Letters to the Editor

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Priority will be given to letters less than 500 words long.
Authors must sign the letter, which may be edited for reasons of space.

NAÏVE ARGUMENT

Sir, oh dear, where to start? I settled down with interest to read the opinion article *People with learning disabilities and specialist services* (*BDJ* 2010; **208:** 203-205). Sadly, I was soon disillusioned by what in my opinion is the rather naive argument put forward by the authors. Throughout the paper, definitions (or part of them) and parts of articles are taken out of context and an interpretation is put on them that could not be made were they in the context of the full original text.

The authors seem to have misconstrued the whole ethos of the specialty of special care dentistry (SCD) which is to encourage patient care in primary care services (both by general dental practice teams and dentists with a special interest), and seem to have missed the fact that GDPs may also be specialists. Specialists and consultants in SCD act, as within all other dental specialties, to provide care that the GDP believes is beyond her/his scope; to provide mentoring, training and support to enable members of the dental team to expand their skills set in SCD; and to encourage shared care between the generalist and specialist care providers. Consultants in SCD also take a lead in service development through working with commissioners, providers and users of the service. Above all else, SCD takes a patient-centred approach, putting patient and public engagement (which is a legislative requirement for public bodies anyway) at the heart of service provision and development.

However, rather than go on at length, I will restrict myself to the three points in the 'in brief' box which authors provide as a potted summary of an article's key messages.

Taking them in turn, the first states 'Raises concerns for provision of specialist services for people with a learning disability'. The article puts forward one concern for which it provides no evidence. The next claims that the article 'Discusses the importance of including enhanced payments for GDPs to allow extra time necessary for care'. Not really, it puts it forward as a way of providing more time for non-salaried dentists to be encouraged to provide care for people with a learning disability. Interestingly, incentive payments have been in place in general medical practice in some primary care trusts (PCTs) for the best part of two years now, and they have not worked in the way PCTs had hoped. There has been little increase in provision of an annual health check for people with learning disabilities since the incentive payment introduction. Nor will they work until other barriers, such as practitioner confidence and skills, are addressed. Thirdly, the authors claim the article 'suggests a model of access for primary care organisations when commissioning dental services'. It mentions six dimensions of access. These are well recognised and were distilled from the seminal works of Penchansky, Thomas and Maxwell in the early 1980s. However, the article goes no further in its explanation of how these domains are configured into 'the model'. Indeed, the reader is referred to a yet unpublished paper for further details. The usual practice of using published evidence to support the argument allows the reader to refer to it for further information. I look forward to gaining a better understanding of the proposed model for improving access by reading the article *Access to dental services for people with learning disabilities: quality care?* in its entirety, although I may have to wait a while as I note that it was only submitted for consideration for publication in November 2009.

J. Fiske MBE, by email

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INSUFFICIENT INSIGHT

Sir, the opinion piece *People with learning disabilities...* by Owens, Dyer and Mistry (*BDJ* 2010; **208:** 203-205) reminds us of the inequalities in access to dental care faced by people with learning disabilities (PwaLD). However, its assertion that the speciality of special care dentistry (SCD) will adversely affect access to dental care is misguided and it shows insufficient insight into the reasons why people with a learning disability do not access dental care.

Its fundamental mistake is to treat access to dental care in isolation and not to acknowledge the lack of access to a full range of health services and the unsatisfactory care often experienced.[1] The previous work on access to dental services for people with learning disabilities, carried out by the salaried dental services and learning disability services in Sheffield[2] involved extensive collaborative effort between dental services and community learning disability teams. Other studies have shown that the issues are more complex than simply making dental services more accessible.[3] Well resourced Community Learning Disability Nursing Teams are essential in facilitating access to health services and this of course would include dental services. Community based consultants and specialists in SCD not only have a role in treating the most complex PwaLD but have an important leadership role. They should be involved in developing pathways of