

ENABLING THE DIGITAL
HEALTH AND CARE RECORD,
THROUGH DATA STANDARDS
AND CITIZEN IMPACT

EPR SCOTLAND



EPR SCOTLAND



Hadleigh Stollar
Founder and Chief Executive
Healthcare Innovation Consortium (HIC)

Welcome to EPR Scotland 2026!

Brought to you by Healthcare Innovation Consortium (HIC)
in collaboration with Convenzis Group

8th September 2026

Hadleigh Stollar

Founder and Chief Executive Officer

Healthcare Innovation
Consortium (HIC)



Regional EPR summits

Wales

18 November 2026

Ireland

11 May 2027

England

29 June 2027



Join the waitlist





**Electronic Patient
Record Network**



**Healthcare
Innovation
Consortium**

A growing community...

the UK's first and only EPR Network

Capgemini 

Altera
DIGITAL HEALTH

ready
COMPUTING

CLEO
systems

XBPEUROPE

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ALCIDION

IGEL

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Si-SQUARED

System



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HARRIS
HEALTH ALLIANCE



enovacom
Saving time for care

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DigiSafe



InterSystems
Creative data technology



iMDsoft

maxims



opentext

RESTART
Interoperable Digital Care



access



XST
GROUP

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EPR SCOTLAND

Soft Market Testing

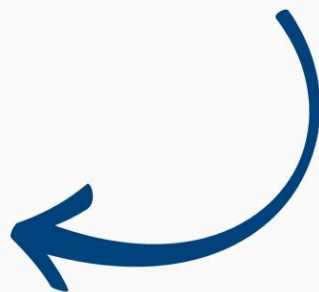


28 OCTOBER 2026



CENTRAL LONDON

Register your interest





**Electronic Patient
Record Network**



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Join the EPR Network



PUBLISH



CONVENE



CONNECT



**SCAN TO JOIN
THE EPR NETWORK**



[hicdigital.co.uk/
epr-network](http://hicdigital.co.uk/epr-network)



**Healthcare
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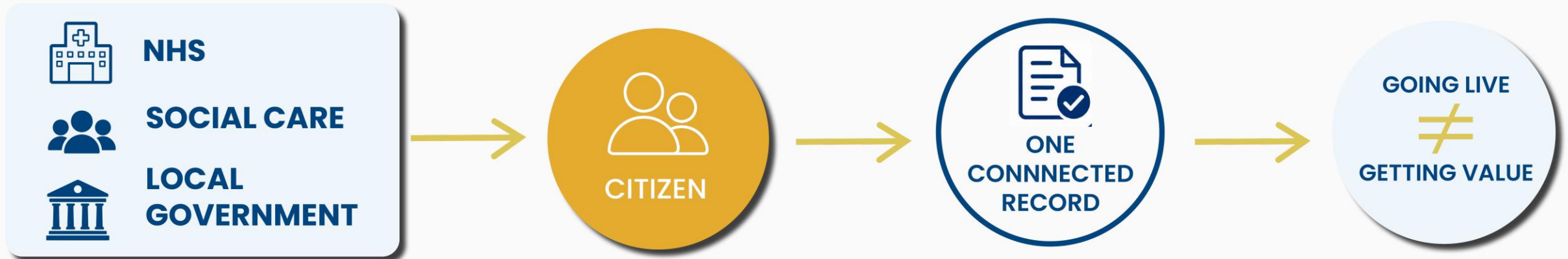


Electronic Patient
Record Network



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Why this event, **why now?**



Healthcare
Innovation
Consortium



EPR
SCOTLAND

**Thank you to Convenzis
Group and the HIC team
for helping making
this happen!**



Thank you to our sponsors and partners

Headline sponsor



Better Knowledge.
Safer Care.





**Electronic Patient
Record Network**



**Healthcare
Innovation
Consortium**

Three things for **today**

1

CONNECT

Sit with someone
you don't know

2

CHALLENGE

Bring your
hardest question

3

ACT

Leave with one thing
you'll actually do



**Healthcare
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Consortium**



EPR SCOTLAND



Jonathan Cameron
Head of Digital Health and Care
Scottish Government



Scottish Government
Riaghaltas na h-Alba
gov.scot

Digital Health and Care

Our Future for Scotland

Jonathan Cameron
Digital Health and Care

EPR Summit – 8 September

Service Reform



A Scotland where people live longer, healthier and fulfilling lives

Strategic Priorities



Digital Front
Door /
MyCare.scot



Digital
Prescribing and
Dispensing



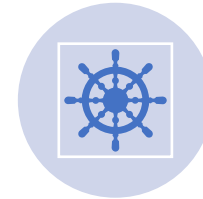
Digital Health
and Care Record



CHI into Local
Government



Cyber Security



AI Hub for
Scotland



National Digital Platform

Technology for health and social care

[Home](#)[About](#)[Service catalogue](#)[Assurance](#)[Blog](#)[Data](#)

The open technology platform for Scotland

National Digital Platform (NDP) will make it simpler to deliver technology that improves the care and wellbeing of people in Scotland.

[More about NDP →](#)

alpha

This is a new service. It will be available to more people soon. [Help us improve it by taking part in research.](#)

MyCare

[Sign out](#) | [My account](#)

Home

Appointments

Messages1

Health and care record

Find a service

About

Support

Home

[View personal details](#)

Hello DIANE DEMO

Date of birth:24 May 1977

CHI number:2405771543

What I can do with MyCare.scot

Right now, you can use this service to:

• check some of your upcoming hospital appointments

• read and download some of your hospital letters

• check your Community Health Index (CHI) number

• check some of the details the NHS has stored about you - like your home address

We will update this service with more features soon.

alpha

This is a new service. It will be available to more people soon. [Help us improve it by taking part in research.](#)

MyCare

[Sign out](#) | [My account](#)

Home

Appointments

Messages1

Health and care record

Find a service

About

Support

Home

• View your appointments

View your appointments

This shows your upcoming, cancelled and past NHS Lanarkshire Dermatology appointments. You can check and download your hospital letter in the 'appointment details' page.

▼ If your appointment is not listed

Upcoming appointment

Dermatology

9:20am on Sunday 23 November 2025

[View appointment details](#)

Upcoming

Appointment attended

Dermatology

Attended

alpha

This is a new service. It will be available to more people soon. [Help us improve it by taking part in research.](#)

MyCare

[Sign out](#) | [My account](#)

Home

Appointments

Messages2

Health and care record

Find a service

About

Support

Home

• Check your messages

Check your messages

Your messages from the NHS in Scotland. Right now, this only shows messages you have received about some of your dermatology appointments in North Lanarkshire. [You can also check your appointments.](#)

▼ If you want to reply to a message

▼ If you think a message is missing

NHS Scotland

You have a new dermatology appointment

Received on Wednesday 15 October 2025

MyCare

18

National Rollout

- MyCare.scot now available for users 18+
- Users can view their medication, allergies and COVID and flu vaccinations
- Access to appointments and the digital mailbox will start rollout later in 2026



Identity

Secure sign-in using
ScotAccount

Health & Care record

View COVID & flu
vaccinations,
medicines and
allergies

Demographics

View personal
information,
including CHI
number

Service finder

Links to useful
information

Service finder

3rd Sector

Mental Health

Scottish Government
Riaghaltas na h-Alba
gov.scot



Digital Health and Care Record

A Digital Health and Care Record provides relevant health and social care information that is accessible and can be contributed to by people using and delivering services.

Underpinned by Care
Reform (Scotland) Act

Information and Data
Standards

Care Reform Act

“Every person who receives health care or a social service in Scotland can have a digital integrated care record.”

