



**MANAGEMENT
OF OPERATING
THEATRES IN
NORTHERN
IRELAND**

CREST
CLINICAL RESOURCES EFFICIENCY SUPPORT TEAM

Background

As part of its continuing study of ways to improve the efficient and effective use of clinical resources, the Clinical Resource Efficiency Support Team (CREST) set up a Working Group to look at operating theatre utilisation and management. The membership of the Working Group which was chaired by Dr J D Laird, Consultant Radiologist (Royal Victoria Hospital) is listed in [Appendix 1](#).

Estimates of the cost of operating theatres vary widely from £151 per hour (Bevan report 1989) to £450 per hour (National Audit Office report 1987). Although this variation illustrates the absence of reliable information; all agree that operating theatres are very expensive to run. Effective management of resources is, therefore, particularly important.

The sub-committee met on a number of occasions and discussed a wide variety of matters relating to the efficient use of operating theatres. Much of the discussion centred on a booklet "Efficiency of Theatre Services" produced in September 1989 by the Association of Anaesthetists of Great Britain and Ireland and the Association of Surgeons of Great Britain and Ireland.

Recommendations

Following their deliberations the Group made the following recommendations.

1. The booklet "Efficiency of Theatre Services" is the most concise and useful report available on this problem. The sub-committee would therefore recommend this booklet to all concerned with theatre management and hospital management in general. (Copies of the booklet can be obtained free of charge by contacting the CREST Secretariat in Dundonald House). The recommendations of the Report are set out in [Appendix 2](#).

2. The sub-committee was unanimous in the view that the most vital element in the improvement of operating theatre efficiency is development of an effective management structure. They endorsed the concepts put forward in Section 1 of the "Efficiency of Theatre Services" booklet. These concepts include the appointment of a Theatre Services Director in addition to a Theatre Superintendent or Theatre Manager. The sub-committee felt that this structure was suitable for all large and medium sized hospitals, but not for small hospitals. In the latter case it was felt that theatres should be managed by a Theatre Superintendent (with adequate clerical help), provided there is a strong and active User's Committee to whom the Superintendent regularly reports.
3. While endorsing the views on Urgent and Emergency surgery (section 3), the sub-committee felt that consideration should be given to a high dependency nursing unit to receive patients operated upon late in the day or at night.
4. The sub-committee entirely endorsed the views on Special Theatres (section 4). The members felt that theatres should not be wholly reserved for particular specialties. Even in the case of Cardiac Surgery or Neurosurgery, where specially equipped theatres are required, these should be available to other specialties when not in use. This principle would also apply to laminar flow theatres. The appropriate allocation of these theatres was seen as an important task for the Theatre Director and Theatre Manager.
5. The section on Medical Staff (section 5) was also endorsed, but the sub-committee drew particular attention to problems arising from absence of staff on annual and study leave. Leave entitlements limit the working year of both anaesthetists and surgeons. If statistics do not recognise this feature the impression of correctable inefficiency is falsely created. Locum cover during holidays, or the appointment of additional permanent staff is therefore recommended.

6. List management and pre-operative anaesthetic assessment (section 6) was recognised as an extremely difficult area. Pre-operative outpatient assessment clinics were shown to have major drawbacks. The sub-committee felt that the most important single feature was good liaison between individual surgeons and anaesthetists. This should allow potential anaesthetic risk patients to be identified in advance.
7. As regards cancellation and underutilisation of lists (section 7), the sub-committee felt that a fixed period of notice (perhaps 3 weeks) should be required for cancellation of any operation list. Cancellation in less than this time would mean that the session would be recorded as underutilisation by the surgeon. Cancellation more than 3 weeks in advance would mean that the session was the responsibility of the Theatre Director.
8. The sub-committee endorsed the view that computerised data collection systems (Section 12) have an important part to play in collection of information for management purposes as well as operational requirements.

Conclusion

With the above additions the sub-committee unanimously supported the concepts outlined in all the various sections of the booklet "Efficiency of Theatre Services" and strongly recommend it to all those involved in theatre management.

Acknowledgements

The Working Group wish to record their appreciation to Professor M Rosen and members of his Working Party for allowing them to draw heavily on their Report and to reproduce the Report's recommendations.

APPENDIX 1 - Membership of the Sub-Committee

Dr J D Laird FRCR (Chairman)

Mr K J S Panasar FRCS

Dr S E Magee FRCOG

Dr I W Carson MD FFARCS

Dr K W Harper MD FFARCS

Mr J A A Archbold BA MB FRCS

Miss P O'Callaghan Nurse Manager of Theatres

Mr A J Wilkinson MD FRCS

Dr P G McClements BSc MRCGP MFPHM

APPENDIX 2 - Efficiency of Theatre Services

Summary of main recommendations

1. **Theatre services management structure** - a Theatre Services Director (or equivalent) should be appointed to establish and implement guidelines for theatre utilisation.
2. **Matching beds, patients and theatre time** - close collaboration between the surgical teams and admitting officer is essential. There should be regular revision of waiting lists.
3. **Urgent and emergency surgery** -the provision of a dedicated theatre is recommended strongly.
4. **Special Theatres** - single specialty theatres should be kept to a minimum.
5. **Training and supervision of medical staff** – Adequate time for training must be allowed.
6. **List management and anaesthetic assessment** - operating lists should be prepared on the day before surgery to enable proper assessment and optimum list arrangement. Pre-admission assessment clinics are recommended.
7. **Cancellation and under-utilisation of lists** - there must be adequate notice of list cancellation to allow re-allocation of resources. Departures from normal practice should be routinely investigated.
8. **Infected cases** - efficient theatre cleaning procedures should be adopted.
9. **Initial and continuing education of theatre staff** - recruitment and retention of trained nursing staff must be enhanced. Additional training should be encouraged and training budgets protected.
10. **Theatre support staff** sufficient supporting staff are essential.
11. **Recovery facilities** - a wider role for anaesthetic assistants would offer more flexibility for recovery area staffing.
12. **Data collection systems** - effective management depends upon the availability of relevant data. Data collection systems may be of value.