Diagnostics FAQs

Frequently Asked Questions on completing the "Diagnostic Waiting Times & Activity" monthly data collection

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1. Data collection process queries

1.1. What is the timetable for returning data to NHS England?

The collection timetable can be accessed via the Unify2 website.
http://nww.unify2.dh.nhs.uk/Unify/interface/homepage.aspx

1.2. How is the data collected?

The data collection is run online via Unify2 - the NHS England data collection, analysis & reporting system. Data is to be reported by commissioners. To enable commissioner reporting, providers will need to submit data on-line. This data will then be aggregated up by Unify to produce commissioner returns.

Providers will download a template in the form of an excel spreadsheet and enter their data broken down by commissioner. There is functionality in the form which semi-automates this (e.g. drop down list of all commissioners and providers - when the provider picks a CCG from the list, a new data sheet is created in their workbook) and which produces a "total" sheet for the provider.

Once completed, providers then upload the spreadsheet online by a designated cut-off date. After that cut-off date commissioners have a set time (usually 10 working days) to review their data, validate its accuracy and make appropriate amendments, including adding in any data from the independent sector. The commissioner will then sign off the return online.

1.3. Which organisations should complete the return?

A provider return should be completed by all organisations that provide any of the 15 diagnostic tests / procedures covered by the return i.e. they have patients waiting for or have carried out in the last month any of the 15 tests listed.

All CCGs should submit a commissioner return. CCG returns are produced online in an automated way (refer to 1.5 and 1.6 below). All commissioners are then required to review their data, validate its accuracy and make any appropriate amendments.

1.4. Should Mental Health trusts complete the return?

All trusts that provide any of the diagnostic tests that are on the monthly template should complete a return. However, it is unlikely that Mental Health Trusts will carry out any of these tests / procedures. In this scenario, there is no need to submit a nil return.

1.5. **How are commissioner returns produced?**

Providers enter data online, into Unify2, which is labelled by CCG. This data is then uploaded into Unify2 and CCG level commissioner returns are produced in an automated way within Unify2. Commissioner returns will then be available online for review, validation and amendment, and add in any data from the Independent Sector.

1.6. **What is the sign-off process for the data collection?**

Commissioners need to review their return and ensure that they are content with the data presented. At this stage, commissioners will be able to amend/validate their data. It is good practice for commissioners to discuss any changes to their data with the relevant provider locally. Once signed off, this return will form part of the finalised data set each month.

2. General queries

2.1. What time period does the return cover?

- The waiting list data is a “snap shot” of the waiting list on the last day of the month in question.
- The activity data is the actual number of procedures carried out during the month in question.

2.2. Should we include patients covered on referral to treatment and cancer waiting times returns?

Yes. It is recognised that there will be some overlap between the diagnostics return and referral to treatment and cancer waiting times returns - for example in the instance where a patient is waiting for a diagnostic endoscopy as part of their consultant-led referral to treatment pathway. This patient should be reported on the diagnostics return (as they are waiting for a diagnostic procedure) **and** on the referral to treatment returns (as the referral to treatment return covers the whole patient pathway, including the diagnostic stage). Data from these separate collections will not be added together for the purpose of official waiting times measurement so there will not be an issue in terms of double counting.

2.3. Should we include patients from all referral routes?

Yes. Include all referral routes (e.g. whether the patient was referred by a GP or by a hospital-based clinician or other route) and also all settings (e.g. outpatient clinic, inpatient ward, x-ray department, primary care one-stop centres etc.).

2.4. Should we include direct referral patients?

Yes. Include patients who are referred for diagnostics directly from their GP / Primary Care.

2.5. Should we include private patients?

Private patients being treated in NHS hospitals should not be included on provider returns. However, NHS patients being treated in the independent sector should be reported by commissioners.

2.6. When a diagnostic test is done in the independent sector but the reporting done by the NHS, should this be reported as NHS activity or IS activity?

If the lead clinician who **reports** the test/procedure is employed by the NHS at that time (even if the test was actually carried out within the independent sector), then the data should be reported as NHS activity by the provider.