To enable secure and efficient sharing of health and social care information

To ensure individuals can access and update their own information

Wider Data Sharing to be considered in the future

Principles and Next Steps

Standards and Coding:

- Single Source of Truth - CHI
- Data Standards
- FHIR / API Driven
- Implement SNOMED CT
- ICD11

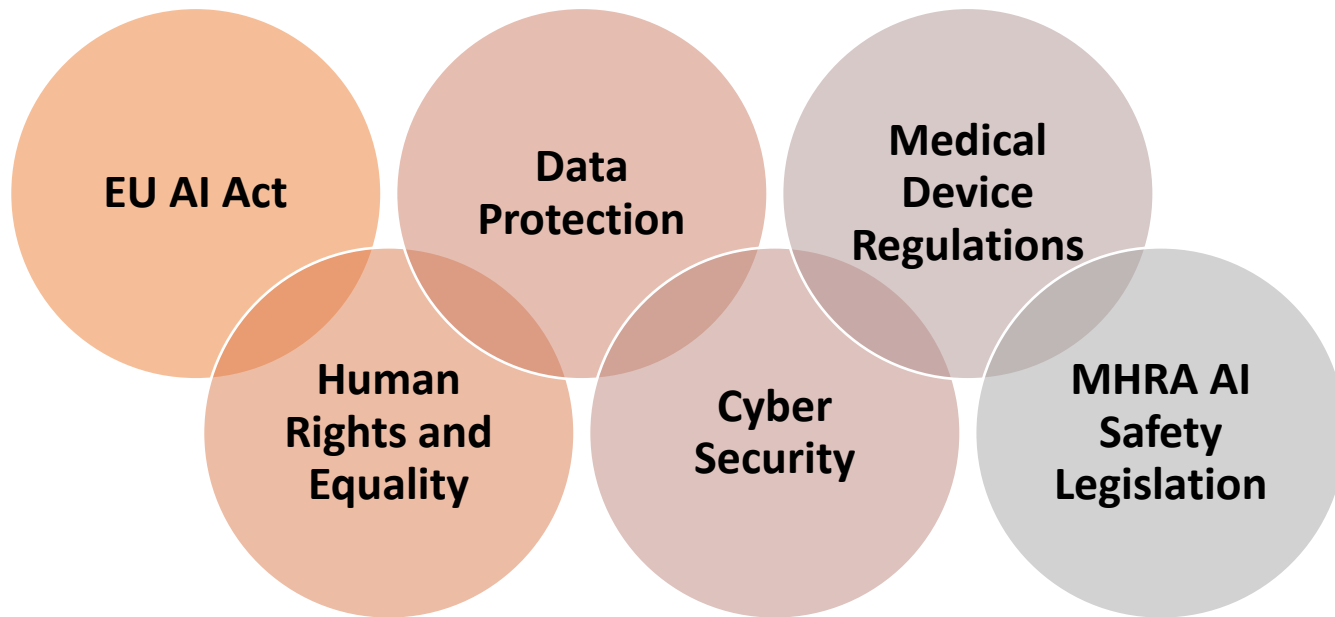
Data Sharing:

- Less administration and duplication.
- “Tell my story once”
- Across Health and Social Care
- Access via MyCare.scot

Next Steps:

- Full Business Case
- Strategic Direction
- Stakeholder Engagement
- Will continue to be shared programme across SG, COSLA and NHS

“AI framework for the safe, efficient and ethical application of AI across our services”



Future Priorities and Focus

- Delivery of Strategic Priorities
- MyCare.scot and DHCR focus
- Development of AI Hub and further guidance
- Data Sharing and Information Standards
- Personalisation of services





Scottish Government
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Digital Health and Care

Our Future for Scotland

Jonathan Cameron
Digital Health and Care

EPR Summit – 8 September

EPR SCOTLAND



Gayle Dellow

Lead Digital Midwife | Chair of MNDN for East
of England
Bedfordshire Hospitals NHS Foundation Trust



EPR SCOTLAND



Rami Riman
Director of Clinical & Business Improvements
InterSystems

EPR SCOTLAND



Morning Break
&
Networking



EPR SCOTLAND



Tracy McClelland
Chief Clinical Informatics
Officer
Alcidion



Nia-marie Quinlan
Senior EPR Programme Manager
North Cumbria Integrated Care
NHSFT



Liz Klein
Chief Nursing Information Officer
North Cumbria Integrated Care NHSFT



Darren McTaggart
Head of Delivery Operations UK
Alcidion

Masterclass panel discussion A real-world perspective on implementation

NORTH CUMBRIA INTEGRATED CARE USE CASE

August 2026





EPR SCOTLAND



Dr Ryan Samuels
Director – UK & Ireland
Eolas Medical

AI KNOWLEDGE AND THE LEARNING HEALTH SYSTEM

The 3am Test

A tired staff member, at 3am, needs an answer to make a safe decision.
How fast do they get it — and can they trust it's current?

Dr Ryan Samuels

Director, UK & Ireland · Eolas Medical



AT THE POINT OF CLINICAL DECISION

Three streams of information collapse into one clinical decision.

Listening

to what the patient is saying.

Scanning

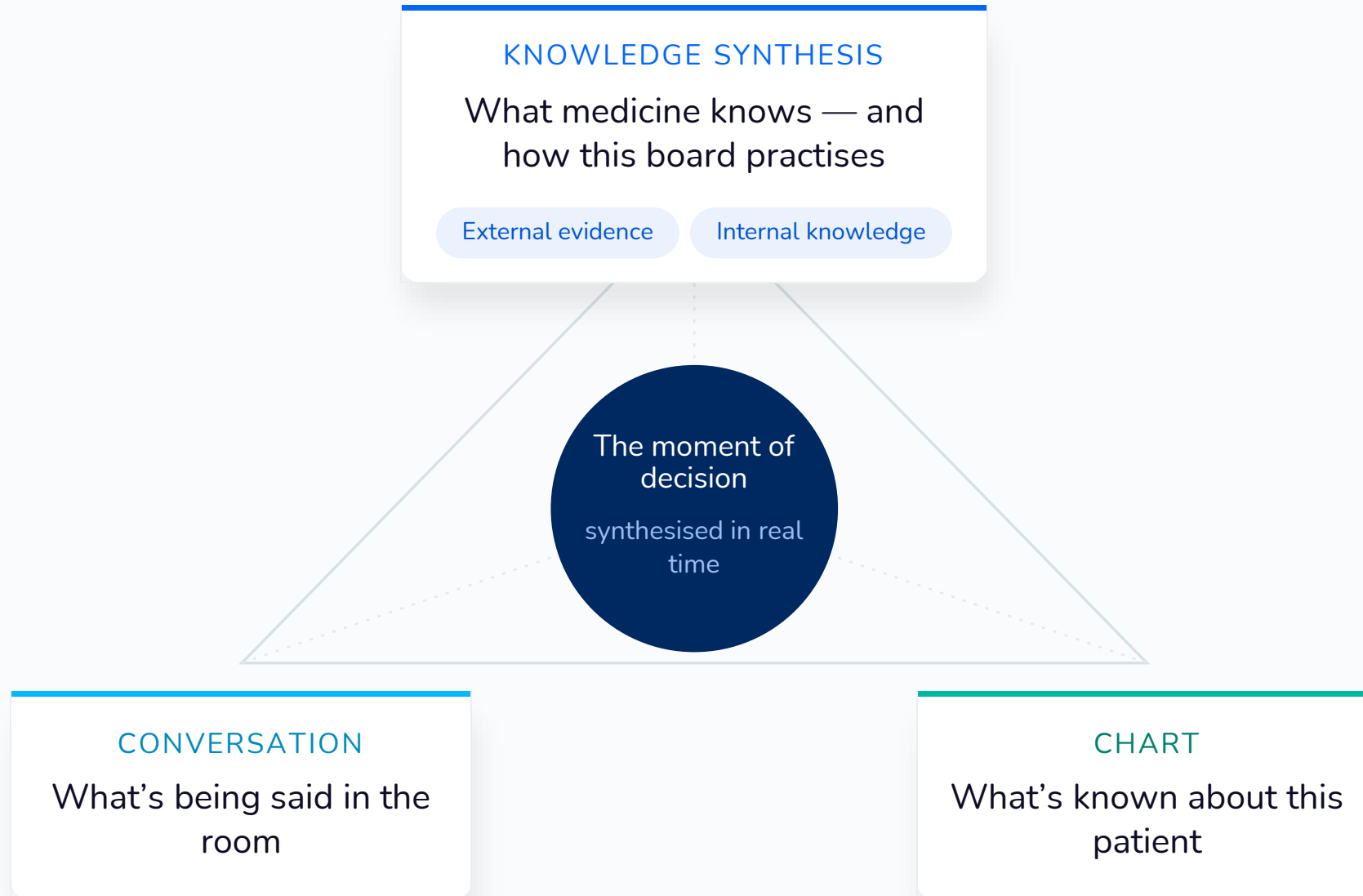
the record for what is already known about them.

Searching

memory for the evidence, and for the way this board does things.

