

# Inclusive dentistry

Exploring ways to improve access to dental care for people experiencing homelessness



Homeless Link

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Homeless Link and Groundswell, as part of the Homeless Health Consortium of the Health and Wellbeing Alliance

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### Introduction

People experiencing homelessness do not simply lack a permanent address, they experience multiple disadvantage and face some of the worst health outcomes in our society. This is reflected across the work of the Homeless Health Consortium members, including, for example, *The Unhealthy State of Homelessness 2022*<sup>1</sup>, and *Bridging the Health Gap*<sup>2</sup>. Some of the stark inequalities people experiencing homelessness face are driven by a combination of social determinants and poor access to services. This is equally so when it comes to the oral health and the ability to access dental services.

Good oral hygiene practices are an essential element of maintaining good oral health. However, some of the social determinants of homelessness can make it difficult for people experiencing homelessness to prevent poor oral health. This paper looks at what dental services are available to people experiencing homelessness to meet their treatment needs, people's experiences of accessing dental services, and the benefits of providing dental services tailored to the needs of people experiencing homelessness.

The difficulties faced by people experiencing homelessness in accessing dental services are varied and can be significant. They range from a lack of information about how dental services work, to being refused care from a dental practice. In common with other socially excluded groups, many people experiencing homelessness have endured trauma, which can also affect their ability to seek and receive treatment.

Further, the way in which NHS dental services are commissioned from practitioners and how they are paid for may not be optimal when it comes to incentivising dental practices to provide care for people experiencing homelessness, who are often vulnerable and with complex treatment needs. However, dental treatment that is tailored to the needs of people experiencing homelessness can make a significant difference to overcoming such obstacles, thereby securing improved oral health outcomes for this group.

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<sup>1</sup> <https://homeless.org.uk/news/the-unhealthy-state-of-homelessness/>

<sup>2</sup> <https://homeless.org.uk/knowledge-hub/bridging-the-gap-understanding-the-health-care-support-and-training-needs-of-frontline-workers-supporting-people-experiencing-homelessness/>

The objectives of this paper are to:

- Understand why people experiencing homelessness might struggle to maintain good oral health and access dental services. This will include feedback from a focus group of Experts by Experience.
- Look at the different types of NHS dental service and how people experiencing homelessness can be supported to receive treatment.
- Investigate alternative models of dental care, developed specifically with people experiencing homelessness in mind.
- Offer some recommendations as to how access to dental services can be improved.

### Common experiences

For some people experiencing homelessness difficulty maintaining good oral health might be as simple as not having regular access to anywhere they can brush their teeth. However, people experiencing homelessness often have multiple and complex vulnerabilities, which mean they may not be able to prioritise good oral health at all. In some cases, their vulnerabilities may unintentionally exacerbate a decline in their oral health.

People experiencing homelessness can struggle with poor mental health and low self-esteem, which reduces an individual's motivation for self-care.<sup>3</sup> This includes seeking treatment for health concerns and can be exacerbated by the fact that the health determinants of people experiencing homelessness are often poor to begin with, when compared with the general population. This can lead people to underestimate their health needs or dismiss milder concerns, rather than seeking treatment.<sup>4</sup>

Tobacco smoking is very prevalent amongst people experiencing homelessness, with various surveys recording between 76% and 85% of respondents being current smokers.<sup>5</sup> As well as causing bad breath and staining the teeth, smoking can lead to a wide variety of oral health problems including oral cancers, more severe periodontal diseases, tooth loss and poor wound-healing.<sup>6</sup>

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<sup>3</sup> Groundswell Healthy Mouths pg1

<sup>4</sup> Bridging the health gap – Homeless Health Consortium - 2022

<sup>5</sup> Healthy Mouths 78%, Room to Breathe 85%, Unhealthy State of Homelessness 76%

<sup>6</sup> <https://www.england.nhs.uk/mids-east/wp-content/uploads/sites/7/2017/03/focus-on-smoking.pdf> pp.4

Dental pain is a significant issue for people experiencing homelessness. Up to 60% say they have experienced it since becoming homeless, and of those 30% report experiencing pain daily.<sup>7</sup> This has led some to self-medicate using alcohol or street drugs such as heroin in a bid to manage their dental pain. Drug use in itself is damaging to oral health and can lead to issues such as mouth sores, tooth loss or decay, inflammatory gum disease, dry mouth and oral cancers.<sup>8</sup> Methadone is also high in sugar, which is detrimental to oral health.

