Public Health England

Protecting and improving the nation's health

A 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	Delivering Healthier Lifestyles in Warwickshire – Commissioned Services' Redesign
Date completed	April 2022
Contact person (name, Directorate, email, phone)	Laura Pain/Ruby Dillon
Name of strategic leader	Georgia Denmark

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?	Warwickshire County Council (WCC) currently commission seven health improvement and lifestyle contracts (see Appendix 1) which seek to support residents to lead healthier lifestyles, and prevent long term health conditions, such as cancer, diabetes, cardiovascular disease, and obesity amongst adults. All seven contracts have been in scope for this review, which sit across two teams, Health, Wellbeing and Self Care, and All Age Targeted Support. Approval has been given by SCLT to re-commission a single integrated service. WCC has a statutory duty to improve the health and wellbeing of the population it serves. This includes the provision of health improvement information, advice and services aimed at preventing illness, and aligns with the early help prevention agenda. WCC has the potential for making a real difference to prevent or delay the onset of citizens becoming ill by addressing key lifestyle risk factors which include obesity, smoking, physical inactivity and the prevention of falls. HEAT analysis will inform the re-commissioning of the physical health service by identifying areas where greatest inequalities exist and ensure consideration of multiple dimensions of health inequalities and inequity are considered in this re-design. It will: • systematically address health inequalities and equity-related issues to physical health services

	• identify what action can be taken to reduce health inequalities and promote equality and inclusion HEAT analysis will allow WCC to ask providers to consider the needs of people with protected characteristics, specify how people in lower socio-economic groups will access the service and how wider determinants of health can be mitigated within their tender responses.
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 • Consider local data such as that available in JSNA, contract performance data, and qualitative data from local research	• Commissioning data/service monitoring data such as activity and payments • JSNA data • Fingertips Profiles • Warwickshire Tackling Inequalities dashboard • PHOF • 2021-2026 Warwickshire Health and Wellbeing Strategy • Public Health Annual Report 2020/2 • Coventry and Warwickshire COVID-19 Health Impact Assessment 2020 • Shape • NHS Digital • NHS Health Checks Data • GP Data • Professional and Residents Engagement Survey results • Core 20 plus 5 • Internal commissioned service reviews

B. Assess - examine the evidence and intelligence

3. Distribution of health

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

Local Picture:

Physical Activity
The Covid-19 Health Impact Assessment highlighted that 37% of respondents felt they were doing more exercise because of the pandemic, nearly a third (31%) felt they were doing less.

Warwickshire's percentage of physically inactive adults (20.1%) is lower than the national average (22.9.6%). Rugby Borough, Stratford-upon-Avon and Warwick Districts all have a lower percentage of physically inactive adults than the national average. However, Nuneaton & Bedworth's percentage of physically inactive adults (25.9%) and North Warwickshire's percentage of physical inactive adults (23.3%) are greater than the national average.

Adult Weight Management
69.2% and 67.4% of adults in Nuneaton and Bedworth and North Warwickshire respectively are classified as overweight or obese. Both of which are greater than the national average (62.3%). Both Stratford (62.3%) and Warwick (63.7%) have a greater percentage of adults consuming the recommended 5 a day compared to the national average (54.6%).

Smoking
Smoking rates are similar to the national average (13.9%) however, both North Warwickshire and Nuneaton & Bedworth have higher rates (15.1% and 14.5% respectively). Rugby Borough also sees a higher percentage of smoking prevalence than the England average, at 14.3%.

During 2021, a smoking review was completed which highlighted a decrease in number of smokers accessing the service, setting a quit date and being smoke free.

NHS Health Check
Diabetes and hypertension prevalence rates are significantly higher in Warwickshire North (although increasing Warwickshire wide). In Warwickshire, the prevalence of hypertension is 15.1%, compared to 15.9% in North Warwickshire and most significantly, 17.1% in Nuneaton and Bedworth. Similarly, estimated diabetes diagnosis rate in Nuneaton and Bedworth proportion percentage is 85.5% (significantly higher than the national average of 78%) and in North Warwickshire is 76.2%, compared to 74% for Warwickshire.

Services data shows a year-on-year reduction in number of completed health checks, with provision halted during the COVID-19 pandemic and not returning to previous levels. Consistently, numbers of completed health checks are lower across Warwickshire North and in Rugby, compared to South Warwickshire.

