NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Black, Asian and other minority ethnic groups: promoting health and preventing premature mortality.

Output: Prioritised quality improvement areas for development.

Date of Quality Standards Advisory Committee meeting: 20 September 2017

Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for promoting health and preventing premature mortality among black, Asian and other minority ethnic groups. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development sources below are included to help the committee in considering potential statements and measures.

1.2 Development sources

The key development sources referenced in this briefing paper are:

Physical activity for children and young people NICE public health guideline 17 (2009)

Immunisations: reducing differences in uptake in under 19s NICE public health guideline 21 (2009)

Type 2 diabetes prevention: population and community-level interventions NICE public health guideline 35 (2011)

Smokeless tobacco: South Asian communities NICE public health guideline 39 (2012)

Hepatitis B and C testing: people at risk of infection NICE public health guideline 43 (2012)

BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups NICE public health guideline 46 (2013)

Weight management: lifestyle services for overweight or obese adults NICE public health guideline 53 (2014)

Common mental health problems: identification and pathways to care NICE clinical guideline 123 (2011)

Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services NICE clinical guideline 136 (2011)

Myocardial infarction: cardiac rehabilitation and prevention of further cardiovascular disease NICE clinical guideline 172 (2013)

Psychosis and schizophrenia in adults: prevention and management NICE clinical guideline 178 (2014)

Type 1 diabetes in adults: diagnosis and management NICE guideline 17 (2015)

Diabetes (type 1 and type 2) in children and young people: diagnosis and management NICE guideline 18 (2015)

Chronic kidney disease in adults: assessment and management NICE clinical guideline 182 (2015)

HIV testing: increasing uptake among people who may have undiagnosed HIV NICE guideline 60 (2016)

Hypertension in adults: diagnosis and management NICE clinical guideline 127 (2016)

2 Overview

2.1 Focus of quality standard

This quality standard will cover promoting health and preventing premature mortality among black, Asian and other minority ethnic groups. It will be relevant in all age groups and all settings.

2.2 Definition

For the purpose of this quality standard, black, Asian and other minority ethnic groups will be defined as per NICE guideline PH46 (2013) BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups:

- South Asian people are immigrants and descendants from Bangladesh, Bhutan, India, Indian-Caribbean (immigrants of South Asian family origin), Maldives, Nepal, Pakistan and Sri Lanka.
- African-Caribbean/black Caribbean people are immigrants and descendants from the Caribbean islands (people of black Caribbean family origin may also be described as African-American).

- Black African people are immigrants and descendants from African nations. In some cases they may also be described as sub-Saharan African or African-American.

- Other minority ethnic groups' include people of Chinese, Middle-Eastern and mixed family origin as follows:

    - Chinese people are immigrants and descendants from China, Taiwan and Hong Kong.

    - Middle-Eastern people are immigrants and descendants from Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syria, the United Arab Emirates and Yemen.

    - People of mixed family origin have parents of 2 or more different ethnic groups

2.3 Incidence and prevalence

Over the last two decades, England has become more ethnically diverse. The proportion of people in England and Wales who identified their ethnic group as White in the decennial census, fell from 94.1% in 1991 to 87.0% in 2011, and correspondingly the proportion identifying as one of the Minority Ethnic Groups has increased[1].

Some black, Asian and other minority ethnic groups face major health inequalities. There is a differential risk of disease for different population subgroups:

- Some BME groups have a higher prevalence of CVD than the general population. Prevalence of angina is higher amongst Pakistani men at all ages, and for Indian women; and Pakistani men and women aged 55 years and older have a higher prevalence of heart attacks, the prevalence of hypertension is highest in black Caribbean groups, while Pakistani women have amongst the lowest prevalence.

- Prevalence of type 2 diabetes is substantially higher among Bangladeshi, Pakistani, Indian, black African, black Caribbean and Chinese populations.

- Rates of all sexually transmitted infections, including HIV are highest amongst black ethnic groups.

[1] 2011 Census: Key Statistics and Quick Statistics for Local Authorities in the United Kingdom,

- The prevalence of longstanding illness ranged from around two in ten Chinese men (22%) and a quarter of Black African men (24%), to around four in ten men in the general population (43%) and almost a half of Irish men (47%). Similarly, among women, the prevalence was lowest in the Chinese and Black African groups (24%) and highest in the general population (47%) and Irish (44%) groups. Prevalence was also high among Black Caribbean women (44%) [2].

- There is variation in behavioural risk factors:

    - Smoking rates remain high in some black, Asian and other minority ethnic groups, such as black Caribbean and Bangladeshi men and black Caribbean women.

    - Pakistani and Bangladeshi groups report low levels of physical activity.

    - Alcohol consumption is far lower amongst black, Asian and other minority ethnic groups – but, of those people who do drink, a large proportion of men from Indian, black Caribbean, black African and Chinese populations do consume above recommended levels.

    - Diet is generally similar or better amongst black, Asian and other minority ethnic groups, except for the use of salt in cooking, which is high amongst black African and Bangladeshi men, black Caribbean and Indian women.

- Obesity and overweight is more prevalent in some black, Asian and other minority ethnic groups in the UK, and it has been found that they are at greater risk of ill health at lower BMI levels.

- Black, Asian and other minority ethnic groups access and engage in services less frequently due to a range of social and cultural factors.[3]

2.4 National outcome frameworks

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

[2] Health Survey for England - 2004: Health of ethnic minorities, ONS 2006
[3] Health Survey for England - 2004: Health of ethnic minorities, ONS 2006

Table 1 Public health outcomes framework for England, 2016–2019

Domain	Objectives and indicators
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.10 Self-harm 2.11 Diet 2.12 Excess weight in adults 2.13 Proportion of physically active and inactive adults 2.14 Smoking prevalence – adults (over 18s) 2.17 Estimated diagnosis rate for people with diabetes mellitus 2.22 Take up of the NHS Health Check programme – by those eligible 2.23 Self-reported well-being
3 Health protection	***Objective*** The population's health is protected from major incidents and other threats, whilst reducing health inequalities ***Indicators*** 3.04 People presenting with HIV at a late stage of infection
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.04 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* 4.09 Excess under 75 mortality rate in adults with serious mental illness* 4.10 Suicide rate**
Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework * Indicator is shared ** Indicator is complementary	

Table 2 NHS outcomes framework 2016–17

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicators*** 1c Neonatal mortality and stillbirths ***Improvement areas*** **Reducing premature mortality from the major causes of death** 1.1 Under 75 mortality rate from cardiovascular disease* 1.4 Under 75 mortality rate from cancer* i One- and ii Five-year survival from all cancers iii One- and iv Five-year survival from breast, lung and colorectal cancer *v One- and vi Five-year survival from cancers diagnosed at stage 1 & 2*** **Reducing premature mortality in people with mental illness** 1.5 i Excess under 75 mortality rate in adults with serious mental illness* *ii Excess under 75 mortality rate in adults with common mental illness** *iii Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services***
4 Ensuring that people have a positive experience of care	***Overarching indicators*** 4a Patient experience of primary care i GP services ii GP Out-of-hours services iii NHS dental services 4b Patient experience of hospital care 4c *Friends and family test* *4d Patient experience characterised as poor or worse* *I Primary care* *ii Hospital care* ***Improvement areas*** **Improving people's experience of outpatient care** 4.1 Patient experience of outpatient services **Improving hospitals' responsiveness to personal needs** 4.2 Responsiveness to inpatients' personal needs **Improving people's experience of accident and emergency services** 4.3 Patient experience of A&E services **Improving access to primary care services** 4.4 Access to i GP services and ii NHS dental services

	Improving women and their families' experience of maternity services 4.5 Women's experience of maternity services **Improving experience of healthcare for people with mental illness** *4.7 Patient experience of community mental health services*
Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

3 Summary of suggestions

3.1 Responses

In total 21 stakeholders (17 registered and 4 non-registered) responded to the 2-week engagement exercise 19/06/2017 – 3/07/2017.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 3 for further consideration by the committee. Full details of all the suggestions provided are given in appendix 1 for information.

Table 3 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Lifestyle advice & behaviour change • Weight management • Physical activity • Tobacco use	BME HF, BDA, Diabetes UK, OG BDA, OPEN, S&CR, KR UK
Type 2 Diabetes • Diabetes	BME HF, Diabetes UK , OG BDA,
Cardiovascular disease • High blood pressure • Cardiac rehabilitation	PHE, RCPsych, BME HF
Mental health • Hospital admissions and formal detentions • Psychological therapies • Perinatal mental health support • Physical health checks	EHRC, Mind, NAT, NHS E, PHE, REF, RCPsych, S&CR

Blood-borne viruses • Hepatitis B & C • HIV	BASL NAT

BASL, British Association for the Study of the Liver
BDA, British Dental Association
BME HF, BME Health Forum
Diabetes UK
EHRC, Equality and human rights commission
KR, Kidney Research UK
Mind
NAT, National AIDS Trust
NHS E, NHS England
OG BDA, Obesity Group of the British Dietetic Association
OPEN, OPENspace research centre, University of Edinburgh
PHE, Public Health England
RCP, Royal College of Physicians
RCPsych, Royal College of Psychiatrists. RSPsych,
REF, Race Equality Foundation
S&CR, The Society and College of Radiographers

4 Suggested improvement areas

4.1 Lifestyle advice & behaviour change

4.1.1 Summary of suggestions

The areas suggested by stakeholders and summarised below all relate to behaviour changes which can support prevention of long term conditions such as cardiovascular disease, chronic kidney disease or diabetes.

Weight management

Stakeholders highlighted that some ethnic groups have greater risks of illness and premature death at lower BMI than those of the general population.

They suggested:

- Taking actions to prevent weight gain and promote healthy lifestyle changes
- Measuring waist circumference alongside BMI to assess risks
- Making referral to culturally relevant structured education programmes and weight management programmes at lower BMI levels

Physical activity

Stakeholders highlighted high levels of inactivity among children and women from minority ethnic groups as an area for quality improvement. They suggested that improving opportunities for physical activity should be affordable and culturally appropriate to improve participation.

Tobacco use

Stakeholders highlighted high prevalence of smoking among men and smokeless tobacco use among women in South Asian communities in particular. Stakeholders suggested that people need support accessing services that are already available to stop smoking. They also highlighted the need to raise awareness of harms among smokeless tobacco users, and to encourage them to seek early treatment for oral health problems.

4.1.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after the table to help inform the committee's discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Weight management	**BMI assessment, multi-component interventions and best practice standards** NICE PH46 Recommendation 2 bullet point 2 **General awareness raising** NICE PH46 Recommendation 3 **Refer overweight and obese adults to a lifestyle weight management programme** NICE PH53 Recommendation 6
Physical activity	**Developing physical activity plans** NICE PH17 Recommendation 3
Tobacco use	**Working with local South Asian communities in areas of identified need** NICE PH39 Recommendation 2 **Providing brief advice and referral** NICE PH39 Recommendation 4

BMI assessment, multi-component interventions and best practice standards

NICE PH46 Recommendation 2 (bullet point 2)

Follow NICE recommendations on BMI assessment, and how to intervene, as set out in Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children (NICE clinical guideline 43). Specifically:

- Weight management programmes should include behaviour-change strategies to increase people's physical activity levels or decrease inactivity, improve eating behaviour and the quality of the person's diet and reduce energy intake. See Recommendation 1.2.4 Lifestyle interventions

General awareness raising

NICE PH46 - Recommendation 3

- Ensure practitioners are aware that members of black, Asian and other minority ethnic groups are at an increased risk of chronic health conditions at a lower BMI than the white population (below BMI 25 kg/m2).

- Ensure members of black, Asian and other minority ethnic groups are aware that they face an increased risk of chronic health conditions at a lower BMI than the white population (below BMI 25 kg/m2).

- Use existing local black and other minority ethnic information networks to disseminate information on the increased risks these groups face at a lower BMI.

Refer overweight and obese adults to a lifestyle weight management programme

NICE PH53 Recommendation 6 [extract]

GP practices and other health or social care professionals who give advice about, or refer people to, lifestyle weight management programmes should:

- Identify people eligible for referral to lifestyle weight management services by measuring their body mass index (BMI). Also measure waist circumference for those with a BMI less than 35 kg/m2. Consider any other locally agreed risk factors.
- For funded referrals, note that:
  - programmes may particularly benefit adults who are obese (that is, with a BMI over 30 kg/m2, or lower for those from black and minority ethnic groups) or with other risk factors (comorbidities such as type 2 diabetes)
  - where there is capacity, access for adults who are overweight should not be restricted (that is, for people with a BMI between 25 to 30 kg/m2, or lower for those from black and minority ethnic groups) or with other risk factors (comorbidities such as type 2 diabetes)
  - there should be no upper BMI or upper age limit for referral.

Working with local South Asian communities in areas of identified need

PH39 Recommendation 4 [extract]

If someone uses smokeless tobacco, ensure they are aware of the health risks (for example, the risk of cardiovascular disease, oropharyngeal cancers and periodontal disease). Use a brief intervention to advise them to stop.

In addition to delivering a brief intervention, refer people who want to quit to local specialist tobacco cessation services (see NICE guidance on smoking cessation services). This includes services specifically for South Asian groups, where they are available.

Developing physical activity plans

NICE PH17 Recommendation 3 [extract]

- Identify groups of local children and young people who are unlikely to participate in at least 1 hour of moderate to vigorous physical activity a day. Work with the public health observatory, schools and established community partnerships and voluntary organisations to achieve this.
- Consult with different groups of children and young people and their families on a regular basis to understand the factors that help or prevent them from being physically active. Pay particular attention to those who are likely to be less physically active. Ensure children and young people from different socioeconomic and minority ethnic groups are actively involved in the provision of activities. Also ensure those with a disability (or who are living with a family member who has a disability) are actively involved.

