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POLICIES

Oral and Maxillofacial Surgery (OMFS) Consultant Workforce in the UK

Review of Current Evidence with Guidance for Trusts and ICBs hosting OMFS Services

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Please email comments to **office@baoms.org.uk**

Executive Summary

Overall Recommendation

Having reviewed the workforce needs for the specialty of oral and maxillofacial surgery in 2026, the minimum recommendation is 1/100,000 Whole Time Equivalents (WTE) across all the UK with recognition that in Regional Units this ratio should be higher. This minimum recommendation is made by the OMFS specialty association based on contemporaneous workforce data[1] and in the context of GIRFT reports[2–5].

We estimate that requires a 30% increase in the Whole Time Equivalent (WTE) consultant workforce with a higher increase in the number of individual specialists (with more consultants working Less Than Full Time LTFT). There are some units which are clearly understaffed highlighted in the OMFS GIRFT Further Faster Report[6].

Special attention to ensure OMFS Head and Neck Surgery Team Size

The Head and Neck Surgery GIRFT[4] makes recommendations about two consultant operating and 24/7 on-call for microvascular surgery/free-flap which will require an expansion of the workforce in most units.

Avoid the diversion of funds needed for consultant OMFS services to create SAS or Oral Surgery Consultant posts where there are backlogs of dentoalveolar surgery.

Oral Surgery specialists and SAS dentists can only provide a very limited element of OMFS services[7]. Changes in access to NHS Dental Care and the lack of Tier 2 and iMOS services in primary care can place pressures on waiting times and service provision in OMFS who are often the 'dentist of last resort' due to their dual qualifications. Trusts and ICBs should be cautious committing resources to address these dental pressures in secondary care by appointing Oral Surgery consultants or SAS grade dentists. When there is appropriate provision in primary care, as is the case in Northern Ireland[8], surgical dentistry can be delivered in a way that matches the Fit for the Future - 10 year plan[9] at less cost without negative impact on OMFS consultant provision.

For a geographically isolated OMFS unit to achieve the GIRFT recommendation of 6 OMFS consultants in an on-call rota may require sharing on-call with a neighbouring unit or developing a network. Reaching 6 OMFS consultants within a network may also require re-directing patients from specialties which interface with OMFS.

On-call rotas with fewer than 6 make the appointment of consultants challenging. Geographical challenges can make sharing of on-call with neighbouring units or developing an on-call network of at least 6 OMFS consultants difficult.

There are patients who need care which only OMFS can provide. In smaller, geographically isolated OMFS units there may not be sufficient 'OMFS only care' across neighbouring Trusts or OMFS networks to support an on-call rota of 6 consultants recommended by OMFS GIRFT.

Trusts in regions with smaller OMFS units should consider how they can work together. This may include a review of care in interface areas including oral surgery, surgical dermatology and plastic surgery which could also be provided by OMFS to ensure that adequate consultant job plans across the patch. This is a strategic priority which requires planning and collaboration.

Additional actions to support OMFS services and training

These include strategies to retain older consultants[10], increase OMFS trainee numbers, helping develop fully run-through training models (supporting OMFS trainees who are second degree students with Fellow posts)[11], and facilitating OMFS specialists from overseas working in the UK. Retaining consultant surgeons with protected characteristics—such as gender, race, disability, or age—requires addressing systemic barriers in career progression, enhancing work-life balance, and ensuring inclusive environments. The fundamental requirement to address all these issues is an adequate workforce size.

Background and Previous Workforce Documents

The current population of the United Kingdom is stated as 69.28 million in mid-2024[12], and is projected to pass 70 million by 2026. As the population grows, the demographics of the population will also change with the numbers over 65 increasing across all four nations of the UK. The mean age in the UK is 40.4 years, and this will rise. Those responsible for providing OMFS Services must plan for these changes.

There are trends across the medical and dental workforce that will also apply to OMFS. Generational changes will lead to more consultants working Less Than Full Time (LTFT)[13,14]. Increasing proportion of female workers in the dental and medical profession have also increased trends in LTFT working[15,16]. Specific to OMFS, the changes in the curriculum of Oral Surgery Specialty Trainees, and loss of experienced SAS grade staff[17], all leave the majority of OMFS patient care only covered by OMFS specialists[18].

