CHKS INSIGHT

Paper records have been with us for generations, but we know they are not safe and hinder efficiency

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CHKS
Insight for better healthcare

One of the biggest challenges facing anyone helping the NHS on its digital journey, is how to confront deeply-held beliefs about the benefits of paper and ease of use. We have been using paper for almost 2,000 years so it feels familiar and above all safe.

However, the reality is that it isn't safe especially if the information typed or written on it it is about patients and the treatment they are having. You might think a locked records office is the answer. Yes, these offices can be locked, but the fact that anyone with a mobile phone has a copying device means the records are not safe. In addition, there is no audit trail with paper. You can't tell who looked at it or why, and you can't tell who altered it and when. It's insecure, not private, and difficult to transport or share.

There are also costs associated with paper. From printing, faxing, copying and postal costs through to the staff costs associated with spending time on paper documentation. Paper cannot be shared as quickly as an electronic record. Both cost and speed of sharing will have an impact on organisational efficiency.

Take continuing healthcare, for example. This is by nature a multi-stage process involving many people from different parts of the NHS and the Local Authorities. How do you get a piece of paper from an acute setting to commissioner and then to Local Authority quickly? It is likely that at some point the paper record will be copied (with consequent privacy and security risk) and then sent on possibly as faxes or email attachments. That means multiple insecure pathways for one set of patient data.

Look in more detail at end of life care planning in a city like London and you can quickly see how paper records are far from ideal and can lead to inappropriate care. Anyone on an end of life care pathway in London could be registered in one of 30 different areas. In addition, there could be as many as ten different types of care plan in use – each with its own format with information recorded in different ways. If a particular individual does not want to be resuscitated and then has a heart attack in a different area from the one they are registered in, it is unlikely the paramedics will have access to their care plan and will try to resuscitate going against their wishes.

There is a better way. Having information recorded and shared electronically in a secure way ensures this can't happen. Systems like our CHC Service Management Tool use secure and personalised care plans that can be shared across teams to give a complete picture of the patient, ensuring providers understand every patients' needs. There is consistency in treatment wherever the individual is cared for. CHC can also work with all ten different formats of care plan.

Recently we did some work with a CCG which had a backlog of over three months' activity relating to continuing care. We came across piles of patient records waiting to be actioned and thus none of these patients was progressing through the system, delaying the provision of care and potentially putting those patients at risk. This means the CCG couldn't even deal with process failures. We managed to clear this backlog in one month.

In order to deliver NHS England's digital strategy and paperless vision, we have to look carefully at the rationale for using paper records and this means understanding the impact on efficiency. It also requires a culture shift which can only happen once we accept the limitations of paper as a way to keep information safe.

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