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British Journal of Oral and Maxillofacial Surgery 57 (2019) 393–394

BRITISH Journal of Oral and Maxillofacial Surgery

www.bjoms.com

Editorial

Getting It Right First Time (GIRFT) — the Oral & Maxillofacial Surgery Report: what happens next?

The year 2018 was noteworthy for two important but unrelated projects, both of which may have a profound impact on the future of our specialty in the United Kingdom. During 2018, the Quality Outcomes in Oral and Maxillofacial Surgery (QOMS) team, highlighted in an earlier BJOMS editorial,[1] aimed to develop practical ways to measure how we treat our patients and thereby raise standards of care. At the end of 2018 the Oral and Maxillofacial Surgery (OMFS) Getting It Right First Time (GIRFT) Project published its report that highlighted the need for outcome measures in our specialty, and mentioned the QOMS project. Making measurable progress with both these projects in the next five years will, in some ways, define our progress.

"Getting It Right First Time" (usually shortened to GIRFT) looks for "unwarranted variation" in surgical care and tries first to understand, and then to address, this variation. GIRFT began as a pilot study within orthopaedic surgery led by Professor Tim Briggs and hosted by the Royal National Orthopaedic Hospital NHS Trust.

After the pilot, an NHSI survey of more than 70 trusts found total savings of up to £30 m for 2014/15 and a further £20 m forecast for 2015/16 as a result of adopting GIRFT's recommendations.[2] After the report on orthopaedic surgery, reports were published on urology, neurosurgery, cardiothoracic surgery, vascular surgery, and general surgery.[3] The GIRFT process is limited to the NHS in England where it will be extended across all 35 surgical and medical specialties.

In 2016 GIRFT advertised for an OMF surgeon to lead the process for our specialty, and Maire Morton, a consultant from Blackburn and previous President of BAOMS, was appointed. Since then she has been working intensely with the GIRFT team generating "deep-dive" datapacks for the specialty as a whole and for Trusts with OMFS departments.

One of the GIRFT recommendations for OMFS is to improve the recording of data about the workforce and human resources. The NHS Digital data on OMFS in Jan 2018 said there were 200 OMFS specialty trainees, a third more than there actually are.[4,5] When the BAOMS Workforce Census is complete, we will be in a strong position to identify errors and contribute to planning. If you are a BAOMS member and have not yet added your details to the census, please stop reading now and use the link from your BAOMS member profile to do so. If you are not a member, use the link from the BAOMS home page.[6]

Finding Trusts that have OMFS departments using the GIRFT data was surprisingly difficult. In many Trusts the data were coded to Oral Surgery, and in some the activity was categorised to another surgical specialty. The data included in the national GIRFT report this time combined OMFS and Oral Surgery. BAOMS has known that there are issues with coding of specialties and has been trying for decades to address this. It is excellent that the top recommendation of the OMFS GIRFT report targets this problem.

GIRFT found that there was no way of identifying procedures under local or general anaesthetic. Within the Hospital Episode Statistics (HES, the procedure codes), which are derived from our hospital coders, there was difficulty identifying major cancer procedures and there was inconsistency in the coding of orthognathic procedures. The second major recommendation in the GIRFT report was to improve clinical coding. To this end BAOMS will produce a coding glossary and precoded operation sheets to be used or adapted by surgeons to aid their clinical coders.

Emergency surgery is provided in almost all OMFS departments, but GIRFT found that some units were admitting very low numbers. The report suggests that units admitting less than 300 emergencies/year should consider whether they should be moving towards a hub and spoke or network arrangement.

Almost all departments of OMFS do dentoalveolar surgery, sometimes for their local community and often as a tertiary referral centre, including referrals from the nearby

https://doi.org/10.1016/j.bjoms.2019.01.019

dental school. Our role in treating these patients makes all OMFS departments aware of the functionality (or otherwise) of the local Managed Clinical Network (MCN). Not all MCN include representation from OMFS, even though we provide all the acute/emergency provision and often do much of the operating. The OMFS GIRFT report recognises this weakness, and recommends that OMFS should be involved in all MCN. The report suggests that a proportion of the dentoalveolar work currently done in hospitals could be transferred to tier two providers in a primary care setting.

For patients who need dentoalveolar surgery there is a direct and almost immediate impact from changes in the contract for NHS Dental Care, and also the presence of primary dental care practices and practitioners who provide this surgery (Begley A, et al A biography of a practice specialising in surgical dentistry 1987-96. Paper presented at the annual meeting of the British Association of Oral and Maxillofacial Surgery, 1996). A quirk of history and geography means that the area in the UK that has the longest track record and best developed specialist practices for providing dentoalveolar surgery is Northern Ireland.[7] During three years of reduced funding of High Street Oral Surgery (from 2014-17), reduced activity was not surprisingly accompanied by a pronounced increase in referrals to secondary care. Since 1 October 2017, the Northern Ireland Health and Social Care Board have been piloting a new contract for dentoalveolar surgery. Called High Street Oral Surgery Personal Dental Services Pilots,[8] these have shown that an appropriate contract leads to an immediate reduction in hospital waiting lists.[9,10]

Improving the pathway for dentoalveolar surgery is one of the themes of OMFS GIRFT, and it suggests that a proportion of the dentoalveolar work that is currently done in hospitals could be transferred to providers in a primary care setting, (sometimes called tier two services). BAOMS highlighted the importance of areas in which we, as OMFS surgeons, have no influence - the General Dental Contract; commissioning specialist practices with appropriate level of reward; and sufficient duration of contract to encourage development. These issues, and the provision of emergency dental services, fall within the remit of the Dental Officers of the UK. In England, we hope that Dental Specialties GIRFT makes strong and appropriate recommendations in these areas.

Starting in May of 2019, all OMFS units have been asked to participate in the GIRFT Surgical Site Infection (SSI) Audit.[11] The 2017 SSI audit had very limited participation by our specialty. This time GIRFT has contacted the Chief Executive of every Trust in England to require participation. If this is the first time you are hearing about this, you have some catching up to do.[11]

Over the next five years application of the lessons that GIRFT has identified, and moving forward with the QOMS initiative, will be hard work for us all, but they will advance care for our patients and our reputation as a quality-driven surgical specialty.

Conflict of interest

Ian Martin is a past President and Trustee of BAOMS, Patrick Magennis is Chair of BAOMS.

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Available online 10 May 2019