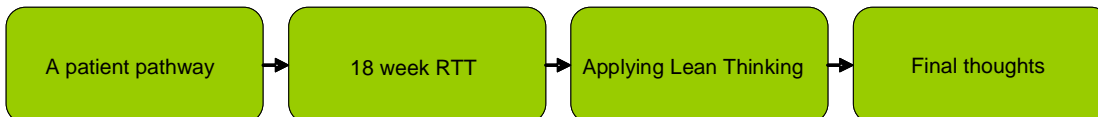


# 18 week Referral to Treatment

## December 2008 – 18 weeks and counting

Julian Winn, WCI Healthcare, discusses the use of **Lean Thinking** to achieve 18 week Referral to Treatment pathways



One of the many challenges that healthcare manager's face is getting patients seen, assessed and treated as soon as possible; and in recent years there has been increasing focus, quite rightly, on reducing waiting times. First there was the maximum 4 hour wait in Accident & Emergency, then a critical look at the waiting times for cancer care and now a broader view that patients should not wait any longer than 18 weeks from the point of referral to the point of treatment – the so called Referral to Treatment Time (RTT).

### A Patient Pathway

An example of a patient pathway is illustrated below. It is a simple pathway with no diagnostic services required.

A male patient decides to have a vasectomy. He makes an appointment to see his GP. The appointment is not urgent so the GP Surgery staff schedule an appointment for a weeks time.

Arriving at the Surgery for his appointment the patient makes his arrival known and .... waits. When the GP is ready our patient goes to the GP and explains what he's there for. The consultation includes a short but important conversation about the nature of the vasectomy procedure, discussion about the general level of health how the patient's decision was arrived at and the likelihood of the procedure not being 100% effective and counselling on the success of reversing the procedure.

The consultation ends with a referral to a Consultant Surgeon; an appointment date arrives 2 weeks later – the appointment is a further 8 weeks away.

Arriving for an outpatient consultation our patient waits to be seen. A nurse calls the patient, takes some vital signs and he returns to wait for the surgeon.

Called to see the surgeon the patient is asked some of the same questions the GP asked and is again told of the likelihood of success ... and failure. Asking when the procedure might take place our patient is told that there is a waiting list but he should hear from the hospital with a date within the next two weeks.

A letter from the hospital arrives 14 days after the consultation. The procedure is scheduled for 7 weeks hence.

Keeping his appointment our patient arrives at the hospital for the procedure and is admitted.

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Lean Thinkers have identified 8 types of waste prevalent in organisations:

1. Over production
2. Over processing
3. Waiting
4. Unnecessary transportation
5. Unnecessary movement
6. Excess inventory
7. Defects or rework
8. Under utilisation of skills and resources

Patient pathways are frequently peppered with all of some of these; let's look at the patient pathway again, highlighting elements of waste that appeared in the process:

<b>Waiting</b>	<p><b>GP consultation</b> 1 week wait from booking to appointment date (and a 20 minute wait in the Surgery)</p> <p><b>Outpatient consultation</b> 10 week wait to be seen by Surgeon (and waiting in the hospital)</p> <p><b>Inpatient date</b> 2 week wait for letter 7 weeks added wait for admission date</p> <p><b>Admitted</b> 20 weeks after initial patient decision to seek procedure and 19 weeks after being referred by the GP</p>
<b>Over processing</b>	The GP and Surgeon went over 'the same ground' (the procedure, the success rate, the possibility of failure and questions about general health)
<b>Unnecessary movement</b>	Into the Nurses office for vital signs, then back to the Outpatients waiting room, then into the surgeons consulting room; none of which were conveniently located next door to each other
<b>Over production</b>	The GP made his notes. The Outpatients Nurse made her observations on a separate sheet and the surgeon made his assessment and record of the consultation in a different case file (which may have contained the vital signs recordings taken by the Nurse). Lots of notes, probably recording much if not exactly the same kind of information – fitness for surgery, understanding of the procedure, consent.