In 2005, in "Developing a Modern Surgical Workforce" a report from the Royal College of Surgeons of England (RCS England)[19] recommended that there should be 0.66 Whole Time Equivalent (WTE = working a 40 hour week) OMFS consultants for a population of 100,000. At that time the mean waiting time for surgery was 81 days or 11 to 12 weeks. In 2025, twenty years later, there are many OMFS patients waiting over 52 weeks for treatment.

In a 2011 RCS England workforce report[20] there were 0.5/100,000 OMFS consultants (350 for a population of 52 million). It was hoped that the number of WTE consultants needed might be reduced as population health improved. For the patients cared for by OMFS, this has not been the case.

Previous workforce documents were based primarily on the majority of OMFS services being delivered by smaller OMFS units in District General Hospitals.

Another major change since these workforce documents were written is the deterioration in the surgical element of primary dental services through changes in the NHS Dental Contract and the impact of the COVID 19 pandemic. OMFS, through their dually qualified nature, have always been the dentist of last resort for primary care doctors and dentists. These will be outlined later.

Table 1. Data from OMFS Specialist List 2026
(overall figures for 'active' specialists including those not working in NHS consultant practice)

Area	OMFS	Population	Per 100,000
UK (4 nations)	569	69,198,004	0.79
England	425	55,980,000	0.76
Scotland	41	5,454,000	0.75
Wales	25	3,136,000	0.80
N Ireland	8	1,885,000	0.42

Current Recommendations for OMFS

Changing demographics and working patterns in OMFS

The trend for both genders towards working Less That Full Time (LTFT) will require an increase in number of consultants as well as the number of Whole Time Equivalents (WTEs).

Data from NHS Digital about OMFS in England has proven to be unreliable about WTE numbers and even gender distribution[15]. Publications by BAOMS[21,22] and Royal College Surgeons of England in their workforce census' in 2023[23] and 2025[1] show that OMFS has an aging consultant population with over 50% working over 44 hours per week (11 sessions). There will be an impact due to retirement in the next few years.

Configuration of OMFS units

The first OMFS "Getting It Right First Time" GIRFT report highlighted the recommendation to move towards regionalised services[2]. The second OMFS GIRFT report went further[3] recommending details of the configuration of OMFS services into regional units.

Geographically Isolated Units – GIRFT recommends a network of at least 6 OMFS consultants for a sustainable on call rota and work-life balance.

There is patient care that only OMFS consultants can provide. In geographically isolated areas with widely spread small units, there may not be sufficient 'OMFS only' care required to provide fulfilling job plans for six consultants. With smaller numbers than 6, even when Trusts share on-call or join into a functional OMFS network, the on-call rota will make OMFS posts hard to fill.

Strategic Redistribution of Patients from Interface Specialties to OMFS to support the service.

OMFS curriculum[24] and care includes areas which interface with other surgical and dental specialties. Interface specialties for OMFS include oral surgery, surgical dermatology and plastic surgery. To create a sustainable OMFS service may require a strategic approach to patients referred for care in these interface specialties. On-call rotas of 6 or more across neighbouring units or OMFS networks are the target.

Supporting an inclusive workforce

To support an inclusive OMFS workforce, Trusts, Health Boards and ICBs should recognise that clinicians with protected characteristics may require adjustments/exemptions[25]. These should be incorporated proactively into workforce planning when they enter or to be retained in the workforce[26]. Protected characteristics include gender, race, disability, or age. OMFS has increasing female resident and consultant numbers[15,27,28]. It is recognised across surgery that neurodiversity[29,30] and other protected characteristics, including age, may require adjustments of rota, on-call, or activity requirements. Age, accident and illness can change a surgeon's ability to work. Anecdotally, OMFS has a good track record of colleagues retained in the workforce with appropriate adjustments[31].

Head and Neck Cancer Services

The nature and scope of OMFS has changed since 2005[2–4]. OMFS undertakes almost all of the surgery and reconstruction for oral cancers[4]. Mouth cancer and skin cancer are both increasing. Where OMFS units provide mouth and skin cancer services, this will require a larger workforce than the national average.