4.1.3 Current UK practice

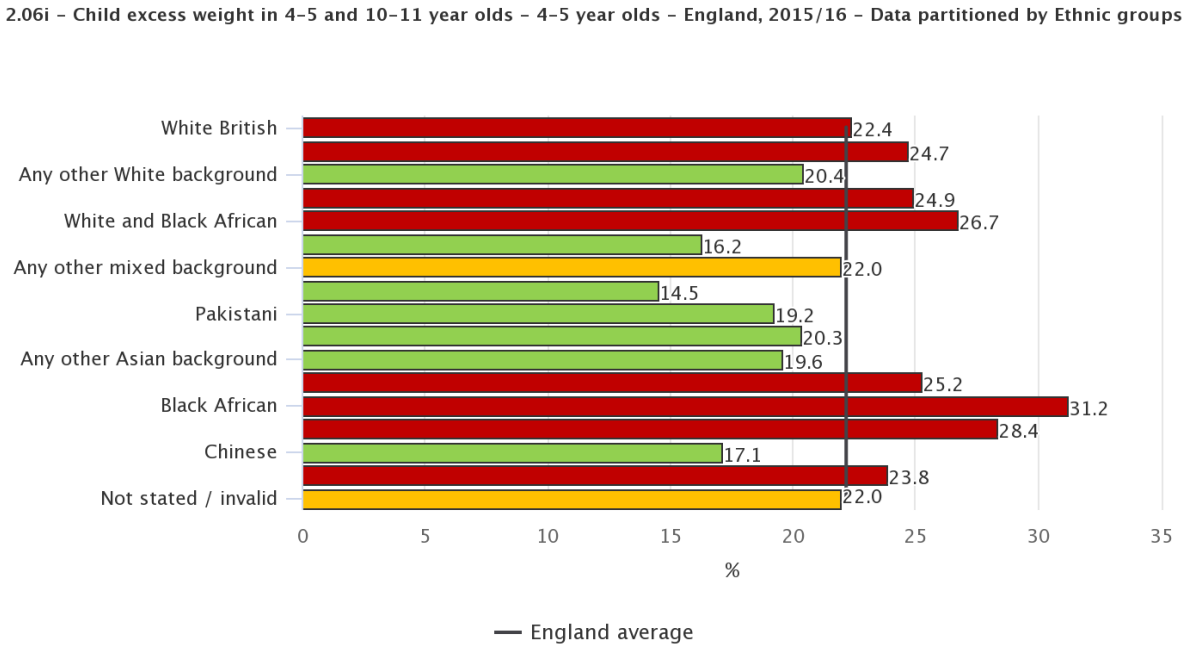
Weight management

Tackling obesity is one of the priority areas included within the Public Health England Strategic Plan[4]. The health consequences of obesity include type 2 diabetes, hypertension, and exacerbation of conditions such as asthma. It is also associated with poor mental health, low self-esteem, stigma and bullying.

Indian, mixed white and Asian, and Chinese children were least likely to be overweight or obese. Children in the black African ethnic group were more than twice as likely to be overweight or obese as children in the Indian ethnic group (31.2% compared with 14.5%)[5]. Figure 1 illustrates that amongst 4-5 year olds, those in the black ethnic groups, and the mixed white and black groups were most likely to be overweight or obese in 2015/16.

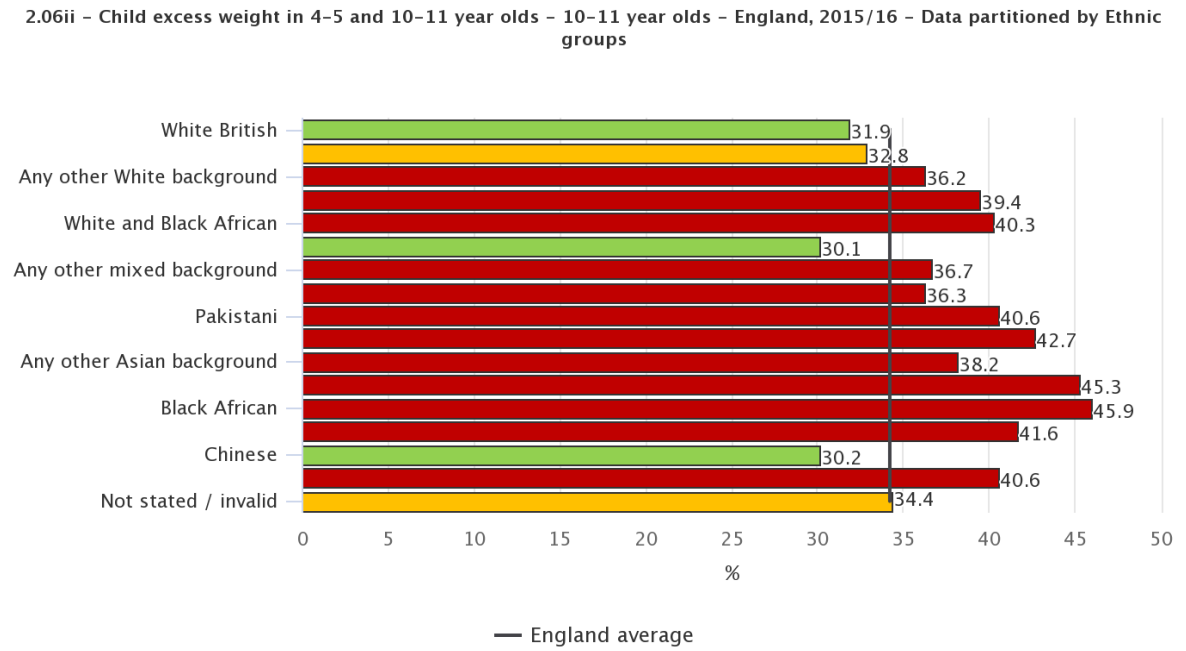
[4] Public health England strategic Plan, PHE 2016
[5] Public Health Outcomes Framework, PHE 2017

Figure 1 Child excess weight in 4-5 year olds, England 2015/16 (Public health outcomes framework, 2017)



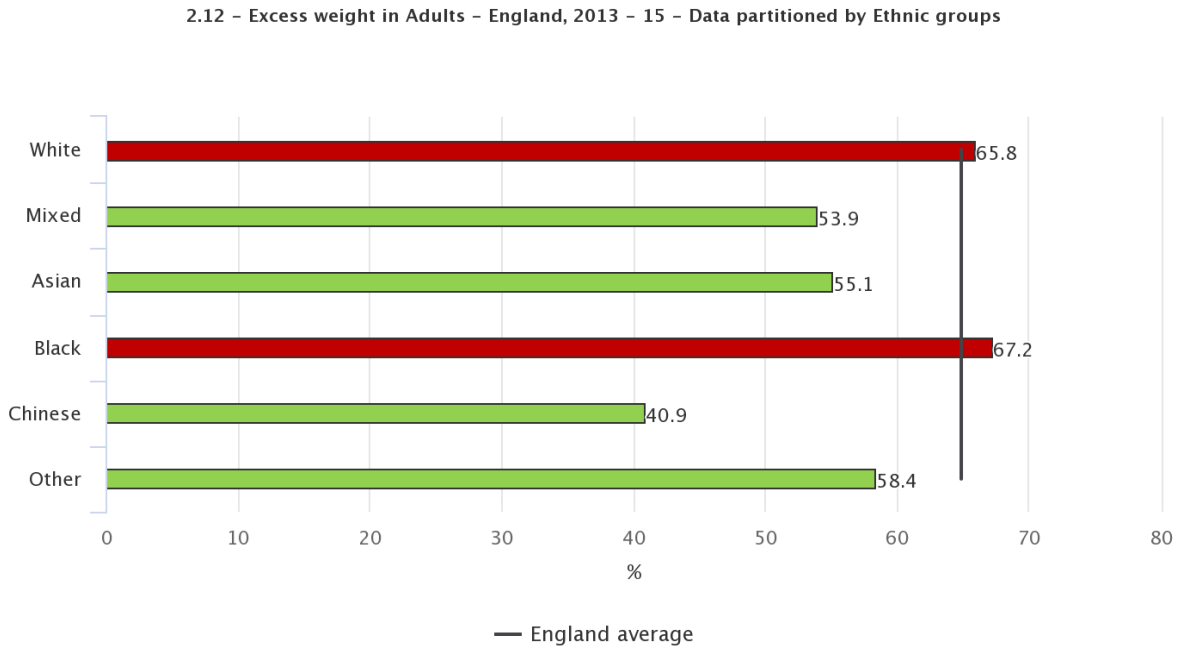
The proportion of children with excess weight was higher at ages 10-11 in all ethnic groups compared with ages 4-5. At ages 10-11, almost all BME groups had significantly high proportions of children with excess weight compared with England as a whole. For children in the black African group, 46% were overweight or obese, compared with less than a third in the mixed white and Asian group (30%) (Figure 2).

Figure 2 Child excess weight in 10-11 year olds, England 2015/16 (Public health outcomes framework, 2017)



Latest data showing excess weight in adults (Figure 3) indicates that white and black ethnic groups have the highest prevalence (65.8% and 67.2% retrospectively). People with Chinese background have the lowest levels of excess weight at 40.9%.

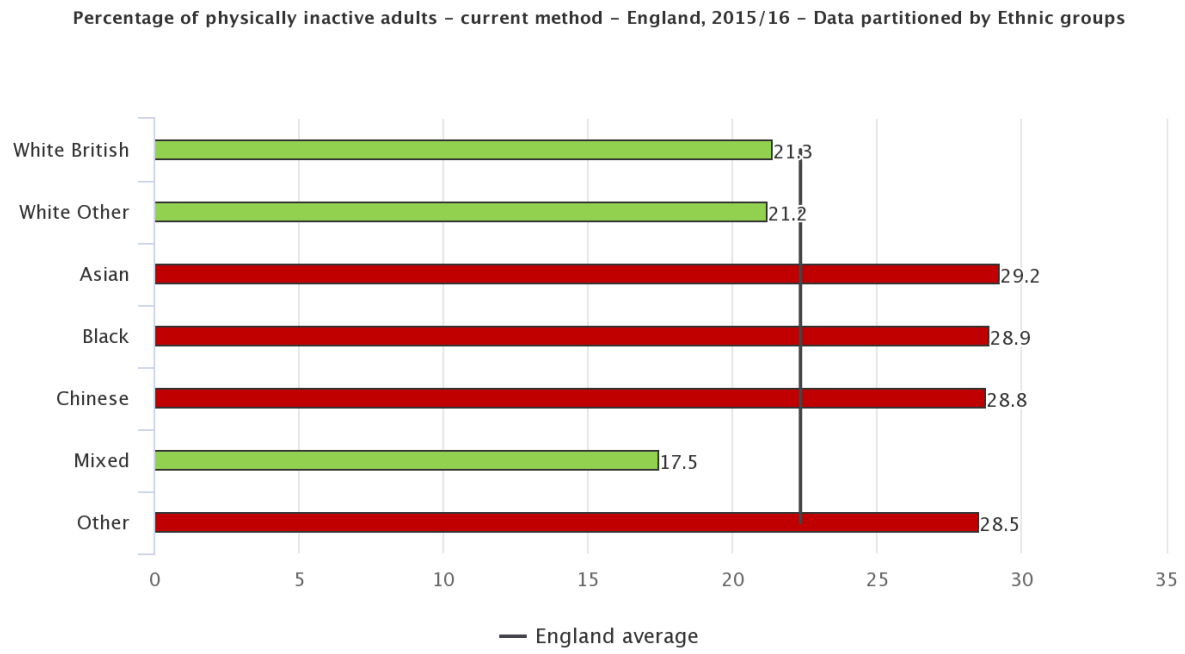
Figure 3 Excess weight in adults by ethnic group (Public health outcomes framework, 2017)



Physical activity

Indicators produced by PHE based on data collected by Sport England, Active Lives survey 2015/16 and presented within the Public Health Outcomes Framework illustrate levels of physical inactivity being substantially higher among minority ethnic groups than among white British and white other groups (Figure 4).

Figure 4 Percentage of physically inactive adults by Ethnic groups (Public health outcomes framework, 2017)

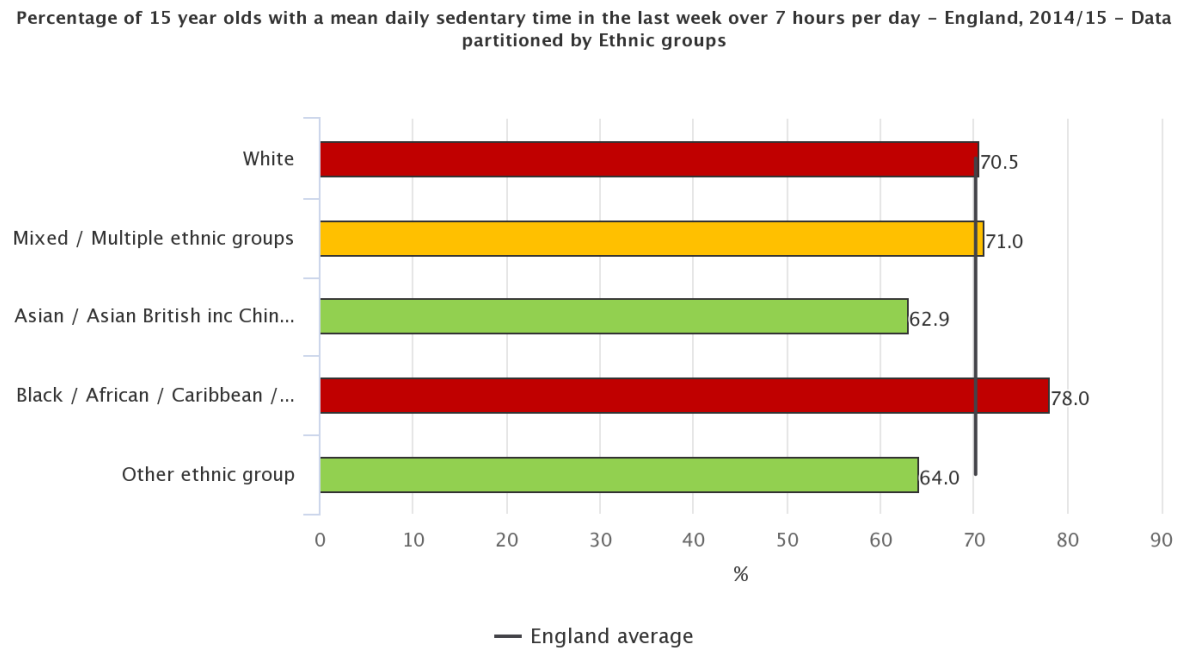


The 2014 What about youth? survey indicated that the total time young people spent undertaking sedentary activities was strongly related to ethnicity. Young people from Asian backgrounds were least likely to say that they undertook sedentary activities for 10 hours or more per weekday (35%) when compared with young people from white (41%) and black (54%) backgrounds. This pattern was also true of weekends, with 66 per cent of young people from Asian backgrounds spending 10 hours or more on sedentary activities, compared with 67 per cent of young people from white backgrounds, and 80 per cent of those from black backgrounds.

Ethnicity was also related to the amount of time spent using a smartphone, with young people from black backgrounds again reporting the greatest amount of time spent on this activity (3.4 hours on weekdays and 4.1 hours on weekend days, compared with 2.9 hours and 3.5 hours among all young people) (Figure 5)[6].

