NHS
Coventry and Warwickshire
Integrated Care Board

Health Equity Assessment Tool (HEAT) – Easy Use Guide

This document aims to provide some further guidance on how to complete the Health Equity Assessment Tool (HEAT). The guidance is not exhaustive but provides prompts and suggestions for data that can be used and how to frame your responses.

For each section, part of an example response has been given to help clarify the type of information that should be included. The example has been based on the scenario of reviewing a smoking cessation service and follows the thread of health inequalities by socio-economic status.

At the back of the document is a list of suggested resources for service and inequalities data, as well as a list of potential groups who you may want to consider within the HEAT, depending on the relevance to the service being reviewed.

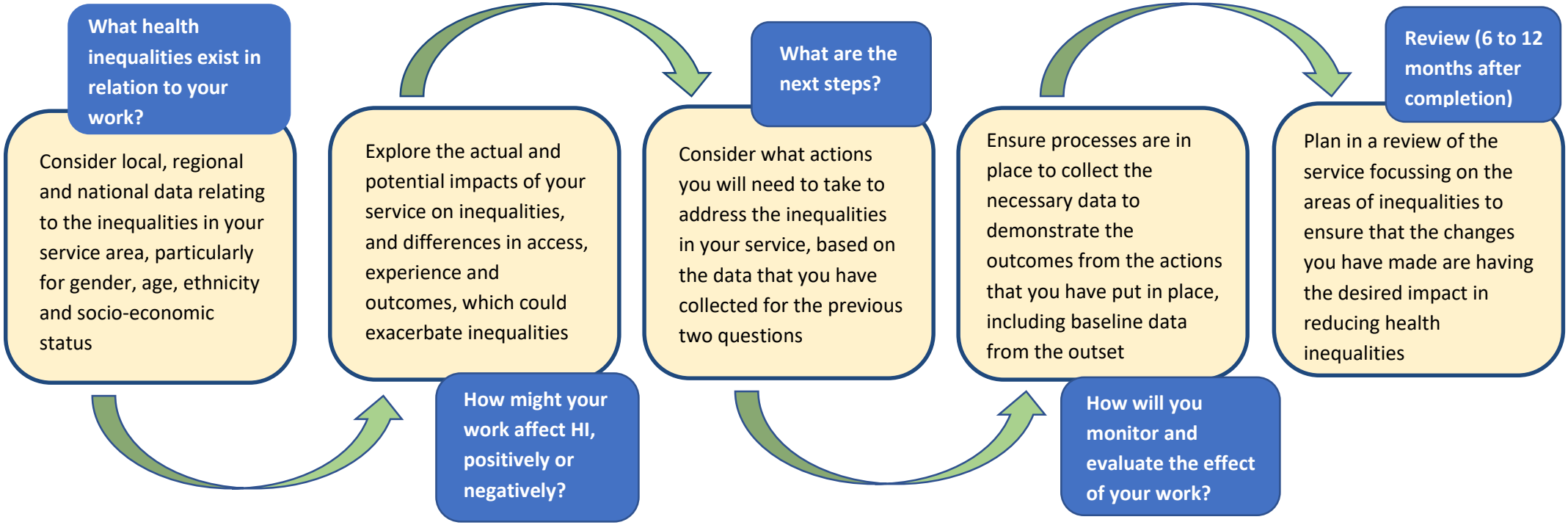
There are two version of the HEAT – a full version and a simplified version. This guidance is aimed at supporting completion of the simplified version. Both versions can be found online, via the link below:

Health Equity Assessment Tool (HEAT) – resources and e-learning

A HEAT assessment can be carried out at any point of the commissioning cycle or at any point that a service is reviewed to identified actions that can be taken to tackle health inequalities.

Support for completing the HEAT will be provided by one of the ICB Health Inequalities Programme Managers. The Programme Manager will provide advice and guidance at the outset of completion and at the midway point.

HEAT process:



Section	HEAT Guidance
1. What health inequalities (HI) exist in relation to your work?	Explore existing data sources (see resources section – not exhaustive) on the distribution of health across different population groups Consider protected characteristics and different dimensions of HI e.g. socioeconomic status or geographic deprivation

Further guidance:

This question is about the inequalities that are faced in general in relation to your programme of work. You can use national, regional or local data to explore this. It is about identifying the specific groups who may experience the worst inequalities so that you can then consider in the next question how this has been experienced in your specific programme.

