

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

QUALITY AND OUTCOMES FRAMEWORK (QOF) INDICATOR DEVELOPMENT PROGRAMME

Briefing paper

QOF indicator area: Erectile dysfunction in men with diabetes

Potential output: Recommendations for indicator development

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Contents

Introduction	2
Stakeholder topic suggestion	2
Overview of diabetes	2
Review of recommendations.....	7
Assessment of recommendations against current practice	9
Initial feasibility assessment.....	10
Key considerations.....	10
References.....	11
Appendix A: Evidence summary	12
Appendix B: Related QOF indicators	15
Appendix C: Assessment of topic and recommendations against prioritisation checklist criteria status	17

Introduction

The QOF indicator area is erectile dysfunction (ED) in men with diabetes and this briefing paper presents an assessment of the suitability of NICE clinical guideline recommendations relevant to primary care that have been proposed by stakeholders for QOF indicator development. The recommendations and underlying evidence are taken from the following guidelines, with no update searches performed:

- Type 2 diabetes: the management of type 2 diabetes (update). NICE clinical guideline 66 (2008). This guideline has been partially updated and replaced by clinical guideline 87.
- Type 1 diabetes: diagnosis and management of type 1 diabetes in children, young people and adults. NICE clinical guideline 15 (2004).

Note: SIGN guideline 116 on the management of diabetes does not include recommendations on ED in men with diabetes.

Stakeholder topic suggestion

The stakeholder submission for this topic identified 3 areas for QOF indicator development for the management of ED in men with diabetes. These are annual review, pharmacological management, and referral to specialist care if pharmacological management is unsuccessful.

Overview of diabetes

Epidemiological summary

Definition

Diabetes is a chronic metabolic disorder caused by defects in insulin secretion and action. There are 2 major types of diabetes. Type 1 diabetes occurs because the insulin-producing cells of the pancreas have been destroyed by the body's immune system and typically develops in children and young adults. Type 2 diabetes is more commonly diagnosed in adults over 40, but is also increasing in young people. In this condition, insulin is produced but is insufficient for the

body's needs. There is also a degree of insulin resistance, where the cells in the body are not able to respond to the insulin that is produced.

Erectile dysfunction (ED) is a manifestation of autonomic neuropathy as a complication of long-term hyperglycaemia¹.

Incidence, prevalence and evidence of variation by age, sex and ethnicity

Type 2 diabetes accounts for around 90% of all diabetes in adults. The prevalence of doctor-diagnosed diabetes in the 2006 Health Survey for England was higher in men (5.6%) than in women (4.2%).

The prevalence of diabetes varies with factors such as mix of ethnic groups and degree of social deprivation. People from minority ethnic communities have up to a 6 times higher than average risk of developing diabetes.

Erectile dysfunction is a common complication of diabetes. There are large differences in the reported prevalence of ED in men with diabetes, ranging from 35 to 90% (Malavige and Levy 2009). These differences may be attributable to differences in methodology and population characteristics. In the Massachusetts Male Aging Study, the age-adjusted probability of complete ED was 3 times greater in men with type 2 diabetes than in those without the condition (Levy 2002). Chronic medical conditions that were significantly associated with complete impotence included hypertension (doubling of risk), diabetes (tripling of risk) and treated heart disease (quadrupling of risk).

Morbidity and mortality

People with type 2 diabetes have a life expectancy that is reduced by up to 10 years and are at increased cardiovascular risk. Mortality attributed to diabetes is suggested as 4.2% of deaths in men and 7.7% of deaths in women in the UK, although the burden is likely to be greater because diabetes is strongly linked to coronary heart disease.

¹ Manifestations of autonomic neuropathy as a complication of long-term hyperglycaemia include gastroparesis, diarrhoea, faecal incontinence, ED, bladder disturbance, orthostatic hypotension, gustatory and other sweating disorders, dry feet, and unexplained ankle oedema.

NICE clinical guideline 66 states that autonomic neuropathy is a late complication of diabetes that presents in diverse ways and affects a variety of organ systems including the skin (sweating), blood vessels (orthostatic hypotension), gastrointestinal tract (gastroparesis, diarrhoea), heart (cardiac arrest), bladder and sexual function. It may blunt the symptoms of hypoglycaemia. Considerable morbidity occurs as a result of many of these problems.

