

# Key Elements to Replicate a Dental Service for People Experiencing Homelessness and Severe and Multiple Disadvantage

## Introduction

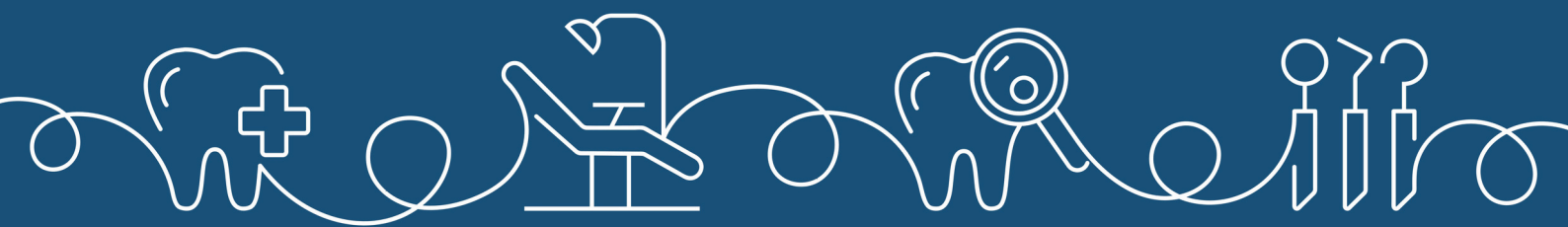
People experiencing homelessness often live with severe and multiple disadvantage, manifesting as complex needs that have a profound impact on their oral health and overall wellbeing. Dental problems such as tooth decay, gum disease, tooth loss, pain, and infection are common, and are frequently left untreated because of barriers to accessing care. Despite having greater needs, many people are unable to receive timely dental treatment, meaning problems often escalate, leading to reliance on emergency care.

Poor oral health affects much more than the mouth; as well as making eating difficult, it can impact systemic health, disrupt sleep, damage confidence, and worsen mental health, making everyday life harder to manage. Ongoing dental pain may also lead some people to use drugs or alcohol as a way of coping, further harming their health and reinforcing cycles of disadvantage. Timely dental care not only improves health and wellbeing, but can also bring economic benefits by reducing costly emergency visits, improving employability, and supporting pathways out of poverty.

## Context and exemplar model

The Community Dental Clinic was established in early 2018 by the Peninsula Dental Social Enterprise (PDSE) CIC, the clinical arm of the Peninsula Dental School at the University of Plymouth. Initially providing pro bono dental care in Plymouth, the service has since secured external (ICB) funding and has expanded locally through the Health Inclusion Pathway, Plymouth, as well as extending to Exeter. It now supports people experiencing severe and multiple disadvantage through an integrated care model that combines dental treatment with access to wider health, housing, and social support services. It adopts several principles and recommendations made by the NICE guideline (NG214) Integrated health and social care for people experiencing homelessness (e.g. NG214.1.1.2 Co-design of services with people with lived experience of homelessness).

PDSE provides a useful exemplar to identify the essential components – principles, structures and operations – as described below, that are transferable to a range of provider types. These could include NHS community dental services, charities, academic institutions, social enterprises, and high-street practices. Within consistent underlying values, structures, and operational components required to support socially excluded populations, business and funding models may differ. For example, rather than an entirely pro bono service, private practices could offer periodic drop-in or emergency sessions free of charge.



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## About this guidance

It has been developed through community engagement, research evidence, input from clinicians, and our experience of designing, implementing, and evaluating the service in practice.

## Intended audience

Future providers who are looking to set up similar services. Commissioners may also find it useful as a reference for understanding the essential components of service design and delivery.

