

Clinical Champions and Super-Users

How grassroots leadership
accelerates EPR adoption
and optimisation

Co-authored by the
Electronic Patient Record
(EPR) Network

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1. Executive Summary

Digital transformation in the NHS is no longer defined by whether an Electronic Patient Record (EPR) system has been deployed. For many organisations, the harder challenge begins after go-live: embedding new ways of working into clinical practice, sustaining engagement beyond initial training and ensuring digital tools genuinely improve care delivery rather than simply digitise existing processes.

Produced by the UK EPR Network and Healthcare Innovation Consortium (HIC), this paper examines one of the most effective yet underutilised mechanisms for closing that gap: the clinical champion and super-user model.

Drawing on real-world experience and case studies from [Alcidion](#), [CLEO Systems](#), [Enovacom](#), [First Databank \(FDB\)](#), [Ready Computing](#) and [System C](#) – spanning acute, emergency, community and integrated care settings – this paper explores how peer-led, clinically grounded support accelerates adoption, strengthens optimisation and builds lasting digital capability within NHS organisations.

The evidence is clear:

Successful EPR programmes are not sustained by technology alone. They depend on trusted individuals within clinical

and operational teams who can translate digital transformation into practical, everyday improvement.

This white paper offers practical insight for NHS digital leaders, EPR programme teams, CIOs and clinical stakeholders on how grassroots leadership can become a core component of successful EPR strategy.



2. Introduction

The NHS has made significant progress in digital transformation over the past decade. Programmes such as the Frontline Digitisation Programme accelerated EPR deployment across the health service, shifting the conversation from implementation to benefits realisation. Frameworks including NHS England's What Good Looks Like, HIMSS EMRAM assessments and the move towards Frontline Productivity increasingly focus not on whether systems exist, but how effectively they are embedded into everyday practice.

Despite widespread adoption, many organisations continue to face a common challenge: turning digital investment into sustained behavioural and operational change.

While EPR systems are now embedded across much of the NHS, adoption often remains inconsistent between teams and departments. Workarounds persist, optimisation programmes compete with operational pressures, and engagement can decline once initial implementation phases conclude.

Against this backdrop, clinical champions and super users have become increasingly important. Positioned within frontline teams, these individuals play a critical role in reinforcing best practice, supporting peers, identifying workflow improvements and helping organisations embed change in ways that feel clinically relevant rather than operationally imposed.

The UK EPR Network was established to support this next phase of digital maturity by bringing together NHS organisations, digital leaders, clinical informatics professionals and technology partners to share learning and practical experience. This white paper explores how grassroots leadership models are helping NHS organisations strengthen EPR adoption and optimisation, and why investing in clinician-led support is becoming an essential component of long-term digital success.



3. The Adoption Gap: Why EPR Value Remains Unrealised

Billions have been invested in NHS digital infrastructure, yet adoption and optimisation challenges remain pervasive. The reasons are well understood, if not always well addressed.

What the evidence shows us

Across NHS organisations, a consistent pattern often emerges following go-live. Initial enthusiasm gives way to frustration as clinical teams encounter systems that do not map intuitively to their workflows. Training delivered as a one-off event before deployment quickly loses impact, while super-users who received additional preparation return to their substantive roles and floor-level support disappears.

Over time, adoption becomes uneven across wards, specialties and sites, often reflecting differences in leadership confidence, digital literacy and the extent to which frontline staff feel heard.

The consequences are predictable: continued reliance on paper-based parallel processes, inconsistent data quality, missed opportunities for clinical decision support and increasing distance between the system's potential and its delivered value. Worse, where systems are perceived as burdensome rather than enabling, clinical resistance hardens and becomes increasingly difficult to reverse.

Policy context

In practice, national frameworks and strategies reinforce this principle. NHS England's What Good Looks Like framework recognises that:

Digital maturity requires more than deployment – it demands meaningful, consistent clinical use and a culture of continuous improvement.

Similarly, HIMSS EMRAM scoring rewards active, integrated clinical engagement rather than system presence alone. The NHS Long Term Workforce Plan identifies digital capability as an essential component of clinical roles, while the Darzi Review's emphasis on productivity and value for money has raised the stakes further.



Organisations must demonstrate return on their EPR investment, not simply record that an EPR exists.

In this context, the question is not if NHS organisations should invest in clinical champion and super-user models. The question is why, despite the evidence, so many organisations continue to treat them as optional extras rather than programme essentials.

