March 2022

# EUROPEAN SOCIAL CHARTER

European Committee of Social Rights

Conclusions XXII-2 (2021)

# UNITED KINGDOM

*This text may be subject to editorial revision.*

The function of the European Committee of Social Rights is to rule on the conformity of the situation in States with the European Social Charter. In respect of national reports, it adopts conclusions; in respect of collective complaints, it adopts decisions.

Information on the Charter, statements of interpretation, and general questions from the Committee, is contained in the General Introduction to all Conclusions.

The following chapter concerns the United Kingdom, which ratified the 1961 European Social Charter on 11 July 1962. The deadline for submitting the 40th report was 31 December 2020 and the United Kingdom submitted it on 9 March 2021.

The Committee recalls that the United Kingdom was asked to reply to the specific targeted questions posed under various provisions (questions included in the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter). The Committee therefore focused specifically on these aspects. It also assessed the replies to all findings of non-conformity or deferral in its previous conclusions (Conclusions XXI-2 (2017)).

In addition, the Committee recalls that no targeted questions were asked under certain provisions. If the previous conclusion (Conclusions XXI-2 (2017)) found the situation to be in conformity, there was no examination of the situation in 2020.

Comments on the 40th report by the Scottish Human Rights Commission were registered on 30 June 2021. Comments on the 40th report by the Children and Young People‘s Commissioner Scotland were registered on 14 July 2021. The reply from the Government to the Children and Young People‘s Commissioner Scotland comments was registered on 26 August 2021. Comments on thematic group II "Health, social security and social protection" by the Amnesty International were registered on 1 July 2021.

In accordance with the reporting system adopted by the Committee of Ministers at the 1196th meeting of the Ministers' Deputies on 2-3 April 2014, the report concerned the following provisions of the thematic group II "Health, social security and social protection":

- the right to safe and healthy working conditions (Article 3);
- the right to protection of health (Article 11);
- the right to social security (Article 12);
- the right to social and medical assistance (Article 13);
- the right to benefit from social welfare services (Article 14);
- the right of elderly persons to social protection (Article 4 of the Additional Protocol).

The United Kingdom has accepted all provisions from the above-mentioned group except Articles 12§2, 12§3, 12§4 and Article 4 of the Additional Protocol.

The reference period was from 1 January 2016 to 31 December 2019.

The conclusions relating to the United Kingdom concern nine situations and are as follows:

– three conclusions of conformity: Articles 11§1, 11§2 and 14§1.

– three conclusions of non-conformity: Articles 3§1, 12§1 and 13§1.

In respect of the other three situations related to Articles 3§2, 11§3 and 14§2, the Committee needs further information in order to examine the situation.

The Committee considers that the absence of the information requested amounts to a breach of the reporting obligation entered into by the United Kingdom under the 1961 Charter.

The next report from the United Kingdom will deal with the following provisions of the thematic group III "Labour Rights":

- the right to just conditions of work (Article 2);

- the right to a fair remuneration (Article 4);
- the right to organise (Article 5);
- the right to bargain collectively (Article 6);
- the right to information and consultation (Article 2 of the Additional Protocol);
- the right to take part in the determination and improvement of the working conditions and working environment (Article 3 of the Additional Protocol).

The deadline for submitting that report was 31 December 2021.

Conclusions and reports are available at www.coe.int/socialcharter.

### Article 3 - Right to safe and healthy working conditions

*Paragraph 1 - Safety and health regulations*

The Committee takes note of the information contained in the report submitted by the United Kingdom.

The Committee recalls that for the purposes of the present report, States were asked to reply to targeted questions for Article 3§1 of the 1961 Charter as well as, where applicable, previous conclusions of non-conformity or deferrals (see the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group “Health, social security and social protection”).

In its previous conclusion, the Committee concluded that the situation in the United Kingdom was not in conformity with Article 3§1 of the 1961 Charter on the ground that all self-employed and domestic workers were not covered by the occupational health and safety regulations (Conclusions XXI-2 (2017)). The assessment of the Committee will therefore concern the information provided by the Government in response to the conclusion of non-conformity and to the targeted question.

The Committee wishes to point out that it will take note of the reply to the question relating to Covid-19 for information purposes only, as it relates to developments outside the reference period (i.e. after 31 December 2019). In other words, the information referred to in the Covid-19 section below will not be assessed for the purposes of Charter compliance in the current reporting cycle.

#### ***Content of the regulations on health and safety at work***

The Committee previously found the situation to be in conformity in this respect (Conclusions XXI-2 (2017)).

In its targeted question on Article 3§1, the Committee asked for detailed information on the regulatory responses adopted to improve occupational safety and health in connection with known and also evolving or new situations such as in the digital and platform economy by, for example, strictly limiting and regulating electronic monitoring of workers, by recognising a right to disconnect, right to be unavailable outside agreed working and standby time, mandatory digital disconnection from the work environment during rest periods. It also requested information on regulations adopted in response to emerging occupational risks.

According to the report, the general legal framework remains largely unchanged. The Health and Safety at Work etc. Act (HSWA) 1974 is the primary piece of legislation covering occupational health and safety in Great Britain. This legislation places general duties on employers to ensure the health, safety and welfare at work of all their employees. This general duty is designed to ensure all workplace risks (including new and emerging risks). The report further states that stress, depression, anxiety are the most commonly reported causes of work-related ill health in Great Britain. The report also states that taking breaks from working with display screen equipment is mandatory under the UK law. Electronic monitoring is strictly regulated through data protection and telecommunications. In some sectors, employers have a legal and regulatory duty to carry out monitoring of staff, such as requirements to ensure animal welfare standards at abattoirs. The Health and Safety Executive’s substance abuse work focuses on prevention and management in the workplace, which would include abuse as a result of the work being undertaken. The evidence base on the long-term effect of injury/concussion in professional sports is still developing but clubs and government bodies are acting.

As regards Northern Ireland, occupational health and safety continues to fall under the Health and Safety at Work Order 1978 and some regulations adopted as a result of the

Order do provide for breaks. There is a Workplace Health Team which has musculoskeletal disorders and work-related stress as one of its stated work priorities.

As regards the Isle of Man, the Health and Safety at Work Inspectorate has reviewed its regulatory framework and in 2019 identified that several key pieces of legislation will benefit from a review and update where appropriate.

The Covid-19 pandemic has changed the way many people work, and many workers now telework or work remotely. Teleworking or remote working may lead to excessive working hours.

The Committee considers that, consistent with States Parties' obligations in terms of Article 3§1, in order to protect the physical and mental health of persons teleworking or working remotely and to ensure the right of every worker to a safe and healthy working environment, it is necessary to enable fully the right of workers to refuse to perform work outside their normal working hours (other than work considered to be overtime and fully recognised accordingly) or while on holiday or on other forms of leave (sometimes referred to as the "right to disconnect").

States Parties should ensure there is a legal right not to be penalised or discriminated against for refusing to undertake work outside normal working hours. States must also ensure that there is a legal right to protection from victimisation for complaining when an employer expressly or implicitly requires work to be carried out outside working hours. States Parties must ensure that employers have a duty to put in place arrangements to limit or discourage unaccounted for out-of-hours work, especially for categories of workers who may feel pressed to overperform (e.g. those during probationary periods or for those on temporary or precarious contracts).

Being connected outside normal working hours also increases the risk of electronic monitoring of workers during such periods, which is facilitated by technical devices and software. This can further blur the boundaries between work and private life and may have implications for the physical and mental health of workers.

Therefore, the Committee considers that States Parties must take measures to limit and regulate the electronic monitoring of workers.

***Protection against hazardous substances and agents***

The Committee previously found the situation to be in conformity in this respect but asked the next report to provide full and detailed information on the legislation and regulations, including any amendments thereto adopted during the reference period, which specifically related to ionising radiation. It also asked whether workers were protected up to a level at least equivalent to that set in the Recommendations by the International Commission on Radiological Protection (ICRP Publication No. 103, 2007) (Conclusions XXI-2 (2017)).

The report states that in Great Britain, the Ionising Radiations Regulations 2017 (S.I. 20171075) (IRR17) revoke and supersede the Ionising Radiations Regulations 1999, implementing the worker safety aspects of the Basic Safety Standards Directive (96/29/2013/59/Euratom). IRR17 applies to a large range of workplaces where radioactive substances and electrical equipment emitting ionising radiation are used. IRR17 requires employers to keep exposure to ionising radiation as low as reasonably practicable. Exposures must not exceed International Commission on Radiological Protection specified dose limits.

As regards Northern Ireland, the Ionising Radiations Regulations (Northern Ireland) 2017 impose duties on employers to protect workers and other persons against ionising radiation arising from work with radioactive substances and other sources of ionising radiation and implement in part Council Directive 2013/59/Euratom laying down basic safety standards for

protection against the dangers arising from exposure to ionising radiation. The same specified dose limits and code of practice applies in Northern Ireland as in Great Britain.

As regards the Isle of Man, it has introduced the Ionising radiation (Application) Order 2019, the Ionising Radiation (Basic Safety Standards and Justification of Practices) Regulations 2019 and the Ionising Radiation (Medical Exposure) Regulations 2019, which implement Council Directive 2013/59/Euratom laying down basic safety standards for protection against the dangers arising from exposure to ionising radiation.

### *Personal scope of the regulations*

The Committee previously found the situation not to be in conformity in this respect on the ground that all self-employed and domestic workers were not covered by the occupational health and safety regulations (Conclusions XXI-2 (2017)).

In response, the report states that the existing United Kingdom's legal framework provides comprehensive employment and social protection to domestic workers and, as a rule, domestic workers are entitled to the same general employment rights as other workers. The report states that it is neither proportionate nor practical to extend criminal health and safety law to the employment of domestic workers in private households.

With regard to the self-employed, the report states that the risks to them from work activities are fully covered by the legal framework. The report states that the self-employed cannot be described as being exposed to the same risks as employed workers, as the working environment, control of such environment is different.

As regards the Isle of Man, Section 51 of the Health and safety at Work etc. Act 1974 states that nothing in this part shall apply in relation to a person by reason only that he employs another, or is himself employed as a domestic servant in a private household. Thus domestic workers in a private household are exempt from health and safety regulation.

The Committee takes note of this information and asks the next report to provide information on whether other protective rules apply to the domestic workers in the Isle of Man and the self-employed.

The Committee also recalls that all workers, including the domestic workers and the self-employed must be covered by health and safety at work regulations and reiterates its conclusion of non-conformity in this regard.

### *Covid-19*

In the context of the Covid-19 crisis, the Committee recalls that it requested information in the targeted questions under Article 3§1 of the 1961 Charter on the protection of frontline workers.

