Transient loss of consciousness

NICE quality standard

Draft for consultation

May 2014

Introduction

This quality standard covers the assessment, diagnosis and specialist referral of adults and young people (aged 16 and older) who have experienced a blackout (the medical term for this is 'transient loss of consciousness' or TLoC for short). For more information see the topic overview.

Why this quality standard is needed

Transient loss of consciousness is very common, affecting up to half the population in the UK at some point in their lives. It is defined as spontaneous loss of consciousness with complete recovery. In this context, complete recovery would involve full recovery of consciousness without any residual neurological deficit. An episode is often described as a 'blackout' or a 'collapse', but some people collapse without transient loss of consciousness; this quality standard does not cover that situation. There are various causes of transient loss of consciousness, including cardiovascular disorders (which are the most common), neurological conditions such as epilepsy, and psychogenic attacks (that is, caused by mental or emotional factors).

Approximately 3–5% of adults who attend accident and emergency departments do so because of transient loss of consciousness; this accounts for up to 6% of urgent hospital admissions. It is particularly common in people aged 65 and older; it has been estimated that up to 23% of this group experience syncope (transient loss of consciousness due to a reduction in blood supply to the brain) over a 10-year period, and there is a high rate of recurrence. Reflex (vasovagal) syncope (which is usually benign) is common in younger people. Many younger people who have a vasovagal

syncope episode may not seek medical help, so the true incidence of transient losses of consciousness – especially in younger people – is uncertain.

The diagnosis of the underlying cause of transient loss of consciousness is often inaccurate, inefficient and delayed. In addition, there is huge variation in the management of the condition. A substantial proportion of people initially diagnosed with, and treated for, epilepsy in fact have transient loss of consciousness with a cardiovascular cause. Some people have expensive or inappropriate tests, or inappropriate specialist referral (unnecessary referral or referral to the wrong specialty); others with potentially dangerous conditions may not receive the correct assessment, diagnosis and treatment.

The aim of initial assessment, diagnosis and specialist referral of people who have had a transient loss of consciousness is to ensure that that they receive the correct diagnosis quickly, efficiently and cost effectively, leading to a suitable management plan for the underlying cause.

The quality standard is expected to contribute to improvements in the following outcomes:

- Emergency hospital admissions.
- Mortality from causes considered preventable.
- Patient experience of clinical care.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measureable quality improvements within a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health:

- NHS Outcomes Framework 2014–15

- Improving outcomes and supporting transparency: a public health outcomes framework for England 2013–2016, Part 1 and Part 1A.

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS Outcomes Framework 2014–15

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare*
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition** 2.2 Employment of people with long-term conditions **Reducing time spent in hospital by people with long-term conditions** 2.3i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
3 Helping people to recover from episodes of ill health or following injury	***Overarching indicator*** 3a Emergency admissions for acute conditions that should not usually require hospital admission
4 Ensuring that people have a positive experience of care	***Overarching indicator*** 4a Patient experience of primary care i GP services ii GP out-of-hours services 4b Patient experience of hospital care ***Improvement areas*** **Improving people's experience of outpatient care** 4.1 Patient experience of outpatient services **Improving people's experience of accident and emergency services** 4.3 Patient experience of A & E services **Improving access to primary care services** 4.4 Access to i GP services **Improving children and young people's experience of healthcare** 4.8 Children and young people's experience of outpatient services
Alignment across the health and social care system * Indicator shared with Public Health Outcomes Framework (PHOF) ** Indicator complementary with Adult Social Care Outcomes Framework (ASCOF)	

Table 2 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities ***Indicators*** 4.3 Mortality from causes considered preventable* 4.13 Health-related quality of life for older people (Placeholder)
Alignment across the health and social care system * Indicator shared with NHS Outcomes Framework (PHOF)	

Coordinated services

The quality standard for transient loss of consciousness specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole transient loss of consciousness care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to adults and young people with transient loss of consciousness in primary and secondary care settings.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of healthcare should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality transient loss of consciousness service are listed in 'Related quality standards'.

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in assessing, caring for and treating adults and young people with transient loss of consciousness in primary and secondary care settings should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting adults and young people with transient loss of consciousness. If appropriate, healthcare professionals should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

Statement 1. People with suspected transient loss of consciousness have a detailed history recorded of the event.

