Is this QOF change good news for men?

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According to NICE, 15% of the total primary care budget is spent on achieving Quality and Outcomes Framework (QOF) points, equating to around £1 billion each year (Robinson, 2011). These are the incentives that were brought out several years ago to help improve patient care, experience and treatment.

Two of the 20 proposed QOF indicators for 2013 are focusing on diabetes and erectile dysfunction (ED). These indicators are hopefully going to be agreed in the next few weeks. At present, NICE is seeking views on all 20 potential clinical and health improvement indicators for the QOF. These two new indicators within the diabetes domain ask clinicians to raise the issue of ED with men in consultations and assess and offer advice to all those who have a record of ED, focusing on contributory factors and treatment options.

It is estimated that the prevalence of men with diabetes who experience ED in England is 35–90% (Malavige and Levy, 2009). However, Haro et al (2006) concluded that the unmet need for treatment of ED was high, with 66% of men having experienced symptoms for 1 year or longer when they eventually sought treatment. They also found that severity seems to be correlated to treatment seeking.

People with diabetes are encouraged to be involved in their own care. However, if the majority of men do not seek advice or treatment for at least a year from the onset of symptoms, these new QOF indicators surely are a welcome addition to the list of indictors for diabetes.

Why should we be interested in a few extra QOF points for ED? Surely, it is just about sex? If you think that, then you are very much mistaken, as actually it is so much more than sex.

The prevalence of ED in men with diabetes varies between 35 and 90% (Malavige and Levy, 2009). It is three times more common in men with diabetes and it tends to occur around 15 years earlier in this group of men than those without diabetes (Feldman et al, 1994).

It is hoped that the proposed new QOF indicators will be an opportunity for GPs, nurses and other community staff to screen these men for the hidden comorbidities such as undiagnosed cardiovascular disease (CVD).

Vascular disease is thought to be the most common organic cause of ED, and this has recently led to evidence that the condition should be seen as an early warning sign for more widespread vascular disease (Aalbers, 2010). Montorsi et al (2003) found that ED precedes the onset of coronary artery disease in about 65% of men. Hodges et al (2007) have also shown that ED can be present for up to 5 years before the occurrence of a vascular event.

The Massachusetts Male Aging Study identified that only 10% of men will seek or receive treatment for their ED (Feldman et al, 1994). Hodges et al (2007) investigated the relationship between ED and coronary vascular disease in 372 people from GP practices in the UK and found almost 50% of men with ED missed opportunities for clinicians to perform risk assessments and provide intervention because the men did not acknowledge or discuss the fact that they had a problem.

ED is considered to be a cardiovascular risk factor with a risk equivalent to smoking. If these indicators are agreed – and the final decision rests with the BMA's GP committee and NHS Employers – this can highlight ED at an earlier stage of the disease and therefore aid screening for further CVD before an event occurs.

For those healthcare professionals who, once they have offered these men a phosphodiesterase type-5 (PDE5) inhibitor (at the lowest cost), do not know what next to offer, then a referral to a specialist is the suggested next course of action.

For a specialist nurse like me, who has been running a nurse-led andrology clinic for more than 15 years, this proposed QOF change gives me the reassurance that patients and their partners are not going to be cast aside in a cost-saving scheme. It may also help those people in regions where prescriptions have been reduced for PDE5 inhibitors, such as we have seen in Berkshire and Oxfordshire recently. ■