NHS Resolution

London Regional Safety and Learning Quarterly Networking meeting

Ingrid Henderson
Associate Safety and Learning Lead London

Justine Sharpe
Safety and Learning Lead London

18 March 2026
12:30 – 14:00

@NHSResolution

Housekeeping

- This is event is being recorded.
- Please use the chat box to submit any questions.
- Feel free to share your innovations in the chat.
- An online feedback link will be shared in the chat at the end and emailed after the webinar.

Agenda

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Time	Item	Speaker
12:30	Introduction to the forum (5 mins)	• Chair, Justine Sharpe, Safety & Learning Lead London - NHSR
12:35	Learning from claims data & missed fractures (15 mins)	• Ingrid Henderson, Associate Safety & Learning Lead – London – NHSR
12:50	Missed fractures; guidelines and consequences (15 mins + 5mins)	• Dr Bob Handley, National GIRFT lead, Orthopaedic Consultant, Oxford University Hospitals NHS Foundation Trust
13:10	Mitigating the risk of missed fractures in the ED (15 mins + 5 mins)	• Dr Samira Akberali, Consultant in Emergency Medicine, Clinical Lead Adult Emergency Department Royal London Hospital, London Region Chair Royal College of Emergency Medicine
13:30	Preventing missed fractures and the use of AI from The Whittington Health NHS Trust (15 mins)	• Dr Mayurun Ramadas, Consultant in Radiology, primarily Paediatrics with subspeciality interest in Adult and Paediatric Neurology, Paediatric MSK. The Whittington Health NHS Trust
13:45	Q&A	• Facilitated by Justine Sharpe
13:55	Summary and Close (5 mins)	• Justine Sharpe

Learning from claims data and missed fractures

Ingrid Henderson

Associate Safety and Learning Lead London – NHS Resolution

Comparison of findings NHSR publication to 2026

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		Total Cost	Total damages paid	Injury site by volume of claims
2022 Missed Fracture Report 2 years of claims data Specialties: Emergency Medicine	Between 2015/16 and 2017/18 there were **78** closed claims where damages were paid	£1.1 million	£469,611	1. Hip (n=19) 2. Finger (n=10) 3. Spine (n=10)
2026 Missed Fracture Analysis 5 years of claims data Specialties: Emergency Medicine Orthopaedics Radiology	Between 2017/18 and 2022/23 there were **826** closed claims where damages were paid	£43.1 million	£18 million	1. Ankle (n=133) 2. Hip (n=125) 3. Scaphoid (n=106)

2026 analysis: Top five injury sites

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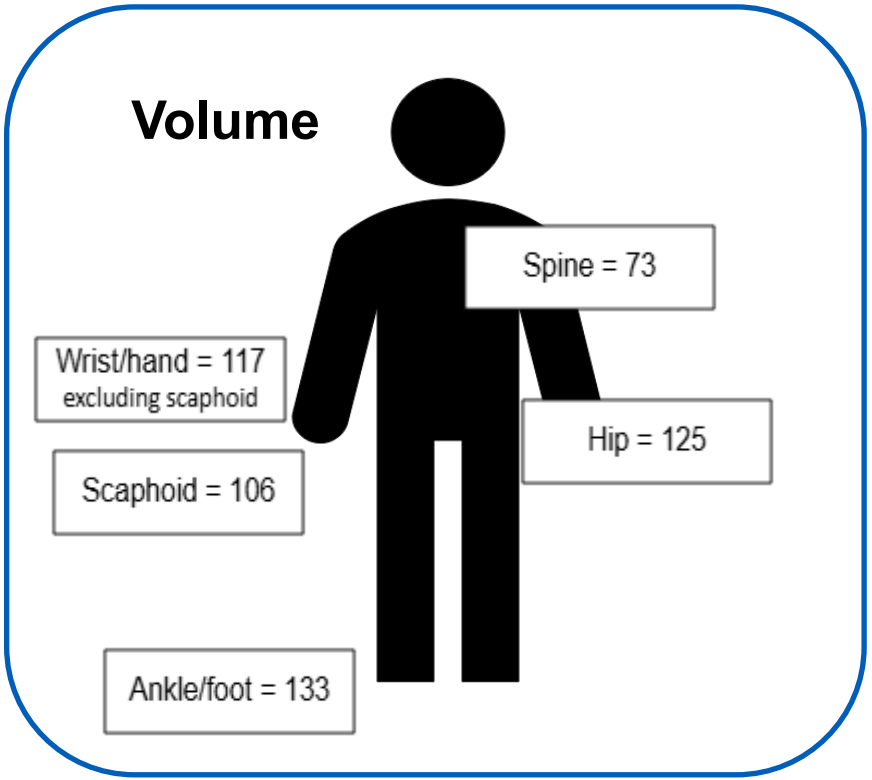
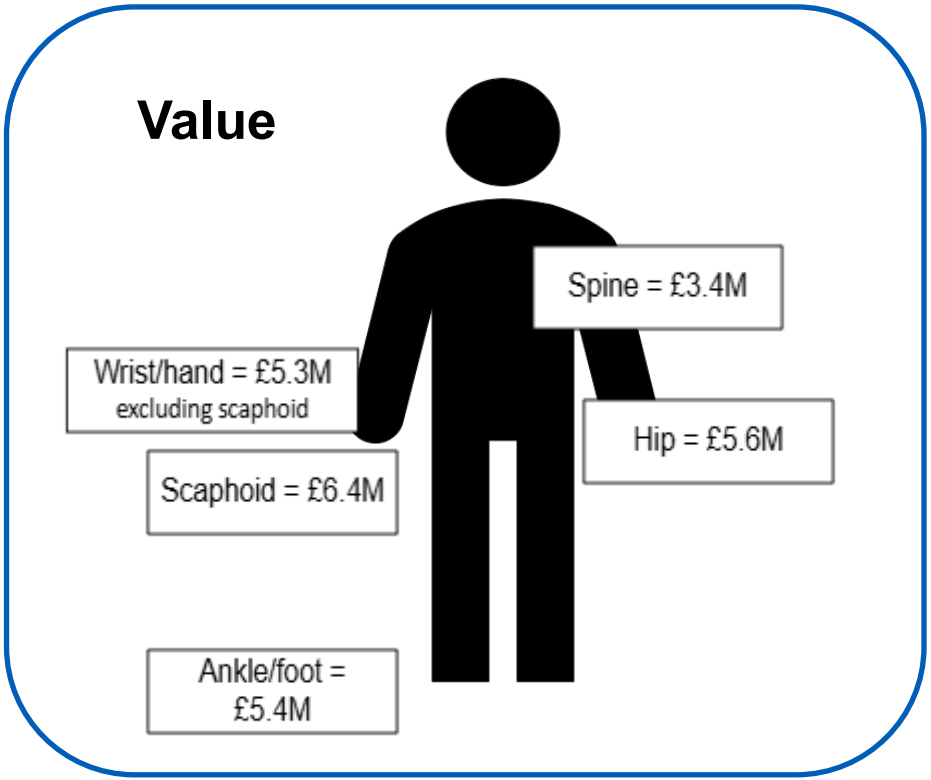
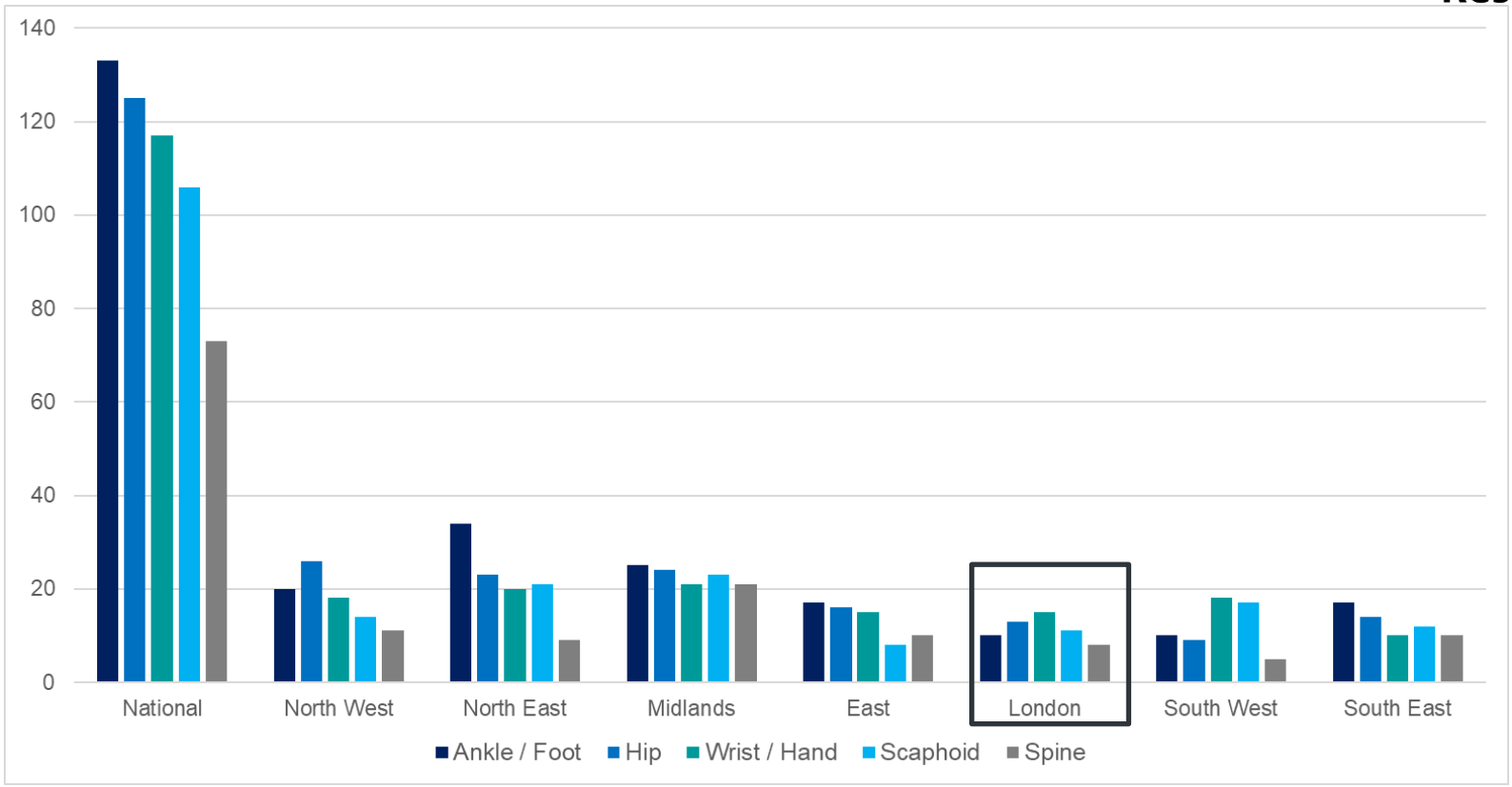




