January 2014

European Social Charter

European Committee of Social Rights

Conclusions XX-2 (2013)

(GREAT BRITAIN)

Articles 3, 11, 12, 13 and 14 of the 1961 Charter

This text may be subject to editorial revision.

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

Information on the Charter and the Committee as well as statements of interpretation and general questions formulated by the Committee appear in the General Introduction to the Conclusions.[1]

The 1961 European Social Charter was ratified by the United Kingdom on 11 July 1962. The time limit for submitting the 32nd report on the application of this treaty to the Council of Europe was 31 October 2012 and the United Kingdom submitted it on 30 November 2012. On 2 October 2013, a letter was addressed to the Government requesting supplementary information regarding Article 3. The Government submitted its reply on 7 October 2013. Comments on the report from the Working Group "Social Charter" of the Conference of International Non-Governmental organisations to the Council of Europe were registered on 03 March 2013.

This report concerned the accepted provisions of the following articles belonging to the thematic group “Health, social security and social protection”:

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

The United Kingdom has accepted all of these articles, with the exception of Articles 3§4; 12§§2 to 4 and Article 4 of the Additional Protocol.

The reference period was 1 January 2008 – 31 December 2011.

The present chapter on the United Kingdom concerns 13 situations and contains:

– 11 conclusions of conformity: Articles 3§1, 3§2, 3§3, 11§1, 11§2, 11§3, 13§1, 13§2, 13§3, 14§1, and 14§2

– 1 conclusion of non-conformity: Article 12§1

In respect of the other situation concerning Article 13§4, the Committee needs further information in order to assess the situation. The Committee consequently asks the Government to comply with its obligation to provide this information in its next report on the articles in question.

The next report from XX deals with the accepted provisions of the following articles belonging to the thematic group “Labour rights”:

- the right to just conditions of work (Article 2),
- the right to a fair remuneration (Article 4),
- the right to organise (Article 5),
- the right to bargain collectively (Article 6),
- the right to information and consultation (Article 2 of the Additional Protocol),

- the right to take part in the determination and improvement of the working conditions and working environment (Article 3 of the Additional Protocol).

The deadline for the report was 31 October 2013.

[1] *The conclusions as well as state reports can be consulted on the Council of Europe's Internet site (www.coe.int/socialcharter).*

Article 3 - Right to safe and healthy working conditions

Paragraph 1 - Safety and health regulations

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

Content of the regulations on health and safety at work

The general legal framework, previously described, remains over all unchanged. The Health and Safety at Work etc. Act (HSWA) 1974, and its Northern Ireland equivalent, the Health and Safety at Work (Northern Ireland) Order 1978, are the primary pieces of legislation covering occupational health and safety in the United Kingdom. The HSWA applies to most workplaces, including offshore installations and nuclear installations, and to most people at work, including the self-employed. In 2008, the Heath and Safety (Offences) Act was adopted. The purpose of the Act is to raise the maximum penalties available to the courts in respect of certain health and safety offences by altering the penalty framework set out in HSWA and the Northern Ireland 1978 Order. An up-to-date consolidated version of the HSWA and the above-mentioned Order are provided. The Isle of Man's health and safety legislative framework is built upon the Health and Safety at Work etc Act 1974 (of the UK Parliament) (as applied to the Island) and the Management of Health and Safety at Work Regulations 2003. Both the Act and the Regulations are Isle of Man adaptations of existing UK legislation.

The EU Directive 89/391/EEC on the introduction of measures to encourage improvements in the safety and health of workers at work was primarily implemented by the Management of Health and Safety at Work Regulations 1999, which established broadly based obligations for employers to evaluate, avoid and reduce workplace risks etc. The report indicates that a range of related and other directives, implemented through national regulations, cover: the management of specific workplace risks (such as musculoskeletal disorders, noise, work at height or machinery); the protection of specific groups of workers (such as new or expectant mothers, young people and temporary workers); measures to complete and maintain the single market in the EU; or the protection of the environment. A similar legal framework exists in Northern Ireland.

On 1 April 2008, the Health and Safety Commission and Health and Safety Executive merged to form a single national regulatory body responsible for promoting the cause of better health and safety at work – the Health and Safety Executive (HSE). The Great Britain's national occupational safety and health policy is outlined in HSE's "The Health and Safety of Great Britain: Be part of the solution". A number of other UK government bodies are responsible for occupational health and safety in some sectors (Office of Rail Regulation; Maritime and Coastguard Agency; Civil Aviation Authority; Office of Nuclear Regulation, currently operating as an Agency of the HSE, but becoming a fully independent regulator in 2014). HS Northern Ireland (HSENI) sets out its strategy for implementing the legal framework in Northern Ireland in its successive Corporate Plans.

The Committee notes that on 29 August 2008, the UK ratified the ILO Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187).

Protection against dangerous agents and substances

Protection of workers against asbestos

In its last conclusion (Conclusions XIX-2), the Committee considered that protective measures against risks related to asbestos were in conformity with the Charter. The report does not contain additional information. The Committee understands that there are no developments with respect to the above-mentioned measures. It considers that the situation is in conformity with Article 3§1 on this point.

Protection of workers against ionising radiation

In its last conclusion (Conclusions XIX-2), the Committee considered that protective measures against risks related to ionising radiation were in conformity with the Charter.

The report indicates that nuclear safety is dealt with by the Office for Nuclear Regulation (ONR), which was formed on 1 April 2011, as an agency of HSE. ONR brings together the safety and security functions of HSE's former Nuclear Directorate, including Civil Nuclear Security and the UK Safeguards Office, along with radioactive materials transport. It is intended that ONR will become a single, integrated regulator, independent of HSE and HSENI.

