

BSS International Sleep Medicine Course 2026

15th - 18th September | Newcastle



British Sleep Society



UK Multidisciplinary Sleep Professionals



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Societal, economic and research aspects

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Conflict of Interest Disclosures for Speakers

1. I do not have any potential conflicts to disclose.



2. I wish to disclose the following potential conflicts of interest:

Type of Potential Conflict	Details of Potential Conflict
Grant/Research Support	
Consultant	
Speakers' Bureaus	
Financial support	
Other	Sleep Charity – evaluation lead for 2x projects (“Dream Start”; Lincs Sleep Hub)



3. The material presented in this lecture has no relationship with any of these potential conflicts, **OR**



4. This talk presents material that is related to one or more of these potential conflicts, and the following objective references are provided as support for this lecture:

- 1.
- 2.
- 3.

Areas to cover

- Section O in the Sleep Med textbook
- Demographic and socioeconomic aspects of sleep disorders (*and see other sessions on sleep disordered breathing, insomnia, sleep in older people!*)
- Forensic aspects of sleep medicine (driving and sleepiness; violence and sexual assaults in sleep)
- Organisation of Sleep Medicine Centres
- Training initiatives in sleep medicine
- Research design and quantitative methods
- Not covered in this talk: Shift work, sleep and sleepiness

Areas to cover

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Demographic aspects of sleep disorders

- Sleep disorders are common
- Impacts are broad. Costs are both direct (health-related) and indirect (e.g. social – employment, risk of accidents etc).
- Over 80 distinct primary sleep disorders (ISDC-3) affecting around a third of the general population in Western Europe (Leger et al., 2008)
- In the UK, 37% of adults experience insomnia (Morphy et al., 2007)
- An estimated 2.5 million individuals (Jehan et al., 2007) are living with obstructive sleep apnoea hypopnoea syndrome (OSAHS)
- 85% of individuals with are OSAHS in the UK are undiagnosed (BLF 2014)
- Narcolepsy is associated with on average over a 10 year delay to diagnosis (Taddei et al., 2016)
- Screening programmes and accurate diagnoses are therefore are crucial.

Demographic aspects of sleep disorders

- Sleep disorders rank amongst the five most costly groups of diseases (Wittchen et al. 2011)
- Lost sleep results in impaired cognitive function (Beddard et al., 1991) and work performance (Ulfberg et al., 1996), greater unemployment rates (Daniels et al., 2008) and increased workplace absenteeism (Walsh et al., 2004)
- The UK is predicted to incur a loss of 1.86% of Gross Domestic Product, equivalent to up to \$40 billion, due to insufficient sleep (RAND Europe 2006)
- Excess social and health-related costs per patient with narcolepsy are over €10,000 (Thorpy et al., 2017)

Socioeconomic aspects of sleep disorders

- Compared to controls, individuals with insomnia have double the likelihood of hospital admission (Kapur et al., 2002)
- Patients with OSAHS utilise 10-20% more healthcare (Kryger et al., 1996)
- Patients with narcolepsy have doubled direct medical costs (Jennum et al., 2009)
- In the year preceding diagnosis of severe OSAHS, patients required twice the number of inpatient days, and incurred twice the healthcare costs, compared to controls (Kryger et al., 1996)
- Managing OSAHS effectively decreases healthcare costs, compared to matched controls who had increasing healthcare utilisation costs during the same period (Albarrak et al., 2005)
- If all drivers in the UK with OSAHS were treated, it is estimated that there would be 40,000 fewer road accidents annually (BLF 2014) in addition to reductions in work-place accidents, healthcare costs, changes in quality of life, improvements in cognitive function and workplace performance (Sassani et al., 2004)

