STAGE 2. Informing the scope

Metabolic dysfunction-associated steatotic liver disease: assessment and management (NG49)

Date of completion: 28/04/2025

Focus of guideline or update: Diagnosis of Metabolic dysfunction-associated steatotic liver disease (MASLD)

2.1 What approaches have been used to identify potential equality and health inequalities issues during the check for an update or during development of the draft scope?
Equality issues were identified during the surveillance and scoping process which included literature search updates, external topic expert feedback and stakeholder consultation.

2.2 What potential equality and health inequalities issues have been identified during the check for an update or during development of the draft scope?
There are multiple equality impact assessments (EIAs) on the history tab for NICE guideline NG49. These reported that while the prevalence of NAFLD is higher in people of Latin American and South Asian family origin (because of higher insulin resistance and metabolic syndrome than in the general population), the performance of the diagnostic tests recommended and subsequent management of NAFLD does not differ between population groups. No other equalities issues were identified. The EIA for liver disease (NICE quality standard QS152) identified that people who are homeless may not access healthcare services and therefore may not receive the support they need if they develop liver disease.

The presence of MASLD is closely linked to type 2 diabetes (T2DM), obesity and other cardiometabolic risk factors. Therefore health inequalities associated with these conditions are also relevant to MASLD.

The equality and health inequalities issues identified for type 2 diabetes (taken from the type 2 diabetes: management guideline (NG28)) and obesity (taken from the recent update of the overweight and obesity management guideline (NG246)) are shown below:

Type 2 diabetes (NG28)

1. *Protected characteristics outlined in the Equality Act 2010 (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation)*

   Age - people with young onset diabetes (aged under 40 years) and those diagnosed for the first time when aged 80 or older were raised as specific groups to consider as treatments may have different risk / benefit profiles.

   Disability – People with a learning disability are more likely to have diabetes, and at a younger age, than the general population. This is most likely due to the higher prevalence of obesity and physical inactivity in this cohort which are largely driven by social factors. People with severe mental illness were raised as a group where it is known that adherence to medicines is particularly low. This was also thought to be true of people with learning disabilities. Furthermore, some medicines used for severe mental illnesses (antipsychotics) can lead to weight gain and increase risk of diabetes. Depression was also noted to be prevalent in people with type 2 diabetes.

   Pregnancy and maternity – this group isn't covered by the guideline as there is a separate guideline on this topic.

   Race – Black and Asian populations have higher prevalence of type 2 diabetes compared to White populations. However, recording of ethnicity is poor across the healthcare system, without which the true extent of variation by ethnicity is difficult to know. It has been suggested that more data is emerging suggesting people in different ethnic groups may respond to treatments differently. For example, it was noted that young South Asian patients tend to have lower BMI but tend to be more beta-cell deficient. Beta-cell deficiency or insulin resistance may be different between phenotypes. It has also been reported that people from Black African, African Caribbean and South Asian family backgrounds are at a higher risk of developing type 2 diabetes from a younger age.

2. *Socioeconomic deprivation (for example, variation by area deprivation such as Index of Multiple Deprivation, National Statistics Socio-economic Classification, employment status, income)*
   Type 2 diabetes prevalence follows a strong socioeconomic gradient which suggests increasing need for early identification and targeted prevention in more deprived areas where the burden of diabetes is greatest.

3. *Geographical area variation (for example, geographical differences in epidemiology or service provision- urban/rural, coastal, north/south)*
   Issues overlapped with the socio-economic factors described above.

4. *Inclusion health and vulnerable groups (for example, vulnerable migrants, people experiencing homelessness, people in contact with the criminal justice system, sex workers, Gypsy, Roma and Traveller communities, young people leaving care and victims of trafficking)*

   Studies have shown very high rates of type 2 diabetes in Gypsy, Roma and Traveller communities although there is limited data available for this vulnerable population.

   People in contact with the criminal justice system are at high risk for diabetes and a key target group for prevention.

Overweight and obesity management (NG246)

- **Age**
    - Overweight and obesity rates increase with age. For people aged 45 to 64, 73% are living with overweight or obesity, and for people aged 65 to 74, 76% are living with overweight or obesity. In contrast, 43% of people aged 16 to 24 are living with overweight or obesity.
    - Older people may need specific consideration in the guideline as they may require additional support for some interventions.
    - Younger people may need specific consideration, as obesity is a chronic, relapsing condition. Earlier onset of obesity is usually linked to worse health outcomes.
- **Disability**

- People with a learning disability are more at risk of overweight or obesity and may require additional support for some interventions.
- People with a physical disability may require additional support for some interventions.
- People with severe mental health problems are more at risk of living with overweight or obesity and may require additional support for some interventions.

