Quality standards advisory committee 3

Black, Asian and other minority ethnic groups: promoting health and preventing premature mortality and Eating disorders – Prioritisation meeting

Minutes of the meeting held on 20th September 2017 at the NICE offices in Manchester

Attendees	**Standing Quality Standards Advisory Committee (QSAC) members** Hugh McIntyre (chair), Jim Stephenson, Ivan Benett, Amanda De La Motte, Keith Lowe, Malcolm Fisk, Ulrike Harrower, Ben Anderson, Jane Ingham, Madhavan Krishnaswamy, Darryl Thompson, Asma Khalil, David Pugh, Ann Nevinson, Barry Attwood, Deryn Bishop, Nadim Fazlani, Eve Scott, Susannah Solaiman **Specialist committee members** **BAME groups** Tauseef Mehrali, Jill Dunbar, Abdul Ghafoor, Nayab Nasir, Irfan Syed, Andrew Smith **Eating disorders** Dasha Nicholls, Hannah Turner, Andrea Morrall, Ursula Philpot, Jessica Parker **NICE staff** Nick Baillie (NB), Julie Kennedy (JK), Ania Wasielewska (AW) {items 4-5}, Sabina Keane (SK) {items 8-9}, Jamie Jason (JJ), Rick Keen (RK) **NICE Observers** Nicola Bodey, Craig Grime, Richard Barratt
Apologies	**Quality standards advisory committee (QSAC) standing members** Helen Bromley, Julia Thompson

Agenda item	Discussions and decisions – BAME groups	Actions
1. Welcome, introductions and plan for the day (private session)	The Chair welcomed the attendees and the quality standards advisory committee (QSAC) members introduced themselves. The Chair informed the committee of the apologies and reviewed the agenda for the day.	
2. Committee business (public session)	**Declarations of interest** The Chair asked standing QSAC members to declare any interests that were either in addition to their previously submitted declaration or specific to the topic(s) under consideration at the meeting today. The Chair asked the specialist committee members to declare all interests. The following interests were declared: <u>Specialist committee members</u> <u>Andrew Smith</u> • None <u>Tauseef Mehrali</u> • None <u>Irfan Syed</u> • None <u>Jill Dunbar</u> • Member of PHAC E Pharmacy Committee. <u>Abdul Ghafoor</u> • None **Minutes from the last meeting** The committee had not reviewed the minutes of the last meeting held on 17th May 2017 and JJ was asked to circulate them.	JJ to circulate minutes from the May meeting
3. QSAC updates	No updates.	

Agenda item	Discussions and decisions – BAME groups	Actions
4 and 4.1 Topic overview and summary of engagement responses	AW presented the topic overview. AW highlighted some of the challenges of the scope of this quality standard and a summary of responses received during the topic engagement. Before the areas were discussed a comment was made regarding the use of 'community/area' and whether the inequalities experienced by BAME groups were more due to economic disadvantage, poor housing and deprivation more than ethnicity. The committee discussed the fact that data on ethnicity is not recorded on death certificates. Although it was acknowledged this is outside the remit of NICE, the committee agreed it should be noted as it impacts on the ability to develop meaningful quality standards.	▪ **Add a bullet for mental health in the briefing paper page 4**
4.2 Prioritisation of quality improvement areas	The Chair and AW led a discussion in which areas for quality improvement were prioritised. It was discussed that the committee felt constrained by the response of stakeholders as it restricts their ability to deal with issues of access and equality. It was noted there were other potential areas such as, tuberculosis, obstetrics and deprivation that were no being explored through this process. The committee agreed that their discussions and the content of the quality standard does not attempt to capture the breadth of health inequalities faced by black and minority ethnic groups. It should not be seen as doing so and is just a starting point. The committee raised concerns about the heterogeneity of the population included in this topic and the different definitions of BAME groups that are applied locally. The committee were advised that the areas for discussion were raised by stakeholders, in line with the process, and that stakeholders will be asked at consultation if the issues prioritised are the right areas for the topic. It was also agreed that areas prioritised would be linked to recommendations developed in existing guidelines and standards. The QSAC considered the draft areas as outlined in the briefing paper prepared by the NICE team. The outcome of discussions is detailed below.	