## Essential components supporting replication

These are organised across three interlinked areas:

1. Foundational values and culture (fundamental principles)
2. Structural and organisational enablers (what must be in place)
3. Operational and clinical components (how the service works day to day)

### Area 1: Foundational values and culture

An individual's life circumstances and experiences, including (but not limited to) homelessness, poverty, or trauma, can significantly affect their health and their ability to access care. Recognising these connections and any consequent limitations for the patient ensures that services are flexible, tailored, and responsive to individual needs, rather than expecting everyone to fit into standard pathways. Thus, any service seeking to replicate the proposed model must be underpinned by a clear dedication to equity, dignity, and social justice, as follows:

- A commitment to social value, with protected funding or resource allocation to support free or low-cost dental care for people experiencing severe and multiple disadvantage.
- A culture of respect, empathy, and non-judgement, recognising patients' lived experiences, trauma histories, and potential mistrust of services.
- Appreciation that mainstream dental delivery models may not be suitable for socially excluded populations, who require tailored and flexible approaches.
- Genuine collaboration with people who have lived experience of homelessness and severe and multiple disadvantage, ensuring co-design is authentic and meaningful rather than tokenistic.
- An emphasis on relationship-building and continuity of care, prioritising psychological safety and trust.



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## Area 2: Structural and organisational enablers

These elements create the conditions that allow trauma-informed, inclusive dental care to be delivered.

### A committed dental provider

- A dental provider (e.g. NHS, charity, social enterprise, academic institution, or practice group) with governance structures that allow flexibility, protected time, and innovation.
- Secure funding arrangements (e.g. salaried staff, commissioned sessions, grant-funded provision, or cross-subsidy models) that reduce reliance on activity-based targets.
- Robust clinical governance, safeguarding procedures and indemnity cover appropriate for working with vulnerable adults.

### Partnerships with community and support organisations

- Strong partnerships with homelessness charities, voluntary-sector organisations, housing providers, outreach teams, and health and social care services.
- Shared referral pathways, secure data sharing, and communication channels that enable coordinated care and reduce patient burdens of, e.g., repeated disclosure of trauma history.
- Recognition of partner organisations as equal contributors, bringing contextual knowledge and trusted relationships within the community.

### Engagement with lived-experience stakeholders

- Early and ongoing involvement of people with lived experience of homelessness and wider severe and multiple disadvantage as co-designers, advisors, and peer contributors.
- Establishment of a Patient and Public Involvement (PPI) group with lived-experience representation, and appropriate support, training and remuneration.

### Workforce wellbeing and support

- Recognition that working with complex needs populations can be psychologically demanding for staff, with access to supervision, reflective practice, debriefing, and peer support.
- A learning culture that encourages curiosity, compassion, and shared problem-solving rather than blame.



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## Area 3: Operational and clinical components

### Flexible, responsive, and trauma-informed care pathways

- Dedicated care pathways via partner organisations, coordinated by an outreach team delivering care in community settings (e.g. hostels, supported accommodation and drop-in centres), including initial consultations in these familiar environments, alongside link workers to support patients' attendance throughout their treatment journey.
- Trauma-informed clinical practice sensitive to complex needs, patient readiness, and competing life challenges.
- Flexible appointment systems to respond to patient needs and constraints through clear but compassionate policies for missed appointments, whilst maximising use of clinical time.

### Workforce and clinical practice principles

- Support for patient confidence and trust through a clinic environment that is welcoming, predictable and accessible, a warm communication style and, whenever possible, continuity of staff.
- Design of bespoke patient documentation (forms and information leaflets) and processes adapted to the patient group's social context and needs including additional learning needs, and simplified materials where required.
- Development of realistic, staged and flexible treatment plans that respond to patient priorities and acknowledge that completion of ideal treatment plans may not always be possible.

### Integration with wider health and social care (“wrap-around” support)

- Collaboration with housing services, social care, mental health, substance use services, and primary care.
- Cross-referral mechanisms and shared care planning to optimise opportunities for holistic support.

### Monitoring, evaluation, and continuous learning

- Evaluation of the service from the outset, capturing all stakeholder perspectives, with both quantitative and qualitative outcomes.
- Use of evaluation findings to support staff development and refine treatment pathways and strategies.
- Commitment to continuous learning and sharing of best practice with other providers, commissioners, and policymakers, to inform wider system change and reduce oral health inequalities.

## In summary

This model is designed to improve access, engagement, and care for people experiencing homelessness and wider severe and multiple disadvantage. It is not a quick fix, nor does it assume that all patients will complete perfect treatment plans. Rather, it prioritises stabilisation, trust and incremental progress towards improved health and wellbeing. The following **Replication Framework** provides detailed guidance on the practical implementation of the model.

