Commissioning Policy
Individual Funding Request

Continuous Positive Airway Pressure (CPAP)
Treatment of Obstructive Sleep Apnoea/Hypopnoea Syndrome (OSAHS)

Criteria Based Access Policy

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## Document Control

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Continuous Positive Airway Pressure for the Treatment of Obstructive Sleep Apnoea/Hypopnoea Syndrome

Policy Statement and Date of Adoption: 13 October 2017

Continuous Positive Airway Pressure [CPAP] for the Treatment of Obstructive Sleep Apnoea/Hypopnoea Syndrome [OSAHS] is not routinely funded by the CCG and is subject to this restricted policy.

General Principles

1. Each Clinician reviewing the patient for this condition should assess the patient against the criteria within this policy prior to issuing a CPAP device.

2. Patients will only meet the criteria within this policy where there is evidence that the treatment requested is effective and the patient has the potential to benefit from the proposed treatment. Where the patient has previously been provided with the treatment with limited or diminishing benefit, it is unlikely that they will qualify for further treatment and the IFR team should be approached for advice.

3. In line with the published document “Guidance - Who Applies for Funding?”, where referrals to secondary care are accepted without funding approval having been secured, responsibility for securing funding approval will fall to secondary care.

4. Where funding approval is given by the Individual Funding Panel, it will be available for a specified period of time, normally one year. This funding will only be extended where it can be demonstrated that the patient is complying with the treatment regime and is receiving benefit from the device.

5. Patients who are overweight and suffer from OSAHS should be referred to weight management services in order to reduce their BMI as this can often aid or resolve their condition (Thomasouli, 2013). Note also that a meta-analysis shows evidence that OSAHS treatment with CPAP promotes significant increases in BMI and weight (Drager L.F., Mar 2015).

6. Patients who are smokers and suffer from OSAHS should be referred to smoking cessation services as smokers have been shown to be 2.7 times more likely to have severe OSAHS than non-smokers (Boldova A., Sep 2014).

7. Patients who drink alcohol and suffer from OSAHS should be offered advice on reducing and ceasing alcohol consumption as the use of alcohol can increase the risk or severity of the condition (NICE, 2008).
8. Patients prescribed with medication to assist with sleeping should be offered advice on reducing the use of these as this can relax upper airway muscles and impact on OSAHS (NICE, 2008).

**Background**

People who suffer from obstructive sleep apnoea/hypopnoea syndrome (OSAHS) breathe shallowing or stop breathing for short periods while sleeping. In deep sleep, the muscles of the throat relax. Normally this doesn’t cause any problems with breathing. In OSAHS, complete relaxation of the throat muscles causes blockage of the upper airway at the back of the tongue. Normal breathing then slows or stops completely. Such an episode is called an apnoea.

During an apnoea, people with OSAHS make constant efforts to breath against their blocked airway until the blood oxygen level begins to fall. The brain then needs to arouse the person from deep relaxed sleep so that the muscle tone returns, the upper airway then opens and breathing begins again. Unfortunately when a person with OSAHS falls back into deep sleep, the muscles relax once more and the cycle repeats itself again and again overnight.

In OSAHS, the apnoeas can last for several seconds and in severe cases the cycle of apnoeas and broken sleep is repeated hundreds of times per night. Most sufferers are unaware of their disrupted sleep but awaken unrefreshed, feeling sleepy and in need of further refreshing sleep.

Factors predisposing to apnoea and hypopnoea include:

- increasing age
- male gender
- obesity
- sedative drugs
- smoking and alcohol consumption.

There may also be a familial component to OSAHS possibly linked to facial or pharyngeal morphology or function but this area requires further research in order to clarify the role played by genetics.

**What is CPAP?**

CPAP stands for continuous positive airway pressure. It is the most popular treatment for obstructive sleep apnoea (OSA). It uses air pressure generated by a machine, delivered through a tube into a mask that fits over the nose or mouth.

**Defining Sleepiness and OSAHS (NICE, 2008)**

Validated tools such as the Epworth Sleepiness Scale [ESS] (MW, 2016) can be used to as a self-assessment tool to measure of a person’s general level of daytime sleepiness, or their average sleep propensity in daily life. The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient’s sleepiness.
<table>
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<th>ESS Score Range</th>
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<tr>
<td>0-10</td>
<td>the patient is within normal levels of day time sleepiness</td>
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<tr>
<td>11-14</td>
<td>the patient has mild day time sleepiness</td>
</tr>
<tr>
<td>15-18</td>
<td>The patient has moderate day time sleepiness</td>
</tr>
<tr>
<td>19-24</td>
<td>the patient has severe day time sleepiness</td>
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</table>

The severity of OSAHS is usually assessed on the basis of both the severity of symptoms (particularly the degree of sleepiness) and/or a sleep study, by using either the apnoea/hypopnoea index (AHI) or the oxygen desaturation index. OSAHS is generally considered mild when the AHI is 5–14 in a sleep study, moderate when the AHI is 15–30, and severe when the AHI is over 30.

