young children, but there is still the problem of funding. There is no new money to support this important policy goal. And with the cash-limited system we have in England, DCby1 presents real challenges. Under the current GDS contract some colleagues may have spare UDA capacity – but many can do no more than swap one group of patients for another.

We want this scheme to succeed, but for that to happen, the funding situation must change. The worthy sentiment behind the initiative will be lost on parents in West Yorkshire, who are unable to access NHS care for themselves or their children. Sadly in too many areas DCby1 is a promise that simply cannot be kept without additional resource.

This comes as the CDO's Starting Well programme kicks off in 13 locations across England. We all know there are serious problems with health inequalities in many areas, especially for children, but when the response in London is limited to action in just three wards in Ealing it is hard to see this plan making a substantial difference. I remind readers that this initiative is not being billed as a pilot. Lessons are not going to be bottled and shared. This is a limited effort in a handful of sites. A cost-free box tick for government on a manifesto pledge – targeting taken to extremes without the scope for transformative change in health outcomes.

In Scotland ChildSmile has worked because it has sought to deliver the appropriate combination of universal and targeted effort: a basic offer for all, a bit extra for those that need it delivered through practices. Genuine outreach that's shaving millions off treatment bills, made possible by a coherent strategy and dedicated investment.

NHS dentists are used to seeing the 'middle class worried well' and their kids. The risk is that we are not seeing the resources or the will to get genuinely 'hard to reach' patients seen by age one, or indeed by any age. Recycling a fraction of existing budgets will only take us so far. Keeping clawback money in dentistry is a step in the right direction – after all we have £85 million unaccounted for – but the sums are small change compared to the health challenge we face.

Authorities, local and national, in England have not yet woken up to the logic of investment and return in oral health services and we urge them to put resources in so DCby1 and Starting Well can become the seeds of a comprehensive programme. I know our position has led some quarters to accuse us of needless negativity. Nothing could be further from the truth. We believe in the power of health professionals, parents and government to deliver – together – transformative changes to children's health.

We urge practitioners with capacity to get involved in DCby1. We only wish it wasn't a hard choice or a numbers game for any GDP. What we seek is a real, coordinated, resourced, strategic effort to get young hard to reach patients in England receiving the care they desperately need. We are still waiting.

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Orthodontics

Hammer horror

Sir, accurate and timely written correspondence between orthodontists and referring dentists is essential, particularly when requesting extractions. In keeping with NHS guidance[1] these letters are now commonly copied to the patient or parent. This has a number of advantages including improving a patient's understanding of the care they are receiving and empowering young people to take more responsibility for their own health.[1,2] However, a recent incident with a shared case has cautioned us to rethink whether this is always desirable.

We referred a 12-year-old boy with autism spectrum disorder from our community-based specialist paediatric dentistry service to our hospital orthodontic department. The orthodontist wrote back requesting extraction of primary canines. Waking early during the school holidays our patient was first downstairs to find the post on the doormat. On seeing his own name on a letter addressed to 'Parent of…' he opened and read it, promptly deciding to complete the requested extractions himself. Fortunately, his sister heard him in the garage and removed a hammer from his hand before it was too late. His parents were understandably shaken and concerned. He was known to be anxious about the proposed extractions but no one had anticipated this scenario.

It can be difficult to judge children's level of understanding, especially in those who display limited verbal communication in the dental setting. This may result in risk of either under- or over-estimating a child's anxiety and ability to cope with treatment, even in the hands of experienced dentists.[3] Self-extraction or other oral self-injurious behaviour has been described before in children with autism[4-6] but not to our knowledge as a manifestation of dental anxiety about proposed treatment nor prompted by a copy of clinical correspondence.

As NHS services come under increasing pressure to deliver efficiency savings, a one-size-fits-all policy on copying correspondence to the patient appears to be an attractive solution with patients' information needs at its heart. However, our experience reminds us that we must never lose sight of getting to know our patients as individuals so that, whenever possible, we can predict the likely effect of our communication and take care to word individual letters accordingly.[7] Furthermore it has prompted us to remember that it is good practice to obtain patient or parental consent to receive copy letters.[1,7]

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Oral health

The loss of Jimmy Steele

Sir, we write to mourn the untimely loss of Jimmy Steele, one of the brightest stars in dentistry. He articulated his vision in the introductory letter to the 'Steele Report' – NHS dental services in England (June 2009).[1]

'Oral health is for the long term and I believe in getting some simple things right. Putting these basics in place is more about co-ordination than money. If it can be done now we can build a national oral health service fit for the 21st century with an oral health legacy to match.'

Implementing his vision would be a fitting epitaph for a dear colleague and friend.

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