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**HEAT Core20PLUS5 Toolkit**

**This toolkit contains an adapted version of the HEAT tool for each of the five clinical priority areas.**

Adapted from Public Health England HEAT tool published in September 2020. A resource produced by NHS England NW Public Health and Office for Health Improvement and Disparities (OHID) NW

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Health Equity Assessment Tool (HEAT):

Full version

Adapted for Core20PLUS5

Clinical Priority 1: Maternity

Date: December 2024

Adapted from Public Health England HEAT tool published in August 2024.

A resource produced by NHS England NW Public Health and Office for Health Improvement and Disparities (OHID) NW.

**HEAT and Core20PLUS5**

**Clinical Priority 1: Maternity**

What is Core20PLUS5?

Core20PLUS5 is NHS England’s approach to reducing healthcare inequalities at a national and system level. “Core20” represents the 20% most deprived members of the population (as defined by the Index of Multiple Deprivation). “PLUS” represents population groups who are at risk of social exclusion, such as inclusion health groups, and other groups sharing protected characteristics. “5” represents five clinical priorities that require accelerated improvement. The fifth priority focuses on maternity, ensuring continuity of care for those from Black, Asian and minority ethnic communities and from the most deprived groups, although see here for an update to this programme ([national letter](https://www.england.nhs.uk/wp-content/uploads/2022/09/B2011-Midwifery-Continuity-of-Carer-letter-210922.pdf), September 2022).

What is HEAT and how can it help?

HEAT is the Health Equity Assessment Tool. It can be used prospectively or retrospectively to help ensure an equitable provision. This adapted HEAT has been developed to enable identification of actions to reduce inequalities in maternal outcomes, including for Black, Asian and minority ethnic communities and from the most deprived groups.

Who is this tool for?

The HEAT tool was developed to be used across a range of programmes and projects. This version of the HEAT tool has been adapted to include specific prompts for maternity system leaders. Applying HEAT to Core20PLUS5 will help systems reach both Core20PLUS5 and maternity outcomes targets, while also helping to reduce the inequalities gap.

How do I use this tool?

The adapted HEAT below contains a series of prompts to enable effective application to the maternity clinical priority area. Following these prompts and filling each section of the tool as fully as possible will help you to identify health inequities within those from ethnic minority and deprived groups and offer the opportunity to identify actions to reduce inequalities in outcomes and inform local plan development. The tool does include a review and is therefore a continuous improvement process.

HEAT is supplemented by an [e-learning module](https://www.e-lfh.org.uk/programmes/health-equity-assessment-tool-heat/) on the NHS Learning Hub, designed to equip professionals with essential skills for undertaking a HEAT assessment.

The tool

|  |  |
| --- | --- |
| Programme or project being assessed |  |
| Date assessment started |  |
| Date assessment completed |  |
| Contact person (name, directorate, email, phone) |  |
| Name of strategic leader (senior responsible officer) |  |
| Lead organisation |  |
| Other organisations engaged |  |
| Community engagement methods used.  Best practice shows that engaging communities is an effective way of identifying, gaining insight and understanding how health inequalities are experienced by communities. So, consider methods of engagement (for example specific questions, focus groups, surveys, Place Standard) which are inclusive, involving a range of affected communities and stakeholders; and an assessment of whether, how and with what impact community engagement can assists with the programme, project or policy and its implementation. |  |
| Agreed review date |  |

|  |  |
| --- | --- |
| **Steps to take** | **Your response – remember to consider multiple dimensions of inequalities, including protected characteristics and socio-economic differences** |
| 1. Prepare – agree the scope of work and assemble the information you need | |
| 1. Your programme of work   Things you may want to consider include:  What are the main aims of your programme, project or policy?  What is the justification, reason or driver for this programme, project or policy?  How do you expect your programme, project or policy to impact (positively or negatively) health inequalities?  Is it a programme, project, service, product, policy or strategy? | **Background Information:**  The purpose of this section is to detail the scope of your service or project, who are your key stakeholders and how you expect your work to reduce inequalities.  Main aims of Core20Plus5 Programme  Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the ‘Core20PLUS’ – and identifies ‘5’ focus clinical areas requiring accelerated improvement.  “Core20” represents the 20% most deprived members of the population (as defined by the Index of Multiple Deprivation). “PLUS” represents population groups who are at risk of social exclusion, such as inclusion health groups, and other groups sharing protected characteristics and should be identified at a local level.  Main aims of Maternity clinical priority  The fifth priority focuses on maternity, ensuring continuity of care for people from Black, Asian and minority ethnic communities and from the most deprived groups, although see here for an update to this programme ([national letter](https://www.england.nhs.uk/wp-content/uploads/2022/09/B2011-Midwifery-Continuity-of-Carer-letter-210922.pdf), September 2022).  Key Stakeholders  Who are the partners who will be supporting and enabling delivery? e.g. health inequality leads, inclusion health leads / networks, specialised services/commissioning leads, population health boards, Local Maternity Systems partners  Reducing inequalities  Applying Core20PLUS5 to your work ensures a targeted approach to those most at risk of inequalities. Without taking a targeted approach to maternity care, there is the potential to widen the inequalities gap.  Examples of targeted approaches include stop smoking services that provide specific support to pregnant smokers who are more likely to be from deprived communities.  Digital Inclusion & Inclusion Health  Ensure [Digital Inclusion](https://www.england.nhs.uk/long-read/inclusive-digital-healthcare-a-framework-for-nhs-action-on-digital-inclusion/) & [Inclusion Health](https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/) Frameworks are considered and implemented throughout all steps of the tool. |
| 1. Data and evidence   What data do you need to gain a greater understanding of need and assess the impact of this programme, project or policy?  You should consider relevant data, evidence, indicators and intelligence you are aware of, for example:   * Nationally available data such as: * [Fingertips health profiles,](https://fingertips.phe.org.uk/) * [Public Health Outcomes Framework](https://fingertips.phe.org.uk/profile/public-health-outcomes-framework) * [Hospital Outcomes S](https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics)tatistics * [Office for National S](https://www.ons.gov.uk/)tatistics * [RightCare](https://www.england.nhs.uk/rightcare/) * Local data such as that available in Joint Strategic Needs Assessment, contract performance data, school attainment and qualitative data from local research, voluntary, community and social enterprise (VCSE) intelligence and community voice * Insights gained form community voices with lived experiences in relation to discrimination, racism, access and multiple disadvantage and displacement | The purpose of this section is to demonstrate local need through presentation of key indicators. You may have your own service level data e.g. Health Equity Audits, JSNAs that could be used. It is also important to highlight what data are not available that you would have found useful. A possible inequity may lie in the data systems themselves. Other key data sources to explore:   * OHID Fingertips, providing a number of profiles and relevant indicators at system and place level.   + [Child and Maternal Health](https://fingertips.phe.org.uk/profile/child-health-profiles) profile   + [Public Health Outcomes Framework](https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/1) * [Quality and Outcomes Framework](https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/general-practice-data-hub/quality-outcomes-framework-qof) * [Maternity Measures Dashboard, NHS Futures](https://future.nhs.uk/Home/grouphome) * [Wider Impacts of COVID-19,](https://analytics.phe.gov.uk/apps/covid-19-indirect-effects/) containing metrics on pregnancy and birth under “impact on healthcare”. * [NHS Atlas of Variation for the Care of Mothers, Babies, Children and Young People](https://fingertips.phe.org.uk/profile/atlas-of-variation)   List any other data sources and indicators that you may have available. |
| 1. Contributors to inequalities   Have you considered the interplay of multiple contributors to inequalities influencing personal experiences? | The purpose of this section is to demonstrate the differentiating factors that contribute to widening health inequalities. Consider the following:   * 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. * Different exposure to social, economic and environmental stressors and adversities, which affect states of mind from an early age and throughout life - stress and psychological wellbeing directly affect resilience, health conditions and health behaviours. * Differences in health behaviours or other risk factors (including genetic vulnerability) which exist within and 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. * Unequal access to or experience of health and other services between social groups. * Inequalities impacted by structural discrimination which results in some groups and individuals - for example, those who identify with one or more of the protected characteristics - experiencing poorer access to services and poorer outcomes |
| 1. Assess - examine the evidence and intelligence | |
| 1. Distribution of health | |
| Based on evidence collected above, which populations face the biggest health inequalities for your topic or service area?  Think about the 4 health inequality domains (socio-economic deprived population; geographic deprivation; inclusion health and vulnerable groups; protected characteristics). | People living in the 20% most deprived areas and experiencing deprivation are among the groups prioritised within the maternity clinical priority. These people are more likely to have poorer maternity outcomes. What does the data tell you above in terms of health inequalities by geographic deprivation / socioeconomic status?  Key considerations to determine the distribution of risk factors for poorer maternity outcomes include:   * Where are your most geographically deprived areas (e.g. those areas in the lowest IMD quintile)? * Where are your isolated communities, such as coastal and rural?   Do you have local level National Statistics Socio-economic Classification (NS-SEC) scores to determine socioeconomic status? See Office for National Statistics’ [Census Maps](https://www.ons.gov.uk/census/maps/choropleth/work/national-statistics-socio-economic-classification-ns-sec) |
| Consider your programme, project or policy against the socio-economic status domain and how it interacts with the domain, and the impact that has or may have. | Consider the following:  Access to Services   * How does the maternity programme ensure equitable access for women from all socio-economic (SES) backgrounds? * Are there any barriers for lower SES women, such as transportation or costs, which might prevent access to maternity services?   Affordability and Financial Support  -[Sure Start Maternity Grant: Overview - GOV.UK](https://www.gov.uk/sure-start-maternity-grant)  -[Healthy Start - GOV.UK](https://www.gov.uk/healthy-start)   * Does the maternity programme provide financial assistance or subsidies to women from lower SES backgrounds? * Are there any fee reductions, insurance coverage, or other forms of financial support to ensure affordability?   Impact on Health Outcomes:   * How does SES impact maternal and neonatal health outcomes within the program? * Are disparities in birth outcomes (e.g., low birth weight, premature births) addressed and reduced across SES groups? |
| Consider your programme, project or policy against the geographic deprivation domain and how it interacts with the domain, and the impact that has or may have. | Consider the following (not limited to):  Geographic Barriers:   * How does the programme ensure equitable access to maternity care for women in geographically deprived areas, such as rural or remote locations? * Are there challenges related to transportation, healthcare facility availability, or distance to maternity services that disproportionately affect women in these regions?   Availability of Services:   * Are maternity services (e.g., antenatal care, labour and delivery, postnatal care), particularly community maternity services, accessible in underserved or remote areas, or do women in these areas need to travel long distances to access care? * Does the programme address gaps in service availability in rural or economically deprived urban areas (e.g., fewer clinics, limited midwife access)?   Outreach and Engagement   * Targeting Geographically Deprived Communities:   + How does the programme ensure that women living in geographically deprived areas are aware of and able to access maternity services?   + Are there targeted outreach efforts in underserved regions (e.g., via mobile clinics, community-based health workers, or telemedicine)? * Cultural and Social Sensitivity:   + How does the programme adapt its services to meet the specific needs of geographically diverse communities, considering the social, cultural, and economic context of these areas?   Healthcare Workforce Distribution   * Workforce Shortages:   + Does the programme address potential shortages of healthcare professionals, such as obstetricians, midwives, and nurses, in geographically deprived regions?   + How are staffing gaps in rural or underserved areas managed to ensure quality maternity care is available? * Training and Support:   + Does the programme offer training or incentives for healthcare workers to practice in deprived or rural areas?   + Are healthcare professionals in geographically isolated areas supported with ongoing training, resources, and access to teleconsultations or expert guidance? |
| Consider your programme, project or policy against the inclusion health and vulnerable groups domain and how it interacts with the domain, and the impact that has or may have. | Inclusion health and vulnerable groups (for example, people experiencing homelessness, prison leavers, young people leaving care): [NHS England » A national framework for NHS – action on inclusion health](https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/)  Inclusion health (IH) groups are those individuals who are at risk of social exclusion. These include: -   * People experiencing homelessness. * People experiencing drug and alcohol dependence. * Migrants * Gypsy, Roma, Traveller communities * Sex workers * People in contact with criminal justice system * People with a Learning Disability   Data collection for IH groups is often incomplete. People in IH groups may not be registered with and may not access GPs. We know they face barriers and have poorer outcomes. It is important to recognise these groups as potentially being at higher risk of poorer maternity outcomes. These groups may not proactively present for maternity care, due to barriers in accessing healthcare. Key questions to address include:   * Do you know the prevalence and distribution of IH groups in your area? * What service level data do you have in relation to these groups? * Where and what are the data gaps for IH groups? |
| Consider your programme, project or policy against experience related to protected characteristics domain and how it interacts with the domain, and the impact that has/may have. | Experience related to protected characteristics:  Protected characteristics according to the Equality Act 2010 are:   * age * disability * gender reassignment * marriage and civil partnership * pregnancy and maternity * race * religion and belief * sex * sexual orientation   According to the data, and the relevant above protected characteristics, are any of these groups more at risk of worse maternity outcomes? |
| 1. Causes of inequalities | |
| Recognising that there are inequalities experienced by the population groups identified, considering the data and evidence, what are the wider determinants and structural discriminatory drivers? Consider the diverse range of social economic factors which influence people’s health and wellbeing. | Wider determinants of health  Social and economic factors influence health\*\*. It is recognised that not all of these factors are in your control, but you need to be aware of the impact they have on your population group in terms of access, experience and outcomes in maternity care. You may be able to make a change in your service that could reduce the impact. Examples for consideration include:   * Education * Have you considered the health literacy of population groups most at risk of health inequalities? * Is patient information appropriate and accessible to all population groups (easy read including pictures/multi-lingual)?   + Must consider both general literacy level and specific literacy needs for certain protected characteristics such as disability needs and lingual. * Systematic/Institutional Racism and discrimination * Have you thought about barriers to accessing healthcare across population groups, particularly among IH groups? * Employment * Have you considered service access for employed people and unpaid carers etc? e.g. do you offer out of hours and weekend appointments? Do you have occupational health offers or outreach services? * How accessible are clinic locations and GP practices, could areas with lower uptake rates be offered free transport provision? Are clinic locations accessible by public transport? Can they be offered in other locations such as workplaces, supermarkets, shopping centres? * Enablers/Assets   + Are there any specific enablers or assets that could be harnessed to reach population groups most at risk of health inequalities? E.g. identifying and working with relevant community groups, other services, people and VCFSE organisations   **Reference: \*\*Hood et al 2015**[**County Health Rankings: Relationships Between Determinant Factors and Health Outcomes – ScienceDirect**](https://www.sciencedirect.com/science/article/pii/S0749379715005140)​ |
| What does the data and evidence tell you are the potential drivers for these inequalities? It may be helpful to consider the following questions:   * Which wider determinants are influential, for example, income, education, employment, housing, community life, racism and discrimination, cultural, environmental? * Are there any factors which indicate structural discrimination or racism will impact upon your programme, project or policy, for example mandatory use of digital access to health advice preventing access for less IT literate individuals and communities? * Which health behaviours play a role? * Does service quality, access and take up increase the chance of health inequalities in your work area? * Does climate change have an impact on health inequalities in relation to your programme, project or policy? * Which of these can you directly control? * Which can you influence? * Which are out of your control? | Consider the following (but not limited to)  Wider Determinants of Health   * Income:   + How does the income level of women in deprived areas impact their access to maternity services, quality of care, and health outcomes?   + Have you considered increased gender income disparity or the risk of intimate partner violence resulting in financial control?   + Are there policies in place to support low-income women with financial assistance or subsidies for maternity care (e.g., transportation, childcare costs)? * Education:   + How does the level of maternal education influence health literacy, access to prenatal education, and engagement in maternity care services?   + Does the programme provide tailored educational resources to women with lower levels of education to address health literacy gaps in maternity care? * Employment:   + How do employment status and working conditions impact access to maternity care for women in deprived areas (e.g., limited maternity leave, job insecurity)?   + Are there specific measures to support pregnant women in low-wage, 0-hour contracts or contracted work (e.g. Uber, Deliveroo etc,), precarious, or part-time employment in accessing care? * Housing:   + How does housing quality and stability affect the maternal health outcomes in geographically or economically deprived areas?   + Are housing conditions (e.g., overcrowding, unsafe environments) addressed by the maternity programme to ensure healthy pregnancy outcomes? * Community Life:   + How does community support (or lack thereof) influence maternal well-being and outcomes, especially in isolated or deprived areas?   + Does the programme utilise community-based initiatives (e.g., peer support groups, local health champions) to enhance maternity care in underserved communities? * Racism and Discrimination:   + How does racial and ethnic discrimination impact women’s access to maternity care, their treatment, and their health outcomes?   + Does the programme address institutional racism and provide culturally competent care to minority ethnic women to reduce the effects of discrimination? * Cultural and Environmental Factors:   + How do cultural beliefs and practices affect engagement with maternity services in different socio-economic or ethnic groups?   + Does the programme consider cultural diversity in its care delivery and offer culturally sensitive services to ensure inclusivity and equitable outcomes?   Structural Discrimination and Racism   * Digital Access and Health Equity:   + Does the mandatory use of digital platforms (e.g., online consultations, digital health advice) exclude less IT-literate individuals or those without reliable internet access, especially in low-income or elderly populations?   + What measures are in place to ensure that women in deprived or rural areas with limited access to technology can still receive quality maternity care (e.g., phone consultations, printed materials)? * Health System Accessibility:   + Are there systemic barriers, such as long wait times, limited availability of services, or geographical inaccessibility, that disproportionately affect women from lower socio-economic backgrounds or minority groups?   + How does the programme work to eliminate these barriers and promote equitable access to maternity services?   Health Behaviours   * Lifestyle and Risk Factors:   + How do health behaviours, such as smoking, alcohol consumption, and poor diet, contribute to maternal and neonatal health inequalities in deprived communities?   + Are there targeted interventions in place to support women in disadvantaged areas with behaviour change programs (e.g., smoking cessation, nutrition education)? * Prenatal Care Engagement:   + How do women’s health behaviours (e.g., avoiding prenatal care visits, late initiation of care) vary across socio-economic and cultural groups, and how does this impact maternity outcomes?   + Does the programme ensure that all women, especially those from vulnerable backgrounds, engage in timely and continuous prenatal care?   Service Quality, Access, and Take-Up   * Quality of Maternity Services:   + How does the quality of maternity care vary across different socio-economic and geographic regions, and does this contribute to disparities in health outcomes?   + Does the programme ensure that women in deprived areas receive the same high standard of care as those in wealthier areas, and if not, what strategies are in place to address the disparity? * Access and Take-Up:   + Are there significant differences in the take-up of maternity services between women from different socio-economic or ethnic backgrounds?   + Does the programme monitor the factors that impact service take-up (e.g., cost, distance, awareness) in deprived communities, and address them to increase engagement?   Climate Change and Environmental Impact   * Impact of Environmental Factors:   + How does climate change, including air pollution, extreme weather events, and other environmental factors, exacerbate health inequalities for pregnant women, especially in deprived areas?   + Does the programme take into account the specific environmental health risks faced by women in geographically deprived areas (e.g., urban heat islands, poor air quality)? * Vulnerability of Deprived Communities:   + Are pregnant women in lower socio-economic areas more vulnerable to the health impacts of climate change, and how does the programme address this vulnerability (e.g., cooling centres, air quality monitoring)?   Control, Influence, and External Factors   * Direct Control:   + Which factors does the programme have direct control over in addressing health inequalities (e.g., service delivery, resource allocation, training for healthcare providers)?   + How can the programme directly improve service accessibility and quality for women in deprived areas, such as through mobile clinics or outreach workers? * Influence:   + Which factors can the programme influence to reduce inequalities (e.g., partnerships with local organisations, advocating for policy changes on transport or housing)?   + How does the programme collaborate with external organisations or agencies to address broader social determinants, like housing or employment, which impact maternal health? * Out of Control:   + Which factors are outside the programme’s control but still contribute to health inequalities (e.g., national policies on income, public health infrastructure, environmental policies)?   + What steps can be taken to mitigate the effects of these external factors, even if they are not directly within the program's control? |
| Consider if any of the following aspects influence or are influenced by your programme, project or policy - if yes, refer to the topic specific-prompts in the appendix, below, and respond here:  • poverty and cost of living  • community engagement  • COVID-19 or incident recovery  • violence prevention  • Core20PLUS5  • major health conditions  • substance misuse  • mental health  • service commissioning  • rural and coastal health  • policy or strategy  • healthy weight  • children and young people  • cardiovascular disease (CVD)  • oral health and dental services | Consider the following (but not limited to)  Poverty and Cost of Living   * Impact on Access and Affordability:   + How does the cost of living affect the ability of women in deprived areas to access maternity services (e.g., transportation, childcare, out-of-pocket expenses)?   + Does the maternity programme offer financial support, subsidies, or services to reduce the financial burden for low-income women (e.g., transportation, accommodation, or basic necessities)? * Social Support:   + Does the programme integrate support for women experiencing financial hardship into the maternity care pathway, such as access to benefits, financial counselling, or support for basic living conditions?   Community Engagement   * Involvement in Design and Delivery:   + How does the maternity programme engage local communities, particularly in deprived areas, in the design and delivery of services?   + Are there community advisory groups, focus groups, or co-design processes in place to ensure that the maternity services reflect the needs of local populations? * Community Health Resources:   + Does the programme collaborate with community organisations, local leaders, or peer networks to ensure maternity care is culturally appropriate, accessible, and well-utilised?   COVID-19 or Incident Recovery   * Impact of COVID-19 on Maternity Services:   + How has the COVID-19 pandemic impacted maternity service delivery, especially in areas with high socio-economic deprivation?   + Did the programme adapt to maintain continuity of care (e.g., through telehealth, remote consultations) during lockdowns or restrictions? * Post-COVID Recovery:   + How does the maternity programme address the backlog of services or delayed care due to COVID-19, particularly for vulnerable or high-risk groups?   + Does the programme ensure that women who were affected by the pandemic’s impact on maternity care (e.g., delayed appointments, isolation) receive appropriate follow-up and support?   Violence Prevention   * Support for Victims of Domestic Violence:   + Does the maternity programme screen for domestic violence and provide support or referrals to women who may be experiencing abuse?   + How does the programme ensure the safety and well-being of pregnant women who may be at risk of violence, especially in deprived communities? * Interventions for At-Risk Women:   + Does the programme provide safe spaces, counselling, and referrals to women who need support in escaping violent situations during pregnancy or after childbirth?   Core20PLUS5   * Addressing Health Inequalities:   + How does the maternity programme address the Core20PLUS5 framework, ensuring equitable access to services for the most deprived 20% of the population?   + Are maternity services tailored to meet the needs of the five identified priority areas (maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, cardiovascular disease)? * Monitoring and Evaluation:   + How does the programme assess progress toward reducing health inequalities, particularly in the areas of maternal and neonatal health, for the most deprived communities?   + How does the programme monitor for unintended consequences?   Major Health Conditions   * Maternal and Infant Health:   + How does the programme address co-existing major health conditions such as diabetes, hypertension, or pre-existing heart conditions, and ensure women with these conditions have appropriate maternity care?   + Does the programme provide specialised care or pathways for women with chronic health conditions that may complicate pregnancy or delivery? * Prevention and Management:   + How does the programme incorporate strategies for the prevention and management of major health conditions in pregnancy (e.g., gestational diabetes, preeclampsia)?   Substance Misuse   * Impact of Substance Misuse on Maternal Health:   + Does the maternity programme screen for substance misuse (e.g., alcohol, tobacco, recreational drugs) during pregnancy, and offer interventions or referrals to treatment services?   + How does the programme ensure that women with substance misuse issues receive the necessary support for both their health and the health of their baby? * Support for Recovery:   + Are there tailored maternity care pathways for women in recovery from substance misuse, ensuring safe and supportive care during pregnancy?   Mental Health   * Perinatal Mental Health:   + How does the programme address perinatal mental health, including screening for conditions such as depression, anxiety, and post-traumatic stress disorder (PTSD)?   + Are mental health services integrated into the maternity care pathway, particularly for women in deprived areas who may face higher levels of mental health challenges? * Support for Vulnerable Groups:   + Does the programme provide specific mental health support for pregnant women experiencing social or economic deprivation, or those from marginalised communities?   Service Commissioning   * Equity in Service Delivery:   + How does the commissioning of maternity services ensure that services are equitable, accessible, and meet the needs of women in deprived areas?   + Does the programme consider geographical and socio-economic disparities when commissioning services, ensuring that resources are allocated to areas with the highest need? * Stakeholder Involvement:   + How does the programme engage with key stakeholders, including healthcare professionals, local authorities, and community organisations, in the commissioning of maternity services?   Rural and Coastal Health   * Access in Rural Areas:   + How does the programme ensure that women in rural or coastal areas have equitable access to maternity care services, considering challenges such as distance, travel time, and fewer healthcare facilities?   + Are there alternative service delivery models, such as mobile clinics or telemedicine, which can improve access to maternity care in rural or remote regions? * Tailored Support for Rural Communities:   + Does the programme consider the unique needs of rural and coastal communities, including economic challenges, lack of local support services, and the impact of isolation on maternal health?   Policy or Strategy   * Alignment with National and Local Policies:   + How does the maternity programme align with national and local public health policies or strategies aimed at reducing health inequalities and improving maternal health?   + Does the programme incorporate policies that target specific population groups, such as those living in poverty or in remote areas, to ensure they receive optimal maternity care? * Advocacy for Policy Change:   + How does the programme advocate for changes in public policy to address the wider determinants of maternal health, such as housing, employment, or healthcare access?   Healthy Weight   * Impact of Maternal Weight on Health Outcomes:   + Does the maternity programme address the relationship between maternal weight (overweight/obesity) and pregnancy-related complications (e.g., gestational diabetes, preeclampsia, and birth complications)?   + How does the programme support weight management during pregnancy, particularly for women in deprived areas who may face barriers to healthy eating and physical activity? * Nutrition and Physical Activity:   + Does the programme promote healthy eating and physical activity among pregnant women, particularly for those who may be at risk for obesity or weight-related complications?   Children and Young People   * Intergenerational Health:   + How does the maternity programme consider the long-term impact of maternal health on the health of children and young people, particularly in deprived communities?   + Does the programme provide support for young mothers to ensure that they receive the care they need for both their own health and the health of their babies? * Early Childhood Development:   + Does the programme address the early development needs of children born into socio-economically disadvantaged families, ensuring access to early childhood health services and support?   Cardiovascular Disease (CVD)   * Impact of CVD on Pregnancy:   + How does the maternity programme address women with pre-existing cardiovascular conditions (e.g., hypertension, heart disease) and ensure safe management during pregnancy and delivery?   + Are there interventions in place to prevent the onset of cardiovascular disease in women during pregnancy, particularly for those with risk factors such as obesity, smoking, or poor diet? * Postpartum Care for CVD:   + Does the programme ensure continued monitoring and management of cardiovascular risk factors for women post-pregnancy, especially for those with gestational hypertension or preeclampsia?   Oral Health and Dental Services   * Impact of Oral Health & Dental Services on Overall Health Outcomes   + Does the dental programme address the relationship between poor oral health and the development of other health conditions (e.g., cardiovascular disease, diabetes, respiratory infections)?   + Does the programme promote the importance of good oral hygiene and regular dental visits, particularly for populations at higher risk of oral health complications, such as children, older adults, or individuals with disabilities? * Access to Care for Oral Health & Dental Services   + How does the programme ensure access to dental care for vulnerable populations, particularly those in deprived areas who may face barriers such as affordability, lack of transportation, or cultural differences?   + How does the dental programme collaborate with other health services (e.g., maternity care, general health services) to ensure that oral health is adequately addressed as part of overall healthcare, particularly for individuals with multiple health concerns? |
| 1. Refine and apply – make changes to your work plans that will have the greatest impact | |
| 1. Potential effects | |
| Considering the above, how is your programme, project or policy likely to reduce health inequalities? | Current service provision   * How does your service/policy currently provide support for individuals of lower socioeconomic status and living in areas of higher deprivation? * Does your current service model/policy take into consideration IH groups who face barriers to accessing healthcare? * Does your current service provision/policy mitigate any of the impacts of the harmful wider determinants of health for those groups most at risk of poorer maternity outcomes? * Reflecting on the information obtained so far, is there any part of your service model/policy that may widen the inequality gap? |
| Does your programme, project or policy have the potential unintended consequence of widening inequalities by, for example:   * 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? * Relying on professional-led interventions? * Not tackling the root causes of health inequalities? * Relying upon digital access? * Relying upon high level of literacy? | Consider the following (but not limited)  Requiring Self-Directed Action Which Is More Likely to Be Done by Affluent Groups   * Access and Engagement:   + Does your programme assume that all women, including those from deprived or vulnerable backgrounds, have the resources (time, education, financial stability) to take self-directed actions (e.g., making appointments, attending health check-ups, following online health advice)?   + Are there mechanisms in place to support women who may face barriers to self-management (e.g., financial barriers, childcare responsibilities, lack of social support)? * Equity of Access:   + How does the programme ensure that women from low socio-economic backgrounds, who may face additional challenges in managing their own health, have the same access to care and the same opportunities to engage in the program?   Not Tackling the Wider and Full Spectrum of Causes   * Addressing Social Determinants of Health:   + Does your programme address only the immediate medical needs of maternity care, or does it also consider the broader social determinants of health (e.g., income, housing, education, employment) that influence maternal and neonatal health outcomes in deprived areas?   + Is there a holistic approach in place that recognises how factors such as mental health, substance misuse, or housing instability might affect access to and the quality of maternity care? * Multi-Agency Collaboration:   + Is your programme collaborating with other sectors (e.g., social services, housing, employment support) to address the full range of factors influencing maternal health, particularly for those in disadvantaged communities?   Not Being Designed with Communities   * Community Involvement in Programme Design:   + How has the programme been designed in collaboration with the communities it aims to serve, particularly those in deprived or marginalised areas?   + Are there consultation mechanisms, such as focus groups or community advisory boards, in place to ensure that the needs and preferences of local populations are considered? * Cultural Sensitivity and Appropriateness:   + Does the programme incorporate culturally sensitive approaches to maternity care to ensure that women from diverse ethnic or cultural backgrounds feel included and supported?   Relying on Professional-Led Interventions   * Engagement of Service Users in Care:   + Does the programme overly rely on professional-led interventions, potentially undermining women’s agency in managing their own health and decisions around maternity care?   + How does the programme balance professional guidance with empowering women to take an active role in their own health, especially those who may face structural barriers to engaging with healthcare providers? * Support for Vulnerable Groups:   + Does the programme provide enough personalised or community-based support to vulnerable groups, such as those with low health literacy or those experiencing social isolation?   Not Tackling the Root Causes of Health Inequalities   * Focus on Long-Term Health Outcomes:   + Does the programme focus solely on addressing immediate health concerns during pregnancy and childbirth, or does it also take a long-term view to tackle root causes of health inequalities (e.g., education, housing, poverty)?   + Are there clear strategies in place to address structural factors, such as access to affordable housing, quality education, and employment, which contribute to health inequalities in maternity care? * Policy and Systemic Change:   + Does your programme advocate for or engage in policy changes that address the systemic causes of health inequalities, such as discriminatory practices, unequal access to resources, or inadequate healthcare infrastructure in deprived areas?   Relying Upon Digital Access: [NHS England » Inclusive digital healthcare: a framework for NHS action on digital inclusion](https://www.england.nhs.uk/long-read/inclusive-digital-healthcare-a-framework-for-nhs-action-on-digital-inclusion/)   * Digital Divide:   + Does the programme assume that all women have access to the necessary digital tools (e.g., internet access, smartphones, computers) to participate in virtual consultations, online health education, or other digital aspects of maternity care?   + How does the programme ensure that women in deprived or rural areas who may lack digital access are not excluded from services? * Alternative Access Options:   + Are there non-digital alternatives (e.g., phone calls, in-person visits) for women who cannot engage with digital platforms? How are these alternatives promoted and integrated into the maternity care system?   Relying Upon High Levels of Literacy   * Health Literacy:   + Does the programme assume that all women have a high level of health literacy, which could disadvantage those with lower literacy levels (e.g., understanding written instructions, interpreting health materials)?   + Are health communications, including consent forms, instructions, and educational resources, available in formats that accommodate low literacy levels (e.g., simple language, visual aids, or audio options)? * Tailoring Communication:   + How does the programme address health literacy disparities by offering tailored communication strategies for women from disadvantaged backgrounds, including those with lower educational attainment? |
| What aspects of mental wellbeing are affected? Consider risk and protective factors. | Consider the following (but not limited to)  Risk Factors for Mental Wellbeing   * Socioeconomic Stressors:   + How do financial stressors (e.g., low income, job insecurity, housing instability) affect the mental wellbeing of pregnant women, particularly in deprived areas?   + Are there specific interventions in place to address the mental health impacts of economic insecurity during pregnancy and early motherhood? * Risk of Intimate Partner Violence & Control   + How does the programme assess and monitor the safety and wellbeing of individuals experiencing intimate partner violence?   + How does the programme identify and address coercive control and its impact on individuals? * Social Isolation and Lack of Support:   + How does social isolation, including lack of family or community support, influence maternal mental health outcomes in vulnerable populations?   + What strategies does the programme employ to reduce isolation and provide emotional and practical support to women, particularly in rural or isolated areas? * Adverse Childhood Experiences (ACEs):   + Does the programme identify women with a history of Adverse Childhood Experiences (ACEs), which can be a significant risk factor for poor mental health during pregnancy?   + How does the programme offer additional mental health support for women with a history of trauma or abuse? * Substance Misuse:   + How does the programme address the relationship between substance misuse (e.g., alcohol, drugs, tobacco) and maternal mental wellbeing?   + Are women with substance misuse issues referred for mental health services to address both substances use and underlying mental health concerns?   Protective Factors for Mental Wellbeing   * Access to Emotional and Psychological Support:   + Does the maternity programme provide adequate access to mental health services (e.g., counselling, therapy, support groups) for pregnant women and new mothers?   + Are there programmes that focus on perinatal mental health, including screening for depression, anxiety, and other mental health conditions that may arise during pregnancy or the postpartum period? * Strong Social Support Networks:   + How does the programme facilitate access to social support networks, such as peer support groups, family counselling, or community support organisations, which can help buffer against mental health challenges?   + Does the programme encourage partner and family involvement in the maternity care process to enhance emotional support? * Access to Information and Education:   + How does the programme ensure that women have access to mental health education about common challenges during pregnancy (e.g., baby blues, postnatal depression, anxiety) and coping strategies?   + Does the programme offer information in multiple formats, considering varying literacy levels and language barriers, to ensure all women can benefit from mental health resources? * Physical Health and Wellness Support:   + How does the programme address the connection between physical health and mental health, such as promoting exercise, healthy eating, and adequate sleep, which can positively influence mental wellbeing?   + Are there specific programmes or interventions that focus on postpartum recovery, which can help prevent mental health issues related to physical exhaustion and discomfort after childbirth? |
| 1. Action plan | |
| What specific actions will you take to maximise the potential for positive impacts and/or to mitigate the negative impacts on health inequalities? Provide a list of actions and targets. | Changes to service provision   * Considering all of the above, what could you change to your service provision/policy to ensure you are targeting provision to those population groups identified in section 2 as having the highest need? * We know that those who face barriers to accessing healthcare, those who are socially excluded, and those living in more deprived areas are at higher risk for poorer maternity outcomes. It can be reasonably assumed that those with poorer access and less likely to attend appointments are less likely to have optimal maternity care. Considering these points and in the absence of local data for certain IH groups, are there any actions that could be taken? * Are there any specific enablers or assets that could be harnessed to reach these groups? Such as identifying and working with relevant community groups, other services, people and VCFSE organisations. * Specifically, what steps are required to ensure that data is collected locally for those population groups most at risk?   The following NHS Futures sites may be helpful to access a range of resources including best practice case study examples:   * [Equity and Health Inequalities Network](https://future.nhs.uk/EHIME/groupHome) and [Healthcare Inequalities Improvement Programme](https://future.nhs.uk/EHIME/groupHome) * [FutureNHS Case Study Hub](https://future.nhs.uk/CaseStudies/grouphome) * [Maternity and Neonatal Safety Improvement Programme](https://future.nhs.uk/MatNeoQI/groupHome) * [Maternity Local Transformation Hub](https://future.nhs.uk/LocalTransformationHub/groupHome) * [National Maternity Leadership](https://future.nhs.uk/NationalMaternityLeadership/groupHome) * [Maternity Workforce Programme](https://future.nhs.uk/MaternityWorkforceProgramme/groupHome)   High Impact interventions (*Source*: [*Maternity high impact area 6: Reducing the inequality of outcomes for women from Black, Asian and Minority Ethnic (BAME) communities and their babies (publishing.service.gov.uk)*](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942480/Maternity_high_impact_area_6_Reducing_the_inequality_of_outcomes_for_women_from_Black__Asian_and_Minority_Ethnic__BAME__communities_and_their_babies.pdf#:~:text=The%20maternity%20high%20impact%20areas%20addressed%20in%20this,pregnancy%20supporting%20parents%20to%20have%20a%20smokefree%20pregnancy)*)*   * Improving planning and preparation for pregnancy * Supporting parental mental health * Supporting healthy weight before and between pregnancy * Reducing the incidence of harms caused by alcohol in pregnancy * Supporting parents to have a smokefree pregnancy * Reducing the inequality of outcomes for those from Black, Asian and Minority Ethnic (BAME) communities and their babies   National Priorities   * In the [Equity and Equality guidance for local maternity systems](https://www.england.nhs.uk/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf), Personalised Care and Support Plans (including that these should be available in a range of formats and languages) and Asset Mapping to support personalised care and planning. |
| How can you act on the specific causes of inequalities identified above? | Consider the following (but not limited to)   * How can your programme, project, or policy address the socio-economic determinants contributing to health inequalities in maternity care? * What strategies are in place and how are they actioned to reduce access barriers, including digital exclusion and low health literacy, for women in deprived communities? [NHS England » Inclusive digital healthcare: a framework for NHS action on digital inclusion](https://www.england.nhs.uk/long-read/inclusive-digital-healthcare-a-framework-for-nhs-action-on-digital-inclusion/) * How does your programme tackle structural inequalities, including racism, discrimination, and gender inequalities, within the maternity care system? |
| What activities will you put in place which will adapt and enhance your programme, project or policy in relation to cultural competencies? For example, consideration of cultures, languages, formats, images, digital, written, spoken, translation services. | Potential examples (but not limited to)  Culturally Tailored Health Education:   * Provide culturally sensitive health education materials, such as brochures, videos, and posters, in multiple languages and formats (e.g., visual aids, audio) to accommodate women from diverse cultural backgrounds and those with low literacy levels.   Use of Interpreters and Translation Services:   * Offer professional interpreter services for non-English-speaking patients, both in person and via phone or video, to ensure clear communication during consultations.   Cultural Awareness Training for Healthcare Providers:   * Provide regular cultural competence training for all healthcare staff to increase understanding of the diverse cultural practices, beliefs, and health perceptions within the community. |
| What specific steps and action will you take to address the identified structural racism and discrimination? | Potential examples (but not limited to) [NHS England — North West » Anti Racist Framework](https://www.england.nhs.uk/north-west/nhs-north-west-bame-assembly/anti-racist-framework/)  Bias Training for Healthcare Providers:   * Implement mandatory anti-racism and cultural competency training for all healthcare staff, focusing on recognising and addressing unconscious bias, microaggressions, and discriminatory behaviours.   Community Consultation and Involvement:   * Engage with local community leaders and advocacy groups to ensure that the voices of marginalised communities are included in the design and evaluation of maternity care services.   Monitoring and Accountability Systems:   * Implement data collection and monitoring systems to track disparities in maternal health outcomes based on race, ethnicity, and socioeconomic status, and hold healthcare providers accountable for addressing these gaps, while also monitoring for unintended consequences. |
| How will you mitigate against the negative impact of when multiple harmful factors interact and result in compounding poor health outcomes for effected communities? | Potential examples (but not limited to)  Integrated Care and Support Services:   * Establish a multi-disciplinary care model that provides integrated services for women, addressing the interrelated factors such as mental health, socioeconomic status, and access to healthcare.   Targeted Outreach and Community Engagement:   * Focus on community outreach to raise awareness of available services, ensuring that those at risk from multiple intersecting factors (e.g., poverty, poor housing, substance misuse) are aware of, and can access, appropriate care.   Trauma-Informed Care and Resilience Building:   * Implement trauma-informed care approaches that recognise and address the impact of past trauma and ongoing stressors, while helping to build resilience in affected women. |
| Which populations face the biggest inequalities for your targeted action? | Potential examples (but not limited to)  [NHS England » A national framework for NHS – action on inclusion health](https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/)  Mothers from Deprived Socioeconomic Backgrounds (Core20)   * Provide additional support for pregnant women in deprived socioeconomic conditions, focusing on access to healthcare, mental health services, and nutritional support.   Ethnic Minorities and Migrant Populations (PLUS)   * Tailor maternity services for ethnic minority women and migrants who may face cultural, language, or structural barriers to healthcare.   Women Experiencing Homelessness or Housing Insecurity (Inclusion Health)   * Develop outreach programmes to engage homeless women or those at risk of homelessness in maternity care, addressing both their healthcare and housing needs.   LGBTQ+ Pregnant Individuals (PLUS)   * Ensure inclusive maternity care for LGBTQ+ individuals, who may experience discrimination or a lack of understanding within traditional maternity services.   Young Mothers and Teenage Pregnancies (PLUS)   * Focus on supporting young mothers, particularly teenage pregnancies, by providing targeted education, mentorship, and social support. |
| Could you design the programme, project or policy with communities who face the biggest health inequalities to maximise the chance of it working for them? What will you need to enable this? | Potential examples (but not limited to)  Co-Design with Communities (e.g., Deprived Socioeconomic Groups)   * Engage local community leaders, advocacy groups, and community members in the design and implementation of maternity services to ensure the programme reflects the unique needs and barriers of women in deprived areas. * What’s Needed: Community outreach workers and facilitators who understand the local context, as well as funding for community engagement activities (e.g., focus groups, town hall meetings).   Inclusive and Culturally Sensitive Approaches (e.g., Ethnic Minorities)   * Work with ethnic minority communities to design culturally appropriate maternity care services, incorporating local customs, beliefs, and languages into the care model to ensure it is accessible and relevant. * What’s Needed: Cultural competency training for staff, interpreting services, and collaboration with community-based organisations that represent these groups.   Peer Support and Mentorship Programs (e.g., Young Mothers)   * Develop peer support groups where young mothers or those at risk of early pregnancy can connect, share experiences, and provide emotional support to one another, guided by trained mentors. * What’s Needed: Peer mentors from within the community, training for mentors, and a platform for regular communication (e.g., group chats, support groups). |
| Could you seek to increase people’s control over their health and lives (if appropriate)? What would this look like? | Potential examples (but not limited to)  Informed Decision-Making and Shared Decision-Making   * Provide pregnant women with clear, accessible information about all their care options, risks, and benefits to allow them to make informed decisions about their pregnancy and birth plan. * What This Looks Like: During prenatal visits, healthcare providers give women written and verbal information in multiple formats (e.g., simple language, visual aids, videos) so they can actively participate in shared decision-making about their care, from choosing delivery methods to deciding on pain relief options.   Peer-Led Support Groups   * Establish peer-led support groups where women can share experiences and advice, empowering them to make informed choices about their health. * What This Looks Like: Pregnant women connect with others who have similar experiences (e.g., first-time mothers, women from ethnic minorities) and receive guidance on self-care, childbirth preparation, and navigating the healthcare system from peers who understand their unique challenges.   Health Coaching and Empowerment Programs   * Offer personal health coaching sessions that empower women to set goals related to their health (e.g., managing stress, improving diet, physical activity) and provide the tools to take control of their well-being. * What This Looks Like: A woman receives one-on-one coaching on how to manage her health, with regular check-ins that help her set achievable goals. The programme could focus on areas such as nutrition during pregnancy, mental well-being, and exercise. |
| Which community groups and consultation methods will you engage to tackle the problem, to maximise the chance of reaching large populations at scale (see [Community-centred public health: taking a whole system approach](https://www.gov.uk/government/publications/community-centred-public-health-taking-a-whole-system-approach)). | Potential examples (but not limited to)  Community-Based Organisations (CBOs) in Deprived Areas   * Local community-based organisations that serve low-income, vulnerable, and marginalised groups (e.g., women’s shelters, food banks, community centres). * Consultation Method: Partner with these organisations to co-design programs, hold focus groups, and distribute surveys to gather feedback and understand the unique needs of the community.   Faith-Based Organisations   * Faith-based groups, such as churches, mosques, and temples, which are trusted spaces for many communities. * Consultation Method: Engage faith leaders to host community forums, where health experts can provide information, listen to concerns, and tailor healthcare messages.   Ethnic Minority Groups   * Ethnic minority communities, including migrant populations, Black, Asian, and Minority Ethnic (BAME) groups. * Consultation Method: Use community mapping and interviews to identify key cultural concerns and challenges in accessing healthcare, then host culturally tailored workshops and surveys.   Youth and Young Parents   * Young parents and teen mothers, who may face unique challenges in accessing maternity and postnatal care. * Consultation Method: Organise peer-led focus groups, online consultations, and social media campaigns to reach young people where they are.   LGBTQ+ Community   * LGBTQ+ individuals, particularly LGBTQ+ pregnant people, who may face discrimination or exclusion from traditional maternity services. * Consultation Method: Work with LGBTQ+ advocacy groups to hold inclusive focus groups and conduct surveys that specifically ask about LGBTQ+ individuals’ experiences and needs in maternity care.   Homeless and Housing-Insecure Populations   * Homeless individuals or those living in temporary accommodation or housing insecurity. * Consultation Method: Use outreach workers to directly engage people in shelters or temporary housing, offering one-on-one consultations or group discussions to understand their barriers to accessing healthcare. |
| Who else can help? | Consider what and who’s input you may be missing |
| 1. Evaluation and monitoring | |
| How will you quantitatively or qualitatively monitor and evaluate the impact of your programme, project or policy on different population groups at risk of health inequalities? Consider what output or process measures you could use. | Consider when you will review outputs and outcomes identified above, which could be at 6 and 12 months.  Output evaluation   * How will you measure the actions that have been achieved?   Outcome evaluation   * How will you measure and how will you document that you have had an impact on access, experience and outcomes for those population groups identified as being at higher risk? This should include consideration of quantitative measures and also qualitative measures (e.g. engaging directly with population groups at high risk) * How does the programme monitor for unintended consequences?   The [3-year Delivery Plan for Maternity and Neonatal Care](https://www.england.nhs.uk/long-read/three-year-delivery-plan-for-maternity-and-neonatal-care-technical-guidance/) includes Determining Success Measures that are used to monitor outcomes and progress, including in particular Theme 4, which looks at standards and structures that underpin safer, more personalised, and more equitable care. |
| Set a health equity assessment review date, recommended for between 6 and 12 months from initial completion. |  |

