Black, Asian and other minority ethnic groups: promoting health and preventing premature mortality

NICE quality standard

Draft for consultation

November 2017

This quality standard covers promoting health and preventing premature mortality among black, Asian and other minority ethnic groups.

It is for commissioners, service providers, health, public health and social care practitioners, and the public.

This is the draft quality standard for consultation (from 29 November 2017 to 3 January 2018). The final quality standard is expected to publish in April 2018.

Quality statements

Statement 1 People from black, Asian and other minority ethnic groups have their views represented in the setting of priorities and design of health and wellbeing programmes.

Statement 2 People from black, Asian and other minority ethnic groups are represented in peer and lay roles within local health and wellbeing programmes.

Statement 3 People from black, Asian and other minority ethnic groups who are at high risk of developing type 2 diabetes are referred to a behaviour change programme.

Statement 4 People from black, Asian and other minority ethnic groups referred to a cardiac rehabilitation programme are given choice of time and venue for the sessions and are followed up if they do not attend

Statement 5 People from black, Asian and other minority ethnic groups can access mental health services in a variety of community based settings.

Statement 6 People from black, Asian and other minority ethnic groups with serious mental illness have a physical health assessment at least annually.

NICE has developed guidance and a quality standard on patient experience in adult NHS services and service user experience in adult mental health services (see the NICE pathway on patient experience in adult NHS services and service user experience in adult mental health services) which should be considered alongside these quality statements.

Other quality standards published by NICE are relevant to promoting health and preventing premature mortality among people from black, Asian and other minority ethnic groups. They should be considered alongside this quality standard when commissioning or providing services for people from black, Asian or other minority ethnic groups.

A full list of NICE quality standards is available from the quality standards topic library.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 The quality standard has statements on specific conditions and on overarching principles for promoting health and preventing premature mortality. Is this approach appropriate and if not what alternative approach would you suggest?

Question 3 Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?

Question 4 Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement.

Local practice case studies

Question 5 Do you have an example from practice of implementing the NICE guidelines that underpin this quality standard? If so, please submit your example to NICE local practice case studies on the NICE website. Examples of using NICE quality standards can also be submitted.

Quality statement 1: Designing health and wellbeing programmes

Quality statement

People from black, Asian and other minority ethnic groups have their views represented in the setting of priorities and design of health and wellbeing programmes.

Rationale

Health and wellbeing programmes can support positive behaviour changes and contribute to promoting health and preventing premature mortality. Ensuring that the views of people from black, Asian and other minority ethnic groups are represented from the initial stage of the programme development helps to create services and offer support that is culturally appropriate and tailored to the needs of people from those ethnic groups.

Quality measures

Structure

a) Evidence of work carried out to gain understanding of ethnicity breakdown in local population.

Data source: Joint Strategic Needs Assessment.

b) Evidence of work carried out to gain understanding of the needs of black, Asian and other minority ethnic groups living in the local area.

Data source: Local data collection, for example, intelligence gathered for the Joint Strategic Needs Assessment.

c) Evidence of local arrangements to ensure that the views of people from black, Asian and other minority ethnic groups are represented in setting priorities for health and wellbeing programmes.

Data source: Local data collection, for example, from programme planning, records from meetings (agendas or minutes) and focus groups.

d) Evidence of local arrangements to ensure the views of people from black, Asian and other minority ethnic groups are represented in the design of health and wellbeing programmes.

Data source: Local data collection, for example, from service planning, records from meetings (agendas or minutes) and focus groups.

Process

Proportion of health and wellbeing programmes that sought the views of people from black, Asian and other minority ethnic groups during setting priorities and the design stage.

Numerator – the number in the denominator that sought the views of people from black, Asian and other minority ethnic groups during setting priorities and the design stage.

Denominator – the number of health and wellbeing programmes commissioned locally.

Data source: Local data collection, for example, service annual report.

Outcome

a) Uptake of health and wellbeing services among people from black, Asian and other minority ethnic groups.

Data source: Local data collection, for example, service workflow

b) Proportion of people from black, Asian and other minority ethnic groups referred to health and wellbeing services who feel that they meet their needs.