In general, the diets of people experiencing homelessness can often be less healthy than the general population, and they tend to be high sugar consumers.<sup>9</sup> This may not be by choice rather a function of the food available to people experiencing homelessness, for example in day centres, where sugary items are commonly offered. Providing fresh fruit as an alternative is one possible solution, however there are high rates of tooth loss amongst people experiencing homelessness which can make fresh fruit difficult and painful to eat.

For their comprehensive Healthy Mouths Report<sup>10</sup>, Groundswell gathered data from 260 people experiencing homelessness about their dental and oral health. Overall, they found that:

- 90% had a problem with their mouth
- 63% were self-conscious about their teeth
- 31% had been unsuccessful signing up with a dentist
- 70% had lost teeth since becoming homeless
- 15% had pulled out their own teeth
- 7% had no teeth at all
- 60% were high sugar users
- 46% had holes in their teeth

### Seeking treatment

While there is a clear need for people experiencing homelessness to access dental services, they do not always find it straightforward to do so. Groundswell called on “health commissioners to ensure that oral health promotion and treatment is available to all people experiencing homelessness”.<sup>11</sup> However, 2021 data show that

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<sup>7</sup> Healthy Mouths pp.13

<sup>8</sup> <http://www.healthyteethdevon.nhs.uk/wp-content/uploads/2020/06/Substance-abuse.pdf>

<sup>9</sup> Healthy Mouths pp.18

<sup>10</sup> <https://groundswell.org.uk/our-approach-to-research/peer-research/healthy-mouths/> pp.1-2

<sup>11</sup> <https://groundswell.org.uk/our-approach-to-research/peer-research/healthy-mouths/#:~:text=Participants%20struggled%20to%20get%20access,to%20all%20people%20experiencing%20homelessness.>

dental problems are the second most reported physical health problem for people experiencing homelessness, but levels of sign-up to a dental practice are much lower than GP registrations.<sup>12</sup> The data also show people being refused the opportunity by dental surgeries to sign up as an NHS patient, due to their homelessness, previous missed appointments or not having a current address.<sup>13</sup>

It is important to note that it is now the norm in England for people to struggle to find a dental practice taking on new NHS patients.<sup>14</sup> Even those who are already signed-up will often wait months or in some cases years to access routine treatment. This applies as much to the general population as any marginalised group, and according to 2022 research from the BBC nearly 90% of NHS dental practices are no longer accepting new adult patients.<sup>15</sup> This situation was exacerbated by the COVID-19 pandemic during which dentists were only able to offer emergency treatment. Even when many restrictions were lifted elsewhere, dental surgeries were subject to strict limits on patient numbers and the need for fallow time between appointments to ventilate surgeries. This led to both increased treatment need across the population, and a backlog in available appointments.

The British Dental Association has also argued that this situation is “being fuelled by a discredited NHS contract, which funds care for barely half the population”<sup>16</sup> and we will touch on this in a subsequent section.

It is perhaps then not surprising that vulnerable people such as those experiencing homelessness, who often already struggle to navigate services that are available, find it extremely difficult to have their dental and oral health needs met.

### In their own words

To explore these difficulties further and how they might be overcome, we held a focus group with Expert by Experience participants, all of whom have direct experience of homelessness. Participants spoke about how they didn't feel that dental services were accessible to them, and what came across strongly were:

- a lack of clarity on entitlement to NHS dental treatment

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<sup>12</sup> Unhealthy State of Homelessness pp.8

<sup>13</sup> Unhealthy State of Homelessness pp.8

<sup>14</sup> <https://www.bbc.co.uk/news/uk-england-bristol-65220184>

<sup>15</sup> <https://www.independent.co.uk/voices/dentist-nhs-waiting-list-teeth-pulling-b2140691.html>

<sup>16</sup> <https://bda.org/news-centre/press-releases/Pages/nhs-dentistry-at-a-tipping-point.aspx>

