Are radiology services improving – a progress update

Hywel Dda University Health Board

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Audit snapshot

What we looked at

1 This review assessed the progress made by Hywel Dda University Health Board (the Health Board) in implementing recommendations from our 2017 Review of Radiology Services. We also looked at whether the Health Board has effective plans to meet current and future demands for radiology services.

Why this is important

2 Radiology plays a central role in diagnosing, monitoring and treating health conditions. It supports hospital, primary and community care services by using different types of scanners and equipment to take high quality images of the inside of the body. These images help doctors understand what is happening in the body so they can plan the right care. Poor radiology services can lead to delays or incorrect diagnosis and treatment resulting in poor patient outcomes. They can also lead to increased costs due to the need to repeat tests, for example.

3 Our 2017 review found that the Health Board managed the radiology service well operationally. However, we found risks to current and future services. These risks came from rising demand, reporting backlogs, problems recruiting staff, and an IT system that did not fully meet the Health Board's needs.

4 The review made 11 recommendations covering 16 areas for improvement. These focused on:

- access to ultrasound services out of hours;
- reducing reporting backlogs;
- collecting patient feedback;

- improving the quality of referrals;
- increasing staff appraisal and training rates;
- better service planning; and
- stronger performance management.

5 Our national report, Radiology Services in Wales, published in 2018 also found similar issues. It showed that radiology services across Wales face common challenges that could affect their long-term sustainability.

What we have found

6 The Health Board has addressed five of the 11 2017 recommendations. It has made short-term improvements in radiology performance. These include reducing long waiting times and improving reporting for key pathways such as the Single Cancer Pathway. However, demand is still high, and performance is not yet sustainable. Ultrasound services face the greatest pressure, with the largest waiting lists and the longest waits across all hospital sites.

7 Despite the Health Board taking targeted action, there are still key risks. There is still no out of hours ultrasound service, and no completed options appraisal or cost-benefit analysis to support a long-term solution. Reporting improvements depend heavily on short-term funding, outsourcing, and extra activity. Workforce shortages continue, particularly in ultrasound and radiology reporting, and there is no fully costed, multi-year plan to replace ageing equipment.

8 Planning and oversight have improved, with better performance reporting and clearer governance. Patient feedback is now routinely captured and compliance with appraisal and mandatory training is above target levels. However, radiology planning is still spread across several documents and focused on short to medium term recovery. The Health Board does not yet have a single, integrated long-term plan covering demand, workforce, equipment, and digital needs.

What we recommend

9 We have made four new recommendations which replace the outstanding recommendations from our 2017 review. The recommendations focus on:

- ultrasound out of hours services;
- improving the quality of referrals;
- analysing patient feedback; and
- developing and maintaining a radiology plan.

Key facts and figures

- Five of the 11 recommendations from our 2017 review are now complete. Six are still outstanding.

- Under Welsh Government's escalation and intervention arrangements, the Health Board is at Level 3 for planned care and Level 4 for fragile services, including radiology services.

- From January 2020 and January 2026, the radiology waiting list more than doubled. It peaked at 14,806 patient pathways[1] in January 2025.

- Between January 2025 and December 2025, the number of patient pathways waiting over eight weeks fell from 7,108 to 1,432. However, it then rose again to 2,858 in January 2026.

- In 2025-26, £3.4 million recurrent funding and £1.4 million non-recurrent funding were allocated to support stabilisation and backlog recovery[2].

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[1] Using the 'open' pathway measure of patients currenting waiting for diagnostic tests. Each pathway is a patient waiting but a patient may need more than one diagnostic test and therefore be on the waiting list more than once. The actual number of patients waiting will be lower than the number of pathways

[2] The 2025-26 Annual Plan included £3.4 million recurrent funding for radiology stabilisation and diagnostic capacity. In July 2025, the Health Board also received £1.4 million non-recurrent funding from Welsh Government to support diagnostic recovery and backlog reduction.

