

WHY Fronts

Asking the question WHY to promote quality service provision

Chris Woodgate, ISAS Officer

Patient experience – the advocate

WHENEVER I think of the word 'advocate', there is always a small part of me that automatically thinks of the memories of the drink Advocaat, which, for me, is generally served at Christmas.

Advocaat is a traditional Dutch/Belgian rich and creamy liqueur made from eggs, sugar and brandy. It has a smooth, custard-like flavour and is similar to eggnog, which they talk about in the American Christmas movies. I think it is best served with lemonade, usually called a snowball, as you get a lovely white foam on the top.

What does this have to do with patient advocacy and the radiographer? Well, on the surface, nothing, but let's take a step back and have a closer look:

What is advocacy? The SCoR Patient Advocacy (2008) document states this is 'primarily concerned with both promoting and protecting the interests of patients and service users.'

How, as radiographers, do we advocate/protect the interests of/for our patients? Is this something you think about or is it something you do unconsciously? For instance, I am sure you all practice the principles of IR(ME)R, health and safety, infection control, the list could go on. All of those are inbuilt to our daily duties and day-to-day working; therefore, do we have it covered, or is there any further we need to go?

I have had the privilege of working with some exceptional radiographers who took advocacy a little step further, which made me think about my own practice and how I could make a difference, no matter how small, to a patient's journey.

Examples are:

- An elderly patient presented to the A/E imaging department with a clinical history

of fall query fracture to the neck of the femur. The patient did have a fracture as the symptoms indicated, but they also had bruising around the face and upper arms, which the radiographer couldn't align with the mechanism of injury; especially the bruising around the upper arms. The radiographer accompanied the patient back to A/E and asked to see the referring clinician, where the concerns of the radiographer were raised. Due to the excellent team working between the services, the radiographer was listened to and a further examination of the patient was made. This led to a referral to social services who were alerted to the fact that the patient had an unusual pattern of bruising and it was requested that they visited the care home to check.

- A skeletal reporting radiographer was reporting an A/E list when they came upon some images of a paediatric patient. The images indicated a fracture, which on consideration the radiographer felt did not match the mechanism of injury. They took their concerns to the duty consultant in A/E as the patient had been seen and discharged by a junior member of the team. Although all child protection questions had been checked with the parents, following consultation with the A/E consultant, the child was recalled. Further examination and questioning brought to light a bullying incident the child had experienced at school and had been too afraid to reveal to his parents. This enabled the parents to deal with the situation whilst feeling supported by the A/E consultant.

The difference we can make when we use the skills we have to advocate for our patients

is amazing. When you red dot an image or its equivalent do you think about the wider context?

Do you ask for talks on how mechanisms of injury should look? Are you ready to be told not to worry about it whilst knowing you have done your best for the patient? If you are ignored, remember to write it down somewhere; you never know when that evidence may come in handy. Never forget that they are your patient until they leave your care.

Within the imaging standard, the patient experience domain is not the only section that enables you to gather evidence about how you care for patients. From the examples, we can see that team working, respect within and outside our discipline allowing our opinions to be heard, and using our own examples in service can motivate others to make a difference. All are covered across the standard to make your service better for your patients.

How, then, does this relate to Advocaat? I suppose, at a stretch, I am asking if you just want to lick at the foam at the top or whether you want to explore the custardy goodness that lies beneath.

As radiographic professionals, are we ready to look below the surface of what it means to truly advocate for our patients? Contemporary healthcare policy is moving beyond simple notions of advocacy to empower patients with shared decision-making, values-based practice and public, patient, professional partnership.

Working in partnership is the way forward, just like the Advocaat and the lemonade.

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Don't despise the day of small things

METEOROLOGIST EDWARD Lorenz presented the hypothesis that became known as the butterfly effect.

He theorised that a minor event, like the flapping of a butterfly's wings in Brazil, could conceivably alter wind currents sufficiently to cause a tornado in Texas.

Or, if you are more scientifically minded, chaos theory, which is a branch of mathematics and is focused on the behaviour of dynamical systems that are highly sensitive to initial conditions. (No, I don't really understand it either!) Lorenz did however come to the simple yet profound conclusion, 'Minuscule changes in input can make macroscopic differences in output.' (That I can understand!)

Do you feel like you don't make a difference to your service or your patients? You are just a mini cog in a great big machine?

Don't worry, I am not using that as my example this month; I am sure you have heard enough allegories to cogs and wheels that you could make up your own. Eeyore famously said (or not so famously depending on how you feel

about Winnie-the-Pooh), "I'd look on the bright side if I could find it!"

Have you lost sight of the 'bright side' recently? Has your 'mojo' gone missing? How do you continue to try and make a difference in your service for your colleagues and patients? I would guess this is a difficult question to answer.

If Lorenz is right, a small change made by you can make a big change further down the line, or if Eeyore is right, you won't know where to begin.

The example I would like to look at is ants; although the queen ant is the centre of attention and the mother of most of the ants in the colony, she's not the chief ruler. The work and survival of the colony is ensured by 'soldier' ants. The older ants are servant-leaders that begin each new activity in the colony by doing the work themselves. The younger ants then imitate the servant-leaders and join in the work.

There are no supervisors, chiefs, or officers amongst the ants. When you see an ant carrying a piece of bread several times larger

than himself up a steep slope, it's a study in diligence. No matter how many times he drops the bread, he goes back and picks it up and starts climbing again until he gets it to where it's supposed to go

The ant never sees work as menial or beneath his dignity. Whether it is moving dirt or carrying breadcrumbs, he merrily goes along doing his job, knowing that in the end it benefits the colony.