Top five injury sites by region



Regional insights – London

85 closed claims
with damages paid

Total cost of closed claims
= **£5.5 million**

Total damages paid
= **£2.6 million**

41 female claimants
Average age = **51** years

44 male claimants
Average age = **42** years

Top 5 missed fracture claims by **injury site**

Scaphoid = 11 claims
Total cost = £704,519

Wrist /hand= 15 claims
Total cost = £751,391

Spine = 8 claims
Total cost =£853,786

Hip = 13 claims
Total cost = £775,874

Ankle / foot = 10 claims
Total cost = £444,455

Overview of 132 missed fracture claims

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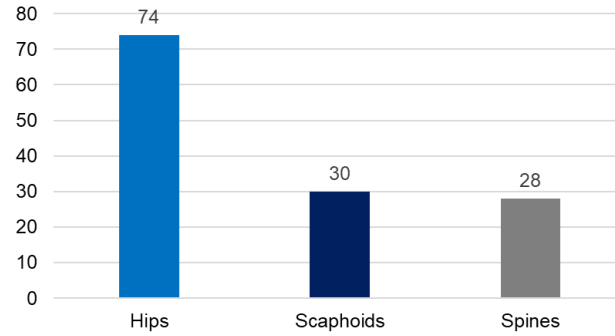
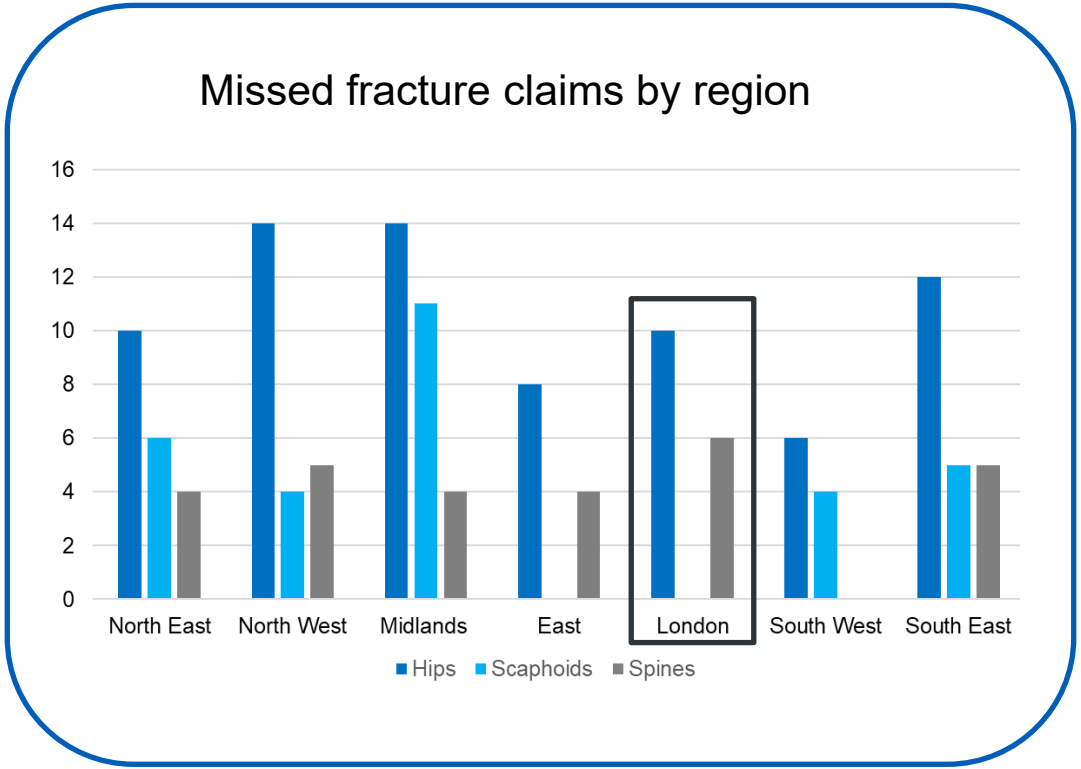
Average age = 58 years
Range = 14 years to 94 years

♀=75 ♂=57





Overview of 74 missed hip fracture claims

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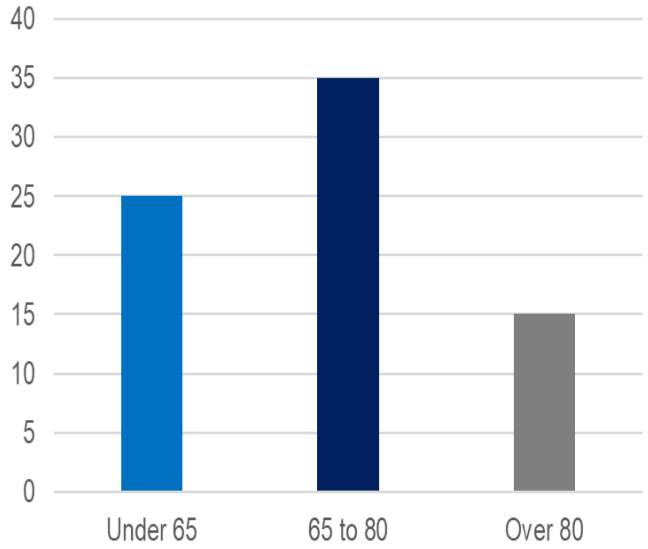
♀ 55