**Note** - Sleep studies would normally only be sought by secondary care clinicians in order to confirm diagnosis including AHI levels.

<table>
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<th>AHI</th>
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<td>0 - 4</td>
<td>the patient is within normal levels</td>
</tr>
<tr>
<td>5 - 14</td>
<td>the patient has mild OSAHS</td>
</tr>
<tr>
<td>15 – 30</td>
<td>The patient has moderate OSAHS</td>
</tr>
<tr>
<td>&gt; 30</td>
<td>the patient has severe OSAHS</td>
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If other tools are used to assess the patient’s level of OSAHS, then full scoring details and references should be supplied showing assessed level of OSAHS for patient.

**Conservative Management of OSAHS**

There are a number of conservative methods that are shown to be useful in treating patients with OSAHS successfully:

- Weight management to reduce the patient’s BMI, (Thomasouli, 2013)
- Avoidance of alcohol, particularly within 6 hours of bedtime, (NICE, 2008)
- Smoking cessation, (Boldova A., Sep 2014)
- Dental devices such as Mandibular Advancement Devices in order to attempt to keep the airway clear by moving the jaw forward. (note: These devices are not prescribed on the NHS) (Sharples L.D., 2016)
- Avoidance of sedative medicines. (NICE, 2008)
- Advising the patient on appropriate levels of sleep overnight. Generally adults should have between 7 and 9 hours of quality sleep per day.*

For patients diagnosed by OSAHS, treatment with CPAP can be lifelong. Therefore, it is imperative that all attempts to manage their OSAHS conservatively are fully engaged with by patients and regularly reviewed.

* Patients seeking advice and treatment for excessive sleepiness should be asked to complete a sleep diary over a period of at least two weeks to assess whether they are getting sufficient high quality sleep.
Surgical Management of OSAHS

Surgical interventions for OSAHS are not recommended by NICE (NICE, 2008). In light of this, the Commissioners have previously published policies in respect of Snoring including soft palate implants, Bariatric Surgery, Nasal Surgery and Tonsillectomy where it is advised that surgery would not normally be provided for adult patients affected by OSAHS.

Driving and OSAHS

It is a legal requirement on every driver not to drive when their ability to drive safely is impaired, including when they are tired.

Untreated OSAHS leads to an increased risk of motor vehicle collisions and driving related incidents are the leading cause of work related deaths in the UK. It is the responsibility of people who are sleepy during the day (regardless of the cause) to cease driving until their symptoms resolve. If the symptoms are severe enough to affect driving performance and are due or very likely due to a medical condition (including OSAHS) the driver must inform the DVLA. Clinicians are responsible for advising the patient appropriately of their requirement to inform the DVLA about their patient’s.

In most cases, the DVLA are happy to allow car drivers to continue driving once they are established on a successful therapy and reviewed by clinicians at intervals of not more than 3 years. (DVLA)

Management of Patients on CPAP

The use of devices can be difficult with patients reporting noise disturbance (for partners/family as well as patients), difficulties with masks fitting and discomfort with using the device. For CPAP treatment to be effective the person must regularly wear their device when they go to sleep although these difficulties can lead to the failure of treatment. (NICE, 2008)

The results from the usage of devices are monitored by the Respiratory Service electronically during regular assessments.

Despite the high efficacy of CPAP to reverse upper airway obstruction in sleep apnoea, treatment effectiveness is limited by variable adherence to prescribed therapy. Studies have shown that compliance with the treatment by patients ranges from 50.6% (Pradeepan S., 2014) to 69% (Gilbert H., 2015), where compliance is equated to using the device for 4 hours, five days per week. Patients who have been issued with a device and advised on its use should be monitored regularly to ensure compliance with treatment. Patients who are having difficulties in compliance due to ill-fitting masks should be offered advice and alternative masks where appropriate.

Insurance and Maintenance of CPAP Device

The NHS invests significant resources in purchasing and supplying these devices to patients. Prior to being issued with a CPAP device on loan, patients must agree in writing to insure the device, normally by inclusion within household insurance policy, and return the device upon request as set out in these guidelines or reimburse the Trust the full cost of a replacement device.
Patients who refuse to agree to this requirement must not be issued with a device.

Patients who fail to return the device to the NHS upon cessation of treatment will be required to pay the full replacement cost of the device.

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**Policy - Criteria to Access Treatment – CRITERIA BASED ACCESS**

Funding Approval for treatment is available from the NHS for patients meeting the criteria set out below.