What this tells me is that you can lead a change from wherever you are, your team lead/manager doesn't need to lead it, and you can benefit the whole service including your patients. It is a bit like saying a person's reputation at work will never rise above their work ethic and how people view them as workers.

The success of the Walt Disney empire is based on the philosophy of its founder: "Whatever you do, do it so well that when people see you do it they'll want to come back and see you do it, and they'll want to bring others and show them how well you do what you do."

Wouldn't it be great to be acknowledged as someone who does things well?

How then do you make that difference; by example in what/how you do things, or by seeing the bright side and suggesting a change? A difference can be made by taking one decision, one change, one risk, one idea; it has the potential to change the atmosphere of your organisation.

That's all it takes; you don't have to make one hundred changes. If you try to do too much at once all you do is divide your energy by one hundred, and result in a 1% chance of success. How about being 100% committed to making one difference, making an all-out effort to put it in place? It will probably be one of the hardest things you do, but that one distinction has the potential to make a 100% difference to your service and patients.

The Imaging Standard gives lots of information around the expectations of your service. Why not pick one you would like to see in place that you feel you are not quite there with; concentrate on that one and then see what comes out of it.

You might be surprised at what comes out of one small difference, or you could be like Eeyore as Benjamin Hoff says in his book *The Te of Piglet*: "Unfortunately complaining is one thing Eeyores are not afraid to do. They grudgingly carry their thimbles to the Fountain of Life, then mumble and grumble that they weren't given enough."

If an ant can do it, so can you.

<https://bit.ly/2S6Kt4o>



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Disappointed

IT IS March already and your gym attendance is waning, the diet is expanding (and not in a good way), winter is over but the pressures you feel at work don't seem to have changed. Do you feel disappointed?

A definition of disappointment might be the gap that exists between expectation and reality; you are probably hitting that gap if you are feeling disappointed.

Most of us have faced disappointment in our lives suffering from some unfulfilled desires (my one true love was not a millionaire), or dashed hopes (I never grew past 5ft 3ins and so my BMI will always be adversely affected... sigh). I bet you can think of a few too.

What do we do about it?

NHS Improvement tools are helpful and they have one in particular which helps us deal with projects that have led to disappointment or are stuck in a mire not

going anywhere. Perhaps this will help me get my gym membership energised again too?

What is the 'magic' that will get our projects back on line again; on reading the advice it seems obvious and perhaps that is the problem. Sometimes we overlook the common sense obvious solutions and look for something 'clever' instead.

What does NHSI recommend:

1. Examine the reasons why the project has failed or stalled – obvious
2. Review the lessons learned and share them – obvious
3. Apply corrective measures according to what you have found in steps 1 & 2 – obvious
4. Identify the signs that something may be going astray, don't make the same mistakes again -obvious.

To be honest, I felt a little disappointed that it

was that obvious. I am sure that many of you could have written something similar or do this without thinking. My disappointment (the gap between reality and expectation) is that there was nothing I couldn't already do and that it would take time to do it rather than an easy time free exercise. As my mother always says, 'nothing is worth doing unless it's done well' so the easy answer appears to be null and void.

In my disappointment, do I do nothing, shrug my shoulders and move on, or like Robert the Bruce's spider do I try, try and try again? If you are able have a look at the NHSI model as it has some handy hints and aide memoire, it can be found at <https://bit.ly/2S7LtpL>

Another of my mother's favourite sayings is "you are too clever for your own good!" Don't lose common sense and the fact that it is easier than you think it might be; sometimes there is just the obvious.

Who is to say that once you iron out the issues you will have something that was worth the effort that will benefit your patients and engage your team? Like my gym attendance, if I pick it up again I know it will be worth the effort. Perhaps I just need to change the time of day of the sessions I book to make sure I am engaged in the process enough to make me want to go back.

Mark Twain gave us one last word of caution. He said, "We should be careful to get out of an experience only the wisdom that's in it and stop there; lest we be like the cat that sits down on a hot stove-lid.

"She'll never sit down on another hot stove-lid again and that is well; but also she'll never sit down on a cold one anymore."

When something goes wrong we say, "I'll never do that again!" What a mistake, especially when it comes to your dreams! Experiencing failure is the price you must pay to achieve success. Sometimes you must face it and overcome it repeatedly in order to be able to move forward and pursue your dream.

Disappointment can point us to where we need to look to help solve a problem, but we need to be careful not to take it too far. We need to build on our experiences and not be defined by our disappointments.

Any help we can get can only be good and helping each other through the disappointments of stalled or failed initiatives is a good definition of team work/working together; and that can't be a bad thing.

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Evidence

HOW MANY times have you heard the expression 'If it is not written down it didn't happen' to make sure you have 'evidence' to show that you did the right thing, at the right time, with the right patient?

I am sure you will agree that this is important, especially when thinking about procedures which have IR(ME)R implications.

If you are looking into aligning with the imaging standard then you will be thinking about evidence. If you are working on your CPD portfolio then you may be thinking how you evidence the 15 standards of proficiency for radiographers as outlined by the HCPC.

So, what is evidence?

Evidence is generally considered to be anything that can be used to prove something; like evidence in a trial or, if we are feeling fanciful, the trail of breadcrumbs that is the evidence of the path that Hansel took through the woods.