♂ 19

Mechanism
Fall
Resistance
Running

Claimant age at incident



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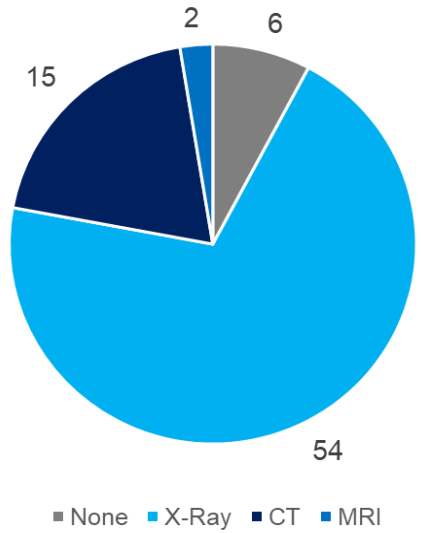

Overview of 30 missed scaphoid fracture claims

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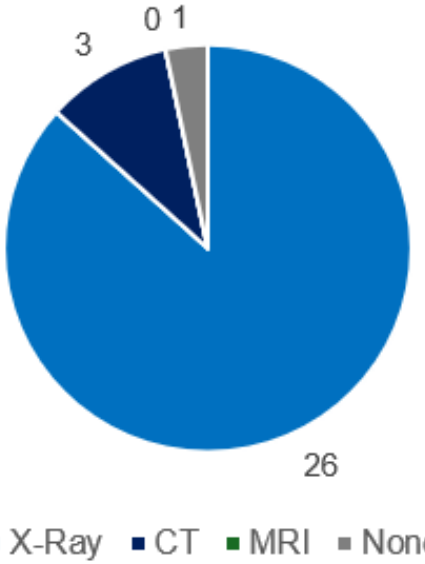
♀ 5

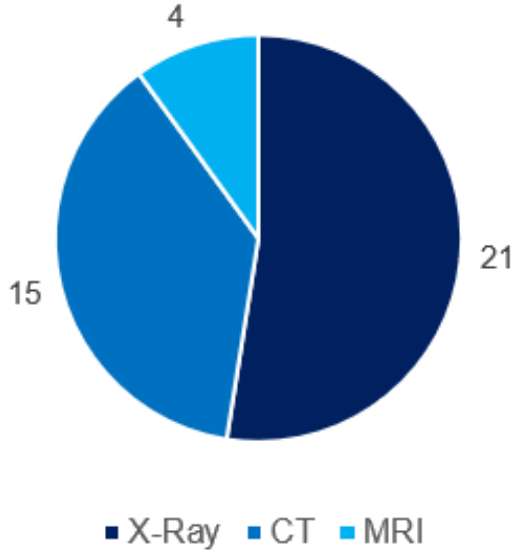
♂ 25

Mechanism
FOOSH
Non-weight bearing impact
RTA

Imaging at initial presentation



Subsequent imaging



Overview of 28 missed spinal fracture claims

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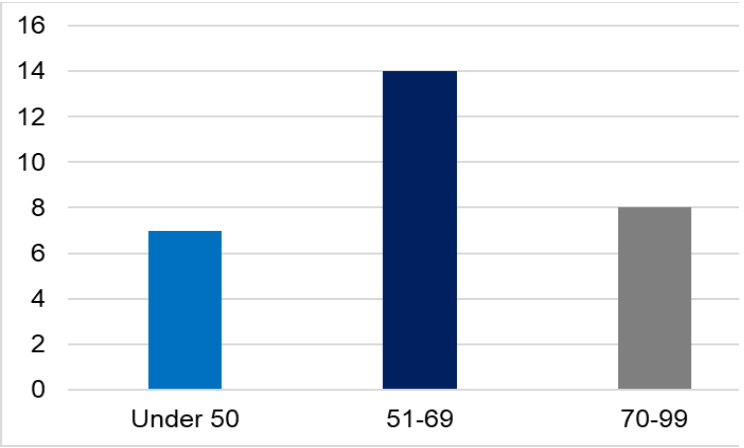
♀ 15

♂ 12

Mechanism
Majority had a fall from under 3m

Claimant age at incident



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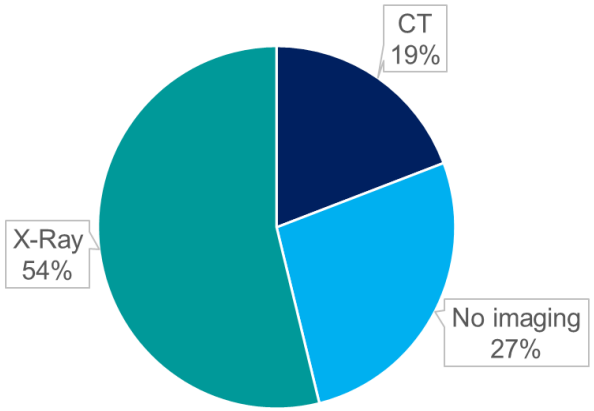

Themes within missed fracture claims

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Primary care review in 50% of claims

Ambulance service involvement in 15% of claims

Poor bone health indicated across claims

Theme	2022 Report	2026 Analysis
Clinical examination	✓	✓
Imaging request	✓	✓
Imaging review	✓	✓
Delay in follow-up	✓	✓
Communication and teamwork	✓	✓

What's next?

Population health management lens to the analysis

Potential impact of optimising bone health in fracture prevention

What do you think would be helpful outputs from this updated analysis?

GIRFT
GETTING IT RIGHT FIRST TIME

NHS England

Missed fractures; guidelines and consequences

Bob Handley
National Clinical Lead for Adult Orthopaedic Trauma

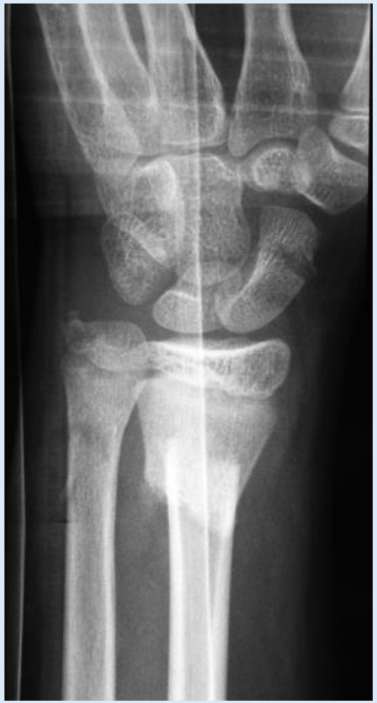
NHS IMPACT
Improving Patient Care Together

Bob Handley…… who am I?

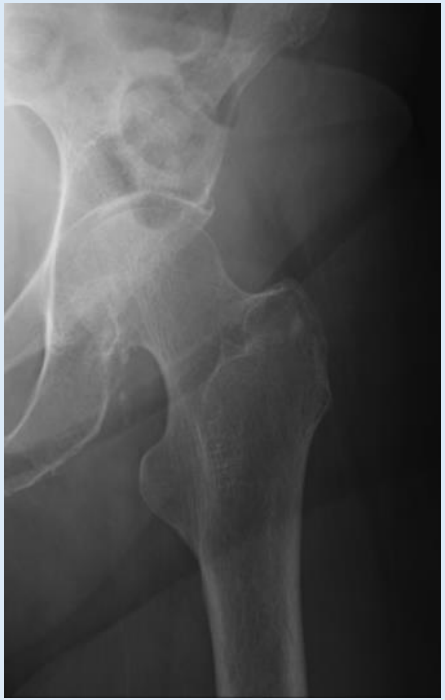
- Currently
  - National clinical lead GIRFT Orthopaedic Trauma
  - Old
- Previously
  - Medical student 1972
  - Member NICE GDG for Hip Fractures
  - Co-chair of the two NICE GDG's for Fractures
  - Chair of BOA Trauma Committee (write BOASTs)
  - Consultant T&O Surgeon Oxford 1994-2025.

