British Association of Oral Surgeons Royal College of Surgeons Edinburgh Nicolson Street Edinburgh
EH8 9DW

BAOS response to OMFS GIRFT report Dec 2018

Clarifying definitions first and background not alluded to in the OMFS GIRFT document

Defining the specialties
According to the directive 2005/36/EC of the European parliament and of the council.

- L 255/119 for Oral Surgery (OS)
- L 255/104 for Maxillofacial Surgery (basic medical training)
- L 255/109 for Dental, Oro-Maxillo-Facial Surgery (basic medical and dental training) i.e. dual degree.

The report does indeed talk about Oral Surgeons and Oral & Maxillofacial Surgeons - however, the two specialities are distinct (the former being dental and the later medical) and it has clearly been difficult to unpick data between the two (especially as there is a huge cross-over in activity).

Oral surgery training does include some Oral Medicine, but Oral Medical staffing and activity was not expressly differentiated.

Defining "Non-Consultant Career Grades" (NCCG) and their activity
NCCG is a very outdated term and one that is no longer used. It is akin to using the term "middle grade". We refer the authors to NHS Employers and BMA guidance.
https://www.bma.org.uk/news/2012/august/employers-back-ban-on-middle-grade-rota-references.
https://www.nhsemployers.org/your-workforce/pay-and-reward/medical-staff/sas-doctors/sas-joint-negotiating-committee/use-of-the-term-middle-grade

These clinicians are often Staff Grade, Associate Specialist and Speciality Grades (SAS Grades), make up a large proportion of the claimed OMFS workforce and are dentally qualified being solely on the GDC register rather than that of the GMC. (https://www.baos.org.uk/resources/MEEOSreview.pdf)

The MEE report 2010 (referenced above) details there were 377 SAS grades to 323 Consultants at that time - the largest ratio of SAS grades to consultants in any medical specialty. It is fair to say historically that that the majority of Staff Grades operated under a named Consultant, but this requirement changed with the 2008 SAS contract and is no longer the case. Because of their experience it is expected that the vast majority of Associate Specialists will practice autonomously.

However, the OMFS GIRFT report does not accurately demonstrate who is doing what and what volume of work is being undertaken (whether it be dentoalveolar, trauma or other procedures) due to problems with coding. Furthermore, the report fails to accurately show the huge volume of work that is undertaken by SAS grades working as senior clinicians, who often in addition to delivering service are supervising and training juniors. (Brotherton et al. The scope of practice of UK oral surgeons. J Oral Surg 2015; 8:2, 83-90)

BAOS are aware from OS SAS colleagues around the country that they were not always involved in OMFS the GIRFT visits and often only learnt that the visit had taken place afterwards. This meant that the OS contribution to this report was potentially not as thorough as it should have been (evidenced by the fact that SAS grades are referred to as NCCGs, for example).

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Remit and terms of Oral Surgery

The document reads as if Oral Surgery is purely dento-alveolar surgery but it should be remembered that it includes facial trauma (hard and soft tissue), salivary gland surgery, orthognathic surgery & TMJ surgery. https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/09/guid-comms-oral.pdf

Dento-alveolar surgery comprises only part of the Oral Surgery as outlined by the Oral Surgery Curriculum. https://www.nwpgmd.nhs.uk/sites/default/files/Oral%20Surgery%20Specialty%20Training%20Curriculum%20Feb%202014.pdf

The Southampton case study does refer to 'minor dento-alveolar activity' (what is major dento-alveolar activity?) and 'minor surgery' - the term 'minor' is outdated and should not be used (compare with 'minor ENT' or 'minor ophthalmology' or even 'minor orthodontics' - they don't exist).

Commissioning of Oral Surgery

There is an established a recognised need for Oral Surgery Consultants leading a Level 3 OS services with management/ governance (MCNs), training and education linked with primary care service providers. Medical Education England report in 2000 (https://www.baos.org.uk/resources/MEEOSreview.pdf) and Oral surgery commissioning 2009 recommended this structure.

In 2009 Oral surgery and Oral Medicine commissioning for NHS England was developed (https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/09/guid-comms-oral.pdf).

The OS commissioning guide states: *'Oral surgery is Substantive and Honorary UK Consultants in Oral Surgery have usually completed the Intercollegiate Specialty Fellowship Examination (ISFE) and they possess clinical competencies that differentiate them from a Specialist, which include: the management of jaw and facial fractures; congenital and acquired jaw anomalies; advanced oral implantology and bone augmentation; diagnosis and treatment of anomalies and diseases of the TMJ; and, diagnosis and treatment of salivary gland diseases. These individuals also have training in management of healthcare delivery, competencies in research and/or critical appraisal competency and are therefore appropriately qualified to lead a MCN. Staff grade and associate specialists (SAS grade clinicians) may undertake this complex clinical work within a multidisciplinary team'.*

A recent paper highlighted the significant extended competency activity undertaken by SAS grades in OMFS units (Brotherton et al. The scope of practice of UK oral surgeons. J Oral Surg 2015; 8:2, 83-90).

