Date: Wednesday, 3 July 2002

Venue: Committee Rooms 3 & 4, National Assembly for Wales

Title: Inequalities in Health Fund

Purpose

1. To provide information on the deployment of the Inequalities in Health Fund.

Summary

2. This paper responds to an action point from previous meeting. Members of the Committee requested a paper to note with an interim evaluation of the Fund and a list of the projects supported. The Fund, which was launched in 2001, is currently supporting 67 projects across Wales. By far the majority of the projects are of 3 years duration and therefore, their impact will emerge over time. This interim evaluation therefore focuses on the number of projects established against the target, and the nature of the projects supported against the criteria set for funding. A list of projects is attached (Appendix 1).

Background

3. The Fund was established by the Assembly Government to stimulate and support new local action to tackle inequalities in health and the factors that contribute to it, including inequities in access to health services. The Fund was launched in February 2001 with coronary heart disease as its first priority. Details of the Fund and the criteria set for its deployment were set out in Welsh Health Circular WHC (2001)06.

4. The core criteria set for the Fund were:

- Involvement of primary/community care teams to enhance/expand their role in addressing inequalities in health.
- Action that reinforces partnership and joint working between organisations in the health, local government and/or voluntary sectors.
- Targeted action to help deprived communities and/or disadvantaged groups within the population.

- Action that helps to address inequalities in health and the factors that cause it, action that contributes to the National Service Framework for Coronary Heart Disease, and action that is consistent with the evidence base.
- Sound project design, and cost normally in the region of £50,000 - £100,000

5. Recognising the need for a sustained effort, the Fund's design allowed projects of up to 3 years duration. While partnership was an important element, any organisation from the NHS, local government or the voluntary sector could lead a project.

6. A streamlined application process was designed for the Fund with the aim of minimising the amount of work involved in submitting bids while at the same time providing sufficient information for assessment of proposals. The response was very encouraging in terms of both the number of proposals received – 112 - and their quality. It demonstrated the commitment that exists throughout Wales to joint action to address inequalities in health and to reduce heart disease.

7. The Inequalities in Health Fund has a total budget of £6 million for 2002-03 of which £5 million is for action to tackle coronary heart disease. On the current expenditure plans of the 67 projects supported, this year's budget is fully committed. The other £1 million, which is being deployed separately, is for action to tackle inequalities in oral health. This will enable the expansion of existing dental initiatives and the development of a fissure sealing programme for children in areas of high dental decay.

Project selection

8. All proposals were assessed against the core criteria by at least two people and ranked accordingly. An Advisory Group of officials and representatives of the NHS, local government and the voluntary sector was established. The Group considered the results of the assessment process and recommended projects for support.

9. The large number of proposals meant that the assessment process took longer than expected. The first tranche of 54 projects was announced in July 2001. A second tranche of 13 projects – to start from April 2002 - was announced in January 2002.

Interim evaluation

10. The aim of the Fund – to stimulate and support new local action to tackle inequalities in health – has been fulfilled. The Fund is currently supporting 67 projects, which is far in excess of the original target of 20-30 projects. All projects are operational but some have experienced delays due to recruitment difficulties.

11. Given that the majority of projects (91%) are of 3 years duration, the impact will take time to appear. This interim evaluation therefore focuses on an assessment of the portfolio of projects supported against the criteria set out for the Fund. The data was collected from an analysis of the administrative records of

each project.

12. All projects are based on partnership. All projects have primary care involvement through individual practices or via Local Health Groups. 96% of projects involve Local Health Groups, which places the Fund's projects at the heart of the new Local Health Boards. This will help to ensure that preventing ill health and tackling inequalities in health sits alongside effective and efficient health services as an equal priority.

13. At the time of approving projects, local authorities were partners in 52% of projects and voluntary sector organisations in 37%. NHS Trusts were partners in 82% of projects, which is helpful to developing their role in their local community. It is expected that partnership working will increase further as projects develop and as links are made with wider community development action. Local Health Alliances are partners in 40% of projects. The project leaders for most projects are Local Health Groups (62%), followed by NHS Trusts (22%), Health Authorities - public health/health promotion services (4%), GP practices (6%) and local authorities (6%).

14. All projects supported by the Fund are contributing to the implementation of the National Service Framework for Coronary Heart Disease. The following table summarises project action across the Framework.

Table 1: Inequalities in Health Fund projects, by contribution to Standards of the National Service Framework for Coronary Heart Disease

	% of projects
Standard 1: Action to decrease risk factors for CHD	61
Standard 2: Primary care action to identify those at risk for assessment/treatment	55
Standard 3: High quality care for everyone with an acute episode of CHD	13
Standard 4: Identification and treatment of those with heart failure	3
Standard 5: Identification and treatment of those with artrial fibrillation	--

15. Some projects are contributing to more than one Standard by, for example, combining screening with wider action in the community to help people to improve their health. It is anticipated that this will increase further as projects develop.

