Development and evaluation of a 'was not brought' pathway: a team approach to managing children's missed dental appointments

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Key points

- Briefly reviews why children's missed dental appointments may be a safeguarding concern.
- Describes a new pathway for managing children's missed dental appointments.
- Presents results of an eight-month service evaluation, highlighting its impact on information sharing and dental team views.
- Proposes that this new WNB-CYP pathway can be recommended to other similar dental services.

Abstract

Introduction Children and young people's (CYP) missed healthcare appointments may be an indicator of neglect. Healthcare providers are encouraged to consider the child as 'was not brought' (WNB) and to assess the need for early multidisciplinary information sharing to safeguard and promote welfare.

Method A new WNB-CYP pathway (flowchart, template patient notes, template letters) for missed appointments was developed. After piloting at one community dental service (CDS) clinic for eight months, a service evaluation was conducted via retrospective review of records and semi-structured interviews with staff.

Results Of 1,238 appointments for CYP, 134 were missed (WNB rate 10.8%) by 91 children. The WNB-CYP pathway was followed consistently 113 times (84.3%) and, when used, three quarters of WNBs were rebooked after communication with parents within three weeks. Written information was shared in 25 cases with general medical practitioners and other health and social care professionals. Staff reported high levels of engagement and pathway acceptability; it relieved uncertainty and supported decision-making, teamwork and inter-professional communication without increasing daily workload. Following minor amendments, the pathway was rolled out service-wide with similar success.

Conclusion A new WNB-CYP pathway facilitated early and consistent sharing of safeguarding information with other professionals about missed CDS dental appointments and improved dental team confidence.

Introduction

Every child has a fundamental right to healthcare.[1] When children miss healthcare appointments, including dental appointments, it may be a sign of neglect and should be followed up rigorously as part of safeguarding and promoting their welfare.[2,3,4] Importantly, non-engagement with health services is frequently noted in serious case reviews (SCRs) conducted when children die or are seriously harmed by maltreatment.[5] Recent expert opinion has highlighted the need for healthcare providers to consider the child's perspective when planning how to respond, and advises considering the child as 'was not brought' (WNB) in place of the traditional terminology 'did not attend' (DNA).[6,7]

Previous work has identified safeguarding deficiencies in the context of primary care dentistry and has asserted the need to improve and enable information sharing between professionals.[8,9,10] A three-cycle audit conducted in our community dental service between 2009–2012 identified inconsistencies in following up missed appointments, despite best efforts.[11] Furthermore it was observed that management on a case-by-case basis was increasingly costly in dentists' time. Lessons learned from SCRs indicate that clear and robust processes are essential and must be evaluated periodically to ensure they are used effectively and remain fit for purpose.[12] In response to these circumstances, a new WNB pathway for managing children and young people's (CYP) missed dental appointments was developed. The aim of this paper is to describe this WNB-CYP pathway, its development, implementation and evaluation.

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Methods

Setting

Sheffield Community and Special Care Dentistry (CSCD) provides specialist dental care for adults and children with disabilities including learning difficulties, communication disorders and complex medical needs,

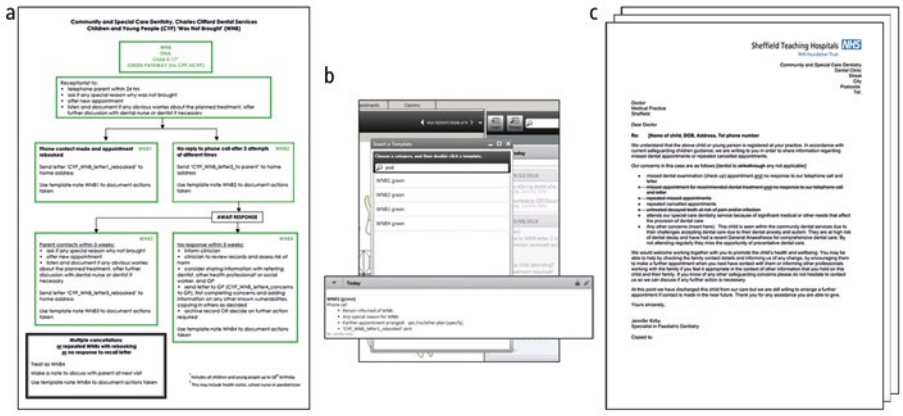

Fig. 1 Schematic to show components of the new 'was not brought - children and young people - green' (WNB-CYP green) pathway: a) flowchart; b) template notes shown as open windows in a de-identified example patient record in CS R4 Clinical+ (Carestream Dental UK); and c) template letters including 'WNB4 letter' to general medical practitioner. For an enlarged version of the flowchart see Figure 2

