

# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

## QUALITY AND OUTCOMES FRAMEWORK (QOF) INDICATOR DEVELOPMENT PROGRAMME

### Briefing paper

**QOF indicator area:** Hypertension: target organ damage

**Potential output:** Recommendation for indicator development

**Date of Primary Care QOF Indicator Advisory Committee meeting:** 12<sup>th</sup> &  
13<sup>th</sup> of June 2013

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## Introduction

This briefing paper presents an assessment of the suitability of measures derived from NICE quality standards, relevant to primary care, to be progressed for Quality and Outcomes Framework (QOF) indicator development. The QOF indicator area is hypertension. The NICE quality standard on hypertension was published in March 2013:

<http://publications.nice.org.uk/quality-standard-for-hypertension-qs28>

The relevant quality statement (statement 2) and underlying recommendation and evidence is taken from the following guidance:

‘Hypertension: clinical management of primary hypertension in adults’ (NICE clinical guideline 127, August 2011)

This paper is based on the evidence presented in NICE clinical guideline 127 and no update searches have been performed.

## Topic selection

### ***Hypertension quality standard (QS28)***

#### **Quality Standards**

NICE quality standards are sets of specific, concise statements and associated measures. They set out aspirational, but achievable, markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions.

Derived from the best available evidence, such as NICE guidance and other evidence sources accredited by NICE Evidence, they are developed independently by NICE in collaboration with NHS and social care professionals, their partners and service users. Quality standards address clinical effectiveness, patient safety and patient experience, and are central to supporting the government's vision for an NHS focused on delivering the best possible outcomes for patients.

**Review of the hypertension quality standard and identification of possible QOF indicators**

The hypertension quality standard was reviewed to identify potential areas for further development as QOF indicators.

Statement 2 in the hypertension quality standard was considered to be an appropriate area for potential QOF indicator development:

*People with newly diagnosed hypertension receive investigations for target organ damage within 1 month of diagnosis.*

The associated process measure is:

- Proportion of people with newly diagnosed hypertension who receive all investigations for target organ damage within 1 month of diagnosis

**Supporting statement from the chair and expert GP on the Quality Standard for hypertension**

The quality statement presented in this briefing paper is clinically valid and important from a primary care perspective and therefore I would like to support the development of a Quality Outcomes Framework (QOF) indicator on investigations for target organ damage for people with newly diagnosed hypertension. It is important for people with hypertension that investigations for target organ damage are carried out as a person's risk of clinical events associated with hypertension is not only determined by their blood pressure, but also by the presence of target organ damage.

Primary care is the appropriate setting to ensure people with hypertension receive investigations for target organ damage and I feel incentivising this through the QOF will improve the quality of care for people with hypertension.

Professor Brian Williams

Professor of Medicine, Department of Cardiovascular Sciences, University of Leicester

Chair for the hypertension quality standard

Primary Care Quality and Outcomes Framework Advisory Committee  
12<sup>th</sup> and 13<sup>th</sup> June 2013  
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John Crimmins

Expert GP on the quality standard for hypertension

## Overview of hypertension

### *Epidemiological summary*

#### Definition

Blood pressure is normally distributed in the population and there is no natural cut-off point above which 'hypertension' definitively exists and below which it does not.

The NICE clinical guideline on hypertension uses the following definitions for hypertension:

- Stage 1 hypertension:  
Clinic blood pressure is 140/90 mmHg or higher **and** subsequent ABPM daytime average or home blood pressure monitoring (HBPM) average blood pressure is 135/85 mmHg or higher.
- Stage 2 hypertension:  
Clinic blood pressure is 160/100 mmHg or higher **and** subsequent ABPM daytime average or HBPM average blood pressure is 150/95 mmHg or higher.
- Severe hypertension:  
Clinic systolic blood pressure is 180 mmHg or higher **or** clinic diastolic blood pressure is 110 mmHg or higher.

NICE clinical guideline 127 recommendation 1.2.6 lists left ventricular hypertrophy, chronic kidney disease and hypertensive retinopathy as examples of target organ damage

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

Hypertension is common in the UK and the prevalence is strongly influenced by age. The Health Survey for England reported that the prevalence of hypertension in 2011 was 31% in men and 28% in women. The survey also found that the proportion of the population with controlled hypertension increased between 2003 and 2011 from 5% to 11% among men, and from 6% to 10% among women but that the proportion of untreated hypertension decreased; from 20% to 14% in men and 16% to 11% in women.

