The real pain points around the use of digital systems in the NHS.

This report contains the findings from HTN's audience survey, commissioned by Aire Innovate, to understand what's really frustrating frontline and IT staff about digital systems today, including:

- The biggest friction points staff face daily
- Where manual workarounds are still happening and why
- The priority areas digital system users say need urgent attention
- Approaches to address these challenges quickly

Read to gain insight directly from those using the systems every day and recommended actions.

Executive Summary

If you're responsible for digital transformation, clinical systems, or improving operational efficiency, this report will provide insight directly from those using the systems every day and actionable ideas.

We asked respondents to share details on the biggest pain points with their organisation's digital systems, where staff currently spend the most time manually entering or transferring data, and the impact of these pain points.

The survey findings cover:

- The pain points with digital systems
- Where do clinicians or admin staff spend the most time manually entering or transferring data between systems?
- Workflows across multiple agencies including third sector
- IT capacity and business case processes on innovation
- What is leading to manual workarounds?
- Do frontline staff have access to tools that allow them to build or customise digital workflows without needing a developer?
- The percentage of forms or patient communications are still handled via paper or email?
- The type of forms or patient communications are still handled via paper or email?
- And we asked, if you could digitise and transform one task tomorrow without needing IT resources or a developer, what would it be?

Here we reveal those pain points with digital systems and actions to be taken in future digital roadmaps.

Pain points with digital systems

The HTN audience highlighted some of the main pain points associated with the use of digital systems at their organisation, with key themes including:

- Not being built around user needs or clinical working practices
- Overcomplication of processes
- Poor integration
- Lack of user-friendliness
- Poor interoperability/connectivity with other systems
- Poor user experience
- Regular downtime
- Poor user support and training
- Delays/slow response

"New IT and digital are driven from the top down and poorly integrated into workflows," one commented.

"Not intuitive, could be more user friendly, the staff prefer to use free text notes, missing data reduces the quality of audits,"

answered another.