Data source: Local data collection, for example, service user survey.

c) Prevalence of obesity among people from black, Asian and other minority ethnic groups.

Data source: Active People Survey, Sport England and local data collection, for example, GP practice data.

d) Physical activity levels among people from black, Asian and other minority ethnic groups.

Data source: Active Lives, Sport England and local data collection, for example, review of service user records held by the provider.

e) Prevalence of tobacco use among people from black, Asian and other minority ethnic groups.

Data source: Office for National Statistics' Annual Population Survey and Local data collection, for example, stop smoking service data.

f) Mental wellbeing among people from black, Asian and other minority ethnic groups.

Data source: Local health data collection, for example mental health and wellbeing joint strategic needs assessment profile.

What the quality statement means for different audiences

Providers of wellbeing programmes, healthy lifestyle programmes, weight management services and smoking cessation services ensure that people from black, Asian or other minority ethnic groups have their views represented when the services and their offer are designed and reviewed. They should ensure that the services they provide reflect the views of people from black, Asian and other minority ethnic groups and are culturally appropriate, accessible and tailored to their needs.

Health, public health and social care practitioners ensure that they deliver services that are responsive to the priorities and needs of people from black, Asian and other minority ethnic groups.

Commissioners (Public Health England, NHS England, Local authorities, clinical commissioning groups), ensure that people from black, Asian and other minority ethnic groups have input into setting priorities and designing health and wellbeing programmes. This may be through ensuring that local population is represented well at the time of public consultation or community workshops that discuss future services. They also ensure that the services they commission have the skills mix and capacity to provide support that is culturally appropriate and tailored to the needs of

people from black, Asian and other minority ethnic groups to make positive behaviour changes.

People from black, Asian and other minority ethnic groups have their views represented when health and wellbeing programmes are designed and planned. They can get involved in the planning work and ensure that the programmes and services take into consideration their cultural background, language skills, customs and beliefs.

Source guidance

- Behaviour change: individual approaches (2014) NICE guideline PH49, recommendation 5
- Type 2 diabetes prevention: population and community-level interventions (2011) NICE guideline PH35, recommendation 2

Definitions of terms used in this quality statement

Health and wellbeing programmes

Health and wellbeing programmes cover all strategies, initiatives, services, activities, projects or research that aim to improve health (physical and mental) and wellbeing and reduce health inequalities. [Adapted from NICE's guideline on community engagement].

Quality statement 2: Peer and lay roles

Quality statement

People from black, Asian and other minority ethnic groups are represented in peer and lay roles within local health and wellbeing programmes.

Rationale

People from black, Asian and other minority ethnic groups should be represented in peer and lay roles within the local health and wellbeing programmes to ensure that the services and support are relevant and acceptable to the community. People who take on peer and lay roles can represent the needs and priorities specific to their ethnic groups but can also raise awareness of the available support among their communities. People in peer and lay roles may also be able to reach people from their communities who are not in touch with services or are socially isolated.

Quality measures

Structure

a) Evidence of local arrangements to ensure that the number of people from black, Asian and other minority ethnic groups taking on peer and lay roles for local health and wellbeing programmes is representative of the demographics of the local community.

Data source: Local data collection, for example, from service planning and service design records, and recruitment records.

b) Evidence of local arrangements to support people from black, Asian and other minority ethnic groups taking on peer and lay roles in local health and wellbeing programmes.

Data source: Local data collection, for example, records of meetings or workshops with people taking on peer and lay roles.

Process

a) Proportion of people working for local health and wellbeing programmes in peer and lay roles who are from black, Asian and other minority ethnic groups.

Numerator – the number in the denominator who are from black, Asian and other minority ethnic groups.

Denominator – the number of people working for local health and wellbeing programmes in peer and lay roles.

Data source: Local data collection, for example, from service annual reports.

b) Proportion of local health and wellbeing programmes with people working in peer and lay roles being representative of the local community.

Numerator – the number in the denominator with people working in peer and lay roles being representative of the local community.

Denominator – the number of local health and wellbeing programmes.

Data source: Local data collection, for example, from service annual reports.

