



RADIOLOGY ACCREDITATION
IN THE UK: THE THEORY
AND THE REALITY

MELANIE HIORNS

Quality accreditation has an increasingly high profile. But is it just another certificate to go on the wall in radiology services' reception? Or does it genuinely bring something new to standards and to patient care?

Accreditation is slowly but surely moving into the mainstream, both in healthcare and in other industries. In the UK, the Imaging Services Accreditation Scheme (ISAS) was opened for registration in June 2009 and the first Radiology Departments are now in the process of being accredited. However, many departments are taking a 'wait and see' approach. Questions such as, 'What's the point?', 'Is this going to become the norm?', 'How hard is it?', 'Does it make any difference?', 'Is it worth it?' and 'Will we have to?' are asked commonly. This article explores the bigger picture about accreditation and the accumulating international evidence base that going through an accreditation process changes practice and improves care, but also describes a personal experience of going through the ISAS accreditation process first hand and what it really means in practice.

In 2006 Braithwaite et al stated: "Accreditation has become ubiquitous across the international health care landscape. Award of full accreditation status in healthcare is viewed, as in other sectors, as a valid indicator of high quality organisational performance. However few studies have empirically demonstrated this assertion. The value of accreditation therefore remains uncertain and this persists as a central legitimacy problem for accreditation providers, policymakers and researchers."¹

Two years later, Greenfield and Braithwaite further commented, "Accreditation, quality and continuous improvement have become an intrinsic part of the discourse and activities of health services. Internationally dating from the 1970s, health care accreditation programmes and accrediting organisations have emerged and developed. There are now many national accreditation organisations and an international body, the International Society for Quality in Health Care (ISQua) which has enrolled members in over 70 countries."²

This work by Greenfield and Braithwaite is the largest international study to date systematically reviewing the impact and/or effectiveness of accreditation. The review included a range of health accreditation schemes, including hospital accreditation, and was not confined to imaging, which is a relatively recent entrant into the accreditation arena. Topics considered included professional attitudes to accreditation, promoting change, organisational impact, financial impact, quality measures, programme assessment, consumer views or patient satisfaction, public discourse, professional

development, and surveyor issues.

Two consistent findings were recorded: that of accreditation promoting change in the organisation, and in promoting professional development. The activity of preparing and undergoing accreditation has been shown in several studies to promote change in health organisations^{3,4}, particularly with respect to organisation and safety. In the studies reviewed, the positive outcomes included the chance for staff to reflect on, and become engaged in, the operation of the organisation; the introduction of continuous quality programmes, improved documentation, improved safety and improved review systems. However to balance this accreditation was not shown to *ensure* high-quality care but was positively associated with some measures of quality. Yet, accredited hospitals showed significant positive change in six defined areas, which was not recognised in non-accredited organisations.

Pomey et al³ describe how the context in which accreditation takes place, including the organisational context, influences the type of change dynamics that occur in Healthcare Organisation (HCO). They found that while accreditation itself was not necessarily the element that initiated change, the accreditation process was a highly effective tool for helping to introduce continuous quality improvement programmes to newly accredited or not-yet-accredited organisations; creating new leadership for quality improvement initiatives; increasing social capital by giving staff the opportunity to develop relationships; and for fostering links between HCOs and other stakeholders. They concluded that the accreditation process is an effective leitmotiv for the introduction of change but is nonetheless subject to a learning cycle and a learning curve. Institutions invest greatly to conform to the first accreditation visit and reap the greatest benefits in the next three accreditation cycles (three to 10 years after initial accreditation)³.

WORK OUT YOUR
TIMESCALE AND
DOUBLE IT

So how do these findings translate into, specifically, radiology accreditation programmes across the world? Accreditation has been in place in North America for a number of years. There are two major programmes, one run by the American College of Radiology⁵, and another by the Joint Commission (an independent, not-for-profit organisation that accredits and certifies more than 18,000 healthcare organisations and programmes in the United States⁶).

Currently, accreditation is confined to advanced imaging techniques such as CT and MRI. This, in part, has been driven by reimbursement policies that may require accreditation and to meet the criteria of CMS (Centres for Medicare and Medicaid Services)⁷, state or federal government, or third-party payers. Medicare is a social insurance programme administered by the United States government, providing health insurance coverage to people who are aged 65 and over, or who meet other special criteria. The ACR outlines how all MRI, CT, PET, breast MRI and nuclear medicine facilities that bill under the Medicare fee schedule, must be accredited by January 2012 to receive Medicare payments for the technical component of these services⁸. Accreditation is also recognised for its value as a marketing tool and is clearly promoted as such.

