Public Health England

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Health Equity Assessment Tool (HEAT): practice example

Health and Wellbeing Team (HWBT) West Midlands (WMs)

Health and Wellbeing Team – practice example

Programme or project being assessed	HWBT – WMs
Date completed	August 2020
Contact person (name, Directorate, email, phone)	Karen Saunders and Lina Martino, HWBT WMs: karen.saunders@phe.gov.uk
Name of strategic leader	Karen Saunders

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?	The HWBT in the WMs have a key role in working with local authorities, the NHS and The voluntary sector to support delivery of improved outcomes for the public's health with a focus on health improvement and reducing health inequalities. The business plan delivery model is project based, with matrix working across multiple teams including place based and functional topics. [1] For the past 5 years the HEAT has been adopted as a strategic management tool to enable the Team to embed health inequalities across our work and to demonstrate us meeting our legal duty to tackle health inequalities (Health and Social Care Act 2012) with examples showcased in national reports. [2],[3] The team's health inequalities lead raised awareness and understanding of the HEAT and supported its application across priorities and programmes. Despite the abundance of other tools in the system, PHE's HEAT was recognised as a practical framework to drive forward work on health inequalities. The national health inequalities team worked very closely with WMs colleagues to raise awareness about the benefits of the HEAT and the WMs team played a key role in the review and refresh of the tool.

	Critical success factors in embedding the HEAT in the Team's approach include: **Strategic leadership and alignment:** the HEAT was set within the context of the legal duty to tackle health inequalities; as a tool for effective governance, quality improvement and an enabler for business plan delivery. Senior leadership commitment, sponsorship and support, and management team buy-in was integral to the approach. **Staff engagement and partnerships:** the health inequalities lead invested time in building capacity and learning about the HEAT via events with team members and external stakeholders. They worked alongside Programme and Project Leads to provide expert advice and support in using the HEAT, bringing constructive challenge and sharing case studies and good practice across functions to obtain buy-in and support. The process was not a tick box exercise, but was a dialogue and partnership focused on assurance, improvement and delivery. [4] **Processes:** the HEAT was integral to strategic planning, business planning, quality plans; training, development and induction and became a part of "business as usual", something staff related to and connected with. HEAT was adopted and became a success over time through manageable steps including building understanding, developing relationships and fostering a receptive culture. **Outcomes:** the health inequalities lead recorded the use and impact of the HEAT through staff insights, case studies and lessons learned, taking stock regularly and reporting to management and strategic leads to demonstrate progress. Staff also championed the HEAT with external stakeholders and were successful in convincing partners of the added value it provides. **Business as usual:** the HEAT principles have continued to be embedded as "business as usual" and form a key part of our work with external stakeholders, most recently as an essential aspect of the wider HWBT response to the pandemic, the team's contribution to recovery planning and helping us to connect the crisis response with our regular health inequalities priorities.
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 Right Care • Consider local data such as that available in JSNA, contract	**Data and evidence:** A significant function of the HWBT is to develop, utilise and disseminate information and intelligence systems to underpin public health action across disciplines and organisations. We provide and interpret a wide range of data, information and advice on evidence of best practice and the cost-effectiveness of interventions to help set priorities. The HEAT has provided a helpful process for assessing the impact of the team's work on improving health, highlighting issues, risks and supporting decision making.

performance data, and qualitative data from local research	Examples include: • **National Child Measurement Programme (NCMP)** [5] The HWBT Obesity Lead applied the HEAT to the NCMP (mandated programme). Areas identified as requiring further attention included the impact of disability and ethnicity. The relationship of dental public health to childhood obesity was also noted as an area where more integrated working could be enabled. These points were then included in the business plan and as part of the joint programme of work with local networks including a bespoke NCMP workshop hosted by PHE focusing on health inequalities and protected characteristics. • **Screening and Immunisation (S and I)** The HWBT worked with the S and I team to apply the HEAT to their programme. A recommendation was made around extending the team's reach and impact. An awareness raising session with Health and Wellbeing Board Officers ensued and this work was featured at a national event on screening and health inequalities. In addition, local screening teams went on to use the principles of the HEAT in local health equity audits arising from quality assurance review processes. [6]
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?	Socio-economic status or geographic deprivation: • **The Best Start in Life:** the HEAT was used to inform a programme of work to strengthen integrated approaches to the Team's work on children, young people and health inequalities. A survey, led by the HWBT and framed within the HEAT's principles, was undertaken across wider teams, to refine joint priorities and to explore ways in which matrix working could be enhanced across lifestyle factors, access to services, wider determinants and vulnerable groups. An organisational development programme then supported matrix working and a data compendium was produced to inform future prioritisation around health inequalities. The approach has since informed programme design for the HWBT. [7] • **Place-based work:** the HWBT has place-based leads who are the strategic lead contact for local authority (LA) public health teams. The place-based leads were trained on use of the HEAT by the HWBT health inequalities lead, providing them with an overarching and consistent framework. Leads fulfilled their local leadership role by building up solid knowledge about health inequalities in the local area and acting as a critical friend, providing non-judgemental challenge, helping the LA to explore issues honestly and helping to identify innovative and effective solutions. The HEAT supported the process of turning evidence into action, assisting LAs to make decisions and improvements, confronting challenges, and promoting the

