Agenda
Rural Social Care & Health Sub-Group

Incorporating SPARSE Rural Members, Rural Assembly and Rural Services Partnership Members. All nominated members & officers of RSN can attend these meetings.

Hosted: Online via Zoom
Date: Monday, 12th April 2021
Time: 11:00am – 12:30pm

1. **Attendance & Apologies.**

2. **Notes from the previous Rural Social Care & Health Sub-Group meeting that took place on 16th November 2020.** (Attachment 1)

3. **Discussion on Health White Paper Changes.** (Attachment 2)

4. **Revitalising Rural: Realising the Vision campaign**
   Click here to find out more about the Revitalising Rural campaign.[1]
   Click here to access chapter on Access to Rural Health and Care Services.[2]

   Revitalising Rural chapter on Access to Rural Health and Care Services
   - **Presentation** from Graham Biggs MBE, Chief Executive, Rural Services Network
   - **Poll** on Asks from the Access to Rural Health and Care Services chapter.
   - **Breakout Rooms**
   - **Feedback from Breakout Rooms**
   - **Next steps** of the campaign

5. **Any Other Business.**
   The next meeting of this group is scheduled for Monday, 15th November 2021.
   You are welcome to register your attendance in advance by following this link.[3]

[1] https://www.rsnonline.org.uk/revitalising-rural
[2] https://rsnonline.org.uk/images/revitalising-rural/access-to-health-and-care.pdf
[3] https://ruralsocialcarehealth-subgroup-meeting2021november.eventbrite.co.uk

Rural Services Network
Kilworthy Park, Tavistock, Devon PL19 0BZ
Tel: 01822 813693
www.rsnonline.org.uk email: events@sparse.gov.uk twitter: @rsnonline

Rural Services Network
Rural Health and Social Care Sub Group meeting

Date: 16th November 2020
Subject: Rural Health and Social Care
Chair: Councillor Cecilia Motley, Shropshire Council
Hosted: Online Event via Zoom

Learning Outcomes
Key issues highlighted by speakers

Ian Morrell, 65 High Street Health Hub

- The Town Council underpinned the No 65 initiative but labelling as such was avoided as a feel of community operation was important.
- Places connect people and the community needs places to go to be together.
- COVID had shown the importance of community connection and of family.
- Digital can be insular in its approach. Connections were best based on both it and communities and family contact.
- In a post-covid world, there will be more reliance on public health and a community approach at dealing with this is best
- The need for community interaction groups had been shown throughout the pandemic and this can be through established groups
- The need for Hub Groups like 65 might be even greater in the difficult times which would follow the pandemic.
- The importance of digital skills in accessing services is growing but there needs to be the support in training, and enable people to use them

Billy Palmer, Nuffield Trust

- The Nuffield Trust was an independent think tank. It had grown out of the root of independent hospitals many of whom had been in rural areas.
- Research undertaken around COVID had shown often problems existed in rural /remote areas.
- There were four key areas that were being explored in terms of rural data, the workforce, (recruitment/retention), distance (travel costs and staff down time travelling), Funding (discretionary funding cuts etc), and capacity (access to extra resources and the resilience of the sector)
- There were, as the pandemic had progressed, in terms of % of population significantly more people shielding in rural areas.
- And yet for A&E and clinic attendances in relation to issues including Mental Health ones the drop off rates from people in rural areas was significantly higher than the already worrying national trend.

Graham Biggs, Rural Services Network

- Revitalising Rural Campaign due to be launched in February 2021 articulating policy asks of Government in a number of key areas.

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- Extensive consultation with membership of RSN.
- 16 key areas, should not be considered in isolation as different elements are vital to ensure sustainable rural communities and successful rural economies to support the national economy
- Document sets out the national policy context for each area along with key asks
- https://www.rsnonline.org.uk/revitalising-rural You can access all of the sections at this link.
- The section on Access to Health Services is available at this link: https://rsnonline.org.uk/images/Revitalising%20Rural/final-branded-copies/Accessible_Health_and_Care_Servi.pdf
- The document would be kept current as circumstances changed etc. as this was the RSN's Policy Framework for the life of the current Parliament. Members would be kept informed on changes.
- Revitalising Rural would be the overarching context of the 9 Seminars in 2021 and the National Conference.

