

WHY Fronts

Asking the question WHY to promote quality service provision

It's all shades of grey!

NOPE I AM NOT TALKING ABOUT A CERTAIN BOOK SERIES; I hope you didn't get your hopes up for something interesting this month!

What I would like to talk about is quality of image. Yes, I know we have colour doppler, MRI & CT but generally in an imaging service we look at images in 'shades of grey'. How then do you assure yourself and others that the images of grey are the best that can be produced?

I am now having to scrape the barrel of knowledge from my student days for some of the theory behind that 'perfect image' and believe me it is now a long way to the bottom of that barrel.

As I recall a quality image consists of the right amount of contrast, blur, noise, artefacts, and distortion; sounds like some weird recipe without the benefit of what amounts are required.

I think you need the 'right amount' of contrast, sharpness rather than blur, reduced noise, as little artefact as possible and the smallest distortion possible; hopefully you agree. So – easy then? Maybe easier said than done.

The modality used makes a difference as to the sensitivity of our shades of grey e.g. CT is generally of a higher sensitivity than conventional radiography, it has more shades of grey so soft tissues can be more easily demonstrated. I could expand further but then I would be really boring, hopefully you get my drift.

One aspect around image quality that isn't mentioned so far is the anatomical positioning of the region being imaged. Basically if you image the wrong 'bit' or image the 'bit' the wrong way the resultant images may not be diagnostic and we enter into the murky realms of IR(ME)R and woe betide a radiation incident. Nobody wants to go there!

How about the fact that the 'bit' is attached to a whole which may not want to assist your sharpness quotient by wriggling about, or that the 'bit' is surrounded by lots of adipose tissue or metal work which messes up the contrast and the artefact portion of the recipe?

It is all starting to add up to a bit of a nightmare now; did somebody

mention the words 'button pusher' (don't get me started)?

I haven't talked about how you view an image, the amount of ambient light can affect how images on a monitor appear, the quality of the monitor makes a difference, the distance from the monitor and lastly if you have left your reading glasses at home then image blur may be an issue. I could go on, but then it would turn into a 'proper paper' rather than a blog and you don't have time to read that!

How can you assure others you do know and understand about image quality? In the Imaging Standard there is a whole section dedicated to this in the Clinical Domain with the statement; 'The service implements and monitors systems to ensure the acquisition of optimal diagnostic quality images.'

Do you know what your service does to ensure optimal diagnostic quality, do you ever contribute to ensuring that the latest evidence is applied to how you obtain quality images, do you talk to colleagues and students about your image quality e.g. do your reporting radiographers feedback about technical issues?

Why not audit your practice, that way your CPD can be updated as you reflect on the findings and make changes or develop practice within your service. Audit isn't hard, if you look back through your copies of Synergy I have talked about this previously, why not give it a try?

You may not have guessed but I am passionate about our profession, I believe no one can do it better than us; it is up to us to provide the evidence to demonstrate that we are highly trained professionals who make a difference every day.

Audit can provide you with that evidence and you never know maybe you will be the one who writes a paper. Perhaps that can be your New Year's resolution – to look at image quality and make a difference to your patients, service and profession?

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Why did you decide to specialise in breast imaging?

MAMMOGRAPHERS who have been qualified as a radiographer for ten years or less are being asked to help with a study investigating career choices.

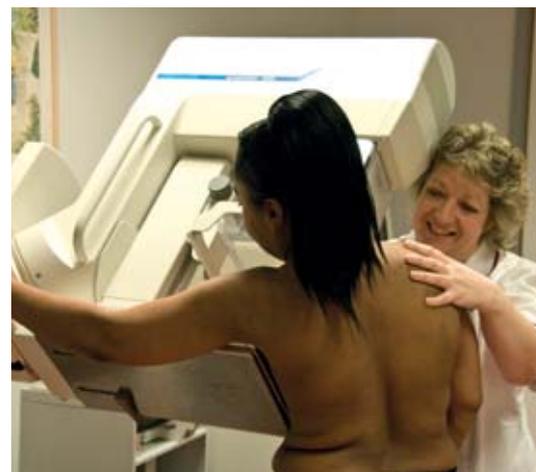
Cambridge Breast Unit and the University of Suffolk, with funding from Symposium Mammographicum, want to find out why practitioners choose to specialise in breast imaging. The survey is part of a larger project involving student radiographers and their views on mammography as a future career option, including allowing male radiographers

to carry out screening.

It is hoped evidence from the study could inform recommendations to address current workforce shortages.

The questionnaire is open until 20 December and takes no longer than 15 minutes to complete. It is anonymous unless participants choose to leave contact details for follow-up questions.

For more information, or questions, contact Kathryn Taylor: kathryn.taylor@addenbrookes.nhs.uk or Ruth Strudwick: rstrudwick@uos.ac.uk



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Chris Woodgate, ISAS Officer

Thinking hats

Alas I am sad to say this is nothing to do with the Cat in the Hat, although some of his quotes may fit with what we see in some of our healthcare organisations:

"And this mess is so deep and so tall,

We can not pick it up.

There is no way at all!"

Ever felt like that? I can understand why if you have.

This is all about Edward de Bono's six thinking hats, which if used in the right way may help the 'Cat in the Hat' clean up some of the mess. De Bono's hats are designed to help you in a decision making process, whether it be how you choose to organise your CPD, think about the next steps in your career or how to improve an aspect of the service you offer to patients. They can be used individually or within a group; if you are looking at changes within your service then suggesting this method may help you and the team.

