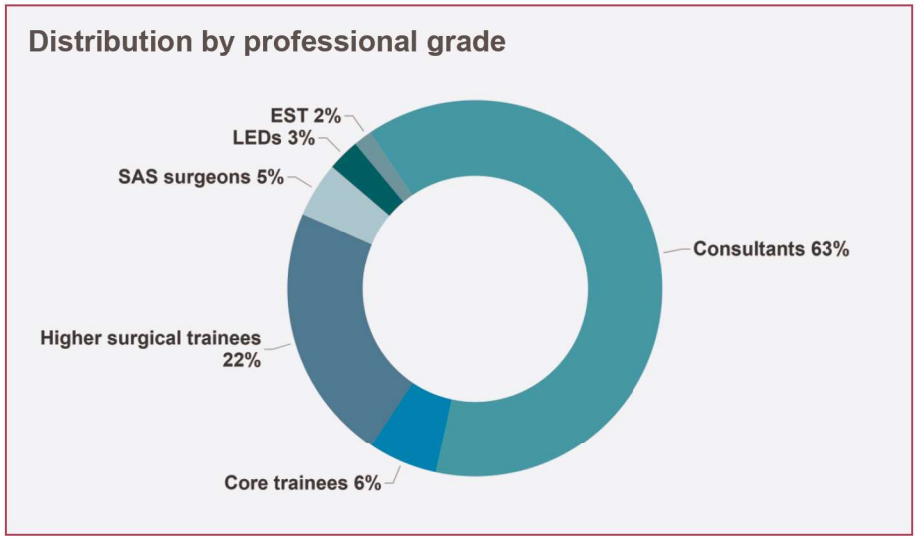
5. Oral and maxillofacial surgery

There were 253 responses from members of the surgical team who declared OMFS as their specialty.

