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FREE GUIDE · DIAGNOSTIC IMAGING ACCREDITATION

The New National Medical Imaging Standards

What the change from DIAS means for your practice, and what is worth doing before 2028.

INSIDE

Based on the draft National Medical Imaging Standards V0.16, published by the Australian Commission on Safety and Quality in Health Care on 1 December 2025, compared clause by clause against the current Diagnostic Imaging Accreditation Scheme Standards.

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THE SHORT VERSION

Every accredited practice re-accredits

The Commission is replacing the DIAS Standards with a new framework, expected to be implemented in early 2028. Three things stand out.

ONE

Four times the size of DIAS

Fifteen standards with 42 criteria become 4 standards with 53 mandatory actions and around 170 sub-points.

TWO

Documents become systems

DIAS is largely satisfied by holding the right documents. The draft asks you to show systems operating, being monitored, and being acted on, with evidence accumulating over time.

THREE

Accountability gets a name

DIAS obliges "the practice". The draft obliges a governing body: the board, CEO, partnership or owner. In a small practice, that is you personally.

The practices that find the transition straightforward will be the ones whose evidence is already organised and accumulating. The rest will be doing it under time pressure, at the same time as everyone else.

AT A GLANCE

	DIAS today	Draft standards
Structure	15 standards, 42 criteria	4 standards, 53 actions, around 170 sub-points
Assessed on	Documents and samples	Systems, monitoring, demonstrated action
Accountable	The practice	A named governing body, including sole owners
Consumer voice	Feedback and complaints	A full Partnering with Consumers standard
Scope	Medicare-funded imaging	Also names dental, chiropractic, point-of-care and specialist rooms
Small practices	Entry Level pathway	No entry pathway; a formal not-applicable process instead

THE SCALE OF IT

What grows, and by how much

Figure 1. Structure of the two frameworks

Counts as published. Sub-points are the assessable detail beneath each mandatory action.

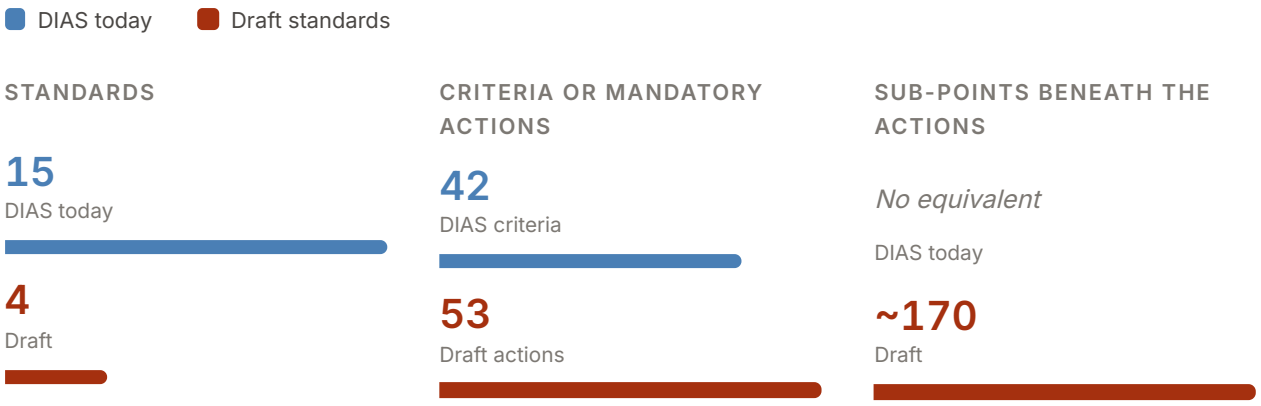
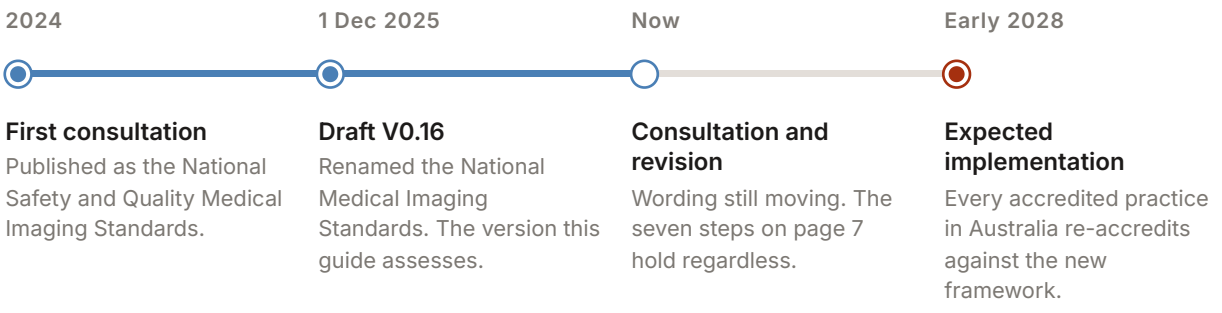


Figure 2. Where the change sits

The draft is not final. The title has already moved once, and the content will move again.



Size is not the real problem.

A practice can read 170 sub-points in an afternoon. What it cannot do in an afternoon is produce a year of dose audits, incident records and complaint resolutions that were never being captured. That is why the useful work starts now rather than in 2027.