The process allows you to move outside your normal thinking style and look at an issue or problem from a number of different perspectives; which gives a well-rounded view of the situation you, your team, or your service may be in.

Each hat allows a different way of thinking, therefore it allows all the team to express an opinion without feeling they are marginalised or difficult, or it can help an individual see from a perspective they are not used to.

1. White Hat – allows you to focus on the information/data that you have and what can be learnt from it.
2. Red Hat – 'wearing' this hat helps you look at the problem/issue using your intuition, gut reaction and emotion. Using this to think how others could react emotionally, especially if they haven't understood or are not fully aware of your reasons behind a decision, e.g. patient's reactions to appointment changes or prep.
3. Black Hat - looks at the potentially negative outcomes. It is not often we allow negative thinking but it does have its uses; it can be used to highlight weak points in a plan. It lets you see what might not work. Once potential weaknesses have been identified you can eliminate them, alter a plan or prepare contingency plans to counter any potential problems.
4. Yellow Hat – this is the optimistic hat that helps you and/or others see the benefits of the decision and the value of it. It is the hat that keeps you going when everything looks gloomy and difficult.
5. Green Hat - represents creativity; where creative solutions to problems/issues are sourced. When this hat is being worn there should be very little criticism of ideas. Ideally, at this point there should be no 'bad' ideas, just ideas.
6. Blue Hat – this is the hat worn by those who chair a meeting, so if you are using the hat as an individual you get to wear this when you pull all the information and ideas together. Blue Hats often ask other Hats to 'come into play' e.g. asking for Green Hats when ideas run dry or Black Hats when contingency planning is needed.

Hopefully you can see that hat wearing can be very useful and not just for decoration!

De Bono's six thinking hats allow you to be sceptical and creative in what is often a purely rational process. Decisions made using this technique can be sounder and more resilient and help you avoid possible pitfalls before a final decision is made.

Why not use this in your practice, especially if your service is going through changes or thinking about Imaging Standards; you never know what the impact may be.

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<http://bit.ly/2GbOufm>

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Terms and Conditions – click/tick or sign here to agree

It seems to me that you can't do anything nowadays without agreeing to Terms and Conditions (T&Cs); my phone, favourite website, Twitter, Snapchat, the list goes on. How many of us actually read the T&Cs? Well I have to hold my 'quality' hand up and say not always, even though I know I should (have you seen how long they are and the size of the print makes me feel my age!)

You will be glad to know that our Imaging Standards do not have terms and conditions, but they do come with an expectation of how we as professionals and our service could perform. Hands up those who know what those expectations are (the link at the bottom of the page will help)? Let me ask another question, do you know what is in the HCPC and your professional body's codes of conduct and/or proficiency? Did you know that the NHS Constitution has a staff expectation section and one of the areas it covers is that you need to 'protect patients from avoidable harm'? The Imaging Standard covers all the expectations on you and will help you to meet them.

Like T&Cs you need to read them to understand what is expected and it is a fairly long document with explanation notes (commentaries). Everything you need to practice safely is there, and as you have ticked that box on your HCPC form to say that you have kept up to date and practice safely, it gives you the evidence to prove it. My advice would be to find an area you are interested in, clinical, patient experience, safety etc. and look to see what it says about those, you might be surprised at how well you do.

For example patient consent – PE3 The service should ensure that all patient groups and/or carers, as appropriate, are involved in decisions about their examinations or

procedures. I am sure that you are all aware that there are two types of consent within imaging services, Implied and Expressed (both of which must be informed).

According to the NHS Choices website 'Consent to treatment is the principle that a person must give their permission before they receive any type of medical treatment or examination. This must be done on the basis of a preliminary explanation by a clinician. Consent is required from a patient regardless of the intervention - from a physical examination to organ donation'.

Three other interesting points are:

- Failure to gain consent is regarded in law as Trespass against the person.
- If a patient is touched by the healthcare professional without consent, this constitutes a crime of battery in English law and assault in Scottish law (Mason & Laurie, 2010).
- All healthcare professionals have a responsibility to ensure that they gain consent before proceeding with any care or treatment.

The majority of (but by no means all) imaging examinations are covered by Implied Consent, that is when the patient adopts particular behaviours, consistent with understanding and complying with the requests of the healthcare practitioner. Such a patient who when asked by a practitioner to undergo a non-invasive procedure such as an x-ray answers yes and place themselves in a position for the image to be taken. I am sure like me you will have given a brief explanation as to what you will be doing and why, as it ensures that you are imaging the correct body part as well as giving reassurance to the patient. That reassurance may be the key to ensuring 'image sharpness'

and avoiding patient movement blur. Like the rest of us patients (albeit implied or verbally) are ticking the 'I agree' box; we need to ensure we have correctly explained the T&Cs.

But what about those patients who are unable to give even implied consent or who are deemed not to have competence; e.g. the unconscious patient or a paediatric patient (they may be giving off verbal & behavioural signals that the last thing they want is an x-ray!). Again NHS Choices comes to our rescue:

- Implied consent may also be assumed in the case of an unconscious patient admitted to an emergency department. It would normally be assumed that the patient would consent to the use of life saving measures in an emergency.
- Someone with parental responsibility may need to give consent for a child up to the age of 16 to have treatment; however if they're able to, consent is usually given by patients themselves.