Respondents mentioned the use of shadow IT, delays in making upgrades requests and adopting new features.
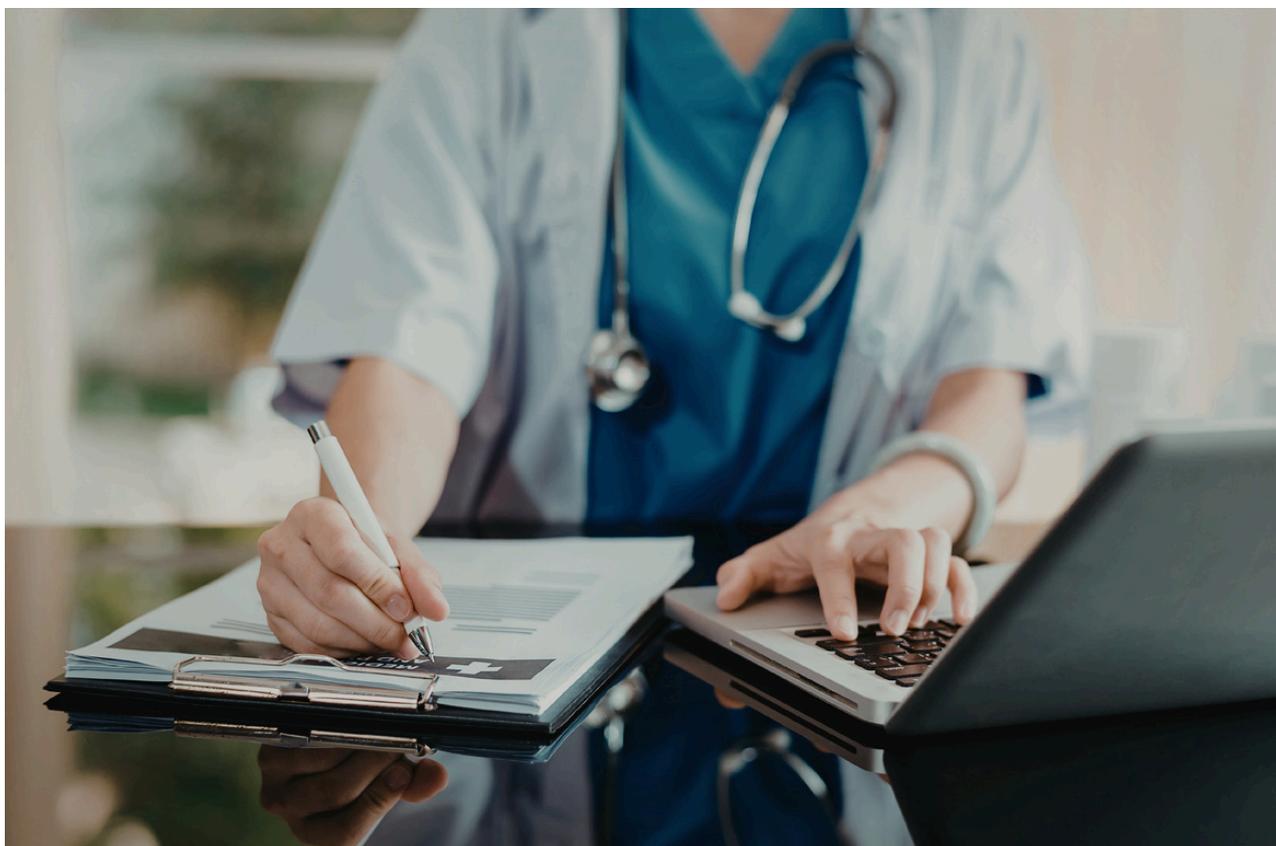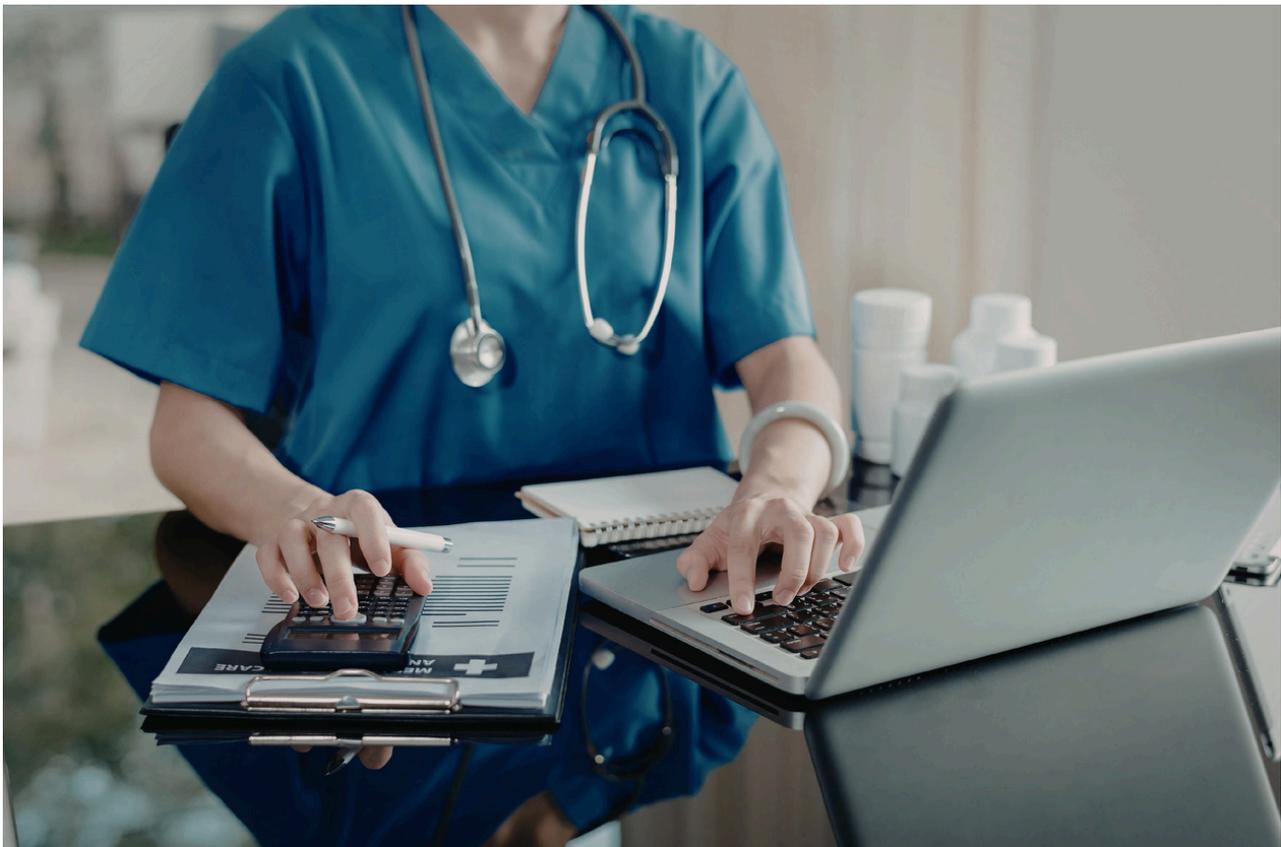
Some respondent talked about complexities around transfers of care, with information currently sent to primary care by PDF file, then requiring manual work to view and rekey.