- the belief they needed to provide ID or a current address to sign-up with a dental surgery
- digital exclusion, e.g., the requirement to sign up and/or complete forms online
- the attitude of some dental practice staff and the feeling they were being judged for experiencing homelessness
- the impact of the increased risk of things like anxiety and unresolved trauma on accessing dental care
- inadequate training for dentists and front facing staff in trauma and psychologically informed approaches and in understanding the complexities faced by people experiencing homelessness<sup>17</sup>

The question of signing up with a dental practice is important, as was reflected in the comments by focus group participants who said:

*"It's getting even more difficult to find an NHS dentist and many lists are full. I've tried 4 different dentists in my local area, with no luck."*

*"There should be signposting by surgeries who cannot see you due to the waiting list, with advice on where you can be seen."*

It would be worth highlighting here that an individual does not 'register' with a dental practice in the same way as they would with a GP surgery. There are no catchment areas for NHS dental provision and an individual is free to sign up with a dental practice near their work, for example, rather than where they live. As such, you can contact any General Dental Service (GDS) offering treatment on the NHS and request an appointment for NHS treatment. However, should you attend a dental check-up or receive a course of NHS treatment at this practice, this does not mean you are 'registered'. Further, while a GDS may have a contract to provide a certain volume of NHS dental treatment, and they may keep a list of patients they provide NHS treatment for, they are under no obligation to accept new patients onto their list.

On the subject of entitlement to treatment and the costs involved, our workshop participants said:

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<sup>17</sup> Single homeless people often have complex lives and experience multiple exclusion due to experiences such as being in care as a child, traumatic brain injury, institutional stays, mental health support needs, drug and alcohol support needs. See for example: <https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/homelessness-exclusion-services-summary.pdf>

*“[People need to be told] what you can and can't get from a dentist”.*

*“There is a lack of information out there for people to know what they are entitled to”*

*“It would be helpful to make it clearer what people's legal rights are for accessing dentists.”*

This correlates with the findings Groundswell set out in their Healthy Mouths report that an inability to meet the costs of treatment presents a significant barrier to access.<sup>18</sup> This might be because people are unaware of exemptions they are entitled to, they may not have the benefits in payment needed to access those exemptions, or they may not have the digital, literacy or language skills needed to access and complete the required forms.

It is also worth noting that there is no legal right to receive treatment from a high street dental practice (GDS), however anyone can call 111 to access emergency dental care from the nearest, most appropriate NHS dental care provider.

It is generally acknowledged that visiting the dentist can be anxiety inducing. Given the prevalence of unresolved trauma experienced by people experiencing homelessness, our focus group participants agreed that surgery staff would benefit from training in trauma-informed approaches and to understand what behavioural responses to trauma look like.

*“[...] more training for staff, including dental hygienists and receptionists on how to work empathically with people with lived experience of homelessness. Trauma informed training.”*

Focus group participants felt an important element in helping overcome many of the barriers they experience to accessing a dental service would be better relationships between the homelessness sector workers and dentists. They felt this would allow a collaborative approach to improving access to healthcare for people experiencing homelessness. As a result, the surgery team could focus on their clinical work while support workers could support their clients to make and keep appointments.

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<sup>18</sup> <https://groundswell.org.uk/our-approach-to-research/peer-research/healthy-mouths/> p.30



*"It's important to develop better relationships with charities, so that information and communication is better between the dentists and the charity sector."*

The importance of relationship building was also highlighted by one participant in terms of the resulting consistency - of dental care team, approach etc. - engendering greater feelings of trust.

*"When I was homeless, I struggled to trust people, so having consistency is important to help build relationships between dentists and people who are experiencing homelessness."*

Finally, focus group participants felt strongly that people experiencing homelessness should be regarded as a vulnerable or marginalised group when accessing NHS dental care.

*"[We need] special dentist surgeries for people experiencing homelessness (just as they have for people with brain damage)"*

*"There should be ring-fenced appointments for marginalised communities and ensure they can register".*

*"[There needs to be a] duty of care/priority of care if you're homeless, because you're more vulnerable than the general population. Make homelessness a protected characteristic."*

## NHS dental service models

One focus group participant commented that *"there should be a combination of several models [of dental service] to respond to as many needs as possible"*. In fact, NHS dental services are provided across three service models; the General Dental Service (mentioned above), the Community Dental Service, and hospital-based dental services providing, for example, maxillofacial surgery.