It may be worth remembering that NHS Choices is often a 'go to' for patients and carers and they will have read these 'T&Cs' and will be expecting us to behave accordingly. There is a lot more on the NHS Choices website around consent and it is easy to access, why not have a look and refresh your knowledge?

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“Quality is not an act, it is a habit”

HOW ARE YOU DOING with your New Year resolution/s? Did you make it to Easter Sunday with your Lent promise? Good intentions...there is a quote in there somewhere but you get the point. We can all think about the good we want to do for ourselves, our family, our patients but how many of us actually get down to putting it into practice relentlessly?

Breaking bad habits and replacing them with good habits can be difficult and no matter what the inducement (Grandma – crusts do not make your hair curl!) they still take hard work.

When did you last perform a reflective review of your practice to identify any 'bad habits' or if we are talking 'standards' any non-conformities? What is a non-conformity, one definition is a failure to conform, especially to standards. I am not suggesting you act like the 'Borg' (Star Trek alert, you will be assimilated, resistance is futile) and think like an automaton without room for change or innovation. What I am suggesting is that occasionally you look at the professional standard, your service standards etc. and ensure that your practice is aligned to ensure patient safety, service efficiency and that you are open to challenge and change to innovate.

What do you do if you find a 'bad habit' or non-conformity? First you have to acknowledge it, a bit like when someone asks if you exercise regularly do you tell the truth. Exercise is a habit we have to develop how well you exercise depends on how

you maintain that habit. I will say no more people can get a bit touchy about exercise habits and I have no wish to cause offence, but if you are like me admitting exercise is an intermittent habit can be difficult (who wants to be known as a sloth).

If we look at a workplace habit how about considering image quality? One habit I was always keen on for myself and others was the use of collimation on an x-ray image. I am sure you remember that collimation reduces the radiation exposure to the patient and the operator without reducing image quality. Can you see your collimation on your final image?

How about side markers, do you always visualise them on the image or do you insert later digitally, what are the potential consequences for patients if we get side markers wrong or they are missing? If you don't get either correct a 100% of the time, is it the end of the world as we professionally know it? No, of course not; but if we want to foster good habits looking at the image and seeing how you could improve next time and then trying to improve with each successive image cements that habit into everyday working. For those of you who are interested in self-assessment on image quality a paper was given at the European Congress for Radiology (ECR) in 2014 entitled 'Self-assessment of clinical image quality in plain radiography: an evidence-based practice for radiographers'. It can be found on line and is an easy read and well worth a look.

Are there any other quality habits you can explore, for example how you safely use and store contrast agents or any other medicines/drugs used in your service, what you do about patient confidentiality, do you regularly put up hazard notices if you engage in mobile radiography in theatre or wards. The list could go on and on.

Just like any resolution or change of habit looking after quality takes a determined effort in the beginning, once established it then becomes a part of life. Is your quality self-assessment like your gym membership fully functioning, in use as much as possible making you feel better about yourself, or is it causing efficiency issues within your budget as you watch the fees disappearing without any of the benefit?

As Aristotle so aptly put it 'quality is not an act, it is a habit', so why not try a new habit and reflect on your practice?

1 N. Kärnä1, et al. 2014. Self-assessment of clinical image quality in plain radiography: an evidence-based practice for radiographers. Electronic Online System. 10.1594/ecr2014/B-1061

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Following the leader

DID YOU EVER PLAY THAT GAME when you were little where some 'lucky' person was chosen to lead and everyone else had to mimic everything they did? I remember the wackier the movements or things we had to do the better the leader was considered. Now childhood days are over we are far above such things, aren't we?

I am sure each and everyone one of us has a 'leader' to follow whether it be a team leader, superintendent radiographer, radiology manager or a chief executive. I would hazard a guess that they do not exhibit the wackier stuff of the childhood game; but I do have to say I have seen some 'strange' behaviours from leaders that I vowed never to copy if I ever became one.

In their article Followership theory: A review and research Agenda (2013) M. Uhl-Bien et al and separately J.S. McCallum (2013) in Followership: The Other Side of Leadership, talk about how important followers are. If you think about it you can't be a leader if no one is following you, plus even your leader has a leader above them they have to follow. When I think about teams I don't recall hearing much about followership, yet the articles above would say that 'without following behaviours there is no leadership' (Uhl-Bien 2013). Well that makes you a very important person, I wonder if your leaders see it that way?

How do you become a good follower – by doing everything you are told or is there more to it than that? McCallum has pulled together eight points which I have touched on below, that outline the importance of good followership behaviours to successful leaders and how those behaviours stand you in good stead for the future.

1. Judgement – take direction, but only when that direction is ethical and proper. Understand the difference between instruction you don't agree with and that which is truly wrong, e.g. it would compromise patient care. Show enough good judgement and someone may make you a leader.

