1.0.7 DOC EIA

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE guidelines

Equality impact assessment

Chronic heart failure

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

3.0 Guideline development: before consultation (to be completed by the developer before draft guideline consultation)

3.0 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?
• Transfer of care between secondary and primary heart failure services. Recommendations have been made to promote collaboration and improve communication between health professionals who are delivering care to patients with heart failure within different health care settings. This includes ensuring care plans are developed and communicated to the multidisciplinary team and patient, having a named healthcare co-ordinator as a contact person, changes made to care plans are communicated with the appropriate staff within the team, and when the patient transfers from one setting to another, such as hospital to GP, communication links are maintained and information flows to facilitate the patient's care moving smoothly between primary and secondary care services according to need. • Home-based rehabilitation packages . Recommendations have been made for personalised exercise based rehabilitation to be provided in a format and setting that is easily accessible for the person. This could be at the hospital in the community or at the person's home. • Information and support on diagnosis and prognosis for patients and carers Recommendations have been made specifically on providing information on the person's diagnosis and prognosis in an open and honest way. For people newly diagnosed an extended consultation should be offered to allow enough time to discuss and explain treatments and to answer questions patients and their carers may have. All patients to be given a

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summary of their diagnosis, treatments and a copy of their care plan including contact details for a healthcare coordinator.

- How to manage chronic heart failure in people over the age of 75. Recommendations on providing rehab programmes within the home and community will facilitate access for an older population who may be frail and not able to travel distances to access these services.
  An older population are more likely to have co-morbidities and on multiple medication for different conditions. Recommendations have been made on what monitoring should be carried out when people are receiving pharmacological treatment for their heart failure. This includes those with chronic kidney disease, atrial fibrillation and directing to other guidance such as the hypertension guideline, medicines optimisation, and medicines adherence. A recommendation has been made for primary care services to recall patients every 6 months as a minimum to review their condition and update the care plan if necessary. Elderly frail patients with limited mobility are often not reviewed by their GP or by heart failure clinics, until they become acutely unwell. A regular review is designed to prevent this.

2. More elderly patients have heart failure with preserved ejection fraction. A significant proportion is due to trans-thyretin (TTR) amyloidosis

The original objective of this question was to see if certain imaging techniques could identify a particular subset of amyloid-HFPEF that may respond to a new treatment.

There are various imaging techniques that can be used to diagnose amyloid HFPEF, including cardiac MRI and bone scintography using DPD tracing. During scoping the view was that the amyloidosis question would complete the diagnostic picture, sitting alongside the question on cardiac MRI imaging for the general HF population. However, as we did not identify any evidence for the effectiveness of cardiac MRI in improving outcomes for the general population of HF patients, the GC were of the view that it would not be appropriate for the guideline to consider, and potentially recommend, secondary imaging for a very narrow subset of HFPEF patients. The focus of the guideline is to provide general, population level advice and this is a specialised sub-condition in a narrow subset of patients. Reviewing the evidence on a particular imaging technique for amyloidosis would be disproportionate in the scheme of a population-level guideline, and therefore this question was dropped from the guideline. An explanation of this is given in MRI linking evidence to recommendations section of the guideline.

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3.1 Have any **other** potential equality issues (in addition to those identified during the scoping process) been identified, and, if so, how has the Committee addressed them?
Yes The committee were aware of evidence showing that NT-proBNP levels are lower in people of west African family origin and are a confounder in the diagnosis of heart failure. Because of the high incidence of heart failure with preserved ejection fraction in these populations a recommendation was amended to include these populations. Be aware that: • obesity, African or African-Caribbean family origin, or treatment with diuretics, angiotensin-converting enzyme (ACE) inhibitors, beta-blockers, angiotensin II receptor antagonists (ARBs) or mineralocorticcoid receptor antagonists (MRAs) can reduce levels of serum natriuretic peptides

3.2 Were the Committee's considerations of equality issues described in the consultation document, and, if so, where?
The committee discussed equality issues throughout the development of the guideline and this has been highlighted in the Linking evidence to recommendations sections of the full guideline. See the following chapters: rehabilitation, pharmacological treatment, transfer between heart failure care settings, communication needs, and cardiac magnetic resonance imaging.

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3.4 Do the preliminary recommendations 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?
No

3.5 Is there potential for the preliminary recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability?
no

3.6 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 3.1, 3.2 or 3.3, or otherwise fulfil NICE's obligation to advance equality?

Completed by Developer: Gill Ritchie, Guideline Lead

Date: 25/01/2018

Approved by NICE quality assurance lead: Nichole Taske

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