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EUROPEAN SOCIAL CHARTER

40th National Report on the implementation of the European Social Charter

submitted by

THE GOVERNMENT OF THE UNITED KINGDOM

Articles 3, 11, 12, 13 and14

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THE EUROPEAN SOCIAL CHARTER

THE UNITED KINGDOM'S FORTIETH REPORT

FEBRUARY 2021

Contents

Article 3 – The right to safe and healthy working conditions

Paragraph 1. issue safety and health regulations;

a) Please provide detailed information on the regulatory responses adopted to improve occupational safety and health in connection with known and also evolving or new situations (including as regards stress and harassment at work; work-related substance use and employer responsibility; strictly limiting and regulating electronic monitoring of workers; mandatory digital disconnection from the work environment during rest periods – also referred to as "digital detox"; health and safety in the digital and platform economy; etc.) and about regulatory responses to newly recognised forms of professional injury or illness (such as work-related self-harm or suicide; burn-out; alcohol or other substance use disorders; post-traumatic stress disorders (PTSD); injury and disability in the sports entertainment industry, including in cases when such injury and disability can take years or even decades to become apparent, for example in cases of difficult to detect damage to the brain; etc.).

Great Britain

The general legal framework remains unchanged overall. 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, supported by guidance and a robust enforcement mechanism, is designed to ensure all workplace risks (including new and emerging risks for health issues as well as safety) are automatically captured, assessed, managed and acted upon.

Horizon scanning to capture emerging risks is an important aspect of the UK's goal-setting approach to risk management. The Health and Safety Executive (HSE) operates a foresight centre that uses horizon scanning, knowledge sharing and a range of futures activities to enable HSE and the broader health and safety system to anticipate and keep pace with change. Reports from the centre can be found here.

Stress, depression or anxiety are the most commonly reported causes of work-related ill health in Great Britain, accounting for 43% of all cases, and 54% of all working days lost due to ill health. HSE's focus has been on developing and supporting appropriate tools to support the management of stress in various different sectors. HSE's Management Standards risk assessment approach is at the heart of our work in seeking to support duty holders in preventing the causes of workplace stressors and reducing sickness absence. The Standards, launched in 2004, are internationally recognised for their effectiveness in the management and control of work-related stress.

Informed by work on public sector stress pilots and violence in the NHS and prison services, bespoke work-related stress material for public sector organisations have been published in the form of 'Talking Toolkits'. These are designed to be easily accessible from a number of different social media platforms. Updated advice for small to medium enterprises (SMEs) which includes additional information on the use of the Management Standards approach have been produced and these aim to simplify risk assessment for work-related stress by identifying the main risk factors, focusing on the underlying causes and their prevention and providing a yardstick to gauge an organisation's performance in tackling the key causes of stress.

Taking breaks from working with display screen equipment is mandatory under UK law. Electronic monitoring is strictly regulated through data protection and telecommunications laws. 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

With specific reference to other areas raised by the committee in its question, such as workplace substance abuse or chronic traumatic encephalopathy (CTE) in sports, these are public health and broader societal issues that have a workplace component and should not be considered in isolation. HSE's substance abuse work focusses 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 effects of injury/concussion in professional sports is still developing but clubs and governing bodies are acting.

Regarding the sports entertainment industry, one of the main aims of the UK's Sporting Future strategy (published in 2015) is creating a more productive, sustainable and responsible sports sector. The UK Government's Duty of Care in Sport Review was published in April 2017. The report has helped raise the profile of issues around the wellbeing, health and safety of sports people, and includes issues such as the risk of brain injuries.

Northern Ireland

In NI, Occupational Health and Safety (OHS) continues to fall under the Health and Safety at Work (NI) Order 1978 (the Order). The definition of 'personal injury' under the Order includes, "any disease and any impairment of a person's physical or mental condition". Some regulations made under the Order do provide for breaks etc. (e.g. Display Screen Equipment Reg.). HSENI's remit only extends to people 'at work'. In regard to stress and harassment etc. HSENI promote and use the 'Management Standards' (https://www.hse.gov.uk/stress/standards/) as a preventative tool. HSENI set up a dedicated Workplace Health Team which has '**musculoskeletal disorders & work-related stress**' as one of its stated work priorities. As part of HSENI's partnership approach to raising the profile of work-related health in Northern Ireland, the Workplace Health Leadership Group Northern Ireland (WHLGNI) was established on 10 August 2016. HSENI supports the work of the group as they seek to ensure that the management of occupational health is given the priority in Northern Ireland that it warrants.

Isle of Man

The Health and Safety at Work Inspectorate (Isle of Man) has recently reviewed its regulatory framework and in 2019 identified that several key pieces of legislation will benefit from a review and update where appropriate. The following have been identified as a priority including those that, when adopted, will improve occupational health and safety in connection with known/evolving/new situations and those other workplace hazards as listed in the question:

i. **Health and Safety at Work etc. Act 1974.** This UK Act was extended to the Is Isle of Man (IOM) with modifications using the powers in the IOM's Health and

Safety at Work etc. Act 1977. The UK Act as it has effect in the IOM, is currently being reviewed and will be updated to reflect changes in the UK Act since 1998, the most recent date the Act was updated.

ii. **Control of Asbestos Regulations.** There is currently no specific asbestos legislation in the IOM and it is proposed that these UK regulations are applied. An implementation date has been agreed.

iii. **Gas Safety (Installation and Use) Regulations**. The IOM's gas regulations are outdated; they do not suit the current family of gas on the Island which was changed in 2012 since their application in 1996. Work is underway to update these regulations and an implementation date has been agreed subject to industry consultation and Tynwald approval.

iv. **Ionising Radiation Regulations.** Since the previous report the Isle of Man Government has introduced the following items of health and safety related legislation with respect to ionising radiation –

- the Ionising Radiation (Application) Order 2019 *[SD 2019/0281]*, which applied (with modifications suitable for the IOM) the Ionising Radiations Regulations 2017, of Parliament [SI 2018 No. 219];
- the Ionising Radiation (Basic Safety Standards and Justification of Practices) Regulations 2019 *[SD 2019/0283]*; and
- the Ionising Radiation (Medical Exposure) Regulations 2019 *[SD 2019/0282].*

Parts 7 and 8 of the Ionising Radiation (Basic Safety Standards and Justification of Practices) Regulations 2019 *[SD 2019/0283]* implement Article 6(1) and 6(2) of Council Directive 2013/59/Euratom laying down basic safety standards for protection against the dangers arising from exposure to ionising radiation. In so doing, this introduces into the law of the Isle of Man the international radiological protection principle of generic 'justification' of classes of practices involving exposure to ionising radiation, that is weighing the health detriments of such practices against the individual or social benefits. This implementation of Article 6(1) and 6(2) of the Directive accordingly gives effect to the recommendations of the International Commission on Radiological Protection as set out in ICRP Publication No. 103.

v. **Management of Health and Safety at Work Regulations**. These regulations have been identified as a priority, but no fixed dated has been yet agreed for review.

vi. **Control of Lead at Work Regulations.** Currently there is no subject specific legislation in the IOM and it is proposed that the Department of Environment, Food and Agriculture (DEFA) should apply these UK regulations, but no fixed dated has been agreed.

vii. **Control of Major Accident Hazards Regulations**. Currently there are no specific COMAH regulations in the IOM and it is proposed that should DEFA apply these regulations to the IOM, but no fixed dated has been agreed.

viii. **Control of Substances Hazardous to Health Regulations.** Currently there are no specific COSHH regulations in the IOM and it is proposed that DEFA should apply these regulations, but no fixed dated has been agreed.

Electricity at Work Regulations. Currently there are no subject specific regulations in the IOM and it is proposed that DEFA applies these regulations, but no fixed dated has been agreed.

Paragraph 1. issue safety and health regulations;

b) With particular reference to COVID-19, provide specific information on the protection of frontline workers (health-care staff including ambulance crews and auxiliary staff; police and other first responders; police and military personnel involved in assistance and enforcement; staff in social-care facilities, for example for older people or children; prison and other custodial staff; mortuary services; and others involved in essential services, including transport and retail; etc.).

Great Britain

The UK Government has put in place a coordinated coronavirus response strategy encompassing all aspects of life and this includes occupational safety and health.

The Health and Safety Executive is providing information and advice on workplace and workforce issues to support the UK response, particularly in the provision of technical advice to protect healthcare workers, and others, providing care to people who have been diagnosed as having the virus. Bespoke support and assistance has also been provided to other frontline workers, such as the police and custodial staff as well as other sectors.

Support has been provided to all through information, advice and guidance relevant to employers and workers in managing the risks associated with re-starting or running their business during the outbreak and being COVID-secure.

Dedicated helplines have been established for workers, the public and Trades Unions to report concerns about workplace practices, and to inform them of the most up to date information on the impact of Covid19. During this period HSE has continued to engage with the tripartite stakeholders and HSE's website is routinely updated to ensure timely and current information is easily accessible.

As a regulator, HSE aims to prevent workplace death, injury or ill health and HSE has continued to investigate work related deaths across all sectors throughout the COVID pandemic. A system of proactive inspections has been rolled out as businesses across the UK reopen to drive engagement with COVID-secure measures. Additional resources have been secured to underpin this approach, which encompasses all businesses and not only those considered a higher risk.

NHS people Plan 2020-2021

As part of the NHS People Plan for 2020/2021 NHS England and NHS Improvement has delivered a range of interventions to ensure rapid access to occupational health, as part of a wider strategy to improve health and wellbeing for all staff but also directly in response to COVID-19. This includes a national health and wellbeing offer, including a national helpline, national text line, apps and self-help guides and a new Our NHS People website.

UK COVID-19 Infection Prevention and Control (IPC) guidance

This is issued jointly by the Department of Health and Social Care (DHSC), Public Health Wales (PHW), Public Health Agency (PHA) Northern Ireland, Health Protection Scotland (HPS)/National Services Scotland, Public Health England (PHE) and NHS England as

official guidance: COVID-19: infection prevention and control (IPC) - GOV.UK (www.gov.uk)

The guidance makes clear that employers should consider the specific conditions of each individual place of work and comply with all applicable legislation, including the Health and Safety at Work etc. Act 1974.

The IPC principles in the guidance document apply to all health and care settings, including the independent/private sector, mental health and learning disabilities, primary care areas, care homes, care at home, maternity and paediatrics (this list is not exhaustive). Further updates will be made to this document as new detail/evidence on COVID-19 emerges and as the pandemic phases/levels change. The guidance document does state that organisations and employers including NHS Trusts, NHS Boards, Health and Social Care Trusts (Northern Ireland), Local Authorities, Independent Sector providers, through their Chief Executive Officer (CEO) or equivalent must ensure:

- monitoring of IPC practices, as recommended in this guidance, and ensure that resources are in place to implement good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).
- testing and self-isolation strategies are in place with a local policy for the response if transmission rates of COVID-19 increase.
- training in IPC measures are provided to all staff, including: the correct use of PPE (including a face fit test if wearing a filtering face piece (FFP3), respirator, and the correct technique for putting on and removing (donning/doffing) safely.
- risk assessment(s) is undertaken for any staff members in at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) staff.
- patients/individuals at high risk/ extremely high risk of severe illness are protected from COVID-19. This must include consideration of families and carers accompanying patients/individuals for treatments/procedures.
- health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.

As part of their employer's duty of care, providers have a role to play in ensuring that staff understand and are adequately trained in safe systems of working, including donning and doffing of personal protective equipment. A fit testing programme should be in place for those who may need to wear respiratory protection. In the event of a breach in infection control procedures, staff should be reviewed by occupational health.

Consultation with Royal Colleges and Unions, including the Royal College of Nursing/ Royal College of Midwifery has been undertaken in developing (and ahead of publication of updated versions of) the IPC guidance.

Northern Ireland

HSENI worked alongside the Departments for the Economy and the Department for Health in NI to provide information on how to manage the hazard associated with COVID-19. As COVID-19 is a public health issue the primary source of information was NI's Public Health Agency. HSENI discharged a mix of advisory and inspection contacts across various industries and sectors especially those which were considered most at risk.

Isle of Man

Protection of frontline workers in relation to COVID-19 and the risks of exposure to other diseases and pathogens in the workplace is regulated within the provisions of the Health and Safety at Work etc. Act 1974 (as applied), and in more detail in the Management of Health and Safety at Work Regulations 2003. The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1985 place duties on employers to report specified cases of exposure to disease and other harmful substances, these regulations apply to employers when their work, as defined by these regulations, involves exposure to certain pathogens and would apply to COVID-19.

The review and update of the Health and Safety at Work Act proposes to make Police Constables employees for the purpose of health and safety legislation, currently Police Constables are not regarded as employees on the Isle of Man, this will afford Constables the same protection as other employees for the purposes of health and safety regulation.

Paragraph 1. issue safety and health regulations;

c) Please provide responses to comments and queries from 2017 conclusions:

Comment: Given that no update has been provided, the Committee asks that the next report provide full and detailed information on the legislation and regulations, including any amendments thereto adopted during the reference period, which specifically relate to ionising radiation. It asks whether workers are 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).

Great Britain

The Ionising Radiations Regulations 2017 (S.I. 2017/1075) (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. They also apply to work with natural radiation, including work in which people are exposed to naturally occurring radon gas and its decay products. Any employer who undertakes work with ionising radiation must comply with IRR17.

IRR17 requires employers to keep exposure to ionising radiations as low as reasonably practicable. Exposures must not exceed International Commission on Radiological Protection specified dose limits. Restriction of exposure should be achieved first by means of engineering control and design features. Where this is not reasonably practicable employers should introduce safe systems of work and only rely on the provision of personal protective equipment as a last resort.

Employers can find practical help in Work with ionising radiation: Ionising Radiations Regulations 2017 Approved code of practice and guidance.

Further information on the UK's radiation legal base, which implements the key principles of radiological protection established by the International Commission on Radiological Protection can be found here.

Northern Ireland

The Ionising Radiations Regulations (Northern Ireland) 2017. The Regulations impose duties on employers to protect employees and other persons against ionising radiation arising from work with radioactive substances and other sources of ionising radiation. The regulations also impose certain duties on employees. The Regulations implement in part as respects Northern Ireland provisions of Council Directive 2013/59/Euratom (OJ No L13, 17.1.2014, p 1) laying down basic safety standards for protection against the dangers arising from exposure to ionising radiation, and repealing Directives 89/618/Euratom, 90/641/Euratom, 96/29/Euratom, 97/43/Euratom and 2003/122/Euratom. The same specified dose limits and code of practice applies in Northern Ireland, as in Great Britain:

Work with ionising radiation: Ionising Radiations Regulations 2017 Approved code of practice and guidance.

Isle of Man

Ionising Radiation Regulations. Since the previous report the Isle of Man Government has introduced the following items of health and safety related legislation with respect to ionising radiation –

i. the Ionising Radiation (Application) Order 2019 [SD 2019/0281], which applied (with modifications suitable for the IOM) the Ionising Radiations Regulations 2017, of Parliament [SI 2018 No. 219];
ii. the Ionising Radiation (Basic Safety Standards and Justification of Practices) Regulations 2019 [SD 2019/0283]; and
iii. the Ionising Radiation (Medical Exposure) Regulations 2019 [SD 2019/0282].

Parts 7 and 8 of the Ionising Radiation (Basic Safety Standards and Justification of Practices) Regulations 2019 *[SD 2019/0283]* implement Article 6(1) and 6(2) of Council Directive 2013/59/Euratom laying down basic safety standards for protection against the dangers arising from exposure to ionising radiation. In so doing, this introduces into the law of the Isle of Man the international radiological protection principle of generic 'justification' of classes of practices involving exposure to ionising radiation, that is weighing the health detriments of such practices against the individual or social benefits. This implementation of Article 6(1) and 6(2) of the Directive accordingly gives effect to the recommendations of the International Commission on Radiological Protection as set out in ICRP Publication No. 103.

Paragraph 1. issue safety and health regulations;

> *d) If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised.* ***Conclusion: "The Committee concludes that the situation in the United Kingdom is not in conformity with Article 3§1 of the Charter on the ground that all self-employed and domestic workers are not covered by the occupational health and safety regulations."***

United Kingdom

The UK disagrees with the conclusions of the committee in both regards. Firstly, the existing UK legal framework provides comprehensive employment and social protections to domestic workers, and as a rule, domestic workers in the UK are entitled to the same general employment rights as workers. It is neither proportionate nor practical to extend criminal health and safety law to the employment of domestic workers in private households. This is predominantly as it would impinge on the privacy rights on the individuals and households concerned and impose undue regulatory burdens from the suite of health and safety obligations, including inspections. The UK notes that this approach is also the case in many other members of the Council of Europe.

Secondly, in regard to the self-employed, the duties of other persons towards the health and safety of the self-employed have not changed in the UK. The risks to the self-employed from the work activities of others, therefore, has full coverage within the legal framework.

The self-employed themselves are also covered by the UK's legal framework in so far as their work activity poses a risk to the health and safety of others, including other workers and members of the public. This is supplemented by listed work activities to ensure that self-employed people carrying out these activities will still have a duty with regard to themselves and others and general duties under section 3(2) of the Health and Safety at Work etc. Act 1974.

Outside of the coverage outlined above, the self-employed cannot be described as being exposed to the same risks as employed workers, as articulated in the Committee's interpretation of the Charter, as the working environment, control of such environment, and relationship is different. The UK contends, therefore, that it is in conformity with Article 3§1 of the Charter and the Committee's interpretation of that Article.

The UK remains committed to improving working conditions and provides a supportive and encouraging environment, with appropriate protections, complemented by effective and proportionate regulation to tackle challenges that come with social and economic change.

Isle of Man

Section 51 of the Health and Safety at Work etc. Act 1974 (as applied to the Isle of Man) 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'.

It is therefore the case on the Isle of Man that domestic servants in a private household (as described in section 51 of the Act) are exempt from health and safety regulation. However, peripatetic persons working in other private households such as hairdressers, appliance engineers, health and social care workers etc. would not normally be regarded as domestic servants.

The Isle of Man did not amend its health and safety law in 2015 when health and safety regulations were dis-applied from some self-employed businesses in the UK, but this change is being considered during a planned review of the Act as it applies in the IOM to bring it into line with the position in the UK.

Paragraph 2. to provide for the enforcement of such regulations by measures of supervision;

> *a) Please provide 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.*

Great Britain

Data on work-related stress and its causes are collected and reported annually. This includes reference to harassment and poor management.

HSE research on the health and safety implications of the GIG economy has recently been published and whilst outside the reference period, has been included for completeness.

Referring to the information provided in response to the first question of the committee (question 1a, Article 3 para 1) many of the specific issues listed above are public health or broader societal issues that have a workplace component and should not be considered in isolation

Northern Ireland

Statistics can be found in HSE NI annual reports, however the statistics are not disaggregated in a way that provides the information requested: https://www.hseni.gov.uk/publications/hseni-annual-reports

Isle of Man

The additional information provided (see end of section on Article 3) contains statistical data on the prevalence of work related death, illness, major injury, disease and dangerous occurrences. The reporting mechanism (RIDDOR 1985) does not (in all cases) require the

reporting of self-harm, PTSD, burn out and alcohol or other substance use disorders to the Inspectorate.

The inspectorate has not conducted specific epidemiological studies to assess long term health impact of new high risk jobs (e.g. cycle delivery services, digital platform based jobs, performers in sports entertainment industries or jobs where there are interactions between employees and clients who use potentially harmful substances such as alcohol or psychoactive products, new forms of high yield stress trading, military and law enforcement or with regards to victims of harassment at work or poor management.

Paragraph 2. to provide for the enforcement of such regulations by measures of supervision;

b) Please provide updated information on the organisation of the labour inspectorate, and on the trends in resources allocated to labour inspection services, including human resources. Information should also be provided on the 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 on the number of breaches to health and safety regulations and the nature and type of sanctions.

Great Britain

The following figures have been published in the Annual Report and Accounts (ARA) since 2010/11. The Annual Report and Accounts are available online at - http://www.hse.gov.uk/aboutus/reports/

	2010/11 £M	**2011/12 £M**	**2012/13 £M**	**2013/14 £M**	**2014/15 £M**	**2015/16 £M**	**2016/17 £M**	**2017/18 £M**	**2018/19 £M**
Government Funding	203	175	159	154	138	134	133	128	126
Income	124	116	117	125	81	90	91	93	91
Annual Spending	327	291	276	279	219	224	224	221	217
Inspector Numbers	1450	1432	1367	1318	1038	1037	988	978	990

- Government funding is the Net Operating cost from HSE's ARA
- Income includes cost recovery and commercial activities
- Annual Spending is the Total Operating Cost from HSE ARA
- The Office for Nuclear Regulation (ONR) became a statutory corporation outside of HSE from 1 April 2014 and are not included from 2014/15 figures onwards

HSE inspection data is available in a published format as general totals only and excludes major accident hazard sites.

2011/12	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
c.21,700	c.22,240	c.23,470	c.20,200	c.18,000	c.20,000	c.20,000	c.20,000

Disaggregated inspection data are taken from live operational data tools and are used for internal verification purposes only. These are not validated as published official statistical information.

HSE publishes data relating to prosecutions and enforcement action. The tables, including historical data are too big to reproduce in this report but are available at http://www.hse.gov.uk/statistics/tables/index.htm#enforcement. It should be noted, however, that a prosecution or enforcement action may not be recorded in same calendar year as the original inspection due to investigation length.

Northern Ireland

HSENI's annual reports, which include information on inspection visits and human resources are available at: https://www.hseni.gov.uk/publications/hseni-annual-reports

Information on HSE prosecutions can be found here:
https://www.hseni.gov.uk/publications/public-register-convictions

Isle of Man

The Enforcing Authority with regards to the Health and Safety at Work etc. Act 1974 (as applied to the IOM) is the Department of Environment, Food and Agriculture (DEFA), which employs the Health and Safety at Work Inspectorate (HSWI) to manage these functions using a team of warranted health and safety inspectors.

Between 2016 and 2019 (the reporting parameters) the Inspectorate consisted of 3 inspectors including a Head of Health and Safety. In December 2018 a part time (50% equivalent) inspector was appointed for a limited term of 2 years to assist with inspection visits and complaints. This part-time post expires in December 2020.

A separate Environmental Health team employs warranted officers and as such investigate matters relating to premises falling within their regulatory responsibility. These tend to be the lower hazard premises and low risk activities including shops, offices, rental and holiday accommodation, food production and food outlets. The figures included in the additional information provided, do not include visits conducted by environmental health officers during the reporting period.

Figures relating to workers and industries have been taken from the 2016 Isle of Man Census report.

Details of specific sanctions are included in the additional information provided (see end of section on Article 3). It is not possible to record the number of actual breaches as not all of these will have been reported or followed up. Breaches are investigated based on a risk and severity of the breach and the available inspector resource when the report of the breach is received.

Types of Enforcement/sanctions

Warning – written/verbal. A verbal warning can be issued to businesses where non-safety critical failures have been identified, such as those relating to administrative breaches where the duty holder has an otherwise satisfactory record of compliance.

Where multiple non-safety critical concerns are identified or minor safety related defects are observed, and where the duty holder has a satisfactory background an inspector will normally issue a written warning identifying the failings found during the visit.

Improvement Notice (IN). An improvement notice is issued where there is a contravention of health and safety law and the contravention is likely to continue. An IN will give a minimum of 21 days for the duty holder to comply with the notice. Generally these notices are issued where there is a systematic or procedural failing. Within the reporting period 13 such notices were issued.

Prohibition Notice. A prohibition notice is served where an imminent risk of danger has been encountered or there is, in the opinion of an inspector, a serious risk of personal injury. It is not necessary to prove a contravention of a statutory provision. Within the reporting period 25 such notices were issued.

Caution. A Caution (also known as a Formal or Police caution) is a formal warning that may be given to persons aged 18 or over who admit to committing an offence. A caution is designed to provide a means of dealing with offending without a prosecution when there is evidence of an offence but the public interest does not require a prosecution. 3 cautions were issued within the reporting period.

Prosecution. A prosecution is the taking of punitive action against a duty holder following a decision making process which is impartial, justified and procedurally correct. There were 6 prosecutions within the reporting period.

Enforcement means all dealings with duty holders that result in the:

- Serving of notices;
- The withdrawing of approvals;
- The varying of licences, conditions or exemptions;
- The issuing of formal cautions; or
- Prosecution; and
- The provision of information or advice, verbally or in writing.

Service requests

The HSWI receives in excess of **1100** service requests and notifications each year. These can be notifications, complaints, enquiries requiring follow up action and include the following:

- RIDDOR reports including major accidents and specified injuries.
- Planning consultations relating to high hazard infrastructure and installations.
- Mechanical Contrivance applications for fairground rides and grandstands.
- Asbestos Notifications for licensed asbestos removal activities.
- Adverse Insurance Reports for failed lifting and other safety critical equipment
- Demolition Notices.
- Ionising radiation notifications/applications.
- CDM Notifications (F10's) – notification of construction projects.

- Weekly planning application notifications
- Event Safety notifications,

Telephone and email enquiries, no records are kept from general enquiries but a reasonable estimate would be around 20 enquiries per week.

Paragraph 2. to provide for the enforcement of such regulations by measures of supervision;

c) Please indicate whether Inspectors are entitled to inspect all workplaces, including residential premises, in all economic sectors. If certain workplaces are excluded, please indicate what arrangements are in place to ensure the supervision of health and safety regulations in such premises.

Great Britain

As co-regulators within the health and safety framework, 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.

Northern Ireland

Together, HSENI and the local councils cover all work situations in Northern Ireland that are subject to the Health and Safety at Work (Northern Ireland) Order 1978. Local Councils are responsible for enforcement in residential care homes.

Isle of Man

Within the current legal framework applicable to health and safety on the Isle of Man, inspectors are empowered to enter any premises that he or she has reason to believe it is necessary to enter (within its jurisdiction).

During the reporting period the HSWI undertook 1671 inspections. It is estimated that there are approximately 3000 business premises on the Isle of Man. However, it is not readily possible from the data that is held to identify the number of unique businesses that were inspected as some were inspected multiple times and some businesses operate from more than one business address. In addition, to maximise the effective use of the HSWI's resources, inspections are targeted on a risk and intelligence-led basis. A breakdown of the available information is set out in the additional information provided (see end of section on Article 3).

Paragraph 2. to provide for the enforcement of such regulations by measures of supervision;

d) *Please provide responses to comments and queries from 2017 conclusions:*

i. ***Comment****: The report fails to give figures regarding occupational diseases in Great Britain. The Committee requests that the next report provide information on that aspect.*

ii. ***Query:*** *The Committee asks that the next report provide detailed information on the new system, particularly with regards to the number of labour inspectors.*

iii. ***Comment:*** *The Committee take note of this information. However, in order to assess compliance with this part of Article 3§2, the Committee needs 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 reserves its position on this point.*

Great Britain

Full statistical data and analysis on the burden of occupational diseases in the UK can be found here.

Information on the number of labour inspectors has been provided in the answer to section 2(b) under Article 3, para 2 above.

The Going to the Right Places Programme (GttRP) has been operating in HSE for five years. The GttRP Programme represents a collaboration of HSE's regulatory function, policy makers, data scientists and statisticians working to develop a strategic approach to collating and using data to ensure that inspection activity is appropriately targeted and delivered.

The FIND-IT targeting tool allows us to collate intelligence from a number of datasets and interrogate these to develop a clearer picture of where inspection activity would best be targeted to achieve maximum impact. It consists of two elements:

- a data engine which contains a variety of algorithms to join disparate datasets without the need for unique identifiers; and,
- a customisable digital platform that allows users to interrogate and exploit the combined data

Improvement of intelligence via the collation of additional data within FIND-IT feeding into the targeting process enables a more detailed exploration of the factors affecting compliance with health and safety risk and which are the best sources of intelligence for these.

Over the past few years, HSE has undertaken benchmarking visits to provide a comparison with what HSE could achieve through inspection activity in the absence of a structured targeted and intelligence-led process. Benchmarking visits were randomly selected from the manufacturing sector and the outcomes were compared with visits selected using structured targeted and intelligence-led process. Full results are as yet available; however, the headlines of this work are:

- Our higher risk sectors have, in general, been chosen appropriately.
- Our process is effective in identifying sites where there is a greater likelihood of serious risks not being managed
- The worst examples arise where there is poor performance in a higher risk sector
- FIND-IT has allowed us to geographically target Priority Local Inspections with a higher likelihood and confidence of finding sites with poor health and safety management where intervention is needed to remove risk. There are further opportunities to improve the targeting and this work continues
- It is important to continue to monitor sectors outside existing higher risk groups

Vulnerable workers form part of the consideration for our inspection priorities and programmes. Inspectors are trained to spot the signs of labour abuse and will consider such issues as part of their normal inspection role, immediately referring any concerns to the relevant enforcement body

HSE helps create a more effective regulatory process through working closely with other enforcement bodies in sharing data and participating in joint initiatives. Where a business is known to be contravening one set of regulations, there is a likelihood that they will not be complying with others. Being able to share information where it is relevant to do so, means HSE are better informed and able to keep workers safe.

All workers are covered by the inspection regime. Statistics on inspections over the reference period have been provided above. The UK does not, however, use percentage of companies undergoing a health and safety inspection as a metric on which to measure the performance of the system.

As set out in the answer to question 3 (above), inspections predominantly take place at higher risk premises or premises where higher risk activities are undertaken. A global percentage does not appropriately reflect this focus on risk to workers.

Northern Ireland

i. NI stats published at https://www.hseni.gov.uk/sites/hseni.gov.uk/files/methodology-note-on-northern-irelands-estimated-work-related-health-statistics-2018.pdf

ii. Published annually in HSENI's annual report - https://www.hseni.gov.uk/sites/hseni.gov.uk/files/hseni-annual-report-and-statement-of-accounts-2018-19_0.pdf

iii. Published annually in HSENI's annual report - https://www.hseni.gov.uk/sites/hseni.gov.uk/files/hseni-annual-report-and-statement-of-accounts-2018-19_0.pdf

In general, HSENI carries out a minimum of 5,000 inspections / interventions in NI per annum.

Isle of Man

The figures for the IOM supplied in the additional information provided (see end of section on Article 3) of this report include all reports received as part of the reporting legislation as applied to the Isle of Man which include those reporting cases of occupational disease.

Paragraph 3.to consult, as appropriate, employers' and workers' organisations on measures intended to improve industrial safety and health.

No information requested, except where there was a conclusion of non-conformity or a deferral in the previous conclusion for your country. For conclusions of non-conformity, please explain whether and how the problem has been remedied and for deferrals, please reply to the questions raised.

No information requested.

Isle of Man additional information

The additional information in Appendix 1, attached, provides further detail, this is summarised as follows.

The total number of notifications received for incidents which occurred in the reporting period (Jan 2016 to Dec 2019) was **1007** and is broken down by year as follows:

2016/17	01.01.16 – 31.05.17*	**379**
2017/18	01.06.17 – 31.05.18	**246**
2018/19	01.06.18 – 31.12.19*	**382**

* Due to a number of reporting lines using several different reporting periods/parameters, (the most common reporting period is June to May) the 2016/17 figures include reports from 1 Jan 2016 to 31 May 2017 and the 2018/19 figures include reports from 1 June 19 to 31 December 19.

PREMISES LISTS

The premises covered by the Health and Safety at Work Inspectorate on the Isle of Man are very similar to those covered by the Health and Safety Executive in the UK and in order to ensure accurate allocation we refer to the following HSE (UK) publication for guidance prior to allocation: http://www.hse.gov.uk/foi/internalops/og/og-00073-appendix1.htm

The number of premises is thought to exceed 3000, particularly as shops, rented accommodation, hotels and guest houses are covered by the Health and Safety at Work etc. Act 1974 as applied to the Isle of Man.

The number of visits carried out between **1 January 2016 and 31 December 2019 was 1671.**

Additional Information IOM- Art

Article 11 – The right to protection of health

Paragraph 1. to remove as far as possible the causes of ill-health

a) Please provide 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.).

United Kingdom

Each of the UK constituent countries experienced either an increase in life expectancy at birth in 2017 to 2019 compared with 2016 to 2018 or saw life expectancy remain unchanged when measured in years. England continued to have the highest life expectancy at birth for males and females, while Scotland continued to have the lowest for both sexes. Similarly to the UK as a whole, the slowdown in life expectancy improvements since 2011 continued to be observed for each constituent country in 2017 to 2019.[1]

Improvements in life expectancy at birth occurred in 2017 to 2019 for males in England, Wales and Scotland, and males experienced the highest life expectancy at birth ever observed in those countries. Male life expectancy at birth remained unchanged in Northern Ireland. Females in England and Northern Ireland experienced increases in life expectancy at birth in 2017 to 2019, resulting in the highest life expectancy seen in those countries. Life expectancy at birth for females in Wales and Scotland remained unchanged.

England

National and sub-national life expectancy

Life expectancy at birth in England was 79.7 years for males and 83.3 years for females in 2017-2019. Although improvements in life expectancy have been low since 2011, compared with previous decades, this is the highest observed life expectancy for both sexes[2]. Disability-free life expectancy at birth, a measure of the average number of years a person might live free from disability or a limiting illness, was 62.9 years for males and 61.9 years for females in 2016-2018[3]. However, life expectancy at birth varies across the country. In 2017-2019, the gap between the highest and lowest life expectancy among local authority areas was 10.5 years for males and 7.7 years for females[4]. When classifying according to the proportion of the population living in rural areas, life expectancy at birth was found to be

[1] Office for National Statistics (24 September 2020). National life tables – life expectancy in the UK: 2017 to 2019
[2] Office for National Statistics (24 September 2020). National life tables – life expectancy in the UK: 2017 to 2019
[3] Office for National Statistics (11 December 2019). Health state life expectancies, UK: 2016 to 2018.
[4] Office for National Statistics (24 September 2020). Life expectancy for local areas of the UK: between 2001 to 2003 and 2017 to 2019

higher for people born in Predominantly Rural areas compared with Predominantly Urban areas in 2015-2017[5].

There are socio-economic inequalities in life expectancy. Inequality in life expectancy at birth between the most and least deprived areas in England was 9.5 years for males and 7.5 years for females in 2016-2018. Inequality in disability-free life expectancy was wider, at 17 years for both males and females[6]. In 2015-2017, higher mortality rates from circulatory disease, cancer and respiratory disease among individuals living in the most deprived fifth of areas compared to the least deprived fifth explained almost two thirds of the gap in life expectancy at birth between these areas[7]. Additionally, rates of drug poisoning deaths have been higher in the most deprived areas compared with the least over the last decade; this is particularly the case for men aged 42, where rates were eight times higher in the most deprived fifth of areas compared to the least deprived fifth[8].

Mortality among minority ethnic groups and homeless populations

While ethnicity is not recorded at death registration in England, information on ethnicity can be obtained through linkage to hospital episode statistics for the majority of deaths. An analysis of this data has shown that the annual average age-standardised death rate for 2014 to 2018 was higher in the White ethnic group than in Asian and Black ethnic minority groups[9]. Office for National Statistics prevalence estimates based on hospital episode statistics data between 2017 and 2020 demonstrate that males and females of South Asian ethnic groups show a higher prevalence of cardio-vascular and metabolic conditions (diabetes) [10].

An analysis of death registrations of homeless individuals in England and Wales sleeping rough or using emergency accommodation at the time of death, such as homeless shelters and direct access hostels, found that the mean age at death was 45 years for males and 43 years for females in 2018[11]; whereas the mean age at death was 76 years for men and 81 years for women in the general population[12].

Blood Borne Diseases

After a peak of new HIV diagnoses in the UK in 2014, a decline has been observed from 6,278 in 2014 to 4,453 in 2018. This decline was particularly marked among gay and bisexual men (GBM) in whom diagnoses fell by 35%. The number of people who probably acquired HIV through injecting drug use has fallen by a third since 2009 (140 to 94) and

[5] Department for Environment, Food & Rural Affairs (26 September 2019). Rural health statistics
[6] Office for National Statistics (27 March 2020). Health state life expectancies by national deprivation deciles, England: 2016 to 2018
[7] Public Health England (June 2019). Segment Tool. https://analytics.phe.gov.uk/apps/segment-tool/
[8] Office for National Statistics (14 October 2020). Deaths related to drug poisoning in England and Wales: 2019 registrations
[9] Public Health England (August 2020). Disparities in the risk and outcomes of COVID-19.
[10] Office for National Statistics (16 October 2020). Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England and Wales: deaths occurring 2 March to 28 July 2020
[11] Mean age at death is not the same as life expectancy, and further information on the mean age at death calculation can be found on the ONS User guide to mortality statistics.
[12] Office for National Statistics (1 October 2019). Deaths of homeless people in England and Wales:2018.

comprised 2% of all new HIV diagnoses in 2018[13]. In 2018, 71% of newly diagnosed GBM were of white ethnicity, whereas among adults who acquired HIV heterosexually, 38% were of white ethnicity and 44% were of Black African ethnicity.

In England, chronic hepatitis C (HCV) prevalence is estimated to have fallen by around 30% since 2015, with 89,000 predicted to have chronic HCV infection in 2019. However, chronic infection remains stable among those who inject drugs. Drug injection continues to be the most important documented risk factor for HCV infection in 2018, being cited as the risk in 93% of all laboratory reports where risk factors were disclosed[14].

Scotland

Life Expectancy Across the Country and Different Population Groups

Scotland's public health challenges, including the country's comparatively poor health, are well known. This includes a significant burden of avoidable disease and suffering – concentrated particularly among those living in our most deprived communities.

The COVID-19 pandemic has both exposed and exacerbated our health inequalities crisis, with further proof of widening inequalities evident in life expectancy figures. Life expectancy in Scotland which had been increasing since the 1950s has now stalled. There has been almost no change in life expectancy in Scotland since 2012, and life expectancy for some in our poorest communities has decreased.

The Scottish Programme for Government includes significant commitments to improve life expectancy and to tackle health inequalities. Public Health Scotland is also undertaking a large programme of work to understand these worrying trends so that it is clear what actions needs to be taken.

- In Scotland in 2017-2019, life expectancy at birth was 77.1 years for males and 81.1 years for females. This is a small increase of around 0.1 years for both males and females since the 2016-2018 figures published last year.
- Life expectancy in Scotland has increased since the early 1980s but has now remained virtually unchanged since 2012-2014
- Female life expectancy at birth was highest in East Renfrewshire (84.0 years) and lowest in Glasgow City (78.5 years).
- Male life expectancy at birth was highest in East Dunbartonshire (80.5 years) and lowest in Glasgow City (73.6 years)
- The majority of Scotland's council areas have experienced a slow-down or a stall in life expectancy growth since 2012-2014 and many areas now have decreasing life expectancy.
- The gap in life expectancy between the 10 per cent most and 10 per cent least deprived areas was 13.3 years for males and 10.0 years for females.
- Life expectancy was highest in accessible rural areas (79.71 for males and 82.93 for females) and remote rural areas (79.35 for males and 83.07 for females) and

[13] Public Health England (December 2019). HIV in the United Kingdom: Towards Zero HIV transmissions by 2030; 2019 report.
[14] Public Health England (May 2020). Hepatitis C in England 2020.

lowest in large urban areas (76.06 for males and 80.63 for females) and other urban areas (76.51 for males and 80.46 for females).

Report on life expectancy statistics available from National Record of Scotland (NRS)[15]. Tables of statistics (disaggregated based on sex, local authority area, Scottish Index of Multiple Deprivation, and urban/rural classification) also available from NRS[16]

Prevalence of particular diseases among relevant groups

See response to Q1 under 11.1 for statistics on deaths from such diseases.

Prevalence of Blood Borne Infectious Diseases

There has been an outbreak of HIV among people who inject drugs originating in the Glasgow area. The latest HIV surveillance data (up to Dec 2019 – published Jun 2020) is publically available[17]. Table 4 summarises the new cases by year and type of transmission for 2019 it was 26 new diagnoses. The Health Board where the cases originated contains a summary and graph for 2015-2019[18].

During 2019, a total of 326 reports of HIV diagnoses were recorded in Scotland: 167 (51%) of these were first ever diagnoses in Scotland and 158 (49%) were known to be positive previously out with Scotland. This total is similar to that reported in 2018 (320)[19]. Of the 167 first ever HIV diagnoses, 62 (37%) were among men who have sex with men (MSM), 54 (32%) were heterosexually acquired and 26 (16%) were among people who inject drugs (PWID). Information on route of transmission is not yet available for 25 individuals.

Proportion of PWID with recently acquired HCV infection[a]

NHS Board	2015-16				2017-18		
	Number recently infected[b]	Number at risk of infection[†]	Proportion[‡]		Number recently infected[b]	Number at risk of infection[†]	Proportion[‡]
Survey total	**18**	**1019**	**1.8% (1.1%-2.8%)[5]**		**18**	**802**	**2.2% (1.4%-3.5%)**

[a]Data are from the Needle Exchange Surveillance Initiative (NESI): a cross-sectional voluntary anonymous survey of people who inject drugs, recruited from selected services that provide injection equipment in mainland Scottish NHS Boards.

[b]In the very early stages of HCV infection, individuals have high levels of HCV virus (RNA) before developing antibodies (anti-HCV); recent infections therefore refer to individuals who are anti-HCV negative and HCV RNA positive. The duration of this state is 1-2 months.

