

Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups

Quality standard

Published: 11 May 2018

www.nice.org.uk/guidance/qs167

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This standard is based on PH49, PH35, NG44, PH38, CG123, CG178, CG185, NG106, NG185, NG183 and CG189.

Quality statements

Statement 1 People from Black, Asian and other minority ethnic groups have their views represented in setting priorities and designing local 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 at high risk of type 2 diabetes are referred to an intensive lifestyle change programme.

Statement 4 People from Black, Asian and other minority ethnic groups referred to a cardiac rehabilitation programme are given a choice of times and settings 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 a serious mental illness have a physical health assessment at least annually.

Quality statement 1: Designing health and wellbeing programmes

Quality statement

People from Black, Asian and other minority ethnic groups have their views represented in setting priorities and designing local health and wellbeing programmes.

Rationale

Health and wellbeing programmes can support positive behaviour changes and contribute to promoting health and preventing premature mortality. People from Black, Asian and other minority ethnic groups may not engage with services or may have a poor experience of those programmes and associated services if they are not culturally sensitive and appropriate. Involving people, community organisations and faith leaders who can represent the views of local minority ethnic groups helps to ensure that the services reflect the needs and preferences of the local population.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of work carried out to gather intelligence about the ethnic diversity of the local population.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, intelligence gathered for the 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: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, intelligence gathered for the joint strategic needs assessment.

c) Evidence of actions taken to gather views of local people from Black, Asian and other minority ethnic groups on priorities for and design of health and wellbeing programmes.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from programme planning, records from meetings (agendas or minutes) and focus groups.

d) Evidence of how intelligence on ethnic diversity, the needs and views of the local population is used to inform commissioning.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, information included in local health equality assessments.

Process

a) Proportion of local health and wellbeing programmes that gathered views of people from Black, Asian and other minority ethnic groups when setting priorities and designing the programmes.

Numerator – the number in the denominator that gathered views of people from Black, Asian and other minority ethnic groups when setting priorities and designing the programmes.

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

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and

provider organisations, for example, service annual reports.

b) Proportion of people representing the views of Black, Asian and other minority ethnic groups involved in setting priorities and designing local health and wellbeing programmes who felt that their views were valued.

Numerator – the number in the denominator that felt their views were valued.

Denominator – the number of people representing the views of Black, Asian and other minority ethnic groups involved in setting priorities and designing local health and wellbeing programmes.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, surveys carried out with people representing ethnic groups.

Outcome

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

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, service workflow.

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

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, service user surveys.

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

Data source: [NHS Digital's Health Survey for England](#) and [National Child Measurement Programme](#), and local data collection, for example, GP practice data.

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

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

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

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, mental health and wellbeing joint strategic needs assessment profiles.

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 the services they provide recognise the beliefs, expectations and values of local people from Black, Asian and other minority ethnic groups. They continually review the services to ensure that they are culturally appropriate, accessible and tailored to the diverse needs of the local population.

Health, public health and social care practitioners recognise the beliefs, expectations and values of local people from Black, Asian and other minority ethnic groups that they support. They ensure that the services they provide are culturally appropriate and accessible. This may mean working in partnership with existing local community groups or faith leaders who can support delivering some of the programmes in non-traditional community-based settings.

Commissioners (Public Health England, NHS England, local authorities and integrated care systems) gather intelligence and gain understanding of the diversity of the local

population and its needs. They ensure that the views of people from minority ethnic groups are represented when priorities are set and local health and wellbeing programmes are designed. This may be through engaging local communities using public consultation or community workshops that discuss future services. These can ensure that the local population is represented by individuals as well as established community groups and educational or religious leaders. The commissioners also ensure that local services 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 advise on what local health and wellbeing programmes should focus on and what culturally sensitive and acceptable services should look like. They share their views during workshops or consultations organised by the commissioners, or through other people who they trust, such as community leaders or faith leaders.

