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Somerset NHS Foundation Trust Annual General Meeting

Please scan the QR code below for the papers:

Kindness, Respect, Teamwork
Everyone, Every day

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Welcome to our **Annual General Meeting**

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Peter Lewis, Chief Executive

September 2026

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National context

- **10 Year Health Plan** – three shifts that set strategic direction
- Continued **huge demand for services**
- **Recovering performance** across the NHS
- **Improving public satisfaction** with the NHS but a long way to go
- Extremely tough **national financial environment**
- Ongoing significant **structural change**
- Focus on **maternity** and **neonatal services**.

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Our context

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- Community Hospitals with Minor Injuries Unit
- Acute Hosptials
- Community Hospitals
- Adult's, Older People's and Younger People's Mental Health Wards

- Somerset Population – c.600,000.
- c.1,600 square miles / Poor travel times.
- Demographic and geographical challenges.
- Good life expectancy but significant healthy life expectancy issue.
- Historical under investment in mental health, community services and primary care.
- Challenges in sustaining critical service mass for acute services.

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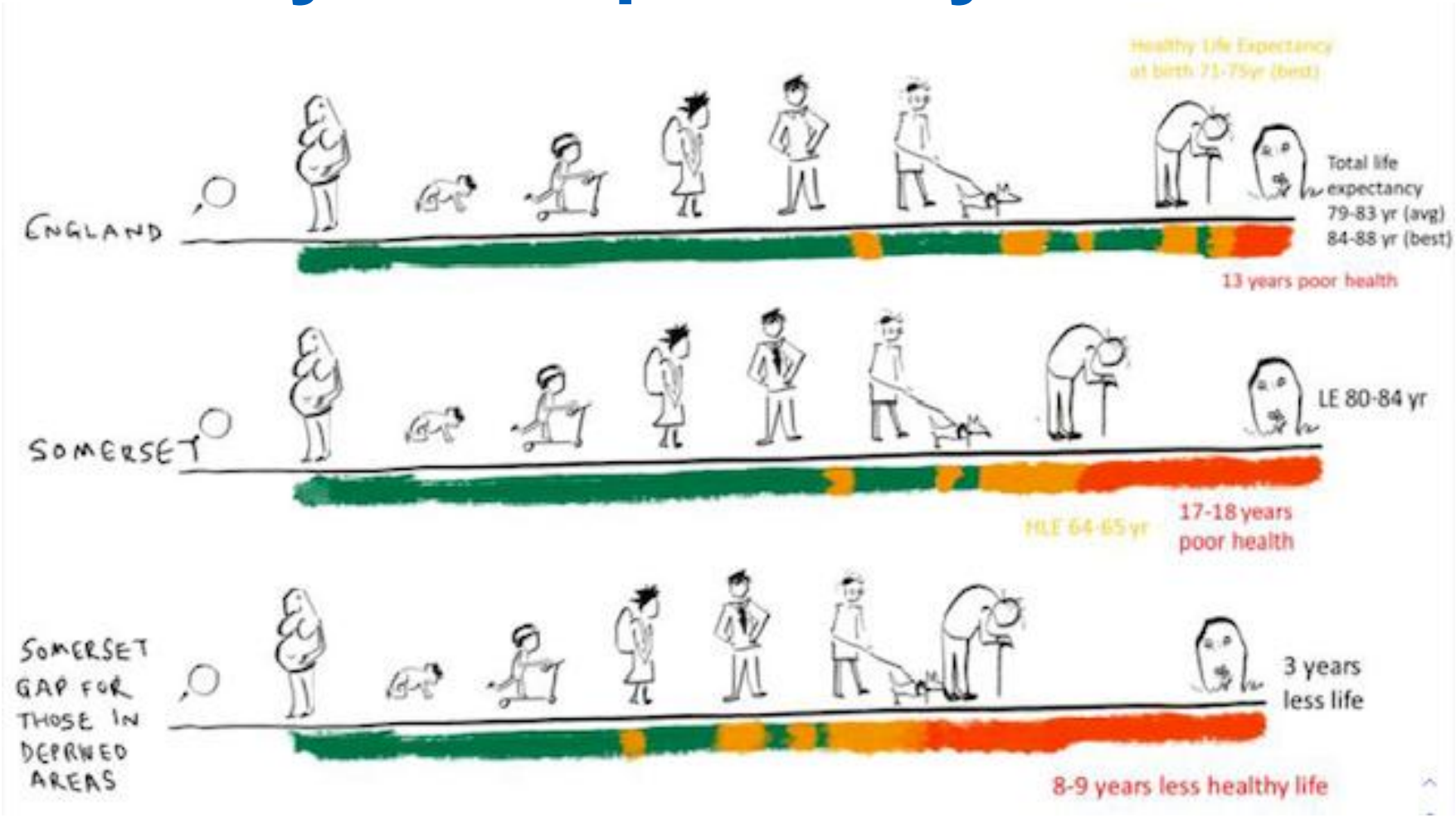
Healthy life expectancy



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Mission:

To improve the health and wellbeing of everyone in Somerset, and to deliver outstanding integrated care by supporting our colleagues and nurturing an inclusive culture of kindness, respect and teamwork.

Vision:

Thriving colleagues, integrated care, healthier people.

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10-Year Health Plan

Three shifts:

- Sickness to prevention
- Hospital to community
- Analogue to digital

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Sickness to prevention

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Trust mission

To improve the health and wellbeing of everyone in Somerset, and to deliver **outstanding integrated care** by supporting our colleagues and nurturing an **inclusive culture of kindness, respect and teamwork**.

Strategic aim

To contribute to **improving population health** and **reducing health inequalities**.

Population health approach

To **understand the health of the population** in the areas in which we provide services, designing services to take account of this and prioritise prevention.

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SPLASH

(Somerset Paediatric Lifestyle Activity and Skills for self Help)

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About the service –
SPLASH is a weight management service for children aged 5 years and below in Somerset. The 12-month programme is designed to help families make changes and encourages children to have a positive relationship with food and activity.

Problem we set out solve - Childhood obesity and excess weight are significant health issues for children and their families. There can be serious implications for a child's physical and mental health, which can continue into adulthood. The number of children with an unhealthy and potentially dangerous weight is a national public health concern.

