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Letter to the Editor

Is this the end of the Oral and Maxillofacial Toolbox? A retrospective analysis of funding for acute OMFS soft tissue trauma provision within the UK

Sir,

We present the findings of our analysis of the funding and costs to provide facial laceration support within the Mid Yorkshire Hospitals NHS Trust Emergency Department (ED).

Within the UK, most facial lacerations are dealt with by OMFS. Historically¹ this service has been provided by on-call junior trainees who assess and suture wounds (if required) in the ED using disposable equipment, generally at the time of initial attendance. A considerable proportion of ED attendances nationally fall within this category meaning this is a core part of junior OMFS duties.¹

We analysed effectiveness of this service model to understand: cost of provision, cost of resource (equipment) and associated remuneration against clinical requirements and patient experience, using the output to modify our own service for head and neck soft tissue injuries.

Over a 3-month period the OMFS department assessed and treated 135 lacerations, with the majority treated within the ED with 46% occurring overnight, despite no clinical guidance to say immediate treatment provides a superior result.² The remaining cases were operated on within the surgical assessment unit treatment room. No patient received their treatment within the OMFS department itself, despite being equipped for minor operations electively.

The cost of disposable equipment for this service was £1013.85 (cost of personnel, sutures and local anaesthetic was excluded). Due to peculiarities of the remuneration process, where “payment” is linked to the patients’ location within the hospital and discharge documentation, no funding could be traced back to the OMFS department despite providing the service.

We conservatively estimated an underpayment for treatment provided of £15,120 over this three-month period. We

based these figures on the current National Tariff Payment System where the minimum value for treatment of a laceration is £112 in a healthy patient without any comorbidities.³ The analysis shows there are clear financial implications to this outdated model and coding arrangements,⁴ especially as the service model is commonplace within OMFS units across the UK.⁵

We have proposed and costed an alternative service model, similar to other acute surgical specialities, where patients return to the treating department when safe to do so as part of a scheduled trauma list (often run daily by a trainee with additional senior support available). Such trauma lists can also maximise use of re-usable instrument trays which are sterilised through theatre services, minimising single use item waste to reduce cost and become more sustainable.

However, whilst this service model has the benefit of ensuring appropriate remuneration, it can more importantly address patient care and trainee development. We aim to evidence this through further work being undertaken with our new service protocol, but proposed benefits are: reduced waiting times, appropriate consent, suitable physical environment, trainee support and assessment opportunity, reduction of non-urgent workload whilst on-call, as well as release of ED treatment rooms back to the hospital.

Furthermore, this service model can promote the OMFS unit as a surgical specialty with expertise in managing facial trauma rather than a hidden service to the rest of the hospital. The changes to the “normal” OMFS workload due to the COVID-19 pandemic may also present an opportunity for units who currently adopt the “traditional toolbox” approach, to implement similar changes to those proposed in this analysis.

Conflict of interest

We have no conflicts of interest.

Ethics statement/confirmation of patients' permission

Not required.

References

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