[6] What about youth survey 2014, NHS Digital 2015

Figure 5 Time spent using smartphone by ethnic group, What about youth survey 2014



Tobacco use

There is wide variation in the prevalence of smoking by ethnic group and sex. According to the 2014 Household Survey, smoking prevalence amongst males was higher than females across all ethnic groups (Table 5)[7].

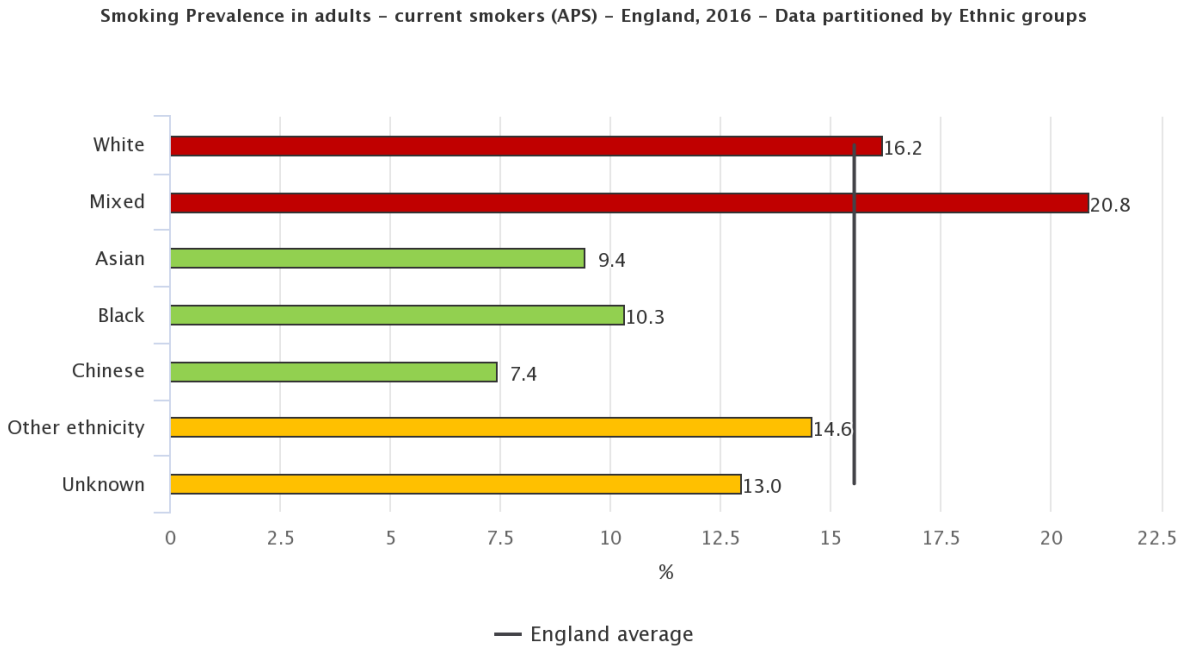
Table 5 Smoking prevalence by Sex and Ethnicity 2014, Integrated Household survey

Ethnicity	Smoking Prevalence (%)		
	Male	Female	Total
White	20.8%	17.0%	18.8%
Mixed / multiple ethnic background	29.4%	19.2%	24.1%
Indian	13.3%	2.8%	8.1%
Pakistani	22.8%	4.0%	13.8%
Bangladeshi	28.1%	4.8%	16.1%
Chinese	20.1%	9.4%	14.4%
Other Asian background	17.5%	5.9%	11.0%
Black / African / Caribbean background	19.1%	8.9%	13.5%

[7] Integrated Household Survey, ONS 2015

The Public Health Outcomes Framework data tool includes data on smoking prevalence in 2016 by ethnic groups derived from Annual population survey (Figure 6).

Figure 6 Smoking prevalence in adults by ethnic group, Annual Population Survey 2016



NHS Digital lifestyles statistics summarise results for people setting quit date and their self-reported outcomes in 2016/17 by ethnic groups (Table 6)[8].

Table 6 People setting a quit date and successful quitters, by ethnic group

Ethnicity	Number setting a quit date	Number of successful quitters	Percentage successful
White	265,628	135,032	*51*
Mixed	5,405	2,470	*46*
Asian or Asian British	13,038	7,268	*56*
Black or Black British	7,764	3,639	*47*
Other ethnic group	3,931	1,947	*50*
Not stated	11,741	5,519	*47*

[8] Statistics on NHS Stop Smoking Services: England, April 2016 to March 2017, NHS Digital 2017

A report produced by Tri-borough Public Health Team & PHE in 2013[9] which looked in depth at tobacco use among local communities found that:

- use of chewing/smokeless tobacco and paan products is common amongst people of South Asian origin
- amongst the South Asian population in the UK, the use of smokeless tobacco is more prevalent amongst those of a Bangladeshi origin, those from older age groups, first generation migrants and those from lower socioeconomic backgrounds
- the prevalence of smokeless tobacco use among Bangladeshi women may be as high as 30%

The report also quotes use of chewing tobacco among South Asian groups data collected by Health Survey for England presented in the table 7.[10]

Table 7 Prevalence of chewing tobacco, by age within South Asian minority ethnic groups and sex

Ethnicity	Men (%)	Women (%)
Indian	4	1
Pakistani	2	1
Bangladeshi	9	16

[9] Paan and Smokeless Tobacco Product Use amongst Bangladeshi Women, Tri-borough Public Health Team & PHE, 2013
[10] Health Survey for England - 2004: Health of ethnic minorities, ONS 2006

4.2 Type 2 diabetes

4.2.1 Summary of suggestions

Type 2 diabetes

Stakeholders highlighted the importance of recognising the enhanced risk of type 2 diabetes within certain black, Asian and minority ethnic groups and raising awareness among the community as well as healthcare professionals. More specifically stakeholders suggested identifying people that have a high risk of developing type 2 diabetes as an area for quality improvement.

Stakeholders also suggested that improving support available for people with type 2 diabetes should be prioritised as an area for quality improvement. They highlighted that people may be encountering language and institutional barriers and need 1:1 tailored support to encourage uptake of the services available.

4.2.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after the table to help inform the committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Type 2 diabetes	**Local joint strategic needs assessments** NICE PH35 Recommendation 2 **Support and individualised care** NICE NG17 Recommendation 1.2.6 **Service provision** NICE NG18 Recommendation 1.5.8

Local joint strategic needs assessments

NICE PH35 Recommendation 2

- Use national and local tools and data from public health data collection agencies, public health reports, the census, indices of deprivation and other sources of high quality data to:
    - identify local communities at high risk of developing type 2 diabetes
    - assess their knowledge, awareness, attitudes and beliefs about the risk factors

  - assess their specific cultural, language and literacy needs

- Identify successful local interventions and note any gaps in service provision. Identify local resources and existing community groups that could help promote healthy eating, physical activity and weight management, particularly within local communities at high risk of developing type 2 diabetes.

Support and individualised care

NICE NG17 Recommendation 1.2.6

Use population, practice‑based and clinic diabetes registers (as specified by the National service framework for diabetes) to assist programmed recall for annual review and assessment of complications and cardiovascular risk.

Service provision

NICE NG18 Recommendation 1.5.8

Record the details of children and young people with diabetes on a population‑based, practice‑based or clinic‑based diabetes register.

4.2.3 Current UK practice

Type 2 diabetes

It is estimated that 3.8 million people aged 16 years and over in England have diabetes (diagnosed and undiagnosed). This is equal to 8.6% of the population of this age group. Diabetes prevalence is higher in men than in women, 9.6% versus 7.6%. There is a clear association between increasing age and higher diabetes prevalence, from 9.0% aged 45 to 54 to 23.8% aged 75 years and over.

Prevalence is higher in people from South Asian and black ethnic groups compared with people from white, mixed or other ethnic groups, 15.2% versus 8.0%. At CCG level, diabetes prevalence ranges from 6.5% to 11.5%. CCGs with the highest estimated diabetes prevalence have high proportions of South Asian and black ethnic groups and high levels of deprivation[11].

Comparisons with the 2014/15 Quality and Outcomes Framework suggest that 76% of people with diabetes have been diagnosed and are included on GP registers. It is estimated that there are 940,000 people with diabetes that are undiagnosed.

[11] Analysis of estimates of diabetes prevalence across England, PHE 2016

According to Diabetes UK Type 2 diabetes is a growing problem in the South Asian community:

- up to six times more common
- increased risk from an earlier age (25, opposed to 40 in the white population)
- increased risk of cardiovascular problems and associated conditions, such as high blood pressure, heart attacks and high cholesterol
- survival rates in younger patients are significantly lower

Diabetes UK found awareness of other risk factors for Type 2 diabetes is also low (2017)[12]:

- 72% people knew that being overweight and inactive are risk factors
- 45% of people thought that having a relative with either type of diabetes increases their risk
- 63% didn't know that having a large waist increases the risk of Type 2 diabetes
- Only 10% were aware that people from black or South Asian backgrounds are at increased risk

In 2016 The Healthier You: NHS Diabetes Prevention Programme (NHS DPP) was launched by PHE, NHS England and Diabetes UK. The programme is expected to help those at high risk of Type 2 diabetes reduce their risk of developing the condition, by being offered a referral to an improved diet, weight loss and increased physical activity programme. The NHS DPP will have full coverage across England by 2020[13].

[12] Diabetes UK & Ipsos MORI survey, 2017
[13] NHS Diabetes Prevention Programme (NHS DPP), NHS England 2016

4.3 Cardiovascular disease

4.3.1 Summary of suggestions

High blood pressure

Stakeholders suggested awareness of different treatment approaches for certain conditions as an area for quality improvement. Conditions such as hypertension respond to different treatment regimens in black, Asian and other ethnic minority groups to those used for white populations.

Cardiac rehabilitation

Stakeholders suggested referral to cardiac rehabilitation is an area for quality improvement because of poor uptake among certain ethnic groups.

4.3.2 Selected recommendations from development source

Table 9 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after the table to help inform the committee's discussion.

Table 9 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
High blood pressure	**Step 1 Treatment** NICE CG127 Recommendation 1.6.8
Cardiac rehabilitation	**Encouraging people to attend** NICE CG172 Recommendations 1.1.5 & 1.1.11 **Lifestyle changes after an MI** NICE CG172 Recommendations in section 1.2

Step 1 Treatment

NICE CG127 Recommendation 1.6.8

Offer step 1 antihypertensive treatment with a calcium-channel blocker (CCB) to people aged over 55 years and to black people of African or Caribbean family origin of any age. If a CCB is not suitable, for example because of oedema or intolerance, or if there is evidence of heart failure or a high risk of heart failure, offer a thiazide-like diuretic.

Encouraging people to attend cardiac rehabilitation

NICE CG172 Recommendation 1.1.5

Deliver cardiac rehabilitation in a non-judgemental, respectful and culturally sensitive manner. Consider employing bilingual peer educators or cardiac rehabilitation assistants who reflect the diversity of the local population.

NICE CG172 Recommendation 1.1.11

Offer single-sex cardiac rehabilitation programme classes if there is sufficient demand.

Lifestyle changes after an MI

NICE CG172 Recommendation 1.2.5

Offer people an individual consultation to discuss diet, including their current eating habits, and advice on improving their diet.

NICE CG172 Recommendation 1.2.8

Advise people who drink alcohol to keep weekly consumption within safe limits (no more than 21 units of alcohol per week for men, or 14 units per week for women) and to avoid binge drinking (more than 3 alcoholic drinks in 1–2 hours).

NICE CG172 Recommendation 1.2.10

Advise people to be physically active for 20–30 minutes a day to the point of slight breathlessness. Advise people who are not active to this level to increase their activity in a gradual, step-by-step way, aiming to increase their exercise capacity. They should start at a level that is comfortable, and increase the duration and intensity of activity as they gain fitness.

NICE CG172 Recommendation 1.2.13

All patients who smoke and who have expressed a desire to quit should be offered support and advice, and referral to an intensive support service (for example, the NHS Stop Smoking Services) in line with Brief interventions and referral for smoking cessation (NICE public health guidance 1). If a patient is unable or unwilling to accept a referral they should be offered pharmacotherapy in line with the recommendations in Smoking cessation services (NICE public health guidance 10).

NICE CG172 Recommendation 1.2.14

After an MI, offer all patients who are overweight or obese advice and support to achieve and maintain a healthy weight in line with Obesity (NICE clinical guideline 43).

4.3.3 Current UK practice

Cardiovascular disease is one of the major causes of death in the under 75s in England. Rates of cardiovascular disease mortality have shown a large decrease over recent years, with the mortality rate per 100,000 almost halving since 2001-03 to 74.6 deaths per 100,000 in 2013-15.[14]

Since ethnic group is not available on death registration records it is not possible to calculate mortality rates based solely on death registration data. There is considerable variation in cardiovascular disease mortality by country of birth.

In 2011-13, the level of mortality amongst those aged under 75 was significantly higher than England amongst men and women born in Central and West Africa, Northern Ireland, Scotland, and Southern Asia. Mortality rates in Bangladesh and Pakistan, both countries within the Southern Asia group were significantly higher[15].

High blood pressure

The British Hypertension Society defines hypertension as the presence of raised systolic or diastolic blood pressure (above 140mmHg or above 90mmHg, respectively). Approximately 24% of adults in England have hypertension or are being treated for high blood pressure[16].

A systematic review found high blood pressure in those of black African ethnicity (three to four times higher than the UK population), and comparatively low in those of Bangladeshi and Pakistani descent[17].

According to Health Survey for England 2004: The Health of Minority Ethnic Groups found:

- mean systolic blood pressure was highest among black Caribbean men (133.3 mmHg) and lowest in Bangladeshi men (121.0 mmHg)
- mean systolic blood pressure was highest in lack Caribbean and Irish women (123.0 mmHg and 124.6 mmHg respectively), while Chinese women had the lowest mean SBP (115.1 mmHg)
- mean diastolic blood pressure was higher in black Caribbean men (74.7 mmHg) and women (73.7 mmHg) than the other minority ethnic groups and the general population[18].

[14] Public Health Outcomes Framework
[15] Public Health Outcomes Framework: Health Equity report, focus on ethnicity, PHE 2017
[16] Analysis of hypertension prevalence estimates in England, PHE 2016
[17] Obesity and ethnicity, National Obesity Observatory 2011
[18] Health Survey for England - 2004: Health of ethnic minorities, ONS 2006

Cardiac rehabilitation

Cardiovascular prevention and rehabilitation services are a vital part of the care pathway for patients with heart disease but not all patients are offered the chance to take part. The National Audit of Cardiac Rehabilitation Annual Statistical Report 2016 found that uptake has reached 49% in 2016[19]. The audit includes ethnicity breakdown but doesn't look at difference in uptake by ethnic group. The main group accessing cardiac rehabilitation is currently British men (Figure 7).