Some examples may be:

1. Documentary – evidence most commonly considered to be written forms of proof.
2. Digital – evidence can be any sort of digital file from an electronic source. This includes email, text messages, instant messages, files and documents extracted from hard drives, electronic financial transactions, audio files, video files.
3. Statistical – Evidence that uses numbers (or statistics) to support a position; this type of evidence is based on research or results.
4. Testimonial – evidence that is spoken, eg by a witness in a trial under oath.

As Mr Wonka said in Charlie and the Great Glass Elevator, "Anyone can ask questions, it's the answers that count."

How then do you make your answers

(evidence) count? As it is my job I am going to relate this to the imaging standard, plus as professionals why would you not want to meet a quality standard and evidence that you do?

On both the SCoR and RCR websites you will find the ISAS webpage; this has lots of information which should help you gather evidence to prove you meet the imaging standard. At the foot of the SCoR page you will find the competency documents which have been developed to help you understand what sort of evidence you may be looking for within each of the five domains in the standard, alongside the latest available evidence to back up the statements.

Those of you who are working through the accreditation process, of which I know there are many hardworking radiographers and support staff, then you will probably have accessed some of the support available through the independent accreditation body, UKAS, such as the traffic light ready tool.

As Roald Dahl points out through the voice of Mr Wonka, "It is the answers that count." If your evidence (answers) don't meet the expectations of the standards and the independent accrediting body, then they won't count.

Perhaps it will be helpful to look at the four examples of evidence and tie those to the standard/accreditation.

Documentary

Written proof; this could be policies, procedures or protocols, best written in a concise manner that are unambiguous. Or it could be the minutes from a staff meeting where your recent audit has been discussed, or the sign in sheet for an update meeting about change of protocol. The list could become endless; but it can also

be used to demonstrate active proficiency and competency to the HCPC, covering more than one agenda is always helpful in reducing workload.

Digital

An electronic copy of your roster showing that you have worked regularly over a range of disciplines as required, or that you are participating in out of hours work. It can also help you show that you are not doing excessive amounts of additional work and that your employer is ensuring you have sufficient rest periods. Emails that you have updating you about changes and any responses you may have made to these, to demonstrate you have read and understood. Evidence of mandatory training that you have completed electronically through your organisation's processes.

Statistical

Any audit data you may have developed to show how a change of practice may benefit patients, or performance data to show improvement or not. You may want to think about actions from the data and write an action plan. Benchmarking across sites if you are a multi-site organisation to show that you are working towards standardisation, so that patients get the same experience whichever site they visit.

Testimonial

This is the evidence gained when the accrediting body attend the site and they assure themselves that 'you do what it says on the tin', ie you are working in line with your policies, protocols and procedures. Also that you know where to look to find something you are not sure of and you know who to go to if 'things' go wrong. If you are not working to accreditation then you can assure yourself via testimonial evidence by reviewing each other's practice, another good source of evidence for the HCPC.

"The matter with human beans," the BFG went on "is that they absolutely refusing to believe in anything unless they is actually seeing it right in front of their own schnozzles."

If you want to know more or have any questions, why not contact me – ChrisW@sor.org – or look at the web page. Search for ISAS on sor.org

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Quality Team Work



A QUOTE by Dr Allan Fromme¹ (psychologist and writer), "People have been known to achieve more as a result of working with others than against them."

Indeed, there is now a body of peer reviewed evidence which shows that working together and achieving has a significant effect on well-being in the work place and a subsequent effect on patient care within that service.

Who wants to work in a service where people are picked on, their failures are jumped on, and their faults criticised? Where there is evidence of vying for a better impression of ourselves by belittling someone else, where we judge who has what job, who's busier, who has more stress, who has it 'rougher'.

I don't think anyone really wants to work in that atmosphere. So, how do we make a difference, how do we make sure we are not adhering to the quote by Lou Holtz, "On this team, were all united in a common goal: to keep my job"?

David Johnson² in the Journal of Healthcare Management states, "Teams allow organizations to accomplish tasks that are too big for one individual; they are the building blocks that make organizational size manageable. Ideally, teams increase consensus concerning a course of

action, buy-in, involvement, and commitment. They improve quality (eg increasing patient safety) by having more than one set of eyes examining a problem invoking the wisdom of crowds resulting in better problem solving."

How do you know if you are in a team, or if your team is improving quality?

David Johnson goes on to describe what he thinks, from his research, a team is. According to David, it is a small number of people with complementary skills who are committed to a common purpose, who have shared decision making with some understanding of each other's roles, contributions to team, and interacting adaptively and dynamically in pursuit of team goals, with an approach where they hold themselves mutually accountable.

The team goal may be, for example, a set of performance goals, or a new way of working for the benefit of patients.

I am hopeful that the majority of you work in an environment like the one described above, but what if you don't or if you think it could be improved?

Why not gather or ask to have a team meeting as your team exists at the moment, then go through a small checklist (as provided by

Professor Michael West):

1. Are you clear about your task as a team?
2. Are you clear about what skills are needed in the team, eg radiographers, radiologists, assistants, management?
3. Is the team the right size, if it is too big it may not work as well?
4. Does everyone clearly understand their roles and the roles of other team members?
5. Does the team have challenging measurable objectives?
6. Does the team work well with other teams in the services and wider organisation?
7. Does your team have a positive supportive, humorous, appreciative atmosphere? Positive teams are more optimistic, cohesive and have a stronger sense of efficacy as a team.
8. Does your team meet regularly to reflect on the quality of care provided and how you could improve it? Teams that regularly take time out to reflect are not only more productive but also more innovative than teams who don't. This type of team is better able to respond to work pressures and adversity.

Why should we do this?