What we've achieved - SPLASH has supported almost 163 families in Somerset since April 2022. 89% of families chose to engage with the programme, 84% of children aged over 2 years decreased their BMI while in the service, and all families reported increased confidence in food-related decision-making. Medical complications of obesity were identified in over 20 children allowing for treatment and ongoing monitoring.

Specialist homelessness healthcare service

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About the service - NHS partners and Somerset Council recognise homelessness as a health and wellbeing issue. Their approach includes our Homeless & Rough Sleepers Outreach Nursing Team who provide nursing care and coordination for anyone experiencing homelessness, rough sleeping or living in temporary/unsecure accommodation across Somerset.

Problem we set out solve - Somerset is a largely rural county, which in common with many places has a housing system under strain. Somerset has the 3rd highest numbers of rough sleepers in the country. Data shows that 94% have multiple needs, 87% have mental health needs, 98% have a physical health condition or disability; and 13% present as neurodivergent.

What we've achieved - Between January 2020 and September 2024, people in Somerset experiencing homelessness attended a total of 28,888 outpatient appointments, 35 per cent of which were delivered by the team of 15 staff who make up the specialist homeless nursing outreach team.

Hospital to community

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Strategic aim

To **strengthen care** and **support** in **local communities**

Our trust is ideally placed to deliver services in local communities because of our range of community, primary and acute services and our 13 community hospitals.

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Wellington Community Hospital

- **Opened in 1892**, rich local history
- **Population** of Wellington and surrounding **area just under 45,000**; higher proportion of over 65s than Somerset average
- **Closure of inpatient beds** at the start of the pandemic
- Creation of a **local health hub** supporting the needs of the local community
- **Over 35 different specialties** run outpatient appointments and diagnostic clinics for hundreds of patients every week.

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Analogue to digital

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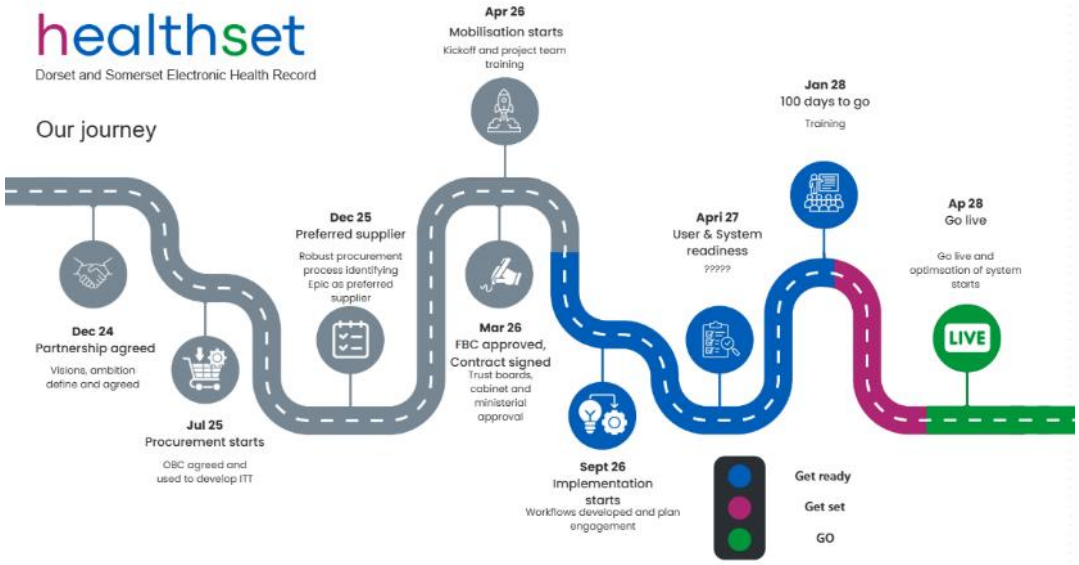
Strategic aim

To deliver the vision of the Trust by **transforming our services** through **research, innovation and digital technologies**.



healthset
Dorset and Somerset Eletronic Health Record

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Digital medicines management

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About the digital transformation – the ‘first of type’ roll out of a new electronic prescription service (EPS) capability, connecting our electronic prescribing and medicine administration (ePMA) system directly with community pharmacy services.

Problem we set out solve – Alongside other related projects, to eradicate drug errors, reduce medicines waste, improve patient safety and streamline workflows to improve patient and colleague experience.

What we’ve achieved - Improved continuity of care between settings, better patient safety and medication prescription accuracy, increased efficiency, improved accessibility and reporting. Significant national recognition - 2025 HSJ Digital award winner, 2026 HSJ Digital award finalist, 2026 NHS Excellence Awards South West runner up, 2026 Clinical Pharmacy Congress award runner up.

Our colleagues

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- Just under 14,000 colleagues
- Strategic aim to support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
- Continued focus on culture and values and improving colleagues' experience.
- Support required to equip colleagues to thrive and deliver transformation.

Colleague experience

- NHS Staff Survey - in every theme, our trust scored higher than the comparator group average. Our highest scoring themes are "we are compassionate and inclusive" and staff engagement.
- Listening report – actions in response to colleague feedback in all elements of the NHS People Promise.

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Our achievements

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Service improvements

- New sexual health service opens in Yeovil
- New urgent treatment centre opens at Yeovil Hospital
- Investment more than doubles support for learning disabilities care at our acute hospitals
- New rheumatology clinic at Wellington Hospital helps more patients get important treatment
- Improvements lead to huge reduction in waiting times for podiatry
- Reusable operating theatre hats puts names to faces
- Yeovil ophthalmology injection suite opens in Yeovil town centre
- New self-referral service aims to detect lung cancer earlier
- New digital app launched to support ADHD patients in Somerset
- Trust launches innovative way of detecting oesophageal cancer earlier
- New frailty same day emergency care service opens at Musgrove Park Hospital.

Our achievements

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Recognition	• Three shortlistings in the 2026 HSJ Awards • Severn Deanery award for best teacher • Win in 2025 HSJ Digital Awards • Shortlisting and win in HSJ Awards 2025 • Acute medicine at MPH rated best in the country for doctor training • Winner in the NHS Excellence Awards • Highly Commended at the 2026 HSJ Partnership Awards
Ongoing development of facilities	• Yeovil Diagnostic Centre – opened in January 2026 • Bridgwater Diagnostic Centre - opened in August 2026 • King's Building, new surgical centre - opened in September 2026 • £54.8 million secured for infrastructure including nearly £50m at YDH • Ongoing discussions about need for new maternity and children's facilities at MPH.

