Public Health England

Protecting and improving the nation's health

Health Equity Assessment Tool (HEAT):

Full version

About Public Health England

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About HEAT

What is HEAT?

HEAT is a tool consisting of a series of questions and prompts, which are designed to help you systematically assess health inequalities related to your work programme and identify what you can do to help reduce inequalities. It will also help you to consider the requirements of the Equality Act 2010.

When and why should I use it?

HEAT has similarities to other health equity assessment tools, but is unique in providing a lightweight yet still systematic framework for assessing and driving action on health inequalities.

It provides an easy-to-follow template which can be applied flexibly to suit your work programme. Its specific prompts ensure consideration of multiple dimensions of health inequalities.

How is it structured?

The tool has 4 stages:

1. Prepare
2. Assess
3. Refine and Apply
4. Review.

It is designed to be completed at the start of a work plan to help you consider its potential effects, but it can be used retrospectively. In practice, your assessment is likely to be iterative and will help you continuously improve the contribution of your work to reducing health inequalities.

Because tackling health inequalities at scale is likely to require 'buy-in' from senior leaders in your organisation or the system you work in, we recommend that the use of the HEAT process is sponsored by a senior leader.

What should be considered when completing it?

There are a number of different dimensions or characteristics to consider when completing HEAT.

1. The protected characteristics outlined in the Equality Act 2010 are as follows:
    - age
    - sex
    - race
    - religion or belief
    - disability
    - sexual orientation
    - gender reassignment
    - pregnancy and maternity
    - marriage and civil partnership

2. Socio-economic differences by individual socio-economic position. For example, National Statistics Socio-economic Classification, employment status, income, area deprivation.
3. Area variations by deprivation level (Index of Multiple Deprivation), service provision, urban/rural or in general.
4. Vulnerable and Inclusion Health groups, for example people experiencing homelessness, people in prison, or young people leaving care.

What should be considered when completing it?

Health inequalities are unjust differences in health and wellbeing between different groups of people (communities) which are systematic and avoidable. Health inequalities in England exist across a range of dimensions or characteristics, including the nine protected characteristics of the Equality Act 2010, socio-economic status, geographic deprivation, or being part of a vulnerable or Inclusion Health group.

Health inequalities may be driven by:

1 Different experiences and distribution of the wider determinants of health or structural factors. For example, the environment, community life, income or housing. In other words, the social economic and environmental conditions in which people live, work and play.

2 Different exposure to social, economic and environmental stressors and adversities. These affect states of mind from an early age and throughout life. Stress and psychological wellbeing directly affect resilience, health conditions and health behaviours.

3 Differences in health behaviours or other risk factors between groups, for example smoking, diet, and physical activity levels have different social distributions. Health behaviours may be influenced by wider determinants of health, like income.

4 Unequal access to or experience of health and other services between social groups.

People who share protected characteristics, as defined in the Equality Act 2010, may experience poorer health outcomes as a direct result of discrimination or due to different experiences of the factors described above.

The tool

Programme or project being assessed	Integrated Sexual Health Service, Warwickshire
Date completed	November 2021
Contact person (name, Directorate, email, phone)	Helen Earp, Sexual Health Commissioner
Name of strategic leader	Paula Mawson, Strategy & Commissioning Manager - Health, Wellbeing & Self-care

Steps to take	Your response – remember to consider multiple dimensions of inequalities, including protected characteristics and socio-economic differences
A. Prepare – agree the scope of work and assemble the information you need	
1. Your programme of work What are the main aims of your work? How do you expect your work to reduce health inequalities?	An integrated innovative sexual health service model aims to improve sexual health by providing easy access to services through open access 'one stop shops', where the majority of sexual health and contraceptive needs can be met at one site, usually by one health professional, in services with extended opening hours and locations which are accessible by public transport. The types of service available from a number of locations should reflect the need of the communities and populations that use them. The 'open access' one stop shops are available for all to access STI screening including HIV testing, treatment and care and a full range of contraception options.
2. Data and evidence What are the key sources of data, indicators, and evidence that allow you to identify HI in your topic? • Consider nationally available data such as health profiles and RightCare	National data and resources: PHE document - Variation in outcomes in sexual and reproductive health in England: A toolkit to explore inequalities at a local level (2020), stated that: • a good overall picture can mask inequalities within an area which need to be addressed • that there are two variations for consideration – warranted (differences in care provision that reflect factors such as user preferences, innovations in person–centred care and clinical responsiveness)