2. Work – usually good followers are diligent, motivated, committed and make an effort. Your leader has a responsibility to create an environment that permits these qualities.
3. Competent – you can't follow a direction properly that makes you work in an area you are not competent in. When things go wrong because the follower does not have a competency, leaders should blame themselves and not the follower; e.g. have you had the training or updates you need to do the job you are asked to do.
4. Honesty – a follower 'owes' a leader an honest and forthright assessment of what the leader is trying to achieve; especially when you feel the leader's agenda is seriously flawed. Respect and politeness are important when delivering such a message but good followers should not sit on their hands while an inept leader drives the proverbial bus over a cliff. Good leaders listen to feedback, poor leaders may be threatened so you may need to tread carefully and you may have to consider talking to a more senior person if patient safety could be compromised.
5. Courage – this ties in with the point above; it takes courage to be honest with your leader about the concerns you may have.
6. Discretion – when you are not happy about what is happening at work don't just moan, use points 4 and 5. If you get a helpful discussion then be discreet about what you say to others; we still have a duty of care to each other and that includes your leader. Don't brag about how you put them in their place or undermine them; remember that might be you in the future, how would you feel?
7. Loyalty – followers ought to be loyal to their organisation and I would argue that those of us who work in the NHS would live and die to protect it. If this is true it allows us to be strong and challenge when challenge is needed; but also it means that at times we act for the 'greater

good' and forgo our personal feelings. Being loyal doesn't mean you are a doormat, rather it means that you consider the needs of the whole team, ensuring you don't create unnecessary problems which would undermine the purpose of your service/team.

8. Ego – how is your ego, are you a good team player? In your service/team, is the goal to be recognised or to ensure your patients receive the best care you are able to give? Good followers are about overall performance, quality of care and the patient not about personal recognition or self-promotion. Personally I think this is the most difficult of all, especially when you see others succeed through personal recognition and /or self-promotion; I didn't say it would be easy and I think the author would agree.

Learnt anything? I did. For me it is about the quiet revolution that comes from good followership, that a difference can be made by the way we follow. It is true that any organisation needs good leaders but they also need good followers; you can have as many good/great leaders as you like; unless they are supported by good followers the outcomes will never match the leadership potential.

Why not put yourself in a leader's shoes and ask what would you like your followers to be like? Think about those things that have inspired you in a leader and those things you would never want to put anyone else through. Encourage your leader and your team to be honest and courageous, you never know what you might achieve.

John S. McCallum. 2013. FOLLOWERSHIP: THE OTHER SIDE OF LEADERSHIP. IVEY Business Journal: Issues: September / October 2013.
Mary Uhl-Bien et al. 2013. Followership theory: A review and research agenda. The Leadership Quarterly 25 (2014) 83–104. © 2013 Elsevier Inc. All rights reserved.
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Expectations

IN MY ONGOING LEARNING (you can never know enough) around quality I found this interesting definition of quality assurance by Techopedia - 'Quality assurance (QA) is the process of verifying whether a product meets required specifications and customer expectations! Nothing new there you may think, but something did catch my eye; 'customer expectations'!

Who are the customers in an imaging service? Quite a hard question to answer; is it those who refer into the service like the surgeons, physicians, GPs and non-medical referrers? Or is it the CCGs who pay the organisation for the service you provide and monitor your performance and activity? Or is it the patients who use the service?

Within the Imaging Standard there is an expectation that your service will encourage those who have contact with the service in a formal or professional capacity to give feedback, and to use that feedback to improve and develop services and foster relationships with colleagues. I think we can safely say that those who refer patients to us have 'customer expectations' as well as those who pay for the service. What about the patients, are they customers or not? Again the Imaging Standard has something to say about this subject, which is to encourage patients, carers and others including staff to give feedback, either verbal or written, and use the feedback to improve and develop the service. More expectations of you and your service.

How do you meet all these expectations, are the expectations realistic, do they come from a point of understanding of what is possible from your service and how do you find out what the

expectations are?

Last summer I looked at what quality assurance might mean for an imaging service and came up with these suggestions:

- a. Safe - everything you do needs to be safe for the patient and the staff performing any task.
- b. Consistent - it should be the same for every patient – in the BBC 'fly on the wall' documentary over the winter period (2016-17) a senior nurse was quoted as saying "it doesn't matter if they come from Buck House or the park bench, they are all treated the same" is that true of everything you do?
- c. Accurate – are you sure that you are doing the 'right test, with the right equipment, at the right time, for the right patient'?
- d. Fit for purpose – is everything you do evidence based, can you demonstrate that it is best practice, that it is efficient and effective, using the best 'tools' to obtain the required result.

I would say these are expectations we should be living up to, do you think they match the expectations of our customers/patients?

The NHS Constitution (2015-updated 2017) describes some expectations, they must do as there is a section which says 'what to do if your expectations are not met'. Within the constitution there are 7 guiding principles which are described as – 'the enduring high-level rules that govern the way that the NHS operates, and define how it seeks to achieve its purpose. They are underpinned by the core NHS values and are made by Regulations like the NHS Constitution itself, the principles should be embedded at every level within the health service and among those organisations providing NHS services'. Quite a 'mouthful' but do you know what these

7 principles are, it might help in understanding if you are meeting them or not?

They are:

1. The NHS provides a comprehensive service available to all
2. Access to NHS services is based on clinical need, not an individual's ability to pay
3. The NHS aspires to the highest standards of excellence and professionalism
4. The patient will be at the heart of everything the NHS does
5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.
6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
7. The NHS is accountable to the public, communities and patients that it serves.

Looking at these expectations can you say you meet the expectations of your customers/patients? If not why not, the expectations expressed don't seem to be too far-fetched? These expectations are integral to the Imaging Standard and working through the standard will help you to meet these expectations. If you don't or feel you can't meet these expectations what do you do?

As Dr Seuss says – "Unless someone like you cares a whole awful lot, nothing is going to get better. It's not."

Once again it is over to you.

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Responsibility

WHO wants to be responsible? It can be a bit scary if you ask me. If I am responsible for something then I am accountable for it. Small children are good example, it can be terrifying being responsible for them.

