

## OMFS PROFORMA WITH EXPLANATION OF CHANGES

Domain: O - Objective / K - Knowledge / CS - Clinical skills / TS - Technical skills

### CURRICULUM (see tracking document 3)

Section	Page	Change	Reason
2.1	4	Addition of the words 'and Ireland'	Previous omission
3.5.1	12-13	Addition of generic paragraphs on genomics, clinical informatics and sustainability. Footnotes to further references added.	These paragraphs have been included in surgical curricula to emphasise the importance of emerging areas in healthcare, ensuring that trainees remain adaptable and informed as surgical practice evolves.
5.4	35	In the Management and leadership section – addition of 'across relevant health services and the variations between nations.	In response to lay/patient feedback, there is a recognised need to strengthen trainees' understanding of the structure and functioning of health systems across the UK. Knowledge limited to the trainee's immediate training jurisdiction may not sufficiently prepare them for the realities of working within or alongside other devolved health systems.
5.4	36	In the Clinical experience section – added wording – 'To ensure opportunities to acquire the breadth of curricular competencies in a variety of learning environments and cultures, trainees should, where geographically possible, complete a training programme that includes rotation through multiple units or sites. This recognises the importance of an ability to constructively compare different approaches to delivering surgical patient care and work-based cultures'.	To ensure optimal exposure and learning from different training cultures and environments, as well as clarifying the need for full curricula coverage. This is consistent with other curricula, namely Urology, Plastic Surgery and Otolaryngology
Throughout curriculum document		<ul style="list-style-type: none"> <li>Amended cover page date and additional authors related to this curriculum update</li> <li>Health Education England (HEE) replaced with NHS England (update)</li> <li>HEE local offices removed (update)</li> <li>Corrected hyperlinks (updates)</li> </ul>	Editorial updates

	<ul style="list-style-type: none"> <li>Minor changes in light of feedback – see summary of feedback and comments in track changes.</li> </ul>	
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**SYLLABUS (see tracking document 2)**

Appendix	Page	Change	Reason
Appendix 2 Syllabus	47	<p>Skill level description change.</p> <p>The words '<i>under direct supervision</i>' have been added to standard 2</p>	To clarify that, while trainees at this level can perform a straightforward procedure fluently, they must do so with continuous oversight from a supervisor to ensure patient safety and proper skill development. This addition also helps to better differentiate this level from others, particularly level 3, where trainees begin to work more independently.

Syllabus topic	Domain (O / K / CS / TS)	Change	Reason for change
<b>COMMON CORE</b>			
Basic sciences			
The clinical method in surgical practice			
Peri-operative care			
Basic surgical skills			
Critical care			
Surgical care of the paediatric patient			
Management of the dying patient			
Health promotion			
<b>MODULES</b>			
Airway		<b>Cricothyroidostomy (page 12) to cricothyroidotomy</b>	<b>Spelling</b>

Craniofacial trauma	CS	Under Clinical skills, subheading assessment, diagnosis and treatment planning (page 19) add Virtual planning 2,3,4	This has always been done and was an inadvertent omission in the previous curriculum. This competence level has been discussed at SAC and is appropriate to Phase 2. This competence level has been discussed at SAC and is appropriate to Phase 3. This competence level has been discussed at SAC and is appropriate to specialisation
Jaw deformity	<ol style="list-style-type: none"> <li>1. TS</li> <li>2. CS</li> <li>3. CS</li> <li>4. CS</li> <li>5. K</li> <li>6. CS</li> </ol>	<ol style="list-style-type: none"> <li>1. Under Orthognathic, mandibular ramus osteotomies (page 76) change the numbers required at Year 4 to 30 and the total numbers required from 30 to 40.</li> <li>2. Under clinical skills (page 25) add zygomatic osteotomy 2,4,4.</li> <li>3. Change the level of Le Fort 3 osteotomy (page 25) from 1,2,3 to 2,3,3.</li> <li>4. Add alloplastic onlays, chin and malar 2,4,4. (page 26)</li> <li>5. Applied anatomy, assessment, role of imaging (page 22) change level from 3,4,4 to 4,4,4.</li> <li>6. Clinical skills (page 24) add Non-surgical approach 2.4.4</li> </ol>	<ol style="list-style-type: none"> <li>1. 30 was a misprint and the requirement has always been a total of 40 with 30 required at Year 4</li> <li>2. This has always been performed and was an inadvertent omission in the previous curriculum.</li> <li>3. This is established practice and is more readily available to trainees either in their own regions or when they do craniofacial placement.</li> <li>4. This has always been done and was an inadvertent omission in the previous curriculum.</li> <li>5. This was a typographical error in the previous curriculum.</li> <li>6. Over several years this option has become accepted practice</li> </ol>
Facial pain and TMJ	<ol style="list-style-type: none"> <li>1. TS</li> <li>2. TS</li> </ol>	<ol style="list-style-type: none"> <li>1. Under operative management (page 29) delete arthroscopy of the TMJ 2,2,4; add level 1 arthroscopy of TMJ 2,3,4.</li> <li>2. Total replacement of TMJ change from 1,2,3 to 2,3,4 (page 29)</li> </ol>	<ol style="list-style-type: none"> <li>1. The change reflects evolution of practice with incorporation of minimally invasive techniques. Level1 arthroscopy of the TMJ is performed in most regions and is accepted as standard of care for diagnosis and initial treatment of temporomandibular dysfunction.</li> </ol>

