Action Plan Health Inequalities

FYFV Priority Programmes	Summary of Commitments for 2018/19 and beyond
Cancer [Prioritising people from BME population, deprived communities and data]	• The Programme has **embedded the requirement to consider health inequalities** in its business planning arrangements • **Segmentation of populations** in order to understand why specific groups experience a particular health inequality will give a better understanding of the impact of interventions • The **National Screening Inequalities Strategy** will support commissioners and other partners to reduce inequalities in screening programmes. This is a 3 year strategy that will focus on improving access to screening for those with protected characteristics and those living in more deprived communities • We will be addressing inequalities with an initial focus on introducing **low dose computed tomography (CT) scanning where lung cancer survival rates are at their lowest.** The roll out of the low dose CT health checks will start to impact this year - particularly in places where they are already underway such as Manchester and London (Royal Marsden). The impact for other areas will be seen over a 1-2 year timescale • In the **rapid diagnosis pathways** for lung, prostate, and colorectal we are mandating implementation of our best practice, timed pathways across three tumour types. This will help to tackle variation by driving up standards in diagnosis no matter where a patient is treated. These are three of the most common cancers and are more likely to occur in the most deprived (lung) and black and minority ethnic (BME) communities (prostate), with colorectal cancer often diagnosed later in black patients. The Cancer programme has **mandated full implementation by the end of this year** for prostate, colorectal and lung cancer. Implementation of these three timed pathways will address the majority of 62 day breaches for consistent achievement of the 85% standard and secure performance for the new 28 day faster diagnosis standard. The pathways will be monitored on a quarterly basis. We are establishing how we will measure impact on health inequalities specifically, but these cancers occur more frequently in more deprived areas so these pathways will play an important role in reducing health inequalities • **Cancer Alliances will be considering local health inequalities in terms of improving delivery of patient education through Health and Well Being Events.** The programme will continue to support Cancer Alliances with a major focus of their work in 18/19 of understanding and reducing variation • Taking on board discussions from the **Empowering People and Communities Taskforce** Roundtable in December 2017 **we will expand the work on engaging with communities affected by cancer** • **Phase 2 of the cancer dashboard will be developed and this will be an enabler to tackling inequalities** by establishing the ability to identify performance by CCG across a range of indicators, including survival

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Mental Health [Prioritising people from BME population, older people, young children]	• **Three of the 2018/19 Programme Key Performance Indicators (KPIs) for the Mental Health programme** have been designed to tackle health inequalities directly, such as improving access to care and outcomes for people with Severe Mental Illness (SMI), and supporting people with SMI to gain and retain meaningful employment • **To improve equality data** by using survey data to undertake an internal analysis of equalities and health inequalities as the programme develops to inform its future roll-out to 2021 and ensure that all KPIs can be broken down by the relevant demographic information and that this becomes standard practice as data quality improves • **Improve Access to Psychological Therapies (IAPT) for older people and BME group** by monitoring the Older Adults and BME Quality Premium over the next year to determine whether incentivising the health system will result in positive change for older people and BME IAPT service users • **For Suicide Prevention** allocate £5 million of transformation funding with majority to go to priority Sustainability & Transformation Partnership (STP) footprints that have either significantly higher suicide rates in middle-aged men (aged 45–49) or a high age-standardised rate. • **To reduce the premature mortality gap for people with Severe Mental Illness (SMI) to** ensure that by 2020/21 280,000 such people have their physical health needs met. This will be achieved by improving access to and the quality of, physical health checks and follow up interventions for people with SMI. In practice this equates to ensuring that approximately 60% of people on the General Practice (GP) SMI register receive a comprehensive physical health assessment and follow-up care, and support Public Health England's (PHE) delivery of the '**preventing ill health by risky behaviours – alcohol and tobacco CQUIN'** and DHSC **tobacco strategy** to support Mental Health Trusts to become smoke free • In **Secure Care,** building on the work capturing narratives of black men in secure care, identifying events in their journey into secure services and what would be helpful in supporting their recovery, NHS England will develop three strands of work: o A peer mentorship programme targeted specifically at black men o A BME specific advocacy project o A personal development and skills training programme, designed specifically to meet the needs of black men • **Other initiatives** include the launch targeted allocation programme to double the amount of access to **Individual Placement Support (IPS) by 2021,** and building on the **Trailblazer sites** working with Young Minds children and young people participation programme, in 2018/19 focus on ideas and project to improve the Health and Justice Services and continue to report on the proportion of people detained under the Mental Health Act who are BME via the **NHS Five Year Forward View Mental Health Dashboard** • Collaborate with **the Equality and Human Rights Commission** on a project on how behavioural insights could be used to increase IAPT usage • Scope the development of a **patients and carers race equality standard (PCRES)**

