

Better Data In, Better Data Out

How the NHS is improving
data quality, governance and
trust in the EPR

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

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1. Executive Summary

Across the NHS, the Electronic Patient Record (EPR) is now a reality rather than ambition. With the Frontline Digitisation programme reaching its March 2026 milestone and the Single Patient Record transitioning from policy commitment to legislation, the question organisations face is if they can trust what their systems contain.

In this paper, the EPR Network and Healthcare Innovation Consortium (HIC) examine the determining factors of whether digital investment develops better care: the quality, consistency and governance of the data captured. Utilising case studies from [IMS MAXIMS](#), [The Access Group](#), [Altera Digital Health](#), [Alcidion](#), [BridgeHead Software](#)

and [Ready Computing](#) – spanning acute to national-scale environments – it explores how organisations are improving and sustaining data capture.

Evidence suggests data quality is not a reporting problem to be solved in hindsight. It is a design problem that begins during capture and is maintained by those who record the information.

We offer practical insight for NHS digital leaders, CIOs, CCIOs, EPR programme teams and supplier partners on how to construct a record that clinicians and organisations want to act on and can do so with confidence.



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.

To find out more about the EPR Network, visit:
www.hicdigital.co.uk/epr-network/

2. Introduction

After a decade of building digital infrastructure, and with some £1.9 billion of national investment into the Frontline Digitisation programme, the NHS has taken EPR coverage to the point where, by March 2026, around 96% of trusts were expected to have implemented or upgraded a system. Focus has now shifted. The Frontline Productivity programme, which succeeded Frontline Digitisation in April 2026, aims for a 2% productivity improvement and focuses on what systems deliver, not simply on their existence.

A poorly deployed system relies on records that are incomplete, inconsistent or inaccessible. These limitations reduce the influence of data on clinical decisions. When every downstream use draws on the same underlying record, from clinical decision support and population health management to AI, weakness at the point of capture propagates throughout care systems.

Now a matter of national concern, the Single Patient Record, enabled through the Health Bill in May 2026, requires healthcare providers to share information at scale. In 2024, the independent Sudlow Review put forward an argument describing health data as “critical national infrastructure” and called for appropriate leadership and investment. From 2027, clinicians are expected to benefit from improved

record access, particularly in priority specialties including maternity and frailty care.

The key to achieving this is acknowledging that a shared record inherits the quality of the data that powers it.

The EPR Network was established by HIC to help NHS organisations, digital leaders, clinical professionals and technology partners navigate the NHS’ shifting priorities. This paper examines one of the most consequential and least visible components of that work. It asks a deliberately practical question: What have organisations done to improve the quality of record data, what changed as a result, and what can be learned from them?



3. The Data Quality Challenge

Poor data quality rarely announces itself. It surfaces indirectly. Clinicians quietly double-check values they do not trust, while operational meetings begin by disputing the numbers. The costs are real but diffuse, which is why they persist.

Policy context

Across NHS England's What Good Looks Like (WGLL) framework treats well-governed, quality data as a necessary foundation. SNOMED CT is the required terminology for capturing clinical terms in EPR systems in England and interoperability increasingly depends on conformance to HL7 FHIR UK Core profiles and open APIs. In November 2025, 70% of trusts were expected to reach the WGLL core standard of digitisation by March 2026.

In July 2026, NHS England's quality strategy spoke plainly: "The NHS collects large amounts of data and reports thousands of national quality metrics. Yet, coverage is incomplete and gaps remain." These gaps obscure the pathway to improvement.

Despite this, analytical ambition keeps rising. Population health management, predictive modelling and AI-enabled tools all assume a record that is complete, coded and current. With an incomplete record, these tools are less effective at best and dangerous at worst.

