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EUROPEAN SOCIAL CHARTER OF 1961

32nd National Report on the implementation of the European Social Charter submitted by

THE GOVERNMENT OF UNITED KINGDOM

(Articles 3, 11, 12, 13 and 14
01/01/2008 – 31/12/2011)

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COUNCIL OF EUROPE

THE EUROPEAN SOCIAL CHARTER

THE UNITED KINGDOM'S THIRTY-SECOND REPORT

NOVEMBER 2012
REVISED OCTOBER 2013

Article 3 – The right to safe and healthy working conditions

Article 3, Paragraph 1

United Kingdom

The general legal framework

1. The position remains generally as previously described. The Health and Safety at Work etc. Act (HSWA) 1974, 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. An up-to-date consolidated version of the Act and Order can be viewed at the Ministry of Justice UK Statute Law Database via the following link:- http://www.statutelaw.gov.uk/. They are listed under the category of UK (Public Act General) as Chapter No. 37 of 1974, and Northern Ireland Statutory Instrument 1978: No. 1039 (N.I. 9) respectively.

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

Great Britain

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

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

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

- Railway safety – Office of Rail Regulation;
- Marine safety – Maritime and Coastguard Agency;
- Aviation safety – Civil Aviation Authority; and
- Nuclear safety - Office of Nuclear Regulation (currently operating as an Agency of the HSE, but becoming a fully independent regulator in 2014).

6. The UK also implements health and safety legislation based on European directives and/or regulations. A key element is the health and safety

Framework directive, primarily implemented in Britain by the Management of Health and Safety at Work Regulations 1999, which established broadly based obligations for employers to evaluate, avoid and reduce workplace risks etc. A range of related and other directives, implemented through national regulations cover:

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

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

Health and Safety Executive

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

9. The GB national occupational safety and health (OSH) policy is outlined in HSE's "The Health and Safety of Great Britain: Be part of the solution"[1]

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

11. Nuclear safety is now dealt with by the Office for Nuclear Regulation (ONR), which was formed on 1 April 2011, as an Agency of the Health and Safety Executive (HSE). In February 2011, a written Ministerial statement announced the UK Government's intention to bring forward legislation to create a new statutory body outside of the HSE to regulate the nuclear power industry. ONR brings together the safety and security functions of HSE's former Nuclear Directorate, including Civil Nuclear Security and the UK Safeguards Office, along with radioactive materials transport. It is intended

that ONR will become a single, integrated regulator, independent of HSE and HSENI.

12. HSENI sets out its strategy for implementing the legal framework in Northern Ireland in its successive Corporate Plans. Its current plan covers the four year period 2011 to 2015. 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.

In its Conclusions 2009 on the UK's 28th Social Charter Report, the Committee referred to the position of domestic workers and asked, having also regard to the Siliadin v. France judgement of the European Court of Human Rights, whether any supervision of this category of workers by the public authorities is foreseen.

12. Domestic servants employed in private households are not covered by UK health and safety law and other related legislation, whilst other domestic workers (such as health or social care workers) are covered. The domestic work sector is not seen as a priority for UK health & safety regulators, who prioritise their resources on those sectors that give rise to the greatest risks to workers and the public, so no active program of interventions is therefore proposed for this employment sector.

The Committee also asked that the next report from the UK contain figures on occupational diseases.

13. Detailed statistics on occupational diseases are published on HSE's website, along with the preferred data sources for the most common work related conditions[1] . Northern Ireland statistics on occupational diseases are included in the Table on page 7.

The Committee also asked for the data that HSE uses to assess the effectiveness of HSE's visits; and whether the slight decrease in overall numbers of staff working for HSE, had affected the number of inspectors, and whether this trend will continue in the coming years.

14. These two questions are best answered by referring the Committee to HSE's Annual Report and Accounts for 2011/12, etc., which are published on the HSE website[2]. These Annual Reports set out how HSE measures its performance against the targets set for it by Government, and in its own Strategy and Delivery Plans. This includes, for example, feedback on HSE's progress against its 2011/12 Delivery Plan (page 10 refers); its financial review (page 25 refers); data on staff numbers, including frontline staffing levels (page 29/30 refers); etc. The Report therefore sets out how HSE measures it effectiveness, and how it is managing staffing levels and other resources, in the context of its current funding levels.

[1] http://www.hse.gov.uk/statistics/causdis/index.htm
[2] http://www.hse.gov.uk/aboutus/reports/index.htm

Article 3, Paragraph 2

Great Britain

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

Accident Statistics:

	2007/08	2008/09	2009/10	2010/11	2011/12(p)
Number of accidents at work, to employees:					
Reported under RIDDOR 95 [4]	138431 Rate of 545.6 per 100,000 employees	133282 Rate of 522.6 per 100,000 employees	122799 Rate of 490.4 per 100,000 employees	115379(p) Rate(p) of 462.1 per 100,000 employees	N/a[6]
Annual estimate - LFS[5]	299000 Rate of 1,050 per 100,000 workers	246000 Rate of 870 per 100,000 workers	231000 Rate of 830 per 100,000 workers	200000 Rate of 710 per 100,000 workers	N/a
Number of fatal accidents, to workers	233 Rate of 0.8 per 100,000 workers	179 Rate of 0.6 per 100,000 workers	147 Rate of 0.5 per 100,000 workers	175 Rate of 0.6 per 100,000 workers	173 Rate of 0.6 per 100,000 workers

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

[5] 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.

(p) Provisional

[6] Provisional non-fatal injury and enforcement statistics for 2011/12, and finalised non-fatal injury and enforcement statistics for 2010/11, will be available in October 2012 following the publication of Health and Safety Statistics. These cannot be released earlier because of National Statistics guidelines. Such access is carefully controlled. Release into the public domain or any public comment on these statistics prior to official publication would undermine the integrity of official statistics. Fatal injury statistics were published in July 2012, therefore provisional fatal injury statistics for 2011/12 are provided.

Enforcement Statistics:

	2007/08	2008/09	2009/10	2010/11(p)	2011/12(p)
Health and safety enforcement notices issued by HSE [6]	7758	8077	9727	11020	N/a
Health and safety enforcement notices issued by LAs	6010	6340	6110	7270	N/a

	2007/08	2008/09	2009/10	2010/11(p)	2011/12(p)
Prosecutions taken by HSE[7]	567 cases (545 convictions) 96% conviction rate	580 cases (535 convictions) 92% conviction rate	505 cases (473 convictions) 94% conviction rate	551 cases (517 convictions) 94% conviction rate	N/a
Prosecutions taken by LAs	155 cases (152 convictions) 98% conviction rate	145 cases (142 convictions) 98% conviction rate	117 cases (114 convictions) 97% conviction rate	129 cases (125 convictions) 97% conviction rate	N/a

23. Statistics on the number of inspection visits that HSE made prior to April 2011 were not collated because they were not required as part of our Public Service Agreement target with Central Government. However, from April 2011, in line with recent health and safety reforms, HSE now records inspection visits[8].

[6] Figures include those notices issued by HSE in 2010/11. Since 1 April 2006 railway safety has been enforced by the Office of Rail Regulation (ORR). Such details are excluded here.
[7] Figures relate to prosecution cases concluded in 2010/11.
[8] http://www.dwp.gov.uk/policy/health-and-safety/

Northern Ireland Statistics:

	2007/08*	2008/09	2009/10	2010/11	2011/12
Number of accidents at work, to employees:		3,134 Rate of 433 per 100,000 employees	3,066 Rate of 401 per 100,000 employees	3,228 Rate of 464 per 100,000 employees	3,119 Rate of 447 per 100,000 employees
Number of fatal accidents, to employees		9 Rate of 1.24 per 100,000 employees	3 Rate of 0.39 per 100,000 employees	4 Rate of 0.6 per 100,000 employees	7 Rate of 1.0 per 100,000 employees
Health and safety enforcement notices issued		382	367	412	285
Prosecutions taken		21	22	17	35
Number of inspections		12,572	15,124	17,306	13,755
Number of occupational diseases		72	51	29	32

* Northern Ireland Statistics for 2007/08 were given in the UK's 28th Report.

Penalties for health and safety offences

24. Section 33 and Schedule 3A of the Health and Safety at Work etc. Act 1974 and Article 31 and Schedule 3A of the Health and Safety at Work (Northern Ireland) Order 1978, set out offences, modes of trial and maximum penalties and include the following:

For most breaches of Sections of the HSW Act and its Northern Ireland equivalent "relevant statutory provisions", failures to comply with enforcement notices or breaches of licence conditions:

Lower court maximum: GB£20,000 and/or 12 months' imprisonment
Higher court maximum: unlimited fine and/or 2 years' imprisonment

On conviction of directors for indictable offences in connection with the management of a company (almost all of the above, by virtue of the HSW Act sections 36 and 37, and Articles 34 and 34A of the Northern Ireland Order), the courts may also make a disqualification order (Company Directors Disqualification Act 1986, sections 1 and 2). The courts have exercised this power following health and safety convictions. Health and safety inspectors draw this power to the court's attention whenever appropriate:

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

Article 3, Paragraph 3

Consultation with employers' and workers' organisations

25. Consultation and involvement takes place through the Board of the 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 on a wide variety of health and safety issues, as well as in the formulation, implementation and review of the national strategy for health and safety at work.

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

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

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 currently being reviewed 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.

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 based within the Department of Infrastructure and is responsible for ensuring compliance with relevant legislation across all sectors of industry and commerce in the Isle of Man. The inspectorate currently comprises of a Chief Inspector, three Inspectors and a Support Officer. In addition to the investigation of incidents and complaints and the pro-active inspection of premises and other work locations, the HSWI deliver education and awareness events and work with Trade Unions, Trade Associations and Professional bodies to review the priority risks and agree strategies to ensure appropriate control measures.

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.

The HSWI Annual Report provides more detail on the work undertaken by Inspectors during the 2010/11 work year. A copy of this report is Annexed below.

Due to significant organisational and personnel changes between 2008 and 2011 the accuracy of available data on reported incidents and the number of investigations undertaken during 2008 and 2009 cannot be verified. These figures have not therefore been included in this report.

The information available for the 2010/11 and 2011/12 work years is more reliable however and summaries are included below.

Isle of Man Population Data

As the accident figures for the 2010/11 year pre-date the most recent Isle of Man census (carried out in April 2011) data from the 2006 census has been used to calculate the 2010/11 Standardised Accident Rate (SAR). Data from the 2011 census has been used to calculate the 2011/12 SAR. A comparison of the two years can be found in Table 3.

Census data	2006	2011
Resident population	80,058	84497
Total in employment	40,783	43134

Table 1 Employment in the Isle of Man by Sector	**Number Employed 2006**	**%**	**Number Employed 2011**	**%**
Agriculture, forestry, fishing	**642**	**2**	**850**	**2**
Manufacturing (all categories)	**2,248**	**5**	**2,295**	**5**
Construction	**3,374**	**8**	**3,352**	**8**
Gas, electricity and water	**603**	**1**	**878**	**2**
Transport and communication	**3,660**	**9**	**3,037**	**7**
Wholesale and retail distribution	**4,550**	**11**	**4,504**	**10**
Insurance, banking, finance, business services	**9,395**	**23**	**10,053**	**23**
Professional, education, medical, scientific services	**8,060**	**20**	**8,917**	**21**
Tourist accommodation	**362**	**1**	**679**	**2**
Catering and entertainment	**1,897**	**5**	**2,129**	**5**
Miscellaneous services	**3,075**	**8**	**3,382**	**8**
Public administration	**2,898**	**7**	**3,058**	**7**
Not stated/inadequately described	**19**	**0**	**0**	**0**
Total	**40,783**	**100**	**43,134**	**100**

Figures taken from the 2006 and 2011Census Surveys undertaken by, Economic Affairs Division, Isle of Man Treasury

Table 2 - HSWI Statistics April 2010 to March 2012	2010/11	2011/12
Total number of incidents reported (investigated)	294 (28)	244 (19)
Number of fatal accidents	0	0
Number of major accidents	33	122
Number of over 3 day accidents	224	82
Number of less than 3 day accidents reported	17	29
Number of dangerous occurrences	19	10
Cases of disease reported	1	1
Number of gas incidents reported (investigated)	14 (14)*	89 (89)**
Number of dangerous occurrences reported (investigated)	19 (7)	10 (5)
Number of cases of disease reported (investigated)	1(0)	1(0)
Number of complaints received (investigated)	200 (185)	131(125)
Number of inspections carried out	500	537
Prosecutions taken	4	1
Cautions issued	2	2
Improvement notices issued	8	5
Prohibition notices issued	7	7

**All 14 were followed up by further enquiries via telephone. Site investigations were carried out on 4 installations*

*** All 89 were followed up by a standard letter requesting more information from the owner of the appliance. Site investigations were carried out on 16 installations.*

Table 3 – Standardised Accident Rates per 100,000 workers	2010/11 (2006 census data)	2011/12 (2011census data)
Employed population	40783	43134
Standardised accident rate per 100,000 workers - majors	80.91	282.84
Standardised accident rate – Over 3 days	549.25	190.10
Standardised accident rate – Over 3 day + majors	630.15	472.95

The investigated incident figures of 28 and 19 (Table 2 – row 1) indicate the numbers of incidents which were the subject of thorough investigation. In approximately 20% of the remaining cases further enquiries were made to establish whether more intrusive investigation was required.

The increase in the number of major injury incidents reported in the 2011/12 year is in part a result of better reporting from the Education and Health Care sectors as

many of the broken bone and dislocation injuries were sustained by school children or elderly residents of care and residential homes.

The disparity between the numbers of gas incidents reported in 2010/11 and 2011/12 is the consequence of a joint initiative run between HSWI and Manx Gas as part of the second phase of the Isle of Man's Natural Gas Pipeline Project, which includes a significant natural gas conversion program affecting two thirds of the Island. Between February 2011 and February 2012 conversion team engineers visited all premises to be included in the program to assess the condition and suitability of existing installations and appliances and they reported any defects identified to HSWI.

Accurate figures for the number of companies and individuals covered by HSWI's interventions are not currently available. Work is in progress to address this issue.

The Inspectorate has however 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, railways, docks and the airport.

Examples of advisory and educational events held during the 2011/12 work year include scaffold awareness, gas safety, quarry safety and training on the issue of silica. These events attracted more than two hundred people in total.

Numerous organisations and premises have received multiple visits during the January 2008 to December 2011 period.

A program of business change to the work recording arrangements of the Health and Safety at Work Inspectorate is currently underway and the consequential improvement in intelligence collection and analysis will be used to influence the priority objectives of the Inspectorate.

Article 3, Paragraph 3

Work to introduce a Health and Safety Consultative Committee, to provide a forum for interested parties to contribute to debate on health and safety and its impact on society, is at an advanced stage.

infrastructure
bun-troggalys

Annual Report of the Health and Safety at

Work Inspectorate

for

April 2010 – March 2011

Foreword by the Minister of Infrastructure

I am pleased to present this, the first annual report of the Health and Safety at Work Inspectorate, following its transfer to the Department of Infrastructure in April 2010. The Inspectorate performs a vital function for the Isle of Man, seeking to protect the safety and welfare of all employees and indeed members of the public who may otherwise find themselves placed at risk through the work activities of public and private sector industries across the Island.

The public perception of 'health and safety' is often distorted by disparaging coverage in the UK media. However it is important to recognise that the Inspectorate works with industry to help manage high risk activities in a variety of areas, for example construction sites, manufacturing bases and even ensuring that the annual visit of the fairground on the promenade for the TT festival meets the safety standards that the public reasonably have a right to expect.

In respect of the strategic future of the Inspectorate, the Department has been conducting a consultation on establishing a Health and Safety Authority for the Isle of Man. That has recently concluded and, as I write this foreword, the report on the consultation findings is being compiled for publication. The full and considered responses have provided much food for thought and will be of great help in informing the future priorities of the Department in the field of health and safety.

This has been a difficult year for the Inspectorate, in particular with regard to capacity and workload; nevertheless much good work has been done in challenging circumstances, which is reflected in this report. I would like to thank the Inspectorate team for their ongoing commitment and in particular the Temporary Head of the Inspectorate, who has provided leadership and support during this period. I look forward to the arrival in July of the new Head of the Health and Safety Inspectorate who will continue to build upon the stakeholder engagement and education that has begun over the past year and to deliver key legislative, policy and performance objectives for the Department.

Hon Phil Gawne MHK
Shirveishagh son Bun-troggalys

Introduction

This is the annual report for the Health and Safety at Work Inspectorate for the period April 2010 – March 2011. At the beginning of this period responsibility for the Inspectorate transferred from the Department of Local Government and the Environment to the Department of Infrastructure as a part of a wider Government reorganisation.

The report explains the role of the Inspectorate and its remit (powers); it covers the work undertaken by Inspectors including inspections, dealing with complaints, enforcement, advice and educational events. The report also includes statistical information on accidents and injuries and the resulting time lost from the workplace (Appendix II). This report has been compiled with the assistance of the Temporary Head of the Health and Safety Inspectorate, who has been with the Department since November 2010.

The Health and Safety at Work Inspectorate – Who We Are and What We Do

The Inspectorate is part of the Department of Infrastructure, with the political responsibility for health and safety at work resting with the Minister for Infrastructure.

Management and Staffing

The Inspectorate currently comprises a Temporary Head of Health and Safety, who will shortly be replaced by a permanent Head, 3 Health and Safety Inspectors and an Administrative Officer. The Head of the Inspectorate operates at Director level, but for administrative purposes reports to the Chief Officer through the Director of Finance to minimise potential conflicts of interest, as the Department is highly operational in nature.

Further to its transfer in April 2010, the Department of Infrastructure has been giving consideration to the structure of the Inspectorate; most particularly a need for effective succession planning has been identified. The Department has a statutory duty to ensure that it has a pool of appropriately qualified, experienced and knowledgeable Inspectors who can work across a wide range of industries; where possible the Department wishes 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. It is therefore intended that a trainee position will be created in the future to assist with this aspiration.

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, although the Office of Fair Trading has specific legal responsibilities for regulating petrol stations and explosives/fireworks.

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). These powers are vital to protecting employees and the public from work related risks and fall only to the Health and Safety at Work Inspectorate.

Community 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 an increasing engagement with employers and other stakeholders throughout this period.

Enforcement

Details of enforcement notices and prosecutions for health and safety offences are also included in this report. The Inspectorate presents files for prosecution to the Attorney General's Chambers in cases where it considers that serious breaches of law have taken place; these cases are prosecuted by the Attorney General.

Licensing

In addition to the general framework of health and safety legislation, the Inspectorate also 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 licenses required for the operation of the Island's seventeen petrol and gas storage depots.

Railways

The Isle of Man has three heritage railways which are owned and operated by the Isle of Man Government, Department of Community, Culture and Leisure and three privately operated railways. There is a legislative requirement for the Health and Safety at Work Inspectorate to conduct an annual safety inspection of all railways to ensure they are safe for use. The necessary expertise to ensure this duty is now provided by a Specialist Inspector contracted from the UK Office of Rail Regulation. However day to day health and safety regulation is undertaken by the Inspectorate.

Inter-Agency Working

The Inspectorate also provides assistance on a regular basis to other agencies and individuals in the course of their duties, including the Police, the Coroner of Inquests and the Fire Service.

Contacts

Temporary Head, Neil Jamieson, HM Principal Inspector
Senior Inspector, Brian Arnold
Senior Inspector, Steve Bentham
Temporary Administrator, Dawn O'Neill

The Health and Safety at Work Inspectorate address is;

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IM1 2SF

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

The Work of the Inspectorate, April 2010 – March 2011

Inspections

Inspection is the process carried out by Health and Safety at Work Inspectorate (HSWI) warranted inspectors which involves assessing relevant documents held by the duty holder, interviewing people and observing site conditions, standards and practices where work activities are carried out under the duty-holders control. Its purpose is to secure compliance with legal requirements for which the Inspectorate is the enforcing authority and to promote improving standards of health and safety in organisations.

During 2010- 2011 Inspectors visited a variety of different premises and activities including construction sites, factory and 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. Approximately 500 proactive inspections were undertaken.

Examples of where routine inspections have prompted further action are listed below:

- During a routine inspection of a hotel it was discovered that the hotel's passenger lift, which had been in service since 1972, had not at any time been independently examined by a competent person. It was further discovered that the lifting ropes had not been changed and no operational checks had been undertaken of the lift's safety gear and landing door locking mechanisms. Maintenance which was being undertaken by the hotel owner was of a questionable standard. A prohibition notice was served requiring the hotel owner to take the lift out of service until a competent person was satisfied that it was safe for use. The Inspectorate was subsequently informed that all the major parts of the lift including the ropes and the gear box have been replaced at the competent person's instruction.

- During an inspection of a concrete batching plant and recycling centre a number of unguarded conveyors and crushing machines were discovered exposing the operators to risk of serious injury. A prohibition notice was served closing the plant until adequate machinery guarding had been fitted.

- Proactive, collaborative working between the Inspectorate and the organisations responsible for a large Highly Flammable Storage facility identified that the plants fire fighting equipment needed to be reviewed. A hazard and operability study (HAZOP) was undertaken which resulted in the installation of a new state of the art fire fighting facility.

Investigations

Investigation is a reactive process which includes all those activities carried out in response to an incident or a complaint to:

- gather and establish the facts
- identify immediate and underlying causes and the lessons to be learned
- prevent recurrence
- detect breaches of legislation for which HSE is the enforcing authority
- take appropriate action, including 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.

Complaints

A complaint is a concern, originating from outside the Health and Safety at Work Inspectorate, 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 were dealt with by the Inspectorate during this period. A total of 28 accidents were also selected for further investigation via the Department's accident selection procedure. A few examples of where investigations have been undertaken resulting in significant enforcement action include;

- A suspected case of carbon monoxide poisoning at a commercial property where building work had been carried out to create a covered area for workers that smoke. The shelter was constructed in an outside yard which also contained the exhaust flue of a gas boiler. When the shelter was covered, the exhaust from the boiler pumped CO into the covered area exposing workers to the risk of CO poisoning. A Prohibition Notice was issued on the use of the shelter and it was subsequently taken down.

- A review of swimming pool use was undertaken by the Inspectorate when a complaint was made by a leisure user patron. Investigations revealed that the majority of swimming pools located in the Island's hotels and leisure facilities were not being staffed with adequate numbers of trained pool side life guards and maintenance staff. Other issues raised included means of raising alarm and control on the number of persons entering the pools. The issues were addressed by discussions with various duty holders and liaison with the Royal Life Saving Society.

- An investigation of a tripping accident involving a member of public who fractured a hip when he fell entering a public building. An improvement notice was served requiring the authority to fit a hand rail on a staircase leading to the entrance of premises.

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, face to face or in writing. During the period of this report, eight Improvement Notices and seven Prohibition Notices were issued; two companies were also formally cautioned.

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 four cases were prosecuted by the Attorney General's Chambers on behalf of the Health and Safety at Work Inspectorate.

Details of the cases are as follows;

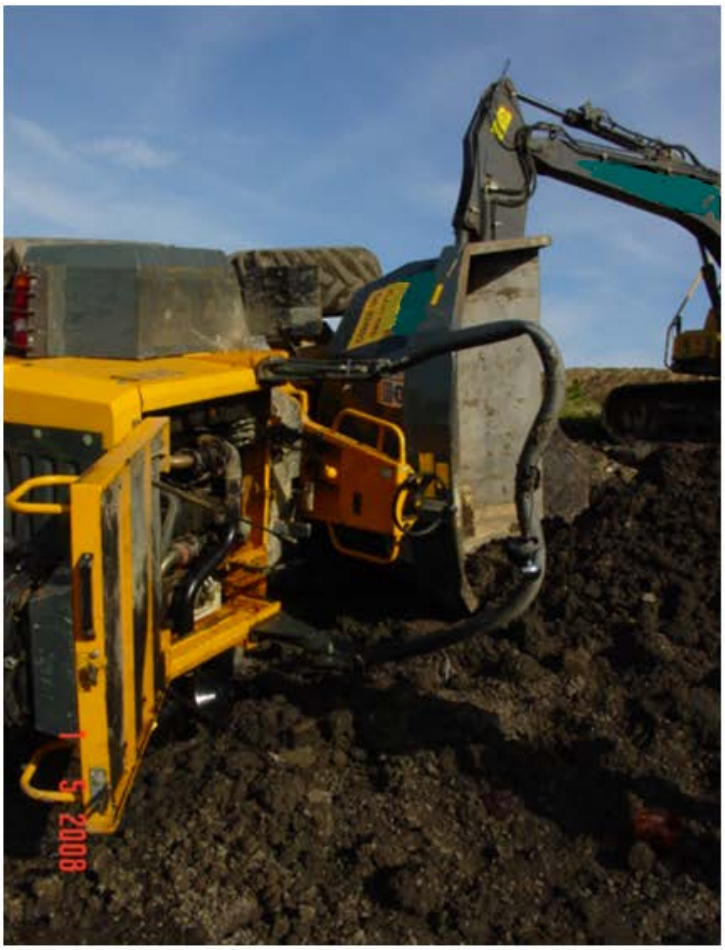
- **Case 1.**

A building company employing workmen was found guilty of breaching the requirements of the Health and Safety at Work etc. Act 1974, the Construction (Health & Safety) Regulations 1985 and the Construction (Head Protection) Regulations 1999.

The prosecution was initiated following a routine inspection of a refurbishment project in which the building's stability had been compromised and was at serious risk of collapse. Workmen had also worked below the structure without hard hats. The contractor pleaded guilty in the Magistrates Courts and was fined £3,600.

- **Case 2.**

Following the investigation of a fatal accident involving a dumper truck driver, where the dumper truck overturned whilst travelling down a steep slope, the principal contractor was prosecuted for a breach of the Health & Safety at Work etc Act 1974.



The company was fined £50,000 for failing to take reasonably practicable precautions to ensure the deceased person had been wearing his seat belt whilst operating the vehicle.

- **Case 3**

Two contractors were prosecuted for breaches of the Health & Safety at Work etc. Act, the Construction (Health & Safety) Regulations 1985 and the Construction (Design & Management) Regulations 2003.

Work was being carried out in a 4 metre deep, unsupported excavation. The ground was very unstable and persons were at risk of being buried. Fines totalling £14,000 were awarded against the companies concerned.

- **Case 4**

An incident in which a man partially fell through a steel mesh grating at a local dock facility was investigated by the Inspectorate and a report submitted to the Attorney General. Fines totalling £10,000 for a breach of the Health and Safety at Work etc. Act 1974 were awarded against the organisation concerned.

Data Collection

As part of its work the Inspectorate collects and monitors data on work place reportable accidents and injuries. The appendices include data on the economically active population of the Isle of Man as of the last interim census in 2006. The figures include % 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, every significant workplace accident or near miss will not 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 is underway to develop better data management systems; further work will be required in future to interrogate the data collected, understand the implications and use it to inform pro-active health and safety work with the community.

Other Work

Assisting other Agencies

Throughout the reporting period the Inspectorate has provided expertise and assistance to a number of agencies including the Police, Fire Service, Building Control and Environmental Health. This work has included the investigation of a suspicious death, a gas explosion at a domestic property and the investigation of a child being seriously scolded in a bath of hot water.

Educational Promotional

A gas safety seminar and a quarry safety seminar were both organised by the Inspectorate and held on the Island during this period. Other events planned for early in the forthcoming year include a seminar on scaffolding safety and six construction safety awareness seminars, organised in conjunction with the Employer's Federation and the Department of Economic Development, which will be provided free of charge to industry.

Department of Infrastructure, June 2011

Appendix I

Isle of Man Population Data

Census data 2006

Resident population	80,058
Economically Active	41,793
Working for one or more employers	35,281
Self employed, employing others	1,832

Employment in the Isle of Man by Sector	Number in Employment	%
Agriculture, forestry, fishing	642	2
Manufacturing (all categories)	2,248	5
Construction	3,374	8
Gas, electricity and water	603	1
Transport and communication	3,660	9
Wholesale and retail distribution	4,550	11
Insurance, banking, finance and business services	9,395	23
Professional, educational, medical and scientific services	8,060	20
Tourist accommodation	362	1
Catering and entertainment	1,897	5
Miscellaneous services	3,075	8
Public administration	2,898	7
Not stated/inadequately described	19	0
Total	40,783	100

Figures taken from the 2011 Digest of Economic & Social Statistics, Economic Affairs Division, Isle of Man Treasury

% of Reported Accidents by Population Type	Total Number of accidents reported 274	%
All types of accidents, by total resident population	80,058	0.34
All types of accidents, by economically active	41,793	0.66
All types of accidents occurring in non-public industry sector	101	36
All types of accidents occurring in public sectors*	173	64

**Public sector includes all Government Departments, Statutory Boards, Offices and Local Government.*

Comparisons with UK accident rates

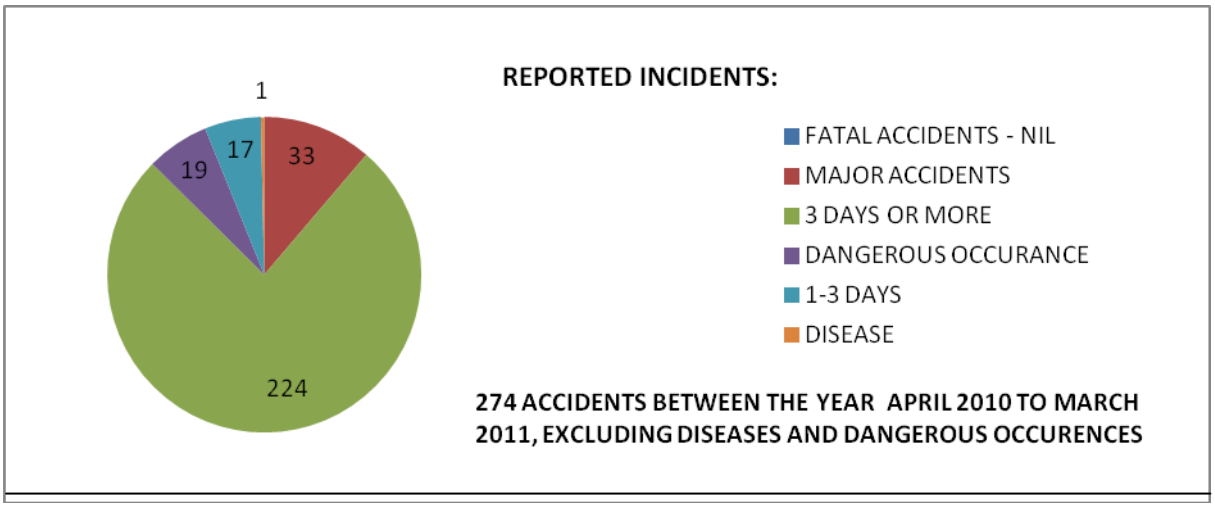
The UK Health and Safety Executive produce an annual report on accident statistics, using the same reporting framework as the IOM (RIDDOR). The most recent figures available for the UK are from 2009/10; these show that the Isle of Man has a lower rate of major injuries than the UK, but a higher rate of reported injuries to employees causing an absence from work of over three days. There were no fatal accidents to IOM workers in 2010/11 although there was one prosecution of an employer in respect of a fatal accident, which had occurred in 2009/10.

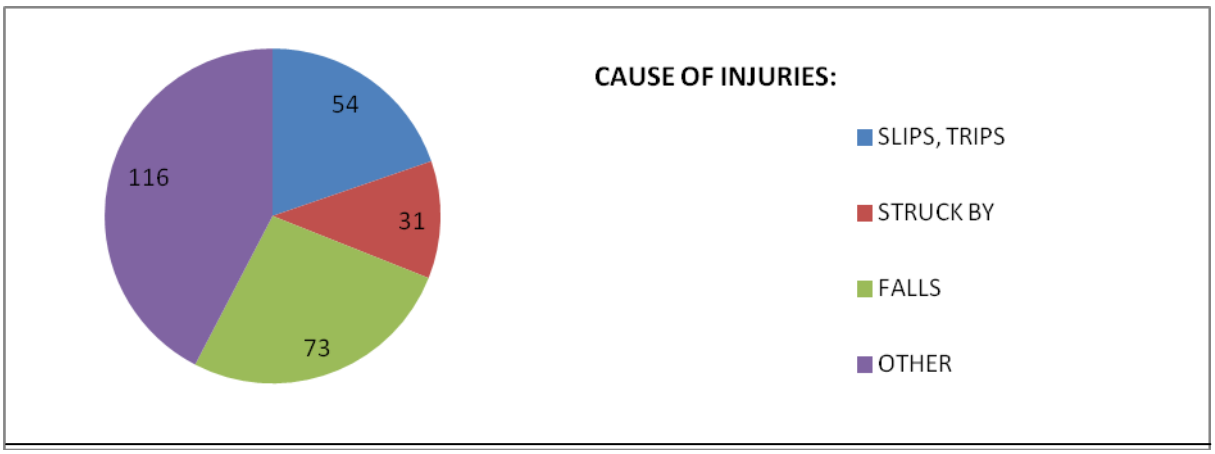
The UK figures are based on an accident rate per 100,000 employees and, as the economic population of the IOM is 41,793 the figures have been adjusted accordingly.

