DATA BURDEN REDUCTION STRATEGY

Quality and Outcomes in Oral and Maxillofacial Surgery Project

BACKGROUND

The Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS) Project is the quality improvement and clinical effectiveness programme for oral and maxillofacial surgery (OMFS). QOMS was initiated in 2018 and is led by the British Association of Oral and Maxillofacial Surgeons (BAOMS). Its overarching aim is to assess and, when necessary, improve the quality of care provided to patients in areas of OMFS practice in the UK. QOMS operates audits across several of those areas of practice.

The QOMS Team recognises that the data collection process for audits is often burdensome on healthcare professionals and support staff. Collecting unnecessary data impacts on people's time and resources and does not align with data protection principles. However, we are equally aware that that the nature of our work and its recent onset means that data collection is currently more data heavy than other, more mature audits. The QOMS project has been collecting data since summer 2021 and, as this policy is written, has not yet reached critical mass.

In line with guidance from NHS England we aim to:

1. Collect data which is proportionate and with a clear business purpose.
2. Where possible, not duplicate other data collections.

STRATEGY

Discussions to limit data burden are regularly undertaken for the audit(s) within each QOMS workstream.

1. AUDIT DEVELOPMENT

Selection of an area of OMFS practice

OMFS surgeons typically practice in only a few of areas OMFS, which cover oncology, trauma, facial and cranial deformities, oral and dentoalveolar surgery, etc. BAOMS have set up subspecialty interest group (SSIG) for each area of practice to update clinicians and allow discussions between them. Surgeons from any SSIG can propose their area of interest to be included in QOMS.

Conditions:

- there should be evidence or no evidence available of variation in clinical practice
- there should be no programme monitoring of quality of care already in place, unless data is not easily available or has been judged insufficient

Selection of procedures, conditions and patient population of interest

The population to be included in each audit needs to be clearly defined in terms of which procedures they are undergoing (e.g. high-volume, high-risk, novel), and which conditions they are affected by (e.g. common/rare, high-risk of complication, poor prognosis…).

Selection of quality-of-care indicators

Indicators should focus on a limited number of meaningful clinical outcomes (e.g. length of stay, risk of complications and return to theatre, recurrence, survival etc). They should be SMART outcomes

(Specific / easily Measurable / Actionable or Achievable by the surgical team/ Relevant and their reporting should be Timely). The QOMS Team also added the condition that indicators should be risk-adjustable.

Outcome: The report will suggest national benchmark (if not already available) and measure of quality of care against existing or new benchmark at the national, regional and hospital levels. The report will also highlight areas of improvement needed that are recognised by the healthcare professionals who will need to act on them.

2. AUDIT DESIGN

Each audit will be developed by a working group, including OMFS consultants and trainees and, where applicable, clinicians from other specialties and other stakeholders (charity, patient groups…). Each audit will be separately assessed by an independent patient and public group panel.

Audit design is an iterative exercise where each item collected has to be useful. Those items should be easily available / collected routinely as part of the care provided. Their selection should be evidence-based and deemed essential for the reporting (e.g. patient demographics and characteristics) or to achieve the objectives of the audit.

When considering risk adjustment:

- If model(s) are available, data collection should include the items necessary to apply those models on the audit data.
- If not available, data collection should include items that have been showed to correlate or affect the selected metric. In time, a new risk-adjustment model will be developed. Part of that process will be to identify variables that are significant, i.e. to be kept, and those that are not useful, i.e. to be discarded from future data collection.

Outcome: Each audit is focused on collecting items that will satisfy its objectives, with no or as little duplication as possible.

3. DATA COLLECTION TOOLS

Data collectors will be provided with strict inclusion criteria (e.g. ICD10/OPCS codes where possible, or disease/procedure specific descriptions if no codes are available).

Outcome: Data are limited to those patients with the required inclusion criteria.

Questions on all study questionnaires are mapped to the objectives of the study, using a strategy of analysis document. Once formed, draft questionnaires are reviewed multiple times by the working group to remove any unnecessary or duplicate questions and advise from external sources might be sought for external validation,

Outcome: Questionnaires are used to collect data that will be used to inform the peer review, the report findings, and the recommendations.

Where an area of practice is known to be high volume, the number of patients to be captures will be limited to a specific number, which will be reviewed as the audit progress.

Outcome: To reduce burden placed on everyone involved at a hospital level.

4. IMPACT OF OUTPUTS ON HEALTHCARE PROVIDERS

There is a plethora of national recommendations aimed to improve healthcare. To maximise the impact of our reports, while not over-burdening healthcare organisations and personnel we:

1. Recommendations are to be made in a limited of pre-agreed metrics
2. Ensure recommendations are evidence-based on our data and wherever possible supported by other national data available
3. Do not set recommendations, similar to already-existing recommendations. Instead we support those in existence or add to the wording of them.
4. Provide short versions of the report, an infographic and a document containing just the recommendations.
5. Provide easy to use tools to accompany the report to facilitate implementation of the findings at a local level.

Version control

Version	Date	Note	Signed off by / Date	Date of next review
1.0	02/10/2024	Original	M Ho / 07/10/2024	01/10/2025