The Head and Neck Cancer GIRFT Report[4] made challenging recommendations regarding the number of consultants required to deliver microvascular on-call services and recommended minimum numbers of consultants in the surgical team.

Increasing Requirement for Dental Elements of OMFS Care

The Hospital Dental Service GIRFT Report highlighted that a majority of 'Oral Surgery' services were being provided by OMFS[7]. The need for urgent management of acute dental infections has increased as access to routine dental care has decreased[32]. There has also been an increase in the complexity of surgery and care provided[4].

The principles of commissioning of surgical dental services in primary care, often called Tier 2 Oral Surgery Services, have been clearly defined[33–35]. Unfortunately, OMFS services are rarely included in the membership of Managed Clinical Networks (MCNs)[36,37].

All Trusts providing OMFS services should be actively involved in the planning of dental commissioning as the impact of changes in the MCN directly affect OMFS services (see later).

Increasing Facial Trauma

OMFS continues to provide almost all the surgery for facial trauma and the amount of trauma that requires a Consultant involvement has increased as, non-Consultant doctors are now less experienced with a narrower skill-base[38], and its nature has changed with more knife crime[39,40].

Current Statistics

In November 2025 BAOMS undertook a snapshot survey of OMFS consultant provision in the UK which reported 505 consultant posts in OMFS. There were 54 consultant posts unfilled, which leaves 451 NHS OMFS Consultant posts. Based on these data the provision is 0.7/100,000, which is close to the calculation based on the OMFS Specialist List. If consultants could be appointed to all the empty posts this could be 0.8/100,000 but the previous option of appointing from EU trained surgeons is less available than before Brexit41,42.

With an OMFS specialist provision of 0.79/100,000, the specialty is struggling to meet demand despite most consultants having an extended working week. Compared to other similar nations with national health care provision (table 2), those nations have a workforce of 1-3/100,000[43]. For equivalent OMFS nations where those providing surgical OMFS care are dual degree trainees, the UK is in the bottom third.

Table 2. OMFS Specialists per 100,000 in European nations with dual degree DOMFS.

Nation	OMFS per 100,000
Switzerland	3
Austria	2.91
Belgium	2.45
Germany	2.27
Greece	2.01
The Netherlands	1.88
Latvia	1.86
Romania	1.3
Slovenia	1.2
Cyprus	1.05
Bulgaria	0.83
United Kingdom	**0.8**
Hungary	0.79
Czech Republic	0.71
Ireland	0.28

Recommendations for UK OMFS Workforce from BAOMS Council

Overall Recommendation

There was unanimous support from the Council of our specialty association for the recommendation of changes aimed at delivering a workforce for OMFS consultants of at least 1/100,000 Whole Time Equivalents across all the UK with recognition that in Regional Units the ratio should be higher to address tertiary referrals from outside the region and increased complexity of services.

It is important that this ratio is present across all regions and all four nations. Northern Ireland has OMFS specialist provision of 0.4/100,000.

We estimate that a 30% increase in the Whole Time Equivalent (WTE) consultant workforce with a higher increase in the number of individual specialists (with more consultants working Less Than Full Time).

Regional OMFS units – need additional workforce to manage tertiary referrals

Regional OMFS units provide care for their regional population but also tertiary referrals from out with their region including from other hub units. This care includes cancer, TMJ, complex trauma, complex deformity and complex skin surgery. To provide this care, their 'net' population should include their catchment area for these tertiary referrals.

Tier 3 Dentoalveolar Services – A potential distraction from core OMFS Consultant service provision

The core OMFS service is the provision of on-call cover across the OMFS curriculum and the inpatient and outpatient care which only OMFS consultants are trained to deliver[3]. Other clinicians can contribute to the on-call, but this must be as part of an on-call rota with OMFS consultants at the top.

A component of OMFS patients are those patients who require complex dentoalveolar surgery, or medically complex patients who require simpler dentoalveolar surgery. This is called Tier 3 Oral Surgery[33–35]. In some regions, there are insufficient dentists in primary care able to deliver more routing oral surgery services, and the burden for this care can fall on OMFS departments. This was recognised in the Dental GIRFT[5] and the OMFS GIRFT[2,3] Reports.

