NHS England

Diagnostics FAQs

Frequently Asked Questions on completing the Monthly Diagnostic Waiting Times and Activity data collection (DM01)

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Data collection process queries

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

The collection timetable is published on the NHS England Statistics web page: https://www.england.nhs.uk/statistics/collections-timetable/ and is also available at: https://datacollection.sdcs.digital.nhs.uk/.

1.2 How are the data collected?

The data collection is run online via the Strategic Data Collection Service (SDCS) - NHS England's secure data collection system. Data are to be reported by providers of diagnostic services. See https://datacollection.sdcs.digital.nhs.uk/.

Providers 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, including the option to read data in from a csv file and a drop-down list of commissioners that generates a new data sheet for each one selected and produces a "total" sheet for the provider.

Once completed, providers upload the spreadsheet online by a designated cut-off date, whereupon the data are validated. Commissioners also have access for a set time after that cut-off date (usually 10 working days) to review their data and perform their own validations.

1.3 Which organisations should complete the return?

A provider return should be completed by all organisations that provide any of the 15 NHS diagnostic tests / procedures covered by the return, that is they have carried out in the last month, or have patients waiting for, any of the 15 tests listed. Separate returns are required from Community Diagnostic Centres (CDCs) comprising activity only, which double-counts the activity reported by the responsible or host trusts.

1.4 How does a CDC return differ from that of other providers?

Organisations hosting and responsible for patients seen at a CDC site are required to include the activity and waiting times for them in their returns, since that covers activity in all settings and they maintain overall clinical responsibility for the patient. However, to identify the contribution of CDCs, a separate CDC return compiles all CDC-funded activity for diagnostic tests performed in the CDC, regardless of where the patient responsibility lies. CDC returns should exclude waiting list information.

1.5 What definitions apply to the DM01 CDC return?

Apart from the distinction between the organisation responsible for the patient and the CDC performing the test at FAQ 1.4 above, the same definition rules and guidance apply. There is no defined waiting list for CDCs, as this is retained by the responsible organisation, but all activity definitions apply.

1.6 Does the CDC data duplicate activity submitted by other organisations?

Yes. The CDC activity data should be included in the submissions of the organisations responsible for the patient's diagnostic pathway – usually the CDC site host organisation.

1.7 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.

1.8 What role do commissioners play?

Commissioners are invited to review the data that providers have attributed to them and check that they are content with the data presented. Statistics based on the returns are published at both the provider and commissioner level.

General queries

2.1 What time period does the return cover?

- The waiting list data are a “snap shot” of the waiting list on the last day of the month in question.
- The activity data are 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 (that is whether the patient was referred by a GP, under direct access arrangements, by a hospital-based clinician or other route) and all settings (such as outpatient clinic, inpatient ward, x-ray department, Community Diagnostic Centre, primary care centre, 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.

2.6 For patients 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 that retains clinical responsibility for the patient should report the patient on their diagnostic waiting list return.

2.7 For diagnostic tests in the independent sector where the image reporting is done by the NHS, who reports the 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 by the NHS provider.

2.8 How do we report Welsh / Scottish residents?

Providers can report non-English residents within their return under the commissioner code 'NONC'. Any diagnostics data for non-English commissioners will not be aggregated into the commissioner and provider totals.

Counting patients on the waiting list

3.1 What patients should be included in the waiting times section?

Include all patients waiting for a listed diagnostic test/procedure funded by the NHS. Patients awaiting a planned or surveillance diagnostic test are excluded unless they are past their due date and so on an active waiting list. Patients receiving unscheduled diagnostic tests are excluded (see section 5.5 for a definition).

3.2 What if a patient is waiting for more than one diagnostic test?

Patients may be waiting for more than one diagnostic test/procedure at the same time. For example, a patient presenting with breathlessness could have a heart or a lung condition and therefore might need to have both cardiology and respiratory tests This may result in more than one diagnostic clock start.

However, patients awaiting two or more diagnostic tests of the same type should have a single waiting time clock if they are to be performed together. Examples include multiple CT scans performed together, audiology hearing and balance tests and both upper and lower ("top and tail") endoscopy. Where there is uncertainty over which test type to attribute the waiting time to, this may be either the first test listed or the most complex test, at the discretion of the submitter.