In response, the report states that the Health and Safety Executive provided information and advice on workplace and workforce issues to protect healthcare and other workers. Support and assistance have also been provided to other frontline workers, such as the police and custodial staff and other sectors. Dedicated helplines have been established for workers. UK Covid-19 Infection Prevention and Control (IPC) guidance has been issued and it applies to all health and care settings. The guidance states that organisations and employers must ensure the monitoring of IPC practices; that testing and self-isolation strategies are in place; that training in IPC measures is provided to all staff; that risk assessment is undertaken for any staff members at risk; that patients/individuals at high risk/extremely high risk of severe illness are protected from Covid-19; that health and care settings are Covid-19 secure as far as possible.

With regard to Northern Ireland, a mix of advisory and inspection contacts were discharged across various industries and sectors especially those considered most at risk.

With regard to the Isle of Man, the protection of frontline workers in relation with Covid-19 and the risks of exposure is regulated by the provisions of the Health and Safety at Work etc. Act 1974 and by the Management of Health and Safety at Work Regulations 2003. The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1985 place an obligation on employers to report specified cases of exposure to diseases and other harmful substances, they apply to workers when their work involves exposure to certain pathogens, and would apply to Covid-19.

In its comments, the Scottish Human Rights Commission states that by August 2020, 47 per cent of Covid-19 deaths registered related to deaths in care homes and by April 2021, Covid-related deaths in Scottish care homes accounted for approximately a third of the more than 10,000 deaths. The Scottish Human Rights Commission stated that clinical guidance was inappropriate, whether adequate personal protective equipment was made available to the staff and residents in care homes and whether the availability and distribution of Covid-19 testing of care home residents and staff was adequate.

*Conclusion*

The Committee concludes that the situation in the United Kingdom is not in conformity with Article 3§1 of the 1961 Charter on the ground that not all self-employed and domestic workers are covered by the occupational health and safety regulations.

**Article 3 - Right to safe and healthy working conditions**

*Paragraph 2 - Enforcement of safety and health regulations*

The Committee takes note of the information contained in the report submitted by the United Kingdom.

The Committee recalls that for the purposes of the present report States were asked to reply to targeted questions for Article 3§2 of the 1961 Charter as well as, where applicable, previous conclusions of non-conformity or deferrals (see the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group "Health, social security and social protection").

In its previous conclusion (Conclusions XXI-2 (2017)), the Committee concluded that the situation in United Kingdom was in conformity with Article 3§2 of the 1961 Charter.

Assessment of the Committee will therefore concern the information provided by the Government in response to the targeted questions.

### *Accidents at work and occupational diseases*

The Committee previously examined (Conclusions XXI-2 (2017)) the situation regarding accidents at work and occupational diseases and concluded that the situation in United Kingdom was in conformity with Article 3§2 of the 1961 Charter. In its targeted question on Article 3§2 with regard to accidents at work and occupational diseases, the Committee asked for information on statistical data on prevalence of work-related death, injury and disability including as regards suicide or other forms of self-harm, PTSD, burn-out and alcohol or other substance use disorders, as well as on epidemiological studies conducted to assess the long(er)-term health impact of new high-risk jobs (e.g. cycle delivery services, including those employed or whose work is managed through digital platform; performers in the sports entertainment industry, including in particular contact sports; jobs involving particular forms of interaction with clients and expected to use potentially harmful substances such as alcohol or other psychoactive products; new forms of high-yield high-stress trading; military and law enforcement; etc.) and also as regards the victims of harassment at work and poor management.

In reply, the report refers to the Health and Safety at Work Summary Statistics for Great Britain which indicates that in 2019, the number of fatal accidents at work was 147. According to the same source, this figure was 144 in 2018 and 2017. The standardised incidence rate of fatal accidents for Great Britain was 0.42 in 2016, 0.44 in 2017, 0.46 in 2018 and 0.34 in 2019. According to the report of the Health and Safety Executive on Workplace in relation to statistics on fatal injuries in Great Britain, the number of fatalities has remained broadly level in recent years – the average annual number of workers who lost their lives at work as a result of work accident over the five years 2016/17-2020/21 is 136.

In Northern Ireland, the number of fatal accidents at work was 13 in 2015/16, 18 in 2016/17, 13 in 2017/2018 and 16 in 2018/19. The incidence rate of such accidents per 100,000 employees was 0.55 in 2016/17, 0.13 in 2017/18 and 0.65 in 2018/19. Agriculture, general manufacturing, health, construction and extractive industries are among the sectors with the highest rates of fatal accidents in Northern Ireland between 2015 – 2019.

As to the non-fatal accidents at work, according to Health and safety at Work Summary Statistics 2019 referred to by the report, in 2019, the number of workers sustaining a non-fatal injury according to self-reports from the Labour Force Survey was 581,000 in Great Britain. This figure was 555,000 in 2018. According to the figures published by the Health and Safety Executive, the rate of self-reported workplace non-fatal injury (per 100,000 employees) was 2,030 in 2016, 1,970 in 2017, 1,770 in 2018 and 1,830 in 2018 and the rate

of employer reported non-fatal injury (generally the more serious injuries that result in more than 7 days absence from work or specified on a pre-defined list of injuries) was 267 in 2016, 265 in 2017 and 258 in 2018.

In Northern Ireland, the number of reported accidents over three days injuries was 1,680 in 2017, 1,898 in 2018 and 1,906 in 2019, with 55% of the injuries occurred in manufacturing and health sector in 2019. Considering the significant increase in the number of non-fatal accidents at work in Northern Ireland, the Committee asks that the next report provide information on the reasons of this increase and on measures taken to reduce the number of accidents at work. In addition, the report does not provide information on figures concerning accidents at work in the Isle of Man. The Committee asks therefore information in this respect.

According to EUROSTAT data, the total number of fatal accidents at work in the United Kingdom was 222 in 2016, 248 in 2017 and 227 in 2018. The standardised incidence rate per 100,000 employees of fatal accidents at work was 1.46 in 2016, 1.65 in 2017 and 1.60 in 2018. These figures appear to be significantly lower than the standardised rates in the EU-27 during the same period (2.29 in 2016, 2.25 in 2017 and 2.21 in 2018).

According to the EUROSTAT data, during the period 2016-2018, the number of non-fatal accidents at work resulting at 4 days of absence from work showed a decreasing trend (from 148,251 in 2016 to 143,053 in 2018). The incidence rate of such accidents was 864.56 in 2016, 840.97 in 2017 and 825.1 in 2018. These figures are lower than the standardised incidence rates in the EU-27 during the same period (1772.37 in 2016 and 1768.93 in 2018).

As to occupational diseases, the Health and Safety at Work Summary Statistics in Great Britain referred to in the report, indicates that 1.4 million workers suffered from work-related ill-health in 2018/2019. In the same period, some 37% of work related health problems were due to musculoskeletal disorders and some 44%, to stress, depression and anxiety. The report also indicates that the rate of self-reported work-related ill health showed a generally downward trend but has been broadly stable in recent years. Similarly, working days lost per worker due to self-reported work-related illness showed a generally downward trend but has been broadly flat recently.

According to the report, the incidence rate (per 100,000 workers) of work-related ill-health in Great Britain was 4,050 in 2016, 3,970 in 2017, 4,120 in 2018, 4,060 in 2019.

Concerning Northern Ireland, that the Occupational Health and Hygiene Group was established in September 2018 and brought together existing functions and specialists within HSENI. The group's primary function is to lead on the delivery of the occupational health priority areas outlined within Health and Safety Executive in Northern Ireland (HSENI)'s draft Corporate Plan 2018-2023, namely: occupational lung diseases; occupational cancers; and work-related stress and musculoskeletal disorders. According to the annual report 2018-2019 of HSENI, the social and financial impact of occupational ill-health in Northern Ireland remains significant. Recent figures suggest an approximate cost of £238 million to the Northern Ireland economy and an estimated 395 people that die each year in Northern Ireland due to work-related diseases. The Occupational Health and Hygiene Group has focused on key areas such as raising general awareness of occupational health within industry, supporting operational workplace health initiatives, seminars and events, providing a source of specialist advice to HSENI operational teams, providing a range of up-to-date resources including web-based information, etc.

The report also indicates that data on work-related stress and its causes, in addition to data on harassment and poor management are yearly collected. In Great Britain, in 2019, 602,000 workers suffered from work-related stress, depression and anxiety (new or longstanding) and 12.8 million working days were lost due to work-related stress, depression or anxiety. The rate of self-reported work-related stress, depression or anxiety was stable but has shown signs of increasing in recent years. Working days lost due to work-related

stress, depression and anxiety shows no clear trend. Workload, lack of support, violence, threats or bullying and changes at work are estimated to be the main causes of work-related stress, depression and anxiety. In Northern Ireland, the Mental Wellbeing at Work Advisory Service have been established within the HSENI has continued to provide advice, guidance and support on how to control the risks associated with work-related stress. During 2018 and 2019, advisors continued to promote and deliver awareness seminars to assist Northern Ireland employers to use HSE's Management Standards as a tool to control the risks associated with work-related stress.

The report does not provide information on work-related suicide or other forms of self-harm, PTSD, burn-out alcohol or other substance use disorders, nor on epidemiological studies conducted to assess the long(er)-term health impact of new high-risk jobs. The Committee reiterates its request in this regard. The Committee considers that if the next report does not provide the requested information, there will be nothing to establish that accidents at work and occupational diseases are monitored effectively.

***Activities of the Labour Inspectorate***

The Committee previously examined (Conclusions XXI-2 (2017)) the situation regarding the activities of the Labour Inspectorate. It considered that in order to assess compliance with this part of Article 3§2, it needed to know the proportion of workers who are covered by inspections and the percentage of companies which underwent a health and safety inspection in the years covered by the reference period. In the meantime, it reserved its position on this point.

The targeted question with regard to activities of the labour inspectorate concerned the organisation of the Labour Inspectorate, and the trends in resources allocated to labour inspection services, including human resources; number of health and safety inspection visits by the Labour Inspectorate and the proportion of workers and companies covered by the inspections as well as the number of breaches to health and safety regulations and the nature and type of sanctions; whether inspectors are entitled to inspect all workplaces, including residential premises, in all economic sectors.

In reply, the report indicates that the annual spending of the labour inspectorate in Great Britain was 224 million pounds sterling in 2016 (approximately 274,220,800 €) and 217 million pounds sterling in 2019 (approximately 247,588,500 €) (government funding plus income, including cost recovery and commercial activities). There were 1,037 inspectors in 2016 and 990 inspectors in 2019. Although the annual report 2018-2019 of Health and Safety Executive in Northern Ireland gives figures concerning the number of persons who were Board members, senior managers and employees of the HSENI, it does not provide a clear data on the number of safety and health inspectors and budgetary resources of the Labour Inspectorate in Northern Ireland. The Committee reiterates its request in this regard.

As to the Isle of Man, the report indicates that between 2016 and 2019, the inspectorate consisted of 3 inspectors including a Head of Health and Safety. In December 2018, a part time inspector was appointed for a limited term. A separate environmental health team employs warranted officers who investigate matters relating to premises falling within the regulatory responsibility.