In any individual person, systolic and/or diastolic blood pressures may be elevated. Diastolic pressure is more commonly elevated in people younger than 50 years of age. With ageing, systolic hypertension becomes a more significant problem, as a result of progressive stiffening and loss of compliance of larger arteries. At least one quarter of adults (and more than half of those older than 60) have high blood pressure. The published QOF achievement data illustrated that in 2011/12 there were 7.6 million people in England with established hypertension, representing 13.6% of the registered population. The incidence of suspected hypertension is also increasing, and is likely to continue to increase because of the ageing population and lifestyle factors.

There are ethnic differences in the prevalence of high blood pressure and mortality arising from complications such as cardiovascular, cerebrovascular and renal disease. Mortality data from England and Wales (1988–92) shows that hypertension-associated mortality is 3.5 times higher than the national average in African-Caribbean populations and 1.5 times higher in British Asian populations.

### **Morbidity and mortality**

Hypertension is one of the most important preventable causes of premature morbidity and mortality in the UK. Hypertension is a major risk factor for ischaemic and haemorrhagic stroke, myocardial infarction, heart failure, chronic kidney disease, cognitive decline and premature death. Raised blood

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pressure is also one of the three main modifiable risk factors for cardiovascular disease (CVD) which account for 80% of all cases of premature coronary heart disease (CHD).

The risk associated with increasing blood pressure is continuous, with each 2 mmHg rise in systolic blood pressure associated with a 7% increased risk of mortality from ischaemic heart disease and a 10% increased risk of mortality from stroke. Intracerebral haemorrhage occurs in about 10% of strokes, and the commonest cause of intracerebral haemorrhage is hypertension.

Untreated hypertension is usually associated with a progressive rise in blood pressure, often culminating in a treatment resistant state due to associated vascular and renal damage.

A person's risk of adverse cardiovascular events is not only determined by their blood pressure but also by the presence of target organ damage, established CVD and other risk factors for CVD such as lifestyle (e.g. diet, smoking, obesity and lack of exercise), diabetes and dyslipidaemia .

### ***Impact on health services***

#### **Primary care**

The clinical management of hypertension is one of the most common interventions in primary care, accounting for approximately 12% of Primary Care consultation episodes and approximately £1 billion in drug costs in 2006.

As the demographics of the UK shifts towards an older, more sedentary and obese population, the prevalence of hypertension and its requirement for treatment will continue to rise.

#### **Secondary care**

Raised blood pressure is one of the three major modifiable risk factors contributing to the development of CVD. CVD has significant cost implications and was estimated to cost the NHS almost £15 billion in 2003 and the economy around £30 billion a year.

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Hypertension is also a major risk factor for ischaemic and haemorrhagic stroke. In England, stroke is estimated to cost the economy around £7 billion per year. This comprises direct costs to the NHS of £2.8 billion, costs of informal care of £2.4 billion and costs because of lost productivity and disability of £1.8 billion.

The recent rise in the prevalence of heart failure also seems to mirror the rise in the prevalence of hypertension, diabetes mellitus, atrial fibrillation and obesity. Heart failure accounts for a total of 1 million inpatient bed days – 2% of all NHS inpatient bed-days – and 5% of all emergency medical admissions to hospital. It is estimated that the total annual cost of heart failure to the NHS is around 2% of the total NHS budget: approximately 70% of this total is due to the costs of hospitalisation.

### ***Current management in primary care***

Routine periodic screening for high blood pressure is now commonplace in England as part of National Service Frameworks for CVD prevention. In addition, indicators for the diagnosis and management of hypertension have been incentivised through the QOF since its inception in 2004 and the management of hypertension in primary care is now part of routine practice in primary care. Consequently, the diagnosis, treatment and follow-up of patients with hypertension is one of the most common interventions in primary care.

Assessment of target organ damage can alert the clinician to possible secondary causes of hypertension, some of which are potentially life threatening and some that may be amenable to potentially curative interventions. It can also support the clinician to decide the appropriate blood pressure threshold at which to consider drug therapy for the treatment of hypertension.

