January 2018

1961 European Social Charter

European Committee of Social Rights

Conclusions XXI-2 (2017)

UNITED KINGDOM

This text may be subject to editorial revision.

The following chapter concerns the United Kingdom which ratified the 1961 Charter on 11 July 1996. The deadline for submitting the 36th report was 31 October 2016 and the United Kingdom submitted it on 11 January 2017.

In accordance with the reporting system adopted by the Committee of Ministers at the 1196th meeting of the Ministers' Deputies on 2-3 April 2014, the report concerns the following provisions of 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 provisions from the above-mentioned group except Article 12§§2 to 4 and Article 4 of the 1988 Additional Protocol.

The reference period was 1 January 2012 to 31 December 2015.

The conclusions relating to the United Kingdom concern 13 situations and are as follows:

– 10 conclusions of conformity: Articles 3§2, 3§3, 11§1, 11§2, 11§3, 13§2, 13§3, 13§4, 14§1 and 14§2;

– 2 conclusions of non-conformity: Articles 3§1 and 12§1.

In respect of the other situation related to Article 13§1 the Committee needs further information in order to examine the situation. The Committee considers that the absence of the information requested amounts to a breach of the reporting obligation entered into by the United Kingdom under the Charter. The Committee requests the authorities to remedy this situation by providing the information in the next report.

During the current examination, the Committee noted the following positive developments:

Article 3§1

The Control of Asbestos Regulations came into force on 6 April 2012, updating previous asbestos regulations to take into account of the European Commission's view that the UK had not fully implemented the EU Directive 2009/148/EC on exposure to asbestos. According to Article 2 of these Regulations, the control limit of the concentration of asbestos on the atmosphere is 0.1 f/cm^3 of air averaged over a continuous period of 4 hours

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The next report will deal with the following provisions of 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 deadlind for submitting that report was 31 October 2017. The report was registered on 21 December 2017. Conclusions on the Articles concerned will be published in January 2019.

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Conclusions and reports are available at www.coe.int/socialcharter as well as in the HUDOC database.

Article 3 - Right to safe and healthy working conditions

Paragraph 1 - Safety and health regulations (Art. 3-2 1996 RESC)

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

Content of the regulations on health and safety at work

The report states that the general legal framework (previously described in Conclusions XX-2 (2013) and XIX-2 (2009), remains unchanged overall. 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.

According to the report, there have been several government reviews of health and safety during the reference period. These found there was no case for radically altering the existing legislation. However, the Health and Safety Executive (HSE) has revoked and amended legislation to make the legal framework for health and safety clearer by removing unnecessary burdens, scrapping outdated legislation and cutting out duplications, amongst other measures.

As regards Northern Ireland, the report indicates that Health and Safety Executive in Northern Ireland (HSENI) sets out its strategy for implementing the legal framework in its successive Corporate Plans. Its plan for the years 2011-2015 sets out the pathway for the better regulation of health and safety at work. That plan has been extended until 2017.

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

Concerning the Isle of Man, the report indicates that the health and safety legislation framework for that is built upon the Health and Safety at Work etc. Act 1974 of the UK Parliament (as applied to the Island) and the Management of Health and Safety at Work Regulations 2003. Both the Act and the Regulations are Isle of Man adaptations of existing UK legislation. These two pieces of core legislation are supplemented by a range of risk and industry specific Acts and Regulations. In 2012 two pieces of legislation – the Construction Health and Safety Regulations 1985 and the Construction Head Protection Regulations 1999 – were revoked. Health and Safety at Work legislation is applicable to all employers, employees and contractors who operate on the Island including those who come to the Island from other jurisdictions.

The Committee points out that in terms of Article 3§1 of the 1961 Charter, regulations concerning health and safety at work must cover work-related stress, aggression and violence specific to work, and especially for workers in atypical working relationships (Statement of Interpretation on Article 3§1 of the 1961 Charter, Conclusions XX-2 (2013)). The report indicates that the Health and Safety at Work Act (HSWA) 1974 and the Management of Health and Safety at Work Regulations 1999 establish a regime for the management of work place hazards, including the risk of work related stress, violence and aggression, requiring risk assessments for all such hazards and other actions. Under Section 2 of the Health and Safety at Work Act, the HSE can take action where an employer has failed to assess the risk to their employers or has failed to take sufficient adequate measures to prevent injury to its employees. Cases of work related violence which result in conditions that meet the revised Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) criteria (come into force from 1 October 2013) must be notified to the HSE.

As regards the Isle of Man, the report indicates that the identification of stress related ill-health is an important and embedded element of inspections and investigations undertaken by the Health and Safety at Work Inspectorate. Inspectors have been trained to identify the possible causes of stress and adopt the UK HSE's guidance when undertaking work place interventions. The potential for health and safety implications as a consequence of work place aggression and violence is also considered during interventions by Inspectors.

The report indicates that the HSE developed the Management Standards approach to tackling work related stress specifically to cope with the individual circumstances an employer may experience. The Management Standards approach is an enhanced risk assessment tool that, among others, informs employers about the process of risk assessment.

Protection against dangerous agents and substances

The Committee examines the levels of occupational prevention and protection provided for by legislation and the regulations pertaining to certain risks.

Protection of workers against asbestos

The report does not indicate any changes to the situation in which the Committee has previously considered to be in conformity (Conclusions XX-2 (2013)). However, the Committee notes from the information published on the HSE's website, that the Control of Asbestos Regulations came into force on 6 April 2012, updating previous asbestos regulations to take into account of the European Commission's view that the UK had not fully implemented the EU Directive 2009/148/EC on exposure to asbestos. According to Article 2 of these Regulations, the control limit of the concentration of asbestos on the atmosphere is 0.1 f/cm^3 of air averaged over a continuous period of 4 hours.

Protection of workers against ionising radiation

The report does not indicate any changes in the situation which the Committee has previously considered to be in conformity (Conclusions XX-2 (2013)). 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).

Personal scope of the regulations

The Committee examines the scope of legislation and regulations with regard to workers in atypical employment.

Protection of temporary workers

In its previous conclusion (Conclusions XX-2 (2013)), the Committee asked for full and updated information on this point. The report indicates that there are no developments with respect to the legal framework relating to the protection of temporary workers. HSE published revised guidance on this topic which addresses the most common issues, particularly where the responsibility lies for training and personal protective equipment requirements.

Other types of workers

In its previous conclusion (Conclusions XX-2 (2013)), the Committee asked for information on the categories of domestic workers covered by health and safety laws. It also asked to be informed on the steps taken to protect health and safety of domestic workers without

interfering with private home. In response, the report indicates that domestic workers employed in private households are not covered by UK health and safety law and other related legislation whilst other workers in a domestic setting such as health and social care workers, are covered. Domestic work describes work that takes place within private households that is governed by an employment relationship and covers occupations such as cleaners, gardeners, secretaries or cooks. The report specifies that it would not be proportionate or practical to extend criminal health and safety law, including inspections, to private households employing domestic workers as this would impose disproportionate burdens and raise issues of privacy. The Committee considers that in the absence of protection of all domestic workers, the situation is not in conformity with the Charter.

As regards self-employed workers, the report states that health and safety law in relation to the self-employed changed from 1 October 2015. Section 3(2) of the Health and Safety at Work Act etc. 1974 will not apply to the self-employed if their work activity poses no risk to the health and safety of others, including other workers and members of the public. The Schedule to the regulations prescribes certain risk work activities to ensure that self-employed people carrying out these activities will still have a duty with regard to themselves and others. This is intended to include those activities where there are high numbers of self-employed persons, which statistically result in high numbers of fatalities or injuries and where EU requirements impose a specific duty on someone who is self-employed to protect themselves from risks to their own health and safety (work in agriculture, construction, gas, railway, with asbestos or GMO). The Regulations also contain a risk-based provision such that those self-employed persons, whose work activities do pose a risk of harm to others, continue to have duties under Section 3(2) of HSWA. Section 1 of the Deregulation Act 2015 amended HSWA to limit the scope of Section 3(2) so that only those self-employed persons who conduct an undertaking described in regulations will continue to have a duty under the provision.