The role of the Community Dental Service (CDS) is to see patients with special needs that can't be accommodated within a General Dental Service (GDS) model due to lack of time or specialist skills. This would include, for example, patients with learning disabilities, complex medical conditions, severe anxiety, and children who need longer appointment times and clinicians with specialist skills to

be involved in their treatment.<sup>19</sup> Several focus group participants felt that there should be measures put in place for providing dental treatment for people experiencing homelessness, and in fact people experiencing homelessness are identified as a vulnerable group in Public Health England's 2021 report *Inequality in Oral Health in England*.<sup>20</sup> However, homelessness, in and of itself, is not viewed as bringing with it additional clinical requirements as such. Therefore, while people experiencing homelessness might be referred to a CDS for treatment for unrelated clinical reasons, and CDSs in some areas do offer bespoke dental services for people experiencing homelessness, individuals technically wouldn't be seen by a CDS just because they are homeless.

In fact, a General Dental Service (GDS) should be able to fulfil most dental treatment needs of people experiencing homelessness. However, an unfortunate and unintended consequence of the way General Dental Services are commissioned is that it becomes financially unviable for a GDS to take on patients with high treatment needs. Briefly, dentists at a GDS are self-employed and are commissioned by NHS England (Integrated Care Boards since 1 April 2023) to provide NHS dental treatment. Since 2006, NHS dentists have been paid per Unit of Dental Activity (UDA). Each GDS is awarded an allocation of UDAs, based on their capacity and local need, and are required to meet this target annually.<sup>21</sup> Most GDSs also work with private patients who pay the service for the full cost of the treatment they receive.

Under previous contracting, dentists were paid by the NHS per item of treatment and this was changed, in part, to support a more preventative approach. Since the introduction of the new contract in 2006, dentists have been paid per course of treatment. These fall into four payment bands depending on the length and complexity of the treatment. As there are four bands, a single course of treatment under the same band could involve one filling, or numerous fillings and a tooth extraction for the same fee and level of remuneration.<sup>22</sup> If a patient does not turn up for their allocated appointment(s), the dentist receives no payment. Therefore, an unintended consequence of the UDA model is that it does not remunerate GDS dentist for taking on patients with high treatment needs and who may struggle to attend appointments. A further unintended consequence of the current

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<sup>19</sup> For more information on NHS Community Dental Services see, for example: <https://www.cnwl.nhs.uk/services/community-services/community-dental>

<sup>20</sup> <https://www.gov.uk/government/publications/inequalities-in-oral-health-in-england> pp.160

<sup>21</sup> For more on NHS dental service commissioning, see: <https://bda.org/advice/Pages/NHS-and-commissioning.aspx>

<sup>22</sup> <https://faq.nhsbsa.nhs.uk/knowledgebase/article/KA-01976/en-us>

contracting is that it requires a dentist to be involved at all levels of treatment, thereby not remunerating practices for taking a skills-mix approach to treatment, for example by involving practitioners such as dental therapists and hygienists.

### **Inclusion health dental service models**

There is no doubt that dental professionals work hard to care for their patients, and the way dental services are provided under the NHS does aim to make dental services available to everyone. However, the unintended consequences of most current NHS dental service contracting and the clear message from focus group participants are that regular treatment pathways do not feel accessible to people experiencing homelessness and they need dedicated support. With this in mind, below we look at some of the alternative treatment models currently being delivered or piloted in England.

#### **The mobile dental van**

Organisations such as Dentaaid<sup>23</sup> and Colgate<sup>24</sup> offer free, ad hoc dental care in a mobile van setting. While Colgate currently works specifically with children, Dentaaid works with people experiencing homelessness, in collaboration with day centres, accommodation providers and community buildings to offer free dental care for people who are not able to access an NHS dental practice.

Once people come on board the mobile van, they are offered dental screening, tooth-brushing, dietary advice and a range of dental treatments. Perhaps most importantly, dental van providers work in the community, hand-in-hand with the organisations supporting their clients into treatment. Dental van teams are also often trained to understand the causes of homelessness and trauma informed approaches and are therefore able to build relationships with individuals who feel marginalised from their community.