Common failure modes

- ▶ Training delivered as a single pre-go-live event, without ongoing reinforcement or peer support
- ▶ Clinical champion roles established informally, without protected time, defined responsibilities, or organisational recognition
- ▶ Digitisation proceeding before workflow optimisation, embedding inefficiency into new systems
- ▶ Clinical feedback mechanisms absent or unresponsive, leading to disengagement from frontline staff
- ▶ Go-live treated as programme completion rather than the beginning of a continuous improvement cycle



Electronic Patient Record Network

Bringing the EPR Community Together

The EPR Network is a neutral, vendor-agnostic forum created by Healthcare Innovation Consortium (HIC).

Bringing together an active and growing community of Trusts, suppliers, clinicians and policymakers, the Network aims to share learning, align on national goals, and tackle shared barriers to digital maturity within UK healthcare organisations.

[Find out more about the EPR Network here](#)

4. Insights and Analysis: What Makes Clinical Champions Work

Workshop design – Recommended workshop agenda

Member experience across the UK EPR Network consistently points to the same conclusion: where clinical champions are embedded thoughtfully, with genuine role definition and organisational support, they become the single most effective mechanism for translating digital capability into clinical reality. The following themes emerge from the case studies and member perspectives gathered for this paper.

1. Optimise before you digitise

One of the most important insights from EPR Network members is that the sequence of transformation matters profoundly.

When organisations digitise existing workflows without first questioning whether those workflows are efficient, they risk encoding inefficiency into the digital system itself.

The result is a system that is technically functional but clinically frustrating – prompting workarounds and undermining engagement from the start.

System C's Visualise, Optimise, Digitise (VOD) model, developed in collaboration with Chief Nursing Informatics Officer Dione Rogers, addresses this directly. The Visualise stage – bringing clinical staff together with every paper document used in patient care, categorising it and mapping current-state processes before any digital decisions are made – ensures that optimisation precedes digitisation rather than following it. This inversion of the usual sequence is not simply a methodology preference. It is a fundamental shift in how clinical staff relate to the digital programme. They are redesigning their own practice, not being asked to accommodate a system.



2. Clinical champions must have structural support

The evidence from member organisations is unambiguous: champions who are nominated informally, without protected time or clear role definition, tend to revert to their substantive clinical responsibilities under pressure.

The model fails not because the individuals lack commitment, but because the organisation has not created the conditions for success.

Members' experience across multiple NHS deployments illustrates what sustainable clinical leadership looks like in practice. Champions are selected based on clinical credibility and influence within their specialty – not simply digital enthusiasm.

They receive protected time where possible and are positioned as peer leaders rather than IT support staff. Their role extends explicitly beyond frontline troubleshooting into optimisation by identifying friction points, feeding into configuration decisions, shaping workflows alongside digital and clinical safety teams and translating data insights into practice improvement.

3. Modular delivery enables champions to drive continuous value

A recurring theme across member contributions is that modular or incremental deployment – introducing digital capabilities in manageable stages rather than attempting full EPR transformation in a single go-live – significantly improves adoption outcomes. When clinical teams can adapt to one capability before the next is introduced, learning is consolidated rather than overwhelmed. Champions can build confidence and competence progressively and their support becomes more targeted and effective at each stage.

Alcidion's approach across sites including Herefordshire and Worcestershire Health and Care NHS Trust, University Hospital Southampton, NCIC, South Tees and Hywel Dda University Health Board demonstrates this consistently. Digital patient flow, electronic observations and structured assessments are introduced in sequence, with clinical champions supporting each stage in real time. The modular model also enables earlier value realisation as organisations do not have to wait for full EPR maturity before benefits begin to accrue.

4. Co-design and feedback loops are non-negotiable

Across every case study in this paper, a common enabling factor emerges.

Organisations that create genuine feedback mechanisms between frontline clinical users and the digital or supplier team consistently outperform those that do not. This is not simply about user satisfaction. It is about the quality of the digital product itself.

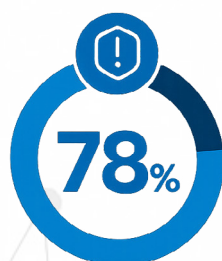
As Ready Computing emphasises, workflows should be user-centred, and feedback mechanisms ensure that. CLEO's peer-led development through clinical champions at the Royal Free is engaging stakeholders from across the Trust to develop a system tailored to staff needs and clinical workflows.