Source guidance

- [Behaviour change: digital and mobile health interventions. NICE guideline NG183 \(2020\)](#), recommendations 1.1.6 and 1.1.8
- [Behaviour change: individual approaches. NICE guideline PH49 \(2014\)](#), recommendation 5
- [Type 2 diabetes prevention: population and community-level interventions. NICE guideline PH35 \(2011\)](#), 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](#)]

Equality and diversity considerations

Due to language and communication difficulties or past experiences of racism and prejudice, some people from Black, Asian and other minority ethnic groups may not have had a positive experience of accessing services. This may prevent them from engaging with services and increase their risk of poor health outcomes. Commissioners and providers seeking to obtain the views and understand the needs of people from Black, Asian and other minority ethnic groups should work closely with existing community groups, faith leaders and educators who may already have links to groups and individuals with poor access to services.

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 are underrepresented in health and wellbeing programmes. To ensure that the programmes are accessed and used by minority ethnic groups, commissioners and providers need to recognise the knowledge, skills and expertise of local communities. People known to and trusted by communities can take on peer and lay roles and encourage uptake of services among groups that may otherwise be reluctant to get involved. They can raise awareness, deliver information and advice in a culturally appropriate manner, and help with designing and providing interventions and services that are relevant, acceptable and tailored to the local population.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local arrangements to ensure that people from Black, Asian and other minority ethnic groups are represented in peer and lay roles for local health and wellbeing programmes.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, 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: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, records of meetings, mentoring sessions, existing support networks or workshops with people taking on peer and lay roles.

Process

Proportion of local health and wellbeing programmes with people working in peer and lay roles who are representative of the local community.

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

Denominator – the number of local health and wellbeing programmes.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service annual reports.

Outcome

a) The number of people from Black, Asian and other minority groups who access local health and wellbeing programmes.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, review of service records.

b) The number of people in peer and lay roles supporting Black, Asian and other minority ethnic groups to improve their health and wellbeing.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, review of service records.

c) Experience of engaging with local health and wellbeing programmes among people from Black, Asian and other minority groups.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, service user surveys.

d) Long-term retention of people in peer and lay roles.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, service annual reports.

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 with established community groups and educational or religious leaders to identify and recruit members of the local community who can support people from Black, Asian and other minority ethnic groups and represent the diverse needs of the local population. They ensure that people in lay roles are supported with resources, information and mechanisms to proactively engage members of the community who may be excluded or disengaged. Service providers also support people in peer and lay roles with feedback, support networks, training and mentoring to allow them to fulfil their responsibilities, reach their full potential and continue with the role.

Commissioners (community and voluntary sector organisations and statutory services) understand the diversity of their local community and make a long-term commitment to funding and supporting effective community engagement approaches, such as peer and lay roles. They secure resources to recruit people to peer and lay roles and provide them with ongoing training and support.

People from Black, Asian and other minority ethnic groups are given support and information by other members of their own community who are working closely with organisations that provide local health and wellbeing services. These people represent the interests and concerns of the community and ensure that local health and wellbeing

programmes and services recognise the beliefs, expectations and values of people from Black, Asian and other minority ethnic groups.

Source guidance

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

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](#)]

Equality and diversity considerations

Due to language and communication difficulties or past experiences of racism and prejudice, some people from the Black, Asian and other minority ethnic groups may not have had a positive experience of accessing services. This may prevent them from engaging with services and increase their risk of poor health outcomes. People in peer and lay roles may be more successful at engaging with and supporting people from similar backgrounds than traditional health and wellbeing services.

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

Quality statement

People from Black, Asian and other minority ethnic groups at high risk of type 2 diabetes are referred to an intensive lifestyle change programme.

Rationale

People from certain ethnic communities have a higher risk of developing type 2 diabetes than those in 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 body mass index (BMI) level. Many cases of type 2 diabetes are preventable through changes to a person's diet and physical activity levels. Evidence-based intensive lifestyle change programmes can significantly reduce the risk of developing type 2 diabetes for those at high risk.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements for identifying and referring people from Black, Asian and other minority ethnic groups at high risk of type 2 diabetes.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, GP contracts.

Process

a) Proportion of people from Black, Asian and other minority ethnic groups identified as being at high risk of type 2 diabetes who are referred to an intensive lifestyle change programme.

Numerator – the number in the denominator who are referred to an intensive lifestyle change programme.