	For all commissioned services most service users/patients are White, British and residing in South Warwickshire, seeing lower access rates from residents residing in Warwickshire North. In October/November 2021 a public engagement exercise was launched to gather feedback on three health programmes provided in Warwickshire: Fitter Futures Weight Management and Physical Activity, NHS Health Checks and the NHS Stop Smoking service. This highlighted: • Some respondents highlighted poor communication and cost being too high for Fitter Futures (Adult Weight Management is free to service users, Physical Activity costs are discounted but vary) • Excluding not sure and those that didn't answer, a majority (73%) of service users who accessed the 'Adult Weight Management' programme would not have accessed Fitter Futures if it were not free • All survey respondents (including those not accessing Fitter Futures) were given an average cost of a discounted Physical Activity on Referral membership (£20) and asked to give their views. 'Too expensive' was the most selected option; excluding 'Not sure', it sits at **47%** of respondents. • Face to face/hosted programmes were the most popular choice across all services, with **75%** choosing this option for NHS Health Checks, **63%** for Fitter Futures and **55%** for Smoking Cessation.
	<u>Socio-economic status or geographic deprivation</u> 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. Access to all services is lower across Warwickshire North. Fitter Futures Warwickshire's eligibility criteria states that an individual must be registered with a Warwickshire GP. However, a significant amount of North Warwickshire residents has a GP outside of area, therefore preventing them from accessing the service. There are 35,233 people living in Warwickshire but registered with a GP outside Warwickshire, with over a third of these (12,960) living in Nuneaton & Bedworth (April 2021). Almost two thirds of those with a GP outside Warwickshire are registered with GPs in Coventry.

	Socio-economic data is collected only for the Smoking Cessation service: **Smoking Cessation** - 1 in 4 individuals in routine and manual occupations smoke compared to 1 in 10 people in managerial and professional occupations - 11% (102) of service users setting a quit date through their GP in Warwickshire are in managerial and professional occupations (15% [28] of those successfully quit were in managerial and professional occupations) - 23% (208) of service users setting a quit date through their GP in Warwickshire are in routine and manual occupations (20% [37] of those successfully quit were in routine and manual occupations) - 18% (30) of service users setting a quit date through a pharmacy in Warwickshire are in managerial and professional occupations (11% [5] of those successfully quit were in managerial and professional occupations) - 22% (36) of service users setting a quit date through a pharmacy in Warwickshire are in routine and manual occupations (26% [12] of those successfully quit were in routine and manual occupations)
	Inclusion health and vulnerable groups (for example, people experiencing homelessness, prison leavers, young people leaving care): Data available through Public Health profiles (Fingertips), shows that: Mental Health: QOF prevalence (all ages) 4,425 individuals (0.73% of the Warwickshire population). No data is collected from the current services in relation to people attending the services from vulnerable groups
	Experience related to protected characteristics: 11.5% of the county population are from an ethnic diverse background (62,857), with approximately twenty-one languages spoken. The most commonly spoken “main language” in Warwickshire is English, followed by Panjabi (2.3%), Polish (2%), Gujurati (0.83%), Urdu (0.82%) and Arabic (0.6%).

	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%) **Physical Activity** • Service users mostly aged 41-60 years • Service users mostly female (59%) • 58% of service users were White (35% unknown, 3% Asian or Asian British) • A range of disabilities were recoded as primary reason for referral. The most commonly seen were diabetes type 1 and 2, hypertension, muscular skeletal condition, cardiac and strength and balance concerns (41% of users had a BMI of 30+, 14% of users had a BMI of 30+ with additional concerns) **Adult Weight Management** • Service users mostly aged 41-60 years • 80% of service users are female • 58% of service users were White (36% unknown, 3% Asian or Asian British) • A range of disabilities were recoded as primary reason for referral. The most commonly seen were diabetes type 1 and 2, muscular skeletal condition, pregnant and overweight (maternal pathway), mental health condition e.g., mild to moderate depression, anxiety, low mood and cardiac (57% of users had a BMI of 30+, 18% of users had a BMI of 30+ with additional concerns)

Smoking Cessation

- Service users mostly aged 45 – 59 years (GPs and Pharmacies) with the second most common age group being 60 and over

With the 2020/21 Stop Smoking programme

- The highest self-reported successful quit rate (38.4%) was for those aged 18-34, followed by those aged 60+ (33.3%). The lowest rate (21.6%) was amongst those aged 45-59.
- By ethnicity, 975 (92.2%) who set a quit date were White, 43 (4.1%) did not state ethnicity.
- By ethnicity, 298 (90.0%) who self-reported successfully quitting were White, 18 (5.4%) did not state ethnicity
- 344 (32.5%) of those setting a quit date were male, 714 (67.5%) were female.
- Male self-reported successful quit rate was 30.5%, for females it was 31.7%.