In Australia and New Zealand, there is a voluntary accreditation scheme jointly administered by The Royal Australian and New Zealand College of Radiologists (RANZCR) and the National Association of Testing Authorities (NATA), which commenced in May 2004, and is open to all diagnostic imaging providers that wish to apply. However, sites that offer MRI services that are eligible for Medicare rebates are required by the Commonwealth government to participate in the RANZCR's MRI Accreditation Registration Programme.

Mandatory accreditation schemes exist in South Korea and Finland, although these have a different configuration to that being developed in the UK.

In the UK, accreditation is only now starting to become established and is still a long way from being a mandatory requirement, although it is certainly possible that this may happen in the future. However, in parallel with schemes elsewhere in the world, it is appropriately influenced by the guidelines of the professional colleges (Royal College of Radiologists and the Society and College of Radiographers). Unlike elsewhere, the actual scheme is exclusively run by a third party, the United Kingdom Accreditation Service (UKAS), which is 'the sole national accreditation body recognised by government to assess, against internationally agreed standards, organisations that provide certification, testing, inspection and calibration services'⁹. UKAS is a non-profit-distributing private company, limited by guarantee. It is independent of government but is appointed as the national accreditation body by the Accreditation Regulations 2009 (SI No 3155/2009) and operates under a memorandum of understanding with the government through the Secretary of State for Business, Innovation and Skills. The Imaging Services Accreditation Scheme sits within UKAS. Background to the development of the Imaging Services Accreditation Scheme is outlined by Garvey, et al.¹⁰

So to take this further, how do some of these findings translate into the role for an imaging services accreditation scheme in the UK in the current political climate? The principles underpinning the original Radiology Accreditation Programme were drawn from those referred to in the 2007 White Paper 'Trust, Assurance and Safety: the regulation of health professionals in the 21st Century'¹¹. More recently (2010), the National Health Service (NHS) White Paper 'Equity and Excellence: Liberating the NHS'¹² set out the Government's long-term vision for future healthcare; that of a patient centred NHS in which the drive for

better health outcomes is clear. It recognises the financial challenges the NHS faces and the role QIPP (Quality, Innovation, Productivity and Prevention) will play in supporting the NHS in identifying efficiencies, whilst driving up quality. An editorial in the *British Medical Journal* in 2008 outlined how most recent NHS reforms have been designed to improve efficiency and productivity **and** also to improve the quality of care.¹³ That trend is ongoing.

Quality is becoming the leading driver in healthcare reform going forward, representing a move away from performance targets per se. This aligns with the core purpose of accreditation, being the formal recognition that an imaging services provider has demonstrated that it has the organisational competence to deliver against key quality measures across four domains which include 'Clinical', 'Facilities, resource and workforce', 'Patient experience', and 'Safety'. These four domains comprise the 'Standard' which has been designed to

- Be patient focussed;
- Cover the functions and systems of a whole diagnostic imaging and interventional radiology service;
- Address the dimensions of quality and support quality improvement.

'Outcomes' are the indicators by which the quality and effectiveness of a service can be assessed. The NHS Outcomes Framework¹⁴ published in December 2010 sets out the outcomes and corresponding indicators that will be used to hold the new NHS Commissioning Board to account and, as such, represents a clear message about the importance of verified outcomes going forward in health policy. Each of the 31 standard statements across the four domains in the ISAS Standard has an associated outcome measure of the individual service's design and choosing. This aligns with the direction of travel of health policy in the UK.

It must, therefore, be hoped that participation in the ISAS programme in the UK will, in itself, be some form of evidence that radiology departments may, in future, submit to the various regulatory bodies such as the Care Quality Commission (CQC), who are the independent regulator of care provided by the NHS (and also of local authorities, private companies and voluntary organisations).

ACCREDITATION ON THE GROUND

The radiology department at Great Ormond Street Hospital for Children has been associated with the emerging accreditation programme since early 2007, when it became one of five pilot sites for the Radiology Accreditation Programme (RAP) across England, and since 2009 has been formally committed to the resulting ISAS accreditation scheme. Ten imaging services have been in the first wave and one has just received accreditation along with Great Ormond Street. One other NHS Trust, having had assessment visits, is anticipating formal accreditation imminently.