The organisation Crisis offers similar dental support for guests in their centres over the Christmas period.<sup>25</sup> While the benefits of this resource were appreciated, our lived experience workshop participants thought this approach would need to be year-round to be truly effective.

Nonetheless, they agreed the dental van approach is positive as it targets those who are most marginalised and therefore less able or likely to access dental care.

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<sup>23</sup> <https://www.dentaaid.org/>

<sup>24</sup> <https://www.colgate.com/en-us/oral-health-education/mobile-dental-van>

<sup>25</sup> <https://www.nature.com/articles/s41404-021-0969-z>

The group also thought this approach is a good steppingstone into mainstream dental services.

A stumbling block is that such services are offered by charities outside the scope of the NHS commissioning and, as such, their continuation depends on donations and grant funding. This may lead to limits being imposed on the complexity of the treatment offered, depending on the success or otherwise of fundraising activity. Further, as our workshop participants recognised, dental vans offer limited scope for more complex interventions or services, such as tooth repair, that require a course of treatment over multiple visits.

Some NHS trusts, such as King's College Hospital NHS Foundation Trust do also offer mobile dental vans via their community dental services.<sup>26</sup> They are also able to offer a wider range of treatment, including referrals for individuals requiring care in a hospital setting. However, patients may still be required to pay for treatment if they are not able to produce a valid exemption certificate, which people experiencing homelessness aren't always able to do.

It should also be noted that the cost of delivering treatment via a mobile dental van can be several times higher than via place-based services, due to the maintenance and running of the vans themselves.<sup>27</sup>

### The partnership model

Originally piloted in Manchester, the partnership model of delivering dental care was developed by clinician and lecturer Dr Ben Atkins.<sup>28</sup> The model focuses on improving access within existing NHS contracts via collaborative cross-sector delivery. This entails local health commissioners, dental practices, VCSE organisations and people with lived experience working collaboratively to help vulnerable people access dental care in their area. Such a model takes a place-based approach to service delivery and success relies on three key elements:

- dental practices offering greater flexibility around appointments and attendance
- patient support and encouragement from peer advocates and/or support workers from VCSE organisations

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<sup>26</sup> <https://www.kch.nhs.uk/services/services-a-to-z/community-special-care-dentistry/>

<sup>27</sup> <https://dentistry.co.uk/2022/11/03/dentaaid-kicks-off-urgent-mobile-dental-unit-appeal/>

<sup>28</sup> <https://www.dentalhealth.org/board-of-trustees-ben-atkins>

- practice staff being trained in trauma-informed approaches to working with people experiencing homelessness

The required flexibility is available within current Integrated Care Board dental commissioning via 4-hour funded sessions. Patients are supported to access dental care during these sessions by peer advocates or support workers from the VSCE organisation already working with the patient. They act as a link, bridging the gap between their client and the surgery. For example, they will support their client to sign up with the surgery, understand their entitlements, complete exemption forms, schedule and attend appointments, and they might advocate for the needs of their client with the surgery team.

Peer advocates and support workers also aid the surgery staff, for example by making sure the surgery is aware of the unique needs of their client, sign up runs smoothly and the required information provided, and by ensuring good general communication with the surgery. Trauma informed care training for dental surgery staff underpins the approach. This ensures they understand the barriers people experiencing homelessness can face, what trauma-based behaviours might look like, and what they can do to create a positive experience for those seeking treatment.

A partnership model approach has also been taken in Leeds where, in 2018, a team lead by Dr Stefan Serban, Consultant in Dental Public Health at NHS England North West<sup>29</sup>, began exploring ways of increasing access to dental services for people experiencing homelessness.

The resulting Leeds model of care was agreed by commissioners within a framework of flexible commissioning, and based on expressions of interest two General Dental Services were identified to take part. Broadly, the flexible commissioning works by reducing the UDA target of the GDS by, say, 10% and the dental service team then sees patients experiencing homelessness for a set period each week, in lieu of delivering the UDAs. For example, each Friday afternoon the practice could hold a drop in or appointment-based session for people experiencing homelessness. The practice is paid a fixed sum irrespective of patient attendance. But any attendance is still recorded via the FPI7 form<sup>30</sup>.

