestos)	1	4		1
Construction (demolition)		2		
Construction (vehicular, fabrication and machinery)	2	1		2
Construction (underground services)		2		
Construction (excavation)		1	1	1
Gas safety	1	2	2	2
Health services	3			3
Waste services	1	1		1
Entertainment	2	1	1	
Hospitality	1	2		1
Dangerous goods		1		
Transport/warehousing	2			
Fire safety		2		3
Agriculture/ arboriculture		1		
Totals	**14**	**26**	**4**	**14**

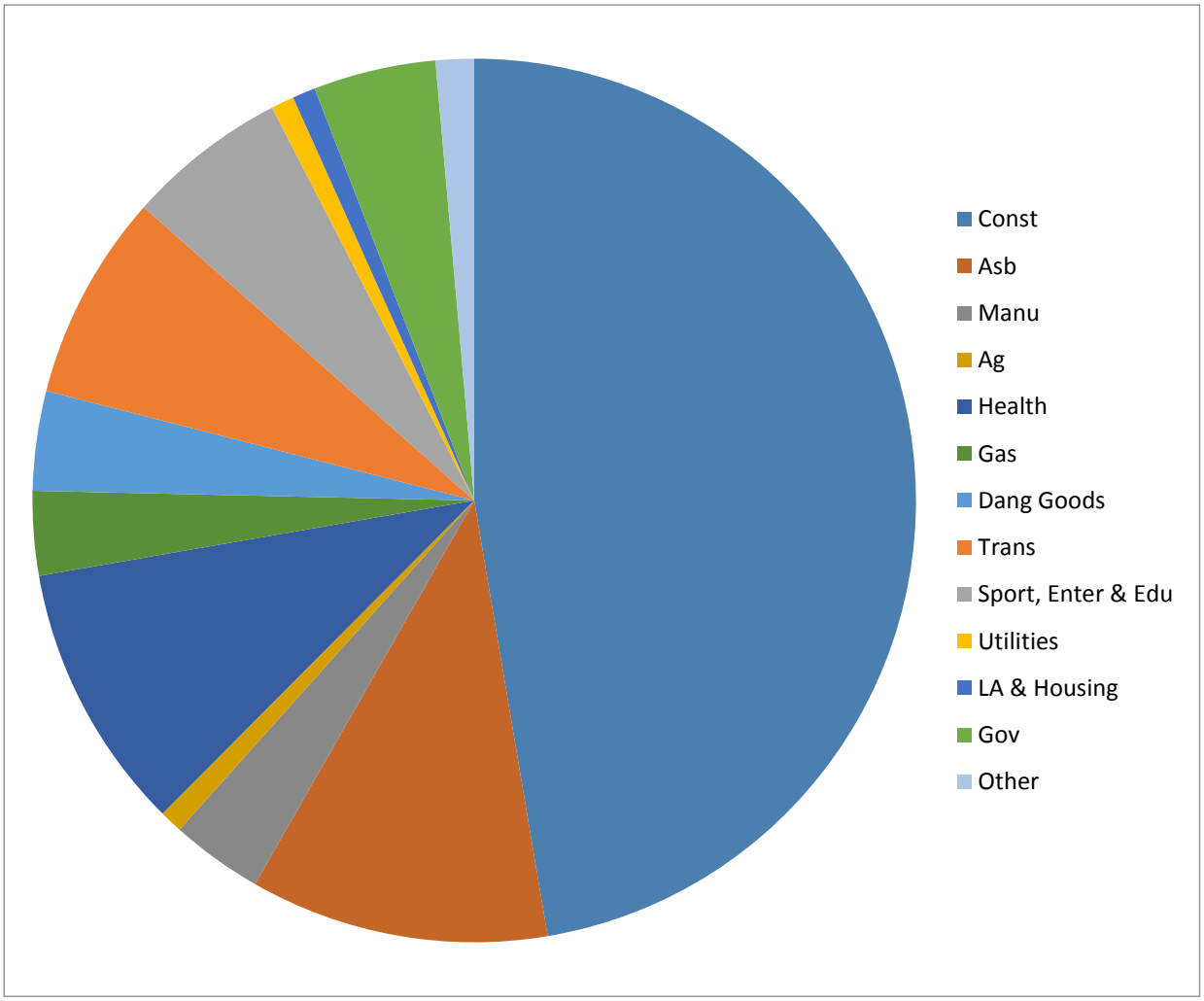
*of the 14 reports forwarded to the AG's department they considered that 11 should be prosecuted and in the other 3 cases alternative action should be taken by the inspectorate. Of the remaining 11 cases 3 are awaiting hearings. 8 cases have been heard 7 defendants have been found guilty and there was a not guilty verdict in the other case.

Appendix III

An example of visits by sector and type January - August 2016

	Const	Asb	Manu	Ag	Health	Gas	Dang Goods	Trans	Sport, Enter & Edu	Utilities	LA & Housing	Gov	Other	**totals**
Accidents	4	0	3	0	15	1	0	9	5	2	0	4	0	43
Complaints	24	7	2	1	1	4	0	5	2	0	1	1	2	50
Advisory	50	7	4	0	10	2	1	6	1	1	2	5	2	91
Proactive	76	6	3	2	4	2	12	2	1	0	0	6	1	115
Enforcement Activities	15	19	0	0	5	2	0	5	12	0	0	0	0	58
Totals	169	39	12	3	35	11	13	27	21	3	3	16	5	357

Number of visits by sector and type January – August 2016



Figures provided by HSWI database

Contacts

Director of ESD – Bernard Warden
Senior Inspector - Robert Greaves
Inspector - Paul Whitaker
Inspector – this post was recently made vacant and a replacement is being recruited
Admin manager – Steve Callister

The Health and Safety at Work Inspectorate address is;

Environment, Safety and Health Division
Department of Environment, Food and Agriculture
Thie Slieau Whallian
Foxdale Road
St Johns
Isle of Man
IM4 3AS

The Inspectorate can be contacted direct on telephone number (01624) 685881, or by email on worksafe.doi@gov.im .Information on the Inspectorate can also be found on the Government website at http://www.gov.im/transport/msd/healthandsafety/welcome.xml

APPENDIX B

REPORT

for the period 1 June 2011 to 31 May 2016 made by the Government of the United Kingdom of Great Britain and Northern Ireland in accordance with Article 22 of the Constitution of the International Labour Organisation, on the measures taken to give effect to the provisions of the

SOCIAL SECURITY (MINIMUM STANDARDS) CONVENTION 1952 (NO. 102)

ratification of which was registered on 27 April 1954.

On ratification, the United Kingdom (UK) accepted Parts II to V and Parts VII and X. The UK subsequently ratified the Council of Europe's European Code of Social Security on 12 January 1968 and accepted the corresponding Parts of the Code, with the exception of Part X on Survivor's Benefits. The Committee of Experts on the Application of Conventions and Recommendations will be aware that concurrent detailed Reports are due to be submitted on compliance with obligations arising under both instruments. The information in the UK's Code Report for 2011 has been expanded below to reflect its additional obligations arising under Convention No.102.

LEGISLATION

Separate, but corresponding, schemes of Social Security operate in Great Britain and Northern Ireland. Reciprocal arrangements between the two ensure that the schemes effectively operate as a single system. The law governing Social Security in Great Britain was amended during the reference period by the measures listed below. Corresponding legislation came into effect in Northern Ireland as listed after the GB measures. Benefit levels are maintained in parity with Great Britain and all rates quoted therefore apply equally.

Copies of the original text of Acts, Regulations and Orders can be viewed at the Government's website[69]. Statutory Instruments (SIs) and Statutory Rules (SRs) can be traced by their year of publication and SI/SR Number quoted below. 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[70]. 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 Communities website[71].

Acts of Parliament

Primary legislation relevant to the benefits covered by the Report and introduced during the reference period includes:

2011

- Pensions Act 2011
  http://www.legislation.gov.uk/ukpga/2011/19/pdfs/ukpga_20110019_en.pdf

2012

- Health and Social Care Act 2012
  http://www.legislation.gov.uk/ukpga/2012/5/pdfs/ukpga_20120005_310516_en.pdf
- Welfare Reform Act 2012
  http://www.legislation.gov.uk/ukpga/2012/5/pdfs/ukpga_20120005_310516_en.pdf

2013

- Enterprise and Regulatory Reform Act 2013, section 72 - abolition of the Agricultural Wages Board in England only (ceased to have effect after 30 September 2013).
  http://www.legislation.gov.uk/ukpga/2012/5/pdfs/ukpga_20120005_310516_en.pdf
- Welfare Benefits Up-rating Act 2013
  http://www.legislation.gov.uk/ukpga/2016/7/pdfs/ukpga_20160007_en.pdf

2014

- Agricultural Sector (Wales) Act
  http://www.legislation.gov.uk/anaw/2014/6/pdfs/anaw_20140006_mi.pdf
- Pensions Act 2014
  http://www.legislation.gov.uk/ukpga/2014/19/pdfs/ukpga_20140019_en.pdf

[69] http://www.opsi.gov.uk/legislation/index.htm
[70] http://www.dwp.gov.uk/publications/specialist-guides/law-volumes/the-law-relating-to-social-security/
[71] https://www.communities-ni.gov.uk/services/law-relating-social-security

- Welfare Reform and Work Act 2016
  http://www.legislation.gov.uk/ukpga/2016/7/pdfs/ukpga_20160007_en.pdf

Statutory Instruments

An alphabetical list of all current secondary legislation, i.e. Regulations and Orders in the form of Statutory Instruments, is available via the link below[72].

All secondary legislation introduced during the five years of the reporting period can be viewed via links in the chronological bookmarks in the left hand side-bar of the list.

The rates of Social Security benefits payable under the respective Parts of the Code were increased during the reference period by the following instruments:

2012

- The Social Security Benefits Up-rating Order 2012 (SI 2012 No 819, NI Equivalent SR 2012 No 116)

2013

- The Social Security Benefits Up-rating Order 2013 (SI 2013 No 574, NI Equivalent SR 2013 No 69)

2014

- The Welfare Benefits Up-rating Order 2014 (SI 2014 No 147, NI Equivalent SR 2014 No.80)
- The Social Security Benefits Up-rating Order 2014 (SI 2014 No 618, NI Equivalent SR 2014 No 78)

2015

- The Welfare Benefits Up-rating Order 2015 (SI 2015 No 124)
- The Social Security Benefits Up-rating Order 2015 (SI 2015 No 457, NI Equivalent SR 2015 No 124)
- Uprating orders Welfare Benefits Up-rating Order 2015 (SI 2015 No 30, NI Equivalent SR 2015 No 139)
- Agricultural Wages (Scotland) Order (SR 2015 No 63)

2016

- The Social Security Benefits Up-rating Order 2016 (SI 2016 No 246 NI Equivalent SR 2016 No 92)

[72] http://www.dwp.gov.uk/docs/c-0031.pdf

The following instruments of relevance are also mentioned in the report:

2011

- Employment and Support Allowance (Limited Capability for Work and Limited Capability for Work-Related Activity) (Amendment) Regulations 2011(SI 2011 No 228, NI Equivalent SR 2011 No 76)
- Employment and Support Allowance (Work-Related Activity) Regulations 2011 (SI 2011 No 1349, NI Equivalent SR 2011 No 265)

2012

- Employment and Support Allowance (Amendment) Regulations 2012 (SI 2012 No 3096, NI Equivalent SR 2013 No 2)
- Employment and Support Allowance (Amendment of Linking Rules) Regulations 2012 (SI 2012 No 919, NI Equivalent SR 2016 No 176)
- Employment and Support Allowance (Sanctions) (Amendment) Regulations 2012 (SI 2012 No 2756, NI Equivalent SR 2016 No 240)

2013

- Job Seekers Allowance Regulations 2013 (2013 No 378)
- Employment and Support Allowance Regulations 2013 (SI 2013 No 379, NI Equivalent SR 2016 No 219)
- Universal Credit, Personal Independence Payment, Jobseeker's Allowance and Employment and Support Allowance (Decisions and Appeals) Regulations 2013 (SI 2012 No 381, NI Equivalent SR 2016 No 221)
- Universal Credit, Personal Independence Payment, Jobseeker's Allowance and Employment and Support Allowance (Claims and Payments) Regulations 2013 (SI 2012 No 381, NI Equivalent SR 2016 No 220)

2014

- Statutory Sick Pay (Maintenance of Records) (Revocation) Regulations 2014 (SI 2014 No 55)
- Statutory Sick Pay Percentage Threshold (Revocations, Transitional and Saving Provisions) (Great Britain and Northern Ireland) Order 2014 (SI 2014 No 897)

2015

- Employment and Support Allowance (repeat Assessments and Pending Appeal Awards) (Amendment) Regulations 2015 (SI 2015 No 437)

2016

- Agricultural Wages (Wales) Order 2016 (SI 2016 No 107)

PART II MEDICAL CARE

Legislative Changes

2012

- Health and Social Care Act 2012
  http://www.legislation.gov.uk/ukpga/2012/5/pdfs/ukpga_20120005_310516_en.pdf

1. The Health and Social Care Act 2012 introduced a new structure to the NHS, including setting up the NHS Commissioning Board, known as NHS England.

2. From April 2013, NHS England became responsible for the commissioning of NHS primary medical services in England.

3. In October 2014, the NHS Five Year Forward View was published. This sets out a vision for the future of the NHS and included new models of care, setting out proposed models that reflect the different structures, populations and localities. This is important, as the diversity of the NHS will not lend itself to a "one size fits all" model. Government is making £200 million available to pilot some of the new models of care set out in the *Five Year Forward View.*

4. On 21st April 2016, NHS England published the GP Forward View, a package of support to help get general practice back on its feet, improve patient care and access, and invest in new ways of providing primary care.

5. The GP Forward View sets out that we are investing an extra £2.4 billion a year for general practice services by 2020/21 – this represents a 14% increase in real terms. The overall investment for general practice includes a £500 million national 'turnaround' package to support GP practices.

6. This is part of a wider package of support for general practice, which contains measures to help boost the workforce, drive efficiencies in workload and modernize primary care infrastructure and technology.

7. The table below shows investment in general practice in England from 2010/11 to 2014/15.

Finance Monitoring: England	2010/11 Outturn £000s	2011/12 Outturn £000s	2012/13 Outturn £000s	2013/14 Outturn £000s	2014/15 Outturn £000s
Total payments for essential & additional services	4,372,287	4,366,855	4,370,320	4,478,229	4,792,294
Quality & Outcomes Framework	1,095,532	1,141,612	1,191,498	1,057,418	664,456
Total other payments	1,286,251	1,333,831	1,376,502	1,528,803	1,682,684
Total Enhanced Services	789,079	764,420	751,364	849,928	1,013,497
Total Net of Dispensing	7,543,149	7,606,718	7,689,684	7,914,378	8,152,931
Total Investment Excluding Reimbursement of Drugs	7,708,548	7,774,469	7,863,838	8,093,357	8,336,207
TOTAL NHS SPEND	8,349,528	8,397,044	8,459,261	8,689,883	8,938,743
TOTAL SPEND	8,349,528	8,397,044	8,459,261	8,766,110	9,001,046

8. Changes to the structure of the NHS in April 2013 mean that some areas of funding are not directly comparable. All figures, unless clearly stated as provisional, are based on actual reported spend.

9. Since 2013/14 Investment in Public Health by Local Authorities has moved from PCT to Local Authority control. NHS Health Checks for 40-70 year olds were part of Local Authority Public Health responsibilities from 2013/14 onwards.

10. Details of the Prime Minister's Challenge Fund, now known as the Prime Minister's GP Access Fund, can be found at: https://www.england.nhs.uk/ourwork/futurenhs/pm-ext-access/

United Kingdom

11. The report 'Investment in General Practice 2010/11 to 2014/15 for England, Wales, Northern Ireland and Scotland'[73] sets out detail of investment in general practice throughout the whole of the United Kingdom and is available through the Information Centre for health and social care website.

12. For the period 2014/15

- £9,001.0m in England, compared to £8,766.1m in 2013/14 (an increase of 2.68 per cent).
- £478.1m in Wales, compared to £475.7m in 2013/14 (an increase of 0.50 per cent).
- £255.2m in Northern Ireland, compared to £249.9m in 2013/14 (an increase of 2.12 per cent).
- £809.9m in Scotland, compared to £802.9m in 2013/14 (an increase of 0.88 per cent).
- £10,544.3m in the UK, compared to £10,294.6m in 2013/14 (an increase of 2.43 per cent).

Resident population

ONS Population estimates[74] for mid year 2015 - United Kingdom

[73] http://www.hscic.gov.uk/catalogue/PUB18469/inve-gene-prac-eng-wal-ni-scot-10-15-rep.pdf
[74] http://www.statistics.gov.uk/STATBASE/Product.asp?vlnk=601

All ages	Persons	65.1millions
	Males	32.1m
	Female	33.0m

Definition of resident population:

The estimated resident population of an area includes all people who usually live there, whatever their nationality. People arriving into an area from outside the UK are only included in the population estimates if their total stay in the UK is 12 months or more. Visitors and short-term migrants (those who enter the UK for 3 to 12 months for certain purposes) are not included. Similarly, people who leave the UK are only excluded from the population estimates if they remain outside the UK for 12 months or more. This is consistent with the United Nations recommended definition of an international long-term migrant. Members of UK and non-UK armed forces stationed in the UK are included in the population and UK forces stationed outside the UK are excluded. Students are taken to be resident at their term time address.

Statistics

Details of Statistics & data collections, during the reporting period, on the subjects set out below can be viewed via the following link:
http://www.ic.nhs.uk/statistics-and-data-collections

Audits and performance: (complaints; ambulance response times; quality and outcomes framework and clinical audits);

Health and lifestyles: (alcohol consumption, drug misuse, smoking, contraception, physical activity, diet, diabetes and mental health and other surveys).

Hospital care: (cancer, coronary heart disease and maternity and also hospital and outpatient activity).

Mental health: (NHS specialist mental health services, uses of the Mental Health Act 1983 and other related information).

Population, geography and international: (neighbourhood, international, public health and population statistics).

Primary care: (GPs, dentists, opticians, pharmacies and prescribed drugs, plus pay and expenses information).

Screening: (includes statistics on breast and cervical cancer screening).

Social care: (Adult social care, carer support, learning disability, older people, disability, children's social services and user surveys).

Workforce: (information on the NHS and social care workforce including vacancies, turnover, sickness and absence).