Although the annual reports and accounts for the reference year of the Health and Safety Executive provide explanations on the inspection activities including targeted inspections, proactive inspections and campaigns conducted in 2018-2019, in particular, in the construction and the agriculture sector, they do not provide the exact number of the total number of inspections in Great Britain. The Annual Reports and Accounts of the HSENI provides that the number of inspections performed by the labour inspection services in Northern Ireland was 5,999 in 2016-2017, 6,233 in 2017-2018 and 5,522 in 2018-2019. As to the Isle of Man, the report indicates that during the reporting period the Labour Inspectorate undertook 1671 inspections. The Committee reiterates its previous request that

the next report provide figures, including Great Britain, Northern Ireland, and Isle of Man, concerning the total number of inspection visits performed by the labour inspectorate during the reference period. The Committee considers that if the requested information is not provided in the next report, there will be nothing to establish that the activities of the Labour Inspectorate are effective in the practice.

According to ILOSTAT data, in 2019, the total number of Labour Inspectorate in the United Kingdom was 960 (989 in 2016, 938 in 2017 and 985 in 2018). The number of labour inspection visits between 2017 – 2019 showed a decreasing trend (from 19,832 in 2016 to 15,847 in 2019) and the number of inspectors per 10,000 employees remained stable: 0.3 between 2017-2019. Annual number of labour inspection visits per inspector was 25 in 2017 and 22 in 2018.

According to "Health and Safety at Work Summary Statistics for Great Britainin Great Britain 2019", in 2018/2019, some 364 cases which were prosecuted or referred to the Crown Office and Procurator Fiscal Service for prosecution in Scotland resulted in convictions while a total of 11,040 notices were issued by the Labour Inspectorate. Total fines for health and safety offences prosecuted by HSE and, in Scotland, the Crown Office and Procurator Fiscal Service (COPFS) amounted to 54.5 million £. The report further states that the year 2019 has seen a fall in the number of cases prosecuted, continuing the trend from the previous year. The number of notices issued by all enforcing bodies showed a decrease compared to the previous year, continuing the long-term downward trend in notices issued. The level of fine issued in 2018/19 has decreased compared to the previous year. The average fine per conviction is at the same level as 2017/18 so this decrease is related to the fall in the number of cases completed.

As to Northern Ireland, the Committee also takes note of the information in the public registry of convictions referred to in the report, that where circumstances warrant it HSENI inspectors may identify and recommend prosecution against an individual or corporate body. According to the information provided in the public registry that between April 2018 and March 2019, the number of prosecutions resulted in a conviction for safety and health regulation was 5; 7 between April 2017 and March 2018; and 12 between April 2019 and March 2020 (outside the reference period).

According to the information provided in the report concerning the Isle of Man, the types of sanctions in case of breach of safety and health regulation are – warning – written/verbal (in cases relating to administrative breaches where the duty holder has an otherwise satisfactory record of compliance.); Improvement Notice (where there is a contravention of health and safety law and the contravention is likely to continue); prohibition Notice ( where an imminent risk of danger has been encountered); Caution**;** Prosecution. There were 6 prosecutions within the reference period.

In response to the targeted question on whether inspectors are entitled to inspect all workplaces, including residential premises, in all economic sectors, the report indicates that in Great Britain, Health and Safety Executive inspectors and Local Authority inspectors are entitled to inspect all workplaces. This includes residential properties such as care homes.

The only exclusion in place applies to domestic properties where these properties are not registered as carrying on a business. Building work at such domestic properties is, however, subject to inspection. In Northern Ireland, HSENI and the local councils cover all work situations that are subject to the Health and Safety at Work Order 1978. Local Councils are responsible for enforcement in residential care homes. In the Isle of Man, inspectors are empowered to enter any premises where there is a reason to believe that it is necessary to enter (within its jurisdiction).

As to the question in the previous conclusion concerning proportion of workers and companies covered by the inspections, the report states that United Kingdom does not use the percentage of companies undergoing a health and safety inspection as a metric on

which to measure the performance of the system. The report estimates that there are approximately 3000 business premises on the Isle of Man. However, it is not readily discoverable from the data that is held to identify the number of unique businesses that were inspected. The annual reports and accounts of the Health and Safety Executive for Northern Ireland referred to in the report do not contain this information. The Committee therefore reiterates its request for information on the proportion of workers who are covered by inspections and the percentage of companies which underwent a health and safety inspection in the years covered by the reference period. The Committee considers that if the requested information is not provided in the next report, there will be nothing to establish that the activities of the Labour Inspectorate are effective in the practice.

*Conclusion*

Pending receipt of the information requested, the Committee defers its conclusion.

### Article 3 - Right to safe and healthy working conditions

*Paragraph 3 - Consultation with employers' and workers' organisations on safety and health issues*

The Committee notes that no targeted questions were asked under Article 3§3 of the 1961 Charter. As the previous conclusion found the situation in the United Kingdom to be in conformity with the Charter, there was no examination of the situation in 2021.

### Article 11 - Right to protection of health

*Paragraph 1 - Removal of the causes of ill-health*

The Committee takes note of the information contained in the report submitted by the United Kingdom, as well as the comments submitted by the Scottish Human Rights Commission on 30 June 2021 and by the Children and Young People‘s Commissioner Scotland on 14 July 2021 and the Government‘s response to the comments of the Children and Young People‘s Commissioner Scotland on 26 August 2021.

The Committee recalls that for the purposes of the present report, States were asked to reply to targeted questions for Article 11§1 of the 1961 Charter, as well as, where applicable, previous conclusions of non-conformity or deferrals (see the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group "Health, social security and social protection").

In its previous conclusion, the Committee concluded that the situation in the United Kingdom was in conformity with Article 11§1 of the 1961 Charter, pending the receipt of the information requested (Conclusions XXI-2 (2017)). The assessment of the Committee will therefore only concern the information provided by the Government in response to the targeted questions.

The Committee wishes to point out that it will take note of the reply to the question relating to Covid-19 for information purposes only, as it relates to developments outside the reference period (i.e. after 31 December 2019). In other words, the information referred to in the Covid-19 section below will not be assessed for the purposes of Charter compliance in the current reporting cycle.

The Committee also notes that the information in the report is very limited with regard to Wales and asks the next report to provide specific information concerning all constituent parts of the United Kingdom rather than a list of links to various websites.

***Measures to ensure the highest possible standard of health***

In its targeted question for this cycle, the Committee asked for overall and disaggregated statistical data on life expectancy across the country and different population groups (urban; rural; distinct ethnic groups and minorities; longer term homeless or unemployed; etc.) identifying anomalous situation (e.g. particular areas in the community; specific professions or jobs; proximity to active or decommissioned industrial or highly contaminated sites or mines; etc.) and on prevalence of particular diseases among relevant groups (e.g. cancer) or blood borne infectious diseases (e.g. new cases HIV or Hepatitis C among people suffering from substance use disorders or who are held in prison; etc.).

The Committee notes from the World Bank data that life expectancy at birth in the United Kingdom in 2019 was 81.2 on average, a slight increase from 2015 when it was 81. In 2019, life expectancy at birth was 79.4 for men (in 2015 it was 79.2) and 83.1 for women (in 2015 it was 82.8). The Committee further notes from the World Bank data that the death rate in the United Kingdom decreased slightly from 9.2 deaths per 1,000 inhabitants in 2015 to 9 deaths per 1,000 inhabitants in 2019.

The report provides statistical information for each of the United Kingdom's constituent countries. Life expectancy at birth in England was 79.7 years for men and 83.3 years for women in 2017-2019. When classifying the proportion of the population living in rural areas, life expectancy at birth was fund to be higher for people born in predominantly rural areas compared with predominantly urban areas in 2015-2017. Inequality in life expectancy at birth between the most and least deprived areas in England was 9.5 years for men and 7.5 years for women in 2016-2018. The annual average age-standartised death rate for 2014 to 2018 was higher in White ethnic group than in Asian and Black ethnic minority groups. An analysis

of death registrations of homeless individuals in England and Wales in homeless shelters and direct access hostels found that the mean age at death was 45 years for men and 43 years for women in 2018. A decline has been observed in new HIV diagnoses. Hepatitis C prevalence has fallen by around 30 per cent in 2019, in comparison with 2015.

In Scotland in 2017-2019 life expectancy at birth was 77.1 years for men and 81.1 years for women. The gap in life expectancy between the most and least deprived areas was 13.3 for men and 10 years for women. Life expectancy was highest in accessible rural areas and remote rural areas and lowest in large urban areas and other urban areas. During 2019, a total of 326 reports of HIV diagnoses were recorded. The number of recently infected with Hepatitis C remained the same in 2015-2016 and 2017-2018.

In Northern Ireland in 2017-2019 life expectancy at birth was 78.8 years for men and 82.6 years for women. The gap in life expectancy between the most and least deprived areas was 7 years for men and 4.8 years for women.

In the Isle of Man, in 2016-2018 life expectancy at birth was 78.9 for men and 83 for women.

The Committee notes that according to the report *United Kingdom: Country Health Profile 2019* (OECD, the European Observatory on Health Systems and Policies and the European Commission) cardiovascular disease remains the biggest cause of death. Also, over one third of all deaths in the United Kingdom can be attributed to behavioural risk factors, such as dietary habits, tobacco smoking, alcohol consumption and low levels of physical activity.

The report provides information on measures taken to reduce the mortality rates from cancer, cardiovascular diseases, respiratory diseases, as well as the measures taken to fight overweight and obesity.

The Scottish Human Rights Commission submitted its comments to the report. It expressed concern that life expectancy for people with learning disabilities, schizophrenia is shorter, the same can be said about Scottish Gypsy Travellers. It also expressed concern that there have been slight increases in specific causes of death in recent years. Children and Young People‘s Commissioner Scotland noted that infant mortality rates in Scotland are the highest in the most deprived areas in the United Kingdom, it also expressed concerns about child obesity.

In response to the comments of the Children and Young People‘s Commissioner Scotland, the Government states that increasing healthy life expectancy and reducing health inequalities across Scotland remains a clear ambition of the Government and there is a range of action being taken to address the underlying causes of health inequalities. Also, in response to the comments of the Children and Young People‘s Commissioner Scotland, the Government states that there are no plans to look specifically into diet of young children, infants or pregnant women.

***Access to healthcare***

In its targeted question, the Committee asked for information about sexual and reproductive healthcare services for women and girls (including access to abortion) and statistical information about early (underage or minor) motherhood, as well as child and maternal mortality.

The report provides information on the maternal and infant mortality. In the United Kingdom, maternal mortality rate per 100,000 live births was 9.2 according to the latest figures, but the report does not specify the exact year. The data in the report shows that the infant mortality rate per 1,000 live births was 3.3 in 2019, a decrease from 2015, when it was 3.9.