Figure 7 Ethnicity by gender, UK CR 2016

ETHNICITY	%	MALE %	FEMALE %
BRITISH	79	70	30
IRISH	3	69	31
ANY OTHER WHITE BACKGROUND	4	72	28
WHITE AND BLACK CARIBBEAN	<1	70	30
WHITE AND BLACK AFRICAN	<1	74	26
WHITE AND ASIAN	<1	77	23
ANY OTHER MIXED BACKGROUND	<1	68	32
INDIAN	2	76	24
PAKISTANI	2	71	29
BANGLADESHI	1	80	20
ANY OTHER ASIAN BACKGROUND	1	80	20
CARIBBEAN	1	58	42
AFRICAN	<1	70	30
ANY OTHER BLACK BACKGROUND	<1	69	31
CHINESE	<1	70	30
ANY OTHER ETHNIC GROUP	1	73	27
NOT STATED	5	71	29
TOTAL	100	70	30

N= 79,008

No information on uptake, completion or outcomes of cardiac rehabilitation among minority ethnic groups has been identified.

[19] The National Audit of Cardiac Rehabilitation Annual Statistical Report 2016, British Heart Foundation 2016

4.4 Mental health

4.4.1 Summary of suggestions

Hospital admissions and formal detention

Stakeholders highlighted high rates of hospital admissions, longer stays, and higher rates of readmissions for black African-Caribbean and black African patients in mental health settings as an area for quality improvement. They also highlighted much higher prevalence of compulsory detentions under the Mental Health Act 1983 among people from ethnic minority groups during their hospital stay.

Psychological therapies

Stakeholders suggested that providing psychological therapies and support by mental health services to people from ethnic minority groups before they enter specialist care through emergency routes is an area for quality improvement.

Perinatal mental health support

Stakeholders highlighted perinatal mental health support for women from minority ethnic groups as an area for quality improvement. They suggested that the support should be offered through Local Maternity Services and other key practices implemented through the National Maternity Transformation Programme.

Physical Health checks

Stakeholders highlighted the need to address physical health among people from ethnic minority ethnic groups with mental health problems, especially those who use antipsychotic medication. They suggested that due to an already increased risk of morbidity, this group should be particularly targeted with health checks and wellbeing advice on obesity, diabetes and heart disease.

4.4.2 Selected recommendations from development source

Table 10 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after the table to help inform the committee's discussion.

Table 10 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Hospital admissions and formal detention	**Community care** NICE CG136 Recommendation 1.4.5 **Assessment and treatment under the Mental Health Act** NICE CG136 Recommendations 1.8.2 and 1.8.5
Psychological therapies	Numerous recommendations in various mental health condition specific guidelines
Perinatal mental health support	**Antenatal and postnatal mental health** NICE CG123 Recommendation 1.3.2.10
Physical health checks	**Monitoring physical health in primary care** NICE CG178 Recommendation 1.5.3.2

Community care

NICE CG136 Recommendation 1.4.5

For people who may be at risk of crisis, a crisis plan should be developed by the service user and their care coordinator, which should be respected and implemented, and incorporated into the care plan. The crisis plan should include:

- possible early warning signs of a crisis and coping strategies
- support available to help prevent hospitalisation
- where the person would like to be admitted in the event of hospitalisation
- the practical needs of the service user if they are admitted to hospital (for example, childcare or the care of other dependants, including pets) [QS]
- details of advance statements and advance decisions
- whether and the degree to which families or carers are involved
- information about 24-hour access to services
- named contacts.

Assessment and treatment under the Mental Health Act

NICE CG136 Recommendation 1.8.2

Carry out an assessment for possible detention under the Mental Health Act (1983; amended 1995 and 2007) in a calm and considered way. Respond to the service user's needs and treat them with dignity and, whenever possible, respect their wishes.

NICE CG136 Recommendation 1.8.5

When detaining a service user under the Mental Health Act (1983; amended1995 and 2007):

- give them verbal and written information appropriate to the section of the Act used, including 'patient rights leaflets' detailing what is happening to them and why, and what their rights are
- repeat this information if they appear not to have understood or are pre-occupied or confused
- give them, and their families or carers if they agree, information about the legal framework of the Mental Health Act (1983; amended 1995 and 2007)
- ensure they have access to an Independent Mental Health Advocate (IMHA).

Antenatal and postnatal mental health

NICE CG123 Recommendation 1.3.2.10

During pregnancy or the postnatal period, women requiring psychological interventions should be seen for treatment normally within 1 month of initial assessment, and no longer than 3 months afterwards. This is because of the lower threshold for access to psychological interventions during pregnancy and the postnatal period arising from the changing risk–benefit ratio for psychotropic medication at this time.

Monitoring physical health in primary care

NICE CG178 Recommendation 1.5.3.2

GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and then at least annually. The health check should be comprehensive, focusing on physical health problems that are common in people with psychosis and schizophrenia. Include all the checks recommended in 1.3.6.1 and refer to relevant NICE guidance on monitoring for cardiovascular disease, diabetes, obesity and respiratory disease. A copy of the results should be sent to the care coordinator and psychiatrist, and put in the secondary care notes.

4.4.3 Current UK practice

Hospital admissions and formal detention

People from ethnic minorities are more likely to be admitted to psychiatric hospitals in England than white British patients. In 2015/16 15.3% of people from black or black British minority ethnic group who were in contact with mental health and learning disability services spent at least one night in hospital. This is higher than any other ethnic minority and more than double in white adults (5.6%)[20].

People from black or black British ethnic group are also more likely to be detained under the Mental Health Act in NHS funded adult secondary mental health and learning disability services (Table11). [21]

Table 11 Detentions under the Mental Health Act in NHS funded adult secondary mental health and learning disability services by ethnicity, estimated 2015/16

Ethnicity	People who spent time in hospital	Number of detentions	Detentions per 100 people
White	78,433	24,954	31.8
Mixed	2,267	907	40.0
Asian or Asian British	5,504	2,495	45.3
black or black British	8,144	3,982	48.9
Other Ethnic Groups	2,436	1,099	45.1

Psychological therapies

The Adult Psychiatric Morbidity Survey found that white British people were the ethnic group most likely to report receiving treatment; 13.3% reported this compared with around 7% of people in minority ethnic groups (including white non-British). Black adults had the lowest treatment rate (6.2%)[22].

Improving Access to Psychological Therapies data for 2015-16 indicates that even when referred, people from minority ethnic groups are less likely to finish treatment (Table 12).[23]

[20] NHS Digital, Mental Health Bulletin, Annual report 2015-16
[21] NHS Digital, Mental Health Bulletin, Annual report 2015-16
[22] Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014
[23] NHS Digital, Psychological Therapies: Annual Report on the use of IAPT services - England, 2015-16

Table 12 Number of referrals received, proportion entering treatment and finishing a course of treatment in the year 2015-16 by ethnic group

Ethnicity	Referrals received	Referrals entering treatment	Referrals finishing a course of treatment
White	929,914	76.4%	58.0%
Mixed	26,430	73.9%	53.1%
Asian or Asian British	56,650	76.4%	51.9%
black or black British	33,608	76.2%	51.5%
Other Ethnic Groups	17,871	73.9%	52.5%

Perinatal mental health support

A study into the experiences of black and Minority Ethnic Maternity Service Users found that medical histories collected at the booking appointment were incomplete and/or inaccurate leading to vulnerable women not being identified by the service or accessing relevant services. The findings included women not being asked about their mental health or being asked about domestic violence in front of their husbands[24].

Physical Health checks

No data has been identified.

[24] A study into the experiences of Black and Minority Ethnic Maternity Service Users at Imperial College Healthcare NHS Trust, April 2011-March 2013

4.5 Blood-borne viruses

4.5.1 Summary of suggestions

Hepatitis B & C

Stakeholders highlighted early diagnosis of Hepatitis B amongst people from black, Asian and other minority ethnic groups as a quality improvement area. They also highlighted the importance of vaccination and follow up to ensure adequate protection and treatment.

HIV

Early diagnosis of HIV amongst people from black, Asian and other ethnic minority groups were highlighted as quality improvement areas. Stakeholders felt this was important as early diagnosis leads to better treatment outcomes.

4.5.2 Selected recommendations from development source

Table 13 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after the table to help inform the committee's discussion.

Table 13 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Hepatitis B & C	**Testing for hepatitis B and C in primary care** NICE PH43 Recommendation 4 – bullet points 1, 2, 8 **Targeting groups at risk of not being fully immunised** PH21 Recommendation 5
HIV	**Local prevalence** NICE NG60 Recommendation 1.1.1 **Reducing barriers to HIV testing** NICE NG60 Recommendation

Testing for hepatitis B and C in primary care

NICE PH43 Recommendation 4

- GPs and practice nurses should offer testing for hepatitis B and C to adults and children at increased risk of infection, particularly migrants from medium- or high-prevalence countries and people who inject or have injected drugs (see Whose health will benefit?).
- GPs and practice nurses should offer testing for hepatitis B and C to people who are newly registered with the practice and belong to a group at increased risk of infection (see Whose health will benefit?).
- Local community services serving migrant populations should work in partnership with primary care practitioners to promote testing of adults and children at increased risk of infection. This should include raising awareness of hepatitis B and C, promoting the availability of primary care testing facilities and providing support to access these services.

Targeting groups at risk of not being fully immunised

NICE PH21 Recommendation 5

- Improve access to immunisation services for those with transport, language or communication difficulties, and those with physical or learning disabilities. For example, provide longer appointment times, walk-in vaccination clinics, services offering extended hours and mobile or outreach services. The latter might include home visits or vaccinations at children's centres.
- Provide accurate, up-to-date information in a variety of formats on the benefits of immunisation against vaccine-preventable infections. This should be tailored for different communities and groups, according to local circumstances. For example, offer translation services and provide information in multiple languages.
- Health professionals should check the immunisation history of new migrants, including asylum seekers, when they arrive in the country. They should discuss outstanding vaccinations with them and, if appropriate, their parents, and offer the necessary vaccinations administered by trained staff.

Local prevalence

NICE NG60 Recommendation 1.1.1

Offer and recommend HIV testing based on local prevalence and how it affects different groups and communities.

Reducing barriers to HIV testing

NICE NG60 Recommendation 1.4.2

Staff offering HIV tests should:

- Recognise and be sensitive to the cultural issues facing different groups (for example, some groups or communities may be less used to preventive health services and advice, or may fear isolation and social exclusion if they test positive for HIV).

4.5.3 Current UK practice

Hepatitis B

It has been estimated that 95% of people with new chronic hepatitis B in the UK are migrants, most of whom acquired the infection in early childhood in the country of their birth. Migrant populations are the main focus for hepatitis B finding and testing in the UK, and infection in childhood is the major route of transmission.

People born or brought up in a country with an intermediate or high prevalence, immigration detainees and those in close contact with someone known to be chronically infected with hepatitis B are among those at increased risk of hepatitis B.

In 2015 88,882 women underwent antenatal screening for HBsAg. 77.7% were classed as British ethnic origin, a further 16.2% were classified as Asian or Asian British origin, 3.9% were classified as other and/or mixed ethnic origin, and 2.1% were classified as black or black British origin. The proportion testing positive was higher among women of black or black British origin and other and/or mixed origin (1.5% and 1.3% respectively) than women of Asian or Asian British origin and white or white British origin (0.4% and 0.2% respectively). The proportion of HBeAg positive women also differed by ethnic group with 25.0% of other and/or mixed ethnic origin women testing positive, 12.5% of Asian or Asian British women, 6.9% of black or black British women and 2.9% of white or white British women[25].

Hepatitis C

In 2015, 176,471 individuals were tested at least once for anti-HCV in 21 participating sentinel centres. Overall, 3,035 (1.7%) of individuals tested positive. The majority of individuals were classified as being of white or white British ethnic origin (80.1 %), a further 14.2% were classified as Asian or Asian British origin, 3.4%

[25] Sentinel surveillance of BBV testing (England): annual report 2015, PHE 2016

were classified as other and/or mixed ethnic origin, and 2.3% were classified as black or black British origin. The proportion positive varied slightly by ethnic group: 1.6% of individuals of Asian or Asian British origin and white or white British origin tested positive, compared to 1.2% of other or mixed ethnic origin individuals and 0.7% of black or black British origin individuals[26].

A report of a parliamentary roundtable event on 'The challenge of hepatitis C for the South Asian community' suggested that variation in the design and delivery of local services are barriers to the diagnosis and treatment of hepatitis C as follows:

- If hepatitis C services are provided by sexual health and drug outreach centres the stigma of visiting such a service can prevent people from the South Asian community from coming forward for diagnosis and treatment.
- There is a lack of information available in the languages spoken by the South Asian community, such as Urdu or Punjabi.
- Some local commissioners had rejected proposals from patient groups to introduce awareness raising and testing campaigns as they did not have the funding or capacity to treat an increased number of newly diagnosed patients.
- Services and awareness raising campaigns are more effective in some localities than others. For example, it was suggested that the South Asian community is much more aware of issues surrounding hepatitis C in London than in other areas.
- There were concerns around the design of immigration services and their impact on access to healthcare. It was feared that, if new immigrants to the UK from the South Asian community felt unable to approach a GP, then a number of hepatitis C cases would remain undiagnosed and untreated.

It was suggested at the roundtable event that GPs may be unaware of the potential to cure hepatitis C using new and effective treatments and this has led to an insufficient number of referrals for treatment. There are also concerns that CCGs will not have sufficient funding to allow for immediate access to new treatments when they become available, delaying improvements in care.[27]

HIV

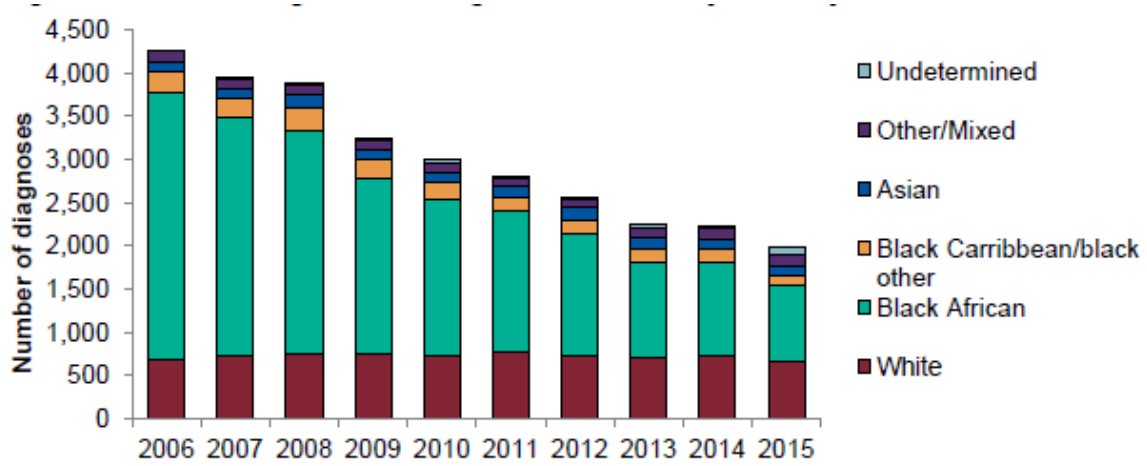
In 2015, an estimated 101,200 people (69,500 men and 31,600 women) in the UK were living with HIV. The overall HIV prevalence was 1.6 per 1,000 people aged 15 and over.