"**When making the move to cloud, we have sometimes literally lifted and shifted something into cloud, meaning we've just moved the problem we have on premise there, and we still need to manage the infrastructure,"** they added.

Another respondent pointed to challenges with keeping up with digital developments, which often don't include enough consideration of the impact on other healthcare providers.

One respondent noted their "EPR is clunky and does not always well fit the workflows of our clinicians. There are multiple ways of recording the same information and this can cause inconsistency in recording. It is not mobile-friendly and takes time to log into and access a record. Only one record can be viewed at a time, and navigation around the system is time-consuming."

"Limited integration between applications" and "multiple sources of truth" was highlighted, with "too many systems doing similar things".

Adding that "comms and training for new projects are difficult to deliver to busy staff" and "usability/functionality not built around clinical working practices".

Where do clinicians or admin staff spend the most time manually entering or transferring data between systems?

- **Entering patient information and manual data entry**
- **Transferring information between systems**
- **Electronic discharge letters**
- **Ad-hoc documentation and manual upload/input of incoming documents from other providers**
- **Transcription to clinical notes/letters, and transitions of care**
- **Duplication and having to copy and paste from one system to another due to a lack of integration and/or interoperability**
- **Limited "write back" functionality for clinical systems**
- **Results reporting**

The HTN audience highlighted manually entering patient information, transferring information from diagnostic systems to EPRs or from EPR to EPMA, electronic discharge letters, manual data entry, ad-hoc documentation, manual upload/input of incoming documents from other providers, transcription to clinical notes/letters, and transitions of care, where manual process take the most time.

Respondents spoke of duplication and having to copy and paste from one system to another due to a lack of integration and/or interoperability. Limited "write back" functionality for clinical systems, limited data fields with transfer capability, and the need to manually review, correct, and code outputs from Ambient Voice solutions, were also listed as challenges.

One respondent discussed issues arising when trying to work around connections between different teams or boundaries of care, noting that "a lot of duplication also occurs around diagnostics, discharge summaries, and letters". Others similarly talked about the need for manual uploading, coding or filing when receiving documents from other providers, time taken on transitions of care, and limited transferable data fields within the EPR meaning "no single source of truth".

Another participant highlighted electronic discharge letters, and gaps between systems meaning clinicians have to copy and paste in sections, taking approximately 10 – 15 minutes extra. The same sentiment came from a different respondent, who talked about how the use of an ambient scribe meant copying and pasting, due to a lack of "pull through" into clinical systems.

"Another major area is the transfer of data between secondary care systems, including eRS, where referrals, discharge summaries, and test results frequently arrive in formats that need manual entry.