Erectile dysfunction is a traumatic complication for some men with diabetes. Although a benign disorder that is not perceived as a life-threatening, it can have a significant impact on the quality of life of men with diabetes, their partners and families.

A retrospective cohort study compared disease-specific health-related quality of life and severity of ED in impotent men with and without diabetes (Penson et al. 2003). The found that men with diabetes reported worse erectile function and intercourse satisfaction at baseline and that in men with diabetes the impact of ED was greater on their emotional life.

Risk factors for ED including sedentary lifestyle, obesity, smoking, hypercholesterolaemia and the metabolic syndrome are very similar to the risk factors for cardiovascular disease. Erectile dysfunction is also considered to be a cardiovascular risk factor conferring a risk equivalent to a moderate level of smoking (British Society for Sexual Medicine, 2008).

Impact on health services

Primary care

The 2009/10 QOF prevalence for the diabetes register is 5.4% for England, 4.1% for Scotland, 4.9% for Wales and 3.9% for Northern Ireland.

Based on several assumptions, it can be estimated that the prevalence of men with diabetes who experience ED within the total England GP registered practice population for persons aged 18 years and over is 1.69% or 1.33% for all ages.

This equates to a notional figure of 138 men with diabetes who may experience ED for an average registered GP list of 10,000 people (children and adults).²

Secondary care

Type 1 and type 2 diabetes in adults are managed in primary care. However, it is common for adults with type 1 diabetes to experience related complications needing hospital admission. Children with type 1 diabetes receive specialist paediatric care. Referral of people with diabetes into secondary care as a result of complications of diabetes or for urological services – or other specialist services such as counselling or management of stress, anxiety and depression – has a significant resource impact on the NHS.

Current management in primary care

GPs play a crucial role in managing diabetes in primary care. Much of the management and monitoring of type 2 diabetes is undertaken by GPs and members of the primary care team. These include encouraging a healthy lifestyle, modifying levels of blood pressure and lipids, and lowering blood glucose to reduce the risk of complications.

This picture of multiple vascular risk factors and wide-ranging complications means that the management of type 2 diabetes draws on many areas of healthcare management. NICE clinical guideline 66 states that an understanding of diabetes, informed choice of management opportunities, and acquiring relevant skills for successful self-management play an important role in achieving optimal outcomes.

GPs and trained nursing staff can address the issue of ED in men with diabetes as part of regular review and provide assessment, education and discussion of treatment options. Men may be offered phosphodiesterase type 5 (PDE-5) inhibitors (which can be prescribed and issued on the NHS for men older than 18

² This is based the prevalence figure of diabetes in adults of 5.4% taken from the QOF register for England 2009/10 and the assumption that 57% of adults with diabetes are male. The prevalence of ED has been assumed to be 50%, which is a pragmatic midpoint taking into account the wide range of prevalence estimates for ED reported in studies (35–90%). The 2009 GP registered population for England has been used.

If the lower ED prevalence estimate of 35% is used, the total GP registered practice population for England would be 1.19% for men aged 18 and older, and 0.93% for all ages.

with diabetes) or the GP may make onward referral to a service offering other medical, surgical, or psychological management of ED.

The Guideline Development Group (GDG) for NICE clinical guideline 66 noted that ED is sometimes not adequately discussed and that the issue of ED should be explored regularly if appropriate, with the explanation that it can be a complication of diabetes and may be amenable to treatment. Therefore, professionals need to be alert to secondary issues such as relationship breakdown.

NHS priorities and timeliness of guidance

The NICE QOF team examined national clinical guidelines, policy documents and national strategies across the UK to assess timeliness of indicators in this topic area. The following were found to be relevant to ED in men with diabetes:

- [Type 2 diabetes \(update\)](#). NICE clinical guideline 66 (2008)
- Scottish Diabetes Framework: action plan. NHS Scotland (2006)
- Diabetes follow-up reports. NHS Quality Improvement Scotland (2006)
- A profile of long-term and chronic conditions in Wales. Welsh Assembly Government (2006)
- Designed to improve health and the management of chronic conditions in Wales: an integrated model and framework. Welsh Assembly Government (2005)
- Diabetes: national overview. NHS Quality Improvement Scotland (2004)
- Scottish Diabetes Framework. NHS Scotland (2002)
- Diabetes National Services Framework. Welsh Assembly Government (2002)
- National Service Framework for Diabetes. Department of Health (2001)