George Bernard Shaw said, "We are made wise not by the recollection of our past, but by the responsibility of our future".

I am not fully sure I agree that history has no part in informing our future, but I do see where he is coming from. Take, for example, the influence David Attenborough's Blue Planet has had on how we recycle and use plastics. A collective responsibility was taken for our ocean's future, to the extent that we now have pledges from various retailers and other companies as to how they will be tackling the issue of plastic in our oceans and personal pledges from individuals and families. Each of us taking a level of responsibility to change the future.

How does that transfer to what you do every day? This blog has cited lots of ways the quality challenge can be met from image quality, to being an influencer for change; leading from where you are not where you think leaders should be. Are you someone who is taking responsibility for an area of your service to improve the quality or to compare what you have with our professional standard (ISAS) to ensure that you comply? Or are you part of a collective that is doing similar work? Or do you find yourself in a service

where there is little importance in meeting our professional standard or in understanding how it can help the future of the service? What can you do and who is responsible for pushing the agenda forward? Responsibility can only be given once it is accepted no one can make you do it.

For example all of us have responsibility to comply with the HCPC standards of conduct, performance and ethics and there is accountability to the HCPC in meeting them, otherwise you may be struck off the register and unable to practice. To be on the register you accept the responsibility that goes with your registration.

Some of you I know will have tried very hard to make a difference but see little or no progress and find obstacle after obstacle in your way. How do you keep motivated and how do you motivate others? There are perhaps some questions you could ask yourself

- What is it about the subject that is not connecting with others, why do they view QA as boring or unexciting; is it in the way it is expressed in the service?
- What can I find that will interest my service to get them started? Often one small task with a successful completion is easier to sell than a large complex task.
- What challenges is my service facing that I can use the professional standard to help meet.

- Am I willing to take responsibility for pushing the agenda, can I use this to further my career, my CV and/or my CPD?

Nelson Mandela said, "I never lose: either I win, or I learn." He would also say, "Don't judge me on my successes, judge me on the number of times I have fallen and gotten up again".

Can you act in a similar fashion taking responsibility; it took Mandela a very long time to achieve the success he did, but he never let go of feeling responsible for ensuring he did everything he could to get emancipation for those he represented.

For those of you who are involved positively in the QA challenge I hope you are having a good time. Does that sound daft? I believe that to be really successful we need to enjoy what we do, yes there will be times when you don't, but I hope you are finding that sense of achievement in making a difference. If you are then your example to others will carry more weight and be attractive, remember we all aspire to something, what a privilege to be someone others aspire to emulate.

The final quote is from Chuck Palahniuk an American writer, "Find joy in everything you choose to do. Every job, relationship, home ... it is your responsibility to love it or change it. "

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GIRFT

I AM NOW RESORTING to gobbledegook; don't you hate all those acronyms, what on earth does GIRFT mean? Some of you I am sure will know what this means, others won't and quite a few probably don't care! It can get a bit too much can't it?

However, this one has intrigued me and therefore I am writing about it; it is in fact NHS England work 'to improve the quality of care within the NHS by reducing unwarranted variations, bringing efficiencies and improving patient outcomes'. Wow, that sounds good, how do they do that? Well, by Getting It Right First Time (GIRFT). Did you just groan and say "all well and good, but did you just see the patient I just had", who couldn't keep still/ lie down/ sit up or assume any position you needed to get a diagnostic image of any quality?

GIRFT work to date has been mainly around surgical specialties, but now Imaging has its own work stream led by Dr Kath Halliday. You are all well aware that imaging has a big part to play in the majority of all patient journeys and how important it is for our patients that we get it right, to get the answer to the question clinicians are asking. This is where my favourite question comes in - 'WHY'. To get it right first time the 'Why' question can be really important; why this modality, why this view, why this procedure? When requests are verified do we ask if it is the right modality, the right pathway, the right projections for the mechanism of injury? If we miss this step do we find ourselves having to re-refer or repeat examinations?

Our professional standards as contained in the Imaging Standard quite rightly brings this

to the fore and is a useful tool in ensuring you can work to GIRFT principles.

I would question though whether just pointing out the standard is really helpful? Forgive me if I appear this way, as really it is not good enough to just point out the answers. If we do not allow the 'Why' question and just point to answers we will never see improvement. The Imaging Standard is all about the evidence – make sure you ask for the evidence behind the changes you are asked to make or for the way your peers/ colleagues do something.

Do we look at using ISAS with the right approach, as good ideas and advice are often wasted by a 'ram it down your throat' strategy? In the true spirit of GIRFT perhaps we should be a little wiser and think about saying the right thing, at the right time, in the right way. It is probably not good to tell someone outright that they are taking too long and that their images need too many repeats to get to diagnostic quality. Rather, use the standard to gather some evidence, demonstrate the outcomes you are looking for, envision your colleagues and peers that there are ways to work differently that make a difference to your patients.

As I am very old I can remember the days when we had a 'blitz' on image quality and repeats, we had hard copy film which went in your locker or handbag so it couldn't be counted. Well, we don't have film anymore but are your team members still hiding the truth from you or themselves? Our approach to the issue can either alienate or get others on board, I know which I would rather. Most if not the majority of our profession want to do what

is best for the patient, to be the best they can be; an encouraging approach can often 'turn the tide'. Surely that is better than the "who are you to tell me!" response when the 'Why' question is asked or issues are discussed. When we look to improve or innovate we need to be aware of our own failings; is it really them or is it me? Is my approach open, honest and am I acting with integrity? Most of your peers and team members will respond positively to someone who isn't pretending to have all the answers.