Socioeconomic aspects of sleep disorders

- Sleep conditions commonly co-exist with other conditions
- Patients with OSAHS have an increased stroke risk, with worse functional and cognitive outcomes if they do experience a stroke (Yeghiazarians et al., 2021; Yaggi et al., 2005)
- There is an increased association with atrial fibrillation (Mehra et al., 2006) and a tripling in the risk of hypertension (Peppard et al., 2000)
- Up to 80% of patients with treatment-resistant hypertension have OSAHS (Perati et al., 2014)
- Patients with OSAHS have increased all-cause mortality (Yaggi et al., 2004)
- Effective OSAHS treatment is proven to improve AF burden (Mehra et al., 2006) and reduce blood pressure (Jonas et al., 2017)
- Antihypertensives can both reduce the severity of OSAHS and blood pressure (Parati et al., 2014)
- The social impact of sleep conditions is broad
- 1/3 of couples sleep in separate beds due to the discomfort of partner's movements in restless legs syndrome (Montplaisir, 2010)
- Partners of patients living with OSAHS experience physical and mental health impacts (Breugelmans et al., 2004) and in fact, report a lower quality of life than the patient (Strawbridge et al., 2004)
- Sleep disorders reduce quality of life, especially when undiagnosed (Daniels et al., 2008)
- The impact of narcolepsy on quality of life is comparable to that of Parkinson's disease or multiple sclerosis (Jennum et al., 2009)

Areas to cover

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Driving and sleepiness

- Annually, 1.35 million people die due to road traffic accidents (RTAs)
- RTAs are the most common cause of death amongst children aged 5-14 years and young adults aged 15-29 years (World Health Organization, 2018)
- The National Sleep Foundation's 2005 Sleep in America Poll found that 60% of adult drivers reported driving while drowsy in the past year.
- Survey data from the CDC indicated that 1/25 adults had fallen asleep behind the wheel in the past month
- Drowsy driving is a major contributor to motor vehicle collisions the National Highway Traffic Safety Administration (NHTSA) in 2017 estimated that drowsy driving led to at least 91,000 crashes, resulting in roughly 50,000 injuries and 800 deaths
- Around 21% of fatal car crashes are thought to involve a person driving while drowsy (Watson et al., 2015)
- Crash risk was 14 times higher for drivers who had reported almost falling asleep behind the wheel (Cummings et al., 2001)
- Another reported that driving while fatigued increases a driver's risk of involvement in a crash or near-crash by nearly four times (Klauer et al., 2006)

Driving and sleepiness

- A variety of sleep disorders can lead to sleepiness and increase the risk of sleep-related RTAs
- Individuals with narcolepsy and hypersomnia are at greatest risk (Åkerstedt, 2019)
- Sleep apnea is associated with a two fivefold increased risk of being involved in a car crash (Åkerstedt, 2019)
- Insomnia is associated with a 2.5x increased the risk of motor vehicle accidents (Åkerstedt, 2019)
- Medications that cause sleepiness can also increase the risk of RTAs, including anxiolytics, hypnotics, certain anticonvulsants and antidepressants, as well as most muscle relaxants and anti-allergic drugs

Driving and sleepiness

- RTAs caused by sleepiness are more likely to occur between midnight and 06:00 hours and, to a lesser extent, in the early afternoon, when the circadian propensity for sleepiness is highest
- Even moderate sleep deprivation affects driving performance to the same degree as low-level alcohol intoxication
- Being awake for 18 hours can have the same negative impact upon the ability to drive safely as being over the drink-drive limit in many countries (Williamson et al., 2000)

Driving and sleepiness

- Standard methods to assess daytime sleepiness, such as the MSLT and MWT relate poorly to driving performance (Philip et al., 2013)
- Performance on driving simulators similarly does not reliably predict the likelihood of RTAs (Alonderis et al., 2018)
- Simple advice can be provided to all drivers, such as regular breaks and strategic naps/caffeine
- European regulations for professional drivers have been summarized in a review (Åkerstedt, 2019) including the European legislation limits the amount of driving time for professional truck drivers to a maximum of 9 hr per day, with the possibility of driving for 10 hr per day for 2 days a week. During the 9 hr, they are allowed to drive for 4.5 hr uninterrupted before taking a statutory break of at least 45 min. However, these have been argued to be insufficient (e.g. not considering circadian timing).

Driving and sleepiness

- Sleep specialists have a major role in preventing sleepiness-related accidents at the wheel
- Physicians are required to inform patients if they have an increased risk of falling asleep at the wheel, whether due to a sleep disorder or a medication that induces sleepiness
- They should also accurately and regularly document what advice they provide
- The ability to drive should be reevaluated periodically in case of a diagnosed and documented sleep disorder
- Physicians should remind drivers that they are liable to prosecution if illegal driving continues against medical advice and that vehicle insurance may be invalidated if it is determined that the person is driving illegally

OSA is very common amongst adults in the UK. OSA can be truly asymptomatic, but can also be associated with excessive sleepiness, which may have an adverse effect on driving whilst OSA is untreated. These people are therefore at increased risk of motor vehicle collisions.