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| 1. Review – identify lessons learned and drive continuous improvement |

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| --- | --- |
| Date completed  (should be 6-12 months after initial completion): |  |
| Contact person (name, directorate, email, phone) |  |
| Have you achieved the actions you set? |  |
| How has your programme, project or policy supported reductions in health inequalities associated with physical and mental health? |  |
| How has your programme, project or policy 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? |  |

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Description automatically generated

Health Equity Assessment Tool (HEAT):

Full version

Adapted for Core20PLUS5

Clinical Priority 2: Severe Mental Illness (SMI)

Date: December 2024

Adapted from Public Health England HEAT tool published in August 2024.

A resource produced by NHS England NW Public Health and Office for Health Improvement and Disparities (OHID) NW.

**HEAT and Core20PLUS5**

**Clinical Priority 2: Severe Mental Illness (SMI)**

What is Core20PLUS5?

Core20PLUS5 is NHS England’s approach to reducing healthcare inequalities at a national and system level. “Core20” represents the 20% most deprived members of the population (as defined by the Index of Multiple Deprivation). “PLUS” represents population groups who are at risk of social exclusion, such as inclusion health groups, and other groups sharing protected characteristics. “5” represents five clinical priorities that require accelerated improvement. The second priority focuses on severe mental illness (SMI), ensuring annual physical health checks for a minimum of 60% of those on the GP SMI register.

What is HEAT and how can it help?

There is an existing [Equally Well UK](https://equallywell.co.uk/resources/physical-health-checks-for-people-living-with-severe-mental-illness-a-partnership-approach-to-improving-health-checks-in-primary-care/) toolkit to help systems and places to self-assess their SMI physical health check offer and identify areas of improvement. Within this checklist, health inequalities are highlighted. HEAT is the Health Equity Assessment Tool. The HEAT tool will support you to address health inequalities within your health check offer. It can be used prospectively or retrospectively to help ensure an equitable provision. This adapted HEAT has been developed to enable identification of actions to ensure that all individuals identified as living with SMI receive annual physical health checks, in order to reduce healthcare inequalities. It should be completed in conjunction with the [Equally Well UK toolkit](https://equallywell.co.uk/resources/physical-health-checks-for-people-living-with-severe-mental-illness-a-partnership-approach-to-improving-health-checks-in-primary-care/).

Who is this tool for?

The HEAT tool was developed to be used across a range of programmes and projects. This version of the HEAT tool has been adapted to include specific prompts for leaders at a system, place and PCN level. Applying HEAT to Core20PLUS5 will help systems and places reach both Core20PLUS5 and SMI targets, while also helping to reduce the inequalities gap.

How do I use this tool?

The adapted HEAT below contains a series of prompts to enable effective application to the SMI clinical priority area. Following these prompts and filling each section of the tool as fully as possible will help you to identify health inequities within high-risk groups and offer the opportunity to identify actions to increase uptake for annual physical health checks among individuals living with SMI, to inform the development of local plans. The tool does include a review and is therefore a continuous improvement process.

HEAT is supplemented by an [e-learning module](https://www.e-lfh.org.uk/programmes/health-equity-assessment-tool-heat/) on the NHS Learning Hub, designed to equip professionals with essential skills for undertaking a HEAT assessment.