THE SIX SHIFTS THAT MATTER

Where the work actually lands

1 Documents to systems

The Safety and Quality Manual, the centrepiece of DIAS Standard 1.1, does not exist in the draft. Its successor requires policies that are monitored for adherence, improved, and kept current. The same pattern runs through the whole document: radiation technique charts become dose audits compared annually against diagnostic reference levels.

> **If your accreditation evidence is a folder assembled shortly before assessment, this is the change that costs the most.**

2 A clinical governance framework

Standard 1 alone carries 21 actions, more than the whole of DIAS. It requires, as separate working systems: risk management, incident management, open disclosure, feedback and complaints, information security, health information management, and quality improvement with data reported to the governing body. None of these exist in DIAS as practice-wide requirements. Hospital departments accredited to the NSQHS Standards are exempt from most of this. Standalone private practices are not.

3 Consumers become a standard

New obligations include the Australian Charter of Healthcare Rights, supported decision-making, and consent for secondary use of patient data. Two will change front-desk process in most practices: financial consent completed before the service whenever the patient incurs a cost, and published information on estimated out-of-pocket costs.

4 Appropriateness becomes assessable

DIAS asks whether a request is valid. The draft asks whether the imaging is appropriate: providers must have processes to identify and reduce low-value imaging, give practitioners feedback on variation from agreed protocols, and determine the clinical objective of each request.

> **An accreditation requirement to reduce services you are paid to perform is a genuine change of posture.**

5 Digital, data and AI

The draft requires contribution to My Health Record, an information security management system, DICOM image provision to requesters, controlled reporting and viewing conditions, and a full governance regime for AI software: ARTG listing, disclosure to patients that AI was used, notation in the report where AI informed the result, and adverse event reporting to the TGA. Few RIS and PACS configurations support AI report notation today. None of this is in DIAS.

6 Cultural safety and environment

New requirements cover culturally safe care for Aboriginal and Torres Strait Islander people, gender diverse people, people living with a disability and children; privacy and dignity in the physical environment; falls prevention and patient transfer; and environmental sustainability.

WHO FEELS IT MOST

The same framework, very different workloads

Standalone private practices

HIGHEST

Carry all 53 actions with no offsetting accreditation. The entire clinical governance standard is new work.

Owner-operators

HIGHEST

Are the governing body under the draft, personally responsible for governance systems the not-applicable process does not excuse on grounds of size.

Dental, chiropractic, point-of-care and specialist rooms

HIGH

Named in scope. Many of these sites have never been assessed against a governance framework of this depth.

Multi-site groups

MODERATE

Sites on different renewal cycles or agencies will transition piecemeal and repeat the work, unless they consolidate first.

Hospital imaging departments

LOWEST

Accredited to NSQHS, these come off lightest: close to half the actions are marked not applicable for them.

WHAT TO DO NOW

Seven steps that pay off either way

The draft is not final and the wording will move. These steps are worth taking regardless, because each also improves your position under the current DIAS standards.

1. **Configure your RIS to capture evidence continuously**
   Dose data, incidents, critical-result acknowledgements, feedback and training records all become assessable. A practice that reaches the end of a cycle with no data has nothing to be assessed on.
2. **Stand up the four governance systems**
   Risk, incident, feedback and complaints, information security. They are the largest new items and the slowest to build a track record for.
3. **Start a dose audit against diagnostic reference levels**
   A year of history at go-live is worth more than a policy saying it will happen.
4. **Fix financial consent and cost estimates**
   Do it while there is no deadline pressure.

5 **Decide your AI position**

Confirm with your vendor whether their product supports the disclosure requirements.

6 **Map your not-applicable claims early**

Each needs your accrediting agency's agreement before assessment.

7 **If you run multiple sites, consolidate first**

One agency and one renewal cycle, settled before the change rather than during it.

ABOUT THE DRAFT, AND THIS GUIDE

What this is based on

The document assessed is V0.16, dated 1 December 2025, watermarked draft. The title has already moved once, from the National Safety and Quality Medical Imaging Standards in the 2024 consultation to the National Medical Imaging Standards now, and the content will move again before the expected early 2028 start. RADops tracks each revision; this guide reflects the draft named above and the comparison counts are ours.

Read the draft yourself

The Commission publishes the draft and its consultation material directly. Read it alongside this guide rather than instead of it.

Draft National Medical Imaging Standards

Australian Commission on Safety and Quality in Health Care

Check the version before you act

Quote the version number and date on anything you write internally. A gap analysis against V0.16 will not match a later draft, and the counts in this guide are tied to that version.

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WHERE RADOPS FITS

Find out where your practice actually stands

RADops is a medical imaging IT and operations consultancy. We work only in medical imaging, and every engagement is delivered personally by Laurence Walker, a registered medical radiation practitioner with 20 years of experience across the public and private sectors.

The starting point is the Accreditation Readiness Review: a fixed-price, remote review of where your practice stands against the current DIAS standards, and what the 2028 change means for you specifically. A written report in 10 business days, and the total time asked of your team is about 90 minutes.

From $990 ex GST for a single site

Group pricing for multi-site practices. No preparation needed from you before we start.

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