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Primary Care [Prioritising workforce, ethnic minorities, learning disabilities, children and risk stratification]	• **Improve access to general practice services** by continuing to monitor assurance against the **Equality and Health Inequalities Analysis (EHIA)** for the improving access to general practice through the GP Forward View (GPFV) Monitoring Survey • **For the workforce** o Target international recruitment for under-doctored areas in areas of deprivation o Increase numbers of GP trainees in hard to recruit areas, which include high areas of deprivation, through the Targeted Enhanced Recruitment Scheme (TERS) o To help retain GPs in the workforce launch the Retention Fund which will include a requirement that all initiatives established are subject to equality/health inequalities screening o Support STPs/Integrated Care Systems (ICS) in developing the workforce plans for primary care workforce trajectories and monitor progress at a regional level • **In Primary Care Commissioning** o Produce guidance for commissioners on Interpreting and Translation services. This guidance will support commissioners and providers of services to improve access to and quality of interpreting and translation services o For asylum seekers Support CCGs to develop health services to rapidly asses health needs for these patients prior to dispersal and settlement across the UK o In optometry examine the case for improving access to sight tests for people with learning disabilities, and if proven, identify opportunities to design and implement new services/Pathways, or extend existing facilities o In dental review the pilot sites working on the *Starting Well: A Smile4Life Initiative*. This programme of dental practice-based initiatives aims to reduce oral health inequalities and improve oral health in children under the age of five years o Primary Care Networks will assess population needs and design services based on segmentation and risk stratification, which will include identifying and addressing health inequalities
Learning Disabilities (relating to mortality) [Prioritising annual health checks, GP registers, mortality, people from BME communities, data]	• **Annual Health Checks** help to reduce recognised health inequalities as well as having patients' reasonably adjusted care needs communicated more effectively to other NHS partners. **NHS England's ambition is for 75% of people on GP Learning Disability Registers to have an Annual Health Check** (AHC) by March 2020. This is one step towards meeting our ambition of reaching **100% of people on GP LD Registers to have an Annual Health Check** • To meet the commitment to increasing the number of people on **GP Learning Disability (LD) Registers by 10%** year on year, we will continue to work in partnership with Voluntary Organisations Disability (VODG) & National Development Team for Inclusion (NDTI) to support and promote the work of Annual Health Checks and GP registers, to make accessible videos and media for people with a learning disability by people with a learning disability • Continue to work with a range of family carer organisations including *Contact*, *Include me too* (a BME group), *Mencap* and *Bringing us together* and others on listening to, acting on and informing families • The **Learning Disabilities Premature Mortality Review Programme** needs to accelerate in 2018/19 as it is rolled-out so as to systematically review and learn from deaths of patients with learning disabilities • The **National Quality Boards' 'Learning from Deaths'** set out that from April 2017 Trusts must publish information on all deaths using the SCJR or equivalent process which would align with Learning Disability Mortality Review Programme (LeDeR). They will be underpinned by the NHS standard contract from April 2018 and are a clearly described deliverable in the 18/19 planning guidance