The tool

|  |  |
| --- | --- |
| Programme or project being assessed |  |
| Date assessment started |  |
| Date assessment completed |  |
| Contact person (name, directorate, email, phone) |  |
| Name of strategic leader (senior responsible officer) |  |
| Lead organisation |  |
| Other organisations engaged |  |
| Community engagement methods used.  Best practice shows that engaging communities is an effective way of identifying, gaining insight and understanding how health inequalities are experienced by communities. So, consider methods of engagement (for example specific questions, focus groups, surveys, Place Standard) which are inclusive, involving a range of affected communities and stakeholders; and an assessment of whether, how and with what impact community engagement can assists with the programme, project or policy and its implementation. |  |
| Agreed review date |  |
| **Steps to take** | | **Your response – remember to consider multiple dimensions of inequalities, including protected characteristics and socio-economic differences** |
| 1. Prepare – agree the scope of work and assemble the information you need | | |
| 1. Your programme of work  Things you may want to consider include:  What are the main aims of your programme, project or policy?  What is the justification, reason or driver for this programme, project or policy?  How do you expect your programme, project or policy to impact (positively or negatively) health inequalities?  Is it a programme, project, service, product, policy or strategy? | | **Background Information:**  The purpose of this section is to detail the scope of your service or project, who are your key stakeholders and how you expect your work to reduce inequalities.  Main aims of Core20Plus5 Programme  Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the ‘Core20PLUS’ – and identifies ‘5’ focus clinical areas requiring accelerated improvement.  “Core20” represents the 20% most deprived members of the population (as defined by the Index of Multiple Deprivation). “PLUS” represents population groups who are at risk of social exclusion, such as inclusion health groups, and other groups sharing protected characteristics and should be identified at a local level.  Main aims of SMI Clinical Priority  To ensure those people living with SMI receive annual health checks, aiming for 60% (in line with the success seen in learning disabilities).  Key Stakeholders  Who are the partners who will be supporting and enabling delivery? e.g. Integrated Care Boards, GP Practices, Community Pharmacies where locally agreed, Mental Health Trusts, Local Authority Public Health Teams, as Commissioners of Health Improvement Services/specialised services, the VCFSE sector and experts by experience (people with SMI and their carers).  Reducing inequalities  Applying Core20PLUS5 to your work ensures a targeted approach to those most at risk of inequalities. Without taking a targeted approach to the physical health management of people living with SMI, there is the potential to widen the inequalities gap. This tool will help you to focus on increasing uptake of annual physical health checks among individuals living with SMI in an equitable way. Examples of targeted approaches include joining up physical healthcare across primary and secondary care and Local Authority commissioned services (stop smoking, weight management, drug and alcohol) e.g. use of [The Bradford Template](https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/05/serious-mental-hlth-toolkit-may16.pdf) to record physical health compatible in SystmOne, EMIS Web and RIO and point of care testing.  Digital Inclusion & Inclusion Health  Ensure [Digital Inclusion](https://www.england.nhs.uk/long-read/inclusive-digital-healthcare-a-framework-for-nhs-action-on-digital-inclusion/) & [Inclusion Health](https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/) Frameworks are considered and implemented throughout all steps of the tool. |
| 1. Data and evidence   What data do you need to gain a greater understanding of need and assess the impact of this programme, project or policy?  You should consider relevant data, evidence, indicators and intelligence you are aware of, for example:   * Nationally available data such as: * [Fingertips health profiles,](https://fingertips.phe.org.uk/) * [Public Health Outcomes Framework](https://fingertips.phe.org.uk/profile/public-health-outcomes-framework) * [Hospital Outcomes S](https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics)tatistics * [Office for National S](https://www.ons.gov.uk/)tatistics * [RightCare](https://www.england.nhs.uk/rightcare/) * Local data such as that available in Joint Strategic Needs Assessment, contract performance data, school attainment and qualitative data from local research, voluntary, community and social enterprise (VCSE) intelligence and community voice * Insights gained form community voices with lived experiences in relation to discrimination, racism, access and multiple disadvantage and displacement | | The purpose of this section is to demonstrate local need through presentation of key indicators. You may have your own service level data e.g. Health Equity Audits, JSNAs that could be used. It is also important to highlight what data are not available that you would have found useful. A possible inequity may lie in the data systems themselves. Other key data sources to explore:   * [BHF Health Systems Data](https://www.bhf.org.uk/for-professionals/healthcare-professionals/data-and-statistics/health-systems-data), presenting local health and CVD data for each ICS, covering local population, health inequalities, disease prevalence, outcomes and achievement data.   + % of individuals with schizophrenia, bipolar affective disorder and other psychoses having a record of blood pressure in the preceding 12 months * OHID Fingertips, providing a number of profiles and relevant indicators at system and place level.   + [Cardiovascular Disease](https://fingertips.phe.org.uk/profile-group/cardiovascular-disease-diabetes-kidney-disease/profile/cardiovascular) profile     - Smoking status of patients with certain conditions recorded in the last 12 months (denominator incl. PCAs)   + [Public Health Outcomes Framework](https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/1)   + [NHS Health Check](https://fingertips.phe.org.uk/profile/nhs-health-check-detailed/data#page/1) profile   + [SMI Profiling Tool](https://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness), within the [Mental Health, Dementia and Neurology](https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide) profile   + [Co-occurring Substance Misuse and Mental Health Issues Profiling Tool](https://fingertips.phe.org.uk/profile-group/mental-health/profile/drugsandmentalhealth)   + [Common Mental Health Disorders Profiling Tool](https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders)   + [Mental Health and Wellbeing JSNA Profile & Toolkit](https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna)   + [Suicide Prevention Profile](https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide) * [Premature mortality in adults with severe mental illness (SMI)](https://www.gov.uk/government/publications/premature-mortality-in-adults-with-severe-mental-illness/premature-mortality-in-adults-with-severe-mental-illness-smi) * [Quality and Outcomes Framework](https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/general-practice-data-hub/quality-outcomes-framework-qof), NHS NW QOF Mental Health Data Pack. A new mental health incentive metric ([MH021](https://www.england.nhs.uk/publication/quality-and-outcomes-framework-guidance-for-2023-24/)) has been introduced in the 2023/24 Quality Outcomes Framework (QOF) for delivery of all six elements of the SMI physical health check * [CIPHA](https://www.cipha.nhs.uk/action/), Enhanced Case Finder. Patient level report to identify vulnerable populations with a set of criteria including demographics, health status (such as long-term conditions) and other risk algorithms (Cheshire and Merseyside only) * NHS Health Check data and evidence   List any other data sources and indicators that you may have available. |
| 1. Contributors to inequalities   Have you considered the interplay of multiple contributors to inequalities influencing personal experiences? | | The purpose of this section is to demonstrate the differentiating factors that contribute to widening health inequalities. Consider the following:   * 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. * Different exposure to social, economic and environmental stressors and adversities, which affect states of mind from an early age and throughout life - stress and psychological wellbeing directly affect resilience, health conditions and health behaviours. * Differences in health behaviours or other risk factors (including genetic vulnerability) which exist within and 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. * Unequal access to or experience of health and other services between social groups. * Inequalities impacted by structural discrimination which results in some groups and individuals - for example, those who identify with one or more of the protected characteristics - experiencing poorer access to services and poorer outcomes. |
| 1. Assess - examine the evidence and intelligence | | |
| 1. Distribution of health | | |
| Based on evidence collected above, which populations face the biggest health inequalities for your topic or service area?  Think about the 4 health inequality domains (socio-economic deprived population; geographic deprivation; inclusion health and vulnerable groups; protected characteristics). | | Socio-economic status or geographic deprivation:  Deprivation is associated with greater prevalence of risk factors that could lead to SMI for your population. What does the data tell you above in terms of health inequalities by geographic deprivation / socioeconomic status?  Key considerations to determine the distribution of risk factors for SMI and healthcare access include:   * Where are your most geographically deprived areas (e.g. those areas in the lowest IMD quintile)? * Where are your isolated communities, such as coastal and rural?   Do you have local level National Statistics Socio-economic Classification (NS-SEC) scores to determine socioeconomic status? See Office for National Statistics’ [Census Maps](https://www.ons.gov.uk/census/maps/choropleth/work/national-statistics-socio-economic-classification-ns-sec) |
| Consider your programme, project or policy against the socio-economic status domain and how it interacts with the domain, and the impact that has or may have. | | Consider the following (but not limited to):  Access to Mental Health Services:   * Does the programme ensure that people from low socio-economic (SES) backgrounds have access to early intervention and treatment for severe mental illness? * Are there barriers like stigma, cost, or lack of local services that disproportionately affect low SES communities?   Inclusivity and Outreach:   * How does the programme engage individuals from disadvantaged SES backgrounds in mental health care? * Are there outreach strategies to reduce gaps in treatment for low-income individuals suffering from SMI?   Social Support and Housing:   * Does the programme address housing instability, social isolation, and other SES challenges that contribute to or exacerbate mental health issues in low SES groups? |
| Consider your programme, project or policy against the geographic deprivation domain and how it interacts with the domain, and the impact that has or may have. | | Consider the following (but not limited to)  Access to Services   * How does your programme ensure that individuals with SMI in deprived geographic areas have adequate access to mental health services, including early diagnosis, treatment, and ongoing support?   Targeted Outreach in Deprived Areas   * How does your project actively engage communities in geographically deprived areas to identify individuals with SMI and provide tailored care to meet their specific needs?   Cultural and Environmental Factors   * How does the geographic deprivation of the community intersect with cultural and environmental factors that may affect the mental health and wellbeing of individuals with SMI?   Resource Allocation and Equity   * Does the allocation of resources (e.g., funding, staffing, mental health services) address the disproportionate mental health needs in geographically deprived areas, and are resources distributed equitably?   Barriers to Engagement and Participation   * What barriers are there to engagement with mental health services in geographically deprived areas, and how does your programme work to overcome these barriers to ensure people with SMI are not excluded?   Service Availability and Flexibility   * How does your programme consider the availability and flexibility of mental health services in deprived geographic areas to meet the needs of individuals with SMI?   Impact of Geographic Deprivation on Health Outcomes   * What is the impact of geographic deprivation on the mental health outcomes of individuals with SMI in your programme, and how do you measure and address this impact? |
| Consider your programme, project or policy against the inclusion health and vulnerable groups domain and how it interacts with the domain, and the impact that has or may have. | | Inclusion health and vulnerable groups (for example, people experiencing homelessness, prison leavers, young people leaving care): [NHS England » A national framework for NHS – action on inclusion health](https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/)  Inclusion health (IH) groups are those individuals who are at risk of social exclusion. These include: -   * People experiencing homelessness. * People experiencing drug and alcohol dependence. * Migrants * Gypsy, Roma, Traveller communities * Sex workers * People in contact with criminal justice system * People with a Learning Disability   Data collection for IH groups is often incomplete. People in IH groups may not be registered with and may not access GPs. We know they face barriers and have poorer outcomes. It is important to recognise these groups as potentially being at higher risk of SMI and less likely to receive annual health checks. These groups may not proactively present for SMI management, due to barriers in accessing healthcare. Key questions to address include:   * Do you know the prevalence and distribution of IH groups in your area? * What service level data do you have in relation to these groups? * Where and what are the data gaps for IH groups? * Do you have Acute Episode Statistics relating to SMI for these groups of people? |
| Consider your programme, project or policy against experience related to protected characteristics domain and how it interacts with the domain, and the impact that has/may have. | | Experience related to protected characteristics:  Protected characteristics according to the Equality Act 2010 are:   * age * disability * gender reassignment * marriage and civil partnership * pregnancy and maternity * race * religion and belief * sex * sexual orientation   According to the data, are any of these groups more at risk of SMI? Of these groups, are any less likely to access healthcare to attend annual physical health checks? |
| 1. Causes of inequalities | | |
| Recognising that there are inequalities experienced by the population groups identified, considering the data and evidence, what are the wider determinants and structural discriminatory drivers? Consider the diverse range of social economic factors which influence people’s health and wellbeing. | | Consider the following (but not limited to)  Social and Economic Factors   * What are the key social and economic factors (e.g., income, education, employment, housing) that contribute to the inequalities experienced by individuals with SMI, and how are these factors addressed within your programme or policy?   Structural Discrimination and Racism   * How does structural discrimination, including racism and cultural stigma, affect access to care and the quality of care for individuals with SMI, particularly within minority or marginalised groups?   Housing and Homelessness   * How does housing instability or homelessness affect the mental health of individuals with SMI, and what steps does your programme take to address these challenges, particularly in areas of geographic deprivation?   Access to Education and Employment   * How do barriers to education and employment (e.g., discrimination in the workplace, lack of training opportunities) affect the mental health outcomes of individuals with SMI, and how does your programme support access to these opportunities?   Social Isolation and Community Support   * How does social isolation and the lack of community support contribute to poor mental health outcomes for individuals with SMI, and what does your programme do to foster social connections and peer support?   Healthcare Access and Systemic Barriers   * How do systemic barriers (e.g., waiting times, geographic location, lack of culturally competent care) contribute to inequities in mental health services for individuals with SMI, and what efforts are being made to reduce these barriers?   Digital Divide and Technology Access [NHS England » Inclusive digital healthcare: a framework for NHS action on digital inclusion](https://www.england.nhs.uk/long-read/inclusive-digital-healthcare-a-framework-for-nhs-action-on-digital-inclusion/)   * How does the digital divide (limited access to technology or the internet) act as a barrier to accessing mental health services for individuals with SMI, and how does your programme ensure digital inclusivity for all populations?   Health Literacy and Empowerment   * How does low health literacy or lack of health empowerment contribute to inequalities in the management and treatment of SMI, and what actions does your programme take to improve health literacy within disadvantaged groups?   Impact of Violence and Trauma   * How do experiences of violence, trauma, or abuse (e.g., domestic violence, childhood trauma) contribute to the onset or worsening of SMI, and how does your programme provide support for individuals who have experienced these adversities?   Cultural Competence and Inclusivity   * How does your programme address the role of cultural competence in reducing inequalities and structural discrimination, particularly for minority ethnic groups with SMI? |
| What does the data and evidence tell you are the potential drivers for these inequalities? It may be helpful to consider the following questions:   * Which wider determinants are influential, for example, income, education, employment, housing, community life, racism and discrimination, cultural, environmental? * Are there any factors which indicate structural discrimination or racism will impact upon your programme, project or policy, for example mandatory use of digital access to health advice preventing access for less IT literate individuals and communities? * Which health behaviours play a role? * Does service quality, access and take up increase the chance of health inequalities in your work area? * Does climate change have an impact on health inequalities in relation to your programme, project or policy? * Which of these can you directly control? * Which can you influence? * Which are out of your control? | | Wider determinants of health  Social and economic factors influence health\*\*. It is recognised that not all of these factors are in your control, but you need to be aware of the impact they have on your population group in terms of access, experience and outcomes in SMI management. You may be able to make a change in your service that could reduce the impact. Examples for consideration include:   * Education * Have you considered the health literacy of population groups most at risk of health inequalities? * Is patient information appropriate and accessible to all population groups (easy read including pictures/multi-lingual)? * Systematic/Institutional Racism and discrimination * Have you thought about barriers to accessing healthcare across population groups, particularly among IH groups? * Employment * Have you considered service access for employed people and unpaid carers etc? e.g. do you offer out of hours and weekend appointments? Are occupation health and outreach offer available? * How accessible are clinic locations and GP practices, could areas with lower uptake rates be offered free transport provision? Are clinic locations accessible by public transport? Can they be offered in other locations such as workplaces, supermarkets, shopping centres? * Enablers/Assets   + Are there any specific enablers or assets that could be harnessed to reach population groups most at risk of health inequalities? E.g. identifying and working with relevant community groups, other services, people and VCFSE organisations.   **Reference: \*\*Hood et al 2015**[**County Health Rankings: Relationships Between Determinant Factors and Health Outcomes – ScienceDirect**](https://www.sciencedirect.com/science/article/pii/S0749379715005140)​ |
| Consider if any of the following aspects influence or are influenced by your programme, project or policy  • poverty and cost of living  • community engagement  • COVID-19 or incident recovery  • violence prevention  • Core20PLUS5  • major health conditions  • substance misuse  • mental health  • service commissioning  • rural and coastal health  • policy or strategy  • healthy weight  • children and young people  • cardiovascular disease (CVD)  • oral health and dental services | | Consider the following (but not limited to)  Poverty and Cost of Living   * How does your programme address the impact of poverty and the cost of living on individuals with SMI, and what support is offered to reduce financial barriers to accessing mental health care?   Community Engagement   * How does your programme engage with the local community to identify and address the mental health needs of individuals with SMI, ensuring their voices and experiences are central to the design and delivery of services?   COVID-19 or Incident Recovery   * How has the COVID-19 pandemic or other significant events (e.g., natural disasters, economic crises) affected individuals with SMI, and what actions has your programme taken to support recovery and address increased mental health challenges?   Violence Prevention   * How does your programme consider the role of violence prevention in supporting individuals with SMI, particularly those who may have experienced violence or trauma that exacerbates their mental health condition?   Core20PLUS5   * How does your programme align with the Core20PLUS5 initiative, ensuring targeted action to reduce inequalities and address the needs of the most vulnerable groups with SMI, particularly those in underserved or deprived areas?   Major Health Conditions   * How does your programme address the interaction between SMI and other major health conditions (e.g., diabetes, hypertension, CVD), particularly for individuals who may experience compounded health risks?   Substance Misuse   * How does your programme address substance misuse in individuals with SMI, recognising that substance use may exacerbate or complicate mental health conditions?   Mental Health   * How does your programme specifically target mental health issues in individuals with SMI, and what interventions are in place to ensure timely diagnosis, effective treatment, and recovery support?   Service Commissioning   * How does your programme engage with service commissioning to ensure that mental health services for individuals with SMI are adequately funded, accessible, and meet the needs of the target population?   Rural and Coastal Health   * How does your programme address the unique mental health challenges faced by individuals with SMI in rural and coastal areas, where access to services may be limited?   Policy or Strategy   * How does your programme align with national and local policy and strategy for addressing mental health inequalities, particularly for people with SMI in vulnerable populations?   Healthy Weight   * How does your programme consider the relationship between mental health and healthy weight for individuals with SMI, particularly those who may struggle with weight management due to medication or lifestyle factors?   Children and Young People [NHS England » Core20PLUS5 – An approach to reducing health inequalities for children and young people](https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/)   * How does your programme address the mental health needs of children and young people with SMI, recognising the unique challenges they face in accessing care and support?   Cardiovascular Disease (CVD)   * How does your programme address the increased risk of cardiovascular disease (CVD) in individuals with SMI, given the higher rates of co-occurrence between SMI and CVD?   Oral Health and Dental Services   * Impact of Oral Health & Dental Services on Overall Health Outcomes   + Does the dental programme address the relationship between poor oral health and the development of other health conditions (e.g., cardiovascular disease, diabetes, respiratory infections)?   + Does the programme promote the importance of good oral hygiene and regular dental visits, particularly for populations at higher risk of oral health complications, such as children, older adults, or individuals with disabilities? * Access to Care for Oral Health & Dental Services   + How does the programme ensure access to dental care for vulnerable populations, particularly those in deprived areas who may face barriers such as affordability, lack of transportation, or cultural differences?   + How does the dental programme collaborate with other health services (e.g., maternity care, general health services) to ensure that oral health is adequately addressed as part of overall healthcare, particularly for individuals with multiple health concerns? |
| 1. Refine and apply – make changes to your work plans that will have the greatest impact | | |
| 1. Potential effects | | |
| Considering the above, how is your programme, project or policy likely to reduce health inequalities? | | Current service provision   * How does your service/policy currently provide support for individuals of lower socioeconomic status and living in areas of higher deprivation? * Does your current service model/policy take into consideration IH groups who face barriers to accessing healthcare?   + It is important to recognise that SMI annual physical health checks offered through GP practices, Community Pharmacies where locally agreed, and Mental Health Trusts may not reach IH groups who are often not registered with GPs. * Does your current service provision/policy mitigate any of the impacts of the harmful wider determinants of health for those groups most at risk of SMI? * Reflecting on the information obtained so far, is there any part of your service model/policy that may widen the inequality gap?   Your HEAT assessment could consider a number of different elements or one particular method:   * SMI annual physical health checks offered at GP practices. * Undertaking SMI physical health checks at outreach venues and at people’s homes. * Community pharmacy SMI physical health checks, where locally agreed.   The purpose of the tool is to help you to increase the uptake of physical health checks in an equitable way. |
| Does your programme, project or policy have the potential unintended consequence of widening inequalities by, for example:   * 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? * Relying on professional-led interventions? * Not tackling the root causes of health inequalities? * Relying upon digital access? * Relying upon high level of literacy? | | Changes to service provision   * Considering all of the above, what could you change to your service provision/policy to ensure you are targeting provision to those population groups identified in section 2 as having the highest need? * We know that those who face barriers to accessing healthcare, those who are socially excluded, and those living in more deprived areas are at higher risk for poorer health outcomes. It can be reasonably assumed that those with poorer access and less likely to attend GP practices are less likely to have SMI diagnosed, and less likely to attend for physical annual health checks. Considering these points and in the absence of local data for certain IH groups, are there any actions that could be taken? * Are there any specific enablers or assets that could be harnessed to reach these groups? Such as identifying and working with relevant community groups, other services, people and VCFSE organisations. * Specifically, what steps are required to ensure that data is collected locally for those population groups most at risk?   Existing Toolkits  A [self-assessment toolkit](https://equallywell.co.uk/resources/physical-health-checks-for-people-living-with-severe-mental-illness-a-partnership-approach-to-improving-health-checks-in-primary-care/) has been co-developed by Experts by Experience, Equally Well UK, OHID NW/NE/Y&H, NHSE NW, Mental Health Providers and General Practice to support systems and places to identify areas of improvement to increase the number and quality of physical health checks for people living with SMI. The toolkit requires input from all organisations involved in the commissioning and delivery of SMI physical health checks and follow-up interventions to review all aspects of the programme, including:   * Commissioning and finance (ICB and place) * Governance and leadership * Data analysis and flows * Engagement with SMI patients * Physical health checks * Interventions, including Making Every Contact Count (MECC) * Pathways into community, acute and specialist services * Service user experience. * Staff training   It identifies a number of themes that may help to improve outcomes among those with SMI:   * Motivating and engaging staff * Clarity of roles and responsibilities * Skills and confidence * Equipment * Recording monitoring and communicating information * Communicating with service users to inspire action * Interfaces with other services |
| What aspects of mental wellbeing are affected? Consider risk and protective factors. | | Consider the following (but not limited to)  Risk Factors   * Social Isolation   + How does social isolation contribute to poor mental wellbeing in individuals with SMI, and what actions does your programme take to reduce this isolation and foster social connections? * Stigma and Discrimination   + How does stigma and discrimination (related to mental illness or other factors such as race, gender, or socio-economic status) affect the mental wellbeing of individuals with SMI, and what steps does your programme take to challenge and reduce these factors? * Economic and Financial Stress   + How does poverty, unemployment, or financial instability impact the mental wellbeing of individuals with SMI, and what strategies does your programme implement to address these factors? * Housing Instability   + How does housing instability or homelessness contribute to poor mental health and wellbeing in individuals with SMI, and how does your programme address these challenges? * Trauma and Adverse Childhood Experiences (ACEs)   + How do trauma or adverse childhood experiences (ACEs) contribute to the development or worsening of SMI, and what interventions does your programme offer to address these underlying issues? * Substance Misuse   + How does substance misuse exacerbate mental health issues and negatively affect the wellbeing of individuals with SMI, and how does your programme address this dual issue? * Medication Side Effects   + How do the side effects of psychiatric medications (e.g., weight gain, fatigue, cognitive impairment) negatively affect the mental and physical wellbeing of individuals with SMI, and how does your programme mitigate these effects?   Protective Factors   * Social Support Networks   + How does the presence of strong social support networks (family, friends, community) contribute to improved mental wellbeing for individuals with SMI, and how does your programme help strengthen these support systems? * Physical Health and Lifestyle   + How does physical health, including exercise, diet, and sleep, play a role in the mental wellbeing of individuals with SMI, and how does your programme promote healthier lifestyles? * Access to Mental Health Care   + How does early access to effective mental health care serve as a protective factor for individuals with SMI, and what does your programme do to ensure timely and continuous access to care? * Engagement in Meaningful Activities   + How does engagement in meaningful activities (e.g., work, education, hobbies, volunteerism) positively influence the mental wellbeing of individuals with SMI, and how does your programme facilitate these opportunities? * Empowerment and Self-Management   + How does empowerment and promoting self-management of mental health help improve wellbeing for individuals with SMI, and what resources or support does your programme provide to encourage these practices? |
| 1. Action plan | | |
| What specific actions will you take to maximise the potential for positive impacts and/or to mitigate the negative impacts on health inequalities? Provide a list of actions and targets. | | Potential examples (but not limited to)  Enhance Access to Early Intervention Services   * Action: Expand access to early intervention for individuals at risk of SMI to address mental health issues before they become severe. * Target: Increase the number of individuals with early signs of SMI receiving care within 3 months of first presentation by 20% over the next year.   Strengthen Community Engagement and Support   * Action: Develop community-based support groups and peer mentoring to encourage social inclusion and reduce isolation among individuals with SMI. * Target: Establish at least 5 new peer support groups in underserved areas by the end of the year, focusing on engaging communities facing higher health inequalities.   Address Socio-Economic Barriers   * Action: Provide financial assistance and housing support to individuals with SMI who face financial and housing instability, as these are key determinants of mental health. * Target: Provide housing support for at least 100 individuals with SMI who are currently homeless or at risk of homelessness within the next 6 months.   Promote Integrated Care for Co-Occurring Conditions   * Action: Implement an integrated care model for individuals with SMI that addresses both mental health and physical health needs, particularly for those with substance misuse or chronic health conditions. * Target: Ensure 80% of individuals with SMI also receive support for physical health conditions like cardiovascular disease or diabetes as part of a holistic care plan.   Combat Stigma and Discrimination   * Action: Roll out anti-stigma campaigns aimed at reducing negative perceptions of mental illness and encouraging more individuals with SMI to seek help without fear of discrimination. * Target: Conduct at least 4 community-based workshops per year in high-deprivation areas to address stigma and promote mental health literacy.   Improve Digital Access and Health Literacy   * Action: Provide digital health literacy training and ensure that online mental health resources are accessible to individuals with SMI, especially in rural or isolated areas. * Target: Offer digital literacy workshops to 500 individuals with SMI across the region within 12 months to improve their access to online support services.   Offer Culturally Sensitive Services   * Action: Ensure that mental health services are culturally competent and tailored to meet the needs of diverse populations, including ethnic minorities and migrant groups. * Target: Train 100% of frontline mental health workers in cultural competency by the end of the year to provide more inclusive services.   Provide Mental Health Support for Children and Families   * Action: Develop targeted interventions for children and young people in families affected by SMI to prevent intergenerational transmission of mental health challenges. * Target: Offer mental health support services to at least 150 children of individuals with SMI within the next year to reduce long-term mental health disparities.   Monitor and Evaluate Impact on Health Inequalities   * Action: Establish a robust system for monitoring and evaluating the effectiveness of mental health interventions on health inequalities, particularly focusing on marginalised communities. * Target: Collect data on health outcomes for at least 1,000 individuals with SMI and measure improvements in mental wellbeing and reduction in health inequalities by the end of the programme's first year. |
| How can you act on the specific causes of inequalities identified above? | | Potential examples (but not limited to)  Addressing Socio-Economic Barriers   * Offer financial assistance and housing support to individuals with SMI who face financial and housing instability. * Provide direct housing support for 100 individuals with SMI, ensuring they have access to stable living conditions, which can improve mental health outcomes.   Reducing Social Isolation   * Develop peer support groups and community-based initiatives to engage individuals with SMI in social activities. * Establish 5 new peer support networks in high-deprivation areas, fostering social connections and reducing isolation for individuals with SMI.   Tackling Stigma and Discrimination   * Implement anti-stigma campaigns and community workshops to challenge negative perceptions of mental illness. * Launch community workshops in underserved areas to raise awareness, reducing stigma and encouraging individuals with SMI to access mental health services without fear of discrimination.   Improving Access to Digital Services   * Provide digital literacy training and ensure online mental health resources are available to all, including those in rural or underserved areas. * Offer digital literacy workshops to 500 individuals with SMI to improve their ability to access online support services and reduce the digital divide.   Offering Culturally Competent Services   * Train staff in cultural competency to ensure mental health services are inclusive of diverse populations. * Provide cultural competency training for 100% of frontline mental health workers to ensure services are tailored to meet the specific needs of individuals from diverse cultural backgrounds.   Improving Monitoring and Evaluation   * Set up a system for monitoring health outcomes and evaluating the effectiveness of interventions for individuals with SMI. * How does the programme monitor for unintended consequences? * Track the health outcomes of 1,000 individuals with SMI over the course of the programme to evaluate improvements in mental health and reductions in health inequalities. |
| What activities will you put in place which will adapt and enhance your programme, project or policy in relation to cultural competencies? For example, consideration of cultures, languages, formats, images, digital, written, spoken, translation services. | | Potential examples (but not limited to)  Culturally Tailored Health Resources   * Develop health information materials (e.g., brochures, websites) that reflect the cultural values, traditions, and languages of the communities you are serving.   Cultural Awareness Training for Staff   * Offer cultural competence training to staff members so they are aware of cultural differences and how these might affect healthcare interactions.   Incorporating Community Feedback   * Consult with local communities to identify their unique cultural needs and preferences to adapt services accordingly.   Use of Multilingual Translation Services   * Implement multilingual translation services for non-English-speaking clients, ensuring that language is not a barrier to accessing mental health support or other services.   Culturally Relevant Health Promotion Campaigns   * Design health promotion campaigns that use culturally relevant formats, images, and messaging to engage specific communities. |
| What specific steps and action will you take to address the identified structural racism and discrimination? | | Potential examples (but not limited to) [NHS England — North West » Anti Racist Framework](https://www.england.nhs.uk/north-west/nhs-north-west-bame-assembly/anti-racist-framework/), [New report: Physical Health Checks for People with a Severe Mental Illness - Race Equality Foundation](https://raceequalityfoundation.org.uk/reports/physical-health-checks-for-people-with-a-severe-mental-illness/), [Physical health checks for people with severe mental illness - Race Equality Foundation](https://raceequalityfoundation.org.uk/health-care/physical-health-checks-for-people-with-severe-mental-illness/)  Implement Anti-Racism Training for Staff   * Provide mandatory anti-racism training for all staff to ensure they understand systemic racism and its impact on health outcomes.   Review and Revise Policies to Promote Equity   * Conduct a comprehensive review of organisational policies and procedures to identify and eliminate potential discriminatory practices.   Establish a Diversity and Inclusion Taskforce   * Create a taskforce dedicated to promoting diversity, equity, and inclusion within the organisation, focusing on addressing structural racism. |
| How will you mitigate against the negative impact of when multiple harmful factors interact and result in compounding poor health outcomes for effected communities? | | Potential examples (but not limited to)  Provide Holistic, Integrated Care for Individuals with SMI   * Establish integrated care teams for individuals with SMI who also experience homelessness, substance misuse, or poverty. These teams would consist of mental health professionals, social workers, substance misuse counsellors, and housing support staff, working collaboratively to address the range of issues contributing to poor health outcomes.   Targeted Support for Vulnerable SMI Families   * Implement family-focused interventions for individuals with SMI who have young children, particularly in areas of high deprivation. This could include providing access to mental health services, parenting support, childcare resources, and financial aid, to prevent the intergenerational transmission of mental health issues.   Increase Access to Community-Based Support Networks for Individuals with SMI   * Develop community health hubs in areas with high deprivation, where individuals with SMI can access mental health care, peer support, substance misuse treatment, and practical assistance (e.g., housing, employment). These hubs should offer services that reduce the burden of accessing multiple, fragmented services. |
| Which populations face the biggest inequalities for your targeted action? | | Potential examples (but not limited to) [NHS England » A national framework for NHS – action on inclusion health](https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/)  People with SMI in Deprived Urban Areas   * Individuals with SMI living in areas of high socioeconomic deprivation often experience poor access to mental health care, housing instability, and substance misuse. These individuals face compounded health inequalities due to the intersection of mental illness and poverty.   People with SMI in Rural and Coastal Areas   * Individuals with SMI living in rural and coastal communities often face geographical barriers to accessing care, including long travel distances, limited local services, and social isolation. This results in higher rates of unmet mental health needs.   Black, Asian, and Minority Ethnic (BAME) Communities with SMI   * People from BAME backgrounds with SMI often face structural discrimination in healthcare settings, leading to delayed diagnosis, misdiagnosis, and poor access to culturally competent care. |
| Could you design the programme, project or policy with communities who face the biggest health inequalities to maximise the chance of it working for them? What will you need to enable this? | | Potential examples (but not limited to)  Co-designing Mental Health Services with Deprived Urban Communities   * In communities with high levels of deprivation, involve individuals with serious mental illness (SMI) in the design process of mental health services. This could include focus groups, surveys, and community-led planning sessions to ensure the services meet the specific needs of these populations. * What’s Needed: Community engagement frameworks, peer support workers, and accessible spaces for feedback. Collaboration with local organisations to build trust and understanding of the community's unique needs.   Developing Culturally Sensitive Mental Health Programmes with BAME Communities   * Design a mental health programme that reflects the cultural needs of Black, Asian, and Minority Ethnic (BAME) groups with SMI. This could involve working with cultural leaders to adapt therapeutic practices and ensuring language support and cultural training for healthcare providers. * What’s Needed: Culturally competent staff, translation services, community partnerships with ethnic or religious organisations, and cultural assessments to understand the diverse needs of BAME populations.   Incorporating Feedback from Rural and Coastal Communities into Mental Health Initiatives   * Work with rural and coastal communities to co-design digital health solutions (e.g., telehealth services) that can reach people with SMI in areas with limited access to in-person care. Engage local community groups to understand barriers to service access. * What’s Needed: Technology infrastructure (e.g., internet access, digital literacy programmes), telehealth platforms that are easy to use, and local community champions who can help spread awareness and encourage participation. |
| Could you seek to increase people’s control over their health and lives (if appropriate)? What would this look like? | | Potential examples (but not limited to)  Offering Personalised Care Plans and Decision-Making for Individuals with SMI   * Provide individuals with SMI the opportunity to co-create personalised care plans with healthcare professionals, where they can make decisions about their treatment options, medication, and lifestyle adjustments. * What This Looks Like: This could include providing clear information on available treatments, along with the potential risks and benefits, allowing individuals to make informed choices about their care.   Developing Community-Led Mental Health Initiatives   * Empower communities with high rates of SMI to create and lead their own mental health support networks, such as support groups, community workshops, and advocacy programmes. * What This Looks Like:This could involve training local residents with lived experience to become mental health ambassadors who provide peer-led education and support within their communities. |
| Which community groups and consultation methods will you engage to tackle the problem, to maximise the chance of reaching large populations at scale (see [Community-centred public health: taking a whole system approach](https://www.gov.uk/government/publications/community-centred-public-health-taking-a-whole-system-approach)). | | Potential examples (but not limited to)  Community Groups to Engage:   * People with SMI in Deprived Urban Areas   + Individuals in deprived urban areas often face barriers such as poor housing, low income, and limited access to mental health services, which can exacerbate their mental health problems.   + Consultation Method: Engage through community-based organisations, host focus groups in local community centres, and use street surveys to gather insights directly from residents. Partner with local peer support groups to facilitate conversations and ensure that the voices of people with lived experience of SMI are included. * Older Adults with SMI   + Older adults with serious mental illness (SMI) may be marginalised and experience compounded issues such as ageism, lack of digital literacy, and physical health problems.   + Consultation Method: Use home visits and caregiver networks to reach older adults, conduct telephone interviews for those less comfortable with digital consultations, and hold community workshops in local day centres or through age-specific mental health support programmes.   Consultation Methods to Maximise Reach:   * Online Surveys & Digital Platforms   + Many people with SMI, especially younger adults, may prefer to engage through digital means, particularly in areas with limited face-to-face service provision.   + Consultation Method: Use digital platforms to conduct surveys, engage in virtual focus groups, and use social media campaigns to raise awareness. Collaborate with digital health platforms where people can share their experiences and feedback anonymously. * Peer-Led Focus Groups   + People with lived experience of SMI may feel more comfortable discussing mental health issues in peer-led settings rather than traditional clinical environments.   + Consultation Method: Peer advocates can facilitate focus groups, support group discussions, and community forums to collect valuable input from individuals with lived experience of mental illness. This also ensures that feedback is coming from those who are most impacted. * Collaborating with Local Health and Social Services   + Many individuals with SMI interact with local services like housing support, social care, or food banks but may not regularly engage with formal mental health services.   + Consultation Method: Conduct joint community consultations through multi-agency partnerships, where representatives from local services engage individuals in informal settings (e.g., at food banks or shelters) and discuss mental health needs. Community health workers can facilitate these consultations in trusted spaces. |
| Who else can help? | | Consider what and who’s input you may be missing |
| 1. Evaluation and monitoring | | |
| How will you quantitatively or qualitatively monitor and evaluate the impact of your programme, project or policy on different population groups at risk of health inequalities? Consider what output or process measures you could use. | | Consider when you will review outputs and outcomes identified above, which could be at 6 and 12 months.  Output evaluation   * How will you measure the actions that have been achieved? * How does the programme monitor for unintended consequences?   Outcome evaluation  How will you measure and how will you document that you have had an impact on access, experience and outcomes for those population groups identified as being at higher risk (both of SMI and of poorer uptake of annual physical health checks)? This should include consideration of quantitative measures and also qualitative measures (e.g. engaging directly with population groups at high risk) |
| Set a health equity assessment review date, recommended for between 6 and 12 months from initial completion. | |  |

