

WORKED EXAMPLE (ILLUSTRATIVE)

Data strategy for a multi-site hospital and clinic group

From vision to scorecard, one level at a time

THE SO WHAT OF THIS DECK

See how a hospital group puts patient safety and privacy first while still funding patient flow, and adapt its clinical safety gate for your own models.

THE SITUATION

An independent hospital and clinic group with four acute hospitals, 22 outpatient and diagnostic clinics and about 9,000 staff, funded through public commissioning contracts and insured and self-paying patients. Planned-care waiting lists are long and beds are blocked by delayed discharges, while a privacy incident and a clinical coding audit have put data governance on the board agenda. The strategy must make care safer and records more trustworthy while getting patients through the system faster.

What we decided at each level, and so what

Level	What we decided, and why	So what for the data strategy
Vision	The board anchored the vision on safe, timely care and named the patient record explicitly, because the privacy incident showed that trust in data is part of trust in care.	Report patient data privacy and accuracy to the same quality committee as clinical safety, not to a separate IT forum.
Mission	The mission commits to joining up care across hospitals and clinics, which only works if a patient is recognised as the same person at every site.	Make the single patient index the first defensive data product, because every safety and flow use case depends on matched records.
Strategic choices	Leadership chose to compete on safety and reliable waits within the region, and ruled out primary care, new regions and models without clinical safety sign-off.	Write the clinical safety gate into the data operating model now, so no predictive model reaches a ward without it.
Themes	Three themes protect patients and income (safety, trusted records, sustainable finances) and one, patient flow, creates the capacity for growth.	Fund trusted records first, because flow and safety analytics are only as good as the records beneath them.
Strategy map	The map shows the patient index and data standards (L1) beneath safety, flow and coding processes at once, and harm (C1) driving length-of-stay cost (F3).	Because three process objectives rest on L1, sequence patient index consolidation ahead of any new analytics build.

What we decided at each level, and so what (continued)

Level	What we decided, and why	So what for the data strategy
Data objectives	Four of six data objectives are defensive (patient index, access and consent, coding, early warning), matching the 40 per cent offence posture; capacity and demand forecasting carry the growth case.	Protect a fixed share of analyst time for the capacity view, so remediation work does not consume the whole team.
Scorecard	Lag measures on harm, waits, delayed discharges and lost coding income are paired with lead measures on record matching, access monitoring and coding timeliness.	Track coding timeliness weekly, because it moves income within a month and helps fund the rest of the strategy.
Portfolio	Coding completeness checks and bed and discharge planning scored highest on value and feasibility; deterioration early warning is high value but needs clinical validation first.	Start with coding checks and the bed view for quick, measurable wins, and take the early warning model through clinical safety review in parallel.
Roadmap	H1 closes the governance gaps behind the incident and audit, H2 builds the capacity command centre and pilots harm surveillance, and H3 scales both across the group.	Hold harm surveillance to a two-ward pilot until the patient index and observations feed have proven reliable.

The cascade: vision to choices

Leadership chose to compete on safety and reliable waits within the region, and ruled out primary care, new regions and models without clinical safety sign-off.

Vision	To give every patient safe, timely care close to home, with a record they and their clinicians can trust.
Mission	We diagnose, treat and support patients across our hospitals and clinics, joining up their care through skilled people, sound clinical processes and trusted information.
Winning aspiration	Be the region's safest and most dependable provider of planned and acute care, with the shortest reliable waits and a clean record on privacy and coding.
Where to play	Planned surgery, diagnostics and outpatient care for publicly funded and insured patients in our region; Acute and emergency care at our four hospitals, linked to our clinics for follow-up; Our region only, partnering with primary and community care rather than owning it
How to win	Safety first: avoidable harm detected and prevented early, with learning shared across sites; Flow: beds, theatres and clinics scheduled as one system across the group; Trust: patient data kept private, accurate and correctly coded, so both care and income are right
Capabilities	Single patient index linking records across hospitals and clinics; Live bed, theatre and clinic capacity management across sites; Clinical documentation and coding quality before every submission; Patient safety surveillance and incident learning; Privacy, access monitoring and consent management in every clinical system
We will not	We will not expand into primary care or new regions during the strategy period; We will not let predictive models influence clinical decisions without clinical safety sign-off; We will not use identifiable patient data beyond direct care without a lawful basis and clear patient information
SO WHAT	Write the clinical safety gate into the data operating model now, so no predictive model reaches a ward without it.

Strategic themes

Three themes protect patients and income (safety, trusted records, sustainable finances) and one, patient flow, creates the capacity for growth.

T1 Patient safety

Detect and prevent avoidable harm, and learn from every incident across sites.

T2 Patient flow

Get patients through clinics, theatres and beds faster by running capacity as one system.

T3 Trusted records

Keep every patient record private, accurate, matched and correctly coded.

