Public Health England

Protecting and improving the nation's health

Health Equity Assessment Tool (HEAT)

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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.

This document provides a simplified version of the tool.

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 e.g. 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:	West Midlands Trauma Vanguard – Coventry and Warwickshire ICB	
Date completed:	09.08.2023	
Contact person:	Lyn Ranson - lynette.parsons@nhs.net	
Name of strategic leader:	Tracy Pilcher	
Question	**Issues to consider**	**Response**
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	The Framework was co-designed by young people and was developed as a response to the NHS England & NHS Improvement Long Term Plan (LTP) commitment to provide additional support for the most vulnerable children and young people with complex needs across multiple domains between the ages of 10-18, including some of the most complex children locally who have been subjected to child exploitation and significant trauma(s) and who are impacted by health inequalities. This funding has enabled the ICB and partners to pilot work with our young people to lead on designing the framework and offers a unique opportunity to respond to assess the impact of this new way of working to achieve cultural and organisational change.

		Our young people have told us that they want: • Practitioners that are trauma informed and understand our story • Practitioners to take time to get to know us and what we like and are good at • Practitioners that are relatable • Practitioners and resources that are accessible and that connect us back with our community (Social Prescribing) • Don't label us as bad • Don't diagnose us as mad One area of focus of the project is with CYP who are open to Youth Justice. We can evidence that reviewing children open to the Service across 2022/23, 35% had an Education, Health, and Care Plan (EHCP) and 65% some form of identified special education needs as identified through their assessment. This represents an increase of 3% and 14% on the previous year, which is likely to reflect that the Service now has a Speech and Language Therapist improving the ability to detect, assess and respond to a child's need. Overall, the need within the YJS cohort is much higher than the schooling population, which, as of January 2023, had 19.4% of pupils with Special Educational Needs and/or EHCP compared to CYJS's 67%. The outcomes relate to the health inequalities of this vulnerable cohort and are outlined below:

		• Decrease in the numbers of CYPS entering or returning to care • Reduction in the number of incidents of serious youth violence linked to gang involvement/affiliation • Reduction in hospital admissions due to mental health crisis/self-injurious behaviour • Increased confidence of Practitioners in being able to identify and respond to trauma • Reduction in the number of children and young people returning to custodial settings • Increase in GP registration • Reduction in school refusal/exclusion • Decrease in the number of young people from refugee/asylum seeking families becoming gang affiliated and involved
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	Our work involved targeted youth worker support using a social prescribing model to connect young people back to their communities and engage with meaningful educational and fun opportunities to assist them to feel good and make friends. Through a social prescribing fund, the project assists young people to access these opportunities and provide financial and practical support to help them to have the equipment, finances and support to maximise participating. These CYP are in complex situations, at risk of coming into care, involved or at risk of criminal exploitation and serious youth violence. The project uses research-based youth worker interventions underpinned by trauma informed approaches that will provide a

		suite of universal and enhanced social prescribing activities that seek to improve the health and well-being of young people open to the project.
	a) Protected characteristics	**Age:** A person belonging to a particular age (e.g. 32 year olds) or a range of ages (e.g. 18-30 year olds) Referrals will be accepted for the Positive Directions Service for any child and young person aged 10-18 years old who has been subjected to singular or cumulative incidents that have resulted in trauma and adversity and fall into one or more of the following categories: • **Edge of Care Team** • **Extended non-attenders of education (attendance less than 50%)** • **Open to Youth Justice** • **Children and young people transitioning from the secure estate into the community.** Whilst all referrals that satisfy the criteria above, priority will be given to those young people that also meet the criteria set out below: • **Not engaged with any specialist support service (including those young people who have been referred but are not engaging) and those with no statutory plan in place, for example no Education, Health and Care Plan (EHCP) or Child Protection Plan**

		• **Children and young people who are victims of domestic abuse (in line with the new Domestic Abuse Bill)** • **Children and young people from asylum seeking and migrant families** • **Children and young people who are gang affiliated and involved** • **Awaiting a neurodevelopmental assessment** Consent: The provider should ensure that there are adequate processes in place to assess for competence and capacity of the young person to ensure consent is in place, and to gain consent from the person/s with parental responsibility for the child/young person if Gillick Competence not met. A full initial assessment should be carried out with the young person once they have consented to access Positive Directions Service which captures not only their history and lived experience, but also their aspirations, hopes for the future, likes and dislikes. Assessments should be shared, with consent, to support any future further assessment should the child or young person be signposted to further services for additional support. A copy of the discharge/transition planning information will be given to the child and young person and with their permission and consent, their family and to any other involved professionals. The impact and efficacy of the

		Positive Directions Service will be measured against the below set of outcome measures. Performance in relation to these outcome measures should be reported via contract monitoring and reporting, as well as the use of case studies with the young person's consent. Safeguarding: the cohort of children that will receive support are all subject to safeguarding statutory intervention due to safeguarding and/or welfare concerns as they will all already have a social worker. The provider should be able to evidence that they have a clear policy in place to follow up cases where a child/young person was not brought to appointments as this may be indicative of wider safeguarding concerns, and any safeguarding concerns will be shared with the child's key worker as per local safeguarding policies, underpinned by Working Together to Safeguard Children 2022. **Disability:** A person has a disability if he/she has a physical, hearing, visual or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities The Provider shall not discriminate between or against children and young people on the grounds of gender, age, ethnicity, disability, religion, sexual orientation or any other characteristics. It is known that a proportion of children will have learning disabilities and/or autism, as profiling

