

Beyond the dashboard

The role of data, benchmarking and AI in delivery of the NHS 10 Year Health Plan

Tuesday 8 September 2026 | 12:30 to 13:30 | MS Teams

Welcome

Rosie Alexander-Bunney, Senior Customer
Success Manager, NHS Benchmarking
Network

12:30 | 5 minutes



Housekeeping



Mute

- You will have joined the session on mute and off camera. If you want to speak at any point please raise your hand and we can enable your camera and mic.



Interact

- We encourage you to interact in the chat, ask questions to our speakers or to other attendees – please introduce yourself!



Recording

- We will be recording and transcribing this session and the recording will be available on the NHSBN website after the event.



Timings

- The session today will run from 12:30-13:30.

Agenda

12:30 to 13:00

- 12:30** Welcome
Rosie Alexander-Bunney
- 12:35** Introduction to NHSBN: 30 years of benchmarking
Emma Bamber
- 12:40** Introduction to CLEAR: innovating care with data and AI
Dr Matt Camilleri
- 12:45** How CLEARaudit can help deliver the 10-year plan
Dr Matt Camilleri
- 12:50** The impact of the CTPA audit at The Royal Wolverhampton
Dr David Rosewarne

13:00 to 13:30

- 13:00** Q&A about the CTPA
- 13:05** How benchmarking can support delivery of the 10-year plan
Emma Bamber
- 13:15** The impact of benchmarking at University Hospitals of Leicester NHS Trust
Ben Shaw
- 13:20** Q&A about how to get the most out of benchmarking
- 13:25** Thank you and close
Rosie Alexander-Bunney

Introduction to NHSBN: 30 years of benchmarking in the NHS

Emma Bamber, Customer Success and Growth Director, NHS Benchmarking Network

12:35 | 5 minutes



NHS Benchmarking Network: Who are we?



We are a **UK-wide, impartial, member-led** community of health and social care organisations.

We believe in the importance of **harnessing the power of data** to drive meaningful change.

Celebrating 30 Years of Insight Through Benchmarking.

1996–2000

Foundations Laid

NHS Benchmarking Club was established.
Hosted by Leicestershire Health Authority.
Pioneering the use of benchmarking data to improve health services, triggering a period of growth and innovation.

2000–2006

Gaining National Recognition

Featured in the *Health Service Journal*.
Growing influence and recognition across the NHS.
Benchmarking becomes an essential improvement tool for our members.

2006–2008

Expanding Our Reach

Launched our first **Community Services** project.
Extending benchmarking beyond acute care.
Strengthening our role across the wider health system.

2008–2010

Stronger Base, Stronger Identity

Rebranded as the **NHS Benchmarking Network**.
Expanded into the devolved nations.
A clearer identity reflecting a growing national footprint.

2011–2013

Broadening Our Impact

Membership reached **350 Organisations**.
Delivered our first **Mental Health** project.
Keynote address from Norman Lamb, Minister for Mental Health.
Introduction of surveys to our datasets.
Supporting improvement across a range of sectors and services.

2013–2015

Strengthening our Impact Through Excellence

Expanded to **15 core benchmarking projects**.
Supporting consistent, data-driven improvement across the NHS.
A period of sustained growth and maturity.

2016–2020

Influencing Policy and Practice

Workforce programme commissioned by NHS England with three initial projects.
National Audit for Care at the End of Life project commissioned by HQIP.
Recognised as a trusted partner at system level.

2020–2026

Shaping the Future of the NHS

CVDPrevent commissioned by HQIP.
Learning Disability Improvement Standards audit commissioned by NHS England.
Workforce programme expanded to nine projects by NHS England.
Driving improvement through data during unprecedented times.



NHS Benchmarking Network

30 years of trusted, meaningful insight

NHS Benchmarking Network: What do we do?



Membership Programme

Why the Network originally formed, offering a programme of benchmarking opportunities and insights to inform decision making within NHS and healthcare organisations.

Healthcare organisations are welcome to join.



Products and Services

We specialise in unlocking the value of data to support driving improvements across services. With over 25 years of experience, our expert team delivers bespoke analytical solutions, helping organisations translate data into meaningful insights that inform strategic and operational decision-making.



National Clinical Audits

National Clinical Audits currently delivered by the NHS Benchmarking Network:



National Audit of Care at the End of Life

Auditing last days of life in hospitals



Learning Disability Improvement Standards

What datasets do we benchmark in the member programme?



Indicators

- National Indicators 🌐
- Community Indicators
- MHLDA Indicators

Cross-sector

- Emergency Care
- Managing Frailty in a Bed-based Setting 📄
- Virtual Wards 📄 📋 🧑🧑 🏠

Acute

- Clinical Coding
- Pharmacy & Medicines Optimisation
- AI enabled CTPA audit

Mental Health

- Adult and Older People's Mental Health
- Children and Young People's Mental Health
- Learning Disability Specialist Services
- MH Pharmacy Pilot

Community

- District Nursing 🏠
- Children's Community Services
- Adult's Community Services
- Intermediate Care 📄 📋 🏠

🌐 Publicly available data

📄 Clinical case review 🏠 Staff survey

📋 PREM survey 🧑🧑 Friends and Family Survey

Current Members

27

Acute NHS Trust
(With Community Services)

16

Mental Health NHS Trust
(Without Community Services)

14

Scottish Health Board

8

Community NHS Trust

26

Mental Health NHS Trust
(With Community Services)

16

Acute NHS Trust
(Without Community Services)

7

Social Enterprise

5

Wales University Health Board

5

Northern Ireland HSCT

3 National Body

6

Professional Body

4

Integrated Care Board

1

Other

1

Channel Islands

1

Charity

1

MH Community & Acute NHS Trust

1

Independent Provider

Introduction to CLEAR: empowering staff to innovate care with data and AI

Dr Matt Camilleri, Lead for Strategic
Partnerships and Associates, CLEAR

12:40 | 5 minutes



The National CLEAR Programme

We deliver the CLEAR Programme which was originally developed in partnership with Health Education England and is now sponsored by NHS England, regions and systems.