The Committee recalls that for the purposes of Article 3§2 of the Charter, all workers, including the self-employed must be covered by health and safety at work regulations as long as employed and self-employed workers are normally exposed to the same risks. Therefore, the Committee considers that the situation is not in conformity with the Charter as regards self-employed workers.

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.

Article 3 - Right to safe and healthy working conditions

Paragraph 2 - Enforcement of safety and health regulations (Art. 3-3 1961 RESC)

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

Accidents at work and occupational diseases

The report indicates that, according to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR, as amended in 2013), under which fatal and defined non-fatal injuries to workers and members of the public arising from work activity are reported by employers, the number of reported injuries decreased from 111 299 (with a rate of 442.6 per 100 000 employees) in 2011/12 to 76 054 (with a rate of 292.9) in 2014/15. The number of fatal accidents also decreased from 171 (with a rate of 0.58) in 2011/12 to 142 (with a rate of 0.46) in 2014/15.

As regards Northern Ireland, the report indicates that the number of accidents at work decreased from 3 119 in 2011/12, with a rate of 447 per 100 000 employees, to 2 740 in 2014/15, with a rate of 381. According to the report, the number of fatal accidents in Northern Ireland was 4 in 2011/12, with a rate of 1.00 per 100 000 employees, 3 in 2012/13 and 2013/14 and rate of 0.43, and 7 in 2014/15 and a rate of 0.97.

The Committee states that, according to the Eurostat figures, the number of non-fatal accidents at work causing at least four calendar days of absence rose during the referenced period (from 227 676 in 2012 to 244 948 in 2014). The standardised rate of incidence of non-fatal accidents at work per 100 000 workers also rose from 894.32 in 2012 to 1 015.31 in 2014. The Committee notes that this rate is significantly lower than the average rate in the EU-28 (1 717.15 in 2012 and 1 642.09 in 2014). The number of fatal accidents at work also rose from 161 in 2012 to 239 in 2014. The standardised incidence rate of fatal accidents at work per 100 000 workers increased from 1.37 in 2012 to 1.62 in 2014. The Committee notes that this rate remain significantly below the average rate in the EU-28 (2.42 in 2012 and 2.32 in 2014). The Committee asks that the next report explain the discrepancy between the figures on accidents at work given in the report and those published by EUROSTAT.

In its previous conclusion (Conclusions XX-2 (2013)), the Committee noted the particularly low level of occupational diseases in Northern Ireland and asked whether that level constitutes an indication of under-reporting. In response, the report explains that it cannot be said with certainty if the perceived low level of occupational diseases is indicative of under-reporting. Health and Safety Executive in Northern Ireland (HSENI) has focussed on occupational health as a priority topic and has prioritised issues (asbestos related ill health, silicosis, musculoskeletal disorders, occupational asthmas, etc.). The report indicates that in Northern Ireland there were 32 occupational diseases in 2011/12, 11 in 2012/13, 17 in 2013/14 and 14 in 2014/15. The Committee asks what steps had been taken to address possible under-reporting of occupational diseases in Northern Ireland.

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

Activities of the Labour Inspectorate

The report indicates that the system of labour inspection in Great Britain continues to apply to all workplaces. The HSE's established enforcement policy statement accommodates the need for inspectors to target key risks and take proportionate action. This focuses enforcement action on serious risks and on those employers seeking an economic advantage from working with poor risk controls and not complying with the law. The Government's reform of the health and safety system implemented from 2011 with the launch of the "Good Health and Safety, Good for Everyone" programme introduced a new categorisation of non-major hazard industries in which inspection is concentrated on the

higher risk industrial sectors. Lower risk sectors are not targeted for inspection, where it is considered to be less effective in terms of outcomes. However, employers in any sector who under-perform in health and safety may still be visited. The Committee asks that the next report provide detailed information on the new system, particularly with regards to the number of labour inspectors.

The report indicates that the Health and Safety at Work Inspectorate (HSWI) of the Isle of Man was moved from the Department of Infrastructure (DOI) to the Department of Environment, Food and Agriculture (DEFA) in July 2014 in order to combine the HSWI with the Island Environmental Health team. Environmental Health Officers are undertaking health and safety inspections in shops, officers, restaurants and some residential homes while Inspectors attached to the HSWI cover health and safety in industrial, agricultural, construction and Government locations. All occupational and community health and safety matters are now covered by the same group of professional inspectors (8 inspectors/officers and two managers).

The Committee notes that under Article 3§2 of the 1961 Charter, States Parties must implement measures to focus labour inspection on small and medium-sized enterprises (Statement of Interpretation on Article 3§2, Conclusions XX-2 (2013)). In response, the report indicates that the HSE is in process of developing an online version of the indicator questionnaire and analysis tool that will give real-time analysis for smaller numbers of employees and a tool providing size-specific guidance for carrying out a risk assessment for work related stress which is more use friendly for smaller employees.

The report indicates that the HSE is reviewing its provision on work related stress. The HSE is working directly with representative employers from sectors of industry that have statistically higher than average incidence rates for work related stress, to provide more data on levels of work related stress, to gather more specific data on the stressors, to review the relevance of the Management Standards approach to these stressors, and to provide additional or specific guidance to these sectors.

The report provides the following figures: as regards Great Britain, the HSE issued 9 908 health and safety enforcement notices in 2011/12, 8 807 in 2012/13, 10 119 in 2013/14 and 9 446 in 2014/15. With respect to the same time periods, local authorities issued respectively 6 045, 4 693, 3 671 and 2 984 health and safety notices. As regards prosecutions taken by HSE, the Committee notes that there were 576 cases (531 convictions – 92% conviction rate) in 2011/12; 606 cases (575 convictions – 95% conviction rate) in 2012/13; 605 cases (567 convictions – 94% conviction rate) in 2013/14; and 650 cases (606 convictions 93% conviction rate) in 2014/15. Local authorities took 98 cases (95 convictions – 97% conviction rate) in 2011/12; 109 cases (104 convictions – 95% conviction rate) in 2012/13; 92 cases (89 convictions – 97% conviction rate) in 2013/14; and 78 cases (76 convictions 97% conviction rate) in 2014/15. The Committee notes from the HSE's Annual Report and Accounts 2014/15 that the number of total HSE staff, including the Health and Safety Laboratory (HSL), in post by full-time equivalents was 2 454 on 31 March 2015 and 3 183 on 31 March 2013.

As regards Northern Ireland, the report provides the following figures: the competent HSENI issued 285 health and safety enforcement notices in 2011/12, 315 in 2012/13, 254 in 2013/14 and 203 in 2014/15. The number of inspections conducted by HSENI was 13 755 in 2011/12, 15 084 in 2012/13, 13 922 in 2013/14 and 10 516 in 2014/15. In this framework, HSENI took 35 prosecutions in 2011/12; 19 in 2012/13, 21 in 2013/14 and 29 in 2014/15.

As regards the Isle of Man, the report provides the following figures for 2012-2016: the HSWI issued 14 improvement notices, 26 prohibition notices, and 4 formal cautions; 14 reports were presented to the Attorney General Chambers for consideration, with the recomendation that 11 cases should be prosecuted and alternative action should be taken by the inspectorate for the other 3 cases. The number of site interventions (proactive inspections and investigations) remains stable, 382 in 2012/13 and 386 in 2015/16.

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.

Conclusion

Pending receipt of 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 report indicates that the situation did not change during the reference period. Consultation and involvement take place through the Board of the Health and Safety Executive (HSE) and Industry Advisory Committees. The HSE issues consultative documents to gather views. The views of social partners, including trade unions, are routinely sought in the formulation, implementation and review of national strategy for health and safety at work. The Health and Safety Executive in Northern Ireland (HSENI) has similar arrangements in place for Northern Ireland.

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 the United Kingdom.