Statement 2. People who present with transient loss of consciousness have an initial assessment that includes recording clinical history and carrying out a physical examination.

Statement 3. People who have had transient loss of consciousness receive a 12-lead ECG during initial assessment.

Statement 4. People who have had transient loss of consciousness and 1 or more ‘red flag’ signs or symptoms identified at initial assessment are referred within 24 hours for specialist cardiovascular assessment.

Statement 5. People who have had transient loss of consciousness are not routinely offered an EEG to investigate the event.

Statement 6. People with a suspected cardiac arrhythmic cause of syncope are offered an ambulatory ECG as a first-line investigation with the type of ECG chosen based on the person’s history and frequency of transient loss of consciousness.

Statement 7. People who have had transient loss of consciousness, who have been referred and are awaiting specialist assessment, are advised not to drive.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

Quality statement 1: Initial assessment – information gathering about the event

Quality statement

People with suspected transient loss of consciousness have a detailed history recorded of the event.

Rationale

If suspected transient loss of consciousness has occurred it is important to establish and collect information as soon as possible about what happened before, during and after the event from the person, including any eye-witness accounts, at the first point of contact. This is critical in confirming whether or not transient loss of consciousness has occurred so that patients can be directed along the correct care pathway. A lack of good quality history-taking could contribute to misdiagnosis and inappropriate subsequent care.

Quality measures

Structure

Evidence of local arrangements to ensure that people with suspected transient loss of consciousness have a detailed history recorded, from the person and from any eye-witnesses, including details about the event.

Data source: Local data collection.

Process

Proportion of people with suspected transient loss of consciousness who have a detailed history recorded, from the person and from any eye-witnesses, including details about the event.

Numerator – the number of people in the denominator who have a detailed history recorded, from the person and from any eye-witnesses, including details about the event.

Denominator – the number of people with suspected transient loss of consciousness.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers ensure that systems are in place for people who have had a suspected transient loss of consciousness to have a detailed history recorded, from the person and from any eye-witnesses, including a detailed description of the event itself.

Healthcare professionals who care for people who have had a suspected transient loss of consciousness record a detailed history from the person and from any eye-witnesses, including a detailed description of the event itself.

Commissioners (clinical commissioning groups, local authorities and NHS England area teams) ensure that they commission services so people who have had a suspected transient loss of consciousness have a history recorded, from the person and from any eye-witnesses, including a detailed description of the event itself.

What the quality statement means for patients, service users and carers

People who have had a blackout have an assessment that includes gathering as much information as possible about what happened. This may include contacting and talking to anyone who witnessed it, gathering information about the circumstances and duration of the event and the person's physical signs before, during and after it.

Source guidance

- Transient loss of consciousness in adults and young people (NICE clinical guideline 109) recommendation 1.1.1.2 (key priority for implementation).

Definitions of terms used in this quality statement

Gathering information about the circumstances and duration of the event and the person's physical signs

People who has had suspected transient loss of consciousness have a detailed history taken and recorded. This includes gathering information about the circumstances and duration of the event and the person's physical signs before, during and after it. The following details should be recorded about:

- circumstances of the event
- person's posture immediately before loss of consciousness prodromal symptoms (such as sweating or feeling warm or hot)
- physical appearance (for example, whether eyes were open or shut, and the colour of the person's complexion during the event)
- presence or absence of movement during the event (for example, limb-jerking and its duration)
- any tongue biting (record whether the side or the tip of the tongue was bitten)
- injury occurring during the event (record site and severity)
- duration of the event (onset to regaining consciousness)
- presence or absence of confusion during the recovery period
- weakness down one side during the recovery period.

[NICE clinical guideline 109, recommendation 1.1.1.2 (key priority for implementation)]

Quality statement 2: Initial assessment – clinical history and physical examination

Quality statement

People who present with transient loss of consciousness have an initial assessment that includes recording clinical history and carrying out a physical examination.

Rationale

The reasons for assessing people who have had a transient loss of consciousness are to diagnose the causes so that the risk of future adverse events, which may include death, can be determined. Information obtained at the initial assessment and carrying out a physical examination is critical in establishing whether a transient loss of consciousness has occurred, making an initial diagnosis and directing patients along the correct care pathway. A lack of good quality information for clinicians could result in patients receiving inappropriate subsequent care that may be costly, ineffective and possibly harmful.