PART III SICKNESS BENEFIT

Statutory Sick Pay (SSP) & Employment and Support Allowance (ESA (C))

Legislative Changes

2011

- Employment and Support Allowance (Limited Capability for Work and Limited Capability for Work-Related Activity) (Amendment) Regulations 2011(SI 2011 No 228)
- Employment and Support Allowance (Work-Related Activity) Regulations 2011 (SI 2011 No 1349)

2012

- Employment and Support Allowance (Amendment) Regulations 2012 (SI 2012 No 3096)
- Employment and Support Allowance (Amendment of Linking Rules) Regulations 2012 (SI 2012 No 919)
- Employment and Support Allowance (Sanctions) (Amendment) Regulations 2012 (SI 2012 No 2756)

2013

- Enterprise and Regulatory Reform Act 2013, section 72 - abolition of the Agricultural Wages Board in England only (ceased to have effect after 30 September 2013)
- Employment and Support Allowance Regulations 2013 (SI 2013 No 379)
- Universal Credit, Personal Independence Payment, Jobseeker's Allowance and Employment and Support Allowance (Decisions and Appeals) Regulations 2013 (SI 2012 No 381, NI Equivalent SR 2016 No 221)
- Universal Credit, Personal Independence Payment, Jobseeker's Allowance and Employment and Support Allowance (Claims and Payments) Regulations 2013 (SI 2012 No 381, NI Equivalent SR 2016 No 220)

2014

- Agricultural Sector (Wales) Act http://www.legislation.gov.uk/anaw/2014/6/pdfs/anaw_20140006_mi.pdf
- Statutory Sick Pay Percentage Threshold (Revocations, Transitional and Saving Provisions) (Great Britain and Northern Ireland) Order 2014 (SI 2014 No 897)
- Statutory Sick Pay (Maintenance of Records) (Revocation) Regulations 2014 (SI 2014 No. 55)

2015

- Uprating orders Welfare Benefits Up-rating Order 2015 (SI 2015 No 30)
  The rate of SSP, as set out in s157(1) SSCBA 1992, has been uprated on an annual basis between 2011 and 2015. This Order contains the latest rate.
- Employment and Support Allowance (repeat Assessments and Pending Appeal Awards) (Amendment) Regulations 2015 (SI 2015 No 437)
- Agricultural Wages (Scotland) Order (SR 2015 No 63)

2016

- Agricultural Wages (Wales) Order 2016 (SI 2016 No 107)

Statutory Sick Pay (SSP)

1. In the event of incapacity for work, and subject to fulfilling entitlement conditions, employed

workers are paid SSP by their employers for the first 28 weeks of incapacity. Once entitlement to SSP has been exhausted employees are able to transfer on to the new Employment and Support Allowance (ESA). Workers, including the self-employed, who do not qualify for SSP can claim ESA from the outset

2. The Agricultural Wages Board set rates of pay and other terms and conditions for agricultural workers, including Agricultural Sick Pay. These terms and conditions were set out in Agricultural Wages Orders. The Agricultural Wages Board was abolished by the Enterprise and Regulatory Reform Act 2013. The last Agricultural Wages (England and Wales) Order was made in 2012 Information about the Order can be accessed here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/69594/awo2012-guidance.pdf

3. The Percentage Threshold Scheme, which enabled employers to recover amounts of SSP from Her Majesty's Revenue and Customs, was abolished by the Statutory Sick Pay Percentage Threshold (Revocations, Transitional and Saving Provisions) (Great Britain and Northern Ireland) Order 2014 (SI 2014/897) The closure of the scheme for late claims following end of 15/16 tax year was on 5 April 2016.

4. Regulation 13 of the Statutory Sick Pay (General) Regulations 1982, which required employers to keep specified records relating to sickness absence and SSP payments was revoked by the Statutory Sick Pay (Maintenance of Records) (Revocation) Regulations 2014. These requirements became redundant following abolition of the Percentage Threshold Scheme. The change came into force on 6 April 2014. This also reduced regulatory requirements for employers. Both this change and change 3 above were made following recommendations of the Independent Review of Sickness Absence conducted by Dame Carol Black and David Frost CBE, published in November 2011. The Government response which was published in January 2013 accepted these recommendations.

5. Agricultural Wages (Wales) Order 2016 replaced, (for Wales only), the Agricultural Wages Order 2012 (which applied to both England and Wales) in accordance with the Agricultural Sector (Wales) Act 2014. It sets out the circumstances in which an agricultural worker in Wales is entitled to agricultural sick pay, and makes provision about calculating the amount of sick pay that they are entitled to. It provides that a payment of SSP is to count towards an agricultural worker's entitlement to agricultural sick pay.

6. The Agricultural Wages (Scotland) Order (No 63) 2015 sets out the circumstances In which an agricultural workers in Scotland is entitled to Agricultural Sick Pay (ASP), and makes provision about calculating the amount of ASP that an employee is entitled to when they have been in continuous employment with the same employer for at least 52 weeks. After a period of 13 weeks ASP an agricultural worker would be, if they are still sick, entitled to SSP. Agricultural workers who have worked less than 52 weeks are entitled to SSP only.

SSP rates and Lower Earnings Limit from 6 April (GB£)

	2012	2013	2014	2015	2016
SSP	£85.85	£86.70	£87.55	£88.45	£88.45
LEL	£107.00	£109.00	£111.00	£112.00	£112.00

SSP and tax is uprated in line with benefit and tax annual uprating. Following the freeze on uprating for the majority of Working Age Benefits introduced by the Welfare Reform and Work Act 2016, most benefits are not going to be generally updated for 4 years. SSP is exempt from the freeze but was not uprated in 2016 as no increase was required to keep in line with the Consumer Price Index (CPI).

Employment and Support Allowance (ESA(C))

The main statutory instruments relevant to Employment and Support Allowance (ESA) in this reporting period are as follows:

7. In 2011 legislation was amended so that certain claimants, including hospital in-patients, those attending residential rehabilitation for the treatment of drug or alcohol addiction, and persons likely to receive chemotherapy treatment within 6 months after the date of the determination could be treated as having limited capability for work or limited capability for work-related activity.

8. Also in 2011 legislation set out the circumstances in which ESA claimants may be required to undertake work-related activity and who such a requirement may be applied to. It made clear that a requirement must be reasonable, having regard to the person's circumstances, and may not require the person to apply for a job, undertake work or undergo medical treatment as part of the work-related activity requirement. It also provided that a lone parent with a child under the age of 13 may only be required to undertake work related activity during normal school hours.

9. In 2012 amendment regulations clarified areas of the work capability assessment which were open to misunderstanding. They made the process easier to understand for claimants and assessors. Changes included taking account of reasonable aids, separation of physical and mental health descriptors, clarifying the term ‘in-patient’, refining wording in the continence descriptors, and clarifying the standing and sitting, manual dexterity, understanding communication, and getting about activities.

10. Also in 2012 regulations amended the previous rule that allowed periods of limited capability for work, separated from another such period by not more than 104 weeks, is to be treated as a continuation of the earlier period.

11. Further regulations introduced a revised sanctions regime for ESA claimants, who would only be subject to lower level sanctions to be applied when claimants failed to comply with requirements that would improve their chances of preparing for work, without showing they had good reason. A hardship regime was also introduced for claimants that were subject to a sanctions.

12. In 2013 regulations removed from legislation references to income-related Employment and Support Allowance, to take account of the roll-out of Universal Credit which was merging various income-related benefits, including income-related Employment and Support Allowance.

13. In 2015 the criteria by which claimants could re-apply for Employment and Support Allowance, following a previous claim where the Work Capability Assessment determined that they did not have Limited Capability for Work, were amended. Following this change claimants had to demonstrate that they had a different health condition to that which the reason for their previous claim, or that that health condition had significantly deteriorated. The aim was to end the ‘looping’ of claimants into and out of the claims process for Employment and Support Allowance, and instead directs them towards claiming Jobseeker’s Allowance, where they can be given the appropriate support to look for work.

The Work Capability Assessment (WCA)

14. Existing incapacity benefits customers are being reassessed using the WCA which is a key factor in determining eligibility for ESA.

15. The WCA was introduced in October 2008 to assess entitlement to ESA. It replaced the

Personal Capability Assessment used to assess entitlement to incapacity benefits (IB).

16. The WCA is a functional assessment that looks at what people can do, as well as what they can't, to identify people for the correct benefit and give them the support they need to get back to work and avoid ending up on long-term sickness benefits. This approach is based on the principle that a health condition or disability should not automatically be regarded as a barrier to work. There is strong evidence that work is good for physical and mental well-being, and that being out of work can contribute to poorer health and other negative outcomes. So, whilst the Government does not want to make it harder for people who genuinely can't work, it does want to engage as many people as possible in employment.

17. The Government is committed to continuously improving the WCA to ensure that it is as fair and accurate as possible. As part of this, the Government had a statutory commitment to independently review the WCA annually for the first five years of its operation. Professor Malcolm Harrington, a highly respected Occupational Physician, carried out the first three reviews in 2010, 2011 and 2012. Dr Paul Litchfield, Chief Medical Officer for BT Group conducted the fourth and fifth reviews in 2013 and 2014, The Government accepted the vast majority of the recommendations that came out of the five independent reviews.

18. In addition, a Department-led review reported in March 2010 and its recommendations have been implemented. These include taking better account of the effects of exhaustion and making greater provision for people awaiting, or in between courses of, chemotherapy. The improvements as a result of this review came in to force on 28 March 2011.

19. Further information on the Work Capability Assessment independent review is available at:

90. https://www.gov.uk/government/publications/2010-to-2015-government-policy-welfare-reform/2010-to-2015-government-policy-welfare-reform

91. Research and Reports

Routes onto Employment and Support Allowance (published in 2010)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214556/rrep774.pdf

Employment and Support Allowance: Customer and staff experiences of the face-to-face Work Capability Assessment and Work-Focused Health-Related Assessment (published in 2010)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214494/rrep719.pdf

Employment and Support Allowance: Findings from a follow-up survey with customers (published in 2011)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214519/rrep745.pdf

Decision making on Employment and Support Allowance claims (published in 2012)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214575/rrep788.pdf

A survey of disabled working age benefit claimants (published in 2013)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224543/ihr_16_v2.pdf

Evidence Based Review of the Work Capability Assessment (published in 2013)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/331582/wca-evidence-based-review.pdf

Understanding the journeys from work to Employment and Support Allowance (ESA) (published in 2015)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/436420/rr902-understanding-journeys-from-work-to-esa.pdf

An Independent Review of the Work Capability Assessment (published in 2010)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/70071/wca-review-2010.pdf

An Independent Review of the Work Capability Assessment – year two (published in 2011)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/70102/wca-review-2011.pdf

An Independent Review of the Work Capability Assessment – year three (published in 2012)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/70123/wca-review-2012.pdf

An Independent Review of the Work Capability Assessment – year four (published in 2013)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/265351/work-capability-assessment-year-4-paul-litchfield.pdf

An Independent Review of the Work Capability Assessment – year five (published in 2014)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380027/wca-fifth-independent-review.pdf

Article 15

Questions (a) to (c) No change

(ii) TITLE II (Article 76)

A. Number of economically active persons protected –
i. Under General scheme 30,512,000 (including Northern Ireland)[a]
ii. Under special scheme nil

B. Total number of residents 65,110,000[b]

C. Percentage A/B 46.86%

Sources: (A) Contributions and Qualifying Years – persons paying Class 1 and or Class 2 National Insurance Contributions 2014/15; and
(B) ONS Population estimates[75] for mid year 2015 - United Kingdom.

Article 16

[75] http://www.statistics.gov.uk/STATBASE/Product.asp?vlnk=601

Question A. (ii)

Title II (Article 66)

Option 4

For the purposes of Article 66 Code the reference wage is **£371.70 per week**, being the median gross weekly earning (excluding overtime) for full-time male employees who are classified as unskilled labourers in the manufacture of machinery other than electrical machinery (SOC 91 and SIC 28), Annual Survey of Hours and Earnings (ASHE) 2014-2015[76].

C. Sickness Benefit (2016/17 rates)

ESA(C)

Week 1-13	£73.10 - personal allowance
Week 14 onwards	£102.15- including WRA component
Week 14 onwards	£109.30 - including Support component

Statutory Sick Pay (SSP) Week 1-28 £88.45

D	£151.90
E	£151.90

D & E comprise: £20.70 Child Benefit for the eldest qualifying child; £13.70 for the second qualifying child and Child Tax Credit of £117.50, in respect of both children.

TITLE V (Article 66)

C. Sickness Benefit

SSP	(a) £88.45	maximum of 28 weeks
ESA(C)	(b) £73.10	Week 1 – 13*; then either:
	(c) £102.15	Week 14 (or WCA) onwards[1]; or
	(d) £109.30	Week 14 (or WCA) onwards[2]

Notes * or to week of WCA if earlier
[1] The work-related activity component was abolished from April 2017
[2] includes support component

D. £151.90

E. £151.90

[76] https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/adhocs/004242weeklypayexcludingovertimeforsoc91andsic282014to2015

F. (a) 45.9%
(b) 43.0%
(c) 48.5%
(d) 49.9%

PART IV UNEMPLOYMENT BENEFITS

Legislative Changes

2013

- Job Seekers Allowance Regulations 2013 (2013 No 378)

In 2013 JSA 'new style' was introduced. It is a contribution-based only benefit available to claimants alongside Universal Credit.

Article 21

Question C (i)

TITLE I (Article 76)

A. Number of economically active persons protected –
i. Under general scheme 28,299,000(including Northern Ireland)[a]
ii. Under special scheme nil

B. Total number of employees 31,420,000[b]

C. Percentage A/B 90%

Sources: (A) Contributions and Qualifying Years – persons paying Class 1 National Insurance Contributions 2014/15; and
(B) ONS Labour Market Stats for mid year 2015 - United Kingdom.

Article 22

TITLE V (Article 66)

Question A (ii)

Title I (Article 66)

B. £371.70 per week

Title II (Article 66) Jobseeker's Allowance (contribution based) 2016/17 rates

C. JSA (a) £73.10
JSA Joint Claim (b) £114.85

Anyone who claims JSA who is part of a couple would receive the higher amount (only if neither of them were working or if their partner was working less than 24 hours a week)

D. £151.90
E. £151.90
F. (a) 43.0%
(b) 50.9%

D & E comprise: £20.70 Child benefit for the eldest qualifying child; £13.70 for the second qualifying child and Child Tax Credit of £117.50, in respect of both children.

PART V OLD AGE BENEFIT

Legislative changes

2011

- Pensions Act 2011
  http://www.legislation.gov.uk/ukpga/2011/19/pdfs/ukpga_20110019_en.pdf

2014

- Pensions Act 2014
  http://www.legislation.gov.uk/ukpga/2014/19/pdfs/ukpga_20140019_en.pdf
- Welfare Benefits Up-rating Act 2013
  http://www.legislation.gov.uk/ukpga/2016/7/pdfs/ukpga_20160007_en.pdf

1. In January 2013 the UK Government published a Command Paper which outlined how the UK Government intended to replace the current two-component state pension (basic State Pension and earnings-related additional State Pension) with a single component flat-rate pension set above the basic level of means-tested support for future pensioners.

2. Subsequently, the Pensions Act 2014 introduced the new State Pension for people reaching state pension age on or after 6 April 2016, radically simplifying state pension provision.

3. Qualification for the new state pension is based on an individual's National Insurance record, with a minimum qualifying period of 10 years usually required to receive any pension. In steady state, the full rate of the new State Pension (previously referred to as the single-tier pension) will be based on 35 qualifying years of National Insurance contributions or credits. Transitional arrangements are in place for those who have qualifying years before 6 April 2016.

4. The new State Pension will cost no more overall that the previous system, but will restructure the system to provide clarity and confidence to help people plan for their retirement.

State Second Pension

5. The State Second Pension (also known as additional State Pension) ended in April 2016 and with it the ability to contract out of the State Second Pension. Up until this point some people were contracted out of the State Second Pension into a private or workplace pension. While the additional State Pension has ended it will remain in payment, to those with entitlement who reached state pension age before 6 April 2016. A proportion of an additional State Pension can be inherited by surviving wives, husbands and civil partners beyond April 2016.

State Pension age

6. Under the Pensions Act 2011 State Pension age for women will gradually increase from 60 to 65 between 2010 and 2018. Then, between 2018 and 2020, State Pension age will increase from 65 to 66 for both men and women. The State Pension age will increase from 66 to 67 between 2026 and 2028 under the Pensions Act 2014. The timing of the increase from 67 to 68 remains set to happen between 2044 to 2046 as set out in the Pensions Act 2007. The changes in State pension age reflect increasing longevity in society and make the State Pension affordable in the long term.

7. The Pensions Act 2014 contains a framework for further changes to state pension age through a regular review by Government.

8. As part of the review process, the Government is required to commission a report from the Government Actuary's Department looking at the implications of life expectancy data for State Pension age. The legislation also requires Government to commission a further independent report covering other relevant factors. This may include variations in life expectancy between socio-economic groups, and the wider economic context at the time of a review. All reports prepared as part of the review must be published.

9. The Government will publish a report on their review of the state pension age every 6 years. The first review will report to Parliament before 7 May 2017.

Article 27

Question B

No change (apart from contribution rates)

Question C (ii)

(ii) TITLE II (Article 76)

A. Number of economically active persons protected -

i. Under general scheme	30,527,000(including Northern Ireland)[a]
ii. Under special schemes	nil
TOTAL	30,527,000

B. Total number of residents 65,110,000[b]

C. Percentage A/B 46.89%

Sources: (A) Contributions and Qualifying Years – persons paying Class 1, Class 2 and or Class 3 National Insurance Contributions 2014/15; and
(B) ONS Population estimates for mid year 2015 - United Kingdom.

Article 28

Question A (ii)

TITLE I (Article 66)

B. £371.70 per week.

TITLE III (Article 66)

C. The standard basic weekly rate of retirement pension received by a married couple is £190.80 (2016/17 rates)

This basic weekly rate of Retirement Pension, for people reaching state pension age before 6 April 2016 comprises £119.30 for a 100% full weekly Retirement Pension payable to a man with 30 qualifying years for himself plus £71.50 in respect of a wife of pension age or a dependent wife under pension age.

D. £151.90

E. £151.90

D and E (where applicable) comprise £20.70 Child Benefit for the eldest qualifying child, £13.70 for the second qualifying and Child Tax Credit of £117.50 in respect of both children. From April 2003 Child Tax Credits replaced Child Dependency Increases payable with State Pension.