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| 1. Review – identify lessons learned and drive continuous improvement |

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| --- | --- |
| Date completed  (should be 6-12 months after initial completion): |  |
| Contact person (name, directorate, email, phone) |  |
| Have you achieved the actions you set? |  |
| How has your programme, project or policy supported reductions in health inequalities associated with physical and mental health? |  |
| How has your programme, project or policy 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? |  |

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Health Equity Assessment Tool (HEAT):

Full version

Adapted for Core20PLUS5

Clinical Priority 3: Chronic respiratory disease

Date: December 2024

Adapted from Public Health England HEAT tool published in August 2024.

A resource produced by NHS England NW Public Health and Office for Health Improvement and Disparities (OHID) NW.

**HEAT and Core20PLUS5**

**Clinical Priority 3: Chronic respiratory disease**

What is Core20PLUS5?

Core20PLUS5 is NHS England’s approach to reducing healthcare inequalities at a national and system level. “Core20” represents the 20% most deprived members of the population (as defined by the Index of Multiple Deprivation). “PLUS” represents population groups who are at risk of social exclusion, such as inclusion health groups, and other groups sharing protected characteristics. “5” represents five clinical priorities that require accelerated improvement. The fourth priority focuses on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations. Smoking cessation positively impacts all 5 clinical priorities and is of relevance to the fourth priority since the main risk factor for COPD is smoking.

What is HEAT and how can it help?

HEAT is the Health Equity Assessment Tool. It can be used prospectively or retrospectively to help ensure an equitable provision of increasing vaccine uptake among those with COPD. This adapted HEAT has been developed to enable identification of actions to encourage groups at high risk of COPD and infective exacerbations to uptake vaccines, and therefore to reduce inequalities in access and outcomes. It may also be used to encourage uptake of stop smoking interventions. This tool may be used in addition to the [CLeaR](https://www.gov.uk/government/publications/clear-local-tobacco-control-assessment) self-assessment tool, which helps users to measure the success of local action to address harm from tobacco.

Who is this tool for?

The HEAT tool was developed to be used across a range of programmes and projects. This version of the HEAT tool has been adapted to include specific prompts for leaders at a system, place and PCN level. Applying HEAT to Core20PLUS5 will help systems reach both Core20PLUS5 and vaccination targets, while also helping to reduce the inequalities gap.

How do I use this tool?

The adapted HEAT below contains a series of prompts to enable effective application to the chronic respiratory disease clinical priority. Following these prompts and filling each section of the tool as fully as possible will help you to identify health inequities within high-risk groups and offer the opportunity to identify actions to increase vaccination uptake for individuals with COPD. When looking at alternative provision, national guidelines should be followed, and when considering alternative models of delivery, appropriate provision should be in place to maintain the integrity of the vaccination programme. The tool does include a review and is therefore a continuous improvement process.

HEAT is supplemented by an [e-learning module](https://www.e-lfh.org.uk/programmes/health-equity-assessment-tool-heat/) on the NHS Learning Hub, designed to equip professionals with essential skills for undertaking a HEAT assessment.

The tool

|  |  |
| --- | --- |
| Programme or project being assessed |  |
| Date assessment started |  |
| Date assessment completed |  |
| Contact person (name, directorate, email, phone) |  |
| Name of strategic leader (senior responsible officer) |  |
| Lead organisation |  |
| Other organisations engaged |  |
| Community engagement methods used.  Best practice shows that engaging communities is an effective way of identifying, gaining insight and understanding how health inequalities are experienced by communities. So, consider methods of engagement (for example specific questions, focus groups, surveys, Place Standard) which are inclusive, involving a range of affected communities and stakeholders; and an assessment of whether, how and with what impact community engagement can assists with the programme, project or policy and its implementation. |  |
| Agreed review date |  |