[26] Sentinel surveillance of BBV testing (England): annual report 2015, PHE 2016
[27] THE CHALLENGE OF HEPATITIS C FOR THE SOUTH ASIAN COMMUNITY a Parliamentary Roundtable Event, supported by Bristol-Myers Squibb (2014)

Although there are significant pockets of HIV in other populations and communities, the most significant burden of HIV continues to be borne by men who have sex with men and by black Africans.

In 2015, black African men and women constituted 47% (1,110/2,360) of new HIV diagnoses among heterosexuals, after adjusting for missing information. This decrease, from 73% (3,170/4,340) in 2006, is likely due to changing migration patterns. In 2015, one in three (35%; 820/2,360) heterosexuals diagnosed was of white ethnicity, compared to one in six in 2006 (16%; 690/4,340). However, the overall number of diagnoses in this group has remained stable over the past decade. Six per cent (140) of diagnoses among heterosexuals were made among black Caribbean/black other men and women in 2015. Equivalent figures were 5% (120) and 7% (170) among heterosexuals of Asian and other/mixed ethnicity respectively.

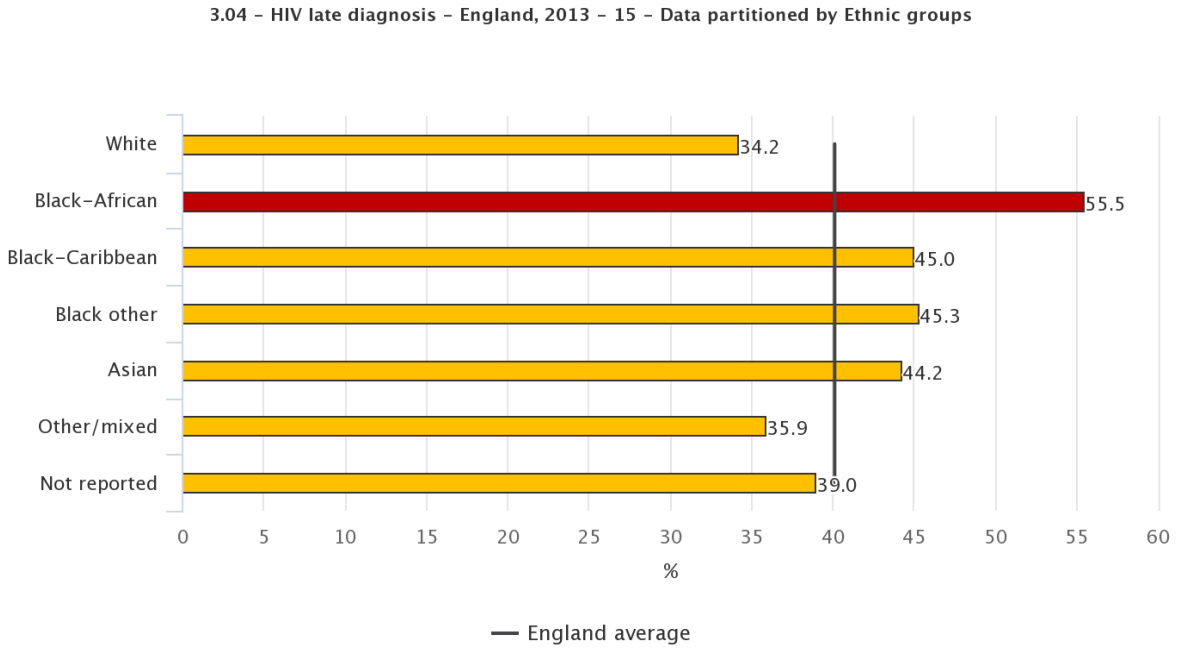
Figure 8 New HIV diagnoses among heterosexuals by ethnicity: UK, 2006-2015



While late diagnosis of HIV has reduced from 56% in 2006, levels in 2015 remain high at 39%. Late diagnosis remains a significant problem in heterosexual people: in 2015, 55% of men and 49% of women were newly diagnosed at a late stage of infection (over half of whom were black African)[28].

[28] HIV in the UK. Public Health England (2016)

Figure 9 HIV late diagnosis, England 2013 - 15



4.6 Additional areas

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the session on 20 September 2017.

Access to end of life care

Stakeholders suggested that access to palliative and end of life care services is an area for quality improvement for ethnic minority groups as access is lower amongst these groups than for white British people. This area is outside of the scope of this quality standard as it does not focus on promoting health or preventing premature mortality.

Appropriate resources to support education

The provision of appropriate resources to support education was suggested as an area for quality improvement. This is an issue that will be highlighted in the supporting information for any relevant quality statements rather than an individual area for quality improvement.

Community engagement

Stakeholders highlighted the importance of community engagement for black, Asian and other ethnic minority groups. More specifically stakeholders suggested this is important to help realise the full potential of all members of society including these groups. NICE has published a quality standard on community engagement: improving health and wellbeing that includes equality considerations highlighting issues that are relevant to all equality groups.

Culturally informed commissioning

Commissioning that is informed by the views and experiences of BME service users, their families and communities will improve access and contribute to recovery was suggested as an area for quality improvement. The primary audience for quality standards is commissioners and all quality statements include a section on what the statement means for commissioners. This area will therefore be an underpinning concept that is referred to throughout the quality standard rather than an individual area for quality improvement.

Respect, cultural appropriateness, and feeling safe and valued

Stakeholders highlighted the importance of using relatable and culturally sensitive language to open up a dialogue around mental health and wellbeing; ensuring support for black, Asian and other ethnic minority communities is delivered in a respectful and culturally appropriate way; and considering where support takes place, ensuring it's in a space where communities can feel safe and valued. These issues are important underpinning concepts for all quality statements in this quality standard rather than an individual area for quality improvement.

Impact of racism and discrimination on health

Stakeholders highlighted the importance of acknowledging and understanding of the impact of racism and discrimination on mental and physical health. This is a broad concept rather than an area for quality improvement and can be highlighted in the supporting information for any relevant quality statements.

Organ donation amongst black, Asian and other minority ethnic groups

Awareness of liver transplantation and the need to increase all organ donation amongst black, Asian and other minority ethnic groups was highlighted as an area for improvement. NICE guideline CG135 Organ donation for transplantation: improving donor identification and consent rates for deceased organ donation doesn't include recommendations on raising awareness and increasing numbers of donors.

Recording ethnicity for people with diabetes

Stakeholders suggested better recording of care pathways through national audits to understand barriers and identify variation in care. This is an issue that will be highlighted in the supporting information for any relevant quality statements rather than an individual area for quality improvement.

Research on black, Asian and other ethnic minority communities

Stakeholders suggested using research about what works in black, Asian and other ethnic minority communities to effectively engage on health issues and encourage positive lifestyle change as a priority area. All quality statements are underpinned by evidence based recommendations. This is a principle of quality standard development rather than an area of quality improvement.

Training for primary care health professionals

Stakeholders highlighted training for health professionals as an area for quality improvement. They specifically suggested there is a lack of awareness of how conditions present differently in black, Asian and other ethnic minority groups which is a barrier to treatment and also suggested there is a need to combat negative perceptions of healthcare in these groups. Quality standards do not include

statements on training; they focus on specific aspects in the delivery of care for which there is evidence of variation. Training may then be considered as one method to improve performance and could be referenced within supporting text.

Uptake of cancer screening

Improving uptake of cancer screening, including prostate cancer for men from black, Asian and other ethnic minority groups was suggested as an area for quality improvement. No recommendations on cancer screening have been identified to support this area.

Appendix 1: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information	BP section
1	BME Health Forum	Improve opportunities for physical activity in children	BME children have particularly low physical activity levels, and higher rates of obesity.	Opportunities for physical activity, particularly in the winter are expensive and therefore disadvantaged children are a lot less active than wealthier children. Councils need to subsidise indoor activities for children eg soft play, trampolining etc. There is no point in just suggesting that people take children out to play when it's cold and dark and wet. This is difficult to do for any parent but culturally, parents from BME groups will not do this as it is perceived as dangerous for children to play under these conditions.		4.1
2	BME Health Forum	Improve support to BME men to stop smoking	Smoking among BME men is still much higher than the rest of population	BME men need to be supported through the links they already have to quit smoking –charities, political groups, mosques etc		4.1

3	British Dental Association	Reducing smokeless tobacco use in South Asian communities	Smokeless tobacco use is associated with oral and pharyngeal cancers, in addition to caries, periodontal diseases and dental abrasion. Oral cancer rates in the UK have increased over recent years, with particularly high incidence (after controlling for socio-economic deprivation) in South Asian women, who are among the main users of smokeless tobacco.	Awareness of the harmful effects is low among users, and the products are commonly used for pain relief; they may mask the discomfort arising from oral diseases and contribute to a reduced likelihood of the user attending a dentist. This, in turn, can delay diagnosis and worsen the prognosis. The BDA supports measures to raise awareness of harms among smokeless tobacco users, and to encourage them to seek early treatment for oral health problems	NICE guidance: Smokeless tobacco: South Asian communities https://www.nice.org.uk/guidance/ph39 Cancer Research UK oral cancer statistics http://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/oral-cancer#heading-Zero	4.1

4	Diabetes UK	Community champions – People within BAME communities trained to deliver information in a culturally appropriate manner	Often people from BAME communities use networks within their cultures to get health information. This is not always clinically accurate. Equally they may not have access to conventional health services and so have limited understanding and support from the national health service.	If people better understand their condition and behaviours that impact their condition they will be able to manage their condition, avoid complications and the risk of premature mortality.	Diabetes UK's community champion programme engages with healthcare specialist and people from BAME communities to develop resources that explain the link between complications and the need to manage diabetes. Communication of how health behaviours, such as diet and exercise, impact on the development of complications which also is affected by diabetes management needs to be simple, concise and be sensitive to culture. The information needs to come from an individual from the community demographic that is respected and appropriate for the specific community. Examples of where this work is successful: Engagement programme with BAME community in London, Bolton, and Huddersfield. This is being expanded into the Midlands.	4.1

5	Kidney Research UK	A need for education and support to make positive lifestyle choices to prevent, manage and treat ill health; for kidney disease, this means education and support on risk factors such as diabetes and hypertension to promote early detection.		The approach taken needs to be the right message from the right messenger e.g. Peer Educators to emphasis greater risk of kidney disease and how to manage		4.1
6	Obesity Group of the British Dietetic Association	Provision of physical activity opportunities locally which are relevant to BAME groups particularly women	Physical activity is known to benefit mental and physical health including weight management and chronic disease management, and to reduce morbidity and mortality. Levels of physical activity are low especially in women and may be even lower in some groups of BAME women, for whom physical activity opportunities available	National surveys of physical activity demonstrate low levels of activity particularly in women e.g. Health Survey Data consistently demonstrates that activity levels in UK adults are lower than recommended and British Heart foundation data showed that activity levels were even lower in Bangladeshi men but especially women (BHF 2012 Coronary Heart Statistics).	Health Survey data Local provision of culturally appropriate physical activity opportunities	4.1

			are not culturally appropriate.			
7	Obesity Group of the British Dietetic Association	Measurement of waist circumference to identify those at high risk	Evidence suggests that some ethnic groups have greater risks of illness and premature death at lower BMI than those of Caucasian ethnicity. This is particularly so in those with a high waist circumference.	Although guidance on lower cut-off points for both BMI and WC for different ethnicities exist for public health action (e.g. WHO), waist circumference is not routinely measured in practice. It is likely that many at risk individuals therefore may not be identified and early opportunities for intervention may be missed.	Individual health records	4.1

8	Obesity Group of the British Dietetic Association	Weight management to prevent excessive weight gain	Evidence suggests that some ethnic groups have greater risks of illness and premature death at lower BMI than those of Caucasian ethnicity. Prevention of excessive weight gain is easier than weight loss.	Referral of high risk individuals to lifestyle weight management programmes (as recommended in recommendation 6 PH53) may not occur in practice. Uptake of services may be lower amongst BAME individuals who either do not recognise their own risk, or are not referred by healthcare professionals.	Local commissioner databases of uptake of commissioned lifestyle weight management programmes among BAME populations. Numbers referred and numbers taking up and completing programmes. These should be identified as KPIs for weight management programme providers in particular in areas with high proportions of BAME populations.	4.1
9	OPENspace research centre, University of Edinburgh	Black and ethnic minorities experience worse health outcomes compared to the general population (Equalities and Human Rights Commission 2016). They also experience poorer access to urban green space and live with poorer quality green space in their		Since the health benefits of urban nature are well evidenced (WHO 2016) this is a health equity and environmental justice issue.	Equality and Human Rights Commission (2016), Healing a divided Britain: the need for a comprehensive race equality strategy https://www.equalityhumanrights.com/sites/default/files/healing_a_divided_britain_-_the_need_for_a_comprehensive_race_equality_strategy_final.pdf CABE 2010a. Urban Green Nation: Building the Evidence Base; Commission for Architecture and the Built Environment (CABE): London, UK,	4.1

		neighbourhoods (CABE 2010a).			World Health Organization 2016. Urban green spaces and Health – a review of the evidence http://www.euro.who.int/en/health-topics/environment-and-health/urban-health/publications/2016/urban-green-spaces-and-health-a-review-of-evidence-2016	
10	OPENspace research centre, University of Edinburgh	There are important distinctions in the health characteristics of black and ethnic minorities (Equalities and Human Rights Commission 2016) and in their use and perceptions of urban green space (CABE 2010b, Roe et al., 2016).		These patterns need to be better understood to target the provision of urban green space appropriately.	Equality and Human Rights Commission 2016. Healing a divided Britain: the need for a comprehensive race equality strategy https://www.equalityhumanrights.com/sites/default/files/healing_a_divided_britain__the_need_for_a_comprehensive_race_equality_strategy_final.pdf CABE 2010b. Community Green: Using Local Spaces to Tackle Inequality and Improve Health; Commission for Architecture and the Built Environment (CABE): London, UK. Roe J., Aspinall P.A., Ward Thompson C. 2016.	4.1