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

Data source: The [Diabetes UK and NHS Digital's 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 an intensive lifestyle change programme who attended the programme.

Numerator – the number in the denominator who attended an intensive lifestyle 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 an intensive lifestyle change programme.

Data source: The [Diabetes UK and NHS Digital's 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 an intensive lifestyle change programme who completed the programme.

Numerator – the number in the denominator who completed an intensive lifestyle 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 an intensive lifestyle change programme.

Data source: The [Diabetes UK and NHS Digital's National Diabetes Audit](#) and local data collection, for example, GP patient records or data providers such as CSUs.

Outcome

a) Change in BMI among people from Black, Asian and other minority ethnic groups completing intensive lifestyle change programmes.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, GP patient records.

b) Change in blood pressure among people from Black, Asian and other minority ethnic groups completing intensive lifestyle change programmes.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, GP patient records.

c) Change in HbA1c among people from Black, Asian and other minority ethnic groups completing intensive lifestyle change programmes.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, GP patient records.

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

Data source: The [Diabetes UK and NHS Digital's 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 people from Black, Asian and other minority ethnic groups who are identified as being at high risk

of developing type 2 diabetes are referred to an intensive lifestyle change programme. They also ensure that systems are in place to start diabetes prevention interventions at a lower BMI threshold in people from minority ethnic groups at increased risk of type 2 diabetes. This may involve people in peer and lay roles raising awareness, assessing risks and providing advice on diabetes prevention among those ethnic minorities.

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 an intensive lifestyle change programme and provide advice to those with a lower level of risk.

Commissioners (integrated care systems, NHS England and local authorities in sustainability and transformation partnership areas) ensure that intensive lifestyle change programmes are available for people from Black, Asian and other minority ethnic groups at high risk of type 2 diabetes. They work with ethnic minorities to ensure that programmes include a range of culturally sensitive and appropriate behaviour change interventions.

People from Black, Asian and other minority ethnic group at high risk of type 2 diabetes are referred to culturally sensitive and appropriate services that can help them achieve a healthy weight and be more active. Those who are not currently at high risk of type 2 diabetes are given information and further support relevant to their needs.

Source guidance

- [Obesity: identification, assessment and management. NICE guideline CG189](#) (2014, updated 2022), recommendation 1.2.8
- [Type 2 diabetes: prevention in people at high risk. NICE guideline PH38](#) (2012, updated 2017), recommendation 1.5.4

Definitions of terms used in this quality statement

Intensive lifestyle change programme

A structured and coordinated range of interventions provided in different venues for people identified as being at high risk of developing type 2 diabetes. It should be local,

evidence-based and quality-assured. The aim is to help people to become more physically active and improve their diet. If the person is overweight or obese, the programme should result in weight loss. Programmes may be delivered to individuals or groups (or involve a mix of both) depending on the resources available. They can be provided by primary care teams and public, private or community organisations with expertise in dietary advice, weight management and physical activity. [[NICE's guideline on preventing type 2 diabetes in people at high risk, glossary](#)]

High risk of type 2 diabetes

High risk is defined as a fasting plasma glucose level of 5.5 to 6.9 mmol/litre or an HbA1c level of 42 to 47 mmol/mol (6.0% to 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 type 2 diabetes: prevention in people at high risk, glossary](#)]

Lower thresholds (23 kg/m² to indicate increased risk and 27.5 kg/m² to indicate high risk) should be used for BMI to trigger action to prevent type 2 diabetes among people with a South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background compared to those used for the general population. [[NICE's guideline on obesity: identification, assessment and management, recommendation 1.2.8](#)]

Equality and diversity considerations

Due to language and communication difficulties, or past experiences of racism and prejudice, some people from Black, Asian and other minority ethnic groups may find it difficult to engage with services. Intensive lifestyle change programmes need to be culturally appropriate, accessible and tailored to the diverse needs of the local population.

Quality statement 4: Cardiac rehabilitation

Quality statement

People from Black, Asian and other minority ethnic groups referred to a cardiac rehabilitation programme are given a choice of times and settings 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. However, uptake among people from Black, Asian and other ethnic minority groups is lower than in the general population. Providing programmes that are culturally appropriate and sensitive, at settings and times that are convenient can increase uptake. Following up people who do not attend allows for a discussion about potential barriers to attendance and how to overcome them. It also gives the opportunity to motivate people to start or to continue with the programme.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

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: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service level agreements.