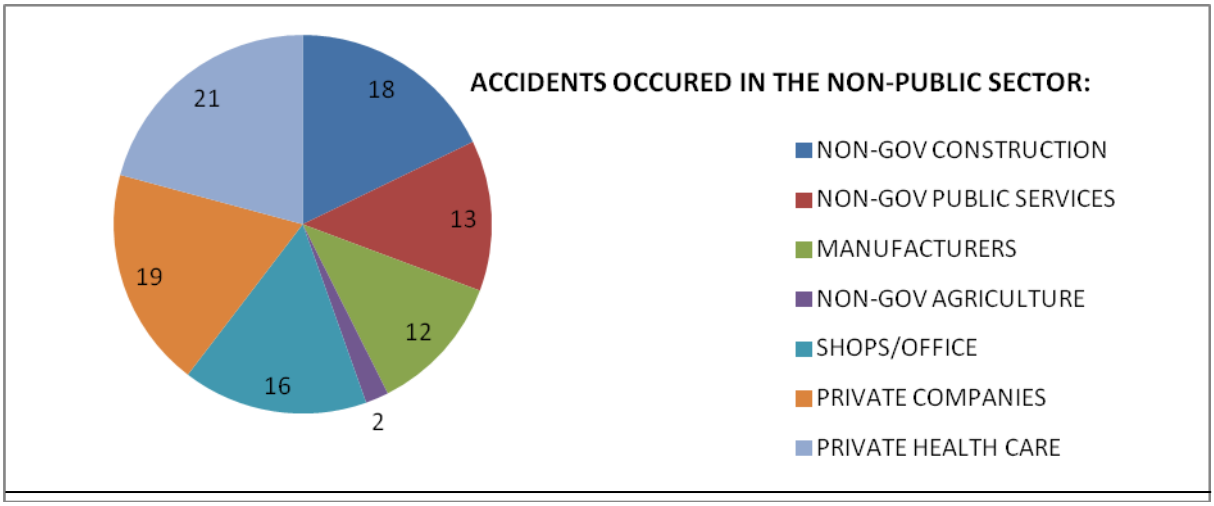
	IOM		UK	
	Actual Number	Estimate Per 100,000	Actual Number	Per 100,000
Fatal Injuries to Workers	0	0	152	0.5
Major Injuries	33	79.0	26,061	101.5
Reported Injuries causing 3 days or more absence from work	224	536.0	95,369	371.5

Appendix II

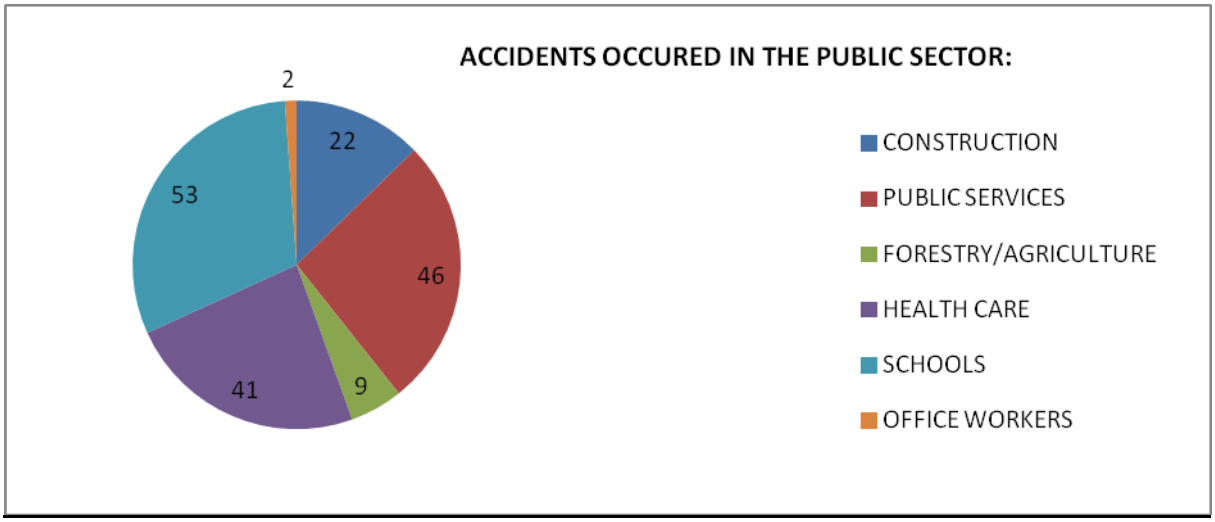
Statistical Report for Work Related Accidents
April 2010 to March 2011 Inclusive

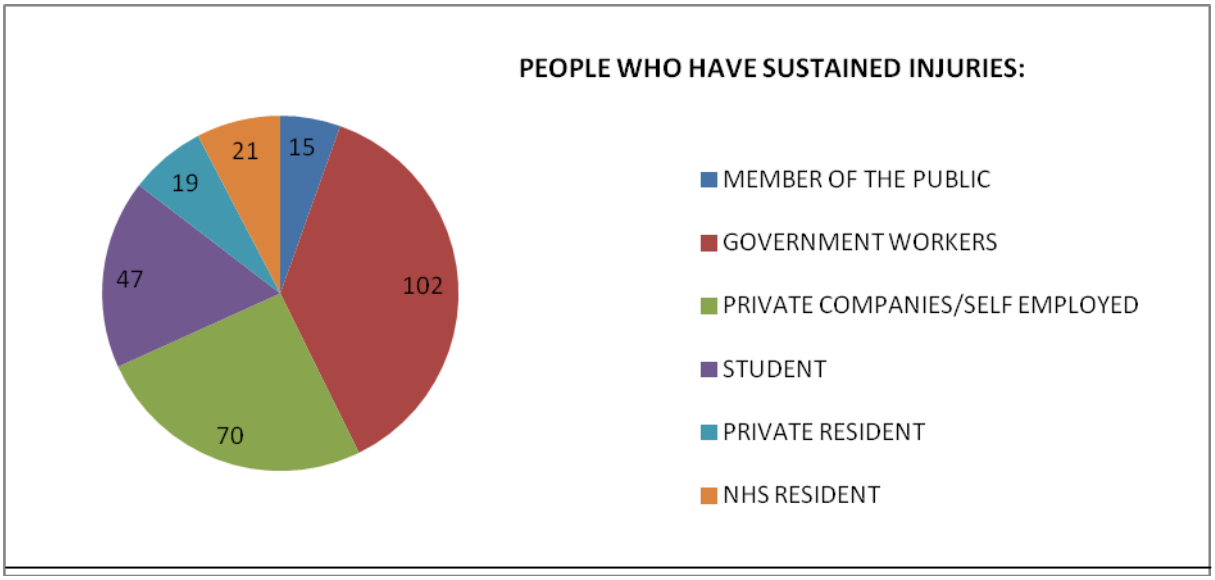






Statistical Report for Work Related Accidents (continued) April 2010 to March 2011 Inclusive





Figures provided by HSWI Administration

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

Life expectancy and principal causes of mortality

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

Cardiovascular Disease

2. Great progress has been made in reducing mortality from cardiovascular disease (CVD). Mortality from Coronary Heart Disease (CHD) and other CVD has been reduced by over 40% in the last decade. The huge improvements we have seen in cardiac care are now beginning to be mirrored in stroke care. Since the publication of the National Stroke Strategy in 2008, and the NICE Quality Standards in 2010, the acute treatment and care of stroke years has improved dramatically. More stroke survivors are receiving thrombolysis so reducing their likelihood and level of disability. Now over 80 per cent of stroke patients spend 90 per cent or more of their hospital stay in a stroke unit where there is clear evidence that care in a stroke unit significantly improves outcomes. This has increased by over 20 per cent since 2009 but there is still variation between areas and the National Health Service (NHS) is continuing to work on this. The award winning Act FAST campaign helps people to recognise the symptoms of a stroke and get emergency help – this has been one of the most successful Government awareness raising campaigns[1].

3. However, demographic changes such as the increase in obesity and an aging population mean that these gains may be lost without further action. This is why the Government is continually seeking to improve CVD outcomes and is currently developing a CVD Outcomes Strategy.

Diabetes

4. The prevalence of diagnosed diabetes in England has increased from 1.3 million in 2003 to 2.5 million in 2011.

5. There is a Department of Health National Service Framework for Diabetes (NSF) with a National Clinical Director (NCD). Delivery started in 2003 to run for 10 years. The contents of the NSF have now been incorporated into the National Institute for Health and Clinical Excellence (NICE) quality standard for diabetes[2] (see section 9).

6. The existing structures of the NHS are changing from the 1 April 2013 and the delivery of the NSF and associated work programmes will become

[1] http://mediacentre.dh.gov.uk/2012/02/27/acting-fast-proves-it-can-save-hundreds-of-lives/
[2] http://guidance.nice.org.uk/QS6

the responsibility of the NHS Commissioning Board and Public Health England.

7. The Quality and Outcomes Framework (QOF) was introduced in 2004. Inclusion of items advocated by NICE is negotiated annually as part of the General Medical Services Contract. It is a voluntary incentive scheme for General Practitioner (GP) practices in the UK. QOF contains diabetes indicators, against which practices score points according to their level of achievement. The QOF items are aggregated by practice, not by patient.

8. The National Diabetes information Services (NDIS) was established in 2009 to provide a comprehensive range of diabetes data, tools and information via one web portal. It uses all the currently available diabetes information sources to provide people with diabetes, providers of diabetes care and health commissioners, with information to aid decision making and improve services.

9. The National Diabetes Audit (NDA) is the world's largest published clinical annual audit and measures care of individual patients from GP and Hospital Episode Statistic databases. The latest audit 2010/11 included 2,150,634 people.

10. The NDA (separate for adults and for children) provides an infrastructure for the collation, analysis, benchmarking and feedback of local clinical data to support effective clinical audit across the NHS. The NDA supports the implementation of the diabetes NSF and aims to improve the quality of patient care by enabling NHS organisations to:

- compare the processes and outcomes of care with similar NHS organisations;
- identify and share good practice;
- identify gaps or shortfalls in commissioning services;
- support identification of progress in meeting Diabetes NSF and NICE guidelines; and
- provide a local health economy view of care and outcomes where primary and secondary care organisations actively participate.

11. Between 2003/4 and 2010/11 the completion of all nine basic diabetes care processes has increased from 7% to 54% of people with diabetes despite the near-doubling of the numbers of people with diabetes.

12. Analysis of 1.4 million people with diabetes known to be alive in the 2007/8 NDA, extrapolated to the whole population with diabetes, showed that over the following year there were 24,000 excess deaths in people with diabetes compared to age and sex matched controls. Some such deaths could be prevented. Research shows that early diagnosis and treatment of diabetes, treatment of cardiovascular risk alongside early identification and treatment of diabetes complications will reduce premature mortality in people who have diabetes.

13. The 'NHS Atlas of Variation in Healthcare for People with Diabetes' was published in 2012. It provides maps comparing diabetes care processes, outcomes, prescription of medicines and achievement of treatment targets according to Primary Care Trust (PCT) geographical location. This allows localities to identify areas of good practice and those needing improvement.

14. The National Paediatric Diabetes Audit has been collecting data from Paediatric Diabetes Units on diabetes care in the UK for 8 years and allows the benchmarking of care processes and outcomes of care in order to facilitate improvement.

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

- Diabetes in pregnancy: Management of diabetes and its complications from pre-conception to the postnatal period (2008).
- Allogeneic pancreatic islet cell transplantation for type 1 diabetes (2008).
- Continuous subcutaneous insulin infusion for the treatment of diabetes mellitus (2008).
- Type 2 diabetes: the management of type 2 diabetes (2009).
- Type 1 diabetes: diagnosis and management of type 1 diabetes in children, young people and adults (updated 2009).
- Neuropathic pain: the pharmacological management of neuropathic pain in adults in non-specialist settings (2010).
- Liraglutide for the treatment of type 2 diabetes mellitus (2010).
- Diabetic foot problems: inpatient management of diabetic foot problems (2011).
- Exenatide prolonged-release suspension for injection in combination with oral antidiabetic therapy for the treatment of type 2 diabetes (2012).

16. In 2011 NICE published the 'Diabetes in adults quality standard' (updated 2012)[1] setting out standards for diabetes care to identify and manage risk factors as well as optimise self-management.

17. The national improvement body for diabetes, NHS diabetes, started in 2009. Their priorities are set by the Department of Health and the NCD. This lively and hugely effective organisation provides national guidance e.g. on commissioning diabetes care; hosts care documents e.g. "Management of adults with diabetes undergoing surgery and elective procedures"; and has successfully set up clinical diabetes networks to promote and share best practice to improve diabetes care.

- Paediatric Network (set up 2009)
- Inpatient Network (set up 2011)
- Older People Network (set up 2011)
- Pregnancy Network (set up 2011)
- Foot care Network (set up 2012)

[1] http://guidance.nice.org.uk/QS6

- Inpatient network (set up in 2009)
- Insulin Pump Network (set up 2012)

18. The NHS Diabetes Foot Network drives initiatives to improve diabetes foot care. The 'Putting feet first' campaign with Diabetes UK was launched in March 2011 to raise awareness of diabetes-related foot complications with recommendations on inpatient diabetes foot care pathway, patient information leaflet on foot care. Most recently there is a campaign to reduce the risk of developing heel pressure sores in inpatients with diabetes by promoting risk assessment with the award-winning Ipswich Touch Test[1].

19. The NHS Diabetes Inpatient Network developed the National Diabetes Inpatient audit in 2009. It is a snapshot audit assessing inpatient diabetes care in England one day a year. In 2011, over 95% of acute hospitals in England took part. This benchmarked information is published and returned to hospitals annually, and the Network facilitates improvement where it is required.

20. In-hospital mortality among 13 million English hospital admissions over 2 years from 2009 was reviewed by NDIS. This showed, after multifactorial matching, that inpatients with diabetes had a 10% increased risk of dying in hospital compared with non-diabetic patients. Results were published by hospital.

21. A Best Practice Tariff for paediatric diabetes – to improve access, management and education of under 19s with diabetes was introduced in April 2012, requiring full implementation by April 2013. This lists 12 standards that a service provider must offer to ensure continued funding for services. It is supported by the NHS Diabetes Regional Paediatric Diabetes networks.

22. The NHS Diabetic Eye Screening Programme is a population based screening programme offered to all eligible candidates aged over 12 years of age. It was launched in 2003. Latest published data August 2012 demonstrates that 98.5 per cent of people with diabetes were offered retinal screening in the previous twelve months.

23. The Government supports a number of campaigns through NHS Diabetes to improve diabetes care and patient safety including:

- In 2009 the 'ThinkGlucose' campaign was launched by the NHS Institute for Innovation and Improvement to help hospitals deliver a clinical pathway to improve diabetes care of inpatients admitted with diabetes as a secondary diagnosis.

- In 2010 the 'safe use of insulin' campaign was launched to improve patient safety. Mandatory training was introduced for all healthcare

1 http://www.diabetes.nhs.uk/qic_diabetes_awards_2012/best_early_detection_and_prevention_initiative/

professionals who prescribe or administer insulin. NHS Diabetes developed a certificated e-learning 'safe use of insulin' training package for healthcare professionals. NHS Diabetes e-learning training packages available:

i) safe use of insulin
ii) safer management of hypoglycaemia
iii) intravenous insulin infusion care
iv) safe use of non-insulin therapies

24. The NHS Health Check Programme is aimed at preventing heart disease, stroke, diabetes and kidney disease. This large-scale public health intervention aims to risk assess over 15 million people aged between 40 and 74 years who are not already known to have one of these conditions. It is expected to detect an estimated 20,000 cases of diabetes and kidney disease earlier each year. People at risk of diabetes are provided with intensive lifestyle advice. It is important to identify people with diabetes early to ensure prompt treatment to optimise glucose control and cardiovascular risk factors to reduce this risk of development of long-term diabetes complications.

25. The Change4life campaign[1] raises awareness of the importance of maintaining a healthy weight, being physically active, and to create a movement to help reduce obesity and the conditions related to obesity, including diabetes. In October 2011, a three-year marketing strategy (2011-14) for the Change4life programme was published as a companion to the document '*Healthy Lives. Healthy People: A call to action on obesity in England'* and describes how Change4life social marketing programme will support local authorities, the NHS and community leaders in response to the emerging evidence base and policy priorities.

Renal

26. Chronic Kidney Disease (CKD) is a long-term progressive condition, which may involve damage or abnormality in both kidneys or loss of kidney function, with or without other evidence of kidney damage. It is estimated that up to 5 million people in England have some degree of kidney impairment which often has no obvious symptoms, but leaves them at a greatly increased risk of heart attack or stroke. Only about 1% of those with CKD go on to develop Established Renal Failure (ERF). ERF is an irreversible, long-term condition for which regular dialysis treatment of transplantation is required if the individual is to survive.

27. Up until recently, the demand for renal replacement therapy (RRT) was increasing at 5% per annum (demand for haemodialysis was increasing at 6-8% per annum) and the increase was expected to continue until at least 2030 due to the ageing population, increasing incidence of diabetes and increased survival rates of patients requiring RRT. However, this has levelled off over the last four years. This is thought to be, in part, at least because patients

[1] http://campaigns.dh.gov.uk/category/change-4-life/

are being identified earlier in primary care (due to the Quality and Outcomes Framework) and fewer are being referred late to secondary care.

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

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

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

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

32. National Procurement Programme called the E16 – to increase haemodialysis provision through partnership with the private sector and development of satellite dialysis units.

33. In September 2008, NICE produced a guideline on the Early Identification and Management of Chronic Kidney Disease (CKD) in adults in primary and secondary care.

34. The 18 weeks target covers from referral to treatment for all patients (whom it is clinically relevant). The Department of Health's 18-weeks programme published on their website commissioning pathways covering the whole of CKD and a further pathway on live kidney donation. These pathways were clinically authored.

35. The introduction of e-GFR (estimated glomerular filtration rate) in April 2006 as the standard measurement of kidney function has meant that CKD is being identified earlier within the primary care system and in many cases enabling preventative work to take place to slow down progression of the disease.

36. Additionally, inclusion of CKD in the Quality and Outcomes Framework (QOF) since April 2006 has incentivised GPs to identify CKD patients earlier

and ensure that they are well managed. It helps GPs ensure that people with CKD get high quality advice and support to modify the lifestyle factors that exacerbate the effect of their disease.

37. A tariff payment system was introduced in April 2010 to standardise the payment for both haemodialysis and peritoneal dialysis, on a session basis. Alongside this, there is a Best Practice Tariff (BPT) to incentivise dialysis via AVF/AVG other then dialysis via tunnelled /non-tunnelled dialysis catheters. In April 2012, a BPT was introduced to incentivise Home Haemodialysis.

38. Since the NSF was published, a NICE Quality Standard for chronic kidney disease had also been produced (2011), which draws on the NSF to set out the priorities for high quality kidney care.

Mortality rates from diseases of the respiratory system

Pneumonia and Bronchitis

39. The UK's previous Report drew the Committee of Social Rights attention to the tables on male death rates[1] and female death rates[2] by selected causes for the period 1996 to 2002 that can be viewed at the NHS website. Death rates for Pneumonia and Bronchitis fell in England & Wales between 2003 and 2007 amongst men and women. The Committee was referred to the following extract indicating that deaths attributed to pneumonia, bronchitis and related diseases in the reference period are recorded as follows:

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

England & Wales * Per miilion population

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

Source: Health Statistics Quarterly 39 p55

40. The Government would draw to the Committee's attention to the following. The UK has historically had high levels of respiratory disease. However some of the apparent excess of mortality may be related to the tendency of doctors in the UK to use the term 'bronchopneumonia', especially when certifying deaths of elderly people when no particular disease is apparent or predominant in the patient's pathology.

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

41. Bronchopneumonia is a poorly defined term for a form of pneumonia which may occur in its own right, but also is a terminal condition in someone who is already frail and immobile, who may have other chronic disease. Figures 1 a, b & c present age specific mortality rates for all respiratory deaths, all pneumonia and bronchopneumonia for the UK for males and females aged 65-74, 75-84 and over 85. The current preferred clinical classification of pneumonia into community-acquired, hospital-acquired and pneumonia in the immunocompromised is currently not captured by death statistics.

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

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

44. Annual rates of respiratory disease are also affected by other factors such as flu epidemics.

Northern Ireland

45. During 2008 to 2010 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		
	2008	**2009**	**2010**
Circulatory Diseases	17.0%	16.3%	16.3%
Respiratory diseases	6.1%	6.4%	5.3%
Pneumonia	2.0%	1.6%	1.5%
Influenza	0.0%	0.5%	0.4%
Cancers	27.9%	26.9%	27.3%
External Causes (e.g. accidents, suicide, assault)	23.4%	21.4%	22.4%

Source : NISRA Website

46. Northern Ireland has an overall mortality rate that is higher than that in England and Wales, but lower than in Scotland[1]. 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 2010*.
*NISRA Website

47. In 2010 circulatory disease was responsible for just under one third of all deaths in Northern Ireland, closely followed by cancer at 28%.

48. In considering Standardised Death Rates that are likely to vary between countries, there are variations for Northern Ireland relating to cancer, circulatory and respiratory diseases. Table 1 provides some examples by cause for Northern Ireland compared with pre May 2004 EU member countries average (standardised for the age and sex of the population).

Table 1 2010 Standardised Death Rates (per 1,000,000 pop): Northern Ireland and pre May 2004 EU member countries.

Cause	**Northern Ireland**	**Pre May 2004 EU member countries**
Malignant Neoplasms Female	63.1	56.8
Malignant Neoplasms Male	65.5	77.6
Diseases of the Circulatory System Female	21.2	15.9
Diseases of the Circulatory System Male	54.1	46.0
Diseases of the Respiratory System Female	10.1	4.9
Diseases of the Respiratory System Male	10.8	8.5

Source: Dept. Health, Social Services & Public Safety

49. 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.

[1] http://www.ons.gov.uk/ons/rel/ukhs/united-kingdom-health-statistics/2010/edition-4--2010.pdf

Table 2 Hospital Inpatient Activity: 2006/07 – 2010/11

Activity Type	Proportion of Total Deaths and Discharges				
	2006/07	2007/08	2008/09	2009/10	2010/11
Coronary Heart Disease	2.5%	2.5%	2.4%	2.2%	2.1%
Cancer	8.0%	8.3%	7.9%	8.0%	8.3%
Diabetes	0.8%	0.7%	0.7%	0.7%	0.7%
Renal Failure	17.5%	17.6%	17.9%	18.4%	18.3%

Source: Hospital Inpatient System, Hospital Information Branch

ENGLAND

Cancer

50. 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.

51. *Improving Outcomes: A Strategy for Cancer*[1], 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.

52. 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.

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

53. 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.

54. 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;
- successful public awareness campaigns;
- surgical training programmes on laparoscopic colorectal cancer and low rectal cancer; and
- continued improvement in patient care pathways.

Access to National Health Services (NHS)

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

56. Access to National Health Service (NHS) primary medical care is in the main provided by General Practitioners under contract to the NHS. Any person can approach any GP 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.

57. The NHS Commissioning Board, is under a duty to secure provision of primary medical services for everyone. Through its local area teams, the NHS Commissioning Board has the power to allocate individuals to a doctor's list if a person experiences difficulties in registering with a GP.

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

59. New arrangements are being piloted in three cities (Central London, Manchester/Salford area and Nottingham) to test where individuals can choose to register with a GP away from the area they normally live. In addition, some primary care centres have been established that enable individual patients to access primary care services without having to be registered with a GP. These NHS Walk-in Centres and Urgent Care Centres provide a local drop-in clinic.

60. To make it simpler for the public to access local health services when they need help quickly we are introducing NHS 111. This service will be available 24 hours a day, 365 days a year, via the new free to call, easy to remember three-digit number. NHS 111 will assess people's medical needs and provide advice and direct them to the local service that is best placed to treat them. In future if people need to contact the NHS for urgent care there will only be two national numbers; 999 for life-threatening emergencies and 111 for everything else.

61. Until the NHS 111 service is rolled-out across the country NHS Direct will continue to provide national 24/7 access to health information, advice and support via the telephone (0845 46 47) and internet (http://www.nhs.uk).

62. NHS Walk-in Centres are a local facility where no appointment is necessary – offering quick access to at least a core range of NHS services, including advice, information and treatment for a range of minor injuries and illnesses. Walk-in centres are 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.

Northern Ireland

63. 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

64. 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.

England and Wales

Preventive measures

Immunisation

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

66. From 2008, HPV immunisation has been offered routinely to all 12- to 13-year-old girls (school year 8) to protect them against their future risk of cervical cancer. A catch up campaign was also introduced and was completed during 2008 to 2010. Also in 2008, the MMR catch up campaign was launched in a bid to improve poor uptake rates, particularly in London. In 2009 H1N1 a Swine Flu programme was developed and rolled out in response to Swine Flu, this was in addition to the routine annual flu vaccinations. In 2010 there were changes to the Pneumococcal conjugate vaccine to extend coverage to an additional 7 serotypes. 2010 also saw the simplification of the routine childhood immunisation schedule combining vaccine administration so that only one visit was necessary between the ages of 12 and 13 months as opposed to two.

67. NICE also introduced in 2010 Public Health Guidance PH21 ‘Reducing Differences in the Uptake of Immunisations’ aimed at increasing immunisation rates in children and young people.

68. The Flu vaccine programme was also extended to include pregnant women from 2010.

Vaccination coverage

69. As part of the wider Health Reforms in England there is an increased focus on improving health outcomes. In January 2012 published a Public Health Outcomes Framework, grouped into four domains, including Public Health Indicators focusing on how improvements are progressing year by year, The Health Protection domain includes indicators that focus on population vaccination coverage.

70. From April 2013, the NHS Commissioning Board (NHSCB) will be accountable for the NHS contribution to public health including immunisation.

71. The Government would refer the Committee to its immunisation website[1] that gives comprehensive details of the UK immunisation resources and programme that operates in England and Wales. Children in Scotland are also protected through immunisation against these serious infectious diseases. The Immunisation Scotland website provides parents and children, as well as health professionals with information relating to immunisation and can be found at http://www.immunisationscotland.org.uk/. Vaccination programmes aim both to protect the individual and to prevent the population from contracting these illnesses.

72. As a public health measure, immunisations have been hugely effective in reducing the burden of disease. It is of public health concern when immunisation rates fall, as this increases the possibility of disease transmission, and hence complications arising from outbreaks of infectious diseases. The then Scottish Executive set a national target rate of 95% uptake among children aged 24 months for completed courses of the pre-school immunisations: diphtheria, tetanus, pertussis, polio, Hib, MenC, and measles, mumps and rubella (MMR). Vaccination uptake rates in Scotland continue to achieve or exceed this figure.

73. In Northern Ireland all parents receive invitations at the appropriate times to have their child immunised. Immunisation for young children usually takes place in the GP surgery or health centre. The immunisations given to 13 year olds and school leavers are usually given in school but parents and young people will be notified at the appropriate time by the school doctor/nurse.

Vaccination coverage rates against hepatitis B

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

2. Estimates from data provided by English National Health Service Primary Care Trusts for coverage of three doses of hepatitis B vaccine at 12 months of age for babies born to hepatitis B infected women for the year 2010/11 ranged from 17-100%. Similarly, estimates of four doses of hepatitis B vaccine at 24 months of age for 2010/11 ranged from 2-100%. However, there are concerns about the quality of the data that these estimates are based upon[2].

[1] http://www.immunisation.org.uk
[2] NHS Immunisation Statistics England 2010-11. http://www.ic.nhs.uk/webfiles/publications/immsstatisticsreplacement/immsreplacement1011/Immunisations_Bulletin_2010_11__v1.3.pdf

Mental health Services

74. Mental ill health is the single largest cause of ill-health and disability in the UK, contributing up to 22.8% of the total burden, compared to 15.9% for cancer and 16.2% for cardiovascular disease. The wider economic costs of mental illness in England have been estimated at £105.2 billion each year. This includes direct costs of services, lost productivity at work and reduced quality of life. In 2008/9, the NHS spent 11% of its annual secondary healthcare budget on mental health services, which amounted to £10.4 billion. Service costs which include NHS, social and informal care amounted to £22.5 billion in 2007 in England. In February 2011 DH published the Government's Mental Health Strategy *No Health without Mental Health*[1] and on 24 July 2012 launched the Implementation Framework for the Strategy. The Strategy states 'good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential' and the Framework translates the Strategy's vision into specific actions, setting out the contribution which specific organisations can make and shows how improving mental health will help organisations meet their broader objectives.

Health professionals

75. The annual workforce census shows that as at 30 September 2011 there were the following full-time equivalent numbers of staff employed by the NHS in England:

All Doctors	134,713
(Excluding GP retainers 134,570)	
of which	
Consultants	36,965
Registrars	38,133
Other Doctors in training	13,860
GPs	35,319
GP retainers	143
All qualified nurses	319,919
of which	
Qualified nursing, midwifery and health visiting staff	306,346
GP Practice Nurses	13,573

Pharmacies

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

1 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766

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

Health Care Spending

77. Estimates of healthcare expenditure in the UK for the period 1997 to 2010 are set out in http://www.ons.gov.uk/ons/dcp171766_264293.pdf. These estimates are consistent with international definitions specified by the Organisation for Economic Co-operation and Development (OECD) in A System of Health Accounts (SHA). OECD (2000, 2011a). These data are provided to OECD annually for inclusion in OECD Health Data. This enables OECD to publish international comparisons on a consistent basis. The tables for this publication in the data section of this publication are at: http://www.ons.gov.uk/ons/rel/psa/expenditure-on-healthcare-in-the-uk/1997---2010/index.html

Northern Ireland

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

	Headcount of staff per 1,000 population			
Staff Groups	**30th September 2008**	**30th September 2009**	**30th September 2010**	**30th September 2011**
Qualified nurses	8.33	8.35	8.26	8.11
Unqualified nurses	2.65	2.67	2.56	2.49
Midwives	0.72	0.71	0.72	0.73
Hospital & Community Medical Staff	2.09	2.09	2.08	2.12
Hospital & Community Dental Staff (excluding general dental practitioners)	0.10	0.10	0.10	0.09

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

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	2008	2009	2010	2011
General medical practitioners	0.65	0.65	0.64	0.64
General dental practitioners*	0.46	0.47	0.52	0.54

Source: Business Services Organisation

* Data on General Dental Practitioners relates to Principal Dentists only, registered to provide Health Service dental treatment

Infant mortality

78. The infant mortality rate in the United Kingdom has continued to fall, from 4.6 per 1,000 live births in 2008 to 4.3 in 2010.

Infant mortality rate (Rate per 1,000 live births)	United Kingdom	England & Wales	England
2006	5.0	5.0	5.0
2007	4.7	4.8	4.8
2008	4.6	4.8	4.7
2009	4.5	4.7	4.6
2010	4.3	4.3	4.3

Source: ONS Mortality Statistics: Childhood, Infant and Perinatal

Perinatal mortality rate

79. The perinatal mortality rate has remained stable, falling slightly from 7.5 deaths per 1000 live & still births in 2008 to 7.4 in 2010.

Perinatal mortality rate (Rate per 1,000 live births)	United Kingdom	England & Wales	England
2006	7.9	8.0	8.0
2007	7.7	7.7	7.7
2008	7.5	7.6	7.5
2009	7.3	7.6	7.6
2010	7.4	7.4	7.4

Source: ONS Mortality Statistics: Childhood, Infant and Perinatal

Pregnant women, mothers and babies

Maternal mortality

80. The maternal mortality rate in the United Kingdom has fallen from 6.2 deaths per 100,000 maternities in 2008 to 5.0 in 2010.

Year	Maternal death rate (due to Pregnancy, Childbirth and the Puerperium) per 100,000 maternities	Number of deaths due to Pregnancy, Childbirth and the Puerperium
2006	6.3	47
2007	6.6	51
2008	6.2	49
2009	6.9	70
2010	5.0	40

Source: ONS, NSRA, General Register Office for Scotland

Northern Ireland

81. From 2008 to 2010 perinatal mortality rates and infant mortality rates in Northern Ireland were as given below:

	2008	2009	2010
Perinatal Deaths	4.7	5.1	5.7
Infant Deaths	7.4	7.8	7.8

Source: NISRA website

ECSR Conclusions

In the Conclusions on the previous Report, the Committee asks for updated information on all measures taken to reduce maternal mortality rates.

82. The UK has a long established programme to review maternal deaths, which widely disseminates its findings and recommendations to help reduce the number of such deaths in the future. Since the programme was established in the early 1950s there has been a 90 per cent reduction in maternal deaths due to direct obstetric complications.

83. In 2011, the scope of the programme, which was extended to incorporate stillbirths and deaths in infancy in the 1990s, was reviewed to ensure it met anticipated requirements, delivered first class output and value for money. The contract for the revised Maternal, Newborn and Infant Clinical Outcomes Review Programme was awarded to MBRRACE-UK (Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries across the UK) in June 2012 with immediate effect. MBRRACE-UK will continue the work previously undertaken to investigate maternal deaths, stillbirths and neonatal deaths. Future plans include extending investigations to include post-neonatal deaths, near-miss events and other serious morbidities.

Maternity Services

84. A range of action has been taken to help improve outcomes for both women and babies. The Department of Health is firmly committed to the principles of good quality woman-centred maternity services and aims to ensure that women receive the highest quality maternity care by focusing on improving health outcomes and women's experience of care, and giving women greater choice over childbirth.

85. The Department has made improving the safety of maternity services an area of improvement for the NHS in the NHS Outcomes Frameworks for 2011-12 and 2012-13. To support the NHS in improving outcomes in pregnancy, labour and immediately after birth, the Department has commissioned the National Institute for Health and Clinical Excellence (NICE) to develop new quality standards on antenatal care, intrapartum care and postnatal care.

86. NICE quality standards are designed to drive and measure priority quality improvements. They are derived from the best available evidence and are central to supporting the Government's vision for an NHS and Social Care system focussed on delivering the best possible outcomes.

87. The Department also commissioned 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, revised July 2008**. The guidelines help to provide clinicians in maternity units with recommendations for safe practice and reduce variations in clinical practice. It also provides women with evidence-based information about a range of key issues including the risks and benefits of induction, so they can make informed decisions about what is right for them and their baby.

- **Anti-D prophylaxis May 2002, revised August 2008**. 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 October 2003, revised March 2008**. 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 revised November 2011**. 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**. 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 February 2007**. 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 September 2007.** 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 March 2008**. This guidance encompasses the management of diabetes and its complications from pre-conception to the postnatal period.

- **Care of pregnant women with complex social factors September 2010.** This guideline covers the management of pregnant women who have complex social factors for example, children in care under Child Protection Orders, new migrants and drug users.

- **Multiple pregnancy September 2011.** 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

88. The availability of a full range of services as close to home as possible is fundamental to safe, high quality maternity care. *Maternity Matters Choice, access and continuity of care in a safe service,* published in 2007, introduced a national choice guarantee for women in England to have a choice by the end of 2009 of how to access maternity care, the type of antenatal care, the place of birth depending on their circumstances and postnatal care.

89. The focus on offering choice has continued since 2010. The Department has made the extension of choice and continuity of care in maternity services a priority for the NHS in the *Operating Framework* for 2012-13.

90. To inform decisions about safe options for place of birth, the Department funded the 'Birthplace in England' study, which was published in November 2011. This provides, for the first time, evidence about the expected outcomes for women and their babies at 'low-risk' of complications at the start of care in labour for births planned at home, in a midwifery facility or in a hospital unit with obstetric services.

Early Access

91. The Government recognises that there is unequal access to, and experience of, services. Women with complex social factors do not always access maternity services early, or attend regularly for antenatal care and poorer outcomes are consequently reported for mother and baby. To assist maternity services to be more proactive in engaging all women, the NICE

clinical guideline on *Pregnancy and complex social factors'* (2010)[1] describes how access to care can be improved.

92. Through the "Better Quality for All" Public Service Agreements (PSA) announced in October 2007, the Department of Health developed a maternity indicator aimed at addressing early access so that 90 per cent of pregnant women will have seen a midwife or a maternity healthcare professional for a health and social care assessment of needs, risk and choices by 12 completed weeks of pregnancy. Data submitted by the NHS indicates that over 90 per cent of pregnant women were being seen by 12 completed weeks of pregnancy in 2011.