					Understanding Relationships between Health, Ethnicity, Place and the Role of Urban Green Space in Deprived Urban Communities. Int. J. Environ. Res. Public Health 13(7): 681. doi:10.3390/ijerph13070681	
11	OPENspace research centre, University of Edinburgh	Poorer general health in black and ethnic minorities is predicated by their use of urban green space and perceptions of quality e.g. safety and aesthetic quality (Roe at al., 2016).		Improving access to and the quality of local neighbourhood green space may therefore help protect general health in black and ethnic minorities.	Roe J., Aspinall, P.A., Ward Thompson, C. 2016. Understanding Relationships between Health, Ethnicity, Place and the Role of Urban Green Space in Deprived Urban Communities. Int. J. Environ. Res. Public Health 13(7): 681. doi:10.3390/ijerph13070681	4.1
12	The Society and College of Radiographers	Support BME individuals in relevant behaviour change	To improve patient experience, to address inequalities	Individual engagement in health, care and wellbeing. To address power issues and marginalisation and enable entrenched health inequalities to be tackled.		4.1
13	The Society and College of Radiographers	Without preconception or condemnation of embedded cultural habit, promote healthy lifestyle changes	To address personal factors in BME healthcare and reduce diet and BMI related health conditions requiring long term medical treatment or intervention	Asian and minority ethnic groups are at an increased risk of chronic health conditions at a lower BMI than the white population.	WHO advice on BMI for Asian populations	4.1

		generally and specifically.				
14	BME Health Forum	Improve diabetes care through 1:1 peer mentoring	Diabetes is a leading cause of premature mortality in BME groups	We work together with organisations that provide 1:1 mentoring for people who have diabetes and dont speak English. They found that some patients were not even aware of their Diabetes diagnosis. They were able to support people take much better control of their diabetes.	Contact Midaye Somali Development Network for evidence.	4.2

15	Diabetes UK	Tailored interventions for management of Type 2 diabetes in BAME communities.	Patients from ethnic minority groups often have poorer glycaemic control and higher rates of diabetes complications than the rest of the population.	Failure to account for cultural differences in generic health education programs reduces their effectiveness for ethnically diverse audiences. Culturally appropriate programs have been shown to be effective in minority ethnic groups. Effective strategies for program design have been identified in the literature. Further methods of culturally tailoring have been identified in the research. Ensuring that health professionals are culturally competent to undertake their work is also a key area for improvement.	Lanting LC, Joung IM, Mackenbach JP, Lamberts SW, Bootsma AH. Ethnic differences in mortality, end-stage complications, and quality of care among diabetic patients: a review. Diabetes Care. 2005;28:2280-2288. Creamer J, Attridge M, Ramsden M, Cannings-John R, Hawthorne K. Culturally appropriate health education for Type 2 diabetes in ethnic minority groups: an updated Cochrane Review of randomized controlled trials. Diabetic Medicine. 2016;33:169-183. Attridge M, Creamer J, Ramsden M, Cannings-John R, Hawthorne K. Culturally appropriate health education for people in ethnic minority groups with type 2 diabetes mellitus. Cochrane Database Syst Rev. 2014;(9):CD006424. Ricci-Cabello I, Ruiz-Perez I, Rojas-Garcia A, Pastor G, Rodriguez-Barranco M,	4.2

					Goncalves DC. Characteristics and effectiveness of diabetes self-management educational programs targeted to racial/ethnic minority groups: a systematic review, meta-analysis and meta-regression. BMC Endocrine Disord 2014;14:60. Nam S, Janson SL, Stotts NA, Chesla C, Kroon L. Effect of culturally tailored diabetes education in ethnic minorities with type 2 diabetes: a meta-analysis. J Cardiovasc Nurs. 2012;27:505-518. The Office of Minority Health. What is cultural competency. Sciences USDoHaH, Ed.; 2013.	

16	Diabetes UK	Identifying people from BAME backgrounds that have a high risk of developing Type 2 diabetes.	People of BAME backgrounds have an increased risk of developing Type 2 diabetes who are. 2-4 times more at risk and also to develop the condition at a much younger age. Undiagnosed Type 2 diabetes or poorly managed diabetes can lead to life changing complications and premature death. This is supported by NICE guidance, PH38, which identifies people of BAME backgrounds as having an increased risk of developing Type 2 diabetes.	There is a huge need for health promotion material that specifically relates to BAME communities. This is needed as the current programmes do not take into account cultural/religious practices that can and do have an impact on lifestyles. NHS Health Checks should be offered for people from BAME backgrounds. Those found to be at an increased risk of developing diabetes due to their BAME background should be offered culturally appropriate opportunity to attend behaviour change interventions to help reduce their risk. Ethnicity data for National Diabetes Prevention Programme needs to be recorded, analysed and reported on, in order to identify issues in variation in access and outcomes, so that these can be addressed.	PH38 -Type 2 diabetes: prevention in people at high risk https://www.nice.org.uk/guidance/ph38 We have over the last 3 years considerable insight into the challenges that BAME communities have about risk and Diabetes. Diabetes UK are in the process of creating resources that are specific to BAME communities. This will include the involvement of healthcare professionals and BAME people living with diabetes There is researched evidence about BAME and physical activity rates being much lower than their white counter parts. This can be seen in Health Authority Education's report. • Health Education Authority 1994, 1995 and Rai D Finch H 1995 Attitudes and barriers to physical activity amongst South Asians and Black Communities in England	4.2

17	Diabetes UK	Population and community interventions that are tailored to engage with BAME individuals	If interventions are not tailored they remain generic with very poor take up – any intervention that does not address lifestyle/cultural/religious /language context will not be taken up. There is a need to tailor services for people in ethnic communities and other groups who are particularly at risk of type 2 diabetes.		Type 2 diabetes prevention: population and community-level interventions Public health guideline [PH35] https://www.nice.org.uk/guidance/ph35	4.2
18	Obesity Group of the British Dietetic Association	BAME individuals with Type 2 diabetes are referred to appropriate structured education sessions which are culturally relevant	Type 2 diabetes is a chronic condition requiring lifestyle management with possible addition of pharmacotherapies. Type 2 diabetes is more common in those who are overweight or obese, and overweight and obesity are more common in BAME individuals than Caucasians. BAME individuals have greater health risks at apparently healthy BMI compared	Although actual attendance may be higher than that recorded, the National Diabetes Audit 2015/16 suggested that improvements in uptake of structured education programmes are needed.	National Diabetes Audit (http://content.digital.nhs.uk/nda) Referral to structured education programmes recorded in patient records.	4.2

			with Caucasian individuals.			
19	BME Health Forum	Improved support to manage blood pressure in BME communities		For some communities, support from the GP is not enough and they need, more 1:1, holistic and long term support. Inability to speak fluent English is a major barrier to accessing good clinical support, and interpreters are frequently not used in health settings.		4.3
20	Public Health England	Education and awareness. Increase awareness and promote uptake of cardiac rehabilitation services among certain ethnic and socioeconomic groups	Increased uptake of cardiac rehabilitation would result in better treatment outcomes for the patient and may reduce the likelihood of re-admission.	Evidence or information that care in the suggested key areas for quality improvement is poor or variable and requires improvement	Services that relate to cardiovascular disease – a condition that has received some attention in relation to ethnicity - there evidence of differential access to hospital and follow-on treatments. Sekhri et al.(2008) concluded that at an early stage after presentation with suspected angina, coronary angiography is underused in South Asians (as well as in older people, women and people from deprived areas). Uptake of cardiac rehabilitation has also been found to be lower among minority ethnic groups (as well as women and those from lower socioeconomic backgrounds) (Bethell, Lewin	4.3

					and Dalal, 2009). References: Bethell H, Lewin R, Dalal H. Cardiac rehabilitation in the United Kingdom. Heart 2009;95:271-5. BMJ 2015; 351 doi: https://doi.org/10.1136/bmj.h5000 (Published 29 September 2015); Sekhri N, Timmis A, Hemingway H, et al Is access to specialist assessment of chest pain equitable by age, gender, ethnicity and socioeconomic status? An enhanced ecological analysis BMJ Open 2012;2:e001025. doi: 10.1136/bmjopen-2012-001025	
21	Royal College of Psychiatrists	Awareness of different treatment approaches for certain conditions specific to BME groups	Certain conditions such as hypertension respond to different treatment regimens in BME groups than those used for Caucasian populations.	Training and an understanding of these treatment approaches as well as a review of the literature and evidence base should be a priority,		4.3

22	Equality and human rights commission	Improve contact with mental health services	Stark disproportionalities for Black people in mental health settings include higher rates of hospital admission, longer stays and higher rates of re-admission.	The proportion of adults in England in 2012 who were at risk of poor mental health (15%) is more than twice as high as those who said they had 'bad' or 'very bad' health in general. In 2012, the proportion of adults in England who were at risk of poor mental health was higher among Pakistani/Bangladeshi and African/Caribbean/Black respondents than White respondents. The higher rate for Pakistani/Bangladeshi people was primarily among women – 28.2% of whom were at risk of poor mental health, compared with 17.4% of White women. Gypsies, Travellers and Roma were found to suffer poorer mental health, compared with the rest of the population in Britain. They also demonstrated a higher prevalence of anxiety and depression. In Scotland, higher proportions of ethnic minority respondents were at risk of poor mental health in 2008, but this was not the case in 2012. There was no breakdown for ethnicity in Wales.	Data on contact with mental health services show 3.6% of the White adult population in England had accessed NHS-funded specialist mental health services for adults in the year 2014/15. For the Black/African/Caribbean/Black British population, the rate was 4.8%, with 3.9% for the Mixed/multiple ethnicity population and 3.3% for the Asian/Asian British population (HSCIC, 2015). During 2014/15, the Black or Black British group had the highest proportion of people who had spent time in hospital in the year, which meant that 12.7 people per 100 who were in contact with mental health and learning disability services from this ethnic group spent at least one night in hospital in the year. This is higher than the figure for any other ethnic minority and more than double the figure for White adults (6.1%) (HSCIC, 2015). A study of	4.4

					readmissions one year after involuntary hospitalisation showed that being of Black African and/or Black Caribbean origin in England was associated with a higher involuntary readmission rate (CAAPC, 2016). People from ethnic minorities (particularly Black African-Caribbean and Black African patients) were also more likely than average to be admitted to psychiatric hospitals in England than White British patients (HSCIC, 2015). In addition, ethnic minorities face different barriers to accessing crisis care. Indian, Bangladeshi and Chinese people had consistently low referral rates to Crisis Resolution and Home Treatment in England teams. Ethnic minorities, particularly Black Caribbean patients, were also generally more likely to be admitted to hospital once they had been seen by a Crisis Resolution	

					and Home Treatment team (Mind, 2013).	

23	Equality and human rights commission	Detention	In 2014, the probability of Black African women being detained under the Mental Health Act 1983 in England and Wales was more than seven times higher than for White British women.	Improve experience in Mental health detention	In England and Wales, of people who stayed in hospital in 2014/15, 40.1% were compulsorily detained under the Mental Health Act 1983 (HSCIC, 2015). Of Black or Black British people with hospital stays, 56.9% were compulsorily detained (including 59.7% of people of African ethnicity). For people of Asian or Asian British ethnicity, the percentage was 50.4% (52.5% for people of Pakistani ethnicity). Among White people, the percentage was 37.5% (with the highest rate, 46.9%, being for those of Other White ethnicity) (HSCIC, 2015). In 2014, the probability of Black African women being detained in England and Wales was more than seven times higher than for White British women. Black Caribbean and Black British women were four times more likely to be detained compared with White British women, and Mixed	4.4

					Black/White women were almost seven times more likely to be detained than White British women (CAAPC, 2016). Individuals detained in prison are vulnerable to self-harm and suicide. Self-inflicted death rates in prison increased in England and Wales from 2008/09 (0.7 per 1,000 prisoners) to 2013/14 (0.9 per 1,000 prisoners). Gypsies, Roma and Travellers in England and Wales are particularly vulnerable to self-harm and suicide in prison. In the years 2008, 2009, 2013 and 2014, White prisoners were more likely to take their own life than prisoners from an ethnic minority. An inspection report on Harmondsworth Immigration Removal Centre (HMIP, 2013) noted mental health problems were not being identified promptly, there were difficulties in obtaining appointments and problems	

					in receiving treatment, even after suicide attempts.	

24	Mind	Health checks and interventions, and wellbeing advice, for people on antipsychotic medication: proactive inclusion of people from BME communities	A particular area of physical health concern is the risk of obesity, diabetes and heart disease among people taking antipsychotic medication. This applies to everyone, but some ethnic groups already have a higher risk of diabetes.	This has been a major focus of work with the updating and promotion of the Lester resource, and relevant CQUIN and outcomes indicators. Unless it is known that the guidance is being comprehensively and effectively implemented, it would be helpful to promote it through this guidance with an emphasis on including people from BME groups, using tailored approaches as required.		4.4
25	Mind	target interventions promoting the physical health of BME people with mental health problems	People with mental health problems are more likely to experience poor physical health so it is important to address both, and to target core public health programmes (eg around smoking and obesity) at people with mental health problems, tailoring them to BME communities as appropriate		People with mental health problems are more likely to experience poor physical health, and people with serious mental health problems die 10–20 years younger than the general population. (Chesney, E., Goodwin, G. M. and Fazel, S. (2014) Risks of all-cause and suicide mortality in mental disorders: a metareview. World Psychiatry, 13:153–160. doi: 10.1002/wps.20128) See p.29 of our report on public health for more on physical health promotion	4.4

					with people with mental health problems	

26	National AIDS Trust	Improved care pathways for BME communities into prompt high quality mental health services	People from black or ethnic minorities are disproportionately affected by poor mental health. NICE quality standards on improving healthcare for BME communities must take account of the greater burden placed upon BME communities of mental health. For example, African people face a significantly increased risk of suffering a psychotic disorder compared with non-Africans. People of African descent in the UK are more likely than white counterparts to be considered in need of mental health treatment and care. NICE Guidance on 'Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health	At NAT, our focus is on HIV. While within the context of HIV it is clear that all people with HIV have elevated mental health needs (compared to the general population) there are specifics to that need amongst black African men and women. These include the impact of the immigration system, the use of alcohol, issues of disclosure and the distinctive aspects of stigma within African communities. One London study found that black African men were those amongst people living with HIV with the highest rates of suicidal ideation. More needs to be done to screen for mental health and ensure that GP surgeries are well placed to identify mental health issues. In 2010 NAT conducted focus groups to discuss people living with HIV's experience of accessing mental health services. One focus group consisted of solely black African participants. Black African participants in this study spoke of frustration at long waiting times and bureaucratic referral procedures for mental health services. While there are specifics to how people living with HIV experience mental health, some of these concerns are likely to be	Please refer to Chapter H on 'Mental Health and TB' in NAT's entitled 'HIV and Black African Communities in the UK': http://www.nat.org.uk/sites/default/files/publications/NAT-African-Communities-Report-June-2014-FINAL.pdf Please refer to the African Health Policy Network's report on 'The Mental and Emotional Wellbeing of Africans in the UK'. http://www.ahpn.org.uk/files/147_The_Mental_and_Emotional_Wellbeing_of_Africans_in_the_UK__AHPN_2013_139.pdf Please refer to the NICE Quality Standard on 'Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services' https://www.nice.org.uk/guidance/CG136/chapter/1-Guidance#access-to-care	4.4

			services' should be taken into consideration. Particularly the recommendation that 'mental health services should work with primary care and local third sector, including voluntary organisations to ensure that all people with mental health problems have equal access to services based on clinical need and irrespective of...background (including cultural, ethnic and religious background)'.	universal.		