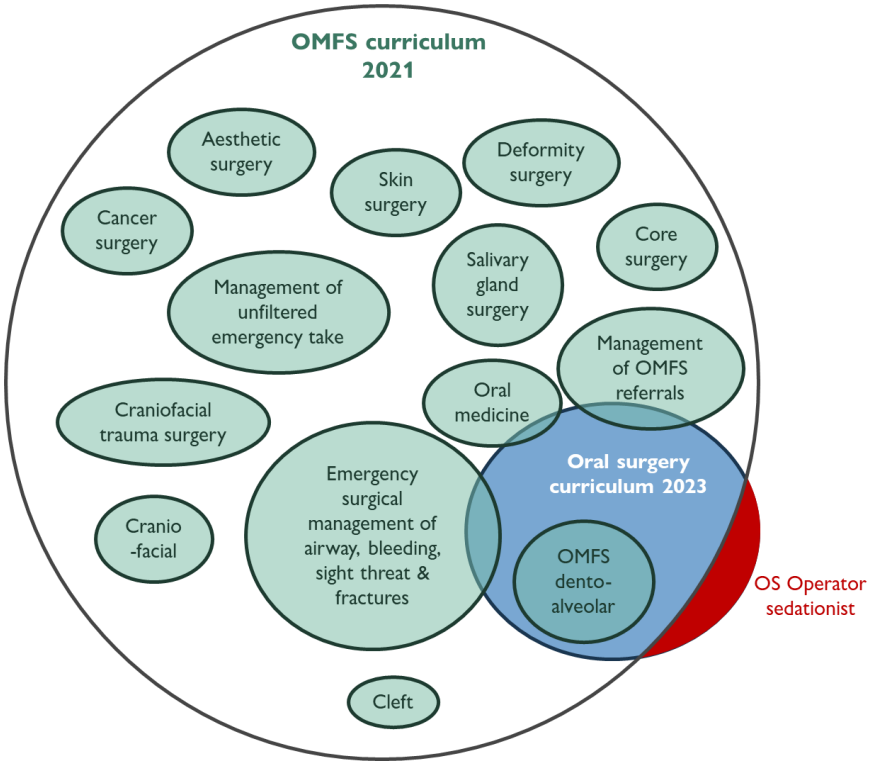
COVID 19 and changes in the NHS Dentistry Contract have reduced the amount of dental surgery provided in primary care. This burden can be directed at OMFS services in some regions but where there are efficient surgical services in primary care, this does not happen. In Northern Ireland the 'item for service' (fee paid per extraction) contract was never stopped[44] which allowed the development of primary care practices which in the year 2019 deliver almost 100,000 surgical treatments (table 3). In 2019 there was an 80:20 NHS to Private provision in these practices. Now the numbers are nearer 50:50.

Table 3. Dentoalveolar codes (OS procedures) performed in NHS primary care practices in Northern Ireland (population 1,885,000) [44]

"Claims"	"Overall Total"	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Extractions											
21	**Total**	**75,993**	**78,798**	**77,248**	**76,598**	**74,230**	**50,337**	**66,234**	**71,707**	**64,373**	**58,210**
2101	Extractions Of Teeth	75,985	78,781	77,231	76,583	74,213	50,333	66,224	71,693	64,359	58,200
2121	Add. Fee for visit	75,956	78,772	77,228	76,581	74,191	50,330	66,224	71,684	64,321	58,188
Surgical removal											
22	**Total**	**15,108**	**15,056**	**17,430**	**19,907**	**19,520**	**5,344**	**9,218**	**11,863**	**12,052**	**13,882**
2201	Rem. Buried Root -Soft Tissue Only	3,724	4,116	4,371	4,617	4,620	1,699	2,652	3,765	3,524	3,607
2202	Rem. Buried Root- Bone Rem Incisal / Canines	1,166	1,122	1,186	1,408	1,428	369	624	791	848	951
2203	Rem. Buried Root -Premolars Molars Ex. Eights	8,274	7,991	9,449	11,172	10,963	2,747	5,021	6,279	6,490	7,631
2204	Rem. Buried Root 3rd Molars Without Division	1,421	1,346	1,555	1,828	1,744	410	751	711	769	1,049
2205	3rd Molars Requiring Division	1,509	1,411	1,811	2,164	1,926	382	752	987	1,172	1,590
2211	Frenectomy	6	5	5	[d]	3	0	3	3	[d]	[d]
2221	Other Oral Surgery	50	84	127	113	108	34	42	49	35	42
Post Op											
23	**Total**	**5,390**	**5,761**	**5,845**	**5,998**	**5,770**	**2,644**	**3,314**	**3,917**	**3,712**	**3,595**
2301	Arrest Of Haemorrhage	299	316	241	251	292	115	153	243	245	189
2302	Removal Of Sutures	572	626	660	763	659	211	231	339	333	341
2311	Treatment Of Infected Sockets	4,620	4,950	5,078	5,147	4,967	2,367	2,972	3,406	3,212	3,132