Sick and preterm babies

93. 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.

94. 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* in 2010[2] - to help health service commissioners and providers ensure they are providing safe, high quality care for sick and premature babies and their families.

Investment in maternity services

95. Maternity expenditure in the NHS for 2010-11 was £2.5 billion, compared to £1.78 billion in 2007-08.

Access to care

Hospital waiting times

96. Following a formal consultation in 2010, the Department of Health ceased collection of outpatient and inpatient waiting times from March 2010, and also ceased publication from April 2010. These data showed the waiting time between referral and first outpatient appointment and decision to admission respectively. Removal of the 13 week outpatient (and 26 week inpatient) standards was confirmed in the Operating Framework for the NHS in England 2010/11.

97. The Department of Health has collected and published data on Referral to Treatment (RTT) consultant-led waiting times since 2007. These are now

[1] http://www.nice.org.uk/nicemedia/live/13167/50817/50817.pdf
[2] http://guidance.nice.org.uk/QS4

the main source of information on NHS waiting times in England. RTT waiting times reflect the full time that individual patients actually wait from referral to starting their treatment – including all appointments and tests - rather than for just one step along their treatment pathway.

98. 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.

99. The operational standards that NHS organisations should meet are that:

- 90% of admitted patients to start treatment within a maximum of 18 weeks from referral
- 95% of non-admitted patients to start treatment within a maximum of 18 weeks from referral
- 92% of patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral

100. The operational standards that 90 per cent of admitted patients and 95 per cent of non-admitted patients should start treatment within 18 weeks were introduced in 2007/08

101. The standard that 92 per cent of patients on an incomplete pathway (patients still waiting to start treatment) should have been waiting no more than 18 weeks was introduced from April 2012.

102. The 92% standard provides an incentive to ensure that those waiting longer than 18 weeks are not forgotten about and that they are treated as quickly as possible.

103. The NHS overall is delivering all of these standards. The latest waiting time statistics for July 2012 show that:

- the average time waited for patients admitted to hospital was 8.5 weeks and 4.1 weeks for patients whose treatment did not require an admission.
- The vast majority of patients started treatment within 18 weeks of referral: 92.7% of admitted patients and 97.7% of outpatients started treatment within 18 weeks of referral.
- At the end of July 2012, 94.0% of patients who have yet to start treatment had been waiting less than 18 weeks.

The NHS Constitution right to start consultant-led treatment within 18 weeks of referral

NHS Constitution

104. The NHS Constitution[1] establishes the principles and values of the NHS in England. It protects the NHS and helps ensure we receive high-quality healthcare that is free for everyone. The NHS Constitution brings together in one place details of what staff, patients and the public can expect from the National Health Service. It also explains what the public can do to help support the NHS, help it work effectively and help ensure that its resources are used responsibly.

105. The NHS Constitution sets out the rights and responsibilities of patients, the public and NHS Staff – including the right to a maximum waiting time between referral and starting treatment. Specifically, patients *"have the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution"*. Patients have the right to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions. If this is not possible, and where patients request it, the local primary care trust (PCT) or strategic health authority (SHA) must investigate offering a range of suitable alternative providers that would be able to see or treat the patient more quickly than the original provider. This is set out in legally binding Directions and Guidance.

Diagnostic Test Waiting Times Data

106. From 1 April 2012, the standard that less than one per cent of patients should be waiting 6 weeks or longer for a diagnostic test was introduced. Statistics on NHS waiting times for 15 key diagnostic tests have been published since 2006. At the end of July 2012, the percentage of patients waiting 6 weeks or over was 0.9% of the total number of waits.

Bed availability

107. General and acute (hospital) bed numbers are decreasing because hospitals are dealing with patients more efficiently. The NHS performs more day cases – the day case rate was 78.8% in 2011/12 compared with 68.4% in 2003/04 - and more people with long-term conditions are supported in their own homes. Advances in medical technology and shorter stays for routine operations mean fewer beds are needed across the service.

108. The Department of Health moved from annual to quarterly collection of beds data in 2010/11. Since then, the average occupancy rate for all beds open overnight has ranged between 84.0% and 86.9% and the average length of stay has come down from 8.2 days in 2000/01 to 5.5 days in 2010/11.

[1] http://www.dh.gov.uk/health/category/policy-areas/nhs/constitution/

ECSR Conclusions - Northern Ireland

Access to Health Care for the most disadvantaged groups

The Committee asks to be kept informed of the most important measures taken to improve access to health care for the most disadvantaged groups.

Autism

109. As required by Section 2 of Autism Act (Northern Ireland) 2011[1], the Department of Health, Social Services and Public Safety (DHSSPSNI) leads on the development of a cross Departmental whole life strategy for those with autism, their families and their carers.

110. In February 2012, the Department launched its Physical and Sensory Disability Strategy and Action Plan 2012-2015. The Strategy aims to achieve improved outcomes, services and support for people in Northern Ireland who have a physical, communication or sensory disability and provides the strategic direction for the further development of services for disabled people over the next three years. The Strategy supports independence for disabled people by promoting the continued uptake of direct payments, the introduction of self-directed support/individualised budgets and through the adoption of person-centred planning as mainstream practice, putting the disabled person at the centre of the care planning process. The Strategy is being implemented by the Health and Social Care Board.

Travellers

111. The DHSSPS together with the Department of Health and Children (Ireland) launched the All Ireland Traveller Health Study[2] Reports on 2 September 2010. A Birth Cohort Follow Up Report[3] was published separately in September 2011. The study examined the health status and health needs of all Travellers living in both Northern Ireland and Ireland. The Traveller community has been recognised as a disadvantaged group and the findings of this study provided a framework to work upon to ensure that Travellers have good access to healthcare services to meet their needs.

112. In response, the Public Health Agency (PHA) and Health & Social Care Board (HSCB) established a Regional Travellers' Health & Wellbeing Forum in October 2010. The focus of the Forum is to implement key priorities identified within the All Ireland Traveller Health Study (AITHS). These priorities were reflected in the Forum Action Plans for 2010/11 and 11/12. The PHA secured the membership and participation of the HSCB, Trusts and Traveller Support organisations in the Forum.

[1] http://www.legislation.gov.uk/nia/2011/27/contents/enacted
[2] http://www.dhsspsni.gov.uk/index/hss/equality/eq-travellers/all-ireland-traveller-health-study.htm
[3] http://www.hscbusiness.hscni.net/services/2219.htm

113. Key actions undertaken within 2011/12 include:

- The PHA produced a Health Intelligence summary report of the findings and recommendations of the AITHS study. The report was complemented with additional data on Travellers and has been made available on the PHA website, disseminated to key stakeholders and used to inform programme planning and funding bids by Traveller Support Groups and others.
- The PHA and HSCB provided funding for An Munia Tober to ensure ongoing meetings of Travellers across Northern Ireland in the context of a Travellers Health Network, utilising the knowledge and experience of Travellers previously employed as Peer Researchers under the AITHS.
- The PHA has continued to provide fund a Health Improvement Contract for Travellers' health in the Belfast.
- The PHA and Belfast Health and Social Care Trust have provided joint funding to employ two Travellers as Belfast Trust staff who will work to improve the interface between Travellers and Trust services in an innovative primary care scheme called the Travellers' Health Advocacy Project.
- The PHA has continued to target cancer screening service improvements with the Traveller community. A working group was established and the Travellers' Health Network prepared reports for consideration for service improvement.
- A Health Intelligence Briefing Report has been developed on the Mental Health needs and circumstances of Travellers. The theme of mental health and levels of suicide and self harm were referenced in the AITHS and a considerable amount of complementary data has been drawn together in the Report. It is planned that stakeholders will be able to use the Mental Health findings to ensure optimum connections to services provided by organisations currently resourced under the 'Protect Life' Suicide Prevention Strategy.
- Ongoing support and input has been provided to various stakeholder organisations and Networks such as An Munia Tober, Safe and Well, Southern Area Action of Travellers (SAAT) and other Traveller Support organisations.
- The Belfast Health and Social Care Trust produced a Traveller Health Strategy[1] in 2011.

Interpreting Services

114. The Northern Ireland Health and Social Care Interpreting Service was established in 2004 with the aim of improving access to health and social care services by members of the ethnic communities who do not speak English either as a first or competent second language.

115. Use of the Service has grown year on year from 1,850 requests in 2004-05 to 63,868 in 2011-12. The Service covers 40 languages and uses a

[1] http://www.belfasttrust.hscni.net/pdf/TravellerHealthStrategySept2011.pdf

central register of over 300 interpreters, all of whom are accredited to Level 3 of the Open College Network NI (Equivalent to NVQ Level 3).

116. Where a request cannot be met through the Service, e.g. if a specific interpreter is not available at short notice, an alternative procedure is in place through a contract managed by the Regional Business Services Organisation. This includes the use of the Big Word Telephone Interpreting Service which can be used for short sessions (less than 10 minutes) or if no face to face interpreter is available.

117. The Equality Commission for Northern Ireland, working with Health and Social Care organisations, has produced a booklet - Race Equality in Health and Social Care (A short guide to good practice in service provision)[1] – which has been made available to staff across Health and Social Care. The booklet contains a section advising staff of the procedures for booking interpreters.

118. The Health and Social Care Trusts provide staff with training on how they can work well with interpreters and this covers a range of topics such as Mental Health Awareness and Domestic Violence.

Health and Social Care Information Booklet

119. The Department and its partner bodies have produced an Information booklet entitled 'Health and Social Care in Northern Ireland'. This booklet is available in a range of different languages[2] and provides migrant workers and minority ethnic communities with basic information on the health and social care system and how to access it.

United Kingdom – comparison statistics

The Committee noted the information on waiting times in Wales and Northern Ireland and asks to be kept informed of any reduction in these as they were said to be higher than those in England. The Committee asks also to be provided with updated figures on professional staffing for Scotland, Wales and Northern Ireland.

- The UK health statistics report published in November 2010 contains information on activity and beds for mental health specialties across the 4 UK countries (tables 6.3 and 8.1) http://www.ons.gov.uk/ons/rel/ukhs/united-kingdom-health-statistics/2010/edition-4--2010.pdf

- In June 2012 national Audit Office published a report on UK comparisons that includes activity, beds and waiting times information. (NB – excluding Mental Health specialties).

[1] http://www.equalityni.org/archive/pdf/ECRaceEqualityandHealthGuide.pdf
[2] http://www.hscbusiness.hscni.net/services/2219.htm

http://www.nao.org.uk/publications/1213/healthcare_across_the_uk.aspx

- The June 2012 national Audit Office report on UK comparisons http://www.nao.org.uk/publications/1213/healthcare_across_the_uk.aspx

Population

- Annual Mid-year Population Estimates for England and Wales, Mid 2011 are at:

http://www.ons.gov.uk/ons/dcp171778_277794.pdf

- The population of England and Wales was estimated to be 56,170,900 in mid-2011, with the population of England estimated to be 53,107,200 and the population of Wales estimated to be 3,063,800

- The population of England and Wales increased by 95,000 (0.2 per cent) between 2011 Census day (27 March) and the mid-year point (30 June)

- In England and Wales there were 187,600 births and 121,000 deaths in the three months between 2011 Census day and the mid-year point

- The estimated flow of international migrants into England and Wales between 2011 Census day and the mid-year point was 98,200 and the estimated flow out of England and Wales was 68,500

Wales

The Welsh Government achieved its target of a minimum of 95% of patients to wait less than 26 weeks from referral to treatment in December 2009. Since then, due to capacity issues in certain specialities, most notably orthopaedics, the NHS in Wales has struggled to sustain the target on a monthly basis, and performance has fluctuated between 92 and 95%.

Recognising the problems within orthopaedics, the Welsh Government allocated an additional £65million over the three years 2011/12 to 2013/14, to remove backlog and introduce sustainable solutions, including introducing lifestyle programmes, improved musculoskeletal services and pain management. In the first year, this resulted in a fall of 92% in the number of patients waiting in excess of 36 weeks. Further improvements are expected in years 2 and 3.

- General guidance and information on NHS statistics for Wales can be viewed at:

http://wales.gov.uk/topics/statistics/theme/health/?lang=en

- Out-patient and in-patient waiting times statistics can be found at:

http://wales.gov.uk/topics/statistics/theme/health/nhsperformance/?lang=en

- Professional Staff directly employed by the NHS (Wales), 30 September 2011

http://wales.gov.uk/docs/statistics/2012/120330sdr532012en.pdf

Scotland

- The latest release of Statistical information on NHS staffing in Scotland as at 30 June 2012 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.

http://www.isdscotland.org/Health-Topics/Workforce/Publications/2012-08-28/2012-08-28-Workforce-Report.pdf

Northern Ireland

Waiting times

In-patients

In 2007/08 a target was set to ensure that by 31st March 2008, no patient would wait more than 21 weeks for in-patient treatment. At 31st March 2008, 56 patients were waiting more than 21 weeks for in-patient treatment. The 2008/09 target reduced the maximum waiting time to 13 weeks by 31st March 2009. At 31st March 2009 there were 387 patients waiting longer than 13 weeks for inpatient treatment. This target remained the same during 2009/10, with 3,252 patients waiting more than 13 weeks at 31st March 2010. The 2010/11 target was set to ensure that by 31st March 2011 the majority of patients should wait no longer than 13 weeks for in-patient treatment, with no patient waiting longer than 36 weeks. At 31st March 2011, 33.3% (17,630) of the total number waiting were waiting more than 13 weeks for in-patient treatment, with 1,261 patients waiting more than 21 weeks. The wording of the target was modified in 2011/12, so that from April 2011, at least 50% of patients should wait no longer than 13 weeks for in-patient treatment, with no one waiting longer than 36 weeks. At 31st December 2011, 42.8% (24,168) of the total number waiting were waiting more than 13 weeks for in-patient treatment, with 5,013 waiting longer than 36 weeks.

Out-patients

In 2007/08 a maximum waiting time target was set for 2007/08, that by 31st March 2008 no patient should wait more than 13 weeks for a first out-patient appointment. At 31st March 2008, there were 59 patients waiting longer than 13 weeks. The target reduced to a maximum waiting time of 9 weeks by 31st March 2009. At 31st March 2009 there were 488 patients waiting more than 9 weeks. This target remained the same until 31st March 2011, with 8,581 patients waiting more than nine weeks at 31st March 2010 and 31,909 waiting more than nine weeks at 31st March 2011. The 2011/12 target included two elements, with a new maximum waiting time set, stating that from April 2011 at least 50% of patients should wait no longer than nine weeks for a first out-patient appointment, with no one waiting longer than 21 weeks. At 31st December 2011,

47.8% (59,378) of the total number waiting were waiting more than nine weeks, with 24,720 patients waiting more than 21 weeks.

Staffing

Health care professionals and facilities

The population of Northern Ireland in 2011 was 1,810,900. In September 2011 there were 5,006 doctors/dentists (excluding GP retainers and GDPs) in the NHS. This included: 1,453 consultants; 1,316 registrars; 536 other doctors in training; 1,160 GPs; and 541 other medical & dental staff. The number of doctors/dentists (excluding GP retainers and GDPs per 100,000 of population is 276. The number of qualified nurses (including Trust employed practice nurses only) per 100,000 of population is 811. Please note that this is not comparable with England because of the integration of social services and health in Northern Ireland. The number of principal General Dental Practitioners per 100,000 of population at 2011 was 54.

Article 11, Paragraph 2 - advisory and educational facilities

Healthy Child Programme

1. The *Healthy Child Programme, Pregnancy and the first five years of life,* published in 2009[1], 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.

2. In July 2011, the Department of Health and Department for Education jointly published *Supporting Families in the Foundation Years* (FitFY)[2] which sets 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.

3. 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 and to doubling the number of families benefiting from the Family Nurse Partnership for disadvantaged teenage parents.

4. 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.

5. In 2009 the Department of Health published the Health 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.

6. 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.

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

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

Public Health

7. 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.

8. 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.

9. The Department has also published a number of documents setting out ambitions for health in England covering drugs, tobacco, alcohol and physical activity. The Public Health Responsibility Deal brings together as of August 2012 over 400 partners across business and wider civil society, who have made a number of pledges to improve health. But the Government will intervene only where necessary, freeing up individuals and communities as much as possible to find local solutions to local problems.

10. There will be a new public health agency, Public Health England (PHE), which will bring together the expertise of a wide range of public health organisations, including the Health Protection Agency, the National Treatment Agency for Substance Misuse and the Public Health Observatories. 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;

[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/

- lead for public health by encouraging transparency and accountability across the system and supporting public health policy development and building the evidence base; and
- develop the workforce by supporting the development of the specialist and wider public health workforce.

11. PHE will largely focus on England, although it will inherit the UK-wide statutory functions currently exercised by the Health Protection Agency, and may carry out other functions by agreement with the Devolved Administrations

12. 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.

13. 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.
- Commission the NHS health checks programme.
- Commission the national child measurement programme.

14. 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

15. 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

Northern Ireland

16. The Department of Health, Social Services and Public Safety 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.

ECSR Conclusions - Health education in schools

The Committee requests the next report to provide up to date information on health education in schools.

Healthy Schools - Tools and planning aids

17. Schools play an important role in supporting the health and wellbeing of children and young people. The Healthy Schools toolkit[1] is designed to help schools to 'plan, do and review' health and wellbeing improvements for their children and young people and to identify and select activities and interventions effectively. This approach seeks to ensure that schools put in place the most appropriate services to meet the needs of children and young people.

18. The toolkit is based on a health behaviour change approach for schools and contains:

- an overview of the Healthy Schools approach;
- examples of schools making health and wellbeing improvements;
- a planning template, a whole school review template and a school story template that can be adapted for each school; and
- information with frameworks to help identify needs, define health and wellbeing outcomes, select activities and interventions and to review achievements.

Principles of evidence-informed practice

[1] http://www.education.gov.uk/schools/pupilsupport/pastoralcare/a0075278/healthy-schools

19. Healthy Schools aims to encourage schools to use evidence-informed practice[1] when selecting activities/interventions during the 'Plan' phase. The practice principles derive from an evidence review conducted by Edcoms, a communications and research agency, in 2010 on behalf of the Department of Health, to identify what works in the school setting to improve the health behaviour of 5-19 year olds.

20. The review drew out some key evidence around how to support health behaviour change with 5-19 year olds on the subjects of: Alcohol; Drugs: Healthy Eating; Physical Activity; Sexual Health and Tobacco.

Northern Ireland

21. In Northern Ireland, a revised curriculum was introduced during the period 2007/08 to 2009/10. The new curriculum is less prescriptive giving teachers more flexibility over how they deliver the curriculum to meet the needs of individual pupils. The minimum to be taught is set out as Areas of Learning (AoL) for each key stage within the Education (Curriculum Minimum Content) Order (NI) 2007.

22. Opportunities for young people to develop knowledge, understanding and skills to deal with issues such as:

- smoking and alcohol abuse;
- relationship and sexuality education;
- road safety; and
- healthy eating

are covered in the new AoLs called Personal Development & Mutual Understanding (PDMU) at Primary level, and Learning for Life and Work (LLW), (personal development strand), at Post Primary level. The Council for Curriculum, Examinations and Assessment (CCEA) has provided guidance materials and resources to all schools to support them in the teaching of Personal Development.

23. In addition, the revised curriculum makes Home Economics compulsory for all pupils in Key Stage 3 (11-14 years old.

[1] http://media.education.gov.uk/assets/files/zip/h/school%20stories.zip

Article 11, Paragraph 3 - the prevention of diseases
Infectious Diseases

1. Health protection legislation was updated in England from April 2010 to give public authorities modernised powers and duties to prevent and control risks to human health from infection or contamination, including by chemicals and radiation. These new measures include an updated system for notification of cases of infectious diseases that may pose a significant risk to human health by attending registered medical practitioners, and a new requirement for notification by diagnostic laboratories of causative agents of infectious diseases identified in human samples[1]. A cross-government 'National Framework for responding to an influenza pandemic' was issued November 2007 and is supported by detailed operational and infection control guidance contingency plans are in place to deal with a range of diseases, particularly zoonotic diseases that require a multidisciplinary approach such as West Nile Virus, SARS and rabies.

2. The childhood immunisation programme continues to maintain high levels of vaccine coverage. Influenza and pneumococcal vaccination programmes are also carried out to immunise high risk groups which include older people. Since 2006, pneumococcal vaccination is now also part of the routine childhood immunisation programme, and it is planned to extend the influenza programme to children aged 2-16 years. The human papillomavirus (HPV) vaccine is being offered routinely to all 12- to 13-year-old girls (school year 8) to protect them against their future risk of cervical cancer. A catch up campaign has also taken place for girls up to the age of 18 year. Immunisation programmes for rotavirus (infants) and shingles (older people) are under consideration.

Reduction of Environmental Risk

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

Air Quality Strategy

In the previous Conclusions, the Committee of Social Rights noted that the UK Government and the devolved administrations published the latest Air Quality Strategy for England, Scotland, Wales and Northern Ireland on 17 July 2007 and asks for the next report to provide information on measures taken following the strategy

Local air quality management

4. The Department for the Environment and Rural Affairs (Defra) and the devolved administrations provide support for local authorities and practitioners

[1] www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114510

to meet these requirements, including the operation of a helpdesk, tools for air quality modelling and monitoring and provide information in these pages about Review and Assessment and Action Planning.

- Guidance
- LAQM support
- Helpdesk
- FAQs
- Review and assessment
- Action planning

5. Local authorities in the UK have statutory duties for managing local air quality under Part IV of the Environment Act 1995 and in Northern Ireland, Part III of the Environment (Northern Ireland) Order 2002.

6. They are required to carry out regular reviews and assessments of air quality in their area against standards and objectives prescribed in regulations for the purpose of local air quality management (LAQM) before undertaking Action Planning if air quality is found to breach the regulations.

7. Up to date information on air quality is at:

England - http://www.defra.gov.uk/environment/quality/air/air-quality/

Scotland - Air Quality in Scotland www.scottishairquality.co.uk

Wales - Air Quality in Wales - the Welsh Air Quality Forum: http://www.welshairquality.co.uk/

Northern Ireland

8. The policy on prevention of air pollution in Northern Ireland is broadly reflective of that applicable across the rest of the UK.

9. The Department of the Environment in Northern Ireland provides technical and financial assistance to local councils to help them assess and manage their local air quality. Real time and archived air quality information is available to the public on the dedicated NI air quality website: www.airqualityni.co.uk, and an annual report on air quality in Northern Ireland has been published by the Department for 2008, 2009 and 2010.

10. A report detailing research on polycyclic aromatic hydrocarbons in ambient air in Northern Ireland[1], an issue shown to be linked to residential coal burning – was published in 2012. The department hopes to take forward this work with further research and to develop policy in this area.

1 http://www.doeni.gov.uk/index/protect_the_environment/local_environmental_issues/air_and_environmental_quality/research.htm

11. Regarding air pollutant emissions from transport, strategic regional and local policy measures are being taken forward by the Department for Regional Development and Roads Service. These measures aim to promote a more sustainable future for transport in Northern Ireland.

Water Strategy

12. The Water Supply (Domestic Distribution Systems) Regulations 2010 (No. 157) further transpose the requirements of Directive 98/83/EC by ensuring that remedial action must be taken where any water quality failure in premises where water is supplied to the public is attributable to the domestic distribution system.

13. The Water Supply (Water Fittings) Regulations (Northern Ireland) 2009 (No. 255) aim to prevent the:

- waste;
- misuse;
- undue consumption; and
- contamination

of drinking water supplied by NI Water.

14. A Water Safety Plan is based on a comprehensive risk assessment and risk management approach that encompasses all steps in the water supply chain from catchment to consumer. The Regulations represent the final stage in the Water Safety Plan approach, and are designed to ensure that water systems in premises do not contaminate the wider mains water supply

15. In 2008, the Department of Agriculture and Rural Development published “The Code of Good Agricultural Practice for the Prevention of Pollution of Water, Air and Soil”. The Code gives practical advice on management practices that can be implemented on farm and underpins the Department’s advisory services. A further update of the Code is scheduled for 2012/2013 to accommodate recent changes to relevant legislation.

16. The water undertaker is working with the agricultural sector to advise on good land management practices that will result in lees pollution of water sources

Contaminated Land

17. Part III of the Waste and Contaminated Land (Northern Ireland) Order 1997 contains the main legal provisions for the introduction of a contaminated land regime in Northern Ireland. This has not been commenced. The Department of the Environment deals with contamination issues on an individual site basis through existing planning and environmental protection controls as part of the process of changing their use. Applications for development or change of land use, made via the planning process, have

dealt effectively with historical contaminated land sites as they were undergoing redevelopment.

18. The Pollution Prevention and Control Regulations (Northern Ireland) 2003 and the Environmental Liability (Prevention and Remediation) Regulations (Northern Ireland) 2009 provide controls in respect of new contamination and pollution.

19. In 2013, the Department will carry out an assessment of the environmental, financial and health risks associated with having a contaminated land regime which differs from that in other regions of the UK. When the outcome of the assessment is known, the Department will be in a position to make an informed decision on the appropriate way forward.

Noise

20. In March 2010 the Department for the Environment and Rural Affairs (Defra) released the Noise Policy Statement for England[1] which contains the Government's policy on noise. It sets out the long term vision of promoting good health and a good quality of life through the management of noise.

21. The Statement sets out the Government's Noise Policy Vision: 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 also establishes three aims relating to avoiding significant adverse impacts on health and quality of life, mitigating and minimising such adverse impacts and, where possible, to contribute to the improvement of health and quality of life.

22. The policy represents an important step forward, by helping to ensure that noise issues are considered at the right time during the development of policy and decision making, and not in isolation. It highlights the underlying principles on noise management already found in existing legislation and guidance. The policy was developed in consultation with key partners within and outside of government. Further to the approaches set out in the Policy Statement, an Interdepartmental Group on Costs and Benefits noise subject group (IGCB(N)) has been set up to develop, agree and disseminate good practice in the use of techniques to monetise the costs of noise.

Northern Ireland

23. Northern Ireland is considering developing a similar policy with direct relevance to the legislative and enforcement structure applicable in that region.

Noise Mapping

[1] http://www.defra.gov.uk/publications/2012/04/05/pb13750-noise-policy-england/

24. The EU Directive 2002/49/EC relating to the assessment and management of environmental noise, commonly referred to as the Environmental Noise Directive ("END") was published in July 2002. The aim of the END is to avoid, prevent or reduce on a prioritised basis the harmful effects, including annoyance, due to exposure to environmental noise. It focuses on the impact of such noise on individuals, complementing existing EU legislation, which sets standards for noise emissions from specific sources.

25. The END required Member States to determine noise exposure through noise mapping, make information available to the public and establish Action Plans. The noise maps provide an overview of the ambient noise climate (unwanted or harmful outdoor sound created by human activities, including that created by transportation, such as road, rail and air traffic, and from industrial activity) in cities and major transportation sources across Europe. The maps indicate for the number of people affected by different levels of ambient noise, the source of that noise (i.e. road, rail, air or industry) and the locations of the people affected. The Northern Ireland noise maps are available to view at www.noiseni.co.uk

26. The mapping was carried out during 2006-07 and 2011-2012 in line with the Department's work to implement the END.

Regulations

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

28. The action plans will seek to manage noise issues and effects including noise reduction if necessary, based on the results obtained through the mapping process. 2011-12 Noise mapping has been completed in Northern Ireland and the next stage of the Defra's work to implement the directive will be to develop action plans. This will include a public consultation.

Clean Neighbourhood and Environment Act (Northern Ireland) 2011

29. This Act came into operation in April 2012 and in addition to clarifying the definition of statutory nuisance, it introduces new powers for district councils in Northern Ireland to deal with audible intruder alarms. The Act also extends the range of premises against which a council can take action under the Noise Act 1996 (which was previously only adopted by Belfast City Council).

United Kingdom - Food Safety

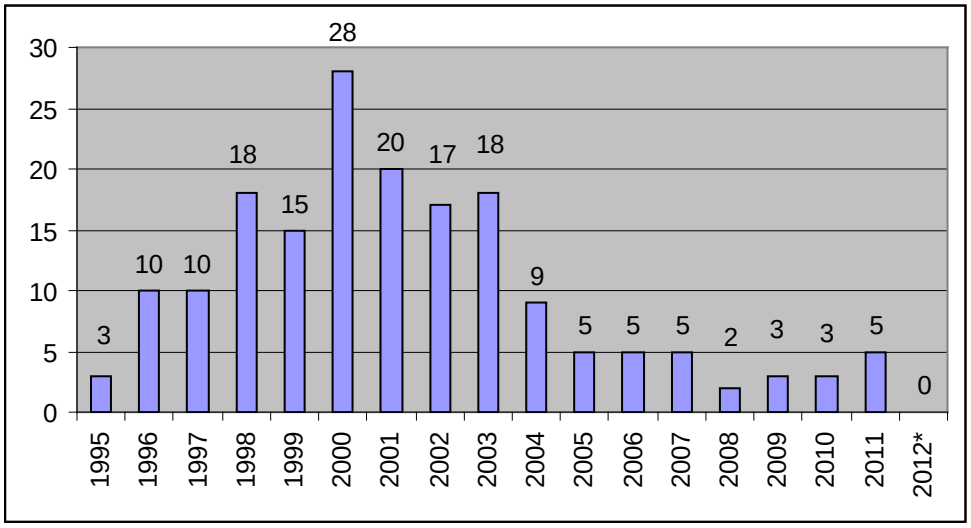
Creutzfeldt-Jakob Disease (CJD)

30. As at 3 September 2012, there have been 176 definite and probable cases of variant CJD (vCJD) in the United Kingdom, of whom none is still alive – see table below. It is thought that most of these cases arose from exposure to Bovine Spongiform Encephalopathy (BSE) infectivity in bovine meat products in the 1980s and early 1990s, before wide-ranging measures minimising potential exposure were introduced. Three cases were probably a result of secondary transmission via non-leucodepleted blood from donors who themselves later developed vCJD.

31. Based on a recent study of the prevalence of the abnormal prion protein associated with vCJD in archived appendix samples, it is estimated that around 1 in 2,000 people in the UK have asymptomatic vCJD (with a statistical confidence interval of between 1 in 3,500 and 1 in 2,500). 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.

32. 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 have since fallen to zero in 2012 to date. There have been no onsets of clinical vCJD in the UK since September 2010.

Number of deaths per annum from vCJD in the UK



33. 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

34. Shortly after vCJD was first identified, the possibility of human-to-human transmission through blood was considered, and precautionary

measures were implemented to reduce what was, at that time, a theoretical risk. The measures were tightened as evidence of transmission via blood began to emerge from animal studies, and following the first possible case of transfusion associated transmission in humans in 2003. 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. In addition, blood products are imported from countries unaffected by vCJD; and since March 2004, all those who have received a blood transfusion since January 1980 have been excluded from blood donation. The Government receives expert advice on potential risks and their management from independent scientific advisory committees.

Surgery/Dentistry

35. Advice has been published on the decontamination, quarantining and where appropriate use as single use only of surgical equipment (including endoscopes), and on the assessment of patients before surgery to identify patients with, or at risk of, CJD. Advice has been issued to all dentists in the UK to use endodontic reamers and files as single use only.

Alcohol

36. The Government is seeking to turn the tide against irresponsible drinking and the Government Alcohol Strategy[1] (March 2012) sets out how local and national government, the alcohol industry and people themselves can achieve this.

37. The strategy includes a strong 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.

38. 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.

There will be an alcohol check within the NHS Health Check for adults from April 2013.

39. Dame Sally Davies, the Chief Medical Officer, will oversee a UK-wide review of the alcohol guidelines so that people at all stages of the life can make informed choices about their drinking.

[1] http://www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol

40. 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.

41. The strategy proposed steps to stem the flow of cheap alcohol by introducing a minimum unit price for alcohol and consulting on a ban on multi-buy price promotions in shops. The Government intends to consult on these measures later in 2012 with a view to introducing primary legislation in 2013

42. 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 9 million people say they drink above the guidelines[1];
- 1.2 m hospital admissions are alcohol-related (7% of the total);
- alcohol is the third biggest lifestyle risk factor for disease and death after smoking and obesity;
- the estimated cost for the NHS around £3.5bn every year; and
- and over 15,000 deaths each year in England are thought to be caused by alcohol.

43. 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[2].

Obesity

44. Levels of overweight and obesity in England continue to remain high. Sixty two per cent of adults, and 30 per cent 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. The *Call to action on obesity in England*[3] was published in October 2011 and sets out:

- a new national ambition to create a downward trend in excess weight in children and adults by 2020;
- that obesity is everybody's business and it is the responsibility of individuals to change their behaviour;
- a focus on adults as well as children, and prevention as well as treatment, and
- a goal to reduce our calorie intake by five billion calories a day, with a challenge to business to play a key part.

[1] For men no more regularly than between 3 to 4 units daily; for women no more regularly than between 2 to 3 units daily

[2] Government's Alcohol Strategy: written evidence submitted by oral witnesses pages 14- 31 /ww.parliament.uk/documents/commons-committees/Health/Writtenevidencebyoralwitnesses.pdf

[3] http://www.dh.gov.uk/health/2011/10/call-to-action/

45. The Public Health Responsibility Deal was established in March 2011 to tap into the potential for businesses and other organisations to improve public health and tackle health inequalities. It challenges them to lead the way in positively shaping and creating an environment that supports people to make informed, balanced choices and live healthier lives.

46. Business and other stakeholders are invited to become partners and pledge to take action. There are five networks covering food, alcohol, health at work, physical activity and behaviour. For example, industry has taken action to cut salt, and trans-fats in our foods, as well as putting calories on menus. Already over 70 per cent of high street fast food and takeaway meals have calorie labelling.

47. In response to the Call for Action on Obesity in England, The Government recently announced the first wide-ranging actions being taken by over 20 major food companies to cut and cap calories, including steps to promote healthier food choices. Thirty three leading drinks companies have also committed to a greater choice of lower strength alcohol products, as well as smaller measures by 2015 – taking a billion units of alcohol out of the market. Further details of the Responsibility Deal are at http://responsibilitydeal.dh.gov.uk/

48. After smoking, poor diet, inactive lifestyles and drinking alcohol above the recommended levels are the most significant drivers of poor health. Initiatives have been put in place addressing the needs of the public and working with manufacturers and retailers

49. Change4Life was launched in 2009 following a substantial programme of research including ethnographic studies. At first, the campaign was aimed at families with children aged 5-11 years but recognising that parental (and grandparental) modelling of poor behaviour continued to have a negative impact on children the campaign expanded into a whole family approach.