F. 65.5 %

TITLE V (Article 66)

C. The weekly rate of retirement pension for a woman employee is £115.90 (2015/2016 rates).

F. 31.9%

Question C

TITLE VI (Article 65)

Period under review (closest published figures)	Cost of living index (RPI) (*)	Index of earnings (**)
A. March 2011	100	100
B. March 2016	18.8	120.2(***)
C. A/B per cent	5.3%	83.2%

(*) Retail Price Index (RPI) All items
(**) Annual Survey of Hours and Earnings
(***) Latest available data on earnings by occupation is for 2010

TITLE VI (Article 65)

		Benefit
Period under review	Average per beneficiary +	Benefit for standard beneficiary*
	I	II
A. March 2011 [2010/11 rates]	see tables below	£97.65
B. March 2016[2015/16 rates]	see tables below	£115.90
C. A/B per cent		84.0%

* Personal Benefit – Category A Basic Pension at 100% rate

Table 1

State Pension: Average amount of benefit in payment - Time Series by category of pension

Time Series	Total	Cat A *	Cat B	Cat ABL	Cat BL	Cat AB
	Average weekly amount of benefit	Average weekly amount of benefit *	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit
May-11	110.54	117.33	116.99	64.8	54.74	141.72
May-12	117.99	124.87	124.24	68.22	57.25	150.7
May-13	121.97	128.6	128.35	69.91	58.33	155.52
May-14	126.46	132.68	132.87	71.78	59.53	160.89
May-15	130.3	135.95	136.92	73.43	60.61	165.38
Nov-15 **	130.71	136.03	137.47	73.38	60.49	165.78

" * "*Includes Additional Pension and Graduated Benefit. " ** " Latest available at time of reporting*
Average amounts are shown as pounds per week and rounded to the nearest penny. Totals may not sum due to rounding. Category C & D (non-contributory) Pensions excluded

SOURCE: *DWP , Data and Analytics, Technology - Work and Pensions Longitudinal Study.*

STATE PENSION AGE:
The age at which men and women reach State Pension age is gradually increasing. Under current legislation, State Pension age for women will equalise with State Pension age for men at 65 in 2018. Both men's and women's State Pension age will increase from 65 to 66 between December 2018 and October 2020. The Pensions Bill 2013-14 contains provision for a State Pension age of 67 to be reached by 2028. For more information see https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207966/espa.pdf.

Table 2

State Pension: Average weekly amount of benefit: Category of pension and gender of claimant, November 2010

Nov-2010	Total	Cat A	Cat B	Cat ABL	Cat BL	Cat AB
Gender of claimant	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit
Total	105.35	112	111.7	62.04	52.5	135.37
Female	93.74	95.39	111.85	62.04	52.5	134.55
Male	124.1	124.18	34	55.8	25.93	143.3

Table 3

State Pension: Average weekly amount of benefit: Category of pension and gender of claimant, November 2015 (latest available)

Nov-2015	Total	Cat A	Cat B	Cat ABL	Cat BL	Cat AB
Gender of claimant	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit
Total	130.71	136.03	137.47	73.38	60.49	165.78
Female	118.08	119.29	137.79	73.5	60.54	164.7
Male	147.68	147.42	35.16	60.31	26.44	172.08

SOURCE: *DWP , Data and Analytics, Technology - Work and Pensions Longitudinal Study. Categories AB & ABL – based on both own and spouse's/civil partner's contribution records*

Categories B and BL - based on spouse's/civil partner's contributions alone.

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PART VII FAMILY BENEFIT

Article 40

1. Child Benefit (CHB) is generally payable to all persons who have responsibility for a child, regardless of means. CHB is a non-contributory benefit and is not treated as taxable income.

2. As of January 2013, claimants may be liable to a tax charge called the 'High Income Child Benefit charge'. Being liable for this charge does not affect entitlement to Child Benefit for a child, but anyone receiving Child Benefit is liable to pay a tax charge linked to the amount of Child Benefit if they or their partner has an individual income of more than £50,000 per year. For every additional £100 over the £50,000 threshold that an individual earns, the tax charge due increases by 1%. This means that any claimant receiving a payment of Child Benefit whose income (or partner's income) is over £60,000 will be liable to pay a charge equal to the total amount of Child Benefit received. Alternatively, claimants affected by the High Income Child Benefit charge have the option to opt-out of receiving Child Benefit, thereby ceasing their payments, which means that they are not subject to the tax charge.

3. Child Benefit is paid to those responsible for children (aged under 16) or qualifying young people. The latter includes those:
    a. in full-time non-advanced education or (from April 2006) on certain approved vocational training courses and who are under 19, or are aged 19 and have been on the same course since their 19th birthdays.
    b. entered for future external examinations, or are in the period between leaving education and the week containing the first Monday in September and are not in work.
    c. aged under 18 who have moved directly from full-time education to being registered for work or training with the Careers service or with Connexions.

4. Generally, entitlement to CHB does not arise for people whose presence in the UK is subject to immigration control, but protection is given to those recognised as refugees, those with settled status (whose leave to enter or remain in the UK is not subject to any limitation) or with discretionary or humanitarian leave to enter or remain in the UK, or who are within the scope of European Community's Social Security co-ordination regulations Regulation (EEC) 1408/71 and 574/72, by virtue of Regulation (EC) 859/2003 or who are covered by a relevant bilateral social security agreement with another country. Entitlement can arise also for nationals of other states party to the European Convention on Social and Medical Assistance (ETS No 14) and the European Social Charter of 1961 (ETS No 36) who are lawfully present in the UK.

5. The Working Tax Credit (WTC) provides financial support, on top of earnings for in-work households with low incomes who are living in the UK. This is paid to families with or without children. The Child Tax Credit (CTC) is a means-tested form of support for families (with children) who are in or out of work and living in the UK.

6. WTC provides support to in-work households on low incomes and additional support is available for disabled workers. It is payable to the person who is working. The "childcare element" of WTC is paid directly to the main carer of the child or children along with Child Tax Credit.

7. Generally, entitlement to a tax credit does not arise for people whose presence in the UK is subject to immigration control, but protection is given to those recognised as refugees, those with settled status (whose leave to enter or remain in the UK is not subject to any limitation) or with discretionary or humanitarian leave to enter or remain in the UK.

8. Access to CTC can be gained for those who are lawfully working in the UK and a national of a State that has concluded an agreement under Article 310 of the Treaty of Amsterdam amending the Treaty of the EU. In the field of social security, for equal treatment of workers who are nationals of the signatory State and their families. Also, if they come within the scope of European Community's Social Security co-ordination regulations Regulation (EEC) 1408/71 and 574/72,by virtue of Regulation (EC) 859/2003.

9. Access to WTC is available to nationals of other states party to the European Convention on Social and Medical Assistance (ETS No 14) and the European Social Charter of 1961 (ETS No 36) who are lawfully present in the UK.

10. Further information on eligibility for tax credits and how awards are calculated is published in leaflet WTC 2[77].

11. In the Summer Budget 2015, the Government announced various measures to ensure the tax credit system is targeted at those who need it most. From 6 April 2016, if a claimant is entitled to Working Tax Credit, whether on its own or in addition to Child Tax Credit, and their family's annual income is below £3850, they will get the maximum amount of all the elements that they qualify for. If income is over that threshold, the maximum amount will be reduced by 48 pence for every pound of income over the threshold.

[77] http://www.hmrc.gov.uk/leaflets/wtc2.pdf

Article 41

Question C

The number of families receiving Child Benefit in the UK for the years covered by this Report are contained in the following table:

The Number of Child Benefit recipients – August each year:

	UK
2011/12	7,920
2012/13	7,550
2013/14	7,461
2014/15	7,416

Note: UK totals include foreign and not known.

The number of families receiving Child Tax Credit in the UK for the year 2014/15 was 7.4 million, comprising some 12.8 million children.

Article 42

The Child Tax Credit rates for the period of this Report.

Child Tax Credit	From April 2012	From April 2013	From April 2014	From April 2015	From April 2016
Family element	545	545	545	545	545
Family element, baby addition[1]					
Child element	2,555	2,690	2,720	2,750	2,780
Disabled child element	2,800	2,950	3,015	3,100	3,140
Severely disabled child element	1,130	1,190	1,220	1,255	1,275
Income thresholds and withdrawal rates					
First income threshold	6,420	6,420	6,420	6,420	6,420
First withdrawal rate (per cent)	41	41	41	41	41
Second income threshold[2]	40,000				
Second withdrawal rate (per cent)	41				
First threshold for those entitled to CTC only	15,860	15,860	15,910	16,010	16,105
Income disregard[3]	10,000	10,000	5,000	5,000	5,000

[1]The baby element component was abolished from April 2011.

[2]For those entitled to the Child Tax Credit, the award is reduced only down to the family element less the excess of income over the second threshold multiplied by the second withdrawal rate.

[3]The amount of increase in income disregarded in the calculation of Tax Credit awards has been reduced from £10,000 to £5,000 in April 2013.

Child Benefit rates for the period of this Report

From	Child Benefit
April 2012	£20.30 eldest child
	£13.40 each other child
April 2013	£20.30 eldest child
	£13.40 each other child
April 2014	£20.50 eldest child
	£13.55 each other child
April 2015	£20.70 eldest child
	£13.70 each other child
April 2016	£20.70 eldest child
	£13.70 each other child

Article 42

In order to qualify for Child Benefit and CTC a claimant must have been living in the UK for a consecutive period of 3 months if they moved to the UK on or after 1 July 2014 and don't have a job. There are some exceptions to this rule. Eligibility to Child Benefit and CTC can be found at the following links:

https://www.gov.uk/child-benefit-move-to-uk
https://www.gov.uk/tax-credits-if-moving-country-or-travelling/moving-to-the-uk

Article 44

No change

PART X SURVIVORS BENEFIT

The position remains as previously described.

The provisions relating to Bereavement Benefits are to be found in Part II of the Social Security Contributions and Benefits Act 1992[78] as follows:

- **Bereavement Payment**: section 36. See also Schedule 3 para 4 for the contribution conditions;

- **Widowed Mother's Allowance and Widow's Pension**: See sections 36A to 39, which apply only to cases where the death occurred before 9 April 2001;

- **Widowed Parent's Allowance and Bereavement Allowance**: sections 39A to 39C, for deaths occurring on or after 9 April 2001. The contribution conditions are detailed in para 5 of Schedule 3.

Article 61

Question C (ii)

TITLE II (Article 76)

A. Number of economically active persons protected -

i.	Under general scheme	30,527, 000 (including Northern Ireland)[a]
ii.	Under special schemes	nil
	TOTAL	30,527,000

B. Total number of residents 65,110,000[b]

C. Percentage A/B 46.89%

Sources: (A) Contributions and Qualifying Years – persons paying Class 1 and or Class 2 National Insurance Contributions 2014/15; and
(B) ONS Population estimates for mid year 2015 - United Kingdom.

[78] http://www.dwp.gov.uk/docs/a2-2501.pdf

Article 62

Question A (ii)

TITLE I (Article 66)

B. £371.70

TITLE IV (Article 66) (2015/16 rates)

C. £112.55

D. £151.90

E. £151.90

F. 50.51%

The weekly rate of widow's benefit at C is £112.55 basic Widowed Parent's Allowance.

D and E (where applicable) comprise £20.70Child Benefit for the eldest qualifying child, £13.70 for the second qualifying and Child Tax Credit of £117.50 in respect of both children. From April 2003 Child Tax Credits replaced Child Dependency Increases payable with State Pension.

TITLE V (Article 66)

C. £112.55
F. 31%

Question C

TITLE VI (Article 65)

Period under review (closest published figures)	Cost of living index (RPI) (*)	Index of earnings (**)
A. March 2011	100	100
B. March 2015	112.6	107.5
C. A/B per cent	88.8%	93.0%

(*) Retail Price Index (RPI) All items
(**) Annual Survey of Hours and Earnings

Over the period of the report, weekly rates of bereavement benefits changed as follows:-

Table 1

	April 2011	April 2015*	Increase %
Widowed Mothers/Parent's Allowance	100.7	112.55	11.8
Widow's Pension	100.7	112.55	11.8

* 2015/16 rates

Average amounts of benefits in payment at the beginning of the reporting period and latest available figures are set out in Tables 2 and 3 below.

Table 2

Widow's Benefits Average Weekly amount of benefit by age of claimant

	Age of claimant										
	Total	Unknown age	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64
	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit
Type of WA	83.15	.	.	.	.	109.03	130.56	83.07	77.85	86.75	81.28
Total											
WP not age related	136.12	.	.	.	.	.	.	.	.	147.82	131.06
WP age related	74.94	.	.	.	.	.	.	52.54	69.53	80.47	73.65
WMA with dependants	145.85	.	.	.	.	112.09	132.58	140.99	154.81	156.01	141.05
WMA without dependants	60.69	.	.	.	.	.	92.90	66.45	55.77	51.33	.
Unknown	.	.	.	.	.	.	.	.	.	.	.

Table 3

Bereavement Benefits Average Weekly amount of benefit by age of claimant

	Age of claimant										
	Total	Unknown age	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64
	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit
Type of BA Total	104.32	.	102.05	102.01	101.50	103.15	107.92	103.03	103.08	106.92	102.42
BA not age related	102.04	.	.	.	.	.	.	.	.	103.01	101.13
BA age related	72.74	.	.	.	.	.	.	45.53	79.50	95.37	.
WPA with dependants	110.63	.	100.70	102.06	101.54	103.23	107.98	111.63	114.45	116.13	113.28
WPA without dependants	76.05	.	.	.	91.46	76.16	66.34	83.93	69.84	67.88	.
Unknown	.	.	.	.	.	.	.	.	.	.	.

DEFINITIONS AND CONVENTIONS: *"-" Nil or Negligible; "." Not applicable; Caseload figures are rounded to the nearest ten; Some additional disclosure control has also been applied. Average amounts are shown as pounds per week and rounded to the nearest penny. Totals may not sum due to rounding.*
SOURCE: *DWP , Data and Analytics, Technology - Work and Pensions Longitudinal Study.*
STATE PENSION AGE: *The age at which men and women reach State Pension age is gradually increasing. Under current legislation, State Pension age for women will equalise with State Pension age for men at 65 in 2018. Both men's and women's State Pension age will increase from 65 to 66 between December 2018 and October 2020. The Pensions Bill 2013-14 contains provision for a State Pension age of 67 to be reached by 2028. For more information see https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207966/espa.pdf.*
Notes:
Average weekly amount of benefit *The amount of Bereavement Allowance (BA) is affected by the introduction in April 2003 of Child Tax Credit. From that date there were no new child dependency increases (CDIs) awarded to BA claimants, although existing CDIs were transitionally protected.*
Type of BA *The category 'WPA with dependants' will include clients getting paid at the personal rate only due to the introduction of Child Tax Credits in April 2003. To obtain figures for those who still receive Child Dependency Increases, under the transitional protection arrangements, use the 'type of dependant' option.*

Part XIII COMMON PROVISIONS

No change

Article 70

Question 1

No change

Article 71

Question 3

Estimated outturn figures (GB£ million) for the year 2015-2016.

Part to which ratification applies	Expenditure on the protection of employees, their wives and children (A)		Insurance contributions borne by the employees protected (B)
II	138,700 (a)		**£**8,662 (b)
III	4,441	(contributions based Employment & Support Allowance)	
IV	341	(contributions based Job Seekers Allowance)	
V	70,973 18,119	(Retirement Pension – Basic Pension and Graduated Benefit) (Retirement Pension - Additional Pension)	
X	571	(Bereavement Benefits)	
	128	(Christmas Bonus – this is a single tax-free payment available for people who get one of the qualifying benefits in the qualifying week)	
TOTAL (excluding II)	£94,573m		£37,645 (c)

(**Source:** Government Actuary Report on the Social Security Benefits Up-rating Order 2016[79] unless otherwise stated).

Expenditure on Part VII Family Benefits and Tax Credits is met wholly from general taxation.

NOTES:
(a) See Her Majesty's Treasury entitled 'Public Expenditure Statistical Analyses 2015-16', page 70, table 4.2[80].
(b) The National Health Service is financed mainly through general taxation with a small element coming from National Insurance Contributions (NICs) paid by workers (£8.662mil) and employers (£12.429 mil) – see Appendix 4 Government Actuary Report). All other expenditure figures are taken from table 4.2 (page 14) in this report.
(c) Does not include NHS Contribution listed against II (b) above. It is not possible to break this figure down according to benefit, except for Part II. Employee's contributions to the National Insurance Fund also help meet the cost of maternity benefits, Guardian's Allowance and Redundancy Payments.

[79] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/494930/53430_GA_UpRating_Report_2016_Accessible.pdf.
[80] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/538793/pesa_2016_web.pdf

Question 4

Percentage B/A 39.81%, but see Note (c) above.

Question 5

The continuing equalisation of women's and men's State Pension age slightly reduced the number of people entitled to old age benefit in 2015/16.

Question 6

i. Benefits have been increased annually as provided for in the Social Security Benefits Up-rating Orders
ii. Full details of the rates of benefits provided from the National Insurance Fund are shown in Appendix 1 of the Government Actuary's Up-rating Report 2016[81].

Question 7

Please see Government Actuary Report.

Copies of this report have been sent to the Confederation of British Industry and the Trades Union Congress

APPENDIX

Response to the Committee of Experts' Observations on the UK's previous Report on Convention No 102 (2012/102nd Session)

[81] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/494930/53430_GA_UpRating_Report_2016_Accessible.pdf

The Committee hopes that, in its next report on the Convention, the Government will also be able to show that the obligations and sanctions under the work-related activity regime are of such a nature as not to unduly limit the protection afforded by Part III of the Convention to sick persons after the 13th week of sickness. In doing so, the Government should take into account the cases of the suspension of benefits admitted by Article 69 of the Convention.

Following a Work Capability Assessment, if a claimant has limited capability for work and is placed in the Work Related Activity Group (WRAG), they are generally expected to take steps to prepare for work. This includes being required to attend and participate in work focused interviews and, where applicable, undertake Work Related Activity (WRA). Delivering work-focused support to these ESA claimants ensures that they remain as close to the labour market as possible.

The first interview following the outcome of the WCA is a crucial part of the claimant journey back to work. During the interview, the work coach will discuss the history of the claimant's health condition, encourage them to recognise that they are still able to work, discuss any challenges and the options available to support them to prepare and move into work. This could include referral to specialist support. If it seems that the claimant's disability or health condition is more than mild to moderate and they may face a complex employment situation arising from their disability, the claimant will be offered the opportunity to be referred to a Disability Employment Adviser for further support.

The work coach and claimant develop an Action Plan, which details any actions the claimant is required to undertake. The meeting will also be an opportunity to discuss the claimant's educational history, experience, skills and interests that may help them move into work in the future or identify a skills or training need.
Support will be tailored appropriately to help the claimant prepare for work whilst recognising their health condition and/or disability. Support and, where appropriate, financial assistance in preparing for and returning to work for ESA claimants placed in the WRAG will be delivered by either a Jobcentre Plus work coach or a Work Programme Provider (generally those claimants who have a reassessment period of 12 months or less following a WCA are referred to a Work Programme provider for support).

ESA claimants and sanctions

As already mentioned above re conditionality, we place emphasis on protecting vulnerable claimants and have safeguarding measures in place.