Any other key points discussed

- Graham Biggs detailed the House of Lords Announcement that their COVID19 Committee had invited the RSN to submit evidence to its Inquiry about long term impacts of the reliance on digital.
- Key Terms of reference focus on:
    - Physical Health
    - Mental Health
    - Social Interaction
    - Quality of Working Life
- A Survey would shortly go to members to help inform the RSN submission.

Next Meeting of the Group would be held on the 12th of April

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Produced by **Jonathan Haseldine**
Senior Parliamentary Researcher at House of Commons
February 2021

NHS WHITE PAPER SUMMARY

Contents

Executive Summary

The founding principles of the NHS – taxpayer-funded healthcare available to all, cradle-to-grave, and free at the point of delivery – remain as relevant now as they were in 1948. Local government delivery is also rooted in firm foundations: in serving its residents, with strong local democratic accountability, and expertise in the health, public health and care needs of its populations. To protect these principles, which are so close to all our hearts, we must back those who make them a reality every day of their lives - by building and constantly renewing a culture of collaboration.

- A goal of joined up care for everyone in England.
- Instead of working independently every part of the NHS, public health and social care system should continue to seek out ways to connect, communicate and collaborate so that the health and care needs of people are met.
- Healthy, fulfilled, independent and longer lives for the people of England will require health and care services, local government, NHS bodies, and others to work ever more closely together.

Two forms of integration which will be underpinned by the legislation:

- integration within the NHS to remove some of the cumbersome boundaries to collaboration and to make working together an organising principle; and
- greater collaboration between the NHS and local government, as well as wider delivery partners, to deliver improved outcomes to health and wellbeing for local people.

The NHS and local authorities will be given a duty to collaborate with each other.

- Bring forward measures for statutory Integrated Care Systems (ICSs).
- These will be comprised of an ICS Health and Care Partnership, bringing together the NHS, local government and partners, and an ICS NHS Body.
- The ICS NHS body will be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership will bring together systems to support integration and develop a plan to address the systems' health, public health, and social care needs.
- The legislation will aim to avoid a one-size-fits-all approach but enable flexibility for local areas to determine the best system arrangements for them.
- A key responsibility for these systems will be to support place-based joint working between the NHS, local government, community health services, and other partners such as the voluntary and community sector.

The government intend to reform the existing legislation to support the workforce by creating the flexibility NHS organisations need – to remove the barriers that prevent them from working together and to enable them to arrange services and provide joined up care in the interests of service users.

- Enabling the NHS and local authorities to arrange healthcare services to meet current and future challenges by ensuring that public and taxpayer value – and joined up care – are first and foremost.
- This will require changes to both competition law as it was applied to the NHS in the Health and Social Care Act 2012 and the system of procurement applied to the NHS by that legislation.

These measures are not intended to address all the challenges faced by the health and social care system. The government is undertaking broader reforms to social care and public health which will support the system in helping people to live healthier, more independent lives for longer. In particular, DHSC recognises the significant pressures faced by the social care sector and remains committed to reform.

Time frame

On current timeframes, and subject to Parliamentary business, the plan is that the legislative proposals for health and care reform outlined in this paper will begin to be implemented in 2022.

The Role of legislation

- In a typical 24-hour period, the NHS in England will see 1 million patients in GP appointments and carry out over 26,000 operations.
- In the social care system, local authorities are supporting almost 150,000 older people and over 40,000 young people in care homes as well as over 440,000 people in the community.
- Councils received 1.9m requests for adult social care support in 2019/20 – equivalent to 5,290 requests for support per day.

- People are living longer; over the next 20 years the population in England is expected to grow by almost 10%, with the number of people aged 75+ expected to grow by almost 60% - an additional 2.7 million people.
- The proportion of people aged 65+ with four or more diseases is set to almost double by 2035, with around a third of these people having a mental health problem.

Key Challenges

- NHS activity has grown every year since records began (at an average of 3.3% a year). Over the last 9 years (between 2009/10 and 2018/1 9) the number of attendances in A&E increased by 4.3 million; the number of GP appointments have risen from 222 million in 1995 to 308 million in 2018/19; and the number of outpatient attendances has increased by almost 36 million since 2009/10.