Outcome

The number of people from black, Asian and other minority groups who access health and wellbeing programmes.

Data source: Local data collection, for example, review of service records.

What the quality statement means for different audiences

Service providers (primary care services, community care services and services in the wider public, community and voluntary sectors) ensure that they work together to recruit members of the local community who are representative of the local population. Once people have been recruited, service providers give them ongoing training and support to fulfil their responsibilities and reach their full potential.

Commissioners (community and voluntary sector organisations and statutory services) ensure that they dedicate resources to recruiting members of the local community to peer and lay roles and to provide them with ongoing training and support.

People from black, Asian and other minority ethnic group using health and wellbeing services are given support and information by members of their local

community who work within these services. Their interests and concerns are also represented by the people working in these services.

Source guidance

Community engagement: improving health and wellbeing and reducing health inequalities (2016) NICE guideline NG44, recommendation 1.3.1

Definitions of terms used in this quality statement

Health and wellbeing programmes

Health and wellbeing programmes cover all strategies, initiatives, services, activities, projects or research that aim to improve health (physical and mental) and wellbeing and reduce health inequalities. [Adapted from NICE's guideline on community engagement]

Peer and lay roles

'Peer and lay roles' are carried out by community members working in a non-professional capacity to support health and wellbeing initiatives. 'Lay' is the general term for a community member. 'Peer' describes a community member who shares similar life experiences to the community they are working with. Peer and lay roles may be paid or unpaid (that is, voluntary). Effective peer and lay approaches are:

- Bridging roles to establish effective links between statutory, community and voluntary organisations and the local community and to determine which types of communication would most effectively help get people involved.
- Carrying out 'peer interventions'. That is, training and supporting people to offer information and support to others, either from the same community or from similar backgrounds.
- Community health champions who aim to reach marginalised or vulnerable groups and help them get involved.
- Volunteer health roles whereby community members get involved in organising and delivering activities.

[NICE's guideline on community engagement]

Representation in peer and lay role

The number of people from black, Asian and other minority ethnic groups taking on peer and lay roles for local health and wellbeing programmes representative of the demographics of the local community.

Quality statement 3: Referring people at high risk of type 2 diabetes

Quality statement

People from black, Asian and other minority ethnic groups who are at high risk of developing type 2 diabetes are referred to a behaviour change programme.

Rationale

People from certain ethnic communities have a higher risk of developing type 2 diabetes than the white European population. This includes people of South Asian, Chinese, black African and African-Caribbean family origin. In these populations, the risk of type 2 diabetes increases at an earlier age and at a lower BMI level. Behavioural interventions, which support people to maintain a healthy weight and be more active, can significantly reduce the risk of developing the condition.

Quality measures

Structure

Evidence of local arrangements to trigger actions to prevent diabetes among black, Asian and other minority ethnic groups.

Data source: Local data collection, for example, GP contracts.

Process

a) Proportion of people from black, Asian and other minority ethnic groups who are at high risk of type 2 diabetes and are referred to a behaviour change programme.

Numerator – the number in the denominator who are referred to a behaviour change programme.

Denominator – the number of people from black, Asian and other minority ethnic groups who are at high risk of type 2 diabetes.

Data source: The Diabetes UK and NHS Digital National diabetes audit and local data collection, for example, GP patient records or data providers such as Commissioning Support Units (CSUs).

b) Proportion of people from black, Asian and other minority ethnic groups referred to a behaviour change programme who attended the programme.

Numerator – the number in the denominator who attended a behaviour change programme.

Denominator – the number of people from black, Asian and other minority ethnic groups who are at high risk of type 2 diabetes referred to a behaviour change programme.

Data source: The Diabetes UK and NHS Digital National diabetes audit and local data collection, for example, GP patient records or data providers such as CSUs.

c) Proportion of people from black, Asian and other minority ethnic groups referred to a behaviour change programme who completed the programme.

Numerator – the number in the denominator who completed a behaviour change programme.

Denominator – the number of people from black, Asian and other minority ethnic groups who are at high risk of type 2 diabetes referred to a behaviour change programme.

Data source: The Diabetes UK and NHS Digital National diabetes audit and local data collection, for example, GP patient records or data providers such as CSUs.

