Institution: Oxford Brookes University

Unit of Assessment: 3, Allied Health Professions, Dentistry, Nursing and Pharmacy

Title of case study: Children's missed health care appointments: changing professional and organisational responses to increase children's safety and wellbeing

Period when the underpinning research was undertaken: 2012–2016

Details of staff conducting the underpinning research from the submitting unit:

Name(s):	Role(s) (e.g. job title):	Period(s) employed by submitting HEI:
Jane Appleton	Professor of Primary and Community Care	[text removed for publication]

Period when the claimed impact occurred: 1 August 2013–31 December 2020

Is this case study continued from a case study submitted in 2014? No

1. Summary of the impact

Our work has led directly to a change in the commonly applied terminology used to record children's non-attendance at routine health care appointments. It has been pivotal in reconceptualising children's missed health care appointments from Did Not Attend (DNA) to Was Not Brought (WNB). This critical difference encourages health care professionals (HCPs) to think and act differently to ensure the wellbeing and safety of children who miss health care appointments. Our work has led to multidisciplinary impact via change in policy, training and clinical practice including: adoption by professional and regulatory bodies; incorporation into safeguarding and competency frameworks; and integration into practice toolkits and guidance to enable professionals to better care for children across the UK.

2. Underpinning research

Children missing scheduled health care appointments is a major challenge and concern for health and social care practitioners. If a child fails to attend a scheduled hospital appointment this may be an indicator of abuse and/or neglect. Despite policy and practice guidance that requires HCPs to follow up children who miss health care appointments, in 2012, Jane Appleton (Oxford Brookes University) and Catherine Powell (University of Southampton and Safeguarding Children Consultant) raised concerns that this was not yet routine practice **[3.1]**. We started to question the Did Not Attend label that led to a lack of recognition of children's needs and their individual rights, the increased likelihood of just re-sending an appointment or (even worse) discharge from the waiting list for lack of engagement. In our review of the evidence for practice, relevant research and policy evidence was synthesised, and the case made for the issue of children's missed health care appointments to be reconceptualised as Was Not Brought rather than Did Not Attend, arguing that this:

- better reflects the circumstances of what is happening in practice,
- is child-centered, and
- is more likely to lead to positive interventions by HCPs to safeguard and promote children's welfare.

Our review aligned with an opinion piece by Michael Roe, a paediatrician from Southampton General Hospital, who also argued that Was Not Brought was a more appropriate term to use than Did Not Attend when applied to children and young people. Our work presented this complex issue in a simple manner and highlighted access to health care as a fundamental right for children and young people (UN Convention on the Rights of the Child, 1989: Article 24). The responsibility for ensuring that this happens, and that health care needs are met, rests primarily with parents, with the competent child gradually taking full responsibility into adulthood (18 years). The review stressed that where there are parental difficulties or disengagement of young people, which may occur within vulnerable families, health care needs may form a low priority and appointments may be missed. At this point, the professional or the organisation may need to intervene to ensure that

the child is safe and well; such action would be in keeping with statutory responsibilities of health services (e.g. Children Act 2004, Section 11) **[3.1]**.

Our collaborative research, funded by the National Society for the Prevention of Cruelty to Children (NSPCC), examined the organisational and professional responses to children's missed health care appointments **[3.2]**. The research provided detailed analysis of the systems, complexities and challenges of responding to children's missed appointments in the acute hospital setting from the perspective of NHS staff. It explored the factors (at both the individual and systems level) that contribute to HCPs failing to take action when a child is not seen as planned. An important outcome of the research was a series of questions for NHS staff to use in their practice to help them consider the significance for the child of missed appointments including: what are the consequences for the child; and does the parent understand the need to get the child to the appointment **[3.3]**? We also published six quality standards for health care organisations to review their own organisational policies against **[3.3]**. We have highlighted in a number of publications that children have a right to access health care services and we need to consider the outcomes for them of non-attendance and not being seen **[3.4, 3.5, 3.6]**.