• Consider local data such as that available in JSNA, contract performance data, and qualitative data from local research	and unwarranted (are service under– or over– provision, failure to implement evidence based guidelines or poor access for service users because of travelling times, socioeconomic factors, unrecognised as well as unmet need, or poor health literacy leading to a decrease in access or quality of provision for service users.) The documents continues to explore inequalities for STIs and reproductive health: • Sexually transmitted infections (STIs) are more likely to be diagnosed in young people, gay, bisexual and other men who have sex with men (MSM) and black and ethnic minorities. • rates of new STI diagnosis are shown to be consistently higher in more deprived populations (as measured by the Index of Multiple Deprivation [IMD]) • Higher proportions of late diagnoses of HIV are seen in women, older people, black ethnic minorities, heterosexual men and women and those living outside of London. • Teenage pregnancy is both a cause and consequence of health and education inequalities. Teenagers have the highest rate of unplanned pregnancy with disproportionately poor outcomes. • At an individual level, the strongest associated risk factors for pregnancy before 18 are free school meals eligibility, persistent school absence by age 14, poorer than expected academic progress between ages 11 to 14, and being looked after or a care leaver • Abortion rates have increased in the older age groups with the relative rate of increase being greatest in women over 35. • Abortion rates increase as levels of deprivation increase. Sexually Transmitted Infections in England: The State of the Nation (2020) highlighted: • There is no current long-term vision for sexual health, including STIs, in England and a national sexual health strategy is urgently needed • Men who have sex with men, young people and some ethnic minority communities are among those disproportionately impacted by STIs. • Current available research does not provide an adequate understanding of the inequalities in sexual health, with little focus on the impact of structural inequalities on STIs. Surveillance data erases the identities of many communities who may be at risk of STIs resulting in a gap in services that meet their needs. • Access to sexual health services has been compromised by the impact of funding cuts on overstretched services in the face of rising demand. There's a clear need for fully funded, sustainable sexual health services. • There's a lack of sexual health champions speaking out about STIs. The lack of these voices, as well as visibility in the wider media, creates a barrier in the fight against STI stigma • While some progress is being made – with declines in rates of STIs such as genital warts – other STIs are skyrocketing. Syphilis and gonorrhoea have increased by 165% and 249% respectively in the past decade.

	The local picture: • In 2019 the population of Warwickshire was 577,933, this comprises 285,507 males and 292,426 females. • In 2019 the rate of STI testing (excluding chlamydia in under 25 year olds) in sexual health services in Warwickshire was 12,398 per 100,000 aged 15 to 24 years, a 5% increase compared to 2018. This is lower than the rate of 19,654 per 100,000 in England in 2019. The positivity rate in Warwickshire was 1.8% in 2019, lower than 2.4% in England • In 2018, the under 18s conception rate per 1,000 females aged 15-17 years in Warwickshire was 13.9, better than the rate of 16.7 per 1,000 in England and comparable to CIPFA nearest neighbour's average of 14.8. Nuneaton and Bedworth continue to have the highest level of under 18's conceptions, although this has seen a decline in recent years. • LARC provision is likely to reflect local geography and services models e.g., there may be more provision in primary care in more rural and semi-rural areas. In Warwickshire, the rates prescribed in primary care was 40.9 in 2019, higher than the rate of 30.0 in England. The rate prescribed in the other settings was 14.4 in 2019, lower than the rate of 20.8 in England. • The total abortion rate per 1,000 women aged 15-44 years in 2020 was 18.2, this is slightly higher than 2019 (18.0), this is similar to the England rate of 18.3 per 1,000. • The total number of abortions in 2020 in Warwickshire was 1884 of which 74 were to women under 18 years, 129 to 18-19 year olds, 468 to 20-24 year olds, 461 to 25-29 year olds, 412 to 30-34 year olds and 340 to 35+ years. • Local abortion data from the service provider shows that there is an equal number of abortions across the county (North and South) • In 2019/20 a total of 3,348 EHC distributions were made, of these 1,123 were in Nuneaton & Bedworth, North Warwickshire, or Rugby. The remaining 2,315 were dispensed in the south districts of Stratford upon Avon and Warwick (this includes Leamington). The key barriers identified by survey responders were times and days of opening, not knowing about the services, services not available in easily accessible locations, worrying about what the staff would think of them.
B. Assess - examine the evidence and intelligence	

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3. Distribution of health
Which populations face the biggest health inequalities for your topic, according to the data and evidence above?

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Socio-economic status or geographic deprivation:
With the onset of Covid-19 and mandated restrictions, changes were made to service delivery, this included the closure of all ‘spoke’ locations that were predominantly in local communities and for contraception, a telephone triage system was put in place as the ‘drop in’ facility closed; and an enhanced online testing offer was established.