Performance

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Performance measure	2025/26	2026/27 (July)	2026/27 Target
Community services: percentage of patients waiting under 18 weeks	89.1%	92.5%	78%
Rapid Response: % of referrals not resulting in admission to hospital	87.2%	89.0%	80%
Percentage of patients seen by the Urgent Community Response service within two hours	92.5%	92.9%	70%
Early Intervention In Psychosis: people to begin treatment with a NICE-recommended care package within 2 weeks of referral	93.7%	100%	60%
Talking Therapies: percentage of patients completing treatment achieving Reliable Recovery	49.5%	46.5%	51%
Talking Therapies: percentage of patients completing treatment achieving Reliable Improvement	72.6%	71.2%	69%
Community mental health (Adults, CYP, Older people, LD): % waiting under 6 weeks	96.6%	93.9%	90%
Talking Therapies RTT : percentage of people waiting under 6 weeks	68.9%	67.7%	75%

Performance measure	2025/26	2026/27 (July)	2026/27 Target
Percentage of mental health inpatients followed up within 72 hours of discharge	97.0%	98.2%	80%
ED and UTC combined : percentage of patients within the 4-hour standard (target: 82% by March 2027)	72.0%	71.0%	71.5% (July)
Average ambulance handover time (minutes)	25.3	21.1	25.6 or less
Diagnostics: percentage of patients waiting under 6 weeks for a diagnostic test	77.6%	83.1%	80.4% (July)
Percentage of patients waiting under 18 weeks for a first appointment (acute)	73.9%	73.4%	73.2% (July)
Referral to treatment: percentage of patients waiting under 18 weeks (acute)	65.4%	64.9%	65.6% (July)
Referral to treatment: percentage of patients waiting over 52 weeks	2.0%	2.7%	1.1% or less (July)
Cancer: percentage of patients diagnosed within 28-days of referral	78.1%	83.9% (June)	80.7% (June)
Cancer - percentage of patients seen within 62 days from urgent GP referral	77.9%	70.6% (June)	75.8% (June)

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Finance

- Achieved an operational £18k surplus position (before receipt of £4.9m non-recurrent deficit funding; re-allocation from NHSE provision)
- Investment - £118m
- National Oversight Framework – Segment 2.

How did we spend our money?

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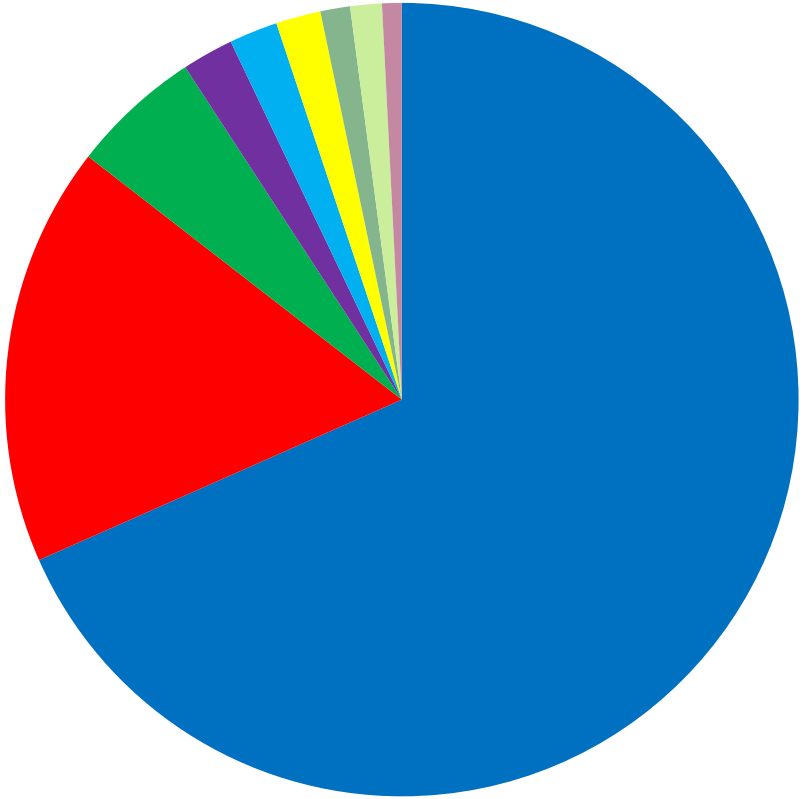
Total expenditure £1,227m



- Colleague costs £839m
- Supplies and services £210m
- Cost of capital £65m
- Premises £26m
- Other £24m
- Clinical negligence £22m
- Establishment £15m
- Purchases of healthcare £16m
- Net finance costs £10m

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Where did our income come from?

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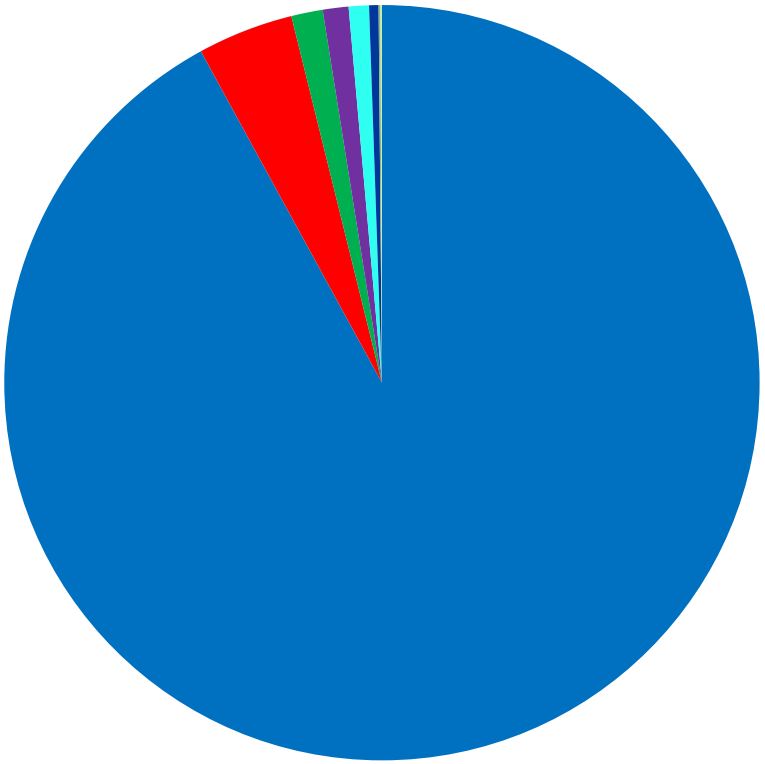
Total income £1,213m