The Committee considers that the situation is in conformity with Article 3§1 on this point.

Personal scope of the regulations

Protection of temporary workers

The Committee examined the regulations relating to the protection of temporary workers in its last conclusion (Conclusions XIX-2) and considered that the situation was in conformity with the Charter. The current report does not contain additional information. The Committee understands that there are no developments with respect to the legal framework relating to the protection of temporary workers. It asks that the next report provides full and updated information on this point.

Other types of workers

In its last conclusion (Conclusions XIX-2), the Committee reiterated that the fact that domestic workers are excluded from any type of inspection of the labour inspectorate is a matter of concern as they are considered a vulnerable category of workers. Therefore, and having also regard to the Siliadin v. France judgement of the European Court of Human Rights, the Committee asked whether any supervision of this category of workers by the public authorities is foreseen.

The report indicates that "domestic servants" employed in private households are not covered by health and safety law and other related legislation, whilst other domestic workers (such as health or social care workers) are covered. The domestic work sector is not seen as a priority for UK health & safety regulators, who prioritise their resources on those sectors that give rise to the greatest risks to workers and the public, so no active program of interventions is therefore proposed for this employment sector. In this context, the report also states that there are particular difficulties in respect to including domestic servants, in regard to the extent to which the state should interfere with the private home.

The Committee notes that the ILO Domestic Workers Convention, 2011 (No. 189) has not yet been ratified by the UK. From other sources (*Domestic workers across the world: global and regional statistics and the extent of legal protection / International Labour/* International Labour Office – Geneva, ILO, 2013), the Committee notes that in the UK, some 138,000 domestic

workers work in private households; in 2008, this figure was equivalent to 0,5% of total employment in the country.

The Committee recalls that all workplaces and all activities must be covered by occupational health and safety regulations. This also includes self-employed workers, home workers and domestic workers (cf. Conclusions XIX-2 Luxembourg; Conclusions XIX-2 Poland; Conclusions XIX-2 Spain). The Committee asks that the next report indicates which are the categories of domestic workers covered by health and safety laws and regulations further to health and social workers; it also asks to be informed on the steps taken to protect health and safety of domestic workers without interfering with private home.

Conclusion

Pending receipt of the requested information, the Committee concludes that the situation in the United Kingdom is in conformity with Article 3§1 of the 1961 Charter.

Article 3 - Right to safe and healthy working conditions

Paragraph 2 - Enforcement of safety and health regulations

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

Occupational accidents and diseases

The Committee notes that Eurostat statistics show that in Great Britain the number of severe accidents (4 days absence or more – not including road traffic accidents and accidents on board of any mean of transport in the course of work) decreased from 159 650 in 2008 to 132 310 in 2010. In addition, the standardised incident rate for this type of accidents per 100 000 workers continued to decrease during the reference period with a rate of 932 in 2008 and 901 in 2010, one of the lowest in Europe and well under the European Union average (27 States), which was 2 269 in 2008 and 1 582 in 2010. As regards Northern Ireland, the report indicates that the number of accidents at work decreased from 3 134 in 2008/09, with a rate of 433 per 100 000 employees, to 3 119 in 2010/11, with a rate of 447.

As regards fatal accidents in Great Britain (excluding road traffic accidents and accidents on board of any mean of transport in the course of work), the data provided by Eurostat show that the total number decreased from 123 in 2008 to 81 in 2009, before going up again to 97 in 2010. Similarly, the standardised incidence rate for this type of accidents went down from 0,83 in 2008 to 0,59 in 2009, before going up to 0,71. The Committee notes that this rate remain significantly below the European Union average (27 States) which was 2,36 in 2008; 1,94 in 2009 and 1,87 in 2010. According to the report, the number of fatal accidents in Northern Ireland went from 9 during 2008/09, with a rate of 1,24 per 100 000 employees, down to 4 in 2010/11 and a rate of 0,6. These figures confirm the positive record of the authorities in the prevention of fatal accidents at work in Northern Ireland.

The Health and Safety Executive statistics indicate that in Great Britain 1 179 000 cases of work-related illness were reported in 2008/09 and 1 152 000 cases in 2010/11. Detailed information are provided with respect to the following diseases: stress, depression, anxiety, musculoskeletal disorders, cancer, asbestos-related diseases, respiratory diseases, deafness, skin diseases, vibration-related diseases. The report indicates that in Northern Ireland there were 72 occupational diseases in 2008/2009, 51 in 2009/2010 and 29 in 2011/2012. The Committee notes the particularly low level of occupational diseases in Northern Ireland during the reference period. It asks that the next report indicates whether the above-mentioned level constitutes an indication of under-reporting. Should this be the case, the Committee asks to be informed on the measures taken to counteract this phenomenon.

Activities of the Labour Inspectorate

The report provides the following figures: as regards Great Britain, the Health and Safety Executive (HSE) issued 7 758 health and safety enforcement notices in 2007/08, 8 077 in 2008/09, 9 727 in 2009/10 and 11 020 in 2010/11. With respect to the same time periods, local authorities issued respectively 6 010, 6 340, 6110 and 7270 health and safety notices. As regards prosecutions taken by HSE, the Committee notes that there were 567 cases (545 convictions – 96% conviction rate) in 2007/08; 580 cases (535 convictions – 92% conviction rate) in 2008/09; 505 cases (473 convictions – 94% conviction rate) in 2009/10; and 551 cases (517 convictions 94% conviction rate) in 2010/2011. Local authorities took 155 cases (152 convictions – 98% conviction rate) in 2007/08; 145 cases (142 convictions – 98% conviction

rate) in 2008/09; 117 cases (114 convictions – 97% conviction rate) in 2009/2010; and 129 cases (125 convictions 97% conviction rate) in 2010/11.

