‘Without rapid progress on prevention and access, there is a real risk that these early gains will stall or reverse’

BDJ In Practice spoke to British Society of Paediatric Dentistry President, **Dr Urshla (Oosh) Devalia**, about the state of the nation’s children’s oral health and where improvements can – and need – to be made.

How would you describe the current state of children’s oral health across the UK?

UD Children’s oral health across the UK remains deeply unequal, with stark and persistent regional and socio economic gaps, and hospital extractions for decay still a leading cause of child admissions among 5–9-year-olds. Children in more deprived communities are several times more likely to be admitted for extractions than their more affluent peers. There is a clear social gradient, reinforcing wider child health inequalities. The most recent survey of 5 year olds in England shows that just over one in five children have experienced obvious decay into dentine, with each affected child having on average more than three teeth involved. Access problems compound this picture, with large proportions of children not seeing an NHS dentist in the previous year, particularly in parts of England.

Long waiting times for extractions remains an issue. Why is this still the case in 2025?

UD Dental extractions under general anaesthetic remain the single largest reason for children’s hospital admissions, yet elective recovery in paediatric theatres has not kept pace with post-pandemic demand. Data from several UK nations show children waiting well over a year, and in some areas close to three years, for extractions under GA, with the longest waits affecting children with additional needs who require care in specialist centres.

These waits reflect a combination of constrained theatre capacity, workforce pressures in paediatric dentistry and anaesthesia, and competition for limited lists with other paediatric specialties. Inadequate prevention and poor access to timely primary care mean more children present late with extensive decay and pain, fuelling demand for hospital-based care that the system is not currently resourced to absorb.

You launched a charter asking for good oral health for every child in the UK. What needs to happen to see this move from rhetoric to reality?

UD Children are our urgent priority, and turning a charter for ‘good oral health for every child’ into policy which will then inform delivery requires national governments and local systems to embed oral health in mainstream child health policy, with clear accountability, data and investment. That means scaling evidence-based prevention, including supervised toothbrushing and professionally applied fluoride varnish, at least twice yearly for all children, with higher frequency for those at increased risk, improving access to NHS dentistry for children, and aligning

commissioning so that community, hospital, and public health teams can plan capacity together rather than in silos.

There is now strong evidence that targeted supervised toothbrushing schemes in primary schools and early year settings can reduce decay, narrow inequalities and cut-down treatment needs, including GAs, while offering good return on investment. For every £1 invested in the NHS supervised toothbrushing programme it is estimated to save an estimated £3 in avoided treatment costs over a five-year period. BSPD will continue to press for long-term funding for such programmes, better measurement of GA waiting times across all nations, and workforce planning that ensures every child can access timely, child-centred dental care close to home.

Recent news reports highlight the drop in levels of adult oral health in England to a level not seen in 25 years. Are you concerned these statistics will translate to data seen in children in subsequent reports?

UD These reports reflect a combination of access challenges, cost-of-living pressures and behaviour changes. It is highly likely that the same underlying drivers – reduced access, dietary pressures, and widening inequalities – will be mirrored in future children's datasets unless there is sustained, targeted intervention.

However, the most recent child survey data show a modest overall improvement in decay levels in 5-year-olds, masking significant regional deterioration in some areas and persistent high disease in the most deprived regions. Without rapid progress on prevention and access, there is a real risk that these early gains will stall or reverse, particularly in communities already carrying the highest burden.

There are significant changes coming in Wales and England. Is this the biggest opportunity to include wider oral health improvements for children?

UD Planned changes to dental contracts and service models in Wales, and potential reforms in England, represent a major opportunity to put children's oral health and prevention at the centre of system design. In Wales, there is already a strong foundation in population-based prevention and targeted programmes, while in England, policy proposals on supervised toothbrushing, expanding water fluoridation, and tackling commercial determinants can be leveraged to deliver real change.

To capitalise on this, reforms must hard wire prevention incentives, protect time and funding for community dental services, and ensure robust data recording on access and outcomes for children. Cross-sector collaboration across all health and social care settings, education, early years, public health and local government will be essential to translate these structural changes into fewer extractions, better school readiness and narrower health inequalities.

Supervised toothbrushing programmes were announced and rolled out in 2026. When would we reasonably expect results of these to trickle through?

UD Evidence from UK and international programmes shows measurable reductions in caries prevalence can be seen within 12 months for children in the most deprived groups once supervised toothbrushing is implemented at scale. Across the wider child population, significant benefits tend to accrue over 24–36 months and beyond, particularly when participation is sustained over multiple school years.

Economic evaluations from programmes such as Childsmile in Scotland suggest that the investment can effectively 'pay for itself' within around three years through reduced treatment need and fewer GAs. For parents and schools, this means some early signals – fewer episodes of pain and urgent visits – within a year, with more substantial shifts in survey data and hospital activity expected over three to five years.

Designed to Smile in Wales is often seen as the gold standard in children's oral health programmes – and there are hopes it will roll out to more children. Is this a programme that you think should be rolled out in other areas of the UK?

UD Designed to Smile in Wales is widely regarded as a leading example of a comprehensive, partnership-based child oral health programme, combining supervised toothbrushing, fluoride varnish, and the provision of toothbrushes and toothpaste to families. Evaluations have demonstrated improvements in children's oral health, cost effectiveness, and particular benefit for those in the most deprived communities, aligning closely with NICE recommendations and UK wide public health guidance.

The core principles of Designed to Smile – targeted, school-based prevention, strong collaboration between community dental services and public health, and sustained funding – are directly transferable to other parts of the UK. BSPD would support the adaptation of this model, alongside learning from programmes such as Childsmile, to create consistent, high-quality, nationally supported prevention offers for children in England, Scotland and Northern Ireland. ◆

Bio

Dr Urshla Devalia, widely known as Oosh, is a highly respected Consultant in Paediatric Dentistry, recognised for her clinical expertise, leadership, and dedication to improving oral health for children and vulnerable groups across the UK.

Dr Devalia serves as Consultant in Paediatric Dentistry at the Royal National ENT & Eastman Dental Hospitals, University College London Hospitals NHS Trust, and as Consultant & Strategic Clinical Lead for Community Dental Services CiC across the East of England. She holds the role of Managed Clinical Network Chair for Paediatric Dentistry for NHS England (East of England), represents the National Paediatric Dental MCN as Chair, and is the National Lead for Mini Mouth Care Matters (Mini MCM).

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