Our findings

Radiology performance

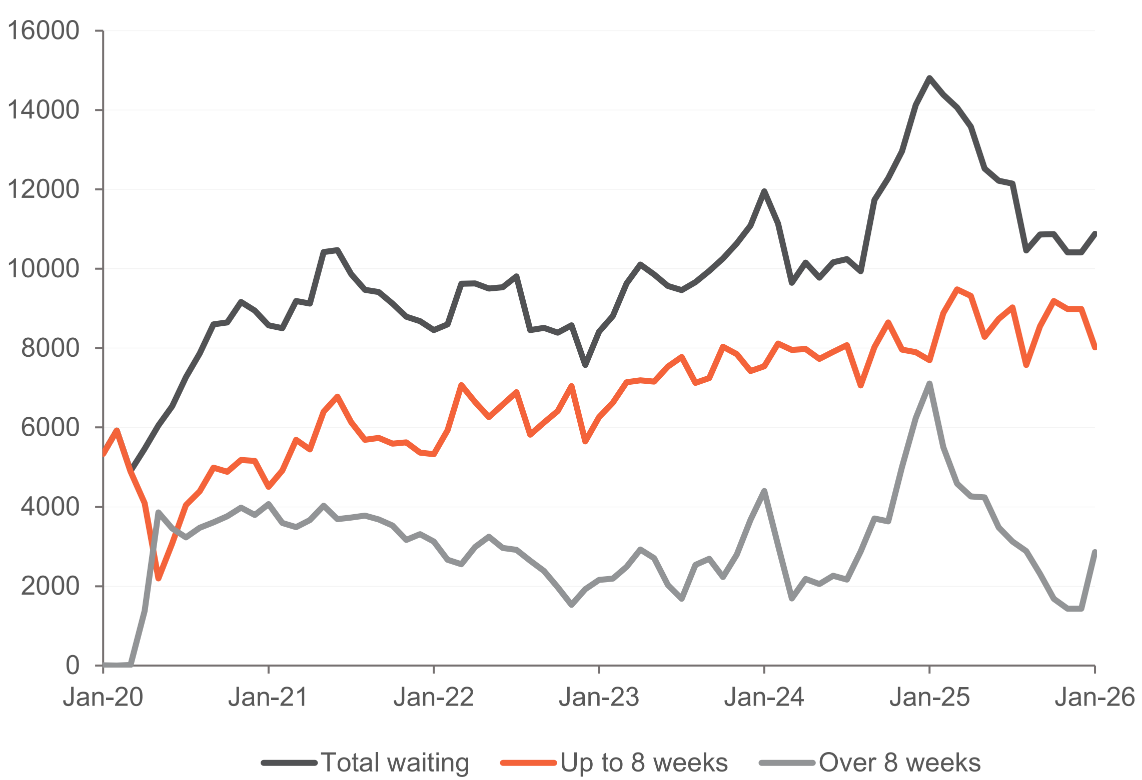
While targeted action has reduced the longest waits, overall demand is still high and current performance is not sustainable

10 All health bodies must meet the Welsh Government diagnostic waiting time target, which states that patients should not wait more than eight weeks for a diagnostic test.

11 **Exhibit 1** shows that the Health Board's radiology waiting list more than doubled between January 2020 and January 2026, reaching a peak of almost 15,000 patient pathways in January 2025. Although most patients are seen within the target waiting time, too many continue to wait longer than eight weeks. In January 2026, 2,858 patient pathways were waiting more than eight weeks.

12 Since early 2025, the overall waiting list has reduced, largely due to sustained action focused on the longest waits. However, demand is still high, with a consistently large number of patients waiting up to eight weeks.

