

Rt Hon Jeremy Hunt MP
Chair, Health and Social Care Committee

Sent via email only

20 July 2022

Dear Jeremy,

One year ago I laid a landmark report in Parliament ([‘Unlocking Solutions in Imaging’](#)) about how the NHS must learn from complaints about imaging.

In complaints we received, we saw serious issues in the way that the NHS reports and follows up on imaging, and how it fails to learn from mistakes. These failings often led to missed opportunities for earlier diagnoses of cancer and, in the most serious case, an avoidable death.

A man died avoidably because of imaging failings

Today we have published a harrowing [case](#) that signifies why it is so important that improvements continue to be made to this diagnostic area. In our investigation we found that a man of 65 died avoidably because a blockage to his intestine was not reported in an abdominal X-ray, and as a result he did not receive the treatment he required. It is essential that the NHS treat complaints as a source of insight to drive improvements in patient care, so that this does not happen to anyone else.

The cases in our original report showed that these issues are not isolated to radiologists, radiographers, or imaging services, but relate to the whole system of requesting, reporting and acting on the findings from imaging. The NHS can only learn from these failings and address these serious patient safety issues through collaboration across clinical specialties, looking at the whole patient journey through imaging.

We made a series of recommendations to support the improvements that are needed. These included that the Department for Health and Social Care (DHSC) and NHS England (NHS E) write to the Committee after six months to provide an update on progress.

Improvements have been made, but more needs to happen

We welcome the significant progress that has been made. There are however still further steps that are needed urgently, including:

- There must be clarity for NHS Trusts, newly established Integrated Care Boards, and others that the improvement work around digital infrastructure is a priority. Digital infrastructure must be treated as a patient safety issue.

It is crucial that we maintain momentum around these recommendations to ensure meaningful and sustained improvement in this area. Attention and buy-in from the NHS’s most senior leaders is essential.



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I ask the Committee to continue to monitor progress against our recommendations and be willing to hold DHSC and NHS E to account if meaningful change is not being sustained.

I look forward to our meeting on 5 September where I would be more than happy to discuss this issue in more detail.

This exchange is copied to William Wragg MP, Chair of Parliament's Public Administration and Constitutional Affairs Committee.

Yours sincerely

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