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Healthcare AI

Practical steps for NHS leaders and solution providers to reduce the burden of clinical documentation

Dr. Simon Wallace | Chief Clinical Information Officer (CCIO), Nuance Healthcare UK and Ireland

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In this blog, we share the output from a workshop held with NHS leaders at the second Nuance UK Healthcare Council on 12 October 2022. Led by Digital Health's Jon Hoeksma, the workshop posed the question: how can we reduce the burden of clinical documentation? Armed with post-it notes our council team members responded to this question using a Stop/Start/More of/Less of matrix. We hope this article provides some practical insights and ideas for other NHS leaders, as well as solution providers, on how to tackle the growing burden of clinical documentation.

Research has revealed NHS doctors, nurses and allied health professionals are spending an average of 13.5 hours per week generating clinical documentation, a 25% increase in the last 7 years. We asked NHS leaders at the second Nuance UK Healthcare Council to reflect on this challenge. Led by Jon Hoeksma, CEO of Digital Health, council members discussed what actions to start or stop in order to help reduce the burden of clinical documentation.

What should we START or do MORE OF to reduce the burden of clinical documentation?

- Collaborate over best practice:
  - Define what is needed in the medical note – what do we need/not need to document?

        - Agree standards for a minimum structured data set and implement the standards set by organisations such as the Professional Records Standards Body (PRSB)
        - Use more structured templates with specialty-specific agreed fields
        - Step back and make sure we are not automating bad processes

- Improve digital solutions:
    - IT providers need to improve interoperability and make it easier to share information from one electronic patient record (EPR) to another
    - Use forms to facilitate more structured data capture
    - Apply more user-centred design to structure the data collection in the EPR
    - Use the data in the chart (do not write it again or copy and paste)
    - Issue healthcare professionals with personal mobile devices to support more flexible ways of working
    - Use solutions like Dragon Medical One to speed up data entry, making it easier to navigate the EPR and capture real-time documentation
    - Start using natural language processing to extract clinical data from the 'free text' in medical records and populate structured/categorised documentation in EPRs

- Increase sharing of data
    - Share data across services/settings (social care, education sector for paediatrics etc.) to reduce the need for repetitive documentation
    - Use digital solutions to share more data directly with patients (e.g. improve patient's view on NHS App.)

- Increase training on digital solutions:
    - Provide all medical students with dummy EPR systems to train on at university
    - Include use of digital records to deliver care on the training syllabus for health professionals
    - Use thorough training plans (online, small group, one-to-one) to increase the adoption of technologies
    - Use EPR data to identify which healthcare professionals are struggling with their documentation and why (and then focus training resources)
    - Continually discuss why the change is good for the clinicians – use data to surface the value to them

- Centralise the purchase of clinical technology to scale Return-On-Investment / maximise savings of bulk purchasing

A key theme was that digital transformation can help reduce the burden of clinical documentation but only when it's delivered with thorough training. The council agreed that including EPR and digital record-keeping as part of the syllabus, early in healthcare professional training, could help ensure new clinicians start their first jobs with core skills/good habits. However, Rebecca Granger, Head of Digital Experience at Ramsay Health Care UK, added that if solution providers used more human-centric design principles this would significantly reduce the amount of training required.

Dr Jay Mehta, CMIO and GP Registrar for the Royal Free London NHS Foundation Trust, described a "keyboard-last" approach for notetaking in the future. In a connected environment, where different systems can feed into the EPR, patient records can be populated using more automated sources, instead of relying on the clinician to act as a scribe. Helen Crowther QN, National Digital Primary Care Nurse Lead and CNIO Office for NHS E&I, highlighted the importance of surfacing meaningful information through these systems. Everything the clinician pulls into the record—regardless of the source—should be easy for readers to understand, whether it's another healthcare professional or the patient themselves.