Do we need education? Two histories;

- Scaphoid fracture



- Hip fracture



Scaphoid # - everyone knows

- 1972 lecture and MDU presentation (Personal communication)
- and every doctor I have questioned who trained subsequently
- not a diagnosis of deduction but one of exclusion
- Sx but negative X-ray – immobilise and re-Xray 10/7
- Then technology….

NICE review question 2016

a) What is the most clinically and cost-effective imaging strategy for patients with clinically suspected scaphoid fracture?

Recommendations and link to evidence NICE 2016 NG38

9. Consider MRI for first-line imaging in people with suspected scaphoid fractures following a thorough clinical examination.

One original cost-utility analysis found that immediate MRI was cost effective compared to immediate CT (£3,854 per QALY) for diagnosing people with a suspected scaphoid fracture. It also found that immediate MRI was dominant compared to indeterminate X-ray followed by MRI, indeterminate X-ray followed by CT, and indeterminate X-ray followed by fracture clinic follow up. This study was assessed as directly applicable with potentially serious limitations.

Comparison of CT and MRI in diagnosing occult hip fracture: a systematic review and meta-analysis

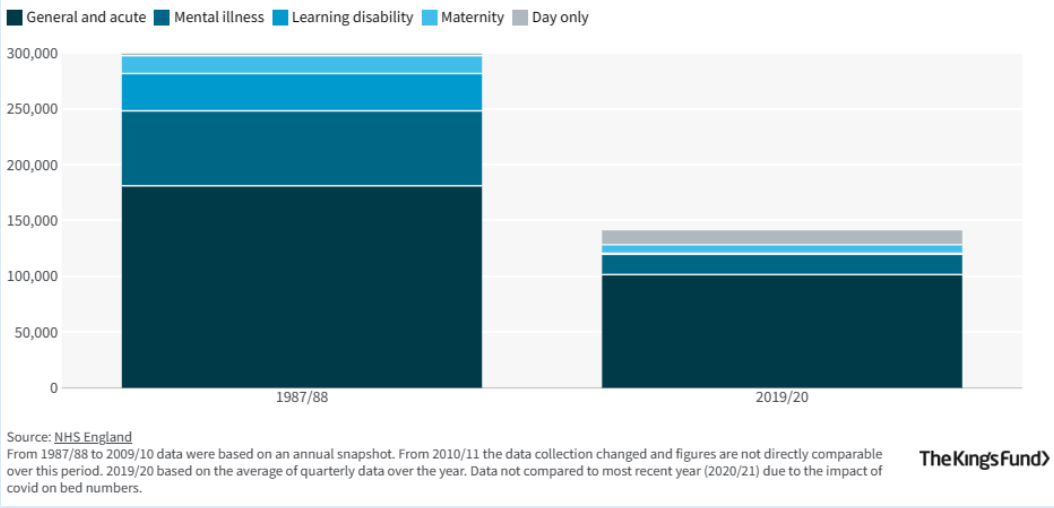
Hongxue Qu [1], Lei Bian [2]

. 2024 Jul 15;16(7):2745–2755. doi: 10.62347/NUBB1946

Both CT and MRI showed good diagnostic efficacy for occult hip fractures. However, MRI consistently outperformed CT, exhibiting significantly higher sensitivity, specificity, and likelihood ratios, thereby providing superior accuracy in confirming or excluding occult fractures.

Hip fracture

- 1972 aware hip pathology may present with knee symptoms (kids)
- NWB older fall patient no fracture on initial image
  - lots of beds – admitted – re-X-ray if no progress
- Then there were beds and technology
- Not many beds investigate if negative try and send home
- Worry about adequacy of initial image.



Source: NHS England
From 1987/88 to 2009/10 data were based on an annual snapshot. From 2010/11 the data collection changed and figures are not directly comparable over this period. 2019/20 based on the average of quarterly data over the year. Data not compared to most recent year (2020/21) due to the impact of covid on bed numbers.

The King's Fund

Hip fracture

- 1972 aware hip pathology may present with knee symptoms (kids)
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- Worry about adequacy of initial image.

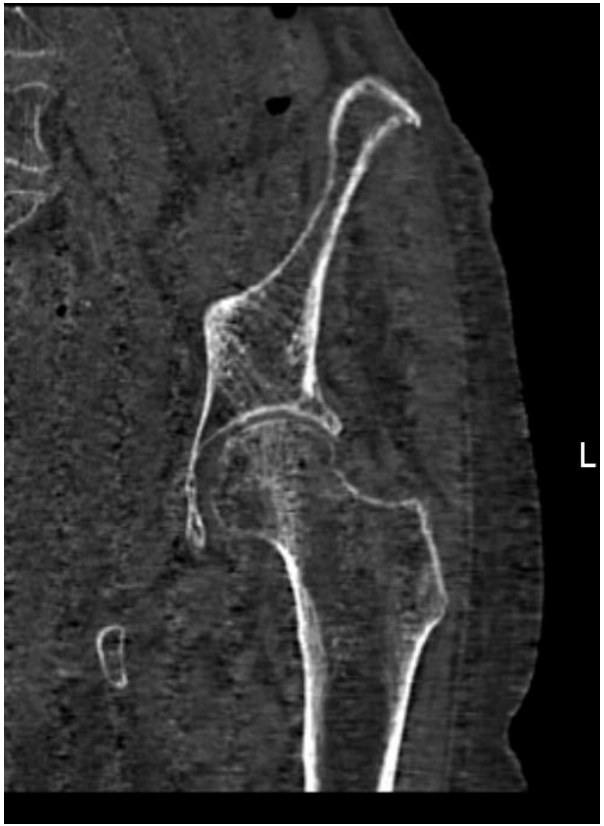
NICE Hip fracture guideline – review question 2009

- In patients with a continuing clinical suspicion of hip fracture, despite negative radiographic findings, what is the clinical and cost-effectiveness of additional imaging (radiographs after at least 48 hours, RNS, US and CT, compared to MRI, in confirming, or excluding, a hip fracture?

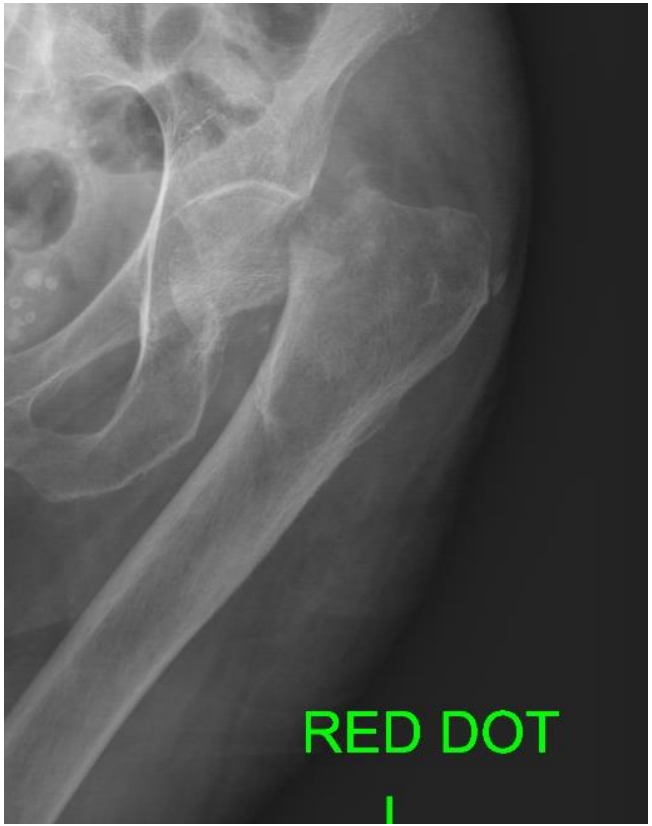
NICE HIP Fracture Guideline CG124 2011

- Offer magnetic resonance imaging (MRI) if hip fracture is suspected despite negative anteroposterior pelvis and lateral hip X-rays. If MRI is not available within 24 hours or is contraindicated, consider computed tomography (CT).

