1.0.7 DOC EIA (2019)

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE guidelines

Equality impact assessment

Venous thromboembolic diseases: diagnosis, management and thrombophilia testing

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 consultation on the draft guideline)

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?
The scoping process identified a number of potential equality issues: Age, IV drug users, people with learning disabilities, people undergoing male to female gender reassignment, religious beliefs, migrant workers and Gypsies, Roma and travellers, people who have a BMI classification of obese III, people who have stage 3 to 5 chronic kidney disease. The Guideline Committee has addressed these areas as follows: **Age** The scoping process identified that there is an increasing incidence of VTE with increasing age and that younger men have the highest risk of recurrent VTE. To enable the committee to make separate recommendations for these people where necessary and possible, subgroup analyses for age were carried out for the following reviews if data was available: IVC filters, the pharmacological treatment and duration of treatment. In addition, there were 2 review questions that specifically looked at the use of an age-adjusted D-dimer test in people aged over 50 years. For the optimum duration of treatment for VTE review, subgroup analyses were performed for several different prognostic tools. The committee made recommendations to use DASH to predict VTE-recurrence specifically in those people aged under 65 years as the DASH tool was found to have good classification accuracy in this age group; comparably, the DASH tool had poor classification

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accuracy in people 65 years of age or older.

For the pharmacological treatment of VTE, analyses were performed for the elderly (65 years of age or older) and those under 65 years of age. The committee agreed that they could not make specific recommendations for this group due to uncertainty around some of the outcomes. In addition, the committee also recommended that comorbidities, contraindications and the person's preferences are also taken into account during the decision-making process. The committee agreed that, taken together, these recommendations should ensure that a suitable treatment regimen is chosen for older people, who often have comorbidities and may be taking other medications. In addition, the committee made a recommendation for a review (at last once yearly) of general health, risk of VTE recurrence, bleeding risk and treatment preferences for people having long-term anticoagulation treatment. This should add an extra level of protection for older people who may have, or develop, cognitive impairment or dementia or be increasingly prone to falls and ensure that their treatment continues to meet their needs.

The IVC filter review identified evidence for people aged 80 years and over, but they were unable to make separate recommendations for this group due to the poor quality of the evidence.

Learning disabilities

The committee discussed the impact learning disabilities may have on each of their recommendations. The committee noted that in particular, there is a need to consider learning disabilities when prescribing pharmacological treatment for VTE, due to the potential impact this disability may have on drug adherence. However, the committee agreed that specific recommendations for this group do not need to be made as poor drug adherence is not specific to the treatment of VTE. Instead, the recommendations for the pharmacological treatment of VTE included a cross reference to the NICE guideline for medicines adherence. The committee also noted that the guideline on patient experience in adult NHS services addresses factors such as disabilities and effective communication and this is referred to in the discussion section. In addition to recommending specific treatment options the committee also recommended that comorbidities, contraindications and the person's preferences are also taken into account during the decision-making process. The committee agreed that taken together these recommendations would enable the issue of adherence for those with learning disabilities to be taken into consideration to ensure that a suitable treatment regimen is chosen.

Gender reassignment, migrant workers and Gypsies, Roma and travellers

People undergoing gender reassignment, migrant workers and Gypsies, Roma and

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travellers were all considered during the guideline development process. The committee did not make any specific recommendations for any of these groups due to a lack of evidence. However, the committee agreed that their recommendations did not need to be adapted for use in these groups because many of the issues concerning these groups were around access to treatment which was not in the scope of this update. They agreed that the pharmacological treatment recommendations offer a range of treatment options in most cases and the clinician and person with VTE can select the most appropriate one for them given their clinical needs, preferences and circumstances. **Obesity** The committee included obesity as a subgroup analysis in a number of reviews: IVC filters, pharmacological treatment, D-dimer testing, outpatient treatment and the pulmonary embolism rule out criteria (PERC) reviews. No evidence was found for people with obesity III (BMI of 40kg/m^2 or more) in the pharmacological treatment review, however the committee discussed evidence from subgroup analyses for people with obesity assessed as a BMI of 30kg/m^2 or more. The evidence was poor due to limited sample sizes and numbers of events and the committee made consensus recommendations for the pharmacological treatment in people with obesity. They also included obesity as a subgroup analysis in the pharmacological treatment research recommendations. **IV drug users** No evidence was found for this group in the any of the reviews, but the committee made a research recommendation to identify the optimal pharmacological treatment strategy for DVT or PE in people who use intravenous drugs. **Religious groups** The committee discussed the issue surrounding animal products in the pharmacological treatment of VTE and the religious implications this could have. The committee were concerned that most of the anticoagulants were of heparin origin and that apixaban and rivaroxaban contain lactose from cow's milk. The committee amended an existing recommendation in the information section to include the animal origin of the above direct oral anticoagulants (DOACs). This section was otherwise out of scope of the update. **Chronic kidney disease** There was limited evidence for the people with chronic kidney disease (also known as renal impairment). The committee made consensus recommendations for the pharmacological treatment of these people based on their level of renal impairment

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or failure. This highlighted the importance of taking note of the requirements for caution, dose adjustment and monitoring in the medicine's summary of product characteristics and following locally agreed protocols or advice from a specialist or multidisciplinary team to ensure that a person with VTE and renal impairment receives the best possible treatment. In addition, the committee also recommended that comorbidities, contraindications and the person's preferences are also taken into account during the decision-making process. The committee agreed that, taken together, these recommendations should ensure that a suitable treatment regimen is chosen for people with renal impairment, who may have additional comorbidities and are likely to be taking other medications.

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?
In addition to discussions for learning disability, the committee discussed general cognitive impairment (such as cognitive impairment due to dementia) and the concerns they had with adherence in these populations, which would be an increasing issue as practice moves increasingly towards treatment with the DOACs which require less monitoring than VKA. However, similar to those people with learning disabilities, the committee agreed that specific recommendations do not need to be made as the problem of drug adherence is not specific to the treatment of VTE. Instead, the recommendations for the pharmacological treatment of VTE included a cross reference to the NICE guideline for on medicines adherence. In addition, the committee made a recommendation for a review (at last once yearly) of general health, risk of VTE recurrence, bleeding risk and treatment preferences for people having long-term anticoagulation treatment. This should add an extra level of protection for people with cognitive impairment and ensure that their treatment continues to meet their needs. The committee also noted that people with VTE often carry anticoagulation alert cards or information to alert people should they fall ill and that these are increasingly contained within the lock screen or apps in smart phones. However, they agreed that the increasing use of such technology could be problematic for older people or those who lacked the technical ability to use such features (or access to smart phones). These issues were out of scope of the update so the committee did not make any recommendations.

3.3 Have the Committee's considerations of equality issues been described in the guideline for consultation, and, if so, where?
The Committee's considerations of equality issues are described in the evidence reviews for each question, in particular in the benefits and harms, and other considerations sections of the discussion sections associated with the relevant review questions.

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?
The committee agreed that none of the recommendations should make it more difficult for any of the groups identified above to access services.

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?
Provided the NICE guideline on medicines adherence is referred to and the recommendations about taking comorbidities, contraindications and the person's preferences into account when offering anticoagulation treatment are followed then no groups should be disadvantaged by the recommendations the committee made.

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 box 3.4, or otherwise fulfil NICE's obligation to advance equality?
No.

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Approved by NICE quality assurance lead: Simon Ellis

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