National Guidance for the Accreditation of Tier 2 Oral Surgery Dentists in England and Wales

Prepared for	Nationally standardised Tier 2 Oral Surgery accreditation framework
Purpose	To support a fair, transparent and clinically robust accreditation process for dentists seeking recognition as Tier 2 Oral Surgery performers, enabling a consistent and standardised approach across commissioners and ICBs
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1. Introduction

This document sets out national guidance for the accreditation of Tier 2 Oral Surgery practitioners in England and Wales, providing a transparent, consistent, and clinically robust framework aligned with the NHS Oral Surgery Commissioning Guide. Its purpose is to support commissioners, Managed Clinical Networks and providers in assuring that patients receive high-quality, safe, and effective oral surgery care delivered by practitioners with the appropriate level of skill, experience and governance.

The British Association of Oral Surgeons (BAOS), as the recognised professional body representing oral surgery in the UK, is uniquely and ideally placed to define the standard of clinical competence, training and professional development required of Tier 2 Oral Surgery performers. BAOS brings national clinical expertise, educational leadership and a deep understanding of workforce development across primary, community and secondary care settings. Through this guidance, BAOS supports a nationally consistent interpretation of the commissioning requirements, while allowing appropriate local flexibility in delivery.

The framework describes the expected standards of practice, eligibility criteria, routes to accreditation and minimum portfolio evidence required to demonstrate competence at Tier 2 level. It emphasises proportionate and defensible governance arrangements, including assessment processes, accreditation panels, maintenance of accreditation and appeals, all of which are mapped to NHS commissioning expectations and principles of clinical governance.

Central to this guidance is BAOS's core mission: to promote excellence in oral surgery through education, training and research for the benefit of patient care. By setting clear national standards and supporting fair accreditation processes, BAOS aims to enhance patient safety, improve quality and consistency of care, support professional development and provide assurance to commissioners and the public, that Tier 2 Oral Surgery services are delivered by appropriately skilled clinicians within robust governance frameworks.

The framework has been informed by the Guide for Commissioning Oral Surgery and Oral Medicine, the NHS Oral Surgery Clinical Standard, the Welsh accreditation model for dentists with enhanced skills in Oral Surgery and the current NHS England documents on Level 2 accreditation.

While commissioning arrangements in Scotland and Northern Ireland differ and this guidance is therefore not directly applicable within those systems, the document remains of relevance. The principles described, including assessment of competence, minimum evidence standards, clinical

governance expectations, and maintenance of accreditation, are transferable and could be used as a reference framework where commissioners or professional bodies seek to assess skill level, assure quality, or move towards greater standardisation of Tier 2 Oral Surgery provision.

With adoption across England and Wales, this guidance establishes a nationally standardised Tier 2 Oral Surgery accreditation framework for these two nations. It provides a consistent definition of the skill level, clinical competence and governance requirements expected of Tier 2 Oral Surgery practitioners, aligned to NHS commissioning principles and underpinned by professional standards set by the BAOS.

2. Tiered Oral Surgery Framework (Tier 1-3)

This section defines the Tier 1, Tier 2 (with a further partition into 2A and 2B) and Tier 3 oral surgery framework used to support consistent commissioning, workforce development and patient pathway design across England and Wales. The model reflects established national guidance, the NHS Oral Surgery Clinical Standard and the Guide for Commissioning Oral Surgery and Oral Medicine (whose original explanation is shown in the table that follows)

LEVEL 1 procedures/conditions (General Dental Practice) Extraction of erupted tooth/teeth including erupted uncomplicated third molars
• Effective management, including assessment for referral unerupted, impacted, ectopic and supernumerary teeth • Extraction as appropriate of buried roots (whether fractured during extraction or retained root fragments), • Understanding and assistance in the investigation, diagnosis and effective management of oral mucosal disease • Early referral of patients (using 2-week pathway) with possible pre-malignant or malignant lesions • Management of dental trauma including re-implantation of avulsed tooth/teeth • Management of haemorrhage following tooth/teeth extraction • Diagnosis and treatment of localised odontogenic infections and post-operative surgical complications with appropriate therapeutic agents • Diagnosis and referral patients with major odontogenic infections with the appropriate degree of urgency. • Recognition of disorders in patients with craniofacial pain including initial management of temporomandibular disorders and identification of those patients who require specialised management
LEVEL 2 procedures/conditions (Tier Two Oral Surgery)