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<sup>29</sup> <https://medicinehealth.leeds.ac.uk/dentistry/staff/747/dr-stefan-serban>

<sup>30</sup> <https://www.nhsbsa.nhs.uk/activity-payment-and-pension-services/dental-activity-processing>

## Homeless Link

The biggest risk with this type of approach is paying for a dentist, dental therapist and dental nurse to potentially sit idle for a period. However, following the lead of the programme developed in Manchester by Dr Ben Atkins, the Leeds model also involves three local charities and VCSE sector link workers as the linchpin for booking and chaperoning clients to appointments.

Unfortunately, not every region has flexible commissioning as a requirement, rather it is at the discretion of the relevant (now) Integrated Care Board. However, ICBs only took on the commissioning role, previously held by NHSE, on 1 April this year, therefore there may be scope for them to introduce flexible commissioning more widely over time.

### Peninsula Dental Social Enterprise Community Clinic

An excellent example of the partnership approach to providing treatment for vulnerable individuals is Peninsula Dental Social Enterprise (PDSE) Community Clinic<sup>31</sup>, a building-based community dental clinic in Southwest England, which is delivered in partnership with PDSE, the University of Plymouth School of Dentistry, and local VCSE support services. The team that set up the clinic wanted to respond to the severely limited access to dental care for people experiencing homelessness in the city and the need for a dedicated service that met their specific needs.<sup>32</sup>

An evaluation<sup>33</sup> of the practice found that a key factor in the success of the PDSE approach is patient readiness, which the team found is influenced not only by pressing need e.g., for emergency treatment, but also through peer or support worker encouragement. The evaluation found that such link workers ensured the success of the clinic by helping people experiencing homelessness to feel that successful treatment was within their reach and through clear communication with the practice and its staff. Furthermore, outreach visits that are carried out at places where people feel comfortable (e.g. residential homelessness hostels), help to break down some of the barriers around the anxiety of going to the dentist and not knowing who patients are coming to see.

What's more, to promote confidence and comfort of their most vulnerable patients, the clinic provides services for people experiencing homelessness in a way that

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<sup>31</sup> <https://peninsuladental.org.uk/>

<sup>32</sup> Paisi et al, Evaluation of a community dental clinic providing care to people experiencing homelessness: A mixed methods approach, Health Expectations, 2020, section 3.4.1

<sup>33</sup> Ibid, section 3.4.1

respects their needs with dedicated time and space while remaining integrated into the overall service. A desire for stigma and embarrassment to be taken into consideration was expressed by our focus group participants.

A hurdle to replicating the Peninsula Dental Clinic more widely is that it functions as a Community Interest Company and relies on non-NHS sources of funding to provide dedicated clinics for people experiencing homelessness. The clinic has expanded to care for people experiencing other forms of severe disadvantage including people with addictions, mental health conditions, survivors of domestic abuse, etc. Further, the clinic team had calculated that the average cost of a course of treatment for a person experiencing homelessness was £854.50, whereas the funding available from the NHS is capped at around £300.<sup>34</sup> Therefore, a significant driver of success is the fact that the clinic's funding structure as a nonprofit CIC effectively subsidizes NHS funding. This is similar to the issue identified with the mobile van models, which are reliant on charity fundraising and grants awards to fund their work. That said, more recently the clinic has attracted NHS funding as part of a wider initiative to integrate healthcare services more effectively for patients with complex needs in the city.

## Recommendations

Based on the approaches explored above, we consider the below factors to be essential to ensuring good dental care is accessible to people experiencing homelessness.

***Collaboration between VCSE organisations, dentists and local commissioners*** is key to ensuring a model of care that works for people experiencing homelessness. Working together to a shared goal to improve access by improving communication, specialist knowledge and understanding. Taking a place-based approach is important to understanding the local issues, interconnections and relationships, and coordinating action and investment locally to improve cohesion and outcomes.

***Exploring alternative funding streams and flexible commissioning.*** Long term value for money can come from providing care that may cost more at the outset than for the average person, but where there is more to be gained across the board in supporting people to rebuild their lives. However, as demonstrated, an adverse

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<sup>34</sup> *ibid*, section 3.2

consequence of the current model, which remunerates in bands, is that people with high need will likely require greater investment in time and resources than a GDS is remunerated for, inadvertently disincentivising care provision. Therefore, advocating for commissioning reform to take into consideration the impact of current commissioning on those most vulnerable, including people experiencing homelessness, is strongly recommended. This could include a wider roll out of flexible commissioning by ICBs, which allowed successful partnerships models to be developed in Leeds and Manchester. It could also include contract reform to allow greater skills mix in the provision of NHS dental treatment and to make it financially viable for a GDS to provide treatment via a range of dental practitioners, e.g. dental therapists and hygienists, as well as dentists themselves.

