

## Commissioning Policy

### Management Of Obstructive Sleep Apnoea

- i. Mandibular Advancement Devices
- ii. Continuous Positive Airway Pressure
  - iii. Surgical Interventions
- iv. Pharmacological Interventions

**April 2010**

**This commissioning policy applies to patients within:**

South Worcestershire Clinical Commissioning Group (CCG)  
 Redditch & Bromsgrove Clinical Commissioning Group (CCG)  
 Wyre Forest Clinical Commissioning Group (CCG)

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## SUMMARY

NHS Redditch & Bromsgrove Clinical Commissioning Group, NHS South Worcestershire Clinical Commissioning Group and NHS Wyre Forest Clinical Commissioning Group (also termed “the Commissioner” in this document) supports the routine NHS funding of treatments/therapies and interventions to assist in the management of patients with obstructive sleep apnoea in line with the patient treatment pathway and clinical eligibility criteria agreed with local specialists in the management of this condition.

*For further information about the treatment pathway, see section 5.*

## 1. Definitions

- 1.1 **Exceptional clinical circumstances** are clinical circumstances pertaining to a particular patient, which can properly be described as exceptional. This will usually involve a comparison with other patients with the same clinical condition and at the same stage of development of that clinical condition and refer to features of the particular patient which make that patient out of the ordinary, unusual or special compared to other patients in that cohort. It can also refer to a clinical condition which is so rare that the clinical condition can, in itself, be considered exceptional. That will only usually be the case if the NHS commissioning body has no policy which provides for the treatment to be provided to patients with that rare medical condition.
- 1.2 A **Similar Patient** refers to the existence of a patient within the patient population who is likely to be in the same or similar clinical circumstances as the requesting patient and who could reasonably be expected to benefit from the requested treatment to the same or a similar degree. When the treatment meets the regional criteria for supra-CCG policy making, then the similar patient may be in another CCG with which the Commissioner collaborates. The existence of one or more similar patients indicates that a policy position is required of the Commissioner.
- 1.3 An **individual funding request (IFR)** is a request received from a provider or a patient with explicit support from a clinician, which seeks funding for a single identified patient for a specific treatment.
- 1.4 An **in-year service development** is any aspect of healthcare, other than one which is the subject of a successful individual funding request, which the Commissioner agrees to fund outside of the annual commissioning round. Unplanned investment decisions should only be made in exceptional circumstances because, unless they can be funded through disinvestment, they will have to be funded as a result of either delaying or aborting other planned developments.

## 2. Scope of policy:

This policy should be considered in line with all other Worcestershire Commissioning Policies. Copies of these Commissioning Policies are available on the Worcestershire’s local website at the following address:

<http://www.worcestershire.nhs.uk/policies-and-procedures/commissioningindividual-funding-requests-ifr/>

## 3. Background:

- 3.1. NHS principles have been applied in the agreement of this policy.
- 3.2. Obstructive Sleep Apnoea (OSA) can be defined as the coexistence of excessive daytime sleepiness with irregular breathing at night. The consequences of untreated sleep apnoea on daily function are multiple and include increased daytime sleepiness, impairment of cognitive function, mood and personality changes. These symptoms can have serious consequences during activities where reduced alertness is dangerous, such as driving, leading to an increased risk of road accidents. There is objective evidence for a 1.3 to 12-fold increase in accident rates among patients with OSA. Sleepiness at the wheel is estimated to cause 20% of road accidents on major highways, although it is unclear how many of these are due to OSA. These accidents usually occur at high speed, without avoidance reactions and are associated with serious injuries and a high mortality rate [SIGN, 2003].
- 3.3. There is an independent association between OSA and hypertension, with marked rises in blood pressure during sleep in patients with OSA. The resulting impact of this rise of blood pressure on myocardial infarction and stroke has not been proven in patients with OSA. A trial published in the New England Journal of Medicine has demonstrated that OSA independently increases risk of stroke or death from any cause and that increased severity of OSA is associated with an incremental increase in the risk of stroke or death [Yaggi et al, 2005].
- 3.4. There are known factors that predispose to apnoeas and hypopnoeas including: increasing age, male gender, obesity, sedative drugs, smoking and alcohol consumption.