5.1 Demographics

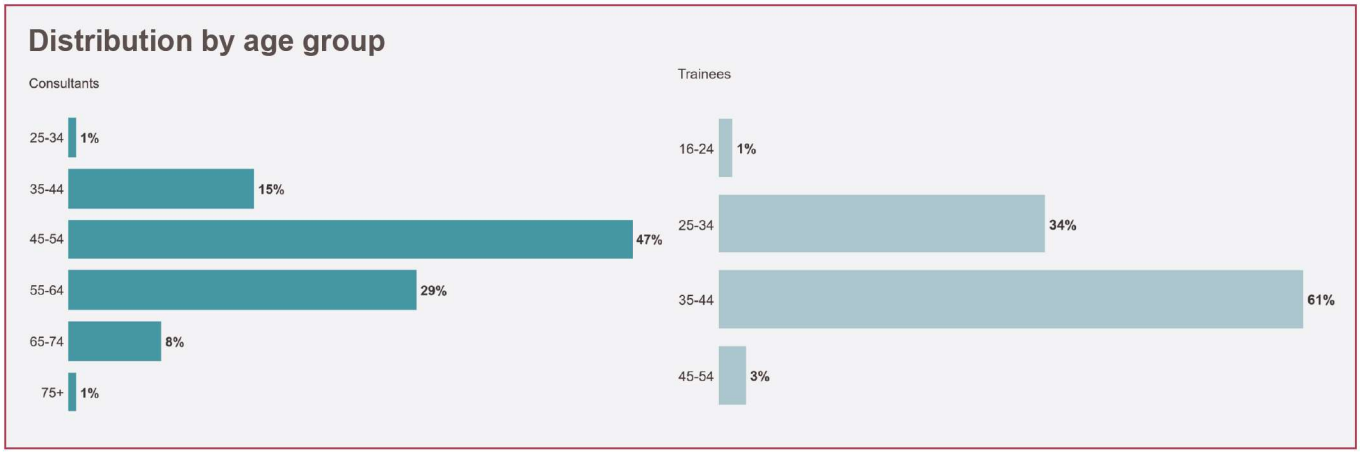


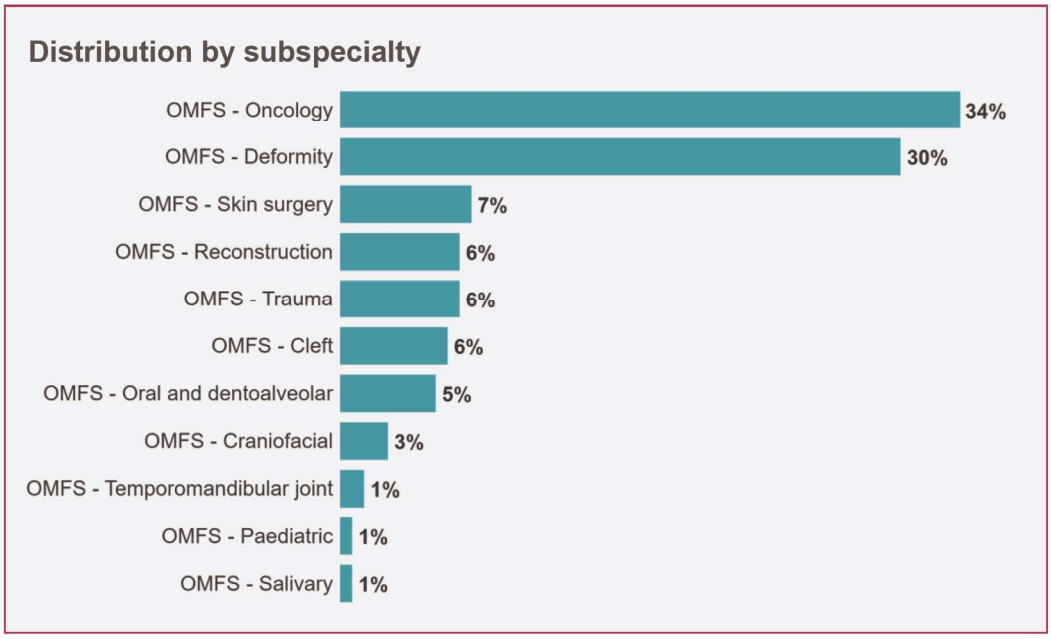
There were 159 responses from consultants and 71 from surgeons in training.

73% of the respondents were male and 26% were female.
Consultants: 81% male, 18% female
Trainees: 67% male, 33% female

Note: Where the sum of the respective "male" and "female" responses is less than 100%, the difference represents the percentage of respondents who selected other gender identities.

Women respondents are slightly over-represented in both consultant and trainee numbers compared with workforce figures.