Quality measures

Structure

Evidence of local arrangements to ensure that people who present with transient loss of consciousness have an initial assessment that includes recording clinical history and carrying out a physical examination.

Data source: Local data collection.

Process

Proportion of people who present with transient loss of consciousness who have an initial assessment that includes recording clinical history and carrying out a physical examination.

Numerator – the number of people in the denominator who have an initial assessment that includes recording their clinical history and carrying out a physical examination.

Denominator – the number of people who present with transient loss of consciousness.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers ensure that systems are in place for people who have had a transient loss of consciousness to have an initial assessment that includes recording their clinical history and carrying out a physical examination.

Healthcare professionals who care for people who have had a transient loss of consciousness record their clinical history and carry out a physical examination.

Commissioners (clinical commissioning groups and NHS England area teams) ensure that they commission services so people who have had a transient loss of consciousness have an initial assessment that includes recording their clinical history, and carrying out a physical examination. Commissioners should have monitoring and auditing procedures in place to ensure that initial assessments take place when a person presents with a transient loss of consciousness.

What the quality statement means for patients, service users and carers

People who have had a blackout have an assessment to find out more about the blackout and why it happened. This will involve recording details of any previous blackouts, medical history, family history of heart disease, and any medicines being taken, checking vital signs such as pulse rate, blood pressure, breathing rate and temperature, and also listening to the chest.

Source guidance

- Transient loss of consciousness in adults and young people (NICE clinical guideline 109) recommendation 1.1.2.1.

Definitions of terms used in this quality statement

Obtaining patient history, physical examination and tests

People who present with transient loss of consciousness have an initial assessment to find out more about the blackout and why it happened which will involve recording the following:

- details of any previous TLoC, including number and frequency
- the person's medical history and any family history of cardiac disease (for example,
- personal history of heart disease and family history of sudden cardiac death)
- current medication that may have contributed to TLoC (for example, diuretics)
- vital signs (for example, pulse rate, respiratory rate and temperature) – repeat if clinically indicated
- lying and standing blood pressure if clinically appropriate
- other cardiovascular and neurological signs.

[NICE clinical guideline 109, recommendation 1.1.2.1]

Quality statement 3: Initial assessment – 12-lead ECG

Quality statement

People who have had transient loss of consciousness receive a 12-lead ECG during initial assessment.

Rationale

A 12-lead ECG is an important initial diagnostic test for predicting adverse events (for example ECG abnormalities which are 'red flag' signs and symptoms may suggest structural heart disease or potential for arrhythmic syncope). It should be used by emergency services or by primary or secondary care to determine who may be at high risk of a serious event and who should therefore be referred for urgent assessment.

Quality measures

Structure

(a) Evidence of local arrangements to ensure that people who have had transient loss of consciousness receive a 12-lead ECG during initial assessment.

Data source: Local data collection.

(b) Evidence of local arrangements to ensure that 12-lead ECG findings are recorded and interpreted competently during initial assessment.

Data source: Local data collection.

Process

Proportion of people who have had transient loss of consciousness who receive a 12-lead ECG during initial assessment.

Numerator – the number of people in the denominator who receive a 12-lead ECG during initial assessment.

Denominator – the number of people who have had transient loss of consciousness.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers ensure that systems are in place to ensure that 12-lead ECGs are readily available and accessible for people who have had transient loss of consciousness during initial assessment.

Healthcare professionals who are involved in the initial assessment perform a 12-lead ECG on the person who has had transient loss of consciousness.

Commissioners (clinical commissioning groups and NHS England area teams) ensure that they commission services to include recording and interpreting a 12-lead ECG in the initial assessment of people who have had transient loss of consciousness. Commissioners should ensure that all service providers have appropriate capacity in place to provide access to 12-lead ECGs. Commissioners may request evidence of practice by auditing current procedure.

What the quality statement means for patients, service users and carers

People who have had a blackout have a 12-lead ECG (ECG is short for electrocardiogram) recorded during initial assessment. This is a test that records electrical signals from the heart and checks for problems that can cause blackouts.

Source guidance

- Transient loss of consciousness in adults and young people (NICE clinical guideline 109) recommendations 1.1.2.2 (key priority for implementation) and 1.1.2.3.