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: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, 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, for example, sessions outside working hours.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, 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: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

b) Proportion of people from Black, Asian and other minority ethnic groups referred to a 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: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

c) Proportion of people from Black, Asian and other minority ethnic groups who missed their cardiac rehabilitation appointment 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 participating in a cardiac rehabilitation programme who missed their appointment.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

a) Rate of uptake of 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 [British Heart Foundation's national audit of cardiac rehabilitation](#). Local data collection, for example, from cardiac rehabilitation programme data collection system.

b) Rates of 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 [British Heart Foundation's national audit of cardiac rehabilitation](#). Local data collection, for example, from cardiac rehabilitation programme data collection system.

c) Service user experience among people from Black, Asian and other minority ethnic groups who accessed cardiac rehabilitation programmes.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, 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 working on overcoming barriers with people who are not willing to engage with services due to poor past experiences or ensuring that the programmes are run on different days, at different times and at venues that are culturally appropriate and convenient. Providers also ensure that a varied range of acceptable and culturally sensitive exercise is available, and people are followed up to continue with the programme.

Healthcare professionals (such as cardiologists and cardiac nurses) identify barriers to attending a cardiac rehabilitation programme and offer individualised support to people from Black, Asian and other minority ethnic groups. They offer cardiac rehabilitation programmes on different days, at different times and venues (such as community centres or places of worship) and ensure that they are culturally appropriate and suitable. Healthcare professionals also follow-up people to motivate them to continue with the programme or understand the obstacles that may prevent people from using the service.

Commissioners (integrated care systems) 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 suitable, acceptable and culturally appropriate. 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 that the sessions are acceptable to them culturally, for example, single sex or with bilingual staff.

Source guidance

- [Acute coronary syndromes. NICE guideline NG185 \(2020\)](#), recommendations 1.8.1 and 1.8.9
- [Chronic heart failure in adults: diagnosis and management. NICE guideline NG106 \(2018\)](#), recommendation 1.9.1

Definitions of terms used in this quality statement

Cardiac rehabilitation

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.

Cardiac rehabilitation programmes should include a range of interventions with health education, lifestyle advice, stress management and physical exercise components. [[NICE's guideline on acute coronary syndromes](#), full guideline and recommendations 1.8.1 and 1.8.19]

Equality and diversity considerations

Due to language and communication difficulties, or past experiences of racism and prejudice, some people from the Black, Asian and other minority ethnic groups may find it difficult to engage with services. Also, some traditions and religious practices may stop people from accessing services on certain days or certain times of the day. Behaviour change programmes need to acknowledge those differences, be culturally appropriate, accessible and tailored to the diverse needs of the local population.

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

People from Black, Asian and other minority ethnic groups are less likely to access mental health treatment than the general population. Mental health illness can be associated with a considerable stigma among people from Black, Asian and other minority ethnic groups. Some people may find community-based services, such as a person's home or other residential settings, community centres and social centres, more appealing, accessible and culturally appropriate than traditional healthcare services. To help combat the stigma and encourage people with mental health problems to access support early, the services need to be visible, accessible and responsive to the needs of the local population.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

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: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, 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: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, 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 services.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

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

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, 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: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from GP records.

c) Service user experience among people from Black, Asian and other minority ethnic groups who accessed mental health services.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, 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 and people from Black, Asian and other minority ethnic groups, healthcare professionals and commissioners to develop local care pathways that promote mental health services tailored to the needs of the local population. They 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 (such as GPs, psychiatrists, mental health nurses) offer people from Black, Asian and other minority ethnic groups different options for where they can access mental health support to ensure they can choose acceptable and culturally appropriate services. They also collaborate with service providers, commissioners, communities and people from Black, Asian and other minority ethnic groups to develop local care pathways that promote mental health services tailored to the needs of the local population.