Common causes of poor quality data

- ▶ Data quality is treated as a reporting function rather than a clinical design responsibility
- ▶ Migration scope is decided by cost, timescale and ease rather than by a stated data quality ambition, carrying forward legacy inconsistencies
- ▶ Structured fields are introduced without retiring the free-text alternative, leaving both incomplete
- ▶ Data quality stewardship is left undefined between teams, leaving no one accountable when quality falls
- ▶ Training is delivered once before go-live, with little behavioural reinforcement afterwards countable when quality falls
- ▶ Quality is measured through audits and exception reports rather than by whether the information is used to make decisions
- ▶ Interoperability is treated as a series of integrations rather than as an enterprise capability requiring governance and ongoing monitoring

What the evidence shows us

Data quality problems are seldom caused by carelessness at the front line. They are a result of design decisions and workflows that ask clinical teams to record information in unintuitive ways.

When the perspectives of member organisations are combined, a consistent pattern emerges.

Free text is quick to write but almost impossible to aggregate. Legacy data, structured around the constraints of an older system, is migrated wholesale into a new one, importing years of inconsistency. Observations are recorded on paper and transcribed later, introducing delay and transcription risk. Data may exist in one system but be invisible in another.

Consequently, confidence in dashboards declines, teams revert to local spreadsheets, and further fragmentation occurs, eroding data quality. Where clinical decision support acts on incomplete data, alerts are dismissed and safety benefits are unrealised. Where the record cannot be trusted, nothing can be safely

automated on top of it.

Insights and analysis: what improves data quality

Member experience across the EPR Network arrives at a single conclusion: data quality is decided at the point of capture and sustained by those capturing it. Everything downstream — validation, cleansing or remedial audit — is expensive compensation for earlier decisions. Five key themes emerge from the case studies gathered for this paper.

Design data capture around clinical decisions, not the system

The most consistent insight across contributions is simple: data quality improves when capture is designed around the decisions clinicians make, rather than which inputs suit the system.

A case study from Herefordshire and Worcestershire Health and Care NHS Trust (HWHCT), where Alcidion's Miya Precision solution was implemented, demonstrates this. Discharge planning across seven community hospitals depended on verbal handovers, manual tracking and teams working without the full picture. The problem was not an absence of data. It was an absence of quality data capture — information arriving too late, sitting in the wrong system or not reaching the people who needed it.

Redesigning capture around how clinical teams worked — structuring transport, medications and clinical sign-off so that ward and operational teams saw the whole picture simultaneously — produced data that was more complete, timely and valuable for the decisions that mattered.

This distinction is important because familiarity is not the same as effectiveness. Information can be routinely captured without necessarily being available or useful at the point a decision is made. When data capture is designed around clinical workflows, and that information is made visible to the people who need it, documentation becomes more than a record of care; it becomes an active part of delivering it.

Structure and automate at source

If capture design sets the ceiling for data quality, structure and automation are the supports that uphold it.

In a high-pressure NHS department, IMS MAXIMS helped redesign observation recording to improve both data quality and clinical workflow:

- ▶ Advancing observation recording from paper to a structured digital process standardised how information was documented
- ▶ Automated calculations and early warning score assessments reduced the risk of manual error

- ▶ Capture was consistent and formatted for reporting and analysis
- ▶ Real-time recording meant information was available at the point of care

Similar insight can be drawn from Altera Digital Health and Queen Victoria Hospital NHS Foundation Trust (QVH), where integrated patient context links were used more than 430,000 times in the months following go live.

This reduced duplication and transcription risk across systems while improving clinicians' access to contextual patient information.

Structuring information at source and automating wherever possible remains one of the most reliable ways to improve completeness without adding to clinical workload.

Utilise migration for data quality reset

Few organisations get a clean start. Those that do rarely capitalise on it.

Working with The Access Group, HWHCT used the withdrawal of its incumbent product as an opportunity to reset its approach to data quality. The Trust faced a difficult choice: migrate its

historical dataset in full or use the transition as a data quality reset. It chose the latter, migrating only what was clinically essential and preserving historical records as an accessible archive.

The critical action was prioritising data quality. Defining data quality ambition before a single record moved allowed migration scope to follow on from that ambition.