2.7. **Patients who are referred to an independent sector provider for a diagnostic test only, who should report their waiting time?**

If the originating trust uses an independent sector provider for the diagnostic test only with clinical responsibility for the patient remaining at the originating trust, then the originating trust should retain clinical responsibility for the patient and should also continue to report the patient on their diagnostic waiting list return.

2.8. **How do we report Welsh / Scottish residents?**

Providers can report non-English residents within their return. There is a back sheet within the provider template for reporting this data. Any non-English data reported by providers will not be aggregated into CCG commissioner returns.

3. Counting patients on the waiting list

3.1. **What patients should be included in the waiting times section?**
Include all patients waiting for a diagnostic test/procedure funded by the NHS.

3.2. **What if a patient is waiting for more than one diagnostic test?**
Patients waiting for two separate diagnostic tests/procedures concurrently should have two independent waiting times clocks – one for each test/procedure. For example, patient presenting with breathlessness could have a heart or a lung condition and therefore there might be the need to have cardiology and respiratory tests concurrently.

Alternatively if a patient needs test X initially and once this test has been carried out, a further test (test Y) is required – in this scenario the patient would have one waiting times clock running for test X. Once test X is complete, a new clock is started to measure the waiting time for test Y.

3.3. **What if a patient is waiting for an inpatient admission that may require a diagnostic test during their stay?**
In the waiting times section, do not include patients who are primarily waiting for an operation or therapeutic procedure. It is recognised that some patients will have unscheduled diagnostics as part of their inpatient stay but their wait should not be reported here unless the primary reason for the wait is for a diagnostic test / procedure.

However, for the activity section, any diagnostic tests/procedures carried out on inpatients who have been admitted primarily for an operation or therapeutic procedure should be reported as diagnostics activity in the “unscheduled” column of the proforma.

Example – patient waiting on inpatient waiting list for removal of growth/tumour. Once in hospital patient needs a scan prior to commencing surgery. For the diagnostics return, this patient would not be reported in the waiting times section (but they would appear on the inpatient waiting times return). However, the scan carried out on them after admission should be reported in the activity section of the diagnostics return as unscheduled activity.

3.4. **What if a patient is waiting for a therapeutic procedure?**
A “therapeutic procedure” is defined as a procedure that involves actual treatment of a person’s disease, condition or injury. Therapeutic procedures should not be included in the return. Only include patients waiting where the prime purpose of the wait is for a diagnostic test/procedure, i.e. do not include patients waiting for a therapeutic operation on the inpatient waiting list who may require routine diagnostic tests/procedures following their admission.

3.5. **What if a patient is waiting for a diagnostic procedure, which on the day ends up being therapeutic?**

In some cases, procedures are originally intended as diagnostic up until a point during the procedure when the healthcare professional makes a decision to undertake a therapeutic treatment at the same time. These procedures should still be reported, i.e. include all tests/procedures where the original intention was a diagnostic test/procedure.

If the procedure is part-diagnostic or intended to be part-diagnostics, these should also be reported. An example of this is electrophysiology studies (EPS) – this is a diagnostic cardiac procedure that often results in an immediate treatment (e.g. insertion of pacemaker). This also commonly occurs with colonoscopy, flexi-sigmoidoscopy and colposcopy (where the endoscopy procedure uncovers a condition that can be treated immediately e.g. removal of polyp).

3.6. **Should we include planned patients?**

Surveillance tests that are **planned for a specific date** or need to be repeated at a specific frequency are not included in the DM01 monthly return for the time that these patients are on planned list. These patients should be booked in for an appointment at the clinically appropriate time and they should not have to wait a further period after this time has elapsed. For example, a patient due to have a re-test in six months time should be booked in around six months later and they should not get to six months, then have to wait again for non-clinical reasons.

When patients on planned lists are clinically ready for their test to commence and reach the date for their planned appointment, they should either receive that appointment or be transferred to an active waiting list and a waiting time clock should start (and be reported in the relevant waiting time return). The key principle is that where patients' tests can be carried out immediately, then they should receive the test or be added to an active waiting list.