- Surgical removal of uncomplicated third molars involving bone removal
- Surgical removal of buried roots and fractured or residual root fragments
- Management and surgical removal of uncomplicated ectopic teeth (including supernumerary teeth)
- Management and surgical exposure of teeth to include bonding of orthodontic bracket or chain
- Surgical endodontics
- Minor soft tissue surgery to remove apparent non-suspicious lesions with appropriate histopathological assessment and diagnosis.

LEVEL 3 procedure/conditions (Secondary Care Oral Surgery)

- Procedures involving soft/hard tissues where there is an increased risk of complications (such as nerve damage, displacement of fragments into the maxillary antrum and fracture of the mandible)
- Management and/or treatment of salivary gland disease
- Surgical removal of tooth/teeth/root(s) that may involve access into the maxillary antrum
- Management of temporomandibular disorders and craniofacial pain that have not responded to initial therapy
- Treatment of cysts
- Management of suspicious/non-suspicious oral lesions
- The placement of dental implants requiring complicated additional procedures such as bone grafting, sinus lifts etc.
- Treatment of complex dentoalveolar injuries
- Management of spreading infections and incision of abscesses (or abscess) requiring an extra-oral approach to drain

Depending on the complexity of the procedure, consultant-led care may be required to manage any of the above and, in addition, is required for the procedures listed below. These procedures will be delivered within a team (which may include specialist trainees, specialists and SAS grades) who have appropriate ability and facilities to provide high quality care for patients:

- management of jaw and facial fractures
- management of congenital and acquired jaw anomalies
- advanced oral implantology and bone augmentation
- diagnosis and treatment of anomalies and diseases of the TMJ

diagnosis and treatment of salivary gland diseases

The tiered approach ensures that oral surgery care is delivered:

- By clinicians with appropriate competence,
- In a setting proportionate to clinical risk,
- With effective use of primary, community and secondary care capacity.

This should allow commissioners to:

- Maintain routine care within general dental services,
- Prevent inappropriate escalation of low-complexity cases,
- Preserve enhanced and hospital capacity for more complex need.

Tier 1-Core Oral Surgery in Primary Care

Tier 1 comprises oral surgery procedures that fall within the expected competence of a General Dental Practitioner (GDP) and are safely delivered within routine primary dental care.

Tier 2 – Intermediate Complexity Oral Surgery (Delivered in Primary or Community Care Settings)

Tier 2 services manage cases that exceed Tier 1 complexity but do not require hospital-based specialist or consultant-led care. Evidence demonstrates that commissioning Tier 2 services improves access, reduces waiting times, and relieves pressure on secondary care services.

In Wales, Tier 2 competence is assured through the All-Wales DES accreditation process, which provides a nationally consistent, independently assessed register of clinicians available to commissioners. This model is increasingly referenced as good practice in workforce assurance.

Tier 2A – Dentists with Enhanced Skills (DES)

- Delivered by dentists who have demonstrated enhanced competence through an accredited portfolio-based process,
- Competence recognised formally,
- Practicing under specific Tier 2 commissioning arrangements.

Tier 2B – GDC-Recognised Oral Surgery Specialists or Experienced DES

- Delivered by GDC-registered Oral Surgery Specialists or an experienced DES,
- Still appropriate for primary or community settings,
- May manage greater surgical complexity or risk than Tier 2A within the same care setting.

The distinction between Tier 2A and Tier 2B enables commissioners to recognise varying levels of practitioner experience and expertise, from those developing their skills to specialists or more experienced dentists. It also provides a clear progression pathway for DES practitioners and supports flexible service models, while maintaining patient safety.