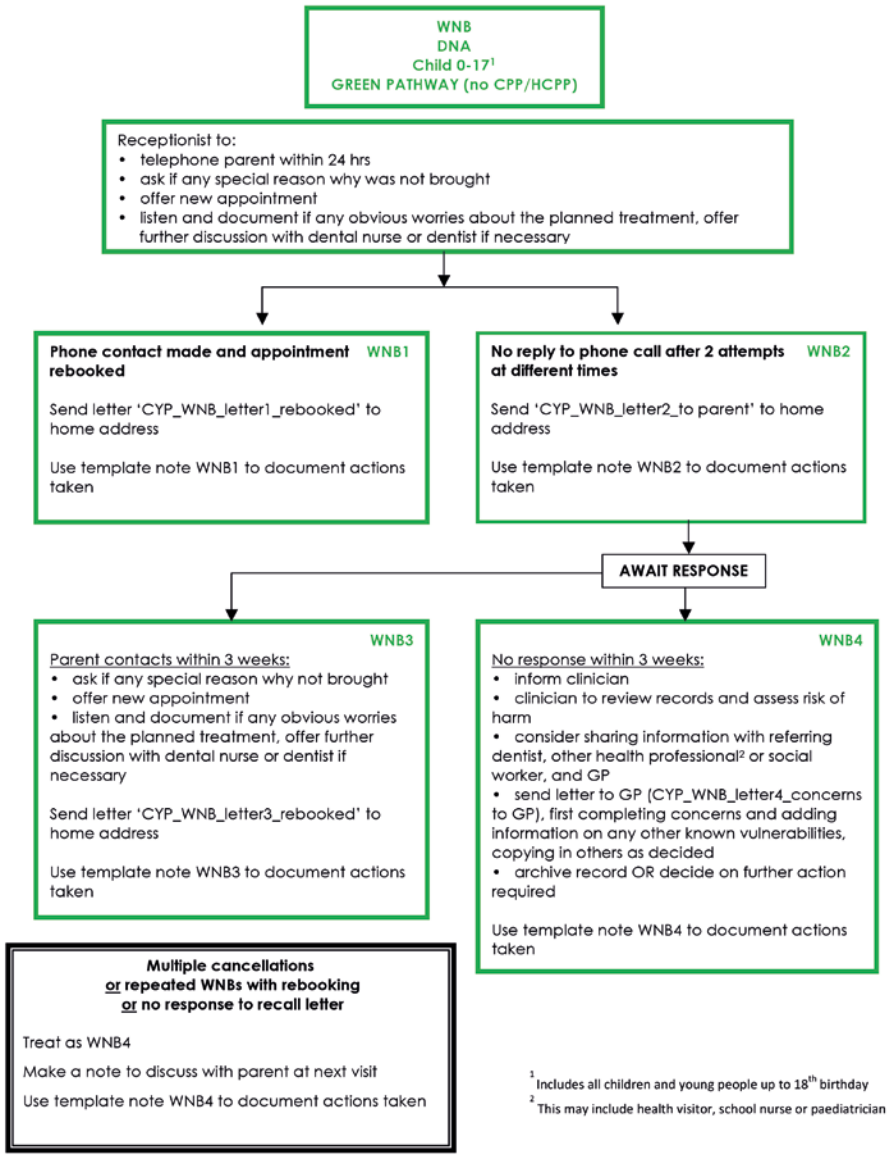

Fig. 2 'Was not brought - children and young people - green' (WNB-CYP green) flowchart

alongside speciality training, undergraduate outreach teaching and dental access roles. The service operates from seven clinic bases, employing a team which includes 22 dentists (12 full-time equivalent) and 31 registered dental care professionals. The ethos of the service includes a longstanding commitment to reducing barriers to healthcare by working with vulnerable families and those with additional needs in a supportive and inclusive manner.

Requirements

The requirements for an ideal WNB pathway were determined:

- To encourage and enable earlier and more consistent information sharing
- To provide a standardised approach
- To maximise efficiency by involvement of the whole skill-mixed dental team
- To reach a defined end point, at which efforts could be considered concluded
- To be easy to learn and apply consistently
- To be feasible without the need for additional resources.