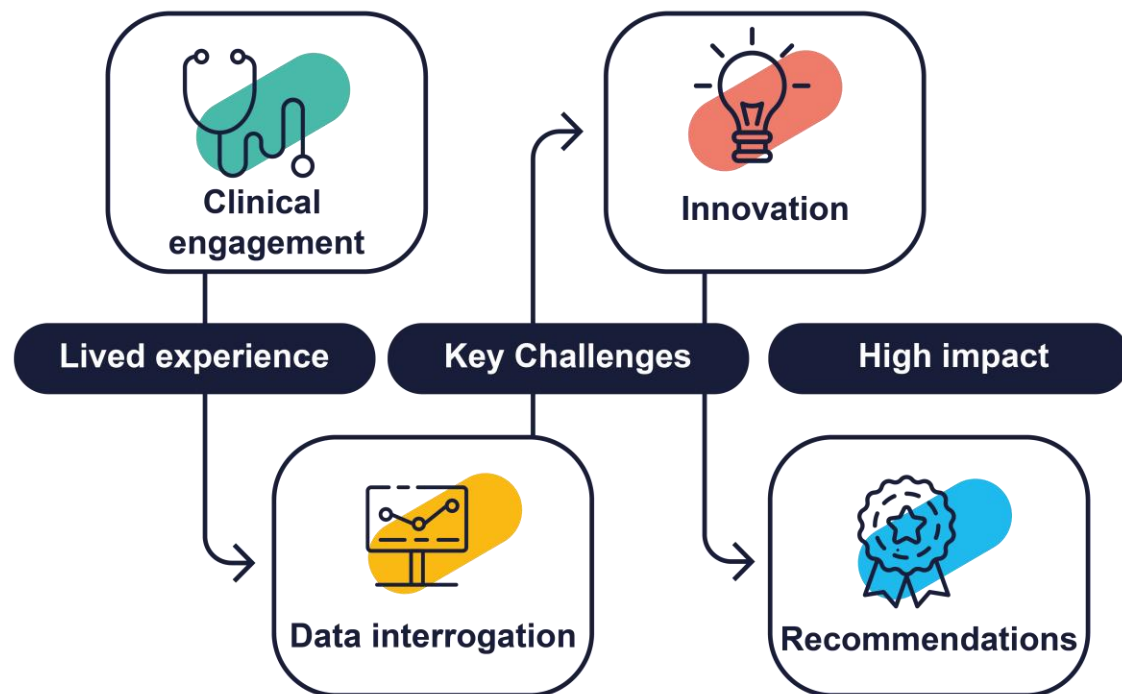
The Clinically-Led workforceE and Activity Redesign (CLEAR) Programme places clinicians at the heart of healthcare decision making and innovation and combines clinical insight and data analysis to create innovative new models of care and workforce redesign.

CLEAR is hosted and delivered in partnership with East Lancashire Hospitals NHS Trust.

Empowering the frontline to design innovative new models of care and workforce

The CLEAR methodology

The CLEAR methodology addresses the project's objectives through four key stages.



CLEAR methodology

1. **Qualitative:** Understand demand and lived experience of front-line team
2. **Quantitative:** Review and perform in-depth quantitative patient level data analysis
3. **Review** and understand key challenges and work with frontline teams to co-develop innovative new models of care and workforce
4. **Publish** recommendations and potential outcomes

The CLEAR transformation journey: from data-led redesign to real world impact

The CLEAR programme supports services to identify the right solutions, adapt them for wider use and deliver lasting impact. It offers an end-to-end approach to sustainable change, or modular support depending on requirements — always built with staff and patients at the centre.

Data-led redesign

Identifying the right solution for transformation

CLEAR Compact/Complete

Diagnose and validate

Understand system pressures and service needs using big data and clinical engagement

Design a new model of care (NMOC)

Develop evidence-based recommendations that reimagine how care is delivered

This stage unlocks transformation by defining what needs to change — and why — while designing new models of care that address future demand and improve patient outcomes.

Spread and scale

Tailoring and preparing proven models of care for wider adoption to accelerate change

CLEAR Focus

Adapt NMOC

Shape an existing model to fit local population needs and service context

Model / plan changes required

Use clinical engagement and scenario modelling to explore feasibility and impact

This phase accelerates transformation by scaling what works, with local flexibility.

Embed and deliver

Supporting services to turn plans into reality through structured implementation

CLEAR Implementation

Plan how to deliver

Align people, processes and systems to prepare for implementation

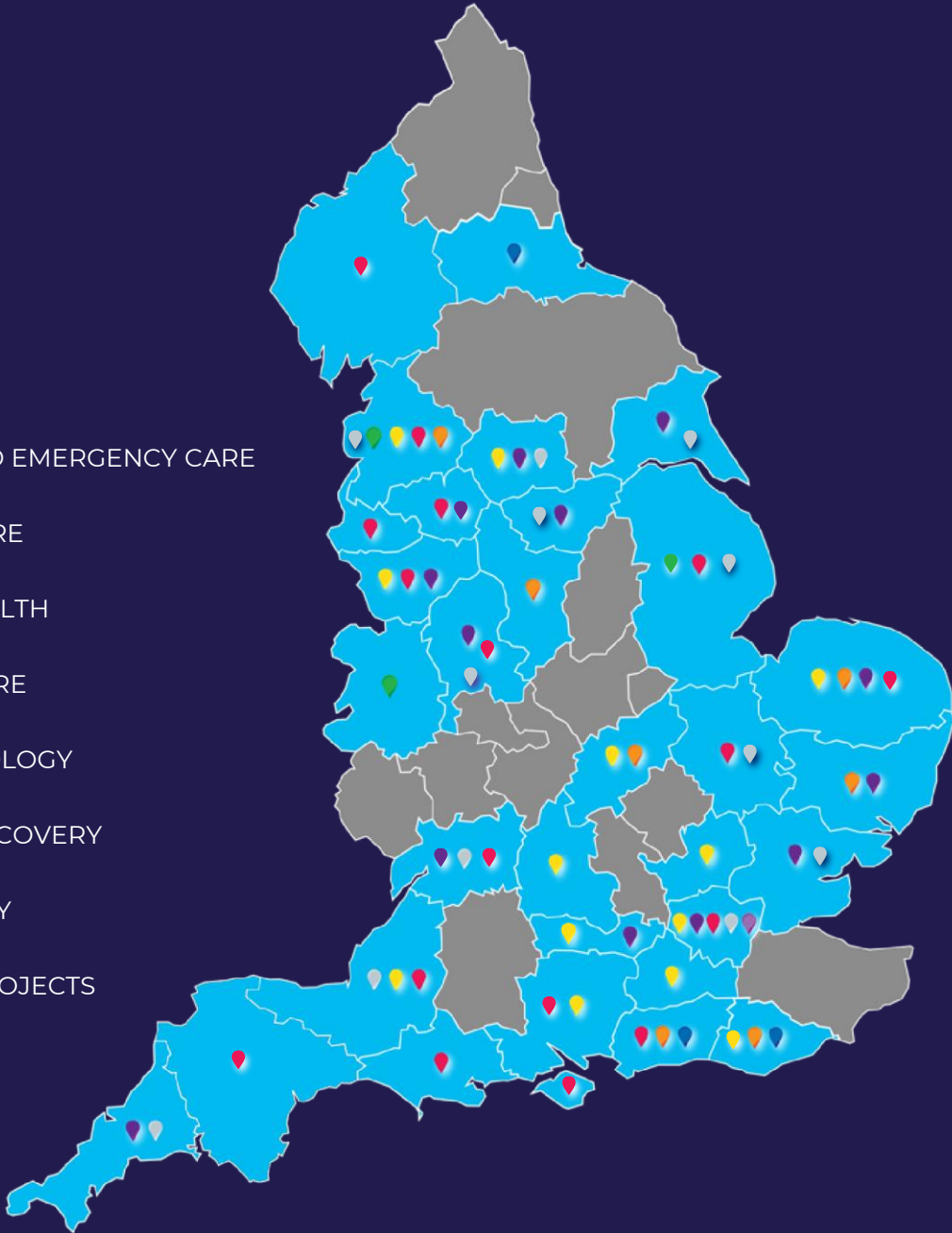
Adopt, implement, integrate

Provide real-time support, workforce planning and refinement through delivery

This is where transformation becomes reality — grounded in planning, supported through delivery, and refined through feedback.