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	• Working with **the Right Care Programme** produce better pathways of care tailored to the needs of people with learning disability. For example the **reasonable adjustments pathway for diabetes care and the pathway for dysphagia,** pathways on epilepsy, sepsis and respiratory conditions are due to be published over the course of the next financial year • NHS England's Learning Disability programme utilises intelligence drawn for the **Mortality Reviews and in partnership with Public Health England's Learning Disability Health Observatory** to identify health inequalities and variation in health needs of the population of people with a learning disability. This includes use of anonymised information from GP practices across the country via the GP Extraction Service (GPES). This data draws from GP held patient information and compares salient health conditions experienced by people with a learning disability with those in the general population • We have also commenced a **"learning into action" group** which seeks to better communicate, signpost and develop best practice interventions across health and social care. **This work will be focussed on high impact pieces of work to address the main identified causes of mortality identified via premature mortality programmes,** ie Specific work on learning disabilities and sepsis, pneumonia, constipation, epilepsy and application of reasonable adjustments
Diabetes [Prioritising diabetes prevention for BME communities]	• Between 2018/19 and 2019/20 we expect around 300,000 people to take up the **NHS Diabetes Prevention Programme.** Providers of the this programme will to work with local health services to tailor delivery towards the needs of high risk groups, including people from BME groups in local communities and to actively market the programme to BME communities. By targeting the programme we expect to deliver the programme to around 64,000 people from BME backgrounds in year, an estimated 26% higher than the figure that would be achieved if the numbers attending were representative of the population
Maternity [Prioritising stillbirths and neonatal death in deprived communities]	• The Maternity Transformation Programme aims to make maternity care safer and more personalised. The programme includes a number of activities designed to help **reduce the stillbirth and neonatal death rate by 20% by 2021,** including implementing the **Saving babies' Lives care bundle, rolling out continuity of carer, improved learning when avoidable stillbirths and neonatal deaths occur**, and **NHS Improvement's Maternity and Neonatal Health Safety Improvement Collaborative** • Local Maternity Systems (which bring commissioners, providers and service users together across Sustainability and Transformation Partnership footprints) have also developed local plans to reduce stillbirths and neonatal deaths including ways to address inequalities. **Element 1 of the care bundle** includes measures to reduce rates of maternal smoking, which is known to correlate with deprivation. • We are actively working with Local Maternity Systems to focus initial roll-out of continuity of care on women at highest risk. **The requirement outlined in *Refreshing NHS Plans is for 2018/19* for 20% of women will be placed on continuity pathways at booking from March 2019** • **By reducing stillbirths and neonatal deaths by a uniform 20% across all deprivation quintiles, this will lead to a reduction in the inequality gap** (for example, the stillbirth rate in the most deprived areas would be 4.6 and in the least deprived 2.7). • The Maternity Transformation Programme will continue to **monitor the stillbirth and neonatal death rate** by level of deprivation, in order to understand the impact of the programme on reducing inequalities • An upcoming evaluation of **the Saving Babies Lives care bundle will demonstrate associations with social deprivation**

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Personalisation
[Prioritising data, disadvantaged groups, segmentation]
	• **NHS England's Personalised Care Programme**, as part of its comprehensive personalised care model, supports the implementation of a range of evidence based approaches which will reduce inequality, in particular integrated personal commissioning (IPC), personal health budgets (PHBs), health literacy, patient activation and social prescribing
	• In the **integrated Personal Commissioning and Personal Health Budgets** programme we will:
	    ◦ **Improve metrics and data collection by** building on formal data collection on PHBs and the data collected as part of the Personalised Care Demonstrator sites. In 2018/19 we will continue to work with demonstrator sites to develop and test other measures that could be included in formal data collection including: Shared decision making in general practice; Social prescribing; Personalised care and support plans; Personal Wheelchair Budgets; Personal Maternity Budgets
	    ◦ **Continue to meet the 40,000 PHB target set out for 2018/19 -** Both personal health budgets and IPC are an increasing priority for the NHS and the Next Steps on the Five Year Forward View includes the ambition that at least 300,000 people benefit from IPC and 40,000 people will have a personal health budget in 2018-19, including in the best STP geographies
	    ◦ The NHS Mandate sets an expectation that 50,000-100,000 people should benefit from a personal health budget by March 2021. NHS Digital does not currently collect demographic data. **In 2018/19 we will be reviewing the PHB data collection with them.**
	• **In Health Literacy** we will continue to work on a national Collaborative on health literacy. Members include leading health ALBs as well as the Department for Education; and a joint Health Education England, PHE and NHS England health literacy toolkit has been published, which will be rolled out in 2018/19
	• **In Patient Activation** evidence confirms the recognition that people in disadvantaged groups are likely to have lower levels of activation and poorer health. The evidence also demonstrates that people at the lowest levels of confidence benefit the most from personalised care, which can reduce health inequalities. NHS England signed a five year licence agreement to use the **Patient Activation Measure (PAM®),** a licenced tool that measures a person's knowledge, skills and confidence in managing their own health and wellbeing. To date, **750,000 PAM licences have been used in over 100 sites across England**. NHS England receives a report from the company that holds the licences on the number of licences used by each CCG, but not demographic data. **The PAM® tool will be used to segment a local population** so that people with lower levels of activation can be identified and offered approaches such as self-management education, health coaching and social prescribing to increase their knowledge skills and confidence to manage their health
	• **In Social Prescribing** NHS England is currently baselining CCGs' existing investment in social prescribing connector schemes with the aim of supporting CCG areas without connector schemes. NHS England is encouraging every CCG and local authority to co-commission a social prescribing connector scheme (in the VCSE sector) for their area. In 2018/19 NHS England will be working **with NHS Digital and a wide range of stakeholders to co-produce a Common Outcomes Framework** to measure the impact of social prescribing. **National guidance will be published in 2018**. This Framework will help local areas consistently measure the impact of social prescribing on the person, on the health and care system and on community groups receiving referrals. NHS England will also be working with the Personalised Care Demonstrator sites to develop and test a formal data collection for social prescribing