Pathway development and implementation

Existing solutions used by four community dental services in the region were reviewed; none fully met our stated requirements. Therefore, a new WNB-CYP pathway was devised de novo consisting of three component parts:

- An explanatory flowchart
- Templates for clinical notes with prompts for action
- Editable template letters.

For an indicative representation of the components, see Figure 1. The full text is provided as 'Supplementary Material 1, 2 and 3'.

Numbering and colour were used to aid navigation and to acknowledge that additional modified colour-coded pathways would be required in due course for special circumstances, such as for children subject to a child protection plan and for vulnerable adults ('adults at risk'). A key element was an information-sharing letter to the child's general medical practitioner (GMP), known as the WNB4 letter. This letter had evolved from the consultant in paediatric dentistry's own clinical letters when previously managing missed appointment concerns on a case-by-case basis.

After multiple iterations of content and layout, the documents were sent for comment to local stakeholders including statutory named and designated safeguarding children

Table 1 Template notes for electronic record keeping at each stage of the Sheffield WNB pathway. Note that these include sufficient detail to function as a script

Stage	Description	Template note
WNB1	The successful contact of the parent/carer and arranging a further appointment within 24 hours after the missed appointment	Phone call Person informed of WNB: Any special reason for WNB: Further appointment arranged: yes /no/other plan (specify) 'CYP_WNB_letter1_rebooked' sent
WNB2	Attempts to contact the parent/carer unsuccessful and letter sent advising them to arrange a further appointment	Phone calls x2 no response 'CYP_WNB_letter2_to parent' sent
WNB3	The parent/carer contacts the dental clinic within three-weeks in response to the WNB2 letter	Parent responded to WNB letter 2 Any special reason for WNB: Further appointment arranged: yes /no/ other plan (specify) 'CYP_WNB_letter3_rebooked' sent
WNB4	Risk of harm assessed, letter sent to GMP and other professionals if appropriate when: no response to WNB2 letter within three weeks or after multiple cancellations or repeated WNBs with rebooking or no response to the recall letter.	No response to WNB letter 2 (or multiple cancellations/WNBs/no response to recall letter) Clinician reviewed records: yes/no Clinician assessed risk of harm: yes/no at risk/not at risk Need for information sharing considered: yes/no Decision to share information with: 'CYP_WNB_letter4_concerns to GP' letter sent: yes/no Copied to: Record to be archived OR note here any further action required

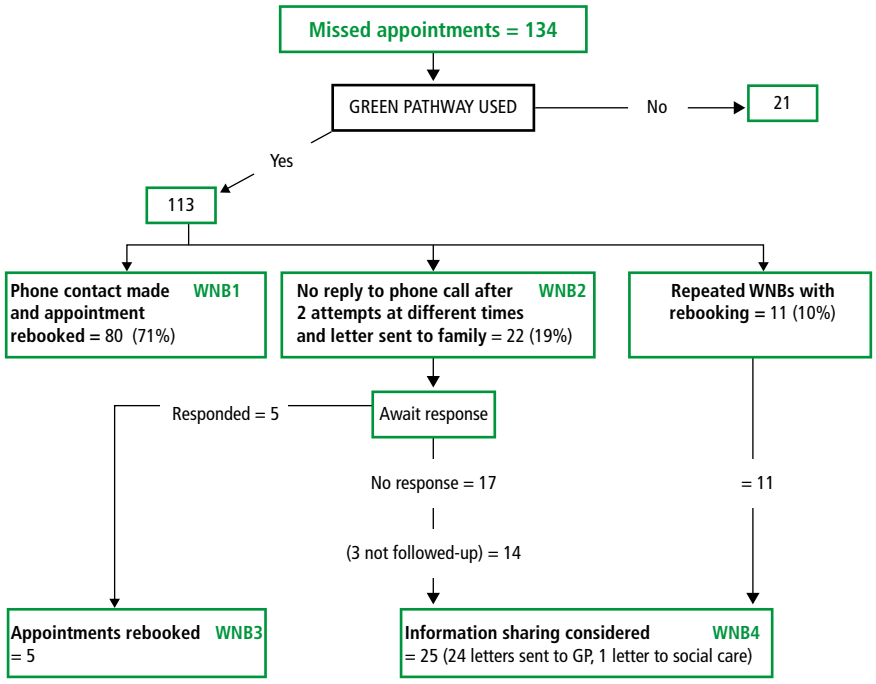

Fig. 3 Results of the evaluation of the pathway over an eight-month pilot period at one clinic site

professionals (nurse, doctor and GMP).[13] In parallel with this, elements of the proposed pathway were tested for six months by the safeguarding lead dentist (JCH) and dental nurse. Support of the senior management team was gained and, by role modelling and by creating and communicating a vision for change, wider staff interest and engagement was generated.