Primary Care activity is not necessarily restricted to Level 2 cases as the report suggests. It is perfectly feasible to treat more complex, Level 3 cases in Primary Care if the treating specialist and team are competent, experienced and skilled enough to do so. To suggest that patients with co-morbidities or needing complex wisdom tooth removal must be treated in hospital is nonsensical - many are treated in out-patient departments in the same way as they can be treated out-with the hospital in suitably staffed units led by Specialist Oral Surgeons very safely and appropriately (and often for much less than the cost of a day-case procedure). The setting is far less important than the competence and experience of the team treating these patients. If the MEE report format was followed (as referenced above) and there was development of increased OS national training numbers and therefore increased numbers of OS Consultants to oversee services across primary and secondary care sectors this would ensure a confluent, quality assured and safe service for patients. It would be easy to ensure treatment by the most appropriate team in the most appropriate setting.

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Comments on OMFS GIRFT recommendations
(including OMFS recommendations in blue text)

- Theme 1: Coding
  - Given most of the report refers to the inaccuracy of the data due to poor coding - it seems correcting this should be the vital first step, before meaningful decisions can be made on these results. (p20 - picture of work we have for both specialties is inaccurate).
  - Outcome coding does not exist sadly due to the current coding systems being predicated upon funding for interventions only and not holistic or non-interventional care. NHS trusts are purely funded on procedures and not the quality related to that care. This must be addressed.
    - 5 Deliver an efficient and patient-focused outcomes audit programme for oral and maxillofacial surgery.
    - 5a Establish how to use real-time data, reduce the duplication of data collection supported by trusts and support continuous improvement.
    - 5b Develop and evaluate a Quality Outcomes in OMFS (QOMS) pilot.
    - 5c Review the National Head and Neck Cancer Audit (HANA) with the other relevant specialties.
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  - Staff activity attribution
    - Theme 1: Data quality and data collection
    - 1 Improve attribution to main specialty to ensure coded in accordance with the NHS Data Dictionary.
    - 1a Ensure that all work under the responsibility of consultant oral and maxillofacial surgeons is consistently attributed to their main oral and maxillofacial specialty in accordance with the NHS Data Dictionary.
    - 1b Where a consultant oral surgeon carries out oral surgery in an oral and maxillofacial unit, ensure that their work is attributed to their main oral surgery specialty in accordance with the NHS Data Dictionary.
    - 1c GIRFT to investigate options to measure or estimate the amount of activity performed by non-consultant career grade staff under consultant supervision in all surgical specialties.
  - We support 1b and 1c but 1a is counterintuitive. Just re-attributing dentoalveolar surgery under OMFS code versus OS codes will not inform workforce development or needs assessment. OMFS surgeons who spend years in expensive training should be using their very skilled selves doing the complex cases e.g. cancer, complex trauma etc. and not routine trauma/extractions/dentoalveolar work.
  - Any developments in coding must be able to identity the workload of the different specialties including OS SAS grades for appraisal and revalidation
  - Correct attribution of activity is vital not least for understanding the make-up of the workforce and for future workforce planning.
  - There is a **fundamental flaw with coding for dental procedures**. Unlike most surgical specialities, dentistry has developed as being predominantly delivered under LA on conscious or consciously sedated patients, not reflecting its highly technical and complex procedures. Due to HES coding these procedures are coded as non-interventional 'consultation' with inappropriate remuneration and recognition. This may also apply to oral medical biopsy procedures and other soft tissue interventions. Even the most common chronic pain condition TMDs are not recognised nor their interventions. This must be addressed.

        - This is reflected in recommendations
            - Theme 2 Produce a clear definition of an out-patient procedure for data collection purposes.
            - 3a Agree the out-patient definition.
            - 3b Establish which oral and maxillofacial out-patient procedures meet the definition.

    - Comorbidity (medical, social and mental health) coding is possible and undertaken in many Trusts. This need will reflect the Level 3 need for specialist care.
    - Differentiate coding between GA, sedation and LA
        - Many Oral and Maxillofacial Units only offer local anaesthetic or general anaesthetic to patients or there is very limited LA and sedation offered. There are many cases going on general anaesthetic lists that could be carried out under LA and sedation.
        - LA surgery requires specific recognition as a surgical intervention and not just a consultation.
    - We support improving training in coding and accessibility to coded activity.
        - 4 Improve the recording of workforce and HR data to support workforce planning.
        - 4a Review and take actions to improve recording attribution of area of work in ESR.
        - 4b Investigate how national locum expenditure can be recorded by specialty.