***Support through peer and/or link worker advocacy*** helps people experiencing homelessness to access and complete dental treatment. Trust is important in overcoming barriers to engagement. Yet it is common for people who have experienced trauma to have lost trust, to feel marginalised and excluded from the community. The links created through peer advocacy help develop patient readiness and staff understanding. Such support could also include help to counter ***digital exclusion***, for example, through support to complete practice sign-up or dental charge exemption paperwork. In many ways, peer or support worker advocacy is the linchpin of any system implemented to improve access to dental care for people experiencing homelessness.

***Trauma and psychologically informed training*** should be made available to dentists and front facing dental surgery staff. This could be offered through bitesize training or embedded within dentistry school curricula and made mandatory training. Throughout the 1-1 interviews, research and consultations with professionals and peers carried out for this report, it was clear that stigma and public perception of people experiencing homelessness was a barrier to them accessing the services they need. People had good experiences of accessing dentists when they felt listened to and were made to feel welcome, in a non-judgemental environment. For some it may be their first time attending a dental service in many years and engagement with people who are able to recognise their needs and vulnerabilities will be more effective.

***Sharing good practice models*** across the wider homelessness and inclusion health sectors to evidence and influence what works, promote good practice and influence service and partnership development.



***Practical guidance and information are a must***, including, for example, leaflets disseminated within homelessness services, on topics such as improving oral health, and eligibility and entitlement to NHS dental care for different groups (e.g., those on benefits, those with restricted eligibility due to immigration status). All practical guidance should be co-produced with people who have lived experience of homelessness; one such example is Groundswell's Healthy Mouths Action Guide.<sup>35</sup> Dissemination plans for such resources should also be co-produced with people who have experience of homelessness, so that they are accessible when and where they are most needed.

## Conclusion

Lengthy waiting lists and the current commissioning landscape make it very difficult for many vulnerable people in England to access the dental care they need. However, innovative practice does exist, demonstrating the scope to work flexibly within current structures to provide dental care to marginalised people such as those experiencing homelessness. This is possible where collaborative working between health, care and housing services is prioritised, based on a health equity approach and flexible, alternative or additional funding streams.

The involvement of people with lived experience is crucial to this work for two reasons. Firstly, to ensure a co-production approach to designing practice delivery which reflect local needs, for example as advisors to Integrated Care Partnerships and Integrated Care Boards in their strategy making, planning and commissioning. Secondly, as peer advocates for vulnerable patients to support their access to trauma informed care. By using innovative approaches tailored to working with people with lived experience, reducing health inequalities and providing services that reach out to people in the places where they are - such as dental vans and the place-based partnership model - more people will have access to the treatment they need, whether emergency, ad hoc or routine full-course, provided by teams with the specialist skills to work with people experiencing homelessness.

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<sup>35</sup> <https://groundswell.org.uk/wp-content/uploads/2017/10/Healthy-Mouths-Guide-Final.pdf>

### **Who are the Homeless Health Consortium?**

Homeless Link, Groundswell and Pathway, work together as the Homeless Health Consortium, which is part of the wider Department of Health and Social Care (DHSC) funded Health and Wellbeing Alliance (HWA). The DHSC-led Alliance programme is designed to facilitate collaboration and co-production between the voluntary and community sector and health system partners – DHSC, NHS England, the UK Health Security Agency (UKHSA) and the Office for Health Improvement and Disparities (OHID) – by bringing the voices and expertise of the sector, and the people and communities they represent, into national policy and delivery.

## What We Do

Homeless Link is the national membership charity for frontline homelessness services. We work to improve services through research, guidance and learning, and campaign for policy change that will ensure everyone has a place to call home and the support they need to keep it.

## Homeless Link

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[www.homeless.org.uk](http://www.homeless.org.uk)  
@HomelessLink

**Let's End Homelessness  
Together**