On receipt of stakeholder comments, further minor revisions were made and the final version (Fig. 2) was approved as a variant to Trust policy. The template clinical notes (Table 1) and letters were uploaded to the electronic clinical record-keeping system (CS R4 Clinical+, Carestream Dental UK). Laminated copies of the flowchart were distributed at one community clinic chosen as the pilot site. Informal one-to-one training was provided to the dental receptionist and senior dental nurse. These key staff members then trained other team members. The 'WNB-CYP green' pathway was introduced in January 2016.

Evaluation

A service evaluation project was registered and approved (Sheffield Teaching Hospitals NHS Foundation Trust, Clinical Effectiveness Unit reference no. 7697). The evaluation sought to assess the use of the pathway and to explore staff experiences and views on its acceptability. The project was limited to evaluating management of missed appointments and did not attempt to evaluate safeguarding children practice in general or child protection referral for any other concerns.

Pathway usage

All missed appointments for children (from birth until their 18th birthday) during the eight-month period from 1 January 2016 to 31 August 2016 were identified retrospectively from electronic clinical record and appointment books (R4 Clinical+). Each child's record and associated letters were reviewed. Data were collected by one investigator (JK) using a pro forma and entered into IBM SPSS Statistics software for analysis.

Dental team views

A purposive sample of dental team members was selected for interview, excluding those who had developed the pathway. Information was provided on what was proposed and, with interviewees' consent, semi-structured interviews were undertaken, audio-recorded and transcribed verbatim by one investigator (JK). Data collection and analysis were conducted concurrently until saturation was reached. Both authors independently read and reviewed the transcripts to identify

Table 2 Information sharing regarding children who reached WNB4 stage over an eight-month period at one clinic site

	Professionals who were contacted by the dental team*	Professionals who responded back to the dental team
Medical		
General medical practitioner	24	2
Social care		
Referral to social care	1	
Named social worker	2	
Local authority		
School nurse	3	
Health visitor	4	
Health inclusion team		2
Multi-agency support team		2

*n = 25 children; may be more than one professional contacted per child; three children – no information sharing

themes from the data, which they subsequently discussed to achieve consensus.

Results

Pathway usage

Of a total of 1,238 appointments for CYP in the six-month evaluation period, 134 were missed, a WNB rate of 10.8%. Ninety-one children missed one or more appointments, of whom 32 missed multiple appointments. The WNB-CYP pathway was used on 84% of occasions (113/134), as summarised in Figure 3. After 71% (80/113) of WNBs managed using the pathway, parents or carers (the term 'parent' will be used hereafter to denote either) were successfully contacted by telephone within 24 hours, re-booked and sent the appointment confirmation 'WNB1 letter'. Of these, 64% (51/80) subsequently attended with no further missed appointments. When attempts to contact the parent were unsuccessful and a 'WNB2 letter' was sent to the parent advising them to contact within three weeks to arrange a further appointment (WNB2), only five of 22 did so. Overall, after 75% (85/113) of WNBs managed using the pathway, contact was successfully made within three weeks and children's appointments rescheduled, or 63% (85/134) if considered from an 'intention to use the pathway' perspective.

For 17 children there was no response to either the phone call or letter. Information was shared with various health and social care professionals for 14 of these and for a further 11 who were 'fast-tracked' to this stage (WNB4) due to multiple WNBs or repeated cancellations (Fig. 3). This was a total of 25 children, or 27.5% of the 91 children with missed appointments. For one child, a child protection referral was made to social care (Table 1). In nearly all cases (24/25) a letter was sent to the GMP (23 WNB4 letters and one copy of social care referral). Concerns were additionally shared with other professionals in over a third of cases (n = 9), as detailed in Table 2. After this, six professionals (including two GMPs) actively responded back to the clinic by telephone regarding concerns in relation to these children (Table 2) and six parents initiated contact with the clinic to rebook. Further appointments were scheduled for 13 children. Eleven subsequently attended, including all nine where there had been communication with professionals in addition to the GMP.