[15] https://www.nrscotland.gov.uk/files//statistics/life-expectancy-areas-in-scotland/16-18/life-expectancy-16-18-publication.pdf
[16] https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/life-expectancy/life-expectancy-in-scottish-areas/2016-2018
[17] https://www.hps.scot.nhs.uk/web-resources-container/hiv-in-scotland-update-to-31-december-2019/
[18] https://www.nhsggc.org.uk/your-health/public-health/public-health-protection-unit-phpu/bloodborne-virus/hiv/hiv-infections-in-people-who-inject-drugs-update-2019/#
[19] https://www.hps.scot.nhs.uk/web-resources-container/hiv-diagnoses-in-scotland-summary-report-to-31-december-2018/

†*The denominator includes all individuals who are at risk of infection, i.e. all anti-HCV negative individuals (both RNA negative and positive)*

‡*95% confidence intervals were calculated using the Wilson Score method and are only shown for the Scotland total. Caution should be taken when comparing proportions across years at the NHS Board level due to small numbers.*

Northern Ireland

Links to Department of Health Statistics and Northern Ireland Statistics and Research Agency website website:

https://www.health-ni.gov.uk/articles/life-expectancy-northern-ireland

http://www.ninis2.nisra.gov.uk/public/Home.aspx

Isle of Man

Outlined below is the Male and Female Life Expectancy for Persons Living on the Isle of Man (Source: Public Health (Isle of Man))

Period	Male Life Expectancy at Birth		
	Rate	Lower CI	Upper CI
2014-2016	79.4	78.6	80.1
2015-2017	79.1	78.3	79.8
2016-2018	78.9	78.2	79.7

Period	Female Life Expectancy at Birth		
	Rate	Lower CI	Upper CI
2014-2016	83.0	82.3	83.7
2015-2017	83.2	82.5	83.9
2016-2018	83.0	82.3	83.7

Paragraph 1. to remove as far as possible the causes of ill-health

b) Please also provide information about sexual and reproductive health-care services for women and girls (including access to abortion services) and include statistical information about early (underage or minor) motherhood, as well as child and maternal mortality. Provide also information on policies designed to remove as far as possible the causes for the anomalies observed (premature death; preventable infection by blood borne diseases; etc.).

United Kingdom

Contraception

Evidence shows that unplanned pregnancies can have a negative effect on women's lives and result in poorer outcomes for both mother and child than for those that are planned. Contraception plays a vital role in preventing unintended pregnancy and a wide range of contraceptive choices are available, free of charge, in a range of primary and community care venues. 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 the 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 conception. In 2018 (the most recent year for which data is available), conception rates for under 18-year-olds in England and Wales declined by 6.1% to 16.8 conceptions per 1,000 women aged 15 to 17 years. In 2018 the conception rate for women under 18 years decreased for the 11th year in a row. This is the longest continued decrease since records began.

Abortion

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. The decision to terminate must rest on the judgement of the two doctors and the woman herself, who must be given enough information and time to help her understand the process so that she can make an informed decision about the options available. In 2019, 99% of abortions in England & Wales were provided free to women and were funded by the NHS. Abortion rates for those aged under 18 have declined over the last ten years but remained the same in 2019 as in 2018 (8.1 per 1,000).

The Abortion Act 1967 does not extend to Northern Ireland. In 2017, the Northern Ireland funding scheme was introduced, to provide government funded abortions in England for residents of Northern Ireland. In cases of hardship, travel costs are also covered. Abortion was decriminalised in Northern Ireland in 2019, in line with the Northern Ireland Executive Formation Act 2019. The UK Government laid regulations for the new framework for

abortions in Northern Ireland in March 2020, as required by law. This meant that the commissioning of abortion services in Northern Ireland became a responsibility of the Northern Ireland authorities, however, due to a range of factors, the Northern Ireland Department of Health has yet to formally commission any abortion services and the scheme to provide UK-Government funded abortions in England for residents of Northern Ireland continues to operate.

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. This brought England in line with Wales and Scotland, who had allowed their residents to take the second pill at home since June 2018 and October 2017 respectively.

Stillbirths, neonatal and maternal deaths

The UK Government's Maternity ambition is to halve the 2010 England rates of stillbirths, neonatal and maternal deaths and brain injuries in babies occurring during or soon after birth by 2025. The ambition also includes reducing the rate of pre-term births from 8% to 6%. Maternal deaths are very rare, with the latest figures showing just 9.2 per 100,000 maternities. Small numbers mean the data has to be combined into a rolling triennial rate, which is only available on a UK-wide basis. This shows a 14% reduction in the triennial maternal mortality rate up to 2015-17, which is in line with the trajectory required to meet the 2020 ambition.

The NHS Long-Term Plan, 2019 (LTP), sets out how the maternity system will continue to accelerate action to achieve the National Maternity Safety Ambition. Key initiatives include implementing an enhanced and targeted continuity of carer model to help improve outcomes for the most vulnerable mothers and babies; investment in neonatal critical care services and networked maternal medicine; and offering all pregnant women with type 1 diabetes continuous glucose monitoring, helping to improve neonatal outcomes.
The NHS Long-Term Plan is available here:
https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

Child health
The UK Government wants to see all children and young people get the best start in life. A wide range of policies to improve child health are being implemented. The Healthy Child Programme provides a framework to identify and treat problems early, help parents to care well for their children, change and improve health behaviours and protect against preventable diseases.

The Healthy Child Programme is available here:
https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning

Statistics

- In 2018, the infant mortality rate decreased to 3.8 deaths per 1,000 live births in England and Wales, compared with 3.9 in 2017; this is above the lowest ever rate of 3.6 recorded in 2014.
- There were 2,488 infant deaths (aged under 1 year) that occurred in England and Wales in 2018; as a result of falling birth rates in recent years this is the lowest number since records began in 1980.
- The infant mortality rate has decreased the most for mothers aged 40 years or over, from 5.8 deaths per 1,000 live births in 2010 to 4.8 deaths per 1,000 live births in 2018.
- In 2018, the neonatal mortality rate remained the same as in 2017, at 2.8 deaths per 1,000 live births in England and Wales.
- The recent increase in the proportion of live births under 24 weeks completed gestation has contributed to a recent increase in the neonatal mortality rate, from 2.5 deaths per 1,000 live births in 2014 to 2.8 deaths in 2017.

Scotland

Sexual and reproductive healthcare services

The Scottish Government has invested in IVF to ensure access is equitable wherever patients live in Scotland and follows National Institute for Clinical Excellence (NICE) Guidance to allow eligible patients up to 3 full cycles of IVF.

The Scottish Government and partners are committed to using the Sexual Health and Blood Borne Viruses Framework (SHBBV), updated in September 2015, to improve sexual health outcomes for people across Scotland. Through this, Scottish Government has provided around £2.5 million funding over the period 2018-2021 for a range of projects and activities to meet the needs of women and girls specifically, or from which they will directly benefit, including:

- SACRO to deliver an online outreach programme to women selling sex online, supporting them to access sexual health services.
- Waverley Care project engaging directly with populations affected by poor sexual health and blood borne viruses using a peer to peer approach to gather their views and experiences.
- 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. The research is intended to inform the development of sexual health services that meet the needs of young people in Scotland.

In 2021, the Scottish Government is committed to developing an interim SHBBV Recovery Framework. This Framework will take stock of the impacts of COVID-19 on sexual health services and people that use services, particularly vulnerable groups, while supporting recovery and renewal and services and providing a bridge to the next multi-year SHBBV framework.

NHS Boards provide abortion services in Scotland. Abortions can be carried out up to the legal limit of 24 weeks gestation and in very limited circumstances after 24 weeks gestation.

Early motherhood
A National Statistics publication for Scotland: Teenage pregnancies;
Year of conception, ending 31 December 2018 – published 25 August 2020[20]

Public Health Scotland (PHS) provides an annual update on teenage pregnancy statistics in Scotland. This is based on age at conception and presented by year of conception and the most recent information is for the calendar year ending 31 December 2018. In the full report data are presented by NHS Board and council area for the age groups: under 16, under 18 and under 20.

Child and maternal mortality
The Best Start: A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland[21] - One of the key aims of Best Start is to introduce continuity of carer which evidence shows improves outcomes for mothers and babies.

The Maternity and Children Quality Improvement Collaborative (MCQIC), is part of the Scottish Patient Safety Programme (SPSP) within the Improvement Hub, Healthcare Improvement Scotland. MCQIC was launched in 2013 with the aim of reducing avoidable harm and morbidity in women, children and babies. MCQIC has an aim to reduce stillbirth by 35% by March 2021, through a focus on fetal monitoring, fetal growth and discussions with women about fetal movement. MCQIC also aims to reduce neonatal mortality by 15% by March 2021 through the delivery of measures including the Preterm Perinatal Wellbeing package

The stillbirth rate in 2019 of 3.5 per 1000 births and stillbirths (National Records of Scotland) is the lowest ever rate on record. There were 165 infant deaths, a rate of 3.3 for every thousand live births in 2019. This is slightly higher than the rate in 2018 (3.2) but low in historical terms. The neonatal death rate was 2.2.[22]

Scotland participates in multiple UK wide audit reports including: MBRRACE-UK[23], the National Neonatal Audit Programme[24], Each Baby Counts[25], National Maternity and Perinatal Audit. MBRRACE-UK National Perinatal Mortality Surveillance[26], Perinatal Confidential Enquiries, National Perinatal Mortality Review Tool and Saving Lives, Improving Mothers' Care reports all set out recommendations for improvements to reduce perinatal and maternal mortality.

[20] https://beta.isdscotland.org/find-publications-and-data/population-health/births-and-maternity/teenage-pregnancies/
[21] Executive Summary https://www.gov.scot/publications/best-start-five-year-forward-plan-maternity-neonatal-care-scotland-9781786527646/
[22] https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/general-publications/vital-events-reference-tables/2019/list-of-data-tables#section4
[23] https://www.npeu.ox.ac.uk/mbrrace-uk/reports
[24] https://www.rcpch.ac.uk/work-we-do/quality-improvement-patient-safety/national-neonatal-audit-programme
[25] https://www.rcog.org.uk/eachbabycounts
[26] https://maternityaudit.org.uk/pages/home

The Scottish Government expect all women to have maternity care that is tailored to their needs provided by the multi-professional team with quality and safety for both mothers and babies central to decision making, in partnership with women.

The Scottish Government's Senior Medical Officer is working with the Royal College of Physicians of Edinburgh and Royal College of Physicians and Surgeons of Glasgow to improve collaborative working and reduce variation across Scotland between physicians and obstetricians in the acute and chronic settings. This work has the support of both college presidents and priorities are strongly influenced by the MBRRACE-UK findings.

On 1 April 2021, Scotland will introduce a national system for reviewing and learning from all deaths of children and young people in Scotland – all live born children up to their 18th birthday, and up to 26th birthday for those in receipt of aftercare or continuing care at the time of their death – with the aim of reducing the number of avoidable deaths in Scotland.

In 2019 there were[27]:

- 292 deaths in the 0-17 age group compared to 371 in 2010
- 165 deaths in the under 1s age group compared to 218 in 2010
- 76 deaths in the 1-14 age group compared to 90 in 2010
- 51 deaths in the 15-17 age group compared to 63 in 2010
- The highest average in 2015-2019 was in the under 1s (172 each year compared to an average of 213 in 2010-2014).
- The next highest was in the 15-17 age range with an average of 14 deaths each year during 2015-2019 (average of 16 deaths per year during 2010-2014)

In 2018, the main causes of deaths[28]:

- in the under 1 age group were congenital malformations, deformations and chromosomal abnormalities
- In 2018, the main causes of deaths in the 15-19 age group were external causes, eg accidents, self-harm

Northern Ireland

Sexual and Reproductive health-care services for women and girls

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 Department's Strategy for Maternity Care in Northern Ireland 2012-2018, contained outcomes to give every baby and family the best start in life, which included performance measures to reduce teenage pregnancies. Although the timescale of the strategy has now passed, implementation is still ongoing. An inequality analysis of pregnancy and early years indicators is included on page 28 of the Department's Annual Health Inequalities Report, which is available to view or download from: https://www.health-ni.gov.uk/sites/default/files/publications/health/hscims-report-2020.pdf

[27] Source: NRS Table DT.03

[28] Source: NRS Table 6.04: 2019 figures not yet available

Access to abortion services

Until 22 October 2019, abortion was only lawful in Northern Ireland if there was a risk to the woman's life or physical or mental health. Section 9 of the Northern Ireland (Executive Formation etc) Act 2019 decriminalised abortion and placed a legal obligation on the Secretary of State for Northern Ireland to establish a framework for abortion services. The legal framework - the Abortion (Northern Ireland) Regulations 2020 came into force on 31 March 2020. Until such time as abortion services are commissioned, the UK Government has made services available in England for women from Northern Ireland.

Links to statistics on teenage births, infant mortality and avoidable mortality in children and young people on DoH Statistics and NISRA website:

https://www.health-ni.gov.uk/publications/health-inequalities-annual-report-2020

http://www.ninis2.nisra.gov.uk/public/Home.aspx

Isle of Man

The Isle of Man Government's Department of Health and Social Care (DHSC) continues to offer a full range of sexual and reproductive health-care services for women and girls.

In 2018 the Isle of Man Government commissioned an Independent Review of the Isle of Man Health and Social Care System. The review's final report was published in April 2019:

https://www.gov.im/about-the-government/departments/cabinet-office/health-and-care-transformation/background/

The review's recommendations have all been accepted by the IOM Government and Tynwald (the IOM's parliament) and they are in the process of being implemented. Amongst other things, this will lead (from April 2021) to a separation of the setting of priorities and the development of policy in both health and social care from the delivery of services. The DHSC will retain the priorities and policy functions and a new public sector body, Manx Care, will be responsible for the delivery of services.

In addition, the Public Health directorate moves from DHSC to the Cabinet Office in 2020.

The Isle of Man has modernised its abortion legislation with the Abortion Reform Act 2019, which was brought into operation in May 2019. This Act brings provision for abortion in the IOM more into line with that in Great Britain.

https://www.legislation.gov.im/cms/images/LEGISLATION/PRINCIPAL/2019/2019-0001/AbortionReformAct2019_2.pdf

Outlines below is the Infant Mortality for the Isle of Man (Source: Public Health (Isle of Man)

	Infant Mortality		
Period	**Rate**	**Lower CI**	**Upper CI**
2015-2017	0.9	0.1	3.2
2016-2018	1.8	0.5	4.7

Article 11, Paragraph 1. to remove as far as possible the causes of ill-health

c) Please provide responses to comments and queries from 2017 conclusions (see extracts of the full conclusions attached to the commissioning email for the context):

i. *The Committee asks for information in the next report on the concrete measures taken to reduce the mortality rate caused by the above mentioned diseases in England, Scotland, Wales and Northern Ireland, as well as statistical data on the number of premature deaths caused by such diseases.*

ii. *The Committee asks to be kept informed on the trends in waiting times for both inpatient and outpatient care, supported by statistical data. It reserves its position on this point.*

iii. *The Committee asks that the next report provide updated information on the levels of overweight and obesity as well as information on the concrete impact/outcome of the measures taken on preventing and reducing obesity both among adults and children.*

iv. *The Committee asks that the next report to provide information on the impact/outcome of the measures taken on improving the mental health of people.*

v. The Committee asks for comments on these matters in the next report. It also asks that the next report contain information on the availability of mental health care and treatment services, including information on the prevention of mental disorders and recovery measures.

vi. The Committee asks that the next report contain information on dental care services and treatments (such as who is entitled to free dental treatment, the costs for the main treatments and the proportion of out-of-pocket paid by the patients).

England

Measures to reduce mortality rates

Statistics available here:
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath

Cancer

Cancer is a priority for this Government and survival rates are at a record high. Since 2010 rates of survival from cancer have increased year-on-year. The NHS Long Term Plan was published in January 2019 and includes ambitions to see 55,000 more people each year surviving cancer for five years in England and 75% of cancers diagnosed at stages 1 and 2 by 2028. The Long Term Plan is available here: https://www.longtermplan.nhs.uk/. The plan

includes a radical overhaul of existing screening programmes, the introduction of a new targeted programme to diagnose lung cancer early, new Rapid Diagnostic Centres to ensure patients are investigated and diagnosed as quickly as possible, and investment in state of the art technology and innovation.

Improving the care and quality of life of people living with and beyond cancer is also a priority. As of March 2019, 85% of NHS trusts have breast cancer Personalised Stratified Follow-Up (PSFU) protocols in place, allowing patients to take greater control of their care. A new survey to monitor Quality of Life for people living with or beyond cancer was launched in September 2020. A case study on PSFU protocols in Southampton NHS Foundation Trust is available here: https://www.england.nhs.uk/wp-content/uploads/2017/07/stratified-follow-up-pathway-southampton.pdf

The NHS Cancer Programme's latest update report which sets out the key achievements from October 2019 to January 2020 in delivering the NHS Long Term Plan for cancer is available here: https://www.england.nhs.uk/wp-content/uploads/2019/12/200124-Quarterly-Report-Q3-Final-22.pdf

Action continues to be taken to improve available treatments. In 2016 £130m was announced to replace older Radiotherapy machines, ensuring patients could receive the most advanced treatment. In December 2018, the first patient received Proton Beam Therapy at the Christie in Manchester, the first time this treatment became available in the NHS in England – another centre operates at University College Hospital in London. The NHS continues to push forward new treatment innovations, for example delivering Chimeric Antigen Receptor T Cell (CAR-T) Therapy treatment to children and young people up to 25 years old with B cell acute lymphoblastic leukaemia (ALL) that is refractory, in relapse post-transplant or in second or later relapse. CAR-T therapy is a truly game-changing personalised therapy for cancer, and NHS cancer patients will be among the first in the world to benefit.

The number of patients beginning treatment for cancer continues to rise. Prior to the pandemic, each month over 10,000 patients started treatment within 62 days of first being referred for tests (compared to around 7,000 per month ten years ago). Urgent cancer referrals increased by approximately 10% from 2018/19 to 2019/20, an increase of over 200,000.

Cardiovascular Disease

The NHS Long Term Plan also identifies cardiovascular disease as a clinical priority and the single biggest condition where lives can be saved by the NHS over the next 10 years. The Plan sets the ambition for the NHS to help prevent over 150,000 heart attacks, strokes and dementia cases.

The national cardiovascular programme has been set up to develop targeted interventions to optimise care by maximising diagnosis and treatment to minimise individual risk factors, and population risk. The programme aims to deliver the commitments set out in the NHS Long Term Plan, which includes:

- Improving and increasing early detection and treatment of CVD to help patients live longer, healthier lives and tackle heath inequalities. Helping people routinely to know their 'ABC' numbers – (atrial fibrillation, blood pressure and cholesterol)
- Commissioning a national CVD Prevention audit for primary care to support continuous clinical improvement
- Publication of the new GP contract which includes CVD specific priorities for CVD case finding and Quality and Outcomes Framework (QOF) changes for blood pressure control plus identification and management of heart failure. Further information on the contract can be found here: https://www.england.nhs.uk/gp/investment/gp-contract/
- Improving the effectiveness of approaches such as the NHS Health Check to rapidly treat those identified with the high-risk conditions, including atrial fibrillation, high blood pressure and high cholesterol (https://www.nhs.uk/conditions/nhs-health-check/)
- Expanding access to genetic testing for Familial Hypercholesterolaemia (FH); enabling us to diagnose and treat those at increased risk of heart attacks
- Establishing Primary Care Networks Directed Enhanced Specifications which include the prevention and early diagnosis of high-risk conditions such as hypertension and heart failure
- Investing in earlier detection and better treatment of cardiovascular conditions – focusing on expanding diagnostics (such echocardiology for heart failure) and treatment services outside of the acute sector
- Blood pressure monitors, alongside programmes of patient education, will be rolled out so at risk groups of people can easily monitor their condition in their own home as well as being offered in their local high street pharmacies.
- Increasing the proportion of patients with heart failure and heart valve disease who complete a course of cardiac rehabilitation, a programme of exercise and information to help people recover following a heart attack, heart surgery or procedure.
- Establishing 20 Integrated Stroke Delivery Networks which will focus on embedding effective and sustainable restoration of stroke services.
- Investing in supporting the testing and early adoption of higher intensity stroke rehabilitation models to improve recovery and life after stroke.

The respiratory programme is focused on respiratory disease which affects one in five people and is the third biggest cause of death in England (after cancer and cardiovascular disease). Hospital admissions for lung disease have risen over the past seven years at three times the rate of all admissions generally. Respiratory diseases are a major factor in winter pressures faced by the NHS; most respiratory admissions are non-elective and during the winter period these double in number.

This new respiratory programme has been set up to improve the treatment and support of people with respiratory disease and deliver the commitments outlined in the NHS Long Term Plan, which includes:

- Enable early and accurate diagnosis of respiratory diseases, by supporting the training of staff to deliver tests such as spirometry.
- Design and develop tools and programmes that will support patients to manage their condition themselves and receive personalised care
- Improve the treatment and care of people who present with community-acquired pneumonia.

To support delivery of the objectives set out in the Long Term Plan, NHS England and NHS Improvement has established 13 respiratory clinical networks across the country. The respiratory networks will bring together leaders from NHS and other health and social care organisations, to transform the diagnosis, treatment and care for respiratory patients in their local area. Changes have also made to the GP contract for 2020/21-2023/24 (to be implemented in 2021) with improved domains for Chronic Obstructive Pulmonary Disease (COPD) and Asthma. The QOF for COPD has been amended to reflect the importance of early and accurate diagnosis, with the addition of timely provision of post bronchodilator spirometry. The asthma review has been amended to incorporate aspects of care positively associated with better patient outcomes and self-management, including a review of inhaler technique and record of exacerbations.

NHSE/I has published case studies on specific interventions used for various patient groups. An example for improving access to palliative care for patients with respiratory disease can be found here: https://www.england.nhs.uk/ourwork/clinical-policy/respiratory-disease/improving-access-and-coordination-to-palliative-care/

Waiting times

Average (median) waiting times for elective treatment ('incomplete Referral-to-Treatment pathways', or RTT waits) are published monthly, alongside the median waits for patients who started treatment within the month. The latter are split between patients whose first definitive treatment required an admission ('admitted pathways') and for those whose first definitive treatment did not require an admission ('non-admitted pathways').

Between 1 Jan 2016 and 1 Jan 2020, the median waiting time increased by 1.6 weeks from 6.8 to 8.4 weeks. For admitted pathways, the median waiting time increased from 10.2 to 11.1 weeks, and for non-admitted pathways, the median waiting time increased from 6.3 to 7.2 weeks.

For more information on RTT data, and a full time series please see: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/

Obesity

In England, 63.3% of adults and 28.2% of children (aged 2-15) are either overweight or obese. Of these, 27.7% of adults and 15% of children are obese. This data is from the Health Survey for England 2018 which is available here: Health Survey for England 2018 [NS] - NHS Digital

Some important successes have been seen since the publication of chapter 1 of the childhood obesity plan in 2016, including average sugar content of drinks subject to the soft drinks industry levy decreasing by 43.7% between 2015 and 2019, and significant investment being made in schools to promote physical activity and healthy eating. Also, working is underway with councils to reduce child obesity locally through ground-breaking schemes.

The Government launched "Tackling obesity: empowering adults and children to live healthier lives" in July 2020. It is available at: www.gov.uk/government/publications/tackling-

obesity-government-strategy/tackling-obesity-empowering-adults-and-children-to-live-healthier-lives. The strategy demonstrates an overarching campaign to reduce obesity, takes forward actions from previous chapters of the childhood obesity plan (published in 2016, 2018 and 2019), including our ambition to halve the number of children living with obesity by 2030, and sets out measures to get the nation fit and healthy, protect against Covid-19 and reduce pressure on the NHS.

Measures include:

- Ban on TV and online adverts for food high in fat, salt and sugar before 9pm, and consulting on how to introduce a total advertising restriction online.
- End of deals like 'buy one get one free' on less healthy food high in fat, salt and sugar.
- Calories to be displayed on menus to help people make healthier choices when eating out – while alcoholic drinks could soon have to list 'liquid calories'.
- New campaign to help people lose weight, get active and eat better after Covid-19 "wake-up call".

Statistics are available here: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-obesity-physical-activity-and-diet/england-2020.

Mental health

The Department of Health and Social Care (DHSC) fund two large scale mental health prevalence surveys from NHS Digital, which provide comprehensive data on the mental health and wellbeing of adults and children and young people in England. A follow-up survey to the children and young people's mental health prevalence survey to show the impact of Covid-19 was published in 2020. The latest results of these surveys are available at:
https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017
https://www.gov.uk/government/statistics/mental-health-of-children-and-young-people-in-england-2020-follow-up-to-the-2017-survey

The Government embarked on a major transformation programme in 2016 through the Five Year Forward View for Mental Health which set ambitions to improve mental health services up to 2020/21. Several reports were published on implementing the Five Year Forward View which are available at:
https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

Outcomes of the Five Year forward View after one year are available here: https://www.england.nhs.uk/wp-content/uploads/2017/03/fyfv-mh-one-year-on.pdf

Outcomes reported in the Dashboard (Jan-March 2019-2020) include:

- For the first time, every general acute hospital with a consultant-led 24-hour A&E department has a liaison mental health service, with 33.1% of liaison mental

health teams operating at the Core 24 service level. 67% now operate 24/7, compared to 39% in 2016.

- The children and young people's access target of 35% by 2020/21 has already been exceeded. Based on the prevalence estimates used to establish the Five Year Forward View ambition, 36.8% of children and young people with a diagnosable condition received treatment in 2019/20. The latest data equates to a 34.7% access rate achieved against this most recent prevalence data, which still exceeds the 34% indicative national trajectory for 2019/20.
- In quarter four of 2019/20 80.5% children and young people with an eating disorder are receiving treatment within one week in urgent cases and 84.4% within four weeks for non-urgent cases. Both of these waiting time measures have increased from around 65% in the first quarter of 2016/17.
- Since April 2019, there is now a specialist community perinatal mental health service in every clinical commissioning group area of England.
- As part of 'the world's most ambitious' talking therapy programme (Improving Access to Psychological Therapies) 87.6% started treatment in less than six weeks and 49.8% moved to recovery in quarter four of 2019/20.

Available here: https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/

The NHS Long Term Plan and the NHS Mental Health Implementation Plan 2019/20-2023/24 set out the next phase on the Government's mental health transformation programme which set out further commitments to improve access to and the quality of mental health services. The report and the Mental Health Implementation Plan are available at:
https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/
https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf

NHS England and Improvement (NHSEI) publishes an NHS Mental Health Dashboard which shows the impact of these transformation programmes through key metrics: https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/

The Department of Health and Social Care commission an annual bulletin setting out key statistics on access to secondary mental health and learning disabilities and autism services.

The latest bulletin is available at:
https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/2018-19-annual-report

The Government has commitment to waiting time standards to ensure timely access to mental health services for:

- Improving Access to Psychological Therapies (IAPT) services:
- Children and Young People's Eating Disorder Services; and
- Early Intervention in Psychosis services.

The Government has also committed to testing additional mental health access services through waiting times pilots for urgent and crisis mental health care and for adults and older

adults in the community. As part of these pilots some local areas will test waiting time standards for adult eating disorder services.

The NHS Mental Health Dashboard provides data on access to services: https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/

With respect to mental health and vulnerable groups, the Government has published guidelines: https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/3-understanding-people. It is a legal requirement that access to mental health services should not be discriminatory on the basis of protected characteristics as defined by the Equality Act 2010.

Dental health care

In England there are three standard charging bands for NHS dental treatment delivered in primary care (high street dentists and community dental services) – Band A - £22.70, Band B - £62.10 or Band C - £269.30, depending on treatment required.

There is no charge for NHS dental treatment for:

- women who are pregnant, or who have had a baby in the preceding 12 months, when the course of treatment starts;
- people under 18; or those aged 19 or under and in full-time education
- people and their partners who are receiving Income-related Employment and Support Allowance (ESA), Income Support or Income-based Jobseekers' Allowance, Universal Credit or Pension Credit Guarantee Credit;
- people named on an NHS Tax Credit Exemption Certificate or a valid HC2 certificate.
- Adults on a low income may be able to get help with the cost of treatment through the NHS Low Income Scheme

Patients receiving dental treatment in an NHS hospital from the hospital dentist are exempt from dental charges. Patients receiving outpatient care from a hospital dentist are exempt from the standard NHS dental charges but charges may be applied for dental appliances such as dentures.

Scotland

Measures to reduce mortality rates

Cardiovascular Disease (Heart Disease and Stroke)

Despite a substantial reduction in the rate of death from coronary heart disease (CHD) over the last decade, it remains one of the leading causes of death in Scotland. In 2018, there were 6,615 deaths in Scotland where CHD was the underlying cause[29].

[29] NHS National Services Scotland, Scottish Heart Disease Statistics Year ending 31 March 2019, published January 2020, available at https://beta.isdscotland.org/find-publications-and-data/conditions-and-diseases/heart-disease-and-blood-vessels/heart-disease-statistics/, accessed 22nd October 2020

Treating and preventing heart disease is a national clinical priority for Scotland. Our priorities and actions to deliver improved prevention, treatment and care for all people living with and affected by heart disease in Scotland are set out in the 2014 Heart Disease Improvement Plan[30].

In 2015 Scottish Government published The Out-of-Hospital Cardiac Arrest (OHCA) strategy, which was developed in collaboration with a range of stakeholders and established the Save a Life for Scotland partnership to deliver against the strategy.

To date, the Save a Life for Scotland partnership has equipped 640,790 people in Scotland with CPR skills. Prior to the development of the strategy, bystander CPR was received by 41% of people who had an OHCA and 1 in 20 people survived to leave hospital. The most recent report against the strategy shows that this has improved to 56% of people who have an OHCA receiving bystander CPR, and 1 in 12 people surviving to leave hospital[31].

In 2019, the Scottish Government committed to the development of a Women's Health Plan. Cardiac disease in women was included as a key pillar in this plan to address the known disparities in outcomes from heart disease for women.

Over the period 2016 – 2018 the under 75 (premature) age standardised mortality rate for coronary heart disease declined by 6% (2016 – 96.1, 2018 – 90)[32].

Treating and preventing stroke is a national clinical priority for Scottish Government. Our priorities and actions to deliver improved prevention, treatment and care for all people living with and affected by stroke in Scotland are set out in the 2014 Stroke Improvement Plan[33].

Key actions have included a public campaign to raise awareness of stroke symptoms (Face Arm Speech Time (to call 999) (FAST)) and the need to seek emergency medical care the development and measurement against the Stroke Care Bundle to ensure the delivery of vital elements of stroke care across Scotland (access to a stroke unit, swallow screen test, CT scanning and aspirin).

Measurement against access to stroke care units and to the full stroke care bundle is monitored and improvement has been demonstrated. In 2019, bundle compliance was 64% across Scotland, an improvement on 59% in 2018[34]. Some previous analyses suggest that

[30] https://www.gov.scot/publications/heart-disease-improvement-plan/pages/4/
[31] Scottish Government, Scottish Out of Hospital Cardiac Arrest Data Linkage Project: 2017/2018 results, 2019, available at https://www.gov.scot/publications/scottish-out-hospital-cardiac-arrest-data-linkage-project-2017-18-results/, accessed 23rd October 2020
[32] National Records of Scotland, Age-standardised Death Rates Calculated Using the European Standard Population, Last updated: 22 August 201, Table 2: Under 75, age-standardised death rates for all causes and certain selected causes, Scotland, 1994 to 2018, available at https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/age-standardised-death-rates-calculated-using-the-esp, accessed 26th October 2020
[33] https://www.gov.scot/publications/stroke-improvement-plan/
[34] Public Health Scotland, Scottish Stroke Improvement Programme: 2020 National Report, 2020 available at https://www.strokeaudit.scot.nhs.uk/Publications/Main.html, accessed 23rd October 2020

increased access to stroke unit care and adherence to the stroke bundle may have contributed to reduced mortality[35,36]

The 2019-2020 Programme for Government committed to the development of a programme to improve stroke pathways and services, including prevention, treatment and care. To do this Scottish Government will; appoint a Specialty Adviser to the Chief Medical Officer on Stroke Care, review and improve the current stroke care bundle to improve outcomes for patients, collaborate across government on stroke prevention and raising awareness of the signs of stroke, begin work to scope out and define what a progressive stroke unit looks like, and ensure that a national planning framework is in place for a high quality and clinically safe thrombectomy service.

Over the period 2016 – 2018 the under 75 (premature) age standardised mortality rate for cerebrovascular disease (including stroke) declined by 10% (2016 18.7, 2018 – 16.8)[3].

Respiratory diseases

Respiratory illnesses present commonly to primary care teams, and represent over one third of acute medical intake in most Scottish hospitals. The ageing population, advances in primary and secondary prevention of cardiovascular diseases, and improvements in acute and chronic management for respiratory complaints means the pressures placed on secondary care respiratory units is far greater than ever before. Ensuring people see the right health care professional, in the right setting, at the right time, continues to be demanding. Scotland faces challenges of prioritisation of those people with serious illnesses; providing access to diagnostic testing to allow primary care clinicians to make independent decisions about their patients; streamlining referral pathways; and providing high quality ongoing care for people with chronic respiratory disease.

Pulmonary malignancy is a clinical priority covered by other guidance. Of the other respiratory complaints asthma, COPD, idiopathic pulmonary fibrosis, bronchiectasis and obstructive sleep apnoea syndrome make up the majority of the workload of respiratory physicians in Scotland. Although each presents its own challenges, there are problems common to all respiratory conditions. There is a strong evidence base for these conditions, and straightforward measures that can be taken to improve outcomes.

In October 2020, the Respiratory Care Action Plan for Scotland was published. Our vision is that everyone with a respiratory condition will be able to access the care and support they need to live well, on their own terms.

A draft plan went out for consultation in December 2019 and ran until July 2020. The plan was redrafted after a significant period of consultation and to ensure it reflects the current situation of Covid-19.

[35] Turner M, Barber M, Dodds H, Murphy D, Dennis M, Langhorne P, Macleod MJ on behalf of the Scottish Stroke Care Audit. Implementing a Simple Care Bundle Is Associated With Improved Outcomes in a National Cohort of Patients With Ischemic Stroke. Stroke. 2015;46:00-00. DOI: 10.1161/ STROKEAHA.114.007608.

[36] Turner, M., Barber, M., Dodds, H., Dennis, M., Langhorne, P., Macleod, M. J. & Scottish Stroke Care The impact of stroke unit care on outcome in a Scottish stroke population, taking into account case mix and selection bias Audit Mar 2015 In : Journal of Neurology, Neurosurgery & Psychiatry. 86, 3, p. 314-8 5 p.

The plan details commitments, covering prevention, diagnosis, care, treatment and support for people in Scotland. The action plan will be followed by a supporting implementation Framework.

Over the period 2016 – 2018 the under 75 (premature) age standardised mortality rate for diseases of the respiratory system declined by 13% (2016- 43.3, 2018 –37.6) and for chronic obstructive pulmonary disease declined by 3% (2016 – 24.3, 2018 - 23.5)[3].

Cancer

The Scottish Government's Cancer Strategy 'Beating Cancer: Ambition and Action' was launched on 15 March 2016. There are 3 areas of the strategy which directly target improving mortality rates – prevention, early detection, and treatment.

Prevention Measures:

- A number of our public health strategies help in prevention of cancer – in particular our four delivery plans on smoking, diet and healthy weight, physical activity and alcohol.
- Invested £732,339 in the ActWell programme (a personalised breast cancer risk reduction programme offered to women attending routine breast screening clinics) between 2016-2019
- Teenage Cancer Trust (TCT) continue to roll-out their pioneering education programme to S1-S3 pupils in Scottish secondary schools. The free sessions provide pupils with information and advice about cancer, prevention and healthy living.

Early Detection Measures:

- Create new processes to capture activity and waiting times' data for diagnostic tests.
- £6 million invested in a new Diagnostic Fund to support swift access to diagnostics for people with a suspected cancer diagnosis.
- Invested £200,000 to increase MRI capacity at the Golden Jubilee National Hospital to enable NHS Boards to prioritise and manage suspected cancer patients faster.
- Invested £2,079,000 in the Detect Cancer Early (DCE) programme including review of referral guidelines and social marketing campaigns to those individuals who are most likely to present with later stage disease and less likely to participate in screening.
- Invested £500,000 in local tests of change throughout 2016-17 to add malignant melanoma to the Detect Cancer Early (DCE) Programme
- Increased the number of Nurse Endoscopists in training: 7 underwent training in 2016, 9 in 2017, 7 in 2018, and 8 in 2019.
- Invested £3 million to ensure an additional 2,000 scopes per annum on a sustainable basis to give people quicker access to vital tests and results.
- Invested a further £8.55 million in improving cancer waiting times performance
- The Scottish Referral Guidelines for Suspected Cancer have undergone an independent, clinically led review with refreshed guidelines published January 2019.

Improving Treatment Measures:

- Invested £2 million to support two further robots for prostate cancer surgery, one in Glasgow and one in Edinburgh.
- £28.6 million has been invested in the first three years of the strategy, to replace and update radiotherapy equipment.
- Funded two radiotherapy physics trainee posts over 2015-16 and 2016-17 to build capacity in radiotherapy services.
- Introduced a new gene expression profiling test for all women with breast cancer who would clinically benefit from it – Oncotyope DX.
- Invested £1,355,347 between 2016-19 enabling the Managed Services Network (MSN) to lead and deliver the improvements set out in their Teenagers and Young Adults Cancer Plan.
- Invested £1,835,054 in funded projects between 2017-2019 as directed by the National Cancer Clinical Advisory Group

Cancer death rate:
https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/age-standardised-death-rates-calculated-using-the-esp#Tables

Waiting times

Information on elective waiting times in Scotland is published quarterly by Public Health Scotland. The publication includes information on the number of patients waiting for a new outpatient appointment and for inpatient/day case treatment, by Health Board and Specialty. The latest publication covers the period January 2010 to June 2020[37]

Figures for quarter ending 31 December 2019 were published on 25 February 2020. The publication showed:

- Over 17% improvement in numbers waiting over 12 weeks for a new outpatient appointment in the quarter ending December 2019 compared with December 2017.At 31
- December 2019, over 1.9 million patients had benefited and were treated within twelve weeks since the Treatment Time Guarantee was introduced in 2012.
- There were more than 7,500 additional inpatient/day cases in calendar year 2019 than in the previous year.

The current standards and guarantees for outpatients and inpatients care in Scotland are:

- **New outpatients National Standard** - 95% of new outpatients waiting no longer than 12 weeks from referral to being seen
- **Treatment Time Guarantee (TTG)** – Following the decision to treat all eligible patients should wait no longer than 12 weeks for treatment as an inpatient or day case

Mental health waiting times

The current standard for Mental Health is as follows:

[37] https://beta.isdscotland.org/find-publications-and-data/healthcare-resources/waiting-times/nhs-waiting-times-stage-of-treatment/

- To deliver a maximum wait of 18 weeks for children and young people waiting for treatment in mental health services for at least 90% of patients.
- To deliver a maximum wait of 18 weeks from a patient's referral to treatment for Psychological Therapies for at least 90% of patients.

Information on Child and Adolescent Mental Health Service (CAMHS) and Psychological Therapies waiting times in Scotland are published quarterly by Public Health Scotland. These publications include information on the number of patients waiting for a new appointment, by Health Board and quarter. The latest publication covers the period quarter ending to June 2019 to quarter ending June 2020, and are available at the following links:

https://beta.isdscotland.org/find-publications-and-data/conditions-and-diseases/mental-health/child-and-adolescent-mental-health-services-camhs-waiting-times/

https://beta.isdscotland.org/find-publications-and-data/conditions-and-diseases/mental-health/psychological-therapies-waiting-times/

Previous quarters' publications from June 2019 onwards can also be found at the above links and pre-June 2019 data here: https://www.isdscotland.org/Publications/index.asp

Published figures on CAMHS show:

- 66.4% of patients seen in quarter ending 31 December 2019 waited less than 18 weeks for a new CAMHS appointment. This figure was 82.5% in the same quarter in 2016.
- The number of patients referred for CAMHS treatment has increased from 8,563 in quarter ending December 2016 to 9,196 in quarter ending December 2019.
- 4,353 children and young people started CAMHS treatment in quarter ending December 2016 and 3,884 in quarter ending December 2019.

Published figures on Psychological Therapies show:

- 79.0% of patients seen in quarter ending 31 December 2019 waited less than 18 weeks for a new appointment. This figure was 77.5% in the same quarter in 2016.
- The number of patients referred for treatment has increased from 25,405 in quarter ending December 2016 to 38,706 in quarter ending December 2019.
- During the quarter ending December 2016 11,393 people started treatment for Psychological Therapies and 17,160 in quarter ending December 2019.

Obesity

Overweight and obesity continues to be a significant challenge in Scotland. The 2019 Scottish Health Survey reported 66% of adults in Scotland were overweight, including obesity, with prevalence relatively stable since 2008. The proportion of children in the healthy weight range was 68% in 2019, with 16% of children in Scotland at risk of obesity. The health risks associated with carrying excess weight are severe as are the

socioeconomic impacts which is why improving diet and healthy weight in Scotland is a public health priority. The 2019 survey and previous years is available online[38].

Scotland's six public health priorities were set out in a publication in June 2018[39].

In July 2018, the Scottish Government published '*A Healthier Future: Scotland's Diet & Healthy Weight Delivery Plan'* which sets out wide ranging action to support people to eat well and be a healthy weight. It sets an ambition to halve childhood obesity by 2030 and significantly reduce diet related health inequalities. Given the complexity of the problem Scotland faces, the plan is wide-ranging with the primary focus being prevention. The plan includes both population-wide level that will benefit everyone in Scotland as well as targeted and tailored support specifically to those individuals, children and families who need it most. Actions are set out across 5 key outcomes:

- Children have the best start in life - they eat well and have a healthy weight
- The food environment supports healthier choices
- People have access to effective weight management services
- Leaders across all sectors promote healthy weight and diet
- Diet-related health inequalities are reduced.

Full details of the measures being taken forward are set out on the Scottish Government website[40].

