British Sleep Society
British Paediatric Sleep Society
UK Multidisciplinary Sleep Professionals

Minutes
Roundtable Meeting
"Credentialing Sleep"

at the BSS Birmingham Sleep 2019
08.00-08.50 hrs, 22nd November 2019

Attendees: Tim Quinnell (TQ; via telephone), Joerg Steier (JS), Sara Parsons (SP), Victoria Cooper (VC), Martin Allen (MA), Alison McMillan (AM), Hugh Selsick (HS), Simon Durrant (SD), Sonya Craig (SC), Jenny Sylvester (EBS)

Apologies: Kirstie Anderson

1) **Welcome**
   JS welcomed all to the meeting.

2) **Introduction**
   Everyone around the table introduced themselves:

   JS - Secretary and President-Elect of the British Sleep Society (BSS)

   HS – past chair of the Sleep section at the Royal Society of Medicine (RSM) and here to represent Kirstie Anderson (current chair) who was unable to attend.

   SD – Incoming BSS Treasurer and Director of the Sleep Research Centre of Academia at the University of Lincoln.

   AM – Consultant Respiratory & Sleep Physician and Member of the BSS Executive Committee.

   MA – Consultant Physician for Respiratory services and Lead in Sleep Services, University Hospitals of North Midlands NHS Trust. 'Get-It-Right-First-Time' Representative of NHS Improvement ("GIRFT").

   SP – Chief Physiologist St George's University London and Consultant Clinician Scientist, ARTP Sleep Co-Chair.

SC – Consultant Physician Respiratory and Sleep, Lead of the SAG Sleep Apnoea of the BTS.

TQ – Current BSS President.

VC – Consultant Clinician Scientist, ARTP Sleep Chair.

3) Expectations "Credentialing Sleep"

HS – A one year post membership programme where people rotate through various units to get the relevant experience that should pull in people from other specialties to come into sleep medicine. An obstacle is that there aren't many units to rotate through and we need to look at how this can be tackled. In addition we need to look as to whether there would be an exam as part of that package.

SD – We may want to consider adopting a model of credentialing sleep similar to the approach of the BPS (British Psychological Society) which is hugely successful in terms of membership, relevance and income due to one of their roles being credentialing, not only for clinical psychologists but also non clinical. Although the current focus is medical sleep credentialing, the BSS should be aiming wider and ensure it is inclusive and avoiding/overcoming barriers. The BPS's main form of credentialing is Chartered Membership, which is recognised by the relevant bodies and can be achieved through an exam or though experience. SD expressed the view that if the BSS doesn't offer a similar option for sleep, then someone else will, such as the AASM (American Academy of Sleep Medicine).

AM – It is unclear if the focus of credentialing is on just medical or for all healthcare professionals. There are currently a lot of organisations that are attempting to do different forms of accreditations, but it's not clear how they fit with service and delivery. The various sleep services will differ in the nature and extent of services they provide.

MA – We need to be mindful of the terminology being used as accrediting services is different to credentialing an individual. If you look at services, there is a mechanism for accrediting laboratories through IQIPS. It establishes whether set standards are being met. The overarching focus is respiratory physiology but there sleep could also be covered in a broad way. Credentialing is a prescriptive process

for physicians. There is a specific process for credentialing and ownership is with doctors. Credentialing is supported and recognised by the GMC and has College ownership and it is quite a laborious process. If the GMC accepting credentialing was the way forward, then they would need to think about the process and shape of training. This would provide an opportunity for the BSS to provide ideas and comments. There is also a political opportunity. The provision of services is getting a lot of traction due to there being no workforce to deliver. People are being invited to advise current and future workforce. In conclusion, this is a time of opportunity. If we were pro-credentialing then there is a 4 month window with the GMC. The areas that might be appropriate for credentialing would be the more complicated areas of sleep. If you are already delivering a service, then you probably wouldn't be expected to undergo further training.

SP – Agrees it should increase standards but is concerned about it not being inclusive and being more for the medical side as opposed to physiology or consultancy side and wonders what this means for other healthcare professionals that are involved.

SC – Had concerns around the delivery of education on sleep medicine and would like to avoid barriers so would prefer a non-exam route. Worries that those areas that do not have credentialing, such as sleep apnea pathway, may not have as high standards and the area would become less specialized. Also respiratory sleep medicine could become less specialised and it could potentially divide the sleep community. In addition, SC raised concerns that if there weren't credentialing on CPAP provision, which is where Trusts make their money within sleep medicine, then there was a possibility that the Trust may decide to not have specific sleep specialists, and in the interests of patients this needs to be avoided.

VC – Had concerns on what credentialing would look like and what may happen if there were not enough credentialed physicians as they usually take the lead and give medical back up to physiologist-run services.

TQ – Agreed with much that had already been said. Summarised that what we want to achieve includes having better standards as well as being able to accommodate all who work in sleep services, adapt to local circumstances and preserve/increase accessibility for patients. Many questions had been raised that needed further consideration, such as where would credentialing be completed, at a hub or every centre? If it is agreed that credentialing should not be necessary for all levels of service or practice then what would be the threshold? Should

credentialing be practical or theory based? How many centres should be accredited to train? How do you accredit centres to provide more complex services and to teach those seeking sleep credentials? Is credentialing truly practical/affordable/fundable?

HS - Need to know the purpose for credentialing so we know how to best approach it. He questioned whether it would be possible to provide a more modular aspect to allow those that are not working in big centres to be credentialed as well.

MA – A lot of answers to the above questions are unknown which is why the GMC have been on the fence for 2-3 years and there is no approved credential service at present. If credentialing was a post-CCT activity the individual may need to pay for this themselves so the funding aspect would also be flawed.

JS – Summarised the above points of 'Pros and Cons'. We would need to be mindful of when would be the time to establish any credentialing, and we would need to look at what can be done, what the curriculum would be and how it would affect services across the UK. Some of the positives were raising standards of sleep services, increasing opportunities and interest in sleep. Some of the concerns were deliverability, practicality, non-inclusivity and funding issues.

The meeting needed to stop at this stage due to the ongoing BSS Scientific Conference. JS/TQ concluded that the agreement had been to take these initial minutes back to the respective committees/societies and discuss internally. Future steps would be best harmonized across associations that were present at the roundtable meeting. It had also been agreed by the BSS executive committee to publish these minutes (website open access) to facilitate a constructive and open discussion.

Action Points (agreed):

1) **All present to take discussion back to their committees**
2) **Publish minutes (open access on BSS webpage)**
3) **Plan future steps together in due course**