From this example it can be seen that there is waste in the patient pathway, some of which is well understood (the waiting), some of which is less well understood or recognised (over production, over processing, unnecessary movement).



Simplify what you do

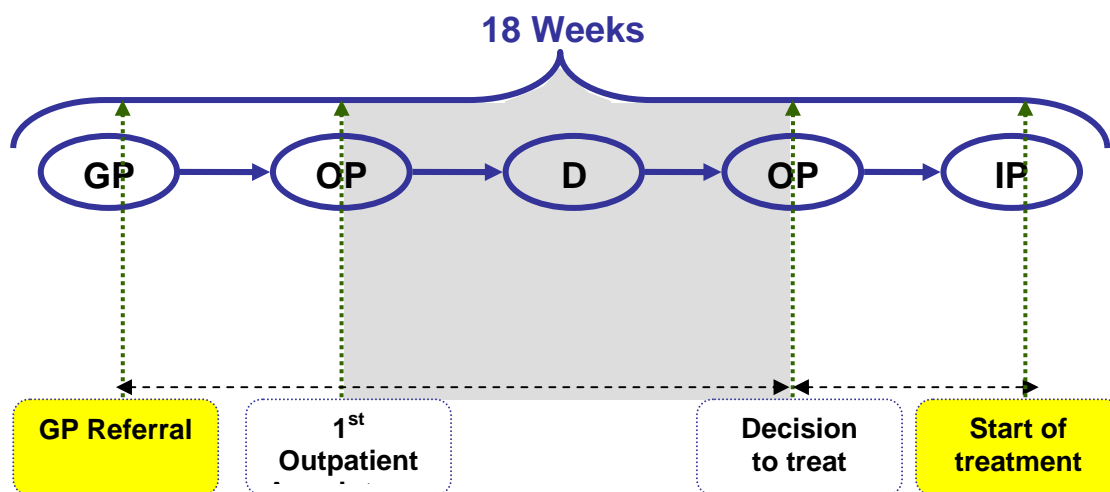
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## 18 week RTT

How can you ensure that patients start to receive care within 18 weeks of referral?

There is no single answer but there appear to be two obvious ones; first, make sure you can measure and track each of the patients referred to your service and second, streamline your processes to make sure wait times are as close to zero as possible.

Tracking the individual patients from the point a referral is received from the GP or a Choose & Book Unique Booking Reference Number is 'converted' is vital – and needs information technology (IT) to inform healthcare managers.



**Fig 1. The 18 week RTT pathway** (Adapted from *Tackling Hospital Waiting*, DH, May 2006)

To assist, IT needs to provide data that incorporates the following minimum data:

- The date of referral receipt
- Date of Outpatient appointment
- Date of diagnostic test or examination, if appropriate
- Date of decision to treat, discharge or wait
- The date of 'admission' for treatment
- The time elapsed from 1 to the date the information is being viewed
- A calculation of the elapsed time in weeks from 1 to 5
- A flag for every patient and speciality breaching 18 weeks

And this information needs to be provided by way of a real-time format, such as a digital dashboard, showing how many patients are at what stage of the RTT and how many weeks into the pathway.

However, this information (and that required by the Department of Health<sup>1</sup>) will be just numbers unless the patient pathways themselves have been improved to reduce the waiting, lead and process times involved in taking a patient from referral through to the start of treatment.

<sup>1</sup> *Changes to the NHS Data Dictionary to support the measurement of 18 week referral to treatment periods*, DSC Notice: 18/2006, NHS Information Standards Board, December 2006

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To meet the 18 week RTT Acute Trusts may need to radically improve their patient pathways. An impressive way to modify the pathways lies in the application of Lean Thinking.

Lean organisations display 4 major traits.