# Replication Framework: Dental Services for People Experiencing Severe and Multiple Disadvantage

## Intended audience

Future providers who are looking to set up similar services. Commissioners may also find it useful as a reference for understanding the essential components of service design and delivery.

## Replication steps

This document outlines the practical steps for replicating the service provided by the Peninsula Dental Social Enterprise Community Clinic.

### 1. Identify oral health needs

**What:** Before setting up services, understand the oral health needs, priorities, and barriers faced by local people experiencing severe and multiple disadvantage manifesting as complex needs.

**How:**

- Explore existing research, local surveys, and reports to identify local oral health needs, challenges, and facilitators; if sufficient evidence exists, no further data collection is required.
- If further evidence or verification is considered necessary, engage with local community and support organisations (homelessness charities, hostels, inclusion health teams) to understand needs, barriers, and facilitators through outreach or informal discussions.
- If gaps are identified in the insights gained, partner with universities, public health teams, or research organisations to gather qualitative insights from people with lived experience and support organisations, to understand barriers and enablers to care.
- Use these findings to guide service design, prioritise interventions, and allocate resources effectively.

### 2. Partner with community and support organisations

**What:** Collaborate with local agencies and organisations that support people with severe and multiple disadvantage, to build trust and facilitating access.

**How:**

- Map local organisations: homelessness charities, housing services, inclusion health teams, hostels, drop-in centres.
- Engage with these community and support organisations to listen to lived experience, build trust, strengthen relationships, and break down barriers to care.
- Establish formal agreements or memoranda of understanding with the organisations.
- Establish referral agreements and cross-service collaboration.
- Identify key support workers to provide essential assistance by delivering reminders to patients, accompanying them to appointments, and offering moral support and encouragement.
- Maintain regular communication and partnership meetings.
- Use these partnerships for outreach, informal introductions, and engagement of patients in dental care.

# Replication Framework: Dental Services for People Experiencing Severe and Multiple Disadvantage

## 3. Integrate with wider health and social care

**What:** Coordination with services addressing broader social and health needs.

**How:**

- Collaborate with housing, social care, mental health, substance use, and primary care services.
- Establish formal agreements or memoranda of understanding with partner organisations
- Implement cross-referral mechanisms and warm handovers (i.e. supported introductions to other services rather than just signposting).
- Share care planning where appropriate, respecting consent protocols and data protection.
- Use dental contact as a gateway to wider support, linking patients to wrap-around services when needed.
- Hold regular multidisciplinary meetings to coordinate care, share learning, discuss emerging concerns, and improve processes.

## 4. Involve people with lived-experience and other stakeholders in service co-design

**What:** Ensure from the outset that services are co-designed with people who have lived experience of severe and multiple disadvantage and with the professionals who support them.

**How:**

- Establish a Patient and Public Involvement (PPI) and stakeholder advisory group comprising people with lived experience of severe and multiple disadvantage and support staff from hostels, inclusion health teams, outreach services, and other relevant agencies.
- Involve this group in designing and reviewing care pathways, referral processes, appointment systems, communication strategies, patient documentation, and service policies.
- Provide safe spaces for participation, along with support, training and fair remuneration for peer involvement, recognising the emotional labour and potential for re-traumatisation.
- Use their insights to ensure services are realistic, accessible, and responsive to both patient and support staff perspectives.
- Include patient feedback loops in service operation, e.g., short surveys or check-ins to capture ongoing lived-experience insights.
- Draw on inputs of support workers, outreach staff, and allied professionals alongside lived-experience contributors, to ensure that services are realistic through being context-sensitive (e.g. housing instability, mental ill-health, substance/alcohol use, safeguarding concerns).