- Theme 2: dentoalveolar surgery takes place in appropriate setting. Recommendation of shifting care to primary care tier 2 and 1 level.
    - With increasing medical and mental health issues in our ageing population and new drugs including bisphosphonates need for Tier 3 Oral surgery care will increase and not diminish.
    - Tier 3 work can also be carried out in primary care within a specialist, appropriately commissioned service
    - 6c recommendation about primary vs secondary care dentoalveolar surgery would need careful assessment/quality assurance of who would be doing the work in primary care. They suggest dentists with enhanced skills and preferably on the OS specialist list (p29). This network does not yet exist in all regions and there are significant governance issues around training and recognition.
        - There are not enough OS specialists available and not enough training posts to supply them. This must be addressed.
        - Some commissioners do not fund IV sedation in primary care. Currently some primary care services cannot cost effectively provide sedation and Tier 2 or 3 OS with current commissioning processes.
        - 6 Take steps to ensure that dentoalveolar surgery takes place in the appropriate setting.
        - 6a Ensure correct coding of: the type of anaesthetic used the presence of an anaesthetist the presence of any co-morbidities.
        - 6b Use the coding and comorbidities data to assess what proportion of dentoalveolar surgery could be carried out in the different settings.
        - 6c Explore the potential impact of moving a proportion of dentoalveolar work out of secondary care and the functionality of the different settings available locally to support an integrated care pathway across both the elective and non-elective elements. This is to include planning and contractual requirements.

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  - 6d Based on the findings from 6b, 6c and examples of good practice, produce a plan to enable the development, implementation and continuous improvement of an integrated pathway for dentoalveolar surgery.

- Theme 3: Improving efficiency by organising care through network: we support the recommendations under theme 3.
  - However, network evaluation should not be mono-speciality; many skin cancer patients are cared for by dermatologists and plastic surgeons. Much of head and neck cancer work is also undertaken by ENT and plastic surgeons.
  - These are examples where cross wide specialty evaluation of delivering same coded care requires careful scrutiny.

- Theme 4: Optimising the secondary care pathway
  - We agree with the main recommendations
    - 11 Improve understanding of follow-up rates and take action accordingly to reduce unwarranted variation.
    - 11a Audit causes of current local follow-up rates.
    - 11b Ensure robust follow-up protocols are in place in all clinical areas to address unwarranted variation in local follow-up rates.
    - 11c Establish ongoing local audits to check that the new protocol is followed and action taken accordingly.
    - 12 Improve the utilisation and use of day case for emergency care in order to reduce length of stay for non-elective patients.
    - 12a Add national reporting of time to theatre for non-elective oral and maxillofacial patients once they are fit for surgery to the theatre dashboard.
    - 12b Review variation in time to theatre and set a best practice target.
    - 12c Align with the development of the local networks (recommendation 7). Develop: specialty-specific emergency lists in larger units dedicated time in the general emergency theatre in smaller units.
    - 12d Explore the feasibility of including oral and maxillofacial trauma procedures in the British Association of Day Surgery data directory.
    - 13 Improve understanding of re-admission rates and take action accordingly to reduce unwarranted variation.
    - 13a Audit causes of current local readmission rates.
    - 13b Develop an action plan and ensure a robust standard protocol is in place.
    - 13c Establish ongoing local audits to check that the new protocol is followed and take action accordingly

- Theme 5: Litigation
- We agree with these recommendations below, however, there is a lack of reference to transparent attribution of clinician in these cases.
- Inclusion of serious events including never events and near misses should be included in this data for a holistic view of clinicians in trouble and repeat offenders.
    - 14 Implement GIRFT 5 point plan for reducing litigation costs.
    - 14a Assess benchmarked position for estimated litigation cost per unit of activity compared to the national average.

- 14b Review claims submitted to NHS Resolution to confirm correct coding. Inform NHS Resolution of any claims that are not coded correctly at CNST.Helpline@resolution.nhs.uk
- 14c Review claims in detail, including expert witness statements, panel firm reports, counsel advice and medical records, to determine where patient care or documentation could be improved.
- 14d Triangulate claims with learning themes from complaints, inquests and serious untoward incidents (SUI). If a claim has not already been reviewed as an SUI, we recommend that this is done to ensure no opportunity for learning is missed.
- 14e Where trusts are outside the top quartile of trusts for litigation costs per activity, GIRFT national clinical leads and regional hub directors will support them in learning from claims, including sharing examples of good practice.

- Theme 6: Procurement
- We agree with recommendations
  - 15 Enable improved procurement of devices and consumables through cost and pricing transparency, aggregation and consolidation, and by sharing best practice.
  - 15a Use sources of procurement data, such as Purchase Price Index and Benchmarking tool (PPIB) and relevant clinical data, to identify optimum value for money procurement choices, considering both outcomes and cost/price.
  - 15b Identify opportunities for improved value for money, including the development of benchmarks and specifications. Locate sources of best practice and procurement excellence, identifying factors that lead to the most favourable procurement outcomes.
  - 15c Use Category Towers to benchmark and evaluate products and seek to rationalise and aggregate demand with other trusts to secure lower prices and supply chain costs.