Priority action being taken forward as part of the Delivery Plan for the period of this report to support people to be a healthy weight includes:

- In July 2018, Scottish Government published *A Healthier Future: Type 2 Diabetes Prevention, Early Detection and Intervention Framework*[41] to tackle the growing prevalence of type 2 diabetes and the significant impact this has on the lives of individuals and on our nation's health. We are now in year three of the programme to improve weight management services for people with, or at risk of, type 2 diabetes or prediabetes are investing £5 million in 2020/21 to support this work: an increase of £2 million compared to the last financial year. A process evaluation of the implementation of the framework by early adopters of the Framework is underway and will report in due course. A mandatory core dataset was introduced in October 2019 to support evaluation and ongoing monitoring of the framework interventions and outcomes.
- In July 2019, NHS Health Scotland (now Public Health Scotland, following a merger) published minimum standards for the delivery of tier 2 and tier 3 weight management services for adults and children[42]. All NHS boards are now required to deliver, or work towards delivering, weight management services in compliance with the guidance set out in these standards. Scottish Government continues to fund weight management support for adults and children annually through the Outcomes Framework. Since 2019, the Scottish Government has invested an additional £3.4 million to support the implementation of the standards for children and young people.
- In October 2018, Scottish Government consulted on detailed plans to restrict the promotion and marketing of foods that are high in fat, sugar or salt, and have little to no nutritional benefit, where they are sold to the public[43]. An independent analysis of the

[38] https://www.gov.scot/collections/scottish-health-survey/
[39] https://www.gov.scot/publications/scotlands-public-health-priorities/
[40] https://www.gov.scot/publications/healthier-future-scotlands-diet-healthy-weight-delivery-plan/pages/1/
[41] https://www.gov.scot/publications/healthier-future-framework-prevention-early-detection-early-intervention-type-2/
[42] http://www.healthscotland.scot/publications/standards-for-the-delivery-of-tier-2-and-tier-3-weight-management-services-in-scotland
[43] https://consult.gov.scot/health-and-social-care/reducing-health-harms-of-foods/

consultation responses was published in September 2019. In the Programme for Government 2020/21[44], Scottish Government reaffirmed its commitment to bring forward legislation to restrict promotions of food high in fat, sugar or salt as soon as possible. Work continues to further improve the evidence base.

- Scottish Government is investing £200,000 over a three year period from 2018/19 to support small and medium-sized enterprises in Scotland to reformulate commonly consumed products. Since 2019, a dedicated Reformulation Connector has been embedded within Food and Drink Federation Scotland to engage with food suppliers, wholesalers, local authorities, retailers and manufacturers to support reformulation and link them to existing support. 19 local champions from 16 local authorities and between 100-150 businesses have signed up to the Reformul8 project launched in January 2020. Success will be measured by comparing sales information, use of menucal and nutritional information from ingredients suppliers.
- Following an earlier consultation (November 2018- February 2019)[45], Food Standards Scotland made recommendations to Ministers in September 2019[46] to improve healthier eating out of home.

Strong accountability remains key and robust governance arrangements are in place for priority actions. Scottish Government is committed to policy and action which is grounded in the evidence. This means it will continue to evaluate actions and their impact and will consider the case for additional measures, where the evidence supports this. The changes set out in the Diet and Healthy Weight Delivery Plan are intended to have long term impacts and we recognise that this means they will take time to have a notable effect.

Given the complex and challenging nature of obesity, and shared ambitions, Scottish Government is keen to work constructively with the other UK administrations to explore the scope for possible common or aligned approaches and have supported UK-wide measures where appropriate such as the Soft Drinks Industry level and UK Reformulation Programme.

In October 2020, the Scottish Government published its latest diet and healthy weight monitoring report. It provides the latest results against the obesity indicator framework originally developed to monitor progress against our Prevention of Obesity Route Map (February 2010), now superseded by the Diet and Healthy Weight Delivery Plan and Active Scotland Delivery Plan (summer 2018)[47].

Mental Health

The Scottish Government Published a 10-year Mental Health Strategy[48] in 2017, setting out a series of actions in themes: prevention and early intervention; accessible services; physical well-being of people with mental health problems; rights, information use and planning; and data and measurement to improve the mental health of the people of Scotland. Progress on those actions has been published each year[49]

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[44] https://www.gov.scot/publications/protecting-scotland-renewing-scotland-governments-programme-scotland-2020-2021/
[45] https://consult.foodstandards.gov.scot/nutrition-science-and-policy/proposals-to-improve-the-out-of-home-environment-i/
[46] https://www.foodstandards.gov.scot/downloads/Diet_and_Nutrition_-_Recommendations_for_an_out_of_home_strategy_for_Scotland.pdf
[47] https://www.gov.scot/publications/diet-healthy-weight-monitoring-report-2020/

[48] https://www.gov.scot/publications/mental-health-strategy-2017-2027/
[49] 2018: https://www.gov.scot/publications/mental-health-strategy-2017-2027-1st-progress-report/

Action 38 of that strategy was to develop a quality indicator profile in mental health which will include measures across six quality dimensions - person-centred, safe, effective, efficient, equitable and timely. The Quality Indicator Profile for Mental Health had its second release in September 2019[50].

The Scottish Government commissioned the collection of patient-level mental health referral, treatment and outcome data in April 2019 to monitor quality and equality of access and treatment. This information is collected (under development) for Child and Adolescent Mental Health Services (CAMHS) and Psychological Therapies (PT), for which waiting times standards have been monitored since 2012. The addition of further services is under review.

Dental Health Care

Entitlement for NHS Treatment

Dental examinations are free for all patients in Scotland. NHS dental treatment is free for everyone aged under 18; those aged under 19 and in full-time qualifying education; pregnant people; nursing mothers until their baby is 12 months old; and people in receipt of the following benefits:

- Income support;
- Universal credit;
  - and had no earnings or net earnings of £435 or less; or
  - which includes an element of child and/or limited capability for work related activity and had no earnings or net earnings of £935 or less during the most recent assessment period;
- Income-related Employment and Support Allowance;
- Income-based Jobseekers Allowance;
- Pension Credit Guarantee; or
- NHS Tax Credits Exemption Certificate

For those people who do not qualify for exemption they are required to pay 80% of their dental treatment costs up to a maximum of £384 per course of treatment. People on a low income but who do not qualify for an exemption may be able to get help with the costs of their dental treatment under the Low Income Scheme. This is an income-related scheme which looks at a patient's, and their partner's, weekly income and requirements and determines how much, if anything, the patient should pay towards their health costs.

Costs of Treatment

The NHS fee structure is complex and varies considerable from patient to patient depending on the treatment required. The table below shows the examples of costs for some types of common NHS treatments. Fees are as at 1 November 2019.

Treatment	Cost
Examination	no charge
Two small X-rays	£ 5.12

2019: https://www.gov.scot/publications/mental-health-strategy-second-annual-progress-report/

[50] https://www.isdscotland.org/Health-Topics/Quality-Indicators/Mental-Health-Quality-Indicator-Profile/Publications/2019-09-17/Introduction/

Simple gum treatment (scale & polish)	£ 11.68
Small amalgam (silver) filling	£ 7.96
Large amalgam (silver) filling	£ 20.40
Root canal treatment (front tooth)	£ 43.00
Single crown (front tooth)	£ 77.36
Simple extraction (one tooth)	£ 7.32
Complete (upper and lower) dentures	£161.52

Wales

Measures to reduce mortality rates

Statistics by cause of death

Cardiovascular Disease

Heart Conditions Delivery Plan

Cancer

Cancer Delivery Plan

Respiratory Disease

Respiratory Health Delivery Plan

Waiting times

Waiting times information

Health Performance Indicators

NHS statistics

Obesity

In February 2020, the Welsh Government announced £5.5 million to help prevent and reduce obesity in Wales.

Healthy Weight: Healthy Wales Delivery Plan

Obesity in Wales Report

Mental Health

Mental Health Delivery Plan

Together for Mental Health impact assessment

Dental health Care

People in Wales are entitled to free treatment if:

- aged under 18, or under 19 and in qualifying full-time education
- pregnant or have had a baby in the previous 12 months
- staying in an NHS hospital and treatment is carried out by the hospital dentist
- an NHS hospital dental service outpatient – but they may have to pay for dentures or bridges

Also entitled if the person or partner – including civil partner – receive, or under the age of 20 and the dependent of someone receiving:

- Income Support
- Income-related Employment and Support Allowance
- Income-based Jobseeker's Allowance
- Pension Credit Guarantee Credit
- Universal Credit and meet the criteria

Also if person is entitled to or named on:

- a valid NHS tax credit exemption certificate

People on a low income may also get help based on an assessment of their circumstances (income and savings).

Those aged under 25 years plus those aged 60 and over are entitled to a free dental check-up.

The cost for dental treatment (dental charges) in Wales:

- **Band 1 course of treatment – £14.70**

  This covers a check-up/examination, and simple treatments such as diagnosis (including radiographs), preventative measures (e.g. applications of fluoride varnish or fissure sealant), and a scale and polish.

- **Urgent dental treatment – £14.70**

  This covers emergency care, such as pain relief or a temporary filling.

- **Band 2 course of treatment – £47.00**

  This covers everything listed in Band 1, plus any further treatment such as fillings, root canal work, or if the dentist needs to take out one or more teeth.

- **Band 3 course of treatment – £203.00**

  This covers everything listed in Bands 1 and 2 above, plus crowns, dentures, bridges and other laboratory work.

The proportion of out-of-pocket paid by patients in Wales

Patient charges are only paid by adults who are eligible to make a contribution to the total cost. The balance is met by the NHS. Some 61% of adults make a contribution toward their NHS dental treatment and 39% receive it free. Based on median contract payments the contribution a fee-paying patient makes to their NHS dental treatment is:

Band 1 and Urgent - 55%
Band 2 - 58%
Band 3 - 63%

Northern Ireland

Measures to reduce mortality rates

Launched in 2014, Making Life Better' (MLB) is Northern Ireland's strategic framework for improving public health. It seeks to create the conditions for individuals, families and communities to take greater control over their lives, including being enabled and supported in leading healthier lives. MLB provides strategic direction to improve health, increase healthy life expectancy, and reduce health inequalities, through strengthened collaboration in a whole system approach across the broad range of social, economic and environmental factors, which influence health and wellbeing. It recognises the impact of long-term conditions.

MLB is underpinned by a range of key policies and strategies covering areas such as obesity prevention, alcohol and drug misuse, mental health promotion, suicide prevention and tobacco use, and a range of actions are being taken forward to prevent and address these issues.

Available statistics on premature mortality:

https://www.health-ni.gov.uk/publications/health-inequalities-annual-report-2020

The Department of Health (NI) published a Diabetes Strategic Framework (DSF) in November 2016. The Framework included a 3-year action plan which aimed to improve outcomes and services for people living with diabetes or at risk of developing diabetes. A Diabetes Network has been established to support the implementation of the DSF and brings together a range of stakeholders, including health and social care professionals and people living with diabetes. Recent actions have included the development and roll out of a Diabetes Prevention Programme for people identified as at risk of developing Type 2 diabetes. The programme offers help and assistance to participants, helping them change their lifestyle, diet and physical activity with the aim of postponing and even preventing Type 2 diabetes. A regional integrated diabetes foot care pathway has also been implemented, focussed on risk assessment, foot health education, management of acute diabetic foot disease and prevention of amputations.

Cancer

Northern Ireland is in the process of developing a new cancer strategy. The Department of Health's vision is for Northern Ireland to become one of the highest performing cancer healthcare systems internationally with a reputation for delivering timely and high quality cancer care, diagnostics and treatment, innovative practice, patient survival rates which compare favourably with similar populations demonstrating a collective approach to leadership committed to providing compassionate care for patients.

The Strategy will focus on fewer people getting preventable cancers; more people surviving for longer after a diagnosis; and, improving the experience of care for cancer patients.

Respiratory Disease

Service framework for respiratory health and wellbeing.

Cardiovascular Disease

Cardiovascular health and well-being - service framework documents

Waiting times

Available statistics on waiting times:

https://www.health-ni.gov.uk/topics/dhssps-statistics-and-research/hospital-waiting-times-statistics

Obesity

The latest reported figures (Health Survey 2018/19) for levels of overweight and obesity in Northern Ireland are that 62% of adults are overweight (37%) or obese (25%). 27% of children aged 2-15 are either overweight (19%) or obese (8%). These figures are similar to those found in 2017/18 surveys. The latest short-term outcomes of the 'A Fitter Future For All 2012-2021' obesity prevention strategy were published in October 2019, with targeted measures and outcome objectives aimed across the early years, children and young people and Adults / General Population. Revised physical activity guidelines, co-produced by the Chief Medical Officers of the four UK nations, were published in September 2019, with recommended physical activity guidelines for children under 5, children and young adults from 5-18, adults aged 19 and over, disabled adults, pregnant women, post-partum women (from birth to 12 months) and older people.

Mental Health

The general indicator for the mental wellbeing of the population in Northern Ireland is GHQ12. Information on the latest figures is available on the Department of Health's website (www.health-ni.gov.uk) and on the Northern Ireland Statistics and Research Agency (www.nisra.gov.uk).

On 19 May 2020 Minister for Health launched a Mental Health Action Plan to kick start the reform of mental health services in Northern Ireland. This includes an action on an outcomes model to accurately measure the outcomes of mental health services.

Mental health services are provided based on clinical need and are available to those who need it when they are needed. The Department of Health regularly publishes statistics on mental health and learning disability services (https://www.health-ni.gov.uk/topics/mental-health-and-learning-disabilities).

On 19 May 2020 Minister for Health launched a Mental Health Action Plan to kick start the reform of mental health services in Northern Ireland. This include an action to create a new 10 year mental health strategy for Northern Ireland.

The webpage below contains comprehensive information on primary care dental services in Northern Ireland including charges for common treatments, the proportion of the dentist's fee payable by non-exempt patients and who qualifies for free treatment:

https://www.nidirect.gov.uk/articles/health-service-dental-charges-and-treatments

Dental care

Eligibility for free dental treatment

Patients get free dental treatment in Northern Ireland if they are:

- aged under 18
- aged 18 and in full-time education
- pregnant, or have had a child, within the 12 months before treatment starts
- a hospital inpatient and the treatment is carried out by a hospital dentist
- getting, or your partner gets Income Support, income-related Employment and Support Allowance, income-based Jobseeker's Allowance, or Pension Credit Guarantee Credit
- entitled to, or named on a valid tax credit exemption certificate
- a war pensioner and need the dental treatment test because of a disability which you get a war pension for
- a Hospital Dental Service outpatient
- a Community Dental Service patient

If you are a Hospital Dental Service outpatient or a Community Dental Service patient, you may have to pay for dentures and bridges.

- Health service charges and optical voucher values HC12

Low Income Scheme
If you have a low income but aren't entitled to free dental care, you might get help with the costs under the Low Income Scheme. To read about applying to the scheme, go to:

- Claim for help with health and travel costs - form HC1

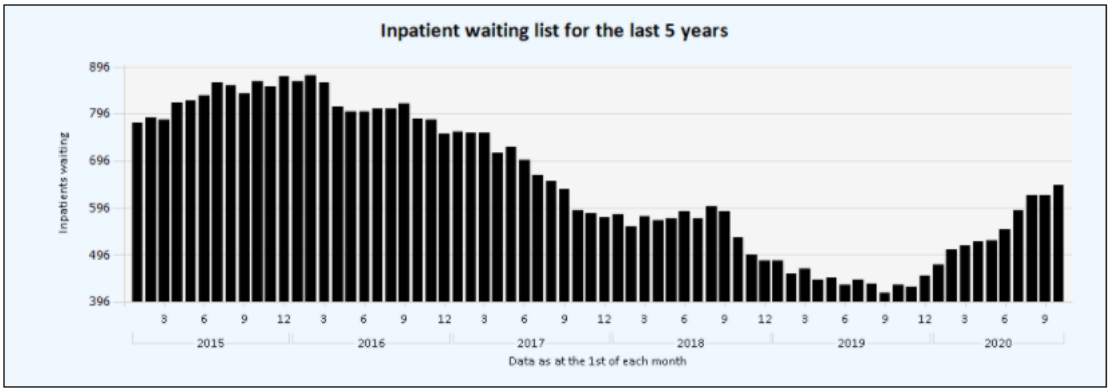
Examples of Health Service dental charges

Dental treatment/ service	Price
Examination (basic – extensive)	from £7.22 to £22.70
One x-ray	£3.53
Two x-rays	£5.03
Scale and polish	£11.46
Amalgam filling	from £7.71 to £19.84
White filling (mainly front teeth only with Health Service)	from £15.12 to £38.40
Root filling molar	£87.01
Root filling premolar	from £48.71 to £56.48
Root filling incisor or canine	£41.35
White crown on front tooth	from £76.93 to £114.66
Metal crown on back tooth	from £76.93 to £102.84
Simple extraction	from £7.13 to £43.02
Surgical extraction	from £19.84 to £49.15
Full upper and lower denture	£157.10
One full denture	£98.04
One partial denture	from £61.50 to £96.94
Denture repair	Free

Isle of Man

The Isle of Man Patient Charter does not currently identify a maximum waiting time such as RTT in the UK and therefore the systems and process used by the Department of Health and Social Care are not currently set up to record and report waiting times in a comparable way to UK approach of RTT.

Since a commitment made in 2018, work has progressed to define and agree the standards and to work towards compliance, as resources allow. The Department has given a commitment to delivering the standards and as such it has embarked upon projects such as Theatre utilisation, which will drive significant improvement to the use of theatre time.



Although significant improvements have been made over the past 5 years COVID-19 has had a significant impact on the volume of activity the Department has been able to provide in 2020. As such overall waiting times have increased.

Due to the swift action of government, the Isle of Man has been able to start its recovery plans from COVID-19 and the hospital is running at full capacity within theatres and endoscopy with operational measures in place protect staff and patients from COVID-19.

Data within the Department also remains an issue, and is constantly under review. Some cleansing data has been achieved when possible but the longer term solution is embedded in the Island's Transformation programme. This includes a robust acute clinical coding function in order to achieve reliable, fully coded data to aid development of dashboards for senior officers to make informed decisions on hospital service delivery and aid reporting and performance.

In order to address waiting times, the Department has taken the opportunity to develop the use of technology and many outpatient clinics have seen the progression of telephone appointments both on island and with the UK. The use of new technology is important to harness in the current climate of uncertainty.

The waiting times for patients on the Isle of Man are reported quarterly in line with the current measured targets and are available on line.

https://www.gov.im/about-the-government/departments/health-and-social-care/waiting-times

Data on waiting times for outpatient appointments, operations, or procedures in 2019/20 are outlined below. The Department is committed to reviewing UK waiting time targets, setting appropriate targets or the Island, and then monitoring and publishing performance data. Performance against waiting time targets is published quarterly on the Department pages of

the Isle of Man Government website under 'Waiting Times'. It aims to update waiting times within 6 weeks of the end of each financial quarter.

Isle of Man Cancer patient referrals in each of the last three years:

In the past 3 years, the following Cancer Waiting Times targets have been monitored in line with the UK targets:

- Two Week Wait – from the date the referral is received to the date of first appointment (clinic appointment or diagnostic test) - 93%.
- 62 day target – from date the referral is received to the date of first definitive treatment for those diagnosed with cancer – 85%.
- 31 day target – from date decision to treat to the date of first definitive treatment for those diagnosed with cancer – 96%.

The Two Week Wait – below is the percentage of people referred on a Two Week Wait pathway who were seen within 14 days:

2020/21 (up to 22/10/20)	69.6%
2019/20	83.0%
2018/19	79.7%

The 2 Week Wait target had started to improve with regular comprehensive reporting of our breach position with a weekly report. However, currently the breach position has been affected by COVID-19 related delays, for example:

- Endoscopy suspension during COVID has led to a backlog of appointments to be accommodated for Colorectal and Upper GI suspected cancer referrals – all patients are being seen but not within the 14 period.
- A significant increase in number of 2 week waiting referrals, previously 50 a week to now 80 plus referrals a week.

The 31 day target – below is the percentage of patients who commenced their first definitive treatment within the 31-day DTT target:

2020/21 (Quarter 1)	80%
2019/20	87%
2018/19	93%
2017/18	93%

The 62 day target – below is the percentage of patients who commenced their first definitive treatment within the 62-day RTT target:

2020/21 (Quarter 1)	75%
2019/20	68%
2018/19	73%
2017/18	82%

Factors which affect the delivery of the Two Week Wait are reflected overall in the 31 day and 62 day target performance. All Cancer Waiting Times targets are subject to fluctuation due to the figures being based on percentages of a smaller number of suspected cancers compared with a bigger UK NHS Trust. For example, Noble's Hospital received 297 Two

Week Wait referrals across reporting specialities during August 2020, whereas Liverpool University Hospitals NHS Foundation Trust received 2,034 against their Two Week Wait standard (based on NHS England provisionally published Cancer Waiting Times for August 2020).

Obesity

Overweight Summary Isle of Man (Source: Public Health (Isle of Man))

	Sex	Period	%	Lower CI	Upper CI
% of reception children overweight or obese	All	2018/19	24.4	21.5	27.6
% Adults overweight or obese (2016 Health and Lifestyle Survey)	All	2016	61.3	59.0	63.5

Weight Management Strategy was consulted upon in Autumn 2019 and the consultation outcome can be found here:

https://consult.gov.im/health-and-social-care/childrens-weight-management-strategy/

Mental Health

In 2019 the DHSC undertook a wide scale randomised patient survey of Community Mental Health patients mirroring the approach undertaken by the Care Quality Commission. Overall the results compared favourably with the English data. A summary of the results from the Community Mental Health Survey and action plan published in December 2019. It is the intention that the department will be undertaking this valuable exercise every two years as part of a cycle of quality improvement.

Such an approach will act as an valuable adjunct to the planned implementation of Patient Related Outcome Measures (PROMS) and Clinician Related Outcome Measures (CROMS) across the clinical pathways as a means of accurately determining and reporting on the effectiveness of Mental Health Service provision. Embedding transparent, evidenced based outcome measures across the Mental Health System is a fundamental objective for 2021.

In addition to the above the Mental Health Service (MHS) is intending to undertake a benchmarking exercise across all service areas utilising the Royal College of Psychiatrists Quality Network Accreditation Scheme. This significant piece of work which will commence in early 2021, will benchmark all community and acute services against explicit best practice guidance. It is the intention that all service areas within Mental Health will achieve full accredited status within 3 years.

The Mental Health Service (MHS) has a caseload in excess of 4500 patients (March 2020). Care and treatment are delivered in line with the stepped care model with provision outlined in the 2019/20 Mental Health and Wellbeing Plan approved by IoM Government, where treatment is determined by acuity of need and age profiles. The majority of provision is delivered within community settings with less than 1% of treatment provided within inpatient settings. The caseload remained broadly consistent with only a 2.8% increase over the reporting period April 2019 – March 2020.

The Mental Health and Wellbeing Plan (2015-2020) can be viewed using this link: https://www.gov.im/media/1353553/strategic-plan-for-mental-health-and-wellbeing-2015-2020.pdf

Suicide prevention has been, and remains, an extremely high priority for both the Mental Health Service and wider Department. The Mental Health Service plays an intrinsic role working collaboratively with key stakeholders and other departments in the advancement of approaches and interventions aimed at mitigating the risk of suicide, these include the following:-

- *Access to and promotion of evidenced based suicide awareness training*. This training which is free and available to the island community was developed by the zero-suicide alliance and is available within the governments "*are you ok campaign*"

- *Self-help support through the production of accessible evidenced based information, guidance.* A range of provision including educational videos have been prepared by local mental health practitioners aimed at increasing awareness in respect of common mental health disorders, again these are available within the "*are you ok campaign*" website https://covid19.gov.im/areyouok

- *Broadening of the existing Community Wellbeing Service*. aimed at significantly increasing the availability of psychological therapies in respect of individuals experiencing low to moderate common mental health problems. This primary care based early intervention model will offer a range of psychological therapies that are evidenced based, delivered in timely manner and subject to rigorous outcome measure.

- *Access to on line counselling*. A pilot aimed at delivering on line counselling/therapy for adults and children has been extended by an additional period in order to harvest additional data on its efficacy. It is anticipated that this provision will provide valuable, additional resource for those experiencing lower level common mental health problems.

- *Access to a dedicated mental health police liaison response.* It is widely acknowledged that individuals experiencing mental health difficulties are disproportionately over represented within the criminal justice system. The realisation of a dedicated resource in 2019 offers proactive joint assessment for individuals suspected of experiencing mental health difficulties at point of contact in the community and in police custody. This collaborative early intervention approach affords timely assessment and where indicated access to the appropriate care or treatment pathway.

- *Planned implementation of a Suicide Rapid Response Group*. This evidence based innovative approach has two key components. The first surrounds the collection of data about individuals who have died suddenly by suspected suicide in order to provide early identification of themes such as emerging methods/locations, clusters or high risk groups. The second revolves around the rapid identification of contacts

associated with the deceased in order to offer prompt psychological intervention and access to services. It is anticipated that this approach will go live in January 2021.

Dental Health Care

The provision of free dental treatment is set out in NHS Dental Services Regulations 2015 and in that respect patient groups exempt from NHS dental charges are set out below:

- You are under 16
- You are aged under 19 and in full-time education
- You are pregnant or have had a baby in the last 12 months
- You have reached state retirement age
- You, or your dependent, receive Income Support
- You receive Income Based Job Seekers Allowance or Employed Persons Allowance
- You are a war disablement pensioner
- You are registered blind

There is no charge for writing a prescription (although the usual charges apply when prescriptions are dispensed) or removing stitches or repairs to dentures. In addition, patients not falling within the above categories may be able to get help with the cost of NHS treatment on low income grounds. In terms of treatments available, there are many treatment options available under the NHS and charges are made to patients for their treatment on a banded system –

Band 1 (for example examinations, X-rays) £18.50 NHS charge,

Band 2 (everything in Band 1 plus fillings or basic root canal treatment etc) which is £50.50; and

Band 3 (everything in bands 1 and 2 plus higher level treatment such as crowns and dentures) at an NHS cost of £219.00.

Paragraph 2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;

a) Please provide 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 (life-long or ongoing) and in schools. Please also provide information about awareness and education in respect of sexual orientation and gender identity (SOGI) and gender violence

England

The Department of Health and Social Care published a Prevention Green Paper[51] in 2019, which set out measures for preventing poor mental health and promoting good mental health and wellbeing.

The report is available at: https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document

Public Health England (PHE) also launched the Prevention Concordat for Better Mental Health, which is underpinned by an understanding that taking a prevention-focused approach to improving the public's mental health is shown to make a valuable contribution to achieving a fairer and more equitable society. The Concordat promotes evidence-based planning and commissioning to increase the impact on reducing health inequalities. The sustainability and cost-effectiveness of this approach will be enhanced by the inclusion of action that impacts on the wider determinants of mental health and wellbeing, such as building the capacity and capability across the workforce to prevent mental health problems and drawing on the expertise of people with lived experience of mental health problems.

The Concordat is available at: https://www.gov.uk/government/publications/prevention-concordat-for-better-mental-health-consensus-statement/prevention-concordat-for-better-mental-health

In Health Education, there is a focus on avoiding the damaging effects and risks of drugs and alcohol. Drug and alcohol education is also a statutory subject in maintained schools as part of the national curriculum for science in key stage 2 and key stage 3.

The Cross-Government Suicide Prevention Strategy was updated in 2017 to include an additional key area for action to address self-harm as an issue in its own right.

The update to the Strategy is available at: https://www.gov.uk/government/publications/suicide-prevention-third-annual-report.

The Government published an Online Harms White Paper[52] in 2019 which set out the regulatory framework to improve safety of people online. Within these online harms, the

[51] A Green Paper is a preliminary report of government proposals that is published for the purposes of public consultations.
[52] White Papers are policy documents produced by the Government that set out proposals for future legislation.

actions aim to address potentially harmful suicide and self-harm content: https://www.gov.uk/government/consultations/online-harms-white-paper

Waiting time standards have been implemented to ensure that children and young people have timely access to eating disorder services and a commitment made to testing new waiting time standards for adult eating disorder services. The Public Health Service Ombudsman (PHSO) published a report into eating disorders which made recommendations to Government for improving the prevention and treatment of eating disorders. The Government published its response to the PHSO in 2019. The PHSO report and the Government's response are available at:
https://www.ombudsman.org.uk/publications/ignoring-alarms-how-nhs-eating-disorder-services-are-failing-patients
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/824522/pacac-inquiry-into-eating-disorders-government-response-print-ready.pdf

The UK Government's Strategy is clear in its commitment to reducing the number of young people using drugs. The approach combines universal action with targeted action for those most at risk or already misusing drugs and includes investing in a range of evidence-based programmes. These have a positive impact on young people and adults, giving them the confidence, resilience and risk management skills to resist drug and alcohol misuse. Examples include:

The online resilience building resource, 'Rise Above', aimed at 11- to 16-year-olds, provides resources to help develop skills to make positive choices for their health, including avoiding drug use.

Talk to FRANK: the Government's drugs information and advice service which provides information and advice to young people and to parents, to help them protect their children from drug and/or alcohol misuse;

Every Mind Matters: a PHE set of resources to help teach PSHE (Personal, Social, Health and Economic education) and RSHE (Relationships, Sex and Health Education) to Upper KS2, KS3 and KS4 students, with flexible, ready-to-use content co-created with teachers, and young people.

PHE has developed its role in supporting local areas: sharing evidence to support commissioning and the delivery of effective public health prevention activities; and launching toolkits to support local areas' responses on specific issues around new psychoactive substances and other drug groups.

Sex education has been compulsory in all maintained secondary schools since 1993. Academies and free schools were not required to teach sex education but were encouraged to do so. When teaching sex education, schools were required to have regard to the statutory sex and relationship education guidance which was last updated in 2000.

Sex and health education was often taught as part of personal, social, health and economic education (PSHE). This subject is still mandatory in independent schools but was never mandatory in state-funded schools.

From September 2020 relationships education became compulsory in all primary schools, relationships and sex education (RSE) became compulsory in all secondary schools, and health education became compulsory in all state funded schools. As part of RSE, pupils are

taught about intimate and sexual relationships including facts about reproductive health and sexually transmitted infections. Sexual orientation and gender identity should be explored at a timely point during secondary education and in a clear, sensitive and respectful manner. When teaching about these topics, it must be recognised that young people may be discovering or understanding their sexual orientation or gender identity.

Northern Ireland

The Public Health Agency (PHA) in Northern Ireland was established in 2009 as part of the reforms to Health and Social Care (HSC) in Northern Ireland. It is the major regional organisation for health protection and health and social wellbeing improvement. Its role also commits it to addressing the causes and associated inequalities of preventable ill-health and lack of wellbeing. It is a multi-disciplinary, multi-professional body with a strong regional and local presence.

The statutory curriculum in Northern Ireland includes Personal Development throughout all 12 years of compulsory education. Personal Development is a process that involves the world of the young person. In this subject strand, pupils have opportunities to explore a range of topics and develop Whole Curriculum Skills and Capabilities. Pupils learn about:

Self-Awareness
Personal Health
Relationships.

Personal Development encourages pupils to become personally, emotionally, socially and physically effective, and to lead healthy, safe and fulfilled lives. It also encourages them to become confident, independent and responsible citizens, making informed and responsible choices and decisions throughout their lives.

The Department of Education requires all grant-aided schools to develop their own policy on how they will address Relationships and Sexuality Education (RSE) within the curriculum. A school's policy should reflect the school's ethos and should be subject to consultation with parents and pupils and endorsed by the Board of Governors.

The curriculum guidance outlines the importance of RSE, the partnership approach needed for effective delivery of RSE (including the need for engagement with parents), the inclusive approach that is required (covering sexual orientation/gender identity) and the importance of the classroom environment.

The Wellbeing Hub shows how the Northern Ireland Curriculum promotes the learning and development of skills that support pupils' wellbeing and mental health. It also supports the Emotional Health and Wellbeing Framework for Children and Young People in Education that's being developed collaboratively by the Departments of Education and Health, the Public Health Agency, the Health and Social Care Board, and the Education Authority (EA). https://ccea.org.uk/learning-resources/wellbeing-hub

Scotland

Sexual Orientation and Gender Identity and gender violence

Generally, the Scottish Government wants to ensure all young people, no matter their sexual orientation or identity, are respected and receive the support they need to make informed choices for themselves. Relationships, sexual health and parenthood (RSHP) education is an integral part of the health and wellbeing area of the Scottish curriculum, and it is for local authorities and schools to decide how the curriculum is delivered based on local needs and circumstances. The Scottish Government published guidance for teachers on RSHP education in 2014 which encourages equality and mutual respect from an early age and supports teachers to deal with issues effecting transgender people in Scotland's schools. This guidance is also clear RSHP education must speak to all children and young people, and be inclusive of their identities and characteristics and the diverse family circumstances in which they grow up. The Scottish Government asks teachers to work closely with parents in the delivery of RSHP education, by discussing proposed lessons and resources with them in advance to ensure children and young people gain knowledge appropriate to their age and stage of education. In September 2019 a national RSHP online resource was launched with age appropriate material for ages 3 -18 for teachers to support consistent RSHP education across Scotland. The resource is continuously updated and contains material on healthy relationships, gender equality, bodily autonomy, consent and sexual exploitation. Material for children and young people with additional support needs is currently under development and will be added to the resource.

On LGBTI equality, the Scottish Government has accepted, in full, the 33 recommendations of the LGBTI Inclusive Education Working Group to embed LGBTI inclusion across the curriculum. The Scottish Government are working in partnership with COSLA to deliver a joint action plan setting out the key milestones to deliver the accepted recommendations by May 2021. An implementation group has since been established, having met multiple times since its inception in January 2019, and continues to do so regularly. The group has agreed to a proposal to take forward complementary work to develop resources for schools on Intersex outwith the Group. This was due to the Group agreeing that more specialist knowledge on this issue was outwith the group's expertise. The Scottish Government is also committed to reviewing and updating guidance for supporting young trans people in schools.

On gender based violence, the Scottish Government funds the Rape Crisis Scotland (RCS) Sexual Violence Prevention Programme. RCS Prevention Workers work with schools to deliver sessions to secondary school students on topics such as body image, sexism, consent and the law, media representations of gender and sexual violence. Since 2016 the programme has worked with over 48,000 young people. In May 2019 Scottish Government published Healthy Relationships and Consent: key messages for young people aged 11-20, a resource for all professionals working with young people to deliver consistency of messaging around these topics. An Easy Read version for young people with additional support needs and one for children ages 3-11 are currently under development. Scottish Government is working with Young Scot on an online resource for young people on different forms of gender based violence, named That's Not Ok. The resource contains multiple scenarios of different forms of gender based violence and signposts to support services. It has been co-designed with young survivors of gender based violence and will be formally launched in November 2020. A Gender based violence/sexual harassment in schools Short Life Working Group 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/sexual harassment. Existing work in schools on anti-bullying as well as learning within the curriculum on safe and healthy relationships, as part of relationships, sexual health and parenthood education, will complement work towards this commitment.

Sexual and reproductive health education

The Scottish Government continues to support work to educate and raise awareness around positive sexual health, through Government, NHS and Third Sector awareness and information campaigns. For example, the Key Messages for Young People on Healthy Relationships and Consent, a resource for professionals, was published in 2019 and provides professionals working with young people (secondary to young adults) consistent communication tools on the topics of healthy relationships and consent.

The Scottish Government has funded a 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 BBV and different methods of contraception amongst young people with learning difficulties.

The Scottish Government also funds the Sexual Health Scotland website[53], which provides a source of information and advice, and signposting to local services, to young people in all parts of Scotland.

The Pregnancy and Parenthood in Young People strategy[54] (published March 2016) promotes sexual health, relationship and parenthood education for all young people. This is supported in schools through relationships, sexual health and parenthood education which is an integral part of the health and wellbeing curriculum.

Alcohol, drugs and smoking prevention education

Rights, Respect and Recovery is Scotland's strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths. The Scottish Government considers that based on the evidence a new approach is required to universal substance use education for young people in schools. The Scottish Government is committed to revising and improving the programme of substance use education in schools to ensure it is good quality, impactful and in line with best practice. The Scottish Government will develop education-based, person-centred approaches that are delivered in line with evidence-based practice to aim to reach 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.

Scottish Government's Alcohol Framework 2018: Preventing Harm[55] sets out 20 actions to prevent and reduce alcohol-related harms across the Scottish population. Scotland's approach is aligned with the World Health Organization's approach of placing the three prevention 'A's' front and centre: Affordability, Availability and Attractiveness. Key actions include 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.

Smoking is the largest single cause of avoidable harm and death in Scotland – accounting for a quarter of all deaths. The Scottish Government has set a target to have created a

[53] https://www.sexualhealthscotland.co.uk/
[54] https://www.gov.scot/publications/pregnancy-parenthood-young-people-strategy/
[55] https://www.gov.scot/publications/alcohol-framework-2018-preventing-harm-next-steps-changing-relationship-alcohol/https:/www.gov.scot/publications/alcohol-framework-2018-preventing-harm-next-steps-changing-relationship-alcohol/

tobacco-free generation by 2034. So our current action plan[56] to tackle the harms from smoking focuses on protecting children and young people from smoking or from being exposed to the smoking of other people. Exposure to second hand smoke increases a non-smoker's chances of developing cancer by 20%. Education plays a large part in our action plan. The majority of 11-13 year old's in Scotland report that they have received education on the harms of smoking as part of their school's curriculum already, but officials from other subjects such as diet, alcohol and drugs are working together to improve the range of educational tools available to schools, clubs, parents, guardians and carers who already are heavily involved in raising awareness about the harms of smoking amongst young people.

Wales

Public Health Wales works to protect and improve health and well-being and reduce health inequalities for the people of Wales.

The Welsh Government provides guidance and services on health and well-being in schools:

Emotional health and well-being in schools: Guidance to help schools promote emotional health and well-being in children and young people.

Substance misuse education: guidance: Advice on good practice for teaching and dealing with substance misuse.

Emotional health and well-being: best practice in schools and early years settings: Guidance on how to promote wellbeing and support pupils with mental health problems.

Responding to issues of self-harm and thoughts of suicide in young people: Guidance for adults who work with children and young people.

Child and adolescent mental health services (CAMHS) and the counselling service: Guidance on their services and how they can work together to provide the most appropriate treatment.

Existing guidance on sex and relationships in education can be found here. It states that it is important that young people recognise diversity and show respect for others regardless of their sexual orientation. Teachers should deal with matters of sexual identity or sexual orientation honestly, sensitively and in a non-discriminatory way, answer appropriate questions and provide factual information. Schools should liaise closely with parents/carers when developing their sex education policy to reassure them of the content of the SRE programme and the context in which it will be presented.

The Welsh Government has consulted on revised draft guidance to provide teachers and school staff with practical support to build high quality provision of Relationships and Sexuality Education as part of a "whole school approach".

Isle of Man

[56] https://www.gov.scot/publications/raising-scotlands-tobacco-free-generation-tobacco-control-action-plan-2018/

Health Education in the IOM is provided in line with the Child Health Programme 0-19 years by the School Nursing and Health Visiting Service. This is inclusive of:

Sexual health education - Focus on risk reduction, with accurate information about the risks of unprotected sex and how to avoid them. To empower pupils with a focus on increasing knowledge, understanding, developing skills and exploring attitudes. Offer a positive and open view of sex and sexuality,

Support sexual self-acceptance. Reinforce value messages appropriate to the pupils' age and experience, for example, promoting delay in first intercourse for younger ages, but emphasising condom use for older groups who are more likely to be sexually active already. Play a part in ensuring that children and young people have a critical awareness of the messages that are portrayed in the media. Delivering of essential sex and relationships education (SRE) and Safeguarding children against sexual exploitation

Reduce incidence of self-harm and its impact, risk taking behaviours, Provision of advice and support to promote a healthy lifestyle. In partnership with specialist services ensure health promotion on appropriate topics is offered as part of the health promotion. Smoking cessation, drug and alcohol advice, reduction of mental health distress.

Promoting Healthy Weight - measuring of children and promoting healthy weight and preventing obesity. Reduction in obesity levels and underweight children. Increase physical activity and healthy eating. Early detection and support for children with eating disorders. Liaise with specialist services and refer as needs indicate.

In the IOM the majority of health education work in the Department of Education, Sport and Culture's schools is delivered through Personal, Social, Health, Economic (PSHE) Education. The Education (Curriculum) Order 2011 includes PSHE (e.g. health, careers, citizenship) under prescribed curriculum general principles for all pupils of compulsory school age. Within PSHE, core topics such as Relationships and Sex Education, Drugs and Alcohol Education, Mental Health, E-Safety and Wellbeing are covered.

PSHE is part of the universal offer in Manx schools. All pupils receive PSHE education, it is not directed to specific individuals or intervention groups. A variety of teaching strategies are adopted and a range of activities planned aimed to increase participation and engagement of pupils. PSHE provision in schools is organised in different ways including discrete lessons, Drop Down Days, cross curricular delivery through other subjects as well as tutor programmes, or a combination of these. Each school has adopted a model that works for their individual school context, meeting the specific needs of their pupils. The pedagogical approach to this is gaining understanding and knowledge, managing risk and making informed choices.

In addition to PSHE, health education content is covered through other subjects including Physical Education, Science and Citizenship.

Paragraph 2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;

b) Provide information on measures to ensure informed consent to health-related interventions or treatment and on specific measures to combat pseudoscience in respect of health issues.

United Kingdom

Consent

The UK Doctors' Regulator, the General Medical Council, published updated guidance on decision making and consent in 2020. It promotes shared decision making as the key to ensuring people receive the treatment and care that they need, based on what matters to them, and ensuring they have all the information they need to give informed consent.

Consent to treatment is the principle that a person must give their permission before they receive any type of medical treatment. Consent is required from a patient regardless of the treatment. The principle of consent is an important part of medical ethics and international human rights law. For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision.

For treatment, consent is usually verbal – citizens will be asked to say whether they agree to any examination or treatment. If the examination or treatment is complicated, for example an operation, they may be asked to sign a form showing they agree to it.

There are a few exceptions when treatment can go ahead without consent from the patient. In an emergency – for example, if a patient cannot give their consent and there is no time for anyone else to make a decision for the individual, doctors can treat them. But they can only do so if this is necessary to save the person's life or stop the person from suffering more serious harm.