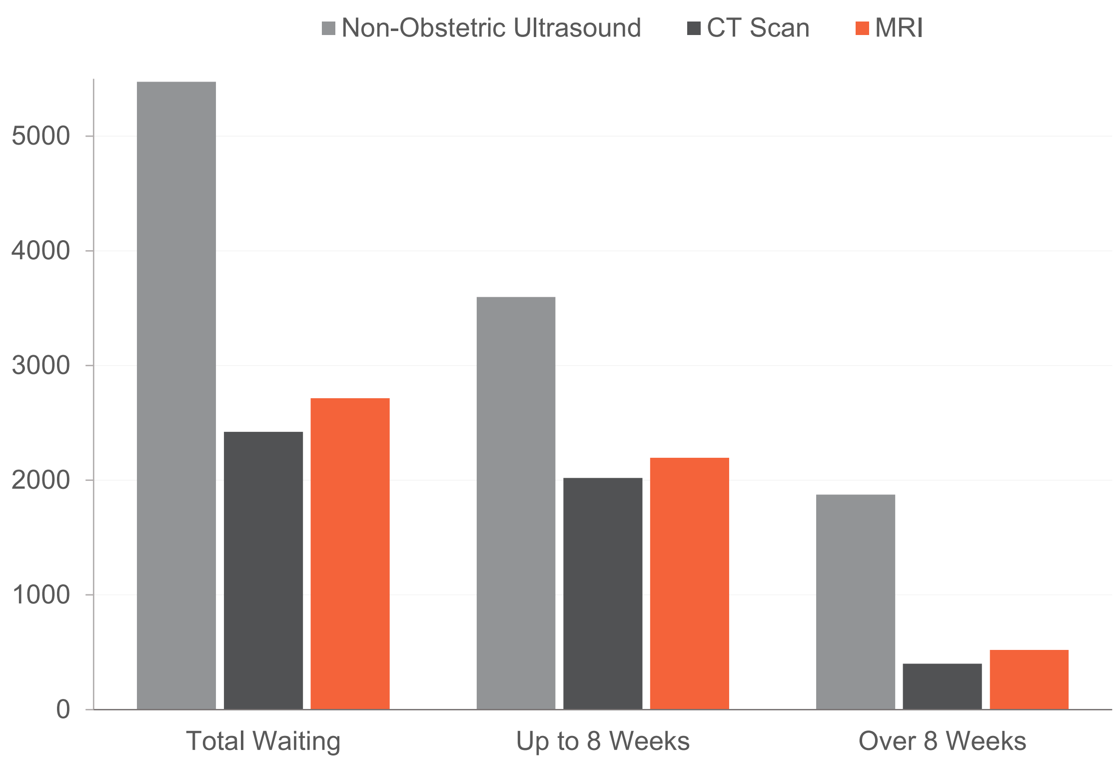
Exhibit 1: number of patient pathways waiting for radiology services, showing total waits and up to and over 8 weeks – January 2020 to January 2026



Source: Diagnostics services waiting times, Welsh Government

13 **Exhibit 2** shows that non-obstetric ultrasound has the largest waiting list and the highest number of patients waiting longer than eight weeks, which shows ongoing pressure on this service. CT (computed tomography) and MRI (magnetic resonance imaging) waiting lists are smaller, and most patients are seen within eight weeks. However, some patients still wait longer than the national target. Overall, demand is still high, particularly for ultrasound.

Exhibit 2: Number of patient pathways waiting for radiology tests, by scan type and waiting time – January 2026



Source: Diagnostics services waiting times, Welsh Government

14 In January 2026, ultrasound had the greatest number of patient pathways waiting over eight weeks at every hospital site. The largest ultrasound waiting list was at Withybush Hospital, with more patient pathways waiting over eight weeks at Withybush and Glangwili Hospitals. Prince Philip Hospital had the largest waiting list for CT and MRI compared with other hospital sites, while Bronglais Hospital had smaller waiting lists for all types of scans. These differences show that demand and capacity vary between hospitals and highlight the need for targeted planning, especially for ultrasound services. We discuss planning arrangements later in this report.

Addressing service risks and challenges

The Health Board understands its main radiology risks, but reliance on short-term actions means ultrasound, workforce, and equipment risks are still high

Ultrasound out of hours service

15 Our 2017 review found that the Health Board did not provide an out of hours non-obstetric ultrasound service. This is still the case. Capacity limits, staff shortages and pressure on daytime services continue to pose clinical and service risks, particularly for urgent and emergency care pathways. Although risks are managed through clinical prioritisation and escalation, this does not address the underlying service gap.

16 In 2017, we recommended that the Health Board assess the impact of not having this service and carry out a cost-benefit analysis to find a sustainable solution. However, we found no completed analysis setting out options, costs, and risks.

Reporting backlog

17 Timely radiology reporting is essential for safe and effective patient care. Our 2017 review found that the Health Board often missed reporting targets and had growing backlogs. Reporting times have since improved in some areas. For example, reports for the Single Cancer Pathway are now completed within seven days, compared to over five weeks in 2024-25.

18 However, these improvements have relied on £1.4 million non-recurrent Welsh Government funding, alongside increased outsourcing, and short-term recovery work. The service still depends heavily on outsourced reporting. There is no clear plan to prevent future backlogs, and reporting times continue to rely on reactive measures.

Referral quality

19 Clear referral guidance helps ensure patients receive the right test at the right time. Poor quality or unnecessary referrals waste capacity and increase pressure on services. Our 2017 review found that referral quality was inconsistent and guidance was not always followed.