Measures to ensure the highest possible standard of health

The Committee notes from WHO that life expectancy at birth in 2015 (average for both sexes) was 81.2 (compared to 80.5 years in 2009). The Committee notes from Eurostat that life expectancy at birth in the EU-28 was estimated at 80.6 years in 2015.

The Committee notes that according to the World Bank data, the death rate (deaths/1,000 population) remained stable with 9 in 2015 compared with 9.02 in 2010.

The report indicates that the infant mortality rate has decreased from of 4.6 per 1,000 live births in 2008 to a rate of 3.7 in 2014. According to the Eurostat data, the average rate for the EU-28 countries in 2015 was 3.6 per 1,000 live births.

The report further indicates that the maternal mortality rate has fallen from 13.95 deaths per 100,000 live births in 2003-2005 to 9.02 in 2011-2013.

The main causes of death remain cardiovascular diseases (CVD), respiratory diseases, diabetes and cancers. The Committee takes note from the report of the detailed information describing the measures taken to reduce premature mortality caused by these diseases.

The report indicates that Northern Ireland has an overall mortality rate that is higher than that in England and Wales, but lower than in Scotland. Circulatory diseases, cancer and respiratory diseases continue to be the main causes of death among both sexes. The Committee notes from the Equality and Human Rights Commission website that in Scotland deaths from coronary heart disease have been the highest in Western Europe since the 1980s. Moreover, the overall death rate from cancer is higher for both men and women compared to men and women in England and Wales.

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.

Access to health care

The Committee notes from the OECD data that the total health expenditure represented 9.8% of the country's GDP in 2015, which is close to the EU average of 9.9%. The Committee notes that the OECD average was 8.9% in 2013.

The Committee noted previously that access to NHS primary medical care is in the main provided by General Practitioners (GP) under contract to the NHS (Conclusions XX-2 (2013)). The report clarifies that currently registration with a GP in England is not based on residency. The procedure for registration is set out in the legislation governing the contracts between NHS England and individual providers of primary medical services. The Committee takes note from the report of the measures taken to improve access to the GP services in England such as the NHS Direct and NHS Walk-in Centres.

The Committee also notes the measures and initiatives taken in Scotland. The Scottish Government is committed to a vision of a modern Primary Care and GP service with more GPs working in Scotland as part of multi-disciplinary teams, alongside nurses, pharmacists, optometrists and other allied health professionals to support patients to live well in their communities, and allow them to access the right person at the right time. The recent 2015/2016 Health and Care Experience Survey has shown an overall positive picture for access to GPs. Over 90% of GP patients said they were able to see or speak to a doctor or

nurse within two working days of requesting an appointment, with an increase in the number of respondents who were happy with their GP opening hours.

The report indicates that in Northern Ireland patients can only receive treatment if they are registered with a GP and to be registered with a GP the patient must be 'ordinarily resident' in Northern Ireland. 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.

The Committee takes note of the information in the report on the health system and measures taken in the Isle of Man. Access to comprehensive medical care (including maternity, early years and health improvement/prevention programmes) is provided at the point of delivery through community, primary and secondary care services. Tertiary care is commissioned from appropriate specialist centres in England. Current priorities for improving public health are the reduction of lifestyle risk factors – such as smoking, overweight and obesity, drug and alcohol misuse, and sexual health.

Concerning hospital waiting times, the Committee noted previously that 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 asked the next report to indicate how this operational standard is being met in practice (Conclusions XX-2 (2013)).

The report indicates that the NHS Constitution states that patients "*have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible*." The two waiting time rights, set out in the Handbook to the NHS Constitution, are: (i) to start consultant-led treatment within a maximum of 18 weeks of referral for non-urgent conditions; and (ii) to be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected. The report lists the operational standards published by the NHS England in the form of percentage thresholds that set a minimum level of performance (for example 95% of patients to be admitted, transferred or discharged within four hours of arrival in all types of accident and emergency department). The report indicates that the rising demand from a growing and ageing population has made the achievement of these standards more challenging in recent years. As of September 2016, the waiting time standards (for four hour accident and emergency waits, 18 weeks from referral-to-treatment, 62 days to start of cancer treatment, and six weeks for diagnostic tests) were being missed.

Statistical data provided in the report show that the number of patients who were waiting longer than the established deadlines have increased towards the end of the reference period in Northern Ireland. For example, at 31 December 2015, 52.4% (35,113) of patients were waiting longer than 13 weeks for inpatient and day case treatment; with 21,413 of these patients waiting over 26 weeks. At 31 December 2015, 70.0% (164,638) of patients were waiting longer than 9 weeks for a first outpatient appointment; with 122,771 of these patients waiting over 18 weeks.

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.

The report indicates that the levels of overweight and obesity in England continue to remain high. Data show that 62% of adults, and 31% of children are either overweight or obese. The Committee notes the concerns of the Equality and Human Rights Commission indicating that the number of people of normal or healthy weight is declining and obesity is on the rise. Only around 30-40% of men and women in Britain are of a normal or healthy weight. The Committee takes of the information in the report on the measures and campaigns undertaken such as the "Childhood Obesity: A Plan for Action", "Change4Life", "Start4Life". It

also takes note that a ten year strategy to prevent obesity was initiated in 2012 in Northern Ireland. 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.

With regard to mental health, the report indicates that according to NHS England in 2014/2015 mental illness was the single largest cause of disability in England and 1 in 4 people are estimated to have a mental health condition. The Committee takes note from the report of the programmes developed to reform mental health services such as: "Suicide Prevention Strategy", "Closing the Gap: Priorities for essential change in mental health", "Better Access to Mental Health by 2020" which set out the commitment to introduce first ever waiting times for mental health, "Future in Mind – children and young people mental health" and the "Five Year Forward View for Mental Health" by the Independent Mental Health Taskforce which set out visions for transforming mental health services by 2020/2021. It also notes the measures taken to improve mental health in Scotland mainly through the Mental Health Strategy 2012-2015. In Wales, *Together for Health* programme contained a number of major health condition delivery plans e.g. heart disease, cancer, diabetes, stroke, neurological conditions, respiratory, liver disease, critically ill and end-of-life care. 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.

The Committee notes from the Equality and Human Rights Commission data that groups vulnerable to pressures such as poverty and victimisation show high rates of mental illness. The risk of having poor mental health scores is higher for certain ethnic groups with high poverty rates (for example the risk of mental health problems is nearly twice as likely for Bangladeshi men than for white men). It is reported that mental health is an issue of concern for both the LGBT and transgender population. 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.

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).

Conclusion

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

Article 11 - Right to protection of health

Paragraph 2 - Advisory and educational facilities

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

Education and awareness raising

In its previous conclusion, the Committee asked for examples of concrete activities and campaigns undertaken by public health services, or other bodies, to promote health and prevent diseases (Conclusions XX-2 (2013)). The report indicates that in April 2013, the Government established Public Health England (PHE) as an executive agency of the Department of Health. PHE supports local authorities (LAs) in England in taking forward their duty to improve the health of their populations, not least through providing the evidence base and advice on public health interventions.

The report lists the range of campaigns carried out by PHE such as: (i) national campaigns to improve the public's health (for example flu vaccination, young people's health and wellbeing "Rise Above"; "Talk to Frank" about drugs advice); (ii) social marketing campaigns like "Starting Well", which includes the flagship Change4Life campaign; "Living Well", which uses the One You brand to inspire and help adults to lead healthier lives and supports smoking cessation; and "Ageing Well", which encourages people to act on a range of signs and symptoms of diseases like cancer, to facilitate earlier diagnosis and help increase survival rates; (iii) campaigns related to maternity and early years such as the "Best Start in Life Programme" aimed at reducing smoking in pregnancy, improving perinatal mental health, improving oral health, reducing inequalities in speech, language and communication, reducing harm from accidents; (iv) campaigns under "Healthy Child Programme" delivered by school nurses related to sexual health, healthy eating, hand washing and antimicrobial resistance.

