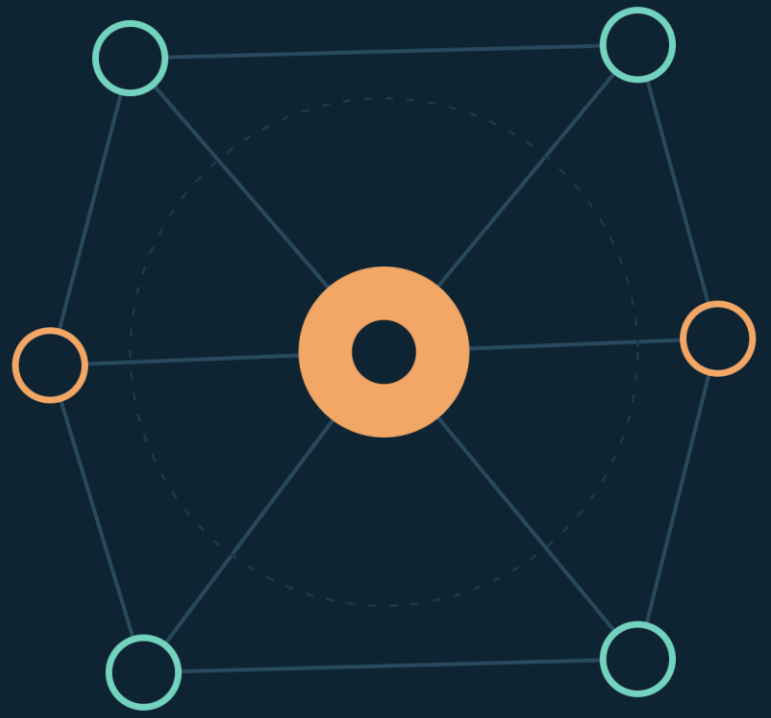
NATIONAL PRIMARY CARE SUMMIT 2026 · DIGITAL TRANSFORMATION

Transformation at scale



What makes digital change land across large health organisations — and how to build across your platform

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WHAT HCA HEALTHCARE UK WENT LIVE WITH

One record, end to end

Hospitals

11 hospital facilities live on Expanse

Inpatient care

eMedicines and bedside documentation on smartphones

Scheduling and Booking

Referral and booking workflow centralisation

ONE CLOUD RECORD

MEDITECH Expanse

On Google Cloud

Diagnostic centres

20 centres: imaging and lab results on one record

Supply chain

Supply chain and stock managemnt linked to care delivered

Revenue and billing

Charge capture at the point of care to billing and revenue mangagement

01 · WHAT MADE IT WORK

Four keys to a successful transformation

1

Organisational readiness

Measured at hard go / no-go gates across people, process and technology

2

Workflow standardisation

One clinical standard across every site; local variation only by exception

3

Dedicated change management

Funded change team, as a central enabler

Personal

Organisational

4

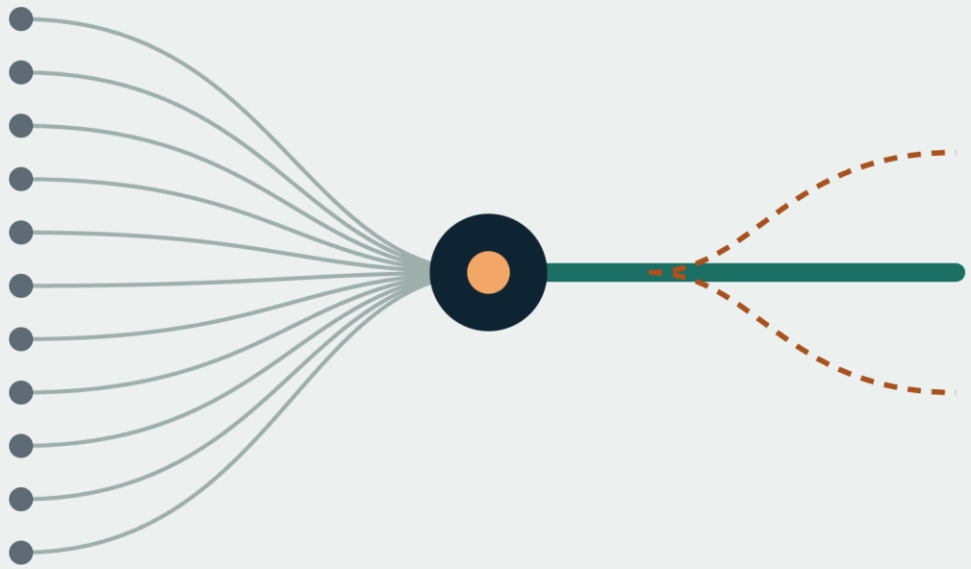
Organisational agility

Platinum, gold and silver command; a central hub and a facility hub at every site

Readiness is organisational, not technical. The software is rarely what fails; what fails is the organisation’s capacity to absorb a change that rewires how every clinician/user works on day one.