CLEAR is supporting the NHS across key priority areas

- The programme has provided rapid support and training to the NHS during the COVID-19 pandemic and continues to support the NHS in restoring and transforming services.
- 90+ CLEAR projects have been completed or underway across key NHS priorities including UEC, mental health, primary care, elective recovery and ophthalmology.

- 
- A map of England is shown, with various regions highlighted in light blue. Numerous colored pins are placed across the map, indicating the locations of CLEAR projects. The pins are color-coded according to the legend: yellow for Urgent and Emergency Care, purple for Critical Care, green for Mental Health, red for Primary Care, blue for Ophthalmology, orange for Elective Recovery, light green for Respiratory, and grey for Bespoke Projects. The pins are distributed across all major regions of England, with a higher concentration in the south and central areas.
- 📍 URGENT AND EMERGENCY CARE
 - 📍 CRITICAL CARE
 - 📍 MENTAL HEALTH
 - 📍 PRIMARY CARE
 - 📍 OPHTHALMOLOGY
 - 📍 ELECTIVE RECOVERY
 - 📍 RESPIRATORY
 - 📍 BESPOKE PROJECTS

How CLEARaudit can help deliver the 10 Year Health Plan

Dr Matt Camilleri, CLEAR

12:45 | 5 minutes



How the audit works — and what it can and cannot see

The pipeline reads what the radiologist wrote. That is both its strength and its limit, and each one is measurable.

What it reads

- Routine free-text radiology reports and request data, **pseudonymised at source** — no new data collection and no additional clinical time
- A language model extracts the **PE outcome, Wells score, D-dimer result and follow-up recommendations** from every report
- 97,969 reports across ten trusts analysed in **around nine hours**
- It uses data the NHS already holds. The constraint on scale is **information governance, not technology**

How we know it is accurate

- Checked against a **three-clinician majority-vote standard** on 299 reports drawn from eight trusts
- **No PE missed in validation** among the 220 determinate cases (sensitivity 95% CI 93–100%); specificity 99.4%
- Agreement with the clinician consensus **at human level** — kappa 0.85, against 0.88 between the clinicians themselves
- Hedged or uncertain reports are **excluded rather than guessed** — 20–24% of records, a stable share across the period

What it cannot see — and why the finding holds

- **It reads reports, not images.** A clot the radiologist did not record cannot be counted
- If small clots are under-recorded, measured detection is **lower than the truth**
- But every comparison is **within the same trust over time**, so a consistent reporting habit largely cancels out
- In our data, subsegmental reporting became **more complete after 2020** — so the fall from 21.9% to 16.0% is, if anything, understated

The limits of the method are as measurable as its findings. Both are stated here.

Source: CLEAR CTPA Midlands validation exercise — 299 reports drawn from eight participating trusts by simple random sampling; 286 comparable after excluding 13 non-rateable rows; accuracy computed on the 220 determinate cases (51 PE-positive). Three independent clinician raters (one consultant radiologist, two resident doctors), majority-vote reference standard on the same report text. Subsegmental share of PE-positive reports across eight trusts with full coverage: 4.33% (2018) rising to 6.02% (2024); the subsegmental extraction flag is not separately validated.

Rising demand, falling detection

The test is being used more each year and finding proportionally less disease. Until now this could not be seen at scale.

Demand and detection have moved in opposite directions

- Emergency CTPA activity across the ten trusts is **3.3 times its 2018 level**
- Over the same period the **detection rate fell from 21.9% to 16.0%** — the lower limit of the RCR standard
- Recorded PE incidence in England roughly doubled over two decades, so **rising disease does not account for it**
- CT is the fastest-growing high-volume modality: **8.3m examinations in 2024/25, up 8.7%**

Variation between trusts is wide and persistent

- 2024 detection rate ranged between **9.9% to 24.0%** — a 2.4-fold difference between comparable acute trusts
- **Four of ten trusts were below the RCR 15% standard;** two have been below it in every year observed
- **Nine of ten** are below their own earlier performance
- The lowest detection rates fall on the **youngest patients** (7.2% under 30, against 19.2% over 80)

The productivity consequence

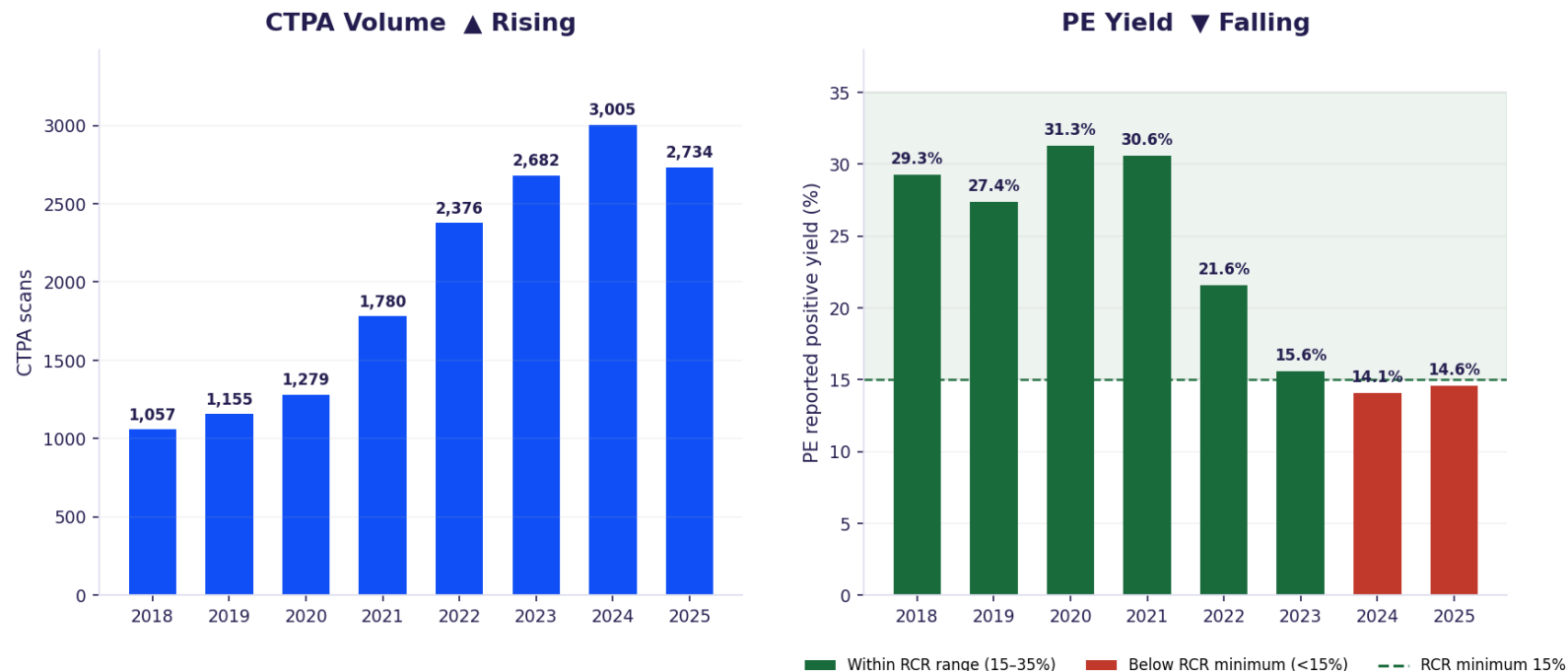
- **~3,200 examinations in 2024** across the ten trusts need not have taken place; **~43,100 scaled to England**
- **~2,700 consultant reporting sessions a year** — about **12.8 WTE** of reporting capacity
- Indicative financial scale **~£7.1m a year** in England (£477k across the ten trusts in 2024)
- Equivalent to **15.7% of all CTPA activity**
- **Reported as the scale of variation, not as a saving available to release**

