Sleep Disordered Breathing scope: stakeholder subgroup discussions **Date: Thursday 12 April 2018** **Group: 3**	
Population: **Groups that will be covered:** • Adults (18 and older) with obstructive sleep apnoea/hypopnoea syndrome (OSAHS) • No specific subgroups of people have been identified as needing specific consideration.	Is the population appropriate? • Are there any specific subgroups that have not been mentioned? <u>Notes from stakeholder discussion</u> • The group agreed that the population was appropriate. • The group suggested the following sub-groups: people with obesity, people with Down syndrome (who might be different for upper airways surgery) and people with congenital neurological problems as populations that may require separate recommendations on a review by review basis, but not as groups needing specifying here.
Key clinical issues that will be covered: We will look at evidence in the areas below when developing the guideline, but it may not be possible to make recommendations in all the areas. 1 Initial identification, assessment and referral of suspected cases of OSAHS. 2 Diagnosis of OSAHS. 3 Management of OSAHS	These are the key areas of clinical management that we propose covering in the guideline. Do you think this is appropriate, acknowledging we must prioritise areas for inclusion? • Is treatment of rhinitis a priority question to ask? Would you ever not treat the rhinitis? • Does severity of disease impact response to treatment (other than with mandibular devices)? <u>Notes from stakeholder discussion</u>

– Treatment of rhinitis in people with OSA – Upper airway surgical interventions – Positional modifiers – Mandibular advancement devices – Positive airway pressure support. 4 Monitoring of people with OSAHS – Determining efficacy of treatment – How to monitor – How to improve adherence 5 Information and support for people with OSAHS. **Key clinical issues that will not be covered:** 1 Clinical and cost effectiveness of CPAP 2 Assessment and management of central sleep apnoea	<u>Initial identification</u> The group noted the following: • Assessment scales are all subjective. • A combination of Epworth and STOP BANG are used in practice. • There are not any scales for assessing patients' ability to drive. • There are some geographical areas with no services for sleep apnoea. • Self-referral should be considered. <u>Diagnosis of OSAHA</u> The group noted the following: • There is a lot of equipment to be considered. • It is challenging to have a broad approach to this question as there a lot of grey areas. • Suggested question: what is the best investigation pathway? • Patients with a negative result on oximetry still need treatment. This needs to be addressed; no body looks at the holistic side of things currently. • A potential issue to explore is why sleep studies should be done if a GP has already diagnosed sleep apnoea. <u>Management of OSAHS</u> The group noted the following: • Mandibular advancement surgery could be covered within upper

	airway surgical interventions. • There are many things related to ENT (for example, enlarged tonsils), not just rhinitis, however, rhinitis management was agreed to be the most relevant single co-existing condition to highlight here. • Lifestyle interventions should be considered. The three key issues in sleep apnoea are alcohol, including problem drinkers and excessive drinkers, smoking and obesity. These need to be addressed in some way either in this guideline or others. Patients who stop drinking improve dramatically and this should be mentioned somewhere in the guideline. <u>Monitoring OSAHS</u> The group noted the following: • Tariffs need to be addressed (telemonitoring). Monitoring recommendations will need to consider the DVLA guidance (e.g. need for annual review for some classes of drivers and only every 3 years for others). • Some CPAP companies allow patients/sleep service to download their own data. • There is an additional cost to put a chip in some devices. <u>Information and support</u> The group noted the following: • Driving information and lifestyle management are both very important. • There is a lot of information on patient forums but no one is

	streamlining it. <u>Tolerance and adherence – how to improve?</u> The group suggested the following: • More training. • Improved feedback methods for patients. • Telemonitoring – manages people through social media. • Following up on the telephone rather than patients coming to clinics. • Advising patients how to adjust their machines over the telephone – this is starting to be introduced in some areas. <u>Areas not covering</u> The group agreed with the areas not being covered.

Further Questions:

1. Are there any critical **clinical** issues that have been missed from the Scope that will make a difference to patient care?

Effectiveness of bariatric surgery on OSAHS.

2. Are there any areas currently in the Scope that are **irrelevant** and should be deleted?

None.

3. Are there areas of **diverse or unsafe practice** or uncertainty that require address?

Variability in follow-up and getting people into the system in the first place.

4. Which area of the scope is likely to have the most marked or biggest health implications for patients?
Follow-up and monitoring.
5. Which practices will have the most marked/**biggest cost** implications for the NHS?
If waiting time is reduced and patients are seen within 8-12 weeks (as per other medical conditions).
6. Are there any **new practices** that might **save the NHS money** compared to existing practice?
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7. If you had to delete (or de prioritise) two areas from the Scope what would they be?
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8. As a group, if you had to rank the issues in the Scope in order of importance what would be your areas be?
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9. What are the priority outcomes? Is the current list correct?
• Current waiting time

- Reducing perioperative risk in surgery
- Nationwide fast tracking system

10. Any comments on guideline committee membership?

- There is a potential overlap between the technologist and the OSAHS nurse roles.
- There are some neurologists who run sleep services.
- Lay members: partner of someone with sleep apnoea, people who manage support groups, representative from a patient group and potentially someone with a working knowledge of DVLA requirements.

Co-optees:

- Bariatric surgeon
- Anaesthetist (for perioperative risk assessment)
- Someone with a working knowledge of DVLA requirements, who worked on the programme
- Someone from OSA alliance