I would suggest that patients could tell you why this is important; wouldn't you want a patient centred, efficient, efficacious and quality experience?

If your 'team' is not working together how can you concentrate fully on your patients? I am sure when you trained and qualified your intention was to be the best you could be, treating your patients as individuals? If you work with others you can enhance the patient experience, especially if at some point you include the patient voice in your team.

Why not think about it? Why not give it a go?

If you're fed up with the same 'banter' from me, why not think about contributing yourself? If you have something to say that will enlighten your colleagues on quality and the Imaging Standard why not drop me a line, a guest contributor is always welcome.

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

References

1. NHS team work – apple pie in the sky. By: West Michael, NHS Employers/Blogs. 07/08/2013.
2. Framing communication in health care action teams. By: Johnson, J. David, International Journal of Healthcare Management, 20479700, Apr2019, Vol. 12, Issue 1



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Room for Improvement (Mind the gap!)

FED UP with house improvement programmes, the self-improvement books/articles? Me, too. Why am I and/or what I have, not good enough the way it is? Perhaps you/it are good enough, but could you/it be better?

I am sure we all know that, if we don't change, we stagnate or, in some cases, fossilise; I am sure you have met people that live in a radiography world that really doesn't exist anymore or have that lovely saying 'in my day'.

In a healthcare setting, someone saying quality improvement can lead to groans and comments such as 'it's just another thing to do' or a further 'box to tick', so why is quality improvement important?

Well, quality improvement is about making healthcare safe, effective, patient-centred, timely, efficient and equitable. I would defy any professional to disagree with those aims/goals, but I have some sympathy for those who feel it is just another burden to bear.

How then do you overcome this and allow your team and others see the benefit of using the imaging standard to improve your service for the benefit of your patients and for your own personal development?

I guess the first thing I would do with a standard is to see where I measure up against it: I would do a 'gap analysis'.

What is a gap analysis? It can be described as a tool you use to identify where you or the service you work in are not working to your/

their full potential, then using that information to plan ways to improve and releasing your potential.

Wow! Rather than telling us how bad we are, a gap analysis can tell us where our potential can be released. To be honest, the first time I heard of a gap analysis I thought it was going to be a 'stick that others could beat me with', where my failings could be demonstrated for all to see.

When in fact, if used properly, a gap analysis can tell me where all my training and experience can be released to improve the care and service I give to patients and to discover new ways of working to make life easier for me, the team and patients.

In its very basic form, a gap analysis should tell you where you are against where you want or should be. For example, as an individual practitioner, you need to meet the standards of proficiency as published by the HCPC; one of these is 'be able to assure the quality of their practice' there are seven sub-headings associated with this.

What evidence do you have in your portfolio which demonstrates any of these requirements? If you don't have any or only one or two then you have found a gap. Or, if you look at the standards for continuing professional development then there is a similar requirement to seek to ensure your CPD has contributed to the quality of your practice and service delivery. Again, do you have any gaps in what the HCPC think you

should be able to demonstrate?

When you look at filling any gaps you may find, what potential can be released for you (or your team) to develop careers, patient care and the service you and your team offer?

The imaging standard can be looked at in the same way, by finding any gaps in evidence your service has to show how you meet the professional standard. Once you find the gaps, look at ways your service can release the potential to improve the service you give.

Within the imaging standard, you have a built-in 'benchmark' to be the best you can be by filling in any gaps and by regularly looking to see where gaps may develop.

Ensuring you build in review or ongoing gap analysis, you and your service have the potential to improve and innovate practice.

In doing this, many of the frustrations we have as professionals can be addressed as we evidence improvement, allowing us to get back to why we entered the profession in the first place – to give patients the best care possible.

Fed up with the same 'banter' from me why not think about contributing yourself? If you have something to say that will enlighten your colleagues on quality and the imaging standard why not drop me a line, a guest contributor is always welcome.

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All Change?

YOU MAY be aware of or have heard about the name change of the Imaging Standard, or you may be totally oblivious. Either way I would like to tell you a little bit about it and why it is a positive step for all services.

The imaging standard is now known as the Quality Standard for Imaging (QSI). It has a new logo which you can see at the top of the page. Before you begin to panic, the standard itself has NOT changed only the name.

Why the change then?

The QSI sets national quality criteria for imaging services, enabling them and you to evaluate performance and make improvements

(where needed) to meet and continually improve against the set criteria.

The former name of the standard, ISAS, was not indicative of its relevance and importance to all services, regardless of their accreditation status, in delivering safe, patient centred care. Both the SCoR and the RCR feel the new name better reflects the overall ethos and philosophy that underpins the standard.

Meeting the standard can be evidenced by accreditation through the independent United Kingdom Accreditation Service (UKAS) as normal. For those of you who are accredited under ISAS, your accreditation status will not

change due to the re-naming and they will send you a new certificate with the QSI logo on it.

The best thing about change is when it results in an improvement, the colleges are enhancing the support they provide to enable services to meet the standard in a planned staged approach.

Each stage will identify what support is available and allows you to build your evidence at a pace you can manage, as ever I will be available for help, support and advice whatever stage you feel your service is at. In order to reflect that my new title will be Quality Improvement Partner and I look forward to working alongside you as work through the standard to develop your service and provide the best patient care possible.

All of this information is available on the new web page www.sor.org/qsi, where you can download the frequently asked questions and a brochure explaining the changes. Over the next couple of months the supporting information will be added to and will include 'how to' webinars and study days as they are arranged.