Overall, the highest time burden occurs wherever systems lack seamless integration, leading to repeated manual data entry across multiple platforms," commented another.
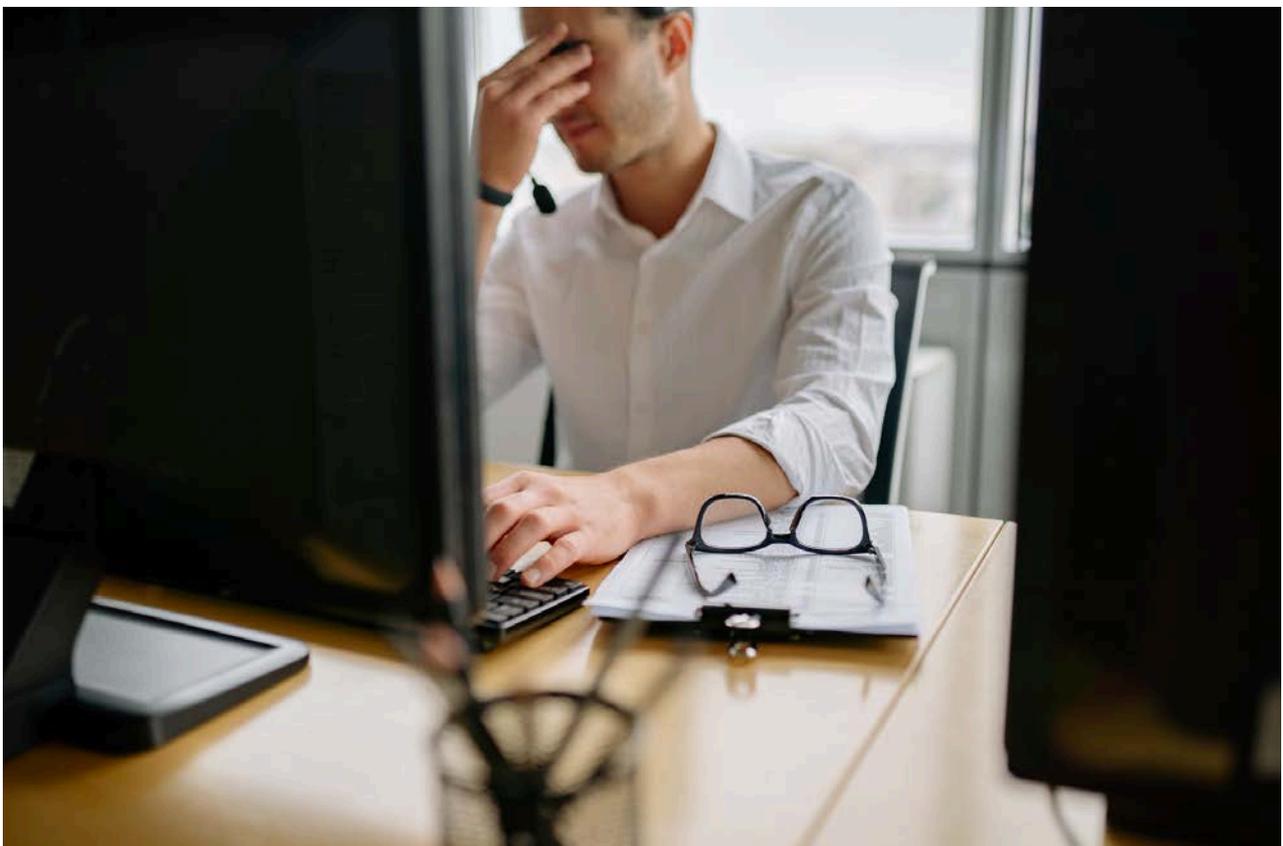
To what extent does this change when thinking about workflows, and workflows across multiple agencies including third sector?

When thinking about how their answers changed when considering workflows and workflows covering multiple agencies including third sector, many respondents talked about added complexities and admin burden. Some mentioned additional workarounds and challenges including difficulties transferring data and issues with interoperability. On the other hand, shared care records were highlighted as supporting data sharing.

Copying and pasting was again mentioned when it came to sharing information with different agencies and systems, and the potential for duplication in shared care records when pulling from multiple different systems was noted.

"I don't think we're there yet," acknowledged one respondent. "We're looking into the personalised health record, anticipating the move to put the power in patient's hands and giving them their own patient-held record that they can then share with different agencies – it's another way of tackling the same problem."

A number of respondents mentioned challenges and barriers existing around data sharing agreements and data protection. "It's difficult to get access allowed from third party agencies for example some clinical systems - they need honorary contracts or SLA between their company and Trust to have just read only access," one person noted.

"There are grave issues for General Practice about the whole data controller responsibilities. Once documents are in the General Practice record as things stand at the moment, the practice becomes responsible and we do not have enough staff to be responsible for third party entries," another reported.