T4 Sustainable finances

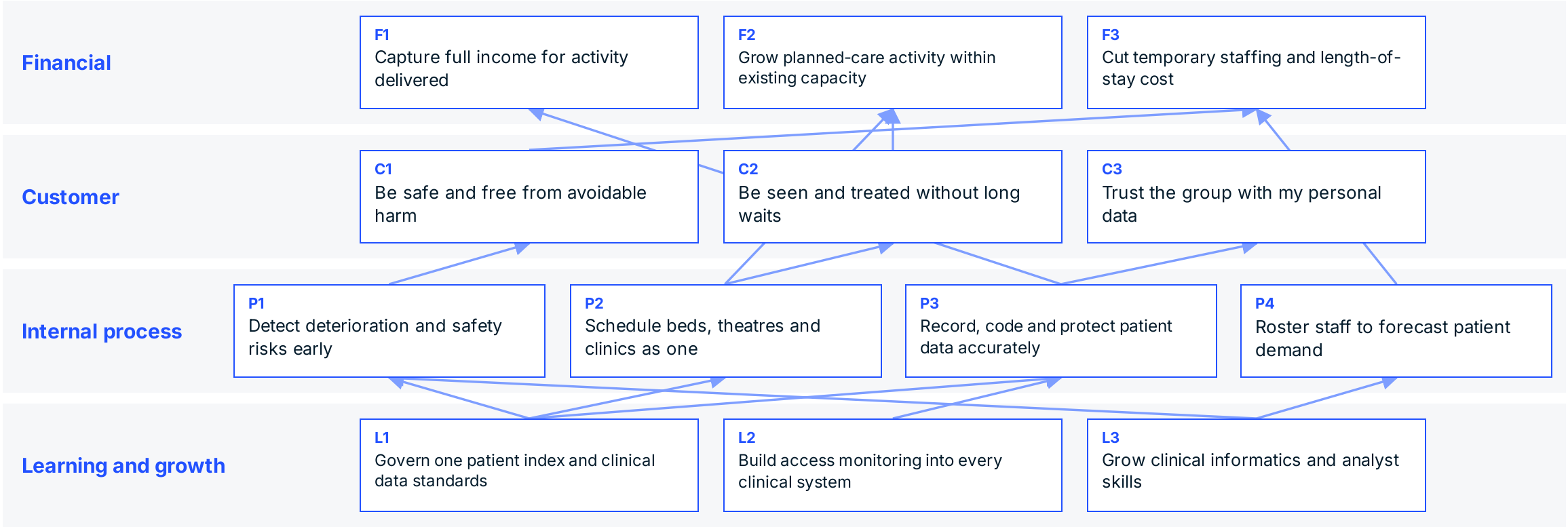
Fund rising demand by capturing income correctly and cutting avoidable cost.

SO WHAT

Fund trusted records first, because flow and safety analytics are only as good as the records beneath them.

Strategy map: cause and effect on one page

Illustrative. Arrows run from cause to effect; learning and growth enables process, process serves customers, customers drive the financials.



SO WHAT Because three process objectives rest on L1, sequence patient index consolidation ahead of any new analytics build.

Posture: 40% offence, 60% defence

A privacy incident and a coding audit make governance non-negotiable, and safety surveillance depends on accurate, matched records, so most effort goes to defence; patient flow is the growth lever, so a protected two-fifths of capacity goes to capacity and demand analytics.

Defence objectives

- D1 Maintain one patient index matching every hospital and clinic record
- D2 Monitor access to patient records and enforce consent at source
- D3 Raise documentation and coding completeness before each monthly submission
- D4 Give clinical teams early warning of deterioration and rising harm

Offence objectives

- D5 Provide one live view of bed, theatre and clinic capacity
- D6 Forecast demand by specialty and site to plan rosters and theatre lists

Data objectives, traced to the strategy map

ID	Data objective	Serves	Type
D1	Maintain one patient index matching every hospital and clinic record	L1, P2	Defence
D2	Monitor access to patient records and enforce consent at source	L2, C3	Defence
D3	Raise documentation and coding completeness before each monthly submission	P3, F1	Defence
D4	Give clinical teams early warning of deterioration and rising harm	P1, C1	Defence
D5	Provide one live view of bed, theatre and clinic capacity	P2, C2	Offence
D6	Forecast demand by specialty and site to plan rosters and theatre lists	P4, F2	Offence

SO WHAT

Protect a fixed share of analyst time for the capacity view, so remediation work does not consume the whole team.

Data strategy scorecard

Illustrative baselines and targets.