20 Since then, the Health Board has made improvements. These include stronger links with primary care, regular meetings between clinical leads, joint reviews of referral processes, updated referral guidance, and clinical audits. Audit findings are shared across services to support learning and improvement.

21 However, we found limited evidence of a consistent approach across the Health Board. While guidance, audits, and feedback mechanisms are in place, there is no standard referral form. There is also no routine reporting to show improvement in referral quality. Systems to record, analyse, and share learning from inappropriate referrals are also underdeveloped.

Equipment and infrastructure

22 Radiology services depend on reliable and up-to-date equipment. Older machines fail more often, cost more to maintain, and may produce lower-quality images. The Health Board recognises these risks, which are recorded in its operational and corporate risk registers.

23 In 2017, we recommended that the Health Board develop an equipment replacement programme. However, we found no fully costed, prioritised multi-year plan covering all radiology equipment. Current arrangements rely on reacting to risks rather than following a clear investment plan.

24 Radiology equipment also depends on digital systems to capture, store, view, and report images. Equipment performance, workflow, and reporting times all rely on these systems.

25 The Health Board is preparing for national radiology system updates, including PACS (Picture Archiving and Communication System) and RIS (Radiology Information System). However, it has not fully developed or tested plans to manage delays or disruption. Our separate review of digital transformation at the Health Board, considers digital risks and dependencies in more detail.

Workforce

26 Our 2017 review highlighted staff shortages and an ageing workforce. Since then, the Health Board has started an Organisational Change Process (OPC) for radiology. This aims to improve leadership, governance, skills, and capacity.

27 Despite this, staff shortages are still a major issue, especially in ultrasound and reporting. The Health Board still relies on agency staff, outsourcing and overtime to keep services running. The Radiology OCP has moved into partial implementation. New leadership, governance, and advanced roles have been introduced. However, many posts were newly created, still being recruited or in early stages at the time of our review. The OCP mainly focuses on leadership and oversight. Its impact on long-term workforce stability is not yet clear.

28 Compliance with mandatory training has improved, with both clinical and non-clinical staff generally meeting the 85% target. In contrast, PADR rates are more variable and tend to fluctuate, indicating a need for greater focus.

Patient feedback

29 Patient feedback helps improve services and understand patient experience. Our 2017 review found that feedback was not collected routinely. Since then, the Health Board has made progress. It has engaged stakeholders through its Clinical Services Plan[3] and introduced regular patient surveys. However, it is not clear how this feedback is analysed or used to improve services.

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[3] The Clinical Services Plan sets out proposals to reconfigure nine fragile services to improve sustainability, access, and patient outcomes over the medium term.

Planning and oversight

Planning has improved, but arrangements are still fragmented and focused on short-term stabilisation

Planning

30 Radiology planning is set out across several documents. These include the Annual Plan, service stabilisation plans, the Clinical Services Plan, and the OCP document. Together, they recognise radiology as a fragile service and outline plans to improve access, performance, and sustainability.

31 However, there is no single, integrated radiology delivery plan. There is no agreed baseline setting out expected demand by scan type and hospital site. The Health Board has carried out demand modelling, but it has not been formally agreed or used consistently to inform planning.

32 As a result, planning is still fragmented. It focuses mainly on short- to medium-term stabilisation and performance recovery. There is limited evidence of a joined-up, long-term plan that brings together demand, capacity, workforce, equipment, and digital needs.

33 In February 2026, the Board agreed changes to radiology services under the Clinical Services Plan. These include both short- and longer-term changes. These include:

- keeping 24/7 emergency diagnostic radiology at all four hospital sites;
- continuing weekday planned diagnostic services at Bronglais Hospital;
- moving Prince Philip and Withybush Hospitals towards seven-day planned services, with weekday interventional radiology; and
- keeping Glangwili Hospital focused on inpatient interventional radiology.

34 The Board also agreed to carry out further work to develop a planned diagnostic radiology hub. This is subject to engagement and approval of a detailed, costed plan. At the time of our review, no implementation plan has been developed.

Monitoring and oversight

35 Our 2017 review found weaknesses in radiology performance reporting. Since then, the Health Board has improved governance and oversight. Accountability is clearer, and performance and risk reporting are more structured.

36 At an operational level, radiology performance is monitored through service-level reports and dashboards. These are reviewed in operational management and performance meetings. They include data on activity, performance against national targets, reporting times, workforce measures, and service risks. This supports day-to-day oversight and escalation.