In 2016, changes to the driving rules for patients with OSA made it harder for health care professionals to advise their patients. In January 2016, a European Commission Directive on Driving¹ led to extensive changes to the "Excessive Sleepiness including OSA" section of the DVLA "Assessing Fitness to Drive – a guide for medical professionals" document of March 2016. Following consultations with professional and patient bodies², the DVLA guidance was subsequently updated in October 2017, see appendix 1. This new guidance was much clearer. A new British Thoracic Society (BTS) position statement was published in 2018, to clarify and standardise the driving advice given to patients with OSA by sleep specialists and their teams.

2026 update

The DVLA guidance has not changed since 2017. However, the patient questionnaires have recently been updated with clinicians' input (SL1 and SL1V), whilst there are 2 separate forms depending on the type of licence, the questions are the same. This statement incorporates information about the updated patient questionnaires.

It is crucial that patients are not deterred from seeking advice and treatment for OSA because of concerns about driving and potential loss of licence and livelihood.

Patients must be given correct advice: generic statements to "stop driving and notify the DVLA", without any informed assessment of sleepiness or OSA, have caused some patients to lose their livelihoods when they were not sleepy and did not have OSA on subsequent assessment.

BTS strongly supports professional drivers being fast-tracked for diagnosis and treatment of symptomatic OSA (within 4 weeks of referral), so that symptoms are rapidly controlled, minimising time away from work³. This will give drivers the confidence to present with symptoms suggestive of OSA.

SCOPE

This statement supports the current DVLA guidance for the UK⁴ however, further updates are expected in the next 12 months. Although patients will initially present to primary care, BTS supports the view that specific advice about driving and sleep disorders should be part of the assessment made by the specialist team. General advice of not to drive if sleepy applies to all drivers, and it is the driver's responsibility to ensure their fitness to drive. This statement is not written for patients specifically. The Sleep Apnoea Trust website may be helpful to them with its Detailed DVLA Guidance for Drivers⁵.

ROLES AND RESPONSIBILITIES

GP or other referring health care professional should:

- Recommend that a patient does not drive if excessive sleepiness is having, or likely to have, an adverse effect on driving, whatever the cause.
- Arrange onwards referral for specialist review if indicated and ensure prioritisation of cases as urgent where
- patients report an impact on vigilant critical activities such as driving, flying or operating dangerous machinery.

BTS Position Statement on Driving and OSA (2026)

<https://www.brit-thoracic.org.uk/about-us/position-statements/>

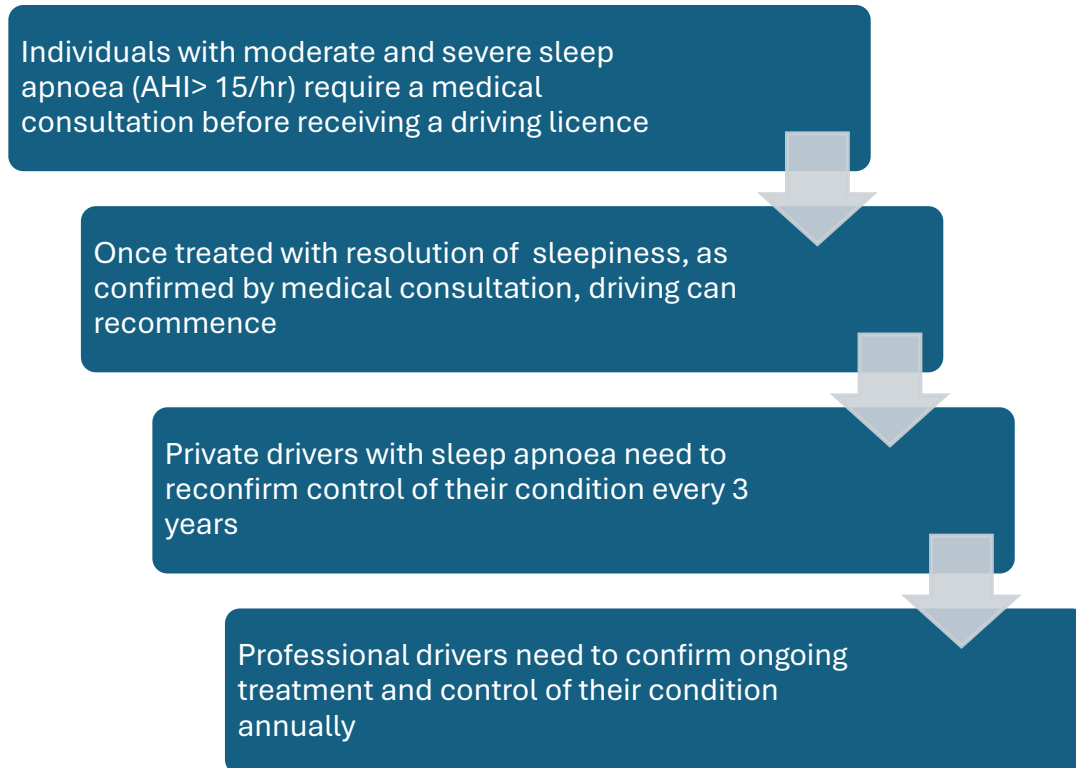
WHEN IS SLEEPINESS EXCESSIVE AND LIKELY TO ADVERSELY AFFECT DRIVING?