Review of recommendations

Summary of NICE clinical guideline recommendations

From NICE clinical guideline 66, 4 recommendations have been identified as being potentially suitable for QOF indicator development:

- NICE recommendation 123: Review the issue of erectile dysfunction with men annually.
- NICE recommendation 124: Provide assessment and education for men with erectile dysfunction to address contributory factors and treatment options.
- NICE recommendation 125: Offer a phosphodiesterase-5 inhibitor (choosing the drug with the lowest acquisition cost), in the absence of contraindications, if erectile dysfunction is a problem.
- NICE recommendation 126: Following discussion, refer to a service offering other medical, surgical, or psychological management of erectile dysfunction if phosphodiesterase-5 inhibitors have been unsuccessful.

From NICE clinical guideline 15, 3 recommendations have been identified as being potentially suitable for QOF indicator development:

- NICE recommendation 1.11.4.1: Men should be asked annually whether erectile dysfunction is an issue.
- NICE recommendation 1.11.4.2: A PDE5 (phosphodiesterase-5) inhibitor drug, if not contraindicated, should be offered where erectile dysfunction is a problem.
- NICE recommendation 1.11.4.3: Referral to a service offering other medical and surgical management of erectile dysfunction should be discussed where PDE5 inhibitors are not successful.

Evidence summary

This is a summary of the evidence supporting the proposed recommendations presented above. This section relates to the evidence summary table in appendix A of this briefing paper.

Clinical effectiveness

The evidence for annual review of ED for both type 1 and type 2 diabetes was based on GDG consensus, which noted that the issue of ED should be explored regularly with men in primary care if appropriate, as outlined in recommendation 123 of NICE clinical guideline 66 and recommendation 1.11.4.1 of NICE clinical guideline 15. The GDG for NICE clinical guideline 66 also noted the importance of providing an explanation (education) that ED can be a complication of diabetes, and that it may be amenable to treatment. The GDG for NICE clinical guideline 15 suggested that a reasonable approach to addressing the problem of ED would be to enquire whether individuals were 'troubled by sexual dysfunction'.

There is RCT evidence to support pharmacological management (PDE-5 inhibitors) for ED in people with type 2 diabetes as outlined in recommendation 125 of NICE clinical guideline 66. The outcomes considered were improved scores on the International Index of Erectile Function, positive response to the global efficacy question and increase in successful intercourse attempts³.

There is RCT evidence to support pharmacological management (PDE-5 inhibitors) for ED in people with type 1 diabetes, as outlined in recommendation 1.11.4.2 from NICE clinical guideline 15. The outcomes considered were achievement and maintenance of penile erections with pharmacological interventions compared with placebo. Another 11 outcomes from questionnaire-based evaluation of male sexual function described significant improvements in erectile function regardless of age, duration of ED, duration of diabetes or type of diabetes.

Recommendation 126 from NICE clinical guideline 66 is based on GDG consensus that other medical and surgical treatment options should be discussed if PDE-5 inhibitors prove ineffective and that onward referral should be made if appropriate. Recommendation 1.11.4.3 from NICE clinical guideline 15 is based on GDG consensus. The GDG stated that men still having a problem after a trial

³ The evidence review for NICE clinical guideline 66 covered only the care that would routinely be provided within diabetes services, and not with that normally provided by other specialist services. The clinical questions thus related to the effectiveness and relative effectiveness of the PDE-5 inhibitor drugs in people with type 2 diabetes.

of PDE-5 inhibitors had failed might have their needs met by expertise available in a variety of care situations.

Cost effectiveness

No cost-effectiveness evidence was presented for the recommendations in this briefing paper.

Assessment of recommendations against current practice

Current practice

The NICE QOF team carried out a search of studies and reports published since 2006 relating to current practice in UK primary care for ED in men with diabetes. It did not identify any UK evaluations or audit studies.

It is reasonable to assume that many men, including men with diabetes who would be eligible for treatment on the NHS, may not consult their GP for treatment because the condition can be perceived as embarrassing.

Health inequalities

Type 2 diabetes is more common in people of low socioeconomic status, in people from minority ethnic groups and in people aged 65 and over. However, there is no evidence that these recommendations can directly affect health inequalities. [Relevance to health inequalities: medium/high].

Will implementation of these recommendations lead to cost-effective improvements in the delivery of primary care?