### ***NHS priorities and timeliness for guidance***

The NICE QOF team examined national clinical guidelines, policy documents and national strategies across the UK to assess timeliness of indicators in this

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topic area. The following were found to be of relevance to hypertension and indicate that hypertension is deemed as an area of high priority for the NHS:

- National Institute for Health and Clinical Excellence (2012) [Watch BP Home A for the measurement of blood pressure and the diagnosis of atrial fibrillation](#). Medical Technologies guidance.
- National Institute for Health and Clinical Excellence (2012) [Percutaneous transluminal radiofrequency sympathetic denervation of the renal artery for resistant hypertension](#). Interventional Procedure guidance.
- National Institute for Health and Clinical Excellence (2011) [Hypertension: clinical management of primary hypertension in adults](#). Clinical Guideline CG127
- NHS Information Centre (2011) [National Pulmonary Hypertension Audit Report](#)
- Map of Medicine (2011) [Hypertension - drug therapy](#)
- National Institute for Health and Clinical Excellence (2010) [The management of hypertensive disorders during pregnancy](#). Clinical Guideline CG107
- NatCen Social Research (2010) [Health Survey for England](#).
- Bupa's Health Information Team (2010) [High blood pressure \(hypertension\)](#)
- Clinical Knowledge Summaries (2010) [Hypertension in pregnancy](#)
- Map of Medicine (2010) [Hypertension in pregnancy](#)
- Clinical Knowledge Summaries (2009) [Hypertension in people who do not have diabetes mellitus](#)
- Royal College of Physicians (2007) [Pharmacological management of hypertension](#)
- Joint Royal Colleges Ambulance Liaison Committee. (2006) [Pregnancy induced hypertension \(including eclampsia\)](#)
- UK National Screening Committee (2006) [Screening for Hypertension in Adults](#)



## Review of recommendations

### ***Summary of NICE guideline recommendations***

The quality standard on hypertension statement 2 was informed by NICE clinical guideline 127. The following recommendations from this guideline informed the basis for the development of this statement, and are therefore presented below.

#### *NICE recommendation 1.2.6*

While waiting for confirmation of a diagnosis of hypertension, carry out investigations for target organ damage (such as left ventricular hypertrophy, chronic kidney disease and hypertensive retinopathy) (see recommendation 1.3.3) and a formal assessment of cardiovascular risk using a cardiovascular risk assessment tool

#### *NICE recommendation 1.3.3*

For all people with hypertension offer to:

- test for the presence of protein in the urine by sending a urine sample for estimation of the albumin:creatinine ratio and test for haematuria using a reagent strip
- take a blood sample to measure plasma glucose, electrolytes, creatinine, estimated glomerular filtration rate, serum total cholesterol and HDL cholesterol
- examine the fundi for the presence of hypertensive retinopathy
- arrange for a 12-lead electrocardiograph to be performed.

### ***Evidence summary***

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

### **Clinical effectiveness**

#### *NICE recommendation 1.2.6*

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The Guideline Development Group (GDG) noted that a person's risk of clinical events associated with hypertension is not only determined by their blood pressure, but also by the presence of target organ damage, as well as CVD or concomitant disease associated with high CVD risk, and calculated CVD risk.

The GDG considered that target organ damage may not always be due to hypertension, even when the two appear to co-exist. The GDG also noted that people with target organ damage are a higher risk group and the best possible assessment of their blood pressure level when initiating treatment seemed appropriate. The GDG therefore concluded that the routine assessment of simple markers of target organ damage, a clinical history and examination to identify associated CVD and when indicated, cardiovascular risk calculation, should all form part of the routine assessment of a person with suspected or confirmed hypertension. However, there was no firm evidence from which to define the exact composition of assessment and the recommendations on these components are therefore consensus-based.

### NICE recommendation 1.3.3

The GDG considered that medical history, physical examination, and limited diagnostic testing serve to identify an individual's profile of cardiovascular risk factors including age and gender, smoking, hyperlipidaemia, diabetes, and family history of CVD. It was noted that testing may detect diabetes and identify signs of developing target organ damage such as left ventricular hypertrophy and angina. It may also detect secondary causes of hypertension.