3. References to the research

Publications:

3.1 Powell, C., & Appleton, J.V. (2012). Children and young people's missed health care appointments: Reconceptualising 'Did Not Attend' to 'Was Not Brought' - a review of the evidence for practice. *Journal of Research in Nursing, 17*(2), 181-192. DOI: 10.1177/1744987112438158

3.2 Appleton, J., Powell, C. & Coombes, L. (2014). Professional and organisational responses to children's missed health care appointments: a child protection concern? *Final report to National Society for the Prevention of Cruelty to Children (NSPCC)*, September 2014. [available on request]

3.3 Appleton, J., Powell, C. & Coombes, L. (2016). Children's missed healthcare appointments: professional and organisational responses. *Archives of Disease in Childhood, 101*(9), 814-818. DOI: 10.1136/archdischild-2015-309621

3.4 Roe, M.F.E., Appleton, J.V. & Powell, C. (2015). Why was this child not brought? *Archives of Disease in Childhood, 100*(6), 511. DOI: 10.1136/archdischild-2014-307856

3.5 Appleton, J.V. & Sidebotham, P. (2017). Was not Brought - Take note! Think Child! Take Action! *Child Abuse Review, 26*(3), 165-171. DOI: 10.1002/car.2476

3.6 Appleton, J.V. (2019). Missed outpatient appointments and unplanned healthcare: the real question is 'why'? *Developmental Medicine and Child Neurology, 61*(7), 743. DOI: 10.1111/dmcn.14106

Grants:

1. Appleton, J.V. (PI) & Powell, C. (CI). (2012-2013) *Children's missed health care appointments: a scoping review*. **NSPCC** GBP2,000
2. Appleton, J.V. (PI) & Powell, C. (CI). (2012-2014) *Professional and Organizational responses to children's missed health care appointments: a child protection concern?* **NSPCC** GBP6,667

4. Details of the impact

The Was Not Brought message has had a significant impact, in both hospitals and the community (in health and social care) because it helps professionals to think differently about why children might be missing scheduled appointments. The change in terminology acts as a cue for analysis and action to prioritise the wellbeing and safety of children. It has led to numerous positive changes in children's safeguarding policies, training and clinical practice.

Impact on Policy

The Was Not Brought message has been adopted by a variety of governing bodies and national societies.

- The recommendation to use Was Not Brought instead of Did Not Attend has been implemented in national safeguarding policy. It is included for the first time in the 4th Edition of *Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff*

published by the Royal College of Nursing (RCN) (2019) on behalf of the 10 Royal Colleges and 12 professional bodies (across medicine, allied health, nursing and midwifery). Significantly, Was Not Brought is now identified as a core competence required of 'all staff working in health care services' and trained in safeguarding from basic Level 1 to specialist Level 5 **[S.1a]**.

- It is a key recommendation of The Children's Society Report (2017) *Stick With Us: Tackling missed appointments in children's mental health service*s, where our Was Not Brought work is cited and providers of specialist Child and Adolescent Mental Health Services (CAMHS) are advised to 'develop processes to respond' **[S.2]**.
- The Royal College of General Practitioners/NSPCC toolkit recommends that all primary care practices should have procedures in place for identifying and following up children who miss scheduled appointments with the practice or with other agencies **[S.3a]**.
- The NHS England Commissioning Standard for Paediatric Dentistry now refers to Was Not Brought **[S.3b]**.
- The British Dental Association (BDA) has published dental guidelines and a care pathway on *Implementing 'Was Not Brought' in your practice*, informed by our work **[S.1c]**.
- The RCN is including, for the first time, reference to Was Not Brought and our work in its revised guidance for nurses, to be published imminently **[S.3c]**.

In a critical commentary of the 2012 Powell and Appleton paper, Professor Eileen Munro who led the Government's 2011 child protection review noted: "*this paper presents a cogent argument for treating children and young people's failure to attend medical appointments differently from that of competent adults. The language change from 'did not attend' to 'was not brought' is a simple mechanism for triggering a different reaction*" **[S.4]**. The Care Quality Commission report (2016) *Not Seen, Not Heard: a review of the arrangements for child safeguarding and health care for looked after children in England* references her review of the 2012 Powell and Appleton paper when highlighting the importance of reframing Did Not Attend as Was Not Brought in policies, protocols and pathways to support multiagency working in keeping children safe **[S.1b]**.