27	NHS England	Accessibility of mainstream primary care and community based mental health services (incl. Psychological services - IAPT) / improving cultural competence in mainstream MH services	Every mental health service should be culturally capable and able to address the diverse needs of a multi-cultural population through effective and appropriate forms of assessment and interventions. Primary/community based services have a crucial role in preventing avoidable deterioration of people's mental health.	Access to acute mental health services is not equal for people from different ethnic backgrounds. Problems with access to primary care and mental health promotion have been reported, and it has been contended that people from BME backgrounds do not get the mental healthservices they want or need. Psychological services such as Improving Access to Psychological Therapies (IAPT) also appear to be more inaccessible for people from minority communities. Black people are also reported to be more likely to be turned away from mental health services when they seek help. This leads to certain groups being more likely to enter specialist care through emergency routes and to significant overrepresentation in secondary mental health care settings.	Access to acute mental health services is not equal for people from different ethnic backgrounds. Problems with access to primary care and mental health promotion have been reported, and it has been contended that people from BME backgrounds do not get the mental healthservices they want or need. Psychological services such as Improving Access to Psychological Therapies (IAPT) also appear to be more inaccessible for people from minority communities. Black people are also reported to be more likely to be turned away from mental health services when they seek help. This leads to certain groups being more likely to enter specialist care through emergency routes and to significant overrepresentation in secondary mental health care settings.	4.4

28	NHS England	Improved awareness of Mental health and reduced stigma among BAME communities	Evidence shows that high quality services for BME communities that are inclusive and recovery-orientated, with an emphasis on positive care experience for service users and greater engagement with carers, are likely to improve public understanding and attitudes towards mental health. This will result in fewer people experiencing stigma and discrimination as a result of their mental health difficulties.	Stigma and discrimination account for increased risk of mental disorders of some of the BME groups	Bhui K, Stansfeld S, McKenzie, K et al Racial/ethnic discrimination and common mental disorders among workers: findings from EMPIRIC study of ethnic minority groups in the United Kingdom. Am J Public Health, 2005, 95(3):496–501.	4.4

29	NHS England	Mental health services tailored to local BAME population need - i.e. more accessible, broader, and flexible care pathways, integrate across the voluntary, community, social care and health sectors	While specialist expertise and skills should exist within all services, there is good evidence to suggest that where the level of need, risk, or exclusion of generic services raises serious concerns about equity and equality, it is appropriate to provide services designed for particular marginalised groups. Integration across across the voluntary, community, social care and health sectors	BME groups tend to report more dissatisfaction with mainstream services compared to community sector or voluntary organisations providing mental health care, and mainstream services are often perceived as more likely to misunderstand their situation and experience. People from BAME backgrounds can also experience additional challenges such as a lack of awareness of services, language barriers, services that do not take account of cultural differences and religious beliefs, and social stigma. This leads to poor health and recovery outcomes for these communities, as well as poor experience and more disengagement and dissatisfaction with mental health services.	As above and also: Keating F & Robertson D Fear, black people and mental illness: a vicious circle? Health and Social Care in the Community, 2004, 12: 439-447.	4.4
30	Public Health England	Improve access to primary mental health and health promotion services /care among certain ethnic groups.	Mental health is a key component to individual's health and wellbeing in certain ethnic groups. Therefore improving access to mental health services is vital. Scale of issue: Evidence reveals that White British people represent	Evidence or information that care in the suggested key areas for quality improvement is poor or variable and requires improvement	Problematic access to primary mental healthcare and mental health promotion has been reported for people from Black and minority ethnic backgrounds. Data from the Increasing Access to Psychological Therapies (IAPT) programme suggest that these services for CMDs	4.4

			72.5% of the inpatient episodes in mental health and learning disability trusts, which is proportionately lower than might be expected. However, Gypsies and Travellers, people of 'other mixed race', Bangladeshi people and 'other Black' people have attendance levels that are proportionately higher than expected from their percentage of the population (CQC, 2013)		may be less accessible to people from minority ethnic communities. There have also been claims that Black people are more likely to be turned away from mental health services when they seek help. There are concerns that children and young people from black and minority ethnic groups are under-represented in child and adolescent mental health services.[1] Reference: Lavis P 'The importance of promoting mental health in children and young people from black and minority ethnic communities' Race Equality Foundation 2014. CQC , 'Equality counts: equality information from CQC for 2013 ,page 16 http://www.cqc.org.uk/sites/default/files/documents/edhr_annual_report_january_2014final.pdf	

31	Race Equality Foundation	Perinatal mental health support for black and minority ethnic women	Poor uptake of services, lack of understanding, poor experiences. Needs to be linked to support offered through Local Maternity Services, and other key practices being implemented through the National Maternity Transformation Programme			4.4
32	Royal College of Psychiatrists	Increased prevalence of mental disorders among certain BME groups in the UK	There's significant evidence of an increased prevalence of mental disorder in UK based BME groups that's disproportionate to the rate of mental disorders in BME countries of origin. The literature is readily available on this.	An understanding of varied treatment approaches and complexities of presentation would be highly beneficial.		4.4
33	The Society and College of Radiographers	Improve access to Mental Health Care with an emphasis on culturally acceptable treatment options that reduce hospital admission and risk of social exclusion.	To identify and treat BME groups earlier and prevent longer term mental health conditions from developing or reaching mental health crisis with the associated impact on relationships, work and home life.	BME groups are more likely to be diagnosed with mental health conditions, more likely to be admitted to hospital and more likely to suffer social exclusion as a result.	Mentalhealth.org Black Asian Minority Ethnic (bame) communities	4.4

34	British Association for the Study of the Liver (BASL)	Vaccines against Hepatitis B and follow up to ensure protection is adequate				4.5
35	British Association for the Study of the Liver (BASL)	Diagnosis of viral hepatitis				4.5
36	British Association for the Study of the Liver (BASL)	Access to treatment of viral hepatitis				4.5
37	National AIDS Trust	Reductions in late HIV diagnosis among black and minority ethnic communities, through implementation of the NICE Public Health Guidance in HIV testing, including the offer of HIV tests to those from high prevalence countries and the routine offers of HIV tests in	There is a wealth of evidence that suggests that early diagnosis of HIV leads to better treatment outcomes. Routine HIV testing (and at the point of registration at a GP surgery) in high prevalence areas is recommended within NICE guidance on 'HIV testing: increasing uptake among people who may have undiagnosed HIV'. It is also recommended that black African men	Black African men and women living in the UK are disproportionately affected by HIV, making up 1.8% of the UK population but 31% of all people accessing HIV care. Similarly, Black Caribbean's make up 1% of the UK population but account for 3% of people living with HIV, with HIV prevalence over four times higher than in the white population. Late diagnosis is the most important predictor of morbidity and premature mortality among people with HIV infection. People diagnosed late have a ten-fold increased risk of death in the year following their diagnosis.	Please refer to Public Health England's report 'HIV in the UK:2016', which reports on epidemiological data on HIV in the UK on a yearly basis, and includes information on the disproportionate impact of HIV on Black Africans. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/602942/HIV_in_the_UK_report.pdf The National AIDS Trust (NAT) published a report in	4.5

		primary and secondary care in areas of high HIV prevalence in England (where diagnosed prevalence exceeds 2 per 1,000 in local population).	and women should have an HIV test and regular HIV and sexually transmitted infection tests if having unprotected sex with new or casual partners. More could be done to increase testing in a variety of clinical settings. Most importantly, primary care testing should be increased, so that HIV testing becomes routine, particularly for BME communities. There is evidence to suggest that BME communities are more likely than MSM (men who have sex with men) to be diagnosed by their GP rather than in sexual health/GUM clinics. So, ensuring HIV testing becomes more routine within this setting is of paramount importance.	Furthermore, someone diagnosed 'very late' (at or below a CD4 count of >200/mm3) loses ten years in life expectancy compared with someone diagnosed in time to start their treatment at a CD4 count of 350 mm. In 2015, 39% of people diagnosed with HIV were diagnosed late (defined as a CD4 count >350/mm3). This rose to 59% for black African men and 51% of black African women, and the proportion of black African heterosexual men and women unaware of their infection was 11% and 10% respectively. Black African men and women are the group most likely to be diagnosed late. With the rates of late diagnosis being higher within BME communities as opposed to other groups disproportionately affected by HIV (such as MSM), more needs to be done to ensure all opportunities to test within this community are taken.	2015 entitled 'HIV and Black African Communities in the UK' which reviews the wide range of policy issues relevant to HIV and Black African communities. http://www.nat.org.uk/sites/default/files/publications/NAT-African-Communities-Report-June-2014-FINAL.pdf Please refer to NICE guidance on 'HIV testing: increasing uptake among people who may have undiagnosed HIV' https://www.nice.org.uk/guidance/ng60	
38	BME Health Forum	Improve uptake of cancer screening including prostate	Screening uptake is low among BME women, Prostate cancer is high in BME men.			4.6

		cancer for BME men				
39	British Association for the Study of the Liver (BASL)	Awareness of liver transplantation and the need to increase donation in the BAME community				4.6
40	Diabetes UK	Better recording of care pathways through national audits to understand barriers and identify variation in care Existing Indicators - To encourage hospital trusts and CCGs to participate in National Diabetes Audits	National diabetes audit data need to ensure robust recording of a patient's ethnic background and for hospital trusts to submit their data to the audit. This will help commissioners, healthcare professionals and patent organisations to better understand what the barrier to care are for people from BAME backgrounds.		National Diabetes Audit National Diabetes In[patient Audit National Diabetes Paediatric Audit National Diabetes Foot care Audit National Pregnancy in Diabetes Audit http://content.digital.nhs.uk/nda	4.6
41	Equality and human rights commission	Improve access to healthcare for marginalised groups	Gypsies and Travellers and migrants experienced poorer access to health and primary care services. They face multiple barriers when seeking to register with GPs,	Improve access to healthcare for marginalised groups	Gypsies and Travellers Gypsies and Travellers experience poorer access to GPs and other primary care services. They often face discrimination when trying to access health services. Their needs have been highlighted by various UN	4.6

			including prejudice and discrimination.		Committees, including those on the Elimination of Racial Discrimination and the Elimination of Discrimination against Women. Gypsies and Travellers remain unregistered with GPs for a variety of reasons that include: being turned down as 'problematic users', a lack of cultural awareness on the part of healthcare professionals, and their nomadic lifestyle presenting barriers to registration (RCGP, 2013). In Scotland, a range of approaches were being employed by health boards to improve services for Gypsy/Travellers. These included outreach initiatives and health visits to sites, as well as linking patients directly to GP practices and dentists (Scottish Parliament, 2012). However, some GP practices refused to register Gypsy/Travellers on the grounds that they had no fixed address or photographic ID, or that they could not guarantee that	

					they would stay in the area for at least three months (Scottish Parliament, 2012). Migrants, refugees and asylum seekers The National Inclusion Health Board in England identified vulnerable migrants as people with particularly poor health, focusing specifically on low-paid or unemployed migrant workers, asylum seekers, refused asylum seekers, refugees, unaccompanied asylum-seeking children, undocumented migrants and trafficked persons (Inclusion Health, 2013). Its commissioning guide also noted both their poor health outcomes and the barriers they face in accessing healthcare, which include: language barriers; a lack of trust in people outside the migrant community; and suspicion of officials and government-supported services. The guide set out ways of identifying and meeting their needs through	

					Joint Strategic Needs Assessments and Joint Health and Well-being Strategies. Evidence about the health of migrants, refugees and asylum seekers (not in detention) is relatively limited. However, particular health concerns arise from the impact of relocation, possible past experience of trauma and from the impact of detention (particularly children). Delayed antenatal care entitlement checks put women at increased risk of pregnancy-associated complications; care was frequently received late and women received fewer antenatal appointments than the minimum standards for England (Shortall et al., 2015). Among migrants, Black African women had a mortality rate four times that of White women in the UK (Cantwell et al., 2011). Changes resulting from the Immigration Act 2014 mean temporary migrants who	

					were previously able to access free NHS care in England need to pay an additional charge, prior to entry, to cover potential NHS costs. There is some confusion about entitlement and the interpretation of regulations appears to be inconsistent, for instance people who are entitled to free treatment may have been charged in error (JCHR, 2007). This confusion means that migrants with complex immigration histories, and/or those who entered the UK prior to the introduction of the new rules, could be refused access to free healthcare, regardless of how long they have lived here (Grove-White, 2014). The Children's Society (2015) stated that charging undocumented migrant children for secondary healthcare threatened the health and wellbeing of the child, posed risks to public health, and prevented health	

					professionals from identifying child protection and safeguarding concerns. Refugees are entitled to free health care. Some asylum seekers whose applications are refused and have exhausted their appeal rights may cease to be entitled to it. However, the EU Fundamental Rights Agency (FRA) noted in 2013 that people are sometimes refused access to health care due to providers' confusion over eligibility rules (FRA, 2013). The Welsh Government introduced regulations in 2009 to allow refused asylum seekers to access free healthcare (Welsh Government, 2009). In 2016, it published a refugee and asylum seekers delivery plan which sets out priorities on health, wellbeing and social care (Welsh Government, 2016). In Scotland, asylum seekers who are refused and have unsuccessfully appealed	

					against the decision can still get health care from the NHS. Migrants may face barriers when seeking to register with GPs in England and Wales (FRA, 2013; Poduval et al., 2015). Registration has frequently been refused because people lack appropriate documents; practice managers and surgery staff sometimes feel pressurised by immigration authorities to check the status of patients who might have overstayed their visas. A study based on data from 2010/11 found that few refugees or asylum seekers had experienced any problems in accessing healthcare in Scotland (Scottish Refugee Council, 2011). Most of those who did were refused asylum seekers and reasons for non-registration included being asked for a letter from the Home Office, being new to the area, not knowing where to register or not having any	

					health problems. A study (Da Lomba and Murray, 2014) of refused asylum seekers' access to and experiences of maternity care in Glasgow found that, although women who had received a negative decision on their asylum claim experienced difficulties relating to language and information, they nonetheless received access to free NHS primary and secondary care. Some migrant communities suffer worse access to health than others. For example there is a body of evidence that suggests Chinese people make the least use of health services of all ethnic minority populations in the UK. This could be impacted by institutional racism within the NHS (where services are perhaps not designed to consider cultural norms), thus unwittingly excluding Chinese people from health services (Tong et al., 2014).	