One test, measured properly, shows the shape of a system-wide measurement gap.

Source: National CLEAR Programme CTPA Midlands pooled analysis, recomputed 26 July 2026, on the eight trusts with complete 2018–2024 coverage for trend, and all ten for 2024. PE incidence: Int J Cardiol (England 1997–2015, 50.2 to 97.8 per 100,000/yr); Lancet Reg Health Eur, Sep 2025. NHS England Diagnostic Imaging Dataset 2024/25. Some of the recorded incidence rise reflects increased ascertainment.

Worked example: CT pulmonary angiography

One acute provider. 16,070 emergency CTPA reports over eight years, read and classified by a validated AI pipeline.



16,070 emergency CTPA reports read and classified

+184% volume growth 2018→2024 (1,057 → 3,005 scans)

29.3% → 14.1% PE yield — now below the RCR 15% minimum

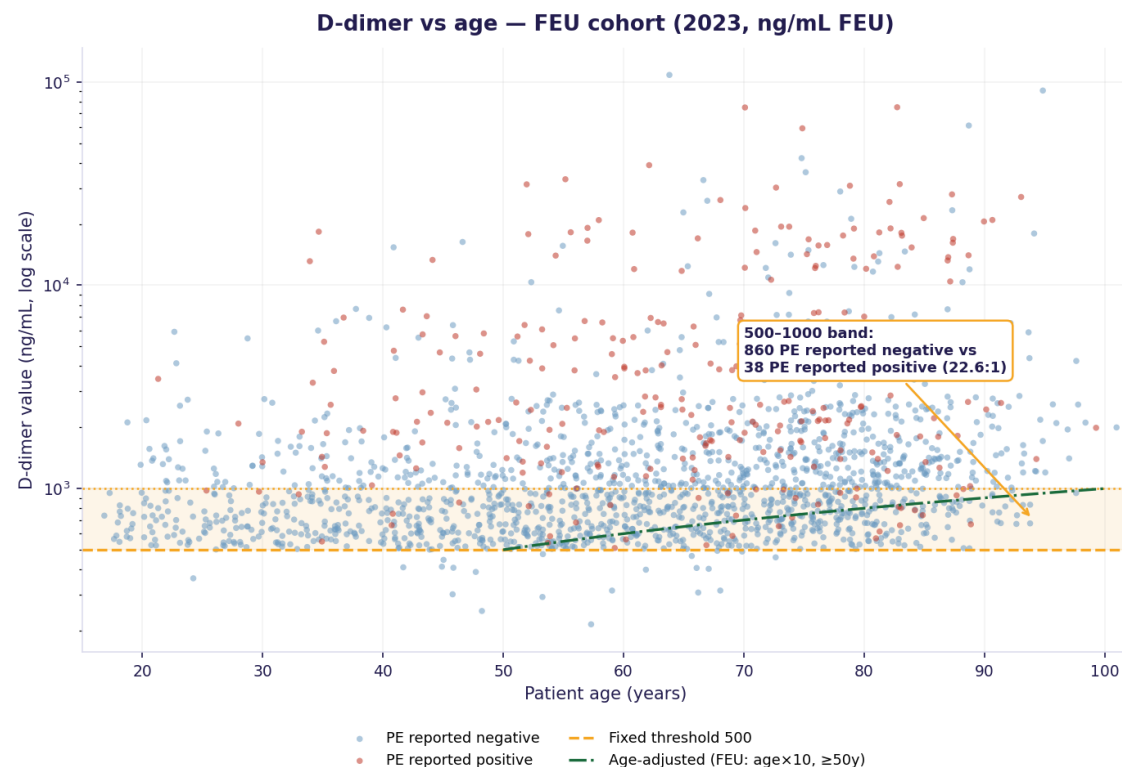
4.0 → 7.9 number needed to scan to find one PE

100% PE sensitivity (95% CI 93–100) against a three-clinician majority-vote reference standard; weighted kappa 0.85, within the range seen between the clinicians themselves.

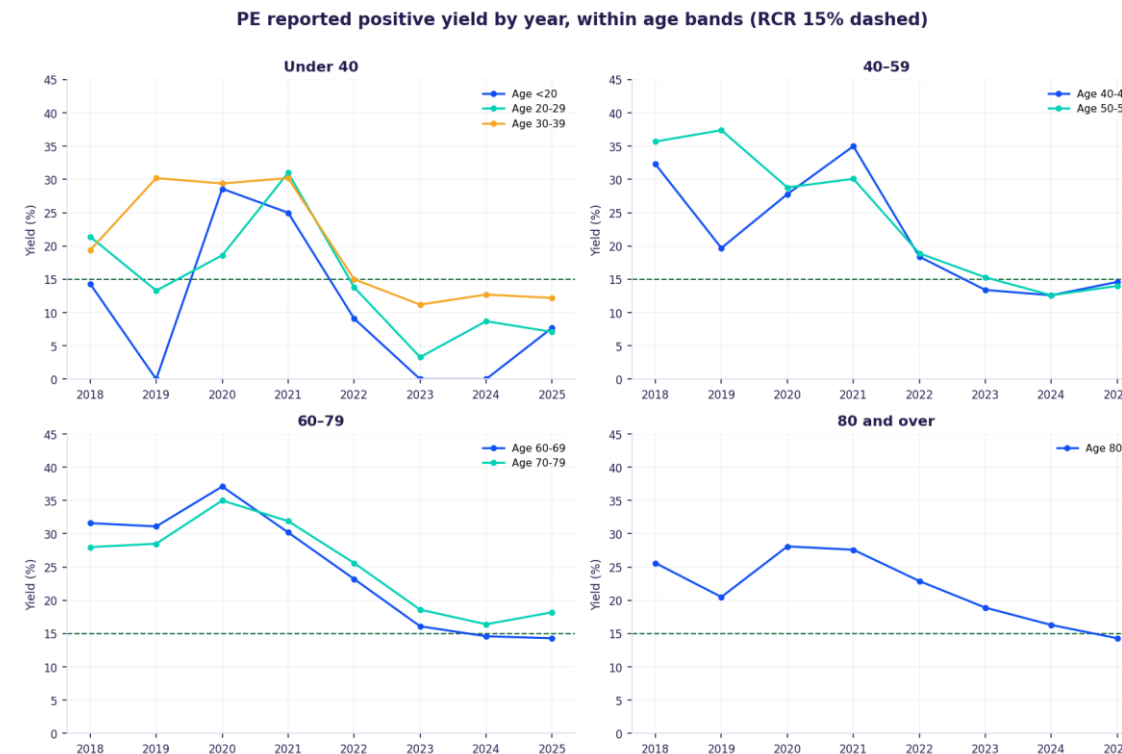
Demand nearly trebled while the share of scans finding a clot halved — a productivity problem visible only inside the reports.