Where a patient needs test X initially and, once this has been carried out, a further test (test Y) is required, the patient would have one waiting time 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 is on an 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; 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 decides 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-diagnostic, this 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 (such as insertion of pacemaker). This also commonly occurs with colonoscopy or flexi-sigmoidoscopy, where the endoscopy procedure uncovers a condition that can be treated immediately (e.g. removal of polyp).

3.6 Should we include planned / surveillance patients?

Surveillance tests that are **planned for a specific date**, or need to be repeated at a specific frequency, are not included in the waiting list part of the 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 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 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 start a waiting time clock that is reported in this 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** will be undertaken on an ad hoc basis or at an undecided time in the future, are

not categorised as planned waits. Once the decision to test or referral for a test has been made, these patients should be placed on an active waiting list and their waits reported in this return.

It is for trusts locally to determine the appropriate arrangements for each individual patient case, using the above definitions on a common-sense 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 screening tests as part of national screening programmes?

No. Screening tests carried out as part of national screening programmes do not count as a diagnostics test/procedure for the purposes of this return. Patients waiting for a test/procedure as part of a screening programme (e.g. Abdominal aortic aneurysm (AAA) screening) should not be included in this return. However, any subsequent diagnostic procedures that are triggered by an abnormal screening result should be included in the return (e.g. Colonoscopy following a positive faecal immunochemical test (FIT)).

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 2.2 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 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 2.6

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

There is no requirement to submit waiting time data for tests not covered by the return. However, note that there are some additional diagnostic tests covered by the Waiting List Minimum Data Set (WLMDS) that are not in DM01.

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

All follow up appointments should be included but see section 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?

All tests should be included irrespective of the setting in which they are carried out, such as outpatient clinic, inpatient ward, x-ray department, Community Diagnostic Centre, primary care setting, etc. Some patients will be admitted for their test, generally as a day case, so should be included in waiting lists. 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.

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. For planned tests that are past their due date, the clock starts when the test was due.

4.1.1 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?

The diagnostic waiting time should start at the point when the patient contacts the trust to arrange a diagnostic appointment. For e-Referrals, this is the date of the first booking of the UBRN (whether for a diagnostic or interface service) or the date it appears on the Appointment Slot Issues list for the Provider. For e-Referrals to a referral assessment service (RAS) then it is the date the referral appears on the referrals for review worklist and for an Advice and Guidance service it is the date it is converted into a referral by the provider. If the RAS or A&G service decides against the diagnostic test, it is removed from the diagnostic waiting list.

4.2 When does the clock stop?

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

4.3 How should the wait be calculated?

The date the referral is made is day zero (irrespective of the time of day the referral is made). The wait increments by a day when the date changes, so the patient is considered to have waited a day on the next calendar date. The number of days waiting can be calculated by subtracting the dates - for example, if a referral is made on a Monday:

- Tuesday (day 1) minus Monday (day 0, referral made) is a one day wait;
- Wednesday (day 2) minus Monday (day 0, referral made) is a two day wait;
- Monday (day 7) minus Monday (day 0, referral made) is a seven day wait.

4.4 What is the exact day a patient breaches the 6 week standard?

The 6 week breach would occur when a patient has waited 42 days for a test. For example, if a referral was made on a Monday (day 0) then day 42 would also be a Monday and would be a breach irrespective of the time of day the referral was made.

Examples:

4.4.1 If a patient is seen on the 42nd day does this count as a breach or would the breach count from the 43rd day?

A 6-week breach occurs when the patient has waited 42 days or more. If a referral was made on Monday 17th February 2025 (day 0), the patient becomes a breach on Monday 31st March 2025 (42 days after the referral was made). If they were still waiting for the test at the end of that day, then they would be counted as a breach in the end of the month snapshot. If they had their test on 31st March 2025, their breach would not be included in the data snapshot at 23:59 that same day as they were no longer on the waiting list (though the test would be counted as activity).

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
0 <01 week	17th Feb 2025 **Referral** - Day 0	1	2	3	4	5	6
01 <02 weeks	24th Feb 2025 - Day 7	8	9	10	11	12	13
02 <03 weeks	03rd Mar 2025 - Day 14	15	16	17	18	19	20
03 <04 weeks	10th Mar 2025 - Day 21	22	23	24	25	26	27
04 <05 weeks	17th Mar 2025 - Day 28	29	30	31	32	33	34
05 <06 weeks	24th Mar 2025 - Day 35	36	37	38	39	40	41
06 weeks plus	31st Mar 2025 **Breach** - Day 42	43	44	45	46	47	48

4.4.2 According to the example in 4.4.1 above, if a patient had their diagnostic test on 17th February 2025 (on the same day the referral was made) they would have been waiting for 0 days. Is this correct?

