NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

EQUALITY IMPACT ASSESSMENT

Chronic kidney disease: assessment and management (update)

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

1.0 Checking for updates and scope: before scope consultation (to be completed by the Developer and submitted with the draft scope for consultation)

1.1 Have any potential equality issues been identified during the check for an update or during development of the draft scope, and, if so, what are they? (Please specify if the issue has been highlighted by a stakeholder)

During the development of the draft scope the following potential equality issues were identified:
 	
CKD assessment and management:
 	
• Age:
  ○ The prevalence and severity of abnormal kidney function and disease increases among older adults. Over a third of adults aged 75 and over have CKD (levels 3 to 5). Frailty which is often linked to older age is independently linked, for all stages of CKD, with adverse clinical outcomes and associated with an increased risk of mortality and hospitalisation.
  ○ The aetiology of CKD in children, and resulting assessment and management, tends to differ from that for adults; congenital anomalies and inherited disorders being the main cause.
 	
• Sex: the prevalence of CKD, of any stage, is higher in women than in men. However, more men than women are reported as starting renal replacement therapy in every age group, with this effect appearing to increase with age.
 	
• Race: the incidence of CKD, as well as progression rates, are higher among

minority ethnic groups. In addition, higher incidence rates are seen in minority ethnic groups for starting renal replacement therapy for end-stage renal disease, with this treatment tending to start at a considerably younger age.

- Pregnancy and maternity: complications in pregnancy for women who have CKD varies according to the stage of their disease, being much greater in those with stages 3-5 than those with stages 1-2. Both the health of the unborn child and the mother can be at risk.

- Socioeconomic group: in areas of deprivation there is a greater prevalence of risk factors for CKD, such as diabetes and hypertension, meaning those from lower socioeconomic groups may be at greater risk of CKD. In addition, a lack of health literacy is associated with lower socio-economic status. Health literacy is important to the chronic disease management process, in terms of gaining access to, understanding, and using information in ways that promote and maintain good health. A lack of health literacy is increasingly recognised as being associated with poorer health outcomes in those with CKD.

- Disability: Difficulties may be experienced in accessing health services and treatments. In addition, CKD may go unrecognised due to diagnostic overshadowing, or lack of awareness by professionals or carers of their different and increased health needs. People with learning disabilities may need specific consideration in particular when discussing treatment options. People with mental health problems who take lithium may need specific consideration when considering treatment options.

Management of mineral and bone disorder in chronic kidney disease:

- Age: Progressive CKD is often associated with decreases in spontaneous dietary protein intake and dialysis with a loss of protein from the body. While restricted protein intake may be beneficial in terms of lowering phosphorus levels and lowering rates of progression to end-stage renal disease, for children, such restrictions may lead to malnutrition.

Management of anaemia:

- Other definable characteristics: CKD in with people with sickle cell disease is common, with kidney complications starting at an early age in children. CKD stage 1 or 2 is present in 26.5% of children with sickle cell disease, with prevalence increasing with age.

1.2 What is the preliminary view on the extent to which these potential equality issues need addressing by the Committee? For example, if population groups, treatments or settings are excluded from the scope, are these exclusions justified – that is, are the reasons legitimate and the exclusion proportionate?

CKD assessment and management:

- Age, sex, race, disability and socioeconomic group: Potential inequality issues will be noted in the review protocols and any evidence relevant to these groups will be extracted. In addition these issues will be highlighted to and discussed by the committee during development of recommendations.

The scope excludes the specific assessment and management of CKD in:

- People receiving RRT (renal replacement therapy, management of end-stage kidney failure by dialysis or kidney transplant). NICE guidance on 'Renal replacement therapy' is due to publish in October 2018.
- People with acute kidney injury. NICE guidance on 'Acute kidney injury: prevention, detection and management', NICE clinical guideline CG169, is currently being updated and is due to publish in April 2020.
- People with rapidly progressive glomerulonephritis. There is separate clinical guidelines on managing glomerulonephritis in adults and children, published by Kidney Disease: Improving Global Outcomes (KDIGO, 2011).

It also excludes:

- Investigation and management of specific causes of CKD.
- Pregnant women.

It was felt these groups require specific management and therefore it was deemed appropriate to exclude them in this guideline.

Management of mineral and bone disorder in chronic kidney disease:

- Age: The original guideline (CG157) recommended protein intakes be age-specific according to reference nutrient intakes, plus additional protein to attempt to compensate for the potential of dialytic and other protein losses. Clinicians felt the need to maintain growth and adequate nutritional status in children was a priority for treatment given. The evidence supporting this recommendation will not be reviewed during this update, the current recommendation will be retained.

Management of anaemia:

- Other definable characteristics: The scope excludes the specific management of anaemia of CKD in people with haematological disorders such as sickle cell disease. The numbers of people with sickle cell anaemia or other anaemias related to haematological disorders in conjunction with CKD is considered relatively rare.

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Approved by NICE quality assurance lead: Kay Nolan

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