ESA claimants assessed as not being able to undertake work-related activity are placed in the Support Group - they are not subject to conditionality or sanctions.
ESA claimants in the WRAG cannot be sanctioned for not finding work or failing to apply for jobs. They are supported with their work related activity continually as agreed in their Action Plan.

Sanctions only apply where ESA claimants refuse to engage with the employment support on offer and will not be applied if the claimant had good reason for not meeting these.

Any decision to impose a sanction is not taken lightly and takes into account a claimant's individual circumstances and capability, including any health conditions, disability or caring responsibilities.

***The Committee would like the Government to specify whether the new single-tier pension, when introduced, would be sufficient by itself to ensure the 40 per cent replacement level required by the Convention or would need to be complemented for this by the product of individual savings*.**

The new State Pension was introduced on 6 April 2016 and currently has a flat rate value of £155.65. As such the new State Pension alone accounts for 42 per cent of the reference wage and in 2016 it is estimated that 89% will receive this full gross amount when negating for the effects of contracting out.

In the first 15 years of the new State Pension system, around three-quarters of people who reach State Pension age under the new system will have a notionally higher State Pension than under the old system.

By 2030, over three million men, and over three million women will have benefitted from a notionally higher State Pension. In addition, because of the triple lock, people who have 30 qualifying years or more, will get the new State Pension with a Starting Amount of £570 a year more than if the basic State Pension had been uprated since 2011 by earnings.

The Committee wishes to recall in this respect that, in accordance with Article 66(7) of the Convention, the wage of the ordinary adult male labourer shall be determined on the basis of the rates of wages for normal hours of work fixed by collective agreements, by or in pursuance of national laws or regulations, where applicable, or by custom, including cost-of-living allowances if any.

For the purposes of Article 66 Code the reference wage is **£371.70 per week**, being the median gross weekly earning (excluding overtime) for full-time male employees who are classified as unskilled labourers in the manufacture of machinery other than electrical machinery (SOC 91 and SIC 28), Annual Survey of Hours and Earnings (ASHE) 2014-2015[82].

Article 66 (4) refers to ISIC Rev 4, Division 28 (Manufacture of Machinery and Equipment N.E.C). ISIC Rev 4 and UK SIC (2007) are identical at the two divisional level. In addition, Division 28 excludes manufacture of electrical machinery, and therefore meets the requirement specified. The requirement also states “a person deemed typical of unskilled labour”. The best match for this criterion is SOC 2010 Sub-Major Group 91 (Elementary Trade and Related Occupations). So, from a Classifications point of view, using SOC 2010 Sub-Major Group 91 in conjunction with UK SIC (2007) Division 28, in the Government’s view, provide the closest possible match to the requirement specified.

The Committee wishes the Government to explain what measures it is taking to reverse this long-term trend of the spread of poverty among the working-age population in the UK and to explain in particular the fact that, compared to 2009–10,

[82] https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/adhocs/004242weeklypayexcludingovertimeforsoc91andsic282014to2015

the number of working-age adults in such low-income households has indeed fallen by 1 percentage point.

The Government has committed to continue to publish the Households Below Average Income (HBAI) report which can be found here: www.gov.uk/government/collections/households-below-average-income-hbai--2. This includes details of how measures of low income (and material deprivation) are calculated, as well as figures on the number and proportion of individuals (including children) living in households affected.

As evidence shows that work is the best route out of poverty, labour market statistics, published monthly in the Labour Market Statistics bulletin, by the Office for National Statistics, also provide an alternative source of data for considering progress. These are published monthly in the Labour Force Survey.

The most recent statistics on relative low income are included in Households Below Average Income 1994/95 – 2014/15, published in June 2016. This shows that between 2009/10 and 2014/15 the proportion of working age adults living in relative low income fell by 1ppt both Before and After Housing Costs. Compared to 2009/10 the number of working age adults living in relative low income Before Housing Costs fell by 100,000 whilst the number living in relative low income After Housing costs was unchanged.

The UK government's approach to tackling working age poverty is based on evidence that shows that work is the best route out of poverty. In 2014/15 just 6% of working age adults in households where all adults are in work were in relative low income, compared to 46% where no one is working.

The previous system we inherited was not working. Welfare spending on people in-work rose from £6bn in 1998 to almost £28bn in 2010. In 2010, we reached the stage where 9 in 10 families with children were eligible for tax credits, and where some families could earn almost £60,000 per year and still be receiving benefits. Yet in this time the number of people in-work poverty actually increased by around 20%.

Instead, this Government has clearly stated its intention to make work pay by moving Britain from a low wage, high tax, high welfare society to a high wage, low tax, low welfare economy and it has set out a package of measures which support that objective, including:

- Introducing a National living Wage of £7.20 in April 2016 which, on current OBR forecasts, is set to reach £9 an hour by 2020;
- increasing the personal tax allowance to £11,000 in 2016/17, taking a further 570,000 people out of income tax altogether; and
- Increasing support with childcare under Universal Credit to 85% of eligible costs and doubling free early years provision for working parents of 3 to 4 year olds.

The latest figures show that the employment rate is at a **record high of 74.5 %** (figures August 2016) and the number of workless households has fallen by 764,000 since 2010.

These changes have contributed to the fall in the risk of relative low income amongst the working age population.

Falls in unemployment and the numbers of workless households have supported incomes at the bottom of the distribution.

Unemployment fell from 8.0% in the first quarter of 2010 to 6.8% in the first quarter of 2014 whilst the proportion of households with a member aged 16-64 that were workless fell from 19% in 2009 to 17% in 2013.

Changes in the personal tax allowance also increased the take home pay of basic rate tax payers.

The fact that at the start of this period many income related benefits were uprated faster than the growth in wages also contributed to faster growth in incomes for people lower down the distribution than at the median. For example, between 2009 and 2013 mean gross weekly pay of full time workers increased by 7.5%, whilst rates of Jobseekers Allowance and Income Support increased by around 11.5%.

APPENDIX C

48th
ANNUAL REPORT ON RATIFIED PARTS OF THE EUROPEAN CODE OF SOCIAL SECURITY MADE BY THE UNITED KINGDOM TO THE COUNCIL OF EUROPE AT STRASBOURG FOR THE PERIOD 1 JULY 2011 TO 30 JUNE 2016

THE UNITED KINGDOM HAS RATIFIED PARTS II, III, IV, V AND VII

LEGISLATION

Separate, but corresponding, schemes of Social Security operate in Great Britain and Northern Ireland. Reciprocal arrangements between the two ensure that the schemes effectively operate as a single system. The law governing Social Security in Great Britain was amended during the reference period by the measures listed below. Corresponding legislation came into effect in Northern Ireland as listed after the GB measures. Benefit levels are maintained in parity with Great Britain and all rates quoted therefore apply equally.

Copies of the original text of Acts, Regulations and Orders can be viewed at the Government's website[83]. Statutory Instruments (SIs) and Statutory Rules (SRs) can be traced by their year of publication and SI/SR Number quoted below. 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[84]. 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 Communities website[85].

Acts of Parliament

Primary legislation relevant to the benefits covered by the Report and introduced during the reference period includes:

2011

- Pensions Act 2011
  http://www.legislation.gov.uk/ukpga/2011/19/pdfs/ukpga_20110019_en.pdf

2012

- Health and Social Care Act 2012
  http://www.legislation.gov.uk/ukpga/2012/5/pdfs/ukpga_20120005_310516_en.pdf
- Welfare Reform Act 2012
  http://www.legislation.gov.uk/ukpga/2012/5/pdfs/ukpga_20120005_310516_en.pdf

2013

- Enterprise and Regulatory Reform Act 2013, section 72 - abolition of the Agricultural Wages Board in England only (ceased to have effect after 30 September 2013).
  http://www.legislation.gov.uk/ukpga/2012/5/pdfs/ukpga_20120005_310516_en.pdf
- Welfare Benefits Up-rating Act 2013
  http://www.legislation.gov.uk/ukpga/2016/7/pdfs/ukpga_20160007_en.pdf

2014

- Agricultural Sector (Wales) Act
  http://www.legislation.gov.uk/anaw/2014/6/pdfs/anaw_20140006_mi.pdf
- Pensions Act 2014
  http://www.legislation.gov.uk/ukpga/2014/19/pdfs/ukpga_20140019_en.pdf

[83] http://www.opsi.gov.uk/legislation/index.htm
[84] http://www.dwp.gov.uk/publications/specialist-guides/law-volumes/the-law-relating-to-social-security/
[85] https://www.communities-ni.gov.uk/services/law-relating-social-security

- Welfare Reform and Work Act 2016
  http://www.legislation.gov.uk/ukpga/2016/7/pdfs/ukpga_20160007_en.pdf

Statutory Instruments

An alphabetical list of all current secondary legislation, i.e. Regulations and Orders in the form of Statutory Instruments, is available via the link below[86].

All secondary legislation introduced during the five years of the reporting period can be viewed via links in the chronological bookmarks in the left hand side-bar of the list.

The rates of Social Security benefits payable under the respective Parts of the Code were increased during the reference period by the following instruments:

2012

- The Social Security Benefits Up-rating Order 2012 (SI 2012 No 819, NI Equivalent SR 2012 No 116)

2013

- The Social Security Benefits Up-rating Order 2013 (SI 2013 No 574, NI Equivalent SR 2013 No 69)

2014

- The Welfare Benefits Up-rating Order 2014 (SI 2014 No 147, NI Equivalent SR 2014 No.80)
- The Social Security Benefits Up-rating Order 2014 (SI 2014 No 618, NI Equivalent SR 2014 No 78)

2015

- The Welfare Benefits Up-rating Order 2015 (SI 2015 No 124)
- The Social Security Benefits Up-rating Order 2015 (SI 2015 No 457, NI Equivalent SR 2015 No 124)
- Uprating orders Welfare Benefits Up-rating Order 2015 (SI 2015 No 30, NI Equivalent SR 2015 No 139)
- Agricultural Wages (Scotland) Order (SR 2015 No 63)

2016

- The Social Security Benefits Up-rating Order 2016 (SI 2016 No 246 NI Equivalent SR 2016 No 92)

[86] http://www.dwp.gov.uk/docs/c-0031.pdf

The following instruments of relevance are also mentioned in the report:

2011

- Employment and Support Allowance (Limited Capability for Work and Limited Capability for Work-Related Activity) (Amendment) Regulations 2011(SI 2011 No 228, NI Equivalent SR 2011 No 76)
- Employment and Support Allowance (Work-Related Activity) Regulations 2011 (SI 2011 No 1349, NI Equivalent SR 2011 No 265)

2012

- Employment and Support Allowance (Amendment) Regulations 2012 (SI 2012 No 3096, NI Equivalent SR 2013 No 2)
- Employment and Support Allowance (Amendment of Linking Rules) Regulations 2012 (SI 2012 No 919, NI Equivalent SR 2016 No 176)
- Employment and Support Allowance (Sanctions) (Amendment) Regulations 2012 (SI 2012 No 2756, NI Equivalent SR 2016 No 240)

2013

- Job Seekers Allowance Regulations 2013 (2013 No 378)
- Employment and Support Allowance Regulations 2013 (SI 2013 No 379, NI Equivalent SR 2016 No 219)
- Universal Credit, Personal Independence Payment, Jobseeker's Allowance and Employment and Support Allowance (Decisions and Appeals) Regulations 2013 (SI 2012 No 381, NI Equivalent SR 2016 No 221)
- Universal Credit, Personal Independence Payment, Jobseeker's Allowance and Employment and Support Allowance (Claims and Payments) Regulations 2013 (SI 2012 No 381, NI Equivalent SR 2016 No 220)

2014

- Statutory Sick Pay (Maintenance of Records) (Revocation) Regulations 2014 (SI 2014 No 55)
- Statutory Sick Pay Percentage Threshold (Revocations, Transitional and Saving Provisions) (Great Britain and Northern Ireland) Order 2014 (SI 2014 No 897)

2015

- Employment and Support Allowance (repeat Assessments and Pending Appeal Awards) (Amendment) Regulations 2015 (SI 2015 No 437)

2016

- Agricultural Wages (Wales) Order 2016 (SI 2016 No 107)

PART II MEDICAL CARE

Legislative Changes

2012

- Health and Social Care Act 2012
  http://www.legislation.gov.uk/ukpga/2012/5/pdfs/ukpga_20120005_310516_en.pdf

13. The Health and Social Care Act 2012 introduced a new structure to the NHS, including setting up the NHS Commissioning Board, known as NHS England.

14. From April 2013, NHS England became responsible for the commissioning of NHS primary medical services in England.

15. In October 2014, the NHS Five Year Forward View was published. This sets out a vision for the future of the NHS and included new models of care, setting out proposed models that reflect the different structures, populations and localities. This is important, as the diversity of the NHS will not lend itself to a "one size fits all" model. Government is making £200 million available to pilot some of the new models of care set out in the *Five Year Forward View.*

16. On 21st April 2016, NHS England published the GP Forward View, a package of support to help get general practice back on its feet, improve patient care and access, and invest in new ways of providing primary care.

17. The GP Forward View sets out that we are investing an extra £2.4 billion a year for general practice services by 2020/21 – this represents a 14% increase in real terms. The overall investment for general practice includes a £500 million national 'turnaround' package to support GP practices.

18. This is part of a wider package of support for general practice, which contains measures to help boost the workforce, drive efficiencies in workload and modernize primary care infrastructure and technology.

19. The table below shows investment in general practice in England from 2010/11 to 2014/15.

Finance Monitoring: England	2010/11 Outturn £000s	2011/12 Outturn £000s	2012/13 Outturn £000s	2013/14 Outturn £000s	2014/15 Outturn £000s
Total payments for essential & additional services	4,372,287	4,366,855	4,370,320	4,478,229	4,792,294
Quality & Outcomes Framework	1,095,532	1,141,612	1,191,498	1,057,418	664,456
Total other payments	1,286,251	1,333,831	1,376,502	1,528,803	1,682,684
Total Enhanced Services	789,079	764,420	751,364	849,928	1,013,497
Total Net of Dispensing	7,543,149	7,606,718	7,689,684	7,914,378	8,152,931
Total Investment Excluding Reimbursement of Drugs	7,708,548	7,774,469	7,863,838	8,093,357	8,336,207
TOTAL NHS SPEND	8,349,528	8,397,044	8,459,261	8,689,883	8,938,743
TOTAL SPEND	8,349,528	8,397,044	8,459,261	8,766,110	9,001,046

20. Changes to the structure of the NHS in April 2013 mean that some areas of funding are not directly comparable. All figures, unless clearly stated as provisional, are based on actual reported spend.

21. Since 2013/14 Investment in Public Health by Local Authorities has moved from PCT to Local Authority control. NHS Health Checks for 40-70 year olds were part of Local Authority Public Health responsibilities from 2013/14 onwards.

22. Details of the Prime Minister's Challenge Fund, now known as the Prime Minister's GP Access Fund, can be found at: https://www.england.nhs.uk/ourwork/futurenhs/pm-ext-access/

United Kingdom

23. The report 'Investment in General Practice 2010/11 to 2014/15 for England, Wales, Northern Ireland and Scotland'[87] sets out detail of investment in general practice throughout the whole of the United Kingdom and is available through the Information Centre for health and social care website.

24. For the period 2014/15

- £9,001.0m in England, compared to £8,766.1m in 2013/14 (an increase of 2.68 per cent).
- £478.1m in Wales, compared to £475.7m in 2013/14 (an increase of 0.50 per cent).
- £255.2m in Northern Ireland, compared to £249.9m in 2013/14 (an increase of 2.12 per cent).
- £809.9m in Scotland, compared to £802.9m in 2013/14 (an increase of 0.88 per cent).
- £10,544.3m in the UK, compared to £10,294.6m in 2013/14 (an increase of 2.43 per cent).

Resident population

ONS Population estimates[88] for mid year 2015 - United Kingdom

[87] http://www.hscic.gov.uk/catalogue/PUB18469/inve-gene-prac-eng-wal-ni-scot-10-15-rep.pdf
[88] http://www.statistics.gov.uk/STATBASE/Product.asp?vlnk=601

All ages	Persons	65.1millions
	Males	32.1m
	Female	33.0m

Definition of resident population:

The estimated resident population of an area includes all people who usually live there, whatever their nationality. People arriving into an area from outside the UK are only included in the population estimates if their total stay in the UK is 12 months or more. Visitors and short-term migrants (those who enter the UK for 3 to 12 months for certain purposes) are not included. Similarly, people who leave the UK are only excluded from the population estimates if they remain outside the UK for 12 months or more. This is consistent with the United Nations recommended definition of an international long-term migrant. Members of UK and non-UK armed forces stationed in the UK are included in the population and UK forces stationed outside the UK are excluded. Students are taken to be resident at their term time address.

Statistics

Details of Statistics & data collections, during the reporting period, on the subjects set out below can be viewed via the following link:
http://www.ic.nhs.uk/statistics-and-data-collections

Audits and performance: (complaints; ambulance response times; quality and outcomes framework and clinical audits);

Health and lifestyles: (alcohol consumption, drug misuse, smoking, contraception, physical activity, diet, diabetes and mental health and other surveys).

Hospital care: (cancer, coronary heart disease and maternity and also hospital and outpatient activity).

Mental health: (NHS specialist mental health services, uses of the Mental Health Act 1983 and other related information).

Population, geography and international: (neighbourhood, international, public health and population statistics).

Primary care: (GPs, dentists, opticians, pharmacies and prescribed drugs, plus pay and expenses information).

Screening: (includes statistics on breast and cervical cancer screening).

Social care: (Adult social care, carer support, learning disability, older people, disability, children's social services and user surveys).

Workforce: (information on the NHS and social care workforce including vacancies, turnover, sickness and absence).