Outcome

a) BMI among people from black, Asian and other minority ethnic groups completing behaviour change programmes.

Data source: Local data collection, for example, GP patient records.

b) Blood pressure among people from black, Asian and other minority ethnic groups completing behaviour change programmes.

Data source: Local data collection, for example, GP patient records.

c) HbA1c among people from black, Asian and other minority ethnic groups completing behaviour change programmes.

Data source: Local data collection, for example, GP patient records.

d) Proportion of individuals enrolled into the NHS Diabetes Prevention Programme from black, Asian and other minority ethnic group.

Data source: Local data collection, for example, data from the local behaviour change service providers.

e) Prevalence of type 2 diabetes among people from black, Asian and other minority groups.

Data source: The Diabetes UK and NHS Digital National diabetes audit and Public Health England's Diabetes prevalence estimates for local populations.

What the quality statement means for different audiences

Service providers (such as GPs and community healthcare providers) ensure that systems are in place to trigger action to prevent diabetes at a lower BMI threshold and to refer people from black, Asian and other minority ethnic group who are at high risk of developing type 2 diabetes to a behaviour change programme.

Health and public health practitioners (such as GPs, practice nurses and community healthcare providers) are aware that some black, Asian and other minority ethnic groups have an increased risk of type 2 diabetes. They refer people who are at high risk to a behaviour change programme and provide people at low and increased risk with appropriate advice.

Commissioners (clinical commissioning groups and NHS England) ensure that a range of behaviour change interventions is available for the health and public health practitioners to refer people from black, Asian and other minority ethnic groups at high risk of diabetes.

People from black, Asian and other minority ethnic group are informed about their risk of diabetes and receive information and further support relevant to their

needs. If they are at high risk of type 2 diabetes, they are referred to services that can help them lose weight and be more active.

Source guidance

- BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups (2013) NICE guideline PH46, recommendation 1
- Type 2 diabetes: prevention in people at high risk (2012, updated 2017) NICE guideline PH38, recommendation 1.5.4

Definitions of terms used in this quality statement

Behaviour change programme

Tailored, personalised help to reduce the risk of type 2 diabetes, including education on healthy eating and lifestyle, help to lose weight and bespoke physical exercise programmes. [NHS Diabetes prevention programme]

High risk of type 2 diabetes

High risk is defined as a fasting plasma glucose level of 5.5–6.9 mmol/l or an HbA1c level of 42–47 mmol/mol (6.0–6.4%). These terms are used instead of specific numerical scores because risk assessment tools have different scoring systems. Examples of risk assessment tools include: Diabetes risk score assessment tool, QDiabetes risk calculator and Leicester practice risk score. Risk can also be assessed using the NHS Health Check. [NICE's guideline on preventing type 2 diabetes in people at high risk]

NICE guideline PH46 specifically recommends using lower thresholds (23 kg/m2 to indicate increased risk and 27.5 kg/m2 to indicate high risk) for BMI to trigger action to prevent type 2 diabetes among Asian (South Asian and Chinese) populations.

Quality statement 4: Cardiac rehabilitation

Quality statement

People from black, Asian and other minority ethnic groups referred to a cardiac rehabilitation programme are given choice of time and venue for the sessions and are followed up if they do not attend.

Rationale

Cardiac rehabilitation programmes improve clinical outcomes for people who have had a cardiac event. Providing people from black, Asian and other ethnic minority groups with a choice of when and where they can access cardiac rehabilitation programmes can increase uptake. The programmes and options available should be culturally appropriate and follow up should be provided to motivate people to start or to continue with the programme.

Quality measures

Structure

a) Evidence of local arrangements to discuss any factors that might stop people from black, Asian or other minority ethnic groups from attending a cardiac rehabilitation programme, before they receive a referral.

Data source: Local data collection, for example, from service level agreement.

b) Evidence of local arrangements to provide cardiac rehabilitation sessions for people from black, Asian and other minority ethnic groups in a variety of settings including at home, in the community or in a hospital.