Yes, if a patient receives a diagnostic test on the same day that they are referred then they have been waiting for 0 days. If a patient was referred on Monday 31st March and received the diagnostic test on Monday 31st March, they would have been waiting for 0 days and this patient should not be counted as being on the waiting list in the March end of the month snapshot; however, the test would be counted as March activity. If the patient received their test on Tuesday 1st April, they would be recorded as waiting 0 days in the March end of the month snapshot but not recorded as an activity in March (this activity would be captured in April data).

4.4.3 Is it possible to have a 0 day wait on the data snapshot?

Yes - if a patient was referred on the last day of the calendar month and was still waiting at the time the snapshot was taken.

4.4.4 If a patient's referral is made at 5pm on day 0, would this patient not count as a breach until 5pm on day 42?

Diagnostic waiting times don't take times of day into account, therefore at the start of day 42 they would become a breach.

4.5 What standards should trusts meet when offering patients diagnostic appointments?

When offering patients appointments for diagnostics tests/procedures, organisations should seek to offer at least two appointments on different days that fulfil "reasonableness" criteria (for a time and date three or more weeks from the time that the offer was made) as outlined by the data dictionary[1]. Organisations may offer appointments that do not fulfil the reasonableness criteria where it is in the best interest of the patient, for example with less than three weeks' notice. These may be subsequently classed as reasonable as long as the patient accepts the offer and this is recorded.

When considering whether an offer is reasonable, organisations should consider from the patient's perspective. However, clock resets for cancellation or failure to attend appointments that do not fulfil reasonableness criteria (see section 4.6) should not be applied.

4.6 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 4.5 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 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.

Note that when a clock is to be reset as above, this happens from the appointment date that the patient cancelled or missed. The clock should continue to tick until that date (ie no clock start date should be in the future). If that is not technically possible, then the start date may be reset to the date the cancellation was advised or to the day a rebooking was made.

[1] Reasonable Offer (www.datadictionary.nhs.uk)

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

Suspensions for medical or non-medical reasons are **not allowed** in the diagnostic waiting times returns. However, as stated in section 4.6, 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.

4.8 When are clock restarts permitted?

Diagnostic waiting time clocks may be reset when patients DNA (see section 4.6) or turn down reasonable appointments (see section 4.5). Specific examples:

4.8.1 If a patient is admitted (Day Case or Elective Inpatient), but is found to be medically unfit for the procedure at that date, does the clock restart?

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

4.8.2 If a patient is admitted for a diagnostic procedure but cannot tolerate it under local sedation, resulting in the procedure being stopped and the patient being relisted to the procedure under general anaesthetic, does the waiting time restart at the point they are relisted?

Clock re-starts are only allowed in very specific circumstances as detailed in the guidance. This 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.

4.8.3 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.

4.8.4 If a test is delayed due to a problem with the equipment which is rectified but the patient refuses to wait, does the clock restart?

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.

4.9 When should a patient be removed from the waiting list and referred back to GP?

If a patient has DNA'd and declined reasonable appointments, the clock is generally reset (see section 4.6). If a patient declines all reasonable appointments because they are out of the country, the same rule applies. Depending on how long the person is

away and local access policies, referring the patient back to the GP might be an option.

If the patient remains on the waiting list and there is a breach, this is covered by the 1% tolerance as it is accepted that there will be a small number of cases where breaches are unavoidable for reasons other than operational pressures.

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 (one against each test). 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-diagnostic, 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 is "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. Exclude activity that had been planned for a specific future period and provided in that period (see 5.4) but include those who had been moved to an active waiting list when their planned test became overdue. 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 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 in A&E or following an emergency admission. Also include any diagnostic tests/procedures carried out on inpatients who have been admitted primarily for an operation or therapeutic procedure. 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 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.

Tests

6.1 Which tests should be reported on the monthly return?

Data should be collected on 15 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 How should we count imaging tests?

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 How should we report “top and tail” endoscopy procedures in same session?

For the activity section, please report this as two procedures – one gastroscopy and one either colonoscopy or flexi-sigmoidoscopy.

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.

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG
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