Enovacom's experience at Wirral University Teaching Hospital illustrates this particularly clearly. The integration of Maquet ventilator data with the Oracle Cerner EPR was technically complex – but the project's success was driven by a continuous feedback loop with ICU nursing staff. Nurses directly influenced two significant design changes: the frequency of automated data capture and the creation of an on-demand button for recording vital signs between intervals. The result was not just adoption, but genuine clinical ownership of the digital tool.

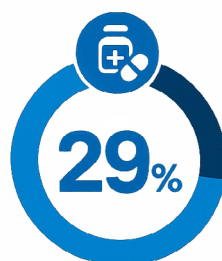
5. Adoption and optimisation are not sequential – they are continuous

Perhaps the most significant shift in thinking required of NHS EPR programmes is the recognition that adoption and optimisation are not phases to be completed in sequence, but parallel, continuous processes. Champions do not finish their work at go-live. Their value – identifying friction, improving usability, scaling successful practices and sustaining engagement – is most needed in the months and years that follow.

FDB's case study from NHS Greater Glasgow and Clyde illustrates what continuous clinical decision support looks like at scale. EPMA data from 2024 shows that 78% of critical interaction alerts were heeded, 29% of duplicate therapy warnings accepted and 24% of allergy alerts acted upon – figures that reflect not just system functionality but sustained clinical engagement with safety-critical tools embedded in prescribing workflows. This is the output of a programme that invested in clinical leadership not as a launch activity, but as an ongoing organisational capability.



Critical interaction alerts heeded



Duplicate therapy warnings accepted



Allergy alerts acted upon

5. Case studies

The following case studies are drawn directly from member organisations and their technology partners. They represent diverse settings, system types and stages of EPR maturity – but share a common thread: the centrality of clinical leadership to sustained digital value.

System C: Visualise, Optimise, Digitise (VOD)

Context

Many NHS trusts still face a gap between EPR deployment and meaningful clinical benefit. Documentation moves from paper to screen, but workflows often stay unchanged. This leads to disengagement, workarounds and inconsistent adoption across wards and specialties. System C identified this pattern across acute trust implementations. The issue was clear: digitisation was happening before optimisation.

Organisations were embedding inefficient legacy processes into digital systems, limiting adoption and reducing value realisation.

Action

System C developed the Visualise, Optimise, Digitise (VOD) model in

collaboration with Dione Rogers, Chief Nursing Informatics Officer. The model places clinical engagement at the centre of transformation. The Visualise stage uses a structured “Paper Picnic.” Clinical staff bring every paper document used in patient care. Documents are categorised, colour coded and logged to create a clear picture of current practice. Process mapping, observation and time-motion analysis identify duplication and inefficiency before digital decisions are made.

The Optimise stage uses workshops where clinicians review complete workflows to remove duplication, reduce variation and redesign pathways. This goes beyond documentation to address full end-to-end processes, ensuring workflows are digitally lean and operationally effective. Leaders focus staff on the practical benefit: less administrative burden and more time for patient care. The Digitise stage converts agreed workflows into CareFlow EPR across mobile and desktop.

Continuous monitoring after go-live identifies issues early, making transformation an ongoing cycle rather than a one-off implementation.

Outcomes

Clinical teams reported stronger ownership of transformation and a clearer understanding of how digitisation improved daily practice. Mobile handover functionality removed the need for end-of-shift terminal updates, enabling real-time documentation at the point of care. Structured data improved consistency across records. Where benefits initially fell short, System C repeated visualisation and optimisation activities to identify gaps and refine workflows, demonstrating continuous improvement beyond go-live.

Relevance to the NHS

VOD aligns with NHS England's What Good Looks Like framework by focusing on meaningful system use rather than deployment alone. It strengthens clinical ownership, reduces reliance on central IT teams and supports the improvement culture recognised by HIMSS EMRAM assessments. It also creates a stronger foundation for integrating emerging capabilities such as ambient voice technology.

Lessons Learned

Two lessons stand out. First, sequence is not optional: digitising before

optimising locks inefficiency into clinical systems.

The Visualise and Optimise stages are not preparation for the real work; they are the work.

Second, clinical engagement fails when it is passive. Trusts that treat engagement as a communications task rather than a structural feature of their programme consistently see higher workaround rates and post-go-live disengagement.