- Social care too has seen activity grow - In 2019/20, there were 1.9 million requests for adult social care support from new clients, an increase of 6% since 2015/16.

- A growing and ageing population - Over the next 20 years the population in England is expected to grow by almost 10%. The number of people aged 75+ is expected to grow by almost 60% an additional 2.7 million people.

- Growing morbidity and complexity of disease - Around 20% of our lives are spent in poor health, which has been increasing in recent year s and is likely to continue in future.

Pretty clear message to MPs:

Legislation of all kinds needs to be carefully calibrated to make only necessary and proportionate changes. The risk of legislative overreach and of an excessive specification of detail, spelling out the exact conditions under which specific organisations can and cannot work together, can lead to burdensome bureaucracy and confusion for those faced with the task of implementation.

Proposals for legislation

3 defining principles:

- any legislation should solve practical problems;
- avoid a disruptive top down reorganisation;
- have broad consensus within the system.

1. Working together and supporting integration

Proposals

1. Integrated Care Systems
2. Duty to Collaborate
3. Triple Aim
4. Foundation Trusts Capital Spend Limits
5. Joint committees
6. Collaborative Commissioning
7. Joint Appointments
8. Patient Choice
9. Data Sharing

Integrated Care Systems

- Aim to legislate for every part of England to be covered by an integrated care system (ICS)
- Intend to establish a statutory ICS in each ICS area (*currently voluntary arrangements*). These will be made up of an ICS NHS Body and a separate ICS Health and Care Partnership, bringing together the NHS, local government and partners.
- The ICS NHS body will be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership will bring together systems to support integration and develop a plan to address the systems' health, public health, and social care needs.
- ICSs will be accountable for outcomes of the health of the population and the government are exploring ways to enhance the role of CQC in reviewing system working

The ICS NHS Body will be responsible for:

- Developing a plan to meet the health needs of the population within their defined geography;
- Developing a capital plan for the NHS providers within their health geography;
- Securing the provision of health services to meet the needs of the system population.

The proposals allow for the ICS NHS Body to delegate significantly to place level and to provider collaboratives. To support our ambition for ICSs to also address broader health outcomes - including through improving population health and tackling inequalities - each

ICS will also be required to establish an ICS Health and Care Partnership, bringing together health, social care, public health (and potentially representatives from the wider public space where appropriate, such as social care providers or housing providers). This body will be responsible for developing a plan that addresses the wider health, public health, and social care needs of the system – the ICS NHS Body and Local Authorities will have to have regard to that plan when making decisions.

NHS Trusts and Foundation Trusts (FTs) will remain separate statutory bodies with their functions and duties broadly as they are in the current legislation.

- The creation of statutory ICS NHS Bodies will also allow NHS England to have an explicit power to set a financial allocation or other financial objectives at a system level.
- There will be a duty placed on the ICS NHS Body to meet the system financial objectives which require financial balance to be delivered.
- NHS providers within the ICS will retain their current organisational financial statutory duties. The ICS NHS Body will not have the power to direct providers, and providers' relationships with the Care Quality Commission will remain unchanged.
- However, these arrangements will be supplemented by a new duty to compel providers to have regard to the system financial objectives so both providers and ICS NHS Bodies are mutually invested in achieving financial control at system level.

Duty to collaborate

This will be supported by a broad duty to collaborate across the health and care system and a triple aim duty on health bodies, including ICSs, as recommended by NHS England. This will require health bodies, including ICSs, to ensure they pursue simultaneously the three aims of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources.

Reserve Power

- As an additional safeguard for financial sustainability, we will take a power to impose capital spending limits on Foundation Trusts, in line with NHS England's recommendation.

Joint Committees

- Implement NHS England's recommendations to remove barriers to integration through joint committees, collaborative commissioning approaches and joint appointments, as well as their recommendation to preserve and strengthen the right to patient choice within systems.

Collaborative Commissioning

- Give NHS England the ability to joint commission its direct commissioning functions with more than one ICS Board, allowing services to be arranged for their combined populations.
- Allow ICSs to enter into collaborative arrangements for the exercise of functions that are delegated to them, enabling a "double-delegation".
- Allow groups of ICSs to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions (and not just commissioning functions).
- Enable NHS England to delegate or transfer the commissioning of certain specialised services to ICSs singly or jointly, or for NHS England to jointly commission these services with ICSs if these functions are considered suitable for delegation or joint commissioning subject to certain safeguards.