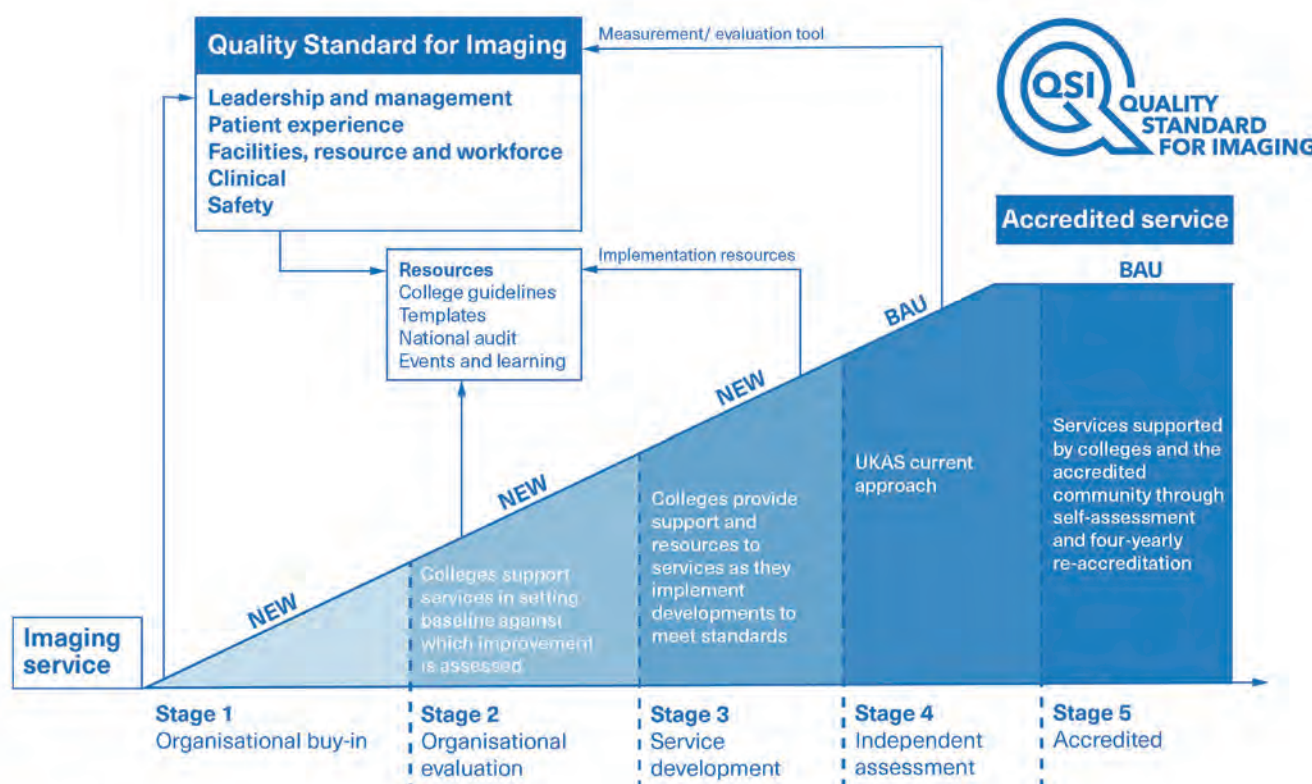
If you have any queries or questions don't hesitate to contact me at QSI@sor.org.

Chris Woodgate

Quality Improvement Partner RCR/SCoR.

www.sor.org/qsi

www.rcr.ac.uk/qsi



I&TP welcomes new editorial members

IMAGING & Therapy Practice has welcomed eight additions to the editorial board.

Each will serve for four years and evaluate articles that are submitted to the magazine and offer authors and potential writers practical tips and technical advice on penning the perfect article for publication.

New board members include Dr Amanda Martin, lead radiographer, Royal Bolton Hospital; Dr Ricardo Khine, divisional lead, City University, London; James Marcus, lecturer, University of Leeds; Laurence Skermer, consultant radiographer, Walsall Manor Hospital; Nicholas Barlow, trainee consultant radiographer, Rotherham Hospital; Thea Buchan, CT superintendent, West Middlesex University Hospital; David Flinton, associate dean education, City, University of London; and Nicola Smith, sonographer, Guy's and St Thomas' Hospital.

They join existing members Claire Donaldson, superintendent radiographer NHS Tayside, SoR vice-president and UK Council member for Scotland; Emily Skelton, research sonographer, King's College London; Fred Murphy, senior lecturer and programme leader, University of Salford; Kumud Titmarsh, formerly associate professor, Kingston University & St George's University of London; Mark Gradwell, senior lecturer, Canterbury Christ Church University; Sarah Naylor, senior lecturer, diagnostic radiography, Derby University; and Trevor Parker, diagnostic radiographer, Hull and East Yorkshire Hospitals NHS Trust.

Welcoming the new board members, Rachel Harris, the Society's professional and education manager and research lead, said: "Welcome to all the new members of the editorial board, who bring a broad spectrum of skills and specialties to add to the wide-ranging expertise of our existing members."

"The work that the I&TP editorial board do is vital to the publication, to maintain the high standard that the journal consistently strives for and achieves."

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Problems

DO YOU find it easy to spot a problem, especially at work?

"There is no way we can do that because ..." or "who came up with this idea, it will never work". Maybe even some of the old favourites: "we don't have enough staff" or "we can't get the funding to do that".

Sometimes, finding a problem is a good thing as it enables out-of-date or poor practice to be addressed and ensures your patients are cared for under evidence-based practice that is up-to-date.