Reflection

The VOD model itself emerged from collaboration between a supplier and an NHS CNIO. This is precisely what the EPR Network and its Special Interest Groups replicate at scale: honest peer exchange between organisations at different stages of maturity. Sharing what has worked, and where implementations required re-optimisation, gives other trusts a practical foundation that generic guidance cannot.

System C
Connecting Care

Alcidion: Clinical Champions in a Modular Model – Accelerating Adoption and Continuous Improvement

Context

Across the NHS, many organisations have successfully deployed EPRs but continue to face a common challenge: adoption is uneven, optimisation stalls and the anticipated clinical and operational benefits are not fully realised.

This gap is often most visible where digital capability exists but workflows, behaviours and confidence have not yet caught up.

Alcidion's experience across UK deployments with Miya Precision EPR and Miya Emergency suggests that two factors are critical to closing this gap: a modular approach to delivery and strong clinical champion networks embedded from the outset.

Action

Rather than treating go-live as the finish line, this model introduces digital capabilities incrementally – allowing clinical teams to adapt in manageable steps – while peer leaders support adoption in real time and drive continuous optimisation long

after deployment. Clinical champions were selected based on credibility and influence within their specialties, given protected time where possible and positioned as peer leaders. Their role extended beyond support into optimisation: identifying friction points, improving usability, shaping workflows and feeding directly into configuration and integration improvements.

- ▶ Herefordshire and Worcestershire Health and Care NHS Trust, digital patient flow was introduced to improve visibility and reduce length of stay across seven community hospitals.
- ▶ University Hospital Southampton NHS Foundation Trust (UHS), rapid deployment in the emergency department succeeded with intense collaboration between members of an extended project management group, working together as one.
- ▶ North Cumbria Integrated Care NHS Foundation Trust (NCIC), clinical champions were embedded early, working alongside digital and clinical safety teams to review content, validate workflows and sense-check hazard logs.
- ▶ South Tees Hospitals NHS Foundation Trust, champions supported consistent use of structured patient safety tools including the digitisation of Martha's Rule.

- ▶ Hywel Dda University Health Board, Miya Precision, Miya Flow and eObs have provided operational teams with a real-time overview across all four acute sites.

Outcomes

Consistent benefits emerged across these sites:

- ▶ Reduced variation in system use across wards and sites
- ▶ Increased staff confidence and reduced reliance on workarounds
- ▶ Improved documentation completeness and data quality
- ▶ Better visibility of patient status and flow across care settings
- ▶ Faster embedding of new workflows and practices
- ▶ A reported reduction in average length of stay of 15% (approximately five days) in community hospital settings at Herefordshire and Worcestershire
- ▶ Sustained momentum for optimisation beyond initial deployment

Jason Teoh, CIO at UHS, described it as the result of *“intense collaboration between members of an extended project management group, working together as one.”*

Relevance to the NHS

This aligns closely with the NHS shift from Frontline Digitisation to Frontline Productivity, maximising the value of existing digital investment. By embedding clinical champions within a modular framework, organisations build local ownership, reduce dependency on central teams and create a repeatable model for continuous improvement. The modular approach enables organisations to realise value earlier and continuously, rather than waiting for full EPR maturity.

Lessons Learned

Adoption and optimisation are not sequential; they must be designed together. Modular delivery creates the conditions for change, but it is clinical leadership and buy-in that translate capability into practice – ensuring that data is not only captured but used to improve care.



ALCIDION

Reflection

Participation in networks such as the UK EPR Network further strengthens this approach. By sharing practical experiences across organisations, clinical leaders can accelerate learning, avoid common pitfalls and scale what works, ensuring that grassroots leadership continues to drive meaningful, system-wide impact.

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The support provided by Alcidion throughout the roll-out has been exceptional.

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Kath Stanbra, Associate Director of Country Wide
Community Services, H&W



Enovacom: From Burden to Benefit: How Nurse-Led Optimisation Transformed ICU Data Integration at Wirral University Teaching Hospital

Context

Wirral University Teaching Hospital NHS Foundation Trust, a Global Digital Exemplar, aims to provide its staff with the best digital tools, a strategy that aligns with its broader vision for data sharing within its regional Integrated Care System (ICS). In its Intensive Care Unit (ICU), the Trust empowered anaesthetists to choose the highest-performing clinical ventilators. However, a significant challenge emerged: the chosen Maquet ventilators could not transfer their complex data in real-time to the Oracle Cerner EPR. This situation forced frontline nurses into manual double-entry, a time-consuming task prone to transcription errors, creating a disconnect between state-of-the-art equipment and clinical usability.

