Consulting Room Allocation

Impact on Clinic Operations & Revenue

Beyond room utilisation — how permanent allocation shapes imaging revenue, staffing efficiency, and consultant negotiations

Prepared for Senior Management | Private Outpatient Clinic | X Consultants | X Rooms | Mon–Sat

Amended for privacy: every figure has been replaced with X.

The core argument

Current thinking

"Are the rooms full?"

Room utilisation is treated as the primary metric. If rooms are booked, operations are considered healthy.

This misses the revenue mechanics entirely.

What we should be asking

"Who is in the rooms, when, and what do they generate?"

Room allocation drives three things simultaneously:

1. Downstream imaging & pathology revenue
2. Nursing & admin staffing efficiency
3. Our negotiating leverage with consultants

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Where we stand today

Statistical snapshot of X active consultants across X rooms

X%	X%	X	X
Simple average utilisation	Median utilisation	Standard deviation (pp)	Correlation hrs vs util%

Key findings

X consultants (X%) sit below X% utilisation — these room-hours generate near-zero downstream revenue.

Simple and weighted averages are nearly identical (X% vs X%), meaning high-volume consultants are not better utilisers. Scheduling more hours does not predict efficiency.

The distribution is wide (IQR: Xpp) — this is not a bell curve with outliers, it is a structural spread across the entire roster.

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Utilisation is concentrated at the bottom

Distribution of consultant utilisation rates (n = X)



X% of consultants fall below X% utilisation — much of the roster is generating minimal downstream activity

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Morning slots are more valuable

Same-day imaging referrals and the time-of-day effect

08:00 – 11:00 **Prime morning**	Same-day imaging referrals can be processed, results reviewed, and follow-up initiated before end of business.	**Highest**
11:00 – 14:00 **Midday**	Same-day referrals still possible but tighter turnaround. Imaging capacity begins to fill.	**High**
14:00 – 17:00 **Afternoon**	Referrals processed next day. No same-day revenue capture. Patient may seek imaging elsewhere.	**Moderate**
17:00 – 20:00 **Evening**	No imaging/pathology capacity. Referrals deferred to next available. Higher risk of patient attrition.	**Lower**

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Staffing is driven by the room rota

Nursing, admin, and support rotas are downstream of room allocation

1

Nursing

Different specialties require different nursing skillsets. A cardiology clinic needs cardiac-trained nurses; dermatology does not. Scattered scheduling forces overstaffing or frequent skill mismatches.

Cluster specialties by day for specialised nursing rotas

2

Admin & reception

Admin workload varies with consultant volume. Days with few consultants at low utilisation still require full admin cover. Consolidation reduces idle admin hours while maintaining service.

Align admin staffing to actual consulting density

3

Imaging & pathology

Same-day referrals require imaging staff when high-converting consultants are present. Evening-heavy schedules create next-day backlogs and underutilise daytime capacity.

Match high-converting consultants to imaging hours

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Future consultant negotiations

A data-driven framework for onboarding and renegotiation

Current approach

Consultants request their preferred days and times. Allocation is first-come, first-served.

No consideration of specialty revenue profile, room scarcity, or downstream conversion.

Proposed approach

Score each request using a points-based system that weights room scarcity, specialty conversion rate, and expected downstream ATV.

Offer optimal time slots based on data, not consultant preference alone.

Proposed scoring factors

Room scarcity	How full is the requested day/time band? Higher scarcity = higher priority threshold.	X%
Specialty conversion	What % of this specialty's patients are referred for imaging or bloods?	X%
Average transaction value	When a referral happens, how much revenue does it generate on average?	X%
Time-band alignment	Does the requested slot allow same-day referral processing?	X%

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Recommended next steps

Phase 1 — Now

Obtain imaging & pathology revenue data

By consultant or specialty, covering the same period as the utilisation data. This unlocks conversion rate and ATV analysis.

Phase 2 — Week 2–3

Build revenue-per-room-hour by specialty

Cross-reference utilisation with downstream revenue to identify which specialties generate the most profit per hour of room time.

Phase 3 — Week 4

Identify reallocation candidates

Low-utilisation, low-conversion consultants whose room-hours could be reassigned to higher-value specialties or time bands.

Phase 4 — Week 5–6

Design & pilot the points-based system

Build the scoring model, calibrate weights against actual data, and test against recent onboarding decisions to validate.

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