I sometimes think the issue isn't the problem we face but rather the way that we deal with it. What do I mean by that? Life is full of problems and difficulties; you face them every day at home at work in your social circle. For example:

- The kids can't find their homework for school this morning: what do you do?
- Due to the homework issue, you need to leave for work right now, but you need to get petrol or you won't get there: what do you do?
- You managed to get to work on time, but the equipment has broken down: what do you do?
- At the end of a bad day, you arrange to meet a friend to commiserate but they cancel – what do you do?

I am sure you can replace those examples with many others.

If your service is looking to meet the quality standard for imaging (QSI) or you have been looking at it yourself for some CPD, has it thrown up some problems? If so, what do you do?

I would like to suggest the example of Murray Spangler.

'Who', you might ask? Mr Spangler was an asthmatic floor cleaner who found sweeping the floors where he worked made his asthma much worse. He looked at this problem and decided to do something about it.

In 1907, he invented the suction floor sweeper and in 1908 patented his device. It worked: his asthma improved, and he had a saleable (if unwieldy) product. Long story short, Spangler went into business with William Hoover and the product was refined and marketed, that is why we 'hoover' today. As the Hoover name stuck, few of us are aware of Mr Spangler and his awesome problem solving,

but it doesn't mean we can't be like him.

Built into every obstacle is an opportunity; every question, an answer; every problem, a solution. Don't be afraid to question methods, systems, and equipment and ask, 'Is there a better way?'

People who dared to ask that question have enriched the world, so what is stopping you being one of them?

We all have a choice of being the person who can spot the problem, discuss the problem, and complain about the problem and yet do nothing, or a solution-oriented person who looks for ways to solve the problem.

Looking back, how would find solutions to the problems posed above rather than bury your head in sand and have a duvet day or be in a really bad mood all day that affects everyone around you.

My solutions would be:

- Ask the question 'have you done a proper look?' (known as the mummy look in my house). I usually have found it within five minutes. Leaving five minutes later will be ok, I still have enough time and problem 1 solution has cleared problem 2 as I had given myself a little extra time for getting petrol.
- Is it really broken? Did anyone try switching it off and on again? Can the work be done elsewhere? Has it been reported? Who has told the waiting patients or anyone else who needs to know? The list goes on, but the world continues to turn.
- Disappointed; but is there anything I can replace it with? A good film, a long soak in the bath, a treat with the kids?

Looking at and meeting the QSI is all about problem-solving and letting go of our preconceived ideas, keeping and enhancing the areas of your service that work well and developing the areas that don't.

It is how we maintain patient care based on a solid evidence base with room for improvement and innovation.

Why don't you try it?

If you have any queries or questions don't hesitate to contact me at QSI@sor.org.

Chris Woodgate
Quality Partner RCR/SCoR.



WHY Fronts

Asking the question WHY to promote quality service provision

Chris Woodgate, Quality Improvement Partner, SCoR & RCR



The Long and Winding Road: Process Mapping

AS I write this it is at the beginning of the summer holidays and the summer films have been released. I particularly enjoyed the film which contains the song The long and winding road, and it made me think of the 'long and winding roads' we can travel in summer; particularly if you are travelling in queues of traffic on the roads or queues at an airport etc.

It also brought to mind (because my brain thinks that way) the often 'long and winding roads' our patients travel from referral to discharge.

This is known as the patient pathway. I am sure you can think of many pathways; Some which came to my mind were the stroke pathway, fractured neck of femur and renal colic pathways. How about the patient pathways which are confined to the imaging service, are you aware of any of those you have in your service?

Sometimes, we are only aware of our little 'bit' of the pathway and not sure about what happens to get the patient to you or what happens when your 'bit' is done. Do you think it would help the patient through the pathway if you did?

An analogy may be a synchronised swimming team: what would happen to their performance if the team members just did their individual

bit? Would the performance be as good as the performance where all the team members understood the whole and could anticipate (be ready to perform) their part and see its importance? If they only performed their small part you would probably get a mess: how would they know when to start or finish, would they flounder around while others did their part?

I am convinced that as radiographers, assistant practitioners, assistants and admin staff if we all understand the whole we can improve that 'long and winding road' to something shorter and slicker.

How do you do this? One answer is to process map the particular patient pathway you want to look at.

Process mapping helps to get a visual picture of how the pathway currently works, by ensuring you have a range of people across the pathway to input what their part is in reality. Hopefully, by doing this, you may be able to pick up areas of duplication, waste, and unnecessary steps, or see where you have it right and how that can be used to support other pathways.

An easy to understand process map (journey) is in the NHSI conventional process mapping document, and it looks like this for getting up in the morning.

Looks easy when you can see it; the hard bit is getting the right people together in a room to identify each step of the process you want to follow and getting the time to do it.

If you pick a patient journey through a part of your service that you are sure is cumbersome, you can gather evidence by doing a process map to show there are unnecessary steps.

I am sure you will be able to get engagement from your managers/team leaders to take this further as ideally you will save time and increase efficiency. After all, who doesn't want to make it better for our patients?

