

**NATIONAL INSTITUTE FOR HEALTH AND CARE
EXCELLENCE**

EQUALITY IMPACT ASSESSMENT

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NICE guidelines

Equality impact assessment

Chest Pain of recent onset: Assessment and diagnosis

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

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?

N/A (Clinical Guidelines Updates do not have a scoping phase)

During protocol development it was agreed that no sub-group reporting of diagnostic test accuracy was required for a range of characteristics, for example, age, gender and ethnicity. The rationale for this was it was outside the scope of the update remit.

Age

This guideline is for Adults only to ensure consistency with original guideline parameters. Mean age plus standard deviation (SD) are reported in the included studies table of the Addendum. Where this was not available, best reported measures were included e.g. range, median. There was insufficient data to report potential differences in DTA by age.

Variation in age of participants in included studies was also discussed by the Committee. Some included all ages over 18 and some imposed other age thresholds as part of their inclusion criteria. The SD was noted to be not more than 13 for any one study (although a few studies did not report SD). As such the Committee were satisfied that the ages of the study participants accurately represented the age of adults who might be presenting with first episodes of stable chest pain.

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3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?

The topic experts advised that age was an important factor in the interpretation of calcium scoring (index test 3). Young patients often have what is known as “soft plaque” within which calcium often does not show up, giving a calcium score of zero. A score of zero does thus not exclude disease in younger populations. The low specificities found for calcium scoring (scores >0 as opposed to >400) is consistent with this since this ability to accurately rule in disease with lower calcium scores is poor. (Age range of the predominant study is 18-95, mean 61; SD 12). However, because the committee decided that calcium scoring should not be recommended as a standalone testing strategy, this issue is not a concern.

There was no detail on age (or any other characteristics) of people who experienced serious adverse events (n=4 in the entire body of evidence for all tests) therefore, within this update it is not possible to evaluate the effect of age on the risk of serious adverse events.

Gender

No studies that solely evaluated men or women were identified for inclusion in the evidence review. However, some studies included a much higher proportion of men than women. As this reflects the demographic that disease is more prevalent in men than women, it was decided that there was no inequality in the evidence base in relation to gender.

One topic expert noted that women tend to describe symptoms differently to men which should be considered when assessing and classifying type of chest pain.

Ethnicity

This body of evidence included studies from all over the world and only 3 studies were from the UK. The remaining studies represent a diverse range of ethnicities and nationalities. This body of evidence may thus not be representative of a UK population and this was considered by the Committee.

3.2 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?

Other potential issues could be related to:-

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3.2 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?

The Committee also identified the following as important considerations:

- People with learning difficulties, conditions such as dementia and with communication impairments may also be misclassified due to the difficulties associated with determining medical history and symptoms, and subsequent assessment of pre-test probability and the most appropriate diagnostic test.
- People who are over-weight or have a disability may be unable to access the MRI scanning machines. Echocardiography may also be difficult with people who are overweight. Computerised Tomography (CT) often also obtains poor quality images from people who are overweight. Recommendations in the original guideline (DG3) include reference to newer generation CT scanners for people who do not fit into standard scanners. This was because new generation scanners were only considered cost effective in this sub-population.

People with disabilities, frailty or limited exercise ability that limit range of movement or manoeuvrability may not be able to undergo some diagnostic tests that involve inducing stress such as stress echocardiography or CMR. They may also require adaptations such as pharmaceutical stress instead of exercise stress tests.

- People with renal impairment or allergies to contrast material would be contraindicated for certain tests.
- People with claustrophobia or difficulty holding breath may be unable to undergo CMR.
- Pregnant women who presents with stable chest would need to be managed medically and investigated after delivery. The exception would be if this became unstable pain which is a medical emergency.
- Geographical variation in access to services and in turn diagnostic tests.

People who do not speak English as a first language may not be able to fully describe their medical history or symptoms. Consequently it may be difficult to accurately establish clinical characteristics and symptom history.

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3.3 Were the Committee's considerations of equality issues described in the consultation document, and, if so, where?

Yes - these are contained in the 'other considerations' section of the Linking Evidence To Recommendations table in the guideline

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?

No.

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Completed by Developer ___ Lorraine Taylor, Associate Director, Clinical Guideline Update Team ___

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Approved by NICE quality assurance lead Christine Carson
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