16. There is considerable coherence between the Fund and Communities First. With a couple of exceptions, at least one of the Fund's projects is operating in all Communities First areas. Some of the

Fund's projects are focused on specific Wards or clusters of Wards while others cover Local Health Group areas or hospital catchment areas.

17. A proactive approach has been taken to ensure links are made between the Fund and Communities First. All projects have been asked to make links with Communities First action in their area and project leaders have been supplied with details of Communities First contacts. Similarly, all Communities First co-ordinators have been provided with a list of the Fund's projects. Given the nature of projects supported by the Inequalities in Health Fund – and the prominent role of local health services - the Fund will help to develop the health component of Communities First.

18. The cost of projects varies. Most of the projects (55%) fall within the £50,000 - £100,000 range (full year cost) while the remainder are split between grants of less than £50,000 (21%) and those of more than £100,000 (24%). One of the aims of the Fund was to support action than meets locally identified needs and the funding criteria was applied flexibly in response to this.

Evaluation

19. Project leaders are required to build evaluation into the project as a core component in order to demonstrate the effectiveness of action. Arrangements have been made for projects to be able to access advice and support on evaluation through the Regional Support Units of the Wales Office of Research and Development (WORD). Arrangements for the evaluation of the overall Inequalities in Health Fund over the 3 years of the programme are in hand.

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Appendix 1

List of projects supported by the Inequalities in Health Fund, June 2002

Local Authority Area	Project Title	Project Ref.	Description	Tranche
Blaenau Gwent	Smoking Cessation Service	072	Support to help adults in disadvantaged communities to stop smoking	1
Blaenau Gwent	Tackling Obesity	090	A community based service with a range of approaches tailored to individuals. To improve the outcomes of obesity management and develop a long term support system for patients.	1
Blaenau Gwent	Foundation for referral – GP exercise referral	091	To train leisure centre staff to NVQ level II to enable them to attend a GP Referral to Exercise course and to provide courses for local people.	1
Blaenau Gwent	Risk Assessment for CHD in Primary Care	094	Work within GP practices to develop disease registers to identify patients, both those at risk and those already diagnosed with heart disease.	1
Blaenau Gwent (+ hospital catchment area)	Angina Management project	005	Rehabilitation for people with angina. Support and advice to minimise risk factors and make lifestyle changes. An individualised programme for physical, psychological and emotional recovery.	1
Blaenau Gwent (+ hospital catchment area)	Heart Failure Management project	006	To increase the ability of patients to understand and control their treatment and to optimise pharmacological therapies. Combines education, counselling, supervision and exercise.	1
Bridgend	Communities Lifestyle Modification Programme	065	Primary care led community programme, supporting sustainable lifestyle changes, targeted at communities and individuals identified at high risk of developing coronary heart disease.	2

Bridgend	Mobile Opportunistic Screening Service	066	To identify people at high risk of developing coronary heart disease who do not traditionally present to, or access, primary health care.	2
Bridgend	Integrated Cardiac Rehabilitation teams	069	To improve access and take-up of cardiac rehabilitation services. To encourage patient groups to take responsibility for their health through advice, education and support.	1
Caerphilly	CHD Resource Centre, Local Health Initiatives	082	Comprehensive information on heart disease and healthy lifestyles, and activities to promote health to the elderly, children, young people.	1
Caerphilly	Disease Register and Structured Risk Assessment Clinics	083	To identify, monitor and report patients' risks of heart disease and to help them to take action to prevent it. Project will also test the effectiveness of a risk assessment software programme.	1
Caerphilly	Exercise On prescription	084	To improve the health and well being by promoting exercise and healthy lifestyles and by addressing factors that contribute to inequalities in health..	2
Caerphilly	Food and Health Advisor	085	Action to improve the health of the younger-aged population by promoting good nutrition	1
Cardiff	Cardiovascular Risk project	010	To reduce morbidity and mortality due to heart disease in the practice population by risk identification and on-going review	2
Cardiff	'Barefoot' Health Workers Project	011	To help local communities to examine culturally appropriate ways of improving health with support to develop and deliver activities that address heart disease	1
Cardiff	A multi-disciplinary team approach to developing a patient focused CHD prevention programme	030	Support to primary health care teams in developing systems to identify those at risk and to develop and implement a targeted programme to reduce risk factors for heart disease.	1