Migrating everything is the default because it is the path of least resistance and lowest immediate risk. It is also how years of inconsistency, accumulated around the limitations of a previous system, are inherited by the new one. Making this informed choice enabled future digital advancement while supporting good governance.

Push for peer-led engagement to sustain structured capture

Structured documentation starts with behaviour, and behaviours decay without reinforcement.

Continuing this work, HWHCT introduced short workflow guides embedded directly within the EPR, setting the standard where the work happens rather than in policy. This produced more durable behaviour change than top-down implementation.

Meanwhile, QVH received three weeks

of 24/7 on-site support and access to a central command centre for real-time issue resolution.

This builds on the clinical champion and super-user model explored in the Network's Q2 2026 white paper, [*Clinical Champions and Super-Users: How Grassroots Leadership Accelerates EPR Adoption and Optimisation*](#), applying it specifically to documentation standards. It is the mechanism by which data quality persists despite operational pressure.

Treat data quality as an enterprise capability

The final theme is the hardest to resource yet the most consequential at scale.



Ready Computing's work with the U.S. Department of Veterans Affairs demonstrates how treating data quality as an enterprise quality can create an accessible and secure patient record.

Faced with a fragmented system, the approach brought data quality into the architecture and operation of the enterprise rather than treating it as a discrete remediation task.

This was enabled by:

- ▶ Aggregation and normalisation across multiple sources
- ▶ Standards-based services
- ▶ APIs for secure external exchange
- ▶ Continuous operational monitoring designed to rectify issues before they caused disruption

The HWHCT case reinforces the same conclusion: quality in isolation is insufficient. Value comes from an open platform and the use of standards such as FHIR to bring observations, medications and tasks from multiple systems into a coherent, actionable view. The result was information that could be used more effectively across clinical and operational settings, with benefits extending to both care delivery and patient experience.

Treating aggregation, normalisation, governance and monitoring as ongoing functions with named owners is demanding, but this enterprise approach is what makes data quality truly impactful.

At Mid Cheshire Hospitals NHS Foundation Trust and East Cheshire NHS Trust, BridgeHead Software provided a Clinical Data Repository and associated services to identify, validate and consolidate clinically relevant information as part of the organisations' wider EPR modernisation.

Rather than treating data quality as a one-off migration task, the approach established a governed repository for information, which was then made available to clinicians through the new EPR. This preserved a reliable longitudinal record while allowing legacy systems to be retired.

4. Case studies

The following case studies are drawn directly from member organisations and their technology partners. Each represents a different point in the EPR lifecycle, but they share a common goal: building information that clinical and operational teams can act on confidently.

Herefordshire and Worcestershire Health and Care NHS Trust (HWHCT) appears in two contributions from different suppliers, addressing different but interlinked challenges: core EPR migration and a real-time view of patient flow. Together, they illustrate how the same underlying commitment to data quality can be applied across different parts of a single organisation.

IMS MAXIMS: Improving Data Quality in an NHS Emergency Department

Context

A busy NHS Emergency Department (ED) department sought to improve the quality of patient data available for clinical decision-making by:

- ▶ Modernising observation recording processes
- ▶ Improving access to real-time information
- ▶ Increasing the use of quality clinical data to support patient safety, operational efficiency and evidence-based decision-making

The organisation recognised an opportunity to improve the standardisation, accuracy and availability of patient observation data.

Moving from paper to structured digital processes aimed to deliver:

- ▶ More consistent data capture
- ▶ Reduced reliance on manual calculations
- ▶ Timely access to information at the point of care

Action

MAXIMS electronic observations (eOBS) solution supported the digital recording of patient observations. Structured data capture standardised how information was documented, ensuring observations were recorded consistently and structured for reporting and analysis.