There is limited information on current practice in UK primary care for the recommendations presented. The GDG noted that ED is sometimes not adequately discussed. It considered that the recommendations would represent a moderate change in practice. It is not clear from the evidence to what extent the recommendations would lead to cost-effective improvements in the delivery of primary care.

Initial feasibility assessment

The recommendations presented could be considered together to provide the basis of a composite review-type indicator on the percentage of men with diabetes with a record of assessment for ED.

Key considerations

The following key considerations summarise the main points made in the briefing paper. The Committee is asked to consider these in its discussions:

- ED is a common complication of diabetes and can have a significant impact on the quality of life of men with diabetes, their partners and families.
- There have been significant changes in the approach to male ED in recent years, stimulated by the advent of the phosphodiesterase type 5 (PDE-5) inhibitors. There is strong clinical evidence for the effectiveness of drug treatment for ED in men with diabetes.
- There is limited information on the current practice for the recommendations presented; the GDG noted that ED is sometimes not adequately discussed with men with diabetes.
- The recommendations presented could be considered together to provide the basis of a composite review-type indicator on the percentage of men with diabetes with a record of assessment for ED.

Assessment against NICE's prioritisation criteria

The recommendations for **review, assessment and referral** have feasibility issues that would need to be considered as part of indicator development. The evidence of clinical effectiveness has been assessed as low. There is no evidence of cost-effectiveness. The expected change in practice is considered to be moderate.

The recommendation for **drug treatment** has feasibility issues that would need to be considered as part of indicator development. The evidence of clinical effectiveness has been assessed as high. There is no evidence of cost-effectiveness. The expected change in practice is considered to be moderate.

References

Department of Health (2004) Health Survey for England 2003. The Stationery Office: London.

Diabetes UK (2010) [Diabetes in the UK 2010 Key statistics on Diabetes](#).

Levy J (2002) Impotence and its medical and psychosocial correlates: results of the Massachusetts Male Aging Study. *British Journal of Diabetes and Vascular Disease* 2: 278

Malavige L, Levy J (2009) Erectile dysfunction in diabetes mellitus. *The Journal of Sexual Medicine*. 6: 1232–47

Penson DF, Latini DM, Lubeck DP et al. (2003) Do Impotent Men With Diabetes Have More Severe Erectile Dysfunction and Worse Quality of Life Than the General Population of Impotent Patients? Results from the Exploratory Comprehensive Evaluation of Erectile Dysfunction (ExCEED) database. *Diabetes Care* 26: 1093–9.

Appendix A: Evidence summary

Selected recommendations from NICE clinical guideline 66 (type 2 diabetes) and NICE clinical guideline 15 (type 1 diabetes)

	Recommendation	Level of evidence	Key outcomes considered (for interventions)	Specific considerations highlighted by guideline developers	Cost-effectiveness evidence
NICE clinical guideline 66 (type 2 diabetes), recommendation 123	Review the issue of erectile dysfunction with men annually.	GDG consensus	n/a	The GDG noted that the issue of erectile dysfunction should be explored regularly with men if appropriate.	None presented
NICE clinical guideline 66 (type 2 diabetes), recommendation 124	Provide assessment and education for men with erectile dysfunction to address contributory factors and treatment options.	GDG consensus	n/a	The GDG noted the importance of providing an explanation that erectile dysfunction can be a complication of diabetes, and that it may be amenable to treatment.	None presented
NICE clinical guideline 15 (type 1 diabetes), recommendation 1.11.4.1	Men should be asked annually whether erectile dysfunction is an issue.	GDG consensus	n/a	The GDG noted the problems surrounding asking all men about impotence, but suggested a reasonable approach to this problem is to enquire as to whether men were 'troubled by sexual dysfunction'.	None presented
NICE clinical guideline 66 (type 2 diabetes),	Offer a phosphodiesterase-5 inhibitor (choosing the drug with the lowest acquisition cost), in the	Meta-analyses and RCTs (level 1)	Validated International Index of Erectile Function (IIEF) –Global	Eleven studies were identified in this area, all of which involved the PDE-5 inhibitors licensed for the treatment of	None presented