Tier 3 – Specialist / Consultant-Led Oral Surgery (Delivered in Secondary Care)

Tier 3 includes oral surgery that requires hospital infrastructure, advanced anaesthetic support, or

management of significant medical or surgical complexity.

Purpose in commissioning

- Reserved for patients who cannot be safely treated in primary or community settings,
- High-cost, low-volume provision requiring careful capacity protection.

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Table: Oral Surgery Procedures by Tier

Note: This table is illustrative and intended to support commissioning decisions. Final inclusion should be informed by local MCN guidance and risk assessment.

Procedure / Case Type	Tier 1 (GDP)	Tier 2A (DES)	Tier 2B (Specialist or Experienced DES)	Tier 3 (Hospital)
Simple exodontia	✓	✓ We will expect this only if the patient needs treatment with sedation	✓	✓ We will expect this only if the patient has extreme medical or dental anxiety needs
Surgical extraction (moderate difficulty)	×	✓	✓	✓ We will expect this only if the patient has extreme medical or dental anxiety needs
Surgical extraction (high difficulty/higher sinus or nerve risk)	×	×	✓	✓
Removal of buried or fractured roots	×	✓	✓	✓
Unerupted or impacted teeth (non-complex)	×	✓	✓	✓

Unerupted or impacted teeth (complex)	✗	✗	✓	✓
Third molar coronectomy	✗	✗	✓	✓
Apicectomy	✗	✓†	✓	✓
Oral soft tissue surgery / biopsy	✗	Limited*	Limited*	✓
Patients with mild medical complexity (ASA II)	✓	✓	✓	✓
Patients with significant medical complexity (ASA III+)	✗	Limited*	Limited*	✓
Need for IV sedation	✗	✓†	✓†	✓ We will expect this only if the patient has extreme medical or dental anxiety needs
Need for general anaesthesia	✗	✗	✗	✓

*Where explicitly supported by local commissioning arrangements and governance.

†Where appropriately commissioned, trained and supported

Why Tier 2 Accreditation Is Critical for Commissioners

1. Assured Clinical Quality

Formal Tier 2 accreditation provides transparent, defensible evidence of competence, reducing variability and reliance on informal credentialing processes.

2. Improved Access and Capacity

Commissioning Tier 2 services enables care to be delivered closer to home, reduces hospital waiting lists, and improves equity of access across geographies.

3. Workforce Sustainability

Tier 2 accreditation supports career progression, retention, and skill development without requiring entry into specialist training, aiding long-term workforce resilience.

4. System-Level Planning

A clear tiered framework supports:

- Route-to-care clarity for referrers,
- Predictable case-mix for providers,
- Better financial and activity modelling for commissioners.

Summary

The Tier 1–3 oral surgery framework, supported by Tier 2 accreditation, provides commissioners in England and Wales with a robust, scalable and quality-assured model for oral surgery service planning. It aligns case complexity with practitioner competence, supports efficient use of NHS resources, and underpins safe expansion of intermediate oral surgery services.

3. What the Oral Surgery Commissioning Guidance Expects of Tier 2 Performers

NHS England commissioning and clinical standard documents describe Tier 2 Oral Surgery as care involving procedural and/or patient complexity beyond routine primary dental practice, but which can usually be delivered in a suitable primary care setting by a clinician with enhanced skills and experience.

Commissioning expectation	Implication for accreditation
Appropriate referral assessment and triage	The dentist must be able to recognise which cases are suitable for Tier 2 care and which cases require referral onward to specialist or secondary care.
Independent delivery of intermediate-complexity oral surgery	The dentist must demonstrate current practical competence in the procedures and case types that fall within commissioned Tier 2 oral surgery.
Recognition of clinical limits	The dentist must show sound judgement, safe escalation, and awareness of personal and service boundaries.
Governance and networked practice	The dentist must work within Managed Clinical Network pathways and take part in audit, benchmarking, and quality assurance.
Patient-centred care	The dentist must demonstrate good communication, governance, valid consent, appropriate record keeping, and evidence of positive patient experience.