THE GOLDEN TRIANGLE

Three streams, synthesised at the moment of decision





STATE OF PLAY

The corners are not equally built

Conversation

Early majority · consolidating



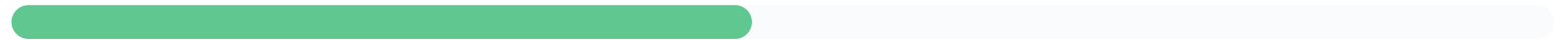
External knowledge

Early-late majority



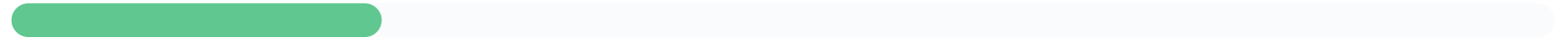
Chart

Partially built · heaviest investment



Internal knowledge

Early adopters · the unsolved half



| The unsolved corner is the one Scotland is best placed to own.

THE 3AM TEST

A tired staff member, at 3am, needs an answer to make a safe decision.

How fast do they get it?

Largely solved. Seconds, from your own approved content.

Can they trust it's current?

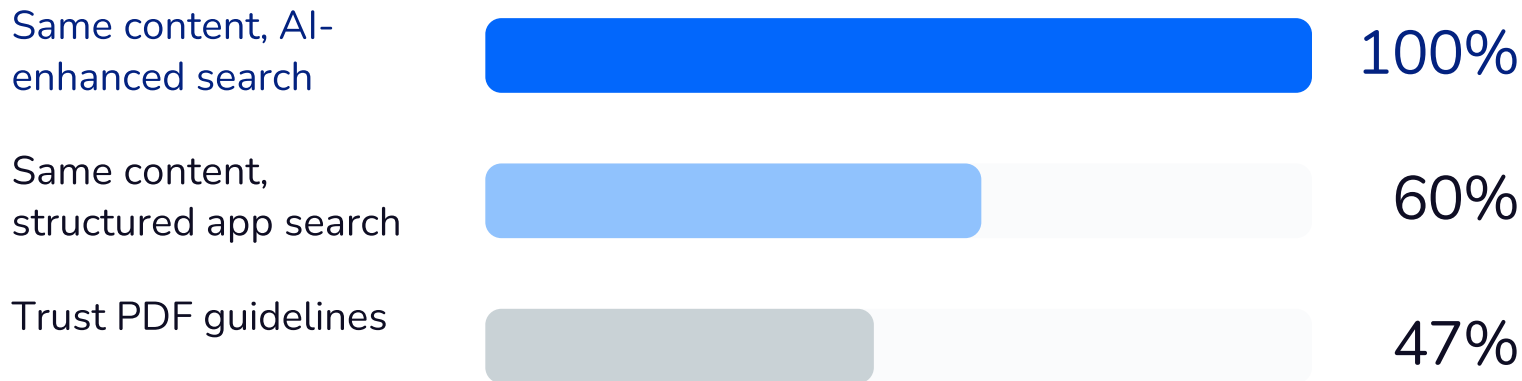
Not solved. This is the rest of the talk.



QUESTION ONE · THE LAST MILE

Publishing the guidance gets you to 60% accuracy. Answering the question gets you to 100%.

Prescribing accuracy, 45 cases — same underlying guidance in all three arms



Waldock et al., Imperial College Healthcare NHS Trust · npj Antimicrobials & Resistance, March 2026 · $p < 0.001$

HOW TO READ THIS

A well-built repository is necessary and not sufficient. Stop at structured search and you are in the 60% group.

Cognitive load down 74%.
Clinician confidence 94/100,
against 72 and 68.



ONE PLACE, EVERY QUESTION

The 3am question is not always a clinical one

“How do ward rounds work on my new ward tomorrow morning?”

“What is the first-line treatment for an upper GI bleed?”

| To the person asking, these are the same question.

Induction

How this ward, this rota and this team actually run.

Operational

Policies, escalation, who to call and when.

Clinical guidelines

The approved local pathway, and the national source behind it.

Referral pathways

Where this patient goes next, and what that service needs.



QUESTION TWO · CAN THEY TRUST IT

Medical knowledge is doubling faster than it ever has

THE VOLUME

The doubling time of medical knowledge has fallen from an estimated fifty years to a matter of months.

Densen, Trans Am Clin Climatol Assoc, 2011

THE BURDEN

Every national update lands on a named clinician who already has a clinical job. Publishing is solved. Keeping up is not.

Three-year cycles reflect author capacity, not clinical risk

| The review cycle is an admin constraint wearing clinical clothes.



WHAT WE BUILT

The whole content lifecycle, in one place

01 · CREATION

Draft the guideline in the platform.

With the national evidence beside you as you write.

02 · REVIEW

Route it to named reviewers.

Tracked and time-stamped, not emailed round as a PDF.

03 · KEEPING CURRENT

National change triggers the update.

SIGN or NICE moves; you see what it affects.

04 · INSIGHTS

Every question becomes evidence.

What was asked, and what was never found.

Search was only ever the first quarter of the problem.



STAGE THREE · THE MECHANISM

National guidance changes. The work starts itself.



~90% less effort to keep the library current. AI drafts it, your people sign it off.

THE BOUNDARY

The AI does not decide. It says: this differs from that — please review it.

Constrained and cited

Answers come only from approved documents, with the source on every claim.

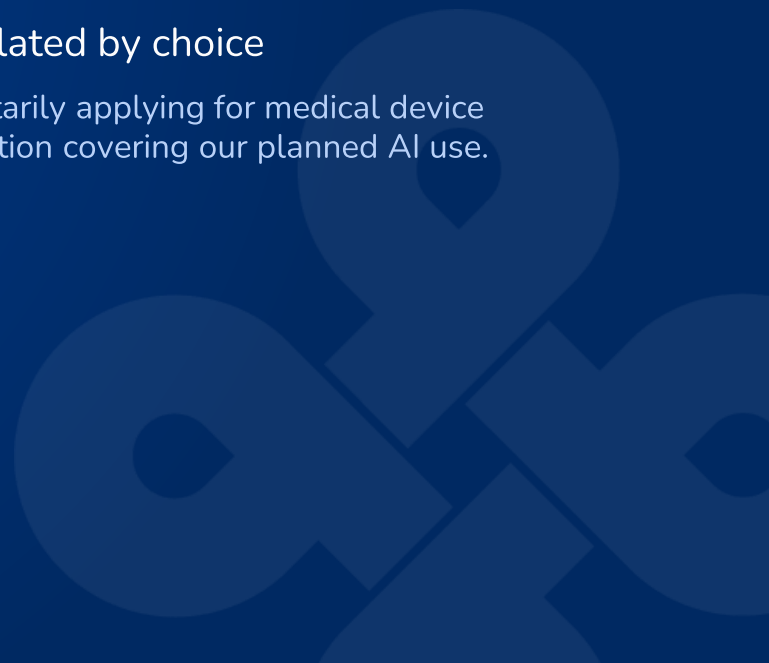
No diagnosis

It retrieves and compares guidance. It does not advise on an individual patient.

Regulated by choice

Voluntarily applying for medical device regulation covering our planned AI use.

The risk in moving fast is outsourcing clinical thinking without noticing.





ONCE FOR SCOTLAND

Scotland has already written the guidance. What is missing is a way to see where it differs.

Fourteen boards, their own approved pathways, and the national sources they were built from. Nothing compares the versions against each other — because reading them all is hours per pathway before any conversation starts.

THE COMPARATIVE LAYER

Two comparisons, run before anyone meets

Board against board

Where does one board's pathway differ from the others'?

Board against national source

Where has local practice drifted from SIGN, NICE or SMC?

Standardisation by evolution, not by negotiation.

Acute upper GI bleed — 3 differences found

4 boards compared

DIFFERS FROM SIGN

Local pathway specifies a 24-hour endoscopy window; SIGN recommends within 24 hours of admission for unstable patients.

Local Pathway v2.1 · SIGN 105 · flagged for review

DIFFERS BETWEEN BOARDS

Two boards use a Blatchford threshold of 1 for discharge; two use 0.

4 source documents cited

NO MATERIAL CHANGE

Remaining sections unchanged against current national guidance.

Safe to republish as in date



Some divergence is deliberate

THE CASE

A board's GLP-1 pathway looks nothing like NICE or SMC guidance — deliberately, because it was built on cost-efficiency grounds the national recommendation was not tested against.

Telling them it differs is useless. They know.