The report points out that statistics on the number of inspection visits that HSE made prior to April 2011 were not collated because they were not required as part of our Public Service Agreement target with Central Government. However, from April 2011, in line with recent health and safety reforms, HSE will start recording inspection visits. As regards Northern Ireland, the report provides the following figures: the competent Health and Safety Executive (HSENI) issued 382 health and safety enforcement notices in 2008/09, 367 in 2009/10 and 412 in 2010/11. The number of inspections conducted by HSENI was 12 572 in 2008/09, 15 124 in 2009/2010 and 17 306 in 2010/11. In this framework, HSENI took 21 prosecutions in 2008/09; 22 in 2009/10 and 17 in 2010/11.

In its last conclusion (Conclusions XIX-2), the Committee asked for the data that HSE uses to assess the effectiveness of HSE's visits; and whether the slight decrease in overall numbers of staff working for HSE, had affected the number of inspectors, and whether this trend will continue in the coming years. The report provides the requested information by referring ot HSE's "Annual Reports & Accounts". The latter set out how HSE measures its performance against the targets set for it by Government, and in its own Strategy. This includes, for example, feedback on HSE's progress against its Delivery Plan; its financial review; data on staff numbers, including frontline staffing levels; etc. The annual reports set out how HSE measures it effectiveness, and how it is managing staffing levels and other resources, in the context of its current funding levels.

Conclusion

Pending receipt the requested information, the Committee concludes that the situation in United Kingdom is in conformity with Article 3§2 of the 1961 Charter.

Article 3 - Right to safe and healthy working conditions

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

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

The Committee examined the machinery and procedures for consultation at national and enterprise levels in previous conclusions (Conclusions XVIII-2 and XIX-2) and concluded that they were in conformity with Article 3§3 of the Charter.

The report indicates that consultation and involvement takes place through the Board of the Health and Safety Executive (HSE) and Industry Advisory Committees. HSE issues consultative documents to gather views. The views of the social partners (including trade unions, such as the Trades Union Congress, and employers' organisations, such as the Confederation of British Industry) are routinely sought on a wide variety of health and safety issues, as well as in the formulation, implementation and review of the national strategy for health and safety at work. The HSE Board is itself representative of employers and workers, and also has a legal duty to consult on proposals for regulations under the Health and Saftey at Work Act. These consultations include consulting representations of employers and workers. The Health and Safety Executive for Northern Ireland (HSENI) has similar arrangements in place.

Conclusion

The Committee concludes that the situation in United Kingdom is in conformity with Article 3§3 of the 1961 Charter.

Article 11 - Right to protection of health

Paragraph 1 - Removal of the causes of ill-health

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

Right to the highest possible standard of health

The Committee notes from WHO that life expectancy at birth in 2009 (average for both sexes) was 80,55 (the EU-27 average that same year was 79,0).

The death rate (deaths/1,000 population) was 9.02 in 2010, this indicator remaining stable during the reference period.

Infant mortality decreased slightly the reference period, with a rate of 4.71 per 1,000 live births in 2008, down to a rate of 4.34 in 2010. These rates are close to the average for the EU-27 countries (with a rate of 4.1 per 1,000 in 2010).

In 2010 the rate of maternal mortality was 4.95 per 100,000 live births, a slight decrease from 6.17 per 100,000 live births in 2008. The report mentions that the United Kingdom has a long established programme to review maternal deaths, which widely disseminates its findings and recommendations to help reduce the number of such deaths in the future. Since the programme was established in the early 1950s there has been a 90% reduction in maternal deaths due to direct obstetric complications.

The main causes of death remain as previously described, that is, cardiovascular diseases (CVD), respiratory diseases, diabetes and cancers. The report states that great progress has been made in reducing mortality from CVD. Mortality from Coronary Heart Disease other CVD has been reduced by over 40% in the last decade. The huge improvements in cardiac care are beginning to be mirrored in stroke care.

Right of access to health care

As regards access to National Health Services (NHS), the report states that the position remains as previously described with a number of developments. The Committee recalls that in its last conclusion it found the situation to be in conformity with the 1961 Charter (Conclusions XIX-2). It refers to previous conclusions (namely Conclusions XV-2) for a general description of the health system.

As regards the developments mentioned in the report, the Committee notes that access to NHS primary medical care is in the main provided by General Practitioners under contract to the NHS. Any person can approach any GP in the area they live and ask to be registered as a patient. GPs are free to decide which patients they accept on their lists, in the same way that a patient can choose which GP they approach. GPs may use their discretion to accept any person as either a registered NHS patient or a temporary registered patient (because their permanent home is elsewhere). The Government expects general practice to exercise this discretion with sensitivity and due regard for the circumstances of each case but with an expectation that legally resident individuals within the UK should be appropriately registered with a GP and entitled to receive NHS primary medical care services. The Committee asks to be kept informed on the implementation of this system.

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

In reply to a question by the Committee on measures taken to improve access to health care for the most disadvantged groups in Northern Ireland, the report provides information on the strategies undertaken to support persons with a physical, communication or sensory disability, as well as the key actions to ensure adequate access to health services for Travellers. It also indicates that interpreting services have been established to improve access to health and social care services by members of the ethnic communities who do not speak English well.