For individuals that needed to be seen face to face following a telephone triage appointment they were, and still are, required to attend a ‘hub’ location in either Nuneaton, Rugby or Stratford.

Despite the focus of population within the main towns of the county, a significant part of Warwickshire is rural in nature.

While Warwickshire is not generally a deprived county, high levels of deprivation do exist in parts of the county - 11.9% (11,425) of children live in low income families, the highest level of this can be seen in Nuneaton and Bedworth Borough.

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Inclusion health and vulnerable groups (for example, people experiencing homelessness, prison leavers, young people leaving care):

Each of the boroughs / districts recorded levels of homelessness above the national average with the exception of Warwick District. North Warwickshire Borough recoded the highest rate per 1,000 population.

Data available through Public Health profiles (Fingertips), shows that:

Overall, in Warwickshire in 2019/2020 there were 3,954 children/young people known to schools who have a learning disability, and 1,435 adults known to services.

In 2019/20 there were 1,589 children who have Autism and are known to schools.

Mental Health: QOF prevalence (all ages) 4,425 individuals (0.73% of the Warwickshire population).

No data is collected from the current service in relation to people attending the services from vulnerable groups, however, links are in place with key stakeholders who support individuals to ensure the service is accessible to them.

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11.5% of the county population are from an ethnic minority background (62,857), with approximately twenty-one languages spoken. Nuneaton and Bedworth and Rugby have the highest populations from an ethnic minority background.

Sexual orientation, UK:2018 found that the proportion of the national population identifying as lesbian, gay or bisexual (LGB) increased from 1.6% in 2014 to 2.2% in 2018 this is comprised of 1.4% identifying as gay or lesbian and 0.9% as bisexual. Locally applied, this translates to a population of approximately 12,714 in Warwickshire.

The population of Warwickshire shows that there are 583,786 in the population, of which 288,334 (49.4%) are males and 295,452 (50.6) are females.
0 – 15 years 106,704 (18.3%)
16-64 years 355,847 (61%)
65+ years 121,235 (20.8%)</td></tr>
<tr><td>4. Causes of inequalities
What does the data and evidence tell you are the potential drivers for these inequalities?

• Which wider determinants are influential? For example, income, education, employment, housing, community life

• Which health behaviours play a role?

• Does service quality, access and take up increase the chance of health inequalities in your work area?

Which of these can you directly control?</td><td>Data available from GUMCAD which relates to STI screening only between 01/04/2020 – 31/3/2021 shows:
• Predominately aged between 20-34 (13,785 of the 21,330 attendees)
• Of the 21,330 attendees 13,755 were women
• Of the 21,330 attendees 2,509 identified as LGBTQ
• 6,859 were born in the United Kingdom, and a further 448 born in other European Countries, 13 from the Caribbean, 184 from sub-Saharan Africa and 249 were from a range of other countries, 13,557 declined to give the information.

In 2019 there was 4.6% of the Warwickshire population (15,300) having no qualifications at all, with 20.8% (28,700) having 5 GCSE grades A* to C or equivalent. Of the school population 16.2% are eligible for free school meals. Persistent absence in secondary school is 12.6%, lower than the region and England rates.

In Warwickshire 4.4% (12,200 (6,700 males and 5,600 females)) of working age adults are unemployed, this is higher in the north of the county than the south.

South Warwickshire – Leamington, has a high number of students due to the University of Warwick.

With the onset of Covid-19 and mandated restrictions, changes were made to service delivery, this included the closure of all ‘spoke’ locations that were predominantly in local communities and for contraception, a</td></tr>
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Which can you influence?
Which are out of your control?
	telephone triage system was put in place as the ‘drop in’ facility closed; and an enhanced online testing offer was established.
	
	The following are identified barriers with the current service model, a number of the below could be directly controlled by the service changing the way it communicates its service, the locations of the services available and the opening times and days.
	