The Committee previously asked for 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 (Conclusions XX-2 (2013)). The report indicates that Change4Life programme makes resources available to schools to support a whole school approach to maintaining a healthy weight, including materials to encourage daily physical activity and healthy eating. PHE published "What works in schools and colleges to increase physical activity" in November 2015. The Childhood Obesity Action Plan states that a Healthy Schools Rating Scheme will be developed for primary schools from 2017/201818 onwards and this will cover physical activity, healthy eating and emotional health and wellbeing.

The Committee recalls that health education in school shall cover the following subjects: prevention of smoking and alcohol abuse, sexual and reproductive education, in particular with regard to prevention of sexually transmitted diseases and AIDS, road safety and promotion of healthy eating habits. It asks confirmation in the next report that the above mentioned subjects are covered by the school curriculum throughout the United Kingdom.

The report further indicates that alcohol and drug education is already a statutory part of the key stage 4 national curriculum for science and teaches children about the effects of recreational drugs, including alcohol, on behaviour, health and life processes. The Government's Drug Strategy confirms the commitment to provide accurate information to young people, and their parents/carers, about drugs and alcohol through education and the FRANK drug information and advice service.

The report indicates that in the Isle of Man a comprehensive programme of 'personal, health, social and economic' education is delivered by teachers in schools, which is overseen by the Department of Education and Children. There is also a programme to support emotional wellbeing and resilience in children and young people.

The Committee takes note from the report of the measures and campaigns undertaken, such as the “Childhood Obesity: A Plan for Action”, “Change4Life”, “Start4Life” to prevent and reduce overweight and obesity.

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.

Counselling and screening

The Committee asked previously information on concrete medical checks carried out through the period of schooling (including their frequency, their objectives, and the proportion of pupils covered) (Conclusions XX-2 (2013)). The report indicates that the National child measurement programme (NCMP) measures the height and weight of all children in state schools age 5-6 and 10-11. The measurements taken in the 2015/16 academic year covered 95% of all pupils. The original purpose of the NCMP was as a surveillance tool to determine the obesity prevalence of primary school aged children but it is now used as a method of screening and offering support to children who are not a healthy weight. Similar programmes operate (with the same purpose and frequency) throughout the UK, such as the Child Measurement Programme for Wales and Scottish Child Health Programme.

The Committee asked the next report to indicate what screening activities are funded and organised by the public health system (Conclusions XX-2 (2013)). The report indicates that the “Healthy Child Programme” offers every family a programme of screening tests, immunisations, developmental reviews, 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. The Committee recalls that there must be free and regular consultation and screening for pregnant women throughout the country. It asks updated information on the available screening programs for pregnant women and their frequency throughout the United Kingdom.

The report also mentions that Public Health England (PHE) developed a major programme targeting cardio-vascular disease prevention, including the NHS Health Checks which is offered to people aged 40-75 on a 5 year rolling basis. The Committee takes note from the report of the national screening programmes targeted at all children and adults in Wales.

The Committee takes note of the information in the report regarding the screening programmes available in the Isle of Man: breast screening, cervical screening and bowel screening.

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.

Conclusion

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

Article 11 - Right to protection of health

Paragraph 3 - Prevention of diseases and accidents

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

Healthy environment

The Committee took note previously of the different measures and regulations applicable for the reduction of environmental risks, in particular in the field of air quality, water quality, noise and food safety (Conclusions XX-2 (2013)). It takes note from the report of the measures taken during the reference period in the areas of water quality, contaminated land, exposure to noise and food safety.

The Committee asked for 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 (Conclusions XX-2 (2013)).

With regard to air pollution, the report "Air Pollution in the United Kingdom 2015", concluded that, overall, the latest data showed an improving picture compared to the previous year's data. The report indicates that the Drinking Water Inspectorate publishes annual reports on the quality of drinking water. The report adds that the drinking water in the United Kingdom is of the highest standard, at a record level of quality and among the best in the world. As regards food intoxication, the Food Standards Agency published research on how many people suffer from food poisoning in the United Kingdom every year providing public officials with the most detailed picture yet of this problem.

Tobacco, alcohol and drugs

The Committee previously asked for information on trends on tobacco consumption (Conclusions XX-2 (2013)). The report indicates that smoking rates in England are at their lowest ever levels – down to 16.9% for adults and 8% for 15 year olds. However, there are considerable regional differences and around 7.7 million people in England still smoke. The report indicates that a new tobacco control plan was developed which focuses on the harmful effects of tobacco on disadvantaged communities.

The Committee takes note of the information on the legal framework, measures taken and statistics related to tobacco consumption in Scotland. The report indicates that a detailed report on the use of tobacco in Northern Ireland was published in December 2015 and a Tobacco Control Action Plan for Wales was elaborated as well.

Concerning alcohol, the Committee noted previously that a Government Alcohol Strategy was adopted in March 2012 which set out how local and national government, the alcohol industry and people themselves can combat irresponsible drinking. The Committee asked to be kept informed on the implementation of this strategy (Conclusions XX-2 (2013)). The report indicates that the authorities continue to build on the Alcohol Strategy launched in 2012 to tackle alcohol as a driver of crime and support people to stay healthy.

The Committee takes note of the measures taken during the reference period such as the new Change4Life campaign, education related to the risks of alcohol consumption in schools, the interdiction of sales of alcohol below the level of duty plus VAT to avoid the worst cases of very cheap and harmful alcohol; awareness raising campaigns for children and young persons.

Survey data show a steady decline, over recent years, in the proportion of 11-15 year olds who drink alcohol (falling from 61% in 2003 to 38% in 2014). The report indicates that however, evidence suggests that alcohol consumption has increased over the long-term and alcohol-related harms are still increasing. Alcohol consumption overall has fallen recently, but long term consumption has risen and a significant minority of people misuse alcohol, for

example 1.1 million hospital admissions are alcohol-related (7% of the total). Moreover, the report indicates that alcohol remains one of the fourth biggest behavioural risk factors for disease and death in the United Kingdom along with smoking, obesity and lack of physical activity; and over 6,800 deaths each year in England are thought to be caused by alcohol.

The report mentions that one of the measures taken through the Drug Strategy is to provide accurate information to young people and their parents/carers on drugs and alcohol through education and the FRANK drug information and advice service.

The Committee asks for updated information in the next report on the measures taken to prevent and reduce the consumption of alcohol, tobacco and drugs among all population, in particular young people, and data on the trends in consumption.

Immunisation and epidemiological monitoring

The report indicates that in the United Kingdom the immunisation programme currently protects against 16 different diseases based on high quality independent expert advice from the Joint Committee on Vaccination and Immunisation.

The most recent additions to the programme are: pertussis for pregnant women (2012); Rotavirus for infants (2013); Shingles for older people (2013); Meningococcal disease serogroup B for infants (2015); Meningococcal disease serogroups ACWY for adolescents (2015). In addition, a seasonal flu programme for children was introduced in 2013. The programme will eventually extend to all children aged 2-16 but started with the youngest children first. In 2016/2017 the vaccine was offered to all children aged 2-7 years old. The report states that the coverage rate for the immunisation programmes is high with more than 90% uptake of the target population for most childhood vaccines. The Committee takes note of the information in the report on the coverage rates for the main vaccines in the Isle of Man which is more than 92%.

The Committee asks for updated figures on the coverage rates for the main vaccines throughout the United Kingdom in the next report.

Conclusion

Pending receipt of the information requested, the Committee concludes that the situation in the United Kingdom is in conformity with Article 11§3 of the 1961 Charter.

Article 12 - Right to social security

Paragraph 1 - Existence of a social security system

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

As regards **family** and **maternity benefits**, the Committee refers to its conclusions on, respectively, articles 16 and 8§1 (Conclusions XX-4 (2015)).

Risks covered, financing of benefits and personal coverage

The Committee refers to its previous conclusions (Conclusions XX-2(2013), XIX-2 (2009) and previous ones) for a description of the separate but corresponding social security schemes operated in Great Britain and Northern Ireland. The report states that reciprocal arrangements between the two ensure that the schemes operate as a single system with contributions and benefit rates and dates of commencement maintained in parity. The Committee notes that the system continues to cover all the traditional risks (medical care, sickness, unemployment, old age, work accidents/occupational diseases, family, maternity, invalidity and survivors) and continues to be based on collective funding: it is funded by contributions (employers, employees) and by the State budget.