- They provide value
- They eliminate waste
- They make radical changes
- They strive for continuous incremental improvement

## Providing value

To provide value organisations need to understand what their customers (patients, commissioners, the Dept. of Health) want.

Value can be expressed in many ways:

Definition 1	Definition 2
The combination of: <ul style="list-style-type: none"> <li>• Quality</li> <li>• Quantity</li> <li>• Price</li> </ul>	<ul style="list-style-type: none"> <li>• any action identified as adding value by the customer</li> <li>• an action that changes the service to provide that value and ...</li> <li>• ..... is completed right first time</li> </ul>

In the case of the 18 week RTT the value has been partly defined - All patients must start to receive treatment within 18 weeks of referral. To achieve that for all patients the average time will have to be much lower - the Dept of Health itself identifies that the average is likely to be in the region of 9 weeks<sup>2</sup>. With this in mind the target is an RTT of 9 weeks, a time scale patients, should we have time to canvass them, would eagerly endorse.

However, the real value may not be a timeline at all. Let's speculate: The real value that has to be delivered is multi-dimensional; the **most appropriate treatment**, in the **swiftest time**, at a **convenient location** for the patient, **provided by someone they trust**, in a **safe environment**.

## Eliminating waste

Learning to see elements of waste and understanding how to eliminate it is not a one-off activity, it's a life-long obsession. The obsession begins with senior managers being convinced that the 8 wastes exist and are within their organisation.

The first step to eliminating the waste is to 'go and see', talk to staff that have to work and manage in processes that are less than ideal. The second step is to have the courage to tackle that waste head-on with and through colleagues at all levels of the organisation.

## Radical change

Being prepared to make a radical change (in mind-set, in the way the organisation works and how it uses its resources) is the only way to break free from the stasis of the status quo. The desire for change needs to filter down through all levels of the organisation. All staff members need to be educated in Lean Thinking and supported and encouraged to innovate and make change.

Delivering patients to the point of treatment within 18 weeks of referral needs radical change.

<sup>2</sup> *Tackling Hospital Waiting: the 18 week patient pathway*, Dept of Health, May 2006

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## Continuous improvement

Improving a process, system or an entire value-stream is not done once and only once; all processes need constant review and improvement, they need challenging to ensure that waste has not crept back in and review to define what else can be done to enhance the way they operate. As noted above, eliminating waste is a life-long obsession and one that requires everyone in the organisation to be educated in Lean principles and liberated to find waste and eliminate it.

Maintaining effective and efficient outpatient and diagnostic services to meet the 18 week pathway demands continuous improvement. Achieving average waiting times that are lower than 18 weeks requires significant determination and continuous improvement in performance.

### Applying Lean Thinking

Having gone to see where wastes might be occurring in the outpatient and diagnostic services, the processes for both need to be mapped. The mapping process will show exactly where delays occur, the dependency lead times, what is carried out and how long staff take to perform that work.

With the current state maps in hand you can then map the new, future processes, eliminating waste, reducing lead-times and exploiting constraints. Developing future processes needs multi-disciplinary team involvement, consensus and planning to ensure standard working across the clinical and administrative teams.

Using radical change as a 'watch phrase', the layout of departments may need to be altered to allow patients to walk or flow easily between them (remember the patient who had to walk to the nurses room for a vital signs recording then back to the waiting room and on to the surgeons consulting room? That's a lot of unnecessary movement).

Enabling patients to flow easily through outpatients and diagnostics is a key element of **Lean Thinking**. Disrupted flow is a major cause of waste – as we have seen it causes waiting times and unnecessary movement of patients. And if information doesn't flow with the patient there is repeated work and the accumulation of unnecessary amounts of paper or electronic data in different systems.

With new pathways and patients flowing easily between process steps the next Lean goal is to provide services at the rate demanded by patients - meeting the demand as it arises.