When consent to treatment is required, it applies to all organisations involved in the provision of that particular treatment

The Mental Health Act 1983 Code of Practice 2015 provides guidance to NHS-funded mental health providers that wherever possible consent for treatment should be sought from patients, this includes provisions for patients to make advanced statements of their choices and preferences. The Code of Practice is available at: https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

The Department of Health and Social Care commissioned an independent review of the Mental Health Act 1983 to improve the dignity and choices of people detained or liable to be detained under the Act. The independent review published a report in 2018 which made over 150 recommendations to Government for improving the Act: https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

The independent review made several recommendations to Government for ensuring a patient's ability to consent whether or not they have capacity and including through advance

statements on choice and preferences is strengthened. the Department of Health and Social Care will publish a response to the independent review of the Mental Health Act 1983 in due course.

With respect to pseudoscience, specialist units across the UK Government have been working at pace to combat false and misleading narratives about coronavirus, ensuring the public has the right information to protect themselves and save lives.

The UK Government has also campaigned on the importance of the measles, mumps and rubella vaccination to counter myths concerning it, for example.

The NHS provides advice on complementary and alternative medicines: https://www.nhs.uk/conditions/complementary-and-alternative-medicine/

Scotland

The Scottish Government recognises that some complementary and alternative medicines services, such as homeopathy, may offer relief to some people suffering from a wide variety of conditions.

It is the responsibility of clinicians, in consultation with their patients, to discuss and agree the best treatment options based on individual clinical need and It is for individual NHS Boards to decide if and which alternative services they make available based on national and local priorities and the needs of their resident populations

The efficacy of alternative services and safety of practitioners outside of conventional healthcare professions are not all subject to statutory regulation. Careful consideration should always be given to potential risks prior to undertaking any unregulated alternative services.

Northern Ireland

Regarding pseudoscience – commissioned services in Health and Social Care (HSC) are in line with best evidence based practice e.g. National Institute for Clinical Excellence guidance. Clinical staff working with HSC are all required to be registered with the relevant authority (HCPC/GMC/Nursing and Midwifery Council) and work within the scope of practise as defined by their professional registration

Isle of Man

Measures to ensure informed consent to health related interventions or treatments in the IOM mirror what is expected of the professionals who seek such consent within the UK NHS. Seeking consent is the clinician's or healthcare professional's responsibility and it is recognised that this is just not a paperwork process. Patients are provided information through various formats about risk in order make an informed decision, including the ability to discuss with the clinician and or healthcare professional the patient's views and preferences, and the outcomes they're most concerned about. The principle of consent is an important part of medical ethics and international human rights law which is applied on Island.

Paragraph 2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;

c*) Please provide responses to comments and queries from 2017 conclusions (see extracts of the full conclusions attached to the commissioning email for the context):*

i. *It asks confirmation in the next report that the above mentioned subjects are covered by the school curriculum throughout the United Kingdom.*

ii. *The Committee asks for updated information in the next report on the concrete measures and campaigns undertaken in England, Scotland, Wales, Northern Ireland and the Isle of Man.*

iii. *It asks updated information on the available screening programs for pregnant women and their frequency throughout the United Kingdom.*

iv. *The Committee asks that the next report provide updated information on the screening programmes for the population at large available in England, Scotland, Wales, Northern Ireland and the Isle of Man.*

England

Education and awareness raising

We want to support all young people to be happy, healthy and safe. We want to equip them for adult life and to make a positive contribution to society. That is why, we have made Relationships Education compulsory for all primary school pupils, Relationships and Sex Education (RSE) compulsory for all secondary school pupils, and Health Education compulsory for pupils in all state-funded schools.

As part of RSE pupils should be taught the facts about reproductive health, including fertility, and the potential impact of lifestyle on fertility for men and women and menopause and how to get further advice, including how and where to access confidential sexual and reproductive health advice and treatment. This subject also covers how the different sexually transmitted infections (STIs), including HIV/AIDs, are transmitted, how risk can be reduced through safer sex (including through condom use) and the importance of and facts about testing. Pupils are also taught about human reproduction, including contraception and sexually transmitted infection, as part of the secondary science curriculum.

In Health Education, there is a strong focus on mental wellbeing, including a recognition that mental wellbeing and physical health are linked. The topics covered in health education include: mental wellbeing; internet safety and harms; physical health and fitness; healthy eating; drugs, alcohol and tobacco; health and prevention and; basic first aid.

Heath is covered throughout the science programmes of the National Curriculum in England. Pupils are taught about topics including health eating and the impact of drugs, diet and exercise on health at both primary and secondary level. In secondary science, they are also taught about the impact of smoking on lung function. Health eating and nutrition is also

covered through the cooking and nutrition strand of the design and technology programme of study. This includes understanding and applying the principles of a healthy diet to cooking.

Road safety is currently part of the Citizenship curriculum at key stage 1. The THINK! Campaign is the Government's road safety campaign.

The Change4Life campaign was launched in 2009 and encourages children and families to eat well and be more active. The campaign supports the Government's childhood obesity agenda. As well as advertising, the campaign is supported with digital assets, including the highly successful Food Scanner app, a website, email programmes and a schools and partnership programme, to ensure year-round support for parents. Change4Life has enjoyed considerable success and unparalleled levels of engagement. Since its launch, more than four million people have signed up and it now has more than 200 national partners. Further details are available at: https://www.nhs.uk/change4life

Start4Life is a Public Health England national programme. It was designed to support children's "first 1,000 days", by encouraging and supporting parents-to-be and families with babies and young children to build parenting skills and set healthy habits right from the outset, to give their children the best start in life. The programme provides trusted NHS advice and practical guidance to drive parental understanding of the critical early days, with support around key topics to deliver behaviour change, including breastfeeding, vaccinations, weaning and perinatal mental health. Start4Life provides information and support through a number of high performing digital tools: the Start4Life website with over 300,000 visitors each month; social media channels with over 90,000 followers, and the flagship email programme (Information Service for Parents) with more than 4,000 new subscribers each month.
Further details are available at: https://www.nhs.uk/start4life

"Tackling obesity: empowering adults and children to live healthier lives", launched in July 2020, demonstrates an overarching campaign to reduce obesity, takes forward actions from previous chapters of the childhood obesity plan, including our ambition to halve the number of children living with obesity by 2030, and sets out measures to get the nation fit and healthy, protect against Covid-19 and protect the NHS.

In support of the obesity strategy, the Department of Health and Social Care launched Better Health, a new campaign to provide adults with the right tools and encouragement to help them 'reset' and introduce changes to improve their health. The campaign launched in July 2020 with a focus on helping those who are overweight or living with obesity to lose weight. The national campaign targeted adults - with a particular focus on high-risk groups – and was activated through a broad mix of media channels, including television, radio, video on demand, social media, digital, out of home advertising and partnership activity.

Better Health offers tools and support to those looking to lose weight, including the NHS 12-week weight loss app that supports people throughout their weight loss journey, and additional tips and advice to help people understand how to make healthier food choices and get active. Further details are available at: https://www.nhs.uk/better-health/

Counselling and screening

Pregnant Women

Antenatal screening covers 17 different conditions and is offered to approximately 700,000 women in England every year.

Screening tests are offered to all pregnant women in the UK for free. By offering screening tests, such as ultrasound scans, blood tests and a questionnaire, it means that expectant women and their partners can make informed choices about their care and their baby's health.

Between 1 January 2016 and 31 December 2019 pregnant women in the UK were screened for:

- Infectious diseases (hepatitis B, HIV or syphilis), via a blood test offered in the early stages of pregnancy, ideally before 10 weeks.
- Sickle cell disease and thalassemia with a blood test ideally before 10 weeks. All pregnant women were offered a test for thalassaemia but not all women were automatically offered a test for sickle cell disease. In areas where haemoglobin diseases are less common, a questionnaire was used to identify the family origins of the baby's mother and father. If the questionnaire showed either parent had a relevant background, then a blood test was offered to the mother.
- Fetal anomaly screening for Down's syndrome, Edward's syndrome and Patau's syndrome was offered by a 'combined test' which uses a blood sample from the mother and the measurement of fluid at the back of the baby's neck. The results are combined to work out the chance of the baby having Down's syndrome, Edward's syndrome or Patau's syndrome. This test becomes available between 10 and 14 weeks of pregnancy. If a woman missed the combined test, she would be offered a quadruple test between 14 and 20 weeks of pregnancy.
- Fetal anomaly screening also included a scan between 18^{+0} and 20^{+6} weeks (often referred to as the 20-week scan) which aims to identify 11 different conditions in detail including the baby's bones, heart, brain, spinal cord, face, kidneys and abdomen.
- Women with existing diabetes were also be offered an eye test to screen for diabetic retinopathy when they present in care for pregnancy.

Further information on the timeline for antenatal screening can be found at:
https://phescreening.blog.gov.uk/2015/08/06/getting-animated-with-our-screening-timeline/

The three antenatal screening programmes which cover screening from 2016-2019 period can be found at:

Programme standards data report April 2016 to March 2017:
https://www.gov.uk/government/publications/fetal-anomaly-screening-programme-standards-data-report

Antenatal screening standards: data report 2017 to 2018
https://www.gov.uk/government/publications/antenatal-screening-standards-data-report-2017-to-2018

Antenatal screening standards data report: 2018 to 2019
https://www.gov.uk/government/statistics/antenatal-screening-standards-data-report-2018-to-2019

PHE Screening (England only) has published Key performance (KPI) data for the given periods at:
https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-and-briefings-2016-to-2017

NHS screening programmes: KPI reports 2017 to 2018
https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2017-to-2018

NHS screening programmes: KPI reports 2018 to 2019
https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2018-to-2019

Other screening

There are five young person and adult population screening programmes in the UK which Public Health England (PHE) monitors and publishes Key Performance Indicator (KPI) data reports on.

The Screening in England report includes key national figures as a high level overview for all programmes, it is available to view here: https://www.gov.uk/government/publications/nhs-screening-programmes-annual-report.

When PHE was set up in 2013 it began publishing screening standards, and the programmes and quality assurance services became one division. This means that some programmes are not included in KPI reports prior to 2013. However, comprehensive Official Statistics reports covering this period are available.

NHS Breast Screening Programme

In England, breast screening is currently offered, every three years, to women aged 50 and 71 years. The Age X research trial has investigated the effectiveness of offering some women an extra screening between 47 and 49, and one between the ages of 71 and 73, it is expected to publish its findings in 2026.

NHS Digital publishes data on breast screening.
Periods 2016-17, 2017-18, 2018-19 can be viewed at: https://digital.nhs.uk/data-and-information/publications/statistical/breast-screening-programme

NHS England is responsible for commissioning breast screening services to meet programme standards including coverage. They are committed to improving coverage and reducing variation between age groups and catchment areas.
Breast screening KPI data reports for each year can be viewed at:

- 2017/18 https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2017-to-2018
- 2018/19 https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2018-to-2019
- 2019/20 https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2019-to-2020

NHS Cervical Screening Programme

Cervical screening is available to women and people with a cervix aged 25 to 64 years. People aged 25 to 49 receive invitations every three years. People aged 50 to 64 receive invitations every five years.

In 2015/16, the United Kingdom National Screening Committee (UK NSC), the independent body that advises minsters and the NHS in the four UK countries on all aspects of population screening, recommended that human papillomavirus (HPV) should replace cytology screening as the primary screen test.

PHE collects routine data to monitor the coverage of cervical screening.
The cervical screening official statistics page is available here: https://digital.nhs.uk/data-and-information/publications/statistical/cervical-screening-programme

The cervical screening quarterly coverage and annual reports are available here: https://www.gov.uk/government/collections/cervical-screening-programme-data
Cervical screening KPI data reports for each year can be viewed at:

- 2017/18 https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2017-to-2018
- 2018/19 https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2018-to-2019
- 2019/20 https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2019-to-2020

NHS England and Improvement (NHSE/I) is responsible for commissioning cervical screening services to meet programme standards including coverage. They are committed to improving coverage and reducing variation between all age groups and catchment areas.

NHS Bowel Cancer Screening Programme
Bowel cancer screening is offered every two years to men and women aged 60 to 74 years. People older than this can request a screening kit to be sent to them every two years. In 2015/16 the UK NSC recommended that Faecal Immunochemical Test (FIT) should replace the previously used Guaiac Faecal Occult Blood Test (gFOBT).

An additional one-off test called bowel scope screening is also offered to men and women around 55 years, but in England only.

In August 2018, Ministers agreed that future bowel cancer screening in England will start at the age of 50, and PHE with NHSE/I are looking at how this can be achieved.

Bowel screening KPI data reports for each year can be viewed at:

- 2017/18 https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2017-to-2018
- 2018/19 https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2018-to-2019
- 2019/20 https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2019-to-2020

NHSE/I is responsible for commissioning bowel screening services to meet programme standards including coverage. They are committed to improving coverage and reducing variation between all age groups and catchment areas.

NHS Abdominal Aortic Aneurysm Screening Programme
Abdominal Aortic Aneurysm (AAA) screening is offered to men during the year that they turn 65 years.

In 2016 the UK National Screening Committee looked at the evidence following a proposal to see whether men screening positive for subaneurysmal aortas should be entered in a lifelong ultrasound surveillance programme. The UK NSC recommended that this should not be introduced.

AAA KPI data reports for each year can be viewed at:

- 2016/17 https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-and-briefings-2016-to-2017
- 2017/18 https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2017-to-2018
- 2018/19 https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2018-to-2019
- 2019/20 https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2019-to-2020

NHSE is responsible for commissioning AAA screening services to meet programme standards including coverage. They are committed to improving coverage and reducing variation between age groups and catchment areas.

NHS Diabetic Eye Screening Programme
Diabetic eye screening is offered to anyone with diabetes who is 12 years old or over. They are invited for eye screening once a year

Diabetic eye screening KPI data reports for each year can be viewed at:

- 2016/17 https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-and-briefings-2016-to-2017
- 2017/18 https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2017-to-2018
- 2018/19 https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2018-to-2019
- 2019/20 https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2019-to-2020

NHSE is responsible for commissioning diabetic eye screening services to meet programme standards including coverage. They are committed to improving coverage and reducing variation between all age groups and catchment areas.

Scotland

Education and awareness raising

Health and Wellbeing is one of the eight curricular areas in Scotland's curriculum, Curriculum for Excellence. Its substantial importance is reflected in its position at the centre of the curriculum and at the heart of children's learning – as well as a central focus of the Scottish Attainment Challenge and the National Improvement Framework for Education. Along with literacy and numeracy it is one of the three core areas that are the responsibility of all staff in the school.

Health and Wellbeing is not a single subject or class. It is organised into six areas:

- Mental, emotional, social and physical wellbeing;
- Planning for choices and changes;
- Physical education, physical activity and sport;
- Food and health;
- Substance misuse; and,
- Relationships, sexual health and parenthood.

Some areas are the responsibility of all staff. Others have a specific focus, with links to other health and wellbeing organisers and other curriculum areas.

Learning in Health and Wellbeing is designed to ensure children and young people develop the knowledge and understanding, skills, capabilities and attributes which they need for mental, emotional, social and physical wellbeing now and in the future. Good health and wellbeing is central to healthy human development, and schools, colleges and other learning establishments have much to contribute to its development.

For each curriculum area, Curriculum for Excellence has experiences and outcomes[57] which set out what each pupil is expected to learn and how they are expected to progress through four levels of learning. Education Scotland also developed benchmarks[58] to provide clarity on the national standards expected within each curriculum area at each level. They set out clear lines of progression across all curriculum areas from Early to Fourth Levels. Their purpose is to make clear what learners need to know and be able to do to progress through the levels, and to support consistency in teachers' and other practitioners' professional judgements. The benchmarks are designed to be concise and accessible, with sufficient detail to communicate clearly the standards expected for each curriculum level.

Substance use education work in our schools is delivered largely through Curriculum for Excellence. Children and young people learn about a variety of substances including alcohol, medicines, drugs, tobacco and solvents. They explore the impact risk taking behaviour has on life choices and health. The Scottish Government has committed to revising and improving substance use education, both in and out of school settings, to ensure it is good quality, impactful and in line with best practice.

Road Safety:
https://roadsafety.scot/learning-zone/

Alcohol
On 1 May 2018, Scotland introduced a Minimum Unit Price (MUP) for alcohol. The Scottish Government is funding a wide ranging independent evaluation programme involving a portfolio of research on price and product range; alcohol sales and consumption; alcohol related harm; and economic impact on the industry. In June 2020, Public Health Scotland published research detailing that MUP was associated with a net reduction of between 4 and 5% in off-trade alcohol sales per adult in its first year. Further research, also published by Public Health Scotland in June 2020, shows that the total volume of alcohol sales per

[57] https://education.gov.scot/education-scotland/scottish-education-system/policy-for-scottish-education/policy-drivers/cfe-building-from-the-statement-appendix-incl-btc1-5/experiences-and-outcomes/#hwb
[58] https://education.gov.scot/improvement/learning-resources/curriculum-for-excellence-benchmarks

adult in Scotland in 2019 remained at its lowest level since 1994 – for the second year running. These are encouraging early results

The Scottish Government delivered a national social marketing campaign to increase public awareness of the UK Chief Medical Officers' weekly low risk limit of 14 units of alcohol per week. The first phase ran in March 2019 for three weeks whilst the second phase ran for six weeks in January and February 2020.

Drugs

Know the Score is a Scottish Government website that is designed to provide information on drugs, including the different kinds of drugs and their effects, to providing information and anonymous support for any individual who requires it. It also has a search function to enable individuals to find support in each local area in Scotland.

The website[59] is currently being reviewed and is in the process of being updated to ensure the latest information and facts are provided with the help of the organisation We Are With You (WAWY).

Tobacco

The Scottish Government's Action Plan commits us to run marketing of some sort every year – mainly around January and march, with a major no-smoking campaign in summers in alternate years. This year's campaign had to be postponed because of the Covid-19 pandemic. However, other measures are ongoing. There has been a consultation[60] on introducing no-smoking areas around hospital buildings and legislation on this will follow shortly. The Scottish Government is also finalising research on price restrictions on tobacco similar to the minimum unit price on alcohol and researchers are also evaluating options to restrict the availability of cigarettes. Research has concluded on options to make cigarettes less attractive to young people. All of these interventions will be considered by Ministers and may form the basis for our next major piece of legislation on smoking. Local enforcement officers maintain close links with retail – providing advice on age of sale as well as enforcing the law where regulations are found to have been breached. The Scottish Government maintains a register of tobacco and e-cigarette retailers and it is an offence to sell these products without being registered.

See information on Paragraph 2 (a) for sex education, STDs and healthy eating.

Counselling and screening

Pregnant Women

In Scotland the following screening tests are offered to all pregnant women to assess the chance of the women or their baby having a health condition or chromosome condition.

- blood tests
- ultrasound scans

These are used to test for:

- blood count, blood group and Rhesus status (positive or negative)
- sickle cell and thalassaemia
- infectious diseases (hepatitis B, syphilis and HIV)

[59] https://knowthescore.info/
[60] https://www.gov.scot/publications/consultation-analysis-prohibiting-smoking-outside-hospital-building/

- Down's syndrome
- Edwards' syndrome
- Patau's syndrome

Women whose first trimester test results show that their baby has a higher chance of having Down's syndrome or Edwards' syndrome or Patau's syndrome will be offered a further screening test called non-invasive prenatal testing, known as NIPT from September 2020. This test can give women more accurate information about how likely it is their baby may have either Down's syndrome, Edwards' syndrome or Patau's syndrome.

Further information on Scotland's Pregnancy Screening programme can be found on the following NHS inform website[61].

Other screening

AAA screening

An abdominal aortic aneurysm (AAA) is a swelling of the aorta, the main artery in the body. Men across Scotland in their 65th year are invited to be screened for AAA. The screening programme aims to reduce the mortality associated with the risk of AAA rupture in men aged 65 years and older.

Breast screening

The NHS offers breast screening to reduce the number of women who die from breast cancer. Screening does this by finding breast cancers at an early stage when they are too small to see or feel. Breast cancer is more common in women aged over 50. The Scottish Breast Screening Programme invites women aged between 50 and 70 years old for screening every three years.

Bowel screening

The Scottish Bowel Screening Programme invites men and women aged between 50 and 74 to take part in screening every two years. Bowel screening aims to find cancer at an early stage when treatment is likely to be more effective. Bowel screening is the only screening programme where the test is completed at home.
The faecal immunochemical test (FIT) replaced the guaiac faecal occult blood test (gFOBt) as the test used in the Scottish Bowel Screening Programme in November 2017.

Cervical screening

Cervical screening is offered to women (and anyone with a cervix) aged between 25 and 64 years.

The cervical screening test (also known as a smear test) takes a sample of cells from the cervix (neck of the womb) and checks it for human papillomavirus (HPV). HPV is the main cause of cervical cancer.

Women on non-routine screening (where screening results have shown changes that require further investigation/follow up) will be invited up to the age of 70.
Work was progressed to implement HPV testing with a view to replacing cervical cytology as the primary test from 2020.

Diabetic retinopathy screening (DRS) programme

[61] https://www.nhsinform.scot/healthy-living/screening/pregnancy/pregnancy-screening

Diabetic retinopathy is an eye condition that occurs when high blood sugar levels damage the cells in the retina. The blood vessels in the retina can leak or become blocked. This condition may cause blindness or serious damage to eyesight.
For people who have diabetes, screening is important because their eyes are at risk of damage from diabetic retinopathy. Screening is a key part of diabetes care to anyone with diabetes aged 12 or over.

Further information on Scotland's adult screening programmes can be found on the following NHS inform website[62].

Wales

See: Curriculum for Wales guidance

Relationships and Sexuality education - covers sexual health.
Health and Wellbeing – covers the promotion of healthy eating/diets and prevention of substance abuse.

Wales Substance Misuse Delivery Plan 2019-2022 – consultation document: https://gov.wales/sites/default/files/consultations/2019-06/consultation-document.pdf

Road Safety Wales. Basic road safety is in the PSE (Personal and Social Education) curriculum for Primary Schools.

Counselling and screening

Pregnant Women

Antenatal screening is provided by each of the local health boards in Wales and overseen by the Antenatal Screening Wales programme which is part of Public Health Wales. Pregnant women are offered an early pregnancy ultrasound at 11-14 weeks of pregnancy and blood tests for HIV, hepatitis B and syphilis and inherited blood disorders (such as sickle cell anaemia and thalassaemia) by 14 weeks. At between 15 and 18 weeks of pregnancy women are offered combined testing for Down's syndrome, Edward's syndrome and Patau's syndrome. If the screening result is between 1 and 5 and 1 and 150 pregnant women are offered non-invasive pre-natal testing (NIPT) or an invasive test. At 18 to 20 weeks of pregnancy women are offered a further fetal anomaly ultrasound to check development.

Other screening

Bowel Screening Wales offers bowel screening to men and women aged 60-74 every two years. Faecal immunochemical testing (FIT) has been provided in Wales since January 2019.

Breast Test Wales offers breast screening to women aged 50-70 every three years. Women aged over 70 can request to be screened every three years.

[62] https://www.nhsinform.scot/healthy-living/screening

Cervical Screening Wales invites women aged 25-64 for cervical screening. Routine high-risk human papilloma virus (HPV) testing has been offered in Wales since September 2018.

The Wales Abdominal Aortic Aneurysm Screening Programme (WAAASP) invites men aged 65 for a one-off AAA screening scan. Men over 65 who have not had a screening can self-refer.

Diabetic Eye Screening Wales offers annual diabetic retinopathy screening to people with diabetes aged 12 years and older.

Antenatal screening is provided by each of the local health boards in Wales and overseen by the Antenatal Screening Wales programme which is part of Public Health Wales. Pregnant women are offered an early pregnancy ultrasound at 11-14 weeks of pregnancy and blood tests for HIV, hepatitis B and syphilis and inherited blood disorders (such as sickle cell anaemia and thalassaemia) by 14 weeks. At between 15 and 18 weeks of pregnancy women are offered combined testing for Down's syndrome, Edward's syndrome and Patau's syndrome. If the screening result is between 1 and 5 and 1 and 150 pregnant women are offered non-invasive pre-natal testing (NIPT) or an invasive test. At 18 to 20 weeks of pregnancy women are offered a further fetal anomaly ultrasound to check development.

The Newborn Hearing Screening Programme offers hearing screening for newborn babies while they are still in hospital after birth or soon after discharge.

The Newborn Bloodspot Screening Wales screening is carried out by a midwife on day 5 of a baby's life and is part of routine postnatal care. It tests for:

- Inherited metabolic disorders
- Medium-chain acyl-CoA dehydrogenase deficiency (MCADD)
- Phenylketonuria (PKU)
- Maple syrup urine disease (MSUD)
- Isovaleric acidaemia (IVA)
- Glutaric aciduria type 1 (GA1)
- Homocystinuria (HCU)
- Congenital hypothyroidism (CHT)
- Cystic fibrosis (CF)
- Sickle cell disorders (SCD)

Northern Ireland

The Department of Education requires all grant-aided schools to develop their own policy on how they will address Relationships and Sexuality Education (RSE) within the curriculum. This includes a requirement that pupils should be provided with accurate, factual information about the following:

- the most common sexually transmitted infections;
- the prevention of HIV/AIDS;
- the ways in which these infections can be transmitted

The Wellbeing Hub shows how the Northern Ireland Curriculum promotes the learning and development of skills that support pupils' wellbeing and mental health. It also supports the Emotional Health and Wellbeing Framework for Children and Young People in Education that's being developed collaboratively by the Departments of Education and Health, the Public Health Agency, the Health and Social Care Board, and the Education Authority (EA). https://ccea.org.uk/learning-resources/wellbeing-hub

The physical safety and health guidance makes clear the importance of children and young people learn about the role of exercise, healthy eating and healthy habits as part of good health.

Smashed Online is an externally produced resource to educate and young people about the risks and dangers associated with underage drinking. The resource supports the delivery of Northern Ireland Curriculum at Key Stage 3 and 4.

Road safety education

Counselling and screening

Pregnant Women

Obesity prevention campaigns to be funded in the 2020/21 year include the continuation of existing 'Extras' and 'Steps' campaigns and the development of a new campaign programme in line with the regional obesity strategy, aimed at encouraging behaviour change for those at risk of Type 2 diabetes

The Infectious Diseases in Pregnancy Screening programme offers screening for: human immunodeficiency virus (HIV), hepatitis B, syphilis and susceptibility of pregnant women to rubella.

In keeping with the National Institute for Health and Care Excellence guidance, the screening blood tests are routinely offered at the mother's pregnancy booking appointment, ideally by 10 weeks gestation or at the earliest opportunity thereafter where the woman presents to maternity services.

The objective of screening for human immunodeficiency virus (HIV), hepatitis B and syphilis is to enable early identification of these conditions among pregnant women, to allow early intervention and reduce the risk of mother-to-child transmission. Pregnant women identified as susceptible to rubella are offered postnatal measles, mumps, and rubella (MMR) vaccination to prevent infection in future pregnancies.

Other screening

The Public Health Agency commissions and quality assures eight population screening programmes:

- **Abdominal aortic aneurysm screening -** An invitation letter is sent to eligible men in the year they turn 65 to attend a local screening clinic; eligible men over the age of 65 can self-refer to the programme office directly.

- **Bowel cancer screening -** Target audience: Men and women, aged 60-74 yrs; screening invitation every 2yrs.
- **Breast cancer screening** (also encompasses surveillance of women at very high risk of breast cancer) **-** Target audience: Women, aged 50-70 yrs; screening invitation every 3yrs.
- **Cervical screening -** Women aged 25-49 yrs invited for screening every three years; those aged 50-64 yrs invited every five years.
- **Diabetic eye screening -** Target audience: Screening offered each year to people registered with diabetes, aged 12 years and over.
- **Infectious diseases in pregnancy screening -** This programme offers screening for: human immunodeficiency virus (HIV), hepatitis B, syphilis and susceptibility of pregnant women to rubella. In keeping with the National Institute for Health and Care Excellence guidance, the screening blood tests are routinely offered at the mother's pregnancy booking appointment, ideally by 10 weeks gestation or at the earliest opportunity thereafter where the woman presents to maternity services.
- **Newborn blood spot screening -**The Newborn Blood Spot Screening Programme offers all newborn babies a blood spot screening test to identify if they are at increased risk of nine rare, but serious, inherited conditions: PKU, MCADD, SCD, CF, CHT, MSUD, IVA, HCU and GA1. The aim of the programme is to improve the outcomes for babies born with one of these conditions, which can cause critical illness, severe disability and death, by achieving early diagnosis and treatment.
- **Newborn hearing screening -**The Newborn Hearing Screening Programme is offered to all babies, who are born or resident in Northern Ireland, up to 6 months of age. The aim of the screening programme is to identify babies who have a significant permanent childhood hearing loss to allow early referral, diagnosis and intervention.

Isle of Man

The Director of Public Health provides an annual report on measures, campaigns and outcomes undertaken on the Island. The last three reports are published which provide further clarity on priorities and activity: https://www.gov.im/dphannualreport#accordion

The reports use data from the Public Health Outcomes Framework (PHOF), which feature statistics that reflect the health of the Isle of Man population.

There have been varying forms of stakeholder engagement led by the Isle of Man Department of Health and Social Care (DHSC) across different audiences undertaken in the 2019/20 year, the purpose of which is to help inform service development, patient and service user expectations and impact of current services:

- **Consultation on Island based abortion services:** Proposals for the new era of Island-based abortion services (the new Abortion Reform Act came into operation May 2019)
- **Eye Care Strategy:** engaging with user representative groups such as Manx Blind Welfare and other third sector groups took place and their views fed into the strategy
- **Dental strategy: liaison** – engaging with the Isle of Man dental association and patients to get their views, which fed into the strategy

- **Service reform:** holding a public consultation and engaging with several stakeholders across private sector businesses, insurance companies and healthcare providers etc.
- **Service user, patient, and public surveys:**
    - Isle of Man Government Health & Lifestyle Survey
    - Mental Health Survey
- **Awareness campaigns:**
    - Dementia awareness: a week of events with service users, families and carers and content shared with the public to promote a greater understanding of dementia
    - Winter wellness: a series of YouTube videos with family GP offering antidotes to the winter blues was created which covered topics such as staying well, eating healthily, wellbeing tips, natural remedies
- **Mental health**
    - Mental Health First Aid: training initiatives took place throughout 2019/20 to have Mental Health first aiders in workplaces
    - Workplace Wellbeing conference hosted by Public Health
- **Professional recognition:**
    - International Nurses Day Annual event
    - Year of the Nurse and Midwife
    - Isle of Man Newspapers Awards for Excellence
- **Staying connected with key groups**
    - HSCC - Health Services Consultative Committee
    - HACA - Health and Care Association

Bowel, Breast and Cervical Screening Programme Isle of Man

The objective of the Screening Programme is to detect cancer at an early stage before it causes symptoms; this enables early treatment and better outcomes for the patient. It is also a way of finding out if people are at higher risk of health problems, so that early treatment can be offered or information given to help them make informed decisions.

Screening tests are offered to different sections of the population dependent upon eligible criteria and risk factors. The aim is to offer screening to the people who are most likely to benefit from it. Screening is a personal choice and the choice to opt out is available at any part of the screening process. The Isle of Man screening programmes broadly follow the NHS England programmes.

Bowel Cancer Screening: 1 April 2019 to 31 March 2020

Automatically offered to men and women every 2 years for those aged 60 – 75 currently registered with a GP. Aged 75 and over can request a free screening kit. Screening is not currently offered to people on the Isle of Man aged under 60.

Month	Invites issued	Kits sent	Uptake%	Positivity %	Screened	Abnormals
Apr-19	649	710	59.48	1.55	386	6
May-19	1056	835	53.13	1.25	561	7
Jun-19	620	618	59.19	0.82	367	3
Jul-19	775	773	61.94	1.04	480	5

Aug-19	620	619	61.13	0.79	379	3
Sep-19	620	619	64.84	0.50	402	2
Oct-19	775	769	57.55	0.90	446	4
Nov-19	651	618	61.60	1.75	401	7
Dec-19	744	772	54.84	0.49	408	2
Jan-20	620	617	64.84	1.24	402	5
Feb-20	620	617	51.45	1.25	319	4
Mar-20	464	463	17.46	0.00	81	0
Total	8214	8030			4632	48

SSP Referrals	Colonoscopy Referrals	Cancer
62	49	unavailable

Breast Screening: 1 April 2018 to 31 March 2019*

Women aged between 50 and 70 are automatically invited for breast screening every 2 years. Women over the age of 70 are not automatically invited for breast screening. However, clients can still refer themselves for screening by contacting the breast screening unit.

No of Women invited on call/recall/Surveillance	No of women tested	Cancer
6180	4989	43

*data for 1/4/19 – 31/3/20 is still being processed

Cervical Screening 1 April to 31 March 2020

Cervical screening is for women and people with a cervix. Screening is offered every 3 years from age 25 to 49 and every 5 years from age 50 to 64. If a transgender (trans) man registered with a GP as female, an invitation will be sent for cervical screening. If registered as a male they will not receive an invitation, but their GP or practice nurse can arrange an appointment for them if they have a cervix. If they are a trans woman they are advised that they do not need cervical screening.

No of Women invited on call/recall/Surveillance	No of women tested	Cancer
5730	5005	unavailable

National Screening Programme sourced Consultant Outpatient referrals received for Gynaecology

Year	Month	Two week wait	Urgent	Routine	ALL
2020	September	1	0	0	1
	May	1	0	0	1
	Total	2	0	0	2

2019	November	0	1	0	1
	July	1	0	0	1
	June	0	0	1	1
	May	1	0	0	1
	Total	2	1	1	4
Total		4	1	1	6

National Screening Programme sourced Consultant Outpatient referrals received for Colposcopy

Month	Two week wait	Urgent	Routine	ALL
2020				
April	2	11	2	15
March	13	36	0	49
February	4	11	0	15
January	6	3	1	10
2019				
December	5	18	0	23
November	0	7	0	7
October	0	7	0	7
September	2	11	1	14
August	1	8	1	10
July	3	6	1	10
June	3	10	0	13
May	5	3	1	9
April	6	11	0	17
Total	50	142	7	199

Paragraph 3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

a) Please describe the measure taken to ensure that vaccine research is promoted, adequately funded and efficiently coordinated across public and private actors.

England

The Department of Health and Social Care commissions research through the National Institute for Health Research (NIHR) and is the largest public funder of health research in the UK. The NIHR along with the Medical Research Council (MRC) both fund a wide portfolio of research activity in vaccines which cover clinical trials for new vaccines, new technologies, ways of improving uptake and cost effectiveness.

The NIHR welcomes funding applications for research into any aspect of human health, including vaccine research. These applications are subject to peer review and judged in open competition, with awards being made on the basis of the importance of the topic to patients and health and care services, value for money and scientific quality. In all disease areas, the amount of NIHR funding depends on the volume and quality of scientific activity.

The vaccination programme in England protects against 16 different diseases. It is based on advice from our expert group, the Joint Committee on Vaccination and Immunisation. They keep abreast of new risks to the population and advise if and when changes to our current vaccination programme may be appropriate.

The UK Vaccine Network brings together industry, academia and relevant funding bodies to make targeted investments in specific vaccines and vaccine technology for infectious diseases with the potential to cause an epidemic.

Scotland

The Scottish Government's Chief Scientist Office (CSO) invests in clinical trials infrastructure through NHS Research Scotland (NRS) in order that NHS Scotland is able to host and support a wide range of public and private sector clinical research including research on vaccines[63]. This includes investments in clinical trials facilities, clinical research support staff, and an infectious disease clinical research network to support the delivery of high-quality studies, as well as a Central Management Team that can coordinate arrangements across Scotland. Recently this infrastructure has supported NHS Scotland participation in trials of COVID-19 vaccines. CSO also provides open competitive opportunities for research grant funding in health protection research, including vaccination research[64]. In addition, Public Health Scotland (formerly Health Protection Scotland) through the Scottish Immunisation Programme conducts and contributes to research evaluations of vaccination programmes delivered by NHS Scotland.

Wales

Health and Care Research Wales promotes research into diseases, treatments and services which can improve and save people's lives.

[63] http://www.nhsresearchscotland.org.uk/

[64] https://www.cso.scot.nhs.uk/funding-2/response-mode-funding-schemes/health-improvement-protection-and-services-research-committee/

Paragraph 3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

b) Please provide a general overview health care 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.).

England

NHS England and Improvement (NHSE/I) is responsible for commissioning healthcare for children, young people and adults across secure and detained settings, which includes prisons, secure facilities for children and young people, and immigration removal centres.

People in prison should have access to the same range and standard of healthcare services as those in the community. This is enshrined in the principle of equivalence in the Health and Social Care Act 2012. The range of services which are directly commissioned for prisons include primary (GP) and secondary care services (hospital care), public health including substance misuse services (under a section 7a agreement with the Department of Health and Social Care), dental, ophthalmic (eye care) services and mental health services.

Under the Care Act 2014, Local Authorities in England are responsible for assessing the care and support needs of adult prisoners, for providing care and support where those needs meet eligibility criteria, and also for transferring care back into the community when people leave prison.

All people in prisons receive an early screening and assessment within the first 24 hours of entry followed through with a second screening within 7 days. The initial or 'reception' screen is a comprehensive health screen to ensure that the physical and mental health needs of an individual are identified in order to meet their identified needs and keep them well and safe for 72 hours or until the second more detailed second assessment is carried out.

It is the responsibility of individual healthcare providers to ensure they have the right number of suitably qualified and experienced members of staff available to ensure they are able to provide safe services for their patients. The NHS Standard Contract 2020/21 sets out requirements to ensure that there are sufficient appropriately registered, qualified and experienced medical, nursing and other clinical and non-clinical staff to enable the services to be provided in all respects and at all times in accordance with their contract.

Scotland

Prisons

Integrated Joint Boards (IJBs) and NHS Boards are responsible for healthcare service delivery to those prisons situated within its geographic area. The service is delivered by multi-disciplinary prison based healthcare teams located within each prison.

Prison Healthcare Directions came into effect on 1 November 2011 and apply to the provision by NHS Boards of healthcare to prisoners in prisons[65]. Every Board which provides, or secures the provision of, healthcare to prisoners in prisons must comply with these Directions. A Memorandum of Understanding between the SPS and NHS Boards with prisons in their area sets out relative responsibilities, governance and accountability. This includes decisions about the deployment of staff, e.g. ensuring that staff teams have an appropriate skill mix of professional staff, which are the responsibility of the relevant Board.

Healthcare services are delivered on an equitable basis to those available in the wider community. This includes access to vaccinations in line with the rest of the population. Additionally, the Scottish Government's 2015 update to the Sexual Health and Blood Borne Viruses Framework recommended the introduction of opt-out BBV testing (hepatitis B and C and HIV) for all new prisoners in Scotland during their induction period. Public Health Scotland has produced guidance to support this, and it provides an important opportunity to test and support a population who may otherwise not engage with health services. Vaccination against hepatitis b is also offered to all prisoners during the induction period in prison. Any course of treatment will continue throughout their sentence and upon release, and across NHS Health Boards. Those prisoners who are hepatitis C antibody positive will also be offered immunisation against hepatitis A.

On reception into prison, everyone has a healthcare consultation with an NHS healthcare professional within 24 hours of arrival, using a nationally agreed admission process, to identify healthcare conditions, other vulnerabilities and medication requirements. This will include physical health, mental health and addiction needs.

Prisoners are able to access healthcare via an internal referral process and links to community specialists are maintained to ensure continuity of care and treatment. Healthcare staff develop care plans for patients with complex medical conditions to ensure clear communication of assessed needs. New referral to clinical specialities will take place through NHS clinically led protocols.

Funding for prisoner healthcare is provided to NHS Boards through their general baseline allocations. NHS Boards receive an annual uplift to their baseline funding to cover pay and other general inflationary pressures. It is for individual Health Boards to determine how best to allocate resources to deliver services that meet the needs of their local population, ensuring that quality, timely care and patient safety remains the priority.

Secure Care for Young People

Secure care aims to provide intensive support and safe boundaries to help highly vulnerable children re-engage and move forward positively in their communities.

Each secure service has a full-time qualified nurse and access to GP, dental and optical services on site. On admission to secure care all young people will receive a full medical check and an assessment of their mental health needs. Secure service are able to make direct referrals to Child and Adolescent Mental Health Services (CAMHS). Centres also have their own in service psychologists or bring in those services when required to provide additional support to the young people in their care.

Covid Pandemic Response: Prisons

[65] https://www.sehd.scot.nhs.uk/pca/PCA2011(M)15PrisonDirections.pdf

The Scottish Government has engaged with the Scottish Prison Service (SPS) and, through the National Prison Care Network, working with NHS Boards to support contingency planning responses.

The SPS's pandemic plan remains in place and robust operational measures implemented to mitigate spread of the virus have ensured that prisons continue to be a setting of low infection rates. The SPS published its COVID-19 route map and related physical distancing guidance on 25 June 2020[66]. In conjunction with local health protection teams and local authorities, the prison service continues to take robust measures to minimise risk in response to recent local outbreaks.

HS Boards, including prison health centres, were asked to identify and proactively manage patients who are at particularly high risk of severe morbidity and mortality from COVID-19, who were advised to shield. Patients requiring to be shield were accommodated in a single room and provided with all meals and medications in their room. The Scottish Government worked with partners to develop a simplified version of the patient advice letter, contextualised to the prison setting.

As part of early contingency planning the Scottish Government worked with partners, including the NHS and SPS, to introduce an alternative sustainable Opioid Substitution Treatment (OST) within prisons during the pandemic to ensure continuity of daily supervised OST. The Scottish Government have supported partners to transition suitable patients in prison on prescribed OST to Buvidal, a new longer-acting formula of buprenorphine, where clinically appropriate. Buvidal is available as a 7-day or 28-day injection, which would reduce administration and treatment episodes. This would ensure continuity of care as there would be no gaps in treatment, which could lead to unplanned and unmanaged withdrawal for the patients.