02 · WORKFLOW STANDARDISATION

Standardise before you digitise



11 sites, many local variants

Clinical design authority

One standard + governed variation

Clinicians own the standard

A design authority signs off order sets, pathways and documentation

Variation by exception

Local differences need a clinical or regulatory case, and are logged

Build once, deploy many

Every later site, upgrade and AI tool inherits the standard

Measure adherence

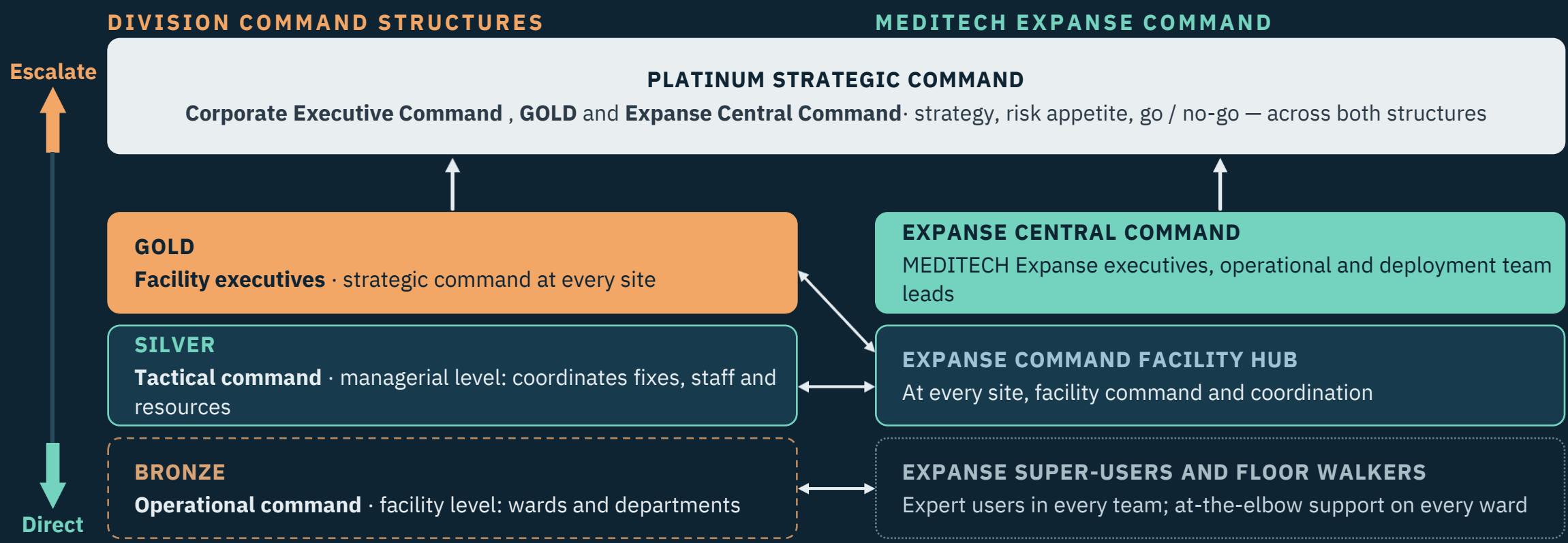
Track use of the standard after go-live, and iterate

Rehearse what matters most

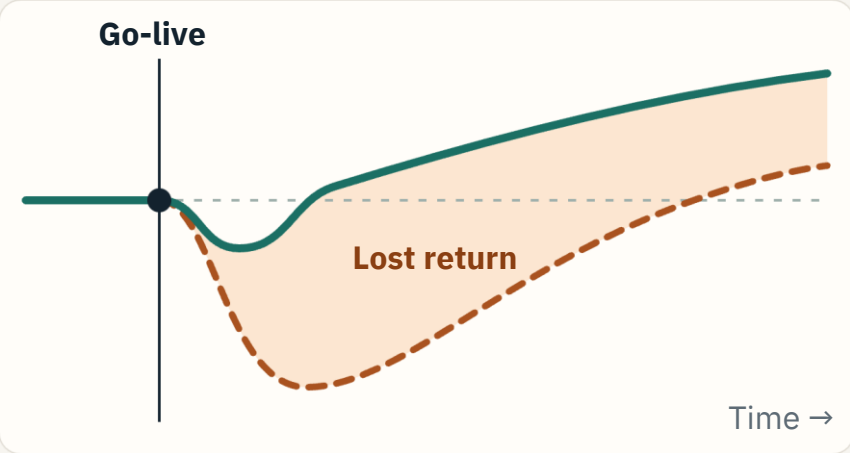
Test-run and simulate high-risk, high-turnover workflows that are clinically or business critical

Design workflows around the new system — don’t rebuild the past in it.