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Older People [Prioritising data, older people]	• **The 2017/18 GMS General Practice contract** introduced routine frailty identification in primary care and made the NHS in England the first national health system to introduce routine frailty identification. The contract targets interventions at people living with severe frailty (around 3% of over 65s) and encourages switching on additional information in the summary care record for those living with moderate and severe frailty (around 15% of over 65s). At the end of quarter 3 (latest available data), over 2.3m people had had a frailty assessment, resulting in 865k people identified living with moderate and severe frailty and over 150k medications reviews, 71k falls assessments and 91k patients consented to sharing additional information in the summary care record • To support this, **NHS England will review full year data from the GMS contract and is currently working with the Kent Integrated Dataset** to better understand the impact of deprivation and other factors on frailty. This will inform future work by NHS England and their partner on frailty, which currently includes: a **frailty core capabilities framework (June 2018), development and testing of a frailty currency (summer 2018), a frailty Right Care Frailty pathway and data pack (summer 2018)** • Our approach to **supporting all older people to age well** is population and needs based. It requires no other characteristics than deficits in health and a notional 65 and above age cut off (so required by the design of Electronic Frailty Index (eFI) to identify people at risk. As a result it **is well centred on reducing inequalities** and expected to align well to other approaches which focus on proactively addressing the wider determinants of poor health outcomes
Children and Young People (including Infant Mortality) [Prioritising data capture and analysis, use of audits and clinical areas such as asthma and cancer]	• In order to have an impact on child mortality, a deeper understanding of trends, modifiable factors, and potential changes/learning for clinicians is needed. There is a need for more granular data on mortality rates and associated factors. NHS England has, therefore, commissioned **a National Child Mortality Database** with potential to be the most comprehensive Database in Europe, gathering not only socioeconomic and health factors but also “active” learning through the capture of modifiable factors. This commissioned database will form the bedrock of future work and will aim to steer targeted work in, for example specific patient populations • Development commenced in 2018. The Database is being developed by the University of Bristol and will be fully operational in 2020. • The new **Child Death Review Guidance** will provide a more rigorous process that better enables learning on a national scale. A new proposed infrastructure requires independent review panels to take place following local individual based reviews by staff involved. This is due to be published in Summer 2018 with implementation strategies taking place over following months. • NHS England’s **Child Digital Health Strategy** emphasises the importance of early intervention and integration across care settings. To enable this, an online health record for parents, carers, and young people themselves, with an electronic **Personal Child Health Record** (ePCHR) will be available in England from April 2018 • The Royal College of Paediatrics and Child Health (RCPCH) supported by NHS England, NHS Improvement and other experts are looking to reduce variability in the recognition and response to deterioration in children and young people across the whole NHS. This will include reviewing early warning systems for children and follows targeted work on **spotting sepsis in CYP**. A group of representatives first met in March 2018 and **aims to achieve a number of quality improvement initiatives across the paediatric care pathways** or wherever very sick children present in the NHS – such as acute services, primary care, 111 services etc. Work in this area is needed to ensure the NHS works better for children: services are joined up; using a common terminology; with appropriate and increased access to child health knowledge • **The National Clinical Audits** are looking at epilepsy (Epilepsy 12) and diabetes (National Paediatric Diabetes Audit). The National Paediatrics Diabetes Audit (NPDA) has shown significant improvements in diabetes care for children, with 27% of children now achieving excellent control in 2015/16 up from 17% in 2013/14, and poor care down from 24% to 18% over the same period) • **Other programmes** of work include the following reviews: o Neonatal Critical Care