ITEM 11.4

	Recommendation	Level of evidence	Key outcomes considered (for interventions)	Specific considerations highlighted by guideline developers	Cost-effectiveness evidence
recommendation 125	absence of contraindications, if erectile dysfunction is a problem.	evidence)	<p>efficacy question (Did the treatment improve your erections?)</p> <p>Sexual Encounter Profile (Qu 2: success in penetration and Qu 3: success in maintaining erection during intercourse)</p>	<p>erectile dysfunction (sildenafil, tadalafil or vardenafil). All the studies compared PDE-5 inhibitors with a placebo.</p> <p>The GDG found that the evidence suggested that the PDE-5 inhibitors (sildenafil, vardenafil and tadalafil) were all significantly effective in the treatment of erectile dysfunction in men with type 2 diabetes.</p> <p>The evidence did not sufficiently distinguish between the PDE-5 inhibitors themselves. There was no evidence on the use of second-line PDE-5 inhibitor therapies if the initial drug proved ineffective.</p> <p>The GDG noted that concern was expressed about cardiovascular safety issues associated with the use of these drugs, even after careful exclusion of nitrate therapy.</p>	
NICE clinical guideline 15 (type 1 diabetes),	A PDE-5 (phosphodiesterase-5) inhibitor drug, if not contraindicated, should be	Level 1 evidence	Achievement, maintenance and duration of penile erections	One large multicentre study of sildenafil at 100 mg/day compared with placebo in men with erectile dysfunction and	None presented

ITEM 11.4

	Recommendation	Level of evidence	Key outcomes considered (for interventions)	Specific considerations highlighted by guideline developers	Cost-effectiveness evidence
recommendation 1.11.4.2	offered where erectile dysfunction is a problem.			type 1 or type 2 diabetes found significantly more men were able to achieve and to maintain erections with sildenafil than placebo at 12 weeks. A smaller prospective study from the UK found that sildenafil at 25 mg or 50 mg, compared with placebo, significantly improved adjusted duration of penile rigidity at base and tip	
NICE clinical guideline 66 (type 2 diabetes), recommendation 126	Following discussion, refer to a service offering other medical, surgical, or psychological management of erectile dysfunction if phosphodiesterase-5 inhibitors have been unsuccessful.	GDG consensus	n/a	The GDG consensus view was that other medical and surgical treatment options should be discussed if PDE-5 inhibitors prove ineffective, and onward referral made if appropriate.	None presented
NICE clinical guideline 15 (type 1 diabetes), recommendation 1.11.4.3	Referral to a service offering other medical and surgical management of erectile dysfunction should be discussed where PDE5 inhibitors are not successful.	GDG consensus	n/a	The GDG consensus was that men still having a problem after a trial of PDE5 inhibitors had failed might have their needs met by expertise available in a variety of care situations, suggesting that the site of such care and advice could not be specified.	None presented

Appendix B: Related QOF indicators

Related existing QOF indicators from 2009/10 indicator set

Erectile dysfunction in type 2 diabetes relates to an existing QOF clinical domain as defined in the 2009/10 GMS Contract guidance. The QOF indicators for this domain are outlined below.

QOF domain 2009/10: Diabetes

Indicator	Points	Payment stages
Records		
DM 19 The practice can produce a register of all patients aged 17 years and over with diabetes mellitus, which specifies whether the patient has type 1 or type 2 diabetes	6	
Ongoing management		
DM 2 The percentage of patients with diabetes whose notes record BMI in the previous 15 months	3	40-90%
DM 5. The percentage of patients with diabetes who have a record of HbA _{1c} or equivalent in the previous 15 months	3	40-90%
DM 23. The percentage of patients with diabetes in whom the last HbA _{1c} is 7 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months,	17	40-50%
DM 24. The percentage of patients with diabetes in whom the last HbA _{1c} is 8 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	8	40-70%
DM 25. The percentage of patients with diabetes in whom the last HbA _{1c} is 9 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	10	40-90%
DM 21. The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months	5	40-90%
DM 9. The percentage of patients with diabetes with a record of the presence or absence of peripheral pulses in the previous 15 months	3	40-90%
DM 10. The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months	3	40-90%
DM 11. The percentage of patients with diabetes who have a record of the blood pressure in the previous 15 months	3	40-90%
DM 12. The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less	18	40-60%
DM 13. The percentage of patients with diabetes who have a record of micro-albuminuria testing in the previous 15 months (exception reporting for patients with proteinuria)	3	40-90%
DM 22. The percentage of patients with diabetes who have a record of estimated glomerular filtration rate (eGFR) or serum	3	40-90%

creatinine testing in the previous 15 months		
DM 15. The percentage of patients with diabetes with a diagnosis of proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists)	3	40-80%
DM 16. The percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months	3	40-90%
DM 17. The percentage of patients with diabetes whose last measured total cholesterol within the previous 15 months is 5mmol/l or less	6	40-70%
DM 18. The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March	3	40-85%