Many council members felt that technology should be put in the hands of patients. Dorothy Bean, CNIO for NHS England & Improvement South-West region, described how this approach "offers patients more control while also driving NHS productivity gains". Kelly Lin, Deputy Director at the Centre for Improving Data Collaboration, NHS England, agreed and said, "even simple tech solutions such as sending texts or emails instead of letters saves an enormous amount of time." Dr James Reed, CCIO at Birmingham and Solihull Mental Health NHS Foundation Trust, added "writing letters feels old-fashioned, it should be sufficient to send a packet of information (data) when communicating to another provider".

Next, the council turned their attention to what things are not working well and identifying activities they felt should stop or reduce.

What should we STOP or do LESS OF to reduce the burden of clinical documentation?

- Stop duplication:
    - Stop the 'copy and paste' culture
    - Stop pasting in the information that already exists without context or amendment
    - Stop the duplication of data capture by real-time sharing of longitudinal patient record in patient context
- Stop note bloat (overdocumentation includes unnecessary information):
    - Note bloat makes the EPR unusable for care teams
    - Stop documenting information that does not bring any value to the patient care
    - Stop being over cautious, fast failing is okay if it's safe!
    - Reduce over documentation of unstructured data
- For nurses, we must stop undertaking risk assessments routinely. These should be based on the practitioner's assessment of need, often these are completed as part of defensive practice and not useful to care.
- Reduce the need to access multiple IT systems:
    - IT solutions need to integrate so that information can be easily shared
    - We shouldn't have to search for data in multiple platforms or duplicate processes/data capture between different healthcare systems
- Stop accepting that use of digital is optional:
    - Stop handwriting notes – it's often illegible
    - Reduce scanning of documents
    - Stop automating bad processes
- Stop the 'not invented here' syndrome (be more open-minded about using solutions developed outside the NHS).
- Stop thinking of doctors and nurses as typists.

This brought the group to the topic of "note bloat", where patient records become overstuffed with too much detail or duplicated information, which can later hinder care teams when they're looking for specific patient data. Dr Peter-Marc Fortune, CCIO for Royal Manchester Children's Hospital, noted that a standardised structure for documentation—which supports digitisation but isn't led by a tool/system—would help reduce note bloat and prevent the urge to over-document. However, Dr Cormac Breen, CCIO at Guy's and St Thomas' NHS Foundation Trust, also noted that it will be difficult to get clinicians to agree on what to remove, as each has their own preferred notetaking approach. Council members also stressed how important interoperability is to help reduce the issue of double documentation.

Documentation improvement is a strategic priority in the NHS

It was clear from the workshop that clinical documentation represents one of the biggest everyday challenges for our Council members and the wider NHS community. Indeed, as trusts continue to shift towards the collaborative environment the Health and Care Act is targeting, introducing more consistency and simplicity to documentation will be instrumental in allowing teams to communicate effectively on a broader scale.

The Council members have identified several key areas to focus on in the NHS's digital journey. As leaders pursue digitisation, it's vital that they avoid simply replicating inefficient documentation processes in a digital space or adding an extra burden to their clinicians. We will continue to explore and refine best practices for documentation ahead of the next council meeting, where we'll reflect on the continuing progress across England's trusts.

Tags: Digitisation of the NHS, Future of Healthcare

More Information

Explore our 2022 survey

How has the documentation burden evolved in the last seven years? We surveyed nearly 1,000 NHS professionals to find out.

Learn more

About Dr. Simon Wallace

Dr. Simon Wallace is the Chief Clinical Information Officer (CCIO) of Nuance's Healthcare division in the UK and Ireland. Simon has worked as a GP, hospital and public health doctor in Brighton and London. His interest in health informatics began in the 90s when he spent a year at the King's Fund investigating the impact of the internet on shared decision making between patients and their healthcare professional. For the past 15 years, he has worked for a range of organisations including Bupa, Dr Foster, Cerner Corporation and GSK across a range of technologies which include electronic patient records, telemedicine, mobile health and lifestyle devices. Simon has a keen interest in the voluntary sector, recently completing a 7 year term as a Trustee for Fitzrovia Youth in Action, a children and young people's charity based in London.

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