- ▶ Automated calculations and early warning score assessments supported accuracy and consistency
- ▶ Real-time recording enabled information to be captured and accessed at the point of care
- ▶ Alignment between clinical, operational, digital and supplier teams ensured the solution met frontline requirements

Outcomes

- ▶ Structured digital workflows improved record completeness and reliability
- ▶ Standardised data capture increased confidence in data quality
- ▶ Automated calculations aided accurate data recording
- ▶ Real-time documentation improved the availability and timeliness of patient information

NHS Relevance

Improving data quality supports safer, more effective healthcare across the NHS. High-quality data enables better clinical decision-making, strengthens patient safety, maximises the value of EPR investment and provides a foundation for analytics, service improvement and future AI-enabled innovation.

Lessons learned

Sustainable improvement requires standardised processes, strong clinical engagement and effective change management. Bringing clinical, operational, digital and supplier teams together from the outset made consistent use viable in a pressured environment.

Reflection

Sharing experiences through the EPR Network helps accelerate learning, spread best practice and support better patient outcomes across the NHS.

maxims

The Access Group; EPR Migration as a Data Quality Reset at HWHCT

Context

HWHCT is a community and mental health trust providing a range of care services, including primary care.

Years of inconsistently structured data had accumulated around the limitations of a previous system. When the incumbent supplier removed the product from its portfolio, HWHCT faced a choice: migrate existing data wholesale or use the transition as an opportunity for a data quality reset.

Action

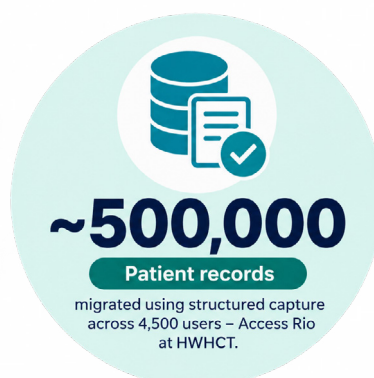
- ▶ The Trust migrated only what was clinically essential. Historical records were preserved as an accessible archive
- ▶ SPAGs (Service Process at a Glance), short workflow guides embedded within the EPR, Access Rio, reduced variation in documentation

Outcomes

- ▶ A single source of trusted information
- ▶ Role-based access maintained information governance at the point of care

- ▶ Structured data capture was embedded across service units
- ▶ Targeted migration avoided carrying inconsistent legacy records into the new EPR, while SPAGs supported more consistent documentation

At a glance



The Deputy CIO Matt Maycock and Deputy CCIO Anna Evans noted the system was already transforming care delivery across the Trust, with structured capture embedded across service units.

NHS Relevance

HWHCT demonstrates that EPR migration is an opportunity to reset data quality, but only with deliberate choices. A well-structured EPR creates the foundations for future innovation while strengthening compliance with information governance requirements, including the Data Security and Protection Toolkit.

Lessons Learned

Improvements came from defining the data quality ambition before a single record even moved. Migration scope should follow that ambition, not precede it.

Peer-led engagement sustains structured capture. The representative model produced more durable behaviour change than top-down implementation and can operate at scale.

Reflection

The EPR Network and its Special Interest Groups enable operational knowledge to travel between organisations and aid both suppliers and the NHS in developing better solutions together.



BridgeHead Software; Preserving Trusted Clinical Information Throughout Modernisation

Context

Mid Cheshire Hospitals NHS Foundation Trust and East Cheshire NHS Trust identified a challenge when they embarked on plans to deploy their new, shared MEDITECH Expanse EPR. Years of historical patient information that continued to hold clinical value was distributed across multiple legacy applications. Migrating this data into the new EPR was seen as costly, complex, and had the potential to derail the project. While leaving information behind in disconnected systems would have fragmented the longitudinal patient record.

The challenge was therefore not simply to retire legacy applications, but to create a long-term data strategy to ensure that trusted patient information was preserved and remained available to clinicians through the new EPR.