50. The Change4Life campaign was later joined by its sister brand Start4Life, which helps pregnant mums-to-be and mums of babies aged 0-5 to adopt healthy behaviours that give their babies the best start in life. In 2011 the alcohol harm campaign was brought under the umbrella of Change4Life

51. Change4Life has subsequently been extended to address the significant issue of alcohol misuse. A new campaign warning people that drinking over the lower-risk guidelines can seriously impact their long-term health launched in February 2012.

52. Change4Life, in the spirit of the Big Society, has formed a relationship through regular communication with a large number of “local supporters” (over 70,000). This places local people, both public spirited individuals and professionals, at the centre of a societal movement for better health. The “local supporters” have proved to be an effective “sales” force and this model is likely to be replicated with other health areas.

53. Change4Life has a number of national partners who contribute mainly in kind or with marketing assistance. Partners have to fulfil a number of criteria before they are allowed to use the Change4Life branding and creative assets. Change4Life has prepared its own "Retail Guidelines", these list food product categories which meet our criteria.

54. Marketing is only one element in the influence that commercial organisations have over consumer choice. As part of the broader health "Responsibility Deal" many commercial partners have already made commitments towards other changes in their business practices, such as the removal of transfats and the addition of calorie labelling for restaurant menus

ECSR Conclusions Introduction - General question on rehabilitation and facilities for drug addicts

55. Each of the four countries has on line facilities providing confidential advice and guidance or links to further services as a first point of call.

In England: "Frank" http://www.talktofrank.com/
In Wales: Dan 24/7 http://dan247.org.uk/Services_Drugs_Alcohol.asp

In Scotland: the Scottish Drug Service
http://www.scottishdrugservices.com/sdd/homepage.htm
In Northern Ireland: NIDirect http://www.nidirect.gov.uk/getting-help-with-drug-or-alcohol-problems

England

56. Additionally, the NHS Choices website – *'Drugs Getting Help'* (http://www.nhs.uk/Livewell/drugs/Pages/Drugtreatment.aspx) provides information on, and links to, local drug treatment and rehabilitation services that are provided by the NHS, and some specialist drug facilities run by charities and private organisations. Outside the NHS, there are many voluntary sector and private drug and alcohol treatment organisations that offer help. There are also residential rehabilitation centres and community services of various types provided by voluntary organisations. These include: structured day programmes; outreach and harm reduction services; counselling services; aftercare; and housing support services.

NHS National Treatment Agency for Substance Misuse

57. More detailed information is set out in the National Drug Treatment Monitoring System Statistics:
http://www.nta.nhs.uk/uploads/statisticsfromndtms201112vol1thenumbersfinal.pdf

The Main findings are summarised as follows:

- Of the 197,110 clients aged 18 and over in treatment contact during 2011-12, 185,428 were in treatment for 12 weeks or more or completed treatment free of dependency before 12 weeks (94%).
- 29,855 (47%) of clients exiting treatment in 2011-12 completed treatment, defined as having overcome their dependency; a further 8,524 (14%) were transferred for further treatment within the community, while 7,123 (11%) were transferred into structured treatment while in custody.
- Of those opiate only clients with a six month review in 2011-12, 51% achieved abstinence from illicit opiates and a further 23% were classified as reliably improved. A further 3% had deteriorated.
- 63% of crack only clients with a six month review in 2011-12 achieved abstinence from crack cocaine and a further 8% were classified as reliably improved. 2% had deteriorated.
- Clients' median age at their first point of contact in their latest treatment journey in 2011-12 was 35 and 73% of clients in treatment were male.
- Most clients were White British (83%), while no other ethnic groups accounted for more than 2% of clients.
- Most clients in contact with treatment were using opiates (81%). Cannabis was the primary drug for 8% of clients and powder cocaine for 5% of clients.
- The most common routes into treatment for clients starting treatment in 2011-12 were self-referrals (40%) and referrals from the criminal justice system (29%).
- Onward referrals from other drug services together accounted for 13%.
- 85% of the clients starting new treatment journeys in 2011-12 were either in treatment for 12 weeks or more or completed treatment free of dependency before 12 weeks.
- Nearly all clients waited less than three weeks to commence treatment (97%).
- Of the clients starting treatment (and where reported) just over half (55%) reported having never injected with 18% currently injecting at time of presentation.
- Where reported, 9% of clients starting new journeys had No Fixed Abode on presenting for treatment, and a further 15% of clients had other housing problems.

58. Numbers in treatment and trends in waiting times during reference period are set out in the tables below:

Table 5.3.1: Numbers in treatment and numbers retained for at least 12 weeks or completing treatment earlier 2005-06 to 2011-12

Year	Number in contact with treatment services	Number retained for at least 12 weeks or	% retained/completing of all in contact

		completing treatment earlier	
2005-06	175,869	145,051	82
2006-07	194,173	163,886	84
2007-08	200,805	182,775	91
2008-09	210,815	194,572	92
2009-10	206,889	192,367	93
2010-11	204,473	191,129	93
2011-12	197,110	185,428	94

Table 5.4 Trends in waiting times for first intervention

Table 5.4.1 shows trends in waiting times for a client's first intervention, between 2006-07 and 2011-12. This shows an increase in the proportion of clients waiting less than 3 weeks, from 87% in 2006-07 to 97% in 2011-12.

Table 5.4.1: Waiting times for first intervention, 2006-07 to 2011-12

Year	Under 3 weeks (n)	%	Over 3 weeks (n)	%
2006-07	62,375	87	9,143	13
2007-08	71,678	91	7,108	9
2008-09	76,168	93	5,660	7
2009-10	73,059	94	4,315	6
2010-11	69,699	96	2,906	4
2011-12	66,358	97	1,860	3

Scotland

59. The NHS Scotland website provides information on current drugs policy and research, as well as links to relevant NHS Health Scotland resources and related websites. http://www.healthscotland.com/drugs.aspx

60. Drug Misuse Statistics Scotland 2011 can be viewed at: http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2012-02-28/2012-02-28-dmss2011-report.pdf

Wales

61. The Welsh Assembly Government's 'Working Together to Reduce Harm' - The Substance Misuse Strategy for Wales 2008-2018 is at http://wales.gov.uk/topics/housingandcommunity/safety/publications/strategy0818/?lang=en

62. The Assembly Government's Annual report on Working Together to Reduce Harm - Substance Misuse for 2012 is at: http://wales.gov.uk/topics/health/publications/health/reports/substance/?lang=en

63. Chapter 2 of the Report covers support for substance misusers – aiding and maintaining recovery. Paragraph 55, on 'Tier 4 Services' (Residential Rehabilitation and Inpatient Detoxification Services), explains that the majority of substance misusers would be treated in the community with the support of substance misuse statutory and voluntary sector services. However a small minority will require more specialist inpatient care. To support these clients the Welsh Government continues to ring fence £1.0m

per annum of the Substance Misuse Action Fund allocated to Community Safety Partnerships (CSPs) for the provision and improvement of Tier 4 services. In 2011-12 a total of 135 people were admitted to Tier 4 services.

Northern Ireland

64. In December 2011 the Northern Ireland Executive approved the revised strategy to prevent and address the harm related to alcohol and drug, known as the New Strategic Direction for Alcohol and Drugs Phase 2 (this can be found online at: http://www.dhsspsni.gov.uk/new_strategic_direction_for_alcohol_and_drugs_phase_2__2011-2016). This framework builds on the previous strategy, which was originally launched in 2006.

65. The development and consultation processes for the revised strategy highlighted a number of priority areas for action, and these include:

- developing a regional commissioning framework for treatment services;
- tackling underage drinking, and alcohol and drug-related anti-social behaviour;
- targeting those at risk and vulnerable;
- reducing the availability of illicit drugs; and
- addressing local community issues.

66. In addition, there are a number of emerging issues that the NSD Phase 2 also seeks to address, including:

- emerging drugs of concern / “legal highs”;
- families and hidden harm;
- population approach to alcohol – role of promotions and price;
- mental health, suicide, sexual violence and abuse, and domestic violence;
- prescription or over-the-counter drugs; and
- recovery.

67. The Department of Health, Social Services, and Public Safety allocates around £8 million to the implementation of the NSD each year. In addition almost £8 million is provided through the mental health budget for the provision of treatment services.

68. Information on persons seeking treatment for alcohol and drug misuse in is available within the 2010-2011 Northern Ireland Drug Misuse Database (http://www.dhsspsni.gov.uk/dmd_bulletin_2010-11.pdf) and the Northern Ireland 2012 Census of Drug and Alcohol Treatment Services (http://www.dhsspsni.gov.uk/census_bulletin_march_12.pdf). A report completed in 2006 (http://www.dhsspsni.gov.uk/opiate_cocaine.pdf) indicated that the overall prevalence of opiate use (and indeed problem drug use) in Northern Ireland remains lower than the prevalence in other parts of the United Kingdom or the island of Ireland. The same report also compares the number of estimated users to those in treatment.

Country	Number	Population (15-64)	Rate (per 1,000)
England	287,670	32,292,156	8.91
Republic of Ireland	14,452	2,588,700	5.58
Northern Ireland	**1,395**	**1,090,990**	**1.28**
Scotland	51,582	3,352,022	15.39

69. Most treatment for alcohol and drug users is delivered within the community and primary care setting by statutory and non-statutory services. Within the statutory services, treatment is typically provided through local community addiction teams consisting of a nurses, social workers and consultants in addictions psychiatry. In addition, there are in-patient treatment programmes with supervision in a controlled medical environment. The voluntary sector also provides a range of services covering counselling and residential places. In order to deliver the best outcomes for patients, it is essential that care pathways are in place covering through-care, aftercare, reintegration and recovery.

70. It is the duty of the Northern Ireland Health and Social Care Board and the Public Health Agency to assess the need for such services and then commission appropriately. Local addiction services are structured on a 4-Tier model:

- **Tier 1** – interventions include provision of drug related information and advice, screening and referral to specialised treatment (primary care, community services);
- **Tier 2** – interventions include provision of drug related information and advice, triage assessment, referral to structured drug treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare;
- **Tier 3** – provision of specialist community-based drug assessment and co-ordinated care-planned treatment and drug specialist liaison.
- **Tier 4** – provision of specialist in-patient and/or residential rehabilitation treatment.

71. Following the reform of the health service in Northern Ireland, the Department of Health, Social Services, and Public Safety tasked the Health & Social Care Board and the Public Health Agency with developing a Regional Commissioning Framework for Addiction Services, aimed at covering the full range of addiction services that should be available across Northern Ireland. This work is considering all drug and alcohol 'treatment' services, within both community and in-patient settings and taking account of both the statutory and non-statutory/independent sectors.

72. The development of a commissioning framework for addiction services provides an opportunity to look at increasing consistency across Northern Ireland, and delivering the best possible outcomes for those suffering from addiction.

73. A range of harm reduction services are also provide within Northern Ireland, including Needle and Syringe Exchange, Substitute Prescribing, the provision on naloxone, etc..

ECSR Conclusions

The Committee asks for the next report to provide information on trends in accidents as well as measures taken to prevent accidents; road accidents, domestic accidents, accidents at school, accidents during leisure time, including those caused by animals.

Statistics

Injury and Poisoning Mortality in England and Wales, 2010 can be viewed at: http://www.ons.gov.uk/ons/dcp171778_254689.pdf and key findings are:

- Injury and poisoning deaths accounted for 3.5 per cent of all deaths registered in England and Wales in 2010. This proportion has remained largely unchanged over the last decade.
- Seventy-nine per cent of female injury and poisoning deaths in 2010 were unintentional, compared with 62 per cent for males.
- The highest rate of accidental deaths in 2010 was from falls; replacing transport accidents which had the highest rate in 2009.
- The mortality rate for transport accidents fell 41 per cent between 2001 and 2010, from 56.6 deaths per million population in 2001, to 33.6 deaths per million in 2010

Trends in road accidents
http://assets.dft.gov.uk/statistics/releases/road-accidents-and-safety-annual-report-2011/rrcgb2011-01.pdf

General overview and trends in reported road casualties 2011
http://assets.dft.gov.uk/statistics/releases/road-accidents-and-safety-annual-report-2011/rrcgb2011-01.pdf

Monitoring reported deer road casualties and related accidents in England to 2010
(Final Report to Highways Agency Deer Initiative - Research Report 11/3.)
http://www.deercollisions.co.uk/ftp/DI%20England%20Monitoring%20DVCs%20to%202010/DI-DVC_England2011_Main_final_rev.pdf

Scottish National Heritage - Deer Vehicle Collisions in Scotland Monitoring Project 2008-2011
http://www.snh.gov.uk/docs/C326794.pdf

Road Safety Framework
The Department for Transport and the Highways Agency published a Safety Framework for the Strategic Road Network in 2011 which can be viewed at:
http://assets.highways.gov.uk/our-road-network/road-user-information/Safety_Framework_for_the_Strategic_Road_Network_2011.pdf

Royal Society for the Prevention of Accidents

The Royal Society for the Prevention of Accidents (RoSPA) was established almost 100 years ago and is a registered charity whose patron is Her Majesty the Queen. Its aim is to: campaign for change; influence opinion; contribute to debate; educate; and inform - for the good of all. By providing information, advice, resources and training, RoSPA is actively involved in the promotion of safety and the prevention of accidents in all areas of life - at work, in the home, on the roads, in schools, at leisure and on, or near, water. Further information on RoSPA is at:
http://www.rospa.com/about/default.aspx

RoSPA's Home and Leisure Accident Surveillance System has some limited statistical information on domestic accidents at:
http://www.hassandlass.org.uk/query/index.htm

Accidents to children in the home: advice and guidance on measures to prevent them can be found at:
http://www.nhs.uk/conditions/Accidents-to-children-in-the-home/Pages/Introduction.aspx

The Child Accident Prevention Trust
The Child Accident Prevention Trust (CAPT) is the UK's leading charity working to reduce the number of children and young people who are killed, disabled or seriously injured in accidents. CAPT has several government and statutory partners, including the respective Departments for Education; Health; Transport and the Scottish Government. Information about CAPT and the advice and guidance it issues can be viewed at: http://www.capt.org.uk/what-we-do

Northern Ireland

The first Home Accident Prevention Strategy and Action Plan 2004-2009 for Northern Ireland aimed to facilitate a reduction in the number of accidental deaths and injuries in the home by raising awareness of home safety, and promote a change in attitudes and behaviour towards home accident prevention. A review of that Strategy recognized the significant progress in implementing the Strategy's action plan. It highlighted key achievements which included the delivery of public awareness campaigns; production of educational resources; delivery of home safety checks, with the provision of safety equipment where required and onward referrals where appropriate; and the delivery of falls prevention programmes. The review noted that falls in the home continues to be the leading cause of death and falls prevention continues to be a key challenge to be addressed. Following the review recommendation, the DHSSPS is leading on the development of a new 10 year Home Accident Prevention Strategy for Northern Ireland to set out the next phase to reduce the number of accidental deaths and injuries in the home.

Wales – Article 11, Paragraphs 1 to 3

1. Responsibility for health and health services in Wales has been devolved to the Welsh Assembly Government since 1999; this part of the report highlights areas where actions in Wales differ to those in England.

2. The information in the report for the period 2008 to 2011 has been presented under the following headings :
A. Healthcare;
B. Public Health;
C. Health Improvement; and
D. Health Protection

A. Healthcare

3. 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*.

4. *Together for Health* identifies a number of themes that collectively set the vision and direction of travel for the National Health Service in Wales (NHS). It sets an ambitious course and should deliver substantial and measurable improvement in health and health care across Wales.

5. It addressed eight major themes:

- improving health and reducing health inequalities;
- mobilising society to support this aim;
- improving quality in health services;
- improving health outcomes for patients;
- restructuring and modernising services;
- being honest and transparent about performance;
- creating a new relationship with the public and patients;
- making far better use of money;
- developing a close partnership with those who work for the NHS.

6. Building on this, a number of delivery plans have been developed e.g. cardiac, cancer, diabetes, stroke and end-of-life care, and some have been published in 2012.

Maternity Services

7. The Welsh Government published its *Strategic Vision for Maternity Services in Wales* in September 2011. The vision states that it will deliver a service that promotes pregnancy and childbirth as an event of social and emotional significance where women and their families are treated with dignity

and respect. For every mother wherever they live and whatever their circumstances, pregnancy and childbirth will be a safe and positive experience so that she, her partner and family can begin parenting feeling confident, capable and well supported in giving their child a secure start in life.

8. Five key themes for action have been developed and the Welsh Government expects the NHS to take action to deliver maternity services which:

- place the needs of the mother and family at the centre so that pregnancy and childbirth is a safe and positive experience and women are treated with dignity and respect;
- promote healthy lifestyles for pregnant women which have a positive impact on them and their family's health;
- provide a range of high quality choices of care as close to home as is safe and sustainable to do so, from midwife to consultant-led services;
- employ a highly trained workforce able to deliver high quality, safe and effective services; and
- are constantly reviewed and improved.

National Population Screening Programmes in Wales

9. Wales has established adult screening programmes for breast, bowel and cervical cancer as well as maternal and child health programmes that include Antenatal, Newborn Hearing and Newborn Bloodspot screening.

10. In January 2011, the Welsh Government announced a £10m investment to upgrade the breast screening service from analogue equipment to digital. The investment included the procurement of 10 new mobile screening units.

11. Work is underway to develop an Abdominal Aortic Aneurysm screening programme for men aged 65 years, with implementation likely to commence during 2013.

12. Projects are also underway to facilitate the introduction of two new tests for MCADD (Medium Chain Acyl Dehydrogenase Deficiency) and sickle cell disorders to the Newborn Bloodspot programme and combined Down's syndrome screening as part of the Antenatal programme.

Medical and Dental Provision

13. At 30 September 2008 there was a whole-time equivalent number of 5,571 medical and dental staff employed by the NHS in Wales. This included 1,933 consultants. By 30 September 2011 there were 5,813 medical and dental staff including 2,171 consultants. Over the same period the number of GPs in Wales increased from 1,940 in 2008 to 2,022 in 2011.

14. The whole-time equivalent number of nurses employed by the NHS in Wales (excluding practice nurses) was 27,806 in 2008 and 27,999 in 2011. The number of nurses (excluding practice nurses) per 100,000 population was around 930 in both years. The number of dentists per 100,000 population increased from 42 at 31 March 2008 to 45 per 100,000 population at 31 March 2011.

Waiting Times

15. The Welsh Government achieved its target of a minimum of 95% of patients to wait less than 26 weeks from referral to treatment in December 2009. Since then, due to capacity issues in certain specialities, most notably orthopaedics, the NHS in Wales has struggled to sustain the target on a monthly basis, and performance has fluctuated between 92 and 95%.

16. Recognising the problems within orthopaedics, the Welsh Government allocated an additional £65million over the three years 2011/12 to 2013/14, to remove backlog and introduce sustainable solutions, including introducing lifestyle programmes, improved musculoskeletal services and pain management. In the first year, this resulted in a fall of 92% in the number of patients waiting in excess of 36 weeks. Further improvements are expected in years 2 and 3.

Healthcare for Vulnerable Groups

17. The issues regarding access to healthcare by vulnerable groups, and those with protected characteristics, are varied and complex. Good practice and the knowledge and experience of delivering to diverse and sometimes complex groups will be shared across Wales. Strategies to address general health inequalities, including issues around diet and healthy eating, are addressed through our two key policies, *Our Healthy Future* and *Fairer Health Outcomes for All* (see paragraphs 25-29).

18. Our soon to be published new, age inclusive, mental health strategy for Wales, *Together for Mental Health,* acknowledges the issues regarding access to mental healthcare by vulnerable groups, including those with protected characteristics. The strategy contains a specific outcome to reduce inequalities in access and reduce poorer outcomes experienced by vulnerable groups.

19. The Mental Health (Wales) Measure 2010 has introduced new and expanded mental health services and rights to the people of Wales. It will ensure that more mental health services are available within primary care and improves access to mental health advocacy for people with mental health problems. It will make sure that all those in secondary care have a care coordinator, a prescribed care and treatment plan and, if discharged from that service, the right to directly request re-assessment.

20. An Effective Services for Vulnerable Groups work programme is already in existence, which is chaired by the Chief Executive of Aneurin Bevan Health Board. The work programme identifies, promotes and supports the development of collaborative approaches to delivery that will provide more effective and efficient services which can improve the life chances of vulnerable people.

21. The Welsh Government ring-fences £1m of its £22m Substance Misuse Action Fund budget for Tier 4 Inpatient Detoxification and Residential Rehabilitation services. This budget is allocated to the 22 Community Safety Partnerships across Wales and is required to be signed off by the Substance Misuse Area Planning Boards, which are co-terminous with the seven Health Boards in Wales. In addition Local Authorities may utilise their non ring-fenced social care budgets to fund additional residential rehabilitation places.

22. There are 4 registered* Residential rehabilitation facilities in Wales, being:

- Open Minds, Wrexham, North Wales (Drug and Alcohol);
- Ty'n Rodyn, Bangor, North Wales (Drug and Alcohol);
- Brynawel House, Llanharren, South Wales (Alcohol Only);
- Rhoserchan Residential Rehab, Aberystwyth, West Wales (Drug and Alcohol treatment).

23. There are three dedicated inpatient detoxification facilities in Wales, being:

- Adfer Ward, Whitchurch Hospital, Cardiff, South Wales (Drugs and Alcohol);
- Calon Lan Unit, Neath Port Talbot Hospital, South Wales (Drugs and Alcohol);
- Hafen Wen, Wrexham, North Wales (Drugs and Alcohol).

24. In addition a number of additional inpatient detoxification beds are available on adult mental health wards at various hospitals throughout Wales.

25. Only a small number of substance misusers will require inpatient treatment and the vast majority of clients will receive their treatment in the community. For those few that do require inpatient treatment, care pathways are in place and care plans are drawn up and tailored to suit individual needs. These plans will include both pre and post treatment support.

B. Public Health

* *Registered with Care & Social Services Inspectorate Wales (CSSIW)*

26. The Welsh Government published the *Our Healthy Future (OHF)* national public health strategic framework in 2009. OHF sets the strategic direction for public health in Wales to 2020. It has two overall goals: to improve the quality and length of life; and to achieve fairer health outcomes for all.

27. To progress these goals, OHF provides:

- strategic direction to 2020;
- a set of themes and priority outcomes for action;
- a systematic approach to integrated planning and action on public health;
- a renewed call for partnership working to deliver the OHF goals; and
- a platform for rebalancing systems and services towards health improvement and problem prevention.

28. *Fairer Health Outcomes for All (FHOFA)* is Wales's first national plan to tackle health inequities, and was published in March 2011.

29. FHOFA's overarching vision is improved health and wellbeing for all, with the pace of improvement increasing in proportion to the level of deprivation. It sets a target to improve healthy life expectancy for everyone and to close the gap between each quintile of deprivation by an average of 2.5%, by 2020. Public Health Wales are developing a measurement and monitoring system for the FHOFA target and a range of supporting indicators.

30. Action to deliver the overall FHOFA target is focused on the following seven priority areas:

- building health into all policies and policies into health;
- giving every children a healthy start in life;
- developing health assets (factors which improve health and well-being) in communities;
- improving health literacy;
- making health and social services more equitable;
- improving the health of the working age population; and
- strengthening the evidence base.

Public Health (Wales) Bill

31. The Programme for Government includes a commitment to "*consult on the need for a public health bill to place statutory duties on bodies to consider public health issues."*

32. This commitment continues the increasing emphasis placed on public health issues in recent years, and builds on key policies such as *Our Healthy Future* and *Fairer Health Outcomes For All.*

33. Early development work is focused on preparing to consult on the need for a Bill, rather than developing detailed proposals for a Bill's content. There are a number of options which could potentially be covered by a new Public Health Bill, if a Bill is to be introduced. There are no pre-determined proposals

for what a Bill's scope and structure should be, and these issues will be explored through the consultation process and further policy development work.

Public Health Wales

34. Public Health Wales was established as an NHS Trust in August 2009 and became fully operational on 1st October 2009.

35. Public Health Wales has the following functions:

- Provides public health services to Local Health Boards (LHBs), Local Authorities (LAs), voluntary bodies, the Welsh Ministers as well as the public. Such services include advice and information on health needs of relevant populations and information on health services quality and delivery;
- supports LHBs and LAs in providing health protection and improvement services and contribute to and where required, co-ordinate emergency responses. Such services include assessment of risks to population health, identification and control of infections, and the provision of advice and information on chemical and environmental hazards;
- provides population-based screening services;
- plans, develops and delivers health improvement services and programmes and advises on local public health strategic frameworks produced by LHBs;
- provides a public health intelligence service to LHBs, LAs, voluntary bodies, the Welsh Ministers as well as the public;
- develops and implements effective methods for communicating health information to the public in Wales; specifically providing support, advice and information to LHB Directors of Public Health in the preparation of local Annual Public Health Reports;
- provides leadership and support for the training, education and development of public health in Wales, working with partners within Wales and across the UK; and
- supports public health research and in particular facilitates strong links between the Observatory and public health research networks.

36. Public Health Wales employs approximately 1100 staff.

C. Health Improvement

Flying Start

37. Flying Start is part of a range of interventions aimed at addressing the impact of child poverty and helping to reduce health and educational inequalities. Flying Start recognises the link between multiple deprivation and low achievement. It builds on international evidence that positive, high-quality, interventions in the early years, with support for parents and carers can significantly improve a child's outcomes in relation to school and in the longer term, helping them to reach their potential.

38. Flying Start is a geographically targeted programme that provides a continuum of multi-agency services for the children and families in its target areas. These families are supported by an intensive health visiting service and can access a core entitlement that also includes free, quality, part-time childcare for two to three year olds, formal and informal parenting support and support for early language development. This entitlement is universally available to all families with children under 4 years of age in the areas in which it runs.

39. Flying Start health visitors have a reduced caseload of 110, allowing them to provide an intensive level of support to children and families. Flying Start children are sensitively screened against recognised developmental milestones enabling the earlier identification of additional needs and the development of tailored learning and care plans. Flying Start staff help to foster families understanding of the value of a healthy lifestyle and diet and play a vital role in reaching Government targets to improve immunisation uptake and breastfeeding rates.

40. Between 2008 and 2011 the programme supported approximately 18,000 children under 4 years of age, and their families, each year.

Health Promotion and Health Education in Schools

41. Following a pilot programme from 1995-1997 the Welsh Network of Healthy School Schemes (WNHSS) was launched in September 1999 to encourage the development of local healthy school schemes within a national framework. These local schemes support the schools in their area to implement changes related to health improvement. Over 99% of maintained schools in Wales for 3-18 year olds were actively involved by March 2010.

42. To ensure consistency of achievement, the WNHSS National Quality Award (NQA) was introduced in 2009. This has clear indicators for 4 aspects of school practice – Leadership and Communication, Curriculum, Ethos and Environment, and Family and Community Involvement – for 7 aspects of health (Mental and emotional health and wellbeing; food and fitness; personal development and relationships; substance use and misuse; environment; safety; and hygiene as a new requirement following the E.coli enquiry). In

addition there are specific criteria for the development of the school as a health promoting workplace; and minimum standards for food in schools, linked to *Appetite for Life*; and for hygiene, linked to *Teach Germs a Lesson.*

43. Schools apply for independent assessment for the National Quality Award after 9 years involvement in the scheme. 17 schools had achieved the NQA by December 2011.

44. There are opportunities across the school curriculum in Wales to support learners to develop the skills and knowledge to encourage a safe and healthy lifestyle from the Foundation Phase through to Post 16 education.

45. There are two Areas of Learning within the Foundation Phase Framework that specifically encourage healthy lifestyles. Personal and Social Development, Well-being and Cultural Diversity and Physical Development introduce children to the concepts of health choices and the importance of diet and how to keep safe and healthy.

46. The *Personal and social education framework for 7 to 19-year-olds in Wales* is the key document schools use when planning their PSE provision and has health and emotional well-being as one of its five key themes. This looks to address Welsh Government priorities, such as:

- Food and fitness;
- children and young people's mental health;
- sexual health; and
- substance misuse prevention.

47. There are further examples within a range of national curriculum subjects such as physical education and science that further strengthen these areas of learning.

48. A range of guidance materials is available to support schools for example Guidance circular 019/2010 *Sex and relationships in education in schools* and *Food and fitness in the school curriculum in Wales.*

49. Since 2004, the Welsh Government and the four Welsh Police Forces have jointly funded the All Wales Schools Liaison Core Programme (AWSLCP) which currently operates in the majority of primary and secondary schools in Wales. They look to teach learners about drug and substance misuse, social behaviour and community and personal safety.

Nutrition

50. In summer 2006 the food and fitness implementation plan for children and young people was launched. The 5 year plan set out ways in which the Welsh Government could help support parents and children and young people in their efforts to eat well, stay fit and achieve the highest standard of health possible. The plan identified actions in schools and the community, as well as training and resources for adults who work with children, to enable them to

learn about healthy eating and physical activity. All actions were implemented by the end of the 5-year period.

51. During 2008/09 an all Wales Hospital Nutrition Care Pathway and All Wales Food Charts were developed, a nutrition awareness campaign for hospital staff launched and health promoting vending introduced. 2009 saw the introduction of the All Wales Nutrition Care Pathway for hospitals, which details the pathway for the nutrition screening of patients on admission and the nutrition care throughout their hospital stay. Building on these achievements in 2010/2011 an All Wales Care Pathway for Community Health settings was piloted and rolled out across Wales.

52. The recommendations from the review of nutritional standards for patient food and drink highlighted that there was wide support for the introduction of Welsh Nutrition Standards for food provided to patients in hospitals and that they should be based on a combination of nutrient and food guidelines. The final standards were launched in late 2011.

53. In September 2008 the Health Promoting Hospital Vending Directions and Guidance were issued to the local health boards, providing clear definitions of what food and drink is permitted to be vended in hospitals in Wales.

54. A pilot scheme to improve access to healthier foods in leisure centres has resulted in a toolkit which is due to be published in 2012.

55. The Welsh Government has funded the Rural Regeneration Unit (RRU) to deliver a Community Food Co-operative Programme for Wales since 2004. The RRU work with communities to set up and support food co-ops with the ultimate aim of empowering them to take ownership of their food co-ops and to eventually run them independently from the support the programme provides.

56. The Welsh Government has funded MEND to deliver the national children obesity referral programme across Wales since 2008. MEND is a community based programme for overweight and obese children aged 5-7 or 7-13 and their families. The multi-disciplinary programme places equal emphasis on healthy eating, physical activity and behavioural change, empowering the child, building self confidence and personal development. Parents and carers join their children in each session to learn about a range of lifestyle choices and the benefits of being more active.

Physical Activity

57. The National Exercise Referral Scheme (NERS) is a Welsh Government funded scheme which has been developed to standardise exercise referral opportunities across all 22 Local Authorities and target clients who are at risk of developing chronic disease.

58. The NERS Scheme offers GPs and other Primary Care practitioners the opportunity to refer patients to exercise. Standard protocols for a number of chronic conditions are being implemented where there are rehabilitation programmes in operation and exercise professionals hold the necessary qualifications.

59. Launched in 2010, *Creating an Active Wales* is a 5-year strategic action plan that focuses on ensuring that all in Wales build physical activity into their daily lives. The action plan was developed in partnership with key stakeholders and partners. It focuses on four strategic aims to:

- develop and maintain a physical environment that makes it easier for people to choose to be more physically active;
- support children and young people to develop the skills to live active lives, and become active adults;
- encourage more adults to be more active, more often throughout life; and
- increase participation in sport, by all sectors of the population.

60. The actions in the plan will provide a menu of opportunities, recognising that activity can be accumulated through a variety of ways. This will be achieved by working to ensure that the environment supports people to be active as part of their daily life and providing opportunities directly for people to participate in play and recreational activities, such as dance or sport.

Tobacco

61. Following consultation, in December 2011 the Tobacco Control Action Plan for Wales was presented for approval in plenary by the Assembly for Wales. The Action Plan was well received by Assembly Members and received cross-party support for its aim to reduce smoking prevalence levels to 16% by 2020 with an ultimate vision of a smoke-free society for Wales. Smoking prevalence in Wales is currently 23%.

62. There has been a co-ordinated adolescent smoking prevention programme based on research which indicates that the uptake of smoking is a complex process and that no single intervention will be successful with all young people. There is a range of related interventions in addition to classroom teaching – Smokebugs and the Smokefree Class Competition and Assist - working together synergistically.

63. The SmokeBugs club is aimed at pupils aged 8-11 and involves some 16,000 young people annually. The Smokefree Class competition is aimed at 11-13 year-olds and involves some 10,000 young people annually.

64. In the Assist programme (previously ASSIST - A Smoking Cessation In Schools Trial), a peer nomination process is used to recruit influential pupils from Year 8 (12-13 year olds). These peer supporters are then trained by professional health promotion experts to intervene in everyday situations with

their peers to reduce smoking uptake and encourage smoking cessation. The ASSIST trial was shown to be effective in decreasing smoking uptake. Two-year follow-up results from the ASSIST trial, published in *The Lancet*, show that smoking prevalence continues to be lower in intervention schools.

65. Research has demonstrated evidence-based specialist smoking cessation services are a highly cost-effective way of helping smokers to stop smoking. Between March 2008 and December 2011, part of the Welsh Government's core funding to Public Health Wales was used to deliver Stop Smoking Wales (SSW), a national smoking cessation service in communities across Wales.

66. The Health Act 2009 gives Welsh Ministers the power to make Regulations placing restrictions on the display of price lists of tobacco products (which is aimed at preventing price lists being used as advertising tools) and the power to prohibit the sale of tobacco products from vending machines. Between 2009 and December 2011 the intention was to bring in a suite of legislative measures intended to protect children and young people.

67. These plans were delayed by judicial review action by the tobacco industry against the English regulations that ban the sale of tobacco from vending machines and the English regulations that ban (a) the Display of Tobacco Products; and (b) the Display of Tobacco Products Price Lists. This action was withdrawn and the Protection from Tobacco (Sales from Vending Machines) (Wales) Regulations 2011 were laid on 27 September and approved in Plenary on 18 October 2011. The other regulations that form the broad suite of measures are scheduled to come into force in 2012.

Alcohol

68. 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. An implementation plan was developed that includes a range of actions specifically targeted at tackling alcohol related harms. As part of the Implementation Plan the Welsh Government is delivering a combination of both population and individual level interventions such as brief interventions to address the harm caused by alcohol.

69. We also have a Strengthening Families Programme 10-14 (SFP), led by Cardiff University, which is a substance misuse prevention intervention for children aged 10 to 14 years old and their parents/carers. The programme aims to reduce alcohol, tobacco and drug misuse through strengthening known protective factors within the family environment, such as communication, resilience skills and parenting.

70. We established Alcohol Concern Cymru in 2009, as a non government organisation, to raise awareness of alcohol misuse issues across Wales

and support the delivery of the Substance Misuse Strategy for Wales 2008-18.