The Committee has received submissions from a non-governmental organisation "Working Group Social Charter" stating that blind and partially sighted people are often, in practice excluded from health services in the United Kingdom due to failures to provide them with health-related information in accessible formats. The Committee invites the Government to submit comments on this matter.

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

In the last examination the Committee adopted a general question addressed to all States on the availability of rehabilitation facilities for drug addicts, and the range of facilities and treatments. The report provides detailed information on rehabilitation and facilities for drug addicts provided by the NHS. It also states there are some specialist drug facilities run by charities and private organisations. Outside the NHS, there are many voluntary sector and private drug and alcohol treatment organisations that offer help. There are also residential rehabilitation centres and community services of various types provided by voluntary organisations. These include: structured day programmes; outreach and harm reduction services; counselling services; aftercare; and housing support services.

Conclusion

The Committee concludes that the situation in the United Kingdom is in conformity with Article 11§1 of the 1961 Charter.

Article 11 - Right to protection of health

Paragraph 2 - Advisory and educational facilities

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

Education and awareness raising

In November 2010, the Government published a White Paper on public health entitled *Healthy Lives, Healthy People: our strategy for public health in* England. The White Paper sets out wide-ranging reforms to how public health is organised in England, with the aim of empowering individuals and giving local communities the tools to address their particular needs, whilst ensuring that central government provides a robust and resilient response to health threats.

The Department of Health has also published a number of documents setting out ambitions for health in England covering drugs, tobacco, alcohol and physical activity. The Public Health Responsibility Deal brings together as of August 2012 over 400 partners across business and wider civil society, who have made a number of pledges to improve health. But the Government will intervene only where necessary, freeing up individuals and communities as much as possible to find local solutions to local problems. The Committee asks the next report to include examples of concrete activities and campaigns undertaken by public health services, or other bodies, to promote health and prevent diseases.

The Committee notes that in Northern Ireland, a revised curriculum was introduced during the period 2007/08 to 2009/10. The new curriculum is less prescriptive giving teachers more flexibility over how they deliver the curriculum to meet the needs of individual pupils. The minimum to be taught is set out as Areas of Learning (AoL) for each key stage within the Education (Curriculum Minimum Content) Order (NI) 2007. The Committee asks the next report to provide updated information on health education in schools in England, namely whether it is a statutory obligation, how it is included in school curricula (as a separate subject or integrated into other subjects), and the content of health education.

Counselling and screening

The report mentions the *Healthy Child Programme, Pregnancy and the first five years of life,* which is the prevention and early intervention programme which sets out the good practice framework for the delivery of services to promote optimal health and wellbeing and reduce health inequalities. The Healthy Child Programme offers every family a programme of screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices. Through the Healthy Child Programme, health visitors provide advice and support to help parents care better for their child.

Schools play an important role in supporting the health and wellbeing of children and young people. The Healthy Schools toolkit is designed to help schools to ‘plan, do and review’ health and wellbeing improvements for their children and young people and to identify and select activities and interventions effectively. This approach seeks to ensure that schools put in place the most appropriate services to meet the needs of children and young people. The Committee asks what concrete medical checks are carried out through the period of schooling (including their frequency, their objectives, and the proportion of pupils covered).

The provides no information on counselling and screening for the population at large. The Committee recalls that pursuant to this provision there should be screening, preferably systematic, for the diseases which constitute the principal cause of death. Preventive screening

must play an effective role in improving the population's state of health. It therefore asks the next report to indicate what screening activities are funded and organised by the public health system.

Conclusion

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

Article 11 - Right to protection of health

Paragraph 3 - Prevention of diseases

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

Healthy environment

The Committee takes note of the different measures and regulations mentioned in the report for the reduction of environmental risks, in particular in the field of air quality, water quality, noise and food safety. Local authorities are required to carry out regular reviews and assessments of air quality in their area against standards and objectives prescribed in regulations for the purpose of local air quality management (LAQM) before undertaking Action Planning if air quality is found to breach the regulations. As regards water, relevant regulations ensure that remedial action must be taken where any water quality failure in premises where water is supplied to the public is attributable to the domestic distribution system. As regards noise, in March 2010 the Department for the Environment and Rural Affairs (Defra) released the Noise Policy Statement for England, which contains the Government's policy on noise. It sets out the long term vision of promoting good health and a good quality of life through the management of noise. Noise maps have also been produced to meet the requirements of the corresponding EU Directive.

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

Tobacco, alcohol and drugs

The Committee notes from another source[1] that the United Kingdom ratified the WHO Framework Convention on Tobacco Control on 16 December 2004. In its previous conclusion, it also noted that the United Kingdom had adopted a range of measures to combat smoking, including the prohibition of smoking in places open to the public and comprehensively banning advertising of tobacco in print, on billboards and on the internet (Conclusions XIX-2).

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

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

The Committee notes the detailed information and statistics provided in the report on treatment for substance misue. Of the 197,110 clients aged 18 and over in treatment misuse during 2011-12, 185,428 were in treatment for 12 weeks or more or completed treatment free of dependency before 12 weeks (94%).

Immunisation and epidemiological monitoring

According to the report, the childhood immunisation programme continues to maintain high levels of vaccine coverage. Influenza and pneumococcal vaccination programmes are also

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

Health protection legislation was updated in England from April 2010 to give public authorities modernised powers and duties to prevent and control risks to human health from infection or contamination, including by chemicals and radiation. These new measures include an updated system for notification of cases of infectious diseases that may pose a significant risk to human health by attending registered medical practitioners, and a new requirement for notification by diagnostic laboratories of causative agents of infectious diseases identified in human samples.

Conclusion

The Committee concludes that the situation in United Kingdom is in conformity with Article 11§3 of the 1961 Charter.