- The ESS alone is unlikely to be adequate, as it is subjective
- The ATS Practice Guidelines offer useful guidance⁸. They emphasise the importance of the clinician identifying a high risk driver by direct questioning. They suggest a high risk driver is one who has moderate to severe daytime sleepiness (suggesting an ESS of >17/24) plus a recent motor vehicle collision (MVC) or a near-miss attributable to sleepiness, fatigue or inattention. They found no compelling evidence to restrict driving privileges in patients with OSA if there had not been a motor vehicle crash or equivalent event.
- People who experience head nodding, hitting the rumble strip, regularly using alerting manoeuvres such as keeping the windows open, stopping for a drink or to stretch, listening to loud music are more likely to have impaired driving due to sleepiness⁹.
- Some specialists impose restrictions on driving, suggesting "some people find they can avoid excessive sleepiness by driving short distances only, driving for less than an hour, driving at times of day when they recognise they are most alert and ensuring adequate night time sleep plus daytime naps".
- Specialist tests of alertness and driving simulation may help to inform these discussions, but do not have any legal standing, and there is no evidence that they predict the likelihood of MVCs. They are not routinely performed in most clinical practice but may have an occasional role in specific circumstances.

Driving and sleepiness: OSA

European guideline (Bonsignore et al., 2016).

UK guideline (DVLA and see BTS Position Statement)



Excessive sleepiness

– including obstructive sleep apnoea syndrome

'Excessive sleepiness' having, or likely to have, an adverse effect on driving includes:

- obstructive sleep apnoea syndrome of any severity
- any other condition or medication that may cause excessive sleepiness
- see also guidance on Primary/central hypersomnias, including narcolepsy

Legislation states that objective sleep study measurements for driving assessment purposes should use the apnoea-hypopnoea index (AHI). Recognising that not all sleep services use AHI, the DVLA will accept results of equivalent objective tests.

The 'Tiredness can kill' leaflet (INF159) is for drivers concerned about excessive sleepiness.

	Group 1 car and motorcycle	Group 2 bus and lorry
Excessive sleepiness due to a medical condition (see relevant chapter) including mild obstructive sleep apnoea syndrome (AHI below 15) or medication.	● Must not drive. Driving may resume only after satisfactory symptom control. If symptom control cannot be achieved in three months the DVLA must be notified.	● Must not drive. Driving may resume only after satisfactory symptom control. If symptom control cannot be achieved in three months the DVLA must be notified.
Excessive sleepiness due to obstructive sleep apnoea syndrome – moderate and severe:	● Must not drive and must notify the DVLA. Subsequent licensing will require: ■ control of condition ■ sleepiness improved ■ treatment adherence. The DVLA will need medical confirmation of the above, and the driver must confirm review to be undertaken every three years at the minimum.	● Must not drive and must notify the DVLA. Subsequent licensing will require: ■ control of condition ■ sleepiness improved ■ treatment adherence. The DVLA will need medical confirmation of the above, and the driver must confirm review to be undertaken annually at the minimum.
Excessive sleepiness due to suspected obstructive sleep apnoea syndrome.	● Must not drive. Driving may resume only after satisfactory symptom control. If symptom control cannot be achieved in three months the DVLA must be notified. See above when diagnosis is confirmed.	● Must not drive. Driving may resume only after satisfactory symptom control. If symptom control cannot be achieved in three months the DVLA must be notified. See above when diagnosis is confirmed.

Sleep- related violence and sexual behaviours

- Violent behaviour during sleep has been estimated to occur in 2% of the population but in 59% of patients with sleep terrors and sleepwalking (Siclari et al., 2010)
- Injurious behaviour in the context of arousal disorders is 1.6-2.8x more common in men
- 80% of potentially lethal behaviours in RBD occur in male individuals
- Violent behaviours in sleep can arise due to RBD, sleep-related seizure disorders and in dissociative disorders
- Sexual behaviours in sleep are associated with arousal disorders, in particular sleepwalking and confusional arousals and sexsomnia
- Similarly, there is a strong male preponderance for sleep-related sexual activity (80%; Schenck et al., 2007)

Sleep-related violence and sexual behaviours

A sleep-related violent offense is supported by:

- the presence of solid evidence for the diagnosis of a sleep disorder, with previous occurrence of similar episodes;
 - the characteristics of the act (occurs upon awakening or immediately after falling asleep, is of abrupt onset and brief duration, impulsive and senseless, occurs without apparent motivation, there is lack of awareness of the individual during event, the victim is coincidentally present and represents a possible arousal stimulus, upon regaining consciousness the individual is perplexed and horrified and does not try to escape, there is amnesia for the event);
 - the presence of precipitating factors (such as attempts to awaken the subject, intake of sedative/hypnotic drugs or prior sleep deprivation).
- Bedroom and bed partner safety
 - Avoid triggers (sleep deprivation; stress; alcohol; bed sharing with minors)
 - Sleep hygiene advice
 - Treat underlying pathology (OSA, PLMD)
 - Criteria to distinguish a simulation from a truly sleep-related illegal act have been proposed by Mahowald and co-workers (Mahowald, 2008):

Areas to cover

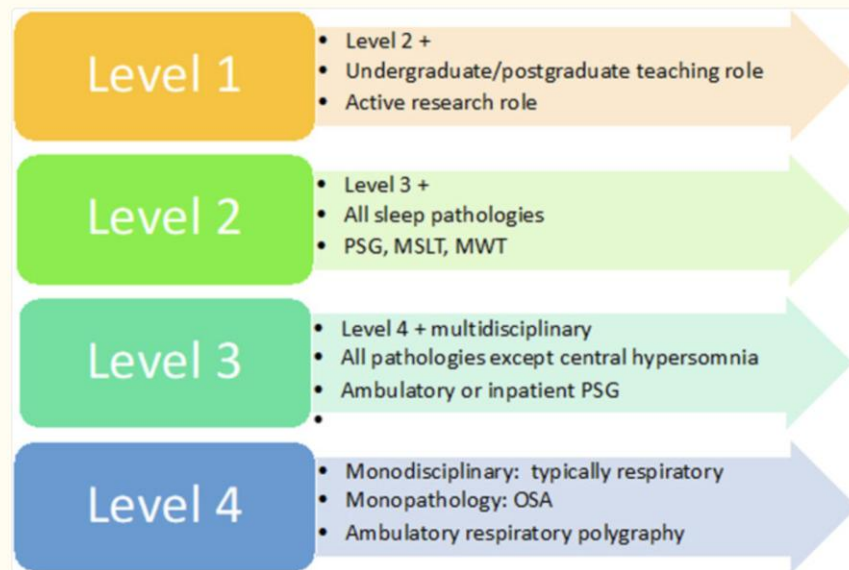
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Organisation of Sleep Medicine Centres

- In Europe, Sleep Medicine Centres are accredited by the national sleep societies joined in the Assembly of National Sleep Societies, an organization within the European Sleep Research Society (ESRS)
- Centres should provide outpatient services and have sleep laboratories, capable of facilitating quality studies
- Staffing should include certified sleep medicine experts, sleep technologists as well as allied health professionals such as nurses, psychologists and orthodontists, trained in sleep medicine
- There should be processes to ensure continual quality assurance in the sleep laboratory, and the continuing education of staff
- Sleep Medicine Centres have three main purposes
 1. to ensure the patient with any sleep disorder gets a complete and multidisciplinary diagnostic and therapeutic approach according to scientific literature and available evidence,
 2. to constitute a reference point for professionals involved in sleep disorder care and for health authorities, and
 3. to the public and medical community to promote sleep medicine.

Organisation of Sleep Medicine Centres

FIGURE 1.



[Open in a new tab](#)

Levels of accreditation. MSLT, Mean Sleep Latency Test; MWT, Maintenance of Wakefulness Test; OSA, obstructive sleep apnea; PSG, polysomnography.

- Procedures should follow the ESRS Standard Operational Procedures (SOPs) for adults in accredited SMCs in Europe (Fischer et al., 2012; updated by Hartley et al., 2024)
- According to these, the SMC must provide at least the following instrumental examinations:
 - polygraphy (PG) (or portable monitoring; or HSAT);
 - polysomnography (PSG); in lab and at home;
 - video PSG (vPSG) in lab; limited channel (one-three) monitoring;
 - PSG vigilance tests (Multiple Sleep Latency Test [MSLT] and Maintenance of Wakefulness Test [MWT]);
 - Actigraphy
- These tests must be performed and scored according to the AASM Manual for scoring sleep and associated events (AASM, 2020)

Hartley, S., Goncalves, M., Penzel, T., Verbraecken, J., & Young, P. (2024). Revised European guidelines for the accreditation of sleep medicine centres. *Journal of sleep research*, 33(6), e14200. <https://doi.org/10.1111/jsr.14200>

Organisation of Sleep Medicine Centres

- Quality assurance should be provided through
 - Inter-scorer reliability procedures, repeated regularly
 - Patient and user feedback and satisfaction
 - Competency certification of staff, following the European guideline for certification of professionals in sleep medicine, with at least some of the medical and non-medical staff having had their competence in sleep medicine certified by national or European scientific societies
- SMCs should also contribute to sharing their knowledge through educational events directed at both patients and the public and other healthcare professionals
- Academic SMCs have a responsibility to develop clinical and basic research, and to promote the translational aspect: from research to clinical practice (Bassetti et al., 2012)

Organisation of Sleep Medicine Centres: UK focus

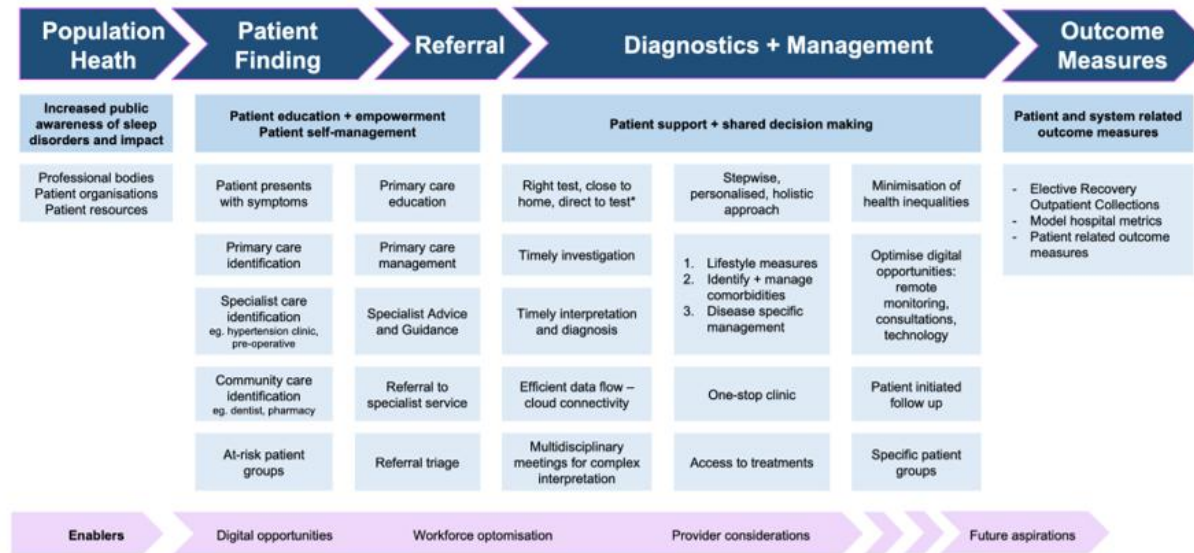


Figure 1: Overview of the optimal sleep pathway

<https://www.sleepsociety.org.uk/wp-content/uploads/2025/02/Optimal-Sleep-Pathway.pdf>

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Training initiatives in sleep medicine

- Opportunities for education and training in sleep medicine:
 - ESRS examinations
 - [HERMES examinations](#)
 - World Sleep Society (WSS) International Sleep Research Training Programme (1 year)
 - [ESRS short-term Research Fellowships \(3 months\)](#)
 - ESRS congress
 - [ESRS and ERS Sleep and Breathing conference](#)
 - BSS congress, webinars and short courses
 - [ISMC conference](#)
 - PGCert in Sleep Medicine
 - [ESRS “E-Sleep” Programme](#)
 - ERS, Assembly 4 Sleep Breathing Disorders symposia at the annual ERS Congress

Training initiatives in sleep medicine

- Health Education England partnership with BSS initiated....
 - Webinars
 - In person courses
 - Multidisciplinary and multiprofessional
 - Membership benefits....

TABLE 2 Previous practical experience in order to certify professionals in sleep medicine

	Medical specialist/Non-medical professional	Sleep technologist (technicians and nurses)
Full PSG procedure	30 patients	300 patients
Scoring, interpreting and reporting PSG	100 PSGs	
Independent scoring of PSG		300 PSGs
MSLT/MWT procedures	10 patients	30 patients
Ambulatory cardiorespiratory recording	50 patients	
Interpretation of sleep questionnaire and sleep diaries	Yes	
Acquaintance of techniques required for technicians and nurses	Yes	
Treatment experience in all sleep disorders	100 patients (medical)	
Evidence of sufficient practical experience of the techniques relevant to their field	Yes (non-medical)	Yes

MSLT, Multiple Sleep Latency Test; MWT, Maintenance of Wakefulness Test; PSG, polysomnography.

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Research design and quantitative methods

- High-quality research is the key to understanding both healthy sleep and sleep pathologies
- **Quality research drives effective clinical care**
- Translating research from the bench to the bedside at pace is key to a developing field
- **Well-designed research delivers meaningful results**
- Patient and public involvement in research design and delivery is key to delivering outcomes which have the potential to improve care
- **Training in research methodology and ethics is crucial**

Research design and quantitative methods

- Both quantitative and qualitative methodologies, as well as mixed methods studies, can provide important insights into aspects sleep medicine
- The methods involved in each are very different and require different skillsets
- The key skill is to ensure the methodology selected is capable of answering the question at hand
- Speak to more experienced researchers, read the literature, access training in research design and ethics
- If you have a good idea, talk to one of us!

TABLE 1 Basic steps in a research process

Steps	Elaborations
Formulate your question/hypothesis	
Get background information	Make sure the research question is of relevance or a replication study
Refine your question/hypothesis	
Design the study	Chose appropriate study design and suitable controls (conditions or groups); measures and feasibility; optional preregistration of study
Apply for finance for the study; write grant application	Calculating costs of study; make data management plan
Get ethics approval	Do not underestimate time to get approval
Recruit subjects; run the study	Recruitment takes time
Analyze data	Explore data first; remember hypothesis and use appropriate test for your hypothesis
Write publication	Chose journal wisely; many grant agencies request open access publishing; reviews take time and rejections occur; it is not uncommon to take 6 months or longer; authorship

Conclusion and take home points

- Sleep disorders are common and have significant personal, societal and economic impacts
- Sleepiness is associated with increased risks of road traffic accidents and sleep specialists have a key role to play in accident prevention
- Sleep-related violence and sexual behaviours are rare but important conditions which require special forensic consideration
- Accreditation of sleep professionals as well as sleep medicine centres can contribute to quality assurance and help ensure high quality and safe care for patients with sleep disorders
- Ongoing high quality research will ensure we continue to deliver improvements in the understanding of sleep pathologies and the delivery of sleep medicine

Questions?



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