42	Equality and human rights commission	Access to palliative and end of life care services for ethnic minorities	Studies reported lower access to palliative and end of life care services for ethnic minorities when compared with White British people.		Studies reported lower access to palliative and end of life care services for ethnic minorities when compared with White British people. This was associated with: a lack of referrals; a lack of awareness of relevant services; and previous bad experiences when accessing care. Furthermore, there was a lack of information in relevant languages or formats and family/religious values conflicting with the idea of hospice care (Calanzani et al., 2013). This suggests that the governments in England, Wales and Scotland need to urgently work with health commissioners and providers to improve practice. Evidence on deaths in London has shown that ethnicity is associated with where people die; on the whole, ethnic minorities are more likely to die in hospital and less likely to die at home or in a hospice than White	4.6

					people, but there are important differences between ethnicities (Koffman et al., 2014). In relation to country of birth, hospital deaths accounted for 52% of deaths of UK-born people, compared with 56% from the Caribbean, 58% from Asia, 58% from Africa and 64% from China. People born in Ireland were least likely to die in hospital (46%) (Koffman et al., 2014). In Scotland, research by Marie Curie (2015) found that Black, Asian and 'Other' ethnic minority communities are underrepresented among those using palliative care services. Many people who are coming to the end of their lives do not receive the care they need and people from different ethnic minorities have very different experiences of accessing care. The barriers that can stop people from different ethnic minorities accessing end of life care include language problems,	

					lack of awareness of palliative care within communities, and a lack of awareness and understanding by health professionals of the needs of ethnic minority communities (Marie Curie, 2015).	
43	Kidney Research UK	The provision of appropriate resources to support education – multi-language (getting the correct languages when needed), audio-visual format, images to reflect BAME target audience and so on.				4.6
44	Kidney Research UK	Using research (such as from Kidney Research UK) about what works in BAME communities to effectively engage on health issues and encourage positive lifestyle change.			https://academic.oup.com/ckj/article/8/5/623/472529/A-peer-outreach-initiative-to-increase-the?searchresult=1	4.6

45	Kidney Research UK	Using research (such as from Kidney Research UK) about BAME attitudes towards deceased organ donation to support donation awareness campaigns			See Clinical Kidney Journal August 2015: A peer outreach initiative to increase the registration of minorities as organ donors Jez Buffin1, Robert Little1, Neerja Jain2, and Anthony N. Warrens3 https://academic.oup.com/ckj/article/8/5/623/472529/A-peer-outreach-initiative-to-increase-the?searchresult=1	4.6
46	Mind	Respect, cultural appropriateness, and feeling safe and valued	These are different elements of making community engagement effective. Always important, they have particular relevance to mental health given different cultural framing of and attitudes to mental and emotional health. These elements are also very important to vulnerable migrants who are likely to experience fear and marginalisation.	Specifically it is important to: • use relatable and culturally sensitive language to open up a dialogue around mental health and wellbeing • harness local expertise and work with them to ensure support for BME communities is delivered in a respectful and culturally appropriate way • consider where support takes place, ensuring it's in a warm, positive, culturally and psychologically-informed space where BME communities can feel 'safe' and valued	Our work cited above is focused in this way. At the same time, public health interventions may be delivered in ways that provide safety and relevance across generations and ethnic groups (see Tottenham Thinking Space case study on p. 25 of our report Our communities, our mental health commissioning for better public mental health Our guidance for commissioning mental	4.6

					health services for adult vulnerable migrants sets out key aspects of involvement: "For migrant communities, [involvement in service planning and delivery] means being recognised, having a safe space to meet, providing mutual support, gaining knowledge, skills and confidence to engage more widely, being listened to with respect and receiving honest feedback about decisions."	
47	Mind	Co-production, bottom-up approaches	BME projects require and favour bottom-up and non-hierarchical developments as these maximise solutions with a better cultural fit	This underpins approaches to health promotion in BME communities. Continuing health inequalities (including young African Caribbean men's over-representation in mental health inpatient services) underline the need for it. There is a strong basis for this approach in NICE's public health and community engagement guidance, but it needs to go beyond engagement and accessing communities to genuine co-production of solutions.	Please see our partnership work with young African Caribbean men – • Up my street projects working with young African Caribbean men to help build resilience, reduce risk factors, and enable the wider community to support the mental health needs of their young people more effectively – publication due out very shortly • 300 Voices - focused on reducing the stigma and	4.6

					discrimination that can exist in statutory mental health settings and the police, using an engagement model described in this toolkit	
48	Mind	Embedding mental health				4.6
49	Mind	Acknowledgement and understanding of the impact of racism and discrimination on mental and physical health	This is important for understanding barriers, establishing relationships and identifying solutions.	Stigma and discrimination are a factor in the over-representation of some BME groups in mental health inpatient services, and may also be a factor in some groups' lack of access.	Reducing stigma and discrimination was the explicit objective of our 300 Voices work with Time to Change. The early findings of our peer support research indicate that for peer support groups in BME communities, common experiences, including of racism and discrimination, are important in establishing peer relationships.	4.6
50	National AIDS Trust	Improved access to healthcare services, particularly primary care, for migrants (including asylum seekers and those with irregular status).	While not all migrants are from black or ethnic minorities, a substantial proportion will be. Data suggests that migrants often have acute health needs, and are at an increased risk of communicable diseases including HIV, TB and	As mentioned above, those diagnosed late have significantly worse outcomes compared to those diagnosed promptly. While any migrant can regardless of immigration status register with a GP, there has been reported low registration amongst migrants. Some may also have difficulty in many instances registering where GP surgeries are not implementing	Please refer to the 2012 study 'Poor uptake of primary healthcare registration among recent entrants to the UK: a retrospective cohort study' which can be access via the link below: http://bmjopen.bmj.com/content/2/4/e001453	4.6

		Access to registration should be improved by targeting resources to migrants to increase awareness of eligibility for primary care among this group, as well as increasing awareness of their eligibility among GPs.	Hepatitis. In 2015, just over half of those newly diagnosed with HIV in England, where country of birth was known, were born abroad. Similarly, almost three quarters of TB cases notified in England in 2015 were born abroad. Chronic Hepatitis B disproportionately affects the non-UK born and ethnic minorities are more likely to be admitted to hospital or to die from liver disease because of Hepatitis C.	regulations correctly and turning migrants away. Recent work by Public Health England found that of a migrant cohort only 32% of migrants register with primary care after settling in the UK. In particular, migrants from Africa were less likely to register than other migrant groups. Migrant groups with the lowest proportion registered are likely to be those with the highest health needs. A lack of registration with primary care provides a barrier to being referred to other healthcare services and limits exposure to health promotion. Improved access to primary care for this marginalised group would significantly improve health outcomes.	Please refer to Public Health England's reports on HIV in the UK, Hepatitis C in England and TB in England: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/602942/HIV_in_the_UK_report.pdf https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/599738/hepatitis_c_in_england_2017_report.pdf https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/581238/TB_Annual_Report_2016_GTW2309_errata_v1.2.pdf	

51	NHS England	Commissioning	Culturally informed commissioning (which in effect is commissioning informed by the views and experiences of BME service users, their families and communities) will improve access and contribute to recovery. A commitment to effective and culturally appropriate mental health commissioning is therefore likely to reduce the overall morbidity from mental ill health in BME communities.	Achieving robust, ethical commissioning is crucial for achieving the first three key areas of improvement listed above.	Joint Commissioning Panel for Mental Health's Guidance for Commissioners of Mental Health Services for People from Black and Minority Ethnic Communities	4.6
52	Race Equality Foundation	Address communication inequality in relation to health inequalities for BME women. Need to improve experiences of health services	Poor communication support can leads to poor outcomes, lack of understanding, lack of adherence with medication, misdiagnosis, impact on patient choice eg understanding around maternity choice. Need to ensure community languages and British sign language interpreters are consistently provided		Local evidence eg Westminster BME Health forum research on maternity, local healthwatch reports eg Southwark, NHS England work in Principles of interpreting services. Race Equality Foundation work on scoping to produce a community languages information standard. See information pages here and literature review is available. Previous project on	4.6

					communication provision. An evaluation report is also available. Review of interpreting provision within primary care report. We have held small focus groups on maternity choice with BME women (as part of the current maternity choice agenda) highlight the need for interpreting provision to enable choice and have positive experience of maternity care. Poor experiences relayed consistently in patent experience surveys of BME patients.	
53	Royal College of Physicians	It is important to ensure recognition of enhanced risk of medical conditions when they affect certain black and minority ethnic groups			Examples: High blood pressure and stroke in diabetes, increase risk of renal disease, different manifestations of some mental health issues.	4.6

54	Royal College of Psychiatrists	Training needs in primary care for BME specific conditions	It's often reported that the lack of awareness of how different conditions might present differently in BME groups is a barrier to treatment and a lack of satisfaction in treatment for BME groups,	Clear standards and further evidence/review of literature would be very beneficial,		4.6
55	The Society and College of Radiographers	Community engagement	To realise the full potential of all members of society including BME groups.	Provision of decision making rights and voice in local decisions; community consensus to underpin local health priorities and outcomes. Address community/environmental factors in BME healthcare.		4.6
56	The Society and College of Radiographers	Health & Social Care staff development and training	Mobilise and enable staff to support and build health literacy for BME groups. To combat negative perceptions of healthcare and enable BME groups with a tailored understanding of issues specific to BME communities eg. BMI, obesity, diabetes – aim to improve healthcare access.	Address relationships between BME community and healthcare providers via staff engagement. All allied health professional, medics and nursing staff must have relevant training and support to develop culturally sensitive care tailored to specific needs of BME groups and be aware of local need.		4.6

57	Equality and human rights commission	Inequalities			In the 2011 Census, Gypsies and Travellers were found to suffer poorer physical health compared with the rest of the population in Britain: 14.1% in England and Wales rated their health as 'bad' or 'very bad'. In Scotland, a greater proportion of Gypsy/Travellers rated their health as 'bad' or 'very bad' (15%) compared with the average for Scotland (6%). Among migrants, Black African women had a mortality rate four times that of White women in the UK. The overall rate of infant mortality in Great Britain decreased between 2008 and 2013. The gap between the White population and other ethnic minorities decreased over this time. In 2012, the infant mortality rates (per 1,000 live births) in England and Wales were: White (3.4); Pakistani/Bangladeshi (6.5); and Black African/Caribbean infants (5.8). However,	4.7

					mortality numbers for ethnic minority populations are relatively small, leading to fluctuations between years. In 2013, the rates for the three ethnicities stood at 3.4, 6.3 and 6.5 respectively (ONS, 2015). In Scotland, data show that the percentage of foetal and infant deaths (combined) in 2012 where mothers were of British or Other European ethnicity was lower than the percentage of total births in those ethnicities in 2011/12. By contrast, in 2012, the percentage of deaths where the mother was from 'South Asian' and 'Other' ethnicity was higher than the percentage of total births in those ethnicities.	

58	Mind	General comment	Given our remit of mental health, that is the focus for our comments but we appreciate the standard will be broader in scope. However it will be important for the standard to consider physical and mental health equally and together.			4.7
59	Mind	General comment	Our comments are largely based on learning from our equality improvement work and may apply to other areas of health promotion. We've unpacked different elements of this learning, but some may practically sit together as one key area for improvement.		Our comments draw in particular on our work with BME groups, specifically young African Caribbean men, South Asian women, vulnerable migrants, together with peer support initiatives within BME communities and public health. Black African and Caribbean people living in the UK have lower reported rates of common mental health problems compared to other ethnic groups, however they are more likely to be diagnosed with severe mental health problems. Black African and Caribbean	4.7

					people are also much more likely to be detained under the Mental Health Act compared to other ethnic groups. Young women from ethnic minorities are much more likely to take their own life than White British women.	
60	Obesity Group of the British Dietetic Association	Emerging practice: A review of evidence of intensive weight loss programmes in this population in particular with regard to diabetes remission would be helpful.			A UK study is due to start later this summer in a South Asian population with type 2 diabetes.	4.7

61	OPENspace research centre, University of Edinburgh	Mental health inequalities are particularly pronounced: the risk of mental health problems is higher in black and ethnic minorities than for the general population (Equalities and Human Rights Commission 2016).		Urban green space offers an opportunity to protect against mental health problems including stress, depression and anxiety (WHO 2016)	Equality and Human Rights Commission (2016), Healing a divided Britain: the need for a comprehensive race equality strategy https://www.equalityhumanrights.com/sites/default/files/healing_a_divided_britain_-_the_need_for_a_comprehensive_race_equality_strategy_final.pdf World Health Organization 2016. Urban green spaces and Health – a review of the evidence http://www.euro.who.int/en/health-topics/environment-and-health/urban-health/publications/2016/urban-green-spaces-and-health-a-review-of-evidence-2016	4.7
62	Tees Esk and Wear Valleys NHS Foundation Trust	General comment	The Trust would wish to emphasise the importance of integration of the guidance within other health promotion programmes.			4.7

63	The Society and College of Radiographers	Emerging practice:			This is a difficult subject with so many papers and potential difficulties with cultural differences The definitions that NICE is using for minorities seems to fail to mention various white minorities such as Europeans in the UK and in particular the white Irish group and Gypsy and Traveller groups many of whom do have specific needs. Although outside of the scope of this standard as considering palliative and end of life care the attached paper has a good description of Ethnicity particularly in box 1 on page 12. https://www.mariecurie.org.uk/globalassets/media/documents/policy/policy-publications/june-2013/palliative-and-end-of-life-care-for-black-asian-and-minority-ethnic-groups-in-the-uk.pdf	4.7