Suggested quality improvement area	Prioritised (yes/no)	Rationale for prioritisation decision	If prioritised, which specific areas to be included?
Lifestyle advice & behaviour change	**Y**	The committee discussed linking weight management and physical activity with diabetes &	**Technical team to explore the option of writing a**

a) Weight management b) Physical activity c) Tobacco use		CVD prevention and management. It was highlighted that impact of lifestyle interventions is difficult to measure. An issue of engagement was raised – the committee discussed the challenge of engaging some BAME communities in healthcare schemes despite significant efforts. The committee heard that key, integrated members of these communities needed to be recruited, to facilitate the healthcare schemes in the community. It was perceived as a quantifiable effort, with clear data showing effectiveness. The committee highlighted that guidance and quality standards on lifestyle changes and diseases already exist. The committee discussed how important it is for the commissioners to understand their communities. They highlighted the Joint Strategic Needs Assessment (JSNA) as a process which is already used to gain this knowledge but there is a need to make the link between this process and the communities. Localising it further by community engagement approaches such as health champions. The committee suggested that the focus of the quality standard should be on population inequalities, rather than a disease-based approach. The committee discussed a statement around commissioners and providers being able to demonstrate their understanding of different needs and how this understanding influences the commissioning of services.	**statement on understanding the needs of the population.**

Diabetes a) Type 2 diabetes	**Y**	The committee highlighted that there already are screening programmes in place such as the NHS health checks and the NHS Diabetes Prevention Programme (NHS DPP), which would facilitate identifying people at risk of diabetes. They also highlighted that the uptake is still an issue especially within BAME communities. The committee discussed the resources already available, the barriers to accessing these resources and examples of good practice. The committee agreed to progress a statement on diabetes and increasing screening uptake as a quality improvement area.	**Technical team to progress a statement on type 2 diabetes.**
Cardiovascular disease a) High blood pressure b) Cardiac rehabilitation	**Y**	The committee discussed that the issues surrounding cardiovascular disease within BAME communities were closely interlinked with Type 2 diabetes and lifestyle changes and thus, it was agreed that further discussion was not necessary. The committee noted the poor uptake of cardiac rehabilitation in BAME populations and agreed that improving uptake of was an area for improvement.	**Technical team to draft a statement on cardiac rehabilitation.**
Mental health a) Hospital admissions and formal detention b) Psychological therapies c) Perinatal mental health support d) Physical Health checks	**Y**	The committee noted there are already numerous quality statements in support of psychological therapies and the statement needs to address more than the therapies. The committee highlighted that access to mental health services is poor among the BAME community. Some of the barriers mentioned were lack of understanding or knowledge of the services and language barriers. Culturally appropriate services and commissioning	**Technical team to draft a statement on people from BAME communities receiving psychological support from mental health services.** **Technical team to draft a statement on physical health checks for people with mental health problems.**

		were discussed by the committee – differences between BAME communities were highlighted. The committee heard that commissioners and providers should be encouraged to access the necessary data that indicates whether or not their practice is appropriate and effective for BAME communities. It was agreed that data collection should not be the primary focus of the quality statement. The committee agreed to focus on accessing the right mental health care from the time of crisis and to prevent the crisis. The committee agreed to focus on physical health checks as a quality improvement area.	
Blood-borne viruses a) Hepatitis B & C b) HIV	**N**	The committee discussed potential to cluster Hepatitis B & C and HIV as blood borne viruses. They also highlighted that testing for TB could fit into this statement and area for quality improvement. The committee also discussed the heterogeneity of the populations and the complexity of risk factors. The committee heard about the recent QS on HIV which focused on destigmatising and normalising HIV testing as part of generic blood testing. The committee agreed that this area should not be prioritised as an area for quality improvement due to the variation in population, prevalence and risk factors as well as the potential to stigmatise specific groups within the population.	**No action.**