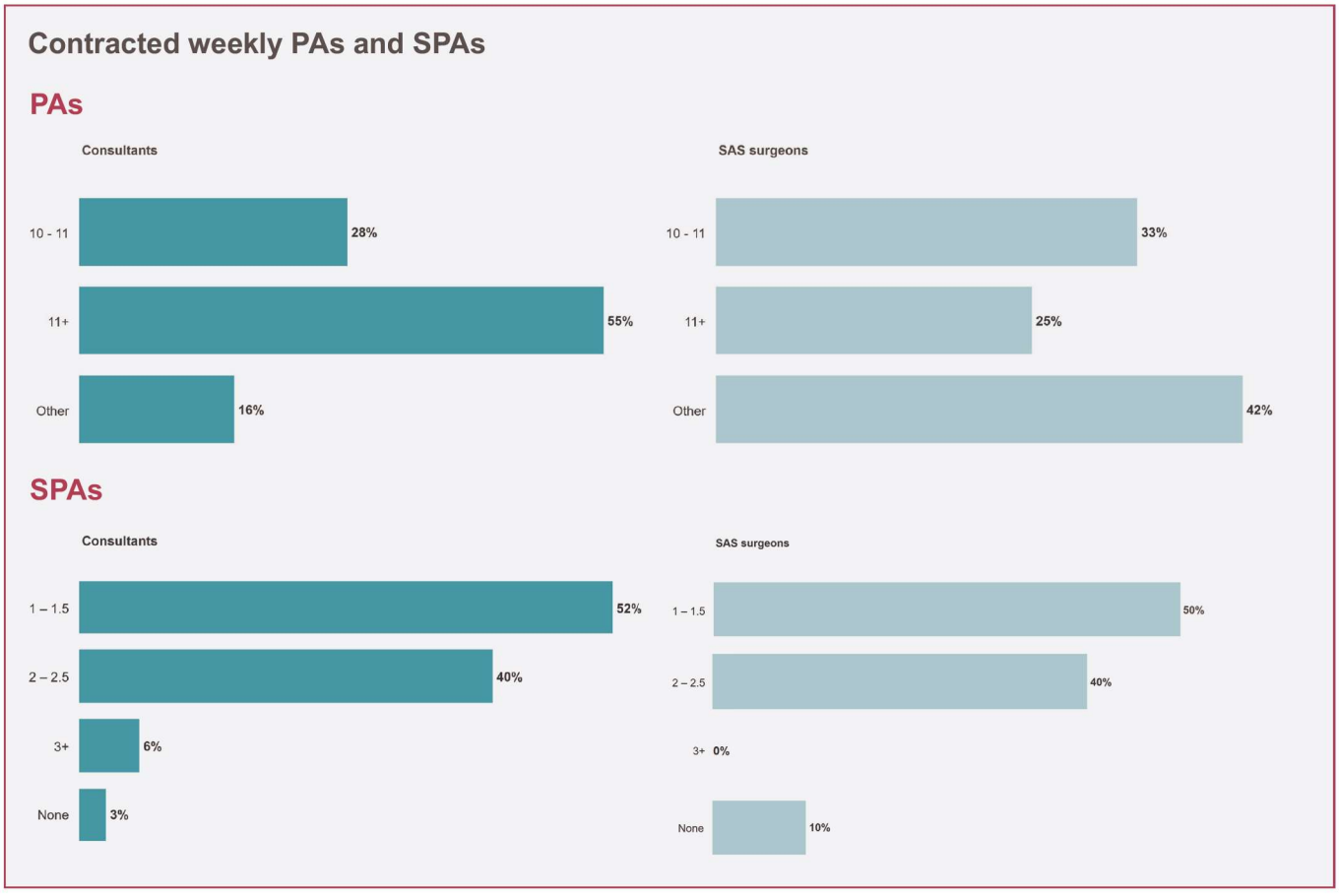




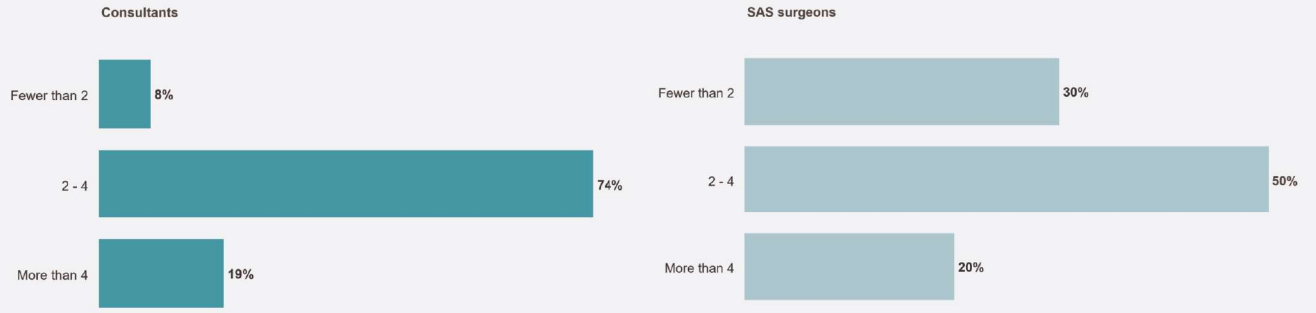
For most OMFS surgeons, the primary subspecialties are deformity and oncology. The census asked respondents to declare their primary subspecialty interest only and so this does not reflect other additional areas of interest they may have.