## **4. Relevant National Guidance and Facts**

### **4.1. Definition and Diagnosis of Sleep Apnoea**

- 4.2. The frequency of apnoeas and hypopnoeas hourly is used to assess the severity of OSA and is called the apnoea/hypopnoea index (AHI). Other measures including oximetry, computerised EEG analysis, autonomic arousal detection or body movement analysis may be equally as good at characterising the severity of sleep apnoea.
- 4.3. OSA may be subdivided into varying degrees of breathing abnormality depending on the AHI:
  - Mild                   AHI 5-14/hr slept
  - Moderate            AHI 15-30/hr slept
  - Severe                AHI >30/hr slept
- 4.4. Clinically significant AHI is likely to be present when AHI  $\geq$  15 events/hour slept in association with unexplained daytime sleepiness or a minimum of two other features of the condition.
- 4.5. The Epworth sleepiness scale (ESS) is a validated method of assessing the likelihood of falling asleep in a variety of situations. The maximum score is 24. The score can be used to subdivide patients into either the normal to mild range (ESS < 10), moderate subjective daytime sleepiness (ESS 10-15) or severe subjective daytime sleepiness (ESS >15). It is recommended that both the patient and their partner complete the scale independently. The correlation between the ESS and OSA is weak, however the ESS is the best available tool to guide the clinician as to the patients perception of his/her sleepiness.
- 4.6. Polysomnography (PSG) records sleep and breathing patterns simultaneously. It is conventionally performed in a sleep centre, but portable home-based versions are available. PSG is carried out at a sleep centre and is a relatively intrusive and costly study whose interpretation can be complex. It

involves a variety of measurements and recordings. The clinical value of performing PSG on all patients has been questioned. Whilst PSG is accepted as the gold standard test in some countries, it has never been independently validated.

- 4.7. Oximetry is often used as the first screening tool. Oximeters detect the oxygen saturation of the arterial blood at the point of recording i.e. usually finger tip. Oximeters are cheap, but have their limitations such as accuracy +/- 3% between individuals and false negative results in certain patient groups. In OSA, the standard method of oximetry data analysis involves counting the number of oxygen desaturations (dips) per hour greater than an agreed value (commonly 4% SpO<sub>2</sub> dip rate of greater than 10 dips per hour).
- 4.8. Using this method, 5-10 dips per hour indicate mild OSA, 10-30 dips moderate and greater than 30 severe. Oximetry needs to be interpreted by a trained observer.
- 4.9. A combination of these diagnostic tools can be used together with the results of a physical examination to confirm diagnosis and assess severity of OSA.

#### **4.10. Evidence in support of interventions for OSA**

- 4.11. The National Institute for Health and Clinical Excellence (NICE) has reviewed the evidence for use of CPAP and recommended the following:
  - CPAP is recommended as a treatment option for people with moderate and severe symptomatic OSA
  - CPAP is only recommended as a treatment option for people with mild symptomatic OSA if lifestyle advice and any other relevant treatment options have been considered and deemed inappropriate or unsuccessful [NICE, 2008].
- 4.12. Economic evaluation by the NICE assessment group identified the increased cost per quality adjusted life year (QALY) gained from CPAP use compared with lifestyle management as £20,585 per QALY gained for mild OSA, £9391 for moderate and £4413 for severe (the analysis excluded road traffic accidents and cardiovascular events). The evidence for treatment of symptomatic patients with mild OSA is not as strong. However, there may be people with mild severity grading, who have considerable OSA symptoms affecting their quality of life that may benefit from CPAP (e.g. lorry drivers).
- 4.13. The Scottish Intercollegiate Guidelines Network (SIGN) published national clinical guidelines "Management of Obstructive Sleep Apnoea/Hypopnoea Syndrome in Adults" in June 2003. These guidelines, together with summaries of relevant Cochrane Reviews, form the basis of the evidence for alternative treatment options summarised in Table 1.

## **5. Commissioning Policy**

- 5.1 The Commissioner considers all lives of all patients whom it serves to be of equal value and, in making decisions about funding treatment for patients, will seek not to discriminate on the grounds of sex, age, sexual orientation, ethnicity, educational level, employment, marital status, religion or disability except where a difference in the treatment options made available to patients is directly related to the patient's clinical condition or is related to the anticipated benefits to be derived from a proposed form of treatment.
- 5.2 The severity of the sleep apnoea should be assessed by a respiratory physician. Patients can not be referred for CPAP treatment by their GPs.