Referral to treatment targets can create pressures to appoint workforce to deliver Oral Surgery care which can distract from developing and maintaining core OMFS services. SAS and Oral Surgery Specialists are trained in the Oral Surgery Curriculum[45] and their ability to provide OMFS care is limited[18].

Figure[18]. Oral Surgery Curriculum Overlap with OMFS Curriculum represented graphically - overlaps and differences are not to scale. *(Reproduced from Capanni PM et al Oral and Maxillofacial Surgery Curriculum (2021) and Oral Surgery Curriculum (2023): A forensic comparison of two documents)*



It might be expected that OMFS hub units which are located near dental schools, where there are significant numbers of oral surgery (OS) consultants and oral medicine (OM) consultants, would need fewer OMFS consultants per 100,000. This is not the case. Hub units co-located with dental schools require at least 1 / 100,000 OMFS consultants as these nearby OS and OM consultants cannot deliver OMFS services and generate OMFS referrals from outside the region.

Managing the transition

Currently OMFS Consultant Appointments are extremely competitive

Training units should consider proleptic appointments and, to be competitive in the appointment process, units should at least match the Liverpool Seniority Policy. Seniority is defined in Section 13 paragraph 7 of Consultants Terms and Conditions and guides the starting salary on the consultant. It states that all time working LTFT should be counted as Seniority when appointing to a consultant post and that OMFS consultants should not be disadvantaged by the time taken to complete their dual dental and medical/surgical training. In the Liverpool Policy Seniority =length of OMFS training =

time after first degree minus any time out of training minus 6 years (approximate time taken to become an Oral Surgery Consultant).

Strategic Approach to OMFS Service Provision

In the context of providing care which only OMFS consultants can provide, with attractive job plans and acceptable on-call rotas, requires a strategic approach to the provision of care at interfaces with other specialties. This is particularly the case in geographically isolated OMFS units where GIRFT recommends a consultant group of at least 6. Specialties whose care interfaces with the OMFS curriculum includes oral surgery, surgical dermatology and plastic surgery.

Retaining older consultants

The aging consultant workforce[21] and the length of OMFS training[46] means urgent changes are needed to make this target achievable in the medium term. To bridge the gap whilst numbers are expanded, efforts must be made to retain existing consultants.

Increasing Resident Numbers

There have been issues with recruitment to OMFS, but in the most recent recruitment round there were significantly more applicants than posts. Expanding resident numbers does not fall into the remit of Trusts or ICBs which host OMFS units, but there are actions such as ensuring Foundation and Core Doctors work in OMFS, employing second degree students as clinical fellows, and supporting post-CCT OMFS fellowships which can all actively support the specialty.

OMFS Fellow posts - developing fully run-through training models by supporting OMFS trainees who are second degree students.

On-call arrangements for OMFS can support training by the creation of 'fellow' posts for trainees who are undertaking second degree studies. This model works well[47,48] and can be cost-effective for Trusts and supportive of OMFS trainees.

Facilitating Overseas OMFS specialists working in the UK (supporting portfolio applications)

Overseas OMFS nations in Europe who were in the same category of OMFS in the EU Professional Qualifications Directive[49] on the night of Brexit can come to the UK to work but few do[41]. Other nations must apply to join the OMFS specialist list using a portfolio application. The dual degree requirement of OMFS means portfolio applications from SAS colleagues are extremely rare.

Trusts can create posts which support overseas OMFS specialists to assemble the portfolio required to successfully apply to join the OMFS specialist list and then become OMFS consultants.