MRI is too much trouble, how about CT
A confident miss



4 weeks



What about repeat plain X-ray – a less confident miss – NICE 2001 said

- Repeat radiographs after 48 hours have limited sensitivity and carry the risks of displacement during the intervening period, as well as those of delay to surgery.

Why not just do it?

- Too expensive?
- Whose patient is it whilst we are waiting?
- Who feels the pain?

Why is it a “miss”, and what are the consequences?

- Following the guidelines but making a mistake
- Not following the guidelines
- Follow up (when can you test and discharge)
- Do we really know the clinical consequences of a “Miss”?

Summary and Potential actions

- Guideline review
- Directed research
- End the “Turf wars” leading to admission fear
- Where pathways exist, all involved clinically should be participate in governance

Mitigating the Risk of Missed Fractures

In the Emergency Department

Dr Samira Akberali

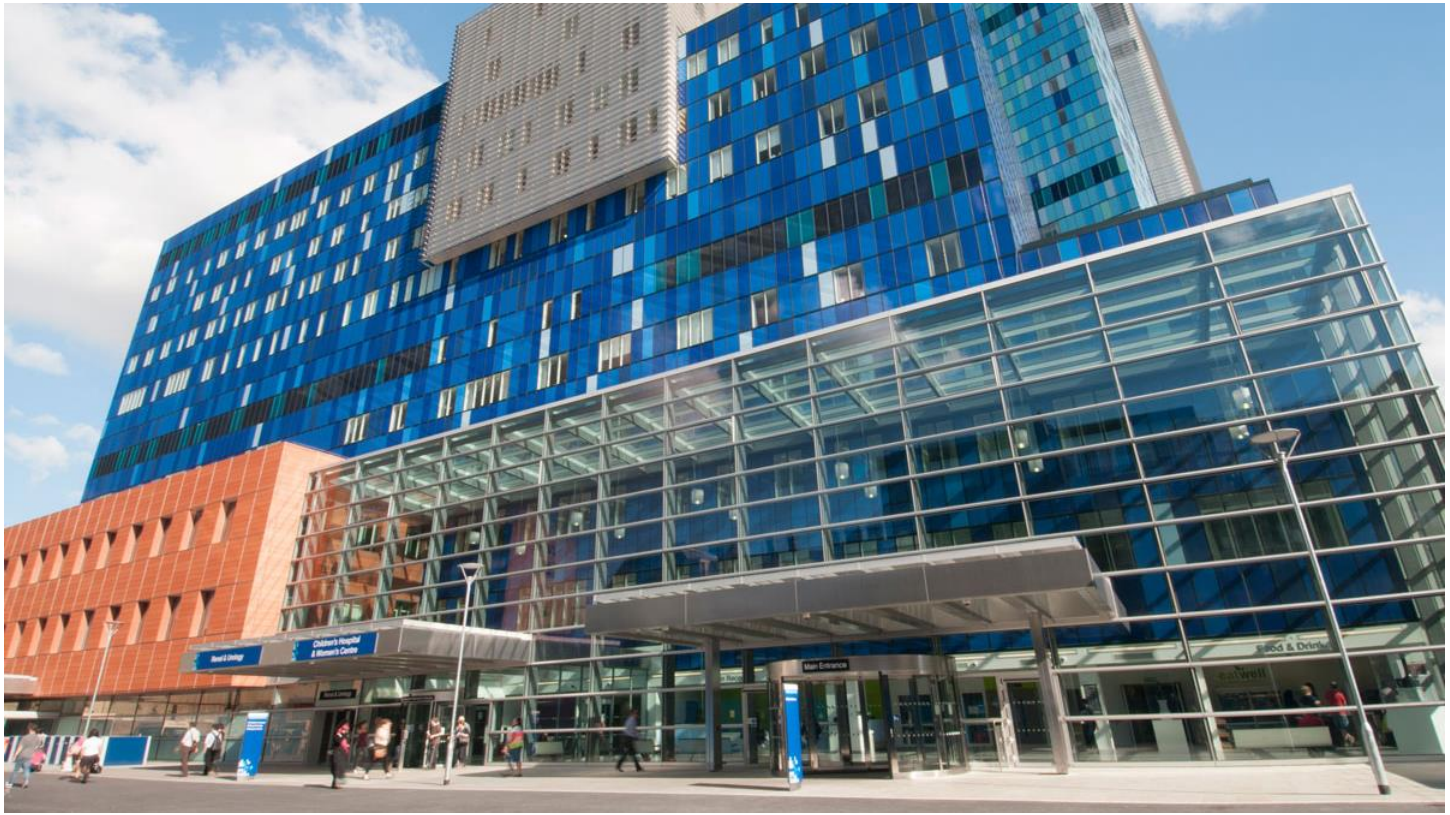
Clinical Lead Royal London Hospital Emergency Department, London Region
Chair RCEM

Why Missed Fractures Occur

- Subtle radiographic findings
- High patient volume and cognitive load
- Incomplete imaging views
- Paediatric anatomical complexity
- Delayed radiology reporting

Clinical Risk and Impact

- Delayed diagnosis and treatment
- Poor functional outcomes
- Potential need for surgery
- Patient complaints and litigation
- Re-attendance to emergency departments


Children's Hospital
& Women's Centre
Main Entrance

Appropriate Clinician Skill and Training

- Radiograph interpretation training – ‘all the classics’
- Senior review for uncertain cases
- Awareness of common pitfalls
- Structured approaches to image interpretation
- Paediatric radiograph familiarity

Real-Time Radiology Reporting

- On-site radiology reporting where available – ideally real time
- Teleradiology support overnight (for sites without out of hours in house radiology)
- Direct discussion with radiologists for equivocal films
- Faster identification of subtle fractures, the Red Dot!, AI Flags

Consistent Radiology Result Checking

- Daily review of radiology reports
- Comparison of ED interpretation vs radiologist report
- Alert systems for unexpected/ Significant findings
- Process for prompt patient recall if required

Clear Referral and Follow-Up Pathways

- Defined orthopaedic referral processes
- Rapid fracture clinic appointments (24–72 hrs)
- Virtual fracture clinics
- Dedicated paediatric review clinics

Emergency Department Adult orthopaedic trauma + adolescent skeletally mature children

NHS Barts Health NHS Trust

Upper limb injuries

clavicle

Lateral clavicle fracture (AP, Velpau + int rotation)

Minimally displaced (less than 5mm) or non-surgical candidate	Displaced (coraco-clavicular ligaments disrupted)
• Apply broad arm/polysling • Refer to NFC	• Apply broad arm/polysling • Refer to on-call orthopaedic registrar (#SR/N/S) • Take MRSA swabs

Mid-shaft clavicle fracture (AP + inclined x-ray)

Undisplaced or non-surgical candidate	Completely displaced (translated) or 1cm shortened and fit for surgery
• Apply broad arm/polysling • Refer to NFC	• Apply broad arm/polysling • Refer to NFC • If arming of skin refer to on-call orthopaedic registrar (#SR/N/S)

Acromioclavicular joint (ACJ) injury (AP, Velpau + int rotation)

Undisplaced (Grade 1 & 2 sprains) or non-surgical candidate	Displaced (Grade 3+) or elite sport
• Apply broad arm/polysling • Discharge from ED if no clinical concern, otherwise refer to NFC	• Apply broad arm/polysling • Refer to NFC

shoulder

Shoulder dislocation (AP + Velpau axial)