37 The Health Board also now submits data to the NHS Benchmarking Network, which was not done at the time of our original review.

38 At Board level, the Board and the Finance and Performance Committee receive routine updates on radiology waiting-time performance through the integrated performance report. This focuses on performance against the Welsh Government target and includes updates on escalation status for planned care and fragile services, as well as key risks affecting radiology services.

39 Radiology risks are regularly escalated through governance structures and recorded in operational and corporate risk registers. These include risks linked to ultrasound services, workforce capacity, equipment condition, and reliance on outsourced reporting.

40 However, many of these governance arrangements are recent, so it is too early to assess their full impact. While performance and risk information is more visible, assurance is still uneven in key areas. This is especially true where services rely on temporary measures or where plans are still developing. Examples include:

- ultrasound resilience;
- quality of outsourced reporting;
- digital system changes; and

- equipment replacement.

Recommendations

41 We have made four new recommendations, which replace the outstanding recommendations from our 2017 review. The status of our 2017 recommendations is set out in **Appendix 2**.

R1 The Health Board should evaluate the clinical, operational, and financial impact of not having an out of hours non-obstetric ultrasound service **(see paragraph 16)**. The evaluation should:

- set out an evidence-based preferred way forward, including clear options, costs, benefits and risks; and
- provide Board-level assurance on how the preferred approach will reduce underlying service risks and improve service resilience.

R2 The Health Board should evaluate how referral quality is managed across radiology services to support effective demand management and service planning **(see paragraphs 19-21)**. This should include:

- agreeing a standardised Health Board-wide referral approach and supporting guidance;
- improving the routine monitoring and reporting of inappropriate referrals, with learning and feedback provided to referrers; and
- using referral quality information to inform demand management, capacity planning and service improvement.

R3 The Health Board should put arrangements in place to routinely analyse patient feedback on radiology services and use it to improve services and support learning **(see paragraph 29)**.

R4 The Health Board should develop and maintain a radiology plan that addresses current and future service challenges **(see paragraphs 30-34)**. The plan should:

- establish and routinely refresh a radiology demand baseline by scan type and hospital site to inform capacity planning;
- set out how workforce capacity will be strengthened, especially in key pressure areas such as ultrasound and radiology reporting, and how reliance on agency staff and outsourcing will be reduced;
- include a fully costed and prioritised equipment replacement programme;
- explain how digital systems and national radiology platforms will be managed safely, including how services will continue if systems are delayed or disrupted; and
- ensure that an appropriate committee receives regular progress updates to support effective oversight and assurance.

Appendices

1 About our work

Scope of the audit

We looked at whether the Health Board has effective arrangements to manage current and future demand for its radiology service. We also assessed the extent to which the Health Board has addressed audit recommendations from our 2017 review of Radiology Services.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the Health Board have a clear planning approach to manage current and future radiology service needs?
- Does the Health Board have effective systems in place to address current radiology demand and drive service improvement?
- Are the Health Board's actions making a measurable difference in managing radiology demand and improving services?

Criteria

In gathering evidence against the above questions, we were looking for the Health Board to show that it had:

- made the expected progress in implementing our 2017 audit recommendations (set out in **Appendix 2**) to address the issues and concerns found in the audit.
- current and longer-term plans in place to manage radiology service demand.

Methods

We undertook our audit work between July 2025 and March 2026

We reviewed key documents, including:

- Annual Plan 2025-26;
- Integrated Performance Report;
- Relevant radiology deep-dive committee papers;
- Workforce modelling and investment cases;
- Organisational Change Process papers relating to radiology services;
- Radiology risk registers and corporate risk escalation papers;
- Capital investment prioritisation work relevant to radiology equipment; and
- Clinical Services Plan consultation materials relevant to radiology services

We interviewed the following:

- Service Director (Acute Hospital and Health Services)
- Deputy Head of Radiology
- Clinical Director for Radiology / Consultant Radiologist
- Chief Operating Officer

We also asked the Health Board to complete and submit a self-assessment, setting out its view of progress against the 2017 recommendations. The Health Board submitted a completed self-assessment and supporting documentation on 6 October 2025.

2 Previous recommendations

Our 2017 Review of Radiology Services made 11 recommendations, covering 16 areas for improvement. Below is the status of those recommendations based on our 2026 work.