Data source: Local data collection, for example, from service level agreements.

c) Evidence of local arrangements to provide cardiac rehabilitation sessions for people from black, Asian and other minority ethnic groups at a choice of times of day, for example, sessions outside of working hours.

Data source: Local data collection, for example, from service level agreements.

Process

a) Proportion of people from black, Asian and other minority ethnic groups referred to a cardiac rehabilitation programme who are offered sessions in a variety of settings including home, the community or a hospital.

Numerator – the number in the denominator offered sessions in a variety of settings including home, the community or a hospital.

Denominator – the number of people from black, Asian and other minority ethnic groups referred to a cardiac rehabilitation programme.

Data source: Local data collection, for example, from patient records.

b) Proportion of people from black, Asian and other minority ethnic groups referred to cardiac rehabilitation programme who did not start the programme who were contacted with a reminder.

Numerator – the number in the denominator who were contacted with a reminder.

Denominator – the number of people from black, Asian and other minority ethnic groups referred to a cardiac rehabilitation programme who did not start the programme.

Data source: Local data collection, for example, from patient records.

c) Proportion of people from black, Asian and other minority ethnic groups who stopped attending the cardiac rehabilitation programme who were contacted with a reminder.

Numerator – the number in the denominator who were contacted with a reminder.

Denominator – the number of people from black, Asian and other minority ethnic groups referred to a cardiac rehabilitation programme who stopped attending the programme.

Data source: Local data collection, for example, from patient records.

Outcome

a) Rates of uptake and adherence to cardiac rehabilitation programmes among people from black, Asian and other minority ethnic groups.

Data source: National data on the uptake of cardiac rehabilitation are available from the National Audit of Cardiac Rehabilitation (NACR). Local data collection, for example, from cardiac rehabilitation programme data collection system.

b) Level of satisfaction with cardiac rehabilitation programmes among people from black, Asian and other minority ethnic groups.

Data source: Local data collection, for example, surveys carried out with people referred to cardiac rehabilitation.

What the quality statement means for different audiences

Service providers (secondary and tertiary care services) ensure they provide individualised support for people from black, Asian and other minority ethnic groups to attend and continue with cardiac rehabilitation programmes. This may include offering cardiac rehabilitation programmes at different times of day and at different venues, providing a varied range of exercise to ensure that acceptable and culturally appropriate options are available, and following up people to motivate them to continue with the programme.

Healthcare professionals identify barriers to attending cardiac rehabilitation programme and offer individualised support to people from black, Asian and other minority ethnic groups. They offer cardiac rehabilitation programmes at different times of day and at different venues and follow up people to motivate them to continue with the programme.

Commissioners (clinical commissioning groups) commission cardiac rehabilitation services that have the capacity and expertise to provide people from black, Asian and other minority ethnic groups with programmes that are acceptable and culturally appropriate for them. They also ensure that the services support people from black, Asian and other minority ethnic groups to attend and adhere to the programme by addressing the barriers to participation.

People from black, Asian and other minority ethnic groups referred to a cardiac rehabilitation programme are supported to attend and keep going to the sessions. This might mean that sessions are available at venues and times convenient to the person or sessions are acceptable to them culturally, for example, single sex or with bilingual staff.

Source guidance

- Myocardial infarction: cardiac rehabilitation and prevention of further cardiovascular disease (2013) NICE guideline CG172, recommendations 1.1.1 and 1.1.9
- Chronic heart failure in adults: management (2010) NICE guideline CG108, recommendation 1.3.1.1

Definitions of terms used in this quality statement

Cardiac rehabilitation

Cardiac rehabilitation is defined as a coordinated and structured programme designed to remove or reduce the underlying causes of cardiovascular disease, as well as to provide the best possible physical, mental and social conditions, so that people can, by their own efforts, continue to play a full part in their community and through improved health behaviour, slow or reverse progression of the disease. Cardiac rehabilitation should consist of a multidisciplinary, integrated approach delivering care in lifestyle risk factor management, psychosocial health, medical risk factor management and the optimal use of cardioprotective therapies, underpinned by psychologically informed methods of health behaviour change and education [NICE's guideline on myocardial infarction, full guideline]

Cardiac rehabilitation programmes should include a range of interventions with health education, lifestyle advice, stress management and physical exercise components. [NICE's guideline on myocardial infarction, recommendations 1.1.1 and 1.1.19]

Quality statement 5: Support for people with mental health problems

Quality statement

People from black, Asian and other minority ethnic groups can access mental health services in a variety of community based settings.