Additional areas suggested	Committee rationale	Area progressed (Y/N)
Access to end of life care	Out of scope – the QS focus is on promoting health or preventing premature mortality.	**N**
Appropriate resources to support education	Not a separate area for quality improvement – to be built into supporting information where relevant.	**N**
Community engagement	This area is already covered by a separate QS on community engagement (QS148).	**N**
Culturally informed commissioning	Technical team to explore if this element can be built into the first statement.	**Y**
Respect, cultural appropriateness, and feeling safe and valued	Not a separate area for quality improvement - important underpinning concepts for all quality statements	**N**
Impact of racism and discrimination on health	Not a separate area for quality improvement - important underpinning concepts for all quality statements	**N**
Organ donation amongst black, Asian and other minority ethnic groups	There are no recommendations in NICE guidelines to support this statement.	**N**
Recording ethnicity for people with diabetes	Not a separate area for quality improvement - will be highlighted in the supporting information for any relevant quality statements.	**N**
Research on black, Asian and other ethnic minority communities	This is a principle of quality standard development rather than an area of quality improvement.	**N**
Training for primary care health professionals	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.	**N**
Uptake of cancer screening	There are no recommendations in NICE guidelines to support this statement.	**N**

5. Resource impact	It was agreed that resource impact would be considered but not elaborated on at this stage. A member of the resource impact team observed the meeting to clarify areas for quality improvement and potential resource impact considerations.	
5.1 Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on BAME groups. It was agreed that the committee would contribute suggestions as the quality standard was developed.	
5.2 Equality and diversity	The NICE team explained that equality and diversity considerations should inform the development of the quality standard, and asked the committee to consider any relevant issues. It was agreed that the	

	committee would contribute suggestions as the quality standard was developed.	
	Discussions and decisions – Eating disorders	**Actions**
6. Committee business (public session)	**Declarations of interest** The Chair asked standing QSAC members to declare any interests that were either in addition to their previously submitted declaration or specific to the topic(s) under consideration at the meeting today. The Chair asked the specialist committee members to declare all interests. The following interests were declared: <u>Specialist committee members</u> <u>Hannah Turner</u> • Teaching and supervising CBT • Research and publications in CBT <u>Dasha Nicholls</u> • Dasha works for a Foundation Trust that receives national referrals outside the scope of typical commissioning pathways. The role and profile in national policy in the field is a factor in attracting referrals. Dasha has no direct financial benefit. • Dasha has co-edited a book for which she receives modest royalties. The book is about management of medical risk in eating disorders based on guidance that is cited in the NICE NG69 guideline for eating disorders. <u>Ursula Philpot</u> • Ursula is the British Dietetic Association representative on the clinical advisory group for the clinical reference group for eating disorders. <u>Jessica Parker</u> • None <u>Andrea Morrall</u> • Andrea is an Employee of Sheffield Health and Social Care Foundation Trust	
7 and 7.1 Topic	SK presented the topic overview and a summary of responses received during engagement on the topic.	

overview and summary of engagement responses		
7.2 Prioritisation of quality improvement areas	The Chair and SK led a discussion in which areas for quality improvement were prioritised. The QSAC considered the draft areas as outlined in the briefing paper prepared by the NICE team. The outcome of discussions is detailed below.	

Suggested quality improvement area	Prioritised (yes/no)	Rationale for prioritisation decision	If prioritised, which specific areas to be included?
Identification and assessment a) Identification and initial assessments in primary and secondary mental health care b) Referral	**N**	The committee discussed the need for early intervention and access with variation highlighted across region and age groups. Mandatory data reporting in the under 18 age group was highlighted as available due to annual national funding. In contrast, adult services were reported as currently limited. The committee also discussed the importance of suspecting eating disorders in primary care. It was however agreed as there are no recommendations on this area in NICE NG69 guideline this will not be prioritised as a quality improvement area. Overall it was agreed not to prioritise identification and assessment as a specific quality improvement area as this could be captured within the next sections on 'treating eating disorders' and final section on 'access and coordinated care'.	
Treating eating disorders a) Treating anorexia	**Y**	The committee discussed the range of treatments for eating disorders.	**The committee agreed to progress 2 statements: Psychological treatment for anorexia nervosa in adults, young people and children in line with NICE NG69**