|  |  |
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| **Steps to take** | **Your response – remember to consider multiple dimensions of inequalities, including protected characteristics and socio-economic differences** |
| 1. Prepare – agree the scope of work and assemble the information you need | |
| 1. Your programme of work  Things you may want to consider include:  What are the main aims of your programme, project or policy?  What is the justification, reason or driver for this programme, project or policy?  How do you expect your programme, project or policy to impact (positively or negatively) health inequalities?  Is it a programme, project, service, product, policy or strategy? | **Background Information:**  The purpose of this section is to detail the scope of your service or project, who are your key stakeholders and how you expect your work to reduce inequalities.  Main aims of Core20Plus5 Programme  Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the ‘Core20PLUS’ – and identifies ‘5’ focus clinical areas requiring accelerated improvement.  “Core20” represents the 20% most deprived members of the population (as defined by the Index of Multiple Deprivation). “PLUS” represents population groups who are at risk of social exclusion, such as inclusion health groups, and other groups sharing protected characteristics and should be identified at a local level.  Main aims of Chronic respiratory disease clinical priority  Diagnose those people with undiagnosed COPD, and drive uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations. It is important to recognise that the main risk factor for COPD is smoking, which crosscuts all Core20PLUS5 clinical priorities. Therefore, it is important to also consider how to reduce smoking prevalence, for example, through brief advice and referrals to stop smoking services.  Key Stakeholders  Who are the partners who will be supporting and enabling delivery? e.g. health inequality leads, inclusion health leads / networks, specialised services/commissioning leads, population health boards, voluntary organisations, local authority tobacco control commissioners, tobacco alliances?  Reducing inequalities  Applying Core20PLUS5 to your work ensures a targeted approach to those most at risk of inequalities. Without taking a targeted approach to chronic respiratory disease management, there is the potential to widen the inequalities gap. Examples of targeted approaches include:   * producing translated materials for non-English speaking individuals to increase uptake of vaccinations * working with community faith leaders to produce films explaining why they chose to be vaccinated and to share information. * mobile vaccination units for people experiencing homelessness. * Offering stop smoking support to priority populations e.g. social housing tenants   For more examples, see here: [Report template - NHSI website (england.nhs.uk)](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.england.nhs.uk%2Fwp-content%2Fuploads%2F2020%2F08%2FPSIRP_template.docx&wdOrigin=BROWSELINK)  The approaches identified within this clinical priority area may be transferrable to maximise vaccination uptake in other population groups and disease areas. When looking at alternative provision, national guidelines should be followed, and when considering alternative models of delivery, appropriate provision should be in place to maintain the integrity of the vaccination programme. |
| 1. Data and evidence   What data do you need to gain a greater understanding of need and assess the impact of this programme, project or policy?  You should consider relevant data, evidence, indicators and intelligence you are aware of, for example:   * Nationally available data such as: * [Fingertips health profiles,](https://fingertips.phe.org.uk/) * [Public Health Outcomes Framework](https://fingertips.phe.org.uk/profile/public-health-outcomes-framework) * [Hospital Outcomes S](https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics)tatistics * [Office for National S](https://www.ons.gov.uk/)tatistics * [RightCare](https://www.england.nhs.uk/rightcare/) * Local data such as that available in Joint Strategic Needs Assessment, contract performance data, school attainment and qualitative data from local research, voluntary, community and social enterprise (VCSE) intelligence and community voice * Insights gained form community voices with lived experiences in relation to discrimination, racism, access and multiple disadvantage and displacement | The purpose of this section is to demonstrate local need through presentation of key indicators. You may have your own service level data e.g. Health Equity Audits, JSNAs that could be used. It is also important to highlight what data are not available that you would have found useful. A possible inequity may lie in the data systems themselves. Other key data sources to explore:   * OHID Fingertips, providing a number of profiles and relevant indicators at system and place level.   + [Public Health Profiles](https://fingertips.phe.org.uk/search/respiratory) (respiratory indicators)   + [Tobacco Control Profiles](https://fingertips.phe.org.uk/profile/tobacco-control)   + [Public Health Outcomes Framework](https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/1)     - Smoking data     - Population vaccination coverage     - Healthcare and Premature Mortality: Under 75 mortality rates from respiratory disease   + [NHS Health Check](https://fingertips.phe.org.uk/profile/nhs-health-check-detailed/data#page/1) profile * OHID, [Excess mortality by cause of death in England and English regions](https://www.gov.uk/government/statistics/excess-mortality-in-england-and-english-regions), specifically for excess deaths caused by acute respiratory infections, chronic lower respiratory diseases, other respiratory diseases * [Power BI Tobacco Control Dashboard](https://app.powerbi.com/view?r=eyJrIjoiMGVmYzlkYTctYjZjZC00ZjUzLTgzOGItYjNkMmRiYjFhNmIzIiwidCI6ImVlNGUxNDk5LTRhMzUtNGIyZS1hZDQ3LTVmM2NmOWRlODY2NiIsImMiOjh9) * [Quality and Outcomes Framework](https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/general-practice-data-hub/quality-outcomes-framework-qof), NHS NW QOF Respiratory Data * [CIPHA,](https://www.cipha.nhs.uk/data-in-action/) Enhanced Case Finder. Patient level report to identify vulnerable populations with a set of criteria including demographics, health status (such as long-term conditions) and other risk algorithms (Cheshire and Merseyside only) * NHS Health Check data and evidence (smoking data) * [Atlas of variation](http://tools.england.nhs.uk/images/RespiratoryAtlas/atlas.html), risk factors and healthcare for respiratory disease * [Respiratory disease | Fingertips | Department of Health and Social Care](https://fingertips.phe.org.uk/profile/respiratory-disease) * [Prevalence and incidence | Background information | Chronic obstructive pulmonary disease | CKS | NICE](https://cks.nice.org.uk/topics/chronic-obstructive-pulmonary-disease/background-information/prevalence-incidence/), considering unidentified and undiagnosed need.   List any other data sources and indicators that you may have available.  Digital Inclusion & Inclusion Health  Ensure [Digital Inclusion](https://www.england.nhs.uk/long-read/inclusive-digital-healthcare-a-framework-for-nhs-action-on-digital-inclusion/) & [Inclusion Health](https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/) Frameworks are considered and implemented throughout all steps of the tool. |
| 1. Contributors to inequalities   Have you considered the interplay of multiple contributors to inequalities influencing personal experiences? | The purpose of this section is to demonstrate the differentiating factors that contribute to widening health inequalities. Consider the following:   * 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. * Different exposure to social, economic and environmental stressors and adversities, which affect states of mind from an early age and throughout life - stress and psychological wellbeing directly affect resilience, health conditions and health behaviours. * Differences in health behaviours or other risk factors (including genetic vulnerability) which exist within and 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. * Unequal access to or experience of health and other services between social groups. * Inequalities impacted by structural discrimination which results in some groups and individuals - for example, those who identify with one or more of the protected characteristics - experiencing poorer access to services and poorer outcomes |
| 1. Assess - examine the evidence and intelligence | |
| 1. Distribution of health | |
| Based on evidence collected above, which populations face the biggest health inequalities for your topic or service area?  Think about the 4 health inequality domains (socio-economic deprived population; geographic deprivation; inclusion health and vulnerable groups; protected characteristics). | Socio-economic status or geographic deprivation:  Deprivation is associated with greater prevalence of risk factors (e.g. smoking) that could lead to chronic respiratory disease, including COPD, for your population. What does the data tell you above in terms of health inequalities by geographic deprivation / socioeconomic status?  Key considerations to determine the distribution of risk factors for chronic respiratory disease include:   * Where are your most geographically deprived areas (e.g. those areas in the lowest IMD quintile)? * Where are your isolated communities, such as coastal and rural?   Do you have local level National Statistics Socio-economic Classification (NS-SEC) scores to determine socioeconomic status? See Office for National Statistics’ [Census Maps](https://www.ons.gov.uk/census/maps/choropleth/work/national-statistics-socio-economic-classification-ns-sec) |
| Consider your programme, project or policy against the socio-economic status domain and how it interacts with the domain, and the impact that has or may have. | Consider the following:  Access to Prevention and Treatment:   * How does the programme ensure access to diagnosis and treatment for chronic respiratory diseases (e.g., COPD, asthma) for lower socio-economic (SES) populations? * Are there any barriers such as cost, healthcare access, or lack of education that disproportionately affect socio-economically disadvantaged groups?   Health Education and Lifestyle Support:   * Does the programme offer education and resources on smoking cessation, air quality, and healthy living to individuals from lower SES backgrounds? * How does the programme address the impact of socio-economic factors (e.g., poor housing, occupational exposure) on respiratory health?   Long-Term Management:   * Is there support for long-term management and follow-up care for people from disadvantaged groups who suffer from CRD? |
| Consider your programme, project or policy against the geographic deprivation domain and how it interacts with the domain, and the impact that has or may have. | Consider the following (but not limited to)  Access to Healthcare in Deprived Areas   * Does your programme ensure equitable access to respiratory care for people living in geographically deprived areas, where services might be limited or harder to access due to factors like distance or transportation barriers?   Environmental Factors Impacting Respiratory Health   * How does your programme consider the local environment in deprived areas, such as air quality, pollution levels, or housing quality (e.g., damp homes), and the subsequent impact on the respiratory health of vulnerable populations?   Tailoring Services to Meet the Needs of Deprived Communities   * Does your programme adapt its services to the specific needs of communities in geographically deprived areas? For instance, are interventions culturally relevant and sensitive to the economic, social, and health challenges faced by these populations? |
| Consider your programme, project or policy against the inclusion health and vulnerable groups domain and how it interacts with the domain, and the impact that has or may have. | Inclusion health and vulnerable groups (for example, people experiencing homelessness, prison leavers, young people leaving care): [NHS England » A national framework for NHS – action on inclusion health](https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/)  Inclusion health (IH) groups are those individuals who are at risk of social exclusion. These include: -   * People experiencing homelessness. * People experiencing drug and alcohol dependence. * Migrants * Gypsy, Roma, Traveller communities * Sex workers * People in contact with criminal justice system * People with a Learning Disability   Data collection for IH groups is often incomplete. People in IH groups may not be registered with and may not access GPs. We know they face barriers and have poorer outcomes. It is important to recognise these groups as potentially being at higher risk of chronic respiratory disease. These groups may not proactively present for COPD management, smoking cessation services or vaccinations, due to barriers in accessing healthcare. Key questions to address include:   * Do you know the prevalence and distribution of IH groups in your area? * What service level data do you have in relation to these groups? * Where and what are the data gaps for IH groups? * Do you have Acute Hospital Episode Statistics relating to COPD (e.g. infective exacerbations) for these groups of people? |
| Consider your programme, project or policy against experience related to protected characteristics domain and how it interacts with the domain, and the impact that has/may have. | Experience related to protected characteristics:  Protected characteristics according to the Equality Act 2010 are:   * age * disability * gender reassignment * marriage and civil partnership * pregnancy and maternity * race * religion and belief * sex * sexual orientation   According to the data, are any of these groups more at risk of chronic respiratory disease, and/or poorer vaccination uptake? |
| 1. Causes of inequalities | |
| Recognising that there are inequalities experienced by the population groups identified, considering the data and evidence, what are the wider determinants and structural discriminatory drivers? Consider the diverse range of social economic factors which influence people’s health and wellbeing. | Consider the following (but not limited to)  Impact of Socioeconomic Status   * How does your programme address the socioeconomic factors such as poverty, housing quality, overcrowding, damp/mould, and employment status that contribute to increased vulnerability to chronic respiratory conditions in disadvantaged populations?   Cultural and Racial Disparities   * Does your programme consider the impact of structural racism and cultural barriers that might limit access to respiratory care for minority ethnic groups or migrant populations?   Social Determinants of Health   * Does your programme address the social determinants of health such as income, education, housing quality, and employment that disproportionately affect populations with chronic respiratory conditions in deprived areas?   Health Inequities Related to Structural Discrimination   * How does your programme account for the impact of structural discrimination, such as racism, classism, or gender discrimination, which may limit access to healthcare or exacerbate health inequalities among marginalised groups with chronic respiratory conditions?   Environmental and Occupational Hazards   * How does your programme address environmental and occupational factors that disproportionately affect populations in deprived areas, such as exposure to air pollution, smoking, or hazardous work environments, which are known to worsen respiratory health? |
| What does the data and evidence tell you are the potential drivers for these inequalities? It may be helpful to consider the following questions:   * Which wider determinants are influential, for example, income, education, employment, housing, community life, racism and discrimination, cultural, environmental? * Are there any factors which indicate structural discrimination or racism will impact upon your programme, project or policy, for example mandatory use of digital access to health advice preventing access for less IT literate individuals and communities? * Which health behaviours play a role? * Does service quality, access and take up increase the chance of health inequalities in your work area? * Does climate change have an impact on health inequalities in relation to your programme, project or policy? * Which of these can you directly control? * Which can you influence? * Which are out of your control? | Wider determinants of health  Social and economic factors influence health\*\*. It is recognised that not all of these factors are in your control, but you need to be aware of the impact they have on your population group in terms of access, experience and outcomes in chronic respiratory disease management. You may be able to make a change in your service that could reduce the impact. Examples for consideration include:   * Education * Have you considered the health literacy of population groups most at risk of health inequalities? * Is patient information appropriate and accessible to all population groups (easy read including pictures/multi-lingual)? * Systematic/Institutional Racism and discrimination * Have you thought about barriers to accessing healthcare across population groups, particularly among IH groups? * Employment * Have you considered service access for employed people and unpaid carers etc? e.g. do you offer out of hours and weekend appointments? Are occupational health and outreach offers available? * How accessible are clinic locations and GP practices, could areas with lower uptake rates be offered free transport provision? Are clinic locations accessible by public transport? Can they be offered in other locations such as workplaces, supermarkets, shopping centres? * Enablers/Assets   + Are there any specific enablers or assets that could be harnessed to reach population groups most at risk of health inequalities? E.g. identifying and working with relevant community groups, other services, people and VCFSE organisations   **Reference: \*\*Hood et al 2015**[**County Health Rankings: Relationships Between Determinant Factors and Health Outcomes – ScienceDirect**](https://www.sciencedirect.com/science/article/pii/S0749379715005140)​  *Heatwaves contribute to poor air quality due to increasing levels of dust in the atmosphere and more frequent wildfires. Moreover, higher temperatures can lead to increased energy demands as we attempt to cool our environments, leading to further emissions.*  [*FINAL-v-4.1-North-West-Climate-Change-and-Health-Narrative-.pdf*](https://www.adph.org.uk/networks/northwest/wp-content/uploads/sites/14/2024/07/FINAL-v-4.1-North-West-Climate-Change-and-Health-Narrative-.pdf) |
| Consider if any of the following aspects influence or are influenced by your programme, project or policy  • poverty and cost of living  • community engagement  • COVID-19 or incident recovery  • violence prevention  • Core20PLUS5  • major health conditions  • substance misuse  • mental health  • service commissioning  • rural and coastal health  • policy or strategy  • healthy weight  • children and young people  • cardiovascular disease (CVD)  • oral health and dental services | Consider the following (but not limited to)  Poverty and Cost of Living   * Does your programme consider the impact of poverty and the cost of living on access to chronic respiratory care, including medications, treatment adherence, and travel to healthcare services?   Community Engagement   * How does your programme incorporate community engagement to raise awareness and improve access to respiratory health services, particularly for marginalised or high-risk groups?   COVID-19 or Incident Recovery   * How has the COVID-19 pandemic affected individuals with chronic respiratory conditions, and what actions are you taking to ensure effective recovery and ongoing care for these patients?   Core20PLUS5   * How does your programme align with the Core20PLUS5 initiative to reduce health inequalities, particularly in communities experiencing the highest burden of chronic respiratory conditions?   Major Health Conditions   * How does your programme integrate care for individuals with chronic respiratory diseases who also suffer from other major health conditions (e.g., cardiovascular disease, diabetes)?   Substance Misuse   * Does your programme account for individuals with chronic respiratory conditions who may be dealing with substance misuse, such as smoking or drug use, which can exacerbate their respiratory health issues?   Mental Health   * How does your programme address the mental health needs of individuals with chronic respiratory conditions, given the high rates of anxiety, depression, and stress in this population?   Service Commissioning   * How does your programme fit within the context of service commissioning, ensuring that adequate resources and services are allocated to areas with high need for chronic respiratory care?   Rural and Coastal Health   * How does your programme address the unique health challenges faced by individuals with chronic respiratory conditions in rural and coastal areas, such as limited healthcare access or increased vulnerability to environmental pollutants?   Policy or Strategy   * How does your programme align with national and local health policies and strategies aimed at improving respiratory health and reducing health inequalities?   Healthy Weight   * How does your programme support individuals with chronic respiratory conditions in achieving and maintaining a healthy weight, given its relevance to conditions like obesity-related asthma and COPD?   Children and Young People   * How does your programme support children and young people with chronic respiratory conditions, such as asthma, by providing age-appropriate care and education?   Cardiovascular Disease (CVD)   * How does your programme address the intersection of chronic respiratory conditions and cardiovascular disease, which often co-occur in patients with significant health disparities?   Oral Health and Dental Services   * Impact of Oral Health & Dental Services on Overall Health Outcomes   + Does the dental programme address the relationship between poor oral health and the development of other health conditions (e.g., cardiovascular disease, diabetes, respiratory infections)?   + Does the programme promote the importance of good oral hygiene and regular dental visits, particularly for populations at higher risk of oral health complications, such as children, older adults, or individuals with disabilities? * Access to Care for Oral Health & Dental Services   + How does the programme ensure access to dental care for vulnerable populations, particularly those in deprived areas who may face barriers such as affordability, lack of transportation, or cultural differences?   + How does the dental programme collaborate with other health services (e.g., maternity care, general health services) to ensure that oral health is adequately addressed as part of overall healthcare, particularly for individuals with multiple health concerns? |
| 1. Refine and apply – make changes to your work plans that will have the greatest impact | |
| 1. Potential effects | |
| Considering the above, how is your programme, project or policy likely to reduce health inequalities? | Current service provision   * How does your service/policy currently provide support for individuals of lower socioeconomic status and living in areas of higher deprivation? * Does your current service model/policy take into consideration IH groups who face barriers to accessing healthcare?   + It is important to recognise that vaccination provision through GP practices will not reach IH groups who are often not registered with GPs. * Does your current service provision/policy mitigate any of the impacts of the harmful wider determinants of health for those groups most at risk of chronic respiratory disease? * Reflecting on the information obtained so far, is there any part of your service model/policy that may widen the inequality gap?   Your HEAT assessment could consider a number of different elements or one particular method:   * Opportunistic vaccination offers at GP practices. * Opportunistic vaccination of inpatients * Undertaking vaccinations at outreach venues * Community pharmacy vaccination offers.   You may also wish to consider smoking cessation services given this is the biggest risk factor for COPD and crosscuts Core20PLUS5 clinical priorities. For example, opportunities for brief advice, brief interventions, referrals to stop smoking services, and training for staff to maximise these opportunities. For further information on brief advice including a training module from the National Council for Smoking Cessation and Training please see [here](https://www.ncsct.co.uk/). |
| Does your programme, project or policy have the potential unintended consequence of widening inequalities by, for example:   * 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? * Relying on professional-led interventions? * Not tackling the root causes of health inequalities? * Relying upon digital access? * Relying upon high level of literacy? | Consider the following (but not limited to)  Requiring Self-Directed Action:   * Does the programme involve self-management of chronic respiratory conditions (e.g., using inhalers, monitoring symptoms) in a way that places a heavier burden on more affluent groups who have better access to resources, time, and knowledge, potentially leaving disadvantaged populations without the necessary support or capacity to manage their condition effectively?   Not Tackling the Full Spectrum of Causes:   * Does the programme primarily focus on clinical interventions (e.g., medication, treatment plans) without addressing the broader social determinants of health such as poor air quality, inadequate housing, or socioeconomic factors that disproportionately affect those in deprived communities and contribute significantly to respiratory health inequalities?   Not Being Designed with Communities:   * Was the programme developed in partnership with communities most affected by chronic respiratory diseases, ensuring that the interventions are relevant, culturally appropriate, and tailored to the specific needs, challenges, and preferences of these communities, rather than being a top-down approach that may overlook local insights?   Relying on Professional-Led Interventions:   * Does the programme overly rely on healthcare professionals (e.g., doctors, nurses) to deliver care and interventions for chronic respiratory disease, rather than integrating community-based approaches, peer support, or educational initiatives that could empower local communities and increase access to care for those who are less likely to engage with professional healthcare?   Not Tackling the Root Causes of Health Inequalities:   * Does the programme address the root causes of health inequalities in chronic respiratory diseases, such as environmental factors (e.g., air pollution, damp housing), socioeconomic disparities, or lack of access to healthcare, or does it focus too narrowly on clinical treatment without confronting these systemic issues?   Relying Upon Digital Access: [NHS England » Inclusive digital healthcare: a framework for NHS action on digital inclusion](https://www.england.nhs.uk/long-read/inclusive-digital-healthcare-a-framework-for-nhs-action-on-digital-inclusion/)   * Does the programme assume that individuals have access to digital resources (e.g., online consultations, digital symptom tracking, mobile health apps) to manage their chronic respiratory conditions, potentially excluding vulnerable populations without reliable internet access, technology, or digital literacy, especially in more deprived areas?   Relying Upon High Levels of Literacy:   * Does the programme rely on high levels of health literacy to understand and engage with its materials or interventions (e.g., written instructions, educational resources), potentially alienating individuals with lower literacy levels, limited English proficiency, or cognitive impairments who may be disproportionately affected by chronic respiratory conditions? |
| What aspects of mental wellbeing are affected? Consider risk and protective factors. | Consider the following (but not limited to)  Risk Factors:   * Impact of Illness on Mental Health:   + How does the chronic nature of respiratory disease contribute to mental health challenges, such as anxiety, depression, or stress, due to symptoms, hospitalisations, or the burden of managing the condition? * Social Isolation:   + How does living with chronic respiratory disease lead to social isolation, especially if individuals are unable to participate in social activities or are dependent on others for daily tasks, which may negatively affect their mental wellbeing? * Economic Stress:   + Does the programme consider the financial strain that chronic respiratory disease can place on individuals, such as job loss, reduced income, or increased healthcare costs, which may contribute to mental health issues like stress and anxiety? * Stigma and Negative Self-Perception:   + Does the programme account for stigma or negative self-perception that individuals with chronic respiratory disease may experience, potentially leading to feelings of shame, low self-esteem, and mental distress? * Limited Access to Mental Health Services:   + Does the programme consider barriers to accessing mental health services for individuals with chronic respiratory disease, especially in underserved or deprived communities, exacerbating mental health risks?   Protective Factors:   * Support Networks:   + Does the programme promote the development of social support networks (e.g., family, peer groups, support organisations) to buffer against the negative effects of chronic illness on mental wellbeing and provide emotional support? * Access to Mental Health Services:   + Does the programme facilitate access to mental health support (e.g., counselling, therapy) for individuals living with chronic respiratory disease to help manage stress, anxiety, and depression, enhancing mental resilience? * Building Resilience:   + Does the programme offer strategies to help individuals build resilience, such as stress management techniques, coping mechanisms, or educational resources, which can improve mental wellbeing and the ability to manage the chronic condition? * Healthy Lifestyle and Coping Strategies:   + Does the programme promote healthy lifestyle choices, such as exercise, nutrition, and smoking cessation, as protective factors for both respiratory and mental health? Are coping strategies included to help individuals manage emotional stress and improve wellbeing? * Empowerment and Self-Efficacy:   + Does the programme empower individuals to take an active role in managing their chronic respiratory disease, fostering a sense of control and self-efficacy, which can improve mental wellbeing and reduce feelings of helplessness? * Community Involvement:   + Does the programme encourage community engagement and participation in activities that promote mental wellbeing, such as local support groups or advocacy, helping individuals feel connected and supported within their communities? |
| 1. Action plan | |
| What specific actions will you take to maximise the potential for positive impacts and/or to mitigate the negative impacts on health inequalities? Provide a list of actions and targets. | Changes to service provision   * Considering all of the above, what could you change to your service provision/policy to ensure you are targeting provision to those population groups identified in section 2 as having the highest need? * We know that those who face barriers to accessing healthcare, those who are socially excluded, and those living in more deprived areas are at higher risk for poorer health outcomes. It can be reasonably assumed that those with poorer access and less likely to attend GP practices are less likely to have COPD identified and optimally managed with appropriate vaccinations. Considering these points and in the absence of local data for certain IH groups, are there any actions that could be taken? * Are there any specific enablers or assets that could be harnessed to reach these groups? Such as identifying and working with relevant community groups, other services, people and VCFSE organisations. * Specifically, what steps are required to ensure that data is collected locally for those population groups most at risk?   The following NHS Futures sites may be helpful to access a range of resources including best practice case study examples:   * [Equity and Health Inequalities Network](https://future.nhs.uk/EHIME/groupHome) and [Healthcare Inequalities Improvement Programme](https://future.nhs.uk/EHIME/groupHome) * [FutureNHS Case Study Hub](https://future.nhs.uk/CaseStudies/grouphome) * [Respiratory Disease Programme](https://future.nhs.uk/RespiratoryDiseaseManager/groupHome) * [OHID Resources - NHS Prevention Programme - FutureNHS Collaboration](https://future.nhs.uk/NHSpp/view?objectID=42187088)   Cost-effective Interventions *(Source:* [*NHS England » Secondary prevention: reducing disparities and improving life expectancy*](https://www.england.nhs.uk/ourwork/prevention/secondary-prevention/)*)*  A review of the cost-effectiveness evidence demonstrates that the following interventions are “high impact”.  [**Smoking cessation in secondary care**](https://www.england.nhs.uk/ourwork/prevention/secondary-prevention/modifiable-risk-factors-high-impact-interventions/#heading-1)   * Cost per quit £475, ROI £2.12 with payback period 4 years. * Ottawa Model of Smoking Cessation in NHS – net return £60m in 1st year, additional £206m supporting NHS staff to quit; reduction in RR of readmission 6% and A&E attendance 3% at 1 year, reduction in smoking-related physician visits (specialist 5% and GP 2%) * LTP modelling estimated in first full year for inpatient and maternity services, cost-benefit ratio £1.85 to NHS. * Impact on demand – 42,000 admissions and 150,000 bed days saved in first full year. * Impact on outcomes – 16% reduction in risk of COPD exacerbations in ex-smokers compared to smokers over 5 years, smoking cessation associated with 40% risk reduction of COPD morbidity, lung function improvements in 2-12 weeks.   [**Seasonal Influenza Programme UK**](https://app.box.com/s/t5ockz9bb6xw6t2mrrzb144njplimfo0/file/1079253178131) **(JCVI)**   * *“JCVI’s advice is aimed at maximising the health benefits from vaccination on the basis of the cost effectiveness of vaccination and this underpins the statutory basis for JCVI recommendations”.*   JCVI currently recommend annual influenza vaccination for at-risk adults, including those with COPD. |
| How can you act on the specific causes of inequalities identified above? | Potential examples (but not limited to)  Economic Stress   * Provide financial support or access to benefits for individuals with chronic respiratory conditions, ensuring that they have assistance with healthcare costs, medication, and lost income. Partner with local social services to ensure these individuals are aware of financial support options.   Limited Access to Mental Health Services   * Integrate mental health support into respiratory care by offering counselling, therapy, or mental wellbeing workshops as part of routine healthcare services. Increase outreach to marginalised communities to ensure they have access to these services.   Lack of Access to Health Services   * Increase access to healthcare services in underserved areas through mobile health clinics or telemedicine, especially for those with chronic respiratory diseases who may find it difficult to travel to medical centres. This can help bridge the gap for people with limited access to in-person care. |
| What activities will you put in place which will adapt and enhance your programme, project or policy in relation to cultural competencies? For example, consideration of cultures, languages, formats, images, digital, written, spoken, translation services. | Potential Examples (but not limited to)  Cultural Sensitivity in Care Delivery   * Provide cultural competency training for healthcare providers to ensure they understand diverse cultural beliefs about health, illness, and treatment. This will enable providers to offer care that is respectful and appropriate to the cultural backgrounds of patients with chronic respiratory diseases.   Multilingual Resources   * Develop and distribute educational materials about chronic respiratory diseases in multiple languages, ensuring that non-English-speaking communities can understand the information. This can include written guides, brochures, and posters that reflect local language needs.   Community Outreach with Culturally Relevant Messaging   * Collaborate with community leaders to create health campaigns that reflect the values and norms of specific cultural groups. This may include using culturally relevant imagery, examples, and messages that resonate with the target audience.   Translation and Interpretation Services   * Offer on-demand translation and interpretation services (both in-person and digital) during medical consultations for patients with chronic respiratory diseases who do not speak the primary language of the healthcare setting. This ensures accurate communication between healthcare providers and patients. |
| What specific steps and action will you take to address the identified structural racism and discrimination? | Potential Examples (but not limited to) [NHS England — North West » Anti Racist Framework](https://www.england.nhs.uk/north-west/nhs-north-west-bame-assembly/anti-racist-framework/)  Inclusive Policy Development   * Review and revise programme policies to ensure they do not inadvertently perpetuate discrimination. This includes creating clear guidelines that prioritise equitable access to care for marginalised communities and address the specific needs of racial and ethnic minorities in relation to chronic respiratory diseases.   Diverse Representation in Leadership   * Ensure diverse representation in leadership roles within the programme, including hiring healthcare professionals and staff from underrepresented racial and ethnic groups. This fosters a more inclusive environment and provides role models for patients from these communities.   Cultural Competency Training   * Implement mandatory training for healthcare providers and staff to address structural racism and unconscious bias in care delivery. This training should focus on the impacts of racism on health outcomes, particularly in relation to chronic respiratory diseases, and teach staff to recognise and combat discriminatory behaviours. |
| How will you mitigate against the negative impact of when multiple harmful factors interact and result in compounding poor health outcomes for effected communities? | Potential Examples (but not limited to)  Holistic Care Approach   * Implement a multidisciplinary care model where healthcare providers (doctors, nurses, mental health professionals, social workers) collaborate to address not only the chronic respiratory disease but also other compounding factors like mental health, socioeconomic status, housing, and access to food. This ensures that all aspects of a patient’s wellbeing are considered and treated.   Targeted Outreach and Community Support   * Conduct outreach programs that provide comprehensive support to communities facing multiple disadvantages (e.g., poor air quality, economic hardship, and limited healthcare access). This might involve mobile health clinics or partnerships with community organisations to deliver services directly in underserved areas.   Addressing Social Determinants of Health   * Advocate for policies that tackle the root causes of poor health outcomes, such as improving living conditions, reducing air pollution, and increasing access to affordable housing and nutritious food in communities disproportionately affected by chronic respiratory diseases. |
| Which populations face the biggest inequalities for your targeted action? | Potential Examples (but not limited to) [NHS England » A national framework for NHS – action on inclusion health](https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/)  Low-Income Communities   * People in low-income households often live in substandard housing with poor ventilation, dampness, or exposure to pollutants, which can worsen conditions like asthma or COPD. They also face challenges in affording medications, healthcare visits, and treatments, making it harder to manage chronic respiratory diseases effectively.   Racial and Ethnic Minorities   * Black, Asian, and ethnic minority groups often experience disproportionately high rates of respiratory diseases due to factors such as poor air quality, structural inequalities in healthcare access, and cultural or language barriers that limit access to care and treatment.   Homeless People   * Homeless individuals are more likely to suffer from chronic respiratory conditions, including COPD and asthma, due to exposure to environmental hazards, inadequate shelter, and poor access to healthcare services. They often face additional barriers to managing their health due to lack of stable housing and social support.   Migrants and Refugees   * Migrants and refugees, particularly those from lower-income backgrounds, are at higher risk of chronic respiratory diseases due to overcrowded living conditions, poor air quality, and limited access to healthcare. Language barriers and lack of familiarity with the healthcare system can also hinder effective management of their conditions. |
| Could you design the programme, project or policy with communities who face the biggest health inequalities to maximise the chance of it working for them? What will you need to enable this? | Potential Examples (but not limited to)  Co-Designing with Local Communities   * Collaborate with low-income, ethnic minority, and homeless populations to co-design the programme. Work with local community leaders and healthcare advocates to ensure the programme meets specific needs, such as addressing cultural beliefs and barriers to healthcare access. For example, develop bilingual health education materials or provide outreach services in community spaces like churches or community centres. * Enabling Factor: Community engagement, partnerships with local organisations and health workers who understand the community’s needs, and flexibility in adapting the programme based on ongoing feedback.   Tailored Health Education and Support   * Offer health education materials in multiple languages and accessible formats for diverse communities (e.g., migrant populations). Provide visual guides and phone-based or in-person health workshops on managing chronic respiratory diseases like asthma or COPD. These resources should take into account cultural preferences and practices around health. * Enabling Factor: Translation services, use of visual aids for lower health literacy levels, and culturally sensitive healthcare workers who can offer personalised advice and support.   Community Health Workers and Peer Support   * Utilise community health workers (CHWs) from the affected communities to help individuals with chronic respiratory diseases. These CHWs can provide education on managing conditions, assist with smoking cessation, and offer peer support groups where individuals can share experiences and advice. For example, a CHW might help a patient navigate the healthcare system, explain how to use inhalers properly, or connect them with local resources. * Enabling Factor: Training community health workers in cultural competence, respiratory health management, and communication skills. Additionally, establishing peer support networks to encourage ongoing engagement and reduce isolation. |
| Could you seek to increase people’s control over their health and lives (if appropriate)? What would this look like? | Potential Examples (but not limited to)  Empowering Self-Management through Education   * Provide self-management workshops for individuals with chronic respiratory diseases, teaching them how to monitor their symptoms, use inhalers properly, and understand when to seek medical help. These workshops could include practical tools like symptom diaries and action plans that empower individuals to take control of their care. * What this looks like: Patients would feel more confident in managing their condition independently, reducing reliance on emergency care and improving overall health outcomes.   Digital Tools for Monitoring and Support   * Offer an app or wearable device that allows patients to track their symptoms, medication use, and environmental triggers for respiratory issues (e.g., pollution, allergens). The app could provide personalised recommendations and reminders, fostering a sense of control over managing their condition. * What this looks like: Patients would have real-time data on their health, allowing them to make informed decisions about their treatment and lifestyle choices. This could improve adherence to treatment and reduce hospitalisations.   Patient-Led Support Groups   * Establish peer support groups where individuals with chronic respiratory diseases can share experiences, coping strategies, and advice on managing their conditions. These groups could be facilitated by trained peers or community health workers, empowering participants to support one another in managing their health. * What this looks like: Patients would gain a sense of community and empowerment, exchanging knowledge on how to better manage their health and advocate for their needs in healthcare settings. |
| Which community groups and consultation methods will you engage to tackle the problem, to maximise the chance of reaching large populations at scale (see [Community-centred public health: taking a whole system approach](https://www.gov.uk/government/publications/community-centred-public-health-taking-a-whole-system-approach)). | Potential Examples (but not limited to)  Engaging Local Community Organisations   * Partner with local organisations that work with low-income, ethnic minority, or migrant populations (e.g., community centres, cultural associations, or advocacy groups). These organisations often have established trust and direct access to hard-to-reach groups, helping spread awareness about respiratory disease prevention and management. * Consultation Method: Focus groups and community forums to understand specific health concerns and barriers to care within these populations. Engage community leaders to co-design health messages and initiatives that resonate culturally and linguistically.   Collaborating with Schools and Educational Institutions   * Collaborate with schools, universities, and youth organisations to educate children and families about the risks of smoking, air pollution, and managing chronic respiratory conditions. Schools often serve as hubs for large community populations, allowing for educational programmes to reach multiple family members. * Consultation Method: Use surveys and workshops in schools to assess knowledge gaps about respiratory diseases, followed by interactive educational sessions for students and their families. These methods ensure broad reach while empowering younger generations to influence family health behaviours.   Partnering with Faith-Based and Religious Organisations   * Partner with faith-based organisations (churches, mosques, temples) that serve as focal points for many communities. These organisations are trusted spaces that often have access to large groups of people from diverse backgrounds. * Consultation Method: Community outreach events held in places of worship, where health professionals can provide educational talks, screenings, and advice on managing respiratory health. Engaging faith leaders to promote health messages can also help normalise discussions about chronic respiratory diseases. |
| Who else can help? | Consider what and who’s input you may be missing |
| 1. Evaluation and monitoring | |
| How will you quantitatively or qualitatively monitor and evaluate the impact of your programme, project or policy on different population groups at risk of health inequalities? Consider what output or process measures you could use. | Consider when you will review outputs and outcomes identified above, which could be at 6 and 12 months.  Output evaluation   * How will you measure the actions that have been achieved? * How does the programme monitor for unintended consequences?   Outcome evaluation  How will you measure and how will you document that you have had an impact on access, experience and outcomes for those population groups identified as being at higher risk? This should include consideration of quantitative measures and also qualitative measures (e.g. engaging directly with population groups at high risk). |
| Set a health equity assessment review date, recommended for between 6 and 12 months from initial completion. |  |

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| --- |
| 1. Review – identify lessons learned and drive continuous improvement |

|  |  |
| --- | --- |
| Date completed  (should be 6-12 months after initial completion): |  |
| Contact person (name, directorate, email, phone) |  |
| Have you achieved the actions you set? |  |
| How has your programme, project or policy supported reductions in health inequalities associated with physical and mental health? |  |
| How has your programme, project or policy 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? |  |

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Description automatically generated

Health Equity Assessment Tool (HEAT):

Full version

Adapted for Core20PLUS5

Clinical Priority 4: Early cancer diagnosis

Date: December 2024

Adapted from Public Health England HEAT tool published in August 2024.