WHAT THAT REQUIRES

A board accepts a difference once, records why, and the system stops raising it — while keeping the rationale on the record for the next review.

Otherwise it becomes noise, and noise gets switched off.



STAGE FOUR · THE LOOP

Every question staff ask becomes evidence

MOST ASKED

What staff searched for most

Where clinical uncertainty actually sits, by specialty and by hour of the day.

NOTHING FOUND

Questions that returned nothing

The knowledge gaps you did not know you had. The most useful signal in the system.

DRIFT

Where local pathways drift from SIGN and NICE

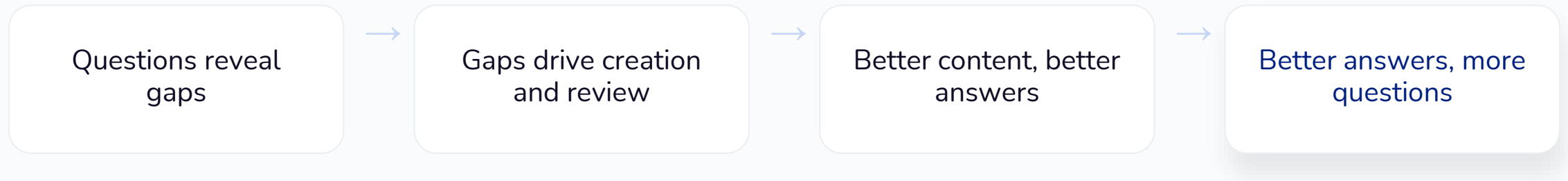
Surfaced continuously, not discovered at the next review.

| None of this is data you can buy. It only exists because someone asked.



THE LOOP

A loop, not a library



Run that across one board and you have a good knowledge service. Run it across fourteen, with the comparison built in, and it becomes national infrastructure.

Scotland could be the first national learning health system.

The 3am question improves the 3am answer.



Demo video and
testimonials

Dr Ryan Samuels

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EPR SCOTLAND



Dr John Thompson

National Associated Clinical Director, CfSD
Centre for Sustainable Delivery. NHS Scotland

nervecentre
NEXT GENERATION EPR

EPR SCOTLAND



Paul Volkaerts
CEO
Nervecentre Software

EPR SCOTLAND



Lunch
&
Networking

EPR SCOTLAND



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The University of Edinburgh

Realising the Value of Electronic Patient Records: Lessons from England



THE UNIVERSITY
of EDINBURGH

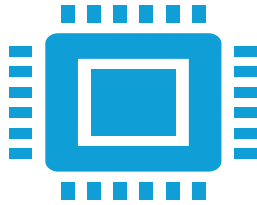
Uusher
institute



The potential of digital health



But implementation is difficult



Sociotechnical systems

People and technology continually shape one another

New technology changes workflows and professional roles

People adapt technology through configuration, workarounds and new ways of working



Complex and adaptive system

Many interconnected actors with often conflicting needs

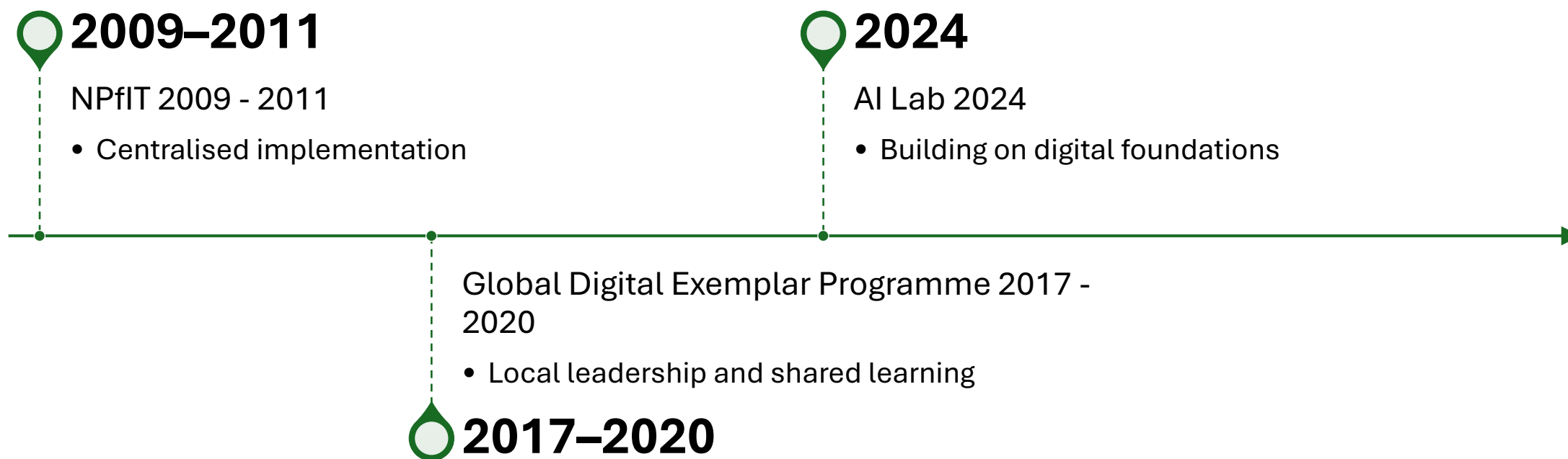
Small changes have unintended consequences

No one is in control and no recipe for success

The system continually evolves

Change is emergent and unpredictable

20 years evaluating England's biggest national digital health programmes



Lessons from England



Lesson 1: Digital transformation is routinely expected to deliver too much, too quickly



Lesson 2: Digital foundations matter



Lesson 3: Go-live is the beginning - not the end



Lesson 4: Set up systems for learning and evaluation

Lesson 1: Digital transformation is routinely expected to deliver too much, too quickly

Ambitious politically-driven implementation timelines

- Ministerial announcements
- Pressure to demonstrate progress quickly (but digitalisation takes time, 7+ years)

As a result...

- Programmes launched too quickly (limited baselines, limited planning)
- An ended too quickly (longer term benefits could not be demonstrated within timeframes)

Lack of progress in delivery tended to be viewed as being due to the overly ambitious implementation timelines specified in the contract, including unrealistic expectations in relation to benefits and the time needed for systems to embed. NPfIT Evaluation



Lesson 2: Digital Foundations Matter

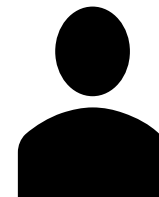
- EPRs are core infrastructures, not standalone systems
- Other applications depend on effective interfaces and interoperability
- Building strong foundations takes time
- Data quality is critical
- Weak foundations limit future innovation, including AI



Lesson 3: Go-live is the beginning - not the end

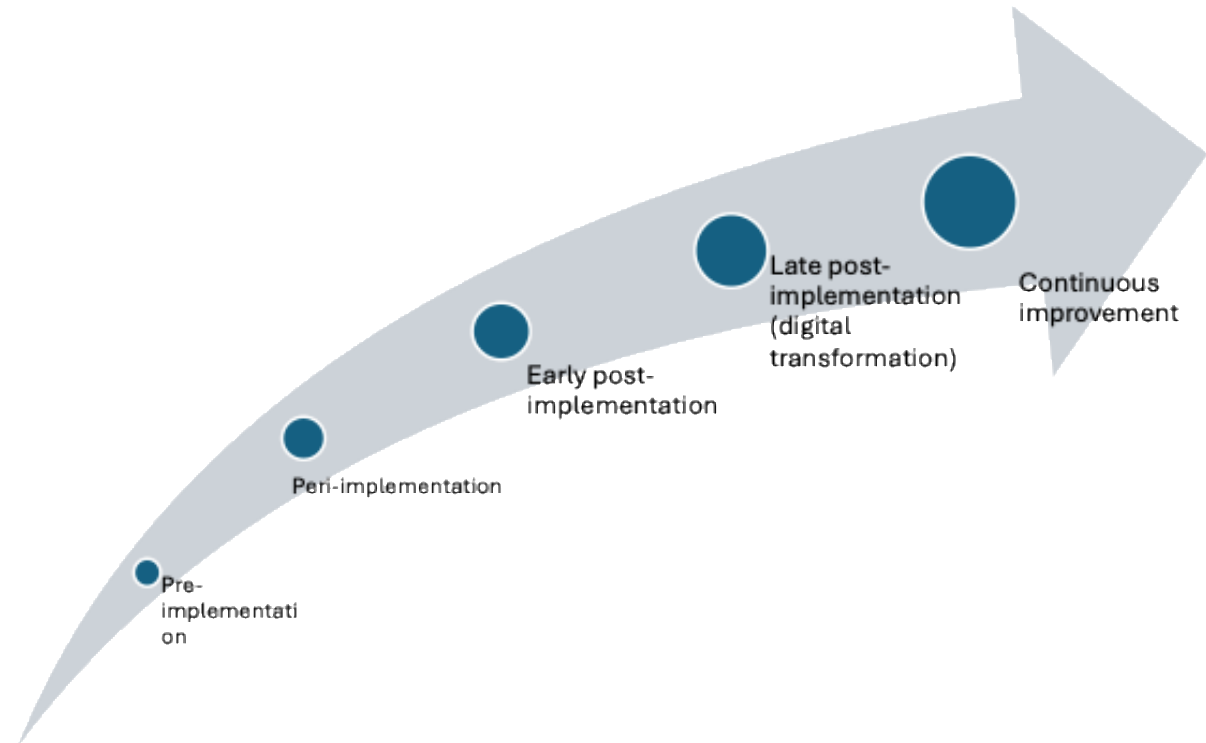
- It's a long-term journey with no endpoint
- Changes in leadership and strategy don't help
- Need 100-year plan
- Move away from projects to programmes
 - Funding structures
 - Developing a long-term strategy and defining the role of digital within this