PART III SICKNESS BENEFIT

Statutory Sick Pay (SSP) & Employment and Support Allowance (ESA (C))

Legislative Changes

2011

- Employment and Support Allowance (Limited Capability for Work and Limited Capability for Work-Related Activity) (Amendment) Regulations 2011(SI 2011 No 228)
- Employment and Support Allowance (Work-Related Activity) Regulations 2011 (SI 2011 No 1349)

2012

- Employment and Support Allowance (Amendment) Regulations 2012 (SI 2012 No 3096)
- Employment and Support Allowance (Amendment of Linking Rules) Regulations 2012 (SI 2012 No 919)
- Employment and Support Allowance (Sanctions) (Amendment) Regulations 2012 (SI 2012 No 2756)

2013

- Enterprise and Regulatory Reform Act 2013, section 72 - abolition of the Agricultural Wages Board in England only (ceased to have effect after 30 September 2013)
- Employment and Support Allowance Regulations 2013 (SI 2013 No 379)
- Universal Credit, Personal Independence Payment, Jobseeker's Allowance and Employment and Support Allowance (Decisions and Appeals) Regulations 2013 (SI 2012 No 381, NI Equivalent SR 2016 No 221)
- Universal Credit, Personal Independence Payment, Jobseeker's Allowance and Employment and Support Allowance (Claims and Payments) Regulations 2013 (SI 2012 No 381, NI Equivalent SR 2016 No 220)

2014

- Agricultural Sector (Wales) Act http://www.legislation.gov.uk/anaw/2014/6/pdfs/anaw_20140006_mi.pdf
- Statutory Sick Pay Percentage Threshold (Revocations, Transitional and Saving Provisions) (Great Britain and Northern Ireland) Order 2014 (SI 2014 No 897)
- Statutory Sick Pay (Maintenance of Records) (Revocation) Regulations 2014 (SI 2014 No. 55)

2015

- Uprating orders Welfare Benefits Up-rating Order 2015 (SI 2015 No 30)
  The rate of SSP, as set out in s157(1) SSCBA 1992, has been uprated on an annual basis between 2011 and 2015. This Order contains the latest rate.
- Employment and Support Allowance (repeat Assessments and Pending Appeal Awards) (Amendment) Regulations 2015 (SI 2015 No 437)
- Agricultural Wages (Scotland) Order (SR 2015 No 63)

2016

- Agricultural Wages (Wales) Order 2016 (SI 2016 No 107)

Statutory Sick Pay (SSP)

7. In the event of incapacity for work, and subject to fulfilling entitlement conditions, employed

workers are paid SSP by their employers for the first 28 weeks of incapacity. Once entitlement to SSP has been exhausted employees are able to transfer on to the new Employment and Support Allowance (ESA). Workers, including the self-employed, who do not qualify for SSP can claim ESA from the outset

8. The Agricultural Wages Board set rates of pay and other terms and conditions for agricultural workers, including Agricultural Sick Pay. These terms and conditions were set out in Agricultural Wages Orders. The Agricultural Wages Board was abolished by the Enterprise and Regulatory Reform Act 2013. The last Agricultural Wages (England and Wales) Order was made in 2012 Information about the Order can be accessed here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/69594/awo2012-guidance.pdf

9. The Percentage Threshold Scheme, which enabled employers to recover amounts of SSP from Her Majesty's Revenue and Customs, was abolished by the Statutory Sick Pay Percentage Threshold (Revocations, Transitional and Saving Provisions) (Great Britain and Northern Ireland) Order 2014 (SI 2014/897) The closure of the scheme for late claims following end of 15/16 tax year was on 5 April 2016.

10. Regulation 13 of the Statutory Sick Pay (General) Regulations 1982, which required employers to keep specified records relating to sickness absence and SSP payments was revoked by the Statutory Sick Pay (Maintenance of Records) (Revocation) Regulations 2014. These requirements became redundant following abolition of the Percentage Threshold Scheme. The change came into force on 6 April 2014. This also reduced regulatory requirements for employers. Both this change and change 3 above were made following recommendations of the Independent Review of Sickness Absence conducted by Dame Carol Black and David Frost CBE, published in November 2011. The Government response which was published in January 2013 accepted these recommendations.

11. Agricultural Wages (Wales) Order 2016 replaced, (for Wales only), the Agricultural Wages Order 2012 (which applied to both England and Wales) in accordance with the Agricultural Sector (Wales) Act 2014. It sets out the circumstances in which an agricultural worker in Wales is entitled to agricultural sick pay, and makes provision about calculating the amount of sick pay that they are entitled to. It provides that a payment of SSP is to count towards an agricultural worker's entitlement to agricultural sick pay.

12. The Agricultural Wages (Scotland) Order (No 63) 2015 sets out the circumstances In which an agricultural workers in Scotland is entitled to Agricultural Sick Pay (ASP), and makes provision about calculating the amount of ASP that an employee is entitled to when they have been in continuous employment with the same employer for at least 52 weeks. After a period of 13 weeks ASP an agricultural worker would be, if they are still sick, entitled to SSP. Agricultural workers who have worked less than 52 weeks are entitled to SSP only.

SSP rates and Lower Earnings Limit from 6 April (GB£)

	2012	2013	2014	2015	2016
SSP	£85.85	£86.70	£87.55	£88.45	£88.45
LEL	£107.00	£109.00	£111.00	£112.00	£112.00

SSP and tax is uprated in line with benefit and tax annual uprating. Following the freeze on uprating for the majority of Working Age Benefits introduced by the Welfare Reform and Work Act 2016, most benefits are not going to be generally updated for 4 years. SSP is exempt from the freeze but was not uprated in 2016 as no increase was required to keep in line with the Consumer Price Index (CPI).

Employment and Support Allowance (ESA(C))

The main statutory instruments relevant to Employment and Support Allowance (ESA) in this reporting period are as follows:

20. In 2011 legislation was amended so that certain claimants, including hospital in-patients, those attending residential rehabilitation for the treatment of drug or alcohol addiction, and persons likely to receive chemotherapy treatment within 6 months after the date of the determination could be treated as having limited capability for work or limited capability for work-related activity.

21. Also in 2011 legislation set out the circumstances in which ESA claimants may be required to undertake work-related activity and who such a requirement may be applied to. It made clear that a requirement must be reasonable, having regard to the person's circumstances, and may not require the person to apply for a job, undertake work or undergo medical treatment as part of the work-related activity requirement. It also provided that a lone parent with a child under the age of 13 may only be required to undertake work related activity during normal school hours.

22. In 2012 amendment regulations clarified areas of the work capability assessment which were open to misunderstanding. They made the process easier to understand for claimants and assessors. Changes included taking account of reasonable aids, separation of physical and mental health descriptors, clarifying the term ‘in-patient’, refining wording in the continence descriptors, and clarifying the standing and sitting, manual dexterity, understanding communication, and getting about activities.

23. Also in 2012 regulations amended the previous rule that allowed periods of limited capability for work, separated from another such period by not more than 104 weeks, is to be treated as a continuation of the earlier period.

24. Further regulations introduced a revised sanctions regime for ESA claimants, who would only be subject to lower level sanctions to be applied when claimants failed to comply with requirements that would improve their chances of preparing for work, without showing they had good reason. A hardship regime was also introduced for claimants that were subject to a sanction.

25. In 2013 regulations removed from legislation references to income-related Employment and Support Allowance, to take account of the roll-out of Universal Credit which was merging various income-related benefits, including income-related Employment and Support Allowance.

26. In 2015 the criteria by which claimants could re-apply for Employment and Support Allowance, following a previous claim where the Work Capability Assessment determined that they did not have Limited Capability for Work, were amended. Following this change claimants had to demonstrate that they had a different health condition to that which the reason for their previous claim, or that that health condition had significantly deteriorated. The aim was to end the ‘looping’ of claimants into and out of the claims process for Employment and Support Allowance, and instead directs them towards claiming Jobseeker’s Allowance, where they can be given the appropriate support to look for work.

The Work Capability Assessment (WCA)

27. Existing incapacity benefits customers are being reassessed using the WCA which is a key factor in determining eligibility for ESA.

28. The WCA was introduced in October 2008 to assess entitlement to ESA. It replaced the

Personal Capability Assessment used to assess entitlement to incapacity benefits (IB).

29. The WCA is a functional assessment that looks at what people can do, as well as what they can't, to identify people for the correct benefit and give them the support they need to get back to work and avoid ending up on long-term sickness benefits. This approach is based on the principle that a health condition or disability should not automatically be regarded as a barrier to work. There is strong evidence that work is good for physical and mental well-being, and that being out of work can contribute to poorer health and other negative outcomes. So, whilst the Government does not want to make it harder for people who genuinely can't work, it does want to engage as many people as possible in employment.

30. The Government is committed to continuously improving the WCA to ensure that it is as fair and accurate as possible. As part of this, the Government had a statutory commitment to independently review the WCA annually for the first five years of its operation. Professor Malcolm Harrington, a highly respected Occupational Physician, carried out the first three reviews in 2010, 2011 and 2012. Dr Paul Litchfield, Chief Medical Officer for BT Group conducted the fourth and fifth reviews in 2013 and 2014, The Government accepted the vast majority of the recommendations that came out of the five independent reviews.

31. In addition, a Department-led review reported in March 2010 and its recommendations have been implemented. These include taking better account of the effects of exhaustion and making greater provision for people awaiting, or in between courses of, chemotherapy. The improvements as a result of this review came in to force on 28 March 2011.

32. Further information on the Work Capability Assessment independent review is available at:

92. https://www.gov.uk/government/publications/2010-to-2015-government-policy-welfare-reform/2010-to-2015-government-policy-welfare-reform

93. Research and Reports

Routes onto Employment and Support Allowance (published in 2010)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214556/rrep774.pdf

Employment and Support Allowance: Customer and staff experiences of the face-to-face Work Capability Assessment and Work-Focused Health-Related Assessment (published in 2010)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214494/rrep719.pdf

Employment and Support Allowance: Findings from a follow-up survey with customers (published in 2011)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214519/rrep745.pdf

Decision making on Employment and Support Allowance claims (published in 2012)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214575/rrep788.pdf

A survey of disabled working age benefit claimants (published in 2013)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224543/ihr_16_v2.pdf

Evidence Based Review of the Work Capability Assessment (published in 2013)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/331582/wca-evidence-based-review.pdf

Understanding the journeys from work to Employment and Support Allowance (ESA) (published in 2015)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/436420/rr902-understanding-journeys-from-work-to-esa.pdf

An Independent Review of the Work Capability Assessment (published in 2010)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/70071/wca-review-2010.pdf

An Independent Review of the Work Capability Assessment – year two (published in 2011)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/70102/wca-review-2011.pdf

An Independent Review of the Work Capability Assessment – year three (published in 2012)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/70123/wca-review-2012.pdf

An Independent Review of the Work Capability Assessment – year four (published in 2013)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/265351/work-capability-assessment-year-4-paul-litchfield.pdf

An Independent Review of the Work Capability Assessment – year five (published in 2014)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380027/wca-fifth-independent-review.pdf

Article 15

Questions (a) to (c) No change

(ii) TITLE II (Article 76)

A.	Number of economically active persons protected –	
i.	Under General scheme	30,512,000 (including Northern Ireland)[a]
ii.	Under special scheme	nil
B.	Total number of residents	65,110,000[b]
C.	Percentage A/B 46.86%	

Sources: (A) Contributions and Qualifying Years – persons paying Class 1 and or Class 2 National Insurance Contributions 2014/15; and
(B) ONS Population estimates[89] for mid year 2015 - United Kingdom.

[89] http://www.statistics.gov.uk/STATBASE/Product.asp?vlnk=601

Article 16

Question A. (ii)

Title II (Article 66)

Option 4

For the purposes of Article 66 Code the reference wage is **£371.70 per week**, being the median gross weekly earning (excluding overtime) for full-time male employees who are classified as unskilled labourers in the manufacture of machinery other than electrical machinery (SOC 91 and SIC 28), Annual Survey of Hours and Earnings (ASHE) 2014-2015[90].

C. Sickness Benefit (2016/17 rates)

ESA(C)

Week 1-13	£73.10 - personal allowance
Week 14 onwards	£102.15- including WRA component
Week 14 onwards	£109.30 - including Support component

Statutory Sick Pay (SSP) Week 1-28 £88.45

D £151.90
E £151.90

D & E comprise: £20.70 Child Benefit for the eldest qualifying child; £13.70 for the second qualifying child and Child Tax Credit of £117.50, in respect of both children.

TITLE V (Article 66)

C. Sickness Benefit

SSP	(a) £88.45	maximum of 28 weeks
ESA(C)	(b) £73.10	Week 1 – 13*; then either:
	(c) £102.15	Week 14 (or WCA) onwards[1]; or
	(d) £109.30	Week 14 (or WCA) onwards[2]

Notes * or to week of WCA if earlier
[1] The work-related activity component was abolished from April 2017
[2] includes support component

D. £151.90

E. £151.90

[90] https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/adhocs/004242weeklypayexcludingovertimeforsoc91andsic282014to2015

F. (a) 45.9%
(b) 43.0%
(c) 48.5%
(d) 49.9%

PART IV UNEMPLOYMENT BENEFITS

Legislative Changes

2013

- Job Seekers Allowance Regulations 2013 (2013 No 378)

In 2013 JSA 'new style' was introduced. It is a contribution-based only benefit available to claimants alongside Universal Credit.

Article 21

Question C (i)

TITLE I (Article 76)

D. Number of economically active persons protected –
iii. Under general scheme 28,299,000(including Northern Ireland)[a]
iv. Under special scheme nil

E. Total number of employees 31,420,000[b]

F. Percentage A/B 90%

Sources: (A) Contributions and Qualifying Years – persons paying Class 1 National Insurance Contributions 2014/15; and
(B) ONS Labour Market Stats for mid year 2015 - United Kingdom.

Article 22

TITLE V (Article 66)

Question A (ii)

Title I (Article 66)

G. £371.70 per week

Title II (Article 66) Jobseeker's Allowance (contribution based) 2016/17 rates

H. JSA (a) £73.10
JSA Joint Claim (b) £114.85

Anyone who claims JSA who is part of a couple would receive the higher amount if neither of them were working or if their partner was working less than 24 hours a week.

I. £151.90
J. £151.90
K. (a) 43.0%
(b) 50.9%

D & E comprise: £20.70 Child benefit for the eldest qualifying child; £13.70 for the second qualifying child and Child Tax Credit of £117.50, in respect of both children.

PART V OLD AGE BENEFIT

Legislative changes

2011

- Pensions Act 2011
  http://www.legislation.gov.uk/ukpga/2011/19/pdfs/ukpga_20110019_en.pdf

2014

- Pensions Act 2014
  http://www.legislation.gov.uk/ukpga/2014/19/pdfs/ukpga_20140019_en.pdf
- Welfare Benefits Up-rating Act 2013
  http://www.legislation.gov.uk/ukpga/2016/7/pdfs/ukpga_20160007_en.pdf

10. In January 2013 the UK Government published a Command Paper which outlined how the UK Government intended to replace the current two-component state pension (basic State Pension and earnings-related additional State Pension) with a single component flat-rate pension set above the basic level of means-tested support for future pensioners.

11. Subsequently, the Pensions Act 2014 introduced the new State Pension for people reaching state pension age on or after 6 April 2016, radically simplifying state pension provision.

12. Qualification for the new state pension is based on an individual's National Insurance record, with a minimum qualifying period of 10 years usually required to receive any pension. In steady state, the full rate of the new State Pension (previously referred to as the single-tier pension) will be based on 35 qualifying years of National Insurance contributions or credits. Transitional arrangements are in place for those who have qualifying years before 6 April 2016.

13. The new State Pension will cost no more overall that the previous system, but will restructure the system to provide clarity and confidence to help people plan for their retirement.

State Second Pension

14. The State Second Pension (also known as additional State Pension) ended in April 2016 and with it the ability to contract out of the State Second Pension. Up until this point some people were contracted out of the State Second Pension into a private or workplace pension. While the additional State Pension has ended it will remain in payment, to those with entitlement who reached state pension age before 6 April 2016. A proportion of an additional State Pension can be inherited by surviving wives, husbands and civil partners beyond April 2016.

State Pension age

15. Under the Pensions Act 2011 State Pension age for women will gradually increase from 60 to 65 between 2010 and 2018. Then, between 2018 and 2020, State Pension age will increase from 65 to 66 for both men and women. The State Pension age will increase from 66 to 67 between 2026 and 2028 under the Pensions Act 2014. The timing of the increase from 67 to 68 remains set to happen between 2044 to 2046 as set out in the Pensions Act 2007. The changes in State pension age reflect increasing longevity in society and make the State Pension affordable in the long term.

16. The Pensions Act 2014 contains a framework for further changes to state pension age through a regular review by Government.

17. As part of the review process, the Government is required to commission a report from the Government Actuary's Department looking at the implications of life expectancy data for State Pension age. The legislation also requires Government to commission a further independent report covering other relevant factors. This may include variations in life expectancy between socio-economic groups, and the wider economic context at the time of a review. All reports prepared as part of the review must be published.

18. The Government will publish a report on their review of the state pension age every 6 years. The first review will report to Parliament before 7 May 2017.

Article 27

Question B

No change (apart from contribution rates)

Question C (ii)

(ii) TITLE II (Article 76)

A. Number of economically active persons protected -

i. Under general scheme	30,527,000(including Northern Ireland)[a]
ii. Under special schemes	nil
TOTAL	30,527,000

B. Total number of residents 65,110,000[b]

C. Percentage A/B 46.89%

Sources: (A) Contributions and Qualifying Years – persons paying Class 1, Class 2 and or Class 3 National Insurance Contributions 2014/15[91]; and
(B) ONS Population estimates for mid year 2015 - United Kingdom.

Article 28

Question A (ii)

TITLE I (Article 66)

[91] http://83.244.183.180/NIRS/live/tabtool.html

B. £371.70 per week.

TITLE III (Article 66)

C. The standard basic weekly rate of retirement pension received by a married couple is £190.80 (2016/17 rates)

This basic weekly rate of Retirement Pension, for people reaching state pension age before 6 April 2016 comprises £119.30 for a 100% full weekly Retirement Pension payable to a man with 30 qualifying years for himself plus £71.50 in respect of a wife of pension age or a dependent wife under pension age.

D. £151.90

E. £151.90

D and E (where applicable) comprise £20.70Child Benefit for the eldest qualifying child, £13.70 for the second qualifying and Child Tax Credit of £117.50 in respect of both children. From April 2003 Child Tax Credits replaced Child Dependency Increases payable with State Pension.

F. 65.5 %

TITLE V (Article 66)

C. The weekly rate of retirement pension for a woman employee is £115.90 [2015/2016 rates].

F. 31.9%

Question C

TITLE VI (Article 65)

Period under review (closest published figures)	Cost of living index (RPI) (*)	Index of earnings (**)
A. March 2011	100	100
B. March 2016	18.8	120.2(***)
C. A/B per cent	5.3%	83.2%

(*) Retail Price Index (RPI) All items
(**) Annual Survey of Hours and Earnings
(***) Latest available data on earnings by occupation is for 2010

TITLE VI (Article 65)

		Benefit
Period under review	Average per beneficiary +	Benefit for standard beneficiary*
	I	II
A. March 2011 [2010/11 rates]	see tables below	£97.65
B. March 2016[2015/16 rates]	see tables below	£115.90
C. A/B per cent		84.0%

* Personal Benefit – Category A Basic Pension at 100% rate

Table 1

State Pension: Average amount of benefit in payment - Time Series by category of pension

Time Series	Total	Cat A *	Cat B	Cat ABL	Cat BL	Cat AB
	Average weekly amount of benefit	Average weekly amount of benefit *	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit
May-11	110.54	117.33	116.99	64.8	54.74	141.72
May-12	117.99	124.87	124.24	68.22	57.25	150.7
May-13	121.97	128.6	128.35	69.91	58.33	155.52
May-14	126.46	132.68	132.87	71.78	59.53	160.89
May-15	130.3	135.95	136.92	73.43	60.61	165.38
Nov-15 **	130.71	136.03	137.47	73.38	60.49	165.78

" * "*Includes Additional Pension and Graduated Benefit. " ** " Latest available at time of reporting*
Average amounts are shown as pounds per week and rounded to the nearest penny. Totals may not sum due to rounding. Category C & D (non-contributory) Pensions excluded

SOURCE: *DWP , Data and Analytics, Technology - Work and Pensions Longitudinal Study.*

STATE PENSION AGE:
The age at which men and women reach State Pension age is gradually increasing. Under current legislation, State Pension age for women will equalise with State Pension age for men at 65 in 2018. Both men's and women's State Pension age will increase from 65 to 66 between December 2018 and October 2020. The Pensions Bill 2013-14 contains provision for a State Pension age of 67 to be reached by 2028. For more information see https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207966/espa.pdf.

