# Approaches to Addressing Sleep Services Waiting Times

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**Endorsed by Association of Respiratory Physiology (ARTP)**

# Introduction

The number of referrals into sleep medicine services is growing with the recognition of the impact sleep problems have on daytime function, ability to drive and the links with other diseases such as cardiac and vascular problems. Sleep referrals are also increasing with the important step in perioperative assessment. As a result the waiting list for sleep diagnostics and subsequent treatment needs to be addressed.

Depending upon the clinical condition a variety of sleep diagnostics may be used including actigraphy, overnight oximetry, a variety of forms of respiratory polygraphy (multichannel) and more complex electroencephalogram (EEG) based recordings, full polysomnography, multiple sleep latency test (MSLT) and maintenance of wakefulness test (MWT).

Beyond making a diagnosis there is a need for treatment which for obstructive sleep apnoea (OSA) is usually continuous positive airways pressure (CPAP), a mandibular advancement device (MAD) and occasionally other forms of intervention, while for other sleep problems no physical therapies and drug treatment may be required.

The diagnostics listed above are captured within DM01 which together with waiting times can be used to track the pathway through diagnosis to management.

The aim of this document is to assist providers and integrated care systems (ICSs) in delivering timely management across sleep pathways, be that within sleep services, via Community Diagnostic Centres or independent providers.

It is essential that the workforce that deliver sleep diagnostics and therapy are engaged in the improvement process and involved in developing and testing solutions locally.

This guide has been endorsed by Association of Respiratory Technology and Physiology (Sleep). Case studies and additional supporting documents will be shared on our Physiological Sciences NHS Futures Page. Physiological Science Programme - FutureNHS Collaboration Platform

# Immediate Actions for Improvement (<6 months)

These are the most essential actions that every system should take to ensure available capacity is maximised. It is essential that the workforce that deliver sleep services are engaged in the improvement process and involved in developing and testing solutions locally.

| | Action | Link / References |
|---|---|---|
| **1.0** | **Accurately Measure the Waiting List:**<br>Ensure that all sleep patients reported on the DM01 waiting list meet the criteria set out in the national DM01 guidance. All test activity should be included. The waiting times clock for a diagnostic test should stop once the test has been performed. Block report sleep studies should not occur, to ensure a timely diagnosis we would recommend urgent sleep studies are reported within 24 hours of study completion and non-urgent studies are reported within one week of study completion. | DM01 Guidance and DM01 FAQs<br>NHS England and Improvement |
| | **Reduce Avoidable Demand / Reduce Unwarranted Variation in Clinical Decision Making** | |
| **2.0** | **Standardise Referral Criteria for all Sleep Diagnostics**:<br>All providers should put in place referral and triage processes for sleep services that align to the NICE Guidelines for Obstructive Sleep Apnoea/Hypopnoea Syndrome and Obesity Hypoventilation. A standardised referral criteria should be developed across all providers in the system ensuring patients are referred in a consistent way and includes all the relevant clinical information. Fast track systems should be in place with a referral to treatment time being less than one month. Please refer to the page titled “Recommended Standardised Referral Criteria for Sleep services” on Page 10 of this guide and the attached references within this guide for more detailed information. Consideration will need to be given separately for patients that commonly see paediatric patients. | NICE Guidance OSAHS/OHS in over 16s 2021<br><br>BTS Guideline for Paediatric SDB (2023)<br><br>Epworth Sleepiness Score<br>STOP Bang<br><br>ARTP Sleep Standards of Care<br><br>Fast Track Service - GIRFT Respiratory Medicine Recommendation 8c<br><br>P29-30 Standardised Referral Form<br><br>Paediatric Sleep Questionnaire<br><br>Optimal Sleep Pathway |

# Immediate Actions for Improvement (2) (<6 months)

These are the most essential short-term actions that every system should take to ensure limited sleep capacity is maximised.