- NHS commissioners £1,116m
- Education & training £50m
- Non NHS commissioners £16m
- Other income £13m
- Non patient care services to other bodies £10m
- Research & development £5m
- Grants and donated income £1m
- Staff recharges £1m

Reflections on 2026/7 so far

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- A year of opportunities and challenges
- Structural change in the NHS continues
- In the short term - focus on operational and financial performance
- Special Care Baby Unit and inpatient maternity services at Yeovil District Hospital reopened on 19 April
- National focus on maternity and neonatal services
- In the medium term – opportunities to transform services to implement the shifts in the 10 Year Health Plan and achieve our strategic objectives
- Investment in community services and maximising use of community hospitals to shift care from acute into community settings.
- Changes to stroke services.

Thank you to our communities

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Somerset NHS Charity
Love Musgrove
Yeovil Hospital Charity

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10 Year Health Plan:
Hospital to Community

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Annual General Meeting
September 2026

GROW ENHANCE TRANSFORM

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Symphony & SFT

SSW Transformation Programme

Passionate about providing Care

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Symphony
Healthcare Services

Our Vision to realise the potential of providing all primary and secondary health care in South Somerset West PCN:

An integrated neighbourhood model

bringing people & services together

to improve community health & wellbeing & reduce health & social inequalities

Symphony South	List Size (31 March 2026)
Buttercross Health Centre	7,868
The Ilchester Surgery	
Crewkerne Medical Centre	12,369
West One Surgery	
Hamdon Medical Centre	6,017
Martock Surgery	10,208
South Petherton Medical Centre	
TOTAL SSW PCN	**36,462**

'Working together across South Somerset West to understand and respond to the health and social care needs of our communities, improving wellbeing and deliver care in the most effective and compassionate way.'

Symphony Healthcare Services

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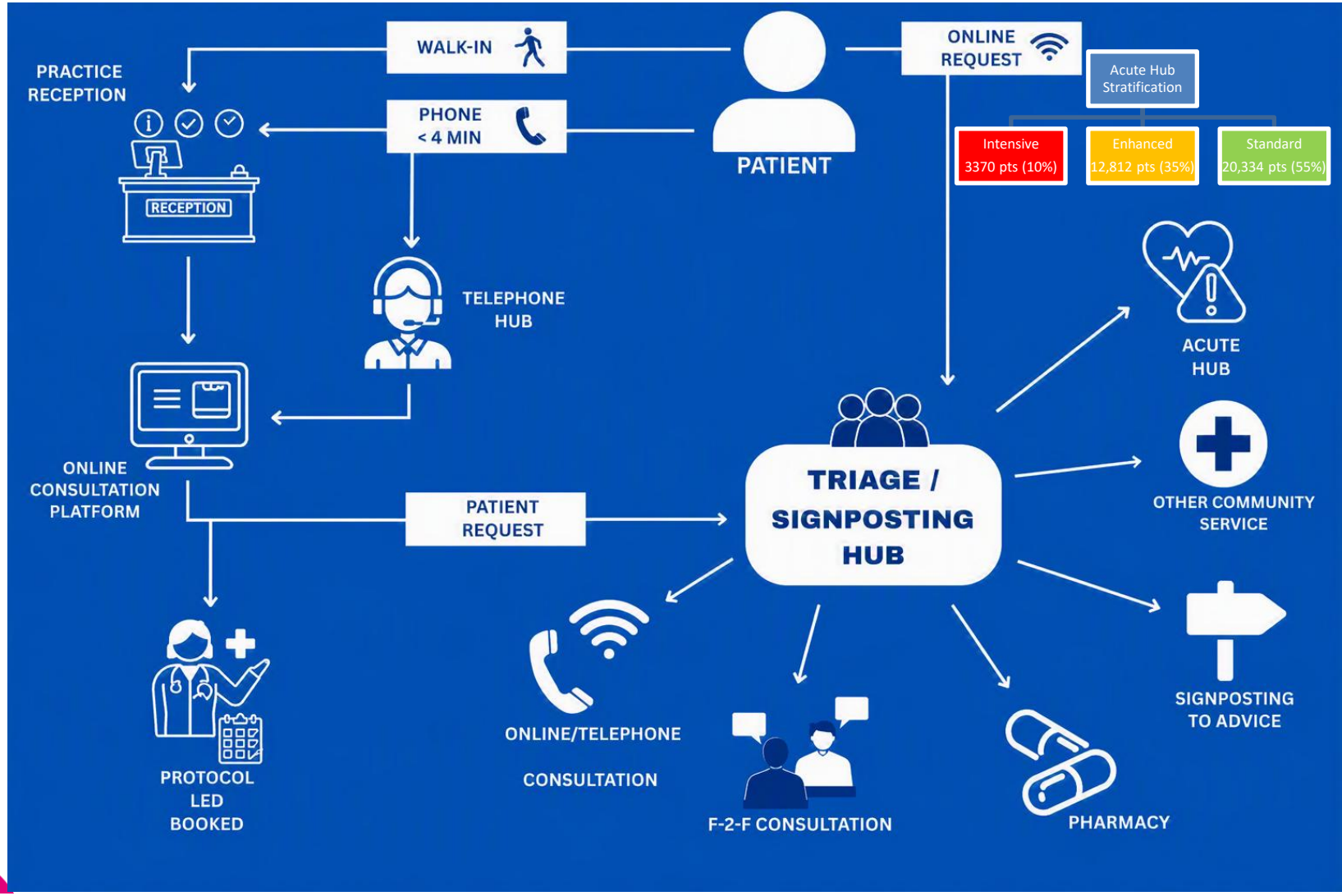
Model for Merged Practices