Data Sharing

- Legislate to ensure more effective data sharing across the health and care system, which is critical to effective integration, and will enable the digital transformation of care pathways.
- introduce powers for the Secretary of State for Health and Social Care to require data from all registered adult social care providers about all services they provide, whether funded by local authorities or privately by individuals (discussed further in the Adult Social Care proposals); and require data from private providers of health care.
- Make changes to NHS Digital's legal framework to introduce a duty on NHS Digital to have regard to the benefit to the health and social care system of sharing data that it holds when exercising its functions; and clarify the purposes for which it can use data.
- Introduce a power for the Secretary of State for Health and Social Care to mandate standards for how data is collected and stored, so that data flows through the system in a usable way, and that when it is accessed/provided (for whatever purpose), it is in a standard form, both readable by, and consistently meaningful to the user/recipient.

Patient Choice

- Integrated services provide an opportunity to offer joined up care to all and provide clear information on the choices people have in how and where their care is delivered. A patient's right to choose where and who will provide their health and care needs will be preserved and strengthened in the new system arrangements.

2. Reducing bureaucracy

Proposals

1. Competition
2. Arranging healthcare services
3. National Tariff
4. New Trusts
5. Removing Local Education Training Boards (LETBs)

Aim to build greater flexibility into the basis provided by the 2012 legislation, where the current framework fails to enhance and streamline accountability, or necessitates complex or bureaucratic workarounds and makes it difficult for the system to integrate and adapt over time as needed.

Competition

Whilst competition can drive service improvement, it has in some cases hindered integration between providers.

Therefore:

- Remove the CMA function to review mergers involving NHS foundation trusts. The CMA's jurisdiction in relation to transactions involving non-NHS bodies (e.g. between an NHS Trust/FT and private enterprise) and other health matters (e.g. drug pricing) would be unchanged.
- Remove NHS Improvement's specific competition functions and its general duty to prevent anti-competitive behaviour.
- Remove the need for NHS England to refer contested licence conditions or National Tariff provisions to the CMA.

Arranging healthcare services

Will use legislation to remove much of the transactional bureaucracy that has made sensible decision-making and collaboration in the system harder. We will reform the approach to arranging healthcare services and create a bespoke regime that will give commissioners more discretion over when to use procurement processes to arrange services than at present, with proportionate checks and balances. Where competitive processes can add value they should continue, but that will be a decision that the NHS will be able to make for itself.

Legislative proposals will remove the current procurement rules which apply for NHS and public health commissioners when arranging healthcare services. They will do this by creating the powers to remove the commissioning of these services from the scope of the Public Contracts Regulations 2015, as well as repealing Section 75 of the Health and Social Care Act 2012 and the Procurement, Patient Choice and Competition Regulations 2013.

- Develop a new provider selection regime which will provide a framework for NHS bodies and local authorities to follow when deciding who should provide healthcare services.
- The provider selection regime will be informed by NHS England's public consultation , and aims to enable collaboration and collective decision-making, recognising that competition is not the only way of driving service improvement, reduce bureaucracy on commissioners and providers alike, and eliminate the need for competitive tendering where it adds limited or no value.
- Commissioners will be under duties to act in the best interests of patients, taxpayers, and the local population when making decisions about arranging healthcare services.

- *We anticipate that there will continue to be an important role for voluntary and independent sector providers, but we want to ensure that, where there is no value in running a competitive procurement process, services can be arranged with the most appropriate provider.*
- *The NHS will continue to be free at the point of care and our proposals seek to ensure that where a service can only be provided by an NHS provider e.g. A&E provision, that this process is as streamlined as possible.*

National Tariff

Will amend the legislation to enable the National Tariff to support the right financial framework for integration whilst maintaining the financial rigour and benchmarking that tariff offers. This includes:

- Where NHS England specifies a service in the National Tariff, then the national price set for that service may be either a fixed amount or a price described as a formula.
- NHS England could amend one or more provisions of the National Tariff during the period which it has effect, with appropriate safeguards.
- Remove the requirement for providers to apply to NHS Improvement for local modifications to tariff prices.
- NHS England should be able to include provisions in the National Tariff on pricing of NHS public health services where exercising public health functions delegated by the Secretary of State.