In response to the Committee's question, the report confirms that 100% of the population ordinarily residing in the United Kingdom is covered by the universal Health Care system. As regards other branches, the Committee notes from the report under the European Code of Social Security that in 2015 some 47% of the resident population was covered in respect of Sickness (30 512 000 individuals), Old-Age and Survivors benefits (30 527 000 individuals) and that 90% of employees (28 299 000 individuals) were insured for unemployment benefits (Job Seeker Allowance). 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. The Committee furthermore recalls that, in order to assess whether a significant proportion of the total and/or active population in the United Kingdom is guaranteed an effective right to social security with respect to the benefits provided under each branch, States parties are required to provide figures in percentage indicating the personal coverage of each branch of social security. 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.

Adequacy of the benefits

According to Eurostat data, the median equivalised annual income was €20 945 in 2015, or €1745 per month. The poverty level, defined as 50% of the median equivalised income, was €10 473 per year, or €873 per month (€218 weekly). 40% of the median equivalised income corresponded to €698 monthly (€174.5 weekly).

The Committee previously found (Conclusions XX-2 (2013)) that the minimum levels of short-term and long-term incapacity benefits, of state pension and of job seeker's allowance were manifestly inadequate. The State contests this finding in its report, arguing that the benefit rates are considered in isolation, without taking into account the safety net of other benefits and credits available. According to the report, contributory benefits are supplemented by a range of non-contributory, means-tested benefits such as income-related Employment and Support Allowance, income-based Jobseeker's Allowance, Housing Benefit, Attendance Allowance, Disability Living Allowance and Personal Independence

Payment. Therefore, according to the report, the overall income of households should be taken into account when assessing the adequacy of benefits. The report points out that 88% of adults in families/benefit units in receipt of contribution-based ESA or JSA in the UK are in households with equivalised incomes above 40% of median income in 2014/15 (as regards households in receipt of less than 40% of median income, the report explains that this could be because they possess large sums of capital or are not taking up their entitlements to income-related benefits). The Committee points out that when social security benefits are income-replacement benefits, their level should be fixed so as to stand in reasonable proportion to previous income and it should never fall below the poverty threshold defined as 50% of median equivalised income and as calculated on the basis of the Eurostat at-risk-of-poverty threshold value. Supplementary benefits, including social assistance, are taken into account only when an income-substituting benefit stands between 40% and 50% of median equivalised income as defined above. Where the level of an income-substituting benefit falls below 40% of median equivalised income, it is manifestly inadequate and its combination with other benefits cannot bring the situation into conformity with Article 12§1.

As regards **Sickness**, all employees earning at least GBP 112 (€158) per week are covered by the Statutory Sick Pay (SSP), a contributory benefit which is paid from the fourth day of incapacity and up to 28 weeks. Workers, including the self-employed, who do not qualify for SSP or have exhausted their entitlement to it can claim Employment Support Allowance (ESA). ESA can be awarded on the basis of either National Insurance (NI) contributions (contributory ESA (ESA(C)) or low income (income-related ESA (ESA (IR)). Both elements can be paid at the same time. To be entitled to contributory ESA, a claimant must have paid or been credited enough NI contributions in the previous two tax years (at least 26 weeks paid contributions or contributions paid/credited for at least 50 times the minimum threshold). Since 2012, this benefit can be paid for up to one year for those capable of work-related activity. Income-related ESA is on the other hand a means-tested non-contributory benefit payable without a time-limit. In 2015, SSP amounted to GBP 88.45 (€120) per week. ESA is paid at different rates depending on the individual's age, circumstances and the stage of the claiming process. In 2015, during the first 13 weeks of incapacity, the rate was GBP 57.90 (€82) or GBP 73.10 (€103) per week, for beneficiaries under 25 years of age and those over this age, respectively. As from the 14th week of incapacity, the rates were GBP 102.15 (€144) per week for those capable of work-related activity or GBP 109.30 (€154) for those requiring support. Those in the support group and on income-related ESA, were also entitled to the Enhanced Disability Premium at GBP 15.75 (€22) a week. In addition, according to the report, claimants may qualify for additional support such as Personal Independence Payment, Housing Benefit, Child Tax Credits, or Child Benefit. The Committee notes that the rates of SSP, as well as the minimum levels of ESA, are lower than 40% of the median equivalised income. Accordingly, regardless of the additional social assistance benefits which might be available, the Committee considers that the level of these benefits is manifestly inadequate.

Since 2008, ESA covers not only short-term incapacity but also long-term incapacity (**disability**). Since 2011, recipients of the former Incapacity Benefit have been reassessed for ESA, taking into account their work capability. The report indicates that, with the progressive introduction since 2013 of the Universal Credit (UC) (see also Conclusions on Article 13§1), ESA will remain as contributory benefit and UC will be the non-contributory benefit. The Committee understands from the report that, during the reference period, long-term incapacity benefits were still paid in some cases, at a basic amount of GBP 105.35 in 2015, i.e. €143 per week, to be increased if the disability started before the age of 35 or between 35 and 44. As regards ESA rates, the Committee refers to its remarks above and notes that increased rates are paid in case of enhanced or severe disability (respectively GBP 15.75 and GBP 61.85 per week, i.e. €22 and €84). As the minimum rates of long-term benefits and ESA remain lower than 40% of the median equivalised income, the Committee considers that the level of these benefits is manifestly inadequate.

According to the report, the Welfare Reform Act 2012 simplified the way **industrial injuries benefits** are claimed. Several old schemes were abolished, and all remaining claimants on those schemes were moved to the existing Industrial Injuries Disablement Benefit (IIDB) scheme, thus establishing a single claiming option for all claimants. All employees are compulsorily protected against employment injury and disease and the level of benefit depends on the incapacity level (which should be at least 14%), whether temporary or permanent. In 2015, the level of benefit in case of 100% disablement was GBP 168 (€237) per week. The Committee considers that the level of this benefit is adequate.

The **Unemployment** scheme was amended in 2013, with the introduction of the New Style Job Seeker Allowance (JSA), a contributory benefit granted for a maximum of 182 days in any period of employment. The contribution conditions that a claimant needs to satisfy to be entitled to new style JSA are the same as for old style JSA (at least 50 minimum weekly contributions paid or credited in the last two years, of which at least 26 weekly contributions paid in one year). In addition to the contributions requirement, new style JSA claimants are also required to be available for work and search for work for up to 35 hours a week. Failure to follow the work related requirements will result in a benefit sanction (suspension of benefit payment for one to 26 weeks). The Committee recalls that there must be a reasonable initial period during which an unemployed person may refuse a job or a training offer not matching his previous skills without losing his unemployment benefits. It refers to its Conclusions XXI-1 (2016), concerning Article 1§2, where it noted that the recipients of unemployment benefit is, in principle, entitled to reject a job offer that does not correspond to their customary occupation during an initial 13-week period ("permitted period"), but that decisions on this issue were made on a case-by-case basis, depending on circumstances. 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. Regardless of whether a jobseeker is entitled to the contributory JSA, a non-contributory benefit (Universal Credit (UC)) is also available to persons whose total income is below GBP 16 000 (€22 583), whose partners do not work more than 24 hours/week and who have been resident in the United Kingdom for at least three months before the claim. The income-related assistance is provided for an unlimited duration, as long as the entitlement conditions continue to be satisfied. In 2015, the rates of the New-Style JSA amounted to GBP 57.90 (€82) per week or GBP 73.10 (€103) per week, depending on whether the claimant was aged between 18 and 24 or was older. The Committee notes from MISSOC that the basic level of non-contributory unemployment benefit for single people was the same as for contribution-based JSA. The Committee understands from the report that the contributory and non-contributory benefit can be combined, and that additional benefits might apply such as the ESA and Personal Independence Payment, in case of work incapacity, as well as Housing benefits, Child benefits and Child Tax Credits. It notes however, that the minimum levels of the unemployment benefits (New Style JSA and non-contributory benefits) are both below 40% of the median equivalised income, and that at least for people younger than 25 this remains the case even when both contributory and non-contributory benefits are taken together. It accordingly considers that the levels of (contributory and non-contributory) unemployment benefits are manifestly inadequate.