Inside the variation

The same dataset then answers what a dashboard cannot: which threshold, which score, which cohort.



D-dimer 500–1,000 band: 860 PE-negative against 38 PE-positive (22.6 : 1).



Yield fell below the RCR 15% minimum in every age band.

Also visible: male yield 23.4% (NNS 4.9) against female 18.1% (NNS 6.2); 27% of scored requests sat at exactly Wells 3.0, yielding 15.2%.

Not just radiology

CTPA is one question against one free-text source. The same pipeline runs against any free text an acute provider already holds.

1 Other investigations

Echo, endoscopy, CT colonography, CTAP — any reported study. Delivered: a national CTC quality-assurance pilot benchmarking technique and reporting against national standards.

2 Clinic letters and notes

Findings recorded in prose but never coded — an echo result buried in a letter, a need behind repeat attendance. Surfaces true prevalence, not just coded prevalence.

3 Scored proformas

Whether the risk score was completed, and whether it discriminates. In CTPA, a quarter of requests sat at a single Wells value with a yield at the floor of the recommended range.

4 Referral and triage text

Advice & Guidance exchanges, straight-to-test decisions, safety-netting quality. A paediatric A&G proof of concept reached 92% agreement with clinician labels on synthetic data.

5 Outpatient follow-up

A blinded audit of follow-up decisions at a specialist trust: clinicians documented PIFU in 3.2% of contacts, independent assessment found 5.8% suitable.

6 Evidence for national audit

Practice measured against a published standard at whole-population scale, rather than a sampled return — the CTPA work is scored against the RCR AuditLive template.

The expensive steps happen once per site. Every question after that costs a fraction of the first.

Delivering the 10 Year Health Plan

Analogue to digital is not only new systems. It is finally reading what the NHS already wrote down.

1 From analogue to digital

No new collection, no new system, no change to the clinical record. The audit reads records the trust already holds, retrospectively, and hands back structured evidence.

2 The productivity ask

The Plan expects sustained annual productivity improvement [confirm: reported as 2% a year]. In the CTPA example, ~1,280 avoidable scans in the peak year — indicatively £179k–£205k of direct scan cost and ~427 radiologist reporting hours.

3 Transparency and ranking

Providers will be measured and ranked on published quality indicators. Free-text audit shows you the mechanism behind your own variation before the outcome is published for you.

4 AI with a clinician in the loop

The Plan is explicit that decisions are not made by the AI system. This is analysis-only: blinded, validated against clinician labels, and it never touches an individual's care.

The Plan sets the destination. This is how an acute provider measures its own pathways well enough to steer.

The impact of the CTPA audit at The Royal Wolverhampton

Dr David Rosewarne, The Royal Wolverhampton NHS Trust

12:50 | 10 minutes



The Royal Wolverhampton
NHS Trust



The National CLEAR Programme

Reducing low-value CTPA: Transforming demand
across two NHS trusts using AI

clearprogramme.org.uk



Reducing low-value CTPA: Transforming demand across two NHS trusts

**RWT & UHNM
analysed 35,000+
CTPA reports (2018–
2023)**

**AI-driven
categorisation
revealed rising
demand & falling
yield**

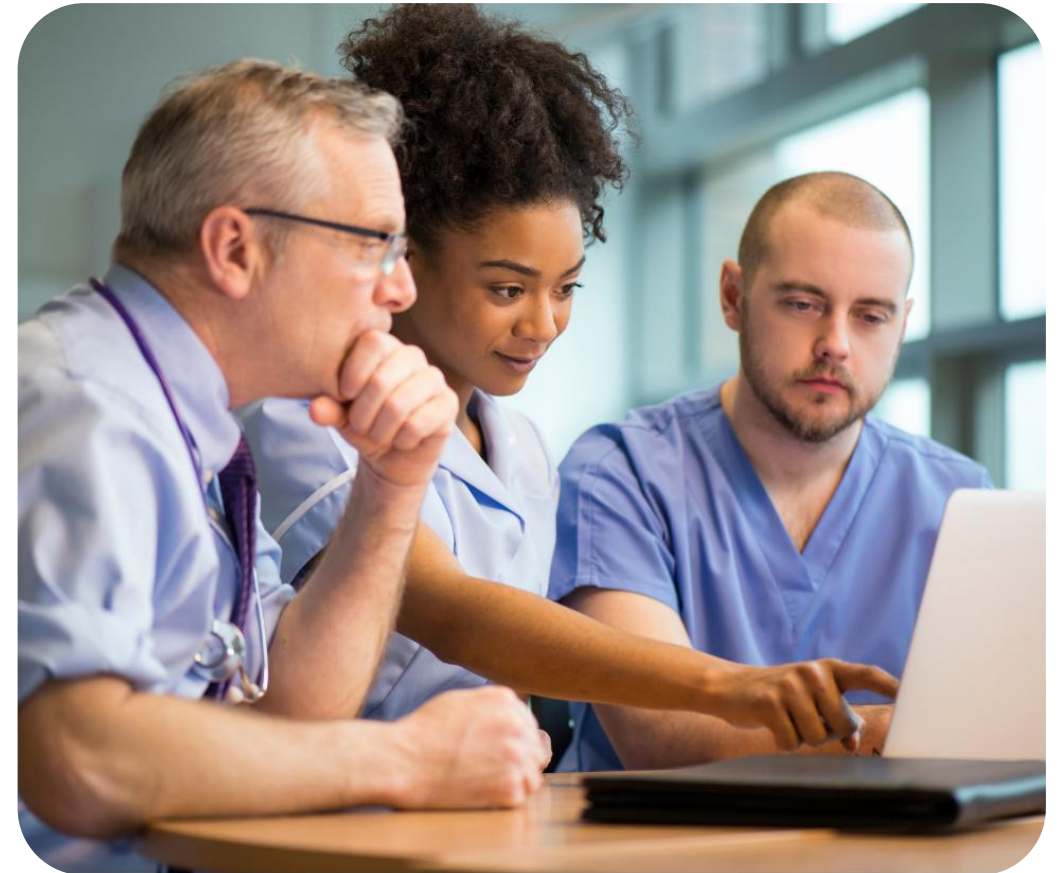
**Evidence-based
thresholds enabled
targeted change**