### **5.3 Mild sleep apnoea**

Patients should be offered behavioural interventions and should be provided with patient information leaflets to help manage their condition (Appendix 2 Sample patient information leaflet). These patients should not normally be referred to secondary care. In those circumstances where patients are referred to secondary care then:

- Funding for CPAP provision will only be available on an exceptional individual case basis if the patient has symptoms that seriously affects their quality of life and ability to go about their daily activities and if lifestyle advice and any other relevant treatment options have been considered and deemed inappropriate or unsuccessful.
- IOD/MAD may be provided if deemed clinically appropriate.

### **5.4 Moderate sleep apnoea**

Patients with moderate sleep apnoea are eligible for NHS funding of an appropriate management option as determined by the treating respiratory physician. CPAP and IOD/MAD are appropriate treatment options for patients with moderate OSA. Patients should also be offered behavioural interventions and patient information leaflets.

### **5.5 Severe sleep apnoea**

Patients with severe sleep apnoea are eligible for NHS funding of an appropriate management option as determined by the treating respiratory physician. In the first instance, this should involve use of a CPAP machine. IOD/MAS is an appropriate treatment option for patients with severe OSA who are unable to tolerate CPAP. Patients should also be offered behavioural interventions and patient information leaflets.

### **5.6 Intra-oral Devices (IOD)/Mandibular Advancement Devices (MAD)**

IOD/MAD is an appropriate treatment option for patients with moderate sleep apnoea and for patients with severe OSA who are unable to tolerate CPAP. IOD/MAD may be considered for patients with mild sleep apnoea if deemed clinically appropriate. The use of IOD/MAD should be monitored to allow device adjustment and assessment of OSA control and symptoms.

### **5.7 Existing users of CPAP/MAD (prior to publication of NICE guidance)**

Patients who received CPAP, either NHS or self-funded, prior to the publication of the NICE guidance and who have benefited from treatment, will be deemed to meet the NICE criteria for access to CPAP and become eligible for NHS funded treatment including equipment. This will only apply from the date of publication of NICE guidance; there will be no retrospective reimbursement of costs incurred prior to this date.

### **5.8 Patients who do not meet the criteria for CPAP/MAD provision, but who self-purchase equipment**

Patients who do not meet the criteria for CPAP provision but who choose to self-purchase the equipment should be clearly advised that they will need to accept responsibility for funding of all costs associated with use of this device, including the costs of hospital follow up and review appointments.

### **5.9 Patients who do meet the criteria for CPAP/MAD provision but who self-purchase equipment (e.g. auto-titrating CPAP)**

Patients who meet the criteria for CPAP or MAD provision, but who choose to self-purchase alternative equipment are eligible for NHS funding of usual maintenance equipment associated with the use of this device and hospital follow up and review appointments. If the required maintenance equipment is not available in the NHS, alternative equipment will be offered in accordance with standard care pathways.

## 5.10 Policy for other modalities of treatment for sleep apnoea

- 5.11 **Use of humidifiers** The evidence does not support routine use of humidifiers in patients with sleep apnoea and consequently humidifiers should not be routinely funded. Consideration should be given to exceptional cases (see below).
- 5.12 **Auto-CPAP machines** The evidence does not support routine use of these machines in patients with sleep apnoea and consequently auto-CPAP machines should not be routinely funded. Consideration should be given to exceptional cases (see below).
- 5.13 **Surgery** The evidence for surgical interventions for treatment of sleep apnoea is considered to be insufficient to support routine funding. For patients presenting with severe sleep apnoea as previously defined, and who have abnormally large tonsils, tonsillectomy will be funded where considered appropriate. This decision needs to be made in consultation with an ENT physician. It is expected that this will only apply to a small number of patients. Exceptional case requests for other surgical interventions should be considered by the Commissioner Non Contracted Activity Panel (NCA). This will require support for the procedure from both a respiratory and ENT consultant, and a case being made for consideration as an exception (for example bariatric surgery in a patient whose OSA is due to morbid obesity).
- 5.14 **Pharmacological treatments including Modafenil** The Area Prescribing Committee (APC) in Worcestershire has reviewed the evidence for use of these agents. There is limited evidence of benefit in patients with sleep apnoea and no particular medication has demonstrated a consistent response. The APC concluded that pharmacological therapies should not be used for sleep apnoea and should not be funded on the NHS in Worcestershire.
- 5.15 **Exceptions:**  
The Commissioner has internal mechanisms through which patients may be considered as an exception to the above policy. Therefore, any clinician wishing to have a patient considered for an intervention for sleep apnoea not supported by the above policy may submit a case to the Commissioner's Individual Funding Request process. The case submitted should clearly detail why the individual request is considered to be exceptional in nature. Exceptionality will need to demonstrate an increased clinical benefit for the individual patient concerned over other patients with the same condition.