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	o Paediatric Intensive Care and Paediatric Surgery Review o Congenital Paediatric Cardiac Surgery Review • In terms of NHS children's services, there are a number of further opportunities to explore in the near future. Long-term conditions such as asthma, epilepsy, diabetes, and transition to adult services present particular challenges. **This is an area of work we will explore in more depth in the coming year** • **The Children, Teenage and Young Adult Cancer Work Programme seeks to improve survival,** improve patient and family experience, and ensure equity of access to care. NCEPOD Study underway to investigate mortality post cancer treatment and identify modifiable factors and the **Children and Young People's Mental Health Programme** includes a commitment that by 2020/21 **70,000 more CYP a year** will access community MH services, implementing an eating disorder access and waiting time standard and reforming inpatient care including reducing distances travelled for treatment
End of Life Care [Prioritising prisons, people with a learning disability, older people with dementia and protected characteristics]	• One of the key priorities in the **End of Life Care Programme is to increase the number of people who are identified as likely to be in their last year of life**. We expect to see an increase in overall numbers but the breakdown in proportion of the increase being cancer or non-cancer cannot be monitored at national level using routine data at present • **In the Prison setting,** we will work in partnership with the Health and Justice Clinical Reference Group and Her Majesty's Prison and Probation Service, a Dying Well in Custody Charter has been published, along with a Self-Assessment Tool for prisons: o In 2018/19 the Charter and Self-Assessment Tool is being piloted in 2 prisons o In addition, the National Partnership Agreement for Healthcare in Prisons for 2018-2021 includes palliative and end of life care as part of its 10 key priorities o During 2018-19, this information will be actively disseminated to the hospice and palliative care community through the Ambitions Partnership so that specialist teams in palliative care in the community can reach out to support health care staff in their local prisons • **For people with a Learning disability we will host a conference in June to publicise the resource published in 2017-18** hosted by the Palliative Care for People with Learning Disability Network. We are exploring the need for an 'easy read' version of the government's end of life care commitments for people with living disability • **In Dementia** we will actively promote a resource to promote advance care planning for people with dementia which was produced during 2017-18 • **For people who are homeless, gypsies and travellers, and people who identify as lesbian, gay, bisexual or trans (LGBT)** a resource was commissioned through the VSCE programme during 2017-18. This resource will be promoted through the Ambitions for palliative and End of Life Care Partnership and wider stakeholders made up of stakeholders from across healthcare and third sector including NHS England
Genomics	• A key aim of the **Genomic Medicine Service** is to provide consistent and equitable care for England's population of 55million. As part of the new contractual model with the Genomic Laboratory Hubs, and the development of the underpinning National Genomic Informatics Service, NHS England will for the first time be able to collate information about activity and performance of genomic testing that is being undertaken across England. This data will enable equity of access to testing to be identified and monitored. Once the new infrastructure and contracts are put in place, regular reporting on equity of access will be possible. The type of data we will be able to present once the service becomes operational (which is scheduled for October 2018):

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	o Number and types of tests being performed – in the future we will be able to break this data down to patient level (currently its by number of tests, rather than number of patients) o It will be possible to break down by clinical indication (e.g. disease area the test relates to), ethnicity, gender and referring organisation. This data will enable us to monitor equity of access
Prison Health [Prioritising CYP BME groups, adults physical and mental health and older people health checks]	• **For Children and Young People** we will work with the HMPPS Youth Custody Service to explore how data can be utilised in order to ensure the equitable treatment of BAME children and young people in secure settings and prioritise the collection of data on ethnicity and other protected characteristics for the development of the Children and Young People Indicators of Performance • **For Adults** we will**:** o Conduct a review of health and justice commissioning to help determine the extent of any extra resources that may be needed to improve services to this patient population who are less physically and mentally healthy, and more likely to engage in high-risk personal behaviour than the general population which will report to the Specialised Services Commissioning Committee o Roll out and implementation of the HJIS so we will have the ability to review both physical and mental health clinical data and compare prevalence in presentation rates for this patient population o Call patients into NHS England's prison health check programme calls patients when they are between 35 and 74 years of age • For **Older People Health & Justice Indicators of Performance (**HJIP) data will collect data on dementia diagnosis • **For Learning Disabilities** we will continue improvements in data collection on Learning disability presentation, and screening uptake. • Outcomes measures will be developed for **Transgender and Gypsy, Romany and Traveller Groups** in 2019/20 for the prison estate and the immigration removal centre (IRC) estate. We are also currently developing a patient questionnaire for health engagement across the IRC estate which will request these additional identifiers alongside satisfaction measures against health engagement • **The 2018/2021 Prison Healthcare national partnership agreement**'s first **objective is to improve health and well-being of people in prison and reduce health inequalities**. We have described 10 priorities to deliver these objectives through an annually refreshed workplan that outlines activities and projects and their associated deliverables, measures and timelines • **The Partnership Agreement** between the Home Office, PHE and NHS England focuses on the immigration removal detention centre populations. This agreement identifies five priorities to achieve this objective and support improved outcomes. The IRC indicators of performance have been developed to secure appropriate measures for this patient population in relation to their access to mental health services and screening for learning disabilities. The patient questionnaire dedicated to this patient group identifies race and ethnicity
ENABLERS	
CCG Allocations/CCG engagement	• NHS revenue funding is shared across the 195 Clinical Commissioning Groups (CCGs) using a target distribution that includes a health inequalities adjustment that helps to support CCGs tackling inequalities to meet the diverse needs of their local populations. We have identified CCGs whose target share is changed the most by this adjustment, either increased or decreased. We will work closely with **NHS Clinical Commissioners and colleagues** across teams in NHS England including CCG Improvement Assessment Framework (IAF) and regional colleagues to better develop an understanding of the CCGs' approach to inequalities
Regional activity	• In addition to STP work, **London Region have been working with the office of the Mayor of London** on his plan to reduce health inequalities, which will provide additional opportunities to address the social determinants of health