4. Purpose of accreditation

Accreditation should confirm that the applicant can safely and independently provide commissioned Tier 2 Oral Surgery care in an appropriate setting. It should give assurance that the performer has the knowledge, judgement, technical ability, governance awareness and patient-centred behaviours required for this role.

Importantly, accreditation should also provide clear assurance to commissioners, and transparency to patients, that Tier 2 Oral Surgery care is being delivered by practitioners who meet nationally agreed standards of competence and governance.

5. Principles

- The process should be transparent, nationally consistent, and evidence based.
- Accreditation should be based on demonstrated contemporary competence rather than title alone.
- The process should be proportionate and fair, with due regard to equality, diversity, and inclusion.
- Judgements should be based on multiple complementary sources of evidence.
- The framework should support both assessment and workforce development.
- This accreditation should be transferable across national ICBs.

6. Scope

This guidance applies to performer accreditation for dentists seeking recognition as Tier 2 Oral Surgery performers in England and Wales. It does not replace separate site and provider assurance requirements relating to facilities, equipment, staffing or contractual arrangements.

7. Eligibility to Apply

Requirement	Expected evidence
Primary qualification and registration	Recognised dental degree; full GDC registration; good standing.
NHS eligibility	On the NHS dental performers list or eligibility for inclusion on an NHS dental performers list in England or Wales, where applicable.
Indemnity	Current indemnity appropriate to the proposed scope of oral surgery practice.
Post-qualification experience	Normally at least 7 years post-qualification, including at least 2 years with significant oral surgery and/or OMFS exposure.
Current activity	Recent relevant oral surgery case mix and evidence of continued practice.

Relevant post-qualification experience may include DCT / SHO posts in Oral Surgery or OMFS, trust grade or specialty doctor posts, specialist practice attachments, supervised primary care oral surgery sessions, or community dental service posts with relevant case mix.

8. Routes to Accreditation

Route	Suitable applicants	Panel expectation
Route 1: Existing Oral Surgery Specialist	Clinicians who are already Oral Surgery Specialists will not need any further accreditation to work in Tier Two Oral Surgery.	Confirmation of specialist status should be the only requirement, along with a reference from a relevant colleague who confirms current practice in Oral Surgery
Route 2: Accredited via direct portfolio	Clinicians who already possess sufficient evidence of competence, recent activity and readiness for independent Tier 2 practice.	Full portfolio submitted for review with no substantial developmental gap.
Route 3: Partial accreditation via direct portfolio	Clinicians with strong experience but incomplete evidence. Clinicians with gaps in their skillset.	Accreditation panel may require additional WBAs, further case evidence, mentoring, or a defined period of supervised development; or some form of partial accreditation that can be managed with suitable triage at a practice level.

9. Standard Required for Accreditation

The panel should only award accreditation when it is satisfied that the applicant can independently and safely:

- assess and triage referrals appropriately;
- identify which cases are suitable for Tier 2 care and which require onward referral;
- diagnose, treatment plan and obtain valid consent;
- carry out relevant oral surgery procedures competently;

- manage common intra-operative and post-operative complications;
- communicate effectively with patients, carers, referrers and colleagues;
- maintain high standards of record keeping, governance, and professionalism.

10. Portfolio Evidence Requirements

Section	Core content	Why it matters	Suggested notes
1. Eligibility and identity	Qualification certificate, GDC registration, appropriate indemnity, performer number, declaration of good standing and personal statement.	Confirms legal and professional eligibility.	Application pack with cover sheet and document checklist.
1. Career history and oral surgery experience	Chronological CV showing all posts, oral surgery exposure, dates, WTE and supervisory arrangements.	Demonstrates maturity of experience and relevance of training.	Highlight DCT/OMFS and supervised OS sessions clearly.
1. Formal education and qualifications	MFDS/MJDF/equivalent; IACSD trained; PGCert/PGDip/MSc; validated oral surgery courses; radiology, consent and emergency training.	Supports the knowledge base but does not replace or demonstrate competence.	Qualifications should strengthen, not automatically confer, accreditation.
2 &3. Clinical logbook	Dated case log covering most recent 24 months, with range, supervision status, complexity (surgical and medical), complications and outcomes.	Provides the clearest picture of contemporary scope and judgement.	Quality, range, and recency are more important than raw numbers.
4. Work-based assessments	DOPS, CBDs, PBAs and other suitable WBAs or reflective logs from most recent 24 months practice. These should show range,	Tests practical competence and clinical judgement in a structured way.	Assessors should be suitable senior clinicians (OS/OMFS Consultants, Oral Surgery Specialists