			<p>2. Total replacement of the TMJ is now more widely performed in most regions and is regarded as the standard of care when conservative management and one open procedure fails. This is reflected in the higher competence levels expected, discussed at SAC with trainee involvement.</p>
Head and Neck	<ol style="list-style-type: none"> <li>1. K</li> <li>2. K</li> <li>3. K</li> <li>4. CS</li> </ol>	<ol style="list-style-type: none"> <li>1. Under pathology and diagnostics excluding thyroid and parathyroid glands (page 30), change the levels for molecular pathology of cancer from levels 3,3,3 to 3,4,4.</li> <li>2. For pathological techniques and relevance to diagnostic process (page 30), change the levels from 3,3,3 to 3,3,4.</li> <li>3. Under radiology / imaging and special investigations (pages 31), add Classification of MRONJ 4.4.4.</li> <li>4. Add dental implants 3,4,4. Add zygomatic implants 2,3,4 (page 36)</li> </ol>	<ol style="list-style-type: none"> <li>1. Since the last curriculum rewrite this is performed routinely as it informs type of adjuvant treatment, which is reflected in the higher competence levels expected.</li> <li>2. Since the last curriculum rewrite a wider variety of pathological techniques are performed routinely for diagnosis which is reflected in the higher competence level expected for this phase of training.</li> <li>3. This was an inadvertent omission when the curriculum was written. The competence levels reflect our better understanding of MRONJ and it's inclusion in the early stages of training.</li> <li>4. Dental implants and zygomatic implants are integral to prosthetic rehabilitation and were inadvertently omitted in the last curriculum. The competence levels have been discussed at SAC with trainee involvement.</li> </ol>
Conditions of the salivary glands			
Conditions of the oral mucosa			
Conditions of the skin module	<ol style="list-style-type: none"> <li>1. CS</li> <li>2. CS</li> </ol>	<ol style="list-style-type: none"> <li>1. Clinical skills (page 50) change levels for sentinel node biopsy from 1,1,1 to 2,3,4.</li> </ol>	<ol style="list-style-type: none"> <li>1. Since the last curriculum was written, this technique has become main stream and is established practice.</li> </ol>

		<ol style="list-style-type: none"> <li>2. Clinical skills (page 50) change levels for therapeutic lymphadenectomy from 2,2,4 to 2,3,4</li> </ol>	<ol style="list-style-type: none"> <li>2. The higher competence level is more appropriate to Phase 3 of training. The change has been discussed at SAC with trainee involvement.</li> </ol>
Restoration of normal aesthetic form and function	<ol style="list-style-type: none"> <li>1. CS</li> <li>2. CS</li> <li>3. CS</li> <li>4. CS</li> </ol>	<ol style="list-style-type: none"> <li>1. Correction of nasal deformity (page 54) change the levels from 2,2,4 to 2,3,4.</li> <li>2. Septal surgery to restore form and function (page 54) change the levels from 1,1,2 to 2,3,4.</li> <li>3. Secondary rhinoplasty techniques with indications for same (page 54) add the levels 1,2,4.</li> <li>4. Harvest of cartilage graft... (page 55) change the levels from 1,1,1 to 2,3,4</li> </ol>	<p>These changes in the competence levels here reflect the ease of availability and access of this surgical technique to trainees in their own regions, during an aesthetic placement in another region or when trainees assist in private practice.</p>
Cleft lip and palate			
Craniofacial			
Dentoalveolar	CS	<ol style="list-style-type: none"> <li>1. Peri-radicular surgery (page 72) change the level from 3,4,4 to 2,3,4</li> <li>2. Add Caldwell Luc antrostomy (page 71)</li> <li>3. Addition of Sinus lift crestal approach and sinus lift lateral approach (page 72)</li> <li>4. Remove indicative numbers for apical surgery (apicectomies) (page 75)</li> <li>5. Inclusion of the indicative numbers for Caldwell Luc Antrostomy, 2 at year 4 and 5 at certification (page 75)</li> </ol>	<ol style="list-style-type: none"> <li>1. The change in competence levels reflects an evolution in practice with less peri-radicular surgery being performed on teeth by oral and maxillofacial surgeons and proportionately more done by specialists in endodontics. Additionally with the advent of osseointegrated dental implants, peri-radicular surgery is not a favoured treatment option.</li> <li>2. This was an inadvertent omission from the previous curriculum and reflects feedback received from trainees</li> <li>3. This follows feedback received from trainees and reflects the adoption of this technique in mainstream OMFS practice.</li> </ol>

			<ol style="list-style-type: none"><li>4. With widespread use of osseointegrated dental implants, peri-radicular surgery is performed less commonly and then mainly by specialists in endodontics.</li><li>5. This follows feedback received from trainees and a review of their logbooks.</li></ol>
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