The ISAS website¹⁵ gives a vast amount of user-friendly information on what accreditation is about, pre application information and preparatory workshops, a

detailed description of the 'The Standard' and all that it entails¹⁶.

In preparing for assessment, an organisation must first outline how much of its service it wants to be considered for accreditation – this is called the 'scope'. Usually the whole service would be included, but there may be instances where only part of the service is included in the scope: for instance, if a new part of the service has only recently been established and this is not ready for the first round.

The Standard comprises four domains. A total of 31 'standard statements' are spread across these four domains, and each standard statement addresses one aspect necessary for the provision of the service. A list of criteria indicates the structures and processes necessary to deliver each particular standard statement. For each criterion, indicative examples of acceptable evidence is given.

The service will then work on its evidence over the upcoming months (typically a year) and will upload it to ISAS via the web-based tool. Once the evidence has been submitted, it is assessed and, if sufficient and appropriate evidence has been provided, a site visit will follow. The assessment team will usually comprise a radiologist, a radiographer, a lay member and a professional UKAS assessor.

Our experience at Great Ormond Street was that initially we completely underestimated the amount of work involved in the whole process. Gathering the evidence is a huge task; we found that it was not so much that we were not doing a lot of good things already, but more that we had never written it down in an organised and joined-up way. Whilst this may appear rather banal, it became evident that our processes were basically safe, and we hopefully offered a high quality, patient focussed and forward looking service but our documentation, whilst present, was scattered in different places (sometimes in people's heads). Everyone knew what they were doing and were doing it well, but this knowledge had been learned over many years. Someone arriving new wouldn't have one place to go to find out about our policies, procedures and protocols. Our document control was not as good as it should have been (and now is) and some areas of the department were doing things in a slightly different way to other areas.

To balance against this, we realised that there was almost nothing we were not already doing that we should have been. We were well ahead of the curve in our patient surveys, our audit programme, our risk management and in our patient-oriented practice. Financially, we were in good order and our management structure was effective and safe.

After a false start, we brought together a group of five key members in the department to lead and to champion the accreditation work. These included a consultant radiologist (who was also the clinical unit chair for the division and thus had professional radiology input, but also had an overview of the wider role of radiology within the hospital and of the hospital's structure and policies), the radiology service chair, the radiology service manager, the

WE BELIEVE WE DELIVER A SAFER QUALITY SERVICE

lead radiology superintendent, and the departmental personal assistant (PA). The PA was invaluable in collating all the evidence once it had been submitted to her and organising it on the web based tool. She was also able to keep an overview of what information was missing, who was supposed to be providing it, and to do the chasing.

The radiology superintendent co-ordinated the activity of a wider group of modality superintendents with respect to their various modalities, and for the documentation and policy writing relating to those areas. The consultant radiologist took responsibility for some of the higher level organisation information and for many of the criteria in the clinical domain. The radiology service chair and service manager co-ordinated everything else. Early in the process, one of these five names was written against every single one of the 131 criteria, so it was very clear who was responsible for that criterion. Tentative dates for completion were added, which were reviewed at least once a month. By the end of the evidence gathering phase, every single person in the department had been involved in accreditation in some way. The task of collating the evidence would have been impossible without this cascade effect.

Once the evidence had been reviewed and accepted, the dates were set for a two-day site visit. This process really starts the adrenaline flowing and it was a time of great coming together for the department to prepare for this, knowing that any one of the 70 of us could be asked a question, or asked to demonstrate something. Many of the staff who had been aware of the accreditation work going on suddenly pricked up their ears and, in the last few weeks, there was a real momentum. People would ask me what it meant to be accredited and would it matter? I could only reply that I hoped it would make us special and would allow us to prove unequivocally that we are a good department, rather than just believing we are.

The two-day visit itself went off uneventfully. Many of the staff were outstanding (and this was recognised and commented on by ISAS) and were genuinely proud to have been involved with it and to be able to show our department, and what we have achieved, to 'outsiders'. The feedback was given straightaway on the second afternoon and the senior management was requested (by ISAS) to be present as they are the

ones who ultimately have responsibility for a safe, quality, hospital. The chief executive attended, which certainly raised the bar. We have some 'mandatory' actions to fulfil (which we absolutely expected and is the norm) and we submitted evidence with respect to these in January 2011.