[1] *WHO Report on the Global Tobacco Epidemic, 2013*

Article 12 - Right to social security

Paragraph 1 - Existence of a social security system

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

Risks covered, financing of benefits and personal coverage

The Committee notes from the report that during the reference period the scope and coverage of the UK's social security system have remained generally as previously described.

The Committee takes note of the Welfare Reform Act 2012 which introduced further substantial changes to the UK's Social Security System, in the framework of which Universal Credit will replace most of the existing income-related benefits for people of working age. The Act also introduced changes to contribution-based Employment Support Allowance (ESA, which had previously replaced both short-term and long-term incapacity benefit).

The Welfare Reform Act of 2012 introduced some time limitation of certain benefits. A one year time limit has be introduced on the entitlement to the contributory ESA for those who are in the Work Related Activity Group. However, those in the Support Group with severe heath conditions are not affected by this change. Claimants whose contributory benefit has ended because of the time limit can become entitled to a further award if they have had limited capacity for work continuously since their entitlement ceased. The Act also abolished the ESA youth provisions according to which young people could qualify for contributory ESA without having to pay National Insurance Contributions.

The Committee also takes note of the UK state pension reform announced in July 2012 which introduces a simpler, single-tier State Pension to provide better support for saving for retirement. According to the report, a flat-rate state pension above the basic level of the means test would bring much needed clarity and simplicity to the pension system and provide a foundation to support automatic enrolment into workplace pensions. The reasons for this reform, according to the report are, among others, the aging of the population and a declining pension saving.

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

As regards the reference period, the Committee notes from the report that Statutory Sick Pay is payable for up to 28 weeks of periods of incapacity for work whereafter a person can claim contribution based Employment and Support Allowance (ESA). To qualify for ESA, a claimant must satisfy the National Insurance contribution conditions, which require that a claimant must have paid a minimum level of contributions in one of the three income tax years prior to the claim and must also meet a second condition made up of credits and contributions in each of the last two tax years. In November 2010, the Government modified the eligibility conditions for ESA so that a minimum level of contributions have to be paid for 26 weeks in one of the two tax years prior to the claim rather than in one of three tax years.

The Committee notes that in its Resolution CM/ResCSS(2013)20 on the application of the European Code of Social Security by the United Kingdom (Period from 1 July 2011 to 30 June 2012)[1], the Committee of Ministers observed that there was a toughening of the qualifying

conditions for the entitlement to ESA on the one hand and a drastic reduction of its duration on the other, which could result in an outright reduction of protection offered by the sickness benefit. The Committee of Ministers invited the Government to show in its next report under the European Code of Social Security that the obligations and sanctions under the work-related activity regime are of such a nature as not to unduly limit the protection afforded by Part III of the Code to sick persons after the 13th week of sickness.

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

As regards the personal coverage, the Committee notes from the report under the European Code of Social Security that as regards unemployment benefit 91% of all employees were covered. For sickness benefit 47% of all residents were covered while for old-age the coverage of all residents stood at 47,5%.

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

Adequacy of the benefits

The Committee notes from Eurostat that 50% of the median equivalised income stood at € 714 in 2011.

In its previous conclusion the Committee held that the minimum levels of Statutory Sick Pay, Short Term Incapacity Benefits and contributory Jobseeker's Allowance for single person were manifestly inadequate.

The Committee notes from the report and from MISSOC that *short-term incapacity benefit* stood at £ 71 (€85) and *long-term incapacity benefit* at £ 94 (€112) per week. ESA and Job-Seekers allowance stood at £67 per week (around €321 per month). As regards the state pension, it stood at £102 (€ 490 per month).

The Committee also notes from the report that there are other types of benefits available, such as housing benefit. It asks whether it is available for single persons earning the minimum levels of short-term and long term incapacity benefits, state pension and job seeker's allowance.

The Committee holds that even if the minimum levels of short term and long term incapacity benefits, state pension and job seeker's allowance may satisfy the requirements of the European Code of Social Security, they are manifestly inadequate in the meaning of Article 12§1 of the Charter as they fall below 40% of the Eurostat median equivalised income.

Conclusion

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

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

[1] *https://wcd.coe.int/ViewDoc.jsp?id=2101131&Site=CM&BackColorInternet=C3C3C3&BackColorIntranet=EDB021&BackColorLogged=F5D383*

Article 13 - Right to social and medical assistance

Paragraph 1 - Adequate assistance for every person in need

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

Types of benefits end eligibility criteria

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

The Committee notes from MISSOC that the following assistance means tested schemes applied during the reference period:

- income support – providing financial help to people who are not in full-time work (16 hours or more a week for the claimant, 24 hours or more for the claimant's partner), who are not required to register as unemployed and whose income from all sources is below a set minimum level;
- income based jobseekers' allowance – a scheme for registered unemployed people whose income from all sources is below a set minimum level and who are not in full-time work (16 hours or more a week for the claimant, 24 hours of more for the claimant's partner);
- pension credit – a minimum income guarantee scheme for people over 60;
- employment and support allowance – an income based social assistance scheme for people unable to work because of sickness or disability;
- housing benefit – a social assistance scheme paid by the municipality to people in and out of work who are on a low income and who need help to meet their rent liability;
- council tax benefit – a social assistance scheme paid by the municipality to people on a low income to meet up to 100% of their liability to contribute to the cost of local authority services.