References

1. Royal College of Surgeons in England. *Advancing the Surgical Workforce: 2025 UK Surgical Workforce Census Report*. https://www.rcseng.ac.uk/-/media/Files/RCS/Standards-and-research/2025-UK-Surgical-Workforce-Census.pdf (2025).
2. Morton, M. *Oral and Maxillofacial Surgery GIRFT Programme National Specialty Report*. https://gettingitrightfirsttime.co.uk/wp-content/uploads/2020/05/OMFS-Report-May20K.pdf (2018).
3. Morton, M. & GIRFT. *The Organisation of Oral and Maxillofacial Services: Developing Integrated Networks of Care*. https://gettingitrightfirsttime.co.uk/wp-content/uploads/2017/07/GIRFT-BAOMS-The-organisation-of-OMFS-services-Advice-Pack-July-2020.pdf (2020).
4. Dawson, C. *et al. Head and Neck Cancer - Getting It Right First Time - GIRFT*. https://gettingitrightfirsttime.co.uk/medical_specialties/head-and-neck-cancer/ (2025).
5. Elizabeth Jones. Hospital Dentistry - Getting It Right First Time - GIRFT Webpage. https://gettingitrightfirsttime.co.uk/medical_specialties/hospital-dentistry/ (2021).
6. Getting It Right First Time (GIRFT). *Further Faster Oral and Maxillofacial Surgery (OMFS GIRFT) - Checklists and Resource Links*. https://gettingitrightfirsttime.co.uk/wp-content/uploads/2025/09/FF-Handbook-OMFS-Master-August-2025.pdf (2025).
7. Elizabeth Jones. *Hospital Dentistry GIRFT Programme National Specialty Report February 2021 GIRFT*. https://gettingitrightfirsttime.co.uk/wp-content/uploads/2021/09/HospitalDentistryReport-Sept21j-1.pdf (2021).
8. UK Government. General Dental Services Statistics for Northern Ireland 2015-2026. https://www.gov.uk/government/statistics/general-dental-services-statistics-for-ni-quarter-2-202526 (2026).
9. UK Government. FIT FOR THE FUTURE: 10 Year Health Plan for England. https://www.england.nhs.uk/long-term-plan/.
10. British Medical Association (BMA). Working in the peri-retirement period: possible changes to working practices. https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/the-ageing-workforce/working-in-the-peri-retirement-period-possible-changes-to-working-practices (2026).
11. Magennis, P. *et al.* The UK Mentoring and Support Programme (MSP) for those considering a career in Oral and Maxillofacial Surgery (OMFS). A review of a 'Register Interest in OMFS' website and the MSP as two key resources created by the British Association of Oral and Maxillo. *Br. J. Oral Maxillofac. Surg.* **59**, 935–940 (2021).
12. Office of National Statistics. Population estimates for the UK, England, Wales, Scotland and Northern Ireland - Office for National Statistics. https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2024.
13. Huizing, F. *et al.* Bridging generational gaps in Surgery: A narrative review on values, well-being, and training preferences. *Surg.* **23**, 333–341 (2025).
14. Huizing, F. *et al.* Future surgeon: bridging the intergenerational gap. *Br. J. Surg.* **110**, 991–992 (2023).
15. Magennis, C. *et al.* Gender changes in oral and maxillofacial surgery (OMFS) in the UK 1996 to 2030. Current trends suggest gender parity of those joining the OMFS specialist list may be achieved by 2048. *Br. J. Oral Maxillofac. Surg.* **63**, 112–117 (2025).
16. Kazzazi, F. *et al.* Trends in Gender, Ethnicity and Less-Than-Full-Time Training among Reconstructive Plastic Surgery Registrars and Consultants between 2009 and 2020. *JPRAS Open* **41**, 428 (2024).

17. Magennis, P. & Begley, A. Oral Surgery (OS) Specialist List 2016 – What will happen when the grandfathers move on? *Br. J. Oral Maxillofac. Surg.* **54**, e120 (2016).

18. Capanni, P. M. M., Magill, S., Walker, T., Varley, I. & Magennis, P. Oral and Maxillofacial Surgery Curriculum (2021) and Oral Surgery Curriculum (2023): A forensic comparison of two documents. *Br. J. Oral Maxillofac. Surg.* **63**, 125–132 (2025).