Surveillance or follow-up tests/procedures that are **not planned for a specific date**, but that will be undertaken on an ad hoc basis or at an undecided time in the future, are not categorised as planned waits and, therefore, these patients should be placed on an active waiting list once the decision to test/referral for a test has been made and waits reported in the DM01 return.

It is for trusts locally to determine the appropriate arrangements for each individual patient case, using the above definitions on a commonsense basis and one where the best possible clinical outcomes can be achieved for the patient.

Planned activity should however be reported in the activity section of the return.

3.7. **Should we include patients with appointments for tests as part of national screening programmes (e.g. routine smear test)?**

No. Tests carried out as part of national screening programmes do not count as diagnostics tests/procedures for the purposes of this return. Patients waiting for a test/procedure as part of a screening programme (e.g. routine smear tests) should not be included in this return. However, any subsequent diagnostic procedure/s that are triggered by an abnormal screening result should be included in the return (e.g. colonoscopy following a positive result for occult blood during Bowel Cancer Screening).

3.8. **How should we report on expectant mothers booked for confinement?**

The reference to the exclusion of expectant mothers booked for confinement in section 1 of the diagnostics waiting time and activity guidance (under Who to Exclude) does not apply to all tests/procedures for which they may be waiting for whilst they are pregnant. Please only exclude tests that relate directly to their confinement. Tests that do not relate to pregnancy, or are due to a complication with the pregnancy should be included, unless they are planned. By planned we mean a procedure or series of procedures carried out as part of a treatment plan which are required for clinical reasons to be carried out at a specific time or repeated at a specific frequency.

For expectant mothers, if they require a diagnostic test which is unrelated to their pregnancy and which they are unable to have until after delivery, these patients should not be added to the diagnostic waiting list until they are medically fit for the test (i.e. after delivery).

3.9. **If a host Trust refers to another Trust for a Diagnostic test, who is responsible for reporting the diagnostic waiting time?**

The trust who maintains overall clinical responsibility for the patient should also hold their waiting time clock. In diagnostics, this tends to be the host trust - they maintain clinical responsibility for the continuing patient care whilst out-sourcing the diagnostic test.

See also Section 2.8

3.10. **What about waiting times for tests not covered by the monthly return?**

In addition to the monthly diagnostics data collection, NHS England monitors, on a less frequent basis, information on other diagnostics tests/procedures not covered by the monthly data collection. This is via a census of provider data that looks at waiting times for all diagnostic tests/procedures.

3.11. **Should Follow Up appointments be reported or only New appointments?**

All follow up appointments should be included, but see 3.6 for how to deal with planned patients.

3.12. **Do we need to include the waiting time for tests carried out in an Inpatient setting i.e. Day Case only or all tests carried out while the patient is an Inpatient?**

All tests should be included irrespective of the setting in which they are carried out - in-patient ward, x-ray dept, outpatient clinic etc . However, if the patient is currently admitted to a hospital bed and is waiting for an emergency or unscheduled test as part of their in-patient treatment you don't need to include this.

4. Measuring the waiting time

4.1. When does the clock start?

The diagnostic waiting time clock starts when the request for a diagnostic test or procedure is made.

4.2. When does the clock stop?

The diagnostic waiting time clock stops when the patient receives the diagnostic test/procedure.

4.3. What standards should trusts meet when offering patients diagnostic appointments?

Organisations should seek to fulfil “reasonableness” criteria when offering patients appointments for diagnostic tests/procedures. In summary, this means they should be offered at least two appointment dates and have at least 3 weeks notice of the appointment. For further information on “reasonableness”, please refer to Data Set Change Notice (DSCN) 37/2003 at the link below:

http://www.isb.nhs.uk/documents/dscn/dscn2003/372003.pdf

Organisations can offer appointments that do not fulfil the reasonableness criteria where it is in the best interest of the patient, for example to receive an appointment with less than 3 weeks notice. However, clock resets for cancellation or failure to attend appointments (see section 4.4) that do not fulfil reasonableness criteria should not be applied.