The report states that since April 2013, local authorities in England have been mandated to provide comprehensive open access sexual health services, including sexually transmitted infection testing and treatment, notification of sexual partners of infected persons and access to full range of contraception methods free from prescription charge. Contraception is also

widely available free of charge through General Practice. The Government remains committed to reducing under 18 contraception. In 2018, contraception rates for under 18-year-olds in England and Wales declined by 6.1 per cent.

In its comments on the report, the Scottish Human Rights Commission submitted that there are negative assumptions about disabled women in the area of sexual and reproductive health and raised an issue about equality of access of services for diverse groups of women.

The report also states that women in England, Scotland and Wales have early access to safe, legal, high quality abortion services under the Abortion Act 1967. In accordance with the Act, two doctors must be of one and the same opinion that an abortion meets one of the grounds set out in the Act. In 2019, 99 per cent of abortions in England and Wales were provided free to women and were funded by the National Health Service. In Northern Ireland, abortion was decriminalized in 2019 and in 2017 the Northern Ireland funding scheme was introduced to provide government funded abortions in England for residents of Northern Ireland and in cases of hardship, travel costs were also covered. Also, since December 2018, women in England have been able to take the second of the two abortion pills for early medical abortion at home up to 10 weeks gestation. In Wales and Scotland such practice was introduced in June 2018 and October 2017 respectively.

The Committee recalls having held that, in respect of abortion, once States Parties introduce statutory provisions allowing abortion in some situations, they are obliged to organise their health service system in such a way as to ensure that the effective exercise of freedom of conscience by health professionals in a professional context does not prevent patients from obtaining access to services to which they are legally entitled under the applicable legislation (International Planned Parenthood Federation – European Network (IPPF EN) v. Italy, complaint No. 87/2012, decision on the merits of 10 September 2013, §69; and *Confederazione Generale Italiana de Lavoro (CGIL)* v. Italy, Complaint No 91/2013, Decision on the merits of 12 October 2015, §166-167). The Committee also held that women who are denied access to abortion facilities in their local region may in effect be deprived of any effective opportunity to avail of their legal entitlement to such services, as the tight time-scale at issue may prevent them from making alternative arrangements (International Planned Parenthood Federation – European Network (IPPF EN) v. Italy, op. cit, §193). The Committee thus asks the next report to contain information on the specific measures taken to provide abortion services in Northern Ireland, especially in connection with travelling arrangements.

The report additionally states that the Scottish Government has invested in IVF to ensure access is equitable wherever patients live in Scotland. Over the period 2018-2021 around 2.5 million pounds funding was provided to meet the needs of women and girls, including an online outreach programme to women selling sex online, supporting them to access sexual health services, engaging directly with populations affected by poor sexual health and blood borne viruses, work to reduce the spread of blood borne viruses, sexually transmitted infections and unintended pregnancies among vulnerable people, a research project to understand young people's attitudes towards, and use of condoms and contraception. Abortions can be carried out up to the legal limit of 24 weeks gestation and in very limited circumstances after that.

The report states that in Northern Ireland the Northern Ireland's Health and Social Care Trusts are commissioned to provide sexual health and reproductive healthcare services, including fertility treatment for those women who meet the given criteria, regardless of their sexual orientation or relationship status.

The report further states that in the Isle of Man Government's Department of Health and Social Care continues to offer a full range of sexual and reproductive healthcare services for women and girls. After the Abortion Reform Act 2019 has been adopted, the provision for abortion was brought more into line with that in Great Britain.

The Committee reiterates its request to provide statistical information about early (underage or minor) motherhood.

The Committee asks the next report to contain information on the public health expenditure as a share of GDP.

The Committee refers to its general question as regards the right to protection of health of transgender persons in the general introduction. The Committee recalls that respect for physical and psychological integrity is an integral part of the right to the protection of health guaranteed by Article 11. Article 11 imposes a range of positive and negative obligations, including the obligation of the state to refrain from interfering directly or indirectly with the enjoyment of the right to health. Any kind of unnecessary medical treatment can be considered as contrary to Article 11, if accessing another right is contingent upon undergoing that treatment (Transgender Europe and ILGA Europe v. Czech Republic, Complaint No. 117/2015, decision on the merits of 15 May 2018, §§74, 79, 80).

The Committee recalls that state recognition of a person's gender identity is itself a right recognised by international human rights law, including in the jurisprudence of the European Court of Human Rights, and is important to guaranteeing the full enjoyment of all human rights. It also recalls that any medical treatment without free informed consent (subject to strict exceptions) cannot be compatible with physical integrity or with the right to protection of health. Guaranteeing free consent is fundamental to the enjoyment of the right to health, and is integral to autonomy and human dignity and the obligation to protect the right to health (Transgender Europe and ILGA Europe v. Czech Republic, op. cit., §§78 and 82).

The Committee invites states to provide information on the access of transgender persons to gender reassignment treatment (both in terms of availability and accessibility). It asks whether legal gender recognition for transgender persons requires (in law or in practice) that they undergo sterilisation or any other medical requirements which could impair their health or physical and psychological integrity. The Committee also invites states to provide information on measures taken to ensure that access to healthcare in general, including sexual and reproductive healthcare, is provided without discrimination on the basis of gender identity.

As a targeted question, the Committee asked for information on measures to ensure informed consent to health-related interventions or treatment (under Article 11§2). The report states that a person must give his or her permission before receiving any type of medical treatment. There are exceptions when treatment can be provided without prior consent, such as emergency situations.

In its comments, the Scottish Human Rights Commission expressed concern about the availability of services to address children and young people‘s mental health and reduce waiting times. Children and Young People‘s Commissioner Scotland noted that there are long waiting times for children and young people for both physical and mental healthcare services.

In response to the comments of the Children and Young People‘s Commissioner Scotland, the Government states certain measures that have been taken to address the issues of mental health, such as additional financing for Mental Health recovery and Renewal Fund, establishment of the Children and Young People‘s Mental Health and Wellbeing Joint Delivery Board, but these measures are outside the reference period for the purposes of the present reporting cycle.

***Covid-19***

In the context of the Covid-19 crisis, the Committee asked the States Parties to evaluate the adequacy of measures taken to limit the spread of virus in the population, as well as the measures taken to treat the ill (under Article 11§3).

For the purposes of Article 11§1, the Committee considers information focused on measures taken to treat the ill (sufficient number of hospital beds, including intensive care units and equipment, and rapid deployment of sufficient numbers of medical personnel).

The report states that in England more than 47,000 former healthcare professionals came forward to support the NHS. In Scotland, it was sought to ensure that infection prevention and control measures in hospital and other care settings are robust. In the Isle of Man, the capacity of hospitals to treat patients is sufficient according to the report, and there are ventilators and specialist equipment available.

The Committee recalls that during a pandemic, States Parties must take all necessary measures to treat those who fall ill, including ensuring the availability of a sufficient number of hospital beds, intensive care units and equipment. All possible measures must be taken to ensure that an adequate number of healthcare professionals are deployed (Statement of interpretation on the right to protection of health in times of pandemic, 21 April 2020).

The Committee recalls that access to healthcare must be ensured to everyone without discrimination. This implies that healthcare in a pandemic must be effective and affordable to everyone, and States must ensure that groups at particularly high risk, such as homeless persons, persons living in poverty, older persons, persons with disabilities, persons living in institutions, persons detained in prisons, and persons with an irregular migration status are adequately protected by the healthcare measures put in place. Moreover, States must take specific, targeted measures to ensure enjoyment of the right to protection of health of those whose work (whether formal or informal) places them at particular risk of infection (Statement of interpretation on the right to protection of health in times of pandemic, 21 April 2020).

During a pandemic, States must take all possible measures as referred to above in the shortest possible time, with the maximum use of financial, technical and human resources, and by all appropriate means both national and international in character, including international assistance and cooperation (Statement of interpretation on the right to protection of health in times of pandemic, 21 April 2020).

*Conclusion*

Pending receipt of the information requested, the Committee concludes that the situation in the United Kingdom is in conformity with Article 11§1 of the 1961 Charter.

**Article 11 - Right to protection of health**
*Paragraph 2 - Advisory and educational facilities*

The Committee takes note of the information contained in the report submitted by the United Kingdom.

The Committee notes that for the purposes of the present report, States were asked to reply to the specific targeted questions posed to States for this provision (questions included in the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter with respect to the provisions falling within the thematic group "Health, social security and social protection") as well as previous conclusions of non-conformity or deferrals.

In its previous conclusion, the Committee found that the situation in the United Kingdom was in conformity with Article 11§2 of the 1961 Charter, pending receipt of the information requested (Conclusions XXI-2 (2017)).

***Education and awareness raising***

In its targeted questions, the Committee asked for information about health education (including sexual and reproductive health education) and related prevention strategies (including through empowerment that can serve as a factor in addressing self-harm conducts, eating disorders, alcohol and drug use) in the community, on a lifelong or ongoing basis, and in schools.

In reply, the report informs of the following publications in England: the Prevention Green Paper, published in 2019 by the Department of Health and Social Care, sets out measures for preventing poor mental health and promoting good mental health and well-being; the Prevention Concordat for Better Mental Health, launched by Public Health England (PHE); the update in 2017 of the Cross-Government Suicide Prevention Strategy; the Online Harms White Paper, published by the Government in 2017, sets out the regulatory framework to improve safety of people online by addressing potentially harmful suicide and self-harm content; the response by the Government in 2019 to the Public Health Service Ombudsman (PHSO)'s report on eating disorders. The report also informs of the UK Government´s strategy to reduce the number of young people using drugs, which combines universal action with targeted action towards those who are most at risk.

The report recalls that sex education has been compulsory in all maintained secondary schools since 1993. It also recalls that academies and free schools are not required to teach sex education but were encouraged to do so. It states that the statutory sex and relationship education guidance was last updated in 2000. Even if out of the reference period, the Committee notes that the report further indicates that from September 2020, relationships education became compulsory in all primary schools, relationships and sex education became compulsory in all secondary schools, and health education became compulsory in all state-funded schools.

The report mentions that the statutory curriculum in Northern Ireland includes "Personal Development" throughout the 12 years of compulsory education, where pupils learn about self-awareness, personal health, and relationships.

Regarding sexual and reproductive health education in Scotland, the report mentions information campaigns held in 2019 on the topics of healthy relationships and consent: the "Common Sense" UK Project to increase sexual health-related awareness and promote sexual health and well-being, as well as to increase the awareness of blood-borne viruses and different methods of contraception amongst young people with learning difficulties; the "Sexual Health Scotland" website, which provides young people in all parts of Scotland with a source of information and advice, and signposting to local services; and the "Pregnancy

and Parenthood in Young People strategy", published in March 2016, that promotes sexual health, relationship and parenthood education for all young people in schools.