Former U.S. Senate Chaplain Richard Halverson wrote: "You can offer your ideas to people as bullets or as seeds. You can shoot them or sow them. Ideas used as bullets kill inspiration and motivation. Ideas used as seeds take root, grow, and bear fruit in the life in which they are planted. But there's a risk: once it becomes part of those in whom it's planted, you'll probably get no credit for originating the idea. But if you're willing to do without the credit...you'll reap a rich harvest."

I know it is easy to talk and I do challenge myself regularly ensuring I am 'walking the walk', nobody likes an old windbag. So can I challenge you when you are looking at 'getting it right first time' that you think about saying the right thing, at the right time in the right way too?

<http://www.sor.org/imagine-services-accreditation-scheme>

<https://www.rcr.ac.uk/clinical-radiology/service-delivery/imaging-services-accreditation-scheme-isas>



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www.sor.org/being-member/my-profile

Many thanks

WHY Fronts

Asking the question WHY to promote quality service provision

Chris Woodgate, ISAS Officer

Good, Better, Best

WHO REMEMBERS English language at school? Learning how the English language works, how as children we may have been confused as to why it wasn't good, gooder, goodest. If any of you have small children or know any I am sure you will have had that conversation.

In healthcare we know about good practice, it is what is commonly agreed as the correct way of doing 'things'. It keeps us and our patients safe, doesn't it? I would pose a question; how do you know that it is 'good practice'? Have you seen the evidence and are you sure everyone is adhering to 'it' whatever 'it' is? I found the following quote when I was researching quality improvement -

"Forget about good.

Good is a known quantity.

Good is what we all agree on.

As long as you stick to good, you'll never have real growth."

—Bruce Mau (Canadian designer)

Oh, if we want to see improvement (growth) then we have to step outside 'good' and look at better or even best; at least I think that is what Bruce Mau is trying to say. So how do you know if you are good, or better or the best? Benchmarking is one obvious way of measuring how well you are doing compared to others. A wise person once said to me "benchmark against others once, then you can only benchmark against yourself". I think what they were trying to say is, how do you know you are benchmarking against a good quality standard, could you be benchmarking against the lowest common denominator? All good questions I would say. How then do you improve professionally, how does your service improve so that quality improvement (growth) is inherent in all you do? I would comment that if the service you work in has a quality improvement programme then you are more

likely to improve professionally.

Of course I am going to talk about the Imaging Standards (it's my job), in all honesty I can't think of another benchmark which will allow a service to develop quality as well as performance, efficiency and effectiveness. It does mean, however, you have to do something about it, learn or re-learn improvement tools to help you on the way and then put them into practice. If your service does not intend to pursue accreditation, does it mean you can't develop the service or yourself professionally? I would say no, you can develop no matter what circumstance you find yourself in, it may just take a little ingenuity.

To help there are examples of quality improvement tools for you to choose from, you can look them up online to learn more. A good site is <https://improvement.nhs.uk/resources/quality-service-improvement-and-redesign-qsir-tools>. Here you will find tools to help whatever part of your service you would like to see improvement in.

1. Analytical Tools
2. Communication
3. People and Change
4. Creativity
5. Project Management
6. Commissioning
7. LEAN
8. Six Sigma
9. Reduce Variation
10. Higher reliability
11. Clinical Systems Improvement

There is lots of information there and sometimes that can be overpowering leaving you not sure what you want/need to look at. If you want to be the best radiographer you can be how would you measure your quality, how would you use some or one of the tools to measure your improvement from good to better to best? How about using the tool

'Fresh Eyes' in the creativity section.

Some of the advice here is to view the situation from a different perspective using 3 'What' questions:

- What is important
- What aspect to focus on
- What ideas and approaches could be used.

Then there are 5 'Why' (my favourite word) questions:

- Why do I/your patient have to come to this place
- Why do I/your patient have to wait
- Why do I/your patient have to do this/have this done
- Why do I/your patient have to see lots of different people
- Why do I/your patient have to see this person again.

If you want to look at a patient journey and try to make it as fast and effective as possible, how would you answer those questions? For example, does your patient need to be seen at the main site or can their journey be reduced by attending a community site? Is it necessary to make the patient take the examination preparation on site or could it be taken at home? Or is the examination really necessary? I am not saying any of these are right or proper but hopefully they make you think.

The final quote comes from Proust who said: "The real voyage of discovery consists not in seeking new landscapes but in having new eyes." Learn to think outside the box, and remember, inspiration comes with perspiration! Expect problems, and don't let them weaken your resolve to be better or best.

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WHY Fronts

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Chris Woodgate, ISAS Officer

Peeling Onions

EVER TRIED to cut an onion without crying? I am willing to guess that some bright spark amongst you has the answer to that conundrum; as I was not prepared to sacrifice my tear ducts on the altar of onion research I looked it up on the internet (isn't that what all sensible people do?).

Well apparently the top two tips are:

- Freeze the onion before chopping (they do recommend thermal finger wear in case of very cold fingers)
- Put a piece of bread in your mouth, i.e. stop the sulfoxides reaching your eyes as you will have a barrier and a slightly open mouth to catch the gases before they reach your eyes.

I would quite like to see family kitchens practicing those solutions, you would all be probably crying anyway with laughter or choking on the bread!

