



# Scanxiety

Redesigning the Diagnostic Experience in the NHS

## Executive Summary

We brought together patients, care providers, support group leaders and service managers to better understand a phenomenon that many of us have sensed for some time but rarely examined directly: scanxiety.

Scanxiety is the anxiety associated with diagnostic imaging; the waiting before the scan, feelings during the scan, and most acutely, the period while waiting for results. It is not confined to patients. It extends to families, to friends, and, as we heard clearly during our discussion, to care providers working in a system that is stretched beyond the limits it was designed for.

For some patients, life becomes “one scan to the next.” One patient described having 20 scans in just over two years, a rhythm of care that leaves little room for psychological recovery. Another spoke of waiting three weeks for CT or MRI results, even though her PET results came back in a week. One admitted she did not tell her husband when she was waiting for results, carrying the burden alone to spare his emotional energy. Many described the same visceral experience: “We dread the phone ringing.”

Scanxiety exists not simply because people fear bad news. It exists because there is a large and often invisible “anxiety window” within the system. This is the period between referral, scan, reporting, multidisciplinary team (MDT) review and communication. Each handover creates uncertainty. Each delay lengthens that uncertainty. And inconsistency in communication amplifies it further.

Technology means that communication is technically easier than ever. Results can be uploaded instantly to apps. Images are available across systems. But without context, without timing clarity, and without support, faster communication can paradoxically create more distress.

The NHS is operating under extraordinary pressure. Radiology teams are working tirelessly to report scans at speed, manage backlogs, and support urgent care. The conversation did not seek to attribute blame. Instead, it recognised that scanxiety is a structural symptom of a system not yet optimised for the scale and expectations of modern diagnostic care.

The good news is that there are practical, meaningful changes we can make now. We propose five initiatives for action:

- 1** A Diagnostic “Tube Map”
- 2** A Communication Preference Plan
- 3** Automatic Follow-Up Scheduling
- 4** Seamless System Integration
- 5** Continuous Continuity

Scanxiety is real. It is prevalent. But it is not inevitable. With thoughtful redesign, we can meaningfully reduce the anxiety window and improve the experience of patients and staff alike.

**Scans help us detect disease and guide treatment. Anxiety helps us detect system faults and can help guide redesign.**

## The Lived Experience

### When Life Becomes “One Scan to the Next”

The most powerful part of our roundtable was not the discussion of systems or policy. It was the lived experience.

Cancer patients in particular described scanning as relentless. “As soon as you get one result,” one participant told us, “you’re waiting for the next scan.” Another said, “Life feels like one scan to the next.”

One patient described undergoing 20 scans in just over two years. Another recalled nine scans in twelve weeks during her staging period. For patients with metastatic or chronic disease, the rhythm of life becomes punctuated by imaging cycles, three months to see if treatment is working, another three months to check for progression.

The anxiety does not begin when the result arrives. It begins the moment the scan is booked.

Many described the particular dread of waiting for a call: “We dread the phone ringing.” Others described a different form of distress from the lack of any communication at all. Some had received scan results through apps without explanation. Some were told nothing until the next clinic appointment. Some said they had never received results at all.

One participant told us she did not tell her husband she was waiting for results. Another described managing her children’s direct and difficult questions about mortality while she herself was in limbo.

Scanxiety is not an abstract term. It is a psychological and relational load that reshapes daily life. It affects family life, work life, and the ability to plan even small aspects of the future.

At the same time, clinicians and service managers described a parallel strain that is often invisible to patients. Radiologists returning from leave to face two weeks’ worth of cancer scans awaiting review. Multidisciplinary team meetings oversubscribed before they even begin. Last-minute requests for 24-hour reporting arriving on the eve of the clinic, compressing already fragile timelines.

This is what constant escalation looks like. A service operating without slack, where capacity is always slightly behind demand, and where professionals carry the quiet knowledge that behind every case is someone waiting, anxiously, for clarity.

