

## 1.0.7 DOC EIA

# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

## NICE quality standards

# Equality impact assessment

## Eating disorders

The impact on equality has been assessed during quality standard development according to the principles of the NICE equality policy.

### 1. TOPIC ENGAGEMENT STAGE

1.1 Have any potential equality issues been identified during this stage of the development process?
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No equality issues have been identified at this stage.
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1.2 Have any population groups, treatments or settings been excluded from coverage by the quality standard at this stage in the process. Are these exclusions justified – that is, are the reasons legitimate and the exclusion proportionate?
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This quality standard will not include the below:
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- people with disordered eating because of a physical health problem or another primary mental health problem of which a disorder of eating is a symptom (for example, depression)
- people with feeding disorders, such as pica or avoidant restrictive food intake disorders (for example, food avoidance emotional disorder or picky/selective eating)
- people with obesity without an eating disorder.

These population groups are covered by a number of other NICE guidelines.
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Completed by lead technical analyst SABINA KEANE

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Approved by NICE quality assurance lead MARK MINCHIN

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### 2. PRE-CONSULTATION STAGE

2.1 Have any potential equality issues been identified during the development of the quality standard (including those identified during the topic engagement process)? How have they been addressed?

In draft statement 1 and in line with NICE NG69 recommendation [1.1.2](#) the QSAC advised that the draft quality standard should ensure that people with an eating disorder and their parents or carers (as appropriate) have equal access to services and treatments (including through self-referral) for eating disorders regardless of:

- age
- gender or gender identity (including people who are transgender)
- sexual orientation
- socioeconomic status
- religion, belief, culture, family origin or ethnicity
- where they live and who they live with
- any physical or other mental health problems or disabilities.

In particular, the under representation of ethnic minority groups and pregnant women accessing specialist eating disorders services was highlighted. Also, males with eating disorders were reported as experiencing barriers and reluctance to attending group therapies or inpatient/day patient facilities.

It was also highlighted that people with an eating disorders should have the opportunity to finish the course of treatment even if they move between services as mentioned in statement 6.

2.2 Have any changes to the scope of the quality standard been made as a result of topic engagement to highlight potential equality issues?

No changes have been made to the scope of the quality standard at this stage.

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2.3 Do the draft quality statements make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?

Draft quality statement 2 focuses on a discussion between healthcare professionals and people with eating disorders about psychological treatment options to suit needs and preferences. Patient choice is important during these discussions. However, it has been highlighted that for some people there may be an additional need for clinical opinion, for example, people with high-risk anorexia nervosa can have avoidant behaviour so may have difficulty deciding on their treatment.

Also for draft quality statements 2 and 4 family therapy as a psychological treatment option is not appropriate for children and young people who have been abused by family members or those who are in care.

Draft quality statement 3 focuses on the provision of binge-eating-disorder-focused guided self-help programmes. Information in the self-help materials included in these programmes should be in a format that suits their needs and preferences.

2.4 Is there potential for the draft quality statements to have an adverse impact on people with disabilities because of something that is a consequence of the disability?

For draft quality statement 3 for people with additional needs related to a disability, impairment or sensory loss, self-help information should be provided as set out in NHS England's [Accessible Information Standard](#). This also applies to draft quality statements 5 and 6 on coordinated care plans, transition protocols and risk assessment.

2.5 Are there any recommendations or explanations that the committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in questions 2.1, 2.2 or 2.3, or otherwise fulfil NICE's obligation to advance equality?

Draft statements 3 on self-help information and draft statements 5 and 6 on coordinated care plans, transition protocols and risk assessment should all be in a format that suits individual's needs and preferences. They should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter or advocate if needed.

Completed by lead technical analyst SABINA KEANE

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