Impact is evidenced throughout the country with the widespread change from Did Not Attend to Was Not Brought in acute hospital and community NHS Trust (n=223 Trusts) and dental policy. Most organisations have a separate policy (see for example Portsmouth Hospitals NHS Trust **[S.5a/b]**) and some have produced patient information leaflets on Was Not Brought **[S.5c]**. The Strategic Lead for Safeguarding Partnerships in Nottingham City Council has reported: "*Policies and procedures across the Local Authority have now been changed to reflect this position. I attend many meetings and conferences with regard to children and over the last 4 years I can barely recollect a professional saying, 'did not attend.' The shift in language in Nottingham has been significant and this has clearly led to improved outcomes for children"* **[S.6a]**. Furthermore, a survey of the UK's 22 NHS Children's Hospitals has shown that 71.5% of the 14 respondents have changed their hospital policy to Was Not Brought **[S.5d]**. Codes have also been introduced in general practice IT systems (EMIS, SystmOne and Snomed) to record Was Not Brought **[S.5e/f]**.

The Safeguarding Children Representative and Vice President of the British Society of Paediatric Dentistry, who has cited our research in lectures, international conferences and dental publications, described the impact of our '*ground breaking paper*' on the dental profession. "*WNB has replaced DNA as the preferred term for missed appointments across the speciality of Paediatric Dentistry, and is becoming more widely known in dentistry. On reflection Dr Powell and Professor Appleton's research was pivotal in unlocking a way forward…Their 2012 paper in a nursing journal continues to have an impact, crossing normal professional boundaries way beyond the original intended audience"* **[S.5g]**. In addition, a major dental software company (Software of Excellence) has added Was Not Brought functionality to its EXACT V13.12 dental software product in response to the move to using Was Not Brought **[S.5h]**.

Impact Through Serious Case Reviews (SCRs): Shifting Staff Awareness

The failure to ensure children's access to health care is recognised as a child protection issue within statutory definitions of neglect. It is known to be a prominent feature in some SCRs and has also been linked to preventable deaths in childhood. The Was Not Brought message is starting to be picked up in some SCR reports, see for example Frame (2017) and Sefton LSCB (2018) **[S.7a]**.

An SCR is undertaken after a child dies or is seriously injured following child abuse or neglect. SCRs look at lessons for all agencies (health, police, education and social care) that can help prevent similar incidents from happening in the future. One SCR report was of a child's death reviewed by [Redacted Name] Local Safeguarding Children Board where the child had missed several appointments. The report's author referred directly to our work and wrote: "*Child X 'Was Not Brought' to 23 appointments over a 2 year period. To describe the missed appointments in these terms focuses the mind more upon parental responsibility, and questions the underlying reasons for why a child would not be brought to so many appointments"* **[S.7b]**.

Evidence from the NSPCC national repository of SCRs demonstrates a move away from the term Did Not Attend since 2012 and a growing trend to thinking about children 'not being brought'. Of the 184 SCRs held within the NSPCC's repository that refer to poor engagement, 13% (24) use the term 'was not brought' in general parlance (i.e. descriptive, not in relation to policy) and 11% (21) specifically recommend a change in terminology and practice from Did Not Attend to Was Not Brought. In total, 9 reviews cited a change in policy from Did Not Attend to Was Not Brought as a result of the SCR recommendations. This demonstrates change in practice and represents an important contribution to improving child safety outcomes **[S.7c]**.

Impact in Practice

In direct response to the Was Not Brought message, Nottingham City Local Safeguarding Children Board created the YouTube video animation *Rethinking Did not Attend* **[S.8a]**. The idea for the video developed directly from our work, when the author of an SCR following a child's death cited our work **[S.6a]**. The video (with 75,258 views) has garnered a lot of positive interest across the UK, Europe, Australia and New Zealand, demonstrating the international reach of the original research **[S.6a; S.6b]**. Was Not Brought is now widely referred to in staff safeguarding training across NHS services, dentistry and social care **[S.1c; S.2b]**, and is now a core competence for child protection practice **[S.1a]**. The video is a powerful reminder that children do not take themselves to appointments, and for practitioners to reflect on the impact of missed appointments on a child's wellbeing. This shift has meant that professionals now do not just record missed appointments as Did Not Attend without analysis, leading to significantly improved early identification and referrals to children's social care **[S6.a]**.

Impact on the Welfare of Vulnerable Adults

Safeguarding trainers have also translated the learning from Was Not Brought for use within adult services, using the same principle in understanding vulnerable adults or people living with poor mental health or with learning disabilities **[S.6b]**. The BDA are also piloting extending the Was Not Brought approach to vulnerable adults, with plans to publish guidelines in due course **[S.5g]**. Nottingham Clinical Commissioning Group have also commissioned a new video *Missing Appointments Matte*r, which has stemmed from our original Was Not Brought work and broadens the focus to adults **[S.8b]**. The charity Inclusion Gloucestershire has used the Was Not Brought title and developed a short film about the difficulties faced by those with disabilities who need assistance to access doctor's appointments **[S.8c]**. These examples in differing contexts demonstrate the reach of the original work.