The guideline group identified the following tests as necessary to obtain an accurate profile of cardiovascular risk. They commented that these tests may help identify diabetes, evidence of hypertensive damage to the heart and kidneys, and secondary causes of hypertension such as kidney disease:

- Urine strip test for blood and protein
- Blood electrolytes and creatinine, and eGFR
- Blood glucose
- Serum total and HDL cholesterol

- 12 lead electrocardiogram.

### **Cost effectiveness**

No cost-effectiveness evidence was presented specifically in relation to assessment of target organ damage.

## **Assessment of recommendations against current practice**

### **Current practice**

No evidence has been identified to illustrate the extent to which the individual elements which constitute an assessment for target organ damage (as listed in recommendation 1.3.3) are being undertaken in primary care in people with newly diagnosed hypertension. In addition, the GDG of the hypertension guideline noted that no useful diagnostic studies were found which might establish primary care screening characteristics for secondary causes of hypertension as a basis for referral.

However, an assessment of CVD risk has since been incentivised in the QOF under indicator PP01 continuously since 2010. At the time of publication, the NICE clinical guideline for lipid modification (2008) stated that formal assessments of cardiovascular risk were being undertaken opportunistically. Since it's incentivisation in QOF an assessment of CVD risk has become part of routine practice for the majority of people with newly diagnosed hypertension. The Health and Social Care Information Centre (HSCIC) report that formal CVD risk assessments were undertaken in 80% of people with newly diagnosed hypertension in England in 2011/12.

### **Health inequalities**

Evidence shows that individual readings for blood pressure can be influenced by a number of factors including age and ethnicity. However, there is no evidence presented in the guideline that suggests the recommendations presented in this briefing paper can directly impact health inequalities [Relevance to health inequalities: moderate].

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

Recommendations 1.2.6 and 1.3.3 would be expected to lead to a moderate shift in practice. There is no evidence presented in the NICE clinical guideline for hypertension to suggest an assessment of target organ damage can directly lead to cost effective improvements in the delivery of primary care.

**Initial feasibility assessment**

As part of the development of the quality standard for hypertension the topic expert group (TEG) considered the need to define what constitutes target organ damage. The TEG noted that NICE clinical guideline 127 recommendation 1.2.6 lists left ventricular hypertrophy, chronic kidney disease and hypertensive retinopathy as examples of target organ damage.

The TEG also noted that although the underpinning guideline recommendation stipulates that investigations are carried out whilst awaiting a diagnosis of hypertension, in order for the statement to be measurable (and a defined population consistently identified across practices) the statement would need to focus on confirmed cases of hypertension. The TEG also considered that to ensure investigations are undertaken in a timely way following diagnosis there was a need to stipulate a timeframe in the statement and one month was considered appropriate, based on their expert opinion. For the purposes of QOF consideration would need to be given as to whether the time frame should be set to allow for tests to be undertaken before and after the diagnosis of hypertension is confirmed.

Due to the extensive deliberations of the TEG, the NICE QOF team considers an indicator based on statement 2 of the quality standard (an assessment of target organ damage) feasible.

**Key considerations**

The following key considerations summarise the key points made in the briefing paper and should be used by the Committee in their deliberations.

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- Indicators on an assessment of target organ damage in people with newly diagnosed hypertension are considered feasible, are supported by expert opinion, and would be expected to lead to a moderate change in practice.
- The GDG of the NICE clinical guideline for hypertension considered that in order to obtain an accurate profile of cardiovascular risk, undertaking tests for target organ damage (included in recommendation 1.3.3) is necessary.
- An assessment of CVD risk in people with newly diagnosed hypertension has been incentivised in the QOF since 2010. Indicators on an assessment of target organ damage would allow more complete profile of cardiovascular risk to be established in people with newly diagnosed hypertension to better inform management in this group.

### ***Assessment against NICE's prioritisation criteria***

The condition is considered to have population prevalence that is high and fully meets the criteria for diagnosis, treatment and monitoring in primary care (by general practitioners or directly employed practice staff). The recommendations selected are considered feasible. Recommendations 1.2.6 and 1.3.3 are based on the expert opinion of the GDG. No evidence of cost effectiveness was presented for these recommendations in the full clinical guideline. The expected change in practice is considered to be moderate.