These benefits are granted to claimants over the age of 16 (60 as regards the pension credit), fulfilling the conditions of entitlement. Claimants to the job-seekers' allowance must be available for all work, be actively seeking work and sign an agreement detailing the type of work, hours and activities to be undertaken by the job-seeker in their search for work. As regards the employment and support allowance, people assessed as capable of returning to work in the future are placed in the Work Related Activity Group and are expected to take part in work focused interviews with a personal adviser, and have access to a range of support to help prepare them for suitable work. People not satisfying these requirements may be suspended from benefits for a period variable, between 1 and 26 weeks. The Committee previously noted, in 2000 and 2003 (Conclusions XV-1 and XVI-1) that sanctions can be appealed and that payment can be maintained, although at a lower rate, in cases of hardship. It notes from the report that under the new Welfare Reform Act 2012 the sanctions will be strengthened and the hardship payments will be granted only to those claimants in greatest need; it asks the next report to clarify what criteria will be applied in practice to ensure that, in conformity with the Charter, a person will not be deprived of his/her means of subsistence.

The report also refers to the social fund, administered by the Department for Work and Pensions, which provides interest free loans, grants and payments through both a regulated and a cash limited discretionary scheme. It provides additional funds to people on top of benefits in a range of circumstances (maternity, funeral, cold weather and winter fuel payments as well as community care grants and repayable budgeting and crisis loans).

As regards medical assistance, the Committee has previously noted that care and treatment under the National Health Service is free of charge and provided to all persons "ordinarily resident" in the United Kingdom. It takes note of the reforms under way, presented in the report, and asks the next report to provide information on their impact from the perspective of Article 13 requirements.

Level of benefits

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

- Basic benefit: the Committee notes from MISSOC that personal allowance paid to a single person aged 25 or over amounted to €75 per week in 2011. A lone parent aged 18 or over also received €75 per week, while a couple both 18 or over received € 117 per week in 2011. In response to the Committee's question on the rate applied to a single person without children, aged between 18 and 25, the report indicates that the weekly personal rates (as of April 2012, outside the reference period) of income-related benefit were €68 for persons actively seeking work (jobseekers' allowance); the sum granted to people with limited capability for work was €67.5, plus either €34 or €41 additional benefits (Work Related Activity Component or Support Component);
- Additional benefits: the Committee notes from MISSOC that supplementary benefits (premiums) apply depending on the circumstances; the family premium amounted to €19; the premium for a couple of pensioners was € 115; other premiums applied to disabled people and carers. In addition, supplementary benefits include Housing Benefit, Council Tax Benefit, Winter Fuel Payment (between €110 and €331, payable to people over 60) and Cold Weather Payment (€28 paid to people receiving specified means tested benefits when the local average temperature is 0° or below over seven consecutive days during the period from 1 November to 31 March). The Committee notes from the report that the amount of any Housing Benefit and Council Tax Benefit varies according to the rates for the area in which the person lives and that as from 2013 (outside the reference period) a "benefit cap" on the total weekly amount of benefits in payment would be introduced, which would be fixed at £350 (€429, at the rate of January 2013) per week for a single person without dependants. The Committee notes that according to official statistical data (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/222729/stats_summary_mar12.pdf) as of December 2011 the average weekly amount of housing benefit was £86.91 (€104) and the average weekly amount of Council Tax Benefit was £15.69 (€19);
- Medical assistance: see above;
- Poverty threshold (defined as 50% of median equivalised income and as calculated on the basis of the Eurostat at-risk-of-poverty threshold value): it was estimated at €714 in 2011.

The Committee recalls that, under Article 13§1 of the Charter, the assistance is deemed appropriate where the monthly amount of assistance benefits – basic and/or additional – paid to a person living alone is not manifestly below the poverty threshold. In the light of the above data, the Committee notes that the monthly amount of personal allowance paid to a single person aged 25 or over amounted to €300, well below the poverty threshold, and that the situation of single persons without children aged between 18 and 25 or of elderly people over 60 was not better. However, when considering the average amount of housing benefit (€416 monthly) and Council Tax Benefit (€76 monthly), the overall amount of assistance is compatible with the poverty threshold. Accordingly, the Committee holds that the situation is in conformity with the 1961 Charter.

Right of appeal and legal aid

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

Personal scope

The Committee previously noted (see Conclusions from XIV-1 of 1998 on) that people entitled to social assistance people should satisfy the "Habitual Residence" test and asked how in practice the authorities assess that a person has a "settled intention" to reside and that (s)he has been actually resident for an "appreciable period of time" and what assistance and advice are available to individuals in preparing their claim that they satisfy the habitual residence test. In response to these questions, the report states that the habitual residence test has two elements: a test of legal right to reside and a test of factual habitual residence, taking into account the individual's personal circumstances and not only the length of residence in the United Kingdom (see https://www.gov.uk/government/collections/decision-makers-guide-staff-guide).

The habitual residence test applies to people with a right to reside coming to the United Kingdom from abroad, including British citizens returning after time abroad. The test does not apply to refugees, beneficiaries of temporary protection or discretionary leave to enter/remain in the UK (including victims of domestic violence), people deported, expelled or removed from another country to the UK and not subject to immigration control. The test also does not apply to EEA nationals working regularly in the UK and, to some extent, to people having worked in the UK. As from 1 May 2011, the exemption from the habitual residence test applicable to EEA workers has been extended, upon certain conditions, to nationals of the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia. Upon specific conditions, Romanian, Bulgarian and Croatian nationals can also be exempted from the habitual residence test.