“Successful EHR [electronic health record] and ePrescribing investments are not quick wins; they are sustainable wins. It takes at least four and, more typically, up to nine years before initiatives produce their first positive annual SER [socio-economic return], and six to eleven years to realise a cumulative net benefit.” EHR IMPACT STUDY



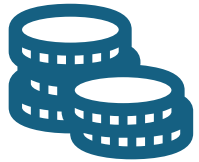
Optimisation

- New needs emerge through use
- Optimisation involves technology, workflows and people
- Optimisation is subjective
- Continuous improvement extends years beyond go-live



Lesson 4: Set up systems for learning and evaluation

Evaluation approaches to inform learning



Understanding impacts

Quantitative studies to assess outcomes and value/cost



Understanding mechanisms

How processes lead to outcomes (e.g. how changes to clinical workflows influence patient safety)

How various parts of a system produce intended and unintended observable effects (e.g. how EPRs affect workload, documentation, interactions)

Quantitative methods

Did it work?

Measures outcomes

Qualitative methods

Why did it work?

Explains mechanisms

Systems science

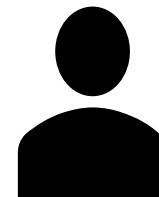
How did the whole system change?

Explains interactions, feedback, adaptation and emergence

Digital transformation can be accelerated through developing a learning ecosystem

- Shared learning facilitating inter-organisational knowledge sharing (can be coordinated nationally)
- Communities of practice
- Informal relationships
- Facilitated by:
 - Common core system (such as EPRs)
 - Prior relationships
 - Geographical proximity
 - Regional alignment

“We have worked extremely closely with [site]. We have more or less cut and pasted all their workflows, all their pharmacy workflows, all their drug administration workflows...without that involvement, the project would have taken longer...I think the result is safer and more robust than it would have been if we had done it without their help.” Implementer GDE



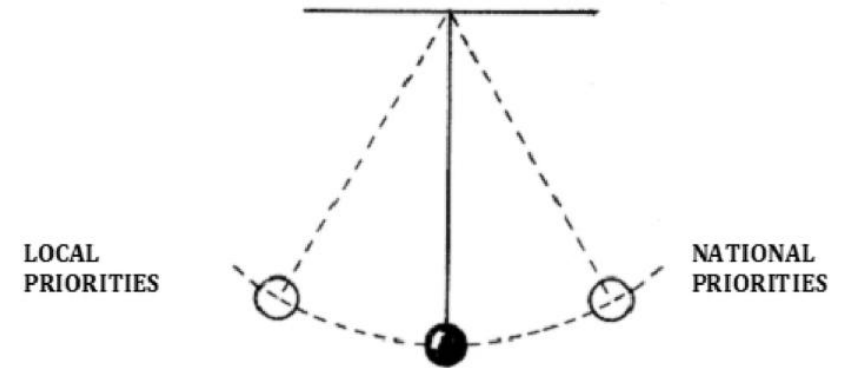
Balancing national strategy with local input in decision making

Top-down and politically driven nature of Programmes

- Can help to ensure high level leadership and support
- But failure of cookie cutter model of standardised procurement
- Limited local involvement in decision making (risk of disengagement, abandonment)
- Importance of clinical engagement

Locally-led initiatives

- Threat to large-scale interoperability
- Organisational drivers may not align with national strategy



Take-aways



EPRs are not primarily a technology challenge



Build foundations

Digital infrastructure is strategic infrastructure



Invest in people

Technology changes workflows before it changes outcomes



Keep learning

Digital transformation is never finished
Evaluation and optimisation create long-term value

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Thank you to NHS England for funding and to
all participants for their time

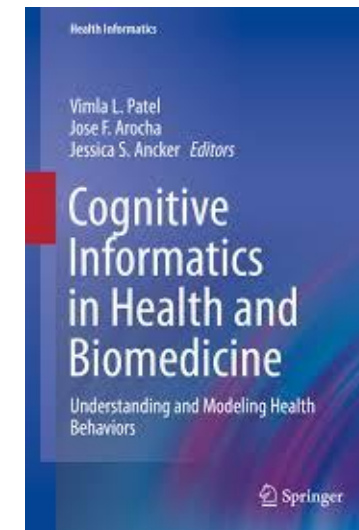


Upcoming book!

*Evaluating AI in Healthcare and Biomedicine:
Foundations for Evidence-Based Decision
Making in the Digital Age*

Tackling how to assess impact, value and
processes

Editors: Kathrin Cresswell, Mirela Progmet,
Eva Weicken



EPR SCOTLAND



Dr Paul Miller

Clinical Lead, Public Services Delivery Scotland
Public Services Delivery Scotland

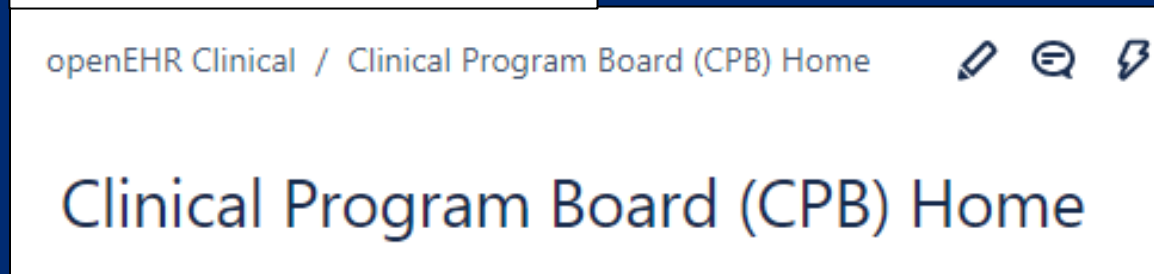
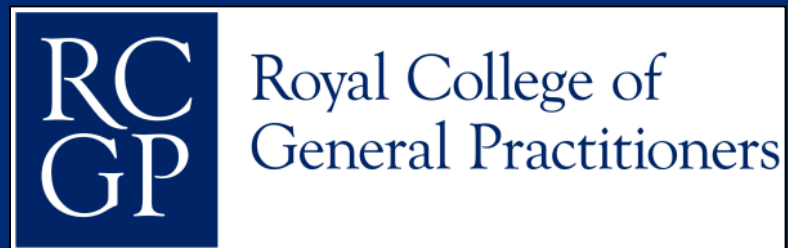
**Public Services Delivery
Scotland**

From Organisational Records to Lifelong Health Records

MyCare.scot and the architecture of patient-centred EPRs



Dr Paul Miller MBChB MRCGP DRCOG FBCS



Public Services Delivery
Scotland



Origins

The first British general practitioner to use a computer in his consulting room was John Preece at Whipton near Exeter in 1970.^{11 12} In 1975 the health centre at Ottery St Mary, also near Exeter, became the world's first paperless general practice.¹³ For a few years in the



Dr Jeremy Bradshaw Smith at Ottery St Mary health centre, which, in 1975, became the first paperless computerised general practice





This pitfall prevents the realisation of a healthier, lifelong patient, the health foundation becomes increasingly problematic, with multiple for person-centred care, that drive clinical practice, through complete involvement in health-care decisions.