Regarding alcohol, drugs and smoking prevention education in Scotland, the report states that the Scottish Government will develop education-based, person-centred approaches that are delivered in line with evidence-based practice with the aim of reaching all children and young people including those not present in traditional settings such as Youth Groups, Community Learning and Development, looked after and accommodated children, excluded children and those in touch with services. The Committee asks that the next report provide updated information on the development of these approaches. In addition, the report refers to the 20 actions set out by the 2018 Scottish Government's Alcohol Framework that includes key actions such as evaluating and reviewing Minimum Unit Pricing for alcohol, consulting on potential alcohol marketing restrictions and pressing alcohol producers to include health information on alcohol product labels. The report further states that the Scottish Government has set a target to have created a tobacco-free generation by 2034. The Committee asks that the next report provide updated information on the development of the current action to tackle the harm of exposure to second-hand smoke.

The report refers to school guidance on emotional health, well-being, sex and relationships provided by the Welsh Government. It also refers to the Child Health Programme 0-19 years by the School Nursing and Health Visiting Service of the Isle of Man, inclusive of sexual health education and support of sexual self-acceptance, reduction of self-harm and risk-taking behaviours, promotion of healthy weight and prevention of obesity.

The Committee takes note of the detailed information provided in the report regarding how subjects such as the prevention of smoking and alcohol abuse, sexual and reproductive education, in particular with regard to the prevention of sexually transmitted diseases and AIDS, road safety, and the promotion of healthy eating habits are covered by the school curriculum throughout the United Kingdom.

The Committee further takes note of the detailed information provided in the report regarding the measures and campaigns launched throughout the United Kingdom on sexual and reproductive health education and related prevention strategies on self-harm conducts, eating disorders, alcohol and drug use in the community. The Committee asks that the next report provide updated information on the implementation of the measures taken in this respect during the reference period.

In its targeted questions, the Committee also asked for information about awareness and education with respect to sexual orientation and gender identity (SOGI) and to gender-based violence. In reply, the report states that in England, sexual orientation and gender identity should be explored at a timely point during secondary education and in a clear, sensitive and respectful manner. In Northern Ireland, education to relationships and sexuality covers sexual orientation and gender identity in schools. In Scotland, teachers broach relationships, sexual health and parenthood education (RSHP), which deals, among other issues, with those relations affecting transgender people in Scotland's school. They have been provided with a continuously updated online resource with age-appropriate material for ages 3-18 so that they can support consistent RSHP education. In Scotland, the Rape Crisis Scotland Sexual Violence Prevention Programme has worked with over 48,000 young people since 2016. In addition, in Scotland, the Short Life Working Group, which deals with gender-based violence and sexual harassment in schools, has been established to identify effective practice, identify gaps and develop a number of resources to support primary and secondary schools to address incidents of gender-based violence and sexual harassment.

### *Counselling and screening*

In its previous conclusion, the Committee asked for updated information on the screening programmes available to pregnant women and the frequency of such screening throughout the United Kingdom (Conclusions XXI-2 (2017)).

In reply, the report indicates that antenatal screening, which is offered for free to approximately 700,000 women in England every year, covers 17 different conditions such as infectious diseases, sickle cell disease and thalassemia, foetal anomalies (Down's, Edward's and Patau's syndrome), and diabetic retinopathy. Regarding Scotland, Wales and Northern Ireland, the report indicates that a similar antenatal screening programme is offered to all pregnant women. The Committee takes note of specific data on the frequency of the tests and on the programme coverage during the reference period.

However, the report does not contain any information on the antenatal screening programme on the Isle of Man. The Committee, therefore, asks again that the next report provide the requested updated information on the screening programmes available for pregnant women and the frequency of such screening on the Isle of Man.

In its previous conclusion, the Committee also asked for updated information on the screening programmes for the population at large available in England, Scotland, Wales, Northern Ireland, and the Isle of Man (Conclusions XXI-2 (2017)).

In reply, the report indicates that in England, the National Health System offers the following screening programmes for breast, cervical and bowel cancers, abdominal aortic aneurysm, and the diabetic eye disease (retinopathy). The report provides specific data on the programme coverage during the reference period. The report also mentions that similar screening programmes are available in Scotland, Wales, Northern Ireland, and the Isle of Man, and provides as well specific data on the frequency of the tests and on the programme coverage during the reference period. The report adds that Wales and Northern Ireland also offer new-born hearing and blood spot screenings.

*Conclusion*

Pending receipt of the information requested, the Committee concludes that the situation in the United Kingdom is in conformity with Article 11§2 of the 1961 Charter.

## Article 11 - Right to protection of health

*Paragraph 3 - Prevention of diseases and accidents*

The Committee takes note of the information contained in the report submitted by the United Kingdom. It also takes note of the comments submitted by the Scottish Human Rights Commission (SHRC), the Children and Young People's Commissioner Scotland (CYPCS), and the comments in response submitted by the United Kingdom Government.

The Committee notes that for the purposes of the present report, States were asked to reply to the specific targeted questions posed to States for this provision (questions included in the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group "Health, social security and social protection") as well as previous conclusions of non-conformity or deferrals.

Therefore, it will focus on the Government's replies to the targeted questions, namely about healthcare services in prison; community-based mental health services; drug abuse prevention and harm reduction; healthy environment; immunisation and epidemiological monitoring; Covid-19; and any previous deferrals or non-conformities.

The Committee wishes to point out that it will take note of the information provided in reply to the question relating to Covid-19 for information purposes only, as it relates to developments outside the reference period (namely, after 31 December 2019). In other words, the information referred to in the Covid-19 section will not be assessed for the purposes of Charter compliance in the current reporting cycle.

In its previous conclusion, the Committee concluded that the situation in the United Kingdom was in conformity with Article 11§3 of the 1961 Charter (Conclusions 2017).

### *Healthcare services in places of detention*

In a targeted question, the Committee asked for a general overview of healthcare services in places of detention, in particular prisons (under whose responsibility they operate/which ministry they report to, staffing levels and other resources, practical arrangements, medical screening on arrival, access to specialist care, prevention of communicable diseases, mental health-care provision, conditions of care in community-based establishments when necessary, etc.).

The Committee notes from the report that prison healthcare services across the United Kingdom operate under the responsibility of health authorities and are based on the principle of equivalence with care provided in the community. The Committee also notes the range of healthcare services provided in prison, the initial screening arrangements, the possibility of being referred to community specialists, as well as the supplementary testing and vaccination for infectious diseases provided in Scotland.

In its comments, the SHRC raises questions with regard to healthcare in police custody, healthcare in prisons, women and detention, older prisoners, and young people in secure care and prison, based on findings by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) reports and various internal review processes, pertaining to Scottish prisons. In response, the Government notes that a range of initiatives to address the issues raised are underway, including with respect to improving the standard of mental health services in prison.

The Committee refers to the most recent CPT reports (2018, 2019, 2020) expressing concerns about mental health provision in Scottish (continued use of long-term segregation for certain vulnerable women prisoners, lack of secure psychiatric beds for women prisoners), English (prolonged segregation, delays in transfers to psychiatric hospitals, insufficient self-harm and suicide prevention strategies), and Northern Irish (inadequate

provision of psychiatric care and the long waiting times for persons to be transferred to an appropriate psychiatric facility for treatment) prisons.

The Committee asks for information on the measures taken to improve prison mental healthcare provision in England, Scotland and Northern Ireland.

### *Community-based mental health services*

In a targeted question, the Committee asked for information regarding the availability and extent of community-based mental health services and on the transition to community-based mental health from former large-scale institutions. The Committee also asked for statistical information on outreach measures in connection with the mental health assessment of vulnerable populations and on proactive measures adopted to ensure that persons in need of mental healthcare are not neglected.

The report refers to various initiatives adopted during the reference period in the area of mental health, such as: the Five Year Forward View for Mental Health, the NHS Long Term Plan and the NHS Mental Health Implementation Plan 2019/20-2023/24, improving mental healthcare waiting times (in England); improving mental healthcare waiting times, the Mental Health Strategy 2017-2027, an Independent Inquiry into Mental Health Services in Tayside (2018, in Scotland); Mental Health Action Plan (2020, outside the reference period, in Wales); the Community Mental Health Survey and action plan 2019, a benchmarking exercise across all service areas, suicide prevention (in the Isle of Man). The section of the report on Scotland provides additional information about the functioning of Community Mental Health Teams and about the shift from inpatient to community based mental health, including information about a reduction in the bed occupancy rate across the country and a marked reduction in the average length of stay during the reference period.

In its comments, the CYPCS notes that there had been a significant increase in the number of children and young people experiencing mental health problems and in youth suicide levels in Scotland during the reference period, caused by issues such as bullying, abuse or witnessing violence, social media, academic pressures, illness, separation or divorce of parents, and bereavement, among others. Children and young people faced delays in mental health treatment and barriers to accessing quality mental healthcare , including a complex and fragmented mental health system, a focus on specialist care and responding to crises instead of early intervention and prevention, a lack of individualised approach and of consultation of children and young people about their treatment as well as limited access to information, advice and sources of support for varied needs and available services, and inadequate community provision. The Government did not address these issues in its response.

Consistent with the World Health Organisation (WHO) Comprehensive Mental Health Action Plan 2013-2030, and other relevant standards, the Committee considers that a human rights-compliant approach to mental health requires at a minimum the following elements: a) developing human rights-compliant mental health governance through, inter alia, mental health legislation and strategies that are in line with the Convention on the Rights of Persons with Disabilities and other relevant instruments, best practice and evidence; b) providing mental health in primary care community-based settings, including by replacing long-stay psychiatric hospitals with community-based non-specialised health settings; and c) implementing strategies for promotion and prevention in mental health, including campaigns to reduce stigmatisation, discrimination and human rights violations.

The Committee notes that the information requested is not provided for all countries/territories other than Scotland, namely with regard to an outline of mental health outreach in the community, and the measures taken to close down/downsize long-stay psychiatric hospitals. Therefore, the Committee reiterates its request.

The Committee further notes that Article 15§3 of the Revised Charter ordinarily provides an opportunity to examine the process of deinstitutionalization of persons with mental health issues. As the 1961 Charter lacks a similar provision, the issue in question falls to be assessed under Article 11§3.

The Committee refers to the latest concluding observations by the Committee on the Rights of Persons with Disabilities (CRPD, 2017) noting that many persons with disabilities were still institutionalised and deprived of the right to live independently and be included within the community, when: (i) they lacked the financial resources to afford personal assistance; (ii) local authorities were of the opinion that they can provide assistance within care homes; and (iii) the cost rationale constituted the main parameter of an assessment. The CRPD also noted the lack of support services and accessible public facilities, including personal assistance, for persons with disabilities, regardless of sex, gender, age and other status, to live independently and be included in the community.