71. Recognising the importance of Social Norms, a comprehensive toolkit has been produced and provided for student welfare services with practical advice on addressing alcohol misuse. The toolkit aims to offer best practice guidelines for addressing alcohol misuse; give guidance on developing appropriate alcohol policy and provide information on student support services and addressing the social environment within Higher Education Institutions.

Mental Health Promotion

72. Between 2008 and 2011 Mental Health First Aid and Time to Change campaign were launched.

73. Mental Health First Aid (MHFA) is a 2 day evidence based training programme that teaches people about mental health problems and provides them with skills and confidence needed to help those experiencing mental distress. Provision of the programme will increase the number of people within our workplaces and communities who understand and have the skills to support people with mental health problems and in some instances save lives.

74. The MHFA programme has been rolled out to nearly 10,000 participants.

75. Mental Health First Aid for Children and Young People offers training for those working and living with young people. It teaches about key mental health issues and how to assist a young person in distress. Rolling the course out amongst the children's workforce will lead to a more supportive environment for mental health and earlier identification and access to help for those with problems.

76. Improving the mental health of the people of Wales is one of the themes included in the *Programme for Government* and *Together for Health*. Tackling the stigma and discrimination associated with mental illness is seen to be key to this.

77. Time to Change Wales, launched in November 2011, is the first national campaign to end the stigma and discrimination faced by people with experience of mental health problems in Wales. This three year campaign is funded by the Big Lottery Fund, Comic Relief and the Welsh Government and is delivered by leading Welsh mental health charities Gofal, Hafal and Mind Cymru. The central aim of the campaign is to change negative attitudes and behaviour towards mental illness.

Sexual Health

78. Launched in 2010, the Welsh Government's *Sexual Health and Wellbeing Action Plan for Wales, 2010-2015,* aims to improve the sexual

health and well being of the population. Four strategic action areas have been identified which will set a clear agenda for the Welsh Government and its partners in the NHS, local government and the third sector. The action areas are developing a culture to support sexual health and wellbeing, better prevention, delivering modern sexual health services, and strengthening health intelligence and research.

Older People

79. The Welsh Government's current *Programme for Government* includes a commitment to introduce "…*a programme of annual health checks, led by GPs, practice nurses, pharmacists and other health professionals, for everyone over the age of 50."*

80. Preparatory work to deliver this commitment is scheduled to take place up to 2013, with implementation to follow. The work is considered to have potential to contribute to the broader agenda of supporting people to manage aspects of their own health, and to promote the importance of preventing avoidable ill health.

81. The *National Service Framework for Older People in Wales* has a prominent focus on falls prevention placing accountability for the NHS in Wales to work in partnership with Local Authorities to take action to prevent falls in older people. This is supported by the *Strategy for Older People in Wales 2008-13*, the first such strategy in the world. With a focus on outcomes, engagement for the development of the third phase of the Strategy for Older People in Wales commenced in 2011.

D. Health Protection

Food Hygiene Rating (Wales) Bill

82. The intention of this Bill is to introduce a mandatory requirement for food businesses to display information about their food hygiene compliance standards, thus ensuring consumers are provided with information about the food hygiene standards of food businesses in Wales, whilst also enabling those consumers to make informed choices about where to eat or shop for food.

83. Food businesses will be required to display their hygiene rating (for example, at the entrance to their food business premises), and local authorities will enforce this requirement. The mandatory display of a good food hygiene rating will benefit businesses – good food hygiene means a good hygiene rating which is good for business. Mandatory display of the hygiene rating awarded will also encourage businesses to improve their procedures and hence drive up standards. The Food Standards Agency will be required to publish all food hygiene ratings on their website.

84. Consultation on the draft Bill concludes on 7 March 2012. The Bill is expected to come into force in the latter part of 2013.

Vaccination

85. The vaccination programme in Wales is the same as in the rest of the UK. The key points below relate to results for children living in Wales in May 2011 and reaching their first, second, fifth, 15th and 16th birthdays in the year ending March 31st 2011, and girls in school year 8 in 2009/2010.

- Annual uptake of all routine immunisations in one year-old children for Wales as a whole now exceeds the 95% target and 18 of the 22 Local Authority areas have exceeded the 95% uptake target for the 5-in-1 immunisation in one year olds for 2010/11.
- Annual uptake of the first dose of MMR at 2 years decreased slightly to 91.5%
- Uptake of the second dose of MMR by 5 years of age increased to 86.9%, the highest ever annual uptake of MMR2 at five years of age.
- Uptake of pre-school 4-in-1 booster in five year-old children has increased to 90.0%.
- Uptake of a complete three dose course of Human Papilloma Virus (HPV) vaccine in girls in the first year of the routine campaign (2009/10 School Year 8) was 81.6%.

Injuries

86. There were over 1100 deaths from external causes of injury and poisoning in 2009 with some of the main causes being falls, poisoning and motor vehicle traffic accidents. For every death, there were 38 in-patient admissions and over 400 emergency department attendances. Almost 1 in 7 of the population attended an emergency department in Wales. In addition, the 42,000 in-patient injury admissions led to 309,844 bed days, an average of 7.4 bed days per admission.

Road Safety

87. There has been significant improvement in road safety in Wales in the last decade. The casualty targets set by the UK Government in 2000 were achieved and exceeded, which included a 46% reduction in the number of people killed and seriously injured and a 63% reduction in the number of children killed and seriously injured by 2010.

88. The Welsh Government is committed to continuing this trend - reducing the number and severity of road traffic collisions, and recognising that such collisions are unacceptable. We have provided over £120m of grant funding since 2000 to different organisations, including local authorities, the Fire and Rescue Service and the Wales Road Casualty Reduction Partnership (responsible for speed enforcement). This funding has been used for a range of road safety interventions such as road improvement schemes, education, training, publicity and enforcement. The Government has also targeted collision clusters on the trunk road network and sought to address these.

89. The Welsh Government recognises the vulnerable nature of certain road user groups and targets some of this funding at those at disproportionate risk of being involved in road traffic collisions, such as motorcyclists and young people. The Government will shortly be consulting on a Road Safety Delivery Plan, setting out its strategic approach to road safety to 2020, setting targets for further casualty reduction and introducing specific actions for itself and its partners.

Child Safety

90. Children in Wales, a national charity, has been funded since 2008 to run a child safety project. The aim of this project is to bring together practitioners on a local level and with policy makers on a national level to improve the practice of promoting child safety across Wales. It formally co-ordinates the large number of agencies involved in preventing non-intentional injuries and death in children and young people. By working in partnership with other agencies; it enables the continued development of Child Safety Action Plans for Wales, establishes a network of child safety practitioners and provides opportunities to access information about policy development, practice and services for children and young people.

91. The Child Safety project has contributed to improvements in the following areas:

- Burn / scald prevention;
- choking / strangulation prevention;
- child safety leadership; and
- child safety infrastructure.

92. The project has also contributed to a change in EU legislation relating to the manufacture of new blind cords, which was a major breakthrough. The new safety standard applies to all internal blinds and corded window coverings in all buildings where children aged 0-42 months have access and are likely to be present.

Older People

93. Falls are a major cause of disability and death in older people in Wales, and result in significant human costs in terms of pain, loss of confidence and independence. Falls prevention is one of the high impact areas identified for public health action. As part of the *1000 Lives Plus* programme, a multi-agency falls collaborative for Wales was launched in 2012 to support practitioners and community based teams to improve care for patients who have fallen.

Sunbed Legislation

94. The Sunbeds (Regulation) Act 2010, applicable to both Wales and England, came into force on 8 April 2011 and requires sunbed businesses to prevent the use of, and access to, sunbeds on their premises by under-18s. It

provides for local authority enforcement of this duty and provides powers that enabled the Welsh Government to make Regulations imposing further conditions on commercial sunbed use in Wales.

95. The Sunbeds (Regulation) Act 2010 (Wales) Regulations 2011 were developed for Wales and came into force on 31 October 2011. As well as ensuring all salons are properly supervised, the Regulations also prohibit the sale or hire of sunbeds to under 18s; extend to businesses that operate from domestic premises the requirement that sunbeds are not used, or offered for use, to under 18s on those premises; prescribe the health information that is to be displayed and made available to adults who may seek to use a sunbed; prohibit the provision or display of any material relating to health effects of sunbed use, other than material containing the health information prescribed; and, require the provision and wearing of safe and appropriate protective eyewear for adults.

96. In September 2011 the Chartered Institute of Environmental Health Wales delivered a series of three training sessions to local authorities in Wales on the implementation and enforcement of this legislation. The Welsh Government also made available grant payments to local authorities in Wales to assist them in the activities they undertook to implement this legislation in Wales. Consideration is currently being given to the options available to Government officials to evaluate the effectiveness of this legislation in Wales.

ISLE of MAN - Article 11, Paragraphs 1 to 3

Article 11, Paragraph 1

The main hospital on the Isle of Man, Nobles Hospital, which opened in 2003, provides all standard General Hospital type services. However, it should be noted that it does not provide specialist services (such as cardiac surgery, neurosurgery and radiotherapy) which it is impossible to safely provide for an island community of 85,000 residents. Such services are provided by referral to NHS centres of excellence in the United Kingdom.

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

A Breast Cancer Screening Call and Recall Service has been established. The uptake of the target population for Breast Cancer screening (50-70) years as at March 2011 was 72.8%.

The Island's cervical screening call and recall for women aged between 20 and 65 years as at March 2012 was 79.7%.

The GDP for the Isle of Man has been re-based and is estimated at £3BN per annum. The gross health budget including mental health for 2012-2013 is £178M – therefore, the % expended on Health is 5.9%.

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

- Doctors (General Practitioners) per 1000 population – 0.58
- Doctors (all doctors) per 1000 population– 3.21
- Dentists per 1000 population – 0.45
- Orthodontists per 1000 population – 0.03
- Pharmacy practices per 1000 population – 0.3
- Optometry practices per 1000 population – 0.15
- Community Nurses per 1000 population – 0.84
- Total Nurses per 1000 population – 12.0
- Midwives per 1000 population – 0.62

Article 11, Paragraph 2

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

Article 11, Paragraph 3

The position remains largely as previously described.

The Island's vaccination programme is analogous to that in the United Kingdom. All twelve of the Isle of Man's GP practices achieved the 90% target for Pre-School Boosters, 5-in-1 and Meningitis C vaccinations, with 11 practices achieving this for MMR and the remaining practice achieving 86% - all in the quarter ended 31 December 2011. This shows a significant rise from 7 of the 12 practices achieving the 90% target in 2007. The overall figure across the Island has risen from 92.48% (31 March 2007) to a 96.90% average of the 4 types of immunisations in the quarter ended 31 December 2011.

The latest Isle of Man Human vaccination programme (against Papilloma Virus (HPV)) commenced on 21 September 2011. The Island's programme is targeted at girls aged 12 – 13 (school year 8) and vaccinates them against HPV, which is responsible for 99% of cervical cancer cases and reduces by 70% the risk of girls who are vaccinated developing cervical cancer in later life. The vaccination programme, now in its third year on the Island, has a high uptake, at 83%. There has been a preceding campaign to raise awareness and provide information about HPV in particular and sexual health issues in general, by targeting school staff, parents and children aged 12 – 13 years.

ARTICLE 12, Paragraph 1 - to establish or maintain a system of social security

United Kingdom

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

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

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 2006 to 31 May 2011, is attached as **Appendix 12A**. 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 12B**. A copy of an annual Report of 2012, updating the UK's position on the application of the Code of Social Security, is attached as **Appendix 12C**.

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.

Great Britain

5. The Department for Work and Pensions Annual Report and Accounts for 2011/12 gives a detailed overview of its current operation, funding and expenditure on benefits and their administration and can be found at:
http://www.dwp.gov.uk/docs/dwp-annual-report-and-accounts-2011-2012.pdf

Welfare Reforms

Sickness Benefits - Statement of Fitness for Work - 'Fit Note'

6. On 6 April 2010 the 'sick note' was replaced by the 'fit note'. The revised medical statement continues to allow GPs to advise whether an employee should refrain from work, but is also able to advise whether it would

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

be appropriate for them to do some work.

7. This will give employers greater flexibility in managing sickness absence. Where this advice is given, the doctor will provide additional information which will help employers consider whether basic adjustments could be made to assist someone to return to work - for example allowing someone with back pain to take regular breaks away from their desk for exercise. Employers will not be bound to implement the doctor's suggested changes, which will be provided at the discretion of employers and with the agreement of the employee. Where no changes are made, the medical statement should be considered as evidence of the individual being unfit for work for sick pay purposes.

The Welfare Reform Act 2012 – Employment and Support Allowance

Great Britain

8. The Welfare Reform Act 2012 introduced further substantial changes to the UK's Social Security system, with the major change being the forthcoming introduction of Universal Credit, which is to replace most existing income-related benefits for people of working age. The Act and its provisions are therefore described in detail in the response to Article 13 in this report.

9. The Act also introduced changes to contribution-based Employment and Support Allowance, which had previously replaced both short-term and long-term Incapacity Benefit.

Time limitation

10. The Welfare Reform Act 2012[1] (link to Act and Explanatory Notes[2] below) introduced a one year time limit on entitlement to contributory Employment Support Allowance (ESA) for those in the Work Related Activity Group. This change has been introduced from 30 April 2012 and has immediate effect on people who are currently claiming contributory ESA as well as those making new claims.

11. The Government is not reducing the levels of support for those with the most severe health conditions or impairments. People who receive contributory ESA and are in the Support Group are being protected and are not affected by this change in entitlement.

12. Claimants whose contributory benefit has ended because of the time limit can become entitled to a further award - regardless of the length of time which has elapsed in the meantime. This applies if they have had limited capability for work continuously since their entitlement ceased, and their health has deteriorated to the extent that they are placed in the Support Group.

[1] http://www.legislation.gov.uk/ukpga/2012/5/introduction/enacted
[2] http://www.legislation.gov.uk/ukpga/2012/5/notes/contents

13. ESA for people in the Work Related Activity Group was never intended to be a benefit for the long term. Introducing a limit on the length of time people in the Work Related Activity Group can claim contributory ESA underlines the principle that with the right support they are expected to move into work.

14. People can currently qualify for many years of benefit on the basis of National Insurance contributions paid over a relatively short period of time. This is no longer acceptable in the current fiscal climate, where the Department sees the need to review the balance between contributions paid and indefinite entitlement to support.

15. Introducing a limit on the length of time people in the Work Related Activity Group can claim contributory ESA is more consistent with the rules for 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. This closer alignment with contributory JSA means that the introduction of time limiting for contributory ESA is a step towards the introduction of Universal Credit.

16. The Department for Work and Pensions (DWP) issued notifications in September 2011 to claimants likely to be affected by time limiting. The DWP recognised the impact this change would have on claimants and the letter was designed to help address their concerns. This was not designed to pre-empt the will of Parliament.

17. The DWP has contacted claimants whose benefit was due to cease before 3 June 2012 and who had not been assessed for income-related ESA. As part of this contact, claimants were asked if they wanted to be considered for a claim to income-related ESA. Claimants whose benefit ends on or after 4 June 2012 received eight weeks notification. Those with underlying entitlement to income-related ESA will automatically receive this when their contributory ESA ends.

18. To help explain recent changes, the DWP has developed an ESA claimant journey information pack which is available from the DWP Adviser and Intermediaries website: http://www.dwp.gov.uk/adviser/updates/esa-claimant-journey/.

Youth provisions

19. The Act also abolishes the ESA 'Youth' provisions. These allow certain young people to qualify for contributory ESA without having to pay National Insurance contributions. From 30 April 2012 all new claimants of ESA 'Youth' will be subject to the same National Insurance contributory conditions as all other claimants. If they qualify for contributory ESA and are then placed in the Work Related Activity Group, a one year time-limit will also apply. They will still be able to claim income-related ESA if they are eligible to do so.

Support for people with cancer

20. The DWP has carefully considered the position of people with a range of serious and life threatening illnesses – including cancer – in relation to the benefits system. Following an internal review changes have been made to the Work Capability Assessment so that more individuals awaiting, undergoing or between courses of certain chemotherapy treatments will automatically be placed in the Support Group without the need for an assessment. These individuals will therefore be protected and will not be affected by time-limiting.

21. Additionally, Professor Harrington, as part of his second Independent Review, asked Macmillan Cancer Support to look into how the Work Capability Assessment assesses people with cancer to provide to him with any recommendations for further improvements.

22. The DWP accepts the evidence presented by Macmillan that the effects of oral chemotherapy can be as debilitating as other types of chemotherapy. The evidence also shows that certain types of radiotherapy and in particular of combined chemo-irradiation can be equally debilitating. As a result of the evidence supplied by Macmillan the DWP has developed detailed proposals for changing the way we assess individuals being treated for cancer.

23. If introduced, these proposals would increase the number of individuals being treated for cancer going into the Support Group. They would also reduce the number of face-to-face assessments for people being treated for cancer as most assessments could be done on a paper basis, based on evidence presented by a GP or treating healthcare professional.

24. The DWP has been seeking a wide range of views on the proposed changes through an informal consultation. This was to gather views of interested stakeholders, including individuals affected by cancer, their families and carers, healthcare practitioners and cancer specialists as well as representative groups and other lobby groups.

Northern Ireland

25. The Northern Ireland Assembly is currently considering measures corresponding to the Welfare Reform Act 2012.

United Kingdom

State Pension Reform

26. On 12 July 2012 the Minister of State for Pensions announced details about the single-tier reform of State Pensions and a review of State Pension age with a white paper to be published in autumn 2012.

27. The reforms would introduce a simpler, single-tier State Pension to provide better support for saving for retirement. A flat-rate state pension

above the basic level of the means test would bring much needed clarity and simplicity to the pension system. It will also provide a foundation to support automatic enrolment into workplace pensions. This will help people to save for their retirement with confidence.

28. The new single-tier system would be introduced in the next Parliament. The reforms will not affect current pensioners. People reaching State Pension age before the reforms are introduced will continue to receive their State Pension in line with current rules. For those reaching State Pension age after the reforms have been introduced, the Government has made it clear that it will recognise contributions that have been made to the current system.

29. It is also intended that the new system should take into account increases in life expectancy when setting State Pension age. Details of the Government's consultation on "State Pension for the 21st century", that took place in April 2011, can be viewed at:
http://www.dwp.gov.uk/consultations/2011/state-pension-21st-century.shtml

Workplace Pensions

30. An ageing population combined with millions of people under-saving is one of the biggest long-term challenges the UK faces. To meet this challenge, the Government has introduced automatic enrolment into workplace pensions from 1st October 2012.

31. Pension saving in the UK is in decline. Since 2003, the number of eligible workers participating in a workplace pension has fallen from 12.6 million (64 per cent) to 11.0 million (56 per cent) in 2011. Less than 1 in 3 workers in the private sector are now contributing to a workplace pension.

32. Longevity is increasing. In the past 25 years, life expectancy at age 65 has increased by 5 years for men and 3 years for women. This means that around 11 million people are not saving enough to achieve the pension income they are likely to want or expect in retirement. Without action this could place unsustainable pressure on the State system or lead to poorer pensioners.

33. The Government is introducing mandatory automatic enrolment into a workplace pension to harness inertia, by making the decision to save a default one. Evidence shows automatic enrolment leads to increased participation. In the United States, case studies show automatic enrolment increased membership of similar schemes among new employees from around 20-40 per cent to around 90 per cent.

34. Automatic enrolment will transform the savings culture by encouraging and supporting millions, who would otherwise face a poorer retirement, to take personal responsibility and save for their future.

35. The Government expects 6 to 9 million people to be newly saving or to save more, generating £11 billion a year more (in steady state) in pension

saving. Automatic enrolment began on time and all employers remain in scope. However, small businesses will be given additional time to prepare for the implementation of automatic enrolment. The timetable has been adjusted so that no small employers will be affected by the reforms before the end of this Parliament in 2015.

36. Employers have to automatically enrol workers who:

- are not already in a qualifying workplace pension scheme;
- are at least 22 years of age;
- are below State Pension age;
- earn more than £8,105 (2012/13) a year; and
- work, or ordinarily work in the UK (under their employment contract).

37. By the end of December 2012 it is expected that around 600,000 workers will be newly saving in a workplace pension scheme and about 4.3 million workers will be enrolled by 2015.

Bereavement Reform

38. In December 2011 the Government issued the consultation paper "Bereavement Benefit for the 21st Century"[1]. The consultation sought views on how bereavement benefit payments should support future working-age widows, widowers and widowed civil partners. The review would not affect those already in receipt of bereavement benefits at the point at which a new scheme would be introduced. Following the consultation the Government published its response[2].

39. The review of Bereavement benefits is not driven with the aim of cutting costs. In fact, the Government will target additional resources on bereavement benefits over a parliament, to ensure that existing recipients are protected, and that those who claim the new benefit get the help that they need when they need it most. When current recipients' claims, which are protected by these reforms, reduce in number over time, a future Government could decide how to reinvest any savings which arise. The consultation sought views to ensure that bereavement benefits provide effective support after the death of a spouse or civil partner that is fit for the 21st century.

40. The Government 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.

41. The proposed new Bereavement Support Payment would be disregarded from Universal Credit for 12 months 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

[1] http://www.dwp.gov.uk/docs/bereavement-benefit.pdf
[2] http://www.dwp.gov.uk/docs/bereavement-benefit-consultation-response.pdf

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. The bereaved will be able to access Jobcentre Plus support on a voluntary basis for three months after bereavement, and will not be subject to conditionality for a further three months.

42. 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.

43. The Government proposes to simplify the conditions of entitlement. The national insurance contribution condition for the new Bereavement Support Payment will be the same as the existing Bereavement Payment. This means that people will get the full payment as long as their late spouse or civil partner paid national insurance contributions at 25 times the lower earnings limit for any one year prior to their death. The amounts of payment will not be affected by the age of the bereaved, but those with a dependent child will receive a higher amount. The upper age for eligibility will align with changes to the State Pension Age.

Annual Abstract of Statistics

44. The Abstract of Statistics 2011 is an annual reference source for information on the main aspects of Benefits, Contributions and Indices of Prices and Earnings. The Abstract for 2011 contains provides data in answer to the following types of questions:

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

It can be viewed at:
http://statistics.dwp.gov.uk/asd/asd1/abstract/abstract2011.pdf

DWP Statistical Summary

45. Information on the numbers of benefit claimants, employment programme, labour market decision and vacancies produced by Department for Work and Pensions are released through a Summary Statistics that can be viewed at:
http://research.dwp.gov.uk/asd/index.php?page=stats_summary

Northern Ireland Statistics

46. Comparable statistics published for Northern Ireland can be viewed at

the Department for Social Development Research and Statistics website pages via the following link.
http://www.dsdni.gov.uk/index/stats_and_research/stats-publications/stats-benefit-publications.htm

ECSR Conclusions

In the General Introduction to the previous Conclusions, the Committee asks for information on the coverage of self-employed persons with regard to all social security schemes under Article 12§1.

47. Under the UK scheme, self employed persons are protected for all branches of social security covered by the Code of Social Security and ILO Convention No. 102, with the exceptions of those covering benefits in respect of unemployment and employment injury. The Isle of Man scheme generally reflects that of the UK.

Conclusions on the UK's previous Report

The Committee asked for information to assess the adequacy of benefits and in particular the minimum level of benefits and the duration of their payment. The Committee also concluded that the situation is not in conformity on the ground that minimum levels of Statutory Sick Pay, Short Term Incapacity Benefit and contributory Jobseeker's Allowance for single persons are manifestly inadequate.

48. As far as time limitation of entitlement is concerned, Statutory Sick Pay (SSP) is payable for up to 28 weeks of periods of incapacity for work, whereafter a person can claim contribution based Employment and Support Allowance (ESA). Contribution based ESA is payable for periods of up to 52 weeks for those persons who fall within the 'work related activity group', but without time limitation for those who are in the 'support group'.

49. Contribution based Jobseeker's Allowance is payable for periods of up to 26 weeks of unemployment. However, the income related strands of both Jobseeker's Allowance and Employment and Support Allowance (for both the work-related activity group and the support group) are payable without time limitation for as long as the qualifying conditions for entitlement remain satisfied.

50. The Committee also indicated that it would consider and assess ESA as a replacement for Incapacity Benefit following its introduction in October 2008. Information on both SSP and ESA is set out in detail in the responses in respect of Part III of the Reports on the Code of Social Security – see **Appendices 12B&C**.

51. More detailed information on benefits rates generally is accessiblke from the following sources:

- A schedule of rates of Social Security Benefits for 2011 and 2012 is set out in:
http://www.dwp.gov.uk/docs/benefitrates2012.pdf

- Information on the average amounts of benefits in payment can be obtained from the DWP Tabulation Tool at http://83.244.183.180/100pc/tabtool.html Tabtool 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: e.g. Child Benefit, Guardian's Allowance and Tax Credits etc. is at:
http://www.hmrc.gov.uk/rates/taxcredits.htm

52. As far as the Social Rights Committee's conclusion is concerned, the Government, respectfully, does not share the committee's view that aggregation of means-tested benefits with flat rate contributory benefit provision should lead to non-conformity with a state's obligation under Article 12, paragraph 1 to establish or maintain a system of social security. The Government would draw the Committee's attention to the UK's general history of compliance with both the Code of Social Security and ILO Convention No. 102.

53. Furthermore, the Government would point out that the ILO's Committtee of Experts, in its Conclusions on the UK's 2010 Code Report, observed that Universal Credit (which is to replace all income related social security benefits from October 2013) may open up for the United Kingdom the possibility to apply the Code on the basis of this universal means-tested scheme with reference to Article 67 of the Code, and asked the Government to study this possibility.

ISLE OF MAN

Responsibility for social security matters was transferred from the former Department of Health and Social Security to the newly formed Department of Social Care from 1st April 2010.

The following changes have occurred within the Island's social security programme since our last report in October 2008.

LEGISLATION

Since the last report, the relevant parts of the United Kingdom Parliament's

- Pensions Act 2007;
- Pensions Act 2008; and
- Pensions Act 2011.

as they relate to basic state pension and additional state pension arrangements have been applied to the Island.

Certain parts of the United Kingdom Parliament's Welfare Reform Act 2009 have also been applied to the Island.

Also, 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

In respect of those persons reaching state pension age on or after 6th April 2010:

- the number of qualifying years required for a full basic state pension are reduced from 44 for men and 39 for men to 30 for both men and women;

- the de minimus requirement of 10 qualifying years is abolished (so every qualifying year now gives rise to entitlement to 1/30th of the maximum rate of basic state pension); and

- widowers and surviving civil partners may inherit their deceased wife's or civil partner's graduated retirement benefit under the same circumstances as apply to widows.

State pension age for women is gradually being increased from 60 to 65 by November 2018. State pension age for both men and women will then increase further to 66 by October 2020. Existing legislation also provides for further increases in state pension age (for both men and women) to 67 by 2036 and to 68 by 2046, though it is highly likely these further increases will be brought forward.

With effect from 6th April 2010-

- **Adult dependency increases** with category A and category C pensions were abolished (subject to up to 10 years' protection for existing recipients); and

- "**Home Responsibilities Protection**" was replaced by contributions credits for parents and carers, available to parents of children under the age of 12, foster parents and carers providing care for a disabled person for at least 20 hours a week. This improves the position of carers as regards protecting their state pension entitlement.

From 6th April 2012 –

- Whereas previously the rates of state pension had been increased each year in line with increases in the UK RPI, a "**triple lock**" guarantee was introduced such that annual increases are now determined by the greater of the increase in UK average earnings, the UK consumer prices index or 2.5%;

- contracting out of the state additional pension scheme (the "State Second Pension") on a money purchase basis was abolished; and

- the flat-rate accrual element of the state second pension was introduced.

UNEMPLOYMENT BENEFITS

Jobseeker's enhanced allowance was abolished (subject to up to 6 months' protection for existing cases) with effect from 6th April 2008. This provided for a 100% enhancement to the basic rates of contribution-based jobseeker's allowance for up to 26 weeks where the claimant had been employed in the Isle of Man throughout the two-year period immediately preceding his claim.

Provision has been made from April 2011 to progressively reduce the amount of benefit payable to persons who claim **jobseeker's allowance** but who repeatedly fail to meet the conditions of entitlement for that benefit, in particular the condition that they take a minimum number of steps in each

week to look for work or to improve their prospects of securing employment.

SICKNESS AND INVALIDITY BENEFITS

The **pension supplement** (which provides an enhancement to the rate of long-term incapacity benefit for certain persons aged 45 or over) ceased to be available to new claimants from 6th April 2008, unless they also qualify for the highest rate of the care component of disability living allowance. The rate payable to existing recipients at 5th April 2008 remains frozen.

The activities and descriptors for the personal capability assessment for **incapacity benefit** (and other incapacity-related benefits) were changed in February 2012, such that they now mirror those used for the employment & support allowance work capability assessment in the United Kingdom. The Island has not yet introduced employment & support allowance, but plans to introduce the contribution-based element only in 2013.

INDUSTRIAL INJURY BENEFITS

Carcinoma of the nasopharynx, osteoarthritis of the knee as it relates to certain occupations in the coal mining industry, and osteoarthritis of the knee as it relates to certain carpet fitters and floor layers were added to the list of prescribed diseases that may qualify a person for **industrial injuries benefit.**

DISABILITY BENEFITS

Entitlement to the higher rate mobility component of **disability living allowance** was extended to certain persons suffering from severe visual impairment from April 2011.

Whereas previously the Island has uplifted the rates of **attendance allowance** and **disability living allowance** to the same levels payable in the UK each April, the rates of those benefits were not increased in April 2012 (whereas they were increased by 5.2% in the UK).

CARER'S BENEFITS

The adult dependant's addition paid with **carer's allowance** was abolished for new claims from 6th April 2010.

BENEFITS TO MEET CARE COSTS

A new benefit – the "**nursing care contribution**" - was introduced from 1st October 2008, following the principle established in the *Coughlan* judgement

in the Court of Appeal for England and Wales in 1999. The nursing care contribution is payable to a person who is resident in a registered nursing home in the Isle of Man and is liable to pay a fee for the cost of their nursing care. Effectively, it is a cash proxy for NHS care for residents of nursing homes. Initially introduced at the weekly rate of £60 and funded out of general revenue, it is now payable at the weekly rate of £100 and is funded from National Insurance contributions.

BENEFITS DURING PREGNANCY AND CHILDBIRTH

The adult dependant's addition paid with **maternity allowance** was abolished for new claims from 6th April 2010.

FAMILY BENEFITS

A reduced rate of **child benefit** for second and subsequent children was introduced from 9th April 2012. Compensatory uplifts were made in income-related benefits to protect those on the lowest incomes.

The enhanced rate of **child benefit** paid in respect of children who remain in full-time non-advanced education after their 16th birthday was abolished from 9th April 2012 (subject to protection for existing claimants at 5th April 2012).

Subject to parliamentary approval, the **lone parent increase of chid benefit** (which has been paid to protected cases since the increase was abolished for new claims in April 1999) will be abolished in April 2013.

INCOME-RELATED BENEFITS

Income Support

The higher rate lone parent premium (payable to lone parents who had been in receipt of income support for at least 12 months) was abolished – subject to up to 12 months' protection - from 5th April 2010. The existence of this premium was viewed as a disincentive for lone parents to take up work.

The rates of personal allowances for persons aged under 25 were significantly reduced from 9th April 2012. It was felt that the rates prior to then were too high and were (a) creating disincentives for young people to take up or return to work, and (b) encouraging some young people to leave their parents' home unnecessarily to establish independent living arrangements financed by social security.

Income-based jobseeker's allowance

As for income support, the rates of personal allowances for persons aged under 25 were significantly reduced from 9th April 2012.

Family Income Supplement and Disability Working Allowance

These benefits, which supplemented the income of families and disabled workers (respectively) who were engaged in remunerative work, were consolidated and replaced by a new benefit – "**Employed Person's Allowance**" from 31st January 2012.

The residential qualification has been brought into line with that for other income-related benefits (i.e., income support and income-based jobseeker's allowance), such that to qualify for Employed Person's Allowance a person must, generally speaking, be an Isle of Man worker (as defined in the Control of Employment Act 1975 (of Tynwald)). However, a person who is not an Isle of Man worker may nevertheless qualify if they can demonstrate that to deny them benefit would be "exceptionally harsh or oppressive".

In the case of couples, at least one partner must now work for at least 30 hours a week to qualify, unless one (or both) of them is severely disabled or has "exceptional caring responsibilities" , in which case at least one of them must work for at least 16 hours a week.

Maternity Payment and Additional Funeral Payment

A £6,000 capital limit was introduced for both payments from 1st April 2008, whilst the rate of the Maternity Payment was substantially uplifted.

From December 2010, where a qualifying person (or their partner) has received a Maternity Payment at any point within the 3 years immediately prior to their latest claim, the amount payable is only one-half of the "standard" rate.

From April 2011 provision was made such that a Maternity Payment shall be made in respect of each child, where a mother gives birth to more than one child arising from the same pregnancy. Provision was also made from that date to extend the categories of people eligible for maternity payments to include certain adopters, guardians and people awarded residence orders.

Exceptional Needs Grants and Budgeting loans

The entitlement criteria for budgeting loans in respect of certain items for persons leaving prison were relaxed, so that such persons may now receive

assistance immediately upon their discharge.

Winter Bonus

Provision made from December 2010 such that people who are not liable for housing costs are not eligible for the winter bonus (this exclusion does not extend to severely disabled persons or their carers). Also, any winter bonus payable to a person who shares the liability for their housing costs is to be calculated on a pro-rata basis.

Subject to parliamentary approval, income-based jobseeker's allowance will cease to be a qualifying benefit for the Winter Bonus from 1st November 2012.

Due to very low take-up the Variable Rate Winter Bonus (targeted at those whose incomes are just above the income support thresholds) which had been introduced in 2007, was abolished in December 2011.

MISCELLANEOUS

The existing "**loss of benefit**" provisions were tightened from November 2010, such that a person who has committed benefit fraud on a single occasion may have some or all of their benefits withdrawn for a period of 4 weeks.

Also from November 2010, provision was introduced for the loss of 1 week's benefit following conviction or caution for certain violent or threatening behaviour towards a member of staff dealing with jobseeker's allowance, as well as extending any other sanction in place at the time by up to 5 weeks.

Subject to parliamentary approval, income-based jobseeker's allowance will cease to be a qualifying benefit for the **Christmas Bonus** from 1st November 2012.