A resource produced by NHS England NW Public Health and Office for Health Improvement and Disparities (OHID) NW.

**HEAT and Core20PLUS5**

**Clinical Priority 4: early cancer diagnosis**

What is Core20PLUS5?

Core20PLUS5 is NHS England’s approach to reducing healthcare inequalities at a national and system level. “Core20” represents the 20% most deprived members of the population (as defined by the Index of Multiple Deprivation). “PLUS” represents population groups who are at risk of social exclusion, such as inclusion health groups, and other groups sharing protected characteristics. “5” represents five clinical priorities that require accelerated improvement. The fourth priority focuses on early cancer diagnosis; specifically, that 75% of cases should be diagnosed at stage 1 or 2 by 2028.

What is HEAT and how can it help?

HEAT is the Health Equity Assessment Tool. It can be used prospectively or retrospectively to help ensure an equitable provision. This adapted HEAT has been developed to enable identification of actions to encourage groups at high risk of cancer to present for screening or with early signs and symptoms, and therefore to reduce healthcare inequalities.

Who is this tool for?

The HEAT tool was developed to be used across a range of programmes and projects. This version of the HEAT tool has been adapted to include specific prompts for leaders at a system, place and PCN level and cancer alliances. Applying HEAT to Core20PLUS5 will help systems reach both Core20PLUS5 and early cancer diagnosis, referral and screening targets, while also helping to reduce the inequalities gap.

How do I use this tool?

The adapted HEAT below contains a series of prompts to enable effective application to early cancer diagnosis. Following these prompts and filling each section of the tool as fully as possible will help you to identify health inequities within high-risk groups and offer the opportunity to identify actions to increase uptake for screening and for early cancer diagnosis, to help to inform local plan development. The tool does include a review and is therefore a continuous improvement process.

HEAT is supplemented by an [e-learning module](https://www.e-lfh.org.uk/programmes/health-equity-assessment-tool-heat/) on the NHS Learning Hub, designed to equip professionals with essential skills for undertaking a HEAT assessment.

The tool

|  |  |
| --- | --- |
| Programme or project being assessed |  |
| Date assessment started |  |
| Date assessment completed |  |
| Contact person (name, directorate, email, phone) |  |
| Name of strategic leader (senior responsible officer) |  |
| Lead organisation |  |
| Other organisations engaged |  |
| Community engagement methods used.  Best practice shows that engaging communities is an effective way of identifying, gaining insight and understanding how health inequalities are experienced by communities. So, consider methods of engagement (for example specific questions, focus groups, surveys, Place Standard) which are inclusive, involving a range of affected communities and stakeholders; and an assessment of whether, how and with what impact community engagement can assists with the programme, project or policy and its implementation. |  |
| Agreed review date |  |

|  |  |
| --- | --- |
| **Steps to take** | **Your response – remember to consider multiple dimensions of inequalities, including protected characteristics and socio-economic differences** |
| 1. Prepare – agree the scope of work and assemble the information you need | |
| 1. Your programme of work  Things you may want to consider include:  What are the main aims of your programme, project or policy?  What is the justification, reason or driver for this programme, project or policy?  How do you expect your programme, project or policy to impact (positively or negatively) health inequalities?  Is it a programme, project, service, product, policy or strategy? | **Background Information:**  The purpose of this section is to detail the scope of your service or project, who are your key stakeholders and how you expect your work to reduce inequalities.  Main aims of Core20Plus5 Programme  Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the ‘Core20PLUS’ – and identifies ‘5’ focus clinical areas requiring accelerated improvement.  “Core20” represents the 20% most deprived members of the population (as defined by the Index of Multiple Deprivation). “PLUS” represents population groups who are at risk of social exclusion, such as inclusion health groups, and other groups sharing protected characteristics and should be identified at a local level.  Main aims of Early cancer diagnosis  Diagnose those people with undiagnosed cancer at early stages (stages 1 or 2) to enable earlier treatment and to improve outcomes.  Reducing inequalities  Applying Core20PLUS5 to your work ensures a targeted approach to those most at risk of inequalities. Without taking a targeted approach to early cancer diagnosis, there is the potential to widen the inequalities gap. Examples of targeted approaches include a [targeted lung health check programme](https://www.england.nhs.uk/contact-us/privacy-notice/how-we-use-your-information/our-services/evaluation-of-the-targeted-lung-health-check-programme/) for those at highest risk of lung cancer, including flexible appointments and reasonable adjustments for certain groups such as those with a learning disability.  Key Stakeholders  Who are the partners who will be supporting and enabling delivery? Partners across PCNs, place and system working e.g. health inequality leads, inclusion health leads / networks, specialised services/commissioning leads, voluntary sector, cancer alliances.  It is advisable to complete separate tools for each cancer that you wish to assess and review. Separate assessment facilitates a more in-depth review of health inequalities, taking into account varying demographics and risk factors profiles for each cancer site. However, it is also important to consider commonalities between cancer types that would ensure improvements across multiple pathways. |
| 1. Data and evidence   What data do you need to gain a greater understanding of need and assess the impact of this programme, project or policy?  You should consider relevant data, evidence, indicators and intelligence you are aware of, for example:   * Nationally available data such as: * [Fingertips health profiles,](https://fingertips.phe.org.uk/) * [Public Health Outcomes Framework](https://fingertips.phe.org.uk/profile/public-health-outcomes-framework) * [Hospital Outcomes S](https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics)tatistics * [Office for National S](https://www.ons.gov.uk/)tatistics * [RightCare](https://www.england.nhs.uk/rightcare/) * Local data such as that available in Joint Strategic Needs Assessment, contract performance data, school attainment and qualitative data from local research, voluntary, community and social enterprise (VCSE) intelligence and community voice * Insights gained form community voices with lived experiences in relation to discrimination, racism, access and multiple disadvantage and displacement | The purpose of this section is to demonstrate local need through presentation of key indicators. You may have your own service level data e.g. Health Equity Audits, JSNAs that could be used. What can these indicators tell you about possible inequalities between population groups? It is also important to highlight what data are not available that you would have found useful. A possible inequity may lie in the data systems themselves.  Other key data sources to explore:   * [Cancer Research UK](https://www.cancerresearchuk.org/health-professional/data-and-statistics) data * [Cancer stats availability summary](https://www.cancerdata.nhs.uk/), providing a guide to available cancer data. * [Local Cancer Intelligence Tool](https://www.nursingtimes.net/learning-units-and-portfolio/cpd-activities/macmillan-local-cancer-intelligence-tool-new-features-31-07-2017/) * [National Cancer Registration and Analysis Service](https://digital.nhs.uk/services/national-disease-registration-service) (NCRAS)   + [NCRAS Service Profiles](http://www.ncin.org.uk/cancer_information_tools/profiles/serviceprofiles), to help commissioners to understand variation across MDTs.   + [NCRAS Survival by Stage](http://www.ncin.org.uk/publications/survival_by_stage), providing information on completeness of staging data and proportion of early staged cancers.   + [Macmillan-NCRAS UK Cancer Prevalence Project](http://www.ncin.org.uk/about_ncin/segmentation), providing cancer prevalence data over a 21-year period.   + [CancerStats](https://cancerstats.ndrs.nhs.uk/) (requires an N3 connection and login, containing a repository for all feedback on datasets which are managed or supported by NCRAS) and [CancerData](https://www.cancerdata.nhs.uk/) (public-facing version containing incidence and mortality data)   + [Emergency presentations of cancer](https://www.gov.uk/government/collections/emergency-presentations-of-cancer)   + [The Cancer Alliance Data, Evaluation and Analysis Service (CADEAS),](https://digital.nhs.uk/ndrs/data/data-outputs/cancer-data-hub/cancer-median-pathways) providing data on cancer waiting times and pathways, as well as COVID-19 Cancer Equity data packs.   + [Local CCG Cancer Profiles](http://www.ncin.org.uk/cancer_information_tools/profiles/ccgprofiles) (requires contacting your Local Knowledge and Intelligence Service for a copy of your profile) * [OHID Fingertips, Cancer Services](https://fingertips.phe.org.uk/profile/cancerservices). Providing data at GP, PCN, sub-ICB, ICB and national level from the National Disease Registration Service. Contains data on:   + Cancer incidence and screening   + Diagnostic services   + Two-week wait referrals   + Emergency presentations and admissions * [OHID Fingertips, GP practice profiles](https://fingertips.phe.org.uk/profile/general-practice)   + Prevalence, screening uptake and coverage, 2 week wait referrals by GP practice (if you know practices by deprivation, this could help to demonstrate inequalities) * Learning Disability register in GP practices. * OHID, [Local Health](https://www.localhealth.org.uk/#c=home), with customisable mapping layers and indicator themes, including cancer incidence and mortality at small level geography * [OHID, Public Health Profiles](https://fingertips.phe.org.uk/search/cancer) * OHID, [Excess mortality by cause of death in England and English regions](https://www.gov.uk/government/statistics/excess-mortality-in-england-and-english-regions), specifically for excess deaths caused by cancer * [Quality and Outcomes Framework](https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/general-practice-data-hub/quality-outcomes-framework-qof), Cancer data * [SHAPE tool](https://shapeatlas.net/) (plot GP practices, deprivation, boundaries, transport routes) * [Aristotle](https://academy.midlandsandlancashirecsu.nhs.uk/aristotle-xi/) (may only apply to certain regions), including the Health Inequalities Dashboard, PCN Profiles and Population Segmentation Tool * [NHSE, Cancer Waiting Times](https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/) - waiting times of people referred by their GP with suspected cancer or breast symptoms and those subsequently diagnosed with and treated for cancer by the NHS in England. * [NHS National Cancer Patient Experience Survey](https://www.ncpes.co.uk/results-2022/) * [NHS RightCare Data](https://www.england.nhs.uk/rightcare/rightcare-resources/) (including Mental Health Conditions Data Packs and [RightCare Toolkit for physical ill-health and CVD prevention in people with SMI)](https://www.england.nhs.uk/rightcare/toolkits/physical-ill-health-cvd-prevention-severe-mental-illness/)   List any other data sources and indicators that you may have available.  Digital Inclusion & Inclusion Health  Ensure [Digital Inclusion](https://www.england.nhs.uk/long-read/inclusive-digital-healthcare-a-framework-for-nhs-action-on-digital-inclusion/) & [Inclusion Health](https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/) Frameworks are considered and implemented throughout all steps of the tool. |
| 1. Contributors to inequalities   Have you considered the interplay of multiple contributors to inequalities influencing personal experiences? | The purpose of this section is to demonstrate the differentiating factors that contribute to widening health inequalities. Consider the following:   * 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. * Different exposure to social, economic and environmental stressors and adversities, which affect states of mind from an early age and throughout life - stress and psychological wellbeing directly affect resilience, health conditions and health behaviours. * Differences in health behaviours or other risk factors (including genetic vulnerability) which exist within and 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. * Unequal access to or experience of health and other services between social groups. * Inequalities impacted by structural discrimination which results in some groups and individuals - for example, those who identify with one or more of the protected characteristics - experiencing poorer access to services and poorer outcomes. |
| 1. Assess - examine the evidence and intelligence | |
| 1. Distribution of health | |
| Based on evidence collected above, which populations face the biggest health inequalities for your topic or service area?  Think about the 4 health inequality domains (socio-economic deprived population; geographic deprivation; inclusion health and vulnerable groups; protected characteristics). | Socio-economic status or geographic deprivation:  Deprivation is associated with greater prevalence of risk factors that could lead to cancer (in addition to later presentation, poorer screening uptake, and therefore later diagnosis) for your population. What does the data tell you above in terms of health inequalities by geographic deprivation / socioeconomic status?  Key considerations to determine the distribution of risk factors for poorer access to healthcare and delayed presentation include:   * Where are your most geographically deprived areas (e.g. those areas in the lowest IMD quintile)? * Where are your isolated communities, such as coastal and rural?   Do you have local level National Statistics Socio-economic Classification (NS-SEC) scores to determine socioeconomic status? See Office for National Statistics’ [Census Maps](https://www.ons.gov.uk/census/maps/choropleth/work/national-statistics-socio-economic-classification-ns-sec) |
| Consider your programme, project or policy against the socio-economic status domain and how it interacts with the domain, and the impact that has or may have. | Consider the following:  Access to Early Screening:   * Does the programme ensure equitable access to cancer screening services (e.g., breast, cervical, and colorectal cancer screenings) for women and men from lower socio-economic (SES) backgrounds? * Are there socio-economic barriers that prevent access to timely diagnosis, such as transportation, awareness, or financial constraints?   Health Education and Awareness:   * Does the programme educate individuals in socio-economically deprived areas about the importance of early cancer detection? * How does the programme raise awareness in lower SES communities about the availability of screening and early diagnosis options?   Impact on Health Outcomes:   * Are there significant differences in cancer survival rates between socio-economic groups, and how does the programme address these disparities? * How is the programme addressing lower early diagnosis rates in people from disadvantaged socio-economic backgrounds? |
| Consider your programme, project or policy against the geographic deprivation domain and how it interacts with the domain, and the impact that has or may have. | Consider the following (but not limited to)  Access to Cancer Screening Services   * Does your programme account for the geographic barriers to cancer screening in deprived areas (e.g., rural or underserved urban populations)?   Transportation and Travel Challenges   * Does your programme address the challenges faced by individuals in deprived areas in accessing cancer treatment due to travel distance or transportation barriers?   Healthcare Infrastructure and Availability   * Does your programme ensure that cancer care infrastructure is distributed equitably, especially in regions of high deprivation, where healthcare resources may be limited?   Health Literacy and Awareness in Deprived Areas   * Does your programme provide tailored health education on cancer prevention and treatment in geographically deprived areas, where there may be lower health literacy or awareness? |
| Consider your programme, project or policy against the inclusion health and vulnerable groups domain and how it interacts with the domain, and the impact that has or may have. | Inclusion health and vulnerable groups (for example, people experiencing homelessness, prison leavers, young people leaving care, people with a learning disability if not receiving annual health checks): [NHS England » A national framework for NHS – action on inclusion health](https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/)  Inclusion health (IH) groups are those individuals who are at risk of social exclusion. These include: -   * People experiencing homelessness. * People experiencing drug and alcohol dependence. * Migrants * Gypsy, Roma, Traveller communities * Sex workers * People in contact with criminal justice system * People with a Learning Disability   Data collection for IH groups is often incomplete. People in IH groups may not be registered with and may not access GPs. We know they face barriers and have poorer outcomes. It is important to recognise these groups as potentially being at higher risk of cancer through poorer access and later presentation. Key questions to address include:   * Do you know the prevalence and distribution of IH groups in your area? * What service level data do you have in relation to these groups? * Where and what are the data gaps for IH groups? |
| Consider your programme, project or policy against experience related to protected characteristics domain and how it interacts with the domain, and the impact that has/may have. | Experience related to protected characteristics:  Protected characteristics according to the Equality Act 2010 are:   * age * disability * gender reassignment * marriage and civil partnership * pregnancy and maternity * race * religion and belief * sex * sexual orientation   According to the data, are any of these groups more at risk of cancer? |
| 1. Causes of inequalities | |
| Recognising that there are inequalities experienced by the population groups identified, considering the data and evidence, what are the wider determinants and structural discriminatory drivers? Consider the diverse range of social economic factors which influence people’s health and wellbeing. | Consider the following (but not limited to)  Socioeconomic Status and Access to Healthcare   * Does your programme address how socioeconomic deprivation impacts access to cancer care and outcomes, such as lower access to preventative services, screenings, and timely treatments for people in lower-income groups?   Education and Health Literacy   * Does your programme consider the role of education and health literacy in influencing people's ability to access cancer services, understand cancer risks, and manage their health?   Cultural and Language Barriers   * Does your programme account for the cultural and language barriers that affect certain groups' access to cancer care, particularly for migrant, ethnic minority, or non-English speaking populations? |
| What does the data and evidence tell you are the potential drivers for these inequalities? It may be helpful to consider the following questions:   * Which wider determinants are influential, for example, income, education, employment, housing, community life, racism and discrimination, cultural, environmental? * Are there any factors which indicate structural discrimination or racism will impact upon your programme, project or policy, for example mandatory use of digital access to health advice preventing access for less IT literate individuals and communities? * Which health behaviours play a role? * Does service quality, access and take up increase the chance of health inequalities in your work area? * Does climate change have an impact on health inequalities in relation to your programme, project or policy? * Which of these can you directly control? * Which can you influence? * Which are out of your control? | Wider determinants of health  Social and economic factors influence health\*\*. It is recognised that not all of these factors are in your control, but you need to be aware of the impact they have on your population group in terms of access, experience and outcomes in cancer care. You may be able to make a change in your service that could reduce the impact. Examples for consideration include:   * Education * Have you considered the health literacy of population groups most at risk of health inequalities? * Is patient information appropriate and accessible to all population groups (easy read including pictures/multi-lingual)? * Systematic/Institutional Racism and discrimination * Have you thought about barriers to accessing healthcare across population groups, particularly among IH groups? * Employment * Have you considered service access for employed people and unpaid carers etc? e.g. do you offer out of hours and weekend appointments? Are there offers via occupational health and outreach teams? * How accessible are clinic locations and GP practices, could areas with lower uptake rates be offered free transport provision? Are clinic locations accessible by public transport? Can they be offered in other locations such as workplaces, supermarkets, shopping centres? * Enablers/Assets   + Are there any specific enablers or assets that could be harnessed to reach population groups most at risk of health inequalities? E.g. identifying and working with relevant community groups, other services, people and VCFSE organisations.   **Reference: \*\*Hood et al 2015**[**County Health Rankings: Relationships Between Determinant Factors and Health Outcomes – ScienceDirect**](https://www.sciencedirect.com/science/article/pii/S0749379715005140)​ |
| Consider if any of the following aspects influence or are influenced by your programme, project or policy  • poverty and cost of living  • community engagement  • COVID-19 or incident recovery  • violence prevention  • Core20PLUS5  • major health conditions  • substance misuse  • mental health  • service commissioning  • rural and coastal health  • policy or strategy  • healthy weight  • children and young people  • cardiovascular disease (CVD)  • oral health and dental services | Consider the following (but not limited to)  Poverty and Cost of Living   * Does your programme consider how poverty and cost of living may influence access to cancer prevention, screening, and treatment, particularly for people in lower-income areas?   Community Engagement   * Does your programme actively engage with local communities to understand their needs, raise awareness, and reduce barriers to cancer care, particularly in underserved or deprived areas?   COVID-19 or Incident Recovery   * Does your programme address the impact of COVID-19 or other health incidents on cancer care access, such as delays in screening, diagnosis, and treatment due to pandemic-related disruptions?   Major Health Conditions   * Does your programme consider the interaction between cancer and other major health conditions, such as cardiovascular disease (CVD), diabetes, or mental health issues, which may impact treatment outcomes or access to care?   Substance Misuse   * Does your programme consider the role of substance misuse (e.g., smoking, alcohol, or drug use) as a risk factor for cancer, and does it offer prevention or support services for people affected by substance misuse?   Mental Health   * Does your programme address the mental health challenges faced by individuals diagnosed with cancer, such as anxiety, depression, or stress related to the diagnosis or treatment process?   Service Commissioning   * Does your programme consider the commissioning of cancer services, including the availability of services in areas of deprivation, and how to ensure equitable access to high-quality care across different populations?   Rural and Coastal Health   * Does your programme address the unique challenges faced by rural and coastal communities in accessing cancer care, such as distance to treatment centres, transportation issues, and availability of local services?   Policy or Strategy   * Does your programme align with or influence national or local cancer policies or strategies aimed at reducing health inequalities and improving outcomes for people affected by cancer?   Healthy Weight   * Does your programme incorporate strategies to address obesity or unhealthy weight, which are key risk factors for several cancers, particularly in deprived populations?   Children and Young People   * Does your programme address the specific needs of children and young people in relation to cancer prevention, early detection, and treatment, ensuring they have age-appropriate resources and support?   Cardiovascular Disease (CVD)   * Does your programme recognise the relationship between cardiovascular disease (CVD) and cancer, particularly for populations with a higher burden of both conditions, and offer integrated care for these co-morbidities?   Oral Health and Dental Services   * Impact of Oral Health & Dental Services on Overall Health Outcomes   + Does the dental programme address the relationship between poor oral health and the development of other health conditions (e.g., cardiovascular disease, diabetes, respiratory infections)?   + Does the programme promote the importance of good oral hygiene and regular dental visits, particularly for populations at higher risk of oral health complications, such as children, older adults, or individuals with disabilities? * Access to Care for Oral Health & Dental Services   + How does the programme ensure access to dental care for vulnerable populations, particularly those in deprived areas who may face barriers such as affordability, lack of transportation, or cultural differences?   + How does the dental programme collaborate with other health services (e.g., maternity care, general health services) to ensure that oral health is adequately addressed as part of overall healthcare, particularly for individuals with multiple health concerns? |
| 1. Refine and apply – make changes to your work plans that will have the greatest impact | |
| 1. Potential effects | |
| Considering the above, how is your programme, project or policy likely to reduce health inequalities? | Consider the following (but not limited to)  Targeting Deprivation and Geographic Barriers   * Does your programme specifically address the geographic and economic barriers to cancer care, ensuring that those in deprived or rural areas have equal access to screening, diagnosis, and treatment?   Addressing Socioeconomic Factors   * How does your programme address socioeconomic inequalities, such as providing financial support for low-income individuals, to ensure they can access cancer care without facing financial strain?   Culturally Tailored Health Education   * Does your programme provide culturally appropriate health education that resonates with marginalised or minority communities to ensure they understand cancer risks, prevention strategies, and treatment options?   Improving Health Literacy and Awareness   * Does your programme improve health literacy in deprived populations, particularly in relation to cancer prevention, early diagnosis, and treatment adherence?   Integrated Support for Co-Morbidities   * How does your programme address the intersection of cancer with other major health conditions (e.g., cardiovascular disease, mental health, or substance misuse) to ensure a holistic approach to care for vulnerable groups?   Community Engagement and Empowerment   * Does your programme actively engage with communities most affected by cancer to co-design solutions that are relevant, accessible, and sustainable in tackling health inequalities?   Addressing Structural Inequalities and Discrimination   * Does your programme consider structural racism and discrimination in the healthcare system, and actively work to eliminate these barriers to accessing cancer care? |
| Does your programme, project or policy have the potential unintended consequence of widening inequalities by, for example:   * 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? * Relying on professional-led interventions? * Not tackling the root causes of health inequalities? * Relying upon digital access? * Relying upon high level of literacy? | Current service provision   * How does your service/policy currently provide support for individuals of lower socioeconomic status and living in areas of higher deprivation? * Does your current service model/policy take into consideration IH groups who face barriers to accessing healthcare?   It is important to recognise that relying on presentation through GP practices will not reach IH groups who are often not registered with GPs.   * Does your current service provision/policy mitigate any of the impacts of the harmful wider determinants of health for those groups most at risk of delayed presentation of cancer? * Reflecting on the information obtained so far, is there any part of your service model/policy that may widen the inequality gap?   Your HEAT assessment could consider a number of different elements or one particular method:   * Cancer screening programmes (in primary care, at outreach venues) * Educational campaigns to encourage screening attendance. * Educational campaigns to recognise symptoms and seek treatment, considering communication methods wider than GP practices e.g. delivering in colleges and sixth forms, using the media such as newspapers and social media. * Improving access to diagnostic pathways   In assessing screening programmes, it is important to think about the complete pathway, since several providers may be involved that rely on each other to increase service user uptake and facilitate access. |
| What aspects of mental wellbeing are affected? Consider risk and protective factors. | Consider the following (but not limited to)  Risk Factors   * Psychological Impact of Cancer Diagnosis   + How does your programme address the mental distress and anxiety that may arise from a cancer diagnosis, particularly for individuals from deprived backgrounds who may face additional stressors? * Social Isolation and Stigma   + Does your programme consider the risk of social isolation and stigma that may be exacerbated by cancer diagnoses, particularly for marginalised or minority communities? * Financial Stress and Job Insecurity   + Does your programme consider how financial stress or job insecurity due to cancer treatment may impact mental wellbeing, especially for those in low-income or unstable employment? * Co-morbidities and Mental Health   + Does your programme address the impact of co-morbidities (e.g., cardiovascular disease, diabetes) on mental health in cancer patients, particularly in deprived populations who may already experience higher rates of other health conditions?   Protective Factors   * Access to Psychological Support   + Does your programme provide mental health support services, such as counselling, cognitive-behavioural therapy (CBT), or mindfulness, to help individuals cope with the emotional challenges of cancer? * Social Support and Community Engagement   + Does your programme foster social support networks, such as peer support groups or community-based initiatives, to reduce isolation and enhance emotional wellbeing? * Physical Activity and Healthy Lifestyle   + Does your programme encourage physical activity, healthy eating, and other wellbeing initiatives that can improve mental health for individuals undergoing cancer treatment, particularly in deprived communities? * Empowerment and Control Over Care   + Does your programme empower patients to have control over their cancer care, such as offering choices in treatment plans or involving them in decision-making to foster a sense of agency and self-efficacy? |
| 1. Action plan | |
| What specific actions will you take to maximise the potential for positive impacts and/or to mitigate the negative impacts on health inequalities? Provide a list of actions and targets. | Changes to service provision   * Considering all of the above, what could you change to your service provision/policy to ensure you are targeting provision to those population groups identified in section 2 as having the highest need? * We know that those who face barriers to accessing healthcare, those who are socially excluded, and those living in more deprived areas are at higher risk for poorer health outcomes. It can be reasonably assumed that those with poorer access and less likely to attend GP practices are less likely to have cancer diagnosed early. Considering these points and in the absence of local data for certain IH groups, are there any actions that could be taken? * Are there any specific enablers or assets that could be harnessed to reach these groups? Such as identifying and working with relevant community groups, other services, people and VCFSE organisations. * Specifically, what steps are required to ensure that data is collected locally for those population groups most at risk?   The following NHS Futures sites may be helpful to access a range of resources including best practice case study examples:   * [Equity and Health Inequalities Network](https://future.nhs.uk/EHIME/groupHome) and [Healthcare Inequalities Improvement Programme](https://future.nhs.uk/EHIME/groupHome) * [FutureNHS Case Study Hub](https://future.nhs.uk/CaseStudies/grouphome) * [Cancer Alliances Workspace](https://future.nhs.uk/canc/groupHome) * [National Cancer Services Networks](https://future.nhs.uk/NationalCancerServicesNetworks/groupHome)   Example of cost-effective interventions  A review of the cost-effectiveness evidence is summarised below, as examples of high impact interventions that you may wish to consider as part of your action plan.  Colorectal cancer (CRC) diagnosis:   * Treatment costs for stage 1 (£3,559) vs stage 4 (£13,206); cost-effective improvements through greater screening uptake e.g. GP endorsement letters and enhanced information leaflets (12% increase in uptake), a cost of £950 per healthy life year gained (S*ource: PHE,* [*Cost-effective commissioning of colorectal cancer care*](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/612370/cost-effectiveness-early-diagnosis-colorectal-cancer.pdf)) * A CRC Return on Investment (ROI) tool available [here](https://www.gov.uk/government/publications/return-on-investment-tool-colorectal-cancer)   Rapid Diagnostic Centres (RDCs):   * Cost savings: £148 per patient (seeing 5 patients per half day session) *Source:* [*Sewell et al. 2020*](https://bjgp.org/content/70/692/e186) |
| How can you act on the specific causes of inequalities identified above? | Potential Examples (but not limited to)  Improving Access to Psychological Support   * Provide free or low-cost mental health services for cancer patients, particularly those from marginalised communities, to address the mental health impact of cancer. Establish community-based peer support groups that offer emotional and psychological support for people living with cancer.   Enhancing Cultural Competence in Healthcare   * Ensure that healthcare providers are trained in cultural competence to effectively communicate with and provide care for diverse populations, particularly those from minority ethnic or immigrant communities. Offer multilingual resources and culturally relevant educational materials to raise awareness about cancer prevention and treatment.   Expanding Access to Early Detection in Underserved Areas   * Establish mobile cancer screening units that travel to rural or deprived areas, where access to healthcare facilities is limited. This can ensure that individuals in underserved communities have the opportunity for early cancer detection and timely intervention, reducing disparities in cancer outcomes. |
| What activities will you put in place which will adapt and enhance your programme, project or policy in relation to cultural competencies? For example, consideration of cultures, languages, formats, images, digital, written, spoken, translation services. | Potential Examples (but not limited to)  Multilingual Materials and Translation Services   * Provide multilingual informational materials (e.g., brochures, websites, and videos) to ensure that cancer prevention, screening, and treatment information is accessible to individuals from non-English-speaking communities. Offer translation services for medical consultations and patient support to ensure clear communication.   Cultural Sensitivity Training for Healthcare Providers   * Implement cultural competence training for healthcare staff to improve understanding of different cultural practices, beliefs, and communication styles, enabling them to provide more effective, respectful, and personalised care to diverse populations.   Community-Led Engagement and Education   * Partner with community leaders and local organisations to co-design health education materials and cancer prevention programmes that are culturally appropriate. This approach ensures that the messages resonate with the target audience and are delivered through familiar and trusted channels, such as community events or local media. |
| What specific steps and action will you take to address the identified structural racism and discrimination? | Potential Examples (but not limited to) [NHS England — North West » Anti Racist Framework](https://www.england.nhs.uk/north-west/nhs-north-west-bame-assembly/anti-racist-framework/)  Inclusive Policy and Leadership Representation   * Ensure diverse representation in leadership and decision-making roles within the programme to reflect the communities served. Implement anti-racist policies in healthcare settings, promoting equal access to cancer care and treatment for all racial and ethnic groups.   Bias Training for Healthcare Providers   * Offer regular anti-racism and implicit bias training for all healthcare providers involved in the cancer care pathway. This training will help reduce unconscious bias in diagnosis, treatment decisions, and patient-provider interactions, ensuring equitable care for all racial groups.   Community-Based Accountability and Feedback Mechanisms   * Create community advisory boards comprising members from marginalised racial and ethnic groups to provide input on programme design and implementation. These boards can help identify and address instances of discrimination or unequal treatment in cancer care, ensuring the programme is responsive to the needs of affected communities. |
| How will you mitigate against the negative impact of when multiple harmful factors interact and result in compounding poor health outcomes for effected communities? | Potential Examples (but not limited to)  Integrated Care Models   * Implement integrated care teams that address multiple health conditions simultaneously, such as cancer, mental health, and co-morbidities (e.g., cardiovascular disease or diabetes). These teams can provide coordinated services to ensure that patients receive comprehensive care that addresses both their physical and mental health needs.   Holistic Support Services   * Provide wraparound services that address social determinants of health, such as housing instability, food insecurity, and financial hardship. This could include partnerships with local social services to offer financial support, nutrition programmes, and housing assistance alongside cancer care to reduce the compounding effects of poverty and illness.   Community Outreach and Education   * Launch community outreach programmes that raise awareness about the interconnected nature of multiple health risks (e.g., the link between smoking, cancer, and cardiovascular disease). By providing targeted education and preventive measures, the programme can reduce the compounded impact of these risk factors in vulnerable communities. |
| Which populations face the biggest inequalities for your targeted action? | Potential Examples (but not limited to) [NHS England » A national framework for NHS – action on inclusion health](https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/)  People from Lower Socioeconomic Backgrounds   * Low-income communities often face barriers to accessing timely cancer care, including lack of health insurance, financial constraints, and living in areas with limited healthcare facilities. These groups may have lower cancer screening rates and higher mortality due to late diagnoses. Targeted actions could include providing free screenings, financial assistance for treatments, and outreach to low-income neighbourhoods.   Ethnic Minority Communities   * Black, Asian, and Minority Ethnic (BAME) communities experience disparities in cancer care, such as delayed diagnoses and poorer survival outcomes due to systemic racism, cultural barriers, and mistrust of healthcare systems. Interventions could include culturally tailored educational campaigns, language support services, and community-led outreach programmes to increase screening participation and treatment access.   People with Disabilities   * Individuals with physical and learning disabilities face significant barriers to cancer care, including accessibility issues, lack of appropriate support, and lower health literacy. Programmes should ensure accessible healthcare facilities, provide specialist support services, and ensure that materials are easy to understand for those with cognitive or physical disabilities.   Homeless People   * People experiencing homelessness are at a high risk for delayed cancer diagnoses due to lack of stable housing and poor access to healthcare. Providing mobile screening units, mental health support, and linkages to housing services can help mitigate these barriers and ensure timely cancer detection and care. |
| Could you design the programme, project or policy with communities who face the biggest health inequalities to maximise the chance of it working for them? What will you need to enable this? | Potential Examples (but not limited to)  Co-Designing with Affected Communities   * Collaborate with community leaders, patients, and local organisations to co-design cancer care programmes. By involving communities in the planning and development stages, you can ensure that the programme meets their specific needs, respects their cultural preferences, and addresses unique barriers to healthcare access. * Enabling Factor: Establish community advisory boards, allocate resources for community engagement, and train staff on participatory design processes to ensure meaningful collaboration.   Tailoring Communication to Local Contexts   * Create culturally relevant educational materials (e.g., videos, brochures) that are translated into local languages and use culturally appropriate imagery. This can help improve health literacy and encourage timely screening and treatment among underserved populations. * Enabling Factor: Work with local translators, cultural consultants, and design experts to create and distribute materials that resonate with diverse communities.   Accessible Healthcare Services in Underserved Areas   * Set up mobile cancer screening units and healthcare pop-up clinics in underserved neighbourhoods or rural areas, ensuring that individuals who face barriers (e.g., transportation, lack of local healthcare facilities) can access screening and early detection services. * Enabling Factor: Partner with local governments, non-profits, and healthcare providers to ensure logistical and financial support for mobile clinics and services that reach those in need. |
| Could you seek to increase people’s control over their health and lives (if appropriate)? What would this look like? | Potential Examples (but not limited to)  Shared Decision-Making in Treatment   * Empower patients to make informed decisions about their cancer treatment by offering clear information about all available options, risks, and benefits. This could include having shared decision-making tools that help individuals weigh their treatment choices and discuss them with healthcare providers. * What This Looks Like: Patient education materials, decision aids (e.g., digital or printed), and consultations that allow patients to actively participate in the treatment planning process.   Self-Management Programmes   * Provide self-management programmes that teach patients how to manage their symptoms, track their health progress, and make lifestyle changes (e.g., diet, exercise, stress management) during cancer treatment. * What This Looks Like: Offering workshops, online resources, or app-based tools that help individuals monitor their health and make informed decisions about their care.   Access to Peer Support Networks   * Create peer support networks where cancer patients can connect with others who have had similar experiences. This empowers individuals by providing them with guidance, shared knowledge, and emotional support, enhancing their confidence in managing their health. * What This Looks Like: Support groups, mentorship programmes, or online forums that facilitate peer-to-peer interaction and guidance, offering a sense of empowerment and control over their cancer journey. |
| Which community groups and consultation methods will you engage to tackle the problem, to maximise the chance of reaching large populations at scale (see [Community-centred public health: taking a whole system approach](https://www.gov.uk/government/publications/community-centred-public-health-taking-a-whole-system-approach)). | Potential Examples (but not limited to)  Engaging with Vulnerable and Marginalised Groups   * Partner with local ethnic community groups (e.g., Black, Asian, and Minority Ethnic [BAME] communities) to understand cultural barriers to cancer care. This could include working with faith-based organisations and community leaders to promote cancer awareness and screening. * Consultation Method: Focus groups and community forums to gather insights on culturally specific barriers and preferences, followed by co-designing culturally relevant education and outreach strategies.   Involvement of Youth and Educational Institutions   * Collaborate with schools and youth organisations to raise awareness of cancer prevention and healthy lifestyles among younger populations. This can help reach wider networks, including families and communities. * Consultation Method: Workshops in schools and peer-led campaigns to educate and involve young people in spreading cancer awareness within their social circles.   Reaching Rural and Remote Communities   * Work with local councils and community centres in rural and coastal areas to ensure equitable access to cancer screening and care. In these areas, healthcare services may be less accessible, so outreach programmes like mobile clinics could be vital. * Consultation Method: Community listening sessions and door-to-door surveys in rural locations to directly engage with residents, identify their needs, and gather feedback on potential interventions. |
| Who else can help? | Consider what and who’s input you may be missing |
| 1. Evaluation and monitoring | |
| How will you quantitatively or qualitatively monitor and evaluate the impact of your programme, project or policy on different population groups at risk of health inequalities? Consider what output or process measures you could use. | Consider when you will review outputs and outcomes identified above, which could be at 6 and 12 months.  Output evaluation   * How will you measure the actions that have been achieved? E.g. add to GP system, coding, using QOF indicators * How does the programme monitor for unintended consequences?   Outcome evaluation  How will you measure and how will you document that you have had an impact on access, experience and outcomes for those population groups identified as being at higher risk of delayed cancer presentation? This should include consideration of quantitative measures and also qualitative measures (e.g. engaging directly with population groups at high risk) |
| Set a health equity assessment review date, recommended for between 6 and 12 months from initial completion. |  |