Average of 767 telephone calls every weekday

Average of 446 triages by GP's every day



Transformation programme roadmap

Key milestones from programme start through scale-up and embed

1 Foundations

Nov 2023 – May 2024

Nov 23: Programme start; staff engagement workshops

Jan 24: PPG engagement begins

Jan 24: Teamnet Portal GoLive

Jan 24: Medicines Management Hub realigned to practice teams

Mar 24: Home visiting review leads to development of weekly Integrated Neighbourhood Multidisciplinary teams meeting (MDTs) across PCN

May 24: Anima Go Live

2 Hub build

Q3 2024 – Jun 2025

Q3/Q4 24: Programmes tested and contact-hub planning completed

Jan 25: Introduction of neighbourhood meetings (Co Senior Leadership) and strengthened cross-organisational relationships

Jan 25: Establishment of a centralised Symphony Contact Hub (call centre)

Feb 25: SFT Community-team working trial in Contact Hub*

Feb 25: Creation of a Community Investigations Hub

Apr 25: Introduction of an Acute Hub to manage patients who do not require continuity of care

May 25: Home visiting referral pathways go live

Jun 25: Daily Contact Hub huddles begin

Jun 25: PSAs refer directly to community services

3 Service expansion

Jul- Dec 2025

Jul 25: Team of Teams coaching sessions as enabler for integrated working

Jul 25: MDT SBAR process implemented

Sep 25: Acute Hub fully functional 5 days/week

Sep 25: Implementation of a dedicated Women's Health Hub

Sep 25: Establishment of a Peri-operative service based within SSW PCN

Sep 25: First Rural Health pop-up clinic held

Oct 25: Second Rural Health pop-up clinic held

Oct-25: Richard Blackwell workshop sharing SSW PCN Population Health Data

4 Scale & embed

Jan 2026 – Jul 2026

Jan 26: MDT coordinators in post

Jan 26: MOU agreed for cross SFT & SHS Portfolio Working

Feb 26: Delivery of Health and Wellbeing Day for the local population: Crewkerne

Feb 26: Direct access pathways for suspected lung and bowel cancer

Mar 26: Development of a patient Risk Stratification Model; HISU identified for MDT review

Apr 26: High-intensity users MDT Reviews

Apr 26: Ask My GP Go Live

Apr 26: Work to identify key performance indicators (KPIs) to measure neighbourhood impact

Apr 26: Workshop to explore working with VCSFE partners using patients identified at high risk of Diabetes (Risk Strat model)

May 26: Diabetes Group Consultation clinic held at Crewkerne Community Hospital

May 26: Delivery of Health and Wellbeing day for local population: Martock

Jun-26: Standardisation of EMIS appointment templates across practices

Jun-26: SMI patients risk stratified for MDT reviews

Jul-26: Merger of 4 GP practices within SSW PCN into Symphony South Healthcare

Jul-26: Establishment of Central Triage Hub

Nov 23 — May 24 — Jun 25 — Sep 25 — Jul26

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Trust OSCA's 2026 Winners in Partnership Category

The Peri-Operative Team won the partnership award working with SSW Symphony primary care, community services and VCSFE partners, the nomination stated:

"they transformed a traditionally hospital-based pathway into a more accessible, neighbourhood-focused model of care. Their peri-operative outreach clinics bring expertise directly into community settings, offering patients education, investigations and personalised care planning closer to home, particularly benefiting those in rural areas who face greater barriers to access.

The impact is clear, with measurable improvements in patient readiness, reduced cancellations and environmental benefits through less travel."

Neighbourhood Health & Wellbeing Days

The first event took place at the Henhayes Centre in Crewkerne in Feb 26 & Martock Parish Hall in May 26. They included a range of services including;

- Social care and carers support
- SFT & Symphony Health services
- Mental health services
- Libraries
- VCSFE community organisations
- Finance and benefits advice services

The days provided information and activities for all ages to help people understand more about their health, discover local support services, and try out wellbeing activities in a friendly environment.

Between 150 and 200 people attended Henhayes and 100 attended Martock

A review by Adult Social care of Martock event stated: "The Martock LiveWell event was a high-impact, successful initiative, delivering both immediate support and longer-term benefits for residents. The combination of strong partnership working, accessible delivery, and a welcoming environment contributed significantly to its success."

CSU Frailty, Falls & Care Home Admissions Review Apr 24 – Mar 26

Neighbourhood / PCN	Frailty 2024/25	Frailty 2025/26	Frailty % change	Falls 2024/25	Falls 2025/26	Falls % change	Care Home 2024/25	Care Home 2025/26	Care Home % change	Volume Change
Bridgwater	1,348	1,369	2%	248	270	9%	210	224	7%	57
Central Mendip	538	655	22%	117	125	7%	89	111	25%	147
Chard, Langport and Ilminster	1,130	1,199	6%	223	243	9%	220	270	23%	139
Frome	529	609	15%	88	91	3%	156	152	-3%	79
North Sedgemoor	1,142	1,161	2%	216	241	12%	247	250	1%	47
South Somerset East	556	522	-6%	120	126	5%	159	167	5%	-20
Taunton Central	1,224	1,376	12%	253	289	14%	275	364	32%	277
Taunton West	717	655	-9%	131	131	0%	125	144	15%	-43
Tone Valley	772	739	-4%	119	139	17%	158	142	-10%	-29
West Mendip	919	1,061	15%	148	192	30%	202	236	17%	220
West Somerset	981	1,027	5%	179	196	9%	203	193	-5%	53
Yeovil	1,021	1,009	-1%	215	210	-2%	331	393	19%	45
South Somerset West	**806**	**725**	**-10%**	**169**	**159**	**-6%**	**221**	**180**	**-19%**	**-132**

Across all 3 metrics, South Somerset West has seen the largest decrease in emergency admissions between 2024/25 and 2025/26

-10% for frailty, -6% for falls, and -19% for care homes with a reduction of 132 acute admissions.

The avoidance of 132 acute admissions, based on an average length of stay of 12.3 days, equates to 1,624 bed days saved annually, representing the equivalent of approximately 4.5 extra inpatient beds available every day across the year

This change correlates with the phased introduction of several operational improvements within SSW:

Jan 25: Introduction of neighbourhood meetings which strengthened cross-organisational relationships including with care homes

Apr 2025: Acute Hub introduced to manage patients where continuity of care is not required. This created capacity to manage patients who needed that continuity

May 2025: Home visiting referral pathways became operational

Jun 2025: Daily Contact Hub huddles commenced

Jun 2025: PSAs enabled to make direct referrals to community services

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WEEKLY NEIGHBOURHOOD MDT

One weekly forum. One coordinated plan. Better outcomes.