Key challenges identified

Doubling of CTPA demand over six years

**Significant drop in positive findings below
RCR's 15–35% recommendation**

Increasing volume of low-value imaging



Three levers for change



Cultural: Raise threshold for requesting imaging



Clinical: Consistent use of Wells score & PERC



Diagnostic: Revisit D-dimer thresholds to reduce unnecessary CTPAs

RWT: evidence-based D-dimer threshold revision

1

**Analysis showed all
'positive' CTPA
results below 700
ng/mL were false
positives**

2

**Issues linked to
artefact & cautious
over-reporting**

3

**Threshold updated
to age-adjusted
levels per NICE
NG158**

RWT: Impact



**New threshold
in place for 6
months**



**Approx. 10%
reduction in
CTPA volume**



**No adverse
safety events
reported**

System benefits beyond cost

Reduced radiation exposure

Freed imaging capacity for urgent diagnostics

Lower risk of inappropriate anticoagulation from false positives

Estimated £200k annual savings across both trusts



A scalable blueprint for the NHS

**AI-enabled report
classification + clinical
insight**

**Method expanded to 15
additional trusts in
Midlands**

**Supports reducing
unwarranted variation**

**Improves diagnostic
yield & relieves radiology
pressure**

Q&A about the CTPA

13:00 | 5 minutes



How benchmarking can support delivery of the 10 Year Health Plan

Emma Bamber, Customer Success and Growth Director, NHS Benchmarking Network

13:05 | 10 minutes



The questions benchmarking answers



How do we compare?

- Your position on activity, workforce, flow and cost against a national peer sample, not only against your own last year.



Is our variation warranted?

- Where you differ from peers, and whether case mix or service model explains it. Benchmarking sets the question; local review answers it.



Which way are we travelling?

- Your trend over time set against the trend in the sample, so you can see whether a change held or the whole sector moved.



Can we provide evidence?

- Independent, validated comparison to support business cases, board papers and productivity plans.

“As part of our continuous improvement journey to achieve an outstanding rating the insights and intelligence gleaned from benchmarking have played a pivotal role in our transformation programmes”

Julian Emms OBE, Chief Executive, Berkshire Healthcare NHS Foundation Trust

Where benchmarking fits in the 10 Year Health Plan



Hospital to community

Baseline admissions, referrals and length of stay against national peers.

Analogue to digital

Set a pre-implementation baseline and track digital return year on year.

Sickness to prevention

Target earlier intervention using flow, length of stay and readmission metrics.

Productivity and transparency

Evidence progress against the 2% productivity requirement through peer comparison.

“ED has utilised data from the previous benchmarking reports to inform not only service improvement ideas such as improving handover delays, but also the data such as the length of time spent in ED, supports the development of business cases when required.”

*Ben Thompson-Jones, Directorate Manager
Mersey and West Lancashire Teaching Hospitals NHS Trust*

Hospital to community: examples from Virtual Wards

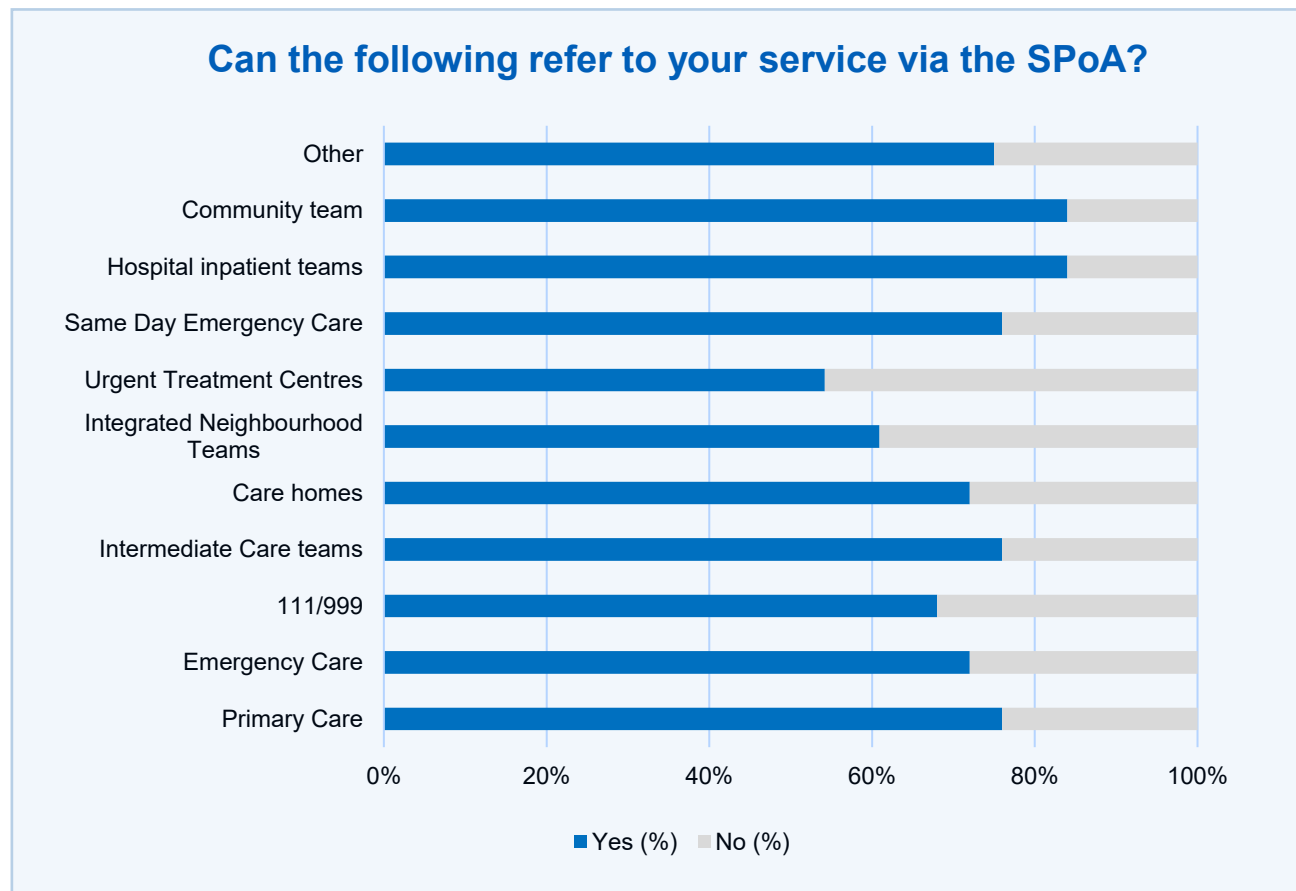


Fig 1. Summary chart from 2025 iteration of Virtual Wards

Further examples of the areas we benchmark

- Hours/days open to new admissions (weekday/weekend)
Reflects when the service can substitute for round-the-clock hospital care.
- Total virtual ward bed capacity, per head of population
Measure of capacity for what may otherwise be hospital care to be delivered in the home.
- Referral source mix: admission avoidance vs step-down
Splits admission-avoidance referrals from step-down/early-supported-discharge referrals.
- Admissions avoided by admitting to the service
Direct, patient-level admission-avoidance rate.
- Discharge destination and change in care package
Indicates whether the community episode reduced or increased ongoing dependency.