Why am I discussing peeling onions? Well there is a metaphor in which 'peeling the onion' means exploring a problem one layer (step) at a time, to understand what has gone wrong in a situation or what is causing trouble in an area. In healthcare you probably know this as root cause analysis, makes it seem less threatening when you realise you will just be peeling an onion (although I have seen root cause analysis bring many a tear to the eye).

How do you 'peel the onion' by a root cause analysis?

You will be looking for the source of an issue/problem and not just the symptoms of that problem, e.g. why are patients waiting longer in area A than area B when the same work and type of patients are seen. Once you have the source you can then take measures to change, develop or innovate practice.

1. Write down the specific problem. This helps you formalise the problem and describe it accurately. It also helps a team focus on the same problem not what each individual thinks the problem is.

2. Brainstorming to ask why the problem occurs then, write the answer down.

If this answer doesn't identify the source of the problem, ask 'why?' again and write that answer down. Loop back until you or the team agree that the problem's root cause has been identified. This may take fewer or more than five 'whys?'

The key is to avoid assumptions and encourage yourself and the team to keep drilling down to the real root cause. If you try to fix the problem too quickly, you may be dealing with the symptoms not the problem, so use five whys to ensure that you are addressing the cause of the problem. Remember, if you don't ask the right questions, you won't get the right answers.

An example of root cause analysis using five whys would be:

- The patient was late in the interventional theatre, it caused a delay. Why?
- There was a long wait for a trolley. Why?
- A replacement trolley had to be found. Why?
- The original trolley's safety rail was worn and had eventually broken. Why?
- It had not been regularly checked for wear. Why?

The root cause is that there is no equipment maintenance schedule. Setting up a proper maintenance schedule helps ensure that patients are not late due to faulty equipment.

Another example of root cause analysis using five whys would be:

- The patient's diagnosis of cancer was considerably delayed. Why?
- The cancer report was not seen by the surgeon. Why?
- The cancer report was filed in the patient's notes without being seen by the surgeon. Why?
- It was the receptionist's job to do the filing. Why?

- The junior doctors were busy with other tasks. Why?

The root cause is that the doctor's other tasks were seen as more important than filing. In an ideal world the system would be changed to; a copy of all cancer reports are sent to the consultant surgeon responsible for the patient and no reports are filed unless they have been signed by a doctor.

Maybe you could use a root cause analysis approach to ask why your children/significant other are not ready to leave the house on time

- Delay in leaving home to get to school/work. Why?
- Person 'A' was not ready. Why?
- They hit the snooze button too many times. Why?
- They were tired. Why?
- They stayed up late playing the latest game on the Xbox. Why?

The root cause is the lure of the Xbox proved too great and they did not get to sleep on time. Unplugging the Xbox at an agreed time to allow for sufficient rest would be a solution. (Good luck with that one!)

Once you have identified the root cause of the issue, you will need to communicate the outcomes to others to ensure that the root cause of the problem is understood and that everyone is focused on working on the correct problem area, not treating its symptoms. Otherwise there will be tears at bedtime!

A serious explanation of root cause analysis can be found at the web address below.

<https://improvement.nhs.uk/resources/quality-service-improvement-and-redesign-qsir-tools/>
<http://www.sor.org/imagine-services-accreditation-scheme>
<https://www.rcr.ac.uk/clinical-radiology/service-delivery/imaging-services-accreditation-scheme-isas>

WHY Fronts

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Meditation... Bulletproof

WHO HAS time for meditation? Can you imagine staff rooms full of lunchtime meditators? No, neither can I, so why mention it then?

The word 'meditation' means 'reflective thinking', a bit like a slow cooker meditation allows your thoughts to slowly simmer until they're done. Most of us would rather act than think and to be honest with busy services and staff vacancies, a lot of the time all you can do is react to the ever increasing workloads you face.

But as Socrates observed, "The unexamined life is not worth living" ...really? Maybe he should have tried living my life; I know how to have fun.

However, he is right in some ways: if you don't carve out time for reflection and meditation, you won't mature. You won't grow in the knowledge you need to succeed. Reflective thinking is uncomfortable for a variety of reasons; for instance, we may have difficulty staying focused, we can find the process dull and we often don't particularly enjoy spending time reflecting on difficult issues. But if we don't, how can we be sure that we work in a service that knows how to improve and/or innovate?

Sometimes it is just easier to brush difficult issues 'under the carpet' rather than to take the time to assess and make changes/developments.

Bullet-proofing is a tool to help you take the time to think and plan, especially when dealing with difficult issues or obstacles. When aiming to improve services, some of the changes that are made will have a knock-on effect in other parts of the organisation or system. Bullet-proofing is a way of thinking through some of the potential issues that may arise when trying to make improvements, or to specifically consider potential consequences for different parts of the system that are involved.

The Buddah is quoted as saying, "Meditation brings wisdom; lack of meditation leaves ignorance. Know what leads you forward and what holds you back and choose the path that leads to wisdom."

How do you bullet-proof (without Kevlar)?

1. Use bullet-proofing to help shape a project, then use it when key decisions need to be made, ie when deciding on the next step, selecting between different improvement ideas, or thinking about implementation.
2. Consider who should be involved. The tool can be used by individuals, such as the project lead or you if you are considering some development actions for yourself. But it is usually more effective if used with a wider group that is drawn from across the

system that is being improved, eg the whole cross sectional team.

3. Start by brainstorming. Think about:

- What might happen?
- What could go wrong?
- What difficulties could occur?