Command structures turn issues into hours, not weeks



A good go-live pays off for years





Prepared · NHS trust
Activity back to normal within months; early savings and medication-safety gains reported



Under-prepared · NHS trust
Early instability, financial strain and regulatory scrutiny; benefits arrived years later

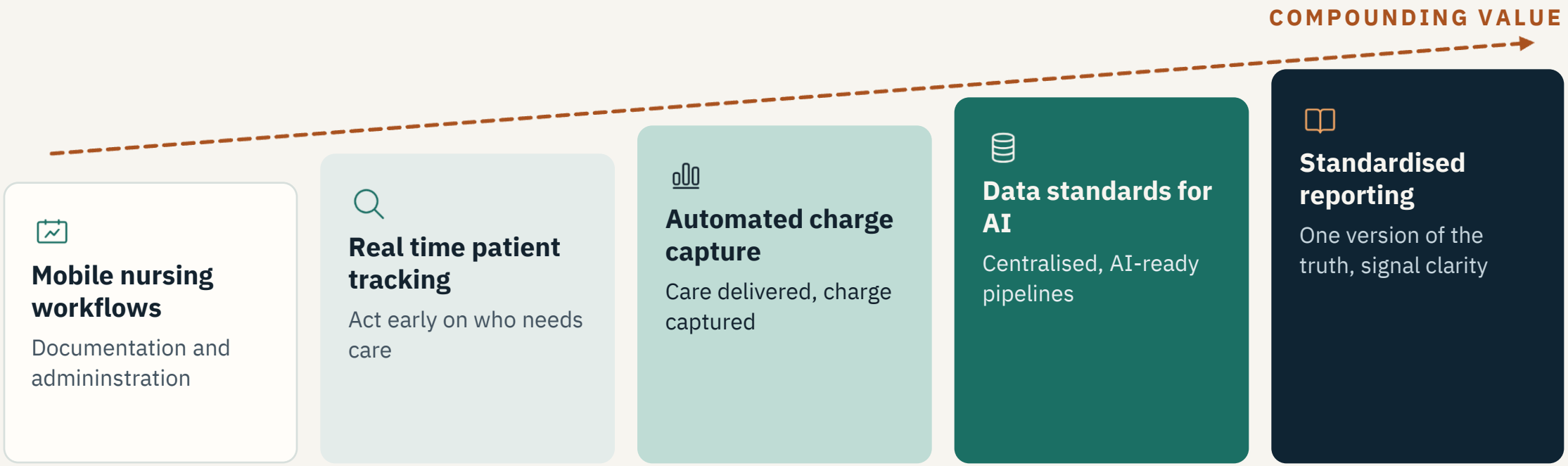
Solid: well-prepared — short dip, early return.
Dashed: under-prepared — deep dip, benefits years late.
Illustrative.

And it lasts: 75% of staff unhappy at go-live were still dissatisfied two or more years later (KLAS, n=40)

Sources: Digital Health NHS case reports (2016–23); KLAS, EHR Implementations 2025