NHS Health Checks

Based on performance between 1st April 2018 and 31st March 2021, the following individuals have accessed the service:

- 18,720 health checks delivered which aims to support individuals aged 40 – 74 with no pre-existing health conditions
- The highest level of attendance was for those aged 40-44 years (18.5%), followed by those aged 50 – 54 years (16.4%).
- 55.7% were female, and 44.2% were male.
- 84.2% of patients were White British, 1.4% Mixed, 5.2% Asian or Asian British, 0.8% Black or Black British, 1.3% Other and 3.2% Refused or Unknown.

4. Causes of inequalities What does the data and evidence tell you are the potential drivers for these inequalities? • Which wider determinants are influential? E.g. income, education, employment, housing, community life, racism and discrimination. • What aspects of mental wellbeing are affected? Consider risk and protective factors. • 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? Which can you influence? Which are out of your control?	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. The following are identified barriers with the current service model: • All the above services require self-directed action by the client/patient. • Service review highlights FFW supports White British, females aged 41-60, and therefore members of ethnically diverse communities are either reluctant or unable to access services or the providers are not undertaking targeted engagement. The same can be said for the NHS Health Check and Stop Smoking programme. • No requirement as part of the current contract for providers to organise suitable translation services. Subsequently, there's a risk some service users are not fully able to engage with the service and benefit from the support offered. • To access Adult Weight Management and Physical Activity on Referral, users must be registered with a Warwickshire GP, limiting access to the service (particularly for residents living in North Warwickshire).
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?	Action stage The HEAT analysis will allow us to: • Inform the service specification • Inform specific tender questions for suppliers • Help identify eligibility criteria for the service • Help identify referral routs and criteria

• relying on professional-led interventions? • not tackling the root causes of health inequalities?	• Identify sources of data we need to collect from future services which demonstrate more fully the impact on inequalities and help monitor equity to service The findings of the service reviews, the Health Inequality Impact Assessment, 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. Potential to widen inequalities: • The new physical health service is likely to have a greater emphasis on virtual delivery, therefore increasing the risk of limiting access for those without the means to access the internet and equipment. • If self-directed action is the only method of contacting and accessing services, the service risks excluding vulnerable individual and communities (maintaining professional and self-referral options is being considered during the second round of engagement)
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? • Could you design the work with communities who face the biggest health inequalities to maximise the chance of it working for them?	**Focus on key priorities – to be considered for the new service** Co-production will be targeted at vulnerable groups identified as receiving an inequitable service from the current physical health services provided. Improve communication and ensure equitable access for groups identified above as not accessing services e.g., ethnically diverse communities, residents across Warwickshire North, males. This should be incorporated in communication plans and reflected in actions, e.g., sponsored posts advertising the services on social media, ensuring there are physical copies of advertisements where need is greatest. A more targeted delivery model (shift from current universal offer) to ensure harder-to-reach groups can make positive long-term behaviour changes. The new model will transition from everyone receiving the same level and degree of support, to a more tailored approach based on the individual. Adopt a place-based approach, therefore increasing engagement with specific cohorts to tackle health inequalities. This might result in those deemed universal having limited opportunity to receive free face to face 12-week weight management support or a heavily discounted leisure centre membership via the physical activity on referral service

• 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?	Risk stratification for NHS health checks, given reduced budget and increased eligibility criteria: Red, Amber, Green categorization (Red: patients to be invited as priority for in-person health, Amber to be invited as second priority with as much as possible completed digitally, Green: directed to surveys and health-related quizzes but not invited by GPs for a health check) Ensuring a variety of formats for support, including face-to-face for the most vulnerable. This should also include individual and group support. Refugee, Asylum Seekers and displaced people – further work needs to be undertaken to understand the needs of these individuals. Workplace support – partnership working to engage workplace settings across Warwickshire to target information on services and encourage access where need is greatest, e.g., stop smoking support in workplaces across Rugby and Warwickshire North. Reviewing eligibility criteria to ensure service are as accessible as possible, e.g. reconsider whether all service users need to be registered with a Warwickshire GP.
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?	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.
Set a health equity assessment review date, recommended for between 6 and 12 months from initial completion. Review date:	