Cardiff	Cardiovascular Disease – Delivering Health Improvement	081	To deliver the requirements of the NSF for CHD to the practice population by identifying those at risk.	2
Cardiff	Heart disease and diabetes - action in black and ethnic minority communities in SW Cardiff	087	A comprehensive primary care led service where current services are patchy and uncoordinated. To overcome language and cultural communication problems and to establish a health screening service.	1
Carmarthen-shire	Outreach Cardiac Rehab Programme	020	Improved access to the cardiac rehabilitation programme through an outreach programme to improve take-up rates, particularly for the elderly people.	1
Carmarthen-shire	Provision of Rapid Access to Chest Pain Clinic	022	A rapid access service to reduce the number of patients referred to Cardiology Outpatient Clinics. To manage patients more appropriately in the community.	1
Carmarthen -shire	Community Heart Disease Prevention programme for Llanelli	024	A community heart disease project targeting those at risk and including an exercise referral scheme, coronary rehabilitation and community nutrition.	1
Carmarthen-shire	Adding years to life for patients with CHD in Carmarthenshire	026	To create a register of patients with heart disease in GP practices and to ensure that those at risk have health screening.	1
Ceredigion	Ceredigion Community Thrombolysis	054	To introduce and evaluate the introduction of primary care pre-hospital community thrombolysis in rural areas.	1
Ceredigion	Communities for Reducing Inequalities in Health	079	Work with people in deprived areas to enable them to identify and take action on heart disease and to develop local action. To improve access to existing services.	1
Denbigh-shire	Health Communities Programme	060	To reduce people at risk of developing coronary heart disease and to improve the outcomes of people with the disease.	2

Denbigh -shire	Community Action on CHD – Rhyl and North Denbighshire	114	To address inequalities in access to, and use of, services that address heart disease and the risk factors that contribute to it. To encourage people to take greater control over their health.	1
Denbigh -shire	Community Action on CHD – Denbigh & South Denbighshire	115	To address inequalities in access to, and use of, services and facilities that address heart disease and the risk factors that contribute to it. To encourage people to take greater control over their health. To develop a screening programme and pilot work for people with mental health needs.	1
Flintshire	Heart of Flintshire project	044	To encourage people to increase exercise in their day-to-day life, to promote healthy eating and to reduce smoking amongst people including young women and people on low incomes.	1
Flintshire	The Mold Primary Care Project	047	To implement standards 1,2, 4 and 5 of the National Service Framework for Coronary Heart Disease.	2
Gwynedd	Calon Lan Gwynedd	016	To establish ‘Calon Lan’, a heart disease rehabilitation service, to improve access to services and resources and to encourage healthy heart lifestyles.	1
Merthyr	Targeted IHD risk factor intervention project	089	Primary care action to review and audit existing services and standards to identify those at risk for primary prevention.	1
Merthyr	Community based multidisciplinary cardiac rehabilitation	100	To promote and support increased life-long exercise and increased independence for heart attack patients.	1
Merthyr	Promoting Health In Small Workplaces	105	To raise awareness of, and promote, cardiovascular health via health promotion in the workplace.	2
Merthyr	Diabetes Care Pathway Project	108	Development of services to reduce the risk of heart disease amongst diabetics in Merthyr Tydfil and Rhondda Cynon Taf.	1

Merthyr	Peer Support System for people with Diabetes in Merthyr & Cynon	111	Action to help patients with heart disease to manage their condition and to publicise the risk factors associated with heart disease.	1
Merthyr	The Merthyr Tydfil 'Heartlinks' Project	112	A targeted physical activity and healthy eating programme which links to complementary services in Merthyr Tydfil.	1
Neath and Port Talbot	Integrated Cardiac Rehab Teams	068	To develop integrated and co-ordinated teams to provide cardiac rehabilitation.	2
Neath and Port Talbot	Healthy Hearts Project	097	To improve access to cardiac rehabilitation programmes. An enhanced, community-led service to meet the needs of communities with a traditionally poor survival rate of myocardial infraction.	1
Neath and Port Talbot	Alive & Ticking – Raising awareness of Heart Disease in the Community	098	A risk assessment service targeted at risk groups. Will provide health and lifestyle advice, and information on additional support and services available locally.	1
Neath and Port Talbot	Heart Food and Health	099	To increase consumption of fruit and vegetables. To improve skills for buying and preparing fruit and vegetables. To promote personal responsibility for health and raise awareness of CHD risk factors.	1
Newport	Big Sister	050	To prevent heart disease for people at risk especially women, ethnic groups and young people. To improve access, support, guidance and awareness.	1
Newport	Ethnic Minority CHD Community Project	051	To improve access to heart disease and diabetes services for people from black and ethnic communities. To increase knowledge and encourage a healthier lifestyle to minimise risks.	1
Newport	CHD care for the Older Population	052	To co-ordinate the provision of consistent and effective care for over 65 year olds who are have, or who are at risk of developing, heart disease.	1