| | Action | Link / References |
|---|---|---|
| **3.0** | **Implement Clinically-led Triage**:<br>Clinical time should be devoted to the process of triage to ensure that all requests for sleep diagnostics are an appropriate use of a scarce resource and prioritised according to clinical need. Where incomplete clinical information has been provided by the referrer the request should be returned to allow for further clarification. Triage can be undertaken by suitably qualified clinical staff (does not necessarily need medical consultant input) or with clinical decision support systems. | Clinical Decision Support System<br><br>Implementation of a computer guided consultation in Liverpool Sleep Service<br><br>Optimal Sleep Pathway |
| **4.0** | **Review of diagnostic test requesting process:**<br>Ensure clear processes are in place regarding who can refer for sleep studies and educate other directorates that commonly refer for sleep (for example cardiology, surgical specialisms, Ear Nose and Throat, anaesthetics) on the standard referral criteria. Ensure that appropriate clinical groups that deal with patients where there is a higher risk of obstructive sleep apnoea, under an agreed framework, can refer straight to test (for example weight loss management groups). | |
| **Improve Service Utilisation Rates** | | |
| **5.0** | **Scientific / Non-Clinician led services:**<br>Services should consider establishment of scientific (or nurse, AHP) led services to clinically triage, diagnose and establish OSA patients on therapy. These services, must have agreed clinical governance processes which defines the referral criteria, clinical triage process or clinical support tools to accept and test a patient, as well as clear escalation processes for clinician input or governance to prescribe positive airways pressure therapy. A senior sleep clinician or sleep consultant should be available for advice and support staff in decision making and education in regular MDTs. Funding arrangements for sleep services, particularly with a focus on adequate staffing and training to ensure they are sustainable, will need consideration. | GIRFT Respiratory Medicine Recommendation 8<br><br>Sleep Service at the North Midlands NHS Trust |

# Immediate Actions for Improvement (3) (<6 months)

These are the most essential short-term actions that every system should take to ensure limited sleep capacity is maximised.

| | Action | Link / References |
|---|---|---|
| | **Improve Service Utilisation Rates** | |
| **6.0** | **Implement Straight to Test and direct to CPAP pathways:** With standardised referral criteria in place, a clinical triage framework and skilled and experienced physiologists (or non-clinicians such as nurses or AHPs), services should look to adopt a straight-to test pathway that can appropriately select patients that can be seen within the non-medical sleep service and receive a diagnostic test without the need for medical consultant review first. Patients with a positive study for obstructive sleep apnoea, and no other complications from the triage, clinical history or diagnostic result should be set up with CPAP therapy prior to a medical consultant review. Patients that require more complex sleep diagnostics following clinical triage or review of clinical history should be referred for these investigations immediately, or if they are not performed at the provider, to another provider that does without undue delay. | GIRFT Respiratory Medicine Recommendation 8b<br><br>Sleep Service at the North Midlands NHS Trust |
| **7.0** | **Improve DNA Rates:** Put in place measurement of DNAs for sleep diagnostics and take action to reduce DNAs through quality improvement plan. E.g. Where DNAs rates are problematic, services should call patients 2-3 days prior to the Sleep Appointment to ensure they are able to attend and if not work to fill vacant slot with another patient. This is likely to be more effective than a telephone/SMS alert. Sleep associate practitioners (see action 8) can support this task. | Reducing DNAs and GIRFT Recommendations Page 9 Further and Faster Handbook Page 8<br>GIRFT Respiratory Medicine – Recommendation 1a |
| **8.0** | **Use Sleep Associate Practitioners to improve patient flow and utilisation rates:** Sleep Associate Practitioners (Band 2 / 3) should be employed to ensure that trained clinical scientists are not spending time on administrative tasks, performing basic mask replacement or troubleshooting and issuing sleep testing equipment. | Explaining Investment in Apprenticeships – NPSTP<br><br>Sleep Service at the North Midlands NHS Trust |

# Immediate Actions for Improvement (4) (<6 months)

These are the most essential short-term actions that every system should take to ensure limited sleep capacity is maximised.