	• Lack of communication using methods other than on the website resulted in people not accessing services.
	• Information is currently only available on the main ISH website – where information is sparce and does not feel inclusive, with services for HIV patients, Sex Workers and LGBTQ not being easy to find
	• The move to a digital platform for testing was not widely communicated across Warwickshire, leaving some individuals believing that services were closed – putting those which are asymptomatic at risk of long term harm.
	• Not all residents have access to the internet, limiting their access to testing.
	• Not all residents are able to receive test kits to their home address (e.g young people)
	• Additional safeguarding is not available through online testing, this could result in some who need additional safeguarding being missed
	• Face to face services are preferred by some, as it enables them to discuss other concerns at the same appointment rather than having to negotiate multiple contacts.
	• The telephone triage system is not accessible to all:
	    o young people cannot have their phones available when they are in school and so miss ‘call backs’, or if in the workplace a confidential place is not always available when the ‘call back’ is received.
	    o Having enough ‘credit’ on phones to make calls
	• Those without a fixed address cannot receive test kits.
	• Individuals who communicate in ways other than spoken, have difficulty engaging with telephone triage, resulting in them not being able to access services.
	• The current hub locations are not easily accessible to those that need to use public transport
	    o Access to public transport – routes taken / on or near a bus route
	    o Cost of public transport
	• Current opening times of the day and days of the week are not accessible to all
	    o Monday – Friday, 9-5 does not fit everyone
	    o Previously had evening and weekend availability

C. Refine and apply – make changes to your work plans that will have the greatest impact	
5. Potential effects In light of the above, how is your work likely to affect health inequalities? (positively or negatively) Could your work widen inequalities by: • requiring self-directed action which is more likely to be done by affluent groups? • not tackling the wider and full spectrum of causes? • not being designed with communities themselves? • relying on professional-led interventions? • not tackling the root causes of health inequalities?	An external review of the current service model and staffing structure is underway, the information from the recent Needs Assessment which includes service user feedback has been provider to the reviewer. This Health Inequality Impact Assessment will also be shared with the reviewer. Assessment will also be made to determine where changes may have led to increased engagement in specific population groups, how this may affect health inequalities within these groups, and how to capitalise on these changes where appropriate. There will also be a focus on those that still do not access services, and how to reach out to them. The findings of the review will be shared with the Senior Leadership of the NHS Trust that is contracted to deliver the service along with Senior Managers within WCC. The findings of the Needs Assessment, the Health Inequality Impact Assessment, the external review and further engagement work with communities will be used to develop a refreshed service specification and performance indicators which will seek to improve the monitoring of data against health inequality indicators. A new contract will be in place to start date from 01st April 2024. The refreshed current model and any future model needs to include a level of self-directed action but ensure that this is not the only method of either contacting or accessing services.
6. Action plan What specific actions can your work programme or project take to maximise the potential for positive impacts and/or to mitigate the negative impacts on health inequalities? • How can you act on the specific causes of inequalities identified above? • Could you consider targeting action on populations who face the biggest inequalities?	Co-production with communities needs to be undertaken and used to shape overall provision but look specifically at locations and accessibility of services, inline with the business units commissioning plan. Partnership working with other health professionals to enable the shared use of clinical settings, as these are often in the heart of a community and offer accessible locations and opening times. Improve communication and ensure equitable access for groups identified above as not accessing services e.g males, LGBTQ, Black Asian and Minority Ethnic Communities, young people and older people ?learning disabilities and autism, mental health? Development of a dual trained workforce, that will ensure services are available to all, with members of the team having enhanced training in engaging and supporting individuals with, for example, learning disabilities, autism and mental health.

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- Could you design the work with communities who face the biggest health inequalities to maximise the chance of it working for them?
- Could you seek to increase people's control over their health and lives (if appropriate)?
- Could you use civic, service and community-centred interventions to tackle the problem – to maximise the chance of reaching large populations at scale?
- Who else can help?

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<td>Develop a model that includes the opportunities to access services, a combination of face to face through appointments, face to face through drop in clinics and online testing and remote prescribing.</td>
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<td>7. Evaluation and monitoring
How will you quantitatively or qualitatively monitor and evaluate the effect of your work on different population groups at risk of health inequalities? What output or process measures could you consider?</td>
<td>Continued monitoring of both GUMCAD and local performance monitoring dashboards to ascertain if any changes implemented have made a difference.

Further engagement with residents who have and have not used the service to continue to understand their feedback, and how this can be used to shape new services.</td>
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<td colspan="2">Set a health equity assessment review date, recommended for between 6 and 12 months from initial completion.
Review date:</td>
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D. Review – identify lessons learned and drive continuous improvement	
Date completed (should be 6-12 months after initial completion):	To be undertaken.
Contact person (name, directorate, email, phone)	
1. Lessons learned Have you achieved the actions you set? How has your work: a) supported reductions in health inequalities associated with physical and mental health? b) promoted equality, diversity and inclusion across communities and groups that share protected characteristics? What will you do differently to drive improvements in your programme? What actions and changes can you identify?	