What evidence is there to answer this question? Which populations face the largest health inequalities with this issue / condition?

Consider local, regional and national data / research

Think about the relevant population and then about the groups in it who could have different access / experience / outcomes from the service - consider

At the very least, the groups to consider are:

✓ Ethnicity ✓ Gender ✓ Socio-economic status ✓ Geography ✓ Age

If possible, consider other groups who may experience less favourable outcomes. You don't need to consider all these groups, just those who you are able to access data on or who you know through different sources that they face inequalities (List of suggested groups at end of document)

Example:

Poverty / socio-economic status – Evidence shows that the is correlation between poverty and smoking, with people living in areas of deprivation being 4 times as likely to smoke that those living in areas of affluence. Other indicators of socio-economic status confirm this relationship, with people in rented accommodation more likely to smoke than those who own their own home, people in routine and manual jobs more likely to smoke than those in professional and technical jobs, and higher prevalence of smoking amongst people with a lack of formal qualifications, those receiving benefits and people with a health problem which limits activity[i]. In a long-term study of over 10,000 civil servants in London, including workers in all socio-economic groups, smoking was found to account for around a third (32% - 35%) of the difference in death rates between the lowest and highest socio-economic groups over a period of 24 years[ii]. Evidence also shows that smokers from disadvantaged areas find it more difficult to stop with the help of stop smoking services than their more affluent neighbours[iii].

Ethnicity – prevalence between different groups
Gender – prevalence difference between men and women
Geography – prevalence in Coventry & Warwickshire – any key differences, outlier areas

Specific groups of concern:

- pregnant women - impact on baby leading to health inequalities later in life
- Any specific groups who are known not to access services – migrants, people with SMI etc
- Young people taking up smoking at an early age – likely to lead to inequalities at a later age

Brief overview of local data by IMD area, and take-up and success of previous smoking cessation services

Section	HEAT Guidance
2. How might your work affect HI (positively or negatively)? How might your work address the needs of different groups that share protected characteristics?	Consider the causes of these inequalities. What are the wider determinants? Think about whether outcomes vary across groups, and who benefits most and least Consider what the unintended consequences of your work might be in regard to: a) Protected characteristics b) Socio-economic status or geographic deprivation c) Specific socially excluded or vulnerable groups eg. people experiencing homelessness, prison leavers, care leavers

Further guidance:

This question is more specific to your particular service. It is the opportunity to explore data collected within the service to analyse who is participating, are certain groups not evident – if so, why might that be?

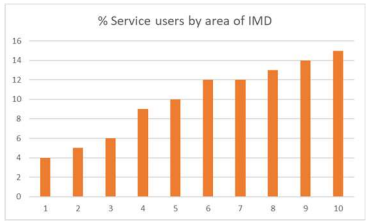
For each group above where you have identified that inequalities exist, consider how your service might impact this population.

Consider different groups within each of the protected characteristics - are there certain subgroups that will be advantaged or disadvantaged by your service? Consider DNA data – are specific groups more likely to DNA, and if so, what barriers could there be to cause this?

Link this to the data which shows you where the inequalities exist.

Example:

Providing smoking cessation services that are open to all and require self-directed action to access the service risk having greater uptake and successful outcomes for those in less derived areas, potentially increasing inequalities. Provision of services in the right way and in the right place and having the appropriate support in place for those from deprived communities is therefore key to reducing inequalities.



Review of service users shows that previous local smoking cessation services have had higher uptake and engagement in areas of greater affluence. This is also reflective of the proportion of service users who have successfully completed the programme and stopped smoking, with higher success rates in areas of less deprivation. Local data is in line with national fundings.

Previous programmes have utilised virtual support, which may risk limiting access to those are digitally excluded. This should be considered in future service development.

Section	HEAT Guidance
3. What are the next steps?	What specific actions will you take to address health inequalities and the needs of groups/communities with protected characteristics? Is there anything that can be done to shift your work 'upstream' to make it more likely to reduce health inequalities?

Further guidance:

Can the service be changed to have a positive impact on HI? Do you need to collect more data in order to understand this properly locally? If certain groups have not used the service or had such good experiences or outcomes, do you know why, or does further work need to be done to explore this. National research may help to answer some of the questions, otherwise it may be possible to talk to service providers and those who didn't take up service offers.

Are there other services you can work with to maximise prevention and prevent HI from arising? Work that can be done to prevent or minimise health inequalities from an early age will have beneficial affects throughout that individual's life.

