estimated the number of referred patients, 60% saw more than 5 per month. Of centres with no policy only 26% estimated that they received >5 referrals per month. Without a policy 72% of referrals came from clinical suspicion alone.

Overall 96% of respondents felt that all patients at high risk of OSA should be screened for OSA. 56 respondents thought it would be ethical to randomise identified cases of OSA to a potential trial of peri-operative CPAP or no CPAP, compared with 40 who did not.

**Conclusions** There is no established UK standard practice for screening for OSA pre-operatively, despite a majority opinion amongst questionnaire responders that high risk patients should be. There would be cost implications if National pre-operative OSA screening was implemented and there therefore needs to be clear evidence based benefit before proceeding.

**Methods**

150 untreated OSAS patients (males-131) were randomised to either the repeatability (n = 50) or incentive arm (n = 100). All performed a simulator run, after initial acclimatisation. In the repeatability arm, patients performed the simulator run on two separate occasions with no knowledge of the results. In the incentive arm, patients performed the simulator run on two separate occasions but just prior to the second run were told about their performance and offered a prize if they could improve their performance by 10%.

**Results**

SDLP in epoch 3 and “veer” reaction time (Veer-RT) were the co-primary outcome variables. Classification of patients into “pass”, “fail” and “indeterminate” were the secondary outcome variables. Results were analysed using paired and unpaired T tests with the level of significance set at p < 0.05.

**Results**

137 patients (repeatability arm-48, incentive arm-89) completed the trial. The median duration between the two simulator runs was 13 days (range, 5–55). SDLP in epoch 3 and Veer-RT were repeatable (P = 0.54, Δ SDLP 0.01 and P = 0.37, Δ Veer-RT 0.13) respectively. There was no effect of an incentive on SDLP in epoch 3 (P = 0.18) and Veer-RT (P = 0.57). There was no difference in the simulator outcome between the two runs [pass (P = 0.70), indeterminate (0.06), fail (P = 0.16)].

**Conclusions**

SDLP and Veer-RT are consistent between runs on the MiniUoLDS and this is not affected by a simple incentive. Advanced office PC based simulators may be helpful when advising patients with OAS about driving.