NICE National Institute for Health and Care Excellence

Putting NICE guidance on the management of insomnia disorders into practice

Case studies

Published: 19 March 2026

www.nice.org.uk

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Overview

Organisation: Queen Victoria Hospital NHS Foundation Trust

Organisation type: NHS Trust

Insomnia disorder is among the top 10 reasons for consulting a GP (Wändell et al. 2025). But, it remains one of the most under-recognised, underserved and overlooked public health complaints in primary care. Sleep loss costs the UK an estimated £34 billion annually (Hafner et al. 2023), the equivalent of 1.86% of the UK's GDP. Improving how someone sleeps has wide-ranging health benefits that go far beyond just feeling less tired. Despite this, the tools available in primary care are largely limited to sleep hygiene advice, nonbenzodiazepines ('Z-drugs'), benzodiazepines and sedating antidepressants. These either do not work, only work short-term, or come with the added problem of dependence, tolerance and addiction.

NICE has recognised the problems associated with dependency-causing medicines in NICE's guideline on medicines associated with dependence or withdrawal symptoms. It sets out that people should be made aware of these risks before a treatment is prescribed. As 1 of only 7 Sleep Centres in the UK managing insomnia in secondary care, people are frequently referred to us who have been on Z-drugs for years. This is despite NICE's technology appraisal guidance on zaleplon, zolpidem and zopiclone for the short-term management of insomnia, which recommends they are used for short-term relief. Many people also arrive having adopted habits they believe are helping their sleep, but which are in fact making things worse. This is not their fault; there is simply very little public awareness of what governs sleep, what undermines it, and how to address it.

Chronic insomnia disorder is complex, with psychological, behavioural and physiological factors all in play, shaped by everything from environment and lifestyle to comorbidities and medicines. Knowing this, we built therapist-led Cognitive Behavioural Therapy for Insomnia (CBT-I) into our service in 2018, well before NICE recommended Sleepio as a self-directed digital option in 2022 (see NICE's HealthTech guidance on Sleepio to treat insomnia and insomnia symptoms). Due to inconsistent commissioning of digital CBT-I tools such as Sleepio and Sleepstation across the UK, we have relied on our own therapist-led provision. Demand has grown year on year, and that waiting list now sits at

12 to 15 months, which for someone in the grip of chronic insomnia is simply too long.

The science of sleep medicine has been slow to reach clinical practice, but the approval of daridorexant in 2024 (see NICE's technology appraisal guidance on daridorexant for treating long-term insomnia) marks a genuine turning point. It is the first medicine of its kind licensed in the UK specifically for chronic insomnia disorder; a dual orexin receptor antagonist that reduces the brain's wake signal rather than broadly sedating it. The development of novel and targeted drugs means we can move away from the addictive, dependency-causing blunt pharmacology drugs of the 1960s. Instead, we can use targeted, science-driven medicines with much better safety profiles and no evidence of addiction.

Often, when people come to us, they are desperate and need help and guidance, having tried multiple strategies. That means not just better access to CBT-I, but flexible ways of delivering it, because insomnia can affect anyone at any age, and a single delivery model will not reach everyone.

There are also people who are not ready for the full CBT-I programme. For example, people who are acutely anxious, but who can still benefit enormously from selected components. These might include stimulus control therapy, sleep restriction, relaxation techniques and education on the physiology of sleep. We began incorporating these principles directly into clinic consultations, using them to support people through the process of coming off Z-drugs and benzodiazepines. We realised that not every person needs to undertake the full program of CBT-I to benefit. Parts of the program are also a lot more relevant to some people than others. By careful detailed clinical assessment we used the principles of CBT-I to help address the sleep challenges people face.

What became clear over time is that not every person needs the full programme. Some components are far more relevant to certain people than others, and a thorough clinical assessment allows you to identify which ones will make the biggest difference for that individual. That targeted approach, grounded in CBT-I principles but tailored to the person in front of you, is now central to how we work.

The majority of our referrals come from GPs, and it became clear that there was limited understanding in primary care of how to manage chronic insomnia disorder well. We responded by running teaching sessions across the local area, not just to improve referral quality, but to give GPs better tools to help the people who never make it onto a waiting list.

Outcomes and learning

Outcomes

We manage chronic insomnia by applying tailored Cognitive Behavioural Therapy for Insomnia (CBT-I) principles as part of each person's individual management plan, delivered directly in clinic. Through this approach we have successfully transitioned people away from long-term use of nonbenzodiazepines ('Z-drugs') and benzodiazepines.

We have now prescribed daridorexant to over 200 people; either once CBT-I principles are in place, or where CBT-I is not suitable. In both scenarios it has proven an effective strategy for transitioning people away from dependency-causing medicines and onto a treatment with a fundamentally better safety profile.

Learning

This case study demonstrates that CBT-I principles can be delivered effectively in clinic, following a thorough sleep assessment. It also shows that daridorexant offers something genuinely different to other hypnotics, by virtue of its unique pharmacology.

Other key learnings include:

- Insomnia remains poorly understood as a public health issue despite its wide-ranging impact on mental wellbeing and physical health. Sleep needs to sit alongside weight management, smoking cessation and exercise as a public health priority.
- Access to CBT-I is insufficient and postcode-dependent. It is the long-term solution for most people, and there are encouraging signs. The Department of Health and Social Care has recognised this and is currently undertaking a tender process to make digital CBT-I available nationally through the NHS.
- By the time people reach a specialist sleep centre, they have tried multiple things and are exhausted. A generic protocol is not enough; time is needed to understand each person's situation and to tailor the approach accordingly. Growing the number of healthcare professionals with a specialist interest in sleep medicine, particularly in primary care, is essential given how many people in the community are yet to have

treatment.

- Insomnia affects all ages and backgrounds. A service built around a single delivery model will inevitably leave the people who need it most without access. Different ways of delivering CBT-I need to be supported and encouraged.
- We need to move away from blunt-acting medicines and embrace the emerging science behind novel, targeted therapies. Sleep is a major contributor to brain health, and more investment in research to understand the key drivers of sleep physiology, and to discover new therapeutic targets, is long overdue.

Supporting information

Wändell P, Ljunggren G, Carlsson AC (2025) The most common diagnoses in primary care, and changes over time, in the total population of Stockholm, Sweden. BMC Primary Care 26(1): 235.

Hafner M, Romanelli RJ, Yerushalmi E, Troxel WM (2023) The societal and economic burden of insomnia in adults: An international study. Published online: RAND Corporation.

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ISBN: 978-1-4731-9406-9