To what extent do IT capacity or business case processes stifle innovation or changes to workflow? Does this also lead to manual workarounds?

A large proportion of respondents highlighted challenges with a lack of capacity. Answers noted the impact of this lack of capacity on the ability to make changes and meet requirements, as well as to adapt and embrace new innovations. Many spoke of having to implement workarounds, and highlighted the potential of these to affect compliance, safety, and workload.

"We're a small team so capacity can be an issue, and dependent on what is being requested there can be a lot of bureaucracy about changes being made," one respondent observed.

Another made a similar observation, adding that this lack of IT capacity led to "colleagues developing their own digital solutions without the required governance and assurance, or carrying on with inefficient non-digital processes".

In other instances, people reported having to resort back to using paper as a workaround when lacking capacity to fix issues. A number of respondents

I considered that these types of workarounds have the potential to impact patient safety.

In other instances, lack of specific skillsets or roles such as business analysts, meant not being able to pursue business cases that would support innovation, a participant highlighted. One person noted that lack of capacity could slow down implementation, with "lots of back and forth and making sure all the hoops are jumped through, especially with AI and going through the DPO".

 "Capacity is one of our biggest challenges - there is a long list of requested changes to systems to support workflows, but we have to prioritise the most urgent or significant needs. This means some services are unable to digitise their recording effectively."

Another respondent said "It creates an ethos of either not trying or doing and asking for permission after" and that "frontline teams may have ideas for streamlining processes or introducing automation, but the need for formal approvals, resource allocation, and compliance checks can delay implementation.

In practice this leads to manual workarounds, such as staff duplicating data entry or using ad hoc tools like spreadsheets and emails to bridge gaps between systems. These workarounds are often necessary to maintain service delivery but are inefficient and increase the risk of errors."

Do frontline staff have access to tools that allow them to build or customise digital workflows without needing a developer?

Only 9.5 percent of respondents indicated that they did have access to these kinds of capabilities, but did not always use them.

Many respondents indicated that frontline staff would usually put in requests to digital teams when requiring certain changes to be made. Where customisation tools were available to frontline staff, these ranged from limited capacity for creating custom templates to building and customising full workflows without developers through no-code or low-code platforms.

One respondent noted that the lack of functionality available to frontline staff

"limited their ability to respond quickly to changing service needs or to optimise processes in real time, reinforcing reliance on manual processes and workarounds".

Another shared how staff on the frontline in their organisation did not have access to the capability for even simpler tasks "like clinic template amendment".

Another added: "I think that's a Nirvana we're nowhere near – we're not in a commercial organisation, and we've always got to have clinical and patient safety at the heart of our design – I don't think it's practical at this point to have frontline staff creating apps."

What percentage of forms or patient communications are still handled via paper or email?

Pie chart:
- 0-19% paper or email — 42.3%
- 20-39% paper or email — 25.7%
- 40-59% paper or email — 20.8%
- 60-79% paper or email — 8%
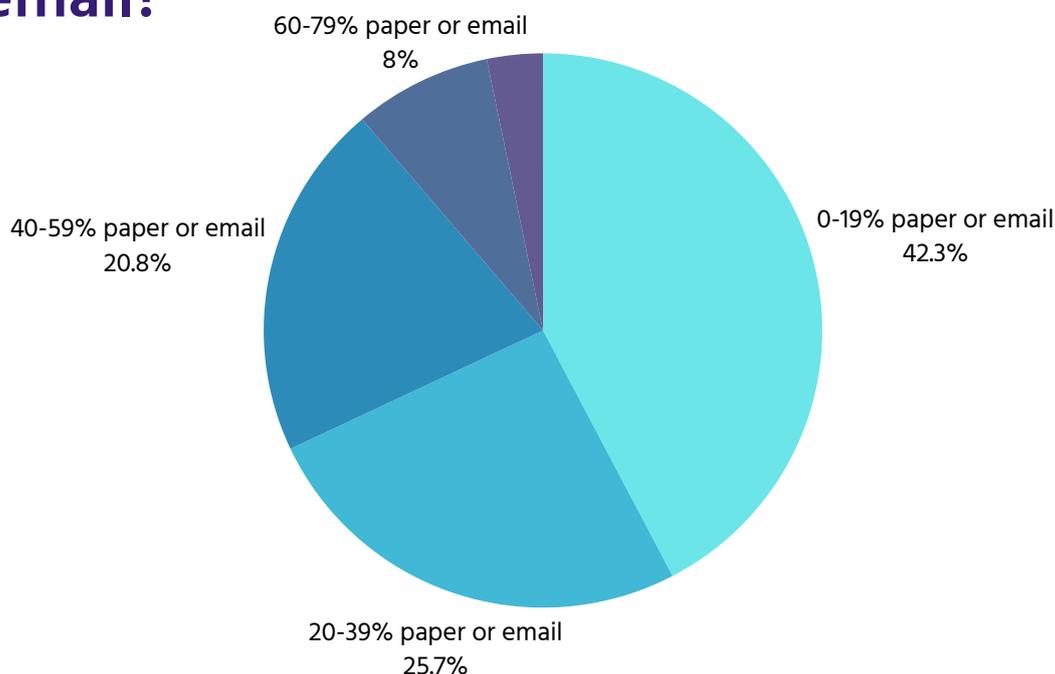
Respondents gave some examples of patient communications that were still being handled via paper or email, including clinic letters, discharge letters, outpatient reports, inpatient noting forms, outpatient forms, appointment letters, and registrations.