According to the report, quoting the relevant case law, to be "habitual resident" in the country the person must have actually taken up residence and lived there for a period, but the period is not fixed and depends on the facts of each case. Amongst the relevant factors to be taken into account are bringing possessions so far as practicable, doing everything necessary to establish residence before coming, having a right of abode, seeking to bring family and having durable

ties with the country of residence or intended residence. A person's financial viability may be a relevant factor, but the test for habitual residence should not be applied so as to prevent access to public funds. It must be applied in a way that allows for the possibility of a claimant establishing both habitual residence and an entitlement to benefits. The appropriate period of time need not be lengthy if the facts indicate that a person's residence has become habitual in nature at an early stage. In some circumstances, the period can be as little as a month, but it must be a period which is more than momentary in a claimant's life history. A period of between one and three months is likely to be appropriate to demonstrate that a person's residence is habitual in nature. Cogent reasons should be given where a period longer than three months is considered necessary (*House of Lords, Nessa v CAO (1999) 1 WLR 1937 HL*). A person with habitual residence in the Common Travel Area who exercised his right to freedom of movement under European Law and then returns to resume his residence in the Common Travel Area may be habitually resident immediately on his return (*Case C-90/97, Swaddling v CAO (1999) All ER (EC) 217*). When deciding where a person is habitually resident, the authorities should take into account the person's main centre of interest (for exemple where the person has a home, job, family, friends, membership of clubs...), length and continuity of residence in the country, length and purpose of the absence from that country, nature of the employment found in the other country to which the person moved for a time and intention of the claimant (this list is not exhaustive or conclusive, other factors might have to be taken into account) (*Case 76/76 Di Paolo; R(U)7/85; R(U)8/88*). The report also confirms that staff at contact centres dealing with claims and telephone enquiries prior to the personal interview are instructed to advise the claimants about the documentary evidence they should bring to support their claim.

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

Conclusion

Pending receipt of the requested information, the Committee concludes that the situation in the United Kingdom is in conformity with Article 13§1 of the 1961 Charter.

Article 13 - Right to social and medical assistance

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

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

It notes that there have been no changes to the situation which it has previously found to be in conformity with the 1961 Charter.

Conclusion

The Committee concludes that the situation in the United Kingdom is in conformity with Article 13§2 of the 1961 Charter.

Article 13 - Right to social and medical assistance

Paragraph 3 - Prevention, abolition or alleviation of need

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

The Committee notes that there have been no changes to the situation which it has previously considered to be in conformity with the Charter. In particular, in response to the question raised in the previous conclusion (Conclusions XIX-2) the report confirms that advice on all benefits and services is available on-line (https://www.gov.uk/benefits-adviser) and that a comprehensive range of non-governmental, voluntary and charitable organisations offer a free welfare rights advisory service, often at community level working together with Local Authority welfare rights services. The largest such organisation is "Citizens Advice", which is funded mainly by a core central government grant from the Department of Business, Innovation and Skills (BIS), together with a variety of project based income, trading income and some other income. The organisation provides free, independent, confidential and impartial advice to everyone on their rights and responsibilities from over 3500 community locations in England and Wales. It reported a total of 690 000 clients, who presented Citizens Advice Bureaus with more than 2.2 million benefits and tax credit issues in 2010-11. Half of all benefits advice related to determining clients' eligibility and entitlement. Similar organisations operate throughout the UK, including Scotland and Northern Ireland.

Conclusion

The Committee concludes that the situation in the United Kingdom is in conformity with Article 13§3 of the 1961 Charter.

Article 13 - Right to social and medical assistance

Paragraph 4 - Specific emergency assistance for non-residents

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

The Committee previously noted that basic social assistance is available under the National Assistance Act (1948) and that the National Asylum Support Service (NASS) provides support to persons who are not lawfully present in the United Kingdom to prevent them from becoming destitute pending their repatriation. It asked whether unlawfully present foreign nationals without resources, other than failed asylum seekers, were also entitled to emergency social assistance. In this respect, the report states that although they are not covered by the National Assistance Act, emergency assistance could be provided when the exclusion would breach their rights under the European Convention on Human Rights or under the European Treaties. Furthermore, the report refers to assistance programmes designed to help over-stayers or other illegal migrants, other than failed asylum seeker's, return and settle in their countries of origin. The Committee asks the next report to clarify whether compliance with the Social Charter is taken into account by the authorities when assessing the need to provide emergency social assistance to people excluded from the National Assistance Act; on a more general level, it asks the next report to provide any relevant data or example of case law concerning the provision of emergency assistance to prevent a breach of the European Convention on Human Rights or other international obligations. In the meantime, it reserves its position on this issue.

The Committee refers to its previous conclusion (Conclusions XIX-2), where it had noted that emergency medical assistance is available free of charge to anyone, including unlawfully present foreign nationals. In particular, primary care is free to all and any primary care treatment which a health professional considers to be immediately necessary would be provided regardless of registration. Registration is on the other hand required in Northern Ireland, but not in case of emergency. The report also indicates that, in certain cases, hospital treatment is also available with no charges, particularly when a clinician considers the treatment to be immediately necessary, or urgent enough not to be able to wait until the patient has returned to their home country. Furthermore, anybody has access free of charge to emergency treatment given within an Accident & Emergency Unit, compulsory psychiatric treatment, family planning services, treatment for sexually transmitted diseases and other infectious diseases.

Conclusion

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

Article 14 - The right to benefit from social services

Paragraph 1 - Promotion or provision of social services

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

Organisation of the social services

The report indicates that in England there is currently a reform aiming at steps to modernise, simplify and consolidate the adult social care statute. To this end, on 11 July 2012, the Government published the White Paper *Caring for our future: reforming care and support*, which provides a framework to support people to stay independent for as long as possible, provide better information to users, improve the quality of care and support, and to ensure that carers have the same rights as users. Besides the White Paper, the Government has also published a draft Care and Support Bill that will enable social care professionals to undertake their role more effectively and empower people who use care and support, their families and carers by supporting them to understand what help is available and how they can best access and navigate care and support. The Committee wishes the next report to provide further information on this reform.