Traumatic shoulder dislocation, first time or recurrent	Traumatic dislocation with bony Bankart or glenoid fracture
• Ensure post-reduction x-rays (AP + Velpau axial) show shoulder in joint • Apply collar and cuff + document neurovascular status • Refer to NFC	• Ensure post-reduction x-rays (AP + Velpau axial) show shoulder in joint • Apply collar and cuff + document neurovascular status • Arrange CT shoulder • Refer to on-call orthopaedic registrar (#SR/N/S)

Shoulder injury, no fracture (AP + Velpau axial)

• Apply polysling • Encourage movement • Discharge from ED if no clinical concern, otherwise refer to NFC

humerus

Proximal humerus fracture (AP + Velpau axial)

Greater tuberosity fracture

Undisplaced GT No history of dislocation	Undisplaced GT History of dislocation or subluxation or bony Bankart lesion (glenoid rim fracture)	Displaced GT
• Apply collar and cuff • Refer to NFC	• Apply collar and cuff • Arrange CT shoulder • Refer to on-call orthopaedic registrar (#SR/N/S) • Take MRSA swabs	• Apply collar and cuff • Arrange CT shoulder • Refer to on-call ortho reg • Take MRSA swabs

Surgical neck fracture

2-part fracture	3 or 4-part minimally displaced	3 or 4-part displaced
• Apply collar and cuff • Refer to NFC	• Arrange CT shoulder • Apply collar and cuff • Refer to NFC	• Arrange CT shoulder • Apply collar and cuff • Refer to on-call ortho reg • Take MRSA swabs

Humeral shaft fracture

• Document neurovascular status including radial nerve function
• Apply humeral brace
• Apply collar and cuff
• Repeat x-ray in brace
• Refer to NFC

elbow

Elbow dislocation

Simple dislocation, no fracture	Associated fracture (radial head, coronoid, ulna, distal humerus)
• Reduce elbow + document neurovascular status • Post-reduction x-ray • Apply broad arm/polysling • Refer to NFC	• Reduce elbow and apply above-elbow POP backslab/splint • Ensure post-reduction x-ray and arrange CT elbow • Refer to on-call orthopaedic registrar (#SR/N/S) • Take MRSA swabs

Elbow injury

Elbow injury, no fracture	Elbow, olecranon fracture undisplaced	Elbow, olecranon fracture displaced
• Apply collar and cuff • Encourage movement • If bursitis or tendonitis – ED advise and discharge • Rule out distal biceps tendon rupture by checking: – Popeye sign → unable to feel biceps tendon at elbow → rapid deceleration mechanism • Discharge from ED if no clinical concern, otherwise refer to on-call orthopaedic reg (#SR/N/S) • Refer to NFC if: ↑ – altered fat pad – unable to extend – bruising/swelling ++	• Apply broad arm/polysling • Refer to NFC	• Apply above-elbow POP backslab • Refer to on-call orthopaedic registrar (#SR/N/S) • Take MRSA swabs

Elbow: radial head fracture, no dislocation

Minimally displaced (Mason 1 and 2)	Displaced or comminuted (Mason 3)
• Apply broad arm/polysling • Refer to NFC	• Apply broad arm/polysling • Arrange CT elbow	• Refer to on-call orthopaedic registrar (#SR/N/S) • Take MRSA swabs

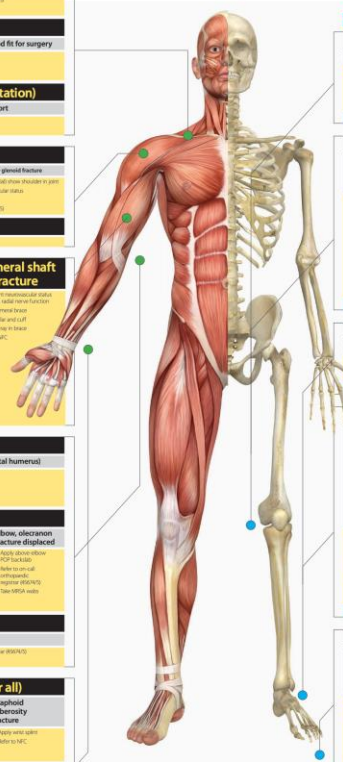
wrist

Wrist injury (you must document ASB tenderness for all)

No fracture seen but examination finding of snuffbox (ASB) tenderness	No fracture seen and no ASB tenderness (wrist sprain)	Confirmed scaphoid waist fracture	Scaphoid tuberosity fracture
• Ensure scaphoid x-rays done • Apply wrist splint • Refer to NFC	• Apply wrist splint • Advice sheet 'Wrist injury' • Discharge if no clinical concern, otherwise refer to NFC	• Arrange CT wrist • Stabilise in below-elbow POP backslab • Refer to NFC	• Apply wrist splint • Refer to NFC

Distal radius fracture

Dorsal capsular avulsion fracture (from triquetral or distal radius)	Positive 'Terry Thomas' sign (scapho-lunate widening)	Undisplaced	Undisplaced intra-articular	Displaced
• Apply wrist splint • Advice sheet 'Wrist injury' • Refer to NFC	• Ensure AP and lateral x-ray of injured wrist **and contralateral wrist** • Apply wrist splint • Refer to NFC	• Apply wrist splint • Refer to NFC	• Stabilise in below-elbow POP backslab • Refer to NFC	• Carry out closed reduction under regional nerve block • Stabilise in below-elbow POP backslab • Repeat x-ray • Take MRSA swabs • Refer to NFC



Lower limb injuries

patella

Patella injury

Dislocation	Fracture undisplaced: able to SLR	Fracture displaced: unable to SLR
• Reduce patella dislocation • Confirm reduction with AP and lateral knee x-ray • Apply cricket pad splint or POP cylinder backslab • Mobilise weight bearing as tolerated • Refer to NFC	• Apply cricket pad splint • Mobilise weight bearing as tolerated • Refer to NFC	• Apply cricket pad splint or POP cylinder backslab • Refer to on-call orthopaedic registrar (#SR/N/S) • Take MRSA swabs • If patient is going home from ED, you **MUST** risk assess for VTE with Plymouth score

All patients with lower limb injuries should be given VTE information +/- advice sheet

knee + fibula

Knee injury

Knee extensor mechanism clinically NOT intact (unable to SLR)	Locked knee (locked in bent position – unable to flex or extend for pain)	Painful knee after injury – no fracture seen (painful but not locked)	Avulsion fracture from femoral or tibial condyles	Tibial plateau fracture
• Apply cricket pad splint or POP cylinder backslab • Examine the hip; x-ray if indicated • Refer to on-call orthopaedic registrar (#SR/N/S) • Mobilise weight bearing as tolerated in cricket pad splint or cast	• Examine the hip; x-ray if indicated • Refer to on-call orthopaedic registrar (#SR/N/S) • Mobilise weight bearing as tolerated	• Apply cricket pad splint; only if indicated (pain++) • Document in History: mechanism, feeling of a 'pop', speed of swelling, previous history of problems • Document in the exam: joint line tenderness, effusion, where tender, obvious ligament laxity or pain on varus/valgus stress • If knee cannot be examined due to pain, refer to NFC • Examine the hip; x-ray if indicated • Discharge from ED if no clinical concern, otherwise refer to NFC • Encourage patient to weight bear as tolerated	• Apply cricket pad splint • Mobilise weight bearing as tolerated • Refer to NFC	• Arrange CT • Refer to on-call orthopaedic registrar (#SR/N/S) • If patient is going home from ED, you **MUST** risk assess for VTE with Plymouth score

Fibula fracture

Head of fibula fracture	Fibular shaft fracture
• Mobilise weight bearing as tolerated • If **a)** Mechanism of injury pivoting with foot planted on ground or **b)** Significant knee swelling/effusion or **c)** Inability to bear weight: apply cricket pad splint and crutches, allow partial weight bearing • Refer to NFC	• Exclude major ankle injury +/- x-ray • Provide a walking boot • Mobilise weight bearing as tolerated • Refer to NFC