Definition of term used in this quality statement

12-lead ECG (electrocardiogram)

A test that records the heart's electrical signals, obtained by attaching electrodes in 10 standard positions on the limbs and the surface of the chest. This provides a display of the electrical activity of the heart viewed from 12 different directions. The information from the 12-lead ECG recording is most useful if the ECG findings

(reported automatically or by a competent healthcare professional) are interpreted in the full context of the detailed history and clinical signs.

[NICE full clinical guideline 109 and expert opinion]

Quality statement 4: Initial assessment – identification of ‘red flag’ signs and symptoms and urgent referral for specialist cardiovascular assessment

Quality statement

People who have had transient loss of consciousness and 1 or more ‘red flag’ signs or symptoms identified at initial assessment are referred within 24 hours for specialist cardiovascular assessment.

Rationale

It is important to identify people who are at high risk of a serious event (such as sudden death) so that they can be referred for urgent cardiovascular assessment. This should happen within 24 hours so that they can be assessed promptly by the most appropriate local service for further investigation and treatment.

Quality measures

Structure

Evidence of local arrangements to ensure that people who have had transient loss of consciousness and 1 or more ‘red flag’ signs or symptoms identified at initial assessment are referred within 24 hours for specialist cardiovascular assessment.

Data source: Local data collection.

Process

Proportion of people who have had transient loss of consciousness and 1 or more ‘red flag’ signs or symptoms identified at initial assessment who are referred within 24 hours for specialist cardiovascular assessment.

Numerator – the number of people in the denominator who are referred within 24 hours for specialist cardiovascular assessment.

Denominator – the number of people who have had transient loss of consciousness and 1 or more ‘red flag’ signs or symptoms identified at initial assessment.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers ensure that systems are in place to refer people within 24 hours for specialist cardiovascular assessment if they have had transient loss of consciousness and 1 or more ‘red flag’ signs or symptoms identified at initial assessment.

Healthcare professionals ensure that they refer people within 24 hours for specialist cardiovascular assessment if they have had transient loss of consciousness and 1 or more ‘red flag’ signs or symptoms identified at initial assessment.

Commissioners (clinical commissioning groups and NHS England area teams) ensure that they commission services to refer people within 24 hours for specialist cardiovascular assessment if they have had transient loss of consciousness and 1 or more ‘red flag’ signs or symptoms identified at initial assessment. Commissioners should ensure that appropriate care pathways are in place between service providers to ensure that people can be referred within 24 hours in line with this statement. This may require clinical commissioning groups and NHS England area teams to work in an integrated way.

What the quality statement means for patients, service users and carers

People who have had a blackout who have any signs or symptoms that could mean that they are at risk of another problem (for example, a heart problem) are referred to a specialist for more investigations within 24 hours.

Source guidance

- Transient loss of consciousness in adults and young people (NICE clinical guideline 109) recommendation 1.1.4.2 (key priority for implementation).

Definitions of terms used in this quality statement

Red flag signs or symptoms

For this guideline, the term 'red flag signs or symptoms' indicates that the person has 1 or more features suggesting that they may be at high risk of a serious adverse event and should be referred for urgent specialist assessment. These include any of the following:

- An ECG abnormality (see recommendations 1.1.2.2 and 1.1.2.3).
- Heart failure (history or physical signs).
- TLoC during exertion.
- Family history of sudden cardiac death in people aged younger than 40 years and/or an inherited cardiac condition.
- New or unexplained breathlessness.
- A heart murmur.

Consider referring within 24 hours for cardiovascular assessment, as above, anyone aged older than 65 years who has experienced TLoC without prodromal symptoms.

[Based on recommendation 1.1.4.2 and expert opinion]

Specialist cardiovascular assessment

Cardiovascular assessment is carried out by a specialist team that includes healthcare professionals who are experts in diseases or disorders of the heart and blood vessels. In some hospitals this may be carried out in a clinic dealing specifically with assessing people who have experienced transient loss of consciousness.

[Based on expert opinion]

Quality statement 5: Initial assessment- EEG

Quality statement

People who have had transient loss of consciousness are not routinely offered an EEG to investigate the event.