So has it been worth it for us? Yes, definitely. We have developed ourselves, and strengthened our relationships with our users (both clinicians and patients). We have made a huge step change in how we challenge our own practice and the evidence we use to demonstrate our good practice. We have improved our documentation beyond measure, and have examined critically all our processes. We believe we deliver a safer quality service to our patients. But it has been hard work.

For other departments considering accreditation these are our top tips:

- Take full advantage of all the pre-application information, advice, and pre-application workshops that ISAS can offer.
- Have a really thorough look at the Standard and all the standard statements in each of the four domains so you know the size of the task.
- Work out your timescale and double it – realistically, it is probably going to take a year of preparation.
- Convene a core group of people who really want to achieve this and make sure your senior management are fully supportive and understand the benefits.
- Distribute the tasks clearly so individuals know what is expected of them personally, and keep a 'project plan' up to date.
- Liaise with ISAS throughout the process so you know that you are heading in the right direction.
- Know that the first time you do anything is the hardest and keep going.
- Keep the faith that this process will make you a better department – both for your staff and for your patients.

Melanie P Hiorns is a consultant paediatric radiologist and honorary senior lecturer. She is also clinical unit chair for medicine and diagnostic and therapeutic services at the Great Ormond Street Hospital for Children NHS Trust. In March 2011 the radiology department at GOSH successfully achieved accreditation against the ISAS standard.

REFERENCES

1. Braithwaite J, Westbrook J, Pawsey M, Greenfield D, Naylor J, Iedema R, Runciman B, Redman S, Jorm C, Robinson M, Nathan S, Gibberd R. A prospective, multi-method, multi-disciplinary, multi-level, collaborative, social-organisational design for researching health sector accreditation 2006 [LP0560737]. *BMC Health Serv Res* 6:113.
2. Greenfield D, Braithwaite J. Health sector accreditation research: a systematic review. *Int J Qual Health Care* 2008 20:172-183.
3. Pomey MP, Lemieux-Charles L, Champagne F, Angus D, Shabah A, Contandriopoulos AP. Does accreditation stimulate change? A study of the impact of the accreditation process on Canadian healthcare organizations. *Implement Sci* 2010 5:31.
4. Juul AB, Gluud C, Wetterslev J, Callesen T, Jensen G, Kofoed-Enevoldsen A. The effects of a randomised multi-centre trial and international accreditation on availability and quality of clinical guidelines. *Int J Health Care Qual Assur Inc Leadersh Health Serv* 2005 18:321-328.
5. American College of Radiology. Available at <http://www.acr.org> Last accessed 30 December 2010.
6. Joint Commission. Available at <http://www.jointcommission.org> Last accessed 30 December 2010.
7. Centres for Medicare and Medicaid Services. Available at <http://www.cms.gov/> Last accessed 30 December 2010.
8. American College of Radiology (Accreditation). Available at <http://www.acr.org/accreditation.aspx> Last accessed 30 December 2010.
9. United Kingdom Accreditation Service. Available at <http://www.ukas.com/about-accreditation/about-ukas> Last accessed 30 December 2010.
10. Garvey CJ, Cook JV, Wiltsher C, Whitley S. Radiology accreditation-towards a safer quality service. *Clin Radiol* 2009 64:853-856.
11. Trust, Assurance and Safety: the regulation of health professionals in the 21st Century. Department of Health 2007. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065946 Last accessed 30 December 2010.
12. Equity and Excellence: Liberating the NHS. Department of Health 2007. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353 Last accessed 30 December 2010.
13. Black N. Quality improvement in the NHS. *BMJ* 2008 336:1143.
14. NHS Outcomes Framework. Department of Health 2010. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944 Last accessed 30 December 2010.
15. Imaging Services Accreditation Scheme. Available at www.isas-uk.org Last accessed 30 December 2010.
16. The ISAS Standard: statements, rationales and criteria. ISAS 2009. Available at http://www.isas-uk.org/Library/ISAS_Standard/ISAS%20Standard%20V1.1.pdf Last accessed 30 December 2010.

QUALITY IS BECOMING THE LEADING
DRIVER IN HEALTHCARE REFORM