There was good overall compliance with the individual elements of the pathway, the action prompts and use of the template clinical notes and letters. However, several points at which there was potential to make better use of the pathway were identified. At WNB1 stage, 10% of parents (8/80) were not sent written confirmation of the appointment. Three patients did not have information sharing considered at the WNB4 stage; all were subsequently contacted by the clinic. The template notes were not always used fully; in eight of the 25 at WNB4 stage, the clinician omitted to document whether they had assessed risk of harm. The final step, after completing all the necessary information sharing actions, was to 'discontinue' courses of treatment and to 'archive' the clinical record, which was completed for only eight of the 25 children and only by senior dentists.

Dental team views

Four interviews were completed with a dental receptionist, a senior dental nurse and two dentists (a dental officer and a specialist in special care dentistry). Analysis revealed five main themes: reflections on previous practice; the role of the pathway in promoting children's welfare; its reception from parents; positive impacts on staff; and ideas for further development.

Reflecting on previous practice

The team acknowledged that their previous management of children's missed appointments had been unstructured, inconsistent and in need of change. They recognised that they had tended to focus on pressures on parents, rather than correctly focusing on the needs of and impact on the child, and this left children at risk. Decisions had been considered the sole responsibility of the dentist:

'Well, it was haphazard and everybody did something different… So some patients were getting absolutely gold standard, and we were ringing every man and his dog about them, and other people weren't.' (Dentist 2);

'There were definitely ones that slipped through the net.' (Senior dental nurse).

Promoting children's welfare

Some team members noticed that using the terminology 'was not brought' had changed their attitude and helped to shift the focus onto the child:

'…those children did not choose not to come; they were not brought… It's not their choice, it's out of their hands.' (Dentist 1);

'It brings in another professional, and it is reaching out, and sharing information.' (Dentist 1).

The WNB pathway was felt to make decision-making and information sharing quicker and easier. The team recognised their important role in safeguarding and promoting children's welfare by identifying vulnerable children and sharing concerns:

'The pathway makes you question your next action… and you share information sooner.' (Dentist 1);

'Even if in your whole working life, it only saves one person's life, it makes it more than worth it.' (Dentist 2).

Reception from parents

Sending the WNB1 or WNB3 letter was thought to have prompted parents to consider their responsibility to bring their child for appointments. Some came personally to the clinic to apologise and re-book. Only one

parent was reported to be displeased but the receptionist was able to defuse the situation by explaining the reason for the new policy and that it applied to all:

'[the new pathway] made [parents] think "Oh, I won't do that again." So, having something physically telling them they had missed an appointment other than just a phone call.' (Receptionist);

'…when people [parents] receive the letter, they had come and apologised about missing the appointment…So when they receive the letter in the post, it makes them think.' (Receptionist).

Positive impacts on staff

Impacts on staff related to ease of use of the pathway, how they had incorporated it into the working day, the effect on teamwork, and relief of professional uncertainty. The team all welcomed the change. Some had initially felt daunted but they had found it easy to learn, particularly with repetition. All the interviewees readily referred to its specific stages by abbreviations, for example, WNB1, WNB2:

'The flow chart is really good, it is self-explanatory and really clear to follow.' (Receptionist);

'There is nothing to panic about… After you do one or two it's just like anything else you do on a daily basis on reception and you will do it automatically.' (Receptionist);

'Once you are doing it regularly, I think that is the key, doing it regularly and following it through each stage it becomes easy.' (Dentist 1).

Generally, the WNB pathway did not increase the daily workload for either reception staff or dentists, rather it helped them to make a decision quickly. Sometimes this was contrary to initial expectations:

'It is just the case of clicking a few extra buttons and type. It wasn't difficult or time consuming.' (Receptionist);

'…actually, instead of me taking the time to think, "Aww, what should I be doing? Where should I be contacting? Who should I speak to?" … the pathway saves you time.' (Dentist 1).

The whole dental team got involved, with the receptionist assuming a pivotal role in the daily tasks, training colleagues and monitoring. Every member felt engaged and empowered to contribute. They described helping each other, with the receptionist cited as the best source of advice:

'Yes, we are all working together to get the same result at the end.' (Receptionist).

Importantly, staff felt that the pathway provided reassurance that they were making the correct decisions:

Box 1 Amended WNB4 template note including question prompts to aid assessment and documentation of risk

WNB4 (green)

No response to WNB letter 2 (or multiple cancellations/no response to recall letter)

- Clinician reviewed records: yes/no
- Clinician assessed risk of harm: yes/no; at risk/not at risk

CONSIDER:

Why was the child attending?

