**QOMS Update May 2019**

**From Fabien Puglia**

**Project Manager QOMS**

Dear Colleagues,

It has almost been a year since QOMS was launched. As the Quality and Outcomes in oral and Maxillofacial Surgery (QOMS) Project was designed for and around the BAOMS membership, we thought that we should give you more regular updates. Hence, this is the first QOMS newsletter.

The Project Team have been making steady progress in delivering a platform for a quality management system for maxillofacial surgery. The consultation on metrics has stimulated a lot of discussions and the project team are grateful to all those who participated. Our particular thanks to the SSIG leads and deputy leads who delivered on this on a tight schedule. During the consultation period a detailed project protocol has been drafted and submitted to Council for approval.

The IT build to support the project is now underway. After considering a number of IT providers the Project Team have decided to use REDCAP as the platform and this will be hosted by Queen Mary University of London. During the build an application will be made to CAG for the necessary information governance approvals to allow data submission. In the interim a 3-month pilot with patient consent is planned for the autumn. We are currently looking for six enthusiastic maxillofacial surgery departments to participate in this pilot. The project team will write to the medical director and Caldicott Guardian for each participating site in the pilot to obtain the necessary approvals. It is intended that there will be a mix of maxillofacial unit profiles in the pilot with departments from large urban centres to those located in smaller cities with a wide geographical distribution. This pilot will be important in refining the project and resolving problems before a full role out in early 2020. After regulatory approval has been obtained for England and Wales the project team will seek the appropriate approvals for Scotland and Northern Ireland. Following that the relevant regulatory bodies in the Republic of Ireland will be approached.

QOMS is still growing and changing. We are looking for a clinician interested in joining as the Project’s Clinical Communication Lead. It is hard to describe what the role will entails but as the project grows, we anticipate that that person will be important to not only promote the project itself but interacting with OMFS departments and surgeons. If you are interested or would like more information, please contact Jeremy McMahon for a chat (jeremymcmahon@nhs.net). Finally, we are also looking for a new lay or patient representative to be part of the Steering Committee. If you know of any patients or patient groups active in OMFS who could be interested, please let us know (see contact below).

As always we are keen to hear your thoughts and questions, do not hesitate to get in touch: baomsprojectmanager@baoms.org.uk.

**From Jeremy McMahon**

**Clinical Lead for QOMS**

Firstly my thanks to the members of the Project Team, Steering Committee for QOMS, BAOMS Council Trustees, and Dr Marisa Mason, Chief Executive for NCEPOD, for all the support, advice, and encouragement over recent months. Marisa has been an essential enabler in getting us this far. Sarah, and the rest of her team at BAOMS Office have been unswerving in their support. I would also echo Fabien’s comments above on the effort the SSIG leads and deputy leads have invested. My particular thanks to Fabien who has done all the hard work on our behalf.

This has been the most challenging task of my career and remains so. I use this opportunity to discuss a few of the most challenging aspects of this project that my colleagues have raised over recent months.

The single most significant concern revolves around our ability to collect data which is complete and accurate enough to allow identification of the best performers. We are attempting to deliver a project which, at the outset will require secondary data entry by the clinical teams. We are doing so at a time when the senior workforce is relatively demoralised, and clinical demands unprecedented. A recent report has suggested that up to 40% of clinical time is taken up with interacting with the electronic health record and associated data entry. That cannot be the most productive way to use the clinical workforce. How to resolve this problem occupies a lot of my time at present. There is no single solution available to us. We are actively pursuing data sharing agreements with any other registry interested in capturing data on an overlapping cohort of patients. We are determined that QOMS will not undermine the efforts of others and that surgeons will only have to enter the same data set once. Discussions with the team from the National Clinical Improvement Program (NCIP) are ongoing. This group are seeking to use the administrative dataset to obtain the denominator and numerators on the metrics relevant to the project. It could be a very useful approach and might provide the necessary data for the project without the requirement for direct surgeon data entry. Nevertheless, to be certain we can deliver a project for everyone across the specialty we will press on with the build as planned.

Another concern that has been raised is data ownership. Please read the QOMS Project Protocol and I feel certain this will allay any anxiety in this respect. Briefly, the data relates to the interface of patients with the clinical team and that is where it belongs. All those who contribute data have ownership of the data. QOMS sets in place a structure that protects anonymity of patients, surgeons, and departments. Requests for data will be assessed to ensure they relate to quality improvement and that data released will respect the anonymity as described above. Use of the data for competitive purposes in publications or presentations is not permitted. All local data will be visible to the local team and useable for appraisal purposes. Similarly, where we receive requests for data outside the membership, which respect the requirement for anonymity, and which will inform the delivery of optimal care, those requests are likely to be viewed favourably.

Some members have been concerned about compulsion. Participation is voluntary for patients, surgeons, and departments. The greater the participation of course the more likely it is we will deliver on our aim to use comparative data to drive up quality of care.

Finally, I hope to see many of you at conference to talk about the project. Please respond to our request and consider participation in the pilot- we need your help.