The Committee notes that the levels of the contribution-based ESA and JSA, as well as of the SSP, have also been found too low to comply with the requirements of ILO Convention No. 102 (Observation (CEACR) – adopted 2016, published 106th ILC session (2017) concerning Social Security (Minimum Standards) Convention 1952, No. 102) and the European Code of Social Security (Committee of Ministers' Resolution CM/ResCSS(2016)21 on the application of the European Code of Social Security by the United Kingdom, Period from 1 July 2014 to 30 June 2015).

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 old-age pension system which applied during the reference period was a two-tier system that consisted of the basic state retirement pension (basic flat-rate benefit) and the second state pension (earnings related additional pension) which was paid to men aged 65 and women aged 63 with at least 30 years of paid or credited contributions. A non-contributory pension (Pension credit) was furthermore available for people who were not entitled to the contributory pension. According to the report, the full basic (contributory) pension for a single person was GBP 115.95 (€164) in 2015, and the average amount paid in November 2015 was GBP 130.71 (€186). This basic amount would be increased under the Graduated Benefit scheme and the Second state pension scheme, depending on the duration and level of contributions. According to the report, the average amount paid in November 2015 was GBP 136.03 (€193) when considering also these increases. The Committee notes that the basic State Pension rate, taken alone, was lower than 40% of the median equivalised income and that there is no defined minimum as regards the graduated benefit and second pension increases. However, it notes from the examples indicated in the report that, conditional upon resources, the basic amount is topped up with the non-contributory pension, the level of which was, in 2015, GBP 151.20 (€214) for a single person, to which a number of additional benefits, depending on personal circumstances (age, disability, winter weather...) might be added (such as the Housing Benefit, the ESA, winter fuel payment of GBP200, i.e. €283; the Christmas bonus of GBP 10, i.e. €14 etc.). 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.

Conclusion

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

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

Article 13 - Right to social and medical assistance

Paragraph 1 - Adequate assistance for every person in need

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

Types of benefits end eligibility criteria

The Committee takes note from MISSOC of the benefits that are administered and paid centrally. The following are granted on the basis of a subjective right:

- Income support – means-tested scheme providing financial help for people who are not in full-time work, who are not required to register as unemployed and whose income from all sources is below a set minimum level.
- Jobseekers' Allowance (income-based): means-tested scheme for resident unemployed people whose income from all sources is below a set minimum level and who are not in full-time work;
- Pension Credit: means-tested minimum income guarantee scheme for men and women over the women's state pension age;
- Employment Support Allowance (ESA): means-tested social assistance scheme for people unable to work because of sickness or disability.
- Housing benefit: means-tested social assistance scheme to help people in and out of work who are on a low income and who need help to meet their rent liability.

The report summarises the the main provisions of the Welfare Reform Act of 2012. The Committee notes that Universal Credit replaced income based Jobseeker's Allowance, as well as income-related Employment and Support Allowance and Income Support. According to the report as of November 2016 over 420,000 claimants were receiving Universal Credit.

In its previous conclusion (Conclusions XX-2 (2013) the Committee noted that under the Welfare Reform Act 2012 sanctions (suspension of benefits) would be strengthened and the hardship payments would be granted only to those claimants in greatest need. It asked the next report to clarify what criteria would be applied in practice to ensure that, in conformity with the Charter, a person is not be deprived of his/her means of subsistence. In response, the report states that if a claimant demonstrates they cannot meet their immediate and most essential needs, including accommodation, heating, food and hygiene, as a result of their sanction, they can apply for a hardship payment. Claimants who are sanctioned can apply for hardship payments equivalent to 60% of their normal benefit payment. Universal Credit claimants can apply for hardship payments as soon as they receive a payment reduced by a sanction. In addition to hardship payments, claimants who are not eligible or do not have day one access are signposted to local authorities where they can receive immediate assistance. Each local authority will tailor their support to meet the needs of their communities.

The Committee notes from the submission of Just Fair to the Committee on Economic, Social and Cultural Rights of October 2015 (Parallel Report regarding the Implementation of the International Covenant on Economic, Social and Cultural Rights in the United Kingdom of Great Britain and Northern Ireland) that available evidence suggests that the post-recession rise in UK hunger is intimately connected to the rise in benefit delays, caused by an increase in both benefit sanctioning, as well as maladministration (particularly with regard to late payment and underpayment). In 2001, 279,840 Job Seekers Allowance (JSA) sanctions were imposed; by 2013, this number had risen to 553,000.

According to Just Fair, stricter sanctions and conditionality regulations were introduced by the Coalition Government on 22nd October 2012. Benefit sanctions are the cessation of benefit payments for a period of 4 – 156 weeks, in circumstances where the Department of Work and Pensions finds that the person has not done everything they can to find work. Just Fair observes that the high percentage of successful appeals against welfare benefit decisions provides further confirmation of the prevalence of poor administration.

The Committee further notes from the same source that previously, when individuals faced hunger due to sanctions or late payment, they could potentially rely on crisis loans to obtain vital short-term expenses, such as food or clothes, or community care grants to obtain basic living essentials, such as cooking equipment. However, fiscal responsibility for crisis loans and community care grants was transferred to local authorities in April 2013.

The potential for crisis loans to assist in securing access to food was greatly diminished by localisation, as many councils restricted eligibility criteria for the fund. As a result, only 20% of the money available had been spent during the first six months of the transfer, with some councils allocating as little as 1% of their crisis loan budgets. In January 2014, the Government announced that the fund would be cut completely by April 2015.

The Committee observes that Just Fair's recommends to the Government to undertake further research in order to determine why food bank usage has significantly increased in recent years. It also recommends that the Government urgently reforms the benefit sanctions scheme, and takes steps to reduce benefit delay.

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.

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 Allowances paid to a single person over 25 years of age stood at € 103 per week in 2015.
- Additional benefits: according to MISSOC the amount of Premium paid to a single person stood at € 46 per week. Winter Fuel Payment, an annual lump sum payment stood at € 282 per year for persons up to the age of 79 and at € 423 if aged 80 of over. Cold weather payment was paid automotically to people receiving specified meanst-tested benefits, which stood at € 35. The Committee notes from another source (https://www.gov.uk/government/statistics/housing-benefit-caseload-statistics) that the average weekly award of housing benefit in 2015 stood at £ 95 (€ 123) for all claimants (all tenure types).
- Poverty threshold, defined as 50% of median equivalised income and as calculated on the basis of the Eurostat at-risk-of-poverty value was estimated at € 873.

The Committee considers that the level of social assistance, including supplements, that can be obtained by a single person without resources is adequate as it is compatible with the poverty threshold.

Right of appeal and legal aid

In reply to the Committee's question the report states that Mandatory Reconsideration (MR) was introduced for Universal Credit and Personal independent Payment in April 2013 and for all other benefits from October 2014. The Committee notes that there has been a significant drop in appeals, particularly in ESA, since the introduction of MR.

According to the report, Mandatory Reconsideration is a key component of the decision making process which if done properly benefits both claimants and the Department. The Department's Social Security Advisory Committee (SSAC) decided to research the effectiveness of its introduction, focusing on ESA. In its recently published Report, whilst it approved the policy, it made a number of recommendations around the process. Even though the statistics suggest that MR is working in that claimants are being given the

opportunity to present new evidence and very few go on to appeal, the department recognises the need for the improvements recommended by SSAC e.g. how it gathers key information from claimants at the MR stage, rather than have this produced only on appeal, and will be addressing these over the coming months. The Committee asks to be kept informed of the results as well as the relevant statistics.

