UNDERSTANDING AND MEASURING OPERATING THEATRE COSTS
(What Worked For Us!!!)

MARCH 2014

SouthWest Healthcare
• Background to the project
• Organisational environment
• Governance structure that emerged
• Outline 2 key areas of improvement
  – Theatre schedule (costs)
  – Managing activity (revenue)
• Did it work?
• Key messages
• 272 beds (216 acute, 36 aged care and 20 mental health) with inpatient sites at Warrnambool and Camperdown
• Warrnambool Campus (212 beds) provides acute, rehabilitation and mental health care
• 3 operating theatres
• Extensive outpatient and community services
• Annual operating budget of $135 mill
• Recently completed $120 mill capital redevelopment
NEW HOSPITAL
In 2011 the South West Healthcare theatre suite was under pressure:
- Waiting list higher than we would like
- Hospital initiated postponements higher than we would like
- Increasing overtime
- Unclear governance/decision making structure

Underpinned by a perceived lack of theatre data to support improvement initiatives.

Mr Denis O’Leary was engaged to assist a theatre redesign project known as ‘The Perfect list’.
What did we all agree on

• Waiting lists were not acceptable.
• There was waste in the system.
• Everybody was paddling hard but maybe not in the same direction.
• Difficult to see a solution without additional:
  o WIES funding
  o Operating theatres
    i.e. we were operating to capacity - even if we get more efficient we can’t treat any more patients!!!
To address the challenges in a meaningful way a new approach was required:

- **Executive ownership:**
  - CEO attended initial workshops with medical and nursing staff and stayed engaged.

- **Finance were "welcomed" into the fold!!!**
  - Finance became involved in a positive way and we developed a language we could both understand.

- **We had an independent expert to keep things on track:**
  - Denis O’Leary brought credibility and independence to discussions.
• *Initial priorities driven by clinicians and patient outcomes (nothing to do with $$$):*
  o Hospital initiated postponements
  o Waiting list
  o Extent of out of hours work
  o Lack of certainty/control on operating lists
  o “frustration”

• The initial priorities were:
  o Revise operating schedule
  o Understand and manage activity
GOVERNANCE AND DECISION MAKING

- Created a decision making forum (Surgical Services Committee).
- Engaged the key groups including Executive and Medical Specialist groups.
- Reinforced Medical Clinical Director role (PD reviewed/clinical meeting established).
- Provided data/information to everybody through Surgical Services meeting.

(underpinned by Denis O’Leary when we hit a crossroad)
It became clear that the theatre schedule was the key to addressing the major pressure points:

- Initial review by Denis O’Leary suggested significant capacity efficiencies could be gained.
- Significant nursing overtime.
- Regular unscheduled “out of hours” work.
- Limited ability to manage/influence when work was done.
- Limited ability to manage what cases were being done.
- Parties acting in good faith and working hard but the system was reactive not proactive.
- Capacity to manage waiting list.
We struggled!!!

The project fell in the middle of implementing a new patient management system which resulted in significant frustration but we tried to identify key indicators that were:

- Available in a timely manner.
- Understandable across all key players.
- Covered off the areas of significant risk.
- Focused on the areas that were identified as targeted improvements.
• Developed indicators that enabled us to focus on the issue:
  o Emergency work
  o Overtime

• Analysis suggested a significant amount of overtime was “predictable” and as such should be converted to “in hours” where possible.
• Modelling suggested new schedule would create significant additional capacity.

• Schedule developed to largely mirror existing allocations i.e. individual surgeons would have similar operating time in new schedule.

• Risk that spare capacity was filled with “emergency” activity and WIES and cost pressure would result.

• Risk that additional “closures” would be required to manage the increase.

• Needed to develop a tool that was both timely and transparent.
How do we monitor?

- Monitoring of contact hours occurs at a weekly level for both elective and emergency work. This can also be drilled down to a speciality level.

- Monitoring of WIES occurs at a monthly level after the WIES for the previous month has been recorded.

- Progress to be reported to the Surgical Services Committee with adjustments to the activity profile, if necessary, being agreed to and supported by the group.
It worked!!!

• Patient access improved
  – Cancellations reduced
  – Waiting list improved significantly

• Safer working hours for patients and staff
  – Majority of work being completed in rostered hours

Believe it or not

• Saved money (entity operating in surplus as well)
• Operating within WIES targets
KEY MESSAGES

- Governance/reporting structure
  - Key people must be at the table and engaged
  - Structure required to create the discipline to maintain change
  - If possible, good independent assistance is invaluable

- Agreed shared goals/principles (not financial!!!)
  - Reduce HIPs
  - Manage and reduce waiting list
  - Out of hours work should be minimised
  - Actively manage activity
• Simple shared indicators to support principles
  o In hours/out of hours activity
  o Total contact hours (with detailed break up available)
  o Employee costs
• Focus on what can be managed
  – Efficient schedule
  – Employee costs
  – Manage within funded activity levels
• Focus on data that is available
  – Timely
  – Everybody understands
From a Finance perspective

- the project was not driven by financial goals (they were a by product)
- Massive amount of data available – find the data that supports the objective (everyone will be different)
- Keep the data as simple as possible
- Focus on the bigger issues and don’t get caught up with needing every piece of detail before proceeding
- Finance need to gain a better perspective of the challenges and “share the risk”
- Get the front line people to lead the project (plus Finance)