New Trusts

Proposals include a provision to allow the creation of new trusts for the purposes of providing integrated care. therefore bringing forward measures that will enable ICSs to apply to the Secretary of State to create a new trust. Any new trust will be subject to appropriate engagement and consultation.

Removing Local Education Training Boards (LETBs)

Proposing to amend the Care Act 2014 (which sets out the functions and constitution of HEE and LETBs) to remove LETBs from statute. We believe removing LETBs from statute with their functions continuing to be undertaken by HEE (and reporting to the HEE Board) will provide HEE with the flexibility to adapt its regional operating model over time

3. Enhancing public confidence and accountability

Proposals

1. Merging NHS England, Monitor and the NHS Trust Development Authority and Secretary of State powers of direction
2. The NHS Mandate
3. Reconfigurations intervention power
4. Arm's Length Bodies (ALB) Transfer of Functions
5. Removing Special Health Authorities Time Limits
6. Workforce Accountability

Merging NHS England etc

The public largely see the NHS as a single organisation and as local health systems work more closely together, the same needs to happen at a national level.

- Legislative proposals focus on ensuring that our accountability arrangements command public confidence, whilst also enabling systems to get on with doing their jobs and making appropriate changes to enable transformation and innovation.

- Intend to continue the work already undertaken to formally bring together NHS England and NHS Improvement into a single legal organisation.

NHS Mandate

- When NHS England, Monitor and the NHS Trust Development Authority are legally merged, the current statutory mandate to NHS England will cover the whole of the combined organisation.
- Proposing to replace the current legislative requirement to have a new mandate each year with a new requirement to always have a mandate in place.

Reconfigurations intervention power

The Secretary of State is currently only able to intervene in such cases upon receiving a local authority referral and may commission the Independent Reconfiguration Panel to provide recommendations. After receiving these, the Secretary of State will communicate his final decision.

- Proposing to broaden the scope for potential ministerial intervention in reconfigurations, creating a clear line of accountability, by allowing the Secretary of State to intervene at any point of the reconfiguration process.
- The Secretary of State will be required to seek appropriate advice in advance of their decision, including in relation to value for money, and subsequently publish it in a transparent manner.

- Will introduce a new process for reconfiguration that will enable the Secretary of State to intervene earlier and enable speedier local decision-making.
- Will issue statutory guidance on how this process will work as well as removing the current local authority referral process to avoid creating any conflicts of interest.
- Will publish further details of proposed arrangements in due course.
- Expect the Independent Reconfiguration Panel to be replaced by new arrangements.

ALBs

- Proposing to create a power in primary legislation for the Secretary of State for Health and Social Care to transfer functions to and from specified ALBs.
- This mechanism will allow us to review where functions are best delivered in order to support a more flexible, adaptive and responsive system.
- In cases where an ALB becomes redundant as a result of transfer of its functions, this power will also include the ability to abolish that ALB.
- The power to transfer functions and the power to abolish an ALB will be only be exercisable via a Statutory Instrument (SI), following formal consultation.

SpHAs

- Proposal will remove the three-year time limit on all SpHAs. Not only is this time limit unnecessary as the functions of the SpHAs are enduring, it is also inconsistent as the time limits only currently impact one SpHA, the Counter Fraud Authority (CFA); and any future SpHAs that come into being would also be subject to the time limit legislation.
- By removing this time limit, we are ensuring all SpHAs are treated equally in legislation and removing the bureaucratic, time consuming and duplicative process.

Workforce Accountability

The Department is proposing to create a duty for the Secretary of State for Health and Social Care to publish a document, once every five years, which sets out roles and responsibilities for workforce planning and supply in England. This document would:

- cover the NHS including primary, secondary, community care and where sections of the workforce are shared between health and social care e.g. registered nurses, and health and public health e.g. doctors and other regulated healthcare professions.
- describe the workforce planning and supply system including the roles of DHSC and its Arm's Length Bodies, NHS bodies and others and how they work together.
- not give any bodies additional functions to those they already have in statute
- be co-produced with (at a minimum) Health Education England and NHS England.

