Alcohol use: risk assessment for people with a long-term condition

NICE indicator
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Indicator

The percentage of patients with one or more of the following conditions: CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia who have been screened for hazardous drinking using the FAST or AUDIT-C tool in the preceding 2 years.

Indicator type

General practice indicator suitable for use in the Quality and Outcomes Framework.

This document does not represent formal NICE guidance. For a full list of NICE indicators, see our menu of indicators.

To find out how to use indicators and how we develop them, see our NICE indicator process guide.

Rationale

Alcohol is a cause of significant public health burden, but use is widespread amongst most groups of society. Alcohol is the leading cause of ill-health, early mortality and disability in those aged 15 to 49 years of age (NHS Digital Statistics on alcohol). Harmful drinking is associated with multiple physical and mental health problems. This indicator intends to identify those people with described morbidities who are at risk of hazardous alcohol consumption. This will help to better manage their conditions. The 2-year timeframe is presented as a pragmatic proposal for measurement purposes. Tools such as AUDIT-C and FAST can help to identify people that may not be alcohol dependent but would benefit from an reducing their alcohol consumption.

Source guidance

Cardiovascular disease: risk assessment and reduction, including lipid modification. NICE guideline NG238 (updated 2023), recommendations 1.1.17, 1.3.10 and 1.4.12

Atrial fibrillation: diagnosis and management. NICE guideline NG196 (2021), recommendations 1.2.2, 1.2.3 and 1.6.11

Alcohol-use disorders: prevention. NICE guideline PH24 (2010), recommendation 9

Specification

Numerator: The number of patients in the denominator who have been screened for hazardous drinking using the FAST or AUDIT-C tool in the preceding 2 years.

Denominator: The number of patients with one or more of the following conditions: CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia.

Calculation: Numerator divided by the denominator, multiplied by 100.

Definitions: Not applicable.

Exclusions: People with an existing diagnosis of an alcohol related disease or disorder.

Personalised care adjustments or exception reporting should be considered to account for situations where the patient declines, does not attend or if the indicator is not appropriate.

Expected population size:

QOF register data for 2022 to 2023 shows:

- 299 patients with CHD for an average practice with 10,000 patients
- 213 patients with atrial fibrillation for an average practice with 10,000 patients
- 99 patients with chronic heart failure for an average practice with 10,000 patients
- 185 patients with STIA for an average practice with 10,000 patients
- 605 patients with diabetes for an average practice with 10,000 patients
- 74 patients with dementia for an average practice with 10,000 patients.

It is not possible to provide a single expected population size as overlap between registers is unknown. To be suitable for use in QOF, there should be more than 20 patients eligible for inclusion in the denominator, per average practice with 10,000 patients, prior to application of personalised care adjustments.

Update information

Minor changes since publication

April 2024: We updated links to source guidance NG238 and added expected population size.

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