Personal scope

The Committee recalls that, under Article 13§1, States are under the obligation to provide adequate medical and social assistance to all persons in need, both their own nationals as well as nationals of States Parties lawfully resident within their territory, on an equal footing. In addition, with reference to its Statement of Interpretation of Articles 13§1 and 13§4 (Conclusions 2013) regarding the scope of Articles 13§1 and 13§4 in terms of persons covered, the Committee considers that persons in an irregular situation in the territory of the State concerned are also covered under Article 13§1, rather than under Article 13§4, which was previously its practice.

The Committee henceforth examines whether the States who have accepted Article 13§1 ensure the right to:

- adequate social and medical assistance for their own nationals and for nationals of other States Parties lawfully resident within their territory on an equal footing;
- emergency social and medical assistance to persons unlawfully present in their territory.

Nationals of States Parties lawfully resident in the territory

In its previous conclusion, in the light of the explanations and case-law examples provided, the Committee found that the "habitual residence" test, as applied in the United Kingdom was in conformity with the Charter. It asked 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.

The Committee notes that since 2013 the Government has introduced a number of changes with regard to EEA nationals' access to benefits. According to the report, these measures are designed to ensure that only those who come to the UK to work, and have a realistic chance of finding work, are able to access the benefits system. In particular, the Committee notes that in December 2013 a more robust Habitual Residence Test was introduced and used for face to face interviews with migrants and returning UK nationals claiming benefits. The strengthened test is intended to help benefit decision makers to make more consistent decisions on benefit entitlement.

- Since 1 January 2014, newly arrived jobseekers have been unable to claim income-based Jobseeker's Allowance until they have been living in the UK for a period of three months. This is in addition to the requirement to demonstrate that they are habitually resident. This measure also applies to UK nationals returning to the UK after an extended absence abroad.
- Since 1 January 2014, immigration regulations only allow EEA nationals to reside in the UK as a jobseeker or as a person who 'retains' worker status for a maximum of six months, unless they have genuine chance of getting work. A 'Genuine Prospect of Work' assessment is applied after six months to EEA nationals claiming income-based Jobseeker's Allowance. The 'Genuine Prospect of Work' assessment considers whether the claimant has an imminent job start or has had a change of circumstances leading to a potential job offer. If compelling evidence not provided, the EEA national's right to reside in UK ends and entitlement to income-based Jobseeker's Allowance stops. If evidence of a job offer is provided, payment of this benefit will be extended to the date of the job start. Furthermore, from November 2014, the length of time new EEA

jobseekers could claim JSA (IB) was reduced from 6 months to 91 days (after satisfying an initial 3 month residence requirement) unless they passed a GPoW assessment. In February 2015 this measure was extended to existing long-term claimants.

- Since 1 April 2014, EEA migrants with a right to reside as a jobseeker are unable to access Housing Benefit.
- Since 10 June 2015, new EEA migrants with a right to reside as a jobseeker are unable to access Universal Credit.

The Committee recalls that Article 13§1 of the Charter does not regulate procedure for admitting foreigners to the territory of States Parties and the rules governing resident status are left to national legislation. As a result, that status may be made subject to a condition of length of residence or presence in the territory. However, once the residence status has been granted and the foreigner concerned becomes lawfully resident, he/she should be made eligible to claim benefits in case of need, without any length of residence requirement.

The Committee notes that for EEA nationals access to benefits has been restricted (three months waiting period and the requirement to prove that there is a genuine prospect of work after three months) or denied (e.g. housing allowance and universal credit). As regards the practical application of these restrictions the Committee notes from the Analysis of EEA Migrants' Access to Income-Related Benefits Measures that In 2015/16, 92% of JSA claims by EEA jobseekers lasting three months or longer were cut short because the claimant was unable to provide evidence of a Genuine Prospect of Work (GPoW). Over the initial period in which measures were introduced (November 2013 to August 2015), there was a 45% fall in new JSA claims by EEA nationals and a 68% fall in the JSA EEA national caseload.

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. The Committee also asks what rules apply to non-EEA nationals. 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.

Nationals of States Parties unlawfully present in the territory

As regards emergency medical assistance, according to the report, some groups of unlawfully present foreign nationals are exempt from charges, such as, among others, asylum seekers, failed asylum seekers receiving support under section 21 of the Nationals Assistance Act 1948 or the Care Act 2014. Other unlawfully present foreign nationals are chargeable for all hospital services they receive, unless the service itself is exempt from charge.

Treatment which a clinician considers to be immediately necessary, or urgent enough not to be able to wait until the patient has returned to their home country, will always be given regardless of whether or not a chargeable patient has paid in advance or will be able to do so. This does not mean that the treatment is then free; hospitals must make and recover charges from the person liable to pay but can decide not to actively pursue for debt when the person is genuinely without funds if not considered cost effective to do so.

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

treatment which a health professional considers to be immediately necessary would be provided regardless of registration.

In its previous conclusion (Article 13§4) the Committee asked 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.

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

The Committee cannot accept the necessity of halting the provision of such basic emergency assistance as shelter, guaranteed under Article 13 as a subjective right, to individuals in a highly precarious situation. The Committee has considered that even within the framework of the current migration policy, less onerous means, namely to provide for the necessary emergency assistance while maintaining the other restrictions with regard to the position of migrants in an irregular situation, remain available to the Government with regard to the emergency treatment provided to those individuals, who have overstayed their legal entitlement to remain in the country (Complaint No. 90/2013, Conference of European Churches (CEC) v. the Netherlands, decision on the merits of 1 July 2014, §123).

The Committee asks the next report to confirm that the legislation and practice comply with these requirements as regards emergency social assistance.

Conclusion

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

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 United Kingdom.

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.

Conclusion

The Committee concludes that the situation in 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 United Kingdom.

The Committee notes that, according to the report, the situation which it has found to be in conformity with the Charter (Conclusions 2013) has not changed.

However, the Committee notes that in their Submission to the Committee on Economic, Social and Cultural Rights of October 2015 (Parallel Report regarding the Implementation of the International Covenant on Economic, Social and Cultural Rights in the United Kingdom of Great Britain and Northern Ireland), Just Fair has observed that Citizens' Advice services have had their funding cut in recent years and struggle to provide the same level of service as previously, at a time when demand is at an all time high due to the extent and breadth of welfare reform. According to Just Fair, reductions in local authority funding have forced councils to reduce funding of local advice charities, including Citizens' Advice Bureaux. Many advice services have therefore been forced to downsize.

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.

Conclusion

Pending receipt of the information requested, the Committee concludes that the situation in 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 United Kingdom.

The Committee refers to its conclusion under Article 13§1 (personal scope) and recalls that Article 13§4 from now on will cover emergency social and medical assistance for nationals of States Parties lawfully present (but not resident) in the territory.

As regards emergency medical assistance, the Committee notes from the report that *primary care* continues to be free to all, other than statutory charges that apply to all patients (unless they qualify for an exemption).

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

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

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

The Committee recalls that States Parties are required to provide non-resident foreigners, without resources, with emergency social and medical assistance. Such assistance must cover accommodation, food, clothing and emergency medical assistance, to cope with an urgent and serious state of need (without interpreting too narrowly the 'urgency' and 'seriousness' criteria). No condition of length of presence can be set on the right to emergency assistance (Complaint No 86/2012, European Federation of national organisations working with the Homeless (FEANSA) v. the Netherlands, decision on the merits of 2 July 2014, §171).

The Committee further recalls that emergency social assistance should be supported by a right to appeal to an independent body. As regards provision of emergency shelter, there must be an effective appeal mechanism before an independent judicial body in order to determine the proper administration of shelter distribution. This right must also be effective in practice (Conference of European Churches (CEC) v. the Netherlands, Complaint No 90/2013, decision on the merits of 1 July 2014 §106).

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.

Conclusion

Pending receipt of the information requested, the Committee concludes that the situation in United Kingdom is in conformity with Article 13§4 of the 1961 Charter.

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 the United Kingdom.