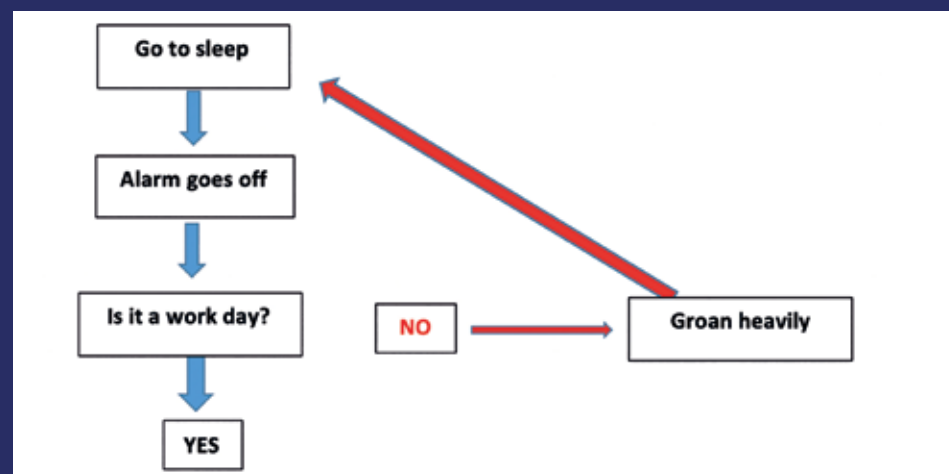
Remember that whatever you identify and want to change may have unintended consequences: another reason why it is important to have all the right people involved in the process.

You don't want to instigate a change which works for your part of the services but causes increased work or chaos in another part of the service. Patience and perseverance are essential to ensure that what you demonstrate visually is actually what happens, that way you can avoid most of the pitfalls.

If you want to know more about this why not look at the NHSI web site at <https://improvement.nhs.uk/resources/mapping-process-overview/>. They have lots of helpful hints and explanations; even giving you a guide on how to perform a process mapping event. If you are really desperate you can always ask me. I am often found at the end of a 'long and winding road'.

If you have any queries or questions don't hesitate to contact me at QSI@sor.org or ChrisW@sor.org

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WHY Fronts

Asking the question WHY to promote quality service provision

Chris Woodgate, Quality Improvement Partner, SCoR & RCR



Feedback

I AM not talking about audio feedback, which is that nasty, ringing noise (often described as squealing, screeching), sometimes present in sound systems.

You can imagine Spinal Tap getting feedback as they ramp the amplifier up to 11, or maybe not. What I would like to look at is how important feedback is in quality improvement.

Feedback is valuable information that can be used to make changes or other important decisions, which helps you make your best better. Feedback can come from colleagues, patients, and other service users, and it can be positive or negative; one is just as important as the other. It is important to remember we need to be aware of weaknesses as well as strengths.

In the Imaging Standard there is a section which concentrates on patient/carer feedback (PE5), and another section which looks at feedback from other clinicians such as GPs, hospital consultants, non-medical requesters (CL7).

It is important to remember that feedback can benefit the giver as well as the receiver. It gives our patients an important voice, and it can also help us streamline our patient pathways with other services.

What other benefits are there?

It can motivate staff: if someone asks for your opinion and then acts upon it, you feel valued and appreciated. Feedback from colleagues outside of imaging may motivate you and them to build better working relationships.

It can improve the service performance because it points you in the direction of where potential weaknesses may be. If the feedback is detailed enough, it may even help to get to the root of an issue faster, allowing your service to improve in effectiveness and efficiency.

Feedback makes for great CPD; it allows you to look at an area and reflect on what has

been said and what you/the service could do about it. For this to work you will need to employ effective listening skills; don't read or hear what you think is being said but stop, take a breath, and try and listen without prejudice. Let the person who is giving the feedback know that you will reflect and, if possible, let them know the outcome of the feedback. I am sure you would want that if the roles were reversed.

It is really important how you deal with feedback on a personal level, especially if it appears critical. Always try to be open to constructive criticism; it can do you good as identified above. Don't personalise it as rejection of you as a person. Don't allow your opinion of yourself to be coloured by the opinion of those who fail to see your best qualities and potential. Try and take the time to reflect on what the feedback has to say and look for that which will help you develop professionally.

There are examples of how feedback (criticism) didn't hold back some notable people. In 1907, the University of Bern turned down a PhD dissertation from a young physics

student. Yet Albert Einstein went on to change the scientific world forever. When a 16 year old student got his report from a teacher in school about his debating, there was a note attached that read, 'A conspicuous lack of success,' but Winston Churchill refused to accept it.

If you are giving feedback I would recommend that you make it as dispassionate as possible. Avoid giving it in the 'heat of the moment'. Reflect on what you want to say and why you want to say it.

Preparation is good so that you can raise specific points rather than generalise and use the word 'I' rather than 'you'. For example, 'I feel that...' which is better than 'You said/did...'

Finally, try and get some positive in so that the recipient/s have something to work with and be prepared to work with them to improve whatever points you have fed back on.

If you have any queries or questions don't hesitate to contact me at QSI@sor.org, org or ChrisW@sor.org. I am always open to feedback!

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WHY Fronts: Eat that Frog (Procrastination)



Asking the question WHY to promote quality service provision

Chris Woodgate, Quality Improvement Partner, SCoR & RCR

THE FAMOUS author Mark Twain is quoted as saying, "If it is your job to eat a live frog, it's best to do it first thing in the morning, and if it is your job to eat two frogs, it's best to eat the biggest one first. You will have the satisfaction that it will be the worst thing you do that day."

The frog is that 'thing' on your to do list that you just don't have any inclination to do. Perhaps it is that piece of reflective work you need for your CPD or the trip to the dentist you really are overdue for.

When the HCPC comes calling for your evidence files you will wish you had done that piece of work or when you do get to the dentist and you have to have something done which could have been avoided if you had only gone earlier.