Action

The project was led by clinicians to meet the digital needs of the nurses. The Enovacom medical device integration solution was implemented to integrate data from Maquet ventilators with the EPR. Following a proof of concept validated in a single day, the initial implementation involved close collaboration with clinical staff to define parameters, frequency and data display before rollout and

user training. The key to success was establishing a “continuous feedback loop” with ICU staff. Through this co-design process, nurses directly drove two major optimisations: adjusting data frequency from a minute-to-minute basis to a more clinically relevant interval to avoid overloading the patient record; and creating an ‘on-demand’ button to allow nurses to record vital signs between the automated hourly intervals, giving them full control over data capture.

Outcomes

The improvements were tangible and user-centric. The most significant outcome was the time saved for each nurse and a reduced risk of transcription errors, directly improving patient safety. The easy-to-use interface was integrated into existing workflows, avoiding the need for complex additional training.

Relevance to the NHS

This approach illustrates how to maximise return on investment by aligning digital tools with clinical needs.

It fosters strong clinical ownership of digital change, reducing dependency on external suppliers. This project provides a repeatable model for continuous optimisation, demonstrating that listening to 'people on the ground' is the key to turning a technical implementation into a sustainable clinical success.

Lessons Learned

Successful digital adoption depends on the ability to adapt technology to clinical workflows.

Actively listening to end-users and responsively evolving the tool based on their feedback is more critical than the technology itself.

Reflection

Sharing practical experiences within networks such as the HIC EPR Network is invaluable. It allows other NHS organisations to discover tangible solutions and accelerate the adoption of proven approaches by connecting clinicians, digital leaders and suppliers to solve real-world challenges. It also allows EPR providers to discover solutions to improve clinical engagement and EPR adoption.



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Pretty much the only tool we could find that would do what we needed it to do. The depth of the product and ability to work in a flexible way to allow us to get all the granular data we needed out of the machines and in the right format to go into the EPR was one of the key things.

Paul Charnley, Director of IT and Information, Wirral University Teaching Hospital NHS Foundation Trust

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FDB (First Databank): How Clinical Champions Helped Embed Safe Prescribing at Scale: Supporting Clinical Adoption and Optimisation of EPMA across NHS Greater Glasgow and Clyde

Context

Before the implementation of System C's CareFlow EPMA solution, Glasgow Queen Elizabeth University Hospital and the team across NHS Greater Glasgow and Clyde used a paper-based system, which presented challenges in managing medication interactions – challenges which, in some cases, potentially impacted patient safety. These incidents underscored the need for a more robust solution to help streamline processes and enhance patient safety.

Action

The CareFlow Medicines Management (CMM) Electronic Prescribing and Medicines Administration (EPMA) and Pharmacy platform, underpinned by FDB's Multilex clinical decision support, was rolled out across Glasgow in 2020. The Hospital Electronic Prescribing and Medicines Administration (HEPMA) project replaced the paper drug chart used by doctors and other prescribers and is also used to carry out drug rounds and record the administration of medicines by nurses. Robert Puckett, Lead HEPMA Pharmacist at NHS Greater

Glasgow and Clyde, was instrumental in the solution's implementation. The hospital initially launched CareFlow EPMA with a pilot that began with a five-ward rollout in 2020. Throughout the process, the team engaged with clinical leaders.

Outcomes

A benefits realisation analysis conducted in 2022 highlighted significant improvements following HEPMA's introduction. Key findings included a reduction in missed doses from 27% to 5% and improved allergy status recording, with only 9% missed compared to 17% on paper-based systems.

These early results underscored the system's potential to improve medication management, aligning with HEPMA's business case themes of better care, workforce, value and health. By 2024, data demonstrated continued success with 78% of critical interaction alerts being heeded, 29% of duplicate therapy warnings accepted and 24% of allergy alerts heeded – demonstrating how FDB-powered alerts actively influence safer prescribing decisions.



This progression highlights the system's scalability and its role in driving consistent improvements in patient safety.