Engagement has also taken place with prison healthcare staff to promote the increased use of telehealth, where appropriate, in order to reduce unnecessary movement people both within and out-with prison for clinical consultations. NHS Near Me can now be accessible in all 15 establishments across the prison estate.

The Coronavirus (Scotland) Act 2020 gave Scottish Ministers powers to order the early release of specified groups of prisoners, in order to protect the health of prison staff and prisoners, and support the safe and effective operation of prisons in Scotland. A limited early release process was held in May 2020 (348 short sentence prisoners released up to 90 days early). This increased the SPS' operational capacity, which increased single cell occupancy, enabled more prisoners to self-isolate or shield, and reduced operational demands on staff. The Scottish Government will keep the option for further early release activity under consideration, depending on the circumstances within the prison estate, and in the wider community.

Northern Ireland

Healthcare in prison is delivered by a highly motivated multidisciplinary team of healthcare professionals who want to make a difference, improve the health outcomes for all people in prison and make Northern Ireland a safer place. The team aims to provide opportunities

[66] https://www.sps.gov.uk/Corporate/Information/covid19/covid-19-information-hub.aspx

for people to develop a positive attitude towards their own health and well-being on an individual basis or through public health initiatives.

The service is designed to provide care that is equivalent to that within the community, enabling and supporting individuals to maintain optimum health and quality of life, inside the prison environment. A high standard of care is provided by a wide variety of healthcare professionals, at least equivalent to the standard expected in a community setting.

Wales

The Partnership Agreement for Prison Health in Wales outlines agreed priorities between Her Majesty's Prison and Probation Service (HMPPS) in Wales the Welsh Government, Local Health Boards and Public Health Wales to drive improvements in the health and wellbeing of those held in Welsh prisons. The document recognises the unique statutory obligations of each partner organisation and builds on the shared objective of ensuring those in prison can live in environments that promote health and well-being and where health services can be accessed to an equivalent standard of those within the community. This supports the overarching aim that prison should be a place where an individual can reform their lives.

To achieve this all parties have agreed to work toward the three objectives of the Welsh Government 'Prosperity for All: The National Strategy for Wales', ensuring that prisons and health services in prisons:

1. Deliver quality health and care services fit for the future
2. Promote good health and well-being for everyone
3. Build healthier communities and better environments

Isle of Man

The Prison Healthcare Service within the Isle of Man Prison is operated by the Isle of Man Department of Health and Social Care (DHSC), and is based managerially within the Integrated Community Care Group.

The Prison Healthcare Service operates 7 days a week cover to reflect the Prison core day. The Prison Healthcare Team provide the essential healthcare requirements of all prisoners, namely provision of medication, medical assessment on reception, attendance at medical emergencies, primary assessment if prisoner unwell, oversight/organisation of in-reaching services and provision of medical advice. The Prison Healthcare Team also provide specialist services to augment their service, such as cognitive behavioural treatment, stop smoking advice and trauma/bereavement support.

The Prison Healthcare Service is supported by a number of in-reaching services, mostly provided by the DHSC and supplemented by third sector groups. Services delivering substantial input include:

- General Practitioner
- Tiered Mental Health
- Drug and Alcohol Services
- General Dentistry

Prisoners also have access to all other services offered by the DHSC on referral by the GP, however this requires secure transport from the Prison to a DHSC site, such as Noble's Hospital.

All Prisoners arriving at the Prison receive a medical assessment by a member of the Prison Healthcare Team within the Healthcare Wing. This includes a full set of observations, physical health wellbeing screening, clinical history taking, smoking, alcohol and illicit drug screening including urine drug test, mental health assessment, opportunity to discuss appropriate referrals and follow ups and COVID-19, TB and flu screening.

Mental Health is provided via a tiered approach – at the lower tiers, prisoners can access counselling or support with anxiety from visiting occupational therapists, CBA is available in house. There is a mental health nurse working within the prison team. Where required, prisoners can be referred upwards for support by a specialist mental health service such as Drug & Alcohol Team or our Consultant Psychiatrist with a special interest in Forensic Psychiatry. For Prisoners requiring intensive forensic psychiatric care in a secure environment, transfers to specialist institutions in the UK can be facilitated.

For individuals transferred into the care of the Community Rehabilitation Service, healthcare provision is transferred to the person's local GP however our Vulnerable Adult Health Visitor provides a fortnightly drop in clinic for any user of the Community Support Service to gain advice and support on how to access health services to manage any health issues or their long term condition.

Paragraph 3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

c) Please provide information on the availability and extent of community-based mental health services and on the transition to community-based mental health from former large-scale institutions. Please provide statistical information on outreach measures in connection with the mental health assessment of vulnerable populations, including those in a situation of poverty or exclusion, the unemployed (especially long-term unemployed). Provide also information on proactive measures adopted to ensure that persons in need of mental health care are not neglected. Please also provide information from prison health-care services on the proportion of inmates who are deemed as having mental health problems and who, according to health-care professionals, do not belong in the prison system or would have possibly been spared of such a situation should suitable mental health services been available to them in the community or in specialised establishments.

England

Please see Mental Health section under Paragraph 1.

For services statistics, information is available here:
https://www.gov.uk/government/statistics/mental-health-services-monthly-statistics-final-april-provisional-may-2020

The Department of Health and Social Care does not collect or publish data on the prevalence of mental health problems in people who are held in prison.

There are already several initiatives in place to ensure that people with mental health difficulties are diverted away from the Criminal Justice System (CJS), wherever possible. Those with less severe offending can and should be supported earlier by Liaison and Diversion services, which are available nationally in all police custody suites to undertake a vulnerabilities assessment at the earliest possible opportunity, or to provide liaison to the court in how best to support the individual.

Where the Court determines that a sentence is the most appropriate form of action, Community Sentence Treatment Requirements (CSTR) are available as an alternative to a custodial sentence, to ensure that those who require it are able to obtain appropriate mental health support in the community, whilst also under the supervision of the criminal justice service.

Where people cannot be safely cared for in prison due to their mental health a referral can be made to a secure hospital under the Mental Health Act 1983.

Scotland

The Scottish Government's Mental Health Strategy 2017-2027[67] describes Scotland's ambition to improve the way mental health services are delivered across community and inpatient settings.

[67] https://www.gov.scot/publications/mental-health-strategy-2017-2027/

Legislation to integrate health and social care in 2016, which aims to improve care and support through joint working between NHS boards and local authorities, supports the infrastructure to realise that ambition. In 2018, the new Scottish General Medical Services Contract was agreed which sets out a new direction for general practice in Scotland. This supports investment in multi-disciplinary teams to increase capacity in primary care, allowing patients to be seen at the right time by the right person. This will improve access for patients, address health inequalities and improve population health including mental health[68].

The Scottish Government has developed more accessible psychological self-help resources and supported a national rollout of computerised cognitive behavioural therapy (cCBT) in 2018

Community Mental Health Teams
Community Mental Health Teams are available in all regional health boards across Scotland. These are made up of a number of professional from different backgrounds, these include; psychiatrist, community psychiatric nurse (CPN), social worker, occupational therapist, clinical psychologist and pharmacist. In addition these teams can include outreach workers, mental health workers, benefits workers, support workers, recovery workers, vocational therapists, arts therapists and psychotherapists.

Community Link Workers (CLW) are non-medical practitioners aligned with GP practices, Scottish Government is in the process of putting link workers in every primary care team to be involved in listening, problem solving, signposting and early intervention public health for people with physical, mental and social problems, working across the whole person.

Psychological therapies:
The Scottish Government has invested £58 million over four years (2016-20) to help boards improve access to Children and Adolescent Mental Health Services (CAMHS) and Psychological Therapies through workforce development, recruitment and retention, and service improvement support. See response to Article 11 para 1 for detail on waiting times.

Improving access to psychological assessment and therapies in rural areas
As part of the broader programme of work to enhance digital services, NHS 24 began to roll out video-conferencing clinics trials from October 2019 to improve access to services, especially those in rural areas.

Independent Inquiry into Mental Health Services in Tayside
An independent inquiry into mental health services in the Tayside region was set up in 2018. The interim report was published in May 2019[69]. The Scottish Government committed to work closely with NHS Boards to ensure that recommendations made from this Independent Inquiry are shared widely to ensure the highest standards in our NHS. The Inquiry's remit, whilst interested in inpatient services, was to consider end-to-end mental health services including the provision of treatment in the community, with an emphasis on prevention and support at the earliest appropriate time.

The Minister for Mental Health commissioned the Quality and Safety Board to learn from the above Inquiry and to ensure consistency in the quality of care across Scotland on 22

[68] https://www.gov.scot/policies/mental-health/
[69] https://independentinquiry.org/wp-content/uploads/2019/05/Independent-Inquiry-Interim-Report-May-2019.pdf

May 2019. The board will consider matters related to quality planning, quality improvement and quality assurance as well as issues of patient safety, all of which relate to services provided to the community.

Quality of Community Care
The majority (75%) of adults in Scotland with mental health problems supported in the community (at home) agreed that their services and support had an impact in improving or maintaining their quality of life[70].

The Quality and Safety Board will consider the quality of community care, as stated above.

ISD also published the first report of the Quality Indicator Profile for Mental Health by NHS National Services Information Services Division (Action 38).

Shift from inpatient to community based mental health
The Scottish Government is continuing with work to further improve prevention and early intervention of mental health problems while supporting the increase in the treatment of people at home, or in a home-like setting.

The Scottish Government have seen successes in the reduction in the bed occupancy rate across Scotland and a marked reduction in the average length of stay. This is indicative of the successes in developing new models of care within community settings, allowing people to receive the support they require in settings more suitable for their needs.

There still remain instances where individuals require specialist support which can only be provided in an inpatient setting, however, the number of psychiatric inpatient admissions has declined further in the last year. As this work progresses, the Scottish Government will continue to work with key partners to address health inequalities, which are evident in statistics, to help build a fairer and more inclusive Scotland.

- In 2018/2019 there were 47,790 mental health discharges, an increase of 3% from 2017/2018. This is the highest number of discharges since 1997/1998.
- Since 1997/1998 the number of patients treated in psychiatric specialties for mood (affective) disorders has seen a steady decline from 6,140 to 2,910, a larger decrease than any other diagnostic group.[71]

The total number of beds available for psychiatric specialities in 2017/18 was 3,941 beds (i.e. 72.6 beds per 100,000 population). This is a decrease from 74.3 beds per 100,000 population 2016/17. Data on psychiatric inpatient beds comes from the annual National Inpatient Bed Census and from Information Services Division of NHS National Services Scotland.

The total net expenditure for general psychiatry services for 2017/18 was £967m for Scotland an increase from 2016/17 when it was £937m.

In 2017/18 Inpatient expenditure was 57% and community expenditure was 37% of the total budget.

[70] https://www.isdscotland.org/Health-Topics/Quality-Indicators/Mental-Health-Quality-Indicator-Profile/Publications/2019-09-17/Introduction/
[71] Source of statistics: https://www.isdscotland.org/Health-Topics/Mental-Health/Publications/index.asp

Statistical information on outreach measures in connection with the mental health assessment of vulnerable populations

The Scottish Health Survey (SHeS) measures mental health and wellbeing. The 2019 data was recently published and there is also the SHeS dashboard[72] with trend data, including for the 2016-2019 period, and also shows breakdowns for sex, age, deprivation income and long - term illness.

The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) provides information on the mental health and well-being of young people. For the time period requested there is data available for 2018[73].

Measures adopted to ensure that persons in need of mental health care are not neglected.

NHS 24 Services
In 2019-20, the Scottish Government allocated £1.5 million to NHS 24 to cover a range of mental health initiatives, such as:

- Trialling improvements to the NHS 24 Breathing Space service by introducing web chat with an NHS 24 adviser;
- Helping those with mild to moderate depression by introducing more widespread access to Cognitive Behavioural Therapy – this would help around 5,000 more people to combine improving their mental health with working and caring;
- Strengthening the content of current self-help platforms provided through NHS inform;
- Improving access to psychological assessment and therapies in rural areas through the use of technology such as video-conferencing; and
- Enhancing the handling of mental health calls to the 111 service with more specially trained staff providing mental health advice.

Also in 2019-20, Scottish Government provided NHS 24 with a further allocation of £1.125 million for its Mental Health Services & Development Programme. This is broken down as follows:

- £825,00 towards the operating costs of the NHS24 Breathing Space free, confidential phone service for anyone experiencing low mood, depression or anxiety.
- A £200,000 contribution to the operating costs of the NHS 24 Living Life free telephone and self-help (CBT) counselling service for adults suffering from low mood, mild to moderate depression and/or anxiety.
- A £100,000 contribution to costs of the Associate Medical Director (Mental Health) and Programme Lead providing clinical governance, strategic planning, external engagement and leadership to NHS24 scheduled/unscheduled mental health services.

Action 15

[72] https://scotland.shinyapps.io/sg-scottish-health-survey/
[73] https://www.gov.scot/publications/scottish-schools-adolescent-lifestyle-substance-use-survey-salsus-drug-use-report-2018/pages/7/

Action 15 of the Mental Health Strategy 2017-27 outlines the Scottish Government's commitment to funding 800 additional mental health workers in key settings, including all A&Es, all GP practices, every police station custody suite, and to Scottish prisons, ensuring that local provision and support is at the heart of our plans. Funding is projected to rise to £35 million by the end of the 2021-22 financial year, subject to budget agreements being reached.

As at 1 July 2020, an additional 485.60 whole time equivalent (WTE) mental health roles have been filled using Action 15 funding. This equates to 60.7% of the overall target.

Prisons

Judges take a number of factors into account when sentencing an offender to a custodial sentence, including any mental health conditions. In relevant cases, where the court is satisfied a person is unable to appreciate the nature or wrongfulness of their actions due to a mental disorder, the court will not convict the person of the offence. These are all matters for the independent courts, and it would be inappropriate for the Scottish Government to speculate as to what those decisions may have been in different circumstances.

There are no robust figures for the prevalence of mental health problems among the prison population in Scotland. However, data from the Forensic Mental Health Services Managed Care Network indicates that since 2018 an average of 35 inmates a year have been assessed as requiring mental health care and treatment in hospital and transferred to secure hospital units. Over this time, the average daily prison population has risen from around 7,500 in 2017-18 to nearly 8,200 in 2019-20.

Wales

Please see Mental Health section under Paragraph 1 and healthcare in prisons under paragraph 3. See Statistics on mental health treatment in Wales.

Northern Ireland

Mental health services are provided based on clinical need and are available to those who need it when they are needed. The 2005 Bamford review of mental health and learning disability services advised to move mental health services towards a mostly community based service. This project has been complete. A final evaluation of the Bamford review is currently under consideration.

In Northern Ireland most mental health services are delivered in the community. The success of this transition to the community can be evidenced in that the number of mental health in-patient beds is approximately 60% of other similar jurisdictions, even though there is a recognised higher mental health need in Northern Ireland. Community mental health services receive over 5,000 referrals each month and see over 23,000 contacts per month.

On 19 May 2020, the Minister for Health launched a Mental Health Action Plan to kick start the reform of mental health services in Northern Ireland. This include an action to create a new 10-year mental health strategy for Northern Ireland.

Isle of Man

As detailed in the response under article 11, paragraph 2, the overwhelming majority of mental health care is delivered in community settings with less than 1% delivered in the acute inpatient arena. Targeting vulnerable groups is a priority. The Mental Health Services (MHS) has and continues to develop positive collaborative relationships with third sector providers to support those experiencing homelessness and housing need, this includes outreach into a homelessness shelter on a weekly basis.

The MHS collects monthly statistical information which includes data on employment status. The current data entry compliance in this domain is however currently poor at 20.3 %. The MHS does not currently have access to data recovery mechanisms that would accurately provide statistical detail in respect of poverty or exclusion. A programme of work is being actioned in 2021 to address the limitations of the existing data recovery processes.

It is well documented that individuals experiencing mental health and or substance misuse difficulties are significantly overrepresented in the criminal justice system The MHS which includes substance misuse services, provide a range of in-reach into the criminal justice system. In-reach into the IOM prison is undertaken on a weekly basis offering both nursing and medical clinical review in respect of individuals experiencing mental health and or substance misuse difficulties. A programme of psychological interventions delivered by occupational therapy and counselling staff is available 3 times a week for individuals experiencing low to moderate mental health difficulties. Local prevalence rates are consistent with that of the UK. In excess of 55% of prisoners are in receipt of treatment from mental health and or substance misuse services.

In addition to the above, the MHS has developed close collaborative working relationships with the IOM Constabulary. A key service delivery is the police mental health liaison service. This evidenced based approach introduces Mental Health Professionals to the criminal justice interface in order to provide early assessment at point of contact in order to expedite access to the appropriate treatment pathway, mitigate the risk of the person in crisis being detained in police custody, and to minimise the distress caused. The service also provides report to the courts in order to ensure that an individual’s mental health treatment is actively considered by the judiciary. Recently retrieved outcome data (mid-2020) indicated that the volume of incidents in which the police had exercised their powers under the Mental Health Act 1998 had reduced by in excess of 34% when compared to the previous 12 months.

Paragraph 3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

d) Please also provide 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. Provide 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, which 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).

England and Wales

The annual statistical bulletin 'Deaths related to drug poisoning in England and Wales: 2019 registrations' was published on 14 October 2020 by the Office of National Statistics. It showed that the number of deaths relating to drug poisoning and drug misuse in 2019 remained similar to 2018, however this is following an increase between 2017 and 2018. The publication is available at: https://www.ons.gov.uk/releases/deathsrelatedtodrugpoisoninginenglandandwales2019registrations

There were 4,393 deaths related to drug poisoning in England and Wales in 2019, a rate of 76.7 deaths per million people. This is similar to the rate in 2018 when there were 4,359 registered deaths (76.3 deaths per million). Deaths involving New psychoactive substances (NPS) have remained stable. There were 125 deaths involving NPS in 2019, an age-standardised rate of 2.1 deaths per million people. The emergence of NPS is a particular challenge for prisons and the National Probation Service and Her Majesty's Prison and Probation Service have worked with Public Health England to create Psychoactive Substances Toolkits to support staff in secure settings. These provide information about NPS use and advice on how to manage associated issues. It is available here: https://www.gov.uk/government/publications/new-psychoactive-substances-toolkit-prison-staff

Evidence based, high-quality treatment is the most effective way of tackling illicit and other harmful drug use. It enables people to recover from dependence, improves their physical and mental health and reduces the harm caused to themselves and people around them, including reducing crime. Drug treatment encompasses a range of treatments (often called 'interventions') and services which help people overcome their dependency and reduce the physical and psychological harms caused by their drug use to themselves, their families and communities.

Evidence-based recommendations for drug treatment are provided by the National Institute for Health and Care Excellence (NICE) guidance. NICE is the independent, expert body responsible for developing authoritative, evidence-based guidance for the health and care system on best practice. *Drug misuse and dependence: UK guidelines on clinical management* were updated in 2017. These guidelines are for clinicians dealing with people with drug problems and cover community and prison-based treatment. They offer guidance on recovery and a holistic approach to the interventions that can support recovery, including

pharmacological interventions. The guidelines highlight the crucial role opioid substitution treatments, like methadone and buprenorphine, have in preventing drug-related deaths. The guidelines can be accessed at: https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

Needle and Syringe Programmes (NSPs) aim to protect society against the repercussions of drug use, including reducing the public health risks of blood-borne viruses (mainly HIV and hepatitis B and C) as well as reducing crime and antisocial behaviour. NSPs give problematic, chaotic drug users, the opportunity to get some control over their lives, allowing them to take the first small steps towards recovery. NSPs provide a route into drug treatment and recovery. Entering drug treatment is protective because it stabilizes people and enables them to improve their physical health and wellbeing. Research has shown that harm reduction interventions, such as providing sterile needles and syringes, are more effective when they are combined with structured treatment services such as opioid substitution treatment.

Harm reduction measures such as NSPs are internationally well-established and their approach is rooted in public health and human rights. The UK has led the way in harm reduction over the past 25 years, most notably halting the spread of the HIV epidemic in the late 1980s and early 1990s through the introduction of needle and syringe exchanges. As a result, the UK has one of the lowest rates of HIV amongst its injecting drug use population in the world.

Scotland

In November 2018 the Scottish Government published Rights, Respect and Recovery - Scotland's strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths. The vision of the strategy is to ensure individuals, families and communities:

- have the right to health and life - free from the harms of alcohol and drugs;
- are treated with dignity and respect;
- are fully supported within communities to find their own type of recovery

The strategy sets out Scotland's response to problematic drug and alcohol use through 3 key priorities; Developing Recovery Oriented Systems of Care, Getting it Right for Children, Young people and Families and Public Health Approach to Justice.

Through Prevention and Early Intervention the Scottish Government is developing a comprehensive approach to early intervention amongst those who are at risk of developing problem drug use alongside those services who are already working with this group and work with key experts, including those with lived and living experience to address stigma as a way to prevent and reduce related harm. Current online resources continue to be developed to ensure they provide accurate, evidence-based, relevant and up to date information and advice, around alcohol and drug use; and how to access help.

Through Recovery Oriented Systems of Care, the Scottish Government wants people who experience problem alcohol and drug use, receive effective services and interventions which support them to reduce harm and achieve their recovery. Access to key interventions have been improved which will reduce harm, specifically focusing on those who inject drugs by launching a peer naloxone pilot. The Scottish Government, national support and local

partnerships continue to support the growth and expansion of Scotland's recovery communities into wider community settings.

Taking a Public Health Approach to Justice to divert those with problematic alcohol and drug use away from the justice system and into treatment. Work with key partners to ensure that people who come into contact with justice agencies are provided with the right support from appropriate services. Our Prison to Rehab pathway ensures that people with alcohol and drug problems receive continuity of care between prison and community services.

The Drug Deaths Taskforce (DDTF) was set up in June 2019 in acknowledgment of the rising number of drug related deaths (DRDs) in Scotland. In July 2019, National Records Scotland published their annual DRD statistics which showed that Scotland had recorded 1,187 drug related deaths in 2018, 253 (27%) more than in 2017 and the highest number ever recorded.

While the majority of the work of the DDTF is being taken forward by its sub-groups, the DDTF as a whole has implemented a number of changes in the times since its formation, along with providing direction and guidance to Health Boards, Alcohol and Drug Partnerships and drug and alcohol treatment services.

More information on the DDTF can be found on its website[74] including a report of its first years activities.

Northern Ireland

The current strategy to address substance use in Northern Ireland, *A New Strategic Direction for Alcohol and Drugs* (NSD), was put in place in 2011. During 2018, the Department of Health undertook a full review of NSD Phase 2 which was published in January 2019.
https://www.health-ni.gov.uk/sites/default/files/publications/health/NSD%20PHASE%202%20Final%20Review%20-%20October%202018_0.pdf)

In summary, the review reported some encouraging signs in relation to reductions in substance use at the population level, e.g. there had been significant reductions in the levels of binge drinking and the percentage of young people who drink and get drunk. Among adults, prevalence of illegal drug use had largely plateaued and significant numbers of individuals and families continue to access treatment and support services for alcohol and drug use. In addition, drug use among young people had fallen significantly.

However, this was offset by increases in a range of indicators related to harm. For example, hospital admissions and deaths as a direct result of harm related to substance use, are high and rising, and there are ongoing concerns about polydrug use, the misuse of prescription drugs and Novel Psychoactive Substances.

Following the publication of the final review, the Department took forward a pre-consultation exercise during 2019 which highlighted the need for a new strategy and gave suggestions for how this should be taken forward and what should be included.

[74] https://drugdeathstaskforce.scot/

Work on co-production of the new substance use strategy began at the end of 2019. This was done in conjunction with a writing group of key stakeholders with representatives of service users, community and voluntary organisations, academics, and other government departments and agencies. It is hoped that the new substance use strategy will be published for formal public consultation in the very near future.

Isle of Man

	Sex	Period	Rate	Lower CI	Upper CI
Deaths from drug misuse	Persons	2016-18	8.4	4.7	12.1
Deaths from drug misuse	Male	2016-18	14.0	7.1	20.8
Deaths from drug misuse	Female	2016-18	2.9	0.1	5.7

Paragraph 3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

e) Please provide information on 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 health problems of the populations affected. Please provide also information about measures taken to inform the public, including pupils and students, about general and local environmental problems.

England

Air, water and other forms of pollution

Public Health England (PHE), as an executive agency of the Department for Health and Social Care (DHSC), provides specialist advice relating to environmental pollutants, including air and water pollution, to support measures to reduce exposure.

PHE has a sustained programme of work to support government to prevent exposure to air pollution, raise the profile of air quality issues, and protect against the health effects of air pollution. This includes the provision of health advice to accompany the Daily Air Quality Index (DAQI). The DAQI highlights short-term increases in air pollution levels, alongside health advice for at-risk individuals, as well as the general population, on proportionate actions that can be taken to reduce health risk. It is available here: Daily Air Quality Index - Defra, UK

PHE provides an important role in the quantification and prevention of adverse health effects that may occur from exposure to chemical contaminants in drinking water. PHE delivers a crucial role in ensuring the safety of the public water supply by providing toxicological advice and health risk assessments to the Drinking Water Inspectorate for the regulatory approval of drinking water products.

PHE plays an advisory role in the overall health risk assessment process of contaminated land and provides advice to local authorities on matters including risk communication, for example - a leaflet for good hygiene when gardening. The leaflet is available here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779168/factsheet_for_contaminated_land.pdf

Furthermore, in 2019, PHE published a report on the topic of public health protection in radiation emergencies. This gives advice on a wide range of radiation emergencies and is intended to be applied pragmatically during preparedness, response and recovery phases, according to the scale and type of release; location-specific factors; and the needs of the local community.

The report is available here: https://www.gov.uk/government/publications/radiation-emergencies-public-health-protection-2019

PHE also produces a Compendium of Chemical Hazards as an online chemical information resource for responding to chemical incidents which is available here: https://www.gov.uk/government/collections/chemical-hazards-compendium

The UK recovery handbooks provide guidance on the management and recovery of chemical, radiation and biological incidents. It is available here: https://www.gov.uk/government/collections/recovery-remediation-and-environmental-decontamination

The Environment Agency is a non-departmental public body, sponsored by the Department for Environment, Food and Rural Affairs (DEFRA), with responsibilities relating to the protection and enhancement of the environment in England. The Environment Agency regulates major industry and waste to protect people and the environment and to support sustainable growth. It seek to do this in a way that minimises the administrative costs on businesses and makes it as easy as possible for them to do the right thing. The regulatory activity of the Environment Agency implements UK legislative requirements for England, designed to protect air, land and water.

Each year, the Environment Agency publishes a report on the environmental performance of regulated business. 'Regulating for people, the environment and growth' that helps us maintain our reputation as a trusted and respected regulator. The most recent report shows the driving down of emissions to air, water and land in regulated sectors. Big challenges remain: businesses are not doing enough to stop serious pollution incidents and the number of illegal activities involving waste is still too high. The next report is due to be published in spring 2021.

Sites regulated by the Environment Agency include chemical installations, facilities which process and treat waste, energy generation, nuclear and non-nuclear uses of radioactive materials, disposal of radioactive waste, onshore oil and gas installations and COMAH sites. Alongside regulatory duties the Environment Agency also carries out enforcement to tackle illegal activities, such as waste crime. We liaise with the police and local authorities among others to combat serious and organised crime groups and large scale fly-tipping.

The Environment Agency manages the UK's national air quality monitoring sites on behalf of Defra and the Devolved Administrations. There are around 300 of these sites, and they are organised into networks. The pollutants measured and method used by each network depends upon the reason for setting up the network, and what the data are to be used for. An interactive monitoring map is available to view the locations of the sites in the UK networks.

The Environment Agency, along with the other UK environment agencies and food safety agencies, collaborates in carrying out independent monitoring and assessment of radioactivity in the environment and publishes the results in the annual Radioactivity in Food and the Environment report.

Education on environmental matters

Topics relating to the environment are included throughout both the science and geography programmes of study within the National Curriculum for England. At primary level, pupils are taught how environments can change, including positive and negative impact of human

actions. In secondary science, pupils are taught about a range of environmental problems linked to pollution, such as the accumulation of toxic materials in an ecosystem, the effects of increased methane and carbon dioxide in the atmosphere and common atmospheric pollutants such as nitrogen oxides. They also learn about nuclear energy and associated issues of radioactive waste disposal and contamination.

Scotland

The Scottish Environment Protection Agency (SEPA) is Scotland's principal environmental regulator and its role is to protect the environment and human health by helping business comply with its environmental obligations. It has a range of enforcement powers to ensure that regulations are complied with. Public Health Scotland (PHS) provides specialist operational support and advice to stakeholders regarding risks to human health from environmental hazards such as flooding, air, water and land contamination. PHS also provides advice and support to stakeholders during acute and chronic environmental incidents where a potential risk to human health exists, through the assessment of potential risk and the provision of advice on mitigation measures to protect human health.

SEPA also undertakes a range of public information activities in order to inform people about both general and local environmental problems. It operates Floodline, a live flooding information and advice service, 24 hours a day, 7 days a week which includes an opt in notification service. Information on bathing water quality through daily water quality predictions are available on the SEPA website[75] and via electronic signs at 28 beach locations, providing real time water quality advice to the public.

On behalf of the Scottish Government, SEPA operates the Volcanic Emissions Network across the North of Scotland extending the geographical coverage of the existing air quality monitoring network in Scotland and forming part of an early warning system to better detect and report on potential effects of volcanic emissions on air quality. Response arrangements, involving SEPA, PHS and other partners, are in place for responding to volcanic or other transboundary airborne hazard events with the potential to impact on human health in Scotland. These arrangements mirror those in place for the Airborne Hazard Emergency Response Service for Scotland, which is operated by SEPA and involves PHS and other partners in assessing the risk to human health from acute airborne hazard incidents and advising on measures to prevent or minimise ongoing exposures. SEPA also operates the Scottish aspect of the Radioactive Incident Monitoring Network and assesses any impact of an incident and advises on clean up.

In addition, SEPA undertakes a range of activities specifically targeting at pupils, including partnership working with a number of local authorities to undertake specific programmes of work linked to schools with local air quality issues and to encourage behaviour change in pupils and parents which feeds into a citizen science project on CleanAir@School, safety in the community events for primary schools in conjunction with local authorities and the police, and the STEM (science, technology, engineering and mathematics) Ambassadors scheme.

Scotland's first Clean Air for Scotland Strategy, published in 2015, set out an ambitious programme of action to promote air quality, and Scotland was the first country in Europe to pass legislation based on World Health Organisation guidelines for a fine particulate matter 2.5 – a pollutant of special concern for human health. An independently led review of our Cleaner Air for Scotland strategy was undertaken in 2019, to make sure Scottish

[75] https://www2.sepa.org.uk/bathingwaters/

Government is doing all we can to improve air quality. The recommendations and conclusions from this review are being used to develop Scotland's next air quality strategy, which will be published in the first part of 2021 following a consultation on the proposals which is currently underway.

The Air Quality in Scotland website[76] provides near real time monitoring data on a range of pollutants from the 100 sites in the Scottish air quality monitoring network. The website also provides an extensive searchable database of historical monitoring data, along with air pollution forecasts, data analysis tools, a variety of background information on air pollution and the Know & Respond system which allows individuals to sign up for voice, text or email alerts about high pollution forecasts. In addition, the website contains two sets of educational resources, Air Pollution Detectives aimed at primary school pupils and Clear the Air for secondary school pupils.

Northern Ireland

Air quality monitoring Northern Ireland

https://www.daera-ni.gov.uk/news/nis-first-clean-air-strategy-aims-protect-peoples-health

Air quality monitoring is carried out using automatic equipment, which monitors air continuously and can provide real-time data. Non-automatic equipment monitoring can provide representative data, for example, monthly average figures.

Monitoring is carried out by both the Department and by district councils. Most of the air quality monitoring sites in Northern Ireland measure one or two pollutants, but there are two multi-pollutant sites: one of these is in Belfast's Lombard Street, while the other is in Derry/Londonderry's Brooke Park.

Data from some of our monitoring sites is fed into the UK network, and provides for quality assurance and quality control of the data as well as analysis and comparison in a national context.

Information on activities undertaken to prevent, monitor and control pollution of the air, land and water can be found here: https://www.daera-ni.gov.uk/topics/pollution

Wales

The Clean Air Plan for Wales

Isle of Man

Isle of Man of Man Government Laboratory

The Isle of Man Government maintains its own Government Laboratory to provide analytical support to its various departments and functions. The Laboratory also serves local authorities, businesses and the wider community.

[76] http://www.scottishairquality.scot/

Through its activities supporting the work of various parts of Government, key agencies, businesses and even the general public the Laboratory plays a pivotal role in the well-being of the Island.

Services include for example the monitoring of bathing water quality, drinking water quality, food safety and quality, gas and leachate from landfill, marine algae/nutrient monitoring, radiation monitoring and river water quality

Environmental Radiation Monitoring (Published by Isle of Man Department of Environmental, Food and Agriculture)

The Isle of Man Government Laboratory carries out its own independent monitoring of environmental radioactivity on the Island, maintaining fixed monitoring stations at several locations on the Island, and also monitors radioactivity levels in food. Since 1989 the Laboratory has issued Annual Reports dealing exclusively with radioactivity in foodstuffs and the general environment. The monitoring results have shown no evidence of hazardous levels of radioactivity on the Island. Please refer to the link for the 2019 Radioactivity Monitoring on the Isle of Man published report.
https://www.gov.im/media/1352161/radmon2019.pdf

Climate Change

The Isle of Man Government has committed to transitioning to a net-zero emissions Island for the benefit of the environment, the Manx people, and future generations.

The Climate Change Bill 2020 sets a target date for net-zero emissions of all greenhouse gases by 2050.

Net-zero means that there will be a balance between the amount of greenhouse gas produced and the amount removed from the atmosphere.

In achieving this goal, an Isle of Man Climate Change Transformation Team has been established to facilitate the transition through the implementation of the Climate Action Plan Phase 1 and the development of the Phase 2 Action Plan.

In 2019 an Independent Report by Professor James Curran was conducted to lay the platform of the Phase 1 Action Plan and guide the Transformation Team in its efforts.

To ensure that the work of the Climate Change Transformation Team is informed by the experiences of our community, for our community, a Citizens' Forum has been established in order to allow the Transformation Team to engage regularly with a representative group of people from across the Island

Paragraph 3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

f) In the context of the COVID-19 crisis, please evaluate the adequacy of measures taken to limit the spread of virus in the population (testing and tracing, physical distancing and self-isolation, provision of surgical masks, disinfectant, etc.) as well as the 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 while ensuring that their working conditions are healthy and safe – an issue addressed under Article 3 above). Please indicate the measures taken or foreseen as a result of this evaluation.

United Kingdom

The UK Government published its Covid Action Plan in March 2020 (a joint plan of the UK and Devolved Administrations). This sets out how the UK was already well prepared for disease outbreaks, having responded to a wide range of infectious disease outbreaks in the recent past, and having undertaken significant preparedness work for an influenza pandemic for well over one decade (eg. our existing plan 'flu plans16). The Government's plans had been regularly tested and updated locally and nationally to ensure they were fit for purpose. This experience provided the basis for an effective response to COVID-19, which has been tailored as more specific information has emerged about the virus.

These plans ensured the UK was equipped to deliver a coordinated multi agency response to minimise the wider societal impact arising from a significant outbreak. The Government recognised that an effective response also required the active participation of a well-informed public and all service providers.

UK planning draws on the idea of a "reasonable worst case (RWC)" scenario. This is not a forecast of what is most likely to happen, but ensures we are ready to respond to a range of scenarios.

Planning Principles
In preparing for, and responding to, a serious disease outbreak, the UK and the Devolved Administrations aim to:

- undertake dynamic risk assessments of potential health and other impacts, using the best available scientific advice and evidence to inform decision making

- minimise the potential health impact by slowing spread in the UK and overseas, and reducing infection, illness and death

- minimise the potential impact on society and the UK and global economy, including key public services

- maintain trust and confidence amongst the organisations and people who provide key public services, and those who use them

- ensure dignified treatment of all affected, including those who die

- be active global players - working with the World Health Organization (WHO), the Global Health Security Initiative (GHSI), the European Centre for Disease Prevention and Control (ECDC), and neighbouring countries, in supporting

international efforts to detect the emergence of a pandemic and early assessment of the virus by sharing scientific information

• ensure that the agencies responsible for tackling the outbreak are properly resourced to do so, that they have the people, equipment and medicines they need, and that any necessary changes to legislation are taken forward as quickly as possible

• be guided by the evidence, and regularly review research and development needs, in collaboration with research partners, to enhance our pandemic preparedness and response. 3.6 The UK Government and the Devolved Administrations have been planning an initial response based on information available at the time, in a context of uncertainty, that can be scaled up and down in response to new information to ensure a flexible and proportionate response.

The fundamental objectives are to deploy phased actions to Contain, Delay, and Mitigate any outbreak, using Research to inform policy development.

The different phases, types and scale of actions depends upon how the course of the outbreak unfolds over time. We monitor local, national and international data continuously to model what might happen next, over the immediate and longer terms.

The overall phases of the Government's plan to respond to COVID-19 were:

• **Contain**: detect early cases, follow up close contacts, and prevent the disease taking hold in this country for as long as is reasonably possible
• **Delay**: slow the spread in this country, if it does take hold, lowering the peak impact and pushing it away from the winter season
• **Research**: better understand the virus and the actions that will lessen its effect on the UK population; innovate responses including diagnostics, drugs and vaccines; use the evidence to inform the development of the most effective models of care
• **Mitigate**: provide the best care possible for people who become ill, support hospitals to maintain essential services and ensure ongoing support for people ill in the community to minimise the overall impact of the disease on society, public services and on the economy.

England

The UK Government has published and regularly updated its guidance on preventing the spread of the guidance, focussing on physical distancing and good hygiene practices as the most effective tools to prevent the spread of the virus: https://www.gov.uk/government/publications/how-to-stop-the-spread-of-coronavirus-covid-19. It is too soon to evaluate the adequacy of measures taken.

The UK Government uses the best available science, along with consideration of the most up-to-date data available at the time to inform Covid-19 related decisions for British citizens. This includes the use of the new Joint Biosecurity Centre (JBC) which leads our biosecurity monitoring system. The JBC brings together epidemiologists alongside other analysts from across government to provide informed advice on decisions about managing the disease.

Workforce:
More than 47,000 former healthcare professionals came forward to support the NHS.

Around 18,000 remain in contact with NHS England and Improvement (NHSE/I) which continues to work with the returners to identify how they can support the response.

The NHS has sustained its workforce resilience during the pandemic by:

- Bringing in new staff;
- Freeing up, redeploying and up-skilling the existing workforce; and
- Supporting staff health and wellbeing with a comprehensive package of emotional, psychological and practical support for staff.

NHS England and Improvement are committed to supporting staff and investing in the workforce. The NHS People Plan published on 30 July 2020 will make sure the right measures are in place to support and grow the workforce and strengthen retention in the NHS.

The NHS is setting up a first wave of staff mental health hubs. These will support frontline staff to overcome barriers to seeking help. The hubs will provide training for managers and senior leaders and a single point of access to assess needs and co-ordinate referrals.

In the first wave of the pandemic more than 28,000 nursing and midwifery students opted into paid placement as part of the COVID-19 “call to arms”, as well as 8,000 Allied Health Professional students.

Over 3,000 medical students graduated early and started work.

Staff Absences
As at 1 October 2020, there were 68,534 total staff absences, of which 19,493 were Covid-19 related.

Nursing Stats:

- Nurse numbers have increased by almost 14,200 in the past year (between June 2019 and June 2020 – excluding health visitors and midwives).
- In the NHS there were almost 83,600 vacancies overall in June (6.7% of the workforce).
- The number of vacancies has decreased by over 28,200 in the 12 months to June (25%).
- As of June 2020, there are over 37,800 nursing and midwifery vacancies, of which the majority are filled by bank and agency staff, which is almost 6,400 (14%) fewer vacancies than in June 2019.

Scotland

Measures To Limit Spread[77]

Physical Distancing
The Scottish Government, in common with other UK nations, is committed to suppressing the virus to the lowest possible level until there is a vaccine and/or effective treatments which mean that the virus no longer poses a threat to public health.

[77] Including safe working conditions for medical staff

Since the outset of the pandemic, the Scottish Government has recognised that, in the absence of a vaccine, physical distancing and good hygiene practices remain the most effective tools to prevent the spread of the virus. This has been clearly and consistently reflected in our general public health advice to the population as well as in the guidance to ensure the safe re-opening and operation of businesses and organisations.

Our approach to physical distancing has been guided by clinical evidence, expert advice and a balanced approach on risks. Decisions on the recommended minimum physical distance has primarily been focussed on the need to protect health, and in particular groups at a higher risks of severe illness from coronavirus (e.g., elderly, those with underlying illnesses, Black and Ethnic Minority communities, and those in precarious jobs). Based on this, 2-metre distancing has become the recommended minimum distance between adults of different households, as the risk of transmission will be increased if the physical distancing was reduced. In line with the scientific evidence, and in recognition of their wellbeing and educational needs, children under the age of 12 are not required to physically distance from other children and adults, both in school and in the community. A precautionary approach has been adopted for older children in secondary schools, where distancing between young people and from adults is encouraged.

Public health messaging has been key in order to ensure adherence to basic public health protection measures. Our FACTS campaign (Face coverings in enclosed spaces; Avoiding crowded places; Cleaning hands and surfaces regularly; Two-metre physical distancing; and Self-isolating if you have symptoms) has been disseminated through multiple Scottish Government communication channels to maximise outreach. To ensure accessibility, the Scottish Government has been leading on the coordination of translations of NHS Inform coronavirus content with NHS Scotland and Public Health Scotland, which continues to be updated on a bi-weekly basis. The FACTS poster, for example, has been created in 38 additional languages and accessible formats.

Face Coverings

The World Health Organisation (WHO) recommends the use of face coverings as a non-pharmaceutical intervention. There is evidence that face coverings bring a benefit in reducing transmission of the virus as they provide protection to those around the wearer should the wearer be asymptomatic or pre-symptomatic and may provide some protection against aerosol transmission.