Action

- Designed and implemented a programme to extract relevant patient information from multiple legacy systems and consolidate it into BridgeHead's Clinical Data Repository (CDR), HealthStore®
- Adopted a governance-led approach to preserving and managing clinical information throughout the transition and thereafter
- Discovery workshops were carried out to identify patient information of clinical value
- Data ingested into the CDR was subject to demographic reconciliation, Master Patient Index validation and other quality assurance processes led by system owners to ensure information remained accurate



Outcomes

- Consolidated, trusted information from legacy Patient Administration Systems, theatre applications, ED systems and other sources, are all now accessible to clinicians via the new EPR, in 'patient context'
- The CDR created a long-term data management foundation to support future interoperability, analytics, clinical research, and emerging AI initiatives

NHS Relevance

Preserving data quality throughout modernisation extends beyond better documentation into a new EPR. It requires organisations to identify, validate and govern clinically valuable information across the digital estate, ensuring that historical information remains accessible and trusted as systems change.

Consolidating patient data into a Clinical Data Repository can also simplify operational processes such as Subject Access Requests by making trusted patient information easier to locate, retrieve and share.

Lessons Learned

Data quality requires disciplined discovery, validation, patient identity management and clinical engagement throughout modernisation.

Organisations should distinguish between operational data and information of enduring clinical value.

Preserving trusted clinical information is not a one-off activity completed at EPR go-live, but an ongoing responsibility underpinned by a robust data strategy.

Reflection

Common challenges are rarely unique to one Trust. Sharing lessons learned helps organisations accelerate digital maturity, avoid repeating mistakes and maximise the value of existing EPR investments.



Altera Digital Health; Delivering Digital Transformation at QVH

Context

QVH delivers several services across the South East, including a Minor Injuries Unit (MIU). Paper processes and fragmented digital systems inefficiencies, duplication and increased risk of manual error. The Trust needed to reduce paper, streamline workflows and establish a single, real-time patient record without compromising operational performance.

Action

- ▶ QVH collaborated with Altera Digital Health to implement a trust-wide EPR, replacing legacy tools with the Altera Sunrise platform
- ▶ A big bang go-live approach avoided prolonged dual running
- ▶ Planning began six months before implementation and was supported by strong clinical leadership and a multidisciplinary programme team
- ▶ A central command centre provided real-time issue resolution, while 24/7 on-site support was provided for three weeks
- ▶ Digital champions supported training and adoption across the Trust

Outcomes



NHS Relevance

The EPR improved care coordination through a single integrated patient record, supporting more consistent documentation and access to patient history. Reducing paper processes and duplicate records also reduced opportunities for transcription error and fragmentation.

Lessons Learned

Rapid adoption is achievable without productivity loss where clinical leadership, training coverage and clinical safety assurance are treated as prerequisites. Avoiding prolonged

dual running also reduces the risk of duplicate and conflicting records during transition.

Reflection

QVH continues to optimise the platform through enhanced reporting, patient-facing services and AI-enabled capabilities.



Alcidion; Connected Data In, Better Decisions Out

Context

Delays in NHS care are complex. Many are compounded by fragmented, delayed or inaccessible information. Not a shortage of data, but information that arrives too late, sits in the wrong system, or cannot reach the person who needs it most. At HWHCT, discharge planning across seven community hospitals depended on verbal handovers, manual tracking, and teams working from incomplete pictures. Patients who were clinically ready to go home were waiting, not because of their condition, but because the right information was not visible to the right people at the right time.

A surgical team in Sydney was asking a similar question: could real-time data give clinicians enough confidence to care for acutely unwell patients at home? In June 2026, the ANZ Journal of Surgery published the results of a randomised clinical trial in patients with acute uncomplicated diverticulitis.

The study found that, for appropriately selected patients, care at home was a safe alternative to hospital admission, with Miya Precision providing the real-time clinical data platform underpinning the virtual care pathway and remote patient monitoring.