Relevance to the NHS

This case study demonstrates how clinical champions and frontline engagement can accelerate the safe adoption and optimisation of EPMA systems at scale. The success of the rollout across NHS Greater Glasgow and Clyde was driven not only by the technology itself, but by the close collaboration between the HEPMA team and clinical users to ensure the system aligned with real prescribing workflows and day-to-day practice. For NHS organisations continuing to expand or optimise EPMA capability, it provides a practical example of how clinician-led support can strengthen adoption,

improve patient safety and drive greater long-term value from digital investment.

Lessons Learned

This case highlights the value of embedding clinical decision support (CDS) directly within the prescribing workflow and the importance of clinical leadership to successful deployments. By providing real-time guidance at the point of prescribing, organisations can reduce the need for retrospective pharmacist interventions, improving efficiency and freeing up clinical time for higher-value activities.

Reflections

Sharing learning across organisations through networks and peer communities can help accelerate optimisation and scale practical solutions across the NHS.

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The success of the pilot was possible due to the engagement and enthusiasm of the clinical teams, working closely with the HEPMA Team to ensure that users received the support they needed to get the most out of the solution.

Robert Puckett, Lead HEPMA Pharmacist,
NHS Greater Glasgow and Clyde

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Ready Computing: From EPR Deployment to Connected Care: Building Integrated Workflows Around the Person

Context

The EPR Network brings together NHS organisations, care providers, local authorities, voluntary sector partners and community-based services to support more coordinated, person-centred care. The challenge is to connect a diverse ecosystem of partners around a shared model for identifying need, coordinating support and improving outcomes. Without a shared operational view, care teams risk working in parallel, with fragmented data, inconsistent workflows and limited visibility across the patient journey.

Action

This model has been proven in practice through Ready Computing's work with Staten Island Performing Provider System (PPS) in New York. Under the leadership of Dr Joseph Conte, Staten Island PPS brings together clinical providers, federally qualified health centres, social care organisations, faith-based organisations, community-based providers and health plans to support underserved communities. Staten Island PPS applied this model through a Social Care Network pilot designed to connect eligible

individuals to support services such as nutrition, housing, transport and care coordination.

The programme demonstrated how a shared technology and operating model can help partners identify need, coordinate referrals, track activity and measure progress across a broad network of clinical and community organisations.

Outcomes

The results were significant. Staten Island PPS reported nearly 40,000 individuals screened, more than 21,000 people connected to services, more than 10,000 families receiving nutrition support and 94% of screened clients completing full assessments.



Its broader community-based work also contributed to measurable improvements in targeted public health initiatives, including a reported 77% reduction in fatal overdoses through its Hotspotting the Opioid Crisis programme.

Relevance to the NHS

For an NHS EPR deployment, the lesson is clear: the success of the record is not only determined by the technology itself. It depends on the ability to translate the EPR into real-world, cross-sector workflows that connect clinical teams, community partners and social care services around the person. This creates a strong case for including a dedicated Integrated Care Workflow and Community Services Lead as part of the EPR deployment team – someone who understands clinical workflow, social care pathways, referral management, consent, information governance, data sharing, service eligibility, reporting and frontline change management. For the EPR Network, this capability is essential.

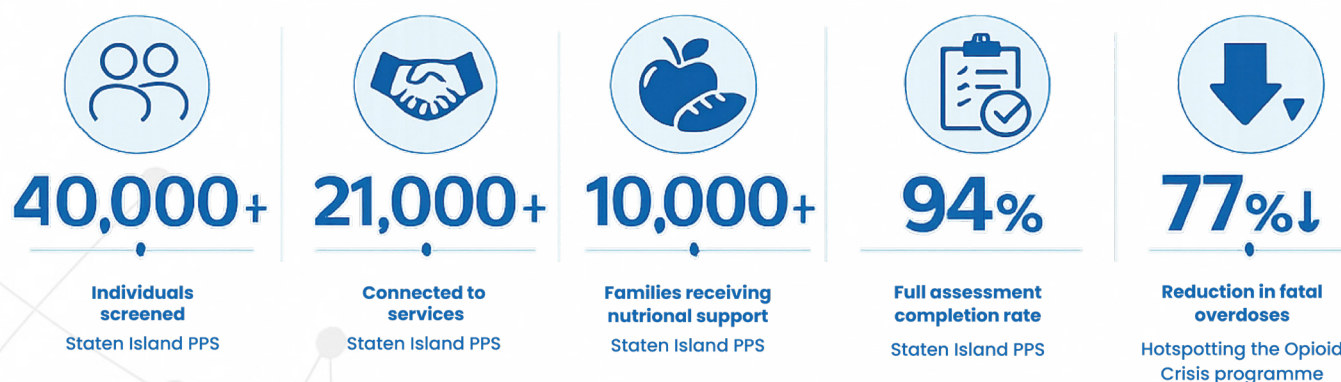
EPR programmes often focus heavily on configuration, migration and go-live readiness. Those elements matter, but they do not guarantee that care teams can coordinate effectively beyond the walls of a trust.