However, face coverings are not a substitute for good hand hygiene and physical distancing, which are the most important measures, and it’s important to remember the FACTS for a safer Scotland that we all need to comply with in order to reduce the transmission of the virus.

In line with the evidence on the benefit of face coverings, the Scottish Government has made the use of face coverings mandatory in a large range of indoor public places, in indoor communal workplaces, shops and on public transport where we know the risk of transmission is highest. The Scottish Government also advises the use of face coverings in places where 2m distancing is difficult, including outdoors.

Data from You.Gov polling[78] indicates that the majority of the public (87%) believe that face coverings are very important or fairly important in helping to keep the spread of the virus under control (at 13-15 October). Additionally, data shows that compliance rates are extremely high with 96% of respondents feeling they are doing very well or fairly well at wearing face coverings in the mandated places (at 15-17 September).

PPE Framework

In response to requests for help in securing PPE supplies from organisations delivering essential public services in community settings, the Scottish Government established a framework in May 2020 with a third party supplier for the supply of PPE.

With the exception of the National Health Service (NHS) and regulated adult care sector, who receive support separately, the organisations that are eligible to purchase from the framework include all Scottish public bodies; registered Scottish charities and voluntary organisations; and authorised private-sector organisations employing staff who provide essential public services where there is a risk to health. Where an organisation is experiencing challenges in securing PPE through their existing supply chains, they can purchase PPE directly from the third party supplier through this framework.

In the first six months of this framework, hundreds of organisations have been able to acquire essential PPE to enable them to carry out their work safely. The framework also provides resilience to organisations across Scotland until at least April 2021.

Shielding

At the start of the pandemic, the Scottish Government asked people at the highest risk from Covid-19 to stay home because the infection rate in the community was so high. Clinicians helped us identify the people who need to be on the shielding list. This could be those with health issues as listed:

- Solid organ transplant recipients
- People with specific cancers
- People with severe respiratory conditions
- People with rare diseases including all forms if interstitial lung disease / sarcoidosis
- People on immunosuppression therapies that significantly increase risk of infection. Or people who have had their spleens removed
- People who are pregnant with significant heart disease, congenital or acquired
- People who are receiving renal dialysis treatment

[78] Surveys are conducted online via YouGov, interviewing c.1000 adults 18+ across Scotland. Fieldwork dates are as shown. YouGov apply weighting to the data to match the population profile to adjust for any over/under representations and to maximise consistency from wave to wave.
Questions and responses:

- How important, if at all, do you think each of the following is in helping to keep the spread of Coronavirus (Covid-19) under control?
- Wearing a face covering: Very important 72%; Fairly important 16%; Not very important 6%; Not at all important 4%; Don't know 3%
- How well, if at all, do you feel you are doing at each of the following?
- Wearing a face covering when it's required: Very well 86%, Fairly well 11%, Not very well 1%, Not at all well 2%, Don't know 1%

The Scottish Government is aware of the harms that can come from shielding. We did not want people to carry on shielding if they did not need to. The Scottish Government has been monitoring these impacts and weighing them up the harms against the benefits of shielding. The Scottish Government has also been listening to those who have been shielding. This feedback has helped develop a new approach to shielding.

There is no longer separate advice for people on the shielding list. They can follow the same guidance[79] as the rest of Scotland. To stay safe, the Scottish Government advises they should strictly follow two metre physical distancing and hand washing measures, wear a face covering in shops, inside hospitality settings and on public transport if able.

In general, Scottish Government advice will continue to be to work from home where possible. Employers must make workplaces safe for all employees. That means employees should be able to physically distance from one another. If this is not possible then other protections must be put into place. We expect that the vast majority of those who have been asked to shield will be able to return to work. Employers have a statutory duty to protect their health and safety. This includes assessing the risk of being infected with coronavirus in the workplace. It also includes taking appropriate steps to reduce this risk.

The Scottish Government knows in some workplaces it is very difficult, or not possible, to maintain physical distancing. The returning to work guidance[80] for workers and employers is updated. The Scottish Government will also continue to work with businesses to develop safe practices. Scottish Hazards[81] provide a confidential service for workers for workplace health and safety advice and support.

If a person is not able to go back to work, they should discuss with their employer what steps they could take to reduce the risk in the workplace.

The best protection for people who are most at risk from the virus is to stop its spread in our communities. But if case numbers are too high, the Scottish Government must take clear steps to provide additional protection, in a way which safeguards individual wellbeing and human rights.

Measures To Treat The Ill

Bed Capacity

To date, and at no point since the COVID-19 outbreak, has the demand for acute beds in Scotland exceeded the available capacity.

Health Boards in Scotland are also planning how to safely and incrementally re-introduce services that have been paused during the COVID-19 emergency. This process is being taken very slowly and kept under continuous review.

Boards also retain capability to reinstate their share of the original re-purposed 3,000 beds surge capacity as required. This capacity can be further augmented, as required, by the use of a new temporary hospital, the NHS Louisa Jordan [up to 1,000 beds].

[79] https://www.gov.scot/publications/coronavirus-covid-19-protection-levels/
[80] https://www.gov.scot/publications/coronavirus-covid-19-returning-to-work/pages/workers/
[81] https://www.scottishhazards.org.uk/

The number of patients in ICU with recently confirmed COVID-19 peaked at around 200 in April, and with the addition on non-covid ICU patients peaked at almost 300. In general, across the course of the pandemic in Scotland, NHS Boards have retained the ability to double their ICU capacity to 360 within one week, treble to 585 in two weeks and, if required, extend this to over 700, subject to staff and supplies.

Health Workforce
Since the outbreak of the pandemic, Scotland has worked hard to ensure that Infection Prevention and Control (IPC) measures in hospital and other care settings are robust. This includes measures such as the appropriate use of PPE, extended use of face masks and coverings, physical distancing, and outbreak management, as well as risk assessed patient care pathways to help guide the implementation of measures for safe and effective care and safe working conditions.

Transparent Face masks
The Scottish Government recognises that opaque face coverings can pose a real challenge for some people who rely on lip-reading or seeing facial expressions in order to communicate and interact with others. Therefore, in June 2020 an Edinburgh-based company was awarded funding to expand its production of face coverings to include reusable coverings with transparent panes, which facilitate lip-reading. This company is now being supported by the National Manufacturing Institute for Scotland (NMIS) and the National Physical Laboratory to upgrade these face coverings to type IIR masks that are suitable for use in clinical settings. The Scottish Government is cautiously optimistic that medical grade transparent masks designed and manufactured in Scotland will soon be available for use in clinical settings.

Future Approach

On 7 October 2020 the First Minister of Scotland announced that further restrictions would be introduced on a nationwide basis with some additional localised measures in place. We have set out plans for a new 5-level system to help tackle the spread of the virus which are due to be introduced from 2 November 2020

Building on the support we put in place at the start of pandemic, our future approach to shielding will be based on the following principles:

- advice must be proportionate to the level of infections in the local community;
- it should be set at a level which optimises the benefits of protection and minimises non-Covid health, social and economic harms;
- it should be practical, empower people to make decisions which are right for them, and be culturally appropriate and tailored to ensure reach and accessibility.

The Scottish Government will introduce levels of advice to protect people with the highest clinical risk, which will be available to view on our website[82], setting out clearly how advice will change depending on the rates of infection in local areas. As the levels in a local area change, the protection advice for people on the shielding list in that area will change as well. People at highest risk should still follow the advice for the general public as a minimum, but these levels provide additional advice for areas like work, schools, shopping and contact with others.

[82] https://www.gov.scot/publications/coronavirus-covid-19-local-measures/

This new advice and guidance will sit alongside a range of measures in place to support this group, including:

- SMS Text Alert Service
- Data on neighbourhood infections
- Information on high and low risk activities
- Workplace risk assessments
- Information on how to shop safely
- Online priority shopping slots
- Helpline (0800 111 4000)
- Local Authority and Third Sector support
- Mental and Physical Health and Wellbeing support
- Vitamin D offer

People are encouraged to adapt this advice to make it right for them. It is a personal decision how to balance the benefits of protection with quality of life. To do this in practice, people told us they needed information about infection rates in local communities, level of risk specific to their health conditions, and how to manage risks on a day to day basis.

The Scottish Government is therefore providing a package of information, tools and advice to those on the shielding list to enable and empower them to make informed decisions about how to stay safe and protect themselves, and to promoting their health and wellbeing more broadly. A practical guide will shortly be published to help them find all this information and balance what is right for them, including:

- Publicly available Neighbourhood Covid infection data[83]
- Information on specific clinical conditions
- Information on high risk activities and keeping safe during common daily activities
- Workplace risk assessments that take account of age, sex, ethnicity, BMI as well as clinical conditions and recommend practical protective measures, with GP issued fit notes for people who cannot work safely

Those on the shielding list will still be able to go to shops and pharmacies but there are a range of shopping and delivery options available to make shopping safer, including supermarket support for those who are clinically at risk.

The SMS Text Service will continue to provide updates and alerts, including to people in outbreak areas who are on the shielding list. Updated advice will also be available online and the national helpline will continue to be available for information, advice and to signpost support, including for those who are struggling with access and affordability issues in relation to food.

The Scottish Government will continue to work with local authorities, health and social care partnerships and their third sector partners to plan and deliver local support, and will continue to promote physical and mental health and wellbeing. The Scottish Government will offer those on the shielding list a free supply of Vitamin D over the winter months to support musculoskeletal health.

Northern Ireland

[83] https://public.tableau.com/profile/phs.covid.19#!/

In Northern Ireland, in response to the urgent need for all residents to be protected from contracting coronavirus and to reduce the public health risk by enabling people, including those in marginalised groups, to comply with government guidance on shielding, self-isolation and social distancing the Department of Health has provided funding to the Northern Ireland Housing Executive through the Department of Communities to support those individuals who have become homeless but who have No Recourse to Public Funds through social care or other housing routes. The Department of Health has sufficient powers under the HPSS Order 1972 (schedule 5) and the HSC Reform Act 2009 to enable the provision of accommodation and other services to individuals with NRPF. This arrangement will be a temporary one, to come to an end when the current public health emergency arrangements are stood down.

Wales

The Coronavirus Control Plan for Wales sets out the existing systems designed to prevent the spread of the virus, as well as the new systems the Welsh Government put in place to respond swiftly to new cases at a local level. Containing outbreaks at source through effective health surveillance, testing, tracing and self-isolation is, most likely, the only way to avoid a return to the strict and intrusive, all Wales, restrictions we have faced together.

Isle of Man

All travel to the Isle of Man by both residents and non-residents is currently restricted by Regulations and managed by the Travel Notification Service which forms part of the broader Covid Response Team of the Cabinet Office. Any arrival on the Isle of Man, resident or non-resident, are required to either register (resident) for return travel or make an application (non-resident) which, if approved, carries with it certain restrictions to manage any potential risk. All arrivals are then required to complete a landing form with additional checks at the point of arrival.

This system enables the quick identification of potential travel related close contacts of any person subsequently proving positive for COVID-19 post arrival through a shared database. The standard period of required self-isolation for arrivals on the Isle of Man is 14 days although there are exemptions to this period which are managed on an individual basis.

A specific Covid 111 call centre has been established within the Covid Response Team resourced by both clinical and non-clinical resource to receive calls from the public regarding COVID-19 symptoms. Anyone reporting symptoms is triaged against an algorithm by a clinician and where a clinical decision is made to test then an appointment can be made immediately with the patient for a swab which is conducted by health care practitioners at a central location. This team manages result notification to patients and is able to provide clinical advice as well ensure the patient is self-isolating which is a legal requirement.

Where a positive case is identified Covid 111 informs Contact Tracing which is also managed by the Covid Response Team with oversight by the Director of Public Health informed by European Centre for Disease Prevention and Control guidelines. The initial contact tracing response is delivered through on-call arrangements by Environmental Health Officers with an ability to scale up where necessary.

Escalation plans are in place to ensure that the ‘right to protection of health’ during the COVID-19 Pandemic is effective and within the capacity of the health services.

At the time of writing (November 2020), there is no evidence of community transmission of COVID-19 on the Isle of Man.

Effective processes and policies have been put in place to allow for the safe delivery of care for both COVID-19 positive and negative patients. This allows for smooth transfer from all tiers of healthcare provision inclusive of rigorous testing and isolation protocols.

There is presently appropriate capacity within Emergency, Critical care and inpatient services to meet current demand with plans in place to increase NIV and Critical Care Capacity as demand requires.

There is an adequate amount of ventilators and specialist equipment for e.g. high flow oxygen and non- invasive ventilation, should the planned public health measures control community transmission within the Isle of Man Government response levels.

There is a system in place for the redeployment of medical and nursing staff to support ring-fenced COVID wards and critical care as well as ensure BAME/ Vulnerable staff members are able to be employed within low risk areas.
Staff have been trained in the use of personal protective equipment (PPE) and fit testing for the use of respirator masks (FFP3). PPE risk assessments are in place effective and monitored.

Paragraph 3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

g) Please provide responses to comments and queries from 2017 conclusions (see extracts of the full conclusions attached to the commissioning email for the context):

The Committee asks for updated figures on the coverage rates for the main vaccines throughout the United Kingdom in the next report.

United Kingdom

Routine childhood vaccinations

- England: For the period between 1 April 2019 to 31 March 2020, coverage increased for most routine childhood vaccinations across England, with the exception of the 5-in-1/6-in-1[84] at 24 months. Dose 1 coverage of the mumps, measles and rubella (MMR) vaccine at 24 months increased from 90.3% last year, to 90.6% this year for the first time in six years in England since a peak of 92.7% in 2013-14.
- Wales: For the period April to June 2020, for in children at one year of age in Wales, uptake of all routine immunisations, apart from rotavirus, remained above 95%.
- Scotland: For the quarter ending June 2020 in Scotland, uptake rates remained high with over 96% of children receiving each routine immunisation by the time they were 12 months old, apart from the rotavirus vaccine, which had 94.1% uptake.
- Northern Ireland: In 2019/20, coverage at 12 months, 24 months and 5 years remained above 90% for routine vaccinations (excluding Hepatitis B).

Adolescent vaccinations:

- England: This refers to latest coverage data submitted by local authorities (to note, not all local authorities provided complete data). For 2018/19, average vaccine coverage for the school leaver booster to year 9 students was 87.6% and 86% for year 10. For Meningococcal ACWY (MenACWY) in 2018/2019, average vaccine coverage to year 9 students was 88% and 86.7% for year 10s. In 2019/20, 64.7% of year 9 females completed the 2-dose human papillomavirus (HPV) vaccination course. HPV vaccine coverage for the priming dose in 2019/20 was 59.2% in Year 8 females (compared with 88.0% in 2018/19) and 54.4% in Year 8 males.
- Wales: For 2019/20, HPV uptake of one dose was 87.3% (school year 9) and 83.5% for two doses (school year 10). For MenACWY, uptake was 85.5% (school year 10) and teenage booster was 85.4% (at 15 years). MMR at age 15 year (2 doses) was 91.7%.
- Scotland: In 2018/19, uptake of the teenage booster immunisations among S3 pupils was around 82%, similar to previous years. Pupils who miss the routine teenage booster immunisation sessions in S3 are offered the vaccines in S4. In 2018/19 an additional 4 to 5% of pupils received these vaccines when they were in S4, taking immunisation rates to over 86% by the end of S4. HPV immunisation uptake rates for S1 to S3 girls remained high in Scotland, 85.4% of eligible girls receiving both doses of the vaccine by the end of S3 in 2018/19.

[84] The 6-in-1 is given as a single injection to protect your baby against 6 serious childhood diseases: diphtheria, hepatitis B, Hib (Haemophilus influenzae type b), polio, tetanus, whooping cough (pertussis)

- Northern Ireland: In 2019/20, coverage of Men ACWY in year 11 was 63.9% and 81.7% in year 12 students. MMR dose 2 at year 12 was 94.7%. Uptake of the school leavers booster for year 11s was 61.6% and 77.9% for year 12s.

Shingles vaccination

- Shingles vaccine is routinely offered to those aged 70 years, with opportunistic vaccination to eligible individuals aged 71 to 79 years who have not previously been vaccinated. During the pandemic, due to the public health advice on social distancing and shielding, general practices were not expected to offer the opportunistic shingles vaccine to those aged 70, unless the patient was already in the GP practice for another reason.
- England: Cumulative shingles vaccine coverage at the end of June 2020, for cohorts offered shingles vaccine prior to the financial year 2019/20, was highest among 76 year olds (76.7%) and lowest among 71 (48.2%) and 77 (48.0%) year olds – half of whom need to wait until their 78th birthday to become eligible for the vaccine.
- Wales: September 2020 uptake was highest at age 76 years at 68.4% and lower at 78 years, 39.3%.
- Scotland: Cumulative shingles vaccine coverage at the end of June 2020 among 70 year olds was 39.7%. This is slightly lower than compared to 2019 (40.0%).
- Northern Ireland: For 2018/19, uptake of shingles vaccine was 45.5% for the routine cohort (70 year olds) and 47.6% for the catch-up cohort (78 year olds).

Pneumococcal for 65+

- England: the proportion of adults aged 65 years on 31 March 2020 who were vaccinated between 1 April 2019 and 31 March 2020 was 12.9% compared to 12.4% in 2018/19 and 11.8% in 2017/18.
- Wales: the proportion of adults aged 65 years and over in 2019/20 who were vaccinated was 60.2%.
- Scotland: The proportion of adults aged 65 years on 31 March 2020 who were vaccinated between 1 April 2019 and 31 March 2020 was 14.6% compared to 12.5% in 2018/19 and 9.2% in 2017/18.
- Northern Ireland: Uptake of the vaccine in individuals 65 years and over was 23.4% during 2018-19.

Pertussis in pregnancy

- England: pertussis vaccine coverage in pregnant women between Jan-March 2020 averaged 72.2% across the quarter, 1.1 percentage points higher than coverage for the same quarter in 2018/19.
- Wales: Pertussis vaccine coverage in pregnant women in 2019/20 was 79.4%, 3.3 percentage points higher than 2018/19.
- Scotland: Pertussis vaccine uptake for pregnant women between Jan-March 2020 across Scotland was 67.3%, which is lower than uptake for the same quarter of 2019 (70.32%).
- Northern Ireland: pertussis vaccine coverage in pregnant women between Jan-March 2020 averaged 73.1% across the quarter, 6.2 percentage points higher than coverage for the same quarter in 2018/19.

Isle of Man

Data Source: Public Health (Isle of Man)

		Period	%	Lower CI	Upper CI
Population vaccination coverage - Dtap / IPV / Hib (1 year old)	All	2018/19	91.2	89	93
Population vaccination coverage - PCV	All	2018/19	92	89.9	93.7
Population vaccination coverage - Dtap / IPV / Hib (2 years old)	All	2018/19	91.3	89.2	93.1
Population vaccination coverage - MMR for one dose (2 years old)	All	2018/19	87.5	85	89.6
Population vaccination coverage - PCV booster	All	2018/19	86.8	84.2	88.9
Population vaccination coverage - Hib / MenC booster (2 years old)	All	2018/19	86.9	84.3	89.1
Population vaccination coverage - MMR for one dose (5 years old)	All	2018/19	92.7	90.8	94.3
Population vaccination coverage - MMR for two doses (5 years old)	All	2018/19	84.5	81.9	86.8
HPV vaccination coverage for one dose (females 12-13 years old)	Female	2018/19	83.8	80.0	87.0
HPV vaccination coverage for two doses (females 13-14 years old)	Female	2018/19	81.5	77.5	84.9

Immunisation	Patient coverage	01-Jul-19	01-Oct-19	01-Jan-20	01-Apr-20	Average %
5 in 1 Immunisations - % Vaccinated by GP	Average IOM %	93.69	95.13	94.49	96.24	94.89
	Av.fig.North West, UK	94.30	93.10	95.00	92.40	93.70
MEN C Immunisations - % Vaccinated by GP	Average IOM %	91.77	91.28	92.23	92.67	91.99
	Av.fig.North West, UK	0.00	0.00	0.00	0.00	0.00
MMR Immunisations - % Vaccinated by GP	Average IOM %	91.19	91.70	93.36	93.34	92.40
	Av.fig.North West, UK	91.20	91.50	91.00	90.50	91.05
Pre School Boosters - % Vaccinated by GP	Average IOM %	89.15	90.91	91.64	91.28	90.74
	Av.fig.North West, UK	88.20	86.90	88.70	86.80	87.65

HPV Dose 1 - Sep/Oct 2019

	Cohort	Vaccinated	% Vaccinated	Consent not given	No response	DNA/Other
Total	962	778	80.9%	79	81	24

Article 12 – The right to social security

Para 1 - to establish or maintain a system of social security;

United Kingdom

Please see the attached consolidated UK 2020 report on the European Code of Social Security and ILO Convention 102 and other social security related conventions. This report addresses the non-compliance findings and the information requested in the Committee's 2017 conclusions. Please read Annex 2 at the end of the report (from p.97): 'Responses to requests for further information' for information, as this annex addresses some of the ECSR's specific requests for information.

Isle of Man

> *The Committee previously noted (Conclusions XIX-2 (2009)) that all persons residing in the United Kingdom were eligible for old age, disability and survivors non contributory pensions; that all unemployed jobseekers meeting the qualifying conditions were eligible for unemployment benefits and that all employed persons were covered in respect of work injury risk. It asks the next report to indicate what categories of persons (i.e. employees, self-employed, unemployed, all residents, etc.) are covered under each branch.*

Employees: all employees with earnings of at least the lower earnings limit for national insurance purposes (currently £120.00 a week) are covered for all branches. Employees with earnings of less than the lower earnings limit for national insurance purposes are not covered for contributory old age, survivors, incapacity or unemployment benefits, but are covered for work injury benefits and are covered for maternity benefit if they have earnings of at least £30 a week. Employees may [also] qualify for income-related social assistance benefits related to each of the branches, depending on their circumstances.

Self-employed: self-employed persons who have profits of at least the lower profits level for national insurance purposes (currently £7,176 a year) and are therefore liable to pay class 2 national insurance contributions, or who have profits below the lower profits level but are not excepted from the payment of class 2 national insurance contributions, are covered for contributory old age, survivors, incapacity and maternity benefits, but not unemployment or work injury benefits. If they are excepted from the requirement to pay class 2 national insurance contributions on account of low profits they will still be covered for maternity benefit if they earnings of at least £30 a week. Self-employed persons may [also] qualify for income-related social assistance benefits related to each of the branches, depending on their circumstances.

Unemployed: Unemployed jobseekers may be eligible for jobseeker's allowance either on account of the national insurance contributions they have paid as an employee (or are treated as having paid as an employee) and/or by way of social assistance. Entitlement to the social assistance benefit (i.e., "income-related" jobseeker's allowance) is normally subject to a residential test, though this may be waived in exceptional circumstances. See https://www.gov.im/categories/benefits-and-financial-support/employment-work-related/jobseekers-allowance/ for more information.

Non-employed: Non-employed people may be eligible for social assistance benefits, in particular income support, depending on circumstances. See https://www.gov.im/categories/benefits-and-financial-support/employment-work-related/income-support/ for more information. Non-employed persons may voluntarily contribute to their future state pension entitlement through the payment of class 3 National Insurance contributions. However, a person cannot voluntarily pay for coverage under any other branch.

Further information about Isle of Man social benefits can be found in the attached Appendix.

> *The Committee requests that the next report provide updated detailed information concerning the personal coverage of social security risks during the relevant reference period. For unemployment, sickness, old-age, disability, work injury and survivors' benefits, the report should provide the percentage of insured individuals out of the total active population.*

Given that the Isle of Man is a small jurisdiction with a relatively transient working age population it is difficult to provide meaningful figures in response to this question.

> *The Committee asks the next report to provide details of the sanctions applicable in the case of a refusal of a job offer not matching the claimant's profile, as well as on the judicial remedies available*

In the Isle of Man, jobseekers are not directed to take up any offer of employment, hence none have been sanctioned in this regard.

> *As regards old-age pensions, the report describes the new State Pension scheme adopted in 2014, which applies to people reaching state pension age on or after 6 April 2016. As the implementation of this reform falls out of the reference period, the Committee will examine it when it will next assess the UK conformity to Article 12§1 of the Charter. It asks the next report to provide all relevant and updated information in this respect.*

The Isle of Man has adopted the UK's new State Pension scheme, but only as regards people reaching state pension age on or after 6 April 2019. The full rate payable in the Isle of Man is about 10% higher than that paid in the UK, but otherwise the rules are identical. Pensioners in the Isle of Man may also be entitled to the Manx Pension Supplement, although this is gradually being phased out for new pensioners over the 20-year period starting from 6 April 2019.

See https://www.gov.im/categories/benefits-and-financial-support/pensions/manx-state-pension/ for more information.

> *The Committee asks the next report to clarify whether a recipient of the minimum state pension whose income would be lower than the legal threshold, even when adding the graduated benefit and second pension increases, would be entitled to receive as a supplement the non-contributory pension. It also asks under what circumstances a person might only receive the basic state pension, without any increases. In the meantime, it reserves its position on this point.*

In the Isle of Man, a non-contributory state pension is available to any person who reached age 80 before 6 April 2016 (subject to certain residency conditions) if they have no entitlement to a state pension or if their state pension entitlement (including any graduated benefit and state second pension increases) is less than the value of the non-contributory pension (currently £80.45 a week).

Appendix

Isle of Man Social Security Benefits

LEGISLATION

Since the last report the only Act of the United Kingdom Parliament which has been applied to the Island is the Pensions Act 2014.

Numerous Statutory Instruments of the United Kingdom Parliament relating to social security, welfare and pensions have been applied to the Island since the last report.

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

It should be noted that the Isle of Man has not adopted the UK's Universal Credit and currently has no plans to do so.

STATE RETIREMENT PENSIONS

A new single tier state pension – the "Manx state pension" - has been introduced for people reaching the state pension age after 6 April 2019.

The design of this pension is exactly the same as the single tier pension introduced in the United Kingdom in April 2016, though the maximum rate payable in the Island is around 10% greater than in the UK.

People who reached the state pension age before 6 April 2019 continue to be paid state retirement pensions under the "old rules".

State pension age in the Isle of Man continues to follow state pension age in the UK.

See https://www.gov.im/categories/benefits-and-financial-support/pensions/manx-state-pension/ for more information.

BEREAVEMENT BENEFITS

The Isle of Man adopted the UK's Bereavement Support Payment in April 2017. However, as regards the rates of allowance payable –

- the Isle of Man does not distinguish between claimants who have dependent children and those who don't have dependent children, as the UK do - the same rate is paid to all those who qualify regardless of whether they have any children; and
- the rate payable in the Isle of Man is significantly greater than the rates payable in the UK.

A number of recipients of previous forms of bereavement allowances continue to be paid under transitional provisions.

UNEMPLOYMENT BENEFITS

No significant changes have been made since the last report.

However, it should be noted that at the time of writing the following are currently suspended, in consequence of the outbreak of the coronavirus in the Island and its impact on the local economy and labour market –

- provision whereby personal allowances for income-based jobseeker's allowance (JSA) are reduced once a person has been claiming JSA for 6 months;
- rules providing that a person is not normally paid benefit for the first 3 days of a claim for JSA;
- rules providing that a person subject to immigration control is not eligible to claim an income-based jobseeker's allowance

See https://www.gov.im/categories/benefits-and-financial-support/employment-work-related/jobseekers-allowance/ for more information.

SICKNESS AND INVALIDITY BENEFITS

From 1 April 2018 for new claims –

- the short-term higher rate of Incapacity Benefit is abolished;
- age additions to long-term Incapacity Benefit are abolished;
- the Manx Pension Supplement paid with long-term Incapacity Benefit is abolished; and
- Government employees who receive full pay whilst absent from work through illness are not eligible for short-term high Incapacity Benefit.

At the time of writing rules providing that a person is not normally paid benefit for the first 3 days of a claim for short-term Incapacity Benefit are currently suspended, in consequence of the outbreak of the coronavirus in the Island and its impact on the local economy and labour market.

The Island has not introduced Employment & Support Allowance (introduced in Great Britain from October 2008, for new claimants) and currently has no plans to do so.

See https://www.gov.im/categories/benefits-and-financial-support/illness-and-disabilities/incapacity-benefit/ for more information.

INDUSTRIAL INJURY BENEFITS

Latex Anaphylaxis, Nasal Carcinoma and Dupuytren's contracture have been added to the list of prescribed diseases for which industrial injuries disablement may be payable.

The rules for Industrial Injuries Benefits in the Isle of Man will continue to be aligned with those in the UK for the foreseeable future.

See https://www.gov.im/categories/benefits-and-financial-support/employment-work-related/industrial-injuries-disablement-benefit/ for more information.

DISABILITY BENEFITS

No significant changes have been made since the last report.

See https://www.gov.im/categories/benefits-and-financial-support/illness-and-disabilities/disability-living-allowance/ and https://www.gov.im/categories/benefits-and-financial-support/illness-and-disabilities/attendance-allowance/ for more information.

CARER'S BENEFITS

No significant changes have been made since the last report.

See https://www.gov.im/categories/benefits-and-financial-support/illness-and-disabilities/carers-allowance/ for more information.

BENEFITS TO MEET ADULT CARE COSTS

No significant changes have been made since the last report.

BENEFITS DURING PREGNANCY AND CHILDBIRTH

No significant changes have been made since the last report.

See https://www.gov.im/categories/benefits-and-financial-support/illness-and-disabilities/carers-allowance/ for more information.

FAMILY BENEFITS

No significant changes have been made since the last report.

See https://www.gov.im/categories/benefits-and-financial-support/families-and-children/child-benefit/ for more information.

INCOME-RELATED BENEFITS

Income Support

It had been agreed that from 2 April 2020 a lone parent would only be eligible to claim income support solely because they are a lone parent if they are responsible for a child (or children) under the age of 6 years (formerly 12 years). However, this change has been postponed until 8 April 2021, in consequence of the outbreak of the coronavirus in the Island and its impact on the local economy and labour market.

The maximum allowances towards childcare cost have reconfigured in recognition of the fact that charges are typically greater in respect of children under 2 years of age.

See https://www.gov.im/categories/benefits-and-financial-support/illness-and-disabilities/income-support/ for more information.

Income-based jobseeker's allowance

See "UNEMPLOYMENT BENEFITS" above.

Employed Person's Allowance (EPA)

The minimum work requirements for EPA are currently set to change for some groups from 20 April 2021. In particular:-

- Lone parents whose youngest child is aged 13 or over will have to work at least 24 hours a week.
- Couples whose youngest or only child is aged under 6 will have to work for at least 35 hours a week whilst couples whose youngest or only child is aged 6 or over will have to work for at least 48 hours a week. But they will be able to make up these hours in whatever combination they choose. So, for example, one partner may work 40 hours a week whilst the other partner works for 8 hours a week. Or they may both work 24 hours a week.

There will be exceptions to the new minimum work requirements where, for example, an adult in the family is sick, disabled, is at least 6 months pregnant or is getting a bereavement support payment.

In certain circumstances hours spent in work-related training or education may be counted as if they are hours spent in work.

There will be no change to the minimum work requirement for disabled workers and couples where one or both partners is a severely disabled person or cares for a severely disabled person. The minimum work requirement will continue to be 16 hours a week.

The maximum allowances towards childcare costs have reconfigured, and increased, in recognition of the fact that charges are typically greater in respect of children under 2 years of age.

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

Maternity Payment and Funeral Payment

There have been no significant changes to the entitlement conditions to the Maternity Payment since the last report. See https://www.gov.im/categories/benefits-and-financial-support/families-and-children/maternity-payment/ for more information.

The universal Funeral Payment has been abolished for deaths occurring after 1 April 2018.

Funeral Payments (formerly referred to as "Additional Funeral Payments") are now available only to recipients of social assistance benefits. See https://www.gov.im/categories/benefits-and-financial-support/death-and-bereavement/funeral-payments/ for more information.

Exceptional Needs Grants and Budgeting loans

There have been no significant changes to the entitlement conditions since the last report. See https://www.gov.im/categories/benefits-and-financial-support/social-security-benefits/budgeting-loans-and-exceptional-needs-grants for more information.

Winter Bonus

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

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

Benefit/Pension	31 March 2016 No.	2016/17 Expenditure £,000	31 March 2020 No.	2019/20 Expenditure £,000
Manx State Pension	-	-	744	1,710
Retirement Pension	19,361	135,977	18,050	142,363
Old Person's Pension	40	146	33	141
Age Addition	(4,411)	445	(3,949)	430
Retirement Pension Premium	(2,936)	1,449	(2,180)	1,263
Pension Supplement	(14,243)	36,761	(13,559)	35,457
Christmas Bonus	(23,417)	953	(24,361)	967
Nursing Care Contribution	377	2,213	383	3,204
Child Benefit	7,853}		7,109}	
No. of children	(13,333)}	10,538	(11,776)}	10,687
Guardians Allowance	0	0	6	14
Contributory Jobseeker's Allowance	168	329	143	306
Incapacity Benefit (Short Term)	797	2,378	631	2,361
Incapacity Benefit (Long Term)	1,565	8,610	1,596	9,423
Maternity Allowance	556	3,669	391	3,568
Paternity Allowance	25	89	7	93
Adoption Allowance	3	22	1	11
Bereavement Support Payment	-	-	92	785
Bereavement Allowance (incl. lump-sum payment)	126	704	40	275
Widow's Pension	22	121	15	106
Funeral Payments	(765)	197	(7)	84
Attendance Allowance	1,222	3,876	1,143	4,803
Disability Living Allowance	2,182	9,470	2,836	11,633
Severe Disablement Allowance	171	557	110	526
Industrial Disablement Benefit	261	745	216	749
Employed Person's Allowance	1,002	9,531	1,094	9,073
Carer's Allowance	265	2.264	514	3,047
Income Support[1]				
- Pensioners	1,718}		1,353}	
- Working age	2,199}	33,465	2,180}	35,178
Income-related Jobseeker's	951	2,982	258	1,367
Total no. of claims/expenditure/budget	40,864	267,491	41,123	279,624

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

BENEFIT RATES

1. NATIONAL INSURANCE BENEFITS

	2016/17 (weekly rates)	2020/21 (weekly rates)
	£	£
Manx State Pension – full rate	-	191.35
Retirement Pension (R.P.)		
Basic R.P. - own insurance	119.30	134.25
- on spouse's insurance	71.50	80.45
Old Person's Pension	71.50	80.45
Age Addition to R.P.	2.00	2.00
Retirement Pension Premium (maximum rate)	16.15	17.50
Pension Supplement (maximum rate)	55.75	53.75
Incapacity Benefit		
Short-term Incapacity Benefit		
over pension age	101.10	114.15
under pension age - lower rate	79.45	86.10
- higher rate	94.05	101.90
Long-term Incapacity Benefit		
standard rate	105.35	114.15
age addition - higher rate	11.15	12.10
- lower rate	6.20	6.70
Bereavement Benefits		
Bereavement Support Payment		
- Lump sum payment	-	3,000.00
- Weekly allowance		121.95
Widowed Parent's Allowance	112.55	121.95
Widow's Pension (transitional cases only)	112.55	121.95
Contribution-Based Jobseeker's Allowance		
Under 25	57.90	58.90
Aged 25 or over	73.10	74.35
Maternity Allowance		
Employed earners maximum rate	179.85	179.85
Self-employed rate	139.58	151.20
earnings threshold	30.00	30.00
Paternity Allowance		
Maximum rate	179.85	179.85
Adoption Allowance		

Maximum rate	179.85	179.85
earnings threshold	30.00	30.00
Industrial Injuries Disablement Benefit		
100%	168.00	182.00
20%	33.60	36.40
Dependants Additions		
Spouse (or person looking after children)		
with R.P. (protected cases only)	65.70	71.20
with Long-term Incapacity Benefit	61.20	66.30
with Short-term Incapacity Benefit	47.65	51.65
Children - with R.P., W.B., Incapacity Benefit (Long-term and higher rate short-term) and, if beneficiary over pension age, with Short-term Incapacity Benefit (protected cases only)	11.35	11.35

2. NON-CONTRIBUTORY BENEFITS

	2016/17 (weekly rates) £	2020/21 (weekly rates) £
Child Benefit		
first child or qualifying young person	20.40	23.05
second or subsequent child or qualifying young person	13.50	15.20
Carer's Allowance	112.10	121.45
Severe Disablement Allowance (S.D.A.) (protected cases only)		
Basic rate	74.65	80.85
Age related additions:-		
higher rate	11.15	12.10
middle rate	6.20	6.70
lower rate	6.20	6.70
Attendance Allowance (A.A.)		
higher rate	75.65	83.25
lower rate	50.70	55.80
Disability Living Allowance (D.L.A.)		
Care Component		
higher rate	75.65	83.25
middle rate	50.70	55.80
lower rate	20.10	22.10
Mobility Component		
higher rate	54.80	62.25
lower rate	20.10	22.10
Dependency Additions		
Spouse (or person looking after children) -		
with Carer's Allowance (protected cases only)	36.55	39.55
with S.D.A.	36.75	39.75
Children - with Carer's Allowance, S.D.A (protected cases only)	11.35	11.35

3. INCOME-RELATED BENEFITS

INCOME SUPPORT

	2016/17 (weekly rates)	2020/21
Personal Allowances	**£**	**£**
Couple, both members aged 18 or over	152.60	163.25
Couple, one member aged 18 or over, one aged 16 or 17	122.05	130.55
Couple, both members aged 16 or 17		
- in respect of whom housing costs are applicable	122.05	130.55
- in respect of whom housing costs are not applicable	91.60	97.90
Single claimant aged not less than 25	100.05	107.00
Single claimant aged between 18 and 24	80.00	85.60
Single claimant aged 16 or 17		
- in respect of whom housing costs are applicable	80.00	85.60
- in respect of whom housing costs are not applicable	60.05	64.25
Lone parent aged 18 or over	100.05	107.00
Lone parent aged 16 or 17	80.00	85.60
First qualifying young person or child	33.35	42.75
Second and subsequent qualifying young person or child	40.35	42.75
Modifications in Special Cases		
(a) Board and Lodging Cases		
Meals Allowances (per day) :-		
- Breakfast	2.65	2.85
- Lunch	3.80	4.10
- Dinner	3.80	4.10
Maximum allowance for board and lodgings, including any additions for meals not included :-		
- Single claimant	160.45	192.25
- Couple	238.05	240.40
Personal Expenses :-		
- Single claimant	32.95	35.25
- Couple	65.90	70.50
Addition for each qualifying young person or child		
First qualifying young person or child	33.35	42.75
Second and subsequent qualifying young person or child	40.35	42.75

(b)	Residential and Nursing Home Cases		
	Maximum allowances for accommodation charges :-		
	- Residential care home managed by DHSC	441.00	481.04
	- Commercial, voluntary or charitable residential care home	441.00	481.04
	- Nursing Home	711.20	800.94
	Allowances for personal expenses	32.95	36.00
(c)	Hospital In-patients (transfer from care homes only)	32.95	36.00
(d)	Lone parents - Childminding costs		
	- Lower rate	160.00	-
	- Higher rate	235.00	-
	- Per child under 2	-	207.00
	- Per child aged 2 or over	-	176.00

Premiums

Pensioner :-		
Awards commencing on or after 8/4/2013:-		
- single	67.60	78.60
- couple	105.75	124.35
Transitionally protected cases (awards pre 8/4/2013):-		
- Single, aged 60-74	67.60	78.60
- Single, aged 75 or over	71.75	78.60
- Couple, both aged 75 or over	105.75	124.35
Incapacity :-		
Awards commencing on or after 8/4/2013:-		
- single	25.50	26.40
- couple	38.25	39.60
Transitionally protected cases (awards pre 8/4/2013):-		
- single	35.60	35.60
- couple	50.70	50.70
Disability premium		
Awards commencing on or after 8/4/2013:-	53.15	62.15
- single	79.75	93.25
- couple		
Transitionally protected cases (awards pre 8/4/2013):-		
- single	16.50	16.50
- couple	23.80	23.80
Higher Disability Premium (awards pre 8/4/2013 only)		
- single	52.10	52.10
- couple	74.45	74.45
Blindness premium (awards pre 8/4/2013 only)		
- claimant or partner	31.50	31.50
- dependent child or young person	14.80	14.80
Mobility Premium		
Awards commencing on or after 8/4/2013:-		
- single	26.20	28.25
- couple	39.30	42.40
- lower	6.00	6.15
Transitionally protected cases (awards pre 8/4/2013):-		
- higher	51.40	51.40
- lower	31.85	31.85
Carer premium		

- single	62.60	68.60
- couple	95.75	102.90
Higher carer premium (awards pre 8/4/2013 only)	62.30	68.60
Attendance premium		
- highest rate	75.65	83.25
- middle rate	50.70	55.80
- lowest premium	20.10	22.10
Disabled child premium	40.60	47.45
Shared care premium	24.70	25.60

Housing Costs

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

Single claimant or couple		
- with no children	116.00	120.50
- with one dependent child	157.00	171.50
- with two dependent children	169.50	185.00
- with three or more dependent children	187.00	204.00
Maintenance and insurance	13.25	14.35
Deductions for inclusive utilities :-		
- heating	18.65	19.90
- lighting	1.55	1.65
- cooking	2.30	2.50
- hot water	2.30	2.50
Reductions in amounts for non-dependent occupants :-		
- in receipt of income support or income-based jobseeker's allowance	14.80	15.30
- in any other case	52.10	52.10

Income-Based Jobseeker's Allowance

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

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

EMPLOYED PERSON'S ALLOWANCE (EPA)

	2016/17	2020/21
	(weekly rates)	
Prescribed Amounts	**£**	**£**
Single claimant who is a disabled worker	220.50	255.30
Lone parent who is not a disabled worker	273.45	298.25
Lone parent who is a disabled worker	328.65	380.55
Couple neither of which is a disabled worker	273.45	298.25
Couple which includes a disabled worker	328.65	380.55
For the first or only child or qualifying young person	21.20	30.10
Increase for each additional child or qualifying young person	61.25	65.45
Disabled Child's Allowance	40.00	46.75
24 hours or more per week work addition	32.70	35.35
Housing costs :-		
Maxima towards rent, loan interest, rates, service charges etc . :-		
Single claimant or couple		
- with no children	116.00	120.50
- with one dependent child	157.00	171.50
- with two dependent children	169.50	185.00
- with three or more dependent children	187.00	204.00
Maintenance and insurance	13.25	14.35
Deductions for inclusive utilities :-		
- heating	18.85	19.90
- lighting	1.55	1.65
- cooking	2.30	2.50
- hot water	2.30	2.50
Reductions in amounts for non-dependent occupants :-	26.55	28.40
Non-householder's contribution	14.80	15.50
Maximum childminding costs -		
- less than 24 hours work per week:		
- 1 child	111.00	-
- more than 1 child	179.00	-
- 24 hours or more work per week:		
- 1 child	160.00	-
- more than 1 child	235.00	-
- less than 24 hours work per week:		
- Per child under 2	-	145.00
- Per child aged 2 or over	-	123.00
- 24 hours or more work per week		
- Per child under 2	-	207.00
- Per child aged 2 or over	-	176.00
Maintenance disregard	24.20	25.90

LUMP SUM PAYMENTS

	2016/17 £	2015/16 £
Christmas Bonus (annual)	40.00	40.00
Winter Bonus (annual)		
Standard rate per claim (reduced rate for shared households)	300.00	350.00
Bereavement Payment (one-off)	2,000.00	-
Funeral Payment (one-off, not means-tested)		
standard rate	210.00	-
enhanced rate	350.00	-
Maternity Payment (one-off)		
Standard rate for each child (reduced rate for repeat claims within 3 years)	500.00	600.00

Article 13 – The right to social and medical assistance

Para. 1 - to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;

a) Please describe any reforms to the general legal framework. Please provide pertinent figures, statistics or any other relevant information, in particular: evidence that the level of social assistance is adequate, i.e. the assistance should enable any person to meet his/her basic needs and the level of the benefits should not fall below the poverty threshold. Information must therefore be provided on basic benefits, additional benefits and on the poverty threshold in the country, defined as 50% of the median equivalised income and calculated on the basis of the poverty risk threshold value published by Eurostat.