The Committee asks for information as follows:

- the number of fully and/or partially closed institutions, or the reduction in the number of beds in long-stay psychiatric hospitals; if a deinstitutionalisation strategy is in place, what the timeline is for the closure of all institutions;
- the alternatives that have been put in place: the type of community-based services, including access to personal assistance, housing options, and access to mainstream services, including employment and education;
- with regard to housing, to what extent people leaving institutions are able to choose where and with whom they would like to live, and whether they are obliged to access a particular living arrangement to access support;
- data on the number of people living in group housing (small group homes, family-type homes, etc.) after leaving institutions, disaggregated by age and impairment;
- how services are funded, how disability-related costs are funded, and how individuals are assessed for access to different support services and allowances;
- how the quality of community-based services is monitored, and how persons with disabilities and their representative organisations are involved in the delivery, monitoring or evaluation of community-based services.

The Committee also asks about the measures taken to ensure that children benefit from adequate mental healthcare services, including early intervention and prevention services, as well as therapeutic community-based services.

### *Drug abuse prevention and harm reduction*

In a targeted question, the Committee asked for information about drug-related deaths and transmission of infectious diseases among people who use or inject psychoactive substances both in the community and in custodial settings. The Committee also asked for an overview of the national policy designed to respond to substance use and related disorders (dissuasion, education, and public health-based harm reduction approaches, including use or availability of WHO listed essential medicines for opioid agonist treatment) while ensuring that the “available, accessible, acceptable and sufficient quality” criteria (WHO’s 3AQ) are respected, subject always to the exigency of informed consent. This rules out, on the one hand, consent by constraint (such as in the case of acceptance of detox and other mandatory treatment in lieu of deprivation of liberty as punishment) and, on the other hand, consent based on insufficient, inaccurate or misleading information (i.e. not based on state of the art scientific evidence).

The report notes that there has been a marked increase in drug-related deaths in England and Wales during the reference period. The SHRC notes that the number of drug related deaths recorded in Scotland increased from 574 in to 2008 to 1264 deaths in 2019. The drug-related death rate in Scotland is higher than that reported for all the European Union

countries, or approximately three and a half times that of the UK as a whole and is widely referred to as a public health emergency. The Scottish Government has set up a taskforce to examine the main causes of drug deaths and develop a way to respond to reduce these deaths. The Government did not address these issues in its response.

The report further refers to the document titled Drug misuse and dependence: UK guidelines on clinical management, which provides clinical guidelines for community and prison-based treatment and was updated in 2017. According to the guidelines, opioid agonist treatments and needle and syringe exchange programs form part of drug treatment and recovery. In 2018, the Scottish Government published the Rights, Respect and Recovery strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths. The Strategy identifies three key priorities: Developing recovery-oriented systems of care, getting it right for children, young people and families, and a public health approach to justice. In 2018, the Northern Ireland Government carried out a full review of the implementation of the New Strategic Direction for Alcohol and Drugs document adopted din 2011.

The Committee asks for information regarding the measures taken to reduce the number of drug-related deaths throughout the United Kingdom.

***Healthy environment***

In a targeted question, the Committee asked for information on the measures taken to prevent exposure to air, water or other forms of environmental pollution, including proximity to active or decommissioned (but not properly isolated or decontaminated) industrial sites with contaminant or toxic emissions, leakages or outflows, including slow releases or transfers to the neighbouring environment, nuclear sites, mines, as well as measures taken to address the health problems of the populations affected, and about measures taken to inform the public, including pupils and students, about general and local environmental problems.

The report provides an overview of monitoring arrangements in the field of air, water and other forms of protection throughout the United Kingdom. In 2019, Public Health England published a report on the topic of public health protection in radiation emergencies and an independent review of the Clean Air for Scotland strategy was undertaken.

Comments received from the SHRC and the CYPCS refer to the grave impacts of air pollution on the most vulnerable, including children, the elderly and those with lung complaints such as asthma, while noting that progress on some of the worst types of air pollutants has stalled during the reference period.

The Report of the Special Rapporteur on the implications for human rights of the environmentally sound management and disposal of hazardous substances and wastes on his mission to the United Kingdom in 2017 highlighted the persistent air pollution, causing increased rates of mortality, morbidity and disability, with magnified risks among the poor and minorities, the contamination from historic landfills, and the legacy of radioactive waste from civil and defence programmes. The 2019 Environmental Implementation Review (EIR) chapter on the United Kingdom also noted the high number of zones with exceedances above the European Union air quality standards for nitrogen dioxide, as well as ongoing issues with water quality, diffuse pollution, notably from nitrates.

The Committee notes that the information requested is not provided, namely about the measures taken to prevent exposure to air, water or other forms of environmental pollution, including proximity to active or decommissioned (but not properly isolated or decontaminated) industrial sites with contaminant or toxic emissions, leakages or outflows, including slow releases or transfers to the neighbouring environment, nuclear sites, mines, as well as measures taken to address the health problems of the populations affected, and about measures taken to inform the public, including pupils and students, about general and

local environmental problems. The Committee considers that if the requested information is not provided in the next report, there will be nothing to establish that the situation in the United Kingdom is in conformity with Article 11§3 of the 1961 Charter.

***Immunisation and epidemiological monitoring***

In a targeted question, the Committee asked States Parties to describe the measures taken to ensure that vaccine research is promoted, adequately funded and efficiently coordinated across public and private actors.

The report provides information about the arrangements in placed aimed at supporting vaccine research across the United Kingdom

***Covid-19***

The Committee asked States Parties to evaluate the adequacy of measures taken to limit the spread of the Covid-19 virus in the population (testing and tracing, physical distancing and self-isolation, provision of surgical masks, disinfectant, etc.).

The report provides a wealth of information on the preventive measures taken to limit the spread of Covid-19 across the United Kingdom. For example, the report outlines the Covid Action Plan published jointly by the United Kingdom and Devolved Administrations in March 2020, and updated subsequently in response to changing circumstances, which provided the basis for responding to Covid-19. Guidance published in England focused on physical distancing and good hygiene practices as the most effective tools to prevent the spread of the virus. The section on Scotland refers to measures such as physical distancing, sourcing and distributing face coverings and personal protective equipment, or shielding.

The Committee recalls that States Parties must take measures to prevent and limit the spread of the virus, including testing and tracing, physical distancing and self-isolation, the provision of adequate masks and disinfectant, as well as the imposition of quarantine and ‘lockdown’ arrangements. All such measures must be designed and implemented having regard to the current state of scientific knowledge and in accordance with relevant human rights standards (Statement of interpretation on the right to protection of health in times of pandemic, 21 April 2020). Furthermore, access to healthcare must be ensured to everyone without discrimination. This implies that healthcare in a pandemic must be effective and affordable to everyone, and that groups at particularly high risk, such as homeless persons, persons living in poverty, older persons, persons with disabilities, persons living in institutions, persons detained in prisons, and persons with an irregular migration status must be adequately protected by the healthcare measures put in place (Statement of interpretation on the right to protection of health in times of pandemic, 21 April 2020).

*Conclusion*

Pending receipt of the information requested, the Committee defers its conclusion.

### Article 12 - Right to social security

*Paragraph 1 - Existence of a social security system*

The Committee takes note of the information contained in the report submitted by the United Kingdom.

In its previous conclusion (Conclusions XXII-2) the Committee found that the situation in the United Kingdom was not in conformity with Article 12§1 of the 1961 Charter on the following grounds:

- the level of the Statutory Sick Pay (SSP) is inadequate;
- the minimum levels of the Employment Support Allowance (ESA) are inadequate;
- the level of long-term incapacity benefits is inadequate;
- the level of unemployment benefits is inadequate.

The Committee found that the minimum levels of these benefits fell below 40% of the median equivalised income and therefore, were inadequate.

The Committee notes that in its report the Government refers to the report of the United Kingdom on the European Code of Social Security and ILO Convention No.102. According to the Government, this report addresses the non-conformities with the Charter and the information requested in the Committee's 2017 conclusions.

The Committee recalls that each national report on Article 12§1 should provide the following information:

- the personal scope: personal coverage of different social security risks. As regards healthcare and family benefit, the report should indicate the percentage of population covered. As regards income-replacement benefits (unemployment, old-age, sickness), the report should indicate the percentage of active population covered.

- adequacy of benefits: the report should indicate the level of the median equivalised income and the minimum levels of all income-replacement benefits.

In the absence of this information the Committee reiterates its previous conclusions of non-conformity.

*Conclusion*

The Committee concludes that the situation in the United Kingdom is not in conformity with Article 12§1 of the 1961 Charter on the grounds that:

- the level of the Statutory Sick Pay (SSP) is inadequate;
- the minimum levels of the Employment Support Allowance (ESA) are inadequate;
- the level of long-term incapacity benefits is inadequate;
- the level of unemployment benefits is inadequate.

### Article 13 - Right to social and medical assistance

*Paragraph 1 - Adequate assistance for every person in need*

The Committee takes note of the information contained in the report submitted by the United Kingdom. The Committee also takes note of the comments submitted by the Scottish Human Rights Commission, the Amnesty International and the Children and Young People Commissioner Scotland (CYPCS).

The Committee notes that for the purposes of the present report, States were asked to reply to the specific targeted questions posed to States for this provision (questions included in the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group "Health, social security and social protection") as well as previous conclusions of non-conformity or deferrals.

Therefore it will focus on the Government's replies to the targeted questions, namely about measures taken to ensure that the right to social and medical assistance is ensured and any previous deferrals or non-conformities.

The Committee wishes to point out that it will take note of the information provided in reply to the question relating to Covid-19 for information purposes only, as it relates to developments outside the reference period (i.e. after 31 December 2019). In other words, the information referred to in the Covid-19 section will not be assessed for the purposes of Charter compliance in the current reporting cycle.

The previous conclusion was deferred its conclusion on Article 13§1 of the 1961 Charter pending the receipt of the information required.

***General legal framework, types of benefits and eligibility criteria***

The report states that the UK welfare system is made up of social security benefits and social assistance measures that together provide a welfare safety net protecting the most vulnerable in society. Universal Credit (UC) is a universal social assistance measure that supports those who can work into work by providing a minimum level of income, and cares for those who cannot work, in line with the UK's view that work is the most effective route out of poverty. UC replaced in 2015 the previous complex system of six main benefits (Income-based Jobseeker's Allowance, Income-related Employment and Support Allowance, Income Support, Working Tax Credit, Child Tax Credit, Housing Benefit) with one simple monthly payment, the same way that many working people are paid.

The report further describes the system existing in different parts of the country, though there is no reference to new pieces of legislation during the reference period.