## 6. Clinically Exceptional Circumstances

- 6.1 If there is demonstrable evidence of a patient's clinically exceptional circumstances, the referring practitioner should refer to the Worcestershire's local "Individual Funding Request Policy" document for further guidance on the process for consideration.

For a definition of the term "clinically exceptional circumstances", please refer to the **Definitions** section of this document.

## 7. Documents Which Have Informed This Policy

- Worcestershire's local: Individual Funding Request Process
- Worcestershire's local: Prioritisation Framework for the Commissioning of Healthcare Services

- West Midlands Strategic Group Commissioning Policy 1: Guiding principles and considerations to underpin priority setting and resource allocation within collaborative commissioning arrangements
- West Midlands Strategic Group Commissioning Policy 4: Use of cost-effectiveness, value for money and cost effectiveness thresholds
- West Midlands Strategic Group Commissioning Policy 16: Prior Approval
- West Midlands Strategic Group Commissioning Policy 9: Individual funding requests

**Table 1: Summary of Evidence for Other Treatment Modalities and Local Policy for Use**

<i>Intervention</i>	<b>Evidence</b>	<b>Recommended place in therapy</b>	<b>Local policy for use</b>
<b>Behavioural (weight, smoking, alcohol, sedatives etc)</b>	Weight reduction does improve symptoms and has been associated with improvement in desaturation and other OSA markers. However, sustained weight reduction is rarely achieved. Other measures may suffice in simple snorers or in mild OSA with few symptoms, but most patients with OSA need additional treatment. There is no RCT evidence to support use of these interventions.	Weight loss should be encouraged in all patients with obesity contributing to their OSA. Other issues should be addressed as a matter of good practice for moderate and severe OSA and as a treatment option for mild OSA.	<b>Offer behavioural interventions to all patients as a matter of good practice. Patient Information Leaflet should be available.</b>
<b>Intra-oral Devices (IOD) = Mandibular Advancement Devices (MAD)</b>	The value of IOD as first line management of mild and moderate OSA has been demonstrated, but effectiveness in severe OSA is limited by a lack of prognostic indicators for success. Comparative studies with CPAP have identified statistically significant objective improvements in favour of CPAP, whilst subjective measures have been comparable. Patients preferred long-term use of IOD to CPAP. Subjective sleepiness scores, ratings relevant to driving and functional status all improve following treatment with IOD.	IOD are an appropriate therapy for snorers and for patients with mild and moderate OSA. IOD are an appropriate alternative therapy for patients who are unable to tolerate CPAP. <b><i>The use of IOD should be monitored to allow device adjustment and assessment of OSA control and symptoms.</i></b>	<b>Local funding for severe patients unable to tolerate CPAP.</b>
<b>Auto-CPAP</b>	The use of APAP is this auto-CPAP in auto-titration has not been established. For the treatment of OSA, studies show that APAP uses a lower treatment pressure than CPAP. However, clinical outcomes with APAP are no better than those with CPAP. It is uncertain whether there is better compliance with the use of APAP.	Not routinely recommended for use. However consideration will be given to patients who fail on a fixed pressure machine.	<b>Not funded in Worcestershire for OSA*</b>
<b>Humidification with CPAP</b>	Evidence has shown that humidifiers prevent upper airway dryness associated with CPAP use. However, there is no evidence of increased adherence with humidifier use.	Not routinely recommended for use. However, consideration will be given to patients who threaten to discontinue CPAP in the absence of humidification.	<b>Not funded in Worcestershire for OSA*</b>
<b>Bi-level Positive Airway Pressure</b>	A well designed RCT found no evidence of benefit for bi-level support over CPAP in straightforward OSA.	Bi-level ventilation should not be used routinely in OSA, but should be reserved for patients with ventilatory failure.	<b>Not funded in Worcestershire for OSA*</b>
<b>Pharmacological Treatment</b>	There is limited evidence for this and no particular medication has demonstrated a consistent response.	Pharmacological therapy should not be used as a first line therapy for OSA.	<b>Not funded in Worcestershire for OSA*</b>
<b>Surgery</b>	Uvulopalatopharyngoplasty (UPPP) – no RCT evidence to support use. Case studies poor and unpredictable. Laser assisted UPPP (LAUP) – Evidence is insufficient to support use. UPPP has an adverse effect on the patient’s subsequent ability to use nasal CPAP. Studies reviewed by Cochrane do not provide evidence to support the use of surgery in sleep apnoea/hypopnoea syndrome, as overall significant health benefit has not been demonstrated.	Tonsillectomy may be beneficial in patients with large tonsils. UPPP or LAUP are not currently recommended until there is clarity on the long term benefits of surgical correction.	<b>Tonsillectomy is supported for patients with severe sleep apnoea and abnormally large tonsils. Other surgical interventions are not funded in Worcestershire for OSA*</b>
<b>Other: Permanent mandibular advancement; Suprahyoid tensing; bariatric surgery; nasal surgery; tracheostomy</b>	For these interventions there is either a lack of positive outcome on OSA or a lack of RCTs to support use.	These interventions should not be used routinely and further evaluation is required.	<b>Not funded in Worcestershire for OSA*</b>