All patients with lower limb injuries should be given VTE information +/- advice sheet

achilles

Achilles tendon injury

No clinical rupture, negative Simmonds test or no palpable gap in tendon	Clinically ruptured, partial rupture or equivocal (not certain)
• Mobilise weight bearing as tolerated • Advise stretching exercises for Achilles tendon as pain allows	• Patient can resume normal activities once pain settles • Discharge (NFC referral not required)	• Apply equinus cast • Advise elevation and non-weight bearing	• Refer to NFC • If patient is going home from ED, you **MUST** risk assess for VTE with Plymouth score

All patients with lower limb injuries should be given VTE information +/- advice sheet

ankle

Ankle injury

Ankle sprain or ligament avulsion fractures (eg tip of fibular fracture)	Weber-A ankle fracture	Weber-B ankle fracture		Isolated medial malleolus fracture: x-ray the whole fibula or document absence of proximal fibular tenderness. Also document presence of syndesmotic tenderness.	Weber-C ankle fracture with/without medial or posterior malleolus fracture
					
	Weber-A	Weber-B			Weber-C
		Widening of the medial mortice or medial/posterior malleolus fracture	No displacement of the medial mortice		
• Provide advice sheet 'Ankle sprain' • Provide a walking boot if indicated • Mobilise weight bearing as tolerated • Patient may mobilise out of the boot if comfortable to do so • Discard the boot by 6 weeks • Discharge if no serious injury appears; otherwise refer to NFC	• Provide advice sheet 'Ankle sprain' • Provide a walking boot if indicated • Mobilise weight bearing as tolerated • Patient may mobilise out of the boot if comfortable to do so • Refer to NFC	• Carry out a closed reduction in ED • Stabilise in below-knee POP backslab • Refer to on-call orthopaedic registrar (#SR/N/S) • Take MRSA swabs • If patient is going home from ED, you **MUST** risk assess for VTE with Plymouth score		• Provide a walking boot • Mobilise weight bearing as tolerated • Elevate in meantime • Refer to NFC **Exception: diabetic or neuropathic patients** • Should remain non-weight bearing • If going home from ED, you **MUST** risk assess for VTE with Plymouth score	• Carry out a closed reduction in ED • Stabilise in below-knee POP backslab • Refer to on-call orthopaedic registrar (#SR/N/S) • Take MRSA swabs • If patient is going home from ED, you **MUST** risk assess for VTE with Plymouth score

All patients with lower limb injuries should be given VTE information +/- advice sheet

foot

Foot injury (AP, lateral + oblique views)

5th metatarsal base (including all types and 'Jones' fractures)	Metatarsal stress fracture	Suspected Lis Franc or midfoot injury: ❑ High energy/very swollen/crush ❑ Fleck avulsion base of 1st/2nd MT ❑ Mal-alignment of the midfoot on x-ray	All other foot injuries
• Mobilise weight bearing as tolerated in a heel bearing shoe • Discharge from ED if no clinical concern, otherwise refer to NFC	• Provide a heel bearing shoe • Mobilise weight bearing as tolerated • Refer to NFC	• Stabilise in below-knee POP backslab • Arrange CT foot • Refer to on-call orthopaedic registrar (#SR/N/S) • Take MRSA swabs • If patient is going home from ED, you **MUST** risk assess for VTE with Plymouth score	• Minor toe fractures – ED advise and discharge • Toe dislocations – reduce, neighbour strap, refer to NFC • Closed hallux IVth fractures – ED advise and discharge • Open hallux IVth fractures – oral antibiotics, ED advise and discharge • Other hallux fractures – refer to NFC • One or more metatarsal shaft/neck fractures – refer to NFC with heel-bearing shoe • Calcaneus and talus fractures – refer to on-call orthopaedic registrar (#SR/N/S) • Other foot injuries – discharge from ED if no clinical concern, otherwise refer to NFC

All patients with lower limb injuries should be given VTE information +/- advice sheet

See VTE prophylaxis for Lower Limb Trauma guidelines

Governance and Safety Netting

Complaint/litigation/Datix reviews

- Audits of missed fractures

- Learning from cases

- Clear patient discharge advice
  – The patter really matters

- Return precautions for worsening symptoms

Key Takeaway

Reducing missed fractures requires layered safety systems:

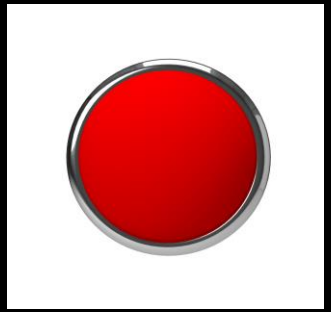
- Skilled clinicians
- Reliable radiology reporting
- Robust result checking
- Clear referral pathways
- Rapid specialist follow-up

PREVENTING MISSED FRACTURES & THE USE OF AI

DR MAYURUN RAMADAS

Whittington Hospital

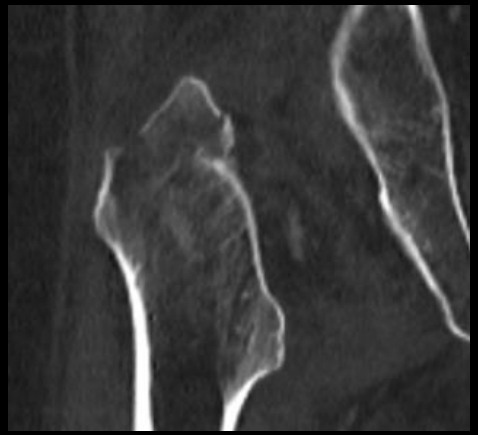
WHY THIS MATTERS FOR NHS RESOURCE

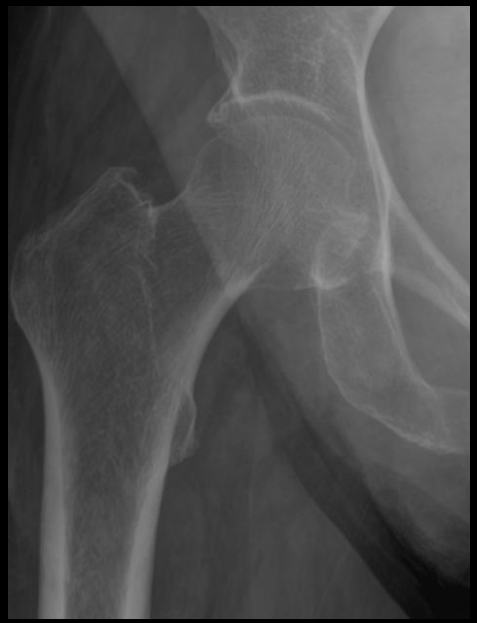


- Missed fractures remain a major contributor to medicolegal cost and patient harm
- Most occur in high-volume plain film imaging
- The challenge: balancing diagnostic certainty, radiation exposure, workforce pressure, and system cost

FROM THE REPORTING ROOM: PRACTICAL OBSERVATIONS

- Paediatric trauma: Plain films often first-line, but subtle fractures and interpretation variability remain common
- Spinal trauma: CT increasingly the diagnostic standard – plain films frequently inadequate for subtle injuries
- Key question: are some traditional plain-film pathways becoming obsolete?