Piera-Jiménez J, Cano I, Carot-Sans G, et al. *Lancet Digital Health*. 2026. doi:10.1016/j.landig.2026.101037





*The **economic cost** of this fragmentation is not linear — it grows quadratically.... keeping a fragmented ecosystem connected **compounds with every system added ...and every time any one system is updated, every connection to it is at risk.***



[World Health Organization. Reference Architecture for Digital Public Infrastructure for Health — draft for public comment, 2026](#)

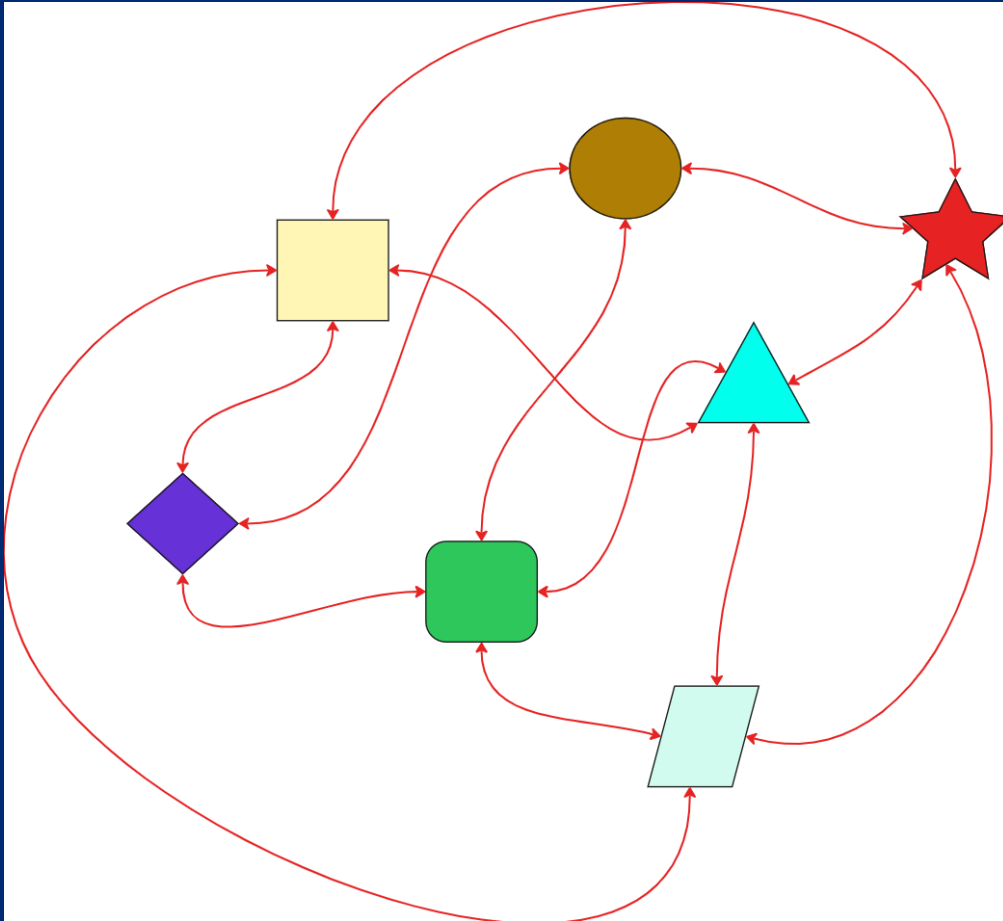




*In the most favourable case
... [same system] ...
approximately two-thirds of
data types will be
“understood” by a receiving
site*



**Quantitating and assessing
interoperability between electronic
health records, [J Am Med Inform
Assoc. 2022 Jan 7;29\(5\):753–760](#)**



The patient is longitudinal



Our systems are not

454 Scottish GP practices currently hold medical records in a system that reaches end of life next year.

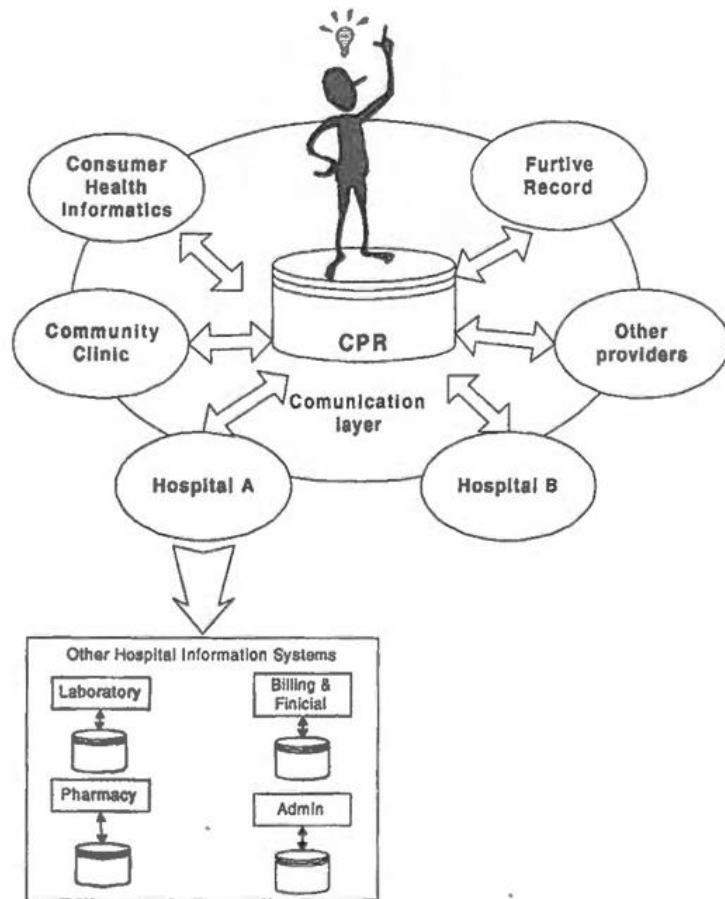


Fig.1 Patient-centered system model

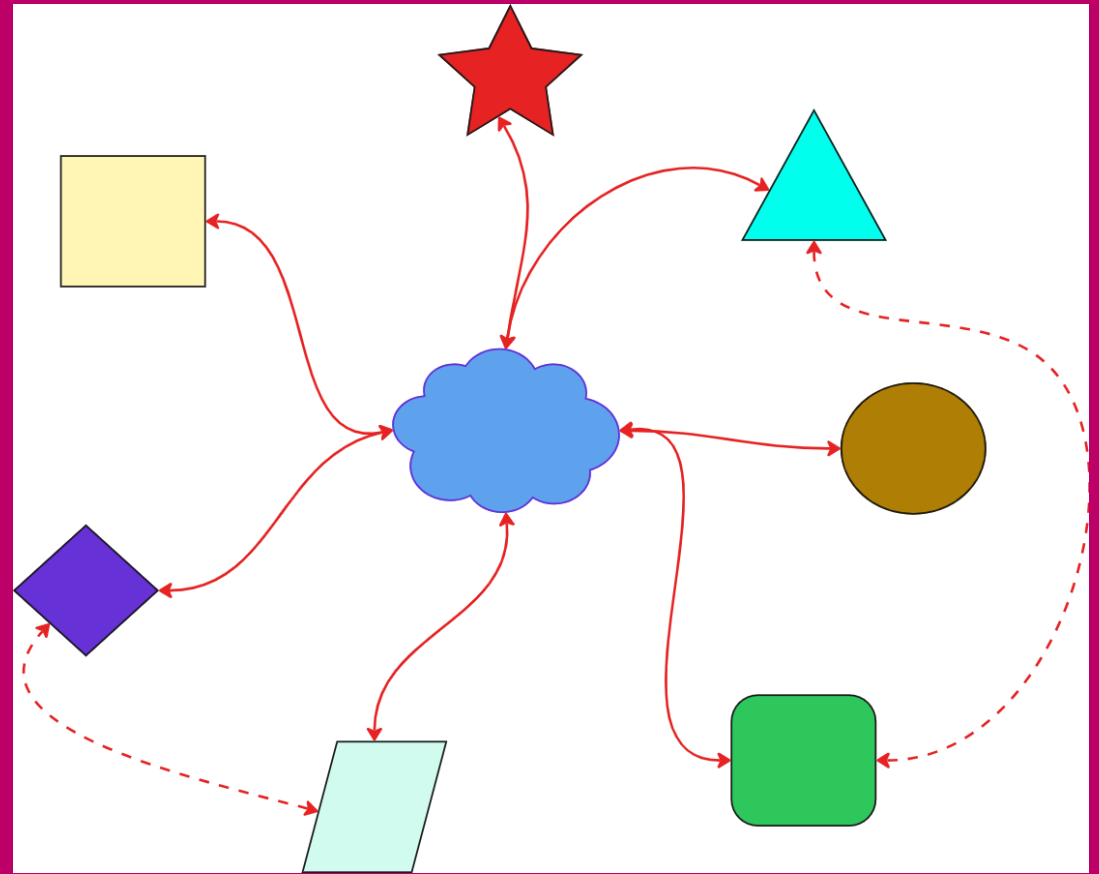
“Patients should be empowered as participants and central partners in the information flow”