\* Exceptional case requests for interventions not routinely funded will be considered by the Individual Funding Request process.

**Sample Content For  
Patient Information Leaflet – Snoring And Sleep Apnoea**

**Appendix 2**

Snoring is a very common problem. It is estimated that 24-50% of men and 14-30% of women are snorers. Often the snorer may be completely unaware of the problem whilst their partner suffers sleepless nights. This can be a source of considerable tension in a relationship.

**What Causes Snoring?**

When we are awake the upper part of the airway to the lungs better is held wide open by muscles. However, when we are asleep these muscles can become rather slack allowing the airways to narrow a little. When this happens, the floppy walls of the airway can vibrate as air moves into the lungs. This vibration is what causes the sound we all know as snoring. In a small proportion of people the walls of the airways almost collapse completely and as a result they may stop breathing altogether for a period of 10 seconds or more. This is called sleep apnoea and can lead to sleepiness during the day, poor concentration and various other medical problems.

Another important contributing factor is mouth breathing. It is normal for human beings to breathe through their nose most of the time and when air travels from the nose to the lungs it does so in a smooth flow. However, if for some reason the nose is blocked then the person must resort to breathing through his or her mouth. Airflow from the mouth to the lungs is not smooth but turbulent, again leading to vibration of the airways and snoring.

**Predisposing Factors**

Snoring is commoner in men and in older people. There are also some medical conditions and certain lifestyle factors which may predispose to snoring:

**Weight** - This is the most important factor. Excess fat, especially around the neck area, squashes the airway and the muscle tone may not be sufficient to prevent it from narrowing. Simply losing excess weight can drastically reduce or even stop snoring.

**Smoking** - Cigarette smoke irritates the lining of the nose causing it to swell and produce excess catarrh. This results in nasal congestion leading to mouth breathing and, as previously explained mouth breathing increases the likelihood of snoring.

**Alcohol/Sleeping Tablets** - Excess alcohol (especially late night drinking) causes a reduction in the tone of the muscles that keep the airway open leading to airway collapse, vibration and snoring. The same is true of sleeping tablets.

**Medical Conditions** - Any condition which causes the nose to become blocked, for example a cold, hay fever, polyps or a broken nose will result in mouth breathing thereby increasing the likelihood of snoring. Also those with small lower jaws or long floppy palates are also more likely to snore.

**Diagnosis**

Snoring is usually diagnosed following a description of the problem by a partner. If the partner also describes periods of stopping breathing in addition to snoring, then the condition known as sleep apnoea may be present. The diagnosis of sleep apnoea is confirmed after monitoring the patient overnight in a sleep laboratory.

**Treatment**

Lifestyle changes such as stopping smoking, losing weight and reducing alcohol consumption may considerably improve or even cure the problem.

Adopting a suitable sleeping position may also help. Most people snore whilst lying on their backs so lying/sleeping on your side or propping yourself up on pillows may help.

Nasal Dilators - There are several commercially available devices such as "Nosovent" or "Breathe Easy Nasal Strips" which are designed to hold the nostrils open and allow a better airflow through the nose. You may have seen rugby players or footballers wearing these on television.

Other modalities of treatment (e.g. nasal sprays) are also available, but these need to be discussed with your general practitioner.

Partners - Snoring can be extremely distressing for the partner. Wearing earplugs, listening to a "walkman", employing relaxation techniques or self-hypnosis may be helpful; if not another room will provide the peace and quiet essential for a good night's sleep.

**Suggested Referral Guidelines for General Practitioners**

**Appendix 3**

**Initial Assessment**

- The first step is to decide whether the patient is simply snoring or has sleep apnoea.
- The Commissioner considers simple snoring to be a low priority and should be managed with lifestyle advice. Referrals to ENT are not appropriate.
- For sleep apnoea refer to the respiratory team ONLY if the patient meets the criteria below
- **Referrals should go direct to the respiratory department in the first instance unless there is an obvious anatomical anomaly requiring ENT input.**

**Criteria for Referral (all to be met)**

- Exclusion and correction of other causes (e.g. cold, hayfever, polyps, broken nose)
- Epworth Sleepiness Score > 10\*
- 2 or more dominant clinical features
- 2 or more other clinical features
- Failure of behavioural interventions (see appendix 1)

\*in some patients excessive daytime sleepiness will be evident despite an Epworth score of <10, it is appropriate for these patients to be referred if all other criteria are fulfilled.

**When referring patients please enclose:**

- Completed Epworth questionnaire
- Partner questionnaire
- Referral rationale for the individual patient.

**Epworth Sleepiness Scale (assesses extent of daytime sleepiness, not tiredness)**

Score	Significance
Score < 10	Normal to mild score
Score 10 – 15	Moderate and potentially clinically significant score
Score 15 and over	Clinically significant

**History**

Dominant	Other
<ul style="list-style-type: none"> <li>• Excessive daytime sleepiness</li> <li>• Impaired concentration</li> <li>• Snoring</li> </ul>	<ul style="list-style-type: none"> <li>• Unrefreshing sleep</li> <li>• Choking episodes during sleep</li> <li>• Witnessed apnoeas</li> <li>• Restless sleep</li> <li>• Irritability/personality change</li> <li>• Nocturia</li> <li>• Decreased libido</li> </ul>

**Suggested Clinical Examinations**

<ul style="list-style-type: none"> <li>• Weight and height</li> <li>• Mandible size</li> <li>• Upper airway obstruction</li> <li>• Pharyngeal appearance</li> <li>• Routine respiratory, cardiovascular and neurological examinations</li> </ul>	<ul style="list-style-type: none"> <li>• Neck circumference</li> <li>• Nasal patency</li> <li>• Oral cavity (for macroglossia and dentition status)</li> <li>• Blood pressure</li> </ul>
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## The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things, try to work out how they would have affected you.

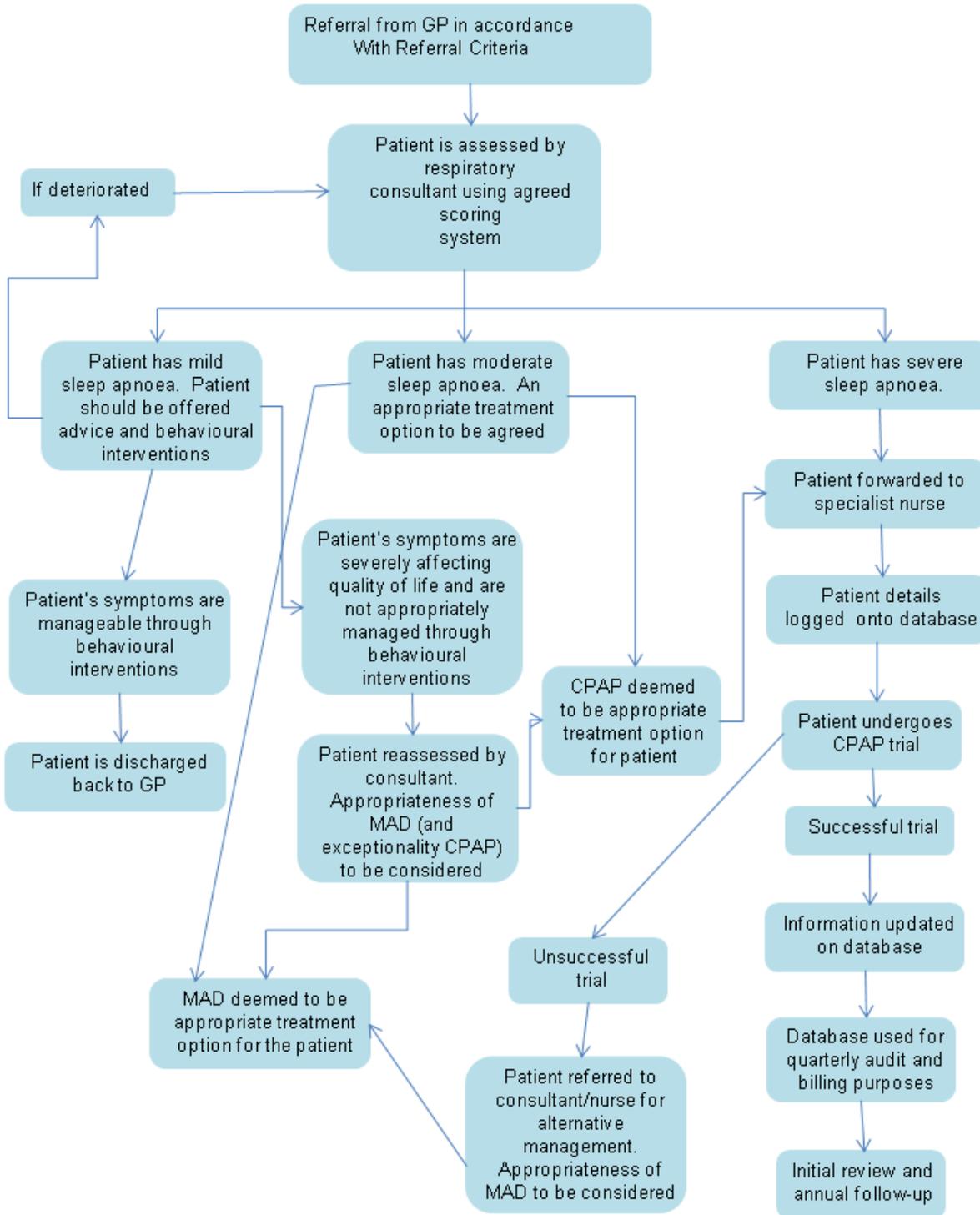
Use the following scale to choose the most appropriate number for each situation.

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (eg a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
<b>TOTAL (max. 24)</b>	

**Pathway of Care for Patients with Sleep Apnoea**

**Appendix 5**



## Equality Impact Assessment Report Template

Your Equality Impact Assessment Report should demonstrate what you do (or will do) to make sure that your function/policy is accessible to different people and communities, not just that it can, in theory, be used by anyone.

- |    |   |  |
|----|---|--|
| 1. | Name of policy or function                  | NHS Worcestershire Management Of Obstructive Sleep Apnoea Commissioning Policy   |
| 2. | Responsible Manager                         | Helen Bryant   |
| 3. | Date EIA completed                          | 12 <sup>th</sup> November 2009   |
| 4. | Description of aims of function/policy      | To provide referral guidelines on the treatment options available to assist with the management of patients obstructive sleep apnoea (mild, moderate or severe). |
| 5. | Brief summary of research and relevant data | Not Applicable   |
| 6. | Methods and outcomes of consultation        | Not Applicable   |

## Results of Initial Screening or Full Equality Impact Assessment

<b>Initial or Full Equality Impact Assessment?</b>	
<b>Equality Group</b>	<b>Assessment of Impact</b>
Race	LOW
Gender	LOW
Disability	LOW
Age	LOW
Sexual Orientation	LOW
Religion or Belief	LOW
Human Rights	LOW

7. Decisions and or recommendations (including supporting rationale) Not Applicable
8. Equality action plan (if required) Not Applicable
9. Monitoring and review arrangements (include date of next full review)

Department	Acute Commissioning
Directorate	Delivery
Director	Simon Hairsnape
Report produced by and job title	Helen Bryant, Commissioning Manager
Date report produced	12/11/2009
Date report published	12/11/2009