4. Additional proposals

1. Social Care
    a. Assurance
    b. Data
    c. Direct payments to providers
    d. Discharge to assess
    e. A standalone power for the Better Care Fund
2. Public Health
    a. Public Health power of direction
    b. Obesity
    c. Fluoridation
3. Safety and Quality
    a. Health Services Safety Investigations Body (HSSIB)
    b. Professional Regulation
    c. Medical Examiners
    d. MHRA new national medicines registries
    e. Hospital Food Standards
    f. Reciprocal healthcare agreements with Rest of World countries

<u>Social Care</u>

On social care: the government intend to bring forward proposals to reflect the themes of supporting integration, reducing bureaucracy and improved accountability in a manner that addresses the specific needs of the social care sector.

DHSC will bring forward measures

- on system assurance and data, to ensure that there are appropriate levels of oversight on the provision and commissioning of social care;

- Legislating to amend the Health and Social Care Act 2008 to expand the powers of the Secretary of State for Health and Social Care, which currently allows the Secretary of State to make payments to not-for-profit bodies engaged in the provision of health or social care services in England. The Bill will widen this to allow direct payments to be made to any bodies which are engaged in the provision of social care services in England.

- and proposals that provide greater flexibility as to at what point assessments for care can be made.

- ICS legislation will complement and reinvigorate place-based structures for integration between the NHS and Social Care, such as Health and Well-Being Boards, the Better Care Fund and pooled budget arrangements.

- The ICS Health and Care Partnership will be a springboard for bringing together health, local authorities and partners, to address the health, social care, and public health needs at a system level, and to support closer integration and collaborative working between health and social care.

- DHSC will support this by published guidance that will offer support for how ICS Health and Care Partnerships can be used to align operating practices and culture with the legislative framework to ensure ICSs deliver for the ASC sector.

- The government will also create a more clearly defined role for Social Care within the structure of an Integrated Care System NHS Board. This will give ASC a greater voice in NHS planning and allocation.

- Aim to work with local authorities and the sector to enhance existing assurance frameworks that will support our drive to improve the outcomes and experience of people and their families in accessing high quality care and support, regardless of where they live.

- To support these goals, the government propose to introduce through the Health and Care Bill, a new duty for the Care Quality Commission to assess local authorities' delivery of their adult social care duties.

- Linked to this new duty they also propose to introduce a power for the Secretary of State to intervene where, following assessment under the new CQC duty, it is considered that a local authority is failing to meet their duties.

- Any intervention by the Secretary of State would be proportionate to the issues identified and taken as a final step in exceptional circumstances when help and support options have been exhausted.

They will also create a standalone power for the Better Care Fund, separating it from the NHS mandate setting process.

<u>Public Health</u>

The government will bring forward measures to:

- make it easier for the Secretary of State to direct NHS England to take on specific public health functions;

- Proposal is to create a power for the Secretary of State for Health and Social Care to require NHS England to discharge public health functions delegated by the Secretary of State alongside the existing section 7A provisions

- help tackle obesity by introducing further restrictions on the advertising of high fat, salt and sugar foods;

- as well as a new power for ministers to alter certain food labelling requirements.

This will ensure consumers can be supported to make more informed, healthier choices about their food and drink purchases.
In addition, the government will be streamlining the process for the fluoridation of water in England by moving the responsibilities for doing so, including consultation responsibilities, from local authorities to central government.

Safety & Quality

They will:

- bring forward measures to put the Healthcare Safety Investigation Branch (HSIB) on a statutory footing; to enable us to improve the current regulatory landscape for healthcare professionals as needed;
- to establish a statutory medical examiner system within the NHS for the purpose of scrutinising all deaths which do not involve a coroner and increase transparency for the bereaved,
- allow the Medicines and Healthcare products Regulatory Agency (MHRA) to develop and maintain publicly funded and operated medicine registries so that we can provide patients and their prescribers, as well as regulators and the NHS, with the evidence they need to make evidence-based decisions.

They will also be bringing forward measures to enable the Secretary of State to set requirements in relation to hospital food. And finally, they will take powers to implement comprehensive reciprocal healthcare agreements with countries outside the EEA and Switzerland ('Rest of World countries') – expanding our ability to support the health of our citizens when they travel abroad, subject to bilateral agreements.

Produced by **Jonathan Haseldine**
Senior Parliamentary Researcher at House of Commons
February 2021