Table 2

State Pension: Average weekly amount of benefit: Category of pension and gender of claimant, November 2010

Nov-2010	Total	Cat A	Cat B	Cat ABL	Cat BL	Cat AB
Gender of claimant	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit
Total	105.35	112	111.7	62.04	52.5	135.37
Female	93.74	95.39	111.85	62.04	52.5	134.55
Male	124.1	124.18	34	55.8	25.93	143.3

Table 3

State Pension: Average weekly amount of benefit: Category of pension and gender of claimant, November 2015 (latest available)

Nov-2015	Total	Cat A	Cat B	Cat ABL	Cat BL	Cat AB
Gender of claimant	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit
Total	130.71	136.03	137.47	73.38	60.49	165.78
Female	118.08	119.29	137.79	73.5	60.54	164.7
Male	147.68	147.42	35.16	60.31	26.44	172.08

SOURCE: *DWP , Data and Analytics, Technology - Work and Pensions Longitudinal Study. Categories AB & ABL – based on both own and spouse's/civil partner's contribution records*

Categories B and BL - based on spouse's/civil partner's contributions alone.

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PART VII FAMILY BENEFIT

Article 40

12. Child Benefit (CHB) is generally payable to all persons who have responsibility for a child, regardless of means. CHB is a non-contributory benefit and is not treated as taxable income.

13. As of January 2013, claimants may be liable to a tax charge called the 'High Income Child Benefit charge'. Being liable for this charge does not affect entitlement to Child Benefit for a child, but anyone receiving Child Benefit is liable to pay a tax charge linked to the amount of Child Benefit if they or their partner has an individual income of more than £50,000 per year. For every additional £100 over the £50,000 threshold that an individual earns, the tax charge due increases by 1%. This means that any claimant receiving a payment of Child Benefit whose income (or partner's income) is over £60,000 will be liable to pay a charge equal to the total amount of Child Benefit received. Alternatively, claimants affected by the High Income Child Benefit charge have the option to opt-out of receiving Child Benefit, thereby ceasing their payments, which means that they are not subject to the tax charge.

14. Child Benefit is paid to those responsible for children (aged under 16) or qualifying young people. The latter includes those:
    a) in full-time non-advanced education or (from April 2006) on certain approved vocational training courses and who are under 19, or are aged 19 and have been on the same course since their 19th birthdays.
    b) entered for future external examinations, or are in the period between leaving education and the week containing the first Monday in September and are not in work.
    c) aged under 18 who have moved directly from full-time education to being registered for work or training with the Careers service or with Connexions.

15. Generally, entitlement to CHB does not arise for people whose presence in the UK is subject to immigration control, but protection is given to those recognised as refugees, those with settled status (whose leave to enter or remain in the UK is not subject to any limitation) or with discretionary or humanitarian leave to enter or remain in the UK, or who are within the scope of European Community's Social Security co-ordination regulations Regulation (EEC) 1408/71 and 574/72, by virtue of Regulation (EC) 859/2003 or who are covered by a relevant bilateral social security agreement with another country. Entitlement can arise also for nationals of other states party to the European Convention on Social and Medical Assistance (ETS No 14) and the European Social Charter of 1961 (ETS No 36) who are lawfully present in the UK.

16. The Working Tax Credit (WTC) provides financial support, on top of earnings for in-work households with low incomes who are living in the UK. This is paid to families with or without children. The Child Tax Credit (CTC) is a means-tested form of support for families (with children) who are in or out of work and living in the UK.

17. WTC provides support to in-work households on low incomes and additional support is available for disabled workers. It is payable to the person who is working. The "childcare element" of WTC is paid directly to the main carer of the child or children along with Child Tax Credit.

18. Generally, entitlement to a tax credit does not arise for people whose presence in the UK is subject to immigration control, but protection is given to those recognised as refugees, those with settled status (whose leave to enter or remain in the UK is not subject to any limitation) or

with discretionary or humanitarian leave to enter or remain in the UK.

19. Access to CTC can be gained for those who are lawfully working in the UK and a national of a State that has concluded an agreement under Article 310 of the Treaty of Amsterdam amending the Treaty of the EU. In the field of social security, for equal treatment of workers who are nationals of the signatory State and their families. Also, if they come within the scope of European Community's Social Security co-ordination regulations Regulation (EEC) 1408/71 and 574/72,by virtue of Regulation (EC) 859/2003.

20. Access to WTC is available to nationals of other states party to the European Convention on Social and Medical Assistance (ETS No 14) and the European Social Charter of 1961 (ETS No 36) who are lawfully present in the UK.

21. Further information on eligibility for tax credits and how awards are calculated is published in leaflet WTC 2[92].

22. In the Summer Budget 2015, the Government announced various measures to ensure the tax credit system is targeted at those who need it most. From 6 April 2016, if a claimant is entitled to Working Tax Credit, whether on its own or in addition to Child Tax Credit, and their family's annual income is below £3850, they will get the maximum amount of all the elements that they qualify for. If income is over that threshold, the maximum amount will be reduced by 48 pence for every pound of income over the threshold.

[92] http://www.hmrc.gov.uk/leaflets/wtc2.pdf

Article 41

Question C

The number of families receiving Child Benefit in the UK for the years covered by this Report are contained in the following table:

The Number of Child Benefit recipients – August each year:

	UK
2011/12	7,920
2012/13	7,550
2013/14	7,461
2014/15	7,416

Note: UK totals include foreign and not known.

The number of families receiving Child Tax Credit in the UK for the year 2014/15 was 7.4 million, comprising some 12.8 million children.

Article 42

The Child Tax Credit rates for the period of this Report.

Child Tax Credit	From April 2012	From April 2013	From April 2014	From April 2015	From April 2016
Family element	545	545	545	545	545
Family element, baby addition[1]					
Child element	2,555	2,690	2,720	2,750	2,780
Disabled child element	2,800	2,950	3,015	3,100	3,140
Severely disabled child element	1,130	1,190	1,220	1,255	1,275
Income thresholds and withdrawal rates					
First income threshold	6,420	6,420	6,420	6,420	6,420
First withdrawal rate (per cent)	41	41	41	41	41
Second income threshold[2]	40,000				
Second withdrawal rate (per cent)	41				
First threshold for those entitled to CTC only	15,860	15,860	15,910	16,010	16,105
Income disregard[3]	10,000	10,000	5,000	5,000	5,000

[1]The baby element component was abolished from April 2011.

[2]For those entitled to the Child Tax Credit, the award is reduced only down to the family element less the excess of income over the second threshold multiplied by the second withdrawal rate.

[3]The amount of increase in income disregarded in the calculation of Tax Credit awards has been reduced from £10,000 to £5,000 in April 2013.

Child Benefit rates for the period of this Report

From	Child Benefit
April 2012	£20.30 eldest child
	£13.40 each other child
April 2013	£20.30 eldest child
	£13.40 each other child
April 2014	£20.50 eldest child
	£13.55 each other child
April 2015	£20.70 eldest child
	£13.70 each other child
April 2016	£20.70 eldest child
	£13.70 each other child

Article 42

In order to qualify for Child Benefit and CTC a claimant must have been living in the UK for a consecutive period of 3 months if they moved to the UK on or after 1 July 2014 and don't have a job. There are some exceptions to this rule. Eligibility to Child Benefit and CTC can be found at the following links:

https://www.gov.uk/child-benefit-move-to-uk
https://www.gov.uk/tax-credits-if-moving-country-or-travelling/moving-to-the-uk

Article 44

No change

Part XIII COMMON PROVISIONS

No change

Article 70

Question 1

No change

Article 71

Question 3

Estimated outturn figures (GB£ million) for the year 2015-2016.

Part to which ratification applies	Expenditure on the protection of employees, their wives and children (A)	Insurance contributions borne by the employees protected (B)
II	138,700 (a)	£8,662 (b)
III	4,441 (contributions based Employment & Support Allowance)	
IV	341 (contributions based Job Seekers Allowance)	
V	70,973 (Retirement Pension – Basic Pension and Graduated Benefit) 18,119 (Retirement Pension - Additional Pension)	
	128 (Christmas Bonus – this is a single tax-free payment available for people who get one of the qualifying benefits in the qualifying week)	
TOTAL (excluding II)	£94,002m	£37,645 (c)

(**Source:** Government Actuary Report on the Social Security Benefits Up-rating Order 2016[93] unless otherwise stated).

Expenditure on Part VII Family Benefits and Tax Credits is met wholly from general taxation.

NOTES:
(a) See Her Majesty's Treasury entitled 'Public Expenditure Statistical Analyses 2015-16', page 70, table 4.2[94].
(b) The National Health Service is financed mainly through general taxation with a small element coming from National Insurance Contributions (NICs) paid by workers (£8.662mil) and employers (£12.429 mil) – see Appendix 4 Government Actuary Report). All other expenditure figures are taken from table 4.2 (page 14) in this report.
(c) Does not include NHS Contribution listed against II (b) above. It is not possible to break this figure down according to benefit, except for Part II. Employee's contributions to the National Insurance Fund also help meet the cost of maternity benefits, Guardian's Allowance and Redundancy Payments.

Question 4

Percentage B/A 40.0%, but see Note (c) above.

[93] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/494930/53430_GA_UpRating_Report_2016_Accessible.pdf.
[94] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/538793/pesa_2016_web.pdf

Question 5

The continuing equalisation of women's and men's State Pension age slightly reduced the number of people entitled to old age benefit in 2015/16.

Question 6

iii. Benefits have been increased annually as provided for in the Social Security Benefits Up-rating Orders
iv. Full details of the rates of benefits provided from the National Insurance Fund are shown in Appendix 1 of the Government Actuary's Up-rating Report 2016[95].

Question 7

Please see Government Actuary Report.

[95] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/494930/53430_GA_UpRating_Report_2016_Accessible.pdf

ANNEX

Response to the Committee of Experts' Conclusions

In view of the reconfiguration of the national welfare system through the introduction of the UC on the basis of a "uniform approach" to all those who are out of work, irrespective of whether they are unemployed or ill, the Committee asks the Government to explain how the risk of sickness will be differentiated from the risks of unemployment and invalidity, and how the UC should be taken into account for the purpose of application of Part III of the Code.

In relation to Part 3 of the Code, Universal Credit does not take a 'uniform approach' to all those out of work, irrespective of whether they are unemployed or ill. There are different rules and payments in place within Universal Credit for those with limited capability for work due to a disability or health condition.

When someone makes a claim to Universal Credit they will state whether they are unable to work through illness or if they are ready to work. Eligibility for limited capability additions will be determined following the outcome of a Work Capability Assessment, which differentiates the risks of unemployment from sickness and invalidity. The claimant would discuss their work capability with the work coach, and they would then decide the reasonableness of having work search activity in their revised claimant commitment.

Someone can stay on Universal Credit whether they are in work, unable to work through sickness, or out of work. Everyone gets paid a standard allowance on Universal Credit, and they will receive additions if they are unwell.

For the purpose of Part 3 of the Code, Universal Credit is a general anti-poverty benefit available to those at risk of falling into poverty. It is payable to people out of work as well as those in work and on a low income. The UK classifies this as a 'social assistance' rather than a 'social security' benefit.

The Government is committed to retaining the contributory principle as far as National Insurance Contribution based social security benefits are concerned. The UK's obligation under the accepted Parts of the Code should continue to be met in this way for the foreseeable future.

Please also specify the complementarity of the SSP, ESA and UC in terms of scope, qualifying and waiting periods, duration, level of benefit, and the regime of sanctions, bearing in mind that, taken together, these benefits should ensure the required level of income security in case of a morbid condition for at least 26 weeks in each case of sickness or until the onset of invalidity, if it comes earlier (Articles 16 and 18 of the Code). In view of the innovative trends in the development of the United Kingdom's social security legislation, the Committee would expect the Government's next report to contain the necessary details and statistics.

Universal Credit is replacing a range of income related benefits, contributory Employment Support Allowance and Statutory Sick Pay will continue separately. In future, Universal Credit will provide means tested support for those on contributory Employment Support Allowance and Statutory Sick Pay. We are currently looking at how contributory Employment Support Allowance and Universal Credit interact but there are no current plans to remove this at present.

As Universal Credit is a form of social assistance it does not fall within the scope of the Code. For the necessary details and statistics refer to those provided for Employment Support Allowance and Statutory Sick Pay under part III in the above.

Referring to the previously asked question concerning the configuration of the benefit package to be taken into account for the purpose of application of Part III of the Code, the Committee considers that, subject to confirmation by the Government, the protection ensured by this arrangement of complementary SSP and ESA benefits is compatible with Article 18(1) of the Code.

The Government continues to provide the same level of support for people who are unable to work because of sickness or a disability. As stated in the UK's 47th report, Statutory Sick Pay can be considered the main benefit covering the majority of persons protected during the whole period of payment of sickness benefit, as prescribed by Article 8 (1) of the Code. In addition people can claim means-tested Income Support if they have additional needs. Employment Support Allowance plays a supplementary role protecting only those who are not covered by Statutory Sick Pay. Taken together, the Government believes these benefits ensure the required level of income security for the duration outlined by Part III of the Code.

Consequently, the indicators of life expectancy, HLE and DFLE of elderly persons as the measure of their capacity for work beyond 65 should be calculated not for the general population but with respect to the abovementioned categories of workers engaged in manual operations and physical labour, including in onerous and hazardous occupations entailing premature physical ageing.

Whilst average life expectancy differs among people from different socio-economic backgrounds, there have been substantial improvements in longevity at age 65 across all socio-economic groups during the last 30 years. All socio-economic classes (including the unclassified group) experienced statistically significant absolute gains in life expectancy at birth and at age 65 between 1982 to 1986 and 2007 to 2011[96].

The Office for National Statistics do not currently produce regular publications on Healthy Life Expectancy and Disability-Free Life Expectancy broken down by Social Economic Class, but plan to do so in the future.

The Government is therefore asked to include in its next report the statistics on the participation rate and worklessness for people aged 65–67 years and belonging to the abovementioned SOC Sub-Major Group 91.

Labour Market Statistics by age group and occupation are published by the Office for National Statistics each month. In addition the Government set out the case for later life working in Fuller working lives: framework for action and more recently, has published, employment statistics on older workers by sector for those aged 50-64 and 65-69[97]. The sample size for people aged 65-67 belonging to SOC 91 in the Labour Force Survey is very small to make meaningful comparisons – however we will consider, in the future, what might be appropriate data and research for understanding the impact on the categories that are mentioned.

The Department for Work and Pensions published a new annual statistical release on 28th July 2016 which provides statistics on economic labour market status by five year age band and gender[98].

Finally, the Government is asked to specify the reasons for abolishing the default retirement age and the lower retirement ages previously established for certain particularly arduous occupations.

The Employment Equality (Age) Regulations were introduced in 2006 to prohibit discrimination in employment because of age. Among other things, they introduced a national Default Retirement Age (DRA) of 65 and prohibited compulsory retirement below 65 unless objectively justified. In effect, the DRA made it lawful for an employer to discriminate against an employee on the grounds of their age when it comes to retirement.

[96] http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/trendinlifeexpectancyatbirthandatage65bysocioeconomicpositionbasedonthenationalstatisticssocioeconomicclassificationenglandandwales/2015-10-21

[97] http://socialwelfare.bl.uk/subject-areas/services activity/employment/departmentforworkandpensions/172963older-workers-by-sector-ad-hoc-statistics.pdf

[98] https://www.gov.uk/government/statistics/economic-labour-market-status-of-individuals-aged-50-and-over-since-1984-experimental

People are living longer, healthier lives and as the structure of our society changes we needed to reappraise the important role older people play: as employees, entrepreneurs and in the wider community. As part of this reappraisal, the UK believed that those who wish to work past 65 and are able to do so should not be denied the opportunity to do so and in removing the DRA, it was ensured that people are not deprived of the opportunity to work simply because they have reached a particular age.

Working longer provides many benefits and there are a range of reasons for pursuing it including the health and social benefits that many people gain and the financial benefits to both the individual and the wider economy. In 2010 the National Institute for Economic and Social Research estimated that extending average working lives by one effective year could increase GDP by around 1 per cent. Removing the DRA is just one of the steps that the UK has taken to enable and encourage people to work for longer.

The removal of the DRA does not mean that individuals can no longer retire at 65 – simply that the timing of that retirement is now a matter of choice rather than compulsion.

The Committee hopes that the measures taken by the Government to reform the pension system would have permitted the new single tier pension, alone or together with pension credit and private pensions, to move over half of pensioners above the 40 per cent threshold fixed by the Code. To show compliance with this key provision of the Code, the Government is asked to include in its next report all the necessary explanations and data.

The new State Pension was introduced on 6 April 2016 and currently has a flat rate value of £155.65. As reported in the 44th Report of the United Kingdom under Article 74 of the ECSS, the reference wage of an ordinary adult labourer for the purposes of Article 66 of the Convention is £330 per week. As such the new State Pension alone accounts for 47 per cent of the reference wage and in 2016 it is estimated that 89% will receive this full gross amount when negating for the effects of contracting out.

In the first 15 years of the new State Pension system, around three-quarters of people who reach State Pension age under the new system will have a notionally higher State Pension than under the old system.

By 2030, over three million men, and over three million women will have benefitted from a notionally higher State Pension. In addition, because of the triple lock, people who have 30 qualifying years or more, will get the new State Pension with a Starting Amount of £570 a year more than if the basic State Pension had been uprated since 2011 by earnings.

It would ask the Government to explain its policy of maintaining the purchasing power of the benefits in payment as well as giving the pensioners a fair share of the resumed growth of the national economy after the crisis.