If you 'eat the frog' it means you just get on and do it before the 'frog' eats you; that is, you will dwell on it all day/week/month until it gets done nagging at your conscience until deadline day. This is commonly known as procrastination.

Once you do the task/job you will have a sense of accomplishment or at least be glad it is all over safe in the knowledge that if the HCPC come calling you will be ready.

How then do you recognise your 'frogs'? Take a look at your day to day tasks and see if you recognise any of the following:-

1. Things you need to do but actually don't want to do;
2. Things you need to do and actually want to do;
3. Things you don't need to do but actually want to do;
4. Things you don't need to do and actually don't do.

Procrastination or the 'frog' is 1. Things you need to do but actually don't want to do. Now you know what your 'frog' is how do you eat it?

Firstly, it is a live frog so you really shouldn't leave it too long or you will also have to catch it again before eating. How



many times have you had to play catch up at work because you didn't do something straight away? The answer is just 'eat it': complete the task, do the unwanted job and get on with the rest of the day.

Plus, an added bonus to immediate action is that you prevent yourself from having to 'eat a frog' that is even older and more unattractive. A task left undone often gets more unwieldy the longer we leave it. (I tell myself this every month as my publishing deadline draws near!)

How does this fit with a quality imaging service? I would venture to suggest that, in terms of quality and safety for our patients, the first 'do no harm' principle is essential for our day to day working.

It is like when we, as radiographers, look at a request and decide if the radiation dose associated with it is justified, or whether a different modality will give a better answer to the question asked. Are we aware on a day to day basis what may potentially harm our patients?

How do we know that practice is safe and 'causes no harm'? Audit of our practice, standard operating procedures and policies can give us evidence to show we are working in a safe environment

for our patients. If we are, then we automatically maintain the quality of care and probably maintain our job satisfaction too.

Audit can be a 'big ugly frog,' but when you get the evidence it produces it can reap rewards where you thought they may be none to gain.

In his book 'Eat that Frog,' Brian Tracey says, "What can I and only I do that, if done really well, will make a real difference?"

Remember that there is only one answer to that question at any given time. If you don't do it, no one else can or will do it, but if you do it, it will make a major difference.

Next time you are given the task (live frog) of completing an audit or other activity associated with quality & safety why not 'eat the frog' immediately? It can do wonders for your CPD.

If you have any queries or questions don't hesitate to contact me at QSI@sor.org.

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www.sor.org/qsi www.rcr.ac.uk/qsi
'Tracey. B. 2002. Eat That Frog. Berrett-Koehler Publishers, Inc. San Francisco
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WHY Fronts: Quality Christmas



Asking the question WHY to promote quality service provision

Chris Woodgate, Quality Improvement Partner, SCoR & RCR



IT IS that time of year again when I write the Christmas edition of WHY Fronts: October. I am still hiding under the quilt pretending it isn't happening.

I know there are some of you who will have bought, wrapped and delivered your gifts even as the December edition comes through the letter box; alas I am not one of those.

I am a last minute, rush job, 'that will do' type of person where Christmas is concerned, although I am more organised than the proverbial petrol station shop on Christmas Eve.

Perhaps this year I can take a leaf out of my own book and take a 'staged approach', as is found within the QSI support information. What might that look like?

Stage 1: Organisational 'buy in' – I can assure that the organisation (my family) is totally committed to Christmas, however, like many finance departments, the bank may not be as fully committed to my projected spend as I wish.

Stage 2: Gap Analysis – This for me is

the easy bit. What do I need compared to what I have? At this moment in time, I have nothing, therefore I need to sit down and write a list of what I do need e.g. Christmas cards (or donation to charity), small gifts for distant relatives, large gifts for closer relatives and a huge pile for children/grandchildren. Then I need to decide the content of a 'huge pile' lots of cheap and cheerful or several expensive? Plus with younger members do I need to wait till nearer the day when the Christmas adverts are at their most persuasive?

Stage 3: Service development – this is when I fill the 'gap': I have to start doing the shopping (small shudder ensues). Perhaps starting with the cards, or not, then the distant relatives as I may have to deliver well before the day. Then the nearest and dearest, giving me time to think about it and give gifts which show some thought and care for the recipient. Then I have to check with the 'other half' that they are happy with the projected spend and that all bases have been

covered (making sure I haven't forgotten anyone).

Stage 4: Accreditation – for me I think this will be when I have everything wrapped and ready to go and Father Christmas is expected at any minute to ensure that my gift giving measures up to his standard. Presents etc. delivered to the correct addresses and then wait with bated breath for the verdict from the recipients. How many requests for gift receipts will I get, how many re-giftings will I recognise in the following months, how many looks of delight as packages are opened or dismay hidden behind polite faces? The highs and lows of a quality Christmas.

Stage 5: Surveillance programme to re-accreditation. Can I be sensible this year and keep the Christmas card list and the gift list so I don't repeat any mistakes next year and/or remember the gifts which went down particularly well? Maybe I could even add to this over the year as children mature and the type of gifts change with age, so I am not sticking to too much of a standardised routine but allow room for improvement?

This is written with my tongue firmly in my cheek, a little bit of Christmas frivolity, but are there any lessons we can learn for service improvement and working towards the Quality Standard for Imaging?

The stages are very real, and the College's support is a gift that will keep giving over the year. For Christmas this year, why not think about your service and give it a 'wash and brush up' with the QSI staged approach?

I am always ready to help and support and the 5 stages can be found at www.rcr.ac.uk/qsi or www.sor.org/qsi.

Seasons greetings to you all: I hope you have a marvellous time!

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