- **Gender reassignment**
  - No equality issues identified.
- **Pregnancy and maternity**
  - Pregnant women are excluded from the scope of this guideline update as they require different management and are covered by separate NICE guidance.
- **Race**
  - There are differences in the prevalence of overweight and obesity by ethnicity and the risk of resulting ill health.
  - For example, people of South Asian descent (defined as people of Pakistani, Bangladeshi and Indian origin) living in England tend to have a higher percentage of body fat at a given BMI compared to the general population. People of South Asian descent are also more likely to have more features of the metabolic syndrome (for example, higher triglycerides and lower high-density lipoproteins in females and higher serum glucose in males) at a given BMI. Likewise, compared to white European populations, people from black, Asian and other minority ethnic groups are at equivalent risk of type 2 diabetes but at lower BMI levels.
  - The differences in prevalence of people living with overweight or obesity and the impact on other health conditions may mean different groups need specific consideration.
- **Religion or belief**
  - No equality issues identified.
- **Sex**

- While men are more likely than women to be living with overweight or obesity, they are less likely to seek support or treatment.

- **Sexual orientation**

  - People who are lesbian, gay, bisexual, trans or questioning (LGBT Q) may be less likely to participate with weight-loss programmes due to both experienced and the perceived threat of discrimination.

- **Socio-economic factors**

  - Overweight and obesity rates differ between socio-economic groups. Children in the most deprived decile are twice as likely to be living with overweight or obesity than children in the least deprived decile. In adults, 35% of men and 37% of women were living with obesity in the most deprived areas, compared with 20% of men and 21% of women in the least deprived areas.

  - Geographical variation in access to NHS weight management services: a lack of universal commissioning of intensive weight loss programmes means that that not all those living with obesity can access bariatric surgery services, owing to access to the former being a prerequisite to surgery.

  - Geographical variation will also exist in terms of whether local environments support people to maintain a healthy weight, and the extent to which local authorities can use legislative and policy levers to help create such environments.

- **Other definable characteristics**

  - Other health conditions: People who are taking some medications or receiving treatment may be at higher risk of excess weight gain due to the side effects of the medication or intervention.

Gypsy, Roma and Travellers: May be less likely to participate with weight-loss programmes due to poor access to, and uptake of, health services as well as both experienced and the perceived threat of discrimination.

MASLD

Race - There is a higher risk of developing the condition in people of Hispanic/ Latino or Asian family origin and a lower risk in people of African family origin. People of Hispanic/ Latino origin have a higher genetic predisposition to MASLD due to a high prevalence of PNPLA3 I148M which increases liver disease risk, and a low

prevalence of HSD17B13 predicted loss-of-function (pLoF) variants, which reduces risk. Metabolic syndrome disproportionately affects Black communities, however Black individuals have a lower risk of certain types of liver disease compared to some other ethnic groups.

Sex - Menopausal status is associated with approximately 2.4-fold higher odds of MASLD. Women aged >50 years have increased odds of advanced fibrosis due to MASLD even after adjustment for covariates. The risk of severe fibrosis is elevated even in normal-weight post-menopausal women with MASLD compared to normal weight pre-menopausal women with MASLD. The association of menopause with severe fibrosis is, in part, mediated by older age and change in body fat composition.

2.3	How can the identified equality and health inequalities issues be further explored and considered at this stage of the development process?

It is unclear whether people of different ages, or ethnicities would indicate a different response to identification, diagnosis and interventions, and therefore this will be considered in the updated evidence review questions in the guideline to determine whether different recommendations are required for these groups.

It is considered likely that different considerations may be required for people with severe mental illness, a learning disability or cognitive impairment (for example those with dementia) and therefore separate recommendations may be required. These groups will therefore be considered in the updated evidence review questions.

2.4	Do you have representation from stakeholder groups that can help to explore equality and health inequalities issues during the consultation process including groups who are known to be affected by these issues? If not, what plans are in place to address gaps in the stakeholder list?

There were 168 registered stakeholder organisations at the time of the scope consultation with a very broad representation from a range of organisations including those representing people with lived experience. NICE has contacted additional diabetes and overweight/ obesity management stakeholder groups to encourage them to register so their views and lived experience can feed into the guideline development process.

2.5 How will the views and experiences of those affected by equality and health inequalities issues be meaningfully included in the guideline development process going forward?
The views and experiences of those affected will be included via engagement with registered stakeholders during the scope and draft guideline consultation process. Feedback will be taken into consideration and where appropriate, the scope and guideline will be updated. Lay members with lived experience of MASLD will be recruited onto the guideline committee. All committee members have equal status, reflecting the importance of their different viewpoints.

2.6 If applicable, what questions will you ask at the draft scope stakeholder consultation about the guideline/update and potential impact on equality and health inequalities?
N/ A

2.7 Has it been proposed to exclude any population groups from the scope? If yes, how do these exclusions relate to any equality and health inequalities issues identified?
No population group has been excluded from the scope.

Completed by developer _Caroline Mulvihill_____

Date_29/04/2025_____
Approved by committee Chair,_Marie Burnham_

Date_29/04/2025_____

Approved by NICE quality assurance lead _ Simon Ellis_____

Date_29/04/2025_____