nervosa b) Psychological treatment for anorexia nervosa, binge eating disorder and bulimia nervosa in adults c) Psychological treatment for anorexia nervosa and bulimia nervosa in children and young people		The committee stated the issues surrounding treatment access as a consistent issue across all age groups. It was noted that as the treatments have a broad scope with not one specific type of treatment appropriate for each eating disorder the NICE team will have to review and focus on specific treatment actions if possible to aid measurability and clarity. The committee agreed to prioritise 2 statements on psychological treatments for anorexia nervosa and guided self-help programmes specifically for binge eating disorders for adults, young people and children.	**guideline recommendations 1.3.10-1.3.17.** **Psychological treatment for binge eating disorder in adults, young people and children in line with NICE NG69 guideline recommendation 1.4.2.**
Physical health assessment, monitoring and management for all eating disorders a) Physical and mental health comorbidities b) Physical health assessment and monitoring for all eating disorders c) Assessment and monitoring of physical health in anorexia nervosa	**Y**	The committee discussed how collaborative working and monitoring varies by region. Collaboration between eating disorder specialists and other healthcare teams was discussed as being crucial when supporting and monitoring effective treatment and management of physical and mental comorbidities by using outcome measures. A physical and mental health GP review for people with anorexia nervosa who are not receiving ongoing treatment for their eating disorder was discussed. However, it was agreed not to prioritise this as a specific quality improvement area as implementation in primary care may be difficult due to GPs having limited relevant expertise of eating disorders. The committee agreed to prioritise a statement on collaborative working between eating disorder specialists and other relevant healthcare teams.	**The committee agreed to progress a statement on eating disorder specialists and other healthcare teams working collaboratively in line with NICE NG69 guideline recommendations 1.8.1 and 1.8.2**
Access and coordinated care	**N**	The committee discussed service access and the lack of continuity of care between inpatient	

a) Improving access to services b) Coordination of care for people with an eating disorder c) Inpatient and day patient treatment d) Working with family members and carers		and outpatient services. Transition between the healthcare services was also highlighted as an issue. For example, students living away from home and their lack of support during holiday periods. The committee agreed to cover coordinated care as an equality and diversity consideration (please see section below). Overall it was agreed not to prioritise this as a specific quality improvement area as this area will be covered within the prioritised statements.	

Additional areas suggested	**Committee rationale**	**Area progressed (Y/N)**
Access to specialist registered dietitian within community eating disorder teams for nutritional therapy	There are no recommendations on this area within the development source NICE NG69.	**N**
Diabetes	NICE team to explore including diabetes as an outcome measure.	**Y**
MARSIPAN regional hubs and networks	There are no recommendations on this area within the development source NICE NG69.	**N**
Occupational therapy	There are no recommendations on this area within the development source NICE NG69.	**N**
Psychological interventions with no current randomised controlled trials	It is not within the remit of NICE quality standards to reassess the evidence of psychological interventions within the NICE guideline.	**N**
Training and competencies	Quality statements on staff training are not usually included in quality standards as healthcare professionals involved in assessing, caring for and treating people with eating disorders should have sufficient and appropriate training and competencies. Training may enable quality improvement to take place but is not considered as a quality improvement area.	**N**

8. Resource impact	Potential costs were noted in relation to treatments for binge eating in adults. Also additional GP time would be needed to carry out a physical and mental health review. In general the committee felt the statements were cost neutral.	
8.1 Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on eating disorders. It was agreed that the committee would contribute suggestions as the quality standard was developed.	
8.2 Equality and diversity	The NICE team explained that equality and diversity considerations should inform the development of the quality standard, and asked the committee to consider any relevant issues. It was agreed that the committee would contribute suggestions as the quality standard was developed. The committee suggested: • British minority ethnic groups having equal access to eating disorder services • Young men having equal access to treatments and inpatient beds • Students supported during their transition between university and home	
9. Next steps and timescales (part 1 – open session)	SK outlined what will happen following the meeting and key dates for the eating disorder quality standard.	
10. Any other business	**Date of next meeting for BAME groups and Eating disorders: 24th January 2018** **Date of next QSAC 3 meeting: 22nd November 2017**	