Organisation of the social services

In its previous conclusion (Conclusions XX-2 (2013)) the Committee asked further information on a reform that aimed to enable social care professionals to undertake their role more effectively and empower care users.

In reply, the report indicates that following the adoption of the Care Act 2014 there is a new care system in place in England from April 2015 that prioritises independence and wellbeing at an early stage and throughout an older person's care journey. The measures set out in the Care Act try to support better access, quality and sustainability. The Care Act 2014 provides the legislative framework for the Adult Social Care system. It defines the way the system works, the responsibilities of local government and their partners, and the rights, outcomes and experience of people who need care, carers and their families. 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.

The report states that in Scotland the Scottish Government works in partnership with service users, carers, local authorities, the National Health Service, the Care Inspectorate as well as the voluntary and independent sectors to improve community care services. In order to improve social services two public bodies have been established in April 2011: the Care Inspectorate who is in charge of inspecting, regulating and supporting the improvement of social care and social work services and the Healthcare Improvement Scotland who takes over the regulation of independent healthcare services and is an authority on the development of evidence-based advice, guidance and standards to support health and social care improvement. 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.

As regards Northern Ireland, the report provides a comprehensive picture of social services expenditure and provision across all major programmes of care and the five Health and Social Care Trusts (HSCTs). The HSCTs provide integrated health and social care services across Northern Ireland, manage and administer hospitals, health centres, residential homes, day centres and other health and social care facilities and they provide a wide range of health and social care services to the community. In 2012, a review of the provision of health and social care services ("Transforming Your Care") was undertaken, with the aim to bring forward recommendations for the future shape of services and provide an implementation plan. The implementation of "Transforming Your Care" is being developed in some of the key areas, such as an Integrated Care Partnerships (bringing together health and social care providers from both the statutory and voluntary sector), a Self Directed Support (increases the choice, flexibility and control that services users have over their social care budget and the services they receive), etc.. 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.

In its previous conclusion (Conclusions XX-2 (2013)) the Committee asked for information on the legislative developments taking place in Wales.

The report indicates that in Wales during the reference period the debate about paying for care was part of the Welsh Government's wider reform of social care, as set out in its strategic direction 'Fulfilled Lives, Supportive Communities' (June 2008). That established the principle of local authority social services supporting individuals to live independently as possible, wherever possible at home. The Welsh Government has reformed arrangements

for the funding of care and support. More fundamental reform of social services in Wales took place outside the reference period.

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.

The report gives information on social services' organisation on the Isle of Man. The responsibility for social and mental care was transferred to the newly formed Department of Health and Social Care from 1st April 2014. The Social Care Division is divided into three service areas: Adults, Children and Families, and Mental Health. The total expenditure across the service areas was of 25.063.000 GBP in 2015/2016. The legal basis for the provision of services to adults is contained in the Social Services Act 2011 and the Chronically Sick and Disabled Persons Act 1981 which provides a legal framework for the assessment and provision of support to those people deemed eligible for Social care services. The report indicates that a Fair Access to Care Services Eligibility Criteria was introduced in December 2013. It assesses those eligible for support and enables charges to be made for the provision of social care services to meet assessed needs. As a requirement of the Regulation of Care Act 2013 all social work staff must be registered with the Health Care Professionals Council (HCPC). The report also indicates a number of services provided including statistics on social services activity.

Effective and equal access

As to the equal and effective access of persons to social services the Committee refers to its previous conclusion where it found the situation to be in conformity.

The report gives a substantial statistical overview for the reference period, including data on social services workforce and personal services activity (places in residential homes, number of clients receiving home care, nursing home care packages etc.) as well as the breakdown of expenditure in 2014/2015 in Northern Ireland by Programme of Care .

The report also indicates a number of measures, programmes and guidance and regulations implemented for improving social services for children and young people. In 2014, the Department for Education reformed the care planning and children's homes regulations to improve the safety of children in residential care. The report underlines that the first cross-government care leaver strategy was published in 2013 which recognised the need to work coherently across government to address care leavers' needs and introduced a number of changes to policies and practices so that care leavers were better supported. A progress update was published in 2014 to ensure that support for care leavers is embedded in all relevant departmental policies.

According to the report, the Children and Families Act 2014 takes forward the government's commitments to improve services for vulnerable children and families; it introduced changes to support the welfare of children.

Quality of services

The Committee refers to its previous conclusions for a detailed description of the quality of services and data protection.

The report indicates that the Care Quality Commission (CQC) oversees national standards and checks whether hospitals, care homes and care services, including care in the home, comply with those standards. The CQC makes sure that health and social care services provide people with safe, effective, high-quality care and encourage care services to improve. It also has the role to promote and protect equality and human rights for everyone who uses health and social care services. It also has an additional responsibility to protect the human rights of people whose circumstances make them vulnerable, such as people

who are being cared for under the Mental Health Act or the Mental Capacity Act Deprivation of Liberty Safeguards.

The report indicates that with the introduction of the Protection of Freedoms Act , in 2012 a specific service to safeguard vulnerable groups clients, the Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children.

The report also indicates that in Northern Ireland the Regulation and Quality Improvement Authority set up in 2005 (RQIA) is responsible for registering, inspecting and encouraging improvement in a range of health and social care services delivered by statutory and independent providers, in accordance with The Health and Personal Social Services (Quality, Improvement and Regulation)(Northern Ireland) Order 2003 and its supporting regulations. The RQIA regulates facilities including residential care homes; nursing homes; children's homes; independent health care providers; nursing agencies; adult placement agencies; domiciliary care agencies; residential family centres; and day care settings. RQIA also inspects schools providing accommodation. The Northern Ireland Social Care Council (NISCC) is the regulatory body for the social care workforce in Northern Ireland. The NISCC was established to increase public protection by regulating the social care workforce and professional training courses for social workers. The standards of professional practice and conduct required of social care workers are set down in the NISCC Code of Practice for Social Care Workers. The NISCC Code of Practice for Employers of Social Care Workers sets down the responsibilities of employers in the regulation of social care workers.

Conclusion

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

Article 14 - The right to benefit from social 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 the United Kingdom.

The report indicates that the Department of Health recognises the vital role played by active individuals and voluntary organisations in delivering client focused services. The White Paper *Caring for our future: reforming care and support* (2012) sets out the Department of Health's commitment to make it easier for people to contribute to their communities through volunteering schemes and to support the growth and development of neighbourhood support models that help people share time, talents and skills with others in their community.

In its previous conclusion (Conclusions XX-2 (2013), the Committee asked for information on the implementation of "The Compact", an agreement which governs relations between the Government and the civil society organisation, such as charities, in England.

In reply to the Committee requests, the report states that "The Compact" lays the foundation for effective, mutually beneficial partnership working between the Government and Civil Society Organisations (CSOs). It includes areas such as promoting CSO's involvement in policy design, service design and delivery, funding arrangements, promoting equality and strengthening independence. According to the report the government remains supportive of the principles of the Compact and will take a decision about re-signing it in due course.

In its previous conclusion (Conclusions XX-2 (2013), the Committee in the absence of information concerning the issue of discrimination, asked 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.

In reply to the question, the report states that the Equality Act 2010 requires equal treatment in access to private and public services, regardless of the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, race, religion or belief, sex, and sexual orientation. It emphasises that civil cases can be brought against those in violation of the Act.

In its previous conclusion (Conclusions XX-2 (2013), the Committee requested information on the total budget for grants from the Department of Health to the voluntary sector.

In reply to the question, the report indicates that the total budget on grants to voluntary sector organisations in 2015/16 was £66,420,935.

The report also underlines that the Care Act (2014) states that local authorities must promote the efficient and effective operation of a sustainable market in services for meeting care and support needs and ensure that there is a meaningful choice of providers who, when taken together, provide a variety of services. This could be independent private providers, third sector, and voluntary and community based organisations, including user-led, mutual and small businesses.

The report also indicates a number of initiatives and reports that provide a framework, supported by detailed advice and tools aiming to encourage public social services to take a more strategic approach towards volunteering.

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.

Conclusion

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