# Position Statement: Improving access to CT scanning in England

This position statement sets out the Taskforce for Lung Health's view on CT scanning and the improvements required to ensure people with lung conditions have timely and equitable access to this important diagnostic tool.

## Key recommendations

1. **Improve the use of GP Direct Access by expanding coverage and enhancing Advice and Guidance.**
2. **Increase scanning capacity, with an emphasis on the most poorly provisioned trusts and ICB areas.**
3. **Tackle workforce shortages to boost radiology staffing numbers and reduce waits for reporting.**

### The importance of CT for respiratory patients

Computed tomography (CT) scanning is a key diagnostic test for many lung conditions, including interstitial lung disease, bronchiectasis, sarcoidosis and lung cancer.[1] The sensitivity of CT makes it the best test available for diagnosing progressive diseases, such as lung cancer and pulmonary fibrosis, at an earlier stage when intervention can have a bigger impact. Early and accurate diagnosis is critical for people with lung conditions – without a diagnosis, people go untreated, putting them at risk of worsening symptoms and potential permanent lung damage and loss of function. Timely access to CT scanning is therefore vital, but challenges in the system prevent this from happening.

### Patients face inequitable waiting times

Waiting times for a CT scan vary significantly depending on referral route. This creates inequalities between pathways, depending on a patient's condition and where they access care. The time it takes for patients to be diagnosed via a CT scan can be impacted by the wait for an initial appointment to be referred, the wait between the referral and the scan, the wait for the report to be shared with the referring clinician, and the wait to be informed of the results.

| Referral route | Waiting time for scan | Waiting time for report |
|---|---|---|
| Acute/A&E | Immediate/after triage | 4 hour target; 91% same day[2] |
| Inpatient | Same day | 24 hour target; 91% same day[3] |
| Lung cancer screening programme | Unclear – appointment date provided on invitation letter | 4 week target |
| Suspected cancer | 2 weeks[4] | 3 day target; total 4 week target met 76.4% of the time in 2024-25[5] |
| GP Direct Access | An urgent direct access referral will aim to be completed, including report, in no more than four weeks | 7 days for urgent requests; total 4 week target[6] |
| Secondary care | Average of 16 weeks for outpatient appointment, and 6 weeks for scan[7] | 4 week target – frequently missed[8] |

Most patients waiting for a CT scan are on the elective waiting list, where their first outpatient appointment and any subsequent testing may be scheduled months into the future. For patients presenting at A&E or already admitted to hospital, a chest X-ray and/or CT scan may be performed and reported on rapidly to inform clinical decisions. Acute and emergency scans account for a high proportion of all scanning, placing significant demand on hospital capacity as most only have one or two CT scanners.[9] Some scanning will be unnecessary and may generate follow-up testing requiring repeat use of the same scanners. For patients

on the elective waiting list, long waits risk their deterioration in the meantime and may result in an emergency hospital admission during which an appropriate scan finally takes place. Earlier elective CT scanning can reduce patient suffering and prevent unnecessary emergency admissions.

Asymptomatic patients with a smoking history can access a CT scan through the Lung Cancer Screening Programme (LCSP) which offers eligible patients a low-dose CT scan to catch lung cancer early. [10] It can also detect COPD, bronchiectasis and pulmonary fibrosis – especially significant for findings of emphysema, which predicts COPD mortality up to 25 years after the scan.[11] The programme has achieved a high early detection rate for lung cancer, with 76.7% of 4,000 cases being identified at stage I or II[12], but there are regional inequalities in access, as it has not yet been fully rolled out across England. Up to 20% of new lung cancers are in never-smokers, and this number is increasing, but these patients won't benefit from screening and may not qualify for a suspected cancer referral.[13] Patients with symptoms must be able to access CT scanning in a timely way regardless of their smoking history.

**GP Direct Access is under-used**

Since 2023, the GP Direct Access scheme (GPDA) has enabled GPs to request imaging, including CT scans, from primary care without the need for a secondary care referral.[14] This aims to reduce waiting times as patients can be referred after a GP appointment, without having to attend a hospital appointment with a consultant. However, GPDA is not available across all of England, there is no formally published data on its rollout, and variability in testing capacity has limited GPs' use of direct referral in some areas of the country.[15] This is creating disparities for patients, inequities in waiting times and downstream pressures on the NHS as a result of delayed diagnoses.