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

Benefit/Pension	1 January 2008 No.	2007/08 Expenditure £,000	31 July 2012 No.	2012/13 Budget £,000
Retirement Pension	16,941	82,559	18,396	115,338
Old Person's Pension	62	167	43	134
Age Addition	(3,739)	413	(3,848)	424
Retirement Pension Premium	(3,847)	1,896	(3,178)	1,813
Pension Supplement	(11,803)	26,041	(13,715)	33,950
Nursing Care Contribution	-	-	350	1,850
Child Benefit	9,820}		10,034}	
No. of children	(16,754) }		(17,002)}	
Lone Parent Increase	(313) }	17,880	(160)}	16,923
Guardians Allowance	2	3	0	6
Contributory Jobseeker's Allowance	107	453	215	685
Enhanced Jobseeker's Allowance	63	210	-	0
Incapacity Benefit (Short Term)	405	1,811	593	2,762
Incapacity Benefit (Long Term)	1,390	5,636	1,618	7,638
Maternity Allowance	354	2,633	463	4,537
Paternity Allowance	3	53	22	108
Adoption Allowance	2	14	4	39
Bereavement Allowance	74}		31}	
Widowed Parent's Allowance	23}	332	71}	648
Widow's Pension	91	424	46	275
Attendance Allowance	1,238	3,174	1,127	4,217
Disability Living Allowance	2,048	6,024	2,145	8,453
Severe Disablement Allowance	195	606	161	662
Industrial Disablement Benefit	217	402	264	534
Family Income Supplement	834	4,707	-	-
Disability Working Allowance	33	93	-	-
Employed Person's Allowance	-	-	1,080	7,313
Carer's Allowance	247	582	259	870
Income Support				
- Pensioners	1,544}		1,638}	
- Working age				
Sick & Disabled	1,163}		1,674}	
Lone Parents	457}		562}	
Others	62}	21,319	109}	31,682
Income-related Jobseeker's	375	2,223	750	3,959
Total no. of claims/expenditure/budget	37,750	179,655	41,660	244,820

BENEFIT RATES

1. NATIONAL INSURANCE BENEFITS

	2007/08 (weekly rates)	2012/13 (weekly rates)
Retirement Pension (R.P.)	**£**	**£**
Basic R.P. - own insurance	87.30	107.45
- on spouse's insurance	52.30	64.40
Old Person's Pension	52.30	64.40
Age Addition to R.P.	2.00	2.00
Retirement Pension Premium (maximum rate)	12.85	15.20
Pension Supplement (maximum rate)	43.65	52.45
Incapacity Benefit		
Short-term Incapacity Benefit		
over pension age	78.05	95.15
under pension age - lower rate	61.35	74.80
- higher rate	72.55	88.55
Long-term Incapacity Benefit		
standard rate	81.35	99.15
age addition - higher rate	17.10	11.70
- lower rate	8.55	5.90
Bereavement Benefits		
Bereavement Allowance	87.30	105.95
Widowed Parent's Allowance	87.30	105.95
Widow's Pension (transitional cases only)	87.30	105.95
Contribution-Based Jobseeker's Allowance		
Aged 16 or 17	35.65	56.25
Aged 18 or over but under 25	46.85	56.25
Aged 25 or over	59.15	71.00
Maternity Allowance (M.A.)		
Employed earners maximum rate	156.10	179.85
Self-employed rate	112.75	135.45
earnings threshold	30.00	30.00
Paternity Allowance		
Maximum rate	180.40	179.85

Adoption Allowance

Maximum rate	156.10	179.85
earnings threshold	30.00	30.00

Industrial Injuries Disablement Benefit

100%	131.70	158.10
20%	26.34	31.62

Dependants Additions

Spouse (or person looking after children)		
with R.P. (protected cases only)	52.30	61.85
with Long-term Incapacity Benefit	48.65	57.60
with M.A. or Short-term Incapacity Benefit	37.90	44.85
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

	2007/08 (weekly rates) £	2012/13 (weekly rates) £
Child Benefit		
school child up to 16	19.90	-
child aged 16 or over at start of school year	29.25	-
first child or qualifying young person	-	20.40
second or subsequent child or qualifying young person	-	13.50
increase for lone parent (protected cases only)	7.45	6.95
Carer's Allowance	48.65	58.45
Severe Disablement Allowance (S.D.A.) (protected cases only)		
Basic rate	49.15	69.00
Age related additions:-		
higher rate	17.10	11.70
middle rate	11.00	5.90
lower rate	5.50	5.90
Attendance Allowance (A.A.)		
higher rate	64.50	73.60
lower rate	43.15	49.30
Disability Living Allowance (D.L.A.)		
Care Component		
higher rate	64.50	73.60
middle rate	43.15	49.30
lower rate	17.10	19.55
Mobility Component		
higher rate	45.00	51.40
lower rate	17.10	19.55
Dependency Additions		
Spouse (or person looking after children) -		
with Carer's Allowance (protected cases only)	29.05	34.40
with S.D.A.	29.25	34.60
Children - with I.C.A., S.D.A (protected cases only)	11.35	11.35

3. INCOME-RELATED BENEFITS

INCOME SUPPORT

	2007/08 (weekly rates)	2012/13 (weekly rates)
Personal Allowances	**£**	**£**
Couple	124.80	-
Couple, both members aged 18 or over		149.60
Couple, one member aged 18 or over, one aged 16 or 17		119.65
Couple, both members aged 16 or 17		
- in respect of whom housing costs are applicable		119.65
- in respect of whom housing costs are not applicable		89.80
Single claimant aged not less than 18	81.85	-
Single claimant aged not less than 25		98.05
Single claimant aged between 18 and 24		78.40
Single claimant aged 16 or 17		
- in respect of whom housing costs are applicable	81.85	78.40
- in respect of whom housing costs are not applicable	48.95	58.85
Lone parent	81.85	-
Lone parent aged 18 or over		98.05
Lone parent aged 16 or 17		78.40
Qualifying young person or child	23.95	-
First qualifying young person or child		32.65
Second and subsequent qualifying young person or child	23.95	39.55

Modifications in Special Cases

(a) Board and Lodging Cases

Meals Allowances (per day) :-		
- Breakfast	2.15	2.55
- Lunch	3.05	3.70
- Dinner	3.05	3.70
Maximum allowance for board and lodgings, including any additions for meals not included :-		
- Single claimant	132.45	157.30
- Couple	196.55	233.35
Personal Expenses :-		
- Single claimant	24.90	32.30
- Couple	49.80	64.60
Addition for each qualifying young person or child	23.95	
First qualifying young person or child		32.65
Second and subsequent qualifying young person or child	-	39.55

(b)	Residential and Nursing Home Cases		
	Maximum allowances for accommodation charges :-		
	- Residential care home managed by DHSS/DSC	337.37	432.32
	- Commercial, voluntary or charitable residential care home	364.00	432.32
	- Nursing Home	587.09	697.13
	Allowances for personal expenses	26.90	32.30
(c)	Hospital In-patients (transfer from care homes only)	23.80	32.30
(d)	Lone parents - Childminding costs		
	- Lower rate	100.00	158.00
	- Higher rate	162.00	233.00

Premiums

Lone parent :-		
- Lower rate	14.35	-
- Higher rate	37.45	-
"standard" rate	-	16.70
Pensioner :-		
- Single, aged 60-74	47.75	64.65
- Couple, one or both aged 60-74	59.35	71.75
- Single, aged 75 or over	63.65	90.45
- Couple, one aged 75 or over	80.25	90.45
- Couple, both aged 75 or over	87.70	98.85
Incapacity :-		
- Single	30.55	35.60
- Couple	43.45	50.70
Disabled Child	34.10	39.80
Carer :-		
- Lower rate	30.10	35.10
- Higher rate	53.40	62.30
Blindness :-		
- Claimant or partner	27.00	31.50
- Dependent child or young person	12.70	14.80
Attendance :-		
- Highest rate	64.50	73.60
- Middle rate	43.15	49.30
- Lowest rate	17.10	19.55

Housing Costs

Public sector housing costs met in full.	-	-

Private sector - maxima towards rent, loan interest, rates, service charges etc . :-

Single claimant or couple		
- with no children	104.00	116.00
- with one dependent child	122.00	150.00
- with two dependent children	133.00	162.00
- with three or more dependent children	145.00	178.00

Maintenance and insurance	10.65	12.95
Deductions for inclusive utilities :-		
- heating	15.25	18.25
- lighting	1.25	1.55
- cooking	1.90	2.30
- hot water	1.90	2.30
Reductions in amounts for non-dependent occupants :-		
- in receipt of income support or income-based jobseeker's allowance	12.10	14.50
- in any other case	42.65	51.10

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 was made for a higher rate lone parent premium;
- 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.

FAMILY INCOME SUPPLEMENT (FIS) / DISABILITY WORKING ALLOWANCE,

replaced by

EMPLOYED PERSON'S ALLOWANCE (EPA)

Prescribed Amounts	**2007/08 (FIS/DWA) (weekly rates) £**	**2012/13 (EPA) (weekly rates) £**
Single claimant or lone parent who is a disabled worker	180.35	216.15
Lone parent who is not a disabled worker	223.60	268.05
Couple (with no children), neither of which is disabled	223.60	268.05
Couple (with no children), which includes a disabled worker	268.05	322.20
For the first or only child or qualifying young person	12.55	20.80
Increase for each additional child or qualifying young person	35.40	60.05
Disabled Child's Allowance	32.70	39.20
24 hours or more per week work addition	26.75	32.10
Housing costs :-		
Public sector housing costs met in full.		
Private sector - maxima towards rent, loan interest, rates, service charges etc . :-		
Single claimant or couple		
- with no children	104.00	116.00
- with one dependent child	122.00	150.00
- with two dependent children	133.00	162.00
- with three or more dependent children	145.00	178.00
Maintenance and insurance	10.65	12.95
Deductions for inclusive utilities :-		
- heating	15.25	18.25
- lighting	1.25	1.55
- cooking	1.90	2.30
- hot water	1.90	2.30
Reductions in amounts for non-dependent occupants :-	21.70	26.05
Non-householder's contribution	12.10	14.50
Maximum childminding costs :-		
- less than 24 hours work per week		
- 1 child	100.00	110.00
- more than 1 child	162.00	177.00
- 24 hours or more work per week		
- 1 child	144.00	158.00
- more than 1 child	213.00	233.00
Maintenance disregard	20.30	23.70

LUMP SUM PAYMENTS

	2007/08 £	2012/13 £
Christmas Bonus (annual)	82.50	82.50
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)		
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)	395.00	500.00

Article 13 – The right to social and medical assistance

Paragraph 1

1. "Gov.UK" (www.gov.uk) has now replaced the previously described "Directgov" as the Government website that brings together information and online services for the public. It provides information from across government departments and elsewhere and includes comprehensive information and guidance on all social and medical assistance aspects in the pages Benefits[1] and NHS Services. NHS Direct [2] provides a 24 hour a day, 365 days a year advice and reassurance service. NHS Choices[3] is the online 'front door' to the NHS. It is the country's biggest health website and gives all the information the public needs to make choices about their health.

Great Britain

Social Assistance

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

Legislation

The Welfare Reform Act 2012

3. The Welfare Reform Act 2012[4] makes the most fundamental reforms to the social security system for 60 years. It will deliver a system that is simpler, fairer and ensures that work always pays. The Act received Royal Assent on 8 March 2012 and has effect in Great Britain. The **Northern Ireland** Assembly is currently considering measures corresponding to the Welfare Reform Act 2012.

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

Universal Credit: welfare that works

5. 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.

6. Once introduced in 2013, the new Universal Credit will, over time, replace the following existing means-tested benefits: income-based

[1] https://www.gov.uk/browse/benefits
[2] http://www.nhsdirect.nhs.uk/
[3] http://www.nhs.uk/aboutNHSChoices/Pages/NHSChoicesintroduction.aspx
[4] http://www.dwp.gov.uk/policy/welfare-reform/legislation-and-key-documents/welfare-reform-act-2012/

Jobseeker's Allowance; income-related Employment and Support Allowance; Income Support; Working Tax Credit; Child Tax Credit; and Housing Benefit.

7. 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.

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

Disability Living Allowance Reform

9. The Government published a consultation paper in December 2010 which announced that, from 2013, Disability Living Allowance will be replaced by a new non-means-tested benefit for extra costs. This will be called Personal Independence Payment. 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.

10. 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 Act also introduces a new individualised and objective assessment to identify those who face the greatest barriers and ensure the award continues to reflect claimants' needs.

Fraud and error

11. The Government is determined to stamp out fraud in the benefits and Tax Credit system. The Act introduces tougher sanctions for people who commit fraud including:

- a minimum penalty of £350 for benefit fraud, as an alternative to prosecution, or 50 per cent of the amount overpaid whichever is the greater, up to a maximum of £2,000 in addition to the current loss of benefit sanction for a four week period and the requirement to repay any overpayment;
- increasing the period that people convicted of fraud will lose their benefit, alongside the punishment that is handed out by the courts and an immediate three years loss of benefit for a serious offence of organised benefit fraud; and
- a £50 civil penalty for people who fail to take reasonable care of their claim and knowingly let a change in circumstance run on and incur an overpayment.

12. The Act also takes powers to enable the creation of a new single, integrated fraud investigation service which will bring together fraud investigators from across Her Majesty's Revenue and Customs, the Department for Work and Pensions and local authorities to catch more people who commit benefit fraud and ensure that anyone accused of benefit or Tax Credit fraud is treated in a similar way.

Sanctions

13. Ahead of the introduction of Universal Credit, the Bill introduces 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.

Hardship

14. The hardship system is to undergo reform so that only those claimants in greatest need receive payments. The Government's intention is to make payments recoverable from some claimants and it is also looking at making hardship payments using a non-cash method, such as a pre-payment card.

Housing Benefit

15. 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 measures to ensure that Housing Benefit for working-age tenants in the social rented sector takes account of whether the property is a reasonable size for its occupants.

Time limiting Employment and Support Allowance

16. The Act applies 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 will 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. People receiving income-related ESA will not have their benefit time limited. Claimants with low or no other sources of income can apply for income-related ESA once their contributory ESA has ended.

17. This measure underlines the principle that Employment and Support Allowance was never intended to be a benefit for the long term for claimants who are able to move towards employment. It will ensure that support for people who are severely ill and people with impairments is well targeted.

Abolishing Employment and Support Allowance (Youth) Provisions

18. The Act abolishes the 'youth' provisions which allow certain young people to qualify for contributory Employment and Support Allowance (ESA) without having to pay National Insurance contributions. This will bring those claiming ESA 'youth' in line with other groups and simplify the benefit system in advance of the introduction of Universal Credit.

Benefit Cap

19. The Government considers it not reasonable or fair that households on out-of-work benefits should receive a greater income from benefits than the average income of working households. The Act therefore sets out powers to cap the amount of benefits a household may receive so that these are in line with average weekly earnings.

20. In order to increase the incentive to find a job, those entitled to Working Tax Credit will be excluded from the benefit cap. In recognition of their additional financial needs, all households which include somebody who is receiving Disability Living Allowance, Attendance Allowance, Personal Independence Payment or Constant Attendance Allowance claimant will also be exempt from this measure as will war widows and widowers.

Lone Parents

21. The Welfare Reform Act 2012 also introduces changes to the 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, if they want to receive support from benefits.

Social Fund Reforms

22. The Act abolishes the discretionary Social Fund and amends payments on account legislation ion order to replace Crisis Loan alignment payments and Budgeting Loans with a new national payments on account scheme. New local provision will replace Community Care Grants and Crisis Loans for general living expenses. The new provision will be the responsibility of local authorities in England and the Scottish and Welsh Governments.

Introducing the Entitlement to Work as a Condition for Contributory Benefits

23. The Act closes a loophole in the entitlement conditions for certain contributory benefits and statutory payments so that claimants will only be able to claim them if they are entitled to work in the United Kingdom.

Child Support Maintenance Reforms

24. Parents are best placed to make the arrangements that will deliver the best outcomes for children. The Act takes powers to encourage parents who are separating to make family-based arrangements, while ensuring that the statutory scheme is still there for those who need it.

Simplification of the Industrial Injuries Disablement Benefit

25. Measures are included with a view 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 customers.

Reform of Appeals Process

26. The Welfare Reform Act 2012 introduces changes to the appeals process so claimants must seek a revision of the disputed decision before making an appeal to the First-tier Tribunal. An increase in the volumes of social security appeals has led to a substantial increase in the Tribunal Service caseload and longer waiting times for appeals to be heard. These measures aim to ensure timely, proportionate and more efficient dispute resolution.

Child Poverty and Social Mobility Commission

27. The Act also makes changes to the Child Poverty Commission legislated for in the Child Poverty Act 2010. The Commission's advisory role will be redefined so that the Government no longer has a duty to request the Commission's advice on its Child Poverty Strategies and to have regard to this advice when developing the strategies. Its accountability functions will be strengthened and its remit will be widened to include social mobility.

Lone Parent Support – Child Poverty

28. The Government is firmly committed to ending child poverty and improving the lives of low income families. Work is recognised as the primary sustainable route out of poverty and so the Government is determined to support lone parents to prepare for, enter and retain paid employment.

29. A range of support is made available to lone parents who are claiming either Jobseeker's Allowance and who are looking for work, or Employment and Support Allowance and who are preparing for a return to work.

30. From May 2012 this will include most lone parents with a youngest child age 5 or over as they will no longer be entitled to Income Support (IS) on the sole grounds of being a lone parent.

31. Support is also provided to those lone parents who have a youngest child aged under six and who are claiming Income Support on the grounds of

being a lone parent. This involves ensuring that we have regular face-to-face contact with them.

Services for Lone Parents

32. A range of measures are available to help lone parents into work.

These services are:

- Get Britain Working (GBW) measures, which comprise of:
    - Work Clubs
    - Work Together
    - Work Experience
    - New Enterprise Allowance

- Flexible Support Fund (FSF) replaces a range of previous support available to help lone parents enter and remain in work.

- Extra financial support to help lone parents stay in work through In Work Credit (IWC). Eligible lone parents receive £40 per week for up to a year when they move into a job of 16 hours per week or more. In London, IWC is paid at £60 per week. IWC will be replaced with the introduction of Universal Credit.

- In Work Advisory Support (IWAS) which provides lone parents who have moved into work with access to a Personal Adviser for the first 26 weeks of work.

- Help to enable lone parents to overcome unexpected difficulties that otherwise could make it difficult for them to remain in employment is available through the Flexible Support Fund.

Lone Parent Obligations and Extension (LPOE) (reducing Child Poverty)

33. From 25 October 2010 most lone parents, with a youngest child aged 7 or over, are no longer entitled to Income Support. They are required to claim Jobseekers Allowance (JSA) if they are able to work or Employment and Support Allowance (ESA) if their capacity for work is limited by a disability or health condition.

34. This change was introduced through three phases for most lone parents who made a new, or repeat claims with:

- A youngest child aged 12 or over from 24 November 2008
- A youngest child aged 10 or over from 26 October 2009, and
- A youngest child aged seven or over from 25 October 2010.

Most existing lone parents' Income Support ended by:

- December 2009 for lone parents with a youngest child aged 12 or over.

- September 2010 for lone parents with a youngest child aged 10 or over.
- April 2011 for lone parents with a youngest child aged seven or over.

Changes from May 2012: Lone Parent Obligation Extension

35. In the 2010 Coalition budget it was announced that the age limit would be further reduced to include lone parents with a youngest child aged 5 or older.

36. From 21 May 2012 the age of the youngest child will reduce to age 5 for new and repeat claims. As with Lone Parent Obligations this change will be introduced in 2 stages for existing lone parents, starting from;

- May 2012 with Phase 4a lone parent claimants with a youngest child aged 6, or turns 6; then from
- August 2012 with Phase 4b lone parent claimants with a youngest child age 5, or turns 5.

37. Lone parents with a youngest child born on or before 21 May 2005 are not part of the LPOE changes and are required to claim JSA/ESA via the Contact Centre when their youngest child turns 7.

Lone parents therefore have choices to make and will need to take action:
- to stop claiming benefit because they have found a job, or
- to make a claim for another benefit if they have not found paid work.

Some lone parents are still eligible to receive Income Support if they:
- have children who are entitled to the middle rate or highest rate care component of Disability Care Allowance;
- receive Carer's Allowance; or
- have a foster child living with them

In addition a lone parent may be able to stay on Income Support if they are undertaking an approved course of education or training and qualify for Transitional protection.

The Social Fund

38. 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.

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

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

41. The new local provision will ensure 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 current centralised system which is more remote.

42. The Social Fund Annual Report[1] for 2011/12 was published in July 2012.

Addressing Financial Exclusion – Credit Union Reform

43. 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.

44. 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.

45. 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[2] and informal views received.

46. On 27th June the Government announced that it will take forward the findings of the Feasibility Study. In particular, the DWP will make a further investment of up to £38 million over the next three years in credit unions. This investment, which is in addition to the £13 million invested in 2011/12, will be conditional upon the credit union industry meeting a number of agreed milestones for collaboration, modernisation and expansion. The Government's aim is to ensure the industry's financial sustainability by the end of the project.

Social Justice

[1] http://www.dwp.gov.uk/docs/2012-annual-report-social-fund.pdf
[2] http://www.parliament.uk/documents/commons-vote-office/June_2012/27-06-

47. 'Social Justice' is about giving individuals and families facing multiple disadvantages the support and tools they need to turn their lives around. The Government published its 'Strategy for Social Justice'[1] in March 2012. Previous approaches to tackling poverty have focused on increasing income levels to bring people above the poverty line. The Social Justice Strategy goes much further, exploring how tackling the root causes of problems can make real and sustained changes to the lives of those facing multiple disadvantages.

48. The principles underpinning this approach are:

- A focus on prevention and early intervention.
- Where problems arise, concentrating interventions on recovery and independence, not maintenance.
- Promoting work as the most sustainable route out of poverty, while offering unconditional support for those who are severely disabled and cannot work.
- Recognising that the most effective solutions will often be designed and delivered locally.
- Ensuring that interventions provide a fair deal for the taxpayer.

Personal Independence Payment

49. Another 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. By reforming Disability Living Allowance, the Government wants to create a fairer, more transparent and sustainable system fit for the 21st century. Personal Independence Payment will support disabled people who face the greatest barriers to participating in society.

50. Government expenditure on disabled people and services is currently around £50 billion a year, including £13.6 billion on DLA (2012/13 forecast). During the past ten years the number of people claiming DLA has risen by almost 34 per cent (from just under 2.4 million to 3.2 million).

51. DLA is seen as a benefit for life, with no inbuilt, systematic mechanism for reviewing awards. There are 130,000 people on DLA who since its introduction in 1992 have never had their award reviewed. Over 70 per cent of the current DLA caseload has an indefinite award. Furthermore, around 50 per cent of decisions are currently made without any supporting medical evidence.

52. The Government remains committed to supporting disabled people and is determined that support should be focussed on those with the greatest need. The reforms include a more objective assessment process, with a face-to-face consultation for most people, that will enable a more accurate and consistent assessment of individual need. The intention is not to judge people purely on the type of disability or impairment they have.

[1] http://www.dwp.gov.uk/docs/social-justice-transforming-lives.pdf

53. The Government wants to ensure that everyone continues to receive the correct level of award and that Personal Independence Payment reflects further changes in our society and advances in medicine or support, including changes in treatments. There is a duty to both claimants and the taxpayer to ensure awards stay correct throughout. All Personal Independence Payment awards will therefore be reviewed at appropriate intervals.

54. Many people who currently receive DLA will continue to receive support under Personal Independence Payment. Personal Independence Payment will be payable to people who are both in and out of work. It will be non-means tested and will not be subject to tax. Personal Independence Payment will not apply to children aged under 16 or people aged 65 and over on 8 April 2013 when it is introduced – children and those aged 65-plus will be able to continue to claim DLA if they are eligible to do so.

55. The Department for Work and Pensions (DWP) has set out proposals to phase in the implementation of Personal Independence Payment[1]. New claims to Personal Independence Payment will begin to be accepted at the Bootle Benefit Centre from April 2013 so that the processes can be monitored and reviewed to check that they are working effectively, in advance of full national rollout for new claims in June 2013. DWP will then begin reassessing existing DLA claimants for Personal Independence Payment from October 2013.

Engaging and consulting disabled people

56. Throughout the development of the proposals for Personal Independence Payment, the Department has had extensive discussions and undertaken consultations with disabled people and organisations of and for disabled people. The Department has completed two formal consultations this year on:

- The assessment criteria – closed on 30 April; over 1,000 response
- The detailed design – closed on 30 June; over 1,600 responses
- The Government is carefully considering the responses and evaluating what further changes may need to be made in light of the representations we received.

The Department intends to publish responses to both consultations and the principal draft PIP Regulations before the end of 2012.

57. The Department has established the Personal Independence Payment Implementation Stakeholder Forum, (formerly known as the Implementation Development Group). The Forum meets regularly and involves over 60 user-led, grass-roots and national organisations, to work with the Department as it designs and develops delivery arrangements for Personal Independence Payment.

58. The Department has applied a User Centred Design approach to the design of PIP. The Department has also worked with people with both

[1] http://www.dwp.gov.uk/docs/pip-briefing-high-level-reassessment.pdf

physical and mental conditions/disabilities as well as with local and national partners to help develop new products and processes. By placing the customer at the heart of design, the Department can make processes, smoother and more effective for those using it. The Department has published answers to the most common and/or frequently asked questions about Personal Independence Payment. These, alongside other information on Personal Independence Payment, can be accessed on the DWP website at www.dwp.gov.uk/pip

ECSR Conclusions

Level of assistance

In their Conclusions, the Social Rights Committee asks what rate of basic benefit is applied to a single person without children, aged between 18 and 25;

59. The weekly personal rates (April 2012 rates) of income-related benefit are either,

- for persons actively seeking work, £56.65 (Jobseeker's Allowance): or
- for those persons with limited capability for work, Employment and Support Allowance of £56.25 (without additional premiums); plus either £28.15 Work Related Activity Component; or £34.05 Support Component.

60. The amount of any Housing Benefit and Council Tax Benefit payable in addition to the rates describe above would vary according to the Local Housing Allowance and Council Tax rates for the area in which the person lives. From 2013, a 'benefit cap' on the total weekly amount of benefits in payment is to be introduced, which would be fixed at £350 per week for a single person without dependants.

Benefit Cap

61. From 2013 the Government will introduce a cap on the total amount of benefit that working-age people can receive so that, broadly, households on out-of-work benefits will no longer receive more in welfare payments than the average weekly wage for working households.

62. On its introduction in 2013, the cap will be set at £500 per week for couple (with or without children) and single parent households; and at £350 per week for single adult households without children. A Technical Explanatory Note on the *Benefit Cap* includes information on how the illustrative median net earned income was arrived at and is set out below. Further background information is set out in the website pages at: http://www.dwp.gov.uk/adviser/updates/benefit-cap/.

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TECHNICAL NOTE ON UK INCOME DATA SOURCES AND DETAILS OF THE COMPARISON BETWEEN THE NEW BENEFIT CAP AND AVERAGE

INCOME

This note describes several data sources that provide information on earnings data, at an individual, family and household level, and how the Family Resources Survey (FRS) complements other sources.

The Annual Survey of Households and Earnings (ASHE)
The Annual Survey of Households and Earnings (ASHE) focuses on employees in employment. It provides rich information about the levels, distribution and makeup of earnings and hours paid for employees within industries, occupations and regions. The survey collects earnings and hours worked information for a pay period in April each year. It does not cover the self-employed. With a one per cent sample of all employees in employment, ASHE is generally regarded as the best source of information on individual employee earnings. Further information about ASHE can be found at:
http://www.statistics.gov.uk/statbase/product.asp?vlnk=13101

Family Resources Survey (FRS)
The FRS is the UK's premier data source on household incomes. It can be used to provide information on earnings from employment and income from self-employment, as well as other income sources received such as income from pensions, tax credits and benefits, income from savings, etc. Unlike ASHE, the FRS collects this information for all individuals in a household, so can be used to derive employment and self-employment income at a family and household level and is generally regarded as the accurate source for this type of information.
http://research.dwp.gov.uk/asd/frs/index.php?page=intro

Labour Force Survey
The primary purpose of the Labour Force Survey (LFS) is to collect information on labour market activity. It also collects some data on employee earnings for a subset of its sample. However, ASHE is the preferred source for average earnings data for individuals in employment as it has a larger sample size, while the FRS is the preferred source for average family or household earnings/incomes But the LFS earnings data can be analysed alongside information on labour market activity. Further information about the LFS can be found at:
http://www.ons.gov.uk/about-statistics/user-guidance/lmguide/sources/household/lfs/index.html

Other statistics on earnings
Average Weekly Earnings (AWE); Further information can be found at:
http://www.statistics.gov.uk/cci/nugget.asp?id=10

Survey of Personal Incomes (SPI); Further information can be found at:
http://www.hmrc.gov.uk/stats/income_distribution/menu.htm

General Lifestyle Survey; Further information can be found at:
http://www.statistics.gov.uk/statbase/product.asp?vlnk=5756

Living Costs and Food Survey; Further information can be found at:

http://www.statistics.gov.uk/statbase/product.asp?vlnk=361

Compared to ASHE, the FRS and LFS, all of these sources have either a smaller size or cover a different subset or group of the population.

HOW THE ILLUSTRATIVE MEDIAN NET EARNED INCOME FOR WORKING FAMILIES HAS BEEN CALCULATED

The Spending Review announced that household welfare payments will be capped on the basis of median earnings after tax and National Insurance Contributions for working households from 2013. This was estimated to be around £500 per week for couple and lone parent households and £350 per week for single adults by 2013/14, when the cap will be introduced.

This estimate was produced using the Department for Work and Pensions' Policy Simulation Model. This is a static micro-simulation model based on data from the 2008-09 Family Resources Survey, up-rated to the relevant year's prices, benefit rates and earnings levels. The modelling was carried out under the current benefit system rules. Note that in cases where households contain more than one benefit unit , the median earnings after tax and National Insurance Contributions were calculated at the benefit unit level.

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63. The aim of the policy is to achieve long term positive behavioural effects through changed attitudes to welfare, responsible life choices and strong work incentives.

64. The cap will apply to the combined income from benefits including:

- the main out-of-work benefits (Jobseeker's Allowance, Income Support and Employment & Support Allowance **except** where the Support Component is in payment);
- Housing Benefit;
- Child Benefit;
- Child Tax Credit; and
- other benefits such as Carer's Allowance.

One-off payments, for example, Social Fund Loans and non-cash benefits, such as Free School Meals, will not be included in the assessment of benefit income.

65. In recognition of their additional needs, all households which include somebody who is receiving Disability Living Allowance, Personal Independence Payment, Industrial Injuries Benefit (and those receiving War Disablement Pension and the equivalent payments from the Armed Forces Compensation Payments Scheme), Attendance Allowance or receiving the support component of Employment Support Allowance will be exempt from the cap. War widows and war widowers will also be exempt.

66. Households with a member who is entitled to Working Tax Credit will also be excluded from the benefit cap. This will increase the incentive for

people on out-of-work benefits to find jobs because once they are in receipt of Working Tax Credit - or the earnings equivalent under Universal Credit - their benefits will no longer be capped.

67. Initially the benefit cap will be delivered by local authorities through Housing Benefit payments. In the long term it will be administered as part of the new Universal Credit system.

68. The Government will introduce the benefit cap through legislation in the Welfare Reform Act 2012 and from October 2013 the cap will also be applied to new claimants of Universal.

69. The Government has announced measures to ease the transition for families and provide assistance in hard cases. It has said that there will be a grace period whereby the benefit cap will not be applied for 39 weeks to those who have been in work for the previous 12 months.

70. A revised Benefit Cap Impact Assessment was published on 16th July 2012: http://www.dwp.gov.uk/docs/benefit-cap-wr2011-ia.pdf

Personal scope

Habitual Residence guidance

The Committee asks to be informed of any significant case-law or administrative guidance which may provide further clarification of how the concepts of 'settled intention' and 'appreciable period of time' are applied in practice.

71. The Habitual Residence Test has two elements: a test of legal right to reside and a test of factual habitual residence. Whether someone is factually habitually resident is assessed in light of the individual's personal circumstances; this cannot only take into account the length of residence in the UK.

72. The note set out below, includes the relevant extracts from the Decision Makers Guide on assessing the factual habitual residence element of the Habitual Residence Test - this includes guidance on the settled intention to remain; appreciative period of time; and legal references. The guide in full is in the public domain and can be found at:
http://www.dwp.gov.uk/publications/specialist-guides/decision-makers-guide/

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071183 Although it is used in both domestic and European law, there is no statutory definition of the term 'habitual residence'. There are different considerations in applying domestic and EC law but in both instances the expression should be given its ordinary and natural meaning. Decision Makers (DM) should determine the question by considering all the facts of the case in a common sense way and applying the

relevant case law.

When the test should be applied

071185 If other conditions of entitlement to benefit are satisfied the DM should consider whether the claimant is excluded from benefit by being a Person Subject to Immigration Control (PSIC). If not the DM should consider

1. whether the claimant is excluded from treatment as a person from abroad in consequence of EC law or under other specific exclusions **if not**

2. whether the claimant has the right to reside in the Common Travel Area (CTA).

If the claimant has the right to reside in the CTA the DM should apply the test for actual habitual residence.

071186 The actual habitual residence test should also be applied if a claimant at any time ceases to be subject to immigration control or gains the right to reside in the CTA (for instance, where a PSIC is granted British citizenship).

Requirement to establish a residence that is habitual in nature

071340 To be habitually resident in a country a person must have actually taken up residence and lived there for a period. It is not sufficient that the person came to this country voluntarily and for settled purposes. He must be resident in fact for an appropriate period of time which demonstrates that his residence has become, and is likely to remain, habitual in nature[1].

1 House of Lords, Nessa v CAO (1999) IWLR 1937 HL

Settled intention to remain

071341 The period of time cannot begin before the person is both living in the UK, and has a settled intention to remain in the UK for the time being. The person does not have to intend to remain permanently.

Relevant factors

071342 Whether and when a person's residence has become habitual in nature is a question of fact. The period is not fixed and depends on the facts of each case. Amongst the relevant factors to be taken into account are bringing possessions so far as is practicable, doing everything necessary to establish residence before coming, having a right of abode, seeking to bring family, and having durable ties with the country of residence or intended residence[1]. The list is not exhaustive and any facts which may indicate whether or not the residence is habitual in nature should be taken into account.

1 House of Lords, Nessa v CAO (1999) IWLR 1937 HL

071343 Only the appropriate weight should be given to factors wholly or partly

outside the person's control. The person may have close relatives, even immediate family, outside the UK. There may be an intention that family members will join the person here when permission to do so can be obtained. The person may, quite reasonably, visit them regularly. That need not indicate that the person himself does not have a settled intention to remain in the UK, or that he cannot be habitually resident here. Cultural differences in the nature of contact between family members should be respected.