Analogue to digital: examples from Pharmacy and Medicines Optimisation

Examples of the areas we benchmark

- Percentage of inpatient, discharge, outpatient and homecare medicines prescribed digitally.
Use of digital solutions in different aspects of patient care.
- Dispensary automation: robot, controlled drug and cabinet use
Measures of digital maturity of pharmaceutical solutions in organisations.
- E-trading: Percentage of orders and invoices processed electronically including vs excluding homecare
Measure of digital maturity of stock and procurement processes compared to peers.
- Digital leadership and workforce: CPIO in post, WTE in digital roles
Understanding of workforce dedicated to digital work, compared to peer organisations.
- Clinical prioritisation tool available on EPMA
Digital maturity of processes in clinical pharmacy work, compared to peers.

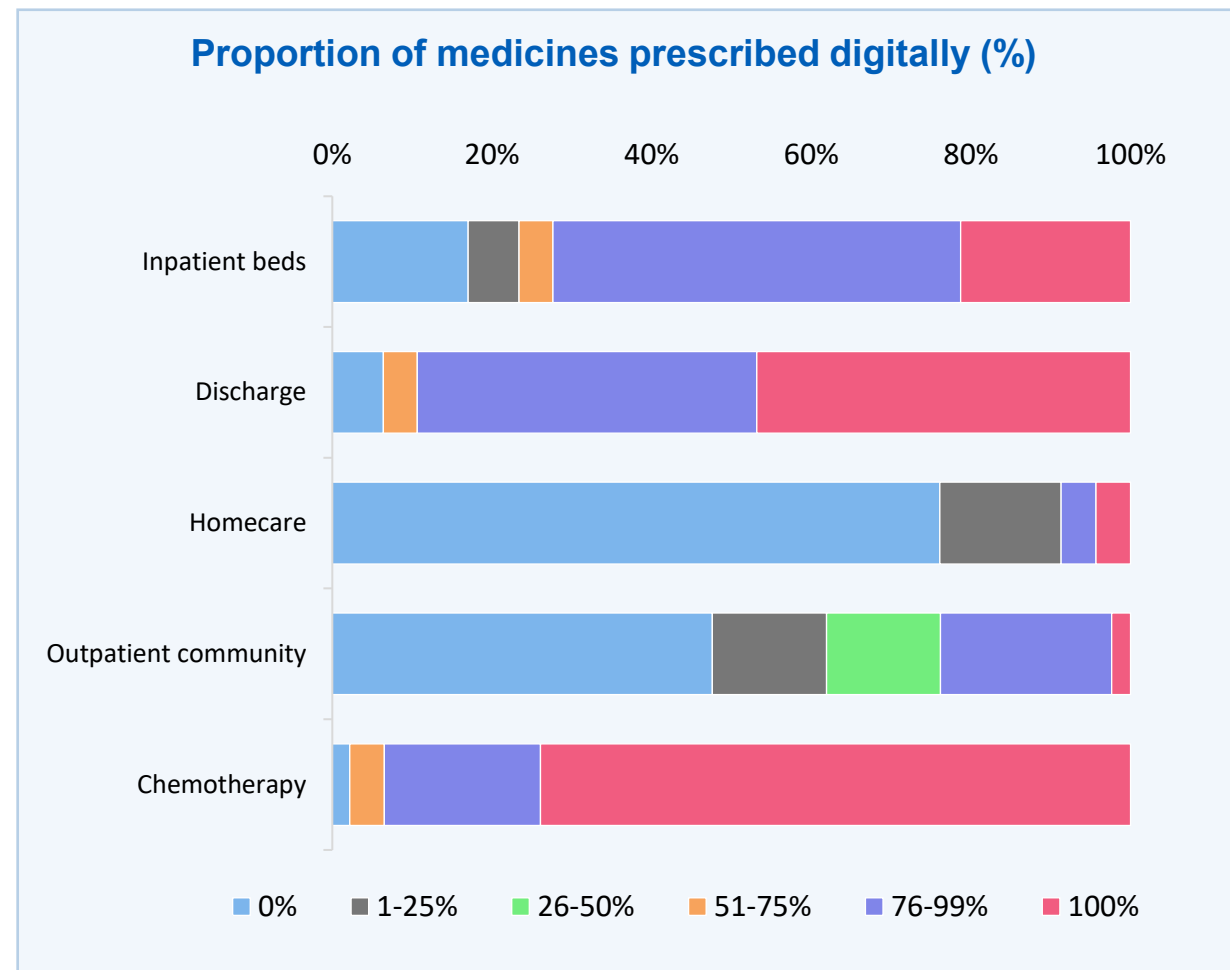


Fig 2. Summary chart from 2025 iteration of Pharmacy and Medicines Optimisation

Sickness to prevention: examples from Managing Frailty

How can benchmarking data help members to prevent patients becoming more acutely unwell?

Examples of the areas we benchmark

- Frailty screening coverage across care settings
Early identification in ED, SDEC, AMU and wards.
- Percentage of patients 65+ screened within 30 minutes
Benchmarks the Long Term Plan front-door target.
- Average time from arrival to frailty screening
Speed of early identification, directly comparable.
- Threshold CFS score that triggers a CGA
Standardisation of assessment trigger points.
- Falls with harm and pressure ulcers on COP wards
Core harm-prevention outcome metrics.
- Deconditioning schemes and advance care planning
Proactive prevention that avoids a future crisis.

Metric	0%	Yes (%)	100%	Example	Sample
<u>Is a "triple assessment" used in frailty screening?</u>				No	61.1%
<u>Is the CFS added to the patient's hospital record?</u>				Yes	92.3%
<u>Is CGA documented in a shared, hospital-accessible record?</u>				No	69.2%

Fig 1. Extract of sample dashboard report from 2025 iteration of Managing Frailty in a Bed-based Setting

Insight: screening coverage and speed are directly comparable against the Long Term Plan 30-minute target, and can be read alongside falls and pressure ulcer rates on care-of-older-people wards.

Productivity and transparency: examples from Emergency Care

Examples of the areas we benchmark

- Mean time in department; percentage within 4, 12 and 24 hours
Core national waiting-time performance, including the four-hour standard.
- Mean time from decision to admit to actual admission
Exit-block and flow bottleneck indicator.
- Ambulance handover: mean time and percentage within 30 and 60 minutes
Key national efficiency and flow metric.
- Total ED workforce WTE and nursing skill mix by band
Staffing level and skill-mix comparison against the peer sample.
- Sickness absence and staff turnover by staff group
Workforce stability and productivity indicators.
- Pay, non-pay and locum, bank and agency spend
Direct cost benchmarking and reliance on temporary staffing.