In this environment, the anxiety window does not only affect patients. Clinicians feel it too. They know that a delayed report may delay a treatment decision. They know that an oversubscribed MDT means another week of uncertainty for someone at home. They understand the stakes of every backlog. The weight of that knowledge accumulates quietly and persistently.

Scanxiety, then, is not simply experienced at the receiving end of the phone. It exists on both sides of it.

## The Anxiety Window

### Where the System Creates Uncertainty

As we listened to these experiences, a pattern emerged.

Scanxiety often sits in the spaces between steps:

Referral → Scan → Report → MDT discussion → Clinic appointment → Communication

Each step is clinically necessary. But the time and opacity between them create an anxiety window.

A scan unlocks the next step, but patients often do not know what that next step is, when it will occur, or who is responsible for it. The system is designed to move information efficiently between professionals. It is less well designed to provide patients with visibility across the whole journey.

Dashboards measure turnaround times. They track reporting performance. They record backlogs. But they do not capture the lived experience of waiting.

For clinicians, the anxiety window can also be acute. Reporting backlogs delay treatment decisions. Radiologists know that behind each case is a person waiting. Managers must balance urgent escalation requests against limited capacity.

Importantly, this is not about fault. The system was not designed for the current scale of imaging demand, nor for the expectations of real-time communication that patients now experience in other parts of life. When we can track parcels to the minute, uncertainty in healthcare feels sharper.

Scanxiety is not emotional fragility. It is structural opacity.

## Communication

### Information Without Context

One of the most debated issues was the release of scan results via digital platforms.

On the one hand, transparency is empowering. Patients should not be excluded from information about their own bodies. On the other, a radiology report without context can be distressing and confusing. As one clinician put it, a scan report can feel like “a one-handed clap” unless it is interpreted within the clinical picture.

We heard about the wide variation. Some patients see results immediately in apps. Others are told nothing until the clinic. Some wait weeks without an update. Some receive calls without preparation.

The issue is not simply speed. It is alignment between information and support.

Patients themselves differ. Some want every detail as soon as it is available. Others prefer headline reassurance first. Some do not want digital release at all. One participant captured it clearly: the problem is not always the result — “it is the waiting without knowing how the result will come.”

New technologies can help here. Generative AI tools could summarise reports in plain language. Automated updates could notify patients when a scan is reported but pending MDT discussion. But speed must be balanced with safety, interpretation and support.

The aim is not simply faster information. It is information designed around human experience.

## Fragmentation and Flow When Systems Do Not Speak

We also heard stark examples of system fragmentation.

One patient described having a scan in a private hospital that could not be transferred seamlessly into the NHS system. Duplicate scans were required because software systems were incompatible. The Image Exchange Protocol exists, but it is not instantaneous and often requires manual intervention.

Others described how radiologists may recommend a repeat scan in four weeks, yet current funding structures require the patient to return to their GP for re-referral. Administrative loops add weeks of delay and further uncertainty.

These are not clinical failures. They are flow failures.

When hospital systems, GP systems and private providers do not communicate smoothly, patients experience the consequences as anxiety. From the patient's perspective, the system appears disjointed. From the inside, clinicians are working around structural barriers.

Integration is not an abstract IT aspiration. It is an anxiety intervention.

## Workforce Reality

### Capacity, Governance and Fear

It would be easy to frame scanxiety purely as a patient experience issue. But doing so would ignore the pressures facing staff.

Radiologists described holiday backlogs, urgent escalation requests, and the tension between speed and safety. Diagnostic radiographers explained that they are legally unable to interpret scans for patients in the moment, even when they know patients are desperate for reassurance.

Service leaders spoke of Integrated Care Board (ICB) funding models that constrain flexibility. Multidisciplinary teams are often oversubscribed. Specialist radiologists in certain areas are scarce.

We must acknowledge a difficult truth: when a system operates at or beyond capacity, the anxiety within it becomes contagious.

Clinicians feel responsible for delays they cannot control. Managers balance risk daily. Staff absorb patient distress while managing their own workload pressure.