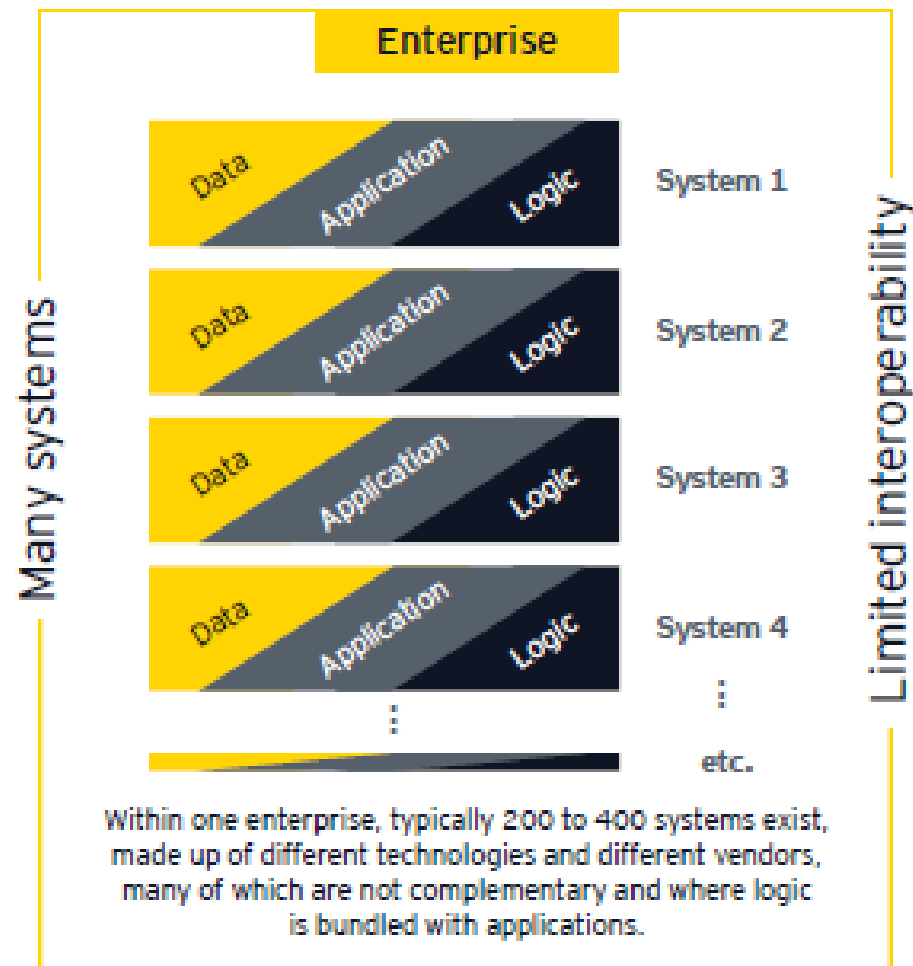


Brennan FP, Kuang YS, Volrathongchai K. Patient-centered information systems. Yearb Med Inform 2000: 79–86.

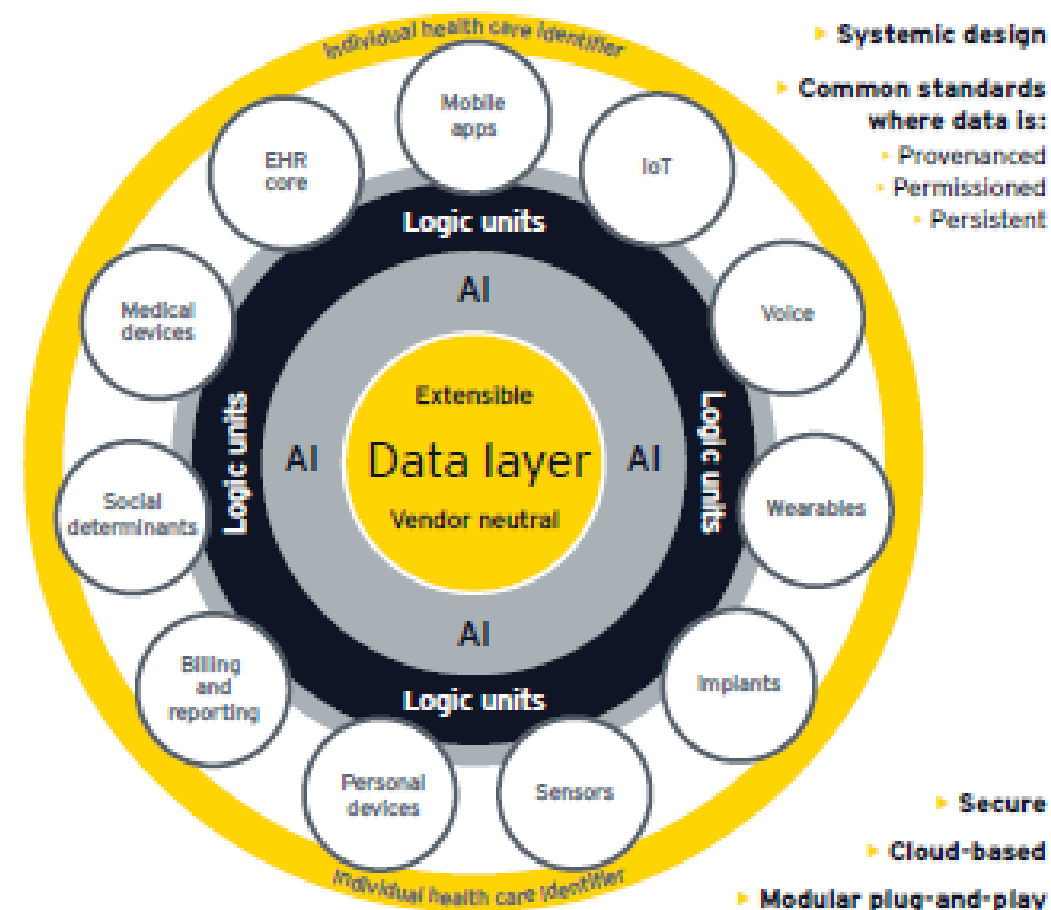
Person-Centred Record

- Persists through time
- Survives system & organisation changes
- Retains meaning
- Usable by multiple services
- Accessible to the person





Present: Many systems all with intimately bound data logic and applications



Future: A cohesive technology stack, giving a unified experience for clinicians, professionals and patients; unique data at the center accessed by applications in real time through micro-services



**HL7[®] FHIR[®]** Release 5

HomeGetting StartedDocumentationData Types

Exchange > RESTful API

This page is part of the FHIR Specification (v5.0.0: R5 - 5.0.0)Page versions: R5 R4B R4 R3 R2

3.2.0 RESTful API

FHIR Infrastructure Work Group

openEHR APIs Overview

REST specifications

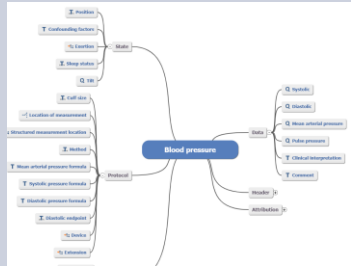
Search...