**CPAP Devices**

Funding for treatment including the issuing of a **single CPAP** device will only be provided by the NHS for patients meeting the criteria set out below:

The patient has been diagnosed with:

1. OSAHS (including mild, moderate or severe OSAHS)

   **AND**

   1.1. Conservative management has been fully engaged in and complied with for a period of at least 6 months by the patient and has not proven successful in reducing the impact of OSAHS

   **OR**

   1.2. Conservative management is inappropriate before commencing treatment.

      (Note – we would not expect conservative management to be inappropriate in many cases and where conservative management is inappropriate patients will be expected to fully engage with conservative management once treatment has commenced)

   **AND**

2. The patient is experiencing significant functional impairment which is likely to be corrected or significantly improved by treatment. Significant functional impairment is defined by the BNSSG Health Community as:

   - Symptoms preventing the patient fulfilling routine work or educational responsibilities
   - Symptoms preventing the patient carrying out routine domestic or carer activities.

   **AND**

3. The patient has signed an agreement to appropriately insure and maintain the CPAP device and return it to the service upon cessation of treatment or reimburse the full replacement cost of the device to the NHS.
**Flowchart – Management Options for Patients with OSAHS**

**Primary Care – Initial Assessment and Support**

- **Patient presents with symptoms of OSAHS including sleepiness**
  - Asses level of OSAHS using tools such as Epworth Sleep Score
  - Indicative OSASH classification

**Secondary Care – Following Initial Conservative Management**

- **Do not refer to Secondary Care – Give advice on conservative mgmt where appropriate**
  - Apply to IFR for funding Approval setting out why patient meets criteria within policy and why conservative mgmt has failed or is inappropriate
  - Assess whether patient is suffering from significant functional impairment – Apply for funding approval where this cannot be demonstrated

- **Refer to Secondary Care**
  - Assess and confirm level of OSAH Continue conservative management Issue CPAP device only if appropriate within the limits of this policy
  - Review and Assess impact, compliance and whether patient still qualifies for and requires a device
  - Secondary Care will continue to manage patient whilst assessing and treating within the limits of this policy

**Treatment Cessation**

Patients will have been considered to have failed to comply with treatment with a CPAP if over a six month period:

- The patient has failed to use the device on average for 70% of days, and
- The patient has failed to use the device on average for 4 hours per night when used.

Patients who fail to comply with these treatment requirements, must cease treatment and return the device to the provider for refurbishment and reissue to another patient where appropriate or reimburse the NHS the full replacement cost of the device.

Patients who do not receive adequate benefit from the treatment (i.e. there is little or no improvement in their AHI or ESS scores) should also be assessed to establish whether it is appropriate for their treatment to continue.

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**Management of Patients With Obstructive Sleep Apnoea**

- **Within Normal limits**
  - Do not refer to Secondary Care – Give advice on conservative mgmt where appropriate

- **Mild OSAHS**
  - Give advice on lifestyle measures/conservative management:
    - BMI reduction – If patient is obese, advise to lose weight,
    - Smoker – advise to stop smoking,
    - Alcohol consumption or sedative – Advise to avoid use, and
    - Mandibular Advancement Device – self funding of device to reduce snoring
  - Improving sleep hygiene

- **Moderate OSAHS**
  - Apply for funding approval where this cannot be demonstrated

- **Severe OSAHS**
  - Referral with a BMI of <30 to Weight Management Services
  - Referral smokers to Smoking Cessation services

- **Indicative OSAHS classification**
  - Do not refer to Secondary Care
  - Give advice on conservative mgmt

- **Funding Refused**
  - Review and Assess impact, compliance and whether patient still qualifies for and requires a device

- **Funding Approved or not required**
  - Do not refer to Secondary Care

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**Footnotes**

1. Funding approval will be granted for assessment by secondary care and treatment only in line with this policy. Patients who are successfully treated following further conservative management and/or are shown to have OSAHS within normal limits or mild OSAHS without S1 will be discharged by secondary care.
2. Patients who are successfully managed with conservative measures or do not fully engage with CPAP therapy will be discharged by secondary care.
Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy.

Individual cases will be reviewed at the CCG’s Individual Funding Request Panel upon receipt of a completed application form from the patient’s GP, consultant or clinician. Applications cannot be considered from patients personally.

If you would like further copies of this policy or need it in another format, such as Braille or another language, please contact the Patient Advice and Liaison Service on 0800 073 0907 or 0117 947 4477.

**Connected Policies**

N/A

**This policy has been developed with the aid of the following references:**

**BIBLIOGRAPHY**


**Approved by (committee):**  Clinical Policy Review Group

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**Produced by (Title):**  Commissioning Manager – Individual Funding

**EIA Completion Date:**  TBC  **Undertaken by (Title):**

**Review Date:**  Earliest of either NICE publication or three years from approval.

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