NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

CLINICAL GUIDELINE EQUALITY IMPACT ASSESSMENT - RECOMMENDATIONS

Clinical guideline: Dyspepsia and gastro-oesophageal reflux disease: investigations and management of dyspepsia, symptoms suggestive or gastro-oesophageal reflux disease or both

1. Have the equality areas identified during scoping as needing attention been addressed in the guideline?

Please confirm whether:

- the evidence reviews addressed the areas that had been identified in the scope as needing specific attention with regard to equality issues (this also applies to consensus work within or outside the GDG)
- the GDG has considered these areas in their discussions.

Note: some issues of language may correlate with ethnicity; and some communication issues may correlate with disability

What issue was identified and what was done to address it?	**Was there an impact on the recommendations? If so, what?**
During the scoping process no specific groups were identified as needing specific attention. The aim of the guideline was to consider all adults (18 years and older) who receive healthcare in all settings within NHS services, irrespective of gender, ethnicity, disability, religion or beliefs, sexual orientation and gender identity or socio-economic status.	
Other comments	

Insert more rows as necessary.

2. Have any equality areas been identified *after* scoping? If so, have they have been addressed in the guideline?

Please confirm whether:

- the evidence reviews addressed the areas that had been identified after scoping as needing specific attention with regard to equality issues (this also applies to consensus work within or outside the GDG)
- the GDG has considered these areas in their discussions.

Note: some issues of language may correlate with ethnicity; and some communication issues may correlate with disability

What issue was identified and what was done to address it?	**Was there an impact on the recommendations? If so, what?**
When considering the evidence to identify what characteristics/symptoms of GORD or symptoms suggestive of GORD indicated the need for an endoscopy to exclude Barrett's oesophagus specific subgroups were recognised by the GDG. They felt the aim of an endoscopy was to rule out Barrett's oesophagus as people with Barrett's oesophagus may have a higher risk of developing gastrointestinal cancers. Any risk factors (or predictors) that could accurately predict Barrett's oesophagus should be included to inform their decision-making. The GDG felt the evidence supported the inclusion of risk factors such as gender, duration and frequency of GORD or GORD symptoms.	Therefore the following recommendation was made: *Do not routinely offer endoscopy to diagnose Barrett's oesophagus, but consider it if the person has GORD. Discuss the person's preferences and their individual risk factors (for example, long duration of symptoms, increased frequency of symptoms, previous oesophagitis, previous hiatus hernia, oesophageal stricture or oesophageal ulcers or male gender).*
As there was limited evidence available to say whether surveillance should be used for people with Barrett's oesophagus to detect progression to cancer the GDG, based on their expertise and knowledge, agreed that a sub group of people may benefit from endoscopic surveillance based on their preferences and risk factors. They also acknowledged that people with low risk of progression to cancer should be made aware that the harms of endoscopic surveillance may outweigh the benefits.	Therefore the following recommendation was made: *Consider surveillance to check progression to cancer for people who have a diagnosis of Barrett's oesophagus (confirmed by endoscopy and histopathology), taking into account:* • *the presence of dysplasia (also see Barrett's oesophagus - ablative therapy [NICE clinical guideline CG106]* • *the person's individual preferences* • *the person's risk factors (for example, male gender, older age and the length of the Barrett's oesophagus segment).* *Emphasise that the harms of endoscopic surveillance may outweigh the benefits in people who are at low risk of progression to cancer (for example people with stable, non-dysplastic Barrett's oesophagus).*

Other comments

Insert more rows as necessary.

3. Do any recommendations make it impossible or unreasonably difficult in practice for a specific group to access a test or intervention?

For example:

- does access to the intervention depend on membership of a specific group?
- does using a particular test discriminate unlawfully against a group?
- would people with disabilities find it impossible or unreasonably difficult to receive an intervention?

No recommendations have been identified as making it impossible or unreasonably difficult in practice for a specific group to access a test or intervention

4. Do the recommendations promote equality?

State if the recommendations are formulated so as to advance equality, for example by making access more likely for certain groups, or by tailoring the intervention to specific groups.

Recommendations are worded and formulated to promote equalities whilst taking into account people's individual needs and preferences.

5. Do the recommendations foster good relations?

State if the recommendations are formulated so as to foster good relations, for example by improving understanding or tackling prejudice.

Recommendations are worded and formulated to foster good relations for all adults (18 years and older) who receive healthcare in all settings within NHS services, irrespective of gender, ethnicity, disability, religion or beliefs, sexual orientation and gender identity or socio-economic status.

Signed:

Susan Spiers

ICG Associate Director

Approved and signed off:

Sharon Summers Ma

CCP Lead