The law relating to annual increases to benefit rates, known as up-rating, requires the Secretary of State for Work and Pensions to review benefit rates each year to determine if they have kept their value in relation to the rise in either prices or earnings, depending on the benefit, over the relevant period. If the Secretary of State determines that the value of benefits have not kept pace with these rises, then he must lay an up-rating order that increases certain benefit rates as required. This has meant that benefits including additional-cost disability benefits and carers' benefits have kept their purchasing power

against increases in prices. When the Secretary of State makes an up-rating order for Great Britain, the Department for Communities is empowered to make a corresponding order for Northern Ireland.

For pensioners, the government has put into place a 'triple guarantee' (or 'triple lock') up-rating policy, which ensures that each year the basic State Pension is increased by the highest of the rise in earnings, price inflation (as measured by the Consumer Prices Index) or 2.5 per cent. This policy has helped to reverse the previous trend whereby the basic State Pension had been falling as a proportion of average earnings, from a low of 15.8 per cent in 2008-9, to a level of 18.2 per cent in 2014-15, the highest level since 1992-93. Further details of the historic levels of benefit rates can be found on the government's website[99].

The government also continues to protect the poorest pensioners through Pension Credit, a means-tested benefit that that has a standard minimum amount, known as the Pension Credit Standard Minimum Guarantee, below which pensioner income need not fall. The legal requirement is that the Standard Minimum Guarantee in Pension Credit is increased each year at least in line with the rise in earnings. In order to ensure that the poorest pensioners benefit from the triple lock, the government applied a 'pass-through', an above earnings increase equivalent to the cash increase of the basic State Pension, to the means-tested standard minimum guarantee between 2011-12 and 2015-16. This prevented increases in the basic State Pension being subsequently clawed back in Pension Credit awards.

The Committee expects the Government's next detailed report to contain full information and statistics on the adjustment of benefits under each accepted Part for the period 2011–16 requested in the report form on the Code under Title VI of Article 65.

The tables under Title VI Article 65 are not always applicable to the UK situation, we therefore here provide the main rates of each benefit that falls under the scope of the Code.

[99] http://www.gov.uk/government/collections/abstract-of-statistics-for-benefits-national-insurance-contributions-and-indices-of-prices-and-earnings

Rates of certain social security benefits 2011-2016

All rates are weekly £ unless stated otherwise. The rates of child benefit and child tax credit are the responsibility of HMRC/HMT. These rates do not take into account premiums, such as disability or carer premiums for ESA and JSA, or other elements of benefit, such as additional State Pension in the case of State Pension.

Statutory Sick Pay

Period	Main rate	
2011-12	81.60	Payable for first 28 weeks of sickness to employees with earnings over £102pw
2012-13	85.85	Payable for first 28 weeks of sickness to employees with earnings over £107pw
2013-14	86.70	Payable for first 28 weeks of sickness to employees with earnings over £109pw
2014-15	87.55	Payable for first 28 weeks of sickness to employees with earnings over £111pw
2015-16	88.45	Payable for first 28 weeks of sickness to employees with earnings over £112pw

Employment and Support Allowance (contribution-based)

Period	Main rate (single person)
2011-12	67.50
2012-13	71.00
2013-14	71.70
2014-15	72.40
2015-16	73.10

Jobseeker's Allowance (contribution-based)

Period	Main rate (man or woman on own National Insurance Contribution)	Man plus dependent wife
2011-12	67.50	105.95
2012-13	71.00	111.45
2013-14	71.70	112.55
2014-15	72.40	113.70
2015-16	73.10	114.85

Basic State Pension

Period	Main rate (man or woman under 80 with own National Insurance Contribution)	Man plus his wife on his National Insurance Contribution – both under 80
2011-12	102.15	163.35
2012-13	107.45	171.85
2013-14	110.15	176.15
2014-15	113.10	180.90
2015-16	115.95	185.45

Child Benefit

Period	Main rate (1st child)	Rate for additional child
2011-12	20.30	13.40
2012-13	20.30	13.40
2013-14	20.30	13.40
2014-15	20.50	13.55
2015-16	20.70	13.70

Child Tax Credit

Period	Family element (annual)	Child element (annual)
2011-12	545	2555
2012-13	545	2690
2013-14	545	2720
2014-15	545	2750
2015-16	545	2780

The Committee regrets to note that the situation has not changed and the rate of the contribution-based benefits has been consistently kept below the minimum standard established by the Code.

The government believes that it maintains a strong welfare safety net that is adequate and balances the requirements of a sustainable welfare system with the need to ensure that work pays. Contribution-based benefits represent one part of the overall welfare system that includes a mixture of income-related and social assistance benefits such as housing benefit and tax credits.

Overall, the proportion of expenditure on contributory benefits as a share of Gross Domestic Product has remained broadly stable over recent years, from 4.8% in 2008/09 to 5.2% in 2016/17, and forecast to be 4.9% by 2020/21. Further details on overall spend on contribution-based benefits can be found on the government's website[100].

The committee may also be interested to note that between 2001 and 2014, the replacement rate provided from benefits for UK couple families with two children rose from 64 to 72 per cent of average earnings. In 2014, the UK replacement rate provided by benefits for couples with two children was higher than the EU average, at 72 to 57 per

[100] http://www.gov.uk/government/statistics/benefit-expenditure-and-caseload-tables-2016

cent. Further details on net replacement rates across the EU can be found on the European Commission's website[101].

With these clarifications, the Committee once again requests the Government to explain whether by following "the traditional Beveridge approach" in determining the flat rate amounts of the contribution-based social insurance benefits, the Government takes into account their role in preventing in-work poverty.

Flat-rate contribution-based benefits, such as Jobseekers Allowance and Employment and Support Allowance, are out-of-work income replacement benefits and as such do not have a bearing on the question of in-work poverty.

Instead, the committee should note that the main rates of Jobseekers Allowance and Employment and Support Allowance provide a basic standard of living to those who are not in work at a level that does not disincentivise moving into work or back into work when the opportunity arises or their health permits.

Furthermore, the government is taking additional steps to incentivise and support people into work. This includes measures such as the introduction of the national living wage, which increases the minimum level of pay per hour for those aged 25 or over; the increases to the personal allowance in income tax which has ensured workers keep more of what they earn; and our reforms to childcare including doubling the hours of free childcare available for working parents of three- and four-year olds from 15 to 30 hours and the introduction of tax-free childcare.

In order to be able to maintain this conclusion, the Committee would like the Government to furnish in its next report comparative statistics of coverage and calculations of the level of contribution-based and income-based ESA and JSA in accordance with the rules established by Articles 66 and 67 of the Code. Please provide the same calculations for SSP.

The rates of contributory ESA and JSA are the same as the income based rates of ESA and JSA respectively.

Calculations for the coverage of contribution based ESA and JSA are provided in part III and part IV respectively in the above. Income based JSA and ESA provide for those who do not have enough national insurance contributions to claim contribution-based benefits and can also top up them in certain circumstances. Income-based JSA is available to those who are: over the age of 18, under the State Pension age, not in full time education, available for work, actively seeking for work and working on average less than 16 hours per week. Income-based ESA is available to those who passed a Work Capability Assessment, full information regarding this process is provided under part III in the above.

Out of 898,000 JSA claims in 2014/2015; 111,000 were contribution only, 11,000 contributory and income-based and 723,000 income-based only. Out of 2.24 million ESA claims in 2014/2015; 507,000 were contributory only, 248.000 contributory and income-based and 1.34 million income-based only[102]. As income-based benefits are means tested it is not possible to calculate the coverage in the same way as for contribution based

[101] http://ec.europa.eu/economy_finance/db_indicators/tab/
[102] http://www.gov.uk/government/statistics/benefit-expenditure-and-caseload-tables-2016

benefits. The Government is committed to retaining the contributory principle as far as National Insurance Contribution based social security benefits are concerned. The UK's obligation under the accepted Parts of the Code should continue to be met in this way for the foreseeable future with income-based benefits falling outside the scope of the Code as they are not a form of social security.

The calculations for SSP can be found under part III of the above.

APPENDIX D

23rd BIENNIAL REPORT ON UNRATIFIED PARTS OF THE EUROPEAN CODE OF SOCIAL SECURITY made by the UNITED KINGDOM

to the Council of Europe at Strasbourg for the period 1 July 2014 to 30 June 2016

The United Kingdom has not ratified Parts VI, VIII, IX and X

United Kingdom

Separate, but corresponding, schemes of Social Security operate in Great Britain and Northern Ireland. Reciprocal arrangements between the two ensure that the schemes effectively operate as a single system. The law governing Social Security in Great Britain was amended during the reference period by the measures listed below. Corresponding legislation came into effect in Northern Ireland as listed after the GB measures. Benefit levels are maintained in parity with Great Britain and all rates quoted therefore apply equally.

Copies of the original text of Acts, Regulations and Orders can be viewed at the Government's website[103]. Statutory Instruments (SIs) and Statutory Rules (SRs) can be traced by their year of publication and SI/SR Number quoted below. 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[104]. 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 Communities website[105].

[103] http://www.opsi.gov.uk/legislation/index.htm
[104] http://www.dwp.gov.uk/publications/specialist-guides/law-volumes/the-law-relating-to-social-security/
[105] https://www.communities-ni.gov.uk/services/law-relating-social-security

PART VI EMPLOYMENT INJURY BENEFIT

I The position remains as previously described. The United Kingdom (UK) is unable to accept Part VI of the Code because UK law and practice are not compatible with the requirements of Article 34 2(b) and (e). These exceptions apart, the requirements of Part VI are met by the provisions in the UK scheme which ensure that all employed workers ('employed earners') are compulsorily protected against employment injury and disease.

II Laws and Regulations introduced during the reporting period

2015

The Social Security (Industrial Injuries) (Prescribed Diseases) Amendment Regulations 2015 (SI 2015 No 87, NI Equivalent SR 2015 No 52)
http://www.legislation.gov.uk/uksi/2015/87/pdfs/uksi_20150087_en.pdf

The Mesothelioma Lump Sum Payments (Conditions and Amounts) (Amendment) Regulations 2015 (SI 2015 No 500, NI Equivalent SR 2015 No 65)
http://www.legislation.gov.uk/uksi/2015/500/contents/made

The Pneumoconiosis etc. Workers' Compensation) (Payment of Claims) (Amendment) Regulations 2015 (SI 2015 No 503, NI Equivalent SR 2015 No 64)
http://www.legislation.gov.uk/uksi/2015/503/contents/made

2016

The Social Security (Claims and Payments) Amendment Regulations 2016 (SI 2016 No 544)
(equivalent regulations are due to be introduced in Northern Ireland in Summer 2016 to support the development of online claims)
http://www.legislation.gov.uk/uksi/2016/544/contents/made

1. Scope

All employees are protected.

2. Conditions for entitlement to benefit

Disability benefits

No change

3. Level of benefits

Examples of weekly rates of Disablement Benefit, and associated increases payable during the period under consideration are shown below:

Disablement Benefit

From April (£GB)	2014/15	2015/16	2016/17
Disablement 100%	166.00	168.00	168.00
Disablement 20%	33.20	33.60	33.60
Reduced Earnings Allowance* (maximum rate)	66.40	67.20	67.20
Retirement Allowance	16.60	16.80	16.80
Constant Attendance Allowance (maximum)	132.80	134.40	134.40
Exceptionally Severe Disablement Allowance	66.40	67.20	67.20

*Reduced Earnings Allowance is not payable in respect of accidents or diseases arising on or after 1 October 1990.

a) No change The levels of benefit for incapacity to work, total loss of earnings capacity (or corresponding lack of faculty) and survivors continue to meet the standards in the Schedule to Part XI of the Code.

b) No change No account is taken of other resources of the beneficiary and his family, but provisions exist to prevent the duplication of state benefits in certain circumstances.

c) Minor change Benefits are uprated annually in line with inflation.

4. Miscellaneous

a) No change

b) No change Industrial injuries benefits are financed from general taxation and are non-contributory.

c) No Change Department for Work and Pensions (DWP) has overall responsibility.

d) Copies of the new regulations are published (see Part II).

III

a) No change None.

b) No change The position remains unchanged. Prescription charges and the costs of dental treatment are borne by recipients of industrial injuries benefits on the same basis as they are borne by people receiving other state benefits. This is at variance with the requirement of Article 34 that persons suffering employment related injury should not contribute to their cost of medical care.

c) No change The Government has no plans to introduce exemption from such measures; to extend ratification to cover Part VI of the Code; or to ratify the Revised Code.

PART VIII MATERNITY BENEFIT

I Laws and regulations do exist to provide benefit cover for pregnancy. Protection is provided under a compulsory scheme, in addition employers may operate a contractual maternity pay scheme.

II Laws and Regulations introduced during the reporting period

The Shared Parental Leave Regulations 2015 SI No 3050
http://www.legislation.gov.uk/uksi/2014/3050/contents/made

The National Insurance Contributions Act 2015
http://www.legislation.gov.uk/ukpga/2015/5/contents

1. Scope

All pregnant working women earning on average at least £30 or more aweek are eligible for maternity benefits.

2. Conditions of Entitlement to benefit

3. Levels of benefit

State MA

a) Rates during the reporting period are as follows (£):

	2013/14	2014/15	2015/16
MA (Standard Rate)	£136.78	£138.18	£139.58

Note: The rate of MA is based on a woman's average weekly earnings. MA is paid at the lower of a standard rate or 90% of the woman's average earnings.

SMP

SMP is earnings related for the first six weeks and set at 90% of average weekly earnings with no upper limit.

Week 7 onwards	2013/14	2014/15	2015/16
Standard weekly rate	£136.78	£138.18	£139.58

b) Other resources are not taken into account.

c) Levels of benefit are reviewed annually as part of the uprating process.

4. Miscellaneous

a) **MA**
MA is financed from employer and employee contributions to the National Insurance Fund.

SMP
No change

b) No change

c) No change

d) Copies of the new regulations are published (see Part II).

III

The Shared Parental Pay (General) Regulations (SI 2014/3050) and the Shared Parental Leave Regulations (SI 2014/3051) came into force on 1 December 2014 for babies whose expected week of birth begins on or after 5 April 2015 and those children placed for adoption on or after 5 April 2015. The regulations implement the scheme provided for by Part 7 of the Children and Families Act 2014.

Employees (mothers, fathers, partners and adopters) may be able to receive Shared Parental Leave and Statutory Shared Parental Pay if they have had a baby or adopted a child.

The Maternity Allowance (Curtailment) Regulations 2014 and the Statutory Maternity Pay and Statutory Adoption Pay (Curtailment) Regulations 2014 also came into force on 1 December 2014 as part of the Shared Parental Leave and Pay scheme. They enable a mother or primary adopter to end their entitlement to MA, SMP or Statutory Adoption Pay early in order to opt into the Shared Parental Leave and Pay.

The National Insurance Contributions Act 2015, made amendments to sections 35A and 35B of the Social Security Contributions and Benefits Act 1992, which relate to MA, to reflect changes to the way that Class 2 National Insurance Contributions (NICs) are assessed and collected as of 6 April 2015. Class 2 NICs are relevant in determining the rate of MA paid to self-employed women and in determining whether women who assist in the business of their self-employed spouse or civil partner are eligible for MA. The changes to the Social Security Contributions and Benefits Act 1992 were made in order to maintain access to MA for these groups following changes to the way liability for Class 2 NICs is assessed and the payments are collected.

The Social Security (Maternity Allowance) (Earnings) (Amendment) Regulations 2015 came into force on 6 April 2015. The changes affect women with an expected week of confinement beginning on or after 12 July 2015. The purpose of these regulations (alongside amendments to the provisions in the Social Security Contributions and Benefits Act 1992 mentioned above) is to safeguard the position of self-employed women who, in consequence of the reforms to assessment and collection of Class 2 NICs might otherwise have been unable to access to MA.

The UK has made considerable improvements to the scope and level of maternity benefits over the past few years, extending coverage to as many working women as is considered possible. This is of particular importance for working women on low pay, with earnings below the Lower Earnings Limit and, therefore, unable to qualify for SMP. The UK's maternity benefits provisions cover more or less all gainfully occupied working women, including part-time and low earning women, as all women earning £30 a week or more are covered.

In the past, before the improvements were introduced, protection tended to be weighted in favour of the higher earning woman. Consequently, as the benefit is now related directly to the woman's past earnings, and not to the average wage of a standard beneficiary, it is difficult to conclude that all recipients of the benefit would receive an amount that would be compliant with the replacement level suggested by the Code.

PART IX INVALIDITY BENEFIT

I Protection is provided under a compulsory insurance scheme.

II Laws and Regulations introduced during the reporting period

Welfare Reform and Work Act 2016
http://www.legislation.gov.uk/ukpga/2016/7/contents/enacted

1. Scope

The position on scope of persons covered remains as previously described.

2. Conditions for entitlement to benefit

As the UK's previous Report explained, the contingencies of Part III and IX of the Code are now covered by Employment and Support Allowance (ESA). ESA replaced Incapacity Benefit (IB) and Income Support (IS), paid on grounds of incapacity, for new claimants from 27 October 2008. All existing IB and IS claims are to be reassessed for ESA.

Following the introduction of Universal Credit (UC), ESA Regulations 2013 replaced the ESA Regulations 2008, effectively removing all references to income-related ESA, and re-introducing ESA as a contributory benefit only.

Once UC is fully introduced, income-related ESA will be absorbed into UC and ESA will exist separately as a contributory benefit only.

Employment and Support Allowance (ESA(C)) - update

Incapacity Benefit Reassessment

The Department for Work and Pensions (DWP) is continuing the reassessment of Incapacity Benefit claimants to identify eligibility for Employment and Support Allowance or fitness for work.

Reassessment of existing incapacity benefits claimants started nationally in April 2011 and it is now expected that more than 1.5 million people will go through the reassessment process. Therefore this exercise will take longer to complete than originally forecast.

Work Capability Assessment

The Government remains committed to continuously improving the Work Capability Assessment (WCA) to ensure that it is as fair and accurate as possible. As part of this process, the Government has a statutory commitment to independently review the WCA annually for the first five years of its operation.

Employment and Support Allowance (ESA) claimants must have limited capability for work or limited capability for work-related activity as a result of the functional impact of their health condition or disability.

This is usually determined initially by a medical certificate supplied by the claimant's doctor, a questionnaire filled in by the claimant and a face-to-face assessment conducted

by a healthcare professional contracted by the Government. A DWP Decision Maker makes the final decision on benefit entitlement.

The WCA is a functional assessment which looks at what people can do, as well as what they cannot, to identify people for the correct benefit and give them the support they need to get back to work and avoid ending up on long-term sickness benefits. This approach is based on the principle that a health condition or disability should not automatically be regarded as a barrier to work. There is strong evidence that work is good for physical and mental well-being, and that being out of work can contribute to poorer health and other negative outcomes.