Primary Care • Community • Social Care • Partners

WHY Purpose

- Complex, high-risk or escalating patients
- Proactive, joined-up care
- Shared decisions and coordinated care
- Less duplication and fragmentation
- Support flow, admission avoidance and discharge

DO What happens

- Review priority patients
- Agree one care plan with clear actions
- Connect services and share information
- Intervene early to prevent escalation
- Bring in specialist services as needed

WIN Outcomes

- Better patient experience and outcomes
- Stronger collaboration and trust
- Reduced duplication and inefficiency
- Integrated neighbourhood care
- Supports discharge and avoids admissions

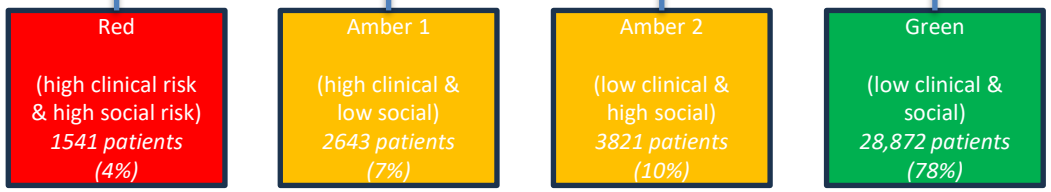
CORE TEAM Community Nursing • Complex Care • Adult Social Care • Community Rehab • Care Coordinators • Alzheimer's Society • Social Prescribers • AHPs

ACCESS THE MDT

Email Fran Bovey • fran.bovey@somersetft.nhs.uk

Include: patient name • NHS number • reason for discussion • services / professionals to involve

Population Health Segmentation (V5)



A note on deprivation

Deprivation scoring is not included in the segmentation due to the way EMIS reporting works. This can be added using IMD scores to a specific segment when developing interventions

Clinical Criteria (any one of the following – 4165 patients):

5+ QOF conditions

10+ repeat medications

1 of Dementia, SMI, LD or EoL

Severe frailty

Housebound

Social Criteria (any one of the following – 5330 patients):

Safeguarding register

Latest BMI 40+

Drug or alcohol abuse last 6 months

Homeless

Lives alone and aged 65+

Has a carer

Is a carer

Asylum seeker or refugee

Veteran or active military service

Main spoken language not English

Sex worker

Prison leaver

Unemployed and aged 18+

On benefits

Traveller

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Using data to inform practice: Serious Mental Illness (SMI) Register
331 patients in SSW on SMI Register

159 in Red - high clinical need and high social need

172 in Amber - high clinical need and low social need

No Green SMI patients as all people with SMI would be considered as high clinical need

- 19 people with SMI and COPD
- 103 people with SMI with CVD including Hypertension
- 49 people SMI with CVD and no Hypertension
- 21 people with SMI and Frailty (moderate or severe)
- 10 people with SMI and Dementia
- 6 people with SMI and Housebound
- 8 people with SMI living in a Care Home
- 4 people with SMI and End of Life

- 41 people with SMI and Diabetes

	Count	% Achieved
Total SMI Patients with Diabetes	41	
Total HbA1c in last 9 months	34	83%
Total BP Check in last 15 months	40	98%
Total Foot Check in last 15 months	32	78%
Total Medication Review in last 15 months	29	71%

144 patients (44%) of the 331 patients on SMI register are not recorded as attended an SMI health review in last year despite multiple call and text invites by Symphony. Need to understand if they were reviewed by SFT on RIO.

6 People with SMI and 3 conditions
(4 Red and 2 Amber)

30 people with SMI and two conditions
(20 Red and 10 Amber)

17 of the 36 people with multiple conditions have not attended an SMI review in last year despite being invited

Joint MDT review led by PCN Clinical Director and AMD for Mental Health reviewed the 36 patients with multiple conditions.
Joint outreach plan being developed for the 144 not engaging with health review invites.

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Development of Integrated Neighbourhood Team

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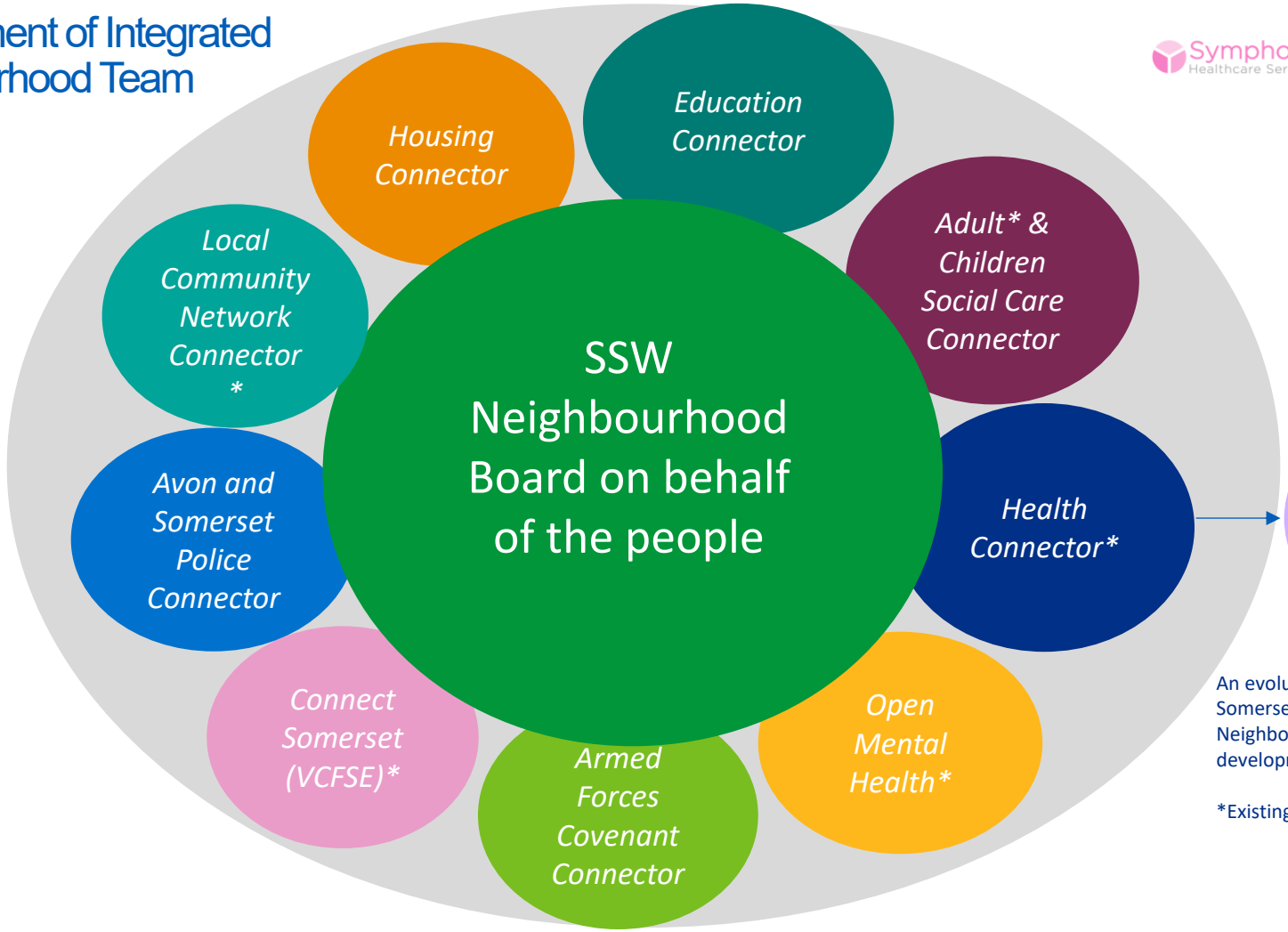