Was any treatment required?

What is the impact of the child not attending?

- Need for information sharing considered: yes/no
- Decision to share information with:
- 'CYP_WNB_letter4_concerns to GP' letter sent: yes/no
- Copied to:
- record to be archived OR note here any further action required

'I do think it has made people not as worried about acting on things because they are following a set pathway… It has taken that massive responsibility off their shoulders.' (Dental nurse);

'So it feels like a bit of a safety net that I am following the right protocol and it is being followed up.' (Dentist 1).

Ideas for further development

Although recommending that the pathway should be implemented service-wide, some limitations were noted. The team requested further guidance regarding multiple missed appointments, as this appeared to be area of confusion. Some expressed frustration that they did not always receive feedback from other professionals when they shared information, and wondered if that information was valued:

'When they have a WNB4, and then they come back and have another appointment, and then they DNA again. So it's gone through the process once, do we start again?' (Receptionist).

The concept of considering children as 'was not brought' had encouraged all the team to also consider the welfare of vulnerable adults who miss appointments:

'They don't make their own appointment, they don't get themselves to appointments, as they are unable to.' (Receptionist);

'The first time I saw it I decided we were going to use it for adults.' (Dentist 2).

Discussion

Regular dental care ensures that children have the opportunity to receive interventions and treatment to prevent dental pain and infection. Parents are responsible for ensuring that they are brought to appointments so that their dental health needs can be met.[14] Yet parents report a variety of reasons for missing appointments including forgetting, illness, no longer needing the appointment and, occasionally, more serious problems or priority clashes.[15] Other reasons, such as inappropriate or inaccessible services or administrative error, may be the fault of the healthcare provider and out of parental control.

A supportive, respectful and understanding approach to missed appointments is essential but the needs of the child, rather than those of the parent, should be kept at the centre of our response.[16,17] It is neither appropriate to simply send a further appointment nor to discharge the child from further dental care without taking other action.[6] Robust processes should be in place to enable sharing information with other professionals and to encourage re-engagement with health services.[12] If the child's needs are persistently not met, a child protection referral to children's social care should be considered.[3,9] In the past, dentists infrequently communicated with other agencies when concerned about dental neglect and rarely made child protection referrals to social care.[18] However a recent study in Sweden found that, against a backdrop of increasing referrals from dentists, missed appointments was dentistry's most common reason for child protection referral.[19]

This service evaluation confirms that our new WNB-CYP pathway encouraged a focus on the child and improved the consistency of our management of missed appointments and information sharing. When the pathway was used, 75% of missed appointments were promptly and successfully rebooked after telephone or postal communication with

parents. For the remainder, children's records were individually reviewed to determine what action was necessary, with few exceptions, resulting in information sharing with a range of other health and social care professionals.

This transformational change, intended to benefit patients, also had perceived benefits for staff. They found use of a standardised pathway increased their job satisfaction and confidence, and did not adversely impact on their working day. The WNB-CYP pathway successfully involved the whole dental team where previously the responsibility had fallen solely on the dentist. Both reception and dental nursing staff welcomed a sense of shared responsibility. The pathway empowered them to manage nearly three-quarters of missed appointments independently of dentist advice. Reception staff noted that the process was not time-consuming and could be fitted into their working day. They reported that the WNB-CYP pathway appeared to be accepted by parents, prompting remarkably few adverse comments, and the team felt confident in their ability to handle these.

National guidance recommends that local systems should enable GMPs to take the lead in action following missed appointments.[20] Yet GMPs do not always receive adequate information to enable them to do this effectively.[21] For a full picture of a child's healthcare needs, it is imperative that dental practitioners share dental information with them. This pathway provided dental staff with more confidence to do so and reassurance of acting appropriately. Furthermore, the dental team often went beyond the express requirements of the pathway, as illustrated by over a third of occasions when information was shared with additional professionals.

However, the dental team did voice uncertainty over whether the information they shared was valued, as they received little direct feedback. We can infer that some GMPs took action on receipt of WNB4 letters because they and other professionals subsequently contacted our service about the children concerned. However, in the absence of direct and specific feedback, as is recommended by safeguarding guidance,[22] inferred feedback alone may not be enough to reinforce and maintain communication pathways and encourage future information sharing and referrals.