5.2 Job plans and activity

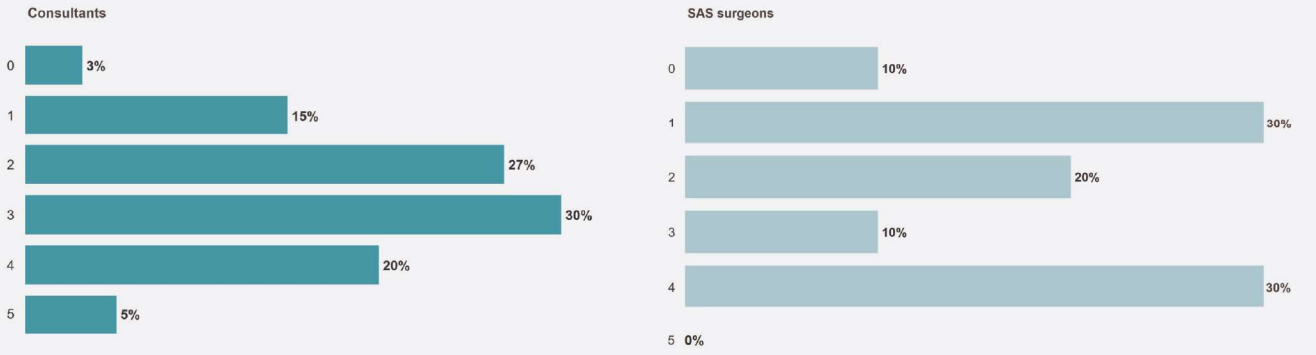
89% of respondents work full time while 11% work LTFT. There is evidence that more OMFS trainees and new consultants want to work LTFT to achieve a better work–life balance, and this applies to both male and female surgeons.



Weekly outpatient clinic activity

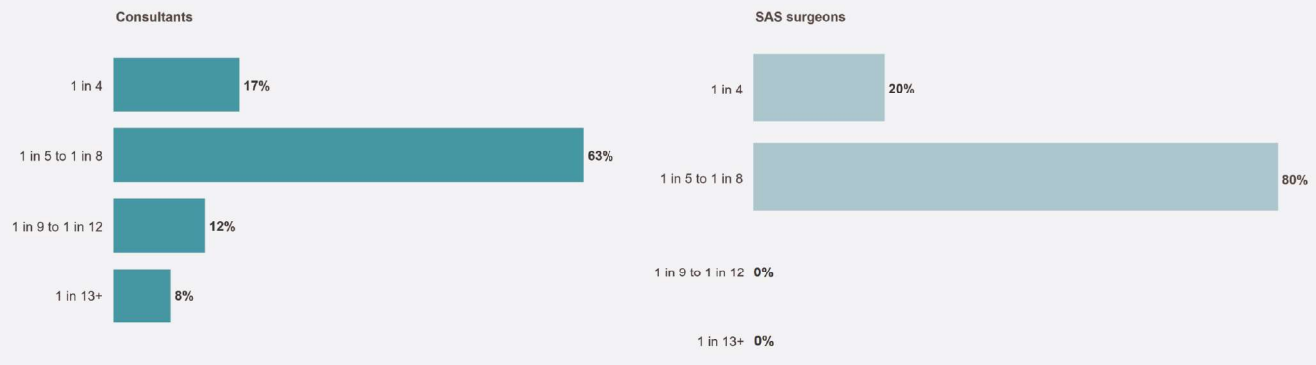


Scheduled weekly operating sessions



83% of consultants and 50% of SAS surgeons have an on-call commitment. None of the SAS surgeons are resident when on call.