### **References**

Health and Social Care Information Centre (2011) Health Survey for England. Trend tables. Available from:

<http://www.hscic.gov.uk/searchcatalogue?productid=10152&q=title%3a%22Health+Survey+for+England%22&sort=Relevance&size=10&page=1#top>

Health and Social Care Information Centre (2011) Quality and Outcomes Framework - 2011-12, England level trend tables. Available from:

<http://www.hscic.gov.uk/article/2021/Website->

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[Search?productid=9548&q=tQOF+data+tables&sort=Relevance&size=10&page=1&area=both#top](http://www.nice.org.uk/search?productid=9548&q=tQOF+data+tables&sort=Relevance&size=10&page=1&area=both#top)

Chronic heart failure: management of chronic heart failure in adults in primary and secondary care NICE clinical guideline 108 (2010). Available from [www.nice.org.uk/guidance/CG108](http://www.nice.org.uk/guidance/CG108)

Diagnosis and initial management of acute stroke and transient ischaemic attack (TIA). NICE clinical guideline 68 (2008). Available from [www.nice.org.uk/guidance/CG68](http://www.nice.org.uk/guidance/CG68)

Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. NICE clinical guideline 67 (2008). Available from [www.nice.org.uk/guidance/CG67](http://www.nice.org.uk/guidance/CG67)

## Appendix A: Evidence Summary

### Evidence summary of NICE clinical guideline CG127 selected recommendations

	Recommendation	Level of evidence	Key outcomes considered	Specific considerations highlighted by guideline developers	Cost-effectiveness evidence
<b>Hypertension: target organ damage</b>					
Recommendation 1.2.6	While waiting for confirmation of a diagnosis of hypertension, carry out investigations for target organ damage (such as left ventricular hypertrophy, chronic kidney disease and hypertensive retinopathy) (see recommendation 1.3.3) and a formal assessment of cardiovascular risk using a cardiovascular risk assessment tool	GDG expert opinion	N/A	<p>The GDG noted that there are four key objectives in the assessment of a person with suspected hypertension</p> <ul style="list-style-type: none"> <li>i. to confirm whether or not blood pressure is elevated</li> <li>ii. to document the presence or absence of blood pressure related target organ damage</li> <li>iii. to evaluate the person's cardiovascular risk either due to established CVD or high CVD risk states, or by calculation of their 10 year CVD risk estimate</li> <li>iv. to consider whether there may be secondary causes for the hypertension</li> </ul> <p>A GDG also considered evidence from a systematic review of 14 antihypertensive randomised drugs trials which found that a mean reduction in diastolic blood pressure of 5–6 mmHg over 5 years achieved a relative reduction in stroke of 42% (95% CI: 33–50%) and CHD of 14% (95%CI: 4–22%).</p>	None presented

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	<b>Recommendation</b>	<b>Level of evidence</b>	<b>Key outcomes considered</b>	<b>Specific considerations highlighted by guideline developers</b>	<b>Cost-effectiveness evidence</b>
				The GDG considered that target organ damage may not always be due to hypertension, even when the two appear to co-exist. For example, the presence of ECG LVH in a person subsequently shown not to be hypertensive would prompt consideration of alternative causes for the ECG abnormality.	
Recommendation 1.3.3	<p>For all people with hypertension offer to:</p> <ul style="list-style-type: none"> <li>• test for the presence of protein in the urine by sending a urine sample for estimation of the albumin:creatinine ratio and test for haematuria using a reagent strip</li> <li>• take a blood sample to measure plasma glucose, electrolytes, creatinine, estimated glomerular filtration rate, serum total cholesterol and HDL cholesterol</li> <li>• examine the fundi for the presence of hypertensive retinopathy</li> <li>• arrange for a 12-lead electrocardiograph to be performed.</li> </ul>	GDG expert opinion	N/A	<p>The GDG considered that medical history, physical examination, and limited diagnostic testing serve to identify an individual's profile of cardiovascular risk factors including age and gender, smoking, hyperlipidaemia, diabetes, and family history of CVD.</p> <p>It was noted that testing may detect diabetes and identify signs of developing target organ damage such as left ventricular hypertrophy and angina. It may also detect secondary causes of hypertension.</p> <p>The GDG noted that the presence of protein in urine identifies people with kidney damage, but does not distinguish between people who have</p>	None presented