Action

- ▶ At HWHCT, Alcidion deployed its Miya Precision patient flow, an open solution that created a unified, real-time view of discharge readiness across all seven sites
- ▶ Transport, medications and clinical sign-off were structured and made visible to ward and operational teams simultaneously
- ▶ At Sydney Local Health District, the independent iCAD trial used Miya Precision to underpin a virtual care pathway, bringing wearable readings, patient-reported outcomes and clinical observations into a real-time view for clinicians to monitor progress remotely



Outcomes



Of virtual care patients in the trial rated their care as 'excellent', compared with 40% in the conventional inpatient group



Average reduction in length of stay across seven community hospitals at HWHCT



Major complications for patients treated virtually, with no admission into inpatient care



Patient retention on the virtual pathway, treated without requiring inpatient admission

NHS Relevance

Both examples reflect the NHS 10 Year Health Plan's ambition to shift care from hospital to community and its emphasis on genuinely patient-centred care. Quality, timely data did not simply speed up a process. It enabled patients to spend less time in hospital, thus reducing the use of scarce inpatient resources and supported a positive experience of care for the Sydney cohort.

Lessons Learned

Data quality improves when capture is designed around clinical decisions rather than system requirements. In both programmes, value came from Miya Precision's open architecture and

use of standards such as FHIR to bring real-time observations, medications, clinical history and patient outcomes from multiple systems into an actionable view.

Reflection

Fragmented data, limited interoperability and delayed information that affects care are universal challenges. The EPR Network exists to turn that shared experience into shared progress.



ALCIDION

Ready Computing; From Fragmented Records to Reliable Decisions at National Scale

Context

The U.S. Department of Veterans Affairs operates across a nationwide network of medical centres, outpatient clinics and care facilities, with more than 130 independent VistA EPR systems. Clinicians could not always access a complete patient history at the point of care. Any national solution therefore had to operate at scale while meeting demanding requirements for performance, security, consent and evolving federal policy.

Action

- ▶ Created the Veterans Data Integration and Federation Enterprise Platform (VDIF), built on InterSystems HealthShare to aggregate and normalise data from VistA and other VA sources
- ▶ Created a unified health record that clinicians and applications can access across the enterprise
- ▶ Standards-based services and APIs support secure exchange with external partners
- ▶ Ready Computing's Wellbase platform continuously monitored the environment to identify and resolve potential issues before they disrupted access



**11.5
million**

Veteran records supported;
platform used by 700,000 users



**1.4
billion**

Data transactions
each month



**200
million**

Veteran health summaries
shared securely



~99%

Platform availability,
0 high-priority incidents

Outcomes

- ▶ A reliable national data foundation for care delivery
- ▶ VDIF gave clinicians a complete view of each Veteran's health record, increasing confidence in point of care data

NHS Relevance

Reliable information depends on consistent aggregation, normalisation, governance and monitoring across every source system. This allows legacy and modern EPR environments to coexist while giving clinical teams a dependable view of patients — a directly relevant model as English providers prepare to contribute to the Single Patient Record alongside their existing systems.

Lessons Learned

Organisations need to establish shared data standards, ownership and monitoring at the beginning of any interoperability programme. Collaboration between teams then helps ensure those standards remain usable at scale.

Reflection

The EPR Network enables organisations to share implementation knowledge and strengthen data quality. Federation challenges are rarely solved once; they require ongoing collaboration as different organisations address similar problems in different environments.



5. Recommendations

Drawing on evidence from EPR Network members presented in this paper, the following recommendations are offered to NHS organisations, digital programme leaders and their technology partners.