Intro >

DOCS

Glossary and conventions

Name	Flags	Card.	Type
Observation	I N		DomainResource
Identifier	Σ	0..*	Identifier
basedOn	Σ	0..*	Reference(CarePlan DeviceRequest ImmunizationRecommendation MedicationRequest NutritionOrder ServiceRequest)
partOf	Σ	0..*	Reference(MedicationAdministration MedicationDispense Procedure Immunization ImagingStudy)
status	7 Σ	1..1	code
category		0..*	CodeableConcept
code	Σ	1..1	CodeableConcept











Joint Initiative Council



New applications

Information Platform

Existing Systems and Data Sources

**National Digital Platform**
Technology for health and social care

Search 

[Home](#) [About](#) [Working with NDP](#) [Service catalogue](#) [Developer resources](#) [Case studies](#) [Contact us](#) 

[Home](#) / [Service catalogue](#)

Service catalogue

Details of the technology services that are available on the National Digital Platform (NDP).

NDP Audit Service

Offers a single source when a person or software accesses patients' sensitive information.

In production

Internal

NDP Authentication Service

Verifies the identity of NHS Scotland staff and members of the public.

In production

NDP Data Access Service

Gives quick access to updated patients' medications and allergies information.

In production

NDP Data Storage Service

For teams that store, update and manage patients' structured and unstructured data.

In production

NDP Demographics Service

Allows health and care staff access to patients' clinical and non-clinical information.

In production

Internal

NDP Integration Service

Facilitates information transfer securely between Health Boards and other organisations.

In production

NDP Vaccination Service

For health and care professionals who need to create, update or check vaccination records.

Internal

In production

Release 5

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Home

This page is part of the FHIR Specification (v5.0.0: R5 - STU). This is the current published version. For a full list of available versions, see the [Directory of published versions](#).
Page versions: **R5** R4B R4 R3 R2

0 Welcome to FHIR®

FHIR is a standard for health care data exchange, published by HL7®.

First time here?
See the [executive summary](#), the [developer's introduction](#), [clinical introduction](#), [patient introduction](#), or [architect's introduction](#), and then the [FHIR overview & how FHIR versions work](#). See also the [open license \(CC0\)](#) (and don't miss the full [Table of Contents](#) and the [Community Credits](#) or you can search this specification).



openEHR

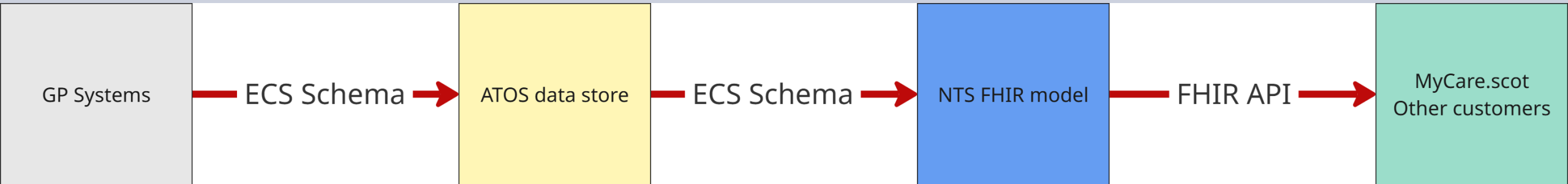
The future of
digital health
is open



CONVERGE & COLLABORATE

ECS to FHIR



Swinney to cut number of health boards from 14 to two



John Swinney announced the plans during his programme for government

1 September 2026 · 1229 Comments

Glenn Campbell, Scotland political editor and **Catherine Lyst**, BBC Scotland

The first minister has confirmed plans to cut the number of health boards providing local services across Scotland from 14 to two.

Programme for Government

- Services fit around people
- Digital/data platforms and shared data definitions
- A Digital Health and Care Record for every person in Scotland

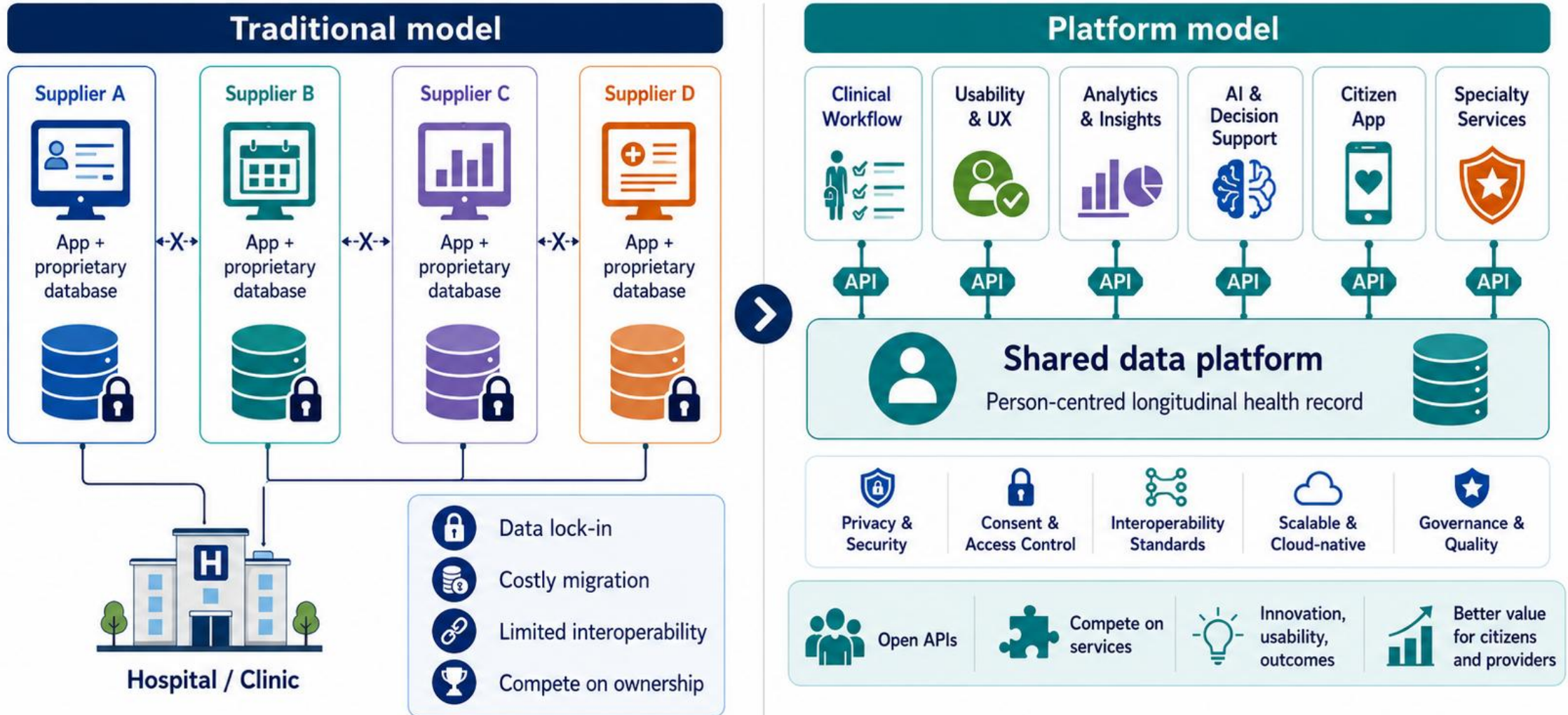
Pathway to change



Change

- Start with service value
- Change incrementally
- Persist reusable data
- Assess and assure continuously

Towards a service-based model



Open platforms do not eliminate suppliers — they change what suppliers compete on.

More choice. More innovation. Better experiences. Better outcomes.



The case for new patient-centred EPR architectures

- Lifelong records
- Persistent meaning
- Fit around the person
- Health records outlive applications

Thank you

This resource may be made available, in full or summary form, in alternative formats and community languages. Please contact us on **0131 275 6000** or email **altformats@nhs.scot** to discuss how we can best meet your requirements.

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Head of Digital Futures
Scottish Care



Laura Wilson
Director for Scotland
Royal College of Pharmacy

EPR SCOTLAND



Hadleigh Stollar
Founder and Chief Executive
Healthcare Innovation Consortium (HIC)

EPR SCOTLAND



Regional EPR summits

Wales

18 November 2026

Ireland

11 May 2027

England

29 June 2027



Join the waitlist





**Electronic Patient
Record Network**



**Healthcare
Innovation
Consortium**

Join the EPR Network



PUBLISH



CONVENE



CONNECT



**SCAN TO JOIN
THE EPR NETWORK**



[hicdigital.co.uk/
epr-network](http://hicdigital.co.uk/epr-network)



**Healthcare
Innovation
Consortium**

For more queries...

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