Rationale

Great caution is needed in performing and interpreting an EEG if the clinical history offers limited or no support for a diagnosis of epilepsy. This is because a 'false positive' result may lead to misdiagnosis and inappropriate treatment. It is important that EEGs are not requested inappropriately in the generalist setting to investigate unexplained transient loss of consciousness.

Quality measures

Structure

Evidence of local arrangements to ensure that people who have had transient loss of consciousness are not routinely offered an EEG to investigate the event.

Data source: Local data collection.

Process

Proportion of people who have had transient loss of consciousness receive an EEG to investigate the event.

Numerator – the number of people in the denominator who receive an EEG to investigate the event.

Denominator – the number of people who have had transient loss of consciousness.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers have systems in place to ensure that an EEG is not offered routinely to investigate transient loss of consciousness.

Healthcare professionals do not offer an EEG routinely to investigate transient loss of consciousness.

Commissioners (clinical commissioning groups and NHS England area teams) ensure that they commission services that do not offer an EEG routinely to investigate transient loss of consciousness. This may be achieved by improving education of healthcare professionals in acute and primary care settings in line with this statement. Clinical commissioning groups and NHS England area teams may wish to audit patients who are offered an EEG after an event.

What the quality statement means for patients, service users and carers

People who have had a blackout should not be routinely offered an EEG (short for electroencephalogram, which is a test that records the brain's electrical activity) to investigate the cause of the blackout.

Source guidance

- Transient loss of consciousness in adults and young people (NICE clinical guideline 109) recommendations 1.1.2.4 and 1.2.2.1.

Quality statement 6: Specialist cardiovascular assessment – ambulatory ECG

Quality statement

People with a suspected cardiac arrhythmic cause of syncope are offered an ambulatory ECG as a first-line investigation with the type of ECG chosen based on the person's history and frequency of transient loss of consciousness.

Rationale

Ambulatory ECGs (including implantable event recorders) are useful for prolonged monitoring over periods of at least 24 hours, and in many cases much longer, to detect intermittent episodes of cardiac arrhythmia (abnormal heart rhythm). Because many cardiac arrhythmias are not present all the time, a longer period of monitoring increases the chances of discovering irregularities, which may improve the likelihood of an accurate diagnosis.

Quality measures

Structure

Evidence of local arrangements to ensure that people with a suspected cardiac arrhythmic cause of syncope are offered an ambulatory ECG as a first-line investigation with the type of ECG chosen based on the person's history and frequency of transient loss of consciousness.

Data source: Local data collection.

Process

Proportion of people with a suspected cardiac arrhythmic cause of syncope who are offered an ambulatory ECG as a first-line investigation with the type of ECG chosen based on the person's history and frequency of transient loss of consciousness.

Numerator – the number of people in the denominator who receive an ambulatory ECG as a first-line investigation.

Denominator – the number of people with a suspected cardiac arrhythmic cause of syncope.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers ensure that systems are in place for people with a suspected cardiac arrhythmic cause of syncope to be offered an ambulatory ECG as a first-line investigation, with the type of ECG chosen on the basis of the person's history and frequency of transient loss of consciousness.

Healthcare professionals ensure that they offer people with a suspected cardiac arrhythmic cause of syncope an ambulatory ECG as a first-line investigation, with the type of ECG chosen on the basis of the person's history and frequency of transient loss of consciousness.

Commissioners (clinical commissioning groups and NHS England area teams) ensure that they commission services for people with a suspected cardiac arrhythmic cause of syncope to be offered an ambulatory ECG as a first-line investigation, with the type of ECG chosen on the basis of the person's history and frequency of transient loss of consciousness. This can be achieved by enhancing training (according to local need) and education.

What the quality statement means for patients, service users and carers

People whose blackout is suspected to be caused by a sudden change in heart rhythm are offered an ambulatory ECG test. This is a test that monitors and records the heart's activity over a period of time. It can help doctors find out if the blackouts are being caused by an abnormal heart rhythm.

Source guidance

- Transient loss of consciousness in adults and young people (NICE clinical guideline 109) recommendation 1.3.2.4 (key priority for implementation).

Definition of term used in this quality statement

Syncope

A brief lapse in consciousness caused by transient reduction in blood flow to the brain. May be caused by many different factors, including emotional stress, vagal stimulation, vascular pooling in the legs, diaphoresis, or sudden change in environmental temperature or body position.