	sharing of data, guidance and strategy documents relating to local priorities. An annual stakeholder survey was conducted to review place-based working and to make refinements to partnership working, considering stakeholders' changing needs and integrating health inequalities throughout. [8]
	Inclusion Health and vulnerable groups (for example, people experiencing homelessness, prison leavers, young people leaving care): The HWBT has always had a strong emphasis on inclusion health groups including those experiencing homelessness, asylum seekers and refugees, GRT, sex workers and victims of modern slavery. The HEAT is central to the team's work in this area, making sure that all members of a population can access the services they need. The HEAT has informed joint priorities with partners and the HWBT'S work has received national recognition. Examples of the HWBT outcomes for Inclusion Health Groups include: • homelessness: a health needs assessment for young homeless population; research on health outcomes; being a key player and advocate in local systems integrating health inequalities and public health priorities in wider work; working with local authorities to improve access to health services for those not having a permanent residence or where accommodation is insecure and work with the Mayoral Taskforce [9] • a WMs-wide needs assessment on language barriers and interpretation • a strategic emphasis, with partners, on refugees, asylum seekers and migrants and their range of health needs and challenges in accessing the system [10] • programmes of work for those who are unable to access health services or prevented from accessing support because of abuse, domestic abuse [11] or modern slavery [12] • programmes of work for those already vulnerable groups who are marginalised and stigmatised including those in the criminal justice system who can fall between services and face discrimination – this includes joint work on TB and housing; work with local communities and schools on Hepatitis A, and collaborative work on migrant health and wellbeing [13]
	Experience related to protected characteristics: Applying the HEAT to our work assures an emphasis on those who may be marginalised and/or stigmatised. Within programmes and projects there is a continued focus on the following: • age (life course approach) • gender (NCMP, health checks) • ethnicity (a HWBT work plan for BAME [14] groups bringing together existing work in a more coherent way and identifying gaps in our understanding of disparities) • disability (a focus on those with learning disabilities, mental health issues and inclusion health groups)

	• religion (work on faith-based settings) [15] • community engagement and asset-based approaches (drugs and alcohol, mutual aid) [16] [17]
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? Which can you influence? Which are out of your control?	**Wider determinants:** The HWBT works to tackle the wider determinants of health, working with strategic partners to support networks and place-based public health systems in local authorities (as above) to drive improvements through wider functions including housing, planning, leisure, transport and economic regeneration. Using the HEAT enables us to further prioritise areas where joint work on the wider determinants will support reductions in health inequalities, for example: • campaigns and awareness raising about the links between poverty, financial hardship and debt and its impacts on health and wellbeing, with the Illegal Money Lending Team[18] • a WMs resource on housing and health underpinned by the HEAT principles • a work programme on gambling and health impacts[19] • the HEAT informed joint work on the Regional Transport Strategy to enable a public health approach [20] • exploring the impact of school closures/exclusions because of COVID-19 and adverse outcomes such as recruitment to County Lines • an interprofessional task and finish group on vulnerability PHE WM is working in partnership with the West Midlands Combined Authority (WMCA) to align strategic health and wellbeing objectives and reduce persisting health inequalities in the region. This is supported by the PHE/WMCA Population Intelligence Hub, which is a virtual intelligence hub established by PHE in collaboration with the WMCA. It is embedded within the WMCA's Inclusive Growth Unit. Its remit is to initiate primary research, support the development of data systems and integrate a wide variety of existing intelligence, resulting in actionable insight to improve outcomes and reduce health inequalities for the West Midlands population. The Hub is continuing to lead and support projects in line with its strategic objectives of demonstrating impact, delivering solutions and increasing capacity, supporting the Inclusive Growth Unit and wider priorities to improve the wider determinants of health across the WMCA. The COVID-19 pandemic has shifted resources and focus to supporting the acute response around the region and informing the development of longer-term recovery plans. A Regional Health Impacts of COVID-19 (RHIC) Task and Finish Group has been convened with representation from the WMCA, PHE, local authorities and the NHS. This group will focus on the relationship between the PHE disparities review and wider health inequalities in the WMCA Region. Key outputs will be a regional analysis of COVID-19 and health inequalities, and a Health of the Region report that

