NCL NON-MSK ULTRASOUND GUIDELINES FAQs

To download and access the NCL Non-MSK Ultrasound Guidelines please visit the NCL GP Website Imaging Topic page

Question	Answer
Is this for secondary care trust USS and InHealth USS?	*Yes this for any referral to an NCL US secondary care department and InHealth.*
It's currently incredibly difficult to find pathways on the NCL website. Therefore difficult for us to be sure we are requesting USS as per pathways, which we can't find. E.g. Barnet Gynae pathways - I can't find them at all.	*The local borough websites have all been merged to form the single NCL GP website. As a result some pathways are being reviewed and currently not visible but work is continuing to assure the NCL GP website is up to date and comprehensive for all clinicians across NCL.* *For any queries please contact gp.website@nhs.net*
Clinical MSK service has a very long waiting list. It is very sad that the ability to have patients treated is being downgraded. We have had to put up with minimal service for patients due to Covid and the new services for US seem to be likely to be increasing waits for service and difficulty in maintaining working people in their jobs when they have MSK lesions needing treatment.	*This new guidance pertains to non-MSK US referrals.* *The capacity – demand mismatch and variability of request is most pronounced for MSK referrals. The number of radiologists and sonographers with the skills to deliver are limited.* *To ensure maximum effective utilisation and value it is intended to expand the "Camden MSK service" model, to a physio/expert holistic MSK assessment first approach across NCL.*
Repeat scan after interval, why not just arrange this rather than require GP to refer again?	*It is generally felt it is safer for GPs to re-refer for imaging if needed. GPs will have access to the patient's history and management. It may be that an interval scan is no longer needed or appropriate, for example if the patient has been referred to secondary care or due to clinical non-clinical changes in circumstances. This also ensures that it is clear where the clinical responsibility lies if an action is required after an US.*
Does this guidance apply to paediatric patients as well and where are paediatric ultrasounds to be referred to?	*No this does not apply to paediatric patients.* *Paediatric ultrasounds should be referred directly to secondary care. In some cases A&G or referral to paediatrics may be helpful.*

If US examination result is negative would imaging specialist suggest alternative investigations?	*The US report may not necessarily suggest alternative investigations if the report is negative. The US report main aim is to answer the clinical question posed in the referral.*
Will NCL ensure that US workers do not give inappropriate advice further tests? Will they use the NCL guidelines to ensure the give correct advice?	Sonographers and Radiologists will adhere to the NCL pathways. Examples of inappropriate advice should be shared with the performing provider with details as to why the advice given was felt to be inappropriate.
We are often requested to repeat the scans for thyroid nodules to ensure no change after 6 months or one year.	*As per the guidance routine follow of thyroid nodules is not recommended, but there may be situations where this is appropriate.* *If you have a query about such a request, please liaise with the relevant imaging department using the contact details within the guidance, seek advice and guidance from secondary care speciality and/or feedback to our team.* *Nodules should be classified based on the British Thyroid Society U Classification Guidelines. Incomplete reports should be sent back to the provider for amendment.*
I am able to recall a patient with thyroid nodule on repeat USS had Ca nodule. If ignored the 2yrly USS this would have been missed.	*U classification is validated and should be used to risk stratify patients.* *U2 patients can be discharged, U3 and above require FNA.* *Any surveillance should be recommended by a thyroid specialist/MDT.*
Does this mean we can only investigate thyroid nodules to look for cancer when they are advanced?	*Any thyroid nodule can be sent for initial US assessment and management based on the British Thyroid Society U classification*
If in such cases ca was diagnosed and not clinically indicated as per 2014 guidance but patient was advised in hospital for repeat scan in 2years, who then takes clinical medico-legal responsibility if not done. Does this mean NCL will explain to patients?	*Advised to ask for specialist advice if there is discordance between U classifications and follow up recommendation.*
Does the referral form (for all our non-MSK providers) auto-populate with the most recent consultation? From secondary care perspective, is this useful? Do we end up duplicating information?	*The new radiology forms do give option to add selected consultations, however the consultation may not clearly present the information or clinical Q. therefore it is important to for clinicians to add this clearly.* *Auto-population should only be used for pertinent information and may detract if not directly relevant to the clinical question, risking referral return.*

Secondary care often repeat InHealth scans when abnormal. Is there a need to review InHealth?	*Scans are either repeated if there is lack in confidence in the report and/or images are not available. For some cases reviewed at MDTs the images cannot solely be relied upon for a second opinion. Common examples include indeterminate thyroid nodules. Feedback is and will continue to be given but this needs to be more co-ordinated across all providers.*
I thought the evidence for USS guided injection for subacromial pain syndrome was limited? Is this no better than blind injection?	*Blind injection performed by an experienced operator is effective (approximately 80% vs US guided 90% +).* *US enables diagnosis between bursitis or tear.*
Who is the person to direct patients to at NCL?	*We understand that some patients may be unhappy about not being offered an ultrasound where they do not meet the agreed clinical criteria. If the GP cannot resolve this in conversation with the patient or their carer, they should direct them to the NCL complaints nclccg.complaints@nhs.net*
Will the local Radiologists and Consultants in secondary care be given this presentation too or will they keep asking us to do repeat scans etc. copying patients in?	*Surveillance imaging justified in many cases. Discrepancy between advice given and NCL pathways should be flagged to clinical specialist or appropriate provider radiologist.* *Once embedded intention is for vetting process to be as clear as possible and applicable to all referrals.*
Are you not able to access clinical records (to view) using Health Information Exchange (HIE) in order to try to gain this more holistic picture of the patient?	*Radiologists can access local provider patient medical records but not that of all patients hence the critical importance of asking a specific clinical question.*
Having access to the test suggested by the radiologist if we do think it is appropriate would be useful.	*Agree and to be taken forward by the NCL Imaging Board, with the proposal that GPs can refer (funded) for the test requested if they are happy to manage based on the result or refer for specialist care if preferred.*
Having access to investigations also reduces unnecessary hospital specialist referrals.- drRP	*The guidance is not designed to be obstructive and access to USS has not been reduced. The main aims are to ensure sufficient clinical information is included referrals, to reduce the amount of referrals for potentially unwarranted US and therefore increase capacity and reduce waiting times for those patients for whom US is helpful.* *Direct access for appropriate investigation can negate specialist referral. Access needs to be balanced with capacity to deliver the service and mechanisms to ensure referrals are targeted to patients that will benefit the*

	most. It is recognised that the UK diagnostics are vastly under resourced, hence the Community Diagnostic Hub program and promised new investment in both equipment and workforce.
Would the rejection have the name and GMC number of the person who rejects the investigations when GP refer the name of the practice and the doctor is on the form?	*Radiologists are recommended to include their GMC number with reports. Any concerns with regard to fitness to practice should be made to the Clinical Directors of the individual providers.*
InHealth reports come back as paper forms – they are not electronic.	*HIE only works if the GP practice is in the borough of the hospital. GPs commonly use it to access US scans in the community.*