According to the Scottish Human Rights Commission, in Scotland in 2016, the Fairer Scotland Action Plan (FSAP) was launched. The focus of this plan was to work with those in communities with lived experience of inequalities and poverty to shape policy moving forward. The FSAP sets out 50 actions and resulted in the creation of a national Poverty and Inequality Commission in 2017, whose main role is to provide independent advice and scrutinise progress on poverty and inequality. Through the Child Poverty (Scotland) Act 2017, the Commission transitioned to a statutory footing from July 2019. Local authorities and health boards now have a statutory duty to deliver joint plans setting out how they tackle child poverty. However, Local councils have experienced a real terms funding cut of almost ten per cent from 2010-2018 with increasing demand for services, particularly from a growing older population.

In its former conclusion (Conclusions 2017), the Committee asked to provide comprehensive comments as regards the situation concerning maladministration and benefit sanctioning, as

well as crisis loans. The report refers to the UK 2020 European Code of Social Security report.

As regards sanctions, the Government submitted in its 2020 European Code of Social Security report that if a claimant fails to comply with work-related requirements for no good reason, the amount of social benefits are to be reduced for a certain period, in accordance with sections 26 and 27 of the Welfare Reform Act of 2012. A claimant cannot have a sanction applied for benefits which do not concern work requirements (such as unemployment benefit). However, if a claimant was subject to a sanction deriving from its work-related requirements and reports a change of circumstances, the sanction will follow them and their benefit will continue to be reduced. the Government indicates that there are no obstacles to anyone on Universal Credit benefit exercising their right to complain and appeal.

As regards crisis loans and hardship payments, the report states that housing benefit has been replaced by Universal Credit (UC) for all new claims, except for people of State Pension age, or those in supported, sheltered or temporary housing. All claimants are entitled to Universal Credit from the first day they claim, the 7 days some had to wait prior to 14 February 2018 has been removed. Claimants can also apply to get a Universal Credit payment to cover up to 1 month before they started their claim. This is called 'backdating'. It is not possible to award a Universal Credit payment as soon as a claim is made, as the assessment period must run its course before the award of Universal Credit can be calculated. Advances are in place to ensure financial support is available as soon as possible, with most claimants able to request an advance of up to 100% of the monthly amount they are due to receive. Crisis loans are no longer available, however a Budgeting Loan can help pay for furniture or household items (for example, washing machines or other 'white goods'); clothes or footwear; rent in advance and other costs. Those in financial difficulties can get help and advice from the government, local councils and other organisations. Claimants can also ask for a hardship payment if they cannot pay for rent, heating, food or hygiene needs because they got a sanction. They need to pay it back through their Universal Credit payments – which will be lower until they pay it back.

***Levels of benefits***

To assess the situation during the reference period, the Committee takes account of the following information:

- Basic benefit: the Committee notes from MISSOC (latest data available of 1 July 2019) that Personal Allowances paid to a single person over 25 years of age stood at € 82 per week in 2019 (a decrease compared to 103 in 2015).
- Additional benefits: according to MISSOC there are premiums paid, for families, pensioners, persons with disabilities or carers. Additional payments through housing benefit to help pay rental costs; amount depends on size and location of accommodation. As regards winter Fuel Payment, an annual lump sum payment stood at € 224 per year for persons up to the age of 79 and at € 335 if aged 80 of over. Cold weather payment is a one-off payment to people receiving specified means-tested benefits, which stood at € 28 in 2019. All the amounts are lower than the amounts paid in 2015. The Committee notes from another source (https://www.gov.uk/government/statistics/housing-benefit-caseload-statistics) that the average weekly award of housing benefit up to May 2018 (latest data available) stood at £ 93.35 (€ 109.1) for all claimants (all tenure types).
- The most updated poverty threshold, defined as 50% of median equivalised income and as calculated on the basis of the Eurostat at-risk-of-poverty value, refers to 2018. In 2018, it was estimated at € 894.33. There is no information concerning 2019.

The Committee takes into account that the level of social assistance, including supplements, that can be obtained by a single person without resources has significantly decreased during

the reference period. According to the information provided by the Scottish Human Rights Commission, since 2010, there have been reforms in the household benefit cap, under-occupancy charge, changes to unemployment support and the roll-out of Universal Credit, with a negative impact on the enjoyment of the rights to social security and to an adequate standard of living and a disproportionate impact on women, children and disabled people. UN Treaty Bodies, particularly the Committee on Economic, Social and Cultural Rights, in its Concluding observations on the sixth periodic report of July 2016 and the UN Special Rapporteur on Extreme Poverty (https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23881, statement of 16 November 2018), have raised concerns about the various changes introduced by the Welfare Reform Act 2012 and the Welfare Reform and Work Act 2016. The Committee also takes note that the Scottish Human Rights Commission has raised in its comments that of the total population in Scotland, 17% is at risk of absolute poverty (below 60% of the median income) and 21% are children. It does not establish how many are under 50%, but it states that children and young people are disproportionately impacted by poverty. Currently almost one in four (240,000) children are officially recognised as living in poverty in Scotland.

The Committee notes that the existing figures show that the level of social assistance, taking into account the basic and additional benefits, has dropped during the reference period and is now below the poverty threshold across the country. The Committee considers therefore that the situation is not in conformity with the Charter. It asks the next report to include information on the different benefits available in average in the country and what has been done to address the raise in poverty level in terms of access to adequate social assistance.

***Right of appeal and legal aid***

The Committee had previously asked in its 2017 Conclusions to provide updated information as regards the right of appeal and legal aid, since the number of appeals had dropped significantly with the changes introduced in 2013 for Universal Credit and Personal independent Payment. The Committee also asked to be kept informed on the relevant statistics on mandatory reconsiderations.

The Government refers to its 2020 European Code of Social Security report. It is recalled that the Welfare Reform Act of 2012, effective from April 2013, was introduced to ensure that more disputes involving Department for Work and Pensions (DWP) decisions could be resolved without the need for referral to Courts and Tribunals Service (HMCTS). DWP will reconsider all decisions before an appeal. If someone disputes a decision, they will need to ask DWP to reconsider the decision before they can appeal to HMCTS. This is known as "mandatory reconsideration". The report state that there are no statistics specifically on mandatory reconsiderations, but that in 2017-18, there were 6,308 Universal Credit appeals received by courts, with an overturn rate of 48%. In 2018-19, there were 11,684 Universal Credit appeals received, with an overturn rate of 58%. The government informed that in 2019/2020, DWP made 161,200 decisions. With respect to appeals, in 2019-20 there were 23,450 appeals received, with an overturn rate of 64%. A pilot assessment on the impact of the mandatory reconsideration was to be conducted in 2019-2020, but the pilot has not yet taken place, due to Covid-19 according to the report. The Committee asks the next report to provide updated information and statistics about the impact of this system.

***Personal scope***

The specific questions asked in relation to Article 13§1 this year do not include an assessment of assistance to nationals of States parties lawfully resident in the territory. Therefore, this particular issue is only assessed if there was a request of information or a non-conformity in previous cycle.

Foreign nationals lawfully resident in the territory

In its previous conclusion (Conclusion 2017), the Committee asked several questions. As regards access to benefits for EEA nationals, it noted that there had been a restriction due to the imposition of a three months waiting period and the requirement to prove that there is a genuine prospect of work after three months, as well as denial with regards to housing allowance and universal credit. The Committee asked if, during the three months waiting period as well as in the case of a failure to provide evidence of a genuine prospect of work after three months, those persons, who have also been denied the right to housing benefit and cannot meet their immediate and most essential needs (including accommodation, heating, food and hygiene) can apply for a hardship payment. If so, the Committee asked what the hardship payment consists of. The Committee also asked what rules applied to non-EEA nationals. Furthermore, the Committee asked to provide updated statistics on the numbers of lawfully resident foreign nationals who fail to meet the habitual residence test and are denied access to benefits because of the restrictions imposed.

Regarding EEA citizens, the Withdrawal Agreement sets out the terms of the UK's withdrawal from the EU and provides for a deal on citizens' rights. In line with its commitments under these Agreements, the Government has committed to preserve the rights of EEA citizens and their family members who are resident in the UK before the end of the transition period (by 31 December 2020), so they can continue to work, study, and access in-country benefits and services as they did before 31 December 2020. This includes maintaining their eligibility to access benefits and includes the hardship payments.

The report further states information for 2020 and 2021, which is outside the reference period. However, there is no reply concerning the waiting period of 3 months.

After 2021, all foreign nationals will be treated in the same manner, without a distinction between EEA citizens and other nationals. This implies that third country nationals are not entitled to benefits or assistance, unless exemptions apply, such as having a refugee status, or until they are eligible and are granted indefinite leave to remain (typically after 5 continuous years in the UK). Information on Universal Credit requests that fail the Habitual Residence Test (HRT) are as follows: 2016/2017 – 800 failed claims; 2017/2018 – 7,600 failed claims and 2018/2019 – 30,700 failed claims. The report states that certain categories of people may be able to apply to have their no-recourse to public funds condition lifted, if their circumstances change and they become in genuine need. The Committee asks the next report to provide information on who can have access to this aid and under which circumstances.

The Committee considers that the 5 years of permanent residence for granting of social assistance benefits to non-nationals is an excessive length and not in conformity with the 1961 Charter.

Foreign nationals unlawfully present in the territory

The Committee recalls that persons in an irregular situation must have a legally recognised right to the satisfaction of basic human material need (food, clothing, shelter) in situations of emergency to cope with an urgent and serious state of need. It likewise is for the States to ensure that this right is made effective also in practice (European Federation of National Organisations working with the Homeless (FEANTSA) v. the Netherlands, Complaint No. 86/2012, decision on the merits of 2 July 2014, §187). The Committee asked in tis 2017 Conclusions whether the legislation and practice comply with these requirements.

The report states that local welfare provision, administered by local councils, is assistance given by a local authority for the purposes of meeting, or helping to meet, an immediate short-term need arising out of an exceptional event, or exceptional circumstances, in order to avoid a risk to the well-being of an individual. Local authorities have the power under their 'general power of competence' (GPOC) as set out in the Localism Act 2011 to provide emergency social assistance (including emergency accommodation and/or subsistence payments) to people living in their area, irrespective of a person's nationality/immigration

status, where a failure to provide assistance would be a breach of their human rights. Recent examples of where local authorities have relied on such powers include the initiative to alleviate rough sleeping in very cold weather or to bring in all vulnerable homeless people in during the Covid 19 pandemic.

Those with no lawful status in England and Wales are able to access NHS secondary care, however, the Charging Regulations place a duty on healthcare providers to make and recover charges where they apply. Certain groups of vulnerable persons are exempt from these charges for all their healthcare needs under the Charging Regulations and this includes refugees, asylum seekers, failed asylum seekers, children looked after by a local authority, victims and suspected victims of modern slavery. Moreover, there are certain services which are always free to all patients, including primary care, NHS and Accident and Emergency services. Some conditions are also exempt from charge, including treatment for specified infectious diseases and treatment required for a physical or mental condition caused by torture, female genital mutilation, domestic violence or sexual violence, except in certain circumstances, such as where the overseas visitor has travelled to the UK for the purpose of seeking that treatment. Since October 2017, with regards to treatments where no exemption applies, it has been a legal requirement for relevant bodies to recover charges in advance of treatment. This means that the patient must pay in advance and in full. However, where a clinician has determined a patient's need for care to be urgent or immediately necessary, that care will never be delayed or withheld, regardless of the patient's ability to pay.