4.4. What happens if a patient cancels or fails to attend their diagnostic appointment?

If a patient cancels an appointment for a diagnostic test/procedure that has been offered under “reasonable” criteria (see section 4.3 above), then the diagnostic waiting time for that test/procedure is set to zero and the waiting time starts again from the date of the appointment that the patient cancelled.

If a patient declines an offer of an appointment sent by post that does not fulfil "reasonableness" criteria, the clock is not reset and the patient should be offered an alternative appointment date.

If a patient does not attend their diagnostic appointment, then the diagnostic waiting time for that test/procedure is set to zero and the waiting time starts again from the date of the appointment that the patient missed.

If a patient does not attend their diagnostic appointment that does not fulfil "reasonableness" criteria, the clock is not reset and the patient should be offered an alternative appointment date.

4.5. For direct access referrals, where it is the responsibility of the patient to arrange booking of the diagnostic appointment, when should the diagnostic waiting times clock start?

In this scenario, the diagnostic waiting time should start at the point when the patient contacts the trust to arrange the diagnostic appointment. For Choose & Book, this will be the point when the UBRN (Unique Booking Reference Number) is converted.

4.6. Can we adjust waiting times to take account periods of suspension?

Medical or social suspensions are **not allowed** in the diagnostic waiting times returns. However, as stated in section 4.4, the waiting time can be set to zero if a patient cancels or fails to attend an appointment, or if they turn down offers that fulfil the reasonableness criteria.

4.7. What is the exact day a 6 patient will breach the 6 week standard?

The 6 week breach would occur when a patient has waited 42 days for a test.

4.8. If a patient is admitted for a diagnostic procedure, but cannot tolerate it under local sedation, resulting in the procedure being stopped, they are then relisted to that the procedure done under general anaesthetic. Does the waiting time restart at the point they are relisted, or does it still continue from original date on list?

Clock re-starts are only allowed in very specific circumstances as detailed in the guidance. The scenario would not qualify for a re-start of the clock. The 1% tolerance built into the performance standard is there to cover cases such as this.

4.9. If a patient has DNA'd but has declined appointments because they are out of the country, should they remain on the waiting list as a breach, or be removed all together and referred back to GP?

If the patient declines a reasonable appointment then the clock would re-start. Depending on how long the person is away then this might be an option.

Alternatively, the patient maybe referred back to GP if local access policies allow for this.

If neither of these options suit and the patient remains on the waiting list then, yes, there will be a breach. The 1% tolerance is there to allow for cases such as these as it is accepted that there will be a very few number of cases where breaches are unavoidable for reasons other than operational pressures.

4.10. If a patient fails to complete the necessary preparation for a test, should this be reported as a clock restart?

6 week waits in these circumstances would be covered by the 1% tolerance and would not warrant a clock restart.

4.11. Is there a clock restart if a patient (Day Case or Elective Inpatient) is admitted, but is found to be medically unfit for the procedure at that date?

6 week waits in these circumstances would be covered by the 1% tolerance and would not warrant a clock restart.

4.12. Is there a clock restart if a test is delayed due to a problem with the equipment which is rectified but the patient refuses to wait>

The only clock adjustments available in diagnostics are for patients turning down reasonable appointments and DNAs. Therefore, there's no adjustment appropriate in either case, unless the patient was unreasonable and wouldn't wait 10 mins for the equipment to be fixed for example.

5. Counting activity

5.1. How should we count patients who had more than one test in their appointment?

Count one unit of activity for each distinct clinical test/procedure carried out. For example, patient having angiography has one scan immediately prior to injecting contrast dye and then a further scan after injection of contrast dye – this would count as one clinical test/procedure even though two scans have been carried out as part of the procedure.

Alternatively if a patient has an angiography followed by an echocardiography on the same day, count this as two distinct clinical tests/procedures and hence two units of activity. Another example is a “top and tail” endoscopy (where a gastroscopy and flexi-sigmoidoscopy or colonoscopy are carried out in the same session). This should be counted as two units of activity as although the procedures are linked, they are distinct and could be carried out separately.