| | Action | Link / References |
|---|---|---|
| 9.0 | **Resupply and Online Troubleshooting:** Trusts should consider the cost benefit and time saved of utilising consumable resupply services to enable scientific staff to focus on providing expertise on diagnostics and best clinical care. | |
| 10.0 | **Use of experienced in-house administrators:** Administrators with knowledge and experience of delivering these types of services should be put in place, rather than centralised generic bookings teams, to ensure new and current patients are appropriately prioritised and clinic capacity is effectively utilised. | United Lincolnshire Hospital – Approach to Echocardiography Recovery<br><br>Sleep Service at the North Midlands NHS Trust |
| 11.0 | **Advice to drivers with excessive sleepiness** Sleep medicine services provide multiple types of diagnostic assessments and treatments for a broad range of conditions. There is very clear guidance from the DVLA that patients with suspected sleep apnoea syndrome should not be driving until they have been assessed for the cause of their excessive day time sleepiness. These patients will need to be fast tracked into services, as described on page 10 of this guidance, and will need prompt support from services to troubleshoot compliance issues. Failure to meet the needs of these patients may result in medical-legal issues. | BTS Statement on Driving and OSA<br><br>Optimal Sleep Pathway |
| 12.0 | **Ensuring access to treatment is available for patients with a confirmed diagnosis.** Sleep services often provide both the diagnostic assessment and the treatment of the condition. Whilst appropriate access to diagnostics is important the most valuable step in the pathway for many patients is the successful treatment and management of the sleep condition. Services must ensure there is adequate resource and availability to set up patients with therapy, such as CPAP, or there are appropriate links to deliver other interventions such as mandibular advancement devices (MAD) and other drug therapies. | Recording and Reporting Referral to Treatment (RTT) Waiting Times<br><br>Clinically Led Respiratory and Sleep Medicine Outpatient Guidance |

# Immediate Actions for Improvement (5) (<6 months)

These are the most essential short-term actions that every system should take to ensure limited sleep capacity is maximised.

| | Action | Link / References |
|---|---|---|
| | **Maximise Service Capacity Across Local System** | |
| **13.0** | **Implement Group Therapy Set Up:**<br>When setting up a patient on CPAP therapy, the instructions on how to use the device, how to clean and maintain the device and consumables is universal. Stretched resources can be better utilised by establishing multiple patients on CPAP in a group setting and delivering this advice in a group setting. Scientists, appropriately qualified nurses and AHPs with the help of support workers can work collectively on sizing and fitting patients ~~up~~ with a mask that can deliver the therapy effectively. | Group CPAP Initiation and Consultation<br><br>Further Faster Presentation – Group CPAP set up |
| **14.0** | **Use Remote Monitoring Technology:**<br>Technology enabled CPAP machines that allow remote monitoring and can facilitate remote follow up and troubleshooting should be embedded in all service models. IT and IG responsible officers within trusts should work alongside service leads to facilitate this model of care and clear service specifications should be developed to ensure patients are monitored effectively. IG leads should liaise with other IG leads in the region that have successfully implemented remote technology in their trusts. | GIRFT Recommendation 26C and D (Page 155) |
| **15.0** | **Initiation of Patient Initiation Follow Up (PIFU):**<br>Patients on Continuous Positive Airways Pressure (CPAP), that have both their symptoms and condition treated, and are deemed non-complex can be switched to PIFU following their next annual review. Patients that have informed the Driver and Vehicle License Agency (DVLA) of their diagnosis of Obstructive Sleep Apnoea Hypnoea Syndrome, must be advised they will be required to provide evidence of effective treatment and compliance which the service will provide. Patients must fully understand PIFU ensuring informed consent and supported shared decision-making processes are in place. | Sandwell and Birmingham PIFU<br><br>PIFU SOP Example<br><br>PIFU Clinical Protocol Example<br><br>Optimal Sleep Pathway<br><br>GIRFT Outpatient Guide Recommendations Page 16 |

# Medium Term Actions for Improvement (7)

These improvement actions are likely to take longer to implement than the immediate actions.