United Kingdom

The poverty threshold in the UK is set at 60% of the median equivalised income and statistics are published annually here.

Universal Credit

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 replaces 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.

Please see the UK's 2020 European Code of Social Security and ILO C102 consolidated report for full details of the UK's social assistance provision.

Scotland

The poverty threshold in Scotland is set at 60% of the median equivalised income and statistics are published annually showing poverty, child poverty, and income inequality statistics for Scotland, as well as poverty rates broken down by a range of equality characteristics. Statistics are publically available[85].

Whilst around 85% of benefit spend in Scotland remains reserved to the UK Government, the Scottish Government has introduced nine benefits, some of which are new and some

[85] https://www.gov.scot/collections/poverty-and-income-inequality-statistics/

of which replace UK benefits. This has provided over £350 million of support to the people of Scotland in 2019-20, including through the introduction of both Young Carer Grant and Funeral Support Payment.

The Scottish Government has set in statute ambitious income-based targets to reduce levels of child poverty by 2030. The target measures, as set out in the Child Poverty (Scotland) Act 2017, are all set on an after housing costs basis – more accurately reflecting the resources available to households to meet their needs after this essential cost has been met.

Northern Ireland

People are considered to be in absolute income poverty if the income of their household is less than 60% of the UK median household income for 2010-11 (adjusted year on year for inflation). Further information on the statistics can be found within the Family Resources Survey.

The Welfare Reform (Northern Ireland) Order 2015 introduced a package of reforms to the welfare state, which mirrored the changes made in Great Britain by the Welfare Reform Act 2012. The Northern Ireland Executive also agreed to provide £501 million to 'top-up' the UK welfare arrangements in Northern Ireland. These funds were delivered as part of a suite of mitigation payments to provide financial assistance for claimants transitioning to the reformed benefits.

Isle of Man

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

Para. 1 - to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;

b) Please indicate any specific measures taken to ensure social and medical assistance for persons without resources in the context of a pandemic such as the COVID-19 crisis.

Please also provide information on the extent and modalities in which social and medical assistance was provided to people without a residence or other status allowing them to reside lawfully in your country's territory.

England and Wales

Social assistance - Covid 19 measures

The UK's primary focus throughout this health emergency has been to ensure that basic income protection is available to people affected by Covid-19.

The UK's Chancellor of the Exchequer (Finance Minister) announced an unprecedented series of measures to support businesses and their employees to mitigate the impact of COVID-19. This included over £9.3billion of extra support through the welfare system.

A 1.7% benefit up-rating was implemented in April, ending the benefits freeze, and the state pension rose by 3.9%, as per the triple lock, reflecting the substantial rise in average earnings in the UK in 2019.

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.

From 17 March 2020, the Government suspended all face-to-face assessments for sickness and disability benefits to protect vulnerable people (and assessment centre staff) from unnecessary risk of exposure to Covid-19. This will remain in place following a consideration of the latest public health guidance. The Department for Work and Pensions continues to complete paper based assessments where possible and has introduced telephone assessments.

To allow staff to be re-deployed to the front line, in April 2020 we suspended recovery of some Government debts such as Tax Credits, benefit overpayments and Social Fund Loans. Recovery is now being re-introduced gradually.

The Department for Work and Pensions launched two information websites on 27 April 2020 - Job Help and Employer Help - to provide jobseekers and employers with a range of guidance and advice including supporting decisions on identifying transferable skills, promoting opportunities of seeking alternative roles or working in different sectors of the economy and supporting staff. These sites also promote other GOV.UK provision such as the National Careers Service and the Department for Education's online skills training initiative and the Skills Toolkit, which was launched in April 2020. Both sites link to 'Find a Job'.

In May 2020, the Department launched the online 'Apply for Pension Credit' service. This supplemented the existing telephone and postal claim services to enable customers to claim Pension Credit with minimal delay while adhering to social distancing/shielding measures.

Call volumes to the UK's Department for Work and Pensions have been extremely high, with more than 2.2 million calls in one day at the peak of the Covid 19 crisis. The Department turned it around with its "Don't call us - we'll call you" campaign. People making new claims for Universal Credit no longer need to call the Department as part of the process. A bolstered frontline team now proactively calls claimants when the Department needs to check any information provided as part of a claim. This has been successful in freeing up capacity and reducing the time that customers need to spend on the phone.

Employment and Support Allowance
We made changes to Employment and Support Allowance (ESA) in response to the COVID-19 outbreak. These included:

- Removing waiting days for ESA 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 ESA 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.

New Style ESA online
On 20 April, we launched the New Style ESA online portal which allows claims to be completed online. We have been receiving claims successfully since then and have seen an increase in applications. For those claimants or appointees who still require a telephony service, this remains available.

Statutory Sick Pay
We amended our legislation so that Statutory Sick Pay (SSP) is payable from day one – as opposed to day four – where an individual is sick or self-isolating due to coronavirus and meets all SSP eligibility conditions, including the requirement to self-isolate for at least four days in a row (including non-working days).

SSP is available to those who are required to self-isolate because they, or someone in their household, has symptoms of Covid-19, and are unable to work as a result. SSP eligibility conditions apply, including the requirement to self-isolate for at least four days in a row (including non-working days).

Statutory Sick Pay is also available to those who are self-isolating because they have been notified by the NHS or public health authorities that they have come into contact with someone who has Covid 19, and are unable to work as a result.

Measures to assist the self employed
The UK Government relaxed the minimum income floor so that the self-employed could access Universal Credit more readily.

Jobcentres
Jobcentres have remained open to support our most vulnerable claimants throughout this health emergency providing a service, in accordance with Public Health England and Devolved Government guidelines on social distancing, to vulnerable claimants unable to access our services through digital/telephony channels.

The Department for Work and Pensions is currently completing a programme of implementing safety measures across our Jobcentres, allowing us to extend our face to face service. We remain open for those who need us but will continue to minimise the requirement for customers to travel to our Jobcentres, conducting the majority of interactions digitally or by phone.

Conditionality
With the outbreak of Covid-19, the Government took the decision to suspend the requirement for face-to-face Jobcentre Plus appointments temporarily for all claimants in Universal Credit, New Style Job Seekers Allowance (JSA) and Employment and Support Allowance (ESA), old-style JSA and ESA, and Income Support. They continued to receive benefits as normal and they were not sanctioned for not taking part in appointments with Jobcentres.

A review has now taken place and, in line with other government decisions to ease lockdown measures, it has been agreed that a return to conditionality and expectations of work availability and work related activity for those who are able and expected to look for and prepare for work is appropriate.

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.

Local Authorities can provide basic safety net support to an individual, regardless of their immigration status, if there is a genuine care need that does not arise solely from destitution, for example if:

- there are community care needs
- they have serious health problems
- there is a risk to a child's wellbeing

Medical assistance – Covid 19 measures

The UK Government took specific measures to ensure that persons without resources could access medical assistance for COVID-19 during the pandemic.

On 29 January 2020, regulations came into force which added coronavirus (COVID-19) to Schedule 1 of The National Health Services (Charges to Overseas Visitors) Regulations 2015. The Government's action means that there can be no charge made to an overseas visitor, for testing or treatment of COVID-19. In addition, treatment provided to children who develop Paediatric Multisystem Inflammatory Syndrome (PMIS), that is being treated as suspected COVID-19, is also exempt from charge.

Furthermore, steps have been taken to ensure those without resources are made aware of the medical assistance available with regards to COVID-19. For example, the information regarding the exemption for COVID-19 has been disseminated to NHS staff, the public and organisations representing vulnerable migrant groups. Translations in 40 languages were made available and published on Public Health England's (PHE) Migrant Health Guide. In addition, the Cost Recovery team liaised with stakeholders representing vulnerable migrant groups to ensure this information was effectively communicated. This included communication that Home Office status checks were not required for those known to be undergoing testing and treatment for COVID-19; ensuring that no patients are deterred from seeking treatment.

Moreover, access to certain services are free to all patients including primary care, NHS111, and Accident and Emergency services. Under the National Health Services (Charges to Overseas Visitors) Regulations, certain groups of vulnerable persons are exempt from charge for all their healthcare needs including refugees, asylum seekers, failed asylum seekers, children looked after by a local authority, victims and suspected victims of modern slavery.

Social assistance - people without residence or other status

People without residence or other status in the UK generally have no recourse to public funds. This means they will not be eligible for an allocation of social housing or homelessness 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).

However, Local authorities have the power to provide support and assistance under social welfare legislation. They also 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 human rights.

Medical assistance - people without residence or other status

Those with no lawful status in the UK 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, NHS111 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 up front and in full. Where a clinician has determined a patient's need for care to be urgent or immediately necessary, however, that care will never be delayed or withheld, regardless of the patient's ability to pay.

Special provisions for maternity care have been made in the Regulations and it is the only service that the Regulations specify should always be deemed immediately necessary, including any routine ante-natal and post-natal care.

Scotland

Social assistance

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 Payments. The Scottish Government has awarded over £80 million to third sector and community organisations, including for services promoting health, wellbeing and access to food – Ministers have subsequently announced a new Community and Third Sector Recovery Programme, backed by £25 million of investment which will aid our third sector to continue to support people and communities in responding to the ongoing impact of the pandemic. The Scottish Government has distributed an additional £22 million for the Scottish Welfare Fund to local authorities to meet additional demand for Crisis Grant and Community Care Grants, arising as a consequence of COVID-19. The Statutory Guidance for the Scottish Welfare Fund states that no more than 3 Crisis Grants can be provided within a 12-month period unless the local authority considers that there are exceptional circumstances. Scottish Local Authorities have been advised that Scottish Ministers' view COVID-19 as an

exceptional circumstance. Local authorities will consider this when assessing applications. (Further details about entitlement to crisis grants is below). A further £20 million, from Scottish Welfare Fund reserves, has been committed to a flexible fund for financial insecurity. Local authorities will provide this broader support by means of food and fuel. Scottish Local authorities can also choose to use this money to top up their Scottish Welfare Fund or Discretionary Housing Payments.

Crisis Grants are specifically designed to provide a safety net for individuals when a disaster or emergency situation occurs and where there is an immediate threat to health and safety of the individual or their family. Crisis Grants do not need to be repaid, however, applicants do need to meet the eligibility criteria, as outlined in the Statutory Guidance[86].

To obtain a Crisis Grant, an individual needs to be on a low income. This does not mean that they need to be on Social Security benefits. EEA Nationals whose rights are protected by the Withdrawal Agreement can apply to be considered for a Crisis Grant on the same basis as UK Nationals. A typical award for a Crisis Grant may be money to ensure an applicant can buy food or fuel. The Fund is not able to provide support with medical items or services as this is listed within the excluded items in Annex A of the Statutory Guidance. It is not able to support people with NRPF due to restrictions imposed by the Home Office. EEA Nationals who come to the UK after the transition period may be subject to NRPF. Asylum seekers are excluded from the Scottish Welfare Fund; refugees are not.

On 12 October 2020, the Scottish Government opened applications for a new Self-Isolation Support Grant. The grant is for those who will face financial hardship due to being asked to self-isolate and will be targeted at people who are in receipt of Universal Credit or legacy benefits, with some discretion to make awards to others in financial hardship.

The Scottish Government has worked with the Convention of Scottish Local Authorities (CoSLA) to provide guidance to Scottish local authorities on offering a similar amount, on a discretionary basis and on public health grounds, to people with no recourse to public funds who would otherwise be eligible for the Grant. Numbers are expected to be small for this and the CoSLA lead on No Recourse to Public Fund will be able to provide further guidance to local authorities in individual cases.

Medical assistance

The Scottish Government amended the National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989 (in January 2020), to ensure that anyone seeking treatment for coronavirus in Scotland, regardless of their nationality or immigration status, is entitled to receive such treatment without charge.

As set out in the Health and Wellbeing theme chapter of the New Scots Refugee Integration Strategy, published in January 2018; the Scottish Government is clear that everyone who is resident in Scotland is entitled to access health care on the same basis. This includes all people seeking asylum and people whose claim for asylum has been refused. They are entitled to register with a GP, access emergency health services, register with a dentist and have eye tests. They can access specialist healthcare if needed, as any other patient can, often through a GP referral. This includes maternity care, mental health services and any other services for specific conditions. All public

[86] https://www.gov.scot/publications/scottish-welfare-fund-statutory-guidance-2019/

health services have a Public Sector Equality Duty that requires them to ensure that the services provided are fit for purpose and meet the needs of all members of society.

The Public Health (Scotland) Act 2008 places duties on NHS boards and on local authorities to protect public health in their areas. NHS Boards have the duty to identify public health need, for example that an individual or family requires to be quarantined, and may require to work with a local authority to establish how the care need necessitated by their condition will be met. These duties are on the basis of public health risk and therefore care provision is on the basis of need not immigration status. As an example, in terms of pandemics or the significant risk of communicable diseases specifically, although post the 31 December 2019 reporting requested, in February 2020 Covid-19 was designated as a notifiable disease for the purposes of the Public Health (Scotland) Act 2008.

Northern Ireland

Social assistance

The Department for Communities has introduced a number of specific measures in response to the Covid-19 crisis.

Statutory Sick Pay

Statutory Sick Pay is payable to employees who are unable to work due to illness. It is paid by employers and can be paid for up to 28 weeks.

The Covid 19 crisis has understandably had a huge impact on people's ability to work and as a result the legislation governing the payment of Statutory Sick Pay (SSP) has been amended to:

- Ensure that those who are isolating from others in accordance with Public Health Guidance will be deemed as incapable of work and can therefore claim SSP.
- Dis-apply the usual 3 waiting days for those incapable of working due to the requirement to stay at home either because they have symptoms of Covid 19 or are living in the household of someone with symptoms of Covid 19.
- Add the following new categories of person who can claim SSP:-
    - Those who are extremely vulnerable and at very high risk of severe illness from Covid 19 due to an underlying health condition and have been advised by Public Health Guidance to shield;
    - Those who have been notified that they have been in contact with a person who has tested positive for Covid 19 or has symptoms of Covid 19;
    - Those with a family member who has symptoms of Covid 19.
- Ensure that SSP can be paid for the full period a person is required to self- isolate or stay at home after testing positive.
- Ensure that SSP can be paid for those who have been advised that they are to undergo a surgical or other hospital procedure and have been advised to stay at home for up to 14 days prior to being admitted to hospital prior to that procedure.

Coronavirus Job Retention Scheme and Maternity Benefits

The Coronavirus Job Retention Scheme was introduced to enable employers to keep their employees on the payroll if they found they were unable to operate due to Covid-19. This is known as being 'on furlough'. The scheme ensured that employees would receive up to 80% of the normal salary.

Statutory Maternity Pay and Maternity Allowance are available to provide financial support to pregnant women. Maternity Allowance (MA) is paid to those women who do not qualify for Statutory Maternity Pay (SMP).

As a result of the Job Retention Scheme, the legislation governing the payment of SMP and MA has been amended to ensure that the calculation of normal weekly earnings to determine entitlement to SMP and the average weekly amount of specified payments made to a woman for determining entitlement to and rate of MA are based on their usual salary, not the furlough amount, and they therefore they receive their full entitlement.

Employment And Support Allowance

Employment and Support Allowance (ESA) is available to those who have a disability or health condition that affects their capacity to work. The relevant legislation has been amended to dis-apply the usual 7 waiting days where a person is infected or contaminated with Covid 19 and is self- isolating to prevent the spread or is caring for a child who is infected.

Universal Credit

Face-to-face assessments for all benefits were suspended. Assessments normally conducted in a Medical Examination Centre or at home are now carried out by telephone, or by considering medical evidence submitted by post and we are exploring ways to make this system more flexible.

All routine appointments have been postponed to protect people visiting the Jobs and Benefits offices as well as staff working in them. All of those already receiving benefits will continue to receive their payments. Nobody will be penalised as a result of not attending the office.

Additional telephone support has been made available to help people with their new claim and staff are working hard to meet demand at such an exceptionally busy period. All follow up activities will be managed on-line or over the phone.

Temporary operational changes to Universal Credit:

A number of temporary operational changes have been introduced to reduce face-to-face contact whilst maintaining access to social security:

- As has always been the case people out of work or on a low income can apply for Universal Credit (UC), which is an online service;
- As detailed above all routine appointments have been postponed to protect those visiting and staff in offices;
- All work search and work preparation has been suspended;
- No inappropriate benefit sanctions will be applied to those who are receiving benefits;

- Verification of things like identity, childcare or housing costs will be completed by phone or through a person's online journal;
- Online or telephone applications for an advance payment without the need to come to the office – getting money to people at the point of need. In addition people can apply by telephone, or through an new online claim form, for a grant through the UC Contingency Fund; and
- The Department is making every effort to process the increase in applications as a result of COVID-19. A series of contingencies are in place to deal with the impact of COVID-19 including staff working overtime and the Department is currently in the process of recruiting additional work coaches to deal with the increased numbers of people claiming UC.

Legislative changes have been made to increase the UC standard allowance for all claimants;

- This means those under 25 will now receive £342.72 and those over 25 will receive £409.89 per month;
- Joint claimants will now receive the increased amount per month of £488.59 if they are both aged under 25 and £594.04 where either is aged over 25;

The increases to rates of UC mean that on average, every UC award will go up by approximately £90 per month. In addition, the start date for the introduction of the temporary increase of the standard allowance takes effect for assessment periods that end on or after the 6th April, instead of in line with uprating meaning that people will benefit from the increased provision more quickly.

For all self-employed claimants, there is a relaxation of the 'minimum income floor' ensuring their UC award will increase to reflect their lower earnings. The relaxation of the MIF has been extended until 30th April 2021.Some claimants will also gain access to a work allowance, and, if they have a partner who is working, access to help with childcare costs. Further amendments have been made to assist the self-employed by ensuring that the treatment of payments made under Coronavirus Job Retention Scheme to fund payments to the self-employed person's employees are applied appropriately and not taken into account within the self-employed person's Universal Credit award. In addition, any other loan or grant to meet the losses or expenses of the claimant's business in relation to the outbreak of coronavirus disease is to be disregarded for the period of 12 months in the calculation of the person's capital.

Payments from both the Coronavirus Job Retention Scheme and the Self-employment Income Support Scheme will be treated as earnings in Universal Credit, i.e. subject to any work allowance and taper and Universal Credit payments will adjust in response to changes in earnings. This means we will take the payments into account in the Assessment Period in which they are received and in this way Universal Credit provides support whilst the claimant has no earnings.

Changes have also been made to ensure that, if a person loses entitlement to Universal Credit on account of their income, the Department will treat the person as re-claiming universal credit for up to 5 assessment periods, rather than closing their claim, meaning a person does not need to make a new claim if earnings reduce.

There have also been adjustments to the local housing allowance rates that will make it more beneficial for private-rented sector tenants. In response to the COVID-19 pandemic, the work search and work availability requirement for new and existing claims in UC and new style JSA were removed until 30th June. The Department has reinstated work search conversations, digitally or via the phone, with all people making a new claim to Universal Credit from 8th July. This is a light-touch discussion that will seek to support and help those new to Universal Credit. It will not involve the threat or potential of a sanction for non-compliance. This light touch approach is being adopted in recognition of the challenging circumstances people still find themselves in, while ensuring help and support is available for those looking to get back into work.

Following on from new claims, claimant commitments will be introduced retrospectively for claims made during the Covid-19 crisis subject to operational capacity. A retrospective review of all existing Universal Credit claimant commitments will also be completed to ensure they are up to date and reflective of any continuing Covid-19 constraints.

The interventions will have the primary objective of engaging with individuals to understand their employment history, labour market aspirations and health status. The content of claimant commitments and subsequent follow up contact will be tailored to suit each individual's circumstances. Work search activities will be agreed in partnership and will reflect any continuing Covid-19 constraints.

Customer care calls will also be made people who are already on Universal Credit or contribution-based Jobseeker's Allowance to introduce them to their work coach, highlight the range of help and support that is available and start to understand what their needs are.

For Old style JSA, coronavirus and/or isolation are excluded for the purposes of a period of sickness.

Legislative changes have also been made to ensure those individuals on temporary release from prison due to the outbreak of COVID-19 will have access to means tested benefits during the period of that release, providing them with financial support during the Covid-19 pandemic. This initiative has been extended until 12th May 2021.

Medical assistance

All visitors to Northern Ireland are entitled to medical emergency services free of charge. A medical emergency is something that is, potentially, immediately life-threatening. It does not include routine monitoring or treatment which should be seen by a GP, pharmacist or dentist or, if appropriate, could wait until a person returns to their home country.

Examples of medical emergencies include:

- a sudden collapse and becoming unresponsive or not breathing
- suspected stroke or heart attack
- becoming unconscious, perhaps after heavy blood loss or accident
- collapse preceded by facial swelling and wheezing or choking episode
- accident leading to injury

Isle of Man

Social assistance

At the time of writing (November 2020), there are no cases of COVID-19 in the community in the Isle of Man and there are no restrictions on businesses or individuals (subject to them having to self-isolate if they suspect they or a member of their family (or other contact) may have contracted COVID-19. However, border restrictions are continuing to have a significant impact on travel to and from the Island and tourism-related businesses.

Additional assistance in the form of a new, temporary welfare benefit has been provided to unemployed persons in the form of the Manx Earnings Replacement Allowance (MERA). MERA was paid as an alternative to jobseeker's allowance where it was to the individual's advantage. It was available from 6 April to 20 September 2020. It was initially paid at the weekly rate of £200, but was reduced to £100 per week from 3 August 2020 to 20 September 2020.

Other easements were made to welfare provisions including the suspension of rules which would normally prevent a person who is subject to immigration control from accessing publicly funded benefits – including social assistance benefits.

Medical assistance

In March 2020 emergency powers enabled the Department of Health and Social Care to provide dedicated facilities for men and women of no fixed abode to reside to comply with restrictions and/or self –isolate if symptomatic.

The emergency powers fell away in summer 2020, but the Department has retained a contingency plan to provide a facility for self-isolation purposes for any person of no fixed abode. All other social and medical assistance available to the population is available to those of no fixed abode.

Article 13, Para. 1 - to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;

c) Please provide responses to comments and queries from 2017 conclusions (see extracts of the full conclusions attached to the commissioning email for the context):

i. *The Committee asks the next report to provide comprehensive comments as regards the situation concerning maladministration and benefit sanctioning as well as crisis loans. The Committee holds that if this information is not provided in the next report, there will be nothing to establish that there is an effective right to social assistance for all persons in need.*

ii. *The Committee asks to be kept informed of the results as well as the relevant statistics [on mandatory reconsiderations].*

iii. *The Committee asks if during the three months waiting period as well as in case of a failure to provide evidence of a genuine prospect of work after three months, the persons concerned, who have also been denied the right to housing benefit, cannot meet their immediate and most essential needs, including accommodation, heating, food and hygiene, can apply for a hardship payment and if so, what the hardship payment consists of.*

iv. *The Committee also asks what rules apply to non-EEA nationals.*

v. *Furthermore, the Committee asks the next report to provide updated statistics on the numbers of foreign nationals, lawfully resident in the UK who fail to meet the habitual residence test and are denied access to benefits because of the restrictions imposed. In the meantime, the Committee reserves its position.*

vi. *The Committee asks the next report to confirm that the legislation and practice comply with these requirements as regards emergency social assistance [for those unlawfully present in the UK]*

Great Britain

For (i) and (ii), please see the attached UK 2020 European Code of Social Security report for information on sanctions and on mandatory reconsiderations (including statistics) – please read Annex 2: Responses to requests for further information.

Measures to address delayed payments/hardship

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, as we have removed the 7 days some had to wait prior to 14 February 2018. 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'. The claimant (or both claimants if a couple) need a good reason for not claiming earlier. Payments are made retroactively.

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.

We continue to pay Housing Benefit and other Department for Work and Pensions legacy benefits for two weeks when people move to Universal Credit.

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
- costs linked to moving house
- maintenance, improvements or security for your home
- travelling costs within the UK
- costs linked to getting a new job
- maternity costs
- funeral costs
- repaying hire purchase loans
- repaying loans taken for the above items

Other financial support
Those in financial difficulties can get help and advice from the government, local councils and other organisations. See here for details of other financial support.

Advance and hardship payments
As mentioned above, if someone does not have enough to live on while they wait for their first payment, they can ask for an advance payment of UC after they’ve made a claim.

They 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.

Alternative Payment Arrangements
If someone is having financial difficulties or is behind on their rent, they or their landlord may be able to apply for an Alternative Payment Arrangement (APA).
Depending on their circumstances, they could get an APA to:

- get their rent paid directly to their landlord
- get paid more frequently than once a month
- receive split payments, if they are part of a couple

Local assistance

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.

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.

Access to social assistance for non-nationals

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. The Government reached similar citizens' rights agreements with the EEA EFTA States (Iceland, Liechtenstein and Norway) and Switzerland.

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 on broadly the same basis as they do now.

The Government has set up the EU Settlement Scheme (EUSS) to enable them to apply for UK immigration status. The deadline for applications for those resident by 31 December 2020 is 30 June 2021. The Government has legislated to ensure the rights of EEA citizens and their family members, including access to benefits and services, are protected also for the duration of the grace period (1 January to 30 June 2021). These protections will apply specifically to resident EEA citizens who can demonstrate that they were exercising a qualifying right to reside (for example, as a worker or student) immediately before the end of the transition period (31 December 2020), and will continue to apply until their applications are finally determined (provided these applications are made by 30 June 2021), including until the outcome of an appeal against a decision to refuse status under the EUSS.

The government introduced a new points-based immigration system from 1 January 2021. This aims to align the treatment of EEA citizens with that of third country nationals. Under this new system, newly arriving EEA citizens will no longer be able to rely on rights under EU law or protections under the Withdrawal Agreements (unless they are protected in another capacity, for example, if they are family members joining their EEA sponsor who was residing in the UK before 31 Dec 2020). They will be subject to the same UK immigration rules and require leave to enter or remain in the UK with no recourse to public funds (public funds do not include contribution-based benefits) as is currently the case for other third country nationals. This means they will not be eligible for most benefits/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).

Non-nationals, in general, are eligible if:

- they have been granted refugee status, humanitarian protection or other types of exceptional leave; or
- they have Indefinite Leave to Remain (settled status) and are habitually resident.

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 (see https://www.gov.uk/government/publications/application-for-change-of-conditions-of-leave-to-allow-access-to-public-funds-if-your-circumstances-change.

Habitual Residence Test statistics

Information on UC contracts which have a recorded failed 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. This reflects the increasing caseload on UC since its rollout. UC data supplied is derived from unpublished management information, which was collected for internal Department for Work and Pensions use only and has not been quality assured to National Statistics or Official Statistics publication standard. The data should therefore be treated with caution. UC cases may be closed for other reasons (for example, "ineligible") but may have failed the HRT – these are not captured in the estimates above.

Information on the number of other (non-UC) claims which failed the Habitual Residence Test are available here:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/639597/analysis-of-migrants-access-to-income-related-benefits.pdf

Emergency assistance for those unlawfully present

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 more recently, to bring in all vulnerable homeless people in during the Covid 19 pandemic.

In response to the pandemic, the Government provided councils with a total of £7.2 billion in funding to support their communities which includes £4.6 billion in un-ringfenced funding. This includes the Next Steps Accommodation programme which makes available the financial resources needed to support local authorities and their partners to prevent those accommodated during the pandemic from returning to the streets. As with all local welfare provision, local councils can use this funding to provide a basic safety net support to an individual, regardless of their immigration status, if there is a genuine care need.

Northern Ireland

Discretionary Support was introduced in November 2016 as a Northern Ireland specific scheme to replace Social Fund Community Care Grants and Crisis Loans for living expenses following their abolition as part of the package of welfare reforms.

Discretionary Support is designed to provide a necessary but temporary response to particular but pressing needs facing the most vulnerable. It aims to address customer needs in an extreme, exceptional or crisis situation where there is significant risk to the health, safety or wellbeing of the claimant or a member of the claimant's immediate family.

Discretionary Support awards are provided as either an interest free loan or a non-repayable grant to assist with a range of crisis situations. This can include an award to assist with living expenses (e.g. a supply of groceries) where a claimant has no means of meeting immediate costs for themselves or their immediate family. Awards can also be made to cover the cost of household items (e.g. beds or cookers). There is no upper limit on the amount that a claimant can receive as a grant however the amount of a loan will take into account the ability to repay.

Some items are excluded from awards (e.g. work related expenses) and, importantly, claimants can normally receive a maximum of three loans and one grant in a rolling 12-month period, except in the case of a disaster.

In 2018/19 approximately £13.6 million was paid in more than 56,000 awards of Discretionary Support. This included £9.6 million in non-repayable grants and £4 million in interest free loans.

In response to the COVID-19 pandemic the Discretionary Support scheme was amended to introduce a non-repayable living expenses grant to assist with short term living expenses where a person, or any member of their immediate family, is diagnosed with COVID-19 or is advised to self-isolate in accordance with official guidance.

For any claim to Discretionary Support the ordinary residence test will apply. Rates of entitlement are as follows:

Single 16-24 / LP under 18 = £79.09pw	**Single 25+ / LP 18+ = £94.59pw**	**Couple both under 18(higher rate) = £112.75pw**	**Couple both 18 + = £137.09pw**

The amount payable equates to 100% of the Universal Credit standard personal adult allowance rate and will, where applicable, include the full child Income Support element for each child. Currently the child rate is £68.27 each week. Originally it would have 60% of the IS personal rate but due to COVID-19 it is currently 100% of the UC rate.

Outside of the Welfare System, the Department for Communities has allocated almost £13m to ensuring vulnerable people impacted by COVID-19 have access to the food they require. A food box scheme operated from April to July 2020 following which funding has been largely used to support the third sector organisations in the provision of food and essential items.

The Department for Communities funds the COVID-19 Community Support Fund which provides essential support for voluntary and community sector groups, through local councils. The local community sector continues to be at the frontline of the response to the pandemic. Councils, through their community development programmes, work with the

Department to direct the funding to those community sector organisations who are responding to need on the ground.

The funding supports local grassroots community and voluntary organisations across council areas working with individuals and communities during the pandemic to target need and alleviate poverty by:

- providing assistance to those on low income and at risk due to financial stress;
- supporting access to food for those most in need;
- helping to connect those living alone or in a rural and border area that are likely to experience challenges in accessing services.

The COVID 19 Community Helpline helps people in need of assistance as a direct result of COVID 19 to access food, medicines, heating/fuel costs or other products and services.

The Warm, Well and Connected initiative is delivered in partnership with local government, 22 Healthy Living Centres and six Rural Support Networks, which together reach 1,500 smaller rural organisations. The 'Warm' part of the initiative may be able to help and support people whose wellbeing has been impacted by cold conditions. This help is for those who have not been able to get help anywhere else and whose finances have been directly affected by the Covid-19 pandemic. The support is given is not monetary or voucher-based. This is a programme with limited levels of support available - support will be small in value and only for those in extreme need who are unable to heat their homes by any other means.

Benefit Sanctions

Details of the published data on benefit sanctions applied in the period from 1 April 2016 to 31 March 2019 are provided in the following tables. The capture of relevant data on sanctions has been developed from 2016 onwards with the report for the 2018/19 financial year representing the first full data set.

Benefit Sanctions for the period 1 April 2016 to 31 March 2017

Benefit	Number of Sanctions	Proportion of Claimants Receiving a Sanction*
Jobseekers Allowance	9,460	1.8%
Employment and Support Allowance	60	0.004%
Income Support	Not available	Not available

***** This is the average number of sanctions per month against the average number of claimants per month.

Benefit Sanctions for the period 1 April 2017 to 31 March 2018

Benefit	Number of Sanctions	Proportion of Claimants Receiving a Sanction*
Jobseekers Allowance	3,840	0.932%

Employment and Support Allowance	40	0.002%
Income Support**	60	0.015%

* This is the average number of sanctions per month against the average number of claimants per month.
** The reporting period is 29 January 2018 to 31 March 2018.

Benefit Sanctions for the period 1 April 2018 to 31 March 2019

Benefit	Number of Sanctions	Total Number of Claimants (at 31 March 2019)*
Jobseekers Allowance	1,340	15,700
Employment and Support Allowance	90	124,000
Income Support	270	28,600
Universal Credit	1,140	35,940

* Data on the proportion of claimants to receive a sanction is no longer reported.

Emergency assistance for those unlawfully present

The Local Government Act (NI) 2014 provides district councils in NI with a similar 'general power of competence' to that given to local authorities in England and Wales by the Localism Act 2011. The general power of competence gives a council the same power to act that an individual generally has i.e. it generally allows councils to do anything that is not specifically prohibited by other laws (before the general power was introduced councils, as bodies corporate, could only do things which legislation specifically allowed them to do). This would mean that councils could use the general power of competence to provide emergency social assistance unless this is specifically prohibited by other legislation. It would be a matter for the council to get its own legal advice on this. According to Paragraph 3, Schedule 3 of the Nationality, Immigration and Asylum Act 2002, which extends to the whole of the UK, nothing prevents local authorities exercising powers or performing duties to the extent that it is necessary to avoid breaching any European Convention on Human Rights (ECHR) right.

Isle of Man

The Isle of Man does not operate benefit sanctioning in the same way as the UK. The Isle of Man has not adopted the UK's Universal Credit. Sanctioning applies only to jobseekers under the provisions of the Jobseekers Act 1995 (as it is applied in the Island), where they are determined to have left employed earner's employment without good reason or are dismissed from employed earner's employment due to misconduct. Very few jobseekers are sanctioned (< 50 a year, on average). No jobseekers have been sanctioned since the outbreak of the coronavirus in the Isle of Man (March 2020).

There is no equivalent to the three months waiting period in the Isle of Man. There is no habitual residence test in the Isle of Man. However, there are residence and presence conditions for certain benefits (in particular, entitlement to social assistance benefits is normally dependent on a person satisfying the *Isle of Man residential condition)*. This

condition may be waived if, in the circumstances, it would be exceptionally harsh or oppressive to deny a particular individual benefit.

Local authorities have the power to provide support and assistance under social welfare legislation. They also 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 ECHR/Treaty rights. Recent examples of where local authorities have relied on such powers include the initiative to alleviate rough sleeping in very cold weather, or more recently, to bring in all vulnerable homeless people in the case of the Covid-19 pandemic.

The Isle of Man has provision to make emergency payments at the outset of a person’s claim for social assistance benefits, which are known as “Start-up Payments”. Such payments are made almost every working day.

Article 13, Para. 2 - to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;

a) Please provide responses to comments and queries from 2017 conclusions (see extracts of the full conclusions attached to the commissioning email for the context):

The Committee asks the next report to provide updated information as regards prohibition of discrimination against persons receiving social or medical assistance in the exercise of their political or social rights.

United Kingdom

No-one receiving social or medical assistance in the United Kingdom has diminished political or social rights.

Isle of Man

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

Article 13, para. 3 - to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;

a) Please provide responses to comments and queries from 2017 conclusions (see extracts of the full conclusions attached to the commissioning email for the context):

The Committee asks the next report to provide comments on these observations and to indicate what measures were taken to mitigate the impact of reduced funding for advice services. It also asks for updated information as regards operation of social services offering advice and personal assistance specifically addressed at persons without adequate resources or at risk of becoming so.

United Kingdom

Funding for Citizens Advice[87]

In 2019/20, the total income for the Citizens Advice national charity grew to £139.1 million from £109.8 million in the previous year. This reflects a higher increase in restricted income to £113.8 million (2019: £84.0 million) and particularly the full-year impact of the Department for Work and Pensions Help to Claim project funding of £34.3 million (2019: £9.8 million) which began in October 2018.

The restricted income includes the Money and Pensions Service funding of £24.5 million (2019: £26.5 million) to deliver money and debt advice. This funding (from the UK Financial Conduct Authority's debt advice levy on financial services) also provided funding of £10.9 million (2019: £9.1 million) for our Pension Wise service. Other significant streams of restricted income include £16.0 million (2019: £16.0 million) from the Department for Business, Energy and Industrial Strategy (BEIS) for our consumer work, £11.0 million (2019: £11.5 million) from the Ministry of Justice for the Witness Service and £8.4 million (2019: £5.4 million) from the Welsh Government.

Total unrestricted income was largely unchanged from the prior year at £25.4 million (2019: £25.7 million). The most significant unrestricted funding continues to be that provided by BEIS to support our core activities. This remained static at £22.3 million (2019: £22.3 million). The majority of our funding is awarded through annual funding agreements, is restricted to a particular area of activity and relates to a specific financial year. Therefore, where restricted income grows there will tend to be a corresponding increase in expenditure in the same year.

Covid 19 funding

In May 2020, the Government announced that Citizens Advice and Citizens Advice Scotland would receive a funding boost of up to £15 million to help them deal with increased demand for advice and information from the public during the COVID-19 pandemic.

[87] Source: Citizens Advice Annual Report 2019/20

The funding allows them to increase their capacity so they can continue to deliver advice on a range of issues, such as if a person cannot pay their bills due to coronavirus, or how they can protect themselves from or report a coronavirus-related scam.

The money is part of a £750 million pot announced by the Chancellor, Rishi Sunak, to help frontline charities continue their vital work during the outbreak.

In line with government advice on social distancing, Citizens Advice, which operates in England and Wales, and Citizens Advice Scotland temporarily closed their 331 offices, suspended outreach services and shifted their advice services online and over the phone.

They have seen a significant increase in demand for telephone advice and webchats, and this funding has helped them to continue to deliver their services remotely as well as ensuring their online content reflects the most up to date advice.

The Department for Digital, Culture, Media and Sport has led the allocation of funding to support charities providing key services to help vulnerable people during the crisis.

Scotland

The Scottish Government provides funding for projects to provide and to support the delivery of free-to-client advice on issues such as welfare (including housing and benefits) and problem debt.

Responsibility for funding available through the UK Financial Conduct Authority's debt advice levy on financial services was devolved in January 2019. The Scottish Government has set out its long-term strategy for the future of free debt advice services in Scotland in its Debt Advice Routemap (December 2019). During the financial year 2018-19 the Scottish Government allocated over £1.4 million in grant funding to debt advice projects. This included over £700,000 in funding administered by the Scottish Legal Aid Board for projects under the Making Advice Work and Early Resolution Advice Programmes, and £200,000 to the Citizens Advice network in Scotland for debt advice provision. During the financial year 2019-20, £3.9 million of debt advice levy funding was allocated by the Scottish Government.

The Scottish Government also includes funding to support the most vulnerable people as part of the block grant provided to all local authorities in the annual local government finance settlement. This provides flexibility to local authorities and it is for each of them to allocate their resources in the way that best meets local needs.

In addition, the Scottish Government provides funding for welfare advice projects including for welfare reform mitigation, through organisations such as Citizens Advice Scotland, Shelter UK, Advice Direct Scotland and the Child Poverty Action Group. This financial year (2020-21), this funding has totalled over £4.4 million.

Wales

The Welsh Government is proud of its long-standing commitment to supporting advice services so we can feel confident some of the most vulnerable people in our society have access to the free and impartial advice that they need to resolve problems with their housing, welfare benefits and managing their financial commitments.

The Welsh Government introduced the Single Advice Fund to enhance its confidence that it was funding strategically planned, cost effective and quality assured advice services. The Deputy Minister and Chief Whip has made over £10 million grant funding available to Advice Service providers through the Single Advice Fund during the period 1st January 2020 to 31st March 2021.

During the period, January to September 2020 over 82,000 people received help through the Single Advice Fund services, to deal with over 190,000 problems on their housing, debts, employment and welfare benefits. Income maximisation is a key activity delivered through the Single Advice Fund and between January 2020 and September 2020, services have helped people to claim over £20 million of additional welfare benefit income.