Think practically, what is within the scope of the service? Ideally, we would improve all poor quality housing to reduce respiratory problems particularly for people in deprived areas, however, that is not within the gift of the health service. Are there ways of working with housing to identify people with a health priority for housing improvements?

Does the contract need to be enforced to collect the relevant data, or do future contract or specification terms need to stipulate the level of data collection?

Examples:

Given the clear links between socio-economic status and smoking prevalence, future smoking cessation programmes will focus a majority of resources in areas in areas in the core 20% (the 20% most deprived areas according to IMD). Engagement will be available digitally but will also provide physical group and drop-in sessions in community locations in deprived areas. The referrals process will be reviewed to ensure that there is appropriate support for people to access the service and does not rely solely on self-actioned referrals. The programme will review the capability to work with schools in deprived areas to deliver information sessions about the dangers of smoking.

Data will be reviewed to ensure that the required information is being captured, covering postcode, gender, ethnicity and all protected characteristics. A process will be put in place for ensuring data quality and completeness is reviewed on a regular basis, and bi-annual reviews of the data will take place to ensure that the service is working with a significant proportion of people from deprived areas and other groups at risk of increased inequalities.

Section	HEAT Guidance
4. How will you monitor and evaluate the effect of your work?	What quantitative and/or qualitative evaluation will be established to check you have achieved the actions you set? What output or process measures will you use?

Further guidance:

Do you have the data available to know if service changes will impact on inequalities?

Improvement of data collection and monitoring could be one of the actions

Do you review the data / outcomes on a regular basis?

If the inequality has been identified through current data, that can be used to evidence impact / change

Examples:

Data collected through the service will be analysed to determine uptake and success rates, stratified by socio-economic status (through IMD level of postcode), ethnicity, gender and geography.

Further qualitative data regarding the appropriateness of the service will be collected through direct contact with those who did not take up the referral to the service, or who did not complete the programme successfully.

Outcomes from the programme will be compared to previous local programmes and to national outcome data for comparable services.

Section	HEAT Guidance
5. Review (To be completed 6 to 12 months after first completion)	Consider lessons learnt – what will you do differently? Identify actions and changes to your programme to drive improvement

Further guidance:

Carry out the actions you set out in section 4. If local data is available, compare before and after.
Identify any actions / processes / outcomes that did not go as you expected, either better or worse
Identify learning points that can be shared across the service and the wider system

Examples:

Outcomes from the programme have demonstrated that working with community groups in area of deprivation have increased the uptake in that area. Utilising community venues in those areas to provide group support has also contributed to an increased success rate. Uptake of the service in areas within IMD 1-3 areas has increased from x% to xx%, and successful quits in these areas have increased from x% to xx%.

Resources:

Resources for data about groups who could be affected by health inequalities include:

- OHID Public Health Profiles (Fingertips)
- ONS data
- OHID Spotlight data
- Strategic Health Asset Planning and Evaluation application (SHAPE)
- OHID – Local Health
- 2021 Census Data
- NOMIS – Census and Labour Market Statistics
- Local JSNA data
- Local contract data
- Service specific data
- DNA data for service

Potential groups who may be affected by health inequalities:

- Socio-economic differences, for example, by National Statistics Socio-economic classification (NS-SEC), employment status, income
- Area or regional variations, for example, by deprivation level using index of multiple deprivation, service provision, urban and rural differences
- Ethnicity, for example among black, Asian and other ethnic minority groups
- Lesbian and bisexual women
- Men, who are less likely to be screened than women
- Excluded and under-served groups, which may be missed within screening cohort identification, including:
- People with severe mental illness (see Population screening: access for people with severe mental illness)
- Drug and alcohol users
- People experiencing domestic violence
- Homeless people
- People in prison
- Young people leaving care

- Gypsy, travellers and boating communities
- Transgender people
- People serving in the military and their dependants
- People with learning disabilities or physical disabilities where the service needs to make reasonable adjustments
- Young parents
- Individuals with limited or no access to the internet
- New migrants
- Pregnant women who book late or present unbooked in labour
- Individuals whose first language is not English

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[i] Likelihood of smoking four times higher in England's most deprived areas than least deprived - Office for National Statistics (ons.gov.uk)
[ii] Association of socioeconomic position with health behaviors and mortality - PubMed (nih.gov)
[iii] 10. SSS + HI v4 (ncsct.co.uk)