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| --- |
| 1. Review – identify lessons learned and drive continuous improvement |

|  |  |
| --- | --- |
| Date completed  (should be 6-12 months after initial completion): |  |
| Contact person (name, directorate, email, phone) |  |
| Have you achieved the actions you set? |  |
| How has your programme, project or policy supported reductions in health inequalities associated with physical and mental health? |  |
| How has your programme, project or policy 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? |  |

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Description automatically generated

Health Equity Assessment Tool (HEAT):

Full version

Adapted for Core20PLUS5

Clinical Priority 5: Hypertension case-finding and optimal management and lipid optimal management

Date: December 2024

Adapted from Public Health England HEAT tool published in August 2024.

A resource produced by NHS England NW Public Health and Office for Health Improvement and Disparities (OHID) NW.

**HEAT and Core20PLUS5**

**Clinical Priority 5: hypertension case finding and optimal management and optimal lipid management.**

What is Core20PLUS5?

Core20PLUS5 is NHS England’s approach to reducing healthcare inequalities at a national and system level. “Core20” represents the 20% most deprived members of the population (as defined by the Index of Multiple Deprivation). “PLUS” represents population groups who are at risk of social exclusion, such as inclusion health groups, and other groups sharing protected characteristics. “5” represents five clinical priorities that require accelerated improvement. The fifth priority focuses on cardiovascular disease prevention; specifically, case finding and management of hypertension, as well as lipid management.

What is HEAT and how can it help?

There are many existing tools for hypertension case-finding. These tools focus on identifying groups who are at highest risk of hypertension. HEAT is the Health Equity Assessment Tool. It can be used prospectively or retrospectively to help ensure an equitable provision. This adapted HEAT has been developed to enable identification of actions to encourage groups at high risk to present for hypertension review and management, and therefore to reduce healthcare inequalities.

Who is this tool for?

The HEAT tool was developed to be used across a range of programmes and projects. This version of the HEAT tool has been adapted to include specific prompts for leaders at a system, place and PCN level. Applying HEAT to Core20PLUS5 will help systems reach both Core20PLUS5 and hypertension targets, while also helping to reduce the inequalities gap.

How do I use this tool?

The adapted HEAT below contains a series of prompts to enable effective application to hypertension case finding and management, and lipid management. Following these prompts and filling each section of the tool as fully as possible will help you to identify health inequities within high-risk groups and offer the opportunity to identify actions to increase uptake for hypertension review and management to inform local plan development. The tool does include a review and is therefore a continuous improvement process.

HEAT is supplemented by an [e-learning module](https://www.e-lfh.org.uk/programmes/health-equity-assessment-tool-heat/) on the NHS Learning Hub, designed to equip professionals with essential skills for undertaking a HEAT assessment.

The tool

|  |  |
| --- | --- |
| Programme or project being assessed |  |
| Date assessment started |  |
| Date assessment completed |  |
| Contact person (name, directorate, email, phone) |  |
| Name of strategic leader (senior responsible officer) |  |
| Lead organisation |  |
| Other organisations engaged |  |
| Community engagement methods used.  Best practice shows that engaging communities is an effective way of identifying, gaining insight and understanding how health inequalities are experienced by communities. So, consider methods of engagement (for example specific questions, focus groups, surveys, Place Standard) which are inclusive, involving a range of affected communities and stakeholders; and an assessment of whether, how and with what impact community engagement can assists with the programme, project or policy and its implementation. |  |
| Agreed review date |  |