Meeting demand is not easy; healthcare managers need to know what the demand is, where patients come from, what the variances in demand are, how demand can be segmented and, when the patients with varying conditions arrive at (in this case) outpatients, how much time the clinical and administrative staff take when in contact with each of them (contact time will have been recorded on the process maps).

Hospitals trend demand and many forecast what the patient demand might be. The logical extension of this is to plan the supply-side (the staff and resources) needed to meet that demand and to have a plan for flexing the supply to meet the actual patient demand. Understanding and meeting the demand will be a key component to achieving the 18 week RTT.

Finally we return to an issue touched on already – continuous improvement. Lean continuous improvement means having staff able and supported to make the changes necessary to eradicate all wasteful process activities. In addition Trusts might want to invite customers (patients and commissioners) into their continuous improvement programme. This will not only ensure a focus on improvement but more importantly on improvements that customers want to see - in other words the value they are seeking. Continuous

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improvement is not a service 'bolt on' it's an essential. And as the Institute for Health Improvement<sup>3</sup> has noted, the capability to improve needs leadership and engagement.

## **Time to act**

Since January 2007 hospital Trusts have been reporting data on the wait in weeks from GP referral to treatment.

Meeting the 18 week RTT by December 2008 is not a single target, since 2005-06 there have been and are milestone targets to meet along the way.

By March 2007 Outpatient appointments are to be within 11 weeks, diagnostic examinations within 13 weeks and inpatient admission within 20 weeks – a total of 44 weeks from referral to admission.

By March 2008 the total wait is to drop to 22 weeks, falling again to 18 weeks by December<sup>4</sup>. Clearly there is much to do between March 2007 and March 2008 if these 'stage of treatment milestones' are to be met. Now is the time to act.

Now is the time to establish an IT reporting system that allows Trust managers to see what the waiting times for individuals and groups of patients are.

Now is the time to go and see how the referral pathway works and to start to identify bottlenecks and constraints in the process.

Now is the time to start thinking Lean. Map the RTT process from end to end, measure waiting and lead times, to bring staff together to plan a referral pathway that will not only shorten the RTT to a maximum of 18 weeks but which will also make working life better for staff so that they can be more productive and effective at work.

And now is the time to look at what needs to be done to support the 18 week RTT; this may include:

- Bed management
- Discharge planning
- Follow-up appointments in hospital or in the community
- Health Record management
- Theatre scheduling
- Pathology services
- Pharmacy services
- Community support services (medical and social)

These are the wider aspects of a Trust's service and what are best described as contributing towards end-to-end value-stream, that collection of activities and processes that enables full value to be delivered to the patient.

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<sup>3</sup> *Seven Leadership Leverage Points*, Reinertsen et al, Institute for Health Improvement, May 2005

<sup>4</sup> *Tackling Hospital Waiting: the 18 week patient pathway*, Dept of Health, May 2006



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## Final Thoughts

Patients deserve to be seen as quickly as possible. No-one likes to wait, why should patients?

As patient's awareness of their right to choose between NHS hospitals and the independent sector increases, meeting the 18 week RTT will become more

and more important. The length of wait could be a key determinant in the patient's decision-making process.

Add to this the financial imperative to make operations more effective, bringing budgets into balance and the new NHS Model Contract<sup>5</sup> with its clauses on penalties for not meeting the RTT target, the urgency with which the issue needs to be tackled is heightened considerably.

December 2008 is not as far away as it may seem.

**Lean Thinking** provides a tried and tested philosophy and a set of tools for improving the performance of organisations. It can be applied directly to assist Trusts in reaching the 18 week RTT and for making some of the radical changes that may be necessary to design Lean processes that speed the patient journey and simplify the assessment and diagnostic processes used by staff.

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Further papers in the series of **Lean Thinking** by Julian Winn are available at [www.wcigroup.com/healthcare](http://www.wcigroup.com/healthcare)

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<sup>5</sup> NHS Contracts 2007-8: SLA Version, Dept of Health, January 2007



Simplify what you do