Dr Paul Litchfield was appointed on 26th February 2013 to carry out the fourth and fifth independent reviews of the WCA, following three previous independent reviews carried out by Professor Malcolm Harrington. Dr Litchfield is Chief Medical Officer and Director of Health, Safety and Wellbeing for BT, a Fellow of the Royal College of Physicians and the Faculty of Occupational Medicine. Dr Litchfield's fourth Independent Review of the Work Capability Assessment[106] was published In December 2013.

This fourth Independent Review made 32 recommendations to the DWP to improve the WCA, and 5 further recommendations to the Department for Communities in Northern Ireland. The recommendations focused predominantly on: the effectiveness of the WCA; simplifying the process; improving decision-making; and mental health.

The Government's response was published on 27 March 2014[107] - in this the Government accepts, or accepts with certain caveats, all but one of the thirty two recommendations falling within the scope of DWP.

The fifth, and final, review was published in November 2014[108].
Dr Litchfield made 28 recommendations that fall within the scope of DWP. These relate to a range of issues including:

- An increase in the number of people being placed in the Support Group, especially younger people
- The need to ensure that communications are as good as they can be, especially for more vulnerable claimants
- Better support for claimants with learning disabilities.

The Government responded[109] to the fifth Independent Review in February 2015 and accepted all but two of the 28 recommendations that fell within the scope of DWP.

The Government is committed to continuously improving the assessment process and want to ensure that the assessment is as fair and accurate as it possibly can be. Dr Litchfield's recommendations allow us to build on improvements already made to the assessment to help further achieve this aim.

[106] https://www.gov.uk/government/publications/work-capability-assessment-independent-review-year-4
[107] https://www.gov.uk/government/publications/government-response-to-the-work-capability-assessment-independent-review-year-4
[108] https://www.gov.uk/government/publications/work-capability-assessment-independent-review-year-5
[109] https://www.gov.uk/government/publications/government-response-to-the-work-capability-assessment-independent-review-year-5

Employment and Support Allowance Pilots

The Government is testing different approaches to supporting Employment and Support Allowance claimants in the Work Related Activity Group (WRAG) with a prognosis of 18 months or more, to move closer to the labour market, to help the Department to understand what works for this claimant group.

The pilots will test the following three variants:

- Health Care Professional (HCP) – work and health related focus;
- Enhanced Jobcentre (JCP) Support – increased employment focus; and
- Work Programme (WP) – flexible support model, determined by the provider.

The pilots will run from 25 November 2013 to 26 August 2016. Claimants will spend two years on the pilot following recruitment.

The overarching intent of the pilots is to test whether an increase in health and work related support for ESA WRAG claimants, with a prognosis of 18 months or more, can deliver better outcomes than the WP and the standard Jobcentre support. Success will be measured through improvements in health and/or perception of individual's health and off flows into employment.

The evaluation will measure the outcomes of all three pilots. Evaluation methods will include qualitative and quantitative survey research with claimants, suppliers and JCP staff. This research will gather evidence on a wide range of topics including details of the support received, delivery challenges, claimant's perceptions of their health conditions and perceptions of readiness to work.

3. Level of benefit

a) Both ESA and Long-term Incapacity Benefit are flat-rate benefits. Rates payable during the period under consideration are shown below:

Amounts in £GB	**2012/13**	**2013/14**	**2014/15**	**2015/2016**	**2016/2017**
Long-term Incapacity Benefit (basic amount)	£99.15	£101.35	£104.10	105.35	105.35
Increase of Long-term Incapacity Benefit for age					
Higher rate	11.70	10.70	11.00	11.15	11.15
Lower rate	5.90	6.00	6.15	6.20	6.20
Invalidity Allowance (Transitional)					
Higher rate	11.70	10.70	11.00	11.15	11.15
Lower rate	5.90	6.00	6.15	6.20	6.20
Employment and Support Allowance					
Personal allowance under 25	56.25	56.80	57.35	57.90	57.90
Personal allowance 25 and over	71.00	85.80	86.65	73.10	73.10
Premiums					
Enhanced disability	14.80	15.15	15.55	£15.75	£15.75
Severe disability	58.20	59.50	61.10	61.85	61.85
Components					
Work related activity	28.15	28.45	28.75	£29.05	£29.05
Support	34.05	34.80	35.75	£36.20	£36.20

(b) to (c) – No change

4. Miscellaneous

a) Repeat Assessment and Pending Appeal Awards (Amendment) Regs 2015. These new measures effect repeat ESA claims and pending appeal awards from **30 March 2015** where the claimant has been found fit for work following a WCA.

The new provisions are designed to prevent people receiving repeat awards of ESA with the same medical condition, where there has been no significant deterioration of that condition. This does not prevent someone whose condition has significantly worsened or who has developed a new condition from making another claim and being entitled to ESA.

ESA payments pending appeal will not be made, where following a fit for work decision on a previous claim, a repeat claim is made and the WCA confirms that the claimant is fit for work once more. This applies just to repeat claims where the claimant was previously found fit for work and payments pending appeal will continue for new claims. These measures are designed to ensure that claimants receive the help and support they need to return to work from Jobseekers Allowance rather than looping around the ESA system without that support.

b) No change

c) No change

d) Copies if the new regulations are published (see part II).

III

The Welfare Reform Act, 2012 introduced a 52 week time limitation to entitlement to contributory Employment Support Allowance (ESA) for those in the Work Related Activity Group. This change had immediate effect, from 30 April 2012 for people currently claiming contributory ESA as well as for those making new claims.

People in the Support Group will not have their benefit time limited because they have the most severe health conditions or impairments and are the least likely to move into work.

People receiving income-related ESA (whether in the Work Related Activity group or the Support group) will not have their benefit time limited.

People moving off contributory ESA as a result of the time limit will be able to apply for income-related ESA, if they are eligible.

The Government would point out that the time limitation on claims for contributory ESA, for those in the Work Related Activity Group, is not compatible with the requirement of Article 58 of the Code for the benefit to be granted throughout the contingency, or until an old age benefit becomes payable. This is an additional reason as to why the UK cannot accept to be bound by the provisions of Part IX of the Code. The Government has no plans to extend ratification to cover Part IX in future.

PART X SURVIVOR'S BENEFIT

Parts I & II Apart from annual increases in the rates of the respective benefits there has been no change to the position as described in previous Reports.

- The current Bereavement benefit caseload is about 67,000.
- The current amount of the award for Bereavement Payment is £GB 2,000
- The average award for Bereavement Allowance (not age related) is £GB 102
- The average award for Bereavement Allowance (age related) is £GB 73
- The average award for Widowed Parent's Allowance (with dependents) is £GB 111
- The average award for Widowed Parent's Allowance (without dependents) is £GB 76

III

The position remains as previously described, the UK is in the unusual position of having accepted the corresponding Part X of ILO Convention No 102, which it ratified in April 1954, but not having accepted Part X of the Code, which it subsequently ratified in January 1968. The difference in approach stemmed from the reform of UK widow's benefit provision in 1965 with the introduction of the new Widow's Mother's Allowance and Widow's Pension, with revised qualifying contribution conditions. As a result of the change in the qualifying contribution conditions the UK could no longer guarantee that in all cases benefit would be payable where the deceased has five reckonable years of insurance (contributions). The UK has not denounced Part X of ILO Convention No. 102 and continues to include information on it in its Article 22 Reports, whilst acknowledging that because of this technicality we cannot guarantee payment of benefit in all cases, as is required by the Convention.

A copy of the extract from the UK's 2016 Article 22 Report to the ILO in respect of Part X Survivor's Benefits is set out in **Annex A** below for information.

Bereavement Support Payment

As part of the UK's welfare reform, a new Bereavement Support Payment is planned to replace the existing suite of Bereavement benefits from April 2017.

The aim of Bereavement Support Payment is to focus the payment on the period immediately following bereavement and to provide fast direct help to meet the immediate financial needs caused by bereavement for those of working age.

Bereavement Support Payment will remain a contributory benefit but the contribution condition has been simplified making it easier to administer and for claimants to understand. The condition will be that the deceased will have had to have paid Class 1 or 2 contributions the equivalent of 25 times the Lower Earnings Limit in any one tax year in their working life.

The age of the surviving spouse/civil partner will no longer be a barrier to receiving additional support as those now under age 45 will be eligible to claim and the upper age limit will align to the state pension age.

The Government's view is that there needs to be a balance between providing appropriate support at a critical time and encouraging people of working age to support themselves and their families, through employment.

The Government therefore proposes to concentrate support on the period immediately after bereavement, by paying an initial lump sum payment followed by monthly installments for a period up to 12 months.

Bereavement Support Payment is a recognition that bereaved spouses/civil partners with dependent children have additional financial needs following bereavement. Widowed parents in receipt of Child Benefit will therefore receive a higher amount.

Continuing income replacement will be provided by other benefits in the welfare system. This will ensure that those less well off will be better off with Bereavement Support Payment than those who are in receipt of the current bereavement benefits.

Bereavement Support Payment unlike the current bereavement benefits will be disregarded from other income related welfare benefits, such as the new Universal Credit, since the payment is designed to help the bereaved with the additional costs of bereavement.

Receipt of the Bereavement Support Payment will not affect access to contributory Jobseeker's Allowance or Employment and Support Allowance, so that bereaved spouses and civil partners can access tailored employment support at the appropriate time.

Bereavement Support Payment unlike the current bereavement benefits will not be taxable.

It is acknowledged that the period of readjustment varies for each individual and this is why bereaved claimants on Universal Credit will not be subject to conditionality for 6 months and that after that period it will be tailored to the individual's circumstances.

Payments made under the War Pensions Scheme or Armed Forces Compensation Scheme will not be affected; neither will it impact those already in receipt of bereavement benefits at the point at which a new scheme is introduced.

Although the simplification of the qualifying contribution conditions might go some way to alleviating the current incompatibility with Part X of both the Code and ILO Convention No 102, the proposed changes, once implemented, would of course raise questions as to compatibility with the requirements of Article 62 and 64 of the Code as far as periodical payments throughout the contingency are concerned.

ANNEX A

Part X UK 2016 Article 22 Report on ILO Convention No 102 Social Security (Minimum Standards) – Extract

PART X SURVIVORS BENEFIT

The position remains as previously described.

The provisions relating to Bereavement Benefits are to be found in Part II of the Social Security Contributions and Benefits Act 1992[110] as follows:

- **Bereavement Payment**: section 36. See also Schedule 3 para 4 for the contribution conditions;

- **Widowed Mother's Allowance and Widow's Pension**: See sections 36A to 39, which apply only to cases where the death occurred before 9 April 2001;

- **Widowed Parent's Allowance and Bereavement Allowance**: sections 39A to 39C, for deaths occurring on or after 9 April 2001. The contribution conditions are detailed in para 5 of Schedule 3.

Article 61

Question C (ii)

TITLE II (Article 76)

A. Number of economically active persons protected -

i.	Under general scheme	30,527, 000 (including Northern Ireland)[a]
ii.	Under special schemes	nil
	TOTAL	30,527,000

B. Total number of residents 65,110,000[b]

Sources: (A) Contributions and Qualifying Years – persons paying Class 1 and or Class 2 National Insurance Contributions 2014/15; and
(B) ONS Population estimates for mid year 2015 - United Kingdom.

C. Percentage A/B 46.89%

Article 62

Question A (ii)

TITLE I (Article 66)

[110] http://www.dwp.gov.uk/docs/a2-2501.pdf

B. £371.70

TITLE IV (Article 66) (2015/16 rates)

C. £112.55

D. £151.90

E. £151.90

F. 50.51%

The weekly rate of widow's benefit at C is £112.55 basic Widowed Parent's Allowance.

D and E (where applicable) comprise £20.70Child Benefit for the eldest qualifying child, £13.70 for the second qualifying and Child Tax Credit of £117.50 in respect of both children. From April 2003 Child Tax Credits replaced Child Dependency Increases payable with State Pension.

TITLE V (Article 66)

C. £112.55
F. 31%

Question C

TITLE VI (Article 65)

Period under review (closest published figures)	Cost of living index (RPI) (*)	Index of earnings (**)
A. March 2011	100	100
B. March 2015	112.6	107.5
C. A/B per cent	88.8%	93.0%

(*) Retail Price Index (RPI) All items
(**) Annual Survey of Hours and Earnings
Over the period of the report, weekly rates of bereavement benefits changed as follows:-

Table 1

	April 2011	April 2015*	Increase %
Widowed Mothers/Parent's Allowance	100.7	112.55	11.8
Widow's Pension	100.7	112.55	11.8

* 2015/16 rates

Average amounts of benefits in payment at the beginning of the reporting period and latest available figures are set out in Tables 2 and 3 below.

Table 2

Widow's Benefits Average Weekly amount of benefit by age of claimant

	Age of claimant										
	Total	**Unknown age**	**18-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**
	Average weekly amount of benefit	**Average weekly amount of benefit**	**Average weekly amount of benefit**	**Average weekly amount of benefit**	**Average weekly amount of benefit**	**Average weekly amount of benefit**	**Average weekly amount of benefit**	**Average weekly amount of benefit**	**Average weekly amount of benefit**	**Average weekly amount of benefit**	**Average weekly amount of benefit**
Type of WA	83.15	.	.	.	.	109.03	130.56	83.07	77.85	86.75	81.28
Total											
WP not age related	136.12	.	.	.	.	.	.	.	.	147.82	131.06
WP age related	74.94	.	.	.	.	.	.	52.54	69.53	80.47	73.65
WMA with dependants	145.85	.	.	.	.	112.09	132.58	140.99	154.81	156.01	141.05
WMA without dependants	60.69	.	.	.	.	.	92.90	66.45	55.77	51.33	.
Unknown	.	.	.	.	.	.	.	.	.	.	.

Table 3

Bereavement Benefits Average Weekly amount of benefit by age of claimant

	Age of claimant										
	Total	**Unknown age**	**18-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**
	Average weekly amount of benefit	**Average weekly amount of benefit**	**Average weekly amount of benefit**	**Average weekly amount of benefit**	**Average weekly amount of benefit**	**Average weekly amount of benefit**	**Average weekly amount of benefit**	**Average weekly amount of benefit**	**Average weekly amount of benefit**	**Average weekly amount of benefit**	**Average weekly amount of benefit**
Type of BA	104.32	.	102.05	102.01	101.50	103.15	107.92	103.03	103.08	106.92	102.42
Total											

	Age of claimant										
	Total	Unknown age	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64
	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit	Average weekly amount of benefit
BA not age related	102.04	.	.	.	.	.	.	.	.	103.01	101.13
BA age related	72.74	.	.	.	.	.	.	45.53	79.50	95.37	.
WPA with dependants	110.63	.	100.70	102.06	101.54	103.23	107.98	111.63	114.45	116.13	113.28
WPA without dependants	76.05	.	.	.	91.46	76.16	66.34	83.93	69.84	67.88	.
Unknown	.	.	.	.	.	.	.	.	.	.	.

DEFINITIONS AND CONVENTIONS: *"-" Nil or Negligible; "." Not applicable; Caseload figures are rounded to the nearest ten; Some additional disclosure control has also been applied. Average amounts are shown as pounds per week and rounded to the nearest penny. Totals may not sum due to rounding.*
SOURCE: *DWP , Data and Analytics, Technology - Work and Pensions Longitudinal Study.*
STATE PENSION AGE: *The age at which men and women reach State Pension age is gradually increasing. Under current legislation, State Pension age for women will equalise with State Pension age for men at 65 in 2018. Both men's and women's State Pension age will increase from 65 to 66 between December 2018 and October 2020. The Pensions Bill 2013-14 contains provision for a State Pension age of 67 to be reached by 2028. For more information see https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207966/espa.pdf.*
Notes:
Average weekly amount of benefit *The amount of Bereavement Allowance (BA) is affected by the introduction in April 2003 of Child Tax Credit. From that date there were no new child dependency increases (CDIs) awarded to BA claimants, although existing CDIs were transitionally protected.*
Type of BA *The category 'WPA with dependants' will include clients getting paid at the personal rate only due to the introduction of Child Tax Credits in April 2003. To obtain figures for those who still receive Child Dependency Increases, under the transitional protection arrangements, use the 'type of dependant' option.*

ANNEX B

Summary of UK issues of incompatibility

Part VI – Employment Injury Benefit

Cost sharing in medical care (as is provided for in Part II Health Care, Article 10, para 2) is not permitted under Part VI, Article 34, para 2. The UK does comply with Article 34, para 2(a) in respect of free GP service, inpatient and outpatient care and home visits, but does not comply with Article 34, para 2(b) and (e) – in respect of cost-sharing for dental care and pharmaceutical and other medical supplies, for which charges may be made.

Part VIII – Maternity Benefit

The UK's maternity benefits provisions cover more or less all gainfully occupied working women, including part-time and low earning women. Maternity Allowance is a system designed to replace former earnings and is not based on an arbitrary level of benefit. Whilst in a high proportion of cases the level of MA paid would reach or exceed that of the standard beneficiary, in many other cases, such as where the previous work was part time, the level of previous wages being replaced, and thus the amount of MA paid could be well below that of the standard beneficiary. In fact the minimum rate of MA could be factored as a percentage of weekly earnings of as little as £30 a week. Consequently it would not be possible, in regard to MA, to guarantee compliance with the Code in this respect.

Part IX – Invalidity Benefit

Historically, the UK's approach has been incompatible with the Article 58 requirement to provide invalidity benefit until the end of the contingency, or until it is replaced by old-age benefit. The contribution conditions for entitlement to invalidity benefit can be satisfied with in a relatively short space of time, i.e. three tax years or so. There could be no guarantee that a person who satisfied the qualifying contribution conditions for invalidity benefit would have worked for a sufficient length of time in the UK to have established a long enough record to establish entitlement to State Retirement Pension. Incapacity Benefit and laterly Employment and Support Allowance are not generally payable beyond a person's state pension age.

Part X – Survivors' Benefit

By way of historical background, the UK accepted Part X on Survivors Benefits when ratifying the ILO Convention No. 102 in 1954, but did not accept to be bound by the corresponding Part X of the Code, which we subsequently ratified in 1968. The difference in approach was a consequence of changes introduced to our Widow's Benefits scheme by the National Insurance Act of 1965.

The UK remains bound by Part X of Convention 102 and the protection offered to the standard beneficiary is above the minimum 40% replacement level required. However, the UK is technically in breach of its obligations, in that we are not in a position to guarantee that the survivors of all workers who have five reckonable years of insurance (contributions) would be protected. This involves workers with a working life of 21 years or more.

More recently, as part of the UK's welfare reform, a new Bereavement Support Payment will replace the existing suite of Bereavement benefits from April 2017. The Government proposes to concentrate support in the 12 month period immediately following bereavement, by making an initial lump sum payment followed by a short period of monthly installments. Such instalments are not likely to be considered to be 'periodical payments' for the purposes of Article 62 of the Code and is therefore likely to be a further obstacle to the UK extending acceptance to this Part of the Code.