|  |  |
| --- | --- |
| **Steps to take** | **Your response – remember to consider multiple dimensions of inequalities, including protected characteristics and socio-economic differences** |
| 1. Prepare – agree the scope of work and assemble the information you need | |
| 1. Your programme of work  Things you may want to consider include:  What are the main aims of your programme, project or policy?  What is the justification, reason or driver for this programme, project or policy?  How do you expect your programme, project or policy to impact (positively or negatively) health inequalities?  Is it a programme, project, service, product, policy or strategy? | **Background Information:**  The purpose of this section is to detail the scope of your service or project, who are your key stakeholders and how you expect your work to reduce inequalities.  Main aims of Core20Plus5 Programme  Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the ‘Core20PLUS’ – and identifies ‘5’ focus clinical areas requiring accelerated improvement.  “Core20” represents the 20% most deprived members of the population (as defined by the Index of Multiple Deprivation). “PLUS” represents population groups who are at risk of social exclusion, such as inclusion health groups, and other groups sharing protected characteristics and should be identified at a local level.  Main aims of Hypertension case finding and management  Diagnose those people with undiagnosed hypertension and ensure effective treatment/management to reduce the risk of stroke, heart disease, mortality from cardiovascular disease.  Reducing inequalities  Applying Core20PLUS5 to your work ensures a targeted approach to those most at risk of inequalities. Without taking a targeted approach to hypertension case finding and management, there is the potential to widen the inequalities gap. Examples of targeted approaches include outreach models for delivering NHS health checks for individuals at risk of exclusion such as people experiencing homelessness, living in temporary accommodation or seeking asylum.  Key Stakeholders  Who are the partners who will be supporting and enabling delivery? Partners across PCNs, place and system working e.g. health inequality leads, inclusion health leads / networks, specialised services/commissioning leads, voluntary sector. |
| 1. Data and evidence   What data do you need to gain a greater understanding of need and assess the impact of this programme, project or policy?  You should consider relevant data, evidence, indicators and intelligence you are aware of, for example:   * Nationally available data such as: * [Fingertips health profiles,](https://fingertips.phe.org.uk/) * [Public Health Outcomes Framework](https://fingertips.phe.org.uk/profile/public-health-outcomes-framework) * [Hospital Outcomes Statistics](https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics) * [Office for National Statistics](https://www.ons.gov.uk/) * [RightCare](https://www.england.nhs.uk/rightcare/) * Local data such as that available in Joint Strategic Needs Assessment, contract performance data, school attainment and qualitative data from local research, voluntary, community and social enterprise (VCSE) intelligence and community voice * Insights gained form community voices with lived experiences in relation to discrimination, racism, access and multiple disadvantage and displacement | The purpose of this section is to demonstrate local need through presentation of key indicators. You may have your own service level data e.g. Health Equity Audits, JSNAs that could be used. What can these indicators tell you about possible inequalities between population groups?  It is also important to highlight what data are not available that you would have found useful. A possible inequity may lie in the data systems themselves.  Other key data sources to explore:   * [CVDPREVENT](https://www.cvdprevent.nhs.uk/home) – primary care indicators at both place and system level. Key indicators include: -   + Hypertension     - Hypertension high risk case finder (CVDP005HYP)     - Hypertension: prevalence (CVDP001HYP)     - Hypertension: BP monitoring (CVDP004HYP)     - Hypertension: treatment to recommended age specific thresholds (all ages) (CVDP007HYP)     - Hypertension: treatment to recommended age specific (79 and under) threshold (CVDP002HYP)     - Hypertension: treatment to recommended age specific (80 and over) threshold (CVDP003HYP)     - Hypertension: potential overtreatment (CVDP006HYP)   + Cholesterol     - Cholesterol: CKD treated with LLT (CVDP010CHOL)     - Cholesterol: CVD treated with LLT (CVDP009CHOL)     - Cholesterol: QRISK 10% or more treated with LLT (CVDP006CHOL)     - Cholesterol: QRISK 20% or more treated with LLT (CVDP003CHOL)     - Cholesterol: CVD treated to threshold (CVDP007CHOL)     - Cholesterol: primary prevention of CVD treated with LLT (CVDP008CHOL)   + CVD     - CVD: prevalence (CVDP001CVD) * [British Heart Foundation (BHF) Tool](https://www.bhf.org.uk/what-we-do/our-research/heart-statistics/health-inequalities-research/exploring-socioeconomic-inequalities) exploring socioeconomic inequalities in coronary heart disease pathway, helping to identify where inequalities lie from risk factors, to diagnosis, to treatment and to mortality rates. * [BHF Tool for managing high blood pressure](https://www.bhf.org.uk/for-professionals/healthcare-professionals/data-and-statistics/managing-high-blood-pressure) – a resource for primary care staff. Presents ICS blood pressure data. * [BHF Health Systems Data](https://www.bhf.org.uk/for-professionals/healthcare-professionals/data-and-statistics/health-systems-data), presenting local health and CVD data for each ICS, covering local population, health inequalities, disease prevalence, outcomes and achievement data. * OHID Fingertips, providing a number of profiles and relevant indicators at system and place level.   + [Cardiovascular Disease](https://fingertips.phe.org.uk/profile-group/cardiovascular-disease-diabetes-kidney-disease/profile/cardiovascular) profile   + [Public Health Outcomes Framework](https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/1)     - Healthcare and Premature Mortality: Under 75 mortality rates from all cardiovascular diseases   + [NHS Health Check](https://fingertips.phe.org.uk/profile/nhs-health-check-detailed/data#page/1) profile * [BP Quality Improvement Tool (BPQI)](https://qitoolkits.innovationagencynwc.nhs.uk/FormQuestions) for C&M and L&SC sub-regions. A practice-based dashboard to risk stratify people with or without a diagnosis of hypertension to be split into priority groups to benchmark quality of blood pressure control against NICE Quality Standards and identify those who are not but should be on the hypertension register. * OHID, [Excess mortality by cause of death in England and English regions](https://www.gov.uk/government/statistics/excess-mortality-in-england-and-english-regions), specifically for excess deaths caused by all CVD and specific types of CVD * [Cardiovascular Disease Prevention Packs](https://fingertips.phe.org.uk/profile/cardiovascular-disease-prevention) * [Quality and Outcomes Framework](https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/general-practice-data-hub/quality-outcomes-framework-qof), NHS NW QOF Hypertension Data Pack * Local Data sources e.g.   + BP@Home data, kiosks, blood pressure machines data   + [CIPHA](https://www.cipha.nhs.uk/data-in-action/), Enhanced Case Finder. Patient level report to identify vulnerable populations with a set of criteria including demographics, health status (such as long-term conditions) and other risk algorithms (Cheshire and Merseyside only) * NHS Health Check data and evidence (blood pressure and cholesterol data)   List any other data sources and indicators that you may have available.  Prescribers may consider accessing information from medicines formularies, recognising that different groups may respond differently to medicines.  *Note: these example data sources are correct at the time of writing (April 2023)*  Digital Inclusion & Inclusion Health  Ensure [Digital Inclusion](https://www.england.nhs.uk/long-read/inclusive-digital-healthcare-a-framework-for-nhs-action-on-digital-inclusion/) & [Inclusion Health](https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/) Frameworks are considered and implemented throughout all steps of the tool. |
| 1. Contributors to inequalities   Have you considered the interplay of multiple contributors to inequalities influencing personal experiences? | The purpose of this section is to demonstrate the differentiating factors that contribute to widening health inequalities. Consider the following:   * 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. * Different exposure to social, economic and environmental stressors and adversities, which affect states of mind from an early age and throughout life - stress and psychological wellbeing directly affect resilience, health conditions and health behaviours. * Differences in health behaviours or other risk factors (including genetic vulnerability) which exist within and 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. * Unequal access to or experience of health and other services between social groups. * Inequalities impacted by structural discrimination which results in some groups and individuals - for example, those who identify with one or more of the protected characteristics - experiencing poorer access to services and poorer outcomes. |
| 1. Assess - examine the evidence and intelligence | |
| 1. Distribution of health | |
| Based on evidence collected above, which populations face the biggest health inequalities for your topic or service area?  Think about the 4 health inequality domains (socio-economic deprived population; geographic deprivation; inclusion health and vulnerable groups; protected characteristics). | Hypertension is a significant contributing factor to numerous other health conditions and can exacerbate the severity of those conditions. Therefore, it is important to consider the complexity of patients with comorbidities, including complex comorbidities, when developing care plans and treatment strategies.  Consider the following (but not limited to)  Socio-Economic Deprivation   * How does the programme address financial barriers to hypertension care for low-income populations and promote access to essential health services?   Geographic Deprivation   * Does the programme have strategies for reaching remote communities, such as mobile health clinics or telemedicine, to ensure equitable access to hypertension care?   Inclusion Health and Vulnerable Groups   * How does the programme ensure access to hypertension care for vulnerable groups, such as the homeless, and provide tailored support for managing hypertension in these populations?   Protected Characteristics   * Does the programme take into account ethnic disparities in hypertension prevalence and outcomes, and what actions are taken to improve culturally competent care and outreach for these populations? |
| Consider your programme, project or policy against the socio-economic status domain and how it interacts with the domain, and the impact that has or may have. | Socio-economic status or geographic deprivation:  Deprivation is associated with greater prevalence of risk factors that could lead to hypertension and hyperlipidaemia for your population. What does the data tell you above in terms of health inequalities by geographic deprivation / socioeconomic status?  Key considerations to determine the distribution of risk factors for hypertension and hyperlipidaemia include:   * Where are your most geographically deprived areas (e.g. those areas in the lowest IMD quintile)? * Where are your isolated communities, such as coastal and rural?   Do you have local level National Statistics Socio-economic Classification (NS-SEC) scores to determine socioeconomic status? See Office for National Statistics’ [Census Maps](https://www.ons.gov.uk/census/maps/choropleth/work/national-statistics-socio-economic-classification-ns-sec) |
| Consider your programme, project or policy against the geographic deprivation domain and how it interacts with the domain, and the impact that has or may have. | Access to Preventive Care:   * Does the programme offer preventive care and early interventions for cardiovascular diseases (e.g., hypertension, heart disease) to lower socio-economic (SES) populations? * Are there barriers to accessing screenings, medications, or lifestyle support for socio-economically disadvantaged individuals?   Health Promotion and Education:   * How does the programme provide education on cardiovascular health, including diet, exercise, and smoking cessation, to individuals in deprived areas? * Are there tailored interventions that address the specific socio-economic and cultural needs of low-income communities?   Management of Chronic Conditions:   * Does the programme provide ongoing management for those living with cardiovascular conditions, particularly in socio-economically disadvantaged groups? * How are socio-economic factors (e.g., stress, food insecurity, limited access to healthy foods) addressed in the management of CVD in low SES populations? |
| Consider your programme, project or policy against the inclusion health and vulnerable groups domain and how it interacts with the domain, and the impact that has or may have. | Inclusion health and vulnerable groups (for example, people experiencing homelessness, prison leavers, young people leaving care):  Inclusion health (IH) groups are those individuals who are at risk of social exclusion. These include: -   * People experiencing homelessness. * People experiencing drug and alcohol dependence. * Migrants * Gypsy, Roma, Traveller communities * Sex workers * People in contact with criminal justice system * People with a Learning Disability   Data collection for IH groups is often incomplete. People in IH groups may not be registered with and may not access GPs. We know they face barriers and have poorer outcomes. It is important to recognise these groups as potentially being at higher risk of hypertension. These groups may not proactively present for hypertension management, due to barriers in accessing healthcare. Key questions to address include:   * Do you know the prevalence and distribution of IH groups in your area? * What service level data do you have in relation to these groups? * Where and what are the data gaps for IH groups? * Do you have Acute Episode Statistics relating to hypertension & CVD for these groups of people? |
| Consider your programme, project or policy against experience related to protected characteristics domain and how it interacts with the domain, and the impact that has/may have. | Experience related to protected characteristics:  Protected characteristics according to the Equality Act 2010 are:   * age * disability * gender reassignment * marriage and civil partnership * pregnancy and maternity * race * religion and belief * sex * sexual orientation   According to the data, are any of these groups more at risk of hypertension or hyperlipidaemia? |
| 1. Causes of inequalities | |
| Recognising that there are inequalities experienced by the population groups identified, considering the data and evidence, what are the wider determinants and structural discriminatory drivers? Consider the diverse range of social economic factors which influence people’s health and wellbeing. | Consider the following (but not limited to)  Access to Affordable Healthcare   * How does the programme address barriers to healthcare access, particularly for low-income groups, and promote affordable hypertension treatment and preventive care?   Housing and Living Conditions   * Does the programme consider the impact of poor housing on hypertension and offer integrated support to improve living conditions as part of hypertension prevention and care?   Workplace Stress and Employment Conditions   * How does the programme address the role of workplace stress and poor employment conditions in hypertension management, and support initiatives that help reduce these pressures for at-risk groups?   Racial and Ethnic Discrimination   * What steps are taken to address systemic discrimination in healthcare settings, ensuring culturally competent care and equal access to hypertension prevention and treatment for ethnic minority groups? |
| What does the data and evidence tell you are the potential drivers for these inequalities? It may be helpful to consider the following questions:   * Which wider determinants are influential, for example, income, education, employment, housing, community life, racism and discrimination, cultural, environmental? * Are there any factors which indicate structural discrimination or racism will impact upon your programme, project or policy, for example mandatory use of digital access to health advice preventing access for less IT literate individuals and communities? * Which health behaviours play a role? * Does service quality, access and take up increase the chance of health inequalities in your work area? * Does climate change have an impact on health inequalities in relation to your programme, project or policy? * Which of these can you directly control? * Which can you influence? * Which are out of your control? | Wider determinants of health  Social and economic factors influence health \*\*. It is recognised that not all of these factors are in your control, but you need to be aware of the impact they have on your population group in terms of access, experience and outcomes in hypertension case finding and management. You may be able to make a change in your service that could reduce the impact. Examples for consideration include:   * Education * Have you considered the health literacy of population groups most at risk of health inequalities? * Is patient information appropriate and accessible to all population groups (easy read including pictures/multi-lingual)? * Systematic/Institutional Racism and discrimination * Have you thought about barriers to accessing healthcare across population groups, particularly among IH groups? * Employment * Have you considered service access for employed people and unpaid carers etc? e.g. do you offer out of hours and weekend appointments? Are there offers via occupational health and outreach teams? * How accessible are clinic locations and GP practices, could areas with lower uptake rates be offered free transport provision? Are clinic locations accessible by public transport? Can they be offered in other locations such as workplaces, supermarkets, shopping centres? * Enablers/Assets   + Are there any specific enablers or assets that could be harnessed to reach population groups most at risk of health inequalities? E.g. identifying and working with relevant community groups, other services, people and VCFSE organisations.   **Reference: \*\*Hood et al 2015**[**County Health Rankings: Relationships Between Determinant Factors and Health Outcomes – ScienceDirect**](https://www.sciencedirect.com/science/article/pii/S0749379715005140)​ |
| Consider if any of the following aspects influence or are influenced by your programme, project or policy  • poverty and cost of living  • community engagement  • COVID-19 or incident recovery  • violence prevention  • Core20PLUS5  • major health conditions  • substance misuse  • mental health  • service commissioning  • rural and coastal health  • policy or strategy  • healthy weight  • children and young people  • cardiovascular disease (CVD)  • oral health and dental services | Consider the following (but not limited to)  Poverty and Cost of Living   * How does the programme address financial barriers related to the cost of living, ensuring access to affordable hypertension treatment, screening, and preventive care for low-income populations?   Community Engagement   * What strategies does the programme use to engage local communities, including community health workers, local organisations, or peer support networks, to enhance hypertension awareness and management?   COVID-19 or Incident Recovery   * How does the programme consider the impact of COVID-19 recovery, ensuring that individuals with hypertension continue to receive care and support, particularly in underserved or vulnerable populations?   Violence Prevention   * Does the programme incorporate violence prevention strategies to reduce stress-related hypertension in communities with high levels of violence, including targeted support for those affected by trauma?   Core20PLUS5   * How does the programme specifically focus on the Core20PLUS5 groups to address hypertension care, particularly in the most deprived areas and for populations at higher risk?   Major Health Conditions   * How does the programme integrate hypertension management with other major health conditions, such as diabetes and CVD, to ensure comprehensive care for at-risk populations?   Substance Misuse   * How does the programme address substance misuse as a risk factor for hypertension, and what support is offered to individuals with substance use disorders in managing their condition?   Mental Health   * How does the programme incorporate mental health support into hypertension care, recognising the link between mental well-being and physical health outcomes?   Service Commissioning   * How does the programme influence service commissioning to ensure that hypertension care is equitably distributed across all areas, including underserved regions?   Rural and Coastal Health   * What specific steps are taken to ensure access to hypertension care in rural and coastal areas, such as through mobile clinics or telemedicine services?   Policy or Strategy   * How does the programme align with and influence policy and strategy to reduce hypertension-related health inequalities, particularly in deprived areas?   Healthy Weight   * How does the programme address healthy weight initiatives, such as nutrition education, weight management programmes, or access to healthy food, to reduce hypertension risk?   Children and Young People   * How does the programme engage children and young people in preventive measures for hypertension, including school-based education and promoting healthy lifestyle choices?   Oral Health and Dental Services   * Impact of Oral Health & Dental Services on Overall Health Outcomes   + Does the dental programme address the relationship between poor oral health and the development of other health conditions (e.g., cardiovascular disease, diabetes, respiratory infections)?   + Does the programme promote the importance of good oral hygiene and regular dental visits, particularly for populations at higher risk of oral health complications, such as children, older adults, or individuals with disabilities? * Access to Care for Oral Health & Dental Services   + How does the programme ensure access to dental care for vulnerable populations, particularly those in deprived areas who may face barriers such as affordability, lack of transportation, or cultural differences?   + How does the dental programme collaborate with other health services (e.g., maternity care, general health services) to ensure that oral health is adequately addressed as part of overall healthcare, particularly for individuals with multiple health concerns? |
| 1. Refine and apply – make changes to your work plans that will have the greatest impact | |
| 1. Potential effects | |
| Considering the above, how is your programme, project or policy likely to reduce health inequalities? | Potential Examples (but not limited to)  Targeted Outreach to Vulnerable Groups   * The programme partners with community organisations, including those serving ethnic minorities and vulnerable populations such as the homeless, to provide tailored education and resources on hypertension management. It also offers culturally competent care and services in accessible locations. * Impact: This ensures that underserved groups receive the information and support they need, addressing disparities in hypertension awareness and care access among these populations.   Comprehensive Health Education and Support   * The programme includes education campaigns focused on healthy diet, exercise, and stress management, with materials tailored to lower literacy levels and available in multiple languages. This is particularly targeted at low-income populations who may face barriers to adopting healthy lifestyles. * Impact: By increasing health literacy and providing practical tools for managing hypertension, this initiative empowers individuals in disadvantaged communities to take control of their health, thereby reducing health inequalities associated with poor lifestyle choices.   Integration with Mental Health and Social Support Services   * The programme includes mental health support for individuals experiencing high levels of stress or anxiety—factors that contribute to hypertension. It also provides social support services for vulnerable groups, such as access to housing or financial assistance. * Impact: Addressing the social determinants of hypertension, such as mental health and living conditions, helps reduce the compounding effects of poverty and stress, improving hypertension management and overall health in deprived communities. |
| Does your programme, project or policy have the potential unintended consequence of widening inequalities by, for example:   * 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? * Relying on professional-led interventions? * Not tackling the root causes of health inequalities? * Relying upon digital access? * Relying upon high level of literacy? | Current service provision   * How does your service/policy currently provide support for individuals of lower socioeconomic status and living in areas of higher deprivation? * Does your current service model/policy take into consideration IH groups who face barriers to accessing healthcare?   It is important to recognise that opportunistic hypertension case-finding through GP practices will not reach IH groups who are often not registered with GPs.   * Does your current service provision/policy mitigate any of the impacts of the harmful wider determinants of health for those groups most at risk of hypertension and hyperlipidaemia? * Reflecting on the information obtained so far, is there any part of your service model/policy that may widen the inequality gap?   Your HEAT assessment could consider a number of different elements or one particular method:   * Opportunistic blood pressure testing at GP practices * Undertaking blood pressure testing at outreach venuesCommunity pharmacy hypertension case finding |
| What aspects of mental wellbeing are affected? Consider risk and protective factors. | Consider the following (but not limited to)  Risk Factors   * Chronic Stress   + Individuals living with untreated hypertension often experience chronic stress due to the health complications associated with high blood pressure, leading to increased anxiety and depression. * Social Isolation   + People with poorly managed hypertension, particularly in low-income communities, may experience social isolation due to their health limitations, such as reduced mobility or the inability to participate in social activities. * Financial Strain   + The cost of managing hypertension (e.g., medications, doctor visits) can cause financial strain for low-income individuals, increasing stress and contributing to mental health decline.   Protective Factors   * Social Support   + Access to family, friends, or community groups that offer emotional and practical support can help individuals with hypertension manage stress and improve mental wellbeing. * Physical Activity   + Regular exercise can help lower blood pressure and is also known to improve mood and reduce symptoms of depression and anxiety. * Access to Mental Health Services   + Providing individuals with hypertension access to mental health services, including counselling or therapy, can help address the psychological aspects of living with a chronic condition. |
| 1. Action plan | |
| What specific actions will you take to maximise the potential for positive impacts and/or to mitigate the negative impacts on health inequalities? Provide a list of actions and targets. | Changes to service provision   * Considering all of the above, what could you change to your service provision/policy to ensure you are targeting provision to those population groups identified in section 2 as having the highest need? * We know that those who face barriers to accessing healthcare, those who are socially excluded, and those living in more deprived areas are at higher risk for poorer health outcomes. It can be reasonably assumed that those with poorer access and less likely to attend GP practices are less likely to have hypertension identified and optimally managed. Considering these points and in the absence of local data for certain IH groups, are there any actions that could be taken? * Are there any specific enablers or assets that could be harnessed to reach these groups? Such as identifying and working with relevant community groups, other services, people and VCFSE organisations. * Specifically, what steps are required to ensure that data is collected locally for those population groups most at risk?   The following NHS Futures sites may be helpful to access a range of resources including best practice case study examples:   * [Equity and Health Inequalities Network](https://future.nhs.uk/EHIME/groupHome) and [Healthcare Inequalities Improvement Programme](https://future.nhs.uk/EHIME/groupHome) * [FutureNHS Case Study Hub](https://future.nhs.uk/CaseStudies/grouphome) * [National Cardiovascular Disease Prevention](https://future.nhs.uk/NationalCVDPrevention/groupHome)   Example of cost-effective interventions  A review of the cost-effectiveness evidence is summarised below, as examples of high impact interventions that you may wish to consider as part of your action plan. (*Source: NHSE,* [*CVD high impact interventions*](https://www.england.nhs.uk/ourwork/prevention/secondary-prevention/cardiovascular-disease-high-impact-interventions/)*)*  Community pharmacy hypertension case finding   * Cost of intervention: £440 set up, £15 per patient for a clinic BP check, £45 for provision of ambulatory blood pressure monitoring. * £14 p.a. savings per controlled patient (5-year time horizon) * Impacts and outcomes: increased identification of hypertension, reduced pressure on GP, healthy behaviour promotion   Cholesterol case finding and management.   * Tool: UCLPartners Proactive Care Framework * Cost: free (admin costs – run search each quarter; clinical time to manage patients) * Impacts and outcomes: fewer CVD events, help meeting QOF targets, free staff time.   NHS Health Check   * ROI: £2.93 per £1 spent (50% uptake), £3.55 per £1 spent (60% uptake), £5.18 per £1 spent (improving follow-up) * Impacts and outcomes: increased management of hypertension and cholesterol, reduced CVD events, healthy behaviours promotion   Optimising hypertension treatment   * ROI: 5mmHg reduction in blood pressure (through improved prevention, detection and management) leads to saving 45,000 QALYs and £850m on health and social costs * Impacts and outcomes: improving management by 10% of those with hypertension prevents 7500 CVD events. |
| How can you act on the specific causes of inequalities identified above? | Potential Examples (but not limited to)  Improving Access to Affordable Care   * Implement subsidised hypertension screening programmes for low-income populations and ensure free access to blood pressure medications for those who cannot afford them.   Increasing Health Literacy   * Provide community-based workshops or online educational campaigns on hypertension, emphasising its causes, risks, and management. These should be tailored to different literacy levels and include multilingual materials for diverse communities.   Addressing Social Determinants of Health   * Develop initiatives to address the housing and income inequalities that disproportionately affect people at risk of hypertension, such as providing subsidised healthy food or offering financial support for healthcare access. |
| What activities will you put in place which will adapt and enhance your programme, project or policy in relation to cultural competencies? For example, consideration of cultures, languages, formats, images, digital, written, spoken, translation services. | Potential Examples (but not limited to)  Multilingual Educational Materials   * Provide hypertension educational resources in multiple languages commonly spoken in the target community (e.g., Spanish, Arabic, Somali) to ensure accessibility for non-English speaking populations.   Culturally Tailored Health Campaigns   * Design health promotion campaigns that reflect the cultural norms and values of the target population, incorporating traditional health practices and beliefs alongside evidence-based hypertension management advice.   Culturally Competent Training for Healthcare Providers   * Offer training for healthcare providers on the cultural needs and sensitivities of diverse populations, focusing on language barriers, health literacy, and how cultural practices can influence hypertension care. |
| What specific steps and action will you take to address the identified structural racism and discrimination? | Potential Examples (but not limited to) [NHS England — North West » Anti Racist Framework](https://www.england.nhs.uk/north-west/nhs-north-west-bame-assembly/anti-racist-framework/)  Implement Anti-Racism Training for Healthcare Providers   * Provide mandatory anti-racism and cultural competency training for all healthcare providers involved in the hypertension programme. This training would focus on understanding how racism and discrimination impact health outcomes and how to provide equitable care.   Inclusive Recruitment and Leadership   * Ensure that staff recruitment at all levels of the programme reflects the diverse communities served, particularly in areas where there are significant racial or ethnic disparities.   Regular Monitoring and Reporting of Disparities   * Establish a system to track the outcomes of hypertension treatment by race, ethnicity, and other demographic factors to identify and address any disparities in care or outcomes. |
| How will you mitigate against the negative impact of when multiple harmful factors interact and result in compounding poor health outcomes for effected communities? | Potential Examples (but not limited to)  Integrated Care Models   * Provide integrated care that combines hypertension management with mental health services, social support, and nutrition counselling.   Community Health Workers   * Employ community health workers (CHWs) from affected communities who can connect individuals with resources, offer guidance on managing hypertension, and provide culturally sensitive support.   Access to Social Services   * Partner with social service agencies to ensure individuals facing financial difficulties or housing instability are connected with resources like financial assistance, food programmes, and safe housing. |
| Which populations face the biggest inequalities for your targeted action? | Potential Examples (but not limited to)  People Experiencing Homelessness   * Individuals who are homeless often face multiple barriers to hypertension management, including lack of stable housing, limited access to healthcare, poor nutrition, and chronic stress.   People with Severe Mental Illness (SMI)   * Individuals who have received a diagnosis of psychosis, schizophrenia or bipolar affective disorder.   Black and Minority Ethnic (BME) Communities   * Black, Asian, and Minority Ethnic (BME) groups often experience disparities in hypertension due to genetic predispositions, socio-economic factors, cultural barriers, and discrimination in healthcare settings.   People Living in Socio-Economically Deprived Areas   * Low-income populations living in socio-economically deprived areas may struggle to afford healthy food, medication, and regular medical appointments for hypertension management. |
| Could you design the programme, project or policy with communities who face the biggest health inequalities to maximise the chance of it working for them? What will you need to enable this? | Potential Examples (but not limited to)  Co-Designing with Affected Communities   * Involve local community groups (e.g., Black and Minority Ethnic (BME) communities, homeless individuals, or low-income families) in the design process of the programme, ensuring that their unique needs and barriers to hypertension management are understood and addressed. * Enabling Action: Use community consultations, focus groups, and collaborative workshops to gather insights, identify challenges, and co-create solutions. Ensure diverse representation in the planning stages to create a culturally relevant programme.   Tailored Health Interventions for Vulnerable Groups   * Create tailored hypertension management plans that cater specifically to the needs of older adults, people with disabilities, and LGBTQ+ communities. For example, offering accessible blood pressure monitoring devices for those with mobility issues or creating support groups for LGBTQ+ individuals. * Enabling Action: Partner with local community health organisations to provide education and resources in accessible formats, such as audio materials, translated written resources, and in-person workshops in the languages spoken by community members.   Mobile Clinics and Outreach in Deprived Areas   * Implement mobile clinics in areas with high levels of socio-economic deprivation (e.g., rural areas, deprived urban neighbourhoods) to provide blood pressure screenings, education, and medication for hypertension. * Enabling Action: Ensure transportation and accessibility for those with physical disabilities or low mobility and involve community leaders to build trust and encourage participation in screenings and care. |
| Could you seek to increase people’s control over their health and lives (if appropriate)? What would this look like? | Potential Examples (but not limited to)  Self-Monitoring and Education   * Provide individuals with blood pressure monitoring kits and offer training on how to track their own blood pressure at home. * What This Looks Like: This empowers individuals to monitor their condition regularly, increasing their control over their health and enabling them to take action if their blood pressure rises outside the recommended range.   Shared Decision-Making in Treatment Plans   * Involve patients in the decision-making process about their hypertension treatment plans, offering choices between different medications, lifestyle changes, and follow-up schedules. * What This Looks Like: Patients become active participants in their healthcare, understanding the options available to them and making informed choices that align with their preferences, which enhances their sense of control and commitment to treatment.   Community-Led Support Groups   * Establish peer-led hypertension support groups where individuals can share experiences, strategies for managing hypertension, and emotional support. * What This Looks Like: These groups allow individuals to feel empowered in managing their health, fostering a sense of community and shared knowledge, while also boosting self-efficacy and motivation. |
| Which community groups and consultation methods will you engage to tackle the problem, to maximise the chance of reaching large populations at scale (see [Community-centred public health: taking a whole system approach](https://www.gov.uk/government/publications/community-centred-public-health-taking-a-whole-system-approach)). | Potential Examples (but not limited to)  Community Health Forums with Diverse Populations   * Organise community health forums in partnership with local organisations, targeting diverse groups such as elderly people, Black, Asian, and Minority Ethnic (BME) communities, and low-income households. * Consultation Method: Use open forums to gather input and raise awareness, complemented by focus groups that allow for deeper discussions on specific barriers these populations face in managing hypertension.   Engaging Local Faith-Based Organisations   * Partner with faith-based organisations (e.g., churches, mosques, temples) to reach underserved communities such as immigrant populations, racial minorities, and people from low socio-economic backgrounds. * Consultation Method: Leverage trusted leaders within these communities to conduct culturally appropriate health workshops and distribute health resources. This approach helps ensure credibility and trust in health messages.   Collaboration with Community Health Workers (CHWs)   * Employ Community Health Workers (CHWs) from the communities they serve (e.g., LGBTQ+ populations, homeless individuals, people with disabilities) to deliver targeted hypertension prevention and management programs. * Consultation Method: CHWs can engage in one-on-one consultations, door-to-door outreach, and host local health events that allow for feedback from the community about the specific needs, preferences, and barriers to hypertension care. |
| Who else can help? | Consider what and who’s input you may be missing |
| 1. Evaluation and monitoring | |
| How will you quantitatively or qualitatively monitor and evaluate the impact of your programme, project or policy on different population groups at risk of health inequalities? Consider what output or process measures you could use. | Consider when you will review outputs and outcomes identified above, which could be at 6 and 12 months.  Output evaluation   * How will you measure the actions that have been achieved? * How does the programme monitor for unintended consequences?   Outcome evaluation  How will you measure and how will you document that you have had an impact on access, experience and outcomes for those population groups identified as being at higher risk? This should include consideration of quantitative measures and also qualitative measures (e.g. engaging directly with population groups at high risk). |
| Set a health equity assessment review date, recommended for between 6 and 12 months from initial completion. |  |

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| 1. Review – identify lessons learned and drive continuous improvement |

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| --- | --- |
| Date completed  (should be 6-12 months after initial completion): |  |
| Contact person (name, directorate, email, phone) |  |
| Have you achieved the actions you set? |  |
| How has your programme, project or policy supported reductions in health inequalities associated with physical and mental health? |  |
| How has your programme, project or policy 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? |  |

**Appendix 1**

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.

HEAT is supplemented by an [e-learning module](https://www.e-lfh.org.uk/programmes/health-equity-assessment-tool-heat/) on the NHS Learning Hub, designed to equip professionals with essential skills for undertaking a HEAT assessment.

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

1. Socio-economic differences by individual socio-economic position. For example, National Statistics Socio-economic Classification, employment status, income, area deprivation.
2. Area variations by deprivation level (Index of Multiple Deprivation), service provision, urban/rural or in general.
3. 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.