[NICE clinical guideline 137]

Quality statement 7: Information for people with transient loss of consciousness – driving advice

Quality statement

People who have had transient loss of consciousness, who have been referred and are awaiting specialist assessment, are advised not to drive.

Rationale

A transient loss of consciousness event can have many underlying causes, some of which may co-exist and interact with each other. People who have experienced transient loss of consciousness may be at risk of injuring themselves or others if they black out again and therefore should be advised to avoid high-risk activity such as driving.

Quality measures

Structure

Evidence of local arrangements to ensure that people who have had transient loss of consciousness, who have been referred and are awaiting specialist assessment, are advised not to drive.

Data source: Local data collection.

Process

Proportion of people who have had a transient loss of consciousness, who have been referred and are awaiting specialist assessment, who have been advised not to drive.

Numerator – the number of people in the denominator who have been advised not to drive.

Denominator – the number of people who have had transient loss of consciousness who have been referred and are awaiting specialist assessment.

Data source: Local data collection

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers ensure that systems are in place so that people who have had transient loss of consciousness, who have been referred and are awaiting specialist assessment, are advised not to drive.

Healthcare professionals ensure that they advise people who have had transient loss of consciousness, who have been referred and are awaiting specialist assessment, not to drive.

Commissioners (clinical commissioning groups and NHS England area teams) ensure that they commission services so that people who have had transient loss of consciousness, who have been referred and are awaiting specialist assessment, are advised not to drive. This can be achieved by ensuring that service providers are sufficiently briefed to advise that people who have had TLoC (and have been referred and are awaiting specialist assessment) are advised not to drive.

What the quality statement means for patients, service users and carers

People who have had a blackout, who are waiting for their appointment to see a specialist, are advised that they must not drive while they are waiting for the appointment. The specialist will be able to give further advice about driving.

Source guidance

- Transient loss of consciousness in adults and young people (NICE clinical guideline 109) recommendation 1.5.2.2.

Status of this quality standard

This is the draft quality standard released for consultation from 8 May to 6 June 2014. It is not NICE's final quality standard on transient loss of consciousness. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5 pm on 6 June 2014. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee's considerations. The final quality standard will be available on the NICE website from October 2014.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its Indicators for Quality Improvement Programme. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's What makes up a NICE quality standard? for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of

100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in Development sources.

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments are available.

Good communication between healthcare professionals and adults and young people with transient loss of consciousness in primary and secondary care, and their families or carers (if appropriate), is essential. Treatment, care and support, and the information given about it, should be both age-appropriate and culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Adults and young people with transient loss of consciousness in primary and secondary care, and their families or carers (if appropriate), should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Further explanation of the methodology used can be found in the quality standards Process guide on the NICE website.

Evidence sources

The document below contains recommendations from NICE guidance that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- Transient loss of consciousness in adults and young people. NICE clinical guideline 109 (2010).

Definitions and data sources for the quality measures

Health and Social Care Information Centre (2013) HES-MHMDS data linkage Report, additional analysis – 2011–12, Experimental statistics (figures on syncope and collapse, p11).

Related NICE quality standards

Published

- Anxiety disorders. NICE quality standard 53 (2014).
- The epilepsies in children and young people. NICE quality standard 27 (2013).
- The epilepsies in adults. NICE quality standard 26 (2013).
- Patient experience in adult NHS services. NICE quality standard 15 (2012).
- Stroke. NICE quality standard 2 (2010).

In development

- Acute coronary syndromes (including myocardial infarction). Publication expected September 2014.
- Head injury. Publication expected October 2014.

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Falls.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 1.

Membership of this committee is as follows:

Mr Lee Beresford
Director of Strategy and System Development, NHS Wakefield Clinical Commissioning Group

Dr Gita Bhutani
Professional Lead, Psychological Services, Lancashire Care NHS Foundation Trust

Mrs Jennifer Bostock
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The following specialist members joined the committee to develop this quality standard:

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Consultant in Emergency Medicine, Isle of Wight NHS Trust

Dr Paul Cooper

Consultant Neurologist, Salford Royal Foundation Trust

Ms Paddy Jelen

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About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific,

concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the quality standards process guide.

This quality standard has been incorporated into the NICE pathway for transient loss of consciousness.

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