	supervision status, complexity (surgical and medical), complications and outcomes.		or Senior DES).
5. Governance and professionalism	Audit, QI, appraisal, peer review, SEA, safeguarding, EDI, infection prevention, medical emergencies, and teaching where relevant.	Demonstrates reflective practice, organisational reliability and professional maturity.	Evidence should be current and proportionate.
6. Specialty-specific CPD	Oral surgery CPD log cross-referenced to competency domains.	Shows ongoing professional development and recency of knowledge.	Covering the previous 3–5 years.
7. Patient-centred practice	Patient feedback, PREMs, complaints, reflection, MSF, compliments, and communication examples.	Confirms that the dentist is not only technically capable but also safe and effective with patients.	Include anonymised example where useful.
8. References and referee reports	Two recent structured references, including at least one experienced DES, Specialist Oral Surgeon, Consultant in OS or Consultant in OMFS.	Independent corroboration of competence, professionalism, and communication.	Use a standard national referee form.

11. Suggested National Minimum Evidence Standard

Item	Suggested Minimum Standard
Post-qualification experience	Normally a minimum 7 years post qualification, including at least 2 years with significant oral surgery and/or OMFS exposure.

Clinical logbook	Recent logbook covering the previous 24 months, showing breadth, continuity and judgement. In the absence of DOPs/CBDs/PBAs, then the logbook should include detailed reflective logs of at least 20 cases.
DOPS	Minimum 10 DOPS, preferably from the previous 24 months.
CBDs	Minimum 5 CBDs, preferably from the previous 24 months.
PBAs	Minimum 5 PBAs, preferably from the previous 24 months.
Governance evidence	Evidence of audit / QI, appraisal, medical emergency training and core mandatory updates.
Patient-centred evidence	Evidence of patient feedback or equivalent, and reflective response where relevant. PROMS/PREMS records.
References	Two satisfactory professional references, including at least one experienced DES, Specialist Oral Surgeon, a consultant in OS or consultant in OMFS.

A national framework should not rely on case numbers alone. The minimum standard should be interpreted alongside the quality of evidence, case complexity, independence, judgement and patient-centred behaviours shown across the whole portfolio.

12. Accreditation Process

Stage	Description	Typical output
1. Administrative screening	Check completeness, eligibility, declarations, identity, and references.	Application accepted for review or returned for completion.
2. Clinical portfolio review	Panel reviews portfolio against national criteria.	Draft panel judgement and any queries.
3. Optional interview	Used where the portfolio is borderline or clarification of judgement, insight or scope is needed.	Clarified evidence base for decision.

4. Decision	Panel decides whether to accredit, accredit with conditions, or defer / not yet accredit.	Formal written outcome with reasons.
5. Entry to register	Successful applicants are recorded on the relevant accredited performer list or register.	Visibility to commissioners and MCNs.

13. Accreditation panel

Panels should operate to nationally consistent standards, declare conflicts of interest, and maintain a clear audit trail of decisions.

Suggested membership	Purpose
Chair, ideally independent or lay	Supports objectivity, fairness, and oversight.
Consultant in Oral Surgery	Provides specialty-specific clinical judgement.
GDC Specialist in Oral Surgery	Adds senior specialty perspective and breadth.
Managed Clinical Network representative	Connects accreditation to service pathways, benchmarking and quality assurance.
Commissioner / NHS England representative	Ensure alignment with commissioning expectations.
Experienced primary care representative	Brings practical service delivery perspective.
Administrative support	Supports process integrity, records, and communication.