The Welsh Government believes it is important to maintain the stability of advice service provision across Wales during these uncertain times, the Deputy Minister and Chief Whip has therefore extended the current advice service grant agreements until 31 March 2021 and, subject to budget confirmation, approved to extend the Single Advice Fund grant funding for a further 12 months until March 2022.

Article 13, para. 4 - to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11 December 1953.

a) Please provide responses to comments and queries from 2017 conclusions (see extracts of the full conclusions attached to the commissioning email for the context):

The Committee refers to its conclusion under Article 13§4 as regards emergency social assistance to unlawfully present foreign nationals and asks what is the situation with lawfully present foreign nationals.

England and Wales

Medical Assistance

The National Health Service is a residency-based healthcare system and people who are 'ordinarily resident' in the UK are eligible for free care. Being ordinarily resident broadly means living here on a lawful and properly settled basis for the time being. Non-nationals, subject to immigration control, must also have 'indefinite leave to remain' in the UK.

Those lawfully present, but not ordinarily resident in the UK 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, NHS111 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 up front and in full. Where a clinician has determined a patient's need for care to be urgent or immediately necessary, however, that care will never be delayed or withheld, regardless of the patient's ability to pay.

Special provisions for maternity care have been made in the Regulations and it is the only service that the Regulations specify should always be deemed immediately necessary, including any routine ante-natal and post-natal care.
Some non-EEA nationals may be entitled to free healthcare in the UK under the terms of a reciprocal healthcare agreement with their country of origin.

Social assistance

People without indefinite leave to remain status in the UK generally have no recourse to public funds. This means they will not be eligible for most benefits, including an allocation of social housing or homelessness 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).

However, local authorities have the power to provide support and assistance under social welfare legislation. They also 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 human rights.

Victims of Domestic Violence

The UK Government is clear that all victims of domestic abuse should be able to access appropriate support at the appropriate time, regardless of their immigration status.

The current Destitute Domestic Violence Concession (DDVC) was developed to allow individuals who have come to the UK on certain spouse routes permission to remain in the UK, for an initial period of three months, in their own right, and independent from their sponsor. The prohibition on no recourse to public funds is lifted, allowing them to make a claim for welfare support from the Department for Work and Pensions. This is to provide immediate social support to eligible migrants who claim to be victims of domestic abuse and are destitute as a result. To be eligible, applicants must be the spouse or partner of someone who is British or permanently settled in the United Kingdom.

On 16 July 2019, the Government committed to review the overall response to migrant victims of domestic abuse in response to the recommendations of the Joint Committee on the Draft Domestic Abuse Bill. The review specifically considered recommendations to extend the period of time that support is offered for under the DDVC and how this relates to a victim's ability to access safe accommodation. The review has been published – https://www.gov.uk/government/publications/migrant-victims-of-domestic-abuse-review

A better evidence base is needed to ensure that funding is appropriately targeted to meet the needs of migrant victims who are not eligible for the DDVC, which is why we have committed to a £1.5 million pilot fund to gather the evidence needed to make robust policy recommendations. The prospectus for the pilot fund was published on 19 October 2020.

Meanwhile, we provided £1.09 million in Tampon Tax funding to organisations providing specialist support for migrant victims of domestic abuse with no recourse to public funds between 2019 and 2021.

Scotland

Medical assistance

Under exemptions in the National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989, as amended: treatment in an accident and emergency or casualty department is free, regardless of the patient's residency status, until they are admitted to an inpatient ward; and no charge can be applied for necessary treatment in respect of any overseas visitor who is a person who is without sufficient resources to pay the charge.

The provision of healthcare in Scotland is a devolved matter for the Scottish Government and anyone who requires urgent or immediate NHS treatment in Scotland will receive it, regardless of their ability to pay when charges apply.

Social assistance

Section 115 Immigration and Asylum Act 1999 sets out that a person will have 'no recourse to public funds' (NRPF) if they are 'subject to immigration control'. Public funds which are restricted are defined under paragraph 6 of the Immigration Rules.

Scottish local authorities have duties to safeguard the welfare of children, young people leaving care and vulnerable adults which can include providing accommodation and financial support when a person has NRPF. These are statutory duties set out in the Children (Scotland) Act 1995 and the Social Work (Scotland) Act 1968.

In February 2019, the Scottish Government and the Convention of Scottish Local Authorities (COSLA) joint-published guidance setting out the legal framework within which local authorities have to make decisions about support provision. The guidance also includes examples of good practice and is clear that human rights assessments are a fundamental element of this work. The guidance helps Scottish local authorities to make decisions about support provision under their statutory duties, within immigration rule restrictions, and in recognition of people's human rights.

The guidance is a first step toward the development of an Anti-Destitution Strategy focusing on how people with NRPF can be better supported within the devolved Scottish context. Engagement work to inform the strategy was underway within the reporting period. The Scottish Government have committed to work in partnership with COSLA to publish the Anti-Destitution Strategy.

In April 2020, supplementary guidance was published by COSLA, building on the 2019 guidance to enhance support for local authorities when making decisions in the context of Covid-19.

Northern Ireland

Medical assistance

All visitors to Northern Ireland are entitled to medical emergency services free of charge. A medical emergency is something that is, potentially, immediately life-threatening. It does not include routine monitoring or treatment which should be seen by a GP, pharmacist or dentist or, if appropriate, could wait until a person returns to their home country. Examples of medical emergencies include:

- a sudden collapse and becoming unresponsive or not breathing
- suspected stroke or heart attack
- becoming unconscious, perhaps after heavy blood loss or accident
- collapse preceded by facial swelling and wheezing or choking episode
- accident leading to injury

Social assistance

The Local Government Act (NI) 2014 provides district councils in NI with a similar 'general power of competence' to that given to local authorities in England and Wales by the Localism Act 2011. The general power of competence gives a council the same power to act that an individual generally has i.e. it generally allows councils to do anything that is not specifically prohibited by other laws (before the general power was introduced councils, as bodies corporate, could only do things which legislation specifically allowed them to do). This would mean that councils could use the general power of competence to provide emergency social assistance unless this is specifically prohibited by other legislation. It would be a matter for the council to get its own legal advice on this. According to Paragraph 3, Schedule 3 of the Nationality, Immigration and Asylum Act 2002, which extends to the whole of the UK, nothing prevents local authorities exercising powers or performing duties to the extent that it is necessary to avoid breaching any European Convention on Human Rights (ECHR) right.

Isle of Man

In the Isle of Man, lawfully present foreign nationals are subject to the same rules of entitlement to benefits as anyone else, save that persons subject to immigration control may not have recourse to publicly funded benefits (which include social assistance benefits).

Article 14 – The right to benefit from social welfare services

Paragraph 1 - to promote or provide services which, by using methods of social work, would contribute to the welfare and development of both individuals and groups in the community, and to their adjustment to the social environment;

a) Please explain how and to what extent the operation of social services has been maintained during the COVID-19 crisis and whether specific measures have been taken in view of possible future such crises.

England

Adult social care

Residential and domiciliary adult social care services have been maintained throughout the pandemic. Following the first wave of the pandemic, the Government established a Taskforce to advise on the preparation for winter and a potential second pandemic wave. This led to the publication, on 18 September 2020, of a comprehensive winter plan, for the adult social care sector, which set out Government commitments and expectations of local systems (both National Health Service and local authorities) and care providers.

The plan covers: (i) measures to reduce the risk of exposure (restrictions on visiting; managed discharge from hospitals; free PPE for the winter); (ii) the national strategy on testing of both workforce and care home residents; (iii) the provision of data to local authorities to enable local responses; (iv) the relationship between the care system and the National Health Service (including clinical support to care recipients); (v) the provision of funding to drive infection control measures (e.g. paying carers to isolate when sick; and restricting staff movement between care settings); and (vi) measures to support the workforce (e.g. the provision of flu vaccines).

The UK Department of Health and Social Care plan to put assurance and support teams in place to take swift and decisive action, where necessary. These teams will work in partnership with local and regional leaders to assess local plans, identify delivery risks, and provide regular feedback to central government so that support can be provided as required, and that policy development is quick and responsive to any emerging issues.

In addition, these teams are expected to proactively work to prevent outbreaks in care settings at particularly high risk but will also take immediate action where outbreaks do occur, supporting the local response and communicating lessons learned so that they can be incorporated into future activity.

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 communication between groups.

In September 2020, the Department of Health and Social Care announced that there will be a new Chief Nurse for Adult Social Care to provide leadership to the social care nursing workforce.

Social care of children
Ensuring that vulnerable children remain protected is a top priority for government. We are considering all options to ensure that local authorities can continue to deliver services effectively.

Government announced on 2 July an additional £500m of funding to support councils. This takes the total grant funding for councils to help their communities through the crisis to £3.7bn, part of an unprecedented level of additional financial support in recent times.

For children at risk of immediate harm, the Department has processes in place to assess contacts from the public, private offices, parliamentarians, and Number 10 alerting us to a child at risk. These processes will be staffed and maintained regardless of Covid19.

Through powers in the Coronavirus Act we took powers to bring additional social workers onto the register of social workers held by the regulator, Social Work England.

In response to coronavirus (COVID-19), the Home Office and the Disclosure and Barring Service (DBS) have put temporary arrangements in place, to provide standard and enhanced DBS checks and fast-track emergency checks of the adults' and children's Barred Lists, free-of-charge.

The temporary regulations allow visits to a looked-after child, as required by the Care Planning, Placement and Case Review (England) Regulations 2010, to be carried out over the telephone, a video link or other electronic communication methods.

The temporary regulations also suspend the minimum frequency of Ofsted inspections, recognizing that assurance visits will be conducted using a risk-based approach.

Scotland

The Coronavirus Act 2020 provided new powers and measures to help protect the public and maintain essential public services. This included the establishment of a temporary social work register to enable retired and student social workers to apply for temporary registration to deal with any staff shortages arising from the Covid pandemic. This register will continue until the emergency measures are no longer required. Sections 16 and 17 of the Act also includes provision to allow local authorities to dispense with particular social care assessment duties where: 'it would either not be practical to comply, or where to do so would cause unnecessary delay in providing services, support, advice, guidance and assistance'. The provision covers social care for adults and children and support for carers.

The Scottish Government has provided transition funding for local carer services to adapt to supporting unpaid carers remotely, so that they can continue to offer information, advice and emotional support to unpaid carers via the telephone and online

Northern Ireland

The public health measures that DoH has had to put in place to control the spread of COVID 19 have brought increased pressure to children and families in Northern Ireland. In recognition of this, the DoH has put in place a range of measures to ensure that children's services can continue to operate effectively.

These measures were adopted to allow Health and Social Care Trusts to adapt quickly to the situation as it develops:

- Legislation has been changed to make it possible for social workers to complete their work within longer timescales or to deliver services in different ways.
- Health and Education have worked together to get vulnerable children into school during lockdown and put in place similar arrangements to open up childcare provision for vulnerable pre-school children, including those who may not have needed childcare prior to Covid-19.
- Guidance for the childcare sector ensured access to childcare for key workers and vulnerable children has been protected since the beginning of the pandemic.
- Additional funding was provided to support a range of measures targeted at alleviating pressures for children's social services and for foster carers, as well as providing extra support for vulnerable young people aged 16-21+ living in supported accommodation.
- DoH has led on the development of a cross-departmental Covid-19 Vulnerable Children and Young Peoples Plan

Alongside its response to the pandemic, the DoH has been able to progress a number of significant initiatives which will be of benefit to children and families in the longer term. They include work on an Adoption and Children Bill, work on a Regional Care and Justice Campus and the completion of a Looked After Children Strategy.

With regard to Adult Services the DoH has put in place a number of policy and practice measures to mitigate against the transmission of COVID -19. These are in relation to advice to care workers, supporting the workforce, significant support to care homes and home care services and closure of services such as day care.

Wales

In relation to Wales, the operation of social services has been monitored by the Welsh Government, with the cooperation of local authorities as the statutory duty bearers. This weekly monitoring has indicated that the operation of social services has been substantially maintained thus far during the pandemic. This has been achieved by local

authorities and service providers redirecting staff to reinforce essential services, and by exploring innovative methods of service delivery, including online approaches, as well as by an expansion of informal provision of care and support.

This has been facilitated by Welsh Government action such as free distribution of PPE to local authorities, service providers and informal carers, specific exemptions to lockdown restrictions for provision of care and support, provision of access to Covid testing, including facilitating routine asymptomatic testing of staff and residents in care homes etc.

Use has also been made of local resources to manage the test, trace and isolate programme. The service and workforce regulators, Care Inspectorate Wales and Social Care Wales, have also refreshed their approaches to their work to support local authorities and the wider sector to respond successfully to the pandemic.

The Welsh Government is currently collating the lessons learned thus far (noting that the pandemic is not yet over) with a view to planning future crisis responses. In particular, the Welsh Government has initiated development of a Stabilisation and Reconstruction Framework in social care which is intended to support addressing the issues which have arisen during the pandemic and create a stronger and more resilient sector for the future.

Isle of Man

In the IOM the Department of Health and Social Care maintained all critical and statutory functions during the COVID-19 crisis and redeployed staff to assist in additional areas - visiting and supporting people at home in lockdown with shopping and care and assisted the additional services provided by the hospital and supported care homes in managing infection control and visiting arrangements in line with emergency powers of the Island.

Paragraph 1 - to promote or provide services which, by using methods of social work, would contribute to the welfare and development of both individuals and groups in the community, and to their adjustment to the social environment;

b) Please provide responses to comments and queries from 2017 conclusions

In this respect the Committee asks the next report to provide information on the implementation of the Care Act 2014 in practice and the impact of this reform on the users of social welfare services.

England

The Care Act placed a new duty on councils to offer a meaningful choice of services, so that people have a range of high quality, appropriate care options to choose from and that they get the services that best meet their needs. It is for local authorities to ensure their statutory duties are met. DHSC commissioned a comprehensive programme of research to evaluate and inform the ongoing implementation of the Care Act 2014. This research programme consisted of five separate studies that have enhanced our understanding of how the Act is being implemented, including the costs associated with delivering different forms of support, for example more personalised services. One of the five studies specifically focused on the impact the Care Act has had on the support that carers receive. The research projects have been completed, and the department has received final project reports back from academics, all of which have been published:

- Care Act Implementation - Improving Choices for Care: A strategic research initiative on the implementation of the Care Act 2014;
- Prevention and Capacity Building Activities - Implementing the Care Act 2014: Building social resources to prevent, reduce or delay needs for care and support in adult social care in England;
- Market Shaping and Personalisation (covering two research projects) - Shifting Shapes: how can local care markets support personalised outcomes?;
- Impact on Carers - Supporting carers following the implementation of the Care Act 2014: eligibility, support and prevention.

In addition to this dedicated research programme, the department continues to work with NHS Digital to ensure that national data collections support the monitoring of the Care Act and its cost. Data collections are kept under review to ensure the department collects the data required to monitor implementation with minimum cost and burden.
The vast majority of care services provide high quality care and support. As of February 2021, 85% of adult social care providers are currently rated good or outstanding by the Care quality commission. For most people the experience of adult social care and support is incredibly positive.

In the 2019/20 Adult Social Care Survey (ASCS), an annual national survey conducted by Councils with Adult Social Services Responsibilities (CASSRs), 89.1% of service users reported that they were satisfied with the care and support they received (including users who were quite, very or extremely satisfied), and 64.2% of users were extremely or very

satisfied with their care and support. These findings are not significantly different from the previous year (89% and 64% respectively). The survey seeks the opinions of service users aged 18 and over in receipt of long-term support services funded or managed by social services and is designed to help the adult social care sector understand more about how services are affecting lives to enable choice and for informing service development. Other findings from the 2019/20 Adult Social Care Survey include that 70% of service users reported that they felt as safe as they want to, and 77% of service users reported that they felt they had control over their daily life. (This includes users who said they have as much control over their daily life as they want to and users who said they have adequate control over their daily life.)

Care Act 2014 easements were introduced in the Coronavirus Act 2020 as a tool to help local authorities continue to meet the most urgent and acute needs in the face of COVID-19. The easements relax some duties on local authorities and allow them to streamline assessments, charge for care and support retrospectively, prioritising care and support more effectively than is possible under the Care Act 2014.

The easements are temporary and should be used as narrowly as possible, based on local authority judgement of their ability to meet the needs of local people in a Care Act compliant way.

The Secretary of State for Health has kept easements under review and, on the basis of expert clinical and social care advice, has concluded that easements have been used appropriately by local authorities and the provision should remain in place.

The Chief Social Workers are regularly engaging with the sector through the Principal Social Worker (PSW) Network. From feedback received, the Chief Social Workers have been satisfied that any easements have been considered and communicated in line with the Ethical Framework for Social Care.

The Department is working with Think Local, Act Personal (TLAP) and the Association of Directors of Adult Social Services (ADASS) to understand the impact on individuals with care and support needs, including those with disabilities, of the changes to Care Act 2014 duties.

Across this research there have been no concerns that the councils that enacted the easements have ceased to support disabled people nor has there been data to suggest that they were adversely affected by the easement.

Paragraph 1 - to promote or provide services which, by using methods of social work, would contribute to the welfare and development of both individuals and groups in the community, and to their adjustment to the social environment;

b) Please provide responses to comments and queries from 2017 conclusions; In this respect the Committee asks that the next report provides information on the impact on client/users after the introduction of these two new public bodies. (Scotland)

Scotland

Healthcare Improvement Scotland (HIS) was established in 2011 as a Public Health Body to improve and scrutinise the quality of healthcare, and to regulate independent healthcare providers.

HIS are responsible for inspecting NHS hospitals to provide assurance of both safety and cleanliness, and the quality of care. They work closely with the Care Inspectorate, who perform a similar regulation and inspection function for social care. Although HIS do not have much locus in social care, there is a growing recognition of the inter-dependencies and mutual support required across a complex system of health and social care.

In response to COVID-19, HIS have been supporting the Care Inspectorate with regulation of care homes, including surveillance/responding to notifications and care home inspections, with a particular focus on infection prevention and control. Also HIS have been carrying out joint inspection of children's services with the Care Inspectorate, Education Scotland and HMICS.

Further to this, HIS' Community Engagement Directorate support Integration Authorities to engage meaningfully with people and communities in the design and delivery of health and care services.

Through HIS' Improvement Hub (ihub), they also offer bespoke support for health and social care partnerships to undertake robust and effective strategic planning, and support the development of community focused commissioning and spread of community-led models of care co-ordination.

HIS also have a wide range of improvement support programmes working across integrated health and social care services.

The Care Inspectorate (statutory name "Social Care and Social Work Improvement Scotland"), is the independent scrutiny and improvement Non Departmental Public Body (NDPB) responsible for the regulation and inspection of care and support services in Scotland.

The Care Inspectorate's scrutiny activity helps to drive continuous improvement and acts as a diagnostic tool on which they can plan improvement support. They work in partnership with a number of bodies to achieve their strategic outcomes:

- People experience high-quality care
- People experience positive outcomes
- People's rights are respected

This includes collaborating with Healthcare Improvement Scotland (HIS), Education Scotland, and HMICS to undertake strategic and joint inspections of service delivery.

In response to the Covid-19 pandemic the Care Inspectorate are employing a flexible, intelligence-led and risk based approach to its scrutiny, assurance and registration activities. They have introduced new quality indicators to augment their Quality Framework for inspection of Care Homes for Adults and Older People, with a focus on Infection, Prevention and Control (IPC) measures, use of PPE, and health and wellbeing of residents during the pandemic.

The Care Inspectorate has continued to make regular contact with care homes and their parent companies in order to support staff and ensure that the Health and Social Care Standards are met. They are also actively working with Health Protection Scotland, local Public Health teams, Health and Social Care Partnerships, local authorities and others in order to monitor, direct and guide services.

Paragraph 1 - to promote or provide services which, by using methods of social work, would contribute to the welfare and development of both individuals and groups in the community, and to their adjustment to the social environment;

b) Please provide responses to comments and queries from 2017 conclusions; In this respect the Committee asks the next report to provide information on the impact of these changes on the users of social welfare services. (NI)

Northern Ireland

Integrated Care Partnerships:

Impact of ICPs on users of social welfare (social care) services There are 17 Integrated Care Partnerships in place across NI, they are local networks involving staff from Health and Social Care Trusts, GPs, Community Pharmacists, the Voluntary & Community sector, local councils and service users and carers. They promote partnership working at a local level to deliver more joined up care with a particular focus on services for older people and people with long term conditions.

Through their work they have designed and delivered improved and more integrated services which will have had an impact on people with long term conditions a sub set of whom will potentially be in receipt of social welfare (care) services.

Some examples of those services include;

- Acute or Enhanced Care at Home for older people (- to avoid admission to hospital and allow older people to receive medical care in their own home)
- Social prescribing services to help improve the health and wellbeing of people with social, emotional or practical needs by empowering them to find solutions, often using services provided by the voluntary and community sector
- Community based support programmes for people living with chronic pain
- Improved pathways of care within the community for people with diabetes
- Integrated falls pathways to prevent falls occurring among older people and to respond quickly when they do occur and prevent hospital admission where possible.

Self-Directed Support:

- Accessing Self Directed Support gives service users more choice and control over their social care services, providing greater flexibility, promoting independence and enabling users to tailor their individual support package to fit their specific needs and preferences.

- In practical terms, Self Directed Support gives service users as much control as they want over their personal budget, the amount of money that is identified and allocated by the HSC Trust to meet their assessed needs. Service users can choose to receive the money as a Direct Payment, a cash payment in lieu of social services provided by the HSC Trust, or opt for a managed budget, where the HSC

Trust holds the budget, but the service user can determine how it is spent in meeting their assessed needs. HSC Trusts will continue to arrange support services for individuals who do not wish to take an active role in directing or managing their support package. Service users can also choose to adopt different levels of control for the different elements of their support package.

Paragraph 1 - to promote or provide services which, by using methods of social work, would contribute to the welfare and development of both individuals and groups in the community, and to their adjustment to the social environment;

b) Please provide responses to comments and queries from 2017 conclusions; The report indicates that the Social Services and Well-being (Wales) Act 2014 came into force in April 2016 outside the reference period. The Committee asks that the next report to provide information on the implementation of this Act in practice and on the impact of this reform on the respective users of these social services. (Wales)

Wales

In order to assess the implementation and impact of the Social Services and Well-being (Wales) Act 2014, the Welsh Government has commissioned a partnership between academics across four universities in Wales and expert advisers led by the University of South Wales to deliver a multi-part formal evaluation of the legislation. The evaluation work commenced in 2018.

The work towards the process element of evaluation, which specifically looks at the implementation of the legislation, has been completed and will report in spring 2021. The team conducted over 100 interviews as part of this process and included stakeholders on a national, regional and local level. Key questions that were asked as part of this process evaluation included; what planning was undertaken by partners for the implementation of the legislation; whether the components of implementation have been completed as intended and if these have permeated into practice; the interpretation of the Act at national, regional and local level; and whether there has been any unintended consequences.

The next phase of the evaluation will be the impact evaluation which will look at the impact of the legislation on those who receive care and support. The findings from this phase of the evaluation will be published in autumn 2022.

The Welsh Government also commissioned a partner project, Measuring the Mountain which considers the experiences of within social care. This project started in 2018 and published its first report in April 2019. Findings from this report highlighted that there are some excellent examples of social care practice in Wales. However, there is still some work to be done, particularly surrounding how we best support carers. The Welsh Government has provided a formal response to this report and its recommendations, and has also extended the work of Measuring the Mountain to ensure we continue to hear the voices of individuals and hear about their experiences of care and support under the legislation. Findings from this next phase will be published in December 2020.

Paragraph 2 - to encourage the participation of individuals and voluntary or other organisations in the establishment and maintenance of such services.

a) Please 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 and in the design and practical realisation of services. Co-production is here understood as social services working together with persons who use the services on the basis of key principles, such as equality, diversity, access and reciprocity.

United Kingdom

The Care Act 2014 sets key expectations for co-production of social services with individuals, families, carers and communities. Local authorities in England are urged to actively promote participation in developing and delivering co-produced approaches to care and support. Local authorities should be providing individuals with the opportunity to design care and support based around their goals, and care and support needs, alongside advice from key professionals.

The Care Act 2014 extends this principle of co-production to market-shaping and commissioning, setting out expectations for local authorities and commissioners to work alongside people with care and support needs, their families and carers, care providers and advocacy groups to develop and find shared solutions.

The Covid-19 Ethical Framework for Adult Social Care reinforces the expectations set out in the Care Act 2014 and provides a set of ethical values and principles for policy makers and response planners to follow when making decisions on the organisation and delivery of care. This includes the principle of 'inclusiveness' which should be achieved through involving and being transparent with individuals in receipt of care and support, families and carers in aspects of planning that affect them and their communities.

The UK Department of Health and Social Care is committed to consulting with individuals, carers, communities and professionals when developing policy. During the Covid-19 outbreak, a wide range of stakeholders have been engaged with to ensure their voices are heard including when producing social care guidance and through the work of the Social Care Covid-19 Support Taskforce.

In 2016, we published the cross-Government care leaver strategy (Keep on Caring). This set out the Government's plan to introduce new legal duties on local authorities (LAs), including: the introduction of a set of 'corporate parenting principles' to govern the way that LAs deliver services to Looked After Children (LAC) and care leavers; a new duty to consult on and publish their 'local offer' for care leavers; and a new requirement on LAs to offer Personal Adviser support to all care leavers to age 25 (support previously ended at age 21 for most care leavers). These changes were included in the Children & Social Work Act (2017), and came into effect in April 2018.

The Keep on Caring strategy also set out a number of further commitments, including to pilot 'Staying Close', which provides an enhanced support package for young people

leaving residential care (similar to Staying Put for young people leaving foster care); piloting 3 care leaver social impact bonds – outcome-based contracts focussed on helping care leavers to engage in education, employment and training – and launching the care leaver covenant, which provides a way for private sector organisations to provide offers of support to care leavers, such as apprenticeships or internships. All of these commitments have been implemented. The Government has also established the Civil Service care leaver internship scheme, which this year is offering over 500 paid internships across Government; and has established a cross-Government Ministerial Board to drive improved outcomes for care leavers.

Clause 2 of the Children & Social Work Act (2017), introduced a new duty on local authorities (LAs) to consult on and publish a 'local offer' for care leavers. This sets out both care leavers' statutory entitlements, as well as any further discretionary support that the LA provides. A group of care leavers in each LA were involved in the development of the draft local offer, which was used as the basis for consulting all care leavers before the LA's offer was published.

Scotland

Community Engagement

Integration Authorities have a range of duties conferred upon them through the Public Bodies (Joint Working) (Scotland) Act 2014, which requires a comprehensive approach to engagement with a range of key stakeholders as they plan and commission health and social care services across Scotland. It requires Integration Authorities to engage and consult with a range of stakeholders, working with local communities and professionals to improve outcomes and sustainability through service redesign. These duties are further reinforced and augmented in statutory guidance, particularly relating to the preparation of strategic commissioning plans.

The Act contains specific integration planning principles, which include local community engagement and participation. Guidance on the principles for planning and delivering health and social care refers specifically to the role of the SHC and the use of its Participation Toolkit. The National Standards for Community Engagement, which were reviewed and updated during 2015-16, are widely accepted as key principles for effective engagement practice. Ultimately, however, the decision of how best to approach this engagement will be for the Integration Authority.

Meaningful and sustained engagement with a range of stakeholders, including those who use services, is critical to ensure constructive dialogue with everyone involved, aimed at improving understanding and taking action to achieve positive change, together.

Service User Representatives on IJBs

There is a mandatory requirement that a service user be included in the Integration Joint Board (IJB) membership[88]. This is alongside a carer, third sector and staff side representative. A service user must be residing in the local authority area and must be

[88] https://www.gov.scot/publications/roles-responsibilities-membership-integration-joint-board/pages/2/

appointed following the establishment of an IJB. As a minimum there must be at least one service user. The way they are appointed to these positions on the IJB will vary depending on local circumstances. For example, types and number of representative groups working within the area.

They are fully supported to put forward their views and lived experience and there is clear guidance on support to enable members to fulfil their role. The following principles are set out in statutory guidance which the IJB should follow:

- Stakeholder members will reflect the views of the groups they represent on the Integration Joint Board; naturally the individuals that comprise these stakeholder groups will be diverse. As such, the appointed person must be able to demonstrate the appropriate experience and skill to reflect the breadth and diversity of views and situations of the individuals or groups that they represent.
- The Integration Joint Board should ensure the appointed member has the resources and support to fulfil their responsibilities to the Integration Joint Board for the full term of their appointment.
- As effective strategic planning is key, the Integration Joint Board must ensure that the appointed stakeholder members are given specific training and support to contribute effectively to the Integration Joint Board, where such training is required. As with professional members, these principles should also be considered when the Integration Joint Board opts to appoint any additional stakeholder members. The implementation of each principle will depend on the nature and basis on which these additional members are appointed.

Roles, Responsibilities and Membership of IJB Statutory Guidance[89].

Self-Directed Support

The Social Care (Self-Directed Support) (Scotland) Act 2013 makes legislative provisions for care and support, community care services and children's services to provide a range of choices to people for how they are provided with social care support. People must be involved in making decisions about their care and support, have as much control over it as they wish; their support must be personalised to their own outcomes (including where they receive social care support commissioned or delivered by the public sector); and respects the person's right to participate in society.

The updated Self-directed Support Implementation Plan 2019-21[90] is a guide for the local planning and delivery of social care support services and sets out what needs to happen to make the changes required to achieve self-directed support across Scotland for people who use social care support, including disabled people and older people and others with protected characteristics. The Scottish Government has worked with stakeholders to develop and publish Self-directed Support Covid-19 guidance for Local Authorities, Health and Social Care Partnerships and social care providers to support local social care

[89] https://www.gov.scot/publications/roles-responsibilities-membership-integration-joint-board/
[90] https://www.gov.scot/publications/self-directed-support-strategy-2010-2020-implementation-plan-2019-21/

systems and services to continue to respond appropriately and flexibly during the pandemic.

Northern Ireland

The Health and Social Care Reform Act (NI) 2009 placed a statutory legislative requirement on certain HSC organisations to involve and consult patients, families, carers and local communities on the planning, delivery and evaluation of services.

In particular, HSC organisations were required to develop individual consultation schemes setting out how they would involve and consult with the Patient Client Council, service users and carers on:

- the planning of how their services are delivered
- the development and proposals for change in the way care is provided
- decisions affecting the provision of care

The DoH engaged with HSC organisations in the development of their schemes and each body now has a consultation scheme, approved by the DoH, in place. The DoH also has its own (Personal and Public Involvement) PPI Consultation Scheme. DoH takes account of PPI involvement in its budgetary planning.

Co- Production

Co-production is part of the professional practice agenda and should be taught, promoted, supported and evaluated as part of all professional training, practice and improvement and development activity.

Improving & Safeguarding Social Wellbeing – A Strategy for Social Work (2012 to 2022) initiatives are co-produced with social workers and/or service users. Significant progress has continued to be made in implementing the Strategy which includes investment in Quality Improvement (QI) learning supported together with the development of a regional QI programme for social work which has significantly enhanced the capacity of social workers to lead quality improvement and innovation. Leadership is central to ensuring opportunities for quality improvement and since 2016 the DoH has supported social workers and people with lived experience to co-produce improvements in practice and service delivery using recognised QI tools and methods.

Other Examples of Co- Production

Co-production was introduced as a new category to the Regional Social Work Awards in 2019/20. These provide a rich source of practice examples have been included in a publication called ‘Social Work The Real Life Stories behind the headlines’ which was launched in March 2020.

A social wellbeing framework which articulates the purpose of social work in improving social well-being was published in June 2017 and a social wellbeing tool based on this framework has been developed by social workers and people with lived experience. This has been piloted and work is ongoing in developing an electronic solution.

New approaches to practice all promote greater partnership working and co-design of care plans.

Local Engagement Partnerships (LEPs) which were set up in 2017 are operational in each Trust area involving social workers, people with lived experience and partner providers.

Social work learning and development (eg Degree, mental health (Approved Social Work), in-service training, Research Methods) has strong service user involvement.

Policy development involves service user – eg Reform of Adult Social Care and the Mental Capacity Act

Wales

The Welsh Government seeks to promote co-productive approaches to social care. Co-production is one of the key principles underpinning the Social Services and Well-being (Wales) Act 2014. The Code of Practice and guidance on the exercise of social services functions and partnership arrangements in relation to Part 2 (General Functions) of the Social Services and Well-being (Wales) Act 2014, which is statutory, notes that part of the duty to promote well-being means putting robust arrangements in place for encouraging the involvement of people.

This means focusing on outcomes rather than processes and outputs so that organisations and arrangements are designed with, and are led by, people who need care and support, and carers who need support. This applies at an individual, organisational and strategic level.

The Code refers to co-production as “a way of working whereby practitioners and people work together as equal partners to plan and deliver care and support”, and explains how this approach:

- Recognises people as assets and as having a positive contribution to make to the design and operation of services
- Supports and empowers people to get involved with the design and operation of services
- Builds on capabilities and empowers people to take responsibility for, and contribute to, their own well-being
- Ensures that practitioners work in partnership with people to achieve personal outcomes at an individual and service level
- Involves people in designing outcomes for services

- Blurs distinctions between providers and people who need care and support, and carers who need support
- Facilitates rather than delivers services

In particular, the code requires that “people must be involved in the design and delivery of services and in the production of a population assessment, and that a co-productive approach will bring a wide variety of experience, skills and knowledge to these processes.” Furthermore, local authorities must also: “Ensure that providers from whom they commission or procure services encourage and enable the involvement of all people in designing the shape of services and how they will operate to deliver personal outcomes, and that providers involve people in evaluation and review.”

In order to assess the implementation and impact of the Social Services and Well-being (Wales) Act 2014, the Welsh Government has commissioned a partnership between academics across four universities in Wales and expert advisers led by the University of South Wales to deliver a multi-part formal evaluation of the legislation. The evaluation will be looking specifically at coproduction as one of the principles of the Act.

An example of the co-productive approach is the abovementioned Measuring the Mountain project, which Welsh Government commissioned in 2018 to consider and collate stories from those with experiences of social care in Wales. Co-production was central to the approach and foundation of the project, with the development of the project taken forward using a co-productive approach guided by expert partners in the form of the Co-production Network in Wales. This approach continued throughout the delivery phase of the project, with the work being guided and delivered by the steering group which not only involves individuals from organisations across Wales but also involves and is led by those with experiences of care and support. In September 2020 the team delivered a Citizen Jury which is a well-established method of engaging with people about a policy issue or on a topic of public importance. The Jury developed a series of recommendations which will be presented to Welsh Government in December 2020.

Isle of Man

There is currently no policy position on use of co-production in the IOM Department of Health and Social Care. It has been explored in a small number of initiatives but not yet established as a mechanism for delivery on a large scale.

Paragraph 2 - to encourage the participation of individuals and voluntary or other organisations in the establishment and maintenance of such services.

b) Please provide responses to comments and queries from 2017 conclusions

The Committee, in the absence of information concerning the supervisory mechanisms to control the quality of services and ensure the rights of the users, asks that the next report provide updated information on the implementation of effective supervisory system of social services also in the private sector.

England

The Care Quality Commission (CQC) conducts robust monitoring and inspections to make sure that all service providers, including those in the private sector, meet quality and safety standards. It also monitors the financial health of the largest and most difficult-to-replace adult social care providers through its market oversight scheme. Under the scheme, the CQC has a duty to notify local authorities if they consider that a provider's services are likely to be disrupted because of business failure. This allows local authorities time to step in and ensure that people continue to receive the services they need. Local authorities have contingency plans in place.

As part of its ongoing monitoring of providers during the COVID-19 pandemic, the CQC has been gathering information from a range of sources to inform its view of risk and take action to keep people safe. The CQC works with partners to support the wider health and social care system to respond to issues at local, regional and national levels and target support where it's most needed.

From October 2020, the CQC have been rolling out their transitional regulatory approach (TRA), which is flexible and builds on what they learned during the height of the pandemic. The key components are:

- a strengthened approach to monitoring, with clear areas of focus based on existing Key Lines of Enquiry (KLOEs), to enable the CQC to continually monitor risk in a service;
- use of technology and local relationships to have better direct contact with people who are using services, their families and staff in services; and
- inspection activity that is more targeted and focused on concerns, without returning to a routine programme of planned inspections.

The CQC will continue to adapt the TRA and remain responsive as the situation changes.

Scotland

The Care Inspectorate's statutory duties and powers are set out in the Public Services Reform (Scotland) Act 2010[91]. For applications from individuals or organisations to

[91] https://www.legislation.gov.uk/asp/2010/8/contents

register a new care service, the Care Inspectorate assesses the quality of services being offered and that the provider meets various requirements.

The Care Inspectorate[92] applies quality frameworks to evaluate the quality of care during inspections and improvement planning. To date, they have published[93] quality frameworks for:

- care homes for older people
- care homes for adults
- care homes for children and young people and school care accommodation (special residential schools)
- support services (not care at home).
- mainstream boarding school and school hostels.

Where concerns in the quality of a care service are identified during an inspection, the Care Inspectorate will work with other agencies to support the necessary improvement. They also have powers to issue notices of improvements and, if required, propose to cancel registration of a service. In response to the pandemic, the Care Inspectorate has augmented their inspection framework, which now includes quality indicators specific to Covid-19, and continues to ensure that the Health and Social Care Standards are the focus of their scrutiny and improvement activity.

In Scotland people have the legal right to be involved in decisions about their care and support under the Social Care (Self-directed Support) (Scotland) 2013[94]. Human rights principles are written in to the Self-directed Support Act[95]. The responsibility for the provision of social care and support services lies with Health and Social Care Partnerships under the "Social Work (Scotland) Act 1968.

The purchasing of social care and support services is governed by the Procurement (Scotland) Regulations 2016. This covers how services should be purchased and includes all sectors.

Northern Ireland

In Northern Ireland, the current supervision policy for social workers in Children's Services dates back to 2008 and was thought to be no longer relevant to contemporary practice. While a more recent supervision policy had been developed and tested for social workers in Adult Services it was considered that there needed to be uniform policy/standards for professional supervision for all social workers irrespective of client group or setting.

Two regional surveys of supervision in social work carried out in 2018 and 2019 highlighted that evidence informed practice is seldom covered in supervision.

[92] https://www.careinspectorate.com/
[93] https://www.careinspectorate.com/index.php/publications-statistics
[94] https://www.legislation.gov.uk/asp/2013/1/contents/enacted
[95] https://www.gov.scot/publications/guide-social-care-self-directed-support-scotland-act-2013/

The combined results of both surveys will inform the review of the current policies and development of a single, uniform policy for the professional supervision of all social workers.

In March 2020, work on the revision of the regional supervision policy was well advanced with the intention to go out for wider consultation of the policy. However due to COVID 19 these plans were postponed. In keeping with decisions to relax existing standards to facilitate greater flexibility and maintain the delivery of essential services, Trusts and social work employers in other sectors were advised that they may use this draft supervision policy to inform alternative arrangements for supervision even though it has not been fully consulted on. The final draft of the policy will be usefully informed by their experiences of providing supervision in different ways during COVID19.

It is also proposed that supervision surveys would be carried out 12 to 18 months after new supervision arrangements are in place to establish if any progress has been made in promoting evidence–based practice through supervision.

Wales

In relation to Wales, supervision of the quality of services in the local authority, third and private sectors, including ensuring the rights of users, is undertaken by the service regulator, Care Inspectorate Wales, and the workforce regulator, Social Care Wales, applying requirements set out in the governing primary legislation, the Regulation and Inspection of Social Care (Wales) Act 2016.

Care Inspectorate Wales registers, inspects and takes action to improve the quality and safety of services for the well-being of the people of Wales in relation to the following services:

- adult services: care homes for adults, domiciliary support services, adult placement schemes and residential family centre services
- children's services: care homes for children, fostering services, adoption services, advocacy services and secure accommodation services
- childcare and play services: child minders, crèches, full day care, sessional day care, out of school care and open access play provision

Particular activities carried out by CIW in discharge of these functions include

- carrying out functions on behalf of Welsh Ministers to provide assurance on the quality and safety of services
- deciding who can provide services
- inspecting and driving improvement of regulated services and local authority social services
- undertaking national reviews of social care services
- taking action to ensure services meet legislative and regulatory requirements
- responding to concerns raised about social care and childcare services

Social Care Wales acts as the social care regulator with the responsibility for workforce development of the social care and early years sector as well as supporting social care research and service improvement in Wales. Its particular focus is on:

- providing public assurance, so that people have confidence in the social care workforce including the early years workforce, and the effectiveness of Social Care Wales
- developing the social care and early years workforce
- leading and supporting improvement to enhance well-being outcomes for children and adults who rely on care and support, their families and carers

Within this framework, the Welsh Government recognises a particular role for advocacy in supporting people to realise their rights and make their voices heard in relation to the care and support which they receive. To support the provision of advocacy in social care, the Welsh Government has issued a Code of Practice in relation to Advocacy under the Social Services and Well-being (Wales) Act 2014, setting out expectations in relation to support for access to advocacy. On 1 January 2020 a revised Code came into force, including a refined definition of an Independent Professional Advocate and amendments to take into account the standards for regulated advocacy services under the Regulation and Inspection of Social Care (Wales) Act 2016.

In the interest of supporting the provision of high-quality statutory advocacy services, the Welsh Government has placed requirements on service providers and responsible individuals of certain advocacy services in Wales, under the Regulation and Inspection of Social Care (Wales) Act 2016. The Regulated Advocacy Services (Service Providers and Responsible Individuals) (Wales) Regulations 2019 came into force on 29 April 2019 and currently apply to advocacy services arranged by local authorities under their duty to assist children, looked after children and certain types of care leavers in making representation about their needs for care and support. The Welsh Government is intending that the 2016 Act framework be extended to providers of advocacy for adults and those children who would not fall within the scope of s178 of the 2014 Act at the point when there is clearer evidence of the impact the requirements of the Act will impose on providers. In the intervening period the Welsh Government has expressed a clear expectation that providers are working toward the future regulation of advocacy for adults.