Govforms

CLOSING REMARKS

Closing reflections on AI implementation

Launch of the Akal Budi Leadership Fellowship 2027

Venue

Max Rayne Auditorium, 1 Wimpole Street, London W1G 0AE
Home of the Royal Society of Medicine

Speaker

Mark Preston Client Director, Govforms Limited

OPENING — Two Worlds

Good evening.

I know I'm standing between you and the end of the evening, so I'll keep this reflective rather than formal.

Let me start with a scene. If you have ever watched a brilliant demo meet the real world, you will recognise it. It takes place in two rooms.

WORLD A: THE DEMO

The first room is the demo. A clinical team is shown an AI tool, and it's dazzling. It reads the patient's notes in seconds. It flags the risk before anyone else spots it. It drafts the discharge letter while you watch. Everyone nods. This, surely, is the future. And the clinician lets herself think: “At last — I get to spend more time caring for people.”

WORLD B: THE WARD

The second room is the ward.

Here, the notes it read so easily are often still on paper — and where they are digital, they sit in systems that don't talk to each other. The risk it flagged so confidently, the consultant won't act on — because she can't see where it came from. And the letter it drafted in the demo now waits behind a governance question no one can answer.

THE TURN: SAME TOOL, DIFFERENT WORLDS

Same tool. Same promise. Two completely different worlds.

And that gap — between the world of the demo and the world of the ward — is where the real work begins.

We've all seen a version of that story. And it tells us exactly where we now are.

THE SHIFT

For two years, the AI conversation has been about possibility. What can these tools do? How intelligent are they? Which model is best?

But we're moving into a different phase.

The question is no longer “What is AI capable of?” It's “What are we capable of doing with it — responsibly, practically, and at scale, in a hospital, with real patients, real risk, and real accountability?”

That is a much harder question — because it is the crossing, from the demo to the ward, that defeats most good intentions. And in healthcare, more than anywhere, that is where AI stops being about technology and becomes about leadership.

Here's the line I'd ask you to hold onto tonight.

> ***In most organisations, the missing layer is not the model. It's the method.***

For me, that method comes down to three points: choose well, build right, and stay human.

REFLECTION 1 — Choose Well

START WITH THE PROBLEM

Because AI implementation has to start with a real problem, not with the technology.

Too often we begin with the tool. “We need an AI strategy.” “We need a chatbot.” But the better starting point is simpler: what is the problem we are actually trying to solve?

Are we trying to give clinicians more time with patients and less with paperwork? To speed up triage? To improve access for the people who currently fall through the gaps? To help a frightened patient understand what happens next?

AI shouldn't be implemented because it's impressive. It should be implemented because it improves something that matters. In healthcare, that isn't a nice-to-have. It's the whole point.

REFLECTION 2 — Build Right

FOUNDATIONS, DATA AND PEOPLE

Because in AI, data readiness is now organisational readiness.

Almost every serious AI conversation ends up in the same place. The organisation isn't ready, because the data isn't ready. It's fragmented. Definitions are inconsistent. Legacy systems don't connect. And too much of how things actually work is trapped in people's heads.

So — can we find the information? Can we trust it? Can we share it safely, explain where it came from, and use it lawfully? AI doesn't create those questions. It exposes them. It shines a light on the strengths and weaknesses that were already there.

That is not a reason to avoid AI. It is a reason to use this moment to fix the foundations.

But foundations aren't only technical. Implementation fails when AI is done to people rather than with them. If staff feel it's being imposed, they'll resist it — sometimes openly, often quietly. So we need clinicians, nurses, service designers, information governance, and patients in the room early enough to shape the outcome. People need permission to experiment, the training to do it well, and clear boundaries they can trust. A policy document alone won't create adoption. A tool alone won't create transformation.

REFLECTION 3 — Stay Human

JUDGEMENT, EMPATHY, ACCOUNTABILITY STAY WITH PEOPLE

Because trust is earned, not demanded — and because the final judgement must always rest with a person.

We talk about trust in AI as if it's something we can require from clinicians and patients. It isn't. Trust is earned — through design, governance, transparency and evidence.

That means being clear about when AI is being used, and honest about what it can and cannot do. It means testing for bias, for hallucination, for the failure that lands hardest on the patient who was already least likely to be heard. It means someone is accountable when things go wrong.

And it means resisting the temptation to over-automate. Some decisions should never be handed to a machine. Some moments in care need human discretion, empathy, and moral responsibility.

The future is not AI replacing clinicians. At its best, it is AI helping clinicians do better work — with more time, more insight, and less friction. That distinction matters more in medicine than almost anywhere else.

GOVFORMS — How We Think

This is exactly how we think about it at Govforms.

We help public sector and healthcare organisations turn complex processes into secure, accessible, production-grade digital services — and to use AI safely inside them. Not as a magic layer bolted on top, but as part of a properly designed service journey, where the form, the data, the workflow, the audit trail and the human review points have all been thought through.

Because the organisations that succeed with AI won't be the ones with the most impressive model. They'll be the ones who can turn AI into safe, reliable, repeatable service delivery. That's the space we're focused on.

CLOSE — Summing Up

So, as you leave tonight, three commitments.

Choose well. Pick the right problem before you pick the tool. Start where AI clearly reduces friction, improves access, or supports a better decision.

Build right. Get the foundations solid — data, security, interoperability, governance — design with the people affected: clinicians, staff and patients, never from a distance — and measure outcomes, not excitement: is care better, faster, safer, fairer?

Stay human. Keep judgement and accountability where they belong: with people. AI can assist and accelerate; it can never be accountable.

Because AI will not implement itself. It will reflect the choices we make around it — the problems we choose, the safeguards we design, the people we include, and the courage we show in moving from discussion to practice.

And remember: we began in two rooms. The distance between them was never about the model. It was the method. And the method is ours to build.

Let's not leave AI implementation to chance. Let's not let it happen to us, or to our patients. Let's shape it deliberately — with ambition, with humility, with evidence, and with responsibility.

> ***So let’s: choose well, build right, stay human.***

Thank you — to our speaker, to our hosts, and to all of you for being part of tonight.

GET IN TOUCH — Contact Details

To discuss safe AI implementation, contact Govforms through:

- Website: govforms.co.uk
- General enquiries: curious@govforms.co.uk
- Commercial and public-sector discussions: Mark Preston, Client Director
- Technical, security and data protection discussions: Nathan Dolan, Technical Director