Lessons Learned

The Staten Island example shows what is possible when technology, workflow and cross-sector operating models are aligned. By embedding integrated care and community workflow capability into an EPR deployment, NHS organisations can better connect people to the right services, improve visibility across the care journey, reduce duplication and create a stronger foundation for measurable population health improvement.

Reflection

A dedicated integrated care and community workflow skillset helps ensure the deployment supports the wider ambition of joined-up, person-centred care.



CLEO Systems: Peer-Led Deployment at Scale: Clinical Champions at Royal Free London NHS Foundation Trust

Context

The team at Royal Free London NHS Foundation Trust are currently undertaking a deployment of CLEO EPS – an electronic prescribing solution which enables quick, seamless prescribing with secure transfer of patient data to a nominated community pharmacy from within an outpatient setting. The pharmacy and clinical team, along with Trust project management support, have been heavily engaged since the very first stages of procurement. Kevin Cahill, Deputy Group Chief Pharmacist at Royal Free, is leading the rollout and is a real advocate for the solution. CLEO Systems also works closely with the Trust's Clinical Safety Officer.

Action

With the deployment due to go live shortly, the CLEO team carried out extensive training with a wide range of clinical colleagues from the Emergency Department, where the solution will be rolled out first.

A team of clinical champions at Royal Free have enabled change to be embedded on the frontline.

Champions and super-users have been established in key clinical areas and the CLEO team were invited to Royal Free's clinical safety workshop, which included key members of the Emergency Department including the matron. As Deputy Group Chief Pharmacist and leading the rollout Kevin Cahill has been particularly strong in leading peer-led training across the team.

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With such a high-quality team at Royal Free, it has really helped the roll out. The team have been so closely involved and even carried out User Acceptance Testing (UAT) of the product.

Lewis Elliot
Project Manager, CLEO Systems





As the adoption will empower patients and clinicians to choose where a prescription can be dispensed, it is well aligned with the Trust Clinical Strategy, the 10 Year Health Plan for England and the NHS digital maturity goals. It also has the added bonus of creating a repeatable model for continuous optimisation for roll outs at other trusts.

Kevin Cahill

Chief Super Intendant Pharmacist,
Royal Free NHS Trust (Barnet)

Relevance to the NHS

This case highlights the value of embedding clinical champions and super-users throughout the deployment lifecycle rather than limiting engagement to training alone. By involving frontline staff and primary care stakeholders early in procurement, testing, clinical safety and rollout activity, Royal Free London NHS Foundation Trust has created a peer-led model that strengthens adoption, builds user confidence and supports smoother operational change. For NHS organisations implementing or optimising digital prescribing solutions, it demonstrates how sustained clinical engagement can reduce reliance on paper-based processes, improve frontline

Outcomes

This approach of in-depth clinical team collaboration and training is working well, as clinicians are supported by trusted peers with continuous engagement rather than one-off training. The model is delivering clear improvements, helping increase CLEO EPS adoption and leading to improved staff confidence and engagement. As adoption leads to reduced reliance on paper and workarounds, it is well aligned with NHS digital maturity goals. It also has the added benefit of creating a repeatable model for continuous optimisation for rollouts at other trusts.



buy-in and create a scalable foundation for long-term digital maturity.

Lessons Learned

The key learning is that early engagement, breadth of involvement across clinical roles and treating champions as genuine co-designers rather than recipients of training makes an immediate and measurable difference to both the experience and the outcome.

Reflection

Clinical Champions are more than a title given to foster stakeholder involvement in a project. For EPR integrations they offer the single greatest bridge between clinical experience, system design and senior decision makers that collectively ensures innovation offers the widest reaching benefit for its users.



“

The clinical leadership has been excellent. We've found that the early and broad clinical engagement across the project is helping with the ease of roll out and will enable sustained success.