	reflects the regional impacts of COVID-19. The RHIC workstream will support the WMCA's wider response to COVID-19, including plans to mitigate impact, prevent an increase in existing inequalities, and build resilience across the system. One of the key priorities for the Hub is to support the embedding of a Health in All Policies (HiAP) approach across WMCA programmes, policies and strategies. An options appraisal identified the preferred option as the modification of existing Equality Impact Assessments to incorporate health and health inequalities, drawing on elements of the HEAT.
C. Refine and apply – make changes to your work plans that will have the greatest impact	
5. Potential effects Considering 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?	**Evidence of impact includes:** • interest in, and take up of, the HEAT across the HWBT and wider teams has been widespread, supportive and enthusiastic – Overall, staff find the HEAT user friendly, flexible and simple to apply • the HEAT enables articulation of the core principles that PHE stands for and makes explicit the existing, and potential, health inequalities components of our work • the HEAT enables a focus on the key aspects of health inequalities – lifestyle/behavioural risk factors, access to services, wider determinants and vulnerable groups • the HEAT has strengthened matrix working and integrated approaches internally, maintaining a focus on the cross-cutting nature of health inequalities • the HEAT is integrated into the Business plan, reinforcing the importance of considering health inequalities across priorities. Bespoke HEAT resources are further utilised across the HWBT, for example for Health Checks and Mental Health • the HEAT is integral to quality improvement work and WMs also contributed to national work in this • the HEAT is part of induction programmes and taster days and discussed with staff on placement, including public health registrars • bespoke training and learning activities are delivered by the health inequalities lead on the HEAT including with external partners and other parts of PHE • the HEAT is promoted with a wide range of external stakeholders including the WM Association of Directors of Public Health; the WMCA and the WMs Health and Wellbeing Officers **External stakeholders have utilised the HEAT as follows, the:** • equality Monitoring Framework for the WMCA Strategic Economic Plan refers to the HEAT [21] • HEAT was aligned to the WMCA Equality Impact Assessment internal process to health proof priorities at Board level

	• WMCA used the HEAT to inform development of their transport strategy • HEAT was applied to WMs Sustainability and Transformation Plan assurance to inform health inequalities priorities [22] • HEAT was applied to a local stroke service reconfiguration to systematically identify potential impacts of the proposed health service changes upon deprived populations • HEAT was used to inform local health overview and scrutiny panels • HEAT was used by the NHS Clinical Senate to promote health inequalities priorities [23] • HEAT was included in discussions with stakeholders about utilising PHE's place-based tools [24]
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? • 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?	**Current Uses of the HEAT:** Currently the HEAT is utilised by the health inequalities lead and the HWBT to inform work on the pandemic response as part of the HWBT Health Inequalities Cell, focusing on its contribution to recovery planning and connecting the crisis response to our regular health inequalities priorities. Each project has used the HEAT to ensure an emphasis on health improvement alongside health protection. Project trackers monitor progress, delivery and risks. Previous work with Transport for West Midlands to develop their health and transport strategy included adapting the HEAT tool for use on smaller schemes. While this was not completed due to limited resources and data, it is being revisited in current work with the WMCA to develop a HiAP approach. Drawing on lessons learned previously, the aim is to develop an approach that builds capacity within WMCA by embedding HEAT elements within existing processes.