Identify areas in your plan of action that could potentially cause problems, then insert them into a table showing how likely the event is to occur and how serious it would be if it did.

		How likely is it to occur	
		Unlikely	Highly Likely
If it did occur	Major problem		Most serious
	Minor problem	Least serious	

Figure 1: Table identifying the likelihood and seriousness of potential problems

4. Analyse/think about the implications of the table. If there are significant numbers of major problems that are highly likely to happen, it may be you need to consider a different approach. Looking at the table will help you to prioritise and change your focus appropriately.

The next steps will depend on the potential problems you have identified. If you are involved in a big project, you may wish to think about how you cover these in your project plan so that you can monitor progress; or if it is a small change then perhaps think about how you could make changes to avoid or mitigate the problems.

Finally, the best quote I have heard on meditation is from the Dalai Lama: "Sleep is the best meditation." It is true isn't it? Often if you sleep on a problem the solutions appear much clearer in the morning.

I have used the NHSI website again for this blog and I would recommend you read what the experts have to say
<https://improvement.nhs.uk/resources/bullet-proofing/>
<http://www.sor.org/imagine-services-accreditation-scheme>
<https://www.rcr.ac.uk/clinical-radiology/service-delivery/imaging-services-accreditation-scheme-isas>

WHY Fronts

Asking the question WHY to promote quality service provision

Chris Woodgate, ISAS Officer

Quality Christmas

HOW DO I beat last year's piece on a 'quality' Christmas (why not look it up)? Not easy from my perspective as I write this in October and part of me can't bear to think about Christmas yet!

I suppose for me that may be the point: when you, your teams, your manager want to look at implementing the imaging standard, do you feel like "I can't bear to think about it, it is too much work". Or, like Christmas, do you worry how you are going to afford it this year?

Yes; like Christmas, implementing the imaging standard is hard work, but you don't get a 'quality' Christmas by accident do you? For some of you it will be planning meals, visits from or to relatives (some who can mix and some who can't), whether you have a real tree or artificial (risks/benefits – specifically tree needles!) and who has control of the remote on the day. In the same vein neither do you get a quality service for patients by accident.

Funding is another issue: how do you afford Christmas? Like the standard, do you weigh the benefit against the cost? Who do you have to persuade that the number of 'gift' items on a list to Santa is too many or too expensive or alternatively the 'must haves' that you can't do without? Who supports you in the campaign for what you want for Christmas; who do you need to get 'on side'? What evidence will you use to persuade, or perhaps explain what service might you have to withdraw if don't get said gift (a dishwasher is for life, not just Christmas - nobody wants to do the washing up on Christmas day do they)?

Or, do you do Christmas by rote? We have traditions and we stick to them; after all that is part of the pleasure of Christmas, isn't it? The comfort and security of knowing how things will be done, the pleasure of Christmases remembered. What happens when life around

you changes, perhaps teenagers wanting to spend Christmas differently, parents who don't cope like they used to and need extra care, or when your children have children of their own and set up their own Christmas traditions? I think we adapt, we put into place a different type of Christmas, which will become our 'norm' But change is never easy and it may take a little time and practice.

All of these examples can be used about the imaging service you provide; the team working to make it happen, the funding to get the essentials you need, the challenge of the changing NHS and how services adapt but still maintain quality.

Why not think about implementing the imaging standard, it really can be the gift that keeps on giving. The standard can provide you with evidence for safe practice, staffing levels, equipment replacement, the importance of research and development and increased team working making sure everyone has a say in how your service operates.

The imaging standard isn't like getting a pair of socks (boring); it is like one of those gifts that gives you a sense of pride and satisfaction (a bit like the special card from your six year old, the first gift from a teenager bought with thought and care rather than provided by your partner for the teen to give you; the list could go on). Being proud of our profession and the care we give our patients is key to a really good imaging service, we are always better than we think we are; and like Christmas we enjoy it more when we are surrounded by our 'teams'.

If you want to know more or want to see for yourself, why not contact me or look at the webpage.

ISAS@sor.org – <http://www.sor.org/imagine-services-accreditation-scheme>

Guide to Inflammatory Arthritis Study Day

Khalida Jan, consultant sonographer, City Hospitals Sunderland

I SIGNED up for this study day to gain more information about what to scan, how to scan and when to scan patients with different inflammatory arthritic conditions, and to improve my background clinical knowledge. The study day was reasonably priced and included practical sessions. The venue was easily accessible with discounted parking, which was a nice touch and made a big difference!

The day was well organised and the delegate packs contained a wealth of printed information and presentation hand-outs, which helped avoid copious notes. The wall posters provided at the end were really beneficial and are something I will use from day-to-day.

There were lectures from two rheumatologists, Drs Richard Wakefield and Jane Freeston, which provided excellent background medical information on the disease processes and put it, and our scans, into the right clinical context.

The sonographer talks from Kate Smith and Borsha Sarker were really helpful on the technique and pitfalls.

Real patients with pathology attended the practical sessions and there were five stations that we all rotated around. The session leaders were all brilliant and very knowledgeable, answering all our questions and being able to practise the views on the actual pathology was very helpful. I now know what the patterns of disease are and feel much more confident using the OMERACT/EULAR grading system for synovitis.

Particularly useful were the tips on careful biplane examination of the 2nd and 5th MCPJs and the 5th MTPJ for erosions, the relevance of the ECU and certain other joints as key sites for pathology. I also learnt a lot of new information about tendon enthesitis and the