The missed appointment rate of 10.8% noted in this study is comparable to the 11–12% appointment rate in our previously published 2009–2011 audit.[11] Missed appointment rates in other UK dental settings have been reported between 16% and 32%.[15,23] Although reducing the missed appointment rate was not a specified aim of the WNB-CYP pathway, it may have the potential to do so in the long-term by changing parental attitudes and behaviour. This would be of interest for further study.

The main limitation during this pilot period was that the pathway was not always used (Fig. 3). Although we anticipated that this would be resolved as it became embedded in daily practice, this was noted for further evaluation when rolled out to other clinics. Guidance was strengthened at an early stage regarding multiple cancellations and repeated WNBs with re-booking, as potential indicators of disguised compliance,[12] with an advised threshold of two or more unexplained events before progressing to WNB4. Other points noted for improvement were the quality of documentation of the dentist's risk assessments (for example, previous dental pain or infection and untreated carious teeth) and the reluctance to 'discontinue' and 'archive' even when all information sharing actions had been appropriately concluded.

Roe's assertion that 'describing children as WNB rather than DNA is advocating for the child and placing the child at the centre' was clearly well received and struck a chord with our team.[16] Furthermore, it prompted them to also consider the needs of vulnerable adults who similarly require a family member or carer to bring them to dental appointments.

Action planning and further developments

As a result of the evaluation findings, an action plan was developed and implemented as follows:

- Add question prompts to the WNB4 template note to assist clinicians with assessing and documenting risk (Box 1)
- Roll-out the 'WNB-CYP green' pathway city-wide to all clinics, backed up with implementation support and guidance from a leadership fellow working alongside the team, and re-evaluate
- Offer to other community dental services in the region
- Adapt for children who are subject to a child protection plan and for looked after children, ensuring that named social workers are also informed; the 'WNB-CYP pink' pathway
- Work with stakeholders to develop and evaluate a version for vulnerable adults ('adults at risk'); the 'WNB-CYP purple' pathway
- Seek feedback from GMPs to explore their views on and response to receipt of the WNB4 letter.

The WNB-CYP pathway was implemented city-wide in CSCD clinics on 1 January 2017. After six months it had been used to manage 89.3% (159/178) of children's missed appointments, a slight improvement on the 84.3% (113/134) usage in the single-clinic pilot. Of these, information sharing was carried out for 40 (28%) of the 143 children with missed appointments, compared to 25 (27.5%) in the pilot period. Excellent staff engagement was again reported. Six children were not followed up, alerting us to the need for constant vigilance in following procedure if we are to ensure that vulnerable children cannot slip through the net.

A limitation of the evaluation is that it was not independent, the investigators being members of the same clinical team, which may have hindered identifying any shortcomings of the pathway if interviewees did not feel able to speak entirely freely. In keeping with a service evaluation project, our methodology was designed to generate information to support local decision-making. Nevertheless, our findings highlight the potential benefits, challenges and considerations of implementing a new approach to managing children's missed dental appointments which may be of interest beyond our own service.

We suggest that this WNB-CYP pathway can be recommended to other community dental services with similar WNB rates, case mix and organisational structure. We strongly recommend that this should be done in consultation and partnership with local safeguarding children professionals. There may also be merit in testing the pathway's effectiveness and acceptability in other settings, such as general dental practice and hospital dental services. Furthermore, it would be of interest to explore in more detail the views and responses of GMPs to our letters.

Conclusion

Use of a new WNB-CYP pathway encouraged a focus on the needs of the child and improved the consistency of management of children's missed appointments in a community dental service setting. It encouraged reappointment of children for necessary dental care in a timely manner, was acceptable to the dental team, and gave staff greater confidence to share information with the child's GMP and other health and social care professionals.

Acknowledgements and Contributor statement

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Contributor statement

JCH conceived, developed and implemented the initial pathway. JK and JCH together designed the evaluation, analysed and interpreted the data, formulated the action plan and drafted and critically revised the manuscript. JK conducted the data collection including interviews, further data analysis and implemented the action plan.