The Committee asks the next report to provide detailed information about emergency social assistance for foreign national unlawfully present in the territory also for Scotland.

***Medical and social assistance during the Covid-19 pandemic***

The report contains very detailed information about Covid-19 Pandemic measures.

In England and Wales, basic income protection has been available to people affected by Covid-19. This included over £9.3billion of extra support through the welfare system. The standard allowance in Universal Credit was temporarily increased by £86.67 per month for 12 months (equivalent to £20 per week) on top of the planned annual uprating. This additional increase means that claimants may be up to £1,040 better off, depending on their circumstances. The UK increased the local housing allowance rates for Universal Credit and housing benefit claimants, so they now cover the lowest 30% of local rents; and the Government increased the national maximum caps, so claimants in inner and central London should also see an increase in their housing support payments. Furthermore, across England the Government had already increased the discretionary housing payment by an extra £40 million for this financial year.

Further measures included: removing waiting days for claimants affected by Covid-19, so it will be payable from day one of the claim, subject to the claimant satisfying the normal conditions of entitlement; Treating all claimants who satisfy the conditions of entitlement and are suffering from Covid-19 or who are required to self-isolate in line with government guidance or caring for a child (or qualifying young person) who falls into either of those categories, including vulnerable individuals who have been advised by the NHS to 'shield' because they are at high risk of severe illness, as having limited capability for work, without the requirement to provide a fit note or to undergo a Work Capability Assessment, etc. As Covid-19 continues to impact both the actions of employers and employees and those looking and preparing for work, work related requirements set will be flexible and responsive to any on-going changes, including considering these where a claimant is unable to meet all of their commitments but have done all that they reasonably can.

The Local Authority Emergency Assistance Grant for Food and Essential Supplies is for local authorities in England to use to support people who are struggling to afford food and other essentials due to Covid-19. This funding is in addition to the £6.5 billion of extra support the

Government is providing through the welfare system. Furthermore, steps have been taken to ensure those without resources are made aware of the medical assistance available with regards to Covid-19.

In Scotland, the Scottish Government has made £350 million available to support the most vulnerable from the threat of Covid-19 and has recently increased this fund further. The Scottish Government has pledged a further £37.6 million to provide support for children eligible for free school meals during school closures and holiday periods and have made an additional £8 million available for Discretionary Housing 8. Payments.

In Northern Ireland, the Department for Communities has introduced a number of specific measures in response to the Covid-19 crisis. In the Ile of Man, the report states that there had not been any case of Covid-19 so far.

The Committee further takes note of the Amnesty International report denouncing the situation concerning the assistance given to the elderly during the Covid-19 pandemic. As this information relates to aspects outside the reference period, it will be taken into account in the next reporting cycle.

*Conclusion*

The Committee concludes that the situation in the United Kingdom is not in conformity with Article 13§1 of the 1961 Charter on the grounds that:

- the level of social assistance benefits is not adequate;
- the granting of social assistance benefits to non-nationals is subject to an excessive length of residence requirement.

### Article 13 - Right to social and medical assistance

*Paragraph 2 - Non-discrimination in the exercise of social and political rights*

The Committee notes that no targeted questions were asked under this provision. As the previous conclusion found the situation to be in conformity there was no examination of the situation in the currect cycle.

**Article 13 - Right to social and medical assistance**

*Paragraph 3 - Prevention, abolition or alleviation of need*

The Committee notes that no targeted questions were asked under this provision. As the previous conclusion found the situation to be in conformity there was no examination of the situation in the current cycle.

### Article 13 - Right to social and medical assistance

*Paragraph 4 - Specific emergency assistance for non-residents*

The Committee notes that no targeted questions were asked under this provision. As the previous conclusion found the situation to be in conformity there was no examination of the situation in the currect cycle.

### Article 14 - The right to benefit from social welfare services

*Paragraph 1 - Promotion or provision of social services*

The Committee takes note of the information contained in the report submitted by the United Kingdom. It also takes note of the information contained in the comments by the Amnesty International (AI), registered on 1 July 2021 and the Scottish Human Rights Commission (SHRC), registered on 30 June 2021.

The Committee recalls that Article 14§1 guarantees the right to benefit from general social welfare services. It notes that for the purposes of the present report, States were asked to reply to the specific targeted questions posed to States for this provision (questions included in the appendix to the letter of 3 June 2020, whereby the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the thematic group "Health, social security and social protection") as well as previous conclusions of non-conformity or deferrals.

Therefore, it will focus on the Government's replies to the targeted questions, namely how and to what extent the operation of social services was maintained during the COVID-19 crisis and whether specific measures were taken in view of possible similar crises arising in the future. The Committee wishes to point out that it will take note of the information provided in reply to the question relating to COVID-19 for information purposes only, as it relates to developments outside the reference period (i.e. after 31 December 2019). In other words, the information referred to in the COVID-19 section will not be assessed for the purposes of Charter compliance in the current reporting cycle.

In its previous conclusion (Conclusions XXII-2 (2017)) the Committee found the situation to be in conformity with the Charter. The report does not indicate any change to the organisation of provision of social services during the reporting period. The Committee acknowledges information provided in response to its previous questions on the implementation of the Care Act 2014 in practice and the impact of this reform on the users of social welfare services in England, on the impact on clients/users after the establishment of two new public bodies in Scotland and on the impact of the new Integrated Care Partnerships on users of social welfare services in Northern Ireland, confirming that the situation remains in conformity with the 1961 Charter.

In response to the targeted questions, the report provides information on the various measures adopted in response to the COVID-19 pandemic in England, Scotland, Wales, Northern Ireland and the Isle of Man. The report confirms, in particular, that social care services were maintained in England, Wales, Northern Ireland and Isle of Man. The Committee understands from the report that social services have also continued to operate in Scotland.

The report states, in particular, that in England following the first wave of the pandemic, the Government established a working group to advise on the preparation for the winter and a potential second pandemic wave . In September 2020, the working group issued a comprehensive winter plan for the adult social care sector, which set out Government commitments and expectations for local systems (both the National Health Service and local authorities) and care providers. The plan covers: (i) measures to reduce the risk of exposure; (ii) a national strategy on testing of both staff and residents of care homes; (iii) the provision of data to local authorities to facilitate local responses; (iv) the relationship between the care system and the National Health Service; (v) the provision of funding for infection control measures; and (vi) staff support measures. The UK Department of Health and Social Care is also planning to set up control and support teams in place to take swift and decisive action, where necessary. These teams will work in partnership with local and regional officials to assess local plans, identify delivery risks, and provide regular feedback to central government so that support can be provided as required and policy development can be

rapid and responsive to any emerging issues. These teams will work proactively to prevent outbreaks in care settings at particularly high risk and will also take immediate action where outbreaks do occur, supporting the local response and communicating lessons learnt so that they can be incorporated into future activities. These teams will also work closely with the Care Quality Commission in England and other key stakeholders in social care and the NHS to maximise the effectiveness of exchanges between different groups. For their part, the Welsh authorities are currently gathering the knowledge gained so far (bearing in mind that the pandemic is not yet over) win order to plan future crisis responses. In particular, the Welsh Government has begun to develop a stabilisation and reconstruction framework for social care with the aim of addressing the issues which have arisen during the pandemic and creating a stronger and more resilient sector for the future. Northern Ireland put in place a number of policies and practical measures to limit the transmission of COVID -19 – advice to care workers, support for staff, significant support to residential and home care services and the closure of services such as day care – as well as measures to ensure that children's services continue to operate effectively. In the Isle of Man, the Department of Health and Social Care maintained all essential services during the COVID-19 crisis and redeployed staff to assist in additional fields – visiting and supporting people at home in lockdown with shopping and care – and supported additional services provided by the hospital and care homes in relation to managing infection control and visiting arrangements in line with emergency procedures.

The Committee notes the concerns raised by the SHRC about the discontinuation or reduction of care packages for disabled people, which according to its data left approximately 30% of those surveyed without any or with reduced support. It also notes from Amnesty International's comments that the Care Quality Commission and other supervisory bodies, such as the ombudsmen, suspended their inspection visits to care homes at the outset of the pandemic, which, combined with the discontinuation of private and service visits, left vulnerable persons in a particularly difficult situation. Amnesty International also highlights the challenges of remote communication in care homes as well as the inadequacy of infection control measures or failure of staff to comply with COVID-19- related recommendations. The Committee further notes that the Association of Directors of Adult Social Services (Adass) raised concerns about waiting lists for care assessments and staff shortages in care services during the pandemic.

*Conclusion*

The Committee concludes that the situation in the United Kingdom is in conformity with Article 14§1 of the 1961 Charter.

### Article 14 - The right to benefit from social welfare services

*Paragraph 2 - Public participation in the establishment and maintenance of social services*

The Committee takes note of the information contained in the report submitted by United Kingdom. It also takes note of the information contained in the comments by the Amnesty International (AI), registered on 1 July 2021 and the Scottish Human Rights Commission (SHRC), registered on 30 June 2021.

The Committee recalls that Article 14§2 requires States Parties to provide support for voluntary associations seeking to establish social welfare services. The "individuals and voluntary or other organisations" referred to in paragraph 2 include the voluntary sector (non-governmental organisations and other associations), private individuals, and private firms.

The Committee further notes that for the purposes of the current examination, States were asked to reply to the specific targeted questions posed to States in relation to this provision (questions included in the appendix to the letter of 3 June 2020, in which the Committee requested a report on the implementation of the Charter in respect of the provisions falling within the scope of the thematic group "Health, social security and social protection") as well as previous conclusions of non-conformity or deferrals. States were therefore requested to provide information on user involvement in social services ("co-production"), in particular on how such involvement is ensured and promoted in legislation, in budget allocations and decision-making at all levels, as well as in the design and delivery of services in practice. Co-production is understood here to mean that social services work together with users of the services on the basis of fundamental principles, such a equality, diversity, accessibility and reciprocity.

In its previous conclusion (Conclusions 2017), the Committee found the situation to be in conformity with the Charter. It acknowledges the information provided in response to its previous question (see Conclusions 2017) on the system of monitoring and inspections in England, Wales, Scotland and Northern Ireland, which confirms that the situation remains in conformity with the 1961 Charter.

The report does not, however, respond to the targeted question on the user participation in social services. The Committee therefore reiterates its question and calls for comprehensive information to be provided in the next report, in particular, on how user participation is encouraged in legislation and other decision-making processes, and whether any practical measures to support it, including budgetary measures, have been adopted or envisaged.

*Conclusion*

Pending receipt of the information requested, the Committee defers its conclusion.