Commissioners (such as integrated care systems and local authorities) collaborate with local communities, people from Black, Asian and other minority ethnic groups, healthcare professionals and service providers to develop local care pathways tailored to the needs of the local population. 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 are given a choice of places to access mental health support. Locations may include their own home, a community or social centre, a GP practice or other local health clinic.

Source guidance

Common mental health problems: identification and pathways to care. NICE guideline CG123 (2011), 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]

Equality and diversity considerations

Stigma attached to mental health problems among people from the Black, Asian and other minority ethnic groups and fear of being sectioned or having children taken away by social services may stop people from accessing mental health support early. To ensure they are culturally appropriate and tailored to the diverse needs of the local population, members of the community should be involved in designing and reviewing the services as well as represented in peer and lay roles to ensure good links into the community.

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

Quality statement

People from Black, Asian and other minority ethnic groups with a 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 and enables action to be taken to prevent worsening health.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

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: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, using [NHS England's practical toolkit for mental health](#)

trusts and commissioners.

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: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, using NHS England's practical toolkit for mental health trusts and commissioners.

Process

Proportion of people from Black, Asian and other minority ethnic groups with a 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 a serious mental illness.

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

Outcome

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

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

b) Prevalence of type 2 diabetes among people from Black, Asian and other minority ethnic groups with a serious mental illness.

Data source: Local data collection, for example, GP patient records or data providers such as Commissioning Support Units (CSUs).

What the quality statement means for different audiences

Service providers (such as GPs or 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 serious mental illness. The results are shared (under shared care arrangements) when the service user is in the care of both primary and secondary services. Service providers may involve people in peer and lay roles to support raising awareness of the increased risks and importance of physical health checks among people from Black, Asian and other ethnic minority groups with a serious mental illness.

Healthcare professionals (such as GPs or nurses) carry out physical health assessments at least annually for people from Black, Asian and other minority ethnic groups with a serious mental illness. They share the results (under shared care arrangements) when the service user is in the care of both primary and secondary services. They also highlight the increased risks and importance of physical health checks to people from Black, Asian and other ethnic minority groups with a serious mental illness.

Commissioners (such as NHS England local area teams) 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. NICE guideline CG178 \(2014\), recommendations 1.5.3.2 and 1.5.3.3](#)

- [Bipolar disorder: assessment and management. NICE guideline CG185 \(2014, updated 2020\)](#), recommendations 1.2.10 to 1.2.14

Definitions of terms used in this quality statement

Serious mental illness

Schizophrenia, bipolar affective disorder and other psychoses. [Adapted from [NICE's guideline on psychosis and schizophrenia in adults](#) and [NICE's guideline on bipolar disorder](#)]

Physical health assessment

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

- weight or body mass index (BMI), diet, nutritional status and level of physical activity
- cardiovascular status, including pulse and blood pressure
- metabolic status, including fasting blood glucose or 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]

Update information

Minor changes since publication

September 2022: Changes have been made to align this quality standard with the [NICE guideline on obesity: identification, assessment and management](#). Links and source guidance references have been updated throughout.

February 2022: The definition of physical health assessment in statement 6 was amended to be clear that either fasting blood glucose or glycosylated haemoglobin (HbA1c) can be used to assess for diabetes, in line with [NICE's 2021 exceptional surveillance of testing for diabetes](#).

November 2020: The source guidance reference for statement 1 was updated to include [NICE's guideline on behaviour change: digital and mobile health interventions](#). For statement 4, the source guidance reference was updated to align this quality standard with the new [NICE guideline on acute coronary syndromes](#).

September 2018: The source guidance for statement 4 was changed to align this quality standard with the updated [NICE guideline on chronic heart failure in adults](#).

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 our [webpage on quality standards advisory committees](#) for details about our standing committees. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](#).

NICE has produced a [quality standard service improvement template](#) 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 guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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. Organisations are encouraged to use the resource impact products for the source guidance to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](#) 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.

ISBN: 978-1-4731-2934-4

Endorsing organisation

This quality standard has been endorsed by Department of Health and Social Care, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [Race Equality Foundation](#)
- [Diabetes UK](#)
- [Chartered Society of Physiotherapy](#)
- [Royal College of Physicians \(RCP\)](#)
- [Mind](#)
- [British Dietetic Association](#)