The role of the panel is not a punitive one, its main purposes are to ensure patients' safety, and to help the maintenance and development of the oral surgery workforce in primary care. Even in the case of a rejection, the aim should always be to provide constructive feedback and solutions for any areas of an application that have been marked as below the necessary standard, so there are continuous development opportunities and the future of the Tier 2 Oral Surgery services is protected.

In those cases of partial accreditation/accreditation at Tier 2A level, the panel will offer advice on

restrictions that are necessary. At a practice level, there'll be a strong onus on their governance and triaging to help the Tier 2A DES work at a suitable level, together with training, completing CPD and being mentored as part of their career progression to Tier 2B accreditation.

14. Role of Managed Clinical Networks

In the NHS, a Managed Clinical Network (MCN) for Oral Surgery acts a consultant led, collaborative group that brings together clinicians from primary, secondary, and tertiary care to provide high quality, consistent and equitable patient care. Governed by the NHS, ICBs or PHBs, MCNs are designed to bridge the gap between different care providers, ensuring that patients receive the right treatment, at the right time, in the right place, regardless of organizational boundaries. They should-

- support consistent standards and referral thresholds;
- provide specialist linkage and quality assurance;
- support benchmarking, outcome review and audit;
- facilitate mentorship and developmental opportunities;
- help maintain a sustainable and safe Tier 2 workforce.

15. Maintaining Accreditation

Accreditation should not be permanent. A reasonable national approach would be reaccreditation every five years, supported by evidence of continued oral surgery activity, CPD, updated case log summary, audit / QI, appraisal, patient feedback, and current indemnity and GDC standing.

An Oral Surgery Specialist would not be expected to submit a logbook of cases as part of the Tier 2 accreditation or reaccreditation process. Recognition as a specialist is accepted as evidence of having met the required standards of training and competence.

However, the specialist may be asked to provide proportionate supporting evidence, such as a current curriculum vitae and confirmation of recent and relevant experience, including evidence of working within a primary care setting. This may be supported, where appropriate, by a clinical reference attesting to current scope of practice and suitability to deliver commissioned Tier 2 Oral Surgery care.

Reaccreditation domain	Expected evidence
Professional standing	Current GDC status, indemnity, and declarations.
Current practice	Summary of oral surgery activity and case mix during the reaccreditation period.
Capability maintenance	WBAs if indicated, reflective logs of notable cases or complications.
Governance	Audit/QI, SEA, complaints and incidents with learning, appraisal evidence.
CPD	CPD record showing learning relevant to oral surgery.

16. Appeals

Applicants should have access to a formal appeals process on grounds such as procedural irregularity, conflict of interest, factual error or failure to consider submitted evidence. Unsuccessful applicants should receive a written explanation, a summary of the deficits identified, and a clear description of the evidence needed for reapplication.

17. Summary Statement

Accreditation as a Tier 2 Oral Surgery performer in England and Wales should be awarded based on demonstrated contemporary competence. No single item of evidence should be sufficient on its own. The strongest decisions will be based on the combination of a credible CV and training history, recent and relevant post-qualification experience, a robust clinical logbook, structured WBAs, postgraduate qualifications where relevant, strong referee evidence, governance activity, and evidence that the dentist communicates well and provides good patient-centred care.

18. Source Documents

1 Guide for Commissioning Oral Surgery and Oral Medicine

2 A framework for the Accreditation Process of Dentists with Enhanced Skills in Oral Surgery in Wales.

3 NHS England: Guidance for Commissioners on the Accreditation of Performers of Level 2 Complexity Care.

4 NHS England: Provider Assurance Framework for Commissioning of Providers of Level 2 Complexity Care.

5 NHS England: Oral Surgery Clinical Standard.

6 NHS England: Introductory Guide for Commissioning Dental Specialties.

7 Accreditation Checklist for Referees – East of England, London and Lancashire Tier 2 Minor Oral Surgery