"Paper and email are often used as a fallback where digital workflows are not interoperable, staff are not trained in available systems, or patients do not have access to digital tools, which perpetuates inefficiencies in care delivery."

"Most of our communication goes via patient portal," a respondent stated. "This includes, appointments, test results, booking summaries, antenatal visit summaries, discharge summaries, personalised care and support plans."

In other organisations, a lot more is being communicated using paper. "Just looking at nursing, midwifery, and AHP, we have about two thousand forms still on paper," a respondent noted. "Even where the digital option is available, we have people still using paper for things. We need to remember the importance of digitising and having that information available to inform patient care."

Sometimes, there were pockets of digitisation, with one respondent saying that whilst most of their trust relies on paper, "maternity is 90 percent digital". Another noted: "A varied mixture, some teams are better off than others but there is still a lot of duplication."

If you could digitise and transform one task tomorrow without needing IT resources or a developer, what would it be?

Respondents considered what they would digitise or transform if they were given the power to do so without IT resources or a developer. Answers were varied, with suggestions ranging from inpatient flow processes for moving between district beds, appointment booking, letter generation, automatic appointment reminders, inpatient records, and multi-agency referrals.

One respondent voiced a desire to procure an up-to-date document management system; another wanted to digitise record keeping with the use of "Copilot or similar"; and for another, automated letter processing within the clinical system itself would be the first priority.

"I would improve referral management processes which I consider are very much manualised and paper based," a respondent reported. Another said: "Clinic template build and customisation; it is a major bottleneck for managing outpatient services efficiently."

Another added: "Honestly, I would just make the system run faster. Slow performance affects almost every task we do, so improving speed would have the biggest impact on productivity and patient care."

"Task management for clinical and administrative teams (auto creation, auto completion, auto recurrence, auto new-task generation)."

Approaches to address these challenges quickly

Mike Odling-Smee, Director and Co-Founder, Aire Innovate

If you spend any time with frontline teams, none of the findings in this report will come as a surprise. What's striking isn't the existence of these problems, it's how long they've persisted. We've invested heavily in core systems, and rightly so. But the reality is this: most of the friction staff experience today sits in the gaps between those systems, and in the workflows wrapped around them.

In my experience, the organisations making the most progress aren't replacing everything. They're taking a more pragmatic approach - rethinking workflows and using AI and automation to remove friction quickly, safely, and at scale.

Here's where I'd focus.

1. Start with workflows, not systems

The NHS has spent years optimising systems. What hasn't always happened is optimising to how people actually work. That's why you still see duplication, workarounds, and inconsistent data capture. The fix isn't another system - it's redesigning the workflow.

When you map something like discharge or referrals properly, you quickly see where the friction is. Capture data once. Structure it properly. Share it.

This is where AI and automation can then start to make a real difference - reducing the burden on staff while improving the quality of what's captured in the first place.