5. Sources to corroborate the impact

S.1 Adoption by Governing Bodies and Regulatory Bodies

S.1a RCN (2019) *Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff.* Intercollegiate Document. (4th ed). **'Was not Brought' referred to on pages 19, 20 and 25.** [available here]

S.1b The Care Quality Commission (2016) report *Not Seen, Not Heard*. *A review of the arrangements for child safeguarding for looked after children in England*. **Cites Munro's critique of our work [S.4] on page 22; reference listed on page 52**. [available here]

S.1c The British Dental Association (2019) *Implementing 'Was Not Brought' in your practice* **refers** [available here] **to [S.8a] on page 7**. The BDA website under 'CPD, References and resources' [available here] links to Kirby J and Harris JC (2018) Development and evaluation of a 'was not brought' pathway: a team approach to managing children's missed dental appointments. *British Dental Journal*. *227*, 291–297. **This paper cites [3.1] and [3.4] on page 291, [3.3] on page 295; see also references 6, 7, 14 on page 297.**

S.2 National Society, The Children's Society's Report (2017) *Stick with us: Tackling missed appointments in children's mental health services.* London. The Children's Society. '**Was not brought' cited on pages 9, 10, 48, 49, 50 and 51; [3.1] listed on page 66**.

S.3 National Guidance and Practice Toolkits

S.3a The Royal College of General Practitioners/NSPCC *Safeguarding Children Toolkit for General Practice* (2014), **pages 11, 54 and 64**. [available here]

S.3b The NHS England *Commissioning Standard for Dental Specialities: Paediatric Dentistry* (2018) **refers to Was not Brought and/or WNB on pages 23, 47, 52, 56 and 67**.

S.3c The Royal College of Nursing (In Press) *Safeguarding children and young people - every nurse's responsibility RCN guidance for nursing staff.* London, RCN. **Refers to WNB and cites and references [3.1] and [3.3] (in press).**

S.4 Critical Commentary, Munro, E (2012) Review: Children and young people's missed health care appointments: Reconceptualising 'DNA' to 'Was Not Brought' - a review of the evidence for practice. *Journal of Research in Nursing* 17(2): 192-194.

S.5 NHS Examples

S.5a Portsmouth Hospitals NHS Trust Management of Non-Attendance for health appointments for children and young people [available here]. **Reference [3.1] cited on pages 2, 5 (twice), 19 – reference listed on page13.**

S.5b NHS Solent Trust 'WNB' and 'DNA' Policy for Children and Adults [available here]

S.5c NHS West Hampshire CCG – WNB Information leaflet [available here]

S.5d A survey of the UK's 22 Children's Hospitals Was Not Brought policies

S.5e **Paper citing reference [3.1] and WNB in general practice.** Gibson, J & Evennett, J (2017). Child not brought to appointment. *British Journal of General Practice 67*(662): 397.

S.5f NHS Derby & Derbyshire CCG Was Not Brought Process & GP IT codes [available here]

S.5g Letter of endorsement: Consultant in Community Paediatric Dentistry, Safeguarding Children Representative and Vice President Designate, British Society of Paediatric Dentistry **explaining how our WNB work has impacted on paediatric dentistry.**

S.5h Blog 'Was Not Brought' is now an Option in EXACT dental software' **Refers to [S.8a]** [available here]

S.6 Children's Social Care Services Examples

S.6a Letter of endorsement: Strategic Lead for Safeguarding Partnerships, Nottingham City Council. **Explains how Nottingham used our WNB work to change policy/practices**.

S.6b Leeds Safeguarding Children/Adults training on WNB: [Details here]

S.7 Serious Case Review Evidence

S.7a Two examples of Serious Case Review (SCR) reports from the NSPCC repository: (i) Frame, H (2017) SCR LN15: overview report. NSPCC SCR Repository. **Reference [3.1] cited on p.29, 30.** [Link to SCR]; (ii) Sefton Local Safeguarding Children Board (2018) Serious Case Review – Martha, Mary and Ben. (2018) NSPCