LETTERS TO THE EDITOR

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DENTIST LEADERSHIP

CDO: Vital Professional Adviser

Sir, Professor Wilson questioned whether the role of the Chief Dental Officer (CDO) (*New Chief Dental Officer – a changed role*, *BDJ* 2014; **218:** 1) had been weakened by the changes following the introduction of the Health and Social Care Act 2012. This response argues that the CDO role remains a vitally important and influential one.

Following the Act, the Department agreed that it would be sensible for NHS England to host the Chief Professional Officers and other leading clinical positions, including the CDO role. This recognised the central role that NHS England was to play in improving health outcomes for people in England, with less direct control from Ministers. This is an aim that I suspect many dentists would support.

Professor Wilson questioned whether as a result of these changes 'the profession ... may be left worse off in terms of high level advice to Ministers and the government'. This has not been the case. The CDO has continued to advise Ministers on topics ranging from dental contract reform to professional regulation. It is clear that Ministers very much value the CDO role and the perspective it can bring. The esteem in which the CDO's advice is held has not been diminished.

Furthermore, the CDO continues to make a contribution well beyond NHS England and the Department of Health. Since April 2013 the CDO has offered advice across Government including to the Department for the Environment and Rural Affairs on reducing the use of dental amalgam in order to comply with EU policy on minimising the impact of mercury on the environment. There has also been significant engagement with the Department for Business, Innovation and Skills around the numbers of dental students in training and the issue of products that are appropriate to use for both children and adults in tooth whitening.

This reality is confirmed by the job description for the new CDO which makes clear that the post holder will 'provide leadership and advice to the Department of Health (DH) to enable it to discharge its functions with regard to the dental profession, and to advise other government departments' and it explicitly names Ministers as recipients of advice.

The real substantive change to the CDO role following the reforms is not actually picked up by Professor Wilson. That is the enhanced part played by Public Health England in terms of preventing dental disease and championing initiatives such as fluoridation through its Director of Dental Public Health. This is only a diminution of the role if there is a feeling that there has to be one figurehead for all oral health issues. Arguably it is better to have a broader coalition committed to this agenda.

This leads to a further point – the issue of scale. Professor Wilson suggests the CDOs in the devolved administrations have a broader remit. This is not that surprising when you consider that Scotland has a population of 5.3 million, Wales 3.1 million and Northern Ireland 1.8 million. They are much smaller nations than England, with its 53.9 million inhabitants (www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population). In such a large health system, it is surely good to supplement the CDO role with other experts in policy, oral health and dentistry. Yet in doing this, the CDO role will always remain the most important and influential of all.

Finally, it is worth mentioning that the application process for the new CDO has never had a greater input from dentists with a professional advisory panel drawn from the Royal Colleges and the Dental School Council.

NEED, DEMAND AND TIME

Sir, I read the thoughtful, well referenced article on manpower planning in periodontology (*BDJ* 2014; **217:** 399-402) as someone with an interest in workforce planning in practice from Dentists with a Special Interest and at specialist level. The authors put the case very clearly based on the incidence of periodontal disease, this being the need for care, as to the number of specialists who might be required if all the disease is to be treated. From a workforce perspective this is only part of the equation as a needs-based model looks at maximum provision if all the need is to be met. Another part of the workforce equation to be considered is: which clinicians can deliver what aspects of the care required?

In addition there is the consideration of demand. How many patients want advanced periodontal therapy? How many will comply with regimes? My clinical experience over 30 years in general practice indicates that only a few of those with moderately severe periodontal disease wish to have the full gambit of therapies; most prefer to opt for a simpler therapy and accept the long-term outcome rather than go through regular treatments. The authors suggest that 14.3% might need specialist care. From a workforce perspective if demand for advanced therapy from a specialist is less than one third then the workforce plan would be very different. This is before one considers who can deliver the care.

Paul Batchelor (*BDJ* 2014; **217:** 405–409) in the same edition notes that there is little evidence to support the use of routine scaling and polishing. I think all authors agree that regular review of oral hygiene (OH) and re-enforcement is of value to all patients. If a preventive approach is adopted and referral to intermediate and specialist is based on compliance with OH regimes then the workforce need may be considerably less. Sadly, the biggest challenge is gaining patient compliance with regular OH regimes and this perhaps requires the dental team to develop communication and motivational skills, and having the time to talk and more especially listen to patients.

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