Lewis Elliot, Project Manager, CLEO Systems

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6. Recommendations

Based on the evidence gathered from UK EPR Network members and the case studies presented in this paper, the following recommendations are offered for NHS organisations, digital programme leaders and their technology partners.

1	Establish Clinical Champion Roles as Programme Essentials, Not Extras As CLEO's partnership at the Royal Free demonstrates, clinical champion and super-user programmes should be designed and resourced at the point of EPR procurement, not added retrospectively when adoption falters. This means defining role criteria, time commitments, backfill arrangements, reporting lines and development pathways before go-live. Organisations that treat this as optional will consistently underperform against those that treat it as structural
2	Optimise Workflows Before Digitising Them Following the sequence established by models such as System C's VOD approach: visualise current-state practice, optimise workflows with clinical teams and only then digitise. Embedding inefficient processes into digital systems does not remove them – it entrenches them. Clinical champions are most effective when they have co-designed the workflows they are supporting.
3	Adopt a Modular Deployment Mindset Where possible, introduce digital capabilities incrementally, allowing clinical teams to embed learning and build confidence at each stage. This reduces cognitive overload, enables earlier value realisation and gives clinical champions a manageable scope of support. Modular delivery, as demonstrated by Alcidion across multiple NHS deployments, is not a compromise – it is a more effective route to full adoption
4	Create and Sustain Genuine Feedback Mechanisms Organisations must build structured channels through which frontline clinical users can surface issues, propose changes and see their input acted upon. This is the single most effective way to sustain engagement beyond go-live. The Enovacom/Wirral example demonstrates that user-driven co-design is not just about satisfaction – it produces a better clinical product.
5	Invest in Integrated Care Workflow Capability As NHS organisations move beyond acute EPR deployment to integrated care models, the ability to extend digital workflows across organisational boundaries – connecting NHS, social care, voluntary sector and community services – becomes essential. Dedicated integrated care workflow capability, as described in the Ready Computing case study, should be considered as a standard component of EPR programme teams.
6	Embed Clinical Decision Support Within Clinical Workflows Clinical decision support tools are most effective when they are seamlessly integrated into prescribing, documentation and assessment workflows at the point of care. The FDB/GGC experience demonstrates that sustained clinical engagement with CDS – not just initial deployment – produces measurable, ongoing improvements in patient safety.
7	Treat Post-Live Optimisation as a Programme, Not an Afterthought The organisations that achieve the greatest return on EPR investment are those that maintain structured optimisation programmes beyond go-live. This means retaining clinical champion networks, scheduling regular workflow reviews, benchmarking against HIMSS EMRAM criteria and creating formal pathways for continuous improvement. The goal is not stability – it is continuous digital maturity.

Join the conversation

As a next step, we invite you to share your experiences and perspectives. Through the Healthcare Innovation Consortium (HIC) EPR Network, NHS organisations, policymakers and industry partners collaborate to share learning and solve common challenges. We welcome your contribution.

Members of the EPR Network

Founding sponsor





About Healthcare Innovation Consortium (HIC)

HIC is a leading independent digital health consultancy that helps organisations design, implement, and scale healthtech solutions that improve patient outcomes and system efficiency. With a mission to put people at the heart of digital transformation, HIC works across the public and private sector to drive meaningful innovation.

To learn more about HIC's EPR consultancy services, visit:
www.hicdigital.co.uk/nhs-epr-transformation/



About Capgemini

Capgemini is a global consulting and digital transformation leader, serving as the Strategic Technology Partner and Founding Sponsor of HIC's EPR Network. Together, they will provide strategic expertise and help drive EPR adoption, interoperability, and digital maturity across NHS Trusts through collaboration and Specialist Interest Groups.



About the Electronic Patient Record Network

This white paper is brought to you by the Electronic Patient Record (EPR) Network, an industry-funded community founded by Hadleigh Stollar, Chief Executive at Healthcare Innovation Consortium (HIC). Recognising the need for a unified platform, Hadleigh launched the EPR Network to bring together EPR vendors, suppliers, and health innovators

— building stronger partnerships with each other and with the NHS to accelerate progress in digital healthcare. The network's mission is to shape and influence policy around EPRs, while fostering meaningful collaboration that improves patient care through better use and integration of digital systems across the health ecosystem.

If you're interested in learning more or joining the network, visit:
www.hicdigital.co.uk/epr-network/