R1 Over the next year assess whether the absence of a non-obstetric ultrasound out of hours service has a negative impact on patient flow and outcomes. If a relationship is found, the Health Board should undertake a cost benefit analysis exercise to inform the way forward **(replaced by R1 2026).**

R2 Develop an action plan detailing how reporting backlogs will be managed sustainably. For example, by making a short-term increase in outsourcing reports whilst workforce and training plans are developed **(replaced by R4 2026).**

R3 Develop mechanisms to ensure that patients' views are routinely gathered **(complete, see paragraph 29).**

R4 To improve the quality of referrals, within the next year the Health Board should **(replaced by R2, 2026)**:

a) review the different radiology referral processes in partnership with key stakeholders including primary care, to set up specific ways in which the processes could be more efficient and effective.

b) agree a standardised Health Board-wide approach to the referral process, including the types of conditions and concerns that should be referred.

c) produce guidance and other supporting materials to clearly explain the updated approach to referrals.

d) communicate the updated approach to all relevant staff and stakeholders, using a range of communication methods.
e) keep a record of all inappropriate referrals including the name of the referrer, reason for inappropriateness and what action was taken.
f) routinely report inappropriate referral rates and any recurring concerns about inappropriate referrals back to key stakeholder groups.

R5 Over the next year, continue to develop and implement consistent methods of recording activity, so that the Health Board is in a better position to take part in NHS Benchmarking Network **(complete, see paragraph 37)**.

R6 Over the next year, increase appraisal rates for non-clinical radiology staff to at least the level of radiographers and ultra-sonographers **(complete, see paragraph 28).**

R7 Over the next year, increase mandatory training rates for all radiology staff to at least 85% **(complete, see paragraph 28).**

R8 Over the next year, establish a baseline level of demand for the service so that the Health Board can better understand and quantify the challenges it faces **(replaced by R4, 2026)**.

R9 Over the next year, develop an annual plan, or operational plan. The plan should set out the workforce needed to meet its current baseline demand as well as future demand **(replaced by R4, 2026).**

R10 Over the next two years, develop an equipment replacement programme **(replaced by R4, 2026)**. The plan should include:

- equipment priorities, requirements and associated costs; and
- outline the risks to the service/patients of not delivering the programme within the required timescales.

R11 Strengthen performance management by (**complete, see paragraphs 35-40**):

- regularly producing performance reports and reporting them to the appropriate committee; and
- widening the range of performance measures aligned to the business and service objectives to include:
  - equipment downtime, vacancy levels, the number of unreported images, performance against internal referral and reporting times.

3 Key terms in this report

Term	Description
Computed Tomography (CT scan)	An imaging test that uses X-rays and computer processing to produce detailed cross-sectional images of the body. It is often used to investigate injuries, detect disease, and guide treatment decisions.
Interventional Radiology	A medical specialty that uses imaging techniques (like X-rays, CT scans, or ultrasound) to guide minimally invasive procedures to diagnose and treat diseases.
Magnetic Resonance Imaging (MRI scan)	An imaging test that uses strong magnetic fields and radio waves to produce detailed images of organs and tissues inside the body. It does not use X-rays and is commonly used to examine the brain, spine, joints, and soft tissues.
Non-obstetric ultrasound	An imaging test that uses sound waves to produce images of structures inside the body not related to pregnancy. It is commonly used to examine organs such as the liver, kidneys, gallbladder, blood vessels, and to investigate pain or swelling.
Outsourcing	When imaging services (like reporting scans or performing imaging procedures) are provided by an external company or third-party organisation rather than the hospital's own radiology department.
Picture Archiving and Communication System (PACS)	A system used to store, view, and share medical images electronically.

Term	Description
Radiology reporting	The process of interpreting images (like X-rays, CT scans, or MRIs) and producing a written report that explains the findings.
Radiology Information System (RIS)	An information system which supports the administrative and clinical workflow of radiology services, including referrals, scheduling, reporting, and results management.
Single Cancer Pathway (SCP)	A healthcare process designed to ensure patients with suspected cancer are diagnosed and treated as quickly as possible within set timeframes.