Rationale

Mental health services may be more accessible and culturally appropriate for people from black, Asian and other minority ethnic groups if they are provided in non-traditional community-based settings, such as a person's home or other residential settings, community centres and social centres. This may help to increase the uptake of mental health interventions by these groups.

Quality measures

Structure

a) Evidence of local arrangements to improve access to mental health services for people from black, Asian and other minority ethnic groups.

Data source: Local data collection, for example, from local commissioning plans.

b) Evidence of local arrangements to ensure that mental health services are provided in a variety of settings that people from black, Asian and other minority ethnic groups can choose from.

Data source: Local data collection, for example, from service level agreements.

Process

Proportion of people from black, Asian and other minority ethnic groups accessing mental health services who are offered support in community-based settings.

Numerator – the number in the denominator offered support in community-based settings.

Denominator – the number of people from black, Asian and other minority ethnic groups accessing mental health support.

Data source: Local data collection, for example, from patient records.

Outcome

a) Rates of uptake of mental health support among people from black, Asian and other minority ethnic groups.

Data source: Local data collection for example, from GP records.

b) Proportion of people from black, Asian and other minority ethnic groups who complete treatment from mental health services.

Data source: Local data collection for example, from GP records.

c) Levels of satisfaction with mental health services among people from black, Asian and other minority ethnic groups.

Data source: Local data collection, for example, surveys carried out with people referred to mental health services.

What the quality statement means for different audiences

Service providers (such as GP practices, community health services, mental health services and independent providers) collaborate with local communities, healthcare professionals and commissioners to develop local care pathways that promote access to mental health services for people from black, Asian and other minority ethnic groups. They should ensure that services are provided in settings accessible and acceptable to people from black, Asian and other minority ethnic groups with mental health problems.

Healthcare professionals offer people from black, Asian and other minority ethnic groups different options for where they can access mental health support. They also collaborate with service providers and commissioners to develop local care pathways that promote access to services for people from black, Asian and other minority ethnic groups with mental health problems.

Commissioners (such as clinical commissioning groups, NHS England local area teams and local authorities) collaborate with healthcare professionals and service providers to develop local care pathways that promote access to services for people from black, Asian and other minority ethnic groups with mental health problems. They ensure that mental health services are provided in a variety of settings and a range of support is available to facilitate access and uptake of services among people from black, Asian and other minority ethnic groups.

People from black, Asian and other minority ethnic groups can access mental health services in a location and of their choice, which may include their own home, a community or social centre, or a GP or other community health clinic.

Source guidance

Common mental health problems: identification and pathways to care NICE guideline CG123, recommendation 1.1.1.7

Definitions of terms used in this quality statement

Community-based settings

Community-based settings include the person's home or other residential settings, community centres and social centres [NICE's guideline on common mental health problems, recommendation 1.1.1.7]

Quality statement 6: Physical health checks for people with serious mental illness.

Quality statement

People from black, Asian and other minority ethnic groups with serious mental illness have a physical health assessment at least annually.

Rationale

Life expectancy for adults with a serious mental illness is significantly lower than for people in the general population. People from some black, Asian and other minority ethnic groups are at an increased risk of cardiovascular disease and type 2 diabetes and these conditions can be exacerbated by the use of antipsychotics. An annual health check helps to pick up on early signs of physical health conditions, such as diabetes or heart disease, and can trigger actions to prevent worsening health.

Quality measures

Structure

a) Evidence of local arrangements to ensure that people from black, Asian and other minority ethnic groups with a serious mental illness have a physical health assessment at least annually.

Data source: Data can be collected using NHS England's Commissioning for Quality Innovation (CQUIN) indicator Improving physical healthcare to reduce premature mortality in people with serious mental illness and Quality and Outcomes Framework (QOF).

b) Evidence of local primary and secondary care services working together to monitor and address the physical health needs of people affected by serious mental illness as part of the Rethink Mental Health Integrated Physical Health Pathway.