Newport	Primary & Community Care Nutrition Project	053	To reduce incidence of heart disease by promoting nutrition in areas with evidence of deprivation and/or social disadvantage.	1
Newport (+ hospital catchment area)	Cardiac Rehabilitation & secondary prevention clients diagnosed with Angina	064	Programme of risk factor assessment and risk factor management for people with angina in order to prevent further cardiac event and to delay the disease process.	1
Pembroke -shire	Pembrokeshire Community Heart Health Project	070 a	A screening project in GP practices and associated programmes and support to help people to reduce their risk of heart disease.	1
Pembroke -shire	Pembrokeshire Community Heart Health Project	070 b	A screening project in GP practices and associated programmes and support to help people to reduce their risk of heart disease.	1
Powys	Community based cardiac rehab programme (Phase IV)	017	A community based exercise programme for people with coronary heart disease to Local Authority Leisure centres in Powys.	2
Powys	Tackling Inequalities in Health together	080	Work with people in deprived areas to enable them to identify and take action on heart disease and to develop local action. To improve access to existing services.	1
Rhondda Cynon Taff	CHD Risk Assessment & Intervention – Rhondda & Taff-Ely	033	To increase screening for heart disease, to monitor the effectiveness of treatment and to produce a care plan across care providers and engage GPs in care plans.	1
Rhondda Cynon Taff	CHD Risk Assessment & Intervention – Cynon Valley	034	To increase screening for heart disease, to monitor the effectiveness of treatment and to produce a care plan across care providers and engage GPs in care plans.	1
Rhondda Cynon Taff	Heart Attack – Active Living Strategy	037	A community-based physical activity initiative for those at risk of heart disease. Will also develop a ‘PALS’ scheme and a ‘Health Walks’ scheme and self help programmes for cardiac rehabilitation.	1

Rhondda Cynon Taff	Heart Attack – Food for Living, Food for Life	038	A programme of practical advice and assistance to those at high risk of heart disease. Will involve professionals and workers in programmes in workplaces, retail outlets and commercial settings.	1
Rhondda Cynon Taff (+ hospital catchment area)	Nursing Service for Heart Failure patients	043	To encourage patients and families to manage and monitor their own condition and to adopt beneficial lifestyle changes. To improve access, advice and support to maximise quality of life and help patients stay at home.	1
Rhondda Cynon Taff	A Healthy Start: Targeting Pregnant Teenagers	106	A midwifery led provision of psycho-social interventions that reduce low birth weight and improve the cardiovascular health of pregnant teenagers and their children	2
Rhondda Cynon Taff	Community-based multidisciplinary cardiac rehabilitation in the Cynon Valley	107	To increase life-long exercise and increased independence by managing weight and cholesterol levels and by improving physical flexibility	1
Swansea	CHD prevention in primary care	040	Additional nursing support to GP practices in communities with a lower than average level of support and a heart disease prevention programme.	1
Swansea	Dietetics in Primary Care	041	Specialist dietetic advice to each GP practice in Swansea to reduce levels of heart disease. Will ensure all patients have access to specialist advice/support.	1
Swansea	Coronary Artery Disease	042	To achieve a 100% coverage of risk assessment for coronary artery disease in Swansea.	1
Torfaen	Targeted Primary prevention heart disease clinics with access to ‘Exercise on Prescription’.	058	Identification of local priorities for action and the development of a programme of action to contribute to reducing the incidence of heart disease and inequalities in health	1

Vale of Glamorgan	Barry Heart Health	009	Work with primary care teams to identify those at risk and to reduce lifestyle risk factors. To encourage stopping smoking, improve nutrition and exercise levels, and reduce stress and alcohol intake. Local campaign to identify and provide local advice and information on reducing CHD.	1
Wrexham	CHD and Travellers – Redressing the Balance	012	To improve access to health care services and to reduce and prevent the incidence of heart disease within a community of travellers.	1
Wrexham	Hearts and Minds	015	To encourage physical health and well being for people with learning difficulties and/or long term mental health problems.	1
Wrexham	Healthy Eating Community Classes	028	To support individuals in weight loss, to facilitate a ‘holistic’ approach to healthy eating and weight loss, and peer support.	2
Wrexham	Targeting CHD action on a deprived housing estate in N Wales	029	To raise awareness of the benefits of health screening, support and access to appropriate health care service, and to encourage a healthier lifestyle.	1
Ynys Mon	Community action to prevent CHD in deprived communities - Ynys Mon	045	To improve access to existing services and to establish ‘Calon Lan’, a heart disease prevention team and community based cardiac rehabilitation services.	1
Ynys Mon	Healthy Community Development Officer	046	To create active and supportive communities to care for the well-being of individuals	2