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?	**Evaluation and monitoring:** • monitoring and evaluation of health inequalities is part of business as usual - through business planning, quality plans, evaluation of training and delivery of induction programmes, staff and stakeholder feedback • the more recent COVID-19 HWBT Health Inequalities Recovery Cell monitors delivery through project trackers, reporting to the HWBT Health Inequalities Strategic Oversight Group • good practice and case studies from our work during the year contribute to our annual assessment process to demonstrate compliance with the legal health inequalities duty • PHE are working with WMCA programme leads to develop a dashboard to assess the health and wellbeing impacts of WMCA activity, with a focus on inclusive growth and inclusive economies – these are underpinned by a set of logic models to link actions/inputs to promote inclusive growth to its outputs, as well as interim (process) indicators, to demonstrate impact against defined objectives and show the contribution made by each part of the system
Set a health equity assessment review date, recommended for between 6 and 12 months from initial completion. Review date: 03/21	

D. Review – identify lessons learned and drive continuous improvement	
Date completed (should be 6-12 months after initial completion):	
Contact person (Name, Directorate, email, phone)	Karen Saunders, HWBT WMs: karen.saunders@phe.gov.uk
8. 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?	Please contact the project lead for further information about the review. **Lessons learned** This is an ongoing and planned process looking at outcomes including: • approaches to topics strengthened by using the HEAT • health inequalities integrated across wider programmes and priorities including in places, the wider determinants of health and inclusion health groups

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?	• the HEAT supports and is used as part of wider delivery, mechanisms, processes and structures to facilitate reducing health inequalities • embedding the HEAT in corporate processes to provide internal assurance and sustainability • supporting partners to apply the HEAT in ways that build capacity within their respective organisations Learning and experience is enabled and disseminated in various ways: • audit programme/reflective practice • business plan • quality plan • evaluation of learning events • external stakeholder feedback

[1] PHE. PHE West Midlands: advice, support and services. 2016. https://www.gov.uk/government/collections/phe-west-midlands-advice-support-and-services
[2] PHE. PHE equality report: 2016. https://www.gov.uk/government/publications/phe-equality-report-2016
[3] PHE. PHE equality report 2019. https://www.gov.uk/government/publications/phe-equality-report
[4] NHS England. Guidance for NHS commissioners on equality and health inequalities legal duties. 2015. https://www.england.nhs.uk/wp-content/uploads/2015/12/hlth-inqual-guid-comms-dec15.pdf
[5] PHE. National child measurement programme. 2020. https://www.gov.uk/government/collections/national-child-measurement-programme
[6] PHE. NHS population screening: inequalities strategy. 2019. https://www.gov.uk/government/publications/nhs-population-screening-inequalities-strategy
[7] Learning for Public Health, West Midlands. Best Start in Life Network. https://www.lfphwm.org.uk/our-networks/best-start-in-life-network
[8] PHE. Improving and protecting the health of people in the West Midlands. 2013. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/669255/West_Midlands_prospectus.pdf
[9] West Midlands Combined Authority. Homelessness Task Force. 2017. https://www.wmca.org.uk/who-we-are/meet-the-mayor/homelessness-task-force/
[10] West Midlands Strategic Migration Partnership. https://www.wmsmp.org.uk/
[11] West Midlands Police and Crime Commissioner. West Midlands Violence Reduction Unit Launches. 2019. https://www.westmidlands-pcc.gov.uk/west-midlands-violence-reduction-unit-launches/
[12] West Midlands Anti-Slavery Network. https://www.westmidlandsantislavery.org/
[13] West Midlands Combined Authority. WMCA Board. 2019. https://governance.wmca.org.uk/documents/s3029/Report.pdf
[14] PHE. COVID-19: review of disparities in risks and outcomes. 2020. https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes

[15] PHE. Faith at end of life: public health approach resource for professionals. 2016. https://www.gov.uk/government/publications/faith-at-end-of-life-public-health-approach-resource-for-professionals
[16] PHE. NHS England. A guide for community-centred approaches for health and wellbeing. 2015. https://www.gov.uk/government/publications/health-and-wellbeing-a-guide-to-community-centred-approaches
[17] West Midlands Mutual Aid. https://www.mutual-aid.co.uk/area/west-midlands
[18] Stop Loan Sharks. https://www.stoploansharks.co.uk/who-we-are/
[19] Gambling Commission. Gambling-related harm as a public health issue. 2018. https://www.gamblingcommission.gov.uk/PDF/Gambling-related-harm-as-a-public-health-issue.pdf
[20] Transport for West Midlands Strategy. https://www.tfwm.org.uk/strategy/
[21] West Midlands Combined Authority. Strategic Economic Plan. https://www.wmca.org.uk/media/1382/full-sep-document.pdf
[22] NHS England. Sutainability and Transformation Partnerships and Integrated Care Systems. https://www.england.nhs.uk/midlands/sustainability-and-transformation-partnerships-and-integrated-care-systems/
[23] West Midlands Clinical Senate. http://www.wmscnsenate.nhs.uk/home/
[24] PHE. Place-based approaches to reduce health inequalities. 2019. https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities