Letters

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Editor's choice

Consultation length

I have read the flurry of letters concerning consultation length with dismay.[1] The call to move to a 15-minute appointment system seems to be gaining ground without any clear argument other than that it is the 'right thing to do'. May I offer a dissenting voice? The right thing to do is to give people the care they need, and the time needed to provide that care. With effective pre-consultation triage, we can customise our appointment offer to the need. At our surgery, we run 5-minute appointments through the day highly successfully. Patients can also have up to 30 minutes if needed. Having fixed 15-minute appointments is a reflection of a doctor-centred 'we know best' approach. Let's be flexible, and provide what people need, not what we think is best for them.

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DOI: https://doi.org/10.3399/bjgp19X705665

Slumber at scale: a digital solution for a tiresome problem

We are grateful to Dr Judith Davidson and her team from Canada for their focus on this highly prevalent condition and for highlighting the effectiveness of cognitive behavioural therapy (CBT) for insomnia within primary care.[1] Indeed, CBT is the treatment of choice according to clinical guidelines. A significant challenge however is how to deliver effective treatment at scale. Certainly within the NHS, where some 12 million prescriptions for sleeping pills are still written annually, it is difficult to imagine there being an adequate supply of clinical psychologists or trained therapists to deliver this CBT. Both logistical and financial barriers suggest that we must look to a more pragmatic and scalable solution.

Digital CBT directly addresses this impasse, offering a demonstrably effective, accessible solution that is also readily scalable and cost-effective. The evidence is strong for equivalence in treatment outcomes between this and more traditional modes of delivery, yet the ability to immediately apply it at population scale is a unique benefit. In addition, the positive outcomes permeate through other health domains with significant improvements shown in mental health and wellbeing.[2,3] Brief clinical tools such as the two-item Sleep Condition Indicator (SCI-02)[4] are also now available to appraise insomnia in general practice. They are well validated and memorable enough to screen for the majority of cases.

GPs have been calling for a solution to the escalating hypnotic prescribing problem and digital CBT can provide it. Sleepio (https://www.sleepio.com/) is one such programme that is referenced as clinically effective in international clinical guidelines, has been subject to NICE MIB briefing, and, through NHS innovation funding, it is being rolled out across London and the Thames Valley. Minimal training is required for this type of automated digital medicine and ways of delivering digital therapies to patients in primary care are being developed. Further work is needed to understand exactly how such solutions can be recommended or prescribed by primary care clinicians; however, the potential for evidence-based digital CBT to satisfy clinical demand for an effective insomnia treatment is compelling. A radical, population-scale approach to this most ubiquitous of problems is long overdue.

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Competing interests

CAE is the co-founder and Chief Medical Officer, DG the UK Clinical Engagement Lead, and IW a Clinical Associate of Big Health (Sleepio). CAE is a shareholder in Big Health, DG is salaried by Big Health, and IW consults for Big Health.

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Commissioning

The editorial on commissioning is very relevant in today's clinical climate,[1] where demands and expectations are soaring and resources are stretched. Involvement of clinicians in decision making is of paramount importance, as spotlighted in this article.

It has been a number of years since CCGs began to involve clinicians. The article perhaps falls short of mentioning the challenges faced by those who took up the task to engage in commissioning and what has been the success. One wonders if any research has been conducted on satisfaction and other outcomes for the clinicians who were involved. One also wonders what are the common barriers that still keep many