		indicates that these children will form part of the cohort. The approach to support will be targeted to ensure that social prescribing offers will be tailored to meet these children's needs, and the team are working in partnership with the Senior Joint Commissioner for Learning Disabilities and Autism to ensure that the commissioned support offer is shared with young people and parents/carers who would benefit from this support. **Gender reassignment (including transgender):** Where a person has proposed, started or completed a process to change his or her sex. The Provider shall not discriminate between or against children and young people on the grounds of gender, age, ethnicity, disability, religion, sexual orientation, or any other characteristics, and this will include equity for any children or young people who identify as transgender. **Marriage and civil partnership:** A person who is married or in a civil partnership. N/A as this project works with under 18's only **Pregnancy and maternity:** A woman is protected against discrimination on the grounds of pregnancy and maternity. With regard to employment, the woman is protected during the period of her pregnancy and any statutory maternity leave to which she is entitled. Also, it

		is unlawful to discriminate against women breastfeeding in a public place. The project might work with young people under the age of 18 that are pregnant. All reasonable adaptations and support would be tailored to ensure that the young person can participate in the service if they would like to do so. **Race:** A group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins. The Provider shall not discriminate between or against children and young people on the grounds of gender, age, ethnicity, disability, religion, sexual orientation or any other characteristics. The service is open to all children from the cohort listed above and would be open to any young people irrespective of race, ethnicity or nationality. For children and parents/carers whose first language is not English they would have access to an interpreter to ensure they can participate in the service. Information about the service will also be made available in a range of different languages and formats. **Religion or belief:** A group of people defined by their religious and philosophical beliefs including lack of belief (e.g. atheism). Generally, a belief should affect an individual's life choices or the way in which they live. The Provider shall not discriminate between or against children and young people on the

		grounds of gender, age, ethnicity, disability, religion, sexual orientation or any other characteristics. The service is open to all children from the cohort listed above and would be open to any young people from any religion. **Sex:** A man or a woman The Provider shall not discriminate between or against children and young people on the grounds of gender, age, ethnicity, disability, religion, sexual orientation or any other characteristics. The service is open to all children, both male and female from the cohort listed above. The service will also work sensitively with children and young people who identify as gender neutral and non-binary and use they/them pronouns to refer to them if preferred. **Sexual orientation:** Whether a person feels generally attracted to people of the same gender, people of a different gender, or to more than one gender (whether someone is heterosexual, lesbian, gay or bisexual). The Provider shall not discriminate between or against children and young people on the grounds of gender, age, ethnicity, disability, religion, sexual orientation or any other characteristics. **Carers:** A person who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support

		The service will work in partnership with young people and their families to ensure that interventions and appointments are tailored to have the minimal impact on family life.
	b) Socio-economic status or geographic deprivation	The cohort of children open to the Coventry Edge of Care Team and Youth Justice Team, as well as the FAST and Youth Justice Team in Warwickshire will include children that have been exposed to significant and cumulative trauma and may originate from lower socio-economic status groups, children from migrant families as well as unaccompanied asylum-seeking young people. Some children might be homeless, and "sofa surfing" if they are distanced from their birth family. The target cohorts may have a greater propensity of being exposed to domestic abuse, intergenerational trauma and parental substance and/or alcohol use.
	c) Specific socially excluded or vulnerable groups e.g. people experiencing homelessness, prison leavers, young people leaving care	The target cohorts are aged 10-18 years and are: • Open to Edge of Care Teams • Disengaged from education/school re-fusal/electively home educated or exclusion • Not engaging with services or subject to a statutory plan (Education and Health Care Plan (EHCP) or Child Protection Plan) • Transitioning back from secure estate to community • At risk of gang affiliation • Refugees and unaccompanied asylum-seeking young people who are disproportionally represented in gang affiliation • Children that live in a home with domestic abuse

		• Young people on the neurodevelopmental pathway who have experienced trauma and adversity, with special priority given to those CYPs who are not engaged with any service provision
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?	See section 2. This work directly focuses on CYP and families that are disadvantaged and experience health inequalities.
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?	Monitoring and evaluation are central to the project as it is a test and learn approach to improve health outcomes influenced by health inequalities and influence future sustainability and commissioning intentions. Evaluation measures include: • Case studies (circ 20 quarterly) to share a deep dive into the impact of the project from the CYP/Family and Practitioners perspective • NHSE data set that maps both the demographic, longitudinal pre intervention and post intervention qualitative and quantitative data quarterly. • Triangulation of CYP presenting in crisis to acute hospitals/ambulance service with self-injurious/youth violence presentations

		• Impact from the participant of the delivery of a suite of Trauma Informed Training modules endorsed by both Coventry and Warwickshire Safeguarding Partnerships. • Collation of the findings from the development of a Trauma Informed self-assessment tool for teams to use to track the impact of the embedding of the approach
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	As a test and learn project working with some of our most vulnerable young people and the impact of the interventions and evaluation data from the test sites are being collated to present to inform future commissioning intentions including the Mental Health strategy, Violence Reduction Partnership and ICS. In addition, as the project learns from what is working well or what might need to be strengthened, the project team and project board is agile and can iterate the modelling to respond to build on what's working well, sharing the learning between two test and learn sites in Coventry and Warwickshire which will inform future sustainability decisions beyond March 2025. The Vanguard has also developed an exit strategy should the project or elements of the project not be commissioned beyond March 2025 to ensure there is a robust intervention plan and step down for the CYP open to the service well before the cessation of the project.