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	Recommendation	Level of evidence	Key outcomes considered	Specific considerations highlighted by guideline developers	Cost-effectiveness evidence
				<p>renal disease and secondary hypertension and those in whom kidney damage is due to essential hypertension.</p> <p>The GDG noted that sodium and potassium levels are checked to exclude hypertension resulting from adrenal disease. Likewise, urea and creatinine measurements, which reflect kidney function, are measured to exclude kidney disease as a secondary cause of hypertension. Glucose levels are tested to evaluate diabetes and cholesterol profiles are used to assess cardiovascular risk.</p> <p>The GDG noted that from an ECG it is possible to determine heart rate, rhythm, conduction abnormalities, left ventricular size and damage to specific regions of the heart muscle. The presence of electrocardiographic left ventricular hypertrophy is a variable used in cardiovascular risk calculators. An echocardiogram might be considered, to confirm or refute the presence of LVH suggested by ECG findings.</p>	

## Appendix B: Related QOF indicators

### ***Related existing QOF indicators from 2013/14 indicator set***

Hypertension is part of the existing QOF clinical domain as defined in the 2013/14 GMS contract guidance. QOF indicators for England for this domain are outlined below. Indicators for Scotland, Wales and Ireland can be found from the relevant countries web pages.

#### **QOF domain 2013/14: Hypertension**

<b>Indicator</b>	<b>Points</b>	<b>Achievement thresholds</b>
<b>Records</b>		
HYP001. The contractor establishes and maintains a register of patients with established hypertension	6	
<b>Ongoing management</b>		
HYP002. The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less	10	44-84%
HYP003. The percentage of patients aged 79 or under with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 140/90 mmHg or less <i>NICE 2012 menu ID: NM53</i>	50	40-80%
HYP004. The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 in whom there is an assessment of physical activity, using GPPAQ, in the preceding 12 months <i>NICE 2011 menu ID: NM36</i>	5	40-80%
HYP005. The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 who score 'less than active' on GPPAQ in the preceding 12 months, who also have a record of a brief intervention in the preceding 12 months <i>NICE 2011 menu ID: NM37</i>	6	40-80%

**QOF domain 2013/14: Cardiovascular disease – primary prevention**

Indicator	Points	Achievement thresholds
<b>Ongoing management</b>		
CVD-PP001. In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score (using an assessment tool agreed with the NHS CB) of $\geq 20\%$ in the preceding 12 months: the percentage who are currently treated with statins <i>NICE 2011 menu ID: NM26</i>	10	40-90%
CVD-PP002. The percentage of patients diagnosed with hypertension (diagnosed on or after 1 April 2009) who are given lifestyle advice in the preceding 12 months for: smoking cessation, safe alcohol consumption and healthy diet	5	40-75%

***Related indicators from the NICE menu of indicators***

All hypertension related indicators on the NICE menu have been negotiated into the 2013/14 QOF and are listed above.

***Related indicators under consideration by the Advisory Committee***

None

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

This appendix provides assessment of the overall topic and recommendation that has been produced by the QOF programme team. This takes into account information presented in this briefing paper against the revised prioritisation checklist as agreed at the July 2009 Advisory Committee.

### Topic Status

This topic meets the prioritization 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"/>
<i>* by general practitioners or directly employed practice staff</i>			

1C Disease Severity		
Score	Scoring criteria	
1	<b>Minor quality-of-life impact, no disability, limited morbidity impact</b>	<input checked="" 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 type="checkbox"/>

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4	Definite quality-of-life impact, significant disability and/or significant morbidity impact	<input type="checkbox"/>
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### **Recommendation Status**

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

<b>Feasibility of each recommendation</b>	
<b>Preconception Care</b>	
NICE recommendation 1.2.6 (CG127)	Green
NICE recommendation 1.3.3 (CG127)	Green

<b>Scores for each recommendation</b>			
	<b>Evidence of clinical effectiveness</b>	<b>Evidence of cost effectiveness</b>	<b>Expected change in practice</b>
<b>Preconception Care</b>			
NICE recommendation 1.2.6 (CG127)	Low	None presented	Moderate
NICE recommendation 1.3.3 (CG127)	Low	None presented	Moderate