Data source: Local data collection, for example, from contracts or local service agreements.

Process

Proportion of people from black, Asian and other minority ethnic with serious mental illness who have had a physical health assessment within the past 12 months.

Numerator – the number in the denominator who have had a physical health assessment within the past 12 months.

Denominator – the number of people from black, Asian and other minority ethnic groups with serious mental illness.

Data source: Data can be collected using NHS England's CQUIN indicator Improving physical healthcare to reduce premature mortality in people with severe mental illness and local data collection, for example, from practice risk registers.

Outcome

Premature mortality rates among people from black, Asian and other minority ethnic groups with serious mental illness.

Data source: Local data collection, for example, from practice risk registers.

What the quality statement means for different audiences

Service providers (such as GPs, community health services and mental health services) have systems in place to ensure that physical health assessments are carried out at least annually for people from black, Asian and other minority ethnic groups with a severe mental illness, and that the results are shared (under shared care arrangements) when the service user is in the care of both primary and secondary services.

Health care practitioners carry out physical health assessments at least annually for people from black, Asian and other minority ethnic groups with a serious mental illness, and share the results (under shared care arrangements) when the service user is in the care of both primary and secondary services.

Commissioners (such as NHS England local area teams and local authorities) ensure that they commission services that can demonstrate they are carrying out physical health assessments at least annually in people from black, Asian and other

minority ethnic groups with a serious mental illness, and include this requirement in continuous training programmes. They also ensure that shared care arrangements are in place when the service user is in the care of both primary and secondary services, to ensure that the results of assessments are shared.

People from black, Asian and other minority ethnic groups with serious mental health problems have regular health checks (at least once a year). This is to check for problems that are common in people being treated for a serious mental illness, such as weight gain, diabetes, and heart, lung and breathing problems. The results are shared between their GP surgery and mental health team.

Source guidance

- Psychosis and schizophrenia in adults: prevention and management (2014) NICE guideline CG178, recommendations 1.5.3.2 and 1.5.3.3
- Bipolar disorder: assessment and management (2014) NICE guideline CG185, recommendations 1.2.10 to 1.2.14

Definitions of terms used in this quality statement

Serious mental health illness

Schizophrenia, bipolar affective disorder or other psychoses. [indicator specification, NHS Digital, 2016]

Physical health assessment

The health check should be comprehensive and focusing on physical health problems such as cardiovascular disease, diabetes, obesity and respiratory disease. The annual check should include:

- weight or BMI, diet, nutritional status and level of physical activity
- cardiovascular status, including pulse and blood pressure
- metabolic status, including fasting blood glucose, glycosylated haemoglobin (HbA1c) and blood lipid profile
- liver function
- renal and thyroid function, and calcium levels, for people taking long‑term lithium

[Adapted from NICE's guideline on bipolar disorder, recommendations 1.2.11 and 1.2.12]

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See quality standard advisory committees on the website for details of standing committee 3 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available on the quality standard's webpage.

This quality standard has been incorporated into the NICE pathway on [topic] [link to pathway and add further pathways if the QS is included in multiple pathways)].

NICE has produced a quality standard service improvement template [add correct link] to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and

Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Improving outcomes

This quality standard is expected to contribute to improvements in the following outcomes:

- prevalence of excess weight and obesity among black, Asian and other minority ethnic groups
- physical activity levels among minority ethnic groups
- tobacco use among minority ethnic groups
- prevalence of diabetes among minority ethnic groups
- diabetes related morbidity among minority ethnic groups
- premature mortality from cardiovascular disease among minority ethnic groups
- inequality in hospital admissions and detentions under the Mental Health Act between people from minority ethnic groups and the general population using mental health services.

It is also expected to support delivery of the Department of Health's outcome frameworks:

- Adult social care outcomes framework 2015–16
- NHS outcomes framework 2016–17
- Public health outcomes framework for England, 2016–19.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance.

Diversity, equality and language

During the development of this quality standard, equality issues were considered and equality assessments are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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