Related indicators from the NICE menu of indicators

There are 5 diabetes-related indicators on the NICE menu of indicators, available from: www.nice.org.uk/aboutnice/qof/indicators.jsp

NICE Menu NM01 The percentage of patients with diabetes in whom the last blood pressure is 150/90 or less in the previous 15 months
NICE Menu NM02 The percentage of patients with diabetes in whom the last blood pressure is 140/80 or less in the previous 15 months
NICE Menu NM12 The percentage of patients with diabetes with a record of testing of foot sensation using a 10 g monofilament or vibration (using biothesiometer or calibrated tuning fork), within the preceding 15 months
NICE Menu NM13 The percentage of patients with diabetes with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes or previous ulcer) or 4) ulcerated foot within the preceding 15 months
NICE Menu NM14 The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months

Related indicators under consideration by the Advisory Committee

Pilot 3 (Oct 10 – Mar 11) The percentage of patients newly diagnosed with diabetes (as of 1 October 2010) who have a record of being referred to a structured education programme within 3 months of entry on to the diabetes register.
Pilot 3 (Oct 10 – Mar 11) The percentage of patients with diabetes who have a record of a dietary review by a suitably competent professional in the previous 15 months.

Appendix C: Assessment of topic and recommendations against prioritisation checklist criteria status

The overall topic and recommendation(s) produced by the QOF programme team have been assessed by comparing information in this briefing paper with the revised prioritisation checklist as agreed at the July 2009 Advisory Committee meeting.

Topic status

This topic meets the prioritisation criteria for prevalence, primary care management and disease severity as outlined in 1A, 1B and 1C below.

1A Population				
The condition is considered to have population prevalence that is high				<input checked="" type="checkbox"/>
The condition is considered to have population prevalence that is medium				<input type="checkbox"/>
The condition is considered to have population prevalence that is low				<input type="checkbox"/>
1B Management				
		Fully meets criteria	Partly meets criteria	Doesn't meet criteria
Score:		[3]	[2]	[1]
The condition is diagnosed in primary care*		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The condition is treated in primary care*		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The condition is monitored in primary care*		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* by GPs or directly employed practice staff				
1C Disease severity				
Score	Scoring criteria			
1	Minor quality-of-life impact, no disability, limited morbidity impact			<input type="checkbox"/>
2	Definite quality-of-life impact, no disability, limited morbidity impact			<input type="checkbox"/>
3	Definite quality-of-life impact, some disability and/or intermediate morbidity impact			<input checked="" type="checkbox"/>
4	Definite quality-of-life impact, significant disability and/or significant morbidity impact			<input type="checkbox"/>

Recommendation status

The individual recommendations are assessed on feasibility, strength of clinical and cost-effectiveness evidence and expected change in practice.

Feasibility of each recommendation	
Recommendation 123 (NICE clinical guideline 66)	Amber
Recommendation 124 (NICE clinical guideline 66)	Amber
Recommendation 125 (NICE clinical guideline 66)	Amber
Recommendation 126 (NICE clinical guideline 66)	Amber
Recommendation 1.11.4.1 (NICE clinical guideline 15)	Amber
Recommendation 1.11.4.2 (NICE clinical guideline 15)	Amber
Recommendation 1.11.4.3 (NICE clinical guideline 15)	Amber

Scores for each recommendation			
	Evidence of clinical effectiveness	Evidence of cost effectiveness	Expected change in practice
Recommendation 123 (NICE clinical guideline 66)	Low	No data available	moderate
Recommendation 124 (NICE clinical guideline 66)	Low	No data available	moderate
Recommendation 125 (NICE clinical guideline 66)	High	No data available	moderate
Recommendation 126 (NICE clinical guideline 66)	Low	No data available	moderate
Recommendation 1.11.4.1 (NICE clinical guideline 15)	Low	No data available	moderate
Recommendation 1.11.4.2 (NICE clinical guideline 15)	High	No data available	moderate
Recommendation 1.11.4.3 (NICE clinical guideline 15)	Low	No data available	moderate