Scanxiety is not born of indifference. It is born of structural strain.

# Designing Out Scanxiety: Five Practical Actions

Despite the pressures described, the discussion was not pessimistic. There are practical, meaningful steps we can take now. Reducing scanxiety does not require a wholesale restructuring of the NHS. It requires deliberate narrowing of the anxiety window.

## **1** A Diagnostic “Tube Map”

Patients repeatedly asked for something simple: visibility.

A clear, visual map of the diagnostic journey — Referral → Scan → Reporting → MDT → Appointment → Communication.

Alongside this, a parcel-tracking style update so patients can see where their scan sits:

- *Scan completed.*
- *Report finalised.*
- *Awaiting MDT discussion.*
- *Clinic scheduled.*

Even when timelines cannot be shortened, transparency reduces uncertainty. A tube map does not change the distance between stations — but it tells you where you are. And knowing where you are reduces uncertainty.

## **2** A Communication Preference Plan

Not all patients want information in the same way.

At the start of the pathway, we should ask:

- *Do you want the full report immediately?*
- *A headline summary first?*
- *A phone call before anything appears in an app?*
- *Results only in the clinic?*

Communication should also reflect family context. Some patients shield children. Some involve extended family. Some dread unexpected phone calls. Others fear digital silence.

A simple communication preference plan, agreed at the outset, would transform the experience of waiting. The goal is not simply to release information faster, but to release it in a way that supports the individual receiving it.

### **3 Automatic Follow-Up Scheduling**

When a radiologist recommends “repeat in four weeks,” the system should not require the patient to re-enter through their GP.

Within agreed governance frameworks, follow-up scans should be auto-scheduled at the point of recommendation.

This is not radical reform. It is the removal of avoidable friction.

Every unnecessary administrative loop lengthens the anxiety window. Every additional referral step introduces delay and uncertainty. Where it is safe to do so, the pathway should move forward automatically.

### **4 Seamless System Integration**

Interoperability is often framed as an efficiency issue. It is also an anxiety issue.

Hospital and GP systems must communicate smoothly. NHS and private providers must exchange imaging without duplication. Reports should follow the patient, not the institution.

Every duplicate scan, every transfer delay, every incompatible system extends uncertainty. This includes screening programmes which can play an increasingly important part of cancer pathways.

Integration is not a technical ambition. It is psychological protection. A connected system is a calmer system.

## 5 Continuous Continuity

Scanxiety reduces dramatically when patients know who is walking the journey with them.

Consistent clinical contacts for example, a named nurse specialist, a familiar consultant, a reliable point of access almost always reduces uncertainty even when timelines cannot be shortened.

Continuity is not a luxury. It is an anxiety buffer.

Where continuity cannot be individual, it can be team-based. Patients should never feel that each scan restarts the relationship from zero. They should feel that someone remains alongside them, holding the thread of their story.

Reducing scanxiety is not only about systems moving faster. It is about systems holding people safely while they wait.

These five steps are tangible. None require waiting for a national overhaul. All can begin locally, iteratively and in partnership with patients.

We cannot eliminate waiting entirely. But we can shrink the uncertainty within it.

## Conclusion

**Scans help us detect disease and guide treatment. Anxiety helps us detect system faults and can help guide redesign.**

Scanxiety is not merely fear of bad news. It is the distress created by uncertainty, inconsistency and fragmentation within the diagnostic pathway.

We cannot eliminate waiting entirely. Nor should we pretend that resources are unlimited. But we can reduce unnecessary opacity. We can align communication with support. We can automate avoidable administrative loops. We can integrate systems more effectively. And we can measure not only turnaround time, but the lived experience of the anxiety window.

Scanxiety is real. It affects patients, families and staff alike. But it is also a design signal and design signals are meant to be acted upon.

The opportunity now is not to promise perfection, but to commit to narrowing the anxiety window. Even modest improvements in visibility, communication and continuity could meaningfully improve the lives of thousands of patients and the clinicians who care for them.

That work can begin now.