5.2. What if a patient is waiting for a diagnostic procedure, which on the day ends up being therapeutic?

In some cases, procedures are intended as diagnostic up until a point during the procedure, when the healthcare professional makes a decision to undertake a therapeutic treatment at the same time. These procedures should still be reported as activity, i.e. include all tests/procedures that are intended to be diagnostic.

If the procedure is part-diagnostic or intended to be part-diagnostics, these should also be reported. An example of this is electrophysiology studies (EPS) – this is a diagnostic cardiac procedure that often results in an immediate treatment (e.g. insertion of pacemaker).

5.3. What do you mean by “waiting list excluding planned” activity?

Count the number of diagnostic tests or procedures carried out during the month for which the patient had waited on a waiting list. Include all relevant tests/procedures irrespective of the referral route (i.e. whether the patient was referred by a GP or by a hospital-based clinician or other route) and also irrespective of the setting in which they are carried out (e.g. inpatient ward, x-ray department, outpatient clinic etc.).

5.4. What is planned activity?

Count the number of planned (or surveillance, sometimes referred to as “re-do” or “follow-up”) diagnostic tests or procedures carried out during the month. A planned diagnostic test/procedure is a procedure or series of procedures carried out as part of a treatment plan which are required for clinical reasons to be carried out at a specific time or repeated at a specific frequency.

5.5. What is unscheduled activity?

Count the number of diagnostic tests or procedures carried out during the month on patients following an emergency admission, as well as any diagnostic tests/procedures on patients in A&E. Include all relevant tests/procedures irrespective of the referral route (i.e. whether the patient was referred by a GP or by a hospital-based clinician or other route) and also irrespective of the setting in which they are carried out (e.g. inpatient ward, x-ray department, outpatient clinic etc.). We want to capture all tests that are unscheduled/unexpected, including those that are ‘unexpectedly’ carried out either on admitted patients or on patients attending clinics or GP walk-in centres etc. as well as those carried out on patients in A&E.

6. Tests

6.1. Which tests should be reported on the monthly return?

Data should be collected on 15 key tests. These are:
Imaging - Magnetic Resonance Imaging
Imaging - Computer Tomography
Imaging - Non-obstetric ultrasound
Imaging - Barium Enema
Imaging - DEXA Scan
Physiological Measurement - Audiology – Audiology Assessments
Physiological Measurement - Cardiology - echocardiography
Physiological Measurement - Cardiology - electrophysiology
Physiological Measurement - Neurophysiology – peripheral neurophysiology
Physiological Measurement - Respiratory physiology - sleep studies
Physiological Measurement - Urodynamics - pressures & flows
Endoscopy - Colonoscopy
Endoscopy - Flexi sigmoidoscopy
Endoscopy - Cystoscopy
Endoscopy – Gastroscopy

6.2. For Imaging tests, how should these be counted?

As with all diagnostic tests/procedures, please count the number of "clinically distinct" units of activity. For example, patient having three CT scans of a knee would count as one unit of activity. However, patient having one CT scan of a knee and one CT scan of a shoulder would count as two units of activity. As a guide, it is likely that one unit of activity equates to one patient visit to the imaging department.

6.3. Should we include endoscopies that have different classifications?

For the four endoscopy procedures covered by the monthly collection (colonoscopy, cystoscopy, flexi-sigmoidoscopy and gastroscopy), please include all endoscopies irrespective of classification (e.g. outpatient, day case etc.).

6.4. How should we report "top and tail" procedures (e.g. gastroscopy and either colonoscopy or flexi-sigmoidoscopy in same session). Should we count this as one procedure or two?

For the activity section, please report this as two procedures.

For the waiting list section, this should be reported as one wait – please record the wait on one of the endoscopy lines. If unsure about which line to record the wait on, as a guide, report the wait against the procedure that is deemed the most clinically significant for that patient.