071344 It is not necessary to have permanent or private accommodation to establish habitual residence. A person may be resident in a country whilst having a series of temporary abodes.

071345 A person's financial viability may be a relevant factor, but the test for habitual residence should not be applied so as to prevent access to public funds. It must be applied in a way that allows for the possibility of a claimant establishing both habitual residence and an entitlement to benefits[1].

1 House of Lords, Nessa v CAO (1999) 1WLR 1937 HL

Appropriate period of time

071346 The appropriate period of time need not be lengthy if the facts indicate that a person's residence has become habitual in nature at an early stage[1]. In some circumstances the period can be as little as a month, but it must be a period which is more than momentary in a claimant's life history[2]. A period of between one and three months is likely to be appropriate to demonstrate that a person's residence is habitual in nature. Cogent reasons should be given where a period longer than three months is considered necessary[3].

1 House of Lords, Nessa v CAO (1999) 1 WLR 1937 HL; 2 CIS/4389/99; 3 CIS/4474/03

Becoming habitually resident

071347 The nature of a person's residence should be considered throughout the period in question, to establish whether or when it became habitual. The fact that a person's residence has become habitual in nature after a period of time does not mean that the residence was habitual in nature from the outset. Residence only changes its quality at the point at which it becomes habitual.

Resuming a previous habitual residence

071348 There may be special cases where a person who has previously been habitually resident in the UK resumes that habitual residence immediately when he returns to the UK following a period living abroad[1]. The only element of habitual residence that is bypassed by a returning former resident is the need to be resident in

the UK for an appreciable period. Factors to be considered in deciding whether the previous habitual residence has been immediately resumed include the settled intention to remain, whether the person is in a position to make an informed decision about residence in the UK, the ties and contacts with the UK retained or established by the person while abroad, the reasons why the claimant left the UK and became habitually resident elsewhere, the similarity between their residence in the UK now and when they were previously here, and the length of the period of absence[2]. This is a different situation to that where a person is temporarily absent from the UK and does not lose their habitual residence during that period of absence.

1 House of Lords, Nessa v CAO (1999) 1WLR 1937 HL; 2 CIS/1304/1997 and CJSA/5394/1998

EC law

071349 When deciding whether a person is habitually resident for EC law DMs should consider whether a person is resuming a previous habitual residence before taking into account other factors in DMG 071354. In such cases it is still necessary to determine whether the person has a right to reside in accordance with the guidance in 071180 et seq.

Resuming previous residence

071350 The guidance at DMG 071351 - 071353 is concerned with EC law[1] which applies a broader meaning to the term 'habitual residence' than that found in the regulations. It does not apply to persons who have returned to the CTA from a country which is not an EC Member State[2].

1 Reg (EC) 883/04, art 7;
2 Court of Appeal; Gingi v Secretary of State for Work and Pensions [2001] 1 CMLR 20

071351 A person with habitual residence in the CTA who exercised his right to freedom of movement under European law and then returns to resume his residence in the CTA may be habitually resident immediately on his return[1].

1 Case C-90/97, Swaddling v CAO (1999) All ER (EC) 217

071352 A JSA(IB), IS, ESA(IR) or SPC claimant who

1. was previously habitually resident in the CTA **and**

2. moved to live and work in another Member State **and**

3. returns to resume the previous habitual residence

is habitually resident immediately on arrival in the CTA.

071353 In deciding whether the claimant is resuming previous residence the DM should take account of the length and continuity of the previous residence in the CTA,

his employment history in the other Member State and whether the claimant has maintained sufficient links with the previous residence to be said to be resuming it rather than commencing a new period of residence.

Example

The claimant, a UK national, lived and worked in UK before moving to Germany where he worked for several years. He was made redundant and having failed to find work in Germany for three months he returned to the UK where he had family and friends. On claiming JSA(IB) he stated that his intention was to find work and remain permanently in the UK. JSA was awarded because he was resuming a previous habitual residence.

Factors to take into account

071354 When deciding where a person is habitually resident for EC law, the DM should take into account the

1. person's main centre of interest[1]
2. length and continuity of residence in a particular country
3. length and purpose of the absence from that country
4. nature of the employment found in the other country to which the person moved for a time **and**
5. intention of the claimant.

Note: This is not an exhaustive or conclusive list. There may be other factors that are important in deciding whether a person is habitually resident in an individual case.

1 Case 76/76 Di Paolo; R(U)7/85; R(U)8/88

Centre of interest

071355 People who maintain their centre of interest in the UK, for example a home, a job, friends, membership of clubs, are likely to be habitually resident in the UK. People who have retained their centre of interest in another country and have no particular ties here are unlikely to be habitually resident in the UK.

Length and continuity of residence

071356 A person who has a home or close family in another country would normally retain habitual residence in that country. A person who has previously lived in several different countries but has now moved permanently to the UK may be habitually resident here.

Length and purpose of absence

071357 Where a person spends time away from the UK, the DM should consider the frequency, length and purpose of the absences and decide whether habitual residence in the UK has been lost. If a person who is working abroad returns frequently, for example to visit family or because a home has been retained here, it is likely that

habitual residence in the UK has not been lost. Infrequent visits or the purchase of a home abroad may point to the opposite.

Employment

071358 The claimant's employment record and in particular the nature of any previous occupation and plans for the future are relevant. A person with the offer of genuine and effective work in the UK, whether full time or part time is likely to be habitually resident here.

Intentions

071359 The fact that a person may intend to live in the UK for the foreseeable future does not, of itself, mean that habitual residence has been established. However, the claimant's intentions along with other factors, for example the purchase of a home in the UK and the disposal of property abroad may indicate that the claimant is habitually resident in the UK.

071360 A claimant who intends to reside in the UK for only a short period, for example on holiday, to visit friends or for medical treatment, is unlikely to be habitually resident in the UK.

071361 Work seekers do not come within the scope of the Regulations and Directives[1] which define 'workers' for the purpose of deeming the satisfaction of the habitual residence test and EEA nationals who are seeking work in the UK may be subject to the test if they have no established link with the UK employment market[2].

1 Regulation 1612/68; Directive 2004/38/EC; 2 Case C-138/02 Collins v Secretary of State for Work and Pensions.

071362 However citizens of the EU are entitled not to be discriminated against whether or not they come within the scope of the regulations and Directives which apply to 'workers'[1]. In a judgment of the ECJ[2] it was held that although the habitual residence test discriminated against work seekers, because it could be satisfied more easily by UK nationals than by nationals of other Member States, that discrimination was not unlawful if it could be justified on the basis of objective criteria independent of nationality. The test had to be proportionate to the legitimate aim of ensuring that there is a genuine link between a claimant and the geographic employment market in question. When this case returned to the domestic courts the Court of Appeal concluded that the habitual residence test was not incompatible with EC law[3].

1 TFEU, Arts 18 & 20; Case C-184/99 (Grzelczyk); 2 Case C-138/02 (Collins) 3 Collins v SSWP [2006] EWCA Civ 376

071363 The period required for the Secretary of State to be satisfied that there is a genuine link with the UK employment market is not defined and must be considered in the light of the circumstances. However it should be long enough to demonstrate the sustained nature and relevance of the search. The Commissioner has held[1] that the period was not sufficient in a case where the claimant

- had not previously worked in any Member State other than temporary work in the UK 17 years previously
- had not made any real enquiries about work before arriving in the country
- had not made any arrangements for accommodation and was staying with a friend
- was single with no dependents
- had close family and a bank account in the USA
- had a return ticket to the USA (although that was bought because it was cheaper than a single)
- had been looking for work for no more than a month.

The Commissioner further expressed the opinion that, in the circumstances, a further month of residence and work search would not be enough even though at the end of that time the claimant found work that was full time but not in the sector in which he was particularly interested.

1 R(JSA)3/06, para 50

……

The Committee asked also for information on what assistance and advice individuals may receive in preparing their claim that they satisfy the habitual residence test.

73. Internal Guidance for staff at contact centres who deal with claims and telephone enquiries prior to the personal interview, stipulates that staff should advise the claimant to take their birth certificate, passport and any documentation they have from the Home Office to the interview. Further guidance is available internally for staff at Jobcentres which confirms they should contact the claimant prior to the interview. During this telephone call the adviser should obtain as much information as possible so as to complete as much information on the electronic Habitual Residence Test form (see **Appendix 13A** e-HRT form) and advise the customer of what further documentary evidence will be required (if any) to further support their answers in relation to the Habitual Residence Test and that this should be brought with them to the interview.

74. The DWP constantly reviews the guidance available to staff, with a view to ensuring that they provide sufficient support to claimants who are required to complete the Habitual Residence Test.

Medical Assistance

England

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

76. The Health and Social Care Act[1], enacted in January 2012, enshrines the principles of a comprehensive health service available to all with access based on clinical need, not the ability to pay. The Act enshrines in law, for the first time, duties on the Secretary of State for Health and on commissioners of health care to reduce inequalities in access and in outcomes. Primary Care Trusts and Strategic Health Authorities will be abolished, reducing bureaucracy and improving value for money. £5.5bn of savings are expected over the current Parliament as a result of the reforms, with a further £1.5bn per year from 2014/15, with every penny of efficiency savings reinvested in patient care to deliver continuous improvement in quality of health care.

77. The reforms will give local clinicians greater responsibility for shaping the health services that their patients need. Clinical Commissioning Groups, which will be fully established by April 2013 and will bring together clinicians, supported by the NHS Commissioning Board, to lead the commissioning of health services for patients without political interference whilst remaining accountable to the public for the quality of outcomes they deliver.

78. The NHS Commissioning Board has been operating in shadow form since October 2011 as a Special Health Authority, in order to be ready to take on its full responsibilities from April 2013, when it will be fully established as an independent body. It will allocate resources to Clinical Commissioning Groups without Ministerial interference, whilst remaining accountable for ensuring expenditure remains within limits set by the Secretary of State for Health and for the health outcomes it delivers.

79. New health and wellbeing boards, which will be fully established from April 2013, will ensure that services work together and are responsive to communities' needs and priorities. They will bring together local commissioners of health and social care, elected councillors and representatives of the new voice of patients, "HealthWatch", to agree a coordinated Joint Health and Wellbeing Strategy for their area, to which commissioners of health care will have to have regard when making commissioning decisions.

80. The Government will set objectives for the NHS and the measures by which we will assess their delivery through a 'mandate' to the NHS Commissioning Board and in the NHS Outcomes Framework. Whilst only part of the relationship between the Department of Health and the NHS in England, these mechanisms are an important element of the way that the Government will hold the health service to account. The NHS Commissioning Board will be legally required to publish an annual report on how it has worked to meet its objectives under the mandate and how effectively it has discharged its duties to improve quality, reduce inequalities and involve the public. The Secretary of State for Health will also be legally required to send to the NHS Commissioning Board and lay before Parliament an assessment of the Board's performance each year, and to publish his own annual report on the performance of the health service in England. This is required to

[1] http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

include an assessment of how he has discharged his duties to secure continuous improvement in the quality of services and to reduce inequalities in access to health services and inequalities in health outcomes.

81. The Government's reforms of the health system in England give a new focus to public health, supporting the NHS to improve health and wellbeing. The Act places the Secretary of State for Health under a duty to take steps to protect the health of the people of England. Public Health England will be established as an executive agency of the Department of Health from April 2013, bring together a range of organisations in a public health system directly accountable to the Secretary of State. The Act gives responsibility to local authorities to improve the health of their local populations, enabling them to draw together the work done by the NHS, social care, housing, environmental health, leisure and transport services and ensuring that we are in a strong position to tackle future national public health challenges at a local level.

Wales

82. In Wales, seven new Local Health Boards (LHBs) were created in 2009 that differ from their predecessors in that they are now responsible for the planning and delivery of all health services within their geographical boundaries, including health improvement and hospital, community and primary care. Each has a board, appointed by, and directly accountable to the Minister for Health and Social Services.

83. In addition three NHS trusts were created – for the Welsh ambulance service, for public health, and for specialist cancer services (Velindre NHS Trust). Specialist care is now commissioned by the Welsh Health Specialised Services Committee (WHSSC), which is accountable to the seven LHBs. Public and patient input is the statutory responsibility of eight community health councils (CHCs), the successors of bodies originally established in 1974.

84. The Minister is supported by the Department for Health, Social Services and Children and the Director General, who is also the Chief Executive of the NHS in Wales. The Deputy Minister takes the lead on policy matters relating to social services and social care, which remain largely a responsibility of local government.

Statistics

Social Assistance Statistics

Households Below Average Income (HBAI)

85. The latest national statistics on Households Below Average Income (HBAI)[1] produced by the Department for Work and Pensions were released on 14 June 2012 according to the arrangements approved by the UK Statistics Authority.

86. Statistics and commentary give an insight into the standard of living of the household population in the United Kingdom, focusing on the lower part of income distribution, for the period up to the end of 2010/11. The latest release updates the statistics previously released on 12/05/2011.

The key points from the latest release are:

'Relative' Low-income indicators

- **Children -** In 2010/11, 18 per cent of children (2.3 million) were in households in the UK with incomes below 60 per cent of contemporary median net disposable household income Before Housing Costs (BHC), and 27 per cent (3.6 million) After Housing Costs (AHC).
    - Compared to 2009/10, this represents a fall of 2 percentage points (0.3m) on a BHC basis and a fall of 2 percentage points (0.2m) AHC.
    - Compared to 1998/99, this represents a fall of 9 percentage points (1.1m) on a BHC basis and a fall of 7 percentage points (0.9m) AHC.

- **Working-age adults -** In 2010/11, 15 per cent of working-age adults (5.5 million) were in households in the UK with incomes below 60 per cent of contemporary median net disposable household income Before Housing Costs (BHC), and 21 per cent (7.8 million) After Housing Costs (AHC).
    - Compared to 2009/10, this represents a fall of 1 percentage point (0.2m) on a BHC basis and a fall of 1 percentage point (0.1m) AHC.
    - Compared to 1998/99, this represents a rise of 1 percentage point (0.5m) on a BHC basis and a rise of 2 percentage points (1.1m) AHC.

- **Pensioners -** In 2010/11, 17 per cent of pensioners (2.0 million) were in households in the UK with incomes below 60 per cent of contemporary median net disposable household income Before Housing Costs (BHC), and 14 per cent (1.7 million) After Housing Costs (AHC).
    - Compared to 2009/10, this represents a fall of 1 percentage point (no change in numbers) on a BHC basis and a fall of 1 percentage point (0.1m) AHC.
    - Compared to 1998/99, this represents a fall of 9 percentage points (0.7m) on a BHC basis and a fall of 14 percentage points (1.3m) AHC.

[1] http://statistics.dwp.gov.uk/asd/index.php?page=hbai

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

Statistical Summaries

87. 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
http://research.dwp.gov.uk/asd/asd1/stats_summary/stats_summary_aug12.pdf
Previous releases in the time series are at:
http://research.dwp.gov.uk/asd/index.php?page=stats_summary

Tax Credits and Statistics

88. A full description of Child Tax Credits and Working Tax Credits and HMRC published rates, method of calculation and related statistics are set out in the April 2012 statistical summary:
http://www.hmrc.gov.uk/stats/personal-tax-credits/cwtc-main-apr12.pdf
The time series can be viewed at:
http://www.hmrc.gov.uk/stats/personal-tax-credits/cwtc-quarterly-stats.htm
Information on both is also provided in the responses to Part VII in the Code of Social Security reports set out in **Appendices 12 B&C**.

Medical Assistance Statistics

Spending on health in the UK
Information on the total UK health expenditure can be found in http://www.ons.gov.uk/ons/dcp171766_264293.pdf . Further more detailed information can viewed at the Office for National Statistics (ONS) website[1].

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

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

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

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

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

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

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

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

Article 13, Paragraph 2

89. The position remains as previously described.

Article 13, Paragraph 3

90. The position remains as previously described.

ECSR Conclusions

In its Conclusions on the UK's previous report, the Committee of Social Rights asks whether services and institutions concerned with informing individuals of their rights concerning social assistance and enabling them to overcome difficulties arising from their need, are provided with sufficient means to give appropriate assistance as necessary?

91. The Government provides advice on all benefits and services though its **Gov.UK** website, which includes an on-line benefits adviser: https://www.gov.uk/benefits-adviser .

92. There is also a comprehensive range of non-governmental, voluntary and charitable organisations offering a free welfare rights advisory service, often at local community level working together with Local Authority welfare rights services. The largest such organisation is 'Citizens Advice'.

Citizens Advice

93. The Citizens Advice Bureau delivers advice services from over 3,500 community locations in England and Wales, run by 382 individual charities. Citizens Advice itself is also a registered charity, as well as being the membership organisation for bureaux. Together they are the Citizens Advice service.

94. In addition to the nationwide network of bureaus, the service provides on line help and guidance through:
http://www.adviceguide.org.uk/index.htm
http://www.adviceguide.org.uk/england/benefits_e.htm

http://www.adviceguide.org.uk/england/about_this_site/get_advice.htm

95. Citizens Advice in England and Wales is funded mainly by a core central government grant from the Department of Business, Innovation and Skills (BIS), together with a variety of project based income, trading income and some other income[1].

96. The service provides free, independent, confidential and impartial advice to everyone on their rights and responsibilities. It reported a total of 690,000 clients who presented Citizens Advice Bureaus with more than 2.2 million benefits and tax credit issues in 2010-11. Half of all benefits advice related to determining clients' eligibility and entitlement[2].

97. Similar organisations operate throughout the UK. Information on Citizens Advice in Northern Ireland is at www.citizensadvice.co.uk and in Scotland at www.cas.org.uk.

Article 13, Paragraph 4

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

Primary health care

99. Primary care continues to be free to all, but it is a general condition of entitlement to free NHS hospital treatment that the person seeking treatment must be "ordinarily resident" in the UK. This broadly means that the person is living here on a lawful, voluntary and properly settled basis. Those people who are not ordinarily resident here are deemed overseas visitors and are subject to the NHS (Charges to Overseas Visitors) Regulations 2011, 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.

100. Some groups of unlawfully present foreign nationals are exempt from charges. These comprise those whose applications for refugee status are still being considered, including appeals; those being supported by the UK Border Agency with section 4 or section 95 support, including failed asylum seekers; those who are victims, or suspected victims, of human trafficking; and children in the care of a Local Authority. 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 as an outpatient (not further emergency treatment); compulsory psychiatric treatment or treatment as a result of a Court order; family planning

1 http://www.citizensadvice.org.uk/index/aboutus/publications/annualreports/annual_report_2012.htm

2 http://www.citizensadvice.org.uk/pdf_the_value_of_benefits_advice.pdf

services; treatment for sexually transmitted diseases, including, from 1 October 2012, HIV treatment; and treatment for many other infectious diseases.

101. Treatment which a clinician considers to be immediately necessary, or urgent enough not to be able to wait until the patient has returned to their home country, will always be given regardless of whether or not a chargeable patient has paid in advance or will be able to do so. This does not mean that the treatment is then free; hospitals must take reasonable steps to recover any debts, but can decide not to actively pursue for debt if not considered cost effective to do so.

102. 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.

103. A Department of Health review of entitlement to free NHS healthcare by overseas visitors is currently ongoing with a view to making the system fairer, less complex and more affordable. The review will respect the NHS's core values and obligations to provide urgent treatment. Denying access to any group is not an option.

Northern Ireland

104. In Northern Ireland the principle is different, if someone is a failed asylum seeker they cannot be deemed as ordinarily resident in Northern Ireland and therefore would not be entitled to free health services. However, where in the opinion of a clinician the treatment required by a patient is immediately necessary, this would never be withheld pending payment. The same free categories of care available to non-entitled patients in Great Britain are available to non-entitled patients in Northern Ireland i.e. A & E, compulsory mental health treatment, communicable diseases and STD treatment (HIV treatment only includes the diagnostic test and associated counselling as described in the document for free)

105. The Department of Health, Social Services and Public Safety (DHSSPS) recently completed a review of overseas visitors healthcare policy and legislation which has resulted in a number of proposals to amend the current position being developed. As part of the review DHSSPS examined the potential for altering the position on charging all failed asylum seekers for healthcare and also examined alternative options to the present position on providing only the free diagnostic test and counselling for HIV. No final decisions have been made on these proposals given the need to hold a public consultation at this point to garner a wide range of views from across all interested stakeholders. It is hoped to launch the public consultation later this year.

106. In Northern Ireland access to the Primary Care system is also 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.

107. 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.

ECSR Conclusions

The Social Rights Committee asks whether unlawfully present foreign nationals without resources, other than failed asylum seekers, are entitled to emergency shelter, food and clothing. In particular, it asks when emergency social assistance may be provided to such persons by local authorities under the National Assistance Act of 1948 or similar legislation.

108. Under Part 3 of the National Assistance Act 1948[1] (the 1948 Act), in particular Sections 21 and 29, each local authority has a duty, in respect of persons aged 18 or over, to make arrangements to provide residential accommodation for those persons who are in need of care and attention, which is not otherwise available to them, and to make welfare arrangements. Furthermore, Section 24(1) identifies the local authority in which an individual is ordinarily resident as the one empowered to provide the residential accommodation. New guidance and directions on ordinary residence, effective from 19th April 2010, were published on 5th March 2010: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113627

109. However, services under Sections 21 and 29 of the 1948 Act may not be provided to certain groups of people from overseas by virtue of Schedule 3 to the Nationality, Immigration and Asylum Act 2002[2]. These groups include nationals of the European Economic Area, people with refugee status abroad, failed asylum seekers who have not co-operated with removal directions and other individuals unlawfully in the UK and who are not asylum seekers. The exclusion does not apply to these groups if a failure to provide services under sections 21 or 29 of the 1948 Act would breach their rights under the European Convention on Human Rights and Fundamental Freedoms or under the European Treaties.

[1] http://www.legislation.gov.uk/ukpga/Geo6/11-12/29/part/III/crossheading/provision-of-accommodation
[2] http://www.legislation.gov.uk/ukpga/2002/41/schedule/3

110. The Government would draw the Committees attention to the response to their Conclusions question as set out below in respect of Article 14, paragraph 1 in this report.

111. From 1st October 2012, migrants who have overstayed their leave to remain in the UK by more than 28 days and then apply for further leave in the UK will be automatically refused. Previous rules allowed people who had come to the UK on a work or study route to make further applications to stay, even if their original leave had long since expired. As a result migrants could apply to stay in the country more than a year after their leave had expired, without any penalty.

112. In the Government's view this revised approach strikes the right balance, allowing those persons whose application to extend their stay is only marginally late the chance to remain in the UK, but forcing the seriously non-compliant to leave the country.

113. The UK Border Agency is working to ensure it identifies anybody who has overstayed their visa and encourages them to leave the country voluntarily. Those tempted to overstay need to be aware of the serious consequences and if they choose not to go will be arrested, detained and removed.

114. Although the immigration status of unlawfully present foreign nationals precludes access to public fund benefits, there are, however, assistance programmes designed to help overstayers or other illegal migrants, other than failed asylum seeker's, return and settle in their countries of origin[1].

115. The Assisted Voluntary Return of Irregular Migrants (AVRIM) programme[2] is not accessible by people who have applied for asylum. It is for people who are in the UK illegally, including those who have overstayed the time allowed by their visa, or have been smuggled into the UK.

Such persons accepted onto this programme, are assisted by an organisation "Choices" in obtaining:

- tickets to the home country;
- help with arranging travel; and
- help with obtaining travel documents.

116. There is also the Assisted Voluntary Returns for Families and Children (AVRFC) programme which is available to both asylum seekers and irregular migrants. It is for families with at least 1 child under 18 years old, and for

1 http://www.ukba.homeoffice.gov.uk/aboutus/workingwithus/workingwithasylum/assistedvoluntaryreturn/

2 http://www.ukba.homeoffice.gov.uk/aboutus/workingwithus/workingwithasylum/assistedvoluntaryreturn/avrim/

individuals under 18. This scheme does not cover EU nationals.

117. The scheme is flexible, to account for family needs, and is similar in support to VARRP; each individual family member qualifies for reintegration assistance, including in some cases financial resettlement assistance. More information can be viewed at the Choices website.
http://www.choices-avr.org.uk/choices/avrim

ISLE OF MAN

Article 13, Paragraph 1

There is no change to the information previously provided, but please see the information supplied above in respect of Article 12, Paragraph 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, 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/

Long-term care - Social care in England

3. When the Coalition Government came to power in May 2010, it recognised the importance of reforming care and support in England. *The Coalition: our programme for government* set out a clear commitment to enabling people who use care and support to be treated with dignity and respect and to have more control over their support. In November 2010, the Government published *A Vision for Adult Social Care*[1], which set out what a reformed system should look like and the steps to be taken in partnership to achieve that vision.

4. In May 2011, the Law Commission's report on adult social care recommended bringing together the different elements of social care law into a single, modern adult social care statute[2].

5. In July 2011, the final report of the Commission on Funding of Care and Support, made recommendations for changes to how the cost of care is shared between the individual and the state.[3] In particular, it proposed that the Government should introduce a cap on lifetime care costs and raise the threshold at which people cease to be eligible for means-tested support.

6. In response to these reports, in September 2011, the Government launched *Caring for our future*, a focused engagement to discuss priorities for reform with people who use care and support, carers, local councils, care providers, and the voluntary sector. On 11 July 2012, the Government published the White Paper *Caring for our future: reforming care and support*[4] *,* which provides a framework for transformation, putting people, not institutions or services, at the forefront of care and support.

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1 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_121971.pdf

2. http://lawcommission.justice.gov.uk/publications/1460.htm

3 http://www.dilnotcommission.dh.gov.uk/our-report/

4 http://www.dh.gov.uk/health/2012/07/careandsupportwhitepaper/

7. The measures set out in the White Paper 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.

8. As a core part of its reform agenda, the Government is also taking steps to modernise, simplify, and consolidate the adult social care statute in England. Alongside the White Paper, the Government has also published a draft Care and Support Bill. This 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.[1] The draft Bill has been closely informed by the recommendations made by the Law Commission.[2]

9. The Government has also published a progress report on funding reform.[3] The Government agrees that the principles proposed by the Commission on Funding of Care and Support would be the right basis for any new funding model. However, there remain a number of important questions and trade-offs to be considered about how those principles could be applied to any reformed system, particularly given the current economic situation. The Government will work with stakeholders and the Official Opposition to consider such questions, before coming to a final view in the next Spending Review.

10. In the meantime, the Government is taking forward a number of the Commission's recommendations both through the White Paper and as part of the draft Care and Support Bill. These include introducing a universal deferred payments guarantee from April 2015, which will mean that that no one will be forced to sell their house in their lifetime to pay for care.

[1] www.dh.gov.uk/health/2012/07/careandsupportbill/
[2] www.dh.gov.uk/health/2012/07/responsetolawcommission/
[3] www.dh.gov.uk/health/2012/07/scfunding/

Wales

Long Term Social Care

Sustainable Social Services: A Framework for Action

11. The White Paper Sustainable Social Services for Wales: A Framework for Action sets out a distinctive approach to the future provision of social services in Wales, which has evolved over the past ten years of devolution. That approach commands a wide degree of consensus among stakeholders in Wales.

Social Services and Well-being (Wales) Bill

12. In January 2013, the Deputy Minister for Children and Social Services will be introducing for scrutiny the Social Services and Well-being (Wales) Bill. The Bill legislates for much of the content of Sustainable Social Services: A Framework for Action, deals with the bulk of the recommendations set out in the Law Commission's Review of Adult Social Care Law, the Family Justice Review and other pieces of work. A public consultation on the principles to be contained within the Bill was carried out in the Spring of 2012. The Bill provides for the first time a number of new duties for the benefit of people (adults, children and carers) in need of care and support.

13. The Regulation and Inspection of Social Services, originally featured in the consultation on the Bill, is now being separately dealt with in a White Paper to be published during the Summer of 2013.

The future funding of care and support in Wales

14. The debate about paying for care is part of the Welsh Government's wider reform for social services, as set out in the White Paper. This reform also builds on 'Fulfilled Lives, Supportive Communities' (June 2008), which established the principle of social services supporting individuals to live independently as possible, wherever possible at home.

15. Like England, the Welsh Government has in recent years looked to reform current arrangements for the funding of care and support. It published a Green Paper in 2009 following consultation with the care sector setting out the arguments on this complex issue. Current thinking in taking this forward is likewise centred on the findings of the Commission on Funding of Care and Support. Although focussed on England, the Commission proposes useful recommendations for Wales. Some of their proposals, such as capping an individual's lifetime contribution towards care costs, mirror the Welsh approach. In 2010, for example, Welsh Ministers introduced a weekly maximum charge of £50 for non-residential care.

16. The Welsh Government are currently looking to see how England will take forward the Commission's proposals as part of their own reforms, for two reasons. Firstly, some of that recommendation impinges on non-devolved matters, such as taxation and welfare benefits. Secondly, the considerable financial cost (£100 million p.a.) of implementing those recommendations, should Ministers wish to do so would not be possible to implement those recommendations in Wales in isolation of similar changes occurring in England, and consequential funding given to Wales.

Scotland

17. The Scottish Government works in partnership with service users, carers, local authorities, the NHS, the Care Commission and 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

18. Following on from the Crerar[1] Review, since 1st April 2011, two new public bodies have been operating in Scotland; The Care Inspectorate[2] (also known as SCSWIS - Social Care and Social Work Improvement Scotland) and Healthcare Improvement Scotland (HIS). These bodies have been created by the Public Services Reform (Scotland) Act 2010.

The Care Inspectorate (CI)

19. The CI will inspect, regulate and support improvement of social care and social work services across Scotland. The Care Commission and the Social Work Inspection Agency (SWIA) will no longer exist and responsibility for elements of the work they did will pass to CI. The child protection work currently done by HMIE will also pass to CI.

Healthcare Improvement Scotland (HIS)

20. 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.

[1] http://www.scotland.gov.uk/Publications/2007/09/25120506/0
[2] http://www.scotland.gov.uk/Topics/Health/Support-Social-Care/Care-Inspectorate

Northern Ireland

Personal Social Services in Northern Ireland

21. Northern Ireland has a population of 1,799,896 people; of whom 431,787 are aged under 18 and 260,497 are of pensionable age (2010). By 2035, it is predicted that the number of people of pensionable age (i.e. age 65 and over) will have risen to 463,000[1]. The number of children under the age of 16 is projected to decline steadily from 382,022 in 2010 to 366,000 by 2035. There will also be a further significant increase in the number of people aged 85 years and over from 29,665 in 2010 to 85,000 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.

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

22. The DHSSPS was established by the Department's (NI) Order 1999. The Health and Social Care (Reform) Act (Northern Ireland) 2009 ("the Reform Act") provides the legislative framework within which the health and social care structures operate. Section 2 of the Reform Act places on the Department a general duty to promote an integrated system of:

i) health care designed to secure improvement:
   - in the physical and mental health of people in Northern Ireland, and
   - in the prevention, diagnosis and treatment of illness; and

ii) social care designed to secure improvement in the social wellbeing of people in Northern Ireland.

23. In terms of service commissioning and provision, the Department discharges this duty primarily by delegating the exercise of its statutory functions to the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) and to a number of other HSC bodies created to exercise specific functions on its behalf. All these HSC bodies are accountable to the Department which in turn is accountable, through the Minister, to the Assembly for the manner in which this duty is performed.

Health and Social Services Board (HSCB)

24. The HSCB, which is established as the Regional Health & Social Care Board, under Section 7(1) of the Health & Social Care (Reform) Act (Northern Ireland) 2009, has a range of functions that can be summarised under three broad headings:

i) Commissioning – this is the process of securing the provision of health and social care and other related interventions that is organised around a "commissioning cycle" from assessment of need, strategic planning, priority setting and resource acquisition, to addressing need

[1] http://www.nisra.gov.uk/archive/demography/population/projections/wni105y.xls

by agreeing with providers the delivery of appropriate services, monitoring delivery to ensure that it meets established safety and quality standards, and evaluating the impact and feeding back into a new baseline position in terms of how needs have changed. The HSCB works closely with the PHA in carrying out this function.

ii) Performance management and service improvement – this is a process of developing a culture of continuous improvement in the interests of patients, clients and carers by monitoring health and social care performance against relevant objectives, targets and standards, promptly and effectively addressing poor performance through appropriate interventions, service development and, where necessary, the application of sanctions and identifying and promulgating best practice. Working with the Public Health Agency (see below), the HSCB has an important role to play in providing professional leadership to the HSC.

iii) Resource management – this is a process of ensuring the best possible use of the resources of the health and social care system, both in terms of quality accessible services for users and value for money for the taxpayer.

25. The HSCB is required by the Reform Act to establish five committees, known as Local Commissioning Groups (LCGs), each focusing on the planning and resourcing of health and social care services to meet the needs of its local population. LCGs are co-terminus with the five HSC Trusts.

Public Health Agency (PHA)

26. The PHA is established as the Regional Agency for Public Health & Social Well-being under Section 12(1) of the Health & Social Care (Reform) Act (Northern Ireland) 2009. Its primary functions can be summarised under three broad headings:

i) Improvement in health and social well-being – with the aim of influencing wider service commissioning, securing the provision of specific programmes and supporting research and development initiatives designed to secure the improvement of the health and social well-being of, and reduce health inequalities between, people in Northern Ireland.

ii) Health protection – with the aim of protecting the community (or any part of the community) against communicable disease and other dangers to health and social well-being, including dangers arising on environmental or public health grounds or arising out of emergencies.

iii) Service development – working with the HSCB with the aim of providing professional input to the commissioning of health and social care services that meet established safety and quality standards and support innovation. Working with the HSCB, the PHA has an important

role to play in providing professional leadership to the HSC.

Health and Social Care Trusts (HSC Trusts)

27. HSC Trusts, which are established under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991, are the main providers of health and social care services to the public, as commissioned by the HSCB. There are now six HSC Trusts operating in Northern Ireland

28. The six HSC Trusts are established to provide goods and services for the purposes of health and social care and, with the exception of the Ambulance Trust, are also responsible for exercising on behalf of the HSCB certain statutory functions which are delegated to them by virtue of authorisations made under the Health and Personal Social Services (Northern Ireland) Order 1994. Each HSC Trust also has a statutory obligation to put and keep in place arrangements for monitoring and improving the quality of health and social care which it provides to individuals and the environment in which it provides them (Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003). Section 21 of the Reform Act places a specific duty on each Trust to exercise its functions with the aim of improving the health and social wellbeing of, and reducing the health inequalities between, those for whom it provides, or may provide, health and social care.

The Regulation and Quality Improvement Authority

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

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

30. Under re-structuring of Health and Social Care services in Northern Ireland, the functions of the Mental Health Commission for Northern Ireland

transferred to RQIA on 1st April 2009. These functions give RQIA a range of responsibilities for people with mental illness and those with learning disability, these include:

- preventing ill treatment;
- remedying any deficiency in care or treatment; and
- terminating improper detention in hospital or guardianship.