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CCG IAF	• In 2017, the NHS England Patient Participation team undertook an assessment of all (then) 207 CCGs structured through an improvement framework that looked at how they engage and involve patients in the work of the CCG. **10 common areas for improvement** were identified. Evidence of the assessment outlined the need for CCGs to provide much better information about how they have addressed equalities and health inequalities in their work with people and communities, along with demographic monitoring of who is contributing and participating in engagement activities. In 2018/19 **we will be supporting CCGs through a regional liaison model to better deliver and demonstrate their engagement work with their populations and to advance their work with their Sustainable Transformational Partnerships (STP) /Integrated Care System (ICS**) • A programme of work is under way to **develop, roll out and support the use of tools, resources and approaches to aid and support NHS commissioning, NHS provider and STP/ICS decisions**, which will promote equality and work to reduce health inequalities. We are testing and plan to launch the **Equality and Health Inequalities Right Care Packs** to further support CCGs to better identify their population and the inequalities that are within it, we will be encouraging CCGs to utilise the data to better engage people in their commissioning and transformation conversations and decisions. This work will complement the work on CCG IAF Indicator 6 on Inequality in unplanned hospitalisation for chronic ambulatory care sensitive and urgent care sensitive conditions
OTHER	
Digital Services **[Prioritising traveller community, disadvantaged groups, homeless, mental health, older people and people living in rural areas]**	• The **Widening Digital Participation (WDP)** programme was set up to provide patients with the skills and confidence to access and benefit from digital health technologies – particularly the most excluded and hardest to reach. Improved digital inclusion reduces inequalities by opening up access to information and services to all. **We will deliver the following projects to better understand patient needs and how to reduce the barriers to inclusion** o **6 digital inclusion pathfinder projects** to develop and test new approaches to tackling the barriers to digital inclusion with a focus on the most excluded. They include projects to: ▪ Provide access and digital skills support to people in social housing in Kent ▪ Improve maternity outcomes for the travelling community in Dorset using digital maternity tools ▪ Reduce inappropriate use of A&E services in Blackpool using digital interventions ▪ Improve digital skills training for nurses (based on recent RCN consultation). o **6 evidenced-based digital inclusion models** from previous pathfinder projects during 2017/18. They include models to improve digital health inclusion for: ▪ Young people with mental health problems ▪ Homeless people ▪ People with hearing and/or visual impairment ▪ Young carers and the people they care for ▪ Older people using social prescribing and digital skills training ▪ Those in rural settings via local digital hubs and digital champions programmes o Publish a **digital inclusion guide** for health and care to provide guidance and support to commissioners, designers and delivery

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	teams. Launched on May 2nd, the guide and accompanying toolkit gives practical steps on the ways they can apply and adopt good digital inclusion practices in their area. It includes information on: ▪ why digital inclusion is so important & how to build a business case ▪ the benefits to NHS organisations and people ▪ a how to guide on building digital inclusion into service and product delivery locally ▪ Principles and standards on digital health design ▪ examples of best practise in action and a directory of available resources • We will develop a set **of digital health training tools** introducing patients to digital health services and products and showing them how they can improve their health outcomes and experiences of health care and services • We will engage with and **support 100,000 people to access and use digital health products** and services through awareness and skills training programmes with national delivery partner Good Things Foundation and their network of UK Online centres

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