2. Be ruthless about eliminating manual rekeying

If clinicians are still copying and pasting between systems in 2026, we have a problem. I don't think we should accept that large-scale integration is the only answer. It's too slow, and teams can't wait.

What I'm seeing work is a more targeted approach - focusing on the highest-friction ata flows and using automation to move structured data between systems. In some cases, AI can help turn unstructured inputs into usable data as well.

It's not glamorous, but it's **one of the fastest ways to give time back to staff.**

3. Give frontline teams the ability to fix things

One of the most consistent frustrations I hear is this: "We know what needs fixing, we just can't get it done." That's usually down to capacity, process, or both. And it's why workarounds, and shadow IT, inevitably appear.

I don't think the answer is less governance. But I do think it's better governance - providing safe environments where frontline teams can configure and improve workflows themselves. When you combine that with automation - so actions, tasks, and pathways happen automatically, you start to unlock a completely different pace of improvement.
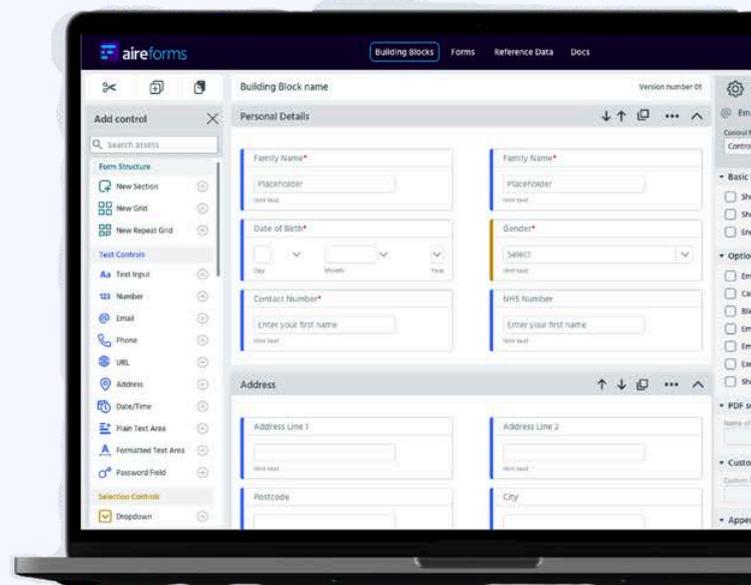
4. Stop tolerating paper where it doesn't need to exist

Paper and email are still everywhere, not because people prefer them, but because the digital alternatives don't quite work. The opportunity here is huge. These are high-volume, repeatable processes that are relatively quick to digitise.

When you combine that with automation and AI, auto-populating forms, generating letters, triaging inputs, you don't just digitise the process, you fundamentally improve it. And importantly, you free up time almost immediately.

5. Fix the gaps between organisations

Some of the biggest inefficiencies I see aren't within organisations, they're between them.

Shared care records help, but they don't solve workflow. They don't stop duplication, delays, or the need to chase information.

What does help is focusing on the pathway itself - designing workflows that work across organisational boundaries, and using automation to move information and trigger actions between teams.

6. Move faster

Speed matters more than we sometimes admit.

When change takes months or years, teams disengage, workarounds become embedded, and the problem gets worse.

The organisations pulling ahead are the ones delivering change in weeks. Not perfect solutions, but better ones - tested, iterated, and improved over time.

That's where low code platforms that combine workflow, integration, automation, and AI are making a real difference. They allow you to start small, prove value quickly, and scale what works.

About Aire Innovate

Aire Innovate comes out of Aire Logic, where we've spent over 20 years working alongside the NHS on everything from national programmes to local pathway redesign, interoperability, shared care, and EPR optimisation. What became clear over time is that many of the hardest problems weren't about the systems themselves, they were about the workflows around them.

Aire Innovate is our response to that. It's a platform designed to help organisations fix the friction without replacing what they already have. We combine configurable workflows with built-in AI and automation, so data can be captured intelligently, tasks can happen automatically, and information can flow between systems without constant manual effort.

In simple terms, it's about helping teams move faster: reducing admin, improving consistency, and making better use of the digital estate that's already in place.

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To book a demonstration and explore how the platform can help you address your biggest pain points in weeks not years.

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