In 2023 NHS England published guidance for GPs on making direct access referrals. The guidance complements the NICE guideline NG12 for cases of suspected cancer and supports GPs in requesting imaging for patients with symptoms warranting urgent investigation but not meeting the threshold for suspected cancer.[16] Since suspected cancer referrals are supposed to lead to a confirmed diagnosis within four weeks, patients wait much longer for a scan if their symptoms or history don't meet the threshold. This creates inequality between the lung cancer pathway and other respiratory pathways. GPDA guidance addresses this discrepancy, but rates of referral for CT are much lower than for other tests, despite its high sensitivity and accuracy.[17] In addition, the proportion of CT scans requested via GPDA varies widely between trusts, with some referring this way almost 60% of the time and others less than 1%.[18]

Low uptake of GPDA for CT may be due to caution among GPs who would rather request a chest X-ray or other tests first, even if symptoms indicate a condition best diagnosed by CT. GPs may not appreciate how direct access differs from a suspected cancer referral or may not feel confident referring without input from a specialist. They may prefer to refer through the suspected cancer pathway instead, but this risks missing patients with other conditions. For example, patients with pulmonary fibrosis are often misdiagnosed until a high-resolution CT confirms their condition; earlier diagnosis via CT would help them get the most out of treatment.[19] Awareness may be low of where GPDA is available, or of how to submit a referral. A CT scan may detect incidental findings better managed in secondary care than by GPs. Yet this reluctance to refer to CT is leaving respiratory patients behind and risks worsening outcomes.[20]

With a planned shift towards providing more care at neighbourhood level, improved Advice and Guidance services are essential to support GPs to make the right referral at the right time and for the management of incidental findings.[21] Evidence-based clinical guidelines should be produced to support NHSE operational guidelines and inform GPs of when direct referral to CT is warranted over other tests. Clinical decision support tools such as iRefer are already available in many trusts and, accompanied by referral guidelines, can be used to identify the right test for each patient, reducing unnecessary investigations and radiation exposure.[22]

Expansion of GPDA is hampered by workforce limitations. Increasing scanning activity automatically increases demand on radiologists to interpret and report scans. Expanding GPDA must be accompanied by careful management of staff capacity. For example, managers of a radiology department in a trust soon to be covered by GPDA must assess the need for additional scanners, and make informed recruitment decisions to handle additional demand and ensure waiting targets are met. Communication between primary and secondary care must give secondary care enough detail about a patient to accept a referral, including results of earlier investigations in primary care, such as spirometry. A lack of dialogue and multidisciplinary working across the scheme means this is currently challenging.[23]

To improve the use of GP Direct Access:

- NHS England must ensure GP Direct Access is expanded to cover the whole of England. This should include publishing data on current GP Direct Access coverage.
- NHS England must provide all GP surgeries with the education and resources required to support GP Direct Access referrals (for example, funding for product licences of iRefer, and a standardised proforma for CT scan requests) and, via the single patient record, make results available directly to the GP to support continuity of care.

**Limited scanning capacity**

There are not enough CT scanners in England to meet current demand, and as demand will only increase, CT scanning capacity must be expanded urgently. In 2021, the UK ranked 37th out of 42 OECD countries for numbers of CT scanners in hospitals at 10 per million, and 30th out of 33 for numbers of scans performed, at just 94 per 1,000 population.[24] This is unacceptable.

The Richards review in 2020 recommended doubling scanning capacity by 2025 to meet increased demand, and replacing all scanners older than 10 years, but this recommendation is yet to be implemented. In 2024, the Darzi investigation also noted that the UK has too many outdated scanners, and that in addition to the low number of machines, their age means they take longer for each scan and break down more often.[25] These inefficiencies are causing growing waiting lists, with more than half of patients waiting more than six weeks for a CT scan, increasing pressure on NHS services as patients are left undiagnosed and untreated.[26]

Doubling the CT scanner estate would cost an estimated £569m, excluding the costs of training and hiring staff, or replacing existing outdated equipment.[27] Although the Labour party pledged before the 2024 election to double the number of MRI and CT scanners, the £1.5bn of funding announced since the election is split between appointments, new surgical hubs, and scanners of both types.[28] This will likely not meet the shortfall in the current estate or that required in future. Another challenge is that more than half of trusts do not have the physical space to accommodate an additional scanner.[29]

Issues in scanning estate vary by location, contributing to geographical disparities. Across England, the ratio of CT scanners to population varies from 56,613 to 130,164 people per scanner, a more than twofold difference.[30] England's most poorly provisioned ICB area, Staffordshire and Stoke-on-Trent, has only 9 CT scanners for 1,180,120 people, and unsurprisingly, ranks 41st out of 42 for the number of people waiting for a scan relative to the number of scanners.[31]

Capacity issues are more severe in routine trust work and elective scanning than in ringfenced programmes such as Community Diagnostic Centres (CDCs), or Lung Cancer Screening, as equipment and some workforce costs are included in their budgets. CDCs have boosted capacity outside of hospitals[32] and have delivered 7.3m diagnostic tests in the year to June 2025, including 1.1m CT scans.[33] CDCs are designed to move non-acute work away from hospitals, not meet emergency CT demand. In March 2025, CT scanning in CDCs accounted for 24% of elective scans, and only 13% of all CT scans, highlighting that much more elective scanning could take place at CDCs.[34]

Boosting scanning activity alone will exacerbate short-term pressures unless the workforce grows to meet demand. Departments must be funded to recruit enough thoracic radiologists, radiographers, and administrators to take full advantage of increased capacity. Longer opening hours in radiology departments would also allow more appointments to be scheduled. Doubling the scanning estate is a significant ask of current NHS budgets but would yield rapid results in shorter waiting times and faster treatment, reducing cost to the system from patients on long waiting lists, who use the health service more often in the meantime, including emergency care.[35] As ICBs become strategic commissioners, there is an opportunity to focus CT investment decisions on those areas with the greatest need.