1	Define the Data Quality Ambition First
	Confirm completeness, structure, coding, ownership – before migration or optimisation. The Access Group's work at HWHCT demonstrates migration scope should follow the ambition. Migrating everything may be the default, but it can carry legacy quality issues into the new system.
2	Design Data Capture Around Clinical Decisions
	Ask what decision each field informs and who acts on it. If this is unclear, completion will be unreliable. Alcidion's work at HWHCT shows that designing around clinical needs produces better records.
3	Structure and Automate at Source
	Adopt structured capture and automate calculation where appropriate. IMS MAXIMS eOBS illustrates how automation and real-time recording remove a whole category of manual error while improving timeliness.
4	Use Peer-Led Reinforcement as a Permanent Capability
	Fund named peer roles with protected time and embed short workflow guidance inside the EPR. Measure training coverage. HWHCT's SPAGs alongside Altera's 120 Digital Champions at QVH, demonstrate the value of embedding peer-led support into everyday workflows.
5	Give Data Quality Named Enterprise Ownership
	Assign accountability for aggregation, normalisation, governance and monitoring across every source system. Ready Computing's example demonstrates that reliability at scale requires continuous monitoring.
6	Build on Open Standards
	Adopt SNOMED CT, HL7 FHIR UK Core profiles and open APIs in preference to bespoke bilateral interfaces. The case studies demonstrate how standards-based platforms can combine data while allowing legacy and modern environments to coexist safely.
7	Prove Quality Through Usage
	Measure adoption of dashboards and decision support, track reduction in parallel spreadsheets and reconcile local and national reporting. Teams must trust the record enough to act on it confidently.
8	Preserve Clinical Information Through Modernisation
	Before retiring legacy systems, identify information of enduring clinical value, validate patient identity and preserve it in a governed, interoperable repository for ongoing clinical access. BridgeHead Software's example shows how modernisation can retain longitudinal context without the burden of maintaining disparate, siloed legacy applications.

6. Conclusion

This paper's contributions come from widely different settings, from a single emergency department to a national service. They arrive at the same conclusion.

Data quality is the accumulated result of how capture was designed, what was carried forward, who was trained to record information and whether anyone is accountable for quality once the programme closed.

Where those decisions were made deliberately, the record became something teams could act on with confidence.

The Single Patient Record will draw on provider records as it finds them, with improved clinical access expected from 2027 in priority specialties.

Population health management, predictive analytics and AI-enabled tools all inherit the quality of the data beneath them. The organisations that invest will be the ones able to use those capabilities safely.

Better data enables better decisions. The reverse is considerably more expensive and less efficient.

Call to action

Join the EPR Network

We aim to share practical experience, accelerate learning and avoid repeating the same mistakes in isolation. Members shape the agenda, contribute to the white paper series and participate in NHS-led Special Interest Groups on the issues that matter most to their organisations. If you're interested in learning more about the Network, visit: <https://hicdigital.co.uk/epr-network/>



Talk to HIC About Digital Maturity

HIC works with NHS organisations and suppliers on EPR benefits realisation and digital maturity. To discuss support for your programme, visit: <https://hicdigital.co.uk/nhs-epr-transformation/>

Members of the EPR Network



About this paper

About Healthcare Innovation Consortium

HIC is a leading independent digital health consultancy that helps organisations design, implement, and scale health tech 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.

About the EPR Network

The EPR Network convenes NHS organisations, digital leaders, clinicians and suppliers around the practical realities of implementing, optimising and getting value from EPRs. The Network exists on a simple premise: the challenges facing organisations are rarely unique and shared learning is faster and cheaper than solving the same problem repeatedly in isolation.

Purpose of the White Paper Series

The white paper series captures member experience on the issues shaping NHS digital delivery. Themes are agreed jointly by HIC and EPR Network leads. Insights are gathered through open calls for contribution with NHS and supplier participants.

Methodology

This paper draws on six case study submissions received from EPR Network members between July and August 2026, prepared to a standard template. Contributions were reviewed for relevance to the theme, strength of evidence and NHS impact, and were fact-checked prior to publication. Thematic analysis was carried out by HIC. Policy context is drawn from published sources current at the time of writing. Figures cited within case studies are those reported by the contributing organisation.

Acknowledgements

We wish to acknowledge the following companies' contributions to this report: IMS MAXIMS, The Access Group, Altera Digital Health, Alcidion, BridgeHead Software and Ready Computing.