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Management response form

Audited body	Hywel Dda University Health Board
Audit name	Are radiology services improving – a progress update
Date received	2 June 2026

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	The Health Board should evaluate the clinical, operational, and financial impact of not having an out of hours non-obstetric ultrasound service **(see paragraph 16)**. The evaluation should: • set out an evidence-based preferred way forward, including clear options, costs, benefits and risks; and • provide Board-level assurance on how the preferred approach	Define the scope of "out of hours" for non-obstetric ultrasound and agree the service standard by **October 2026**. Complete a gap analysis of current provision, including workforce, demand, activity, clinical risk, transfer implications and financial impact, by **February 2027**. Develop and appraise option(s) for future provision, setting out costs, benefits, risks and workforce requirements, by **June 2027**.	October 2026 February 2027 June 2027	Head of Radiology

	will reduce underlying service risks and improve service resilience.	Present a preferred option with an implementation recommendation to the appropriate Board or Committee for assurance and decision by **July 2027**	July 2027	
R2	The Health Board should evaluate how referral quality is managed across radiology services to support effective demand management and service planning **(see paragraphs 19-21)**. This should include: • agreeing a standardised Health Board-wide referral approach and supporting guidance; • improving the routine monitoring and reporting of inappropriate referrals, with learning and	Establish a **Radiology Referral Management Group** with approved terms of reference, membership and reporting arrangements by **November 2026**.	November 2026	Clinical Director - Radiology
		Develop and approve a Health Board-wide radiology referral standard and supporting referrer guidance, including IR(ME)R compliance requirements, by **June 2027**. Undertake a formal audit of referral quality across all sites and modalities against the newly developed standards and IR(ME)R requirements by **November 2027**, with findings communicated promptly to clinical leads to enable the timely implementation of targeted improvement actions.	June 2027 November 2027	Clinical Director - Radiology

	feedback provided to referrers; and • using referral quality information to inform demand management, capacity planning and service improvement.	Implement routine monitoring of inappropriate or incomplete referrals across all sites and modalities, together with a feedback mechanism for referrers, by **June 2028**.	June 2028	Clinical Director - Radiology
		Use referral quality data to inform demand management, capacity planning and service improvement priorities, with a formal report to the relevant governance group by **November 2028**.	November 2028.	Deputy Head of Radiology
R3	The Health Board should put arrangements in place to routinely analyse patient feedback on radiology services and use it to improve services and support learning **(see paragraph 29)**.	Finalise the operating model and complete recruitment to the Quality Manager through the agreed OCP process by **February 2027.**	February 2027	Head of Radiology
		Map all existing sources of patient feedback (concerns, complaints, surveys, compliments) and current reporting arrangements across radiology services by **July 2027**	July 2027	
		Implement a standard process for collecting, triangulating and reviewing radiology patient feedback from all available sources (e.g. concerns, complaints, surveys, compliments) by **November 2027**.	November 2027	

		Commence reporting to Radiology Governance and Care Group meetings, **demonstrating and evidencing that insights derived from patient feedback** are informing service improvement actions and delivering measurable improvements in patient experience indicators by **March 2028**	March 2028	Quality Assurance Manager - Radiology
R4	The Health Board should develop and maintain a radiology plan that addresses current and future service challenges **(see paragraphs 30-34)**. The plan should: • establish and routinely refresh a radiology demand baseline by scan type and hospital site to inform capacity planning; • set out how workforce capacity will be strengthened, especially in key pressure areas such as	**Establish analytics capacity required to implement a radiology demand and capacity tool** and produce a consistent baseline by modality and site, including agreed data definitions, reporting requirements and ownership arrangement, by **December 2027.**	December 2027	Deputy Head of Radiology
		Produce a workforce plan for key pressure areas, including ultrasound and reporting capacity, setting out actions to reduce reliance on agency staffing and outsourcing, by **January 2028.**	January 2028	Deputy Head of Radiology
		Complete a prioritised and costed equipment requirements and replacement programme aligned to risk, service need and capital planning by **December 2026.**	December 2026	Deputy Head of Radiology

	ultrasound and radiology reporting, and how reliance on agency staff and outsourcing will be reduced; • include a fully costed and prioritised equipment replacement programme; • explain how digital systems and national radiology platforms will be managed safely, including how services will continue if systems are delayed or disrupted; and • ensure that an appropriate committee receives regular progress updates to support effective oversight and assurance.	Scope the requirement for a stand-alone Radiology digital system (including Radiology National platforms) or update the existing site business continuity and contingency arrangements to manage disruption to digital systems and national radiology platforms by **December 2026.**	December 2026	Radiology Systems Manager
		Complete and submit the overarching Radiology plan (analytics, workforce, equipment, digital) for committee oversight and agreement of committee update schedule by **March 2028.**	March 2028	Head of Radiology