RQIA has also assumed responsibility for monitoring, inspecting and enforcement of Ionising Radiation (Medical Exposure) Regulations [IR(ME)R] and conducting prison health inspections. It is also a designated body of OPCAT – the Optional Protocol of the United Nations Convention Against Torture.

Patient and Client Council (PCC)

31. The PCC, which is established under Section 16 (1) of the Health & Social Care (Reform) Act (Northern Ireland) 2009, is a regional body supported by five local offices operating within the same geographical areas covered by the five HSC Trusts and LCGs. The overarching objective of the PCC is to provide a powerful, independent voice for patients, clients, carers, and communities on health and social care issues through the exercise of the following functions:

i) to represent the interests of the public by engaging with the public to obtain their views on services and engaging with Health and Social Care (HSC) organisations to ensure that the needs and expectations of the public are addressed in the planning, commissioning and delivery of health and social care services;
ii) to promote the involvement of patients, clients, carers and the public in the design, planning, commissioning and delivery of health and social care;
iii) to provide assistance to individuals making or intending to make a complaint relating to health and social care; and
iv) to promote the provision of advice and information to the public by the HSC about the design, commissioning and delivery of health and social care services.

Health and Social Care Reform and Modernisation

32. In June 2011, the Minister for Health, Social Services and Public Safety announced a Review of the Provision of Health and Social Care (HSC) Services in Northern Ireland would be undertaken. The Review was to provide a strategic assessment across all aspects of health and social care services, examining the present quality and accessibility of services, and the extent to which the needs of patients, clients, carers and communities are being met. It was to bring forward recommendations for the future shape of services and provide an implementation plan. The review was published in December 2011 as 'Transforming Your Care: A Review of Health & Social

Care in Northern Ireland'[1].

Access to Services

33. Health and Social Care (HSC) Trusts are responsible for assessing an individual's social care needs and for deciding what services to provide. HSC Trusts have a duty to give a community care assessment to anyone who, in their view, might be in need of services. The specifics of an individual's assessment are a matter for the Trust concerned and it is for them to decide how best to assess the needs of their local population. Eligibility criteria vary according to the service being assessed for, but typically factors such as frailty, disability, social isolation or exclusion and vulnerability are used to determine need. All service users who are unhappy at any stage of the care management process have the right to make a complaint under the HSC Complaints Procedure[2]. In addition, Agencies and Establishments regulated by the RQIA ("regulated services") must operate a complaints procedure that meets the requirements of the HSC Complaints Procedure. Each Trust has in place arrangements to facilitate such complaints, and details of how to do this will be provided to the client when the assessment is being carried out. Where a complaint cannot be resolved at a local level (that is through the registered provider and/or the HSC Trust), service users or their representatives may approach the Northern Ireland Commissioner for Complaints (the Ombudsman).

Personal Social Services Activity in Northern Ireland

34. A comprehensive picture of social services expenditure and provision across the five HSC trusts which provide personal social services in Northern Ireland, and across all major Programmes of Care, can be found at:
www.dhsspsni.gov.uk/hss/ssi/index.html

Statistical information

England

The full range of Social Care statistics can be viewed at:
http://www.ic.nhs.uk/statistics-and-data-collections/social-care

Work Force Statistics:
http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers

Monthly NHS Hospital and Community Health Service (HCHS) Workforce Statistics in England - July 2012, Provisional Statistics:
http://www.ic.nhs.uk/webfiles/publications/010_Workforce/monthly%20workforce%20publication%20figs%20oct%2012/Monthly_HCHS_Workforce_July_2012_Bulletin.pdf

[1] http://www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-report.pdf
[2] http://www.dhsspsni.gov.uk/hsccomplaints.htm

Wales

Social Services statistics:
http://wales.gov.uk/topics/statistics/theme/health/social-services/;jsessionid=53F7D2B220DFAC1CEE69B66BDA88215E?lang=en

Local Authority Social Services Staff Numbers, 31 March 2012
http://wales.gov.uk/topics/statistics/headlines/health2012/1210241/?lang=en

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

Staff of Scottish Local Authority Social Work Services, 2010
http://www.scotland.gov.uk/News/Releases/2011/06/29102506

Northern Ireland - Statistical information

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

TABLE TOTAL (NET) PSS EXPENDITURE (£UK) BY PoC 2010/11

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	186,668	7	186,661	21.09
Elderly Care	510,758	89,252	421,506	47.61
Mental Health	60,661	15,970	44,691	5.05
Learning Disability	174,280	6,366	167,914	18.97
Physical & Sensory Disability	65,418	2,560	62,859	7.10
Health Promotion & Disease Prevention	0	0	0	
Primary Health & Adult Community	1,627	0	1,627	0.18
Total	999,412	114,155	885,258	100.00

36. In Northern Ireland there is an integrated health and personal social service system. The integrated programme of care definitions are specific to Northern Ireland and are not necessarily comparable with similar headings in other parts of the UK. For example dementia services are part of the elderly

programme of care in NI whereas they fall within mental health in other parts of the UK. The way children and elderly people with other special needs are classified can also be different.

Table - Personal Social Services Activity (31 March 1999 - 2008) [1, 2, 3, 4, 5]

PSS Activity	1999	2001	2003	2005	2007	2008	2009	2011
Places in residential homes	7,027	6,701	6,830	6,556	5,558	5,405	5,405	5,992
Places in nursing homes	9,788	9,375	9,189	9,301	9,571	9,799	9,852	9,833
Residential home care packages	3,344	3,877	4,511	4,453	4,526	4,497	4,103	4,207
Nursing home care packages	5,106	5,882	7,382	7,567	7,768	7,728	7,946	8,149
Domiciliary care packages	6,306	6,828	7,110	8,184	8,429	9,608	n/a	n/a
Persons receiving finance for direct payments for care	12	33	81	248	660	1,144	1,491	2,098
Persons receiving home help/home care	28,115	27,401	26,339	26,066	23,913	22,599	21,039	n/a
Persons receiving meals services	4,374	4,092	4,657	6,284	6,670	5,755	5,171	4,245
Persons registered at statutory day centres	9,464	10,487	10,403	10,281	9,366	9,163	9,327	8,260

[1] Information on places in residential and nursing homes was provided by the RQIA from 31 March 2007 to present. Information presented for 2007 to 2011 refers to places registered in these homes at 30 June.
[2] Information on residential, nursing home and domiciliary care packages presented for 2008 refers to 30 June 2007. Information for 2011 refers to 30 June 2011.
[3] DHSSPS discontinued the collection of information on domiciliary care packages from 30 September 2007.
[4] DHSSPS discontinued the collection of information on home help from 30 June 2010.
[5] Information on persons receiving meals on wheels includes frozen meals provided from 2004/05 to present.
Sources: Community Information Branch, DHSSPS

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

Client Group	1999	2001	2003	2005	2007	2008	2009	2010	2011
Children [1]	323	293	320	392	403	-381	386	360	365
Elderly	4,836	4,579	4,706	4,492	3,945	3,706	4,436		3,513
Mentally Ill	631	604	637	548	602	595	545		356
Learning Disabled	1,173	1,180	1,120	1,070	1,005	898	840		539
Physically Disabled / Sensory Impaired	70	45	47	44	64	65	52		18

[1] Information on the number of places in residential homes for children was provided by the RQIA for 31 March 2007.. Information for 2008 – 2009 is taken at 30 June. 2010 is at 19 August 2010 and 2011 is of 4 January 2012.
Sources: Community Information Branch, DHSSPS

Social Services Personnel

37. The figures below are taken from the Human Resource Management System as at 31st December 2011. This data excludes staff with a whole-time equivalent (WTE) less than or equal to 0.03 (except home helps) and staff on career breaks.

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

	Full-Time	Part-Time		Total	
	Headcount	Headcount	WTE	Headcount	WTE
Social Worker Band 5	38	20	13.87	58	51.87
Social Worker Band 6	1,503	510	333.31	2,013	1,836.31
Social Worker Band 7	874	157	109.97	1,031	983.97
Social Worker Band 8A/8B/8C	276	23	14.91	299	290.91
Social Worker (non AfC)	8	0	0.00	8	8.00
AYE Social Worker Band 5	77	8	4.03	85	81.03
Social Work Placement Student (non AFC)	102	0	0.00	102	102.00
Social Work Support/Social Care Band 2	130	673	467.87	803	597.87
Social Work Support/Social Care Band 3	434	871	610.75	1,305	1,044.75
Social Work Support/Social Care Band 4	242	144	93.59	386	335.59
Social Work Support/Social Care Band 5	814	449	312.10	1,263	1,126.10
Social Work Support/Social Care Band 6	40	13	10.66	53	50.66
Social Work Support/Social Care Band 7/8A/8B/8C	30	9	6.33	39	36.33
Social Work Support/Social Care (non AfC)	47	7	4.49	54	51.49
Home Helps/Domiciliary Care Bands 2-4	83	4,857	1,823.	4,940	1,906.

			55		55
Total	4,698	7,741	3,805.43	12,439	8,503.43

United Kingdom

Safeguarding Vulnerable Groups

38. The Vetting and Barring Scheme[1] (VBS) aims to prevent unsuitable people from undertaking certain paid or volunteer work with children or vulnerable adults ('regulated activity'). It does this by vetting all those who wish to work with vulnerable groups and barring those where the information shows they pose a risk of harm and (in due course) vetting those who wish to do certain other types of work ('controlled activity'). The VBS built on the existing barring schemes for children and vulnerable adults and uses information from police, workforce regulators, service inspectors, education and library boards, health and social care bodies and employers to provide a comprehensive and consistent measure of protection for vulnerable groups.

39. The VBS establishes definitions of those working in regulated activity (work which a person barred from working with children and/or vulnerable adults must not do) which apply to employees and volunteers engaged in work across health, social care, education, supported housing, sports and leisure facilities whether provided by the state or by the private or independent sectors. Arrangements under the VBS are proactive, with vetting taking place on an individual's first application to work with children or vulnerable adults. This will make it far more difficult for abusers to gain access to the most vulnerable groups in our society.

40. The Independent Safeguarding Authority established on 2 January 2008 is central to the Vetting and Barring System. It is responsible for barring decision making across England, Wales and Northern Ireland and maintains lists of individuals barred from working with children and/or vulnerable adults.

41. A report of a review of the Vetting and Barring Scheme was published in February 2011 and changes as a result of the review have been made by way of the Protection of Freedoms Act 2012[2]. The changes will ensure that the VBS focuses on work which involves close and unsupervised contact with vulnerable groups and will achieve better sharing of responsibility for safeguarding between the state and employers, voluntary organisations and charities. The changes will be implemented in phases, starting in September 2012 when new definitions of work with children and vulnerable adults will be introduced.

Looked after Children

[1] http://www.isa.homeoffice.gov.uk/PDF/VBS_Guidance.pdf
[2] http://www.isa.homeoffice.gov.uk/default.aspx?page=0

England

Care planning for looked after children and care leavers

42. Revised regulations and guidance, which came in to force on 1st April 2011, streamline processes to increase the emphasis on more effective care planning, with a focus on the child, and are designed to improve the quality and consistency of care planning, placement and case review for looked after children. They also aim to improve the care and support provided to care leavers.

43. The revised regulations and guidance aim to improve the clarity of the regulatory framework for looked after children and care leavers for practitioners and offer them one coherent and easily accessible package relating to care planning and case review for looked after children.
http://www.education.gov.uk/rsgateway/DB/SFR/s001046/index.shtml

44. The documents below outline what is required of local authorities in care planning, placement and case review and supporting care leavers:

Volume 2: Care Planning, Placement and Case Review (England) Regulations 2010 and statutory guidance[1]
This document specifies the requirements for care plans, including health and education plans, placement decisions and monitoring and case reviews. It consolidates previous regulations and guidance, providing a central source of reference for local authority work with looked after children.

Young people's guide to the care planning regulations
The Department for Education worked with the Office of the Children's Rights Director to produce a young person's guide to the Care Planning regulations. Advice is also published on the 'Rights4me' website:
https://rights4me.org/home/library/rights/right-placement-moves.aspx

'Sufficiency' guidance
This statutory guidance [2] provides clarification on the 'sufficiency duty' placed on local authorities under 22(G) of the Children Act 1989, to secure sufficient accommodation to meet the needs of their looked after children. Training materials on the 'sufficiency duty' can be downloaded via the link[3] .

Volume 3: Planning Transitions to Adulthood for Care Leavers: Statutory Guidance on the Care Leavers (England) Regulations 2010[4]

[1] https://www.education.gov.uk/publications/standard/publicationDetail/Page1/DCSF-00185-2010
[2] https://www.education.gov.uk/publications/standard/publicationDetail/Page1/DCSF-00186-2010
[3] http://media.education.gov.uk/assets/files/pdf/s/statutory%20guidance%20securing%20sufficient%20accommodation%20for%20looked%20after%20children%20march%202010.pdf

[4] https://www.education.gov.uk/publications/standard/publicationDetail/Page1/DFE-00554-

These regulations and guidance are intended to ensure that care leavers are given the same level of care and support their peers would expect from a reasonable parent and that they are provided with the opportunities and chances needed to help them move successfully to adulthood.

Volume 5: Children Act 1989 Guidance and Regulations: Children's Homes

This guidance, published in March 2011[1], contains the requirements set out by Government to support local authorities who are responsible for working with children's homes providers so that the children they look after are given the best possible care and support.

It provides guidance to local authorities in England and their staff, about their functions under Parts 3 and 6-8 of the Children Act 1989. It is issued as guidance under section 7 of the Local Authority Social Services Act 1970 which requires local authorities in exercising their social services functions, to act under the general guidance of the Secretary of State. Local authorities should comply with this guidance when exercising these functions, unless local circumstances indicate exceptional reasons that justify a variation.

In addition it provides guidance to providers of children's homes about their responsibilities under the Care Standards Act 2000. Local Authorities in acting as commissioners of places in children's homes should be aware of and take note of the requirements on those providers under this legislation and reflect it in their commissioning standards and contract specifications.

Statistics

45. National statistics on Outcomes for Children Looked After produced by the Department for Education were released on 14th December 2011 according to the arrangements approved by the UK Statistics Authority.

46. This was the second year that this annual Statistical Release had been published. It contains information on the outcomes for looked after children as at 31 March 2011. Outcomes reported include education, health, offending and substance misuse.

47. .For the first time this year information is included to show performance against the new Impact Indicator for attainment gaps for looked after children. This indicator includes a change to the definition previously used to monitor the attainment of looked after children and covers children who have been continuously looked after for at least 6 months - those who would be eligible for the pupil premium payment.

2010

[1] https://www.education.gov.uk/publications/standard/publicationDetail/Page1/DFE-00024-2011

48. Also included are comparisons between the new definitions used this year and those previously used which cover children continuously looked after for 12 months.

Key points are:

- Of the children looked after continuously for 6 months during the year ending 31 March 2011:
  - At Key Stage 1, 65 per cent achieved the expected level in reading and 71 per cent achieved the expected level in mathematics compared with 63 per cent and 68 per cent in 2010 for each subject respectively.
  - At Key Stage 2, 53 per cent achieved the expected level in English and 52 per cent achieved the expected level in mathematics compared with 51 per cent and 50 per cent in 2010 for each subject respectively.
  - At Key Stage 4, 13.2 per cent achieved the 5+ A*-C at GCSE or equivalent including English and mathematics compared with 12.0 per cent in 2010.

- Of the children looked after continuously for 12 months at 31 March 2011:
  - 7.3 per cent of those aged between 10 and 17 years had been convicted or subject to a final warning or reprimand during the year.
  - 4.3 per cent were identified as having a substance misuse problem during the year.
  - 79.0 per cent were up to date in their immunisations.
  - 82.4 per cent had their teeth checked by a dentist within the last 12 months.
  - 70.5 per cent of children who completed National Curriculum year 11 during the 2009/10 school year were in full time education at 30 September 2010 and 17.5 per cent were unemployed.

Impact Indicators

This Statistical First Release (SFR) introduced two new Impact Indicators for looked after children:

- The Impact Indicator for Key Stage 2 is the attainment gap between looked after children and non-looked after children achieving level 4 in both English and mathematics. The attainment gap Impact Indicator is 31 percentage points, a narrowing of 2 percentage points compared with the gap in 2010.
- The Impact Indicator for Key Stage 4 is the attainment gap between looked after children and non-looked after children achieving 'The Basics' - grade A* to C in GCSE or equivalent English and

mathematics. The attainment gap Impact Indicator is 44.7 percentage points, a widening of 3.9 percentage points compared with the attainment gap in 2010.

Following the publication of the SFR in December, additional tables were published in March 2012. Figures are presented relating to Special Educational Needs (SEN) provision and attainment, absence and exclusions. Key findings are published within the text. Throughout this publication comparisons have been made between looked after children and all children as well as changes over the last five years, period of 2007 to 2011.

Wales

49. National Statistics on Children Looked After by Local Authorities in Wales, produced by the Welsh Assembly Government, were released on 15th September 2011. This release updates the statistics previously released on 16th September 2010.
http://wales.gov.uk/docs/statistics/2011/110915sdr1662011en.pdf

The key points from the latest release are:

- 5,419 children were looked after on 31 March 2011, an increase of 5 per cent over the previous year and a rate of 87 per 10,000 population aged under 18.
- The number of looked after children has increased by 20 per cent over the last five years.
- 9 per cent of children looked after at 31st March 2011 had three or more placements during the year.
- Educational attainments improved over the previous year, with the exception of Key Stage 3 assessments.
- Local authorities were in touch with 93 per cent of 19 year old care leavers; 48 per cent of 19 year old care leavers were known to be in education, training or employment.

Revision note
Some very minor amendments have been received from data providers since the publication of this release. These do not change the message within the data and no revision is being made to this release. However, the updates will be reflected in the next annual update to this release, and in the meantime, the revised data can be found in StatsWales tables.
http://www.statswales.wales.gov.uk/ReportFolders/ReportFolders.aspx.

Scotland

50. 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.

51. 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[1] to ensure they meet national standards.

52. 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.

53. 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

Child Safety and Wellbeing Statistics

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

Looked After Children (Children in Care)

54. The Department of Health, Social Services and Public Safety's 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.

55. The strategy aims to increase support for vulnerable children and to improve outcomes for care-experienced young people by:

[1] http://www.scswis.com/

- 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.

The Children and Young People's Strategic Partnership (CYPSP)

56. The Health and Social Care Board has established the Children and Young People's Strategic Partnership (CYPSP) which met for the first time in January 2011. The CYPSP is a multi agency partnership that includes the leadership of key statutory agencies and community and voluntary organisations that have a responsibility for improving the lives of children and young people in Northern Ireland. The CYPSP will focus on the outcomes for children and young people and the action that will improve these outcomes. The CYPSP is responsible for providing the strategic direction that ensures a unified approach to integrated planning and commissioning for all children and young people in Northern Ireland. The purpose of the CYPSP is reflected in the Outcomes Framework of 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.

57. The CYPSP has established a number of Regional Sub-Groups which carry out integrated planning and commissioning for specific groups of children and young people at particular disadvantage. The Regional Sub-Groups concentrate on those things which cannot be achieved more locally and have to be worked through by the agencies at Northern Ireland level. The Regional Sub-Groups have been established to address the needs of:

- young carers;
- Black and Minority Ethnic Children and Young People;
- Children and Young People with Disabilities;
- Transition;
- Children and Young People Offending; and
- Children and Young People with Emotional and Behavioural Difficulties

CYPSP – Regional Group on the Health Needs of Looked After Children

58. A Regional group on the health needs of Looked After Children has been established. The Group's work is formalised through the regional group under CYPSP Looked After Children and Aftercare. 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.

59. 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.

Northern Ireland - Statistics
http://data.gov.uk/data/resource_cache/47/47f4307c-5d94-4d6b-8225-c2cda32d4c95/stats_and_research_cib_children_in_care.htm

ECSR Conclusions (Article 14§1)

The Committee noted in its Conclusions that an appraisal was being made in England of the national guidelines on the admissibility criteria set by local authorities for access to social services. The Committee asks what are these criteria. It also asks to be kept informed of the results of this appraisal.

60. In England, local authorities are responsible for assessing a person's needs and where they meet the eligibility criteria for care, agree with the individual what care and support they require. *Prioritising need in the context of Putting People First: a whole system approach to eligibility for social care* was published in 2010 and sets out the national eligibility framework which local authorities use for allocating social care resources fairly, transparently and consistently. The framework can be found at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113154

61. In July 2012, the Government published its social care White Paper '*Caring for our future: reforming care and support' ;*
http://www.dh.gov.uk/health/2012/07/careandsupportwhitepaper

62. The White Paper recognises the need for more consistency in how the eligibility criteria are used by local authorities. The Government committed itself to introducing a national minimum eligibility threshold by 2015. The eligibility criteria will be set out in legislation through the draft Care and Support Bill which was published together with the White Paper. www.dh.gov.uk/health/2012/07/careandsupportbill/

The Committee asks again whether nationals of other States Parties are guaranteed equal treatment in the United Kingdom as regards access to social services. If the next report does not provide the requested information, there will be nothing to show that the situation in United Kingdom is in conformity with Article 14§1 of the Charter.

63. Responsibility for the funding of a person's social care depends on the individual circumstances. This is a matter for local authorities to consider. Under Part 3 of the National Assistance Act 1948[1] (the 1948 Act), in particular Sections 21 and 29, each local authority has a duty, in respect of persons aged 18 or over, to make arrangements to provide residential accommodation for those persons who are in need of care and attention, which is not otherwise available to them, and to make welfare arrangements. Furthermore, Section 24(1) identifies the local authority in which an individual is ordinarily resident as the one empowered to provide the residential accommodation. New guidance and directions on ordinary residence, effective from 19th April 2010, were published on 5th March 2010: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113627

64. However, services under Sections 21 and 29 of the 1948 Act may not be provided to certain groups of people from overseas by virtue of Schedule 3 to the Nationality, Immigration and Asylum Act 2002[2]. These groups include nationals of the European Economic Area, people with refugee status abroad, failed asylum seekers who have not co-operated with removal directions and other individuals unlawfully in the UK and who are not asylum seekers. The exclusion does not apply to these groups if a failure to provide services under sections 21 or 29 of the 1948 Act would breach their rights under the European Convention on Human Rights and Fundamental Freedoms or under the European Treaties.

65. The answer to the Committee's question therefore turns on whether nationals of other States Party fall within the personal scope of the Social Charter, 1961 and on whether they are lawfully or unlawfully in the UK. The Government would also draw the Social Rights Committee's attention to the Government's response above to their Conclusions question in respect of Article 13 and concerning the rights of unlawfully present foreign nationals.

[1] http://www.legislation.gov.uk/ukpga/Geo6/11-12/29/part/III/crossheading/provision-of-accommodation
[2] http://www.legislation.gov.uk/ukpga/2002/41/schedule/3

Article 14, Paragraph 2

Role of the voluntary sector in the development and maintenance of services

1. In health and social care, voluntary sector organisations and social enterprises play valuable roles in delivering innovative, high quality, user-focused services, and achieving outcomes that can provide real social value. Supporting active and inclusive communities, and encouraging people to use their skills and talents to build new friendships and connections, are central elements to our vision for care and support.

2. Strong communities can improve our health and wellbeing, and reduce health inequalities. They are ideally placed to reach those hard to reach groups that statutory organisations struggle to reach. They have a strong track-record of designing services based on insight into clients' needs, and are often well placed to respond flexibly to those needs.

3. The voluntary and community sector is also uniquely placed to reach socially isolated people and connect them to befriending services and other networks of friendship and support. We have already set out our vision for social care in the Giving White Paper[1] , published in May 2011, and set up Big Society Capital to give social enterprises, charities and voluntary organisations access to greater resources to make a difference in their communities.

4. The 2013/14 Public Health and Adult Social Care Outcome Frameworks, to be published this autumn, will set out how we will measure the wellbeing of each local area. This will include a focus on the effects of social isolation, and we will work with the care and support sector to establish measures of loneliness that help to identify isolation. By April 2013 we will also publish an atlas of variation in wellbeing to help local authorities identify areas for improvement.

5. The Department of Health has well-established working relationships with voluntary sector organisations and social enterprises. Working with voluntary sector and social enterprise partners in the development of policy is a matter of routine, supported where appropriate by long-standing voluntary sector grant schemes.

6. The Department of Health's Voluntary Sector and Social Enterprise programme exists to maximise the extent to which voluntary sector organisations and social enterprises are able to achieve their full potential in contributing to improved health and well-being services and outcomes.

7. The Department of Health is signed up to implementing The Compact[2], an agreement which governs relations between the Government and civil

[1] http://www.cabinetoffice.gov.uk/resource-library/giving-white-paper
[2] http://www.cabinetoffice.gov.uk/news/government-and-voluntary-sector-agree-new-compact

society organisations, such as charities, in England. It aims to encourage successful partnership between the Government and civil society organisations to ensure better outcomes for citizens and communities.

Engagement of individuals in the development and maintenance of Services

8. The Big Society[1] is a positive vision set out by Government of the relationship between citizen, community and state. It champions citizens' right to take control over their lives. The Big Society puts individuals, families, communities and groups in the driving seat. It is about government recognising that people are entitled to take action themselves, and helping them to do so by removing the bureaucratic barriers that stand in the way. Its goal is a better quality of life for everyone, especially those made vulnerable by social breakdown.

9. The Department of Health's reform agenda across public health, the NHS and social care is very much a Big Society one: it seeks to decentralise power in public services, give local people more control over local institutions, individuals more control over their health, care and support, and to democratise information to support this.

10. Current Department of Health examples of the range of activity and actions that are contributing to the six policy priorities for Big Society:

- **Catalysing Social Action** e.g. Dignity in Care Campaign[2], National Dementia Declaration[3], self care week, Horsesmouth[4] (online mentoring for people with dementia and their families), DH's strategic vision for volunteering in health and care, Time to Change - building a social movement for mental health[5]
- **Giving power away** e.g. personal budgets and direct payments, Clinical Commissioning Groups, Shared Decision Making, local Healthwatch, health and wellbeing boards
- **Ensure transparency and openness** e.g. publication of the Information Revolution[6]
- **Building people's capability** e.g. the Expert Patient Programme[7], Health Trainers, local Healthwatch[8], Inclusion Health[1], development of complementary currencies such as Timebanking

[1] http://www.cabinetoffice.gov.uk/content/big-society-overview
[2] http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/SocialCare/Socialcarereform/Dignityincare/index.htm
[3] http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/MediaCentre/Statements/DH_120892
[4] http://www.horsesmouth.co.uk/
[5] http://www.time-to-change.org.uk/
[6] http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120080
[7] http://www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/expert-patients-programme.aspx
[8] http://www.healthwatch.co.uk/

- **Strengthen democratic accountability** e.g. health and wellbeing boards, strengthening scrutiny powers of local authorities

11. As part of the commitment to ensure users of care are involved in the development and maintenance of services the Department of Health made a commitment in the White Paper *Caring for our future: reforming care and support* that we will involve communities in decisions about health and social care commissioning.

12. The Government want communities to be much more involved in the decisions taken by local authorities and the NHS about commissioning plans. As part of our NHS modernisation, we will expect local health and care commissioners to identify how the skills and networks in a community can make an important contribution to the health and wellbeing of local people and build this into their joint strategic needs assessments and health and wellbeing strategies. This will promote care and support which keeps people active and connected to their communities. It will mean that care and support draws on community networks where possible, rather than segregating people in formal services. Commissioners will also need to consider how they can further support and nurture these community networks and increase people's awareness and understanding about how they can improve their own health and wellbeing.

13. People who use care services, and carers, must be confident that their voice will be heard and their feedback will be taken seriously. This is essential to improving quality in the care and support system, and to preventing abuse.

14. The Government is also strengthening the ways that people can feed back on their care and support. The Government supports the development of websites which allow people who use services, and carers, to feed back directly to providers and commissioners about good or poor quality practice, and provide user ratings. We will work with these websites to ensure that they work effectively and safely for people using care services, carers, and care providers. From April 2013, we will also pool the comments from high quality feedback websites onto a feedback area of the provider quality profile, bringing online feedback together in one place. These feedback websites will make it easier for people to raise concerns, and will help people to make better choices about care providers by highlighting the experience of others who have used that service. Together, this will drive improvements in people's experience of care.

15. The Government is also establishing new local Healthwatch organisations from April 2013, which will champion the views of people using social care and health services. We expect that local Healthwatch organisations will make active use of their power of entry, allowing them to visit any care services in their local area, including those they have received

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1 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114067

concerns about, talk to the people using them, and make recommendations back to the providers and local authority commissioners.

16. Local Healthwatch organisations will also be able to make reports and recommendations to the Overview and Scrutiny Committee, the Care Quality Commission or Healthwatch England if they have concerns about services. We will provide training for new local Healthwatch organisations to take on their responsibilities in relation to care and support, which will include ensuring that Healthwatch organisations have a good understanding of human rights for people in care homes.

17. The Government will also support work led by voluntary organisations and the care home sector to develop approaches to help local Healthwatch make best use of lay people and programmes connecting care homes with their communities. This will help ensure that local Healthwatch is best placed to fulfill its functions, helping to spot and resolve users' concerns in care homes as they arise. Later this year, we will start testing this approach in specific locations, working with local Healthwatch, voluntary sector and provider organisations to learn lessons that could be adopted in a wider roll-out.

18. This will complement the use of experts by experience - people with experience of using care services - who are also working alongside Care Quality Commission inspectors, gathering the experiences and views of people that use those services and feeding them back into the inspection process.

Northern Ireland

19. 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.

20. 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.

21. 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.

22. 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.

23. The Northern Ireland Social Care Council (NISCC)[1] 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.[2] The enforcement of the Codes for employers is a matter for the Regulation and Quality Improvement Authority which regulates registered services in Northern Ireland.

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

Isle of Man

Article 14, Paragraph 1

Responsibility for social services was transferred from the former Department of Health and Social Security to the newly formed Department of Social Care from April 2010.

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

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

The expenditure of the Social Services Division in 2010/11 was:

Division	Expenditure (GB£)
Adults	**23,597,257**
Children and Families	**17,978,244**
Mental Health	**13,077,303**
Central and Support Services	**5,119,013**

The number of staff employed by Social Services Division as at 31 December 2011 was 864.5 [whole time equivalents (wte)].

Eligibility Criteria were introduced in March 2008 based on the guidance given in England and Wales for "Equal Access to Service Users". Their use is to ensure that all citizens have equal access to services based on their assessed needs. The criteria are publicly available so that the process is open and transparent.

The Government encourages all existing social work and social care staff to register with the English Professional Body and all new staff must be registered as a condition of employment. Legislation has been drafted and is expected to be implemented from 2013 to ensure that all staff are required to be registered.

Children and 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:

- 34 social work staff (all qualified) an increase of 10 posts from the previous return implemented to improve the quality of practice.
- 5 social work assistants to provide direct support to families
- Three family centres to help parents develop budgeting, housekeeping and child care skills.
- 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 Child and Adolescent Mental Health Service has been established to provide mental health services to those under the age of 16. This is led by a consultant psychiatrist and has four other professionals in the team providing psychological and therapeutic services.
- A juvenile youth justice team, jointly funded by Social Services, Health, Probation and the Police has been established to deal with youth crime.

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. The unit is currently expanding its remit to offer less secure accommodation but more support to looked after children, those at risk of becoming looked after and those looked after children and young people needing additional educational support.
- 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. The Government agenda to provide integrated services has been re-energised and is expected to be part of the Children's Plan for 2013/15.

Adult Services

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

- 210 beds for older people in four resource centres located in major centres of population. Provision includes long term care, day care and respite care.
- Hospital to Home Service Established 4 Beds.
- 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 18 service users currently receiving support; Community Care Team has 20 service users currently receiving support.
- More intensive care packages provided.
- 5,600 Meals on Wheels provided in July 2012 this is a slight increase since 2008.
- 350 Service users receiving home care, 18 Dementia Care, 20 Community Care and 109 receiving domestic services via our contract.
- Building completed on a 32 (30 long term and 2 respite) place residential Elderly Mentally Infirm (EMI) unit in the Douglas area to enable all continuing care beds within the hospital to be closed and residents transferred to community-based settings. This unit has opened and is being utilised fully.
- Building has commenced on a 16 place (14 long term and 2 short term) residential EMI unit in the Ramsey area.
- The Disability Employment Service has increased its range of operations and has managed to place some 19 per cent of the Island's people living with a learning disability into some form of employment;
- The provision of care in the community for older people and those with a disability is also undertaken through contracts with voluntary organisations. The range and terms of the contracts have continued to increase and improve the support given to older people and those with disabilities in their own homes.
- A Carers Strategy has been developed which seeks to improve the help given to carers.
- Work has commenced on reviewing services provided for people with Learning Disabilities. Day Services are being reviewed with the aim of providing day services for people with learning disabilities which are person centred, community based and flexible offering a wide range of options including social, leisure, employment and learning opportunities. 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 being reviewed with the aim of increasing the range of respite care options to better support carers and increase the number of carers who can be supported.

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:

- Provision of 20 Acute Beds for those with mental health problems plus 14 beds for rehabilitation/continuing care. Day treatment services are being developed to enable a significant number of people with mental health problems to remain at home during their illness but receive appropriate treatment as a day patient;
- Community based services include a community support team for older people with a mental health problem living at home; and
- A community drug and alcohol team which is led by a consultant psychiatrist and comprises a psychologist, physician, social worker, probation officer, specialist nurses, a health education worker and education representative. Community based treatments are being provided such as supervised methadone treatment, drug arrest referral scheme, home detoxification and a co-ordinated approach is being taken to ensure effective treatment and prevention.

Social Housing

Responsibility for the provision of public sector housing was transferred from the former Department of Local Government and Environment to the newly formed Department of Social Care from 1st April 2010. The legal basis for the provision of public sector and affordable housing is contained in the Housing Act 1955, the Housing (Miscellaneous Provisions) Act 1976, and the Housing (Miscellaneous Provisions) Act 2011.

Public Sector Housing is provided by the Isle of Man Government through the Department of Social Care and 17 local authority housing providers underwritten and funded by Government. Financial assistance is provided to lower income First Time Buyers by way of subsidised dwellings, grants and low interest Top Up loans.

- For an overall population of 84,500, there are currently 5508 general need public sector housing units, and 645 sheltered units for older people. There have been 618 general needs allocations and 162 sheltered allocation in the reporting period;
- Financial assistance for house purchase is provided to lower income First Time Buyers by way of subsidised dwellings, grants and low interest Top Up loans. 207 First Time Buyers have been assisted in the reporting.

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 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 Social Services' 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.