Our Health INT Structure

An evolution of existing South Somerset West PCN & Neighbourhood business development meeting

*Existing members

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We value your feedback

Questions
&
Discussion

Symphony & SFT SSW
Transformation Programme
Feedback Survey

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10 Year Health Plan:
Treatment to Prevention

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SFT AGM 17.9.26

Dr Florence Lock,
Consultant in Public Health

The national shift and why it matters in Somerset

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17-21 years lived in poor health

4-5 year fall in healthy life expectancy in last decade

9 year inequality in healthy life expectancy

A population health approach aims to improve the health and wellbeing of an entire population whilst reducing health inequalities

Prevention and health inequalities are interlinked: improving the average is not enough if the gap widens.

Our SFT Population Health Programme

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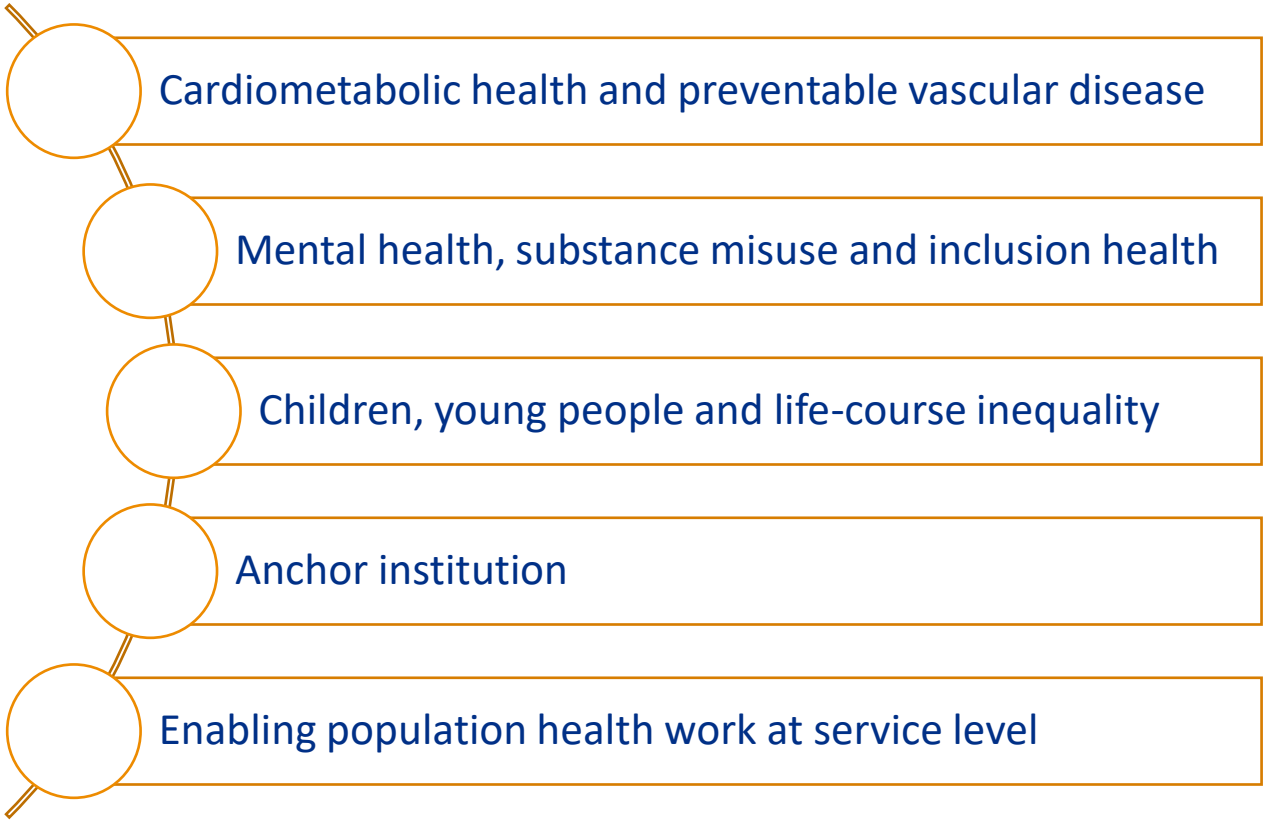
Vision: Improve healthy life expectancy and reduce the inequality in healthy life expectancy for the Somerset population



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Using our wider influence as an anchor institution