19. Royal College of Surgeons of England. Developing a Modern Surgical Workforce. 1–16 https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/developing-a-modern-surgical-workforce/ (2008).

20. Royal College of Surgeons, E. Surgical Workforce Census Report 2011 — Royal College of Surgeons. https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/surgical-workforce-census/ (2011).

21. Magennis, P., Begley, A., Dhariwal, D. W., Smith, A. & Hutchison, I. Oral and Maxillofacial Surgery (OMFS) Consultant Workforce in the UK: Pension pressures, changing job-plans, changing demographics, recruitment issues and the COVID backlog in elective surgery mean that urgent action and strategic planning are needed. *Br. J. Oral Maxillofac. Surg.* **60**, e8–e9 (2022).

22. Magennis, P., Begley, A., Dhariwal, D. K., Smith, A. & Hutchison, I. Oral and Maxillofacial Surgery (OMFS) Consultant Workforce in the UK: reducing consultant numbers resulting from recruitment issues, pension pressures, changing job-plans, and demographics when combined with the COVID backlog in elective surgery, requires. *Br. J. Oral Maxillofac. Surg.* **60**, 14–19 (2022).

23. Royal College Of Surgeons England & Royal College of Surgeons. *Advancing the Surgical Workforce: 2023 UK Surgical Workforce Census Report*. https://www.rcseng.ac.uk/-/media/Files/RCS/Standards-and-research/RCS-Advancing-The-Surgical-Workforce-Digital.pdf (2024).

24. Woolley, E. & Laugharne, D. Oral and Maxillofacial Surgery Curriculum 2021. *General Medical Council* https://www.iscp.ac.uk/media/1105/oral-maxillofacial-surgery-curriculum-aug-2021-approved-oct-20.pdf (2020).

25. Royal College of Surgeons of England. Shaping the future of surgical training: our response to NHS England's Medical Education Review. https://www.rcseng.ac.uk/about-the-rcs/government-relations-and-consultation/nhs-englands-medical-education-review-response/ (2026).

26. Ellis, R. *et al.* The impact of disability on recruitment to higher surgical specialty training: A retrospective cohort study. *Surg.* **22**, 344–351 (2024).

27. Magennis, P. & Begley, A. Gender in Oral and Maxillofacial Surgery (OMFS) – trends and comparisons. *Br. J. Oral Maxillofac. Surg.* **54**, e127–e128 (2016).

28. Magennis, C. Study data in question if inaccurate 'NHS Digital' Information on oral and maxillofacial surgery (OMFS) Gender, ST numbers (+40%) or consultant numbers (-20%) are representative. *British Medical Journal* https://bmjopen.bmj.com/content/12/2/e055516.responses#study-data-in-question-if-inaccurate-nhs-digital-information-on-oral-and-maxillofacial-surgery-omfs-gender-st-numbers-40-or-consultant-numbers--20-are-representative (2022).

29. Henderson, J. Breaking Barriers: A Call for Change for Neurodivergent Surgeons. *Surgery International* https://surgery.international/breaking-barriers-a-call-for-change-for-neurodivergent-surgeons/ (2026).

30. El Boghdady, M. & Shinwari, H. Neurodiversity in surgery: Embracing cognitive difference in a demanding profession. *Surgeon* (2026) doi:10.1016/J.SURGE.2026.01.001.

31. Richards, R. *et al.* Toward late career transitioning: A proposal for academic

surgeons. *Can. J. Surg.* **60**, 355–358 (2017).

32. Robertson, D. D. & Smith, A. J. Significant increase in hospital admissions for the management of severe dental infection in England 2000–2020. *J. Infect.* **83**, 496–522 (2021).

33. NHS England. *Guide for Commissioning Oral Surgery and Oral Medicine*. https://www.dental-referrals.org/wp-content/uploads/2015/10/guid-comms-oral.pdf (2015).

34. Domah, F., Shah, R., Green, J. & Attard, A. Guide for Commissioning Oral Surgery.' Moving towards the future NHS? *Br. J. Oral Maxillofac. Surg.* **56**, e89 (2018).