In Wales, the Social Services and Well-being (Wales) Bill is currently being reviewed. Its aim is to provide a number of new duties for the benefit of persons in need of care and support. The Committee asks the next report to provide information on these legislative developments as well.

Concerning Scotland, the report states that since 1 April 2011, two new public bodies have been established: the Care Inspectorate and the Healthcare Improvement Scotland. These bodies have been created by the Public Services Reform (Scotland) Act 2010. First, the Care Inspectorate is in charge of inspecting, regulating and supporting the improvement of social care and social work services across Scotland. Second, the Healthcare Improvement Scotland takes over the regulation of independent healthcare services.

Regarding Northern Ireland, the Committee asked in its previous conclusion about information on the reform of social services. The report indicates that the Health and Social Care (Reform) Act (Northern Ireland) 2009 ("the Reform Act") provides the new legislative framework within which the health and social care structures operate. Section 2 of the Reform Act places on the Department of Health, Social Services and Public Safety (DHSSPS) a general duty to promote an integrated system of health care designed to secure improvement of physical and mental health and in the prevention, diagnosis and treatment of illness, and social care designed to secure improvement in the social wellbeing of people. Thus, DHSSPS discharges this duty by delegating the exercise of its statutory functions to the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) and to a number of other HSC bodies created to exercise specific functions on its behalf. All these HSC bodies are accountable to the DHSSPS which in turn is accountable, through the Minister, to the Parliamentary Assembly for the manner in which this duty is performed.

Effective and equal access

In its previous conclusion, the Committee asked about the admissibility criteria set by local authorities for access to social services. In this regard, a guidance called *Prioritising need in the context of Putting People First: a whole system approach to eligibility*, which sets out in great

detail the national eligibiliy framework used by local authorities for allocating social care resources fairly, transparently and consistently has been published in 2010.

The Committee also asked whether nationals of other States Parties were guaranteed equal treatment in the United Kingdom as regards access to social services. According to the Nationality, Immigration and Asylum Act 2002, certain groups of people from overseas may not have access to social services, these include: nationals of the European Economic Area, people with refugee status abroad, failed asylum seekers who have not co-operated with removal directions and other individuals unlawfully in the UK who are not asylum seekers. However, the exclusion does not apply to these groups if a failure to provide services under the 1948 Act would breach their rights under the European Convention on Human Rights and Fundamental Freedoms or under the European Union Treaties.

Quality of services

The Committee refers to its previous conclusion for a detailed description of the quality of services and data protection. In addition, the present report indicates that it is the Care Quality Commission that oversees national standards and checks whether hospitals, care homes and care services, including care in the home, comply with those standards.

The report mentions the safeguarding of vulnerable groups. In this regard, it is the Vetting and Barring Scheme (VBS) that aims at preventing unsuitable people from undertaking certain paid or volunteer work with children or vulnerable adults. The VBS establishes definitions of those working in regulated activity (work which a person barred from working with children and/or vulnerable adults must not do) which apply to employees and volunteers engaged in work across health, social care, education, supported housing, sports and leisure facilities whether provided by the state or by the private or independent sectors. It is the Independent Safeguarding Authority established in January 2008 that is responsible for barring decision making across England, Wales and Northern Ireland and maintains lists of individuals barred from working with children and/or vulnerable adults.

Conclusion

Pending receipt of the information requested, the Committee concludes that the situation in United Kingdom is in conformity with Article 14§1 of the 1961 Charter.

Article 14 - The right to benefit from social services

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

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

The report states that in social care, voluntary sector organisations and social enterprises play valuable roles in delivering user-focused services. Moreover, the Government set out its vision for social care in the Giving White Paper, published in May 2011, and set up Big Society Capital to give social enterprises, charities and voluntary organisations access to greater resources to make a difference in their communities.

Regarding the relations with civil society, the Committee notes from the report that the Department of Health is implementing The Compact, an agreement which governs relations between the Government and civil society organisations, such as charities, in England. This Department aims at encouraging successful partnership between the Government and civil society organisations to ensure better outcomes for citizens and communities. The Committee asks the next report to provide further information on the implementation of this agreement.

As part of the commitment to ensure users of care are involved in the development and maintenance of services, the Department of Health made a commitment in the White Paper *Caring for our future: reforming care and support* that will involve communities in decisions about health and social care commissioning. In addition, the report indicates that users and carers can give feed-back directly to providers and commissioners about good or poor quality practice and provide user ratings.

As to the equal and effective access to the provision of social services by voluntary organisations the Committee refers to its previous conclusion where it found the situation to be in conformity with the 1961 Charter.

The Committee refers also to its previous conclusion under Article 14§1, which it found to be in conformity with the 1961 Charter, regarding the supervision of the quality of the services offered by various providers of social welfare services.

In the absence of information concerning the issue of discrimination, the Committee wishes to know whether and how the Government ensures that services managed by the private sector are effective and are accessible on an equal footing to all, without discrimination at least on grounds of race, ethnic origin, religion, disability, age, sexual orientation and political opinion.

The Committee wishes the next report to indicate the total budget for grants from the Department of Health to the voluntary sector.

Conclusion

Pending receipt of the information requested, the Committee concludes that the situation in United Kingdom is in conformity with Article 14§2 of the 1961 Charter.