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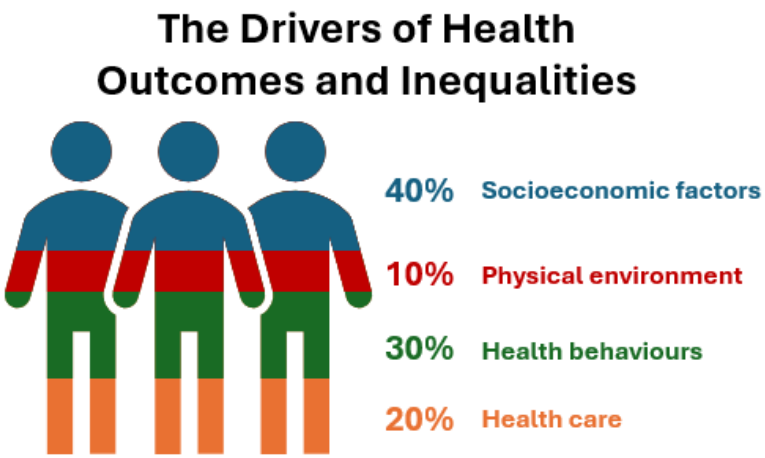
SFT is rooted in the Somerset community, with the opportunity to influence local social, economic and environmental determinants of health



- Widening access to quality work
- Purchasing more locally and for social benefit
- Using buildings and spaces to support communities
- Reducing environmental impact
- Working more closely with local partners

Making population health part of every service

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See the gap	Design for equity	Build into systems	Grow capability
Develop service-level insight and improve data quality so inequalities are visible	Strengthen EQIA so evidence and likely impacts inform change from the start	Use Healthset opportunities and connect population health with planning, improvement and governance	Support communication, learning, evaluation, research and partnership working

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10 Year Health Plan:
Analogue to Digital

Kindness, Respect, Teamwork
Everyone, Every day

Annual General Meeting
September 2026

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1

Digital, Data and Technology Strategy

2

Electronic Health Record (EHR) Programme

3

Using Data and Artificial Intelligence safely to improve care

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Our strategy

The 10-year plan sets out three core shifts and while analogue to digital is called out as one of the shifts, **digital, data and technology underpin all three**.

Our five-year Digital, Data and Technology Strategy explains how information and technology will support better health, more care at home and easier access to services.

It underpins our organisational aim to improve the health and wellbeing of everyone in Somerset and to provide outstanding integrated care

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What the strategy means for people

A five-year plan to make care more joined-up, accessible and secure.

Connected services

Unified electronic health record (EHR) across acute, community and mental health services.

More control over your care

Access to records, with tools that help people manage their health and wellbeing, while maintaining equity and inclusivity

Better information, closer to home

Timely information to support joined-up care across our services and with our partners.

Safe and secure services

Data protection, privacy and security, with colleagues supported to use technology safely.

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Our delivery plan

We will continue to build our secure foundations, introduce modern systems and new technologies, then embed new ways of delivering care.

Build secure foundations

- Procure an EHR and approve business case
- Set cyber, safety and AI governance

Launch Healthset Programme

- Recruit the EHR team and commence the system build
- Introduce AI and automation into corporate and administrative functions

Prepare and connect teams

- Support integrated neighbourhood and care teams
- Prepare for simpler, consistent ways of working
- Prepare and train colleagues

Go live with Healthset

- EHR go-live in April 2028
- Launch patient-facing portal access
- Stabilise and embed new ways of working

Adopt and optimise

- Use real-time data and decision support
- Optimise the EHR; switching off older systems

Embed, learn and evolve

- Use AI where it is safe, useful and approved
- Strengthen primary and social care links

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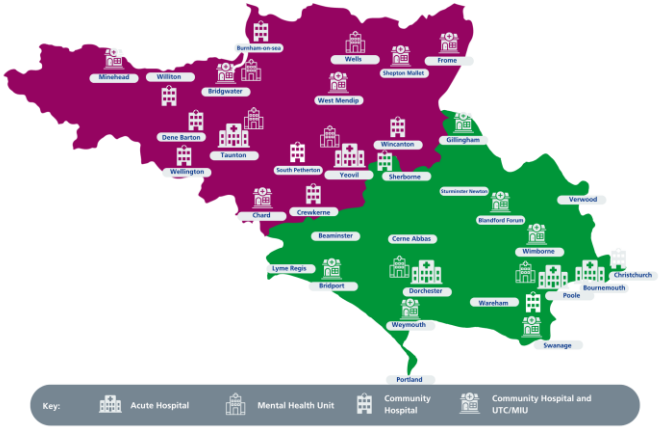
Healthset: one shared record

Connecting acute, community and mental health services across Somerset and Dorset.

Healthset will create a unified electronic health record (EHR), giving care teams one up-to-date view of each person's care.

Built on Epic and configured for local services.



ACUTE

Coordinate hospital care

COMMUNITY

Support neighbourhood and home-based care

MENTAL HEALTH

Connect physical and mental health care

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One record, fewer gaps in care

For patients and service users, a shared record is intended to make care safer, more joined-up and easier to navigate.

Tell your story fewer times

Teams can see the same up-to-date information across services, reducing repeated questions and missing context.

Safer handover between services

Simpler workflows and one source of information support co-ordinated decisions and continuity of care.

More access to your information

Patient-facing tools and the future portal will help people access records, communicate with care teams and manage their health and wellbeing.

Outcome: streamlined decisions, more time for care and smoother transitions closer to home.

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Using data and AI to improve care

We use information to understand local needs, plan services and support safer, more joined-up care.

1 Predict (Plan ahead)

Use information to understand changing needs and prepare services.

- Anticipate demand
- Support timely decisions

2 Prepare (Be ready)

Use reliable information to help services respond and involve local people.

- Support emergency planning
- Listen to patients and the public

3 Prevent (Act earlier)

Spot risks sooner and plan around the health needs of local communities.

- Identify early warning signs
- Target support where it is needed

4 (Improve) Learn and adapt

Use evidence, research and feedback to improve care and how services work.

- Support research and learning
- Build confidence in using data

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Where are we with AI

We use information to understand local needs, plan services and support safer, more joined-up care.

Safe foundations

Our readiness has been externally assessed.

Governance, safety and assurance processes are in place.

Copilot and ambient voice

Copilot and ambient voice technology are being adopted across the organisation.

Clinical AI in diagnostics

Clinical AI is being used in diagnostic services.

Building capability

We are bringing together capacity, training and solution resources.

Focused workstreams and staff development will help maximise AI's potential.

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Lead Governor Report

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Thank you for attending our Annual General Meeting

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