35. Modgill, O. & Shah, A. Guide for commissioning oral surgery: the development of a calibration tool. *Br. Dent. J.* **228**, 623–629 (2020).

36. NHS England & NHSNetworks. Dental clinical standards and the role of managed clinical networks - NHS Networks. https://networks.nhs.uk/blog/dental-clinical-standards-and-the-role-of-managed-clinical-networks/ (2026).

37. NHS England SW. NHS England — South East » Oral Surgery Managed Clinical Network. https://www.england.nhs.uk/south-east/info-professionals/dental/info/kssldn/oral-surgery/ (2026).

38. Davies, R., Hammond, D., Magennis, P. & Hutchison, I. The BAOMS National Facial Injury Surveys: A Cross-Sectional Temporal Survey Study of the Facial Injury Tissue-Type presenting to UK Emergency Departments over 11 years. *Br. J. Oral Maxillofac. Surg.* **56**, e67–e68 (2018).

39. Olding, J., Olding, C., Bew, D. & Fan, K. Penetrating head & neck trauma - Epidemiology and injury characteristics in terror-related violence, interpersonal violence and deliberate self-harm at a level 1 trauma centre. *Surgeon* **17**, 133–138 (2019).

40. Hassanzadeh, H., Visavadia, B. & Yeung, E. Challenge of major knife crime related maxillofacial injuries. *Br. J. Oral Maxillofac. Surg.* **62**, 575–576 (2024).

41. Magennis, P. *et al.* United Kingdom immigration and emigration of oral and maxillofacial Surgery (OMFS) specialists 2000-2020: how might Brexit impact on OMFS? *Br. J. Oral Maxillofac. Surg.* **58**, 1304–1309 (2020).

42. Magennis, P., Dhariwal, D. K., Hölzle, F., Smith, A. & Hutchison, I. Impact of Brexit - 2020 may be the first year in a decade when no new Oral and Maxillofacial Surgery (OMFS) trainees or new OMFS specialists from Europe started working in the UK. *Br. J. Oral Maxillofac. Surg.* **60**, 86–87 (2022).

43. Magennis, P., Hölzle, F., Ulrich, H. P., Acero, J. & Hutchison, I. The specialty of oral and maxillofacial surgery (OMFS) in Europe – Part 1: service configuration, regulation, and provision. *Br. J. Oral Maxillofac. Surg.* **60**, 1332–1339 (2022).

44. Magennis, P., Ulrich, H.-P., Schneider, M. & Wiegner, J.-U. Oral and maxillofacial surgery in the United Kingdom and Germany. *Die MKG-Chirurgie 2024 174* **17**, 240–247 (2024).

45. General Dental Council. *Oral Surgery Specialty Training Curriculum*. https://www.gdc-uk.org/docs/default-source/quality-assurance/dental-specialty-training/specialty-curricula/oral-surgery-specialty-training-curriculum-2023_a.pdf?sfvrsn=8c7367ec_3/ Oral-Surgery-Specialty-Training-Curriculum-2023_a .pdf (2023).

46. Magennis, P., Begley, A., Douglas, J. & Dhariwal, D. K. Duration of specialty training in Oral and Maxillofacial Surgery in the United Kingdom for trainees joining the OMFS specialist list between 2002 and 2019. *Br. J. Oral Maxillofac. Surg.* **58**, 1282–1290 (2020).

47. Holden, A. M., Cabot, L. B., Turner, J. & Fan, K. Oral and maxillofacial surgery accelerated dental programme for medical graduates: a review of fourteen graduating years (2010-2023). *Br. J. Oral Maxillofac.*

Surg. **63**, 203–207 (2025).

48. Al-Najjar, Y., Rowe, A., Naredla, P., Magennis, P. & Smith, A. T. Three changes to reduce the loss of dual degree trainees from OMFS national specialty selection in the UK: evidence based proposals. *Br. J. Oral Maxillofac. Surg.* **60**, 36–41 (2022).

49. Office for Official Publications of the European Communities. *Recognition of Professional Qualifications in Practice - European Commission. European Comission* (2016).

Version control

Version	Changes	Approved by
2015	Original	BAOMS Council
2021	Post-covid amendments	AT Smith BAOMS Council
2026	Update	P Magennis / DJW Keith BAOMS Council