Frequency of on-call commitments



5.3 Recruitment and retirement

There is a significant problem with recruitment, reflecting the requirement for dual medical and dental degrees. This is a particular issue for ST3 posts as ST1 posts are already oversubscribed. This is an area that can be expanded with increased ST1 run-through posts that have head and neck themed training posts.

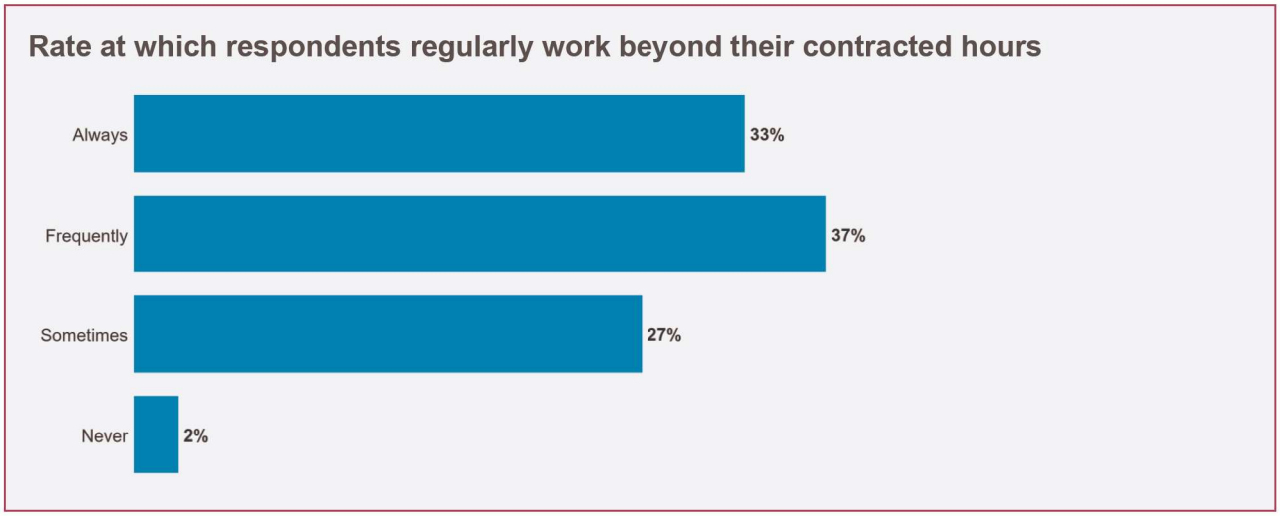
The consultant cohort in OMFS is older than for other specialties owing to the longer training duration. In addition, the specialty has the highest expected retirement rate, at 35% over the next four years. Consideration should be given to retaining older surgeons in the workforce as pensions and pay are one of the reasons for retirement.

It is predicted that there will soon be too few consultants to maintain service needs. Increased use of the hub and spoke model should be explored in areas where this is not yet in place so teams are larger with less onerous on-call commitments.

There are shortages in the East of England region and in Northern Ireland due to insufficient resources.

The higher proportion of women trainees will increase the number of women consultants in OMFS.

5.4 Change in working practices



20% of referrals from primary care are for oral conditions that are treated non-operatively.

Larger centres have a heavy trauma workload, which is not reflected in the data. (These centres have no elective commitment when on call.) The hub and spoke model can make this less onerous but will not work in all geographic areas.

The recent introduction of EPRs has greatly reduced the numbers of patients being seen in clinic, which in turn has reduced the number of cases for surgery. Improvements in EPRs and electronic dictation with better administrative support would improve efficiency.

SAS staff in OMFS are mainly dentists and their practice comprises predominantly dentoalveolar work. This group should be supported and developed in the workforce but because they are generally dentally qualified, they do not have the qualifications and opportunities to progress to consultant level as they would in other medical specialty posts via the portfolio route.