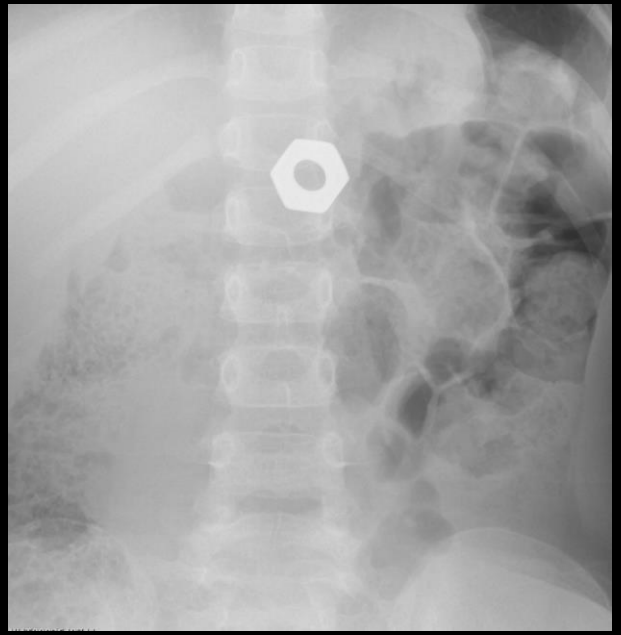


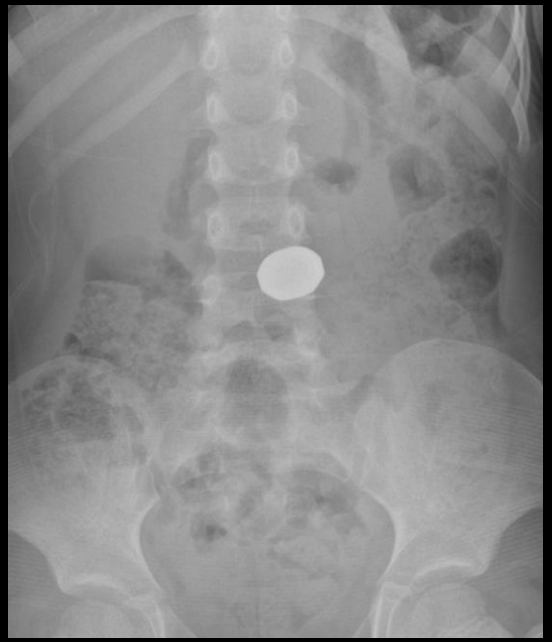


PLAIN FILM ERRORS & HUMAN FACTORS

- Errors often occur in busy acute settings with high reporting volume
- Diagnostic confidence varies with experience, fatigue, and subspecialty expertise
- Paediatric imaging and subtle fractures particularly vulnerable

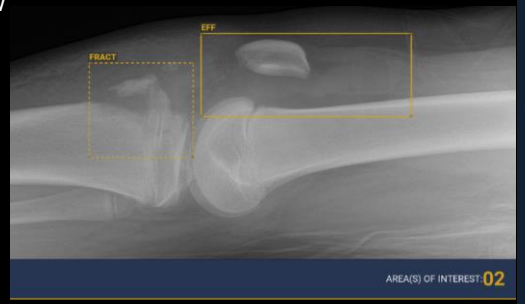
CASE



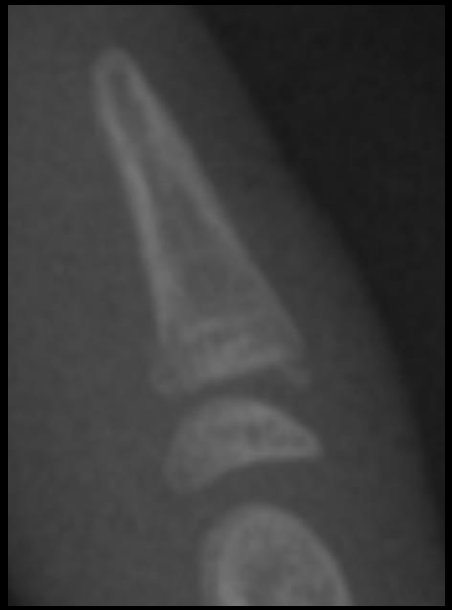


AI: SAFETY NET OR CONFIDENCE GAP?

- AI tools may reduce missed fractures and triage abnormal studies
- Potential resource benefit if they reduce litigation and repeat imaging
- But raises questions about radiologist confidence, reliance, and workflow integration – Training!

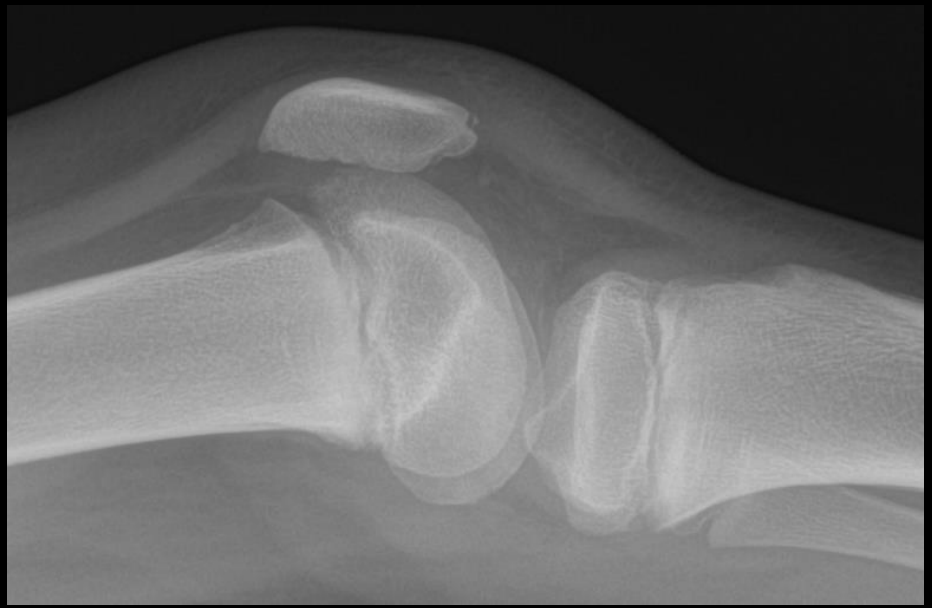


CASE 1




NEGATIVE
2
ANALYZED
2
RECEIVED
DID YOU RECEIVE ALL THE IMAGES?
Please note, that if Gleamer did not receive all the images in the study then the result may be inaccurate.
BoneView
DISLOCATION
EFFUSION
FRACTURE
LESION
NO

CASE 2

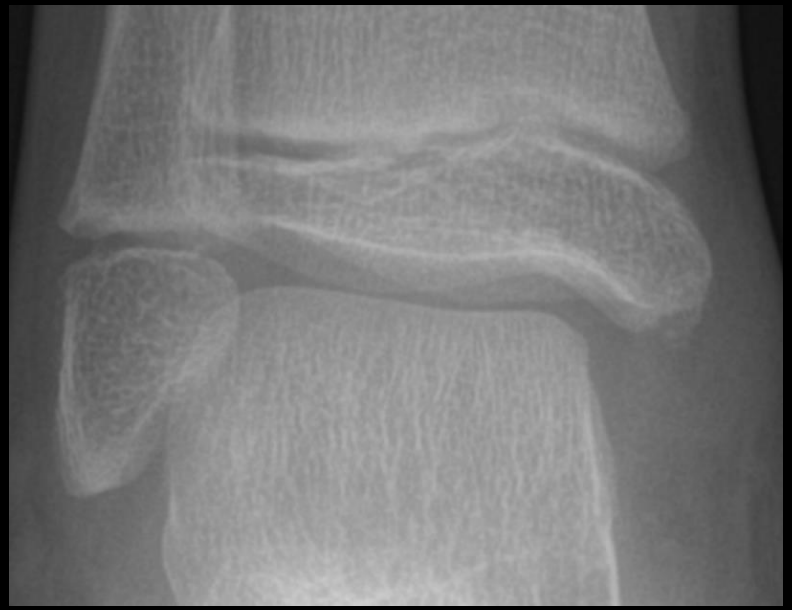


CASE 3

Probability

Certainty
Suspicion
Suggestion
Consider

Clinically correlate



RESOURCE STRATEGY MOVING FORWARD

- Optimise pathways that minimise missed injuries, not just imaging cost

  COMMUNICATION – LANGUAGE --> Combative or Constructive

- Consider where CT-first strategies reduce downstream harm and cost
- Invest in AI support, training, and subspecialty expertise

DISCUSSION QUESTION

- Should imaging policy prioritise radiation protection, lowest upfront imaging cost, or lowest total system cost including missed diagnoses and medicolegal risk?

THANK YOU

- Q&A
- Mayurun.ramadas@nhs.net

NHS Resolution

Summary & Close

We hope you have found this event useful, please remember complete this short survey here to help us with future events

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