# Replication Framework: Dental Services for People Experiencing Severe and Multiple Disadvantage

## 5. Develop flexible, responsive, and trauma-informed care pathways

**What:** Pathways that build trust, reduce barriers, and adapt to patient needs.

**How:**

- Identify a designated staff member responsible for managing communications and referrals.
- Make regular outreach visits to hostels, day centres, and supported housing to build trust, reduce barriers, promote good oral health and support early engagement in care.
- Assess individual patient readiness and priorities using informal discussions or brief screening tools.
- Use link workers or peer supporters to accompany patients and provide appointment reminders.
- Offer flexible appointment systems, longer appointment times in order to give patients time and space to share their experiences and feel heard, and a short-notice waiting list.
- Apply trauma-informed care principles: safety, choice, empowerment, privacy, informed consent, and sensitivity to anxiety, mental health, or substance use.
- Provide private treatment spaces, explain each step of care in plain language, and offer options to pause or stop treatment at any point.

## 6. Develop and apply workforce and clinical practice principles

**What:** Clinical and administrative practices that accommodate complex needs.

**How:**

- Apply flexible treatment sequencing to meet both clinical urgency and patient priorities.
- Develop staged treatment plans, prioritising pain relief and infection management, followed by patient-led priorities such as early attention to visible anterior teeth to support dignity, confidence and engagement.
- Use visual aids or written summaries to help patients understand priorities.
- Adapt appointments based on attendance, health, or social circumstances.
- Promote continuity of staff to build familiarity and trust.
- Use welcoming communication: personal greetings, introductions, and rapport-building.
- Encourage small gestures like remembering patient names or prior conversations to reduce power imbalances.
- Recognise trauma, anxiety, and mental health factors in treatment planning, informed consent, and pain management.



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## 7. Develop administrative and operational infrastructure

**What:** Systems to manage referrals, documentation, appointments, and patient flow.

**How:**

- Assign dedicated outreach/admin staff to manage referrals, bookings, reminders, and liaison.
- Develop bespoke patient documentation capturing dental needs, social context, trauma history, and support worker details.
- Implement clear, compassionate policies for missed appointments, re-referral, and emergency access.
- Maintain a welcoming, predictable, and accessible clinic environment.
- Maintain a short-notice waiting list to fill cancellations quickly.

## 8. Monitor, evaluate to drive iterative improvement

**What:** Embed monitoring and evaluation to inform ongoing adaptation and improve service delivery.

**How:**

- Collect quantitative and qualitative data on attendance, treatments, wellbeing, trust, and oral health outcomes, partnering with universities, public health teams, or research organisations where appropriate.
- Engage patients, staff, and partner organisations in regular feedback.
- Hold review meetings to interpret findings and adjust pathways, outreach, and eligibility criteria.
- Use PPI groups to co-interpret data and refine service delivery.

## 9. Develop appropriate workforce culture, values, and support

**What:** Organisational ethos supporting patient dignity and equity, and staff wellbeing.

**How:**

- Promote equity, inclusion, and sensitivity to patient's social context.
- Provide staff support: debriefing, reflective practice, peer support, and access to counselling.
- Foster reflective practice, celebrate successes, and maintain motivation.
- Ensure power-sharing with patients and stakeholders to enable meaningful co-design.
- Build a culture of empathy, patience, and trust, recognising the unique challenges of socially excluded populations.

# Replication Framework: Dental Services for People Experiencing Severe and Multiple Disadvantage

## 10. Promote wide knowledge sharing for system-level impact

**What:** Use learning to improve broader systems and support replication.

**How:**

- Publish case studies, guidance, or webinars to share best practice.
- Present evaluation evidence to policymakers, commissioners, and other providers.
- Engage staff in cross-organisational learning and training.
- Use research findings to advocate for service replication, funding, and reduction of oral health inequalities.
- Document operational procedures, patient-facing materials, and lessons learned to facilitate replication by other providers.

## Authors

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## Further support

Questions about any aspect of replicating the service, including securing funding or making a case to NHS commissioners or other funding bodies, can be directed to [pdse.impact@plymouth.ac.uk](mailto:pdse.impact@plymouth.ac.uk)

## Further reading

Paisi M, Baines R, Worle C, Withers L, Witton R. Evaluation of a community dental clinic providing care to people experiencing homelessness: A mixed methods approach. [Health Expectations. 2020;23\(5\):1289-1299.](#)

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