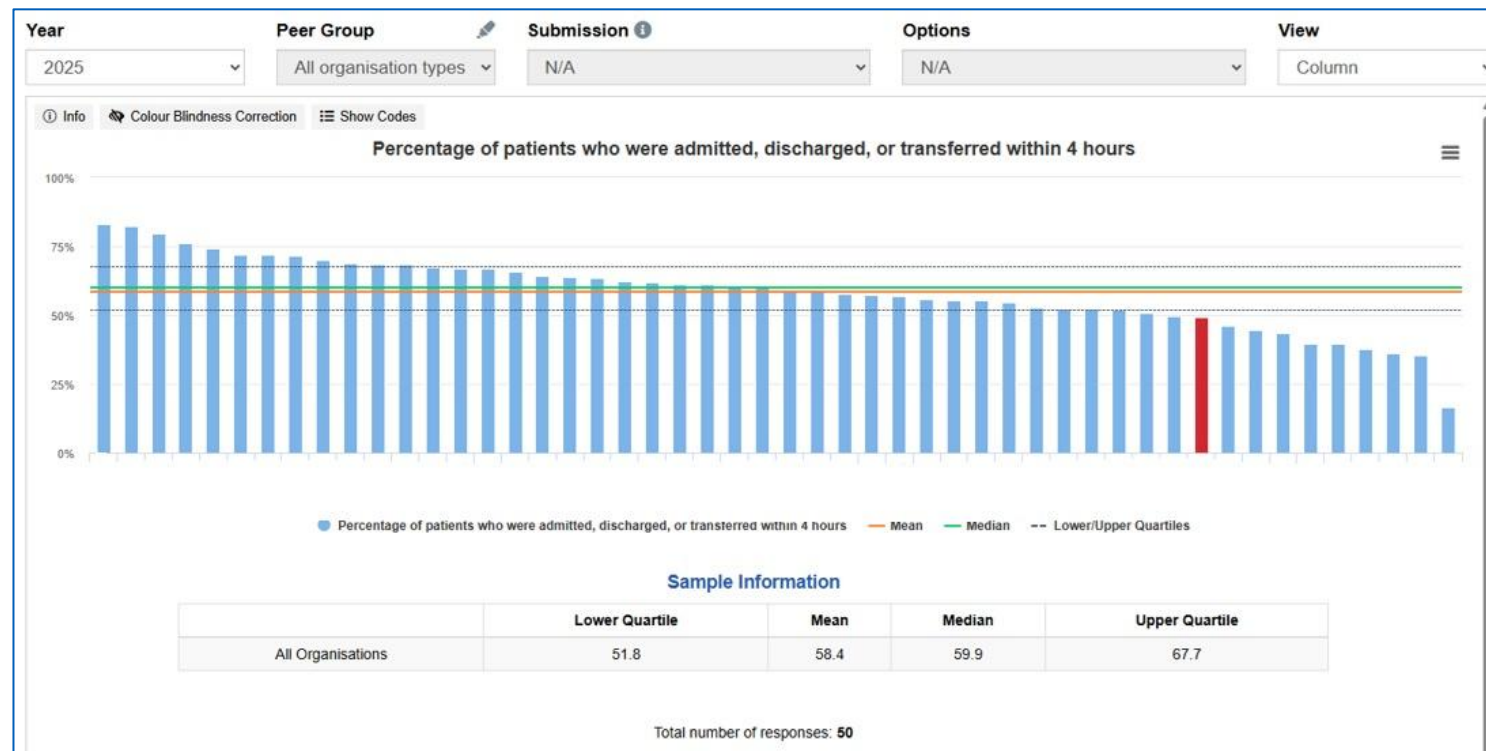


Fig 4. Screen grab of the data explorer for the 2025 iteration of Emergency Care

New for 2026: Clinical Coding Benchmarking

No national dataset lets an organisation compare how its coding service is structured, how productive it is, how accurate it is, or what it costs to run. **From March 2027, participating organisations will have that evidence.**



What the review covers

- A quality improvement review of coding as a service
- Service make-up and working practices
- Comparisons around over-coding and under-coding



Six data sections

- Overview and workforce
 - Activity and productivity
 - Accuracy and finance
 - Supporting information
- Service level only — no specialty or HRG analysis.*



What it helps you do

- Evidence staffing and skill mix decisions
- Quantify and contextualise backlog risk
- Strengthen assurance and governance

Clinical Coding 2026: specification is in draft; data collection opens this month with outputs from March 2027.

What acute membership includes

Insight and network: what every member gets

Online data explorers

Member participant reports

Shared learning compendiums

Networking opportunities

Dedicated support

Acute datasets:

- Emergency Care
- Managing Frailty in a Bed-based Setting
- Pharmacy and Medicines Optimisation
- Virtual Wards
- Clinical Coding

Plus: the CTPA AI Audit

An AI-supported audit of your CT pulmonary angiography reports, benchmarked against RCR standards.

Now included at no additional cost!

What others have done with the data

Frimley Health NHS Foundation Trust

Question Rising ED admissions of frail patients and delays to geriatric assessment.

Action A proactive frailty pathway with a frailty streamer in ED, rapid assessment clinics and virtual wards.

Outcome **40% fewer** acute frailty patients seen in ED, **84% more** seen in frailty assessment areas, CGA completion up **81%**.

Gloucestershire Hospitals NHS Foundation Trust

Question The frailty assessment unit was blocked, with stays beyond the intended 72 hours.

Action Extended operating hours, six short-stay beds, a paramedic advice line and closer working with community teams.

Outcome Average length of stay in the frailty assessment unit fell from **16 days to 2 days**.

The impact of benchmarking at University Hospitals of Leicester NHS Trust

Ben Shaw, Director of Financial Sustainability,
University Hospitals of Leicester NHS Trust

13:15 | 5 minutes



**University Hospitals
of Leicester**

NHS Trust



The benchmarking approach at University Hospitals of Leicester NHS Trust



University Hospitals
of Leicester
NHS Trust

1

Benchmarking data collections completed

2

Benchmarking outputs received

3

Comparison of benchmarking data to:

- Five-year plan
- CIP targets

4

Identification of cost saving and improvement opportunities

5

Tracking of achievements against identified cost saving and improvement opportunities

- Through the year
- At end of year

Q&A about how to get the most out of benchmarking

13:20 | 5 minutes



Find out more

Three ways to take this further after today's session.

Provide your details to talk to us about membership

Membership is the route in: acute, community, mental health and cross-sector datasets, member reports and the data explorers.

Acute membership also includes the AI-supported CTPA audit at no additional cost.

Book to meet with a member of team

We will share a link in the chat, you can book in directly with a member of the team to hear more.

Stay in touch with the Network

Slides and the recording will be available on the NHSBN Website.

Follow us on LinkedIn for future updates or sign up for our Newsletter.

Get in touch: nhsbn.enquiries@nhs.net

Thank you

For any further information, please get in touch:

nhsbn.enquiries@nhs.net

www.nhsbenchmarking.nhs.uk