From the Ombudsman Robert Behrens CBE

Nadine Dorries MP

Minister for Patient Safety,
Suicide Prevention and Mental Health

Sent via email only

7 July 2021

Dear Minister,

I am writing to share a new PHSO report on how the NHS can learn from complaints about imaging, which I have laid in Parliament today. The report, *Unlocking Solutions in Imaging: working together to learn from failings in the NHS*, includes the learning from complaints that raise significant concerns about patient safety. It will be published on our website at midnight on Thursday 8 July and you can access an embargoed copy here.

We have produced this report to support and encourage NHS staff, leaders, and policy-makers to deliver safer care for patients.

The report draws on PHSO's unique evidence base to highlight four themes:

- **failure to follow national guidelines on reporting unexpected imaging findings**
- **failure to act on important unexpected findings**
- **delays in reporting imaging findings**
- **failure to learn from past mistakes.**

These failings led to missed opportunities for earlier diagnoses of cancer and, in the most serious case, an avoidable death. The cases show that these issues are not isolated to radiologists, radiographers, or imaging services, but relate to the whole system. These failings can only be learnt from and addressed through collaboration across clinical specialties, looking at the whole patient journey through imaging.

The investigations found that failings often resulted from an absence of adequate policies, processes, and digital reporting capabilities. Crucially, our report highlights the central importance of a culture of continuous learning and improvement. This is essential to ensure the same mistakes don't happen again.

We are acutely aware of the current pressures on the NHS and the need to ensure the NHS recovers well from the pandemic. There are currently **5 million** people waiting for elective care in the NHS. Alongside other diagnostic services, imaging will play an essential role in the care of many of these patients. The scale of the challenge facing the NHS is not a reason to avoid or postpone making improvements to the quality and safety of care, however. Rather, it underlines the urgent need for Government and the NHS to make the much-needed improvements

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we have identified, so NHS services can recover well from the challenges created by the pandemic, and so these challenges are not compounded by unsafe care.

We have made a number of recommendations to support the NHS in delivering the improvements needed. This includes a recommendation that the Department for Health and Social Care and NHS England writes to the Committee in six months to provide an update on progress. Our recommendations build on the work of the Healthcare Safety Investigation Branch, the Care Quality Commission, and the Independent Review of Diagnostic Services for NHS England led by Professor Sir Mike Richards.

We ask the Department of Health and Social Care to commit to these recommendations and use the learning from PHSO's cases to prioritise the improvements necessary to ensure that NHS services and staff can deliver safe, high-quality patient care.

Yours sincerely,

Rob Behrens

Rob Behrens CBE
Ombudsman and Chair
Parliamentary and Health Service Ombudsman