Perspective	Objective	Measure	Type	Baseline to target	Initiative	Owner
Value	Prevent avoidable harm	Inpatient falls and pressure injuries causing harm per 1,000 bed days	Lag	2.4 to 1.6	Deterioration and harm surveillance	Chief medical officer
Value	Shorter waits for planned care	Planned-care patients treated within 18 weeks of referral	Lag	64% to 80%	Group capacity command centre	COO
Value	Capture full income	Activity income lost to incomplete or late coding	Lag	3.1% to 1.0%	Clinical coding improvement	CFO
Stakeholder	Discharge patients when ready	Medically ready patients still in hospital after 24 hours	Lag	18% to 10%	Group capacity command centre	Chief nurse
Stakeholder	Clinical leads use the capacity view	Ward and theatre leads using the live capacity view daily	Lead	0% to 85%	Group capacity command centre	COO

SO WHAT

Track coding timeliness weekly, because it moves income within a month and helps fund the rest of the strategy.

Data strategy scorecard (continued)

Illustrative baselines and targets.

Perspective	Objective	Measure	Type	Baseline to target	Initiative	Owner
Data operations	One record per patient	Patient records matched to a single index entry	Lead	86% to 99%	Patient index consolidation	Head of health records
Data operations	Access under watch	Clinical systems with automated access monitoring	Lead	2 of 11 to 11 of 11	Privacy and access monitoring	Data protection officer
Data operations	Coded on time	Inpatient episodes coded within five working days of discharge	Lead	61% to 95%	Clinical coding improvement	Head of clinical coding
Capability	Ownership in place	Critical data domains with a named clinical or operational owner	Lead	1 of 6 to 6 of 6	Clinical data governance board	Chief clinical information officer
Capability	Informatics skills on the wards	Clinicians and managers trained in data and safety analytics	Lead	40 to 400	Clinical informatics academy	Director of workforce

Prioritised use cases

Use case	Theme	Value	Feasibility	Decision it improves
Bed and discharge planning	T2	5	4	Which patients can go home today, and what is holding each of them up?
Coding completeness checks	T3	4	5	Which episodes are under-coded or missing documentation before submission?
Harm and incident pattern analysis	T1	4	4	Which wards, procedures or shifts show rising harm, and what is driving it?
Theatre list optimisation	T2	4	4	How should we fill and sequence theatre lists so no session runs short?
Inappropriate access detection	T3	4	4	Which record accesses look inappropriate and need investigation today?
Deterioration early warning	T1	5	3	Which inpatients need a senior clinical review in the next hour?
Demand-led rostering	T4	4	3	How many nurses, with which skills, does each ward need next week?
SO WHAT	Start with coding checks and the bed view for quick, measurable wins, and take the early warning model through clinical safety review in parallel.			

Build once, use many: data products by use case

Coding completeness checks and bed and discharge planning scored highest on value and feasibility; deterioration early warning is high value but needs clinical validation first.



SO WHAT

Start with coding checks and the bed view for quick, measurable wins, and take the early warning model through clinical safety review in parallel.

Roadmap

H1 closes the governance gaps behind the incident and audit, H2 builds the capacity command centre and pilots harm surveillance, and H3 scales both across the group.

Horizon 1: 0-6 months

- Clinical data governance board: owners named for six critical data domains, with clinical safety sign-off for models
- Privacy and access monitoring on the four highest-risk clinical systems
- Patient index consolidation across the four hospitals, then the clinics
- Clinical coding improvement: completeness checks before each monthly submission

Horizon 2: 6-18 months

- Group capacity command centre with a live bed, theatre and clinic view across all sites
- Deterioration and harm surveillance piloted on two medical wards under clinical safety review
- Theatre list optimisation in the two busiest hospitals
- Clinical informatics academy: first 200 clinicians and managers trained

Horizon 3: 18-36 months

- Deterioration and harm surveillance extended to all adult inpatient wards
- Demand-led rostering for nursing across every site
- Privacy and access monitoring on all eleven clinical systems, with records shared with community partners for direct care

SO WHAT

Hold harm surveillance to a two-ward pilot until the patient index and observations feed have proven reliable.

The first 100 days

Weeks 1-2: Mandate and safety baseline

- Data strategy mandate agreed by the board, with the chief medical officer, COO and CFO as sponsors
- Baselines for harm, waits, delayed discharges and coding income loss agreed with finance
- Actions from the privacy incident and coding audit folded into one plan

Weeks 3-6: Control foundations

- Clinical data governance board running, with data owners named
- Access monitoring designed for the highest-risk clinical systems
- Patient matching rules agreed across hospital and clinic systems

Weeks 7-10: First value on the wards

- Coding completeness checks live before the monthly submission
- Live bed view piloted in one hospital's daily discharge meeting
- Use-case portfolio scored and sequenced with clinical leads

Weeks 11-14: Prove and fund

- Recovered coding income and delayed-discharge change reported against baseline
- Funding case for the capacity command centre and harm surveillance
- Data strategy scorecard reviewed monthly at the quality committee

SO WHAT

Leave day 100 with an approved roadmap, a funded first tranche, live forums and two quick wins in delivery.

Build yours

- Strategy Cascade and Scorecard Workbook: the templates behind this example
- Scorecard Measures Library: measures and definition cards
- Strategy Workshop Kit: the three workshops that produce it

scikiq.org/data-strategy