To increase scanning capacity:

- ICB commissioners must make funding available for trusts to replace end-of-life scanners and boost capacity, prioritising those areas with the longest waiting lists.
- NHS England's CDC programme team should work with local areas where CT scanning capacity is not being fully utilised to promote their access.

**Workforce shortages**

The NHS does not employ enough radiography and radiology staff.[36] Analysis by the Royal College of Radiologists has shown that as a result, reporting on scans is regularly outsourced to external providers.[37] The rollout of GP Direct Access, lung cancer screening, and political pressure to reduce elective care

waiting lists add more pressure to an already under-resourced system.[38] The NHS must recruit more radiologists and radiographers, and plan for progression to retain current staff.

There are challenges to recruitment and retention across the career pathway:

- Not enough trainee radiologists specialise in interpreting chest and lung CTs (thoracic radiology), and there are not enough roles for them to go into. This exacerbates delays in diagnosis and treatment for respiratory conditions, particularly those where CT is essential, such as bronchiectasis or interstitial lung disease.[39]
- Trained radiologists struggle to find posts matching their education and experience, due to widespread recruitment freezes and uncertain funding settlements.[40] In 2024, 470 FTE posts were advertised, well below the number needed to meet the shortfall.[41] Locum work and international recruitment has increased, particularly in smaller departments, which are then more vulnerable to disruption when staff move on.[42]
- Retention is further threatened by shrinking amounts of staff training time, partly due to high demand for reporting on acute scans[43] but also limitation on progression. Supported by radiologists, advanced practitioner radiographers can make clinical decisions where appropriate.[44] With these radiographers able to report on other imaging such as X-rays, radiologists can spend more time interpreting CT scans.
- Experienced consultants are leaving the NHS at an earlier age, with radiologists leaving the NHS at a median age of 50 in 2024.[45] This is leading to a loss of expertise among senior clinicians, who ideally would be able to teach and support trainees at the beginning of their own careers. 26% of radiologists specialising in chest/lung CTs are forecast to retire in the next five years, the joint-highest amongst all specialisms.[46] This puts extra pressure on radiologists at all career stages.

The Richards review in 2020 recommended expanding the imaging workforce by 2,000 radiologists and 4,000 radiographers.[47] Five years later, the clinical radiology consultant workforce has grown by fewer than 800 full-time posts.[48] In 2024, recruitment was frozen in one in five radiology departments, and the number of advertised vacancies for consultants fell to 152, from 519 in 2023.[49] This left a shortfall of 1,962 posts – meaning in 2024 only 7% of consultant roles required to meet clinical demand were actually advertised. Shortfalls are worse in some areas than in others: London has 9.9 radiologists per 100,000 people compared to only 5.5 in the East Midlands.[50] This contributes to regional inequalities in patient waiting times, as well as cost to the local system through outsourcing.[51] At the same time, CT scanning is growing at a faster pace than other modalities, increasing by 8.4% in 2023-24 compared to 2.6% growth in chest X-rays.[52] This generates more, and more complex, imaging for radiologists to report. The NHS is forced to outsource reporting as otherwise the system would collapse.[53] Outsourcing also duplicates work in cases where the report quality is not high enough or where scans are complex, and NHS staff must review imaging themselves. The amount paid by the NHS for outsourced reports has doubled since 2019, from £108m to £216m a year, reflecting the lack of adequate growth in staff numbers and working hours required for timely reporting.[54]

AI is part of government plans to free up clinician time and speed up reporting of scans[55], and is already being used by many radiologists and radiographers.[56] Research conducted into using AI to report on chest imaging has shown it can be a useful tool, but doesn't perform noticeably better than a radiologist.[57] Where AI tools have been introduced, only 6% of radiology departments reported a decreased workload and 56% reported no change, according to Clinical Directors.[58] AI and digital tools are a prominent part of the new 10 Year Health Plan for England[59], and can be used to support radiography, but cannot replace the need to increase staffing numbers as a route out of the workforce crisis.

83% of trusts listed a lack of radiographers as a challenge to expanding their scanning capacity in 2024[60] and in 2023, the NHS Long Term Workforce Plan noted that diagnostic radiographers were among the roles with the greatest predicted shortfall in numbers by 2036/37.[61] The transformation of respiratory diagnostics, and tackling the inequalities in access to CT scanning, requires these workforce issues to be overcome.

To tackle workforce shortages:

- The upcoming 10 Year Workforce Plan must include targets for the number of trained radiologist posts to be filled by 2035, which can be used by DHSC as an accountability mechanism for those ICBs not providing enough resource to staffing.
- The upcoming 10 Year Workforce Plan must lay out how ICBs and trusts can utilise the power of AI to assist in diagnosis via CT but must not solely rely on it to boost workforce capacity.
- ICBs must provide trusts with the funding needed to recruit specialist radiologists on a permanent or otherwise more secure basis.

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