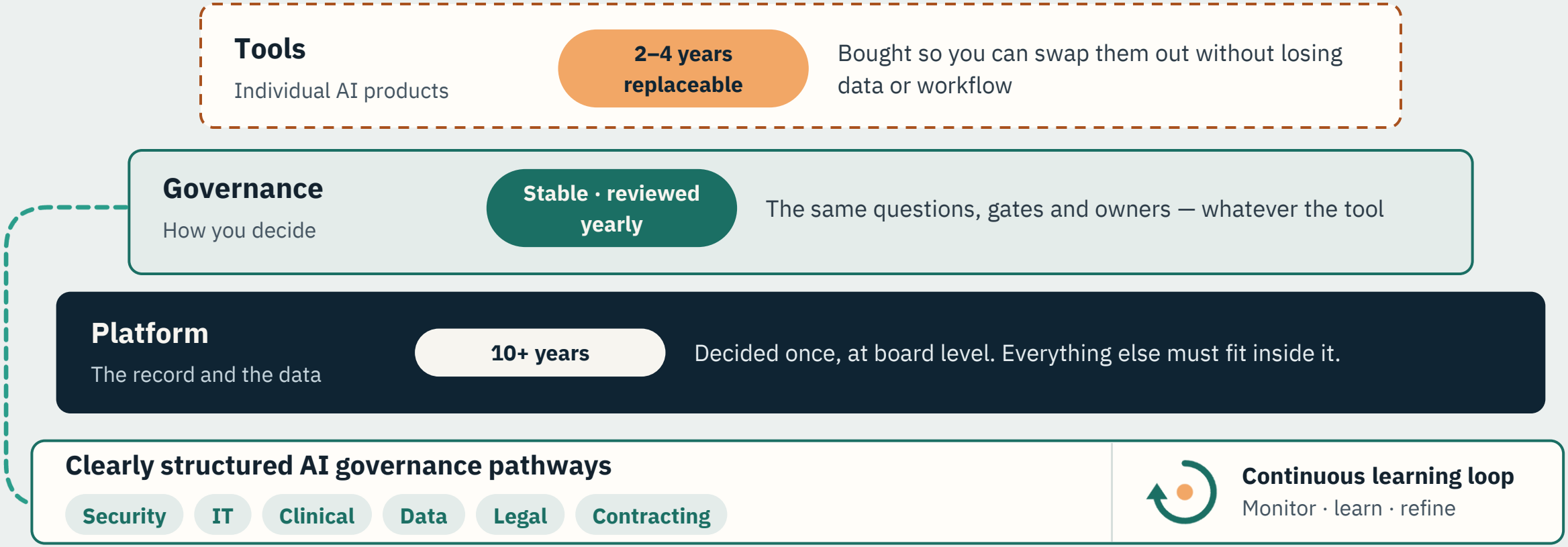
05 · ENABLING TRANSFORMATION

One platform, compounding efficiency



THE PLATFORM IS THE FOUNDATION FOR INNOVATION

Three layers, three speeds



Five questions before any AI deployment

Problem
Which **measured** problem does it solve — minutes, backlog, risk?

Evidence
Is there independent evidence from a setting like ours?

Fit
Does it fit our standard workflow and write back to the record?

Safety
Safety case, DPIA, device status and AI Act duties clear?

Value
Time returned and cost per user at scale, not just in the pilot?

The durability tests — questions that make a decision survive five years

Inside the record?
No separate login or data copy

Can we leave with our data?
Data return and exit support contracted

Ready for lifecycle oversight?
Monitoring and incident routes agreed

Will the supplier survive?
Viability checks, plus an exit plan

Will the EPR build it anyway?
Due in 18–24 months? Justify buying now

08 · PLATFORM VS BUY

Platform first, buy by exception

Criterion	EHR platform (native)	Best-of-breed (buy)
Integration	Reads and writes the record natively	Through APIs or FHIR; depth varies or RPA
Innovation	Paced by the vendor's roadmap	Fast-moving; newest capability first
Workflow fit	Inherits your agreed standard	May need workflow change or rework
Governance	One contract, DPIA and safety case	Each tool adds its own assurance
Cost	Often bundled and predictable	Per-user licences add up at scale
Supplier risk	Lower; long-term partner	Viability risk; needs an exit plan

A decision rule

Platform when the workflow lives in the EHR and the feature is on its roadmap within your planning horizon.

Buy when it is mature now, writes back through open standards, and you hold an exit plan.

Build rarely — only where your data or need is unique.

Get roadmap dates and pricing in writing before you choose.

Value opportunity vs value trap examples

	VALUE OPPORTUNITY	VALUE TRAP
Clinician time An input, not an output	Attribute freed minutes to a named output — added clinics, faster letters, less after-hours work	Report “minutes saved” as the return — time is the input; value is what it is spent on
Episode integrity Non-negotiable in private care	Notes, codes and charges written into the episode and clinician-verified — complete, auditable, billable	Private care - time saved cannot be used to reduce perceived value
Consultants & workforce Attraction and care	A reason consultants choose to practise with you — less admin, more attention on the patient	Bought as an unintegrated tool— uneven roll-out, unused licences, sceptical consultants

Another organisation’s value case won’t solve your problem — define your own before you buy.

Two things to take home

On transformation

The technology is the easy part. The real challenge is changing how an organisation works.

On AI decision making

Decide against your own problem. It is OK to go slow and learn from those who go first.