References

1. Office of the High Commissioner for Human Rights. United Nations Convention on the Rights of the Child. 1989. Available at https://downloads.unicef.org.uk/wp-content/uploads/2010/05/UNCRC_united_nations_convention_on_the_rights_of_the_child.pdf (accessed July 2019).
2. Harris J C, Balmer R C, Sidebotham P D. British Society of Paediatric Dentistry: a policy document on dental neglect in children. *Int J Paediatr Dent* 2018; **28:** e14–e21 (first published 14 May 2009).
3. National Institute for Health and Care Excellence. Child maltreatment: when to suspect maltreatment in under 18s. 2009. Available at https://www.nice.org.uk/guidance/cg89 (accessed July 2019).
4. Office of the Chief Dental Officer England. *Commissioning Standard for Dental Specialties - Paediatric Dentistry*. London: NHS England, 2018. Available at https://www.england.nhs.uk/wp-content/uploads/2018/04/commissioning-standard-for-dental-specialties-paediatric-dentristry.pdf (accessed July 2019).
5. Woodman J, Brandon M, Bailey S, Belderson P, Sidebotham P, Gilbert R. Healthcare use by children fatally or seriously harmed by child maltreatment: analysis of a national case series 2005–2007. *Arch Dis Child* 2011; **96:** 270–275.
6. Powell C, Appleton J V. Children and young people's missed health care appointments: reconceptualising 'Did Not Attend' to 'Was Not Brought' - a review of the evidence for practice. *J Res Nurs* 2012; **17:** 181–192.
7. Roe M F E, Appleton J V, Powell C. Why was this child not brought? *Arch Dis Child* 2015; **100:** 511–512.
8. Harris J C, Elcock C, Sidebotham P D, Welbury R R. Safeguarding children in dentistry: 1. Child protection training, experience and practice of dental professionals with an interest in paediatric dentistry. *Br Dent J* 2009; **206:** 409–414.
9. Harris J, Sidebotham P, Welbury R. *Child protection and the dental team: an introduction to safeguarding children in dental practice*. Sheffield: COPDEND, 2006. Updated 2013. Available at https://bda.org/childprotection (accessed July 2019).
10. Harris J, C M, Welbury R, Cairns A M. The Scottish dental practitioner's role in managing child abuse and neglect. *Br Dent J* 2013; **214:** E24.
11. Harris J C, Firth L M, Chadwick B L. Clinical audit of children's missed dental appointments in a city-wide salaried community dental service in relation to guidance on when to suspect child maltreatment. *Child Abuse Rev* 2017; **26:** 172–183.
12. Sidebotham P, Brandon M, Bailey S *et al. Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014*. London: Department for Education, 2016, pp143-145, p195.
13. Royal College of Paediatrics and Child Health. Safeguarding Children and Young People: Roles and competences for healthcare staff. Available at https://www.rcpch.ac.uk/resources/safeguarding-children-young-people-roles-competencies-healthcare-staff (accessed July 2019).
14. Appleton J, Powell C, Coombes L. Children's missed healthcare appointments: professional and organizational responses. *Arch Dis Child* 2016; **101:** 814–818.
15. Simons D, Pearson N, Dittu A. Why are vulnerable children not brought to their dental appointments? *Br Dent J* 2015; **219:** 61–65.
16. Roe M. WNB versus DNA: why children cannot "not attend." *BMJ* 2010; **341:** 1052.
17. Arai L, Stephenson T, Roberts H. The unseen child and safeguarding: 'Did not attend' guidelines in the NHS. *Arch Dis Child* 2015; **100:** 517–520.
18. Harris J C, Elcock C, Sidebotham P D, Welbury R R. Safeguarding children in dentistry: 2. Do paediatric dentists neglect child dental neglect? *Br Dent J* 2009; **206:** 465–470.
19. Kvist T, Cocozza M, Annerbäck E M, Dahllöf G. Child maltreatment - prevalence and characteristics of mandatory reports from dental professionals to the social services. *Int J Paediatr Dent* 2017; **27:** 3–10.
20. Department of Health and Social Care. National service framework: children, young people and maternity services. 2004. Available at https://www.gov.uk/government/publications/national-service-framework-children-young-people-and-maternity-services (accessed July 2019).
21. French L R, Turner K M, Morley H, Goldsworthy L, Sharp D J, Hamilton-Shield J. Characteristics of children who do not attend their hospital appointments, and GPs' response: a mixed methods study in primary and secondary care. *Br J Gen Pract* 2017; **67:** e483–e489.
22. Department for Education. Working together to safeguard children. 2015. Available at https://www.gov.uk/government/publications/working-together-to-safeguard-children--2 (accessed July 2019).
23. Rodd H D, Clark E L, Stern M R, Baker S R. Failed attendances at hospital dental clinics among young patients with cleft lip and palate. *Cleft Palate Craniofac J* 2007; **44:** 92–94.