| | Action | Link / References |
|---|---|---|
| **16.0** | **Implement a common waiting list across all sites of all providers within an ICB ensuring elective routine diagnostic work is delegated to community diagnostic centres:** Community Diagnostic Centres (CDC) are now widely available to perform high volume non-complex testing for suspected obstructive sleep apnoea. Implementation of a standardised referral criteria should help to identify suspected obstructive sleep apnoea. Where there is a clinical suspicion of other sleep disorders patients should be seen in specialist sleep centres for diagnosis and treatment. | Sleep Clinics in England |
| **17.0** | **Use of Capacity within Community Diagnostics Centres:** ICBs and service leads must continue to expand sleep capacity and access to these services across systems through Community Diagnostic Centres. Sleep diagnostics is a mandated service for any standard or large model CDC. | NHSE CDC Programme |
| **18.0** | **Access Nationally Accredited Training Programmes:** Where there is a skills gap in workforce providers should encourage enrolment in appropriate commissioned programmes with the National School of Healthcare Science (NSHCS) or ARTP. The NSHCS have apprenticeships at Level 2 and Level 4 as well as the Post Graduate Certificate in Sleep. Training at each level can deliver the entire sleep pathway as proposed in this guide. ARTP can also offer professional exams targeted at particular areas of the pathway, for example polygraphy and the set up and delivery of CPAP for individuals that have not completed a commissioned course with NSHCS. | National School for Healthcare Science<br><br>ARTP Sleep<br><br>ARTP Workforce Progression Planning |

# Deliver National Investment to Expand Sleep Workforce (>1 Year)

Local improvement actions are complemented by national investment in the sleep workforce. National investment is now supporting expansion in both the training places for accredited Sleep Scientists and international recruitment of scientists to work in Community Diagnostic Centres.

The latest national expansion in training places is summarised below, with implementation being led jointly with the National School of Healthcare Science and NHS England to ensure delivery. Future investment in workforce will be determined through the Multi-Professional Education and Training Investment Plan (METIP). Each year METIP is determined by the future workforce requirements across the geographical distribution in the United Kingdom. Any investments not utilised in the current financial year will be reconsidered in future years METIPs and available training investments may be adjusted against training posts and courses where there is low demand.

| | Programmes | Numbers 25/26 est. |
|---|---|---|
| | **Physiological Science Apprenticeships:** Associate and Practitioner apprenticeships are available at L2, L4 and L6 to support departments in acute providers and CDCs | 197 |
| | **Sleep PG Cert:** Increase in supply of trained Sleep Scientists the Sleep PG Cert training scheme. | 30 |
| | **Respiratory STPs:** Expansion of Respiratory STP numbers (3 year training) | 25 |
| | **Respiratory HSSTs:** Expansion of Respiratory HSST numbers (5 year training) | |
| | **Practice Educators:** Funding of Practice Educators | 6 |

# Recommended Standardised Referral Criteria for Sleep Services

In order to ensure appropriate triage and prioritisation of patients to sleep services **all** referrals should include the following information.

- Occupation – It is important to highlight if the patient is a vocational driver or has a vigilance critical occupation (for example a pilot, Group 2 license holders (heavy goods vehicle (HGV) or other transport drivers including taxi drivers)
- Pregnancy - Whether female patients are pregnant
- Presence of excessive day time sleepiness (measured by Epworth)
- Driving Status - Group 1 driving license holder
- Important Medical Information – Presence of Unstable cardiovascular disease, awaiting major surgery requiring a pre-operative assessment, non-arteric ischaemic optic neuropathy, severe daytime hypercapnoea or hypoxaemia and chronic opioid usage

- Vigilance critical occupations or patients with hypercapnoea should be seen urgently within 2 weeks of the referral.
- Other priority patients may include patients with heart failure, cerebral vascular accident (stroke) and atrial fibrillations should be seen at the earliest opportunity so not to delay a diagnosis and commencement on treatment.

**References and Recommended Reading**


NICE Guidance OSAHS/OHS in over 16s 2021

BTS Guideline for diagnosing and monitoring paediatric sleep disordered breathing

Epworth Sleepiness Score and Paediatric Sleep Questionnaire

STOP Bang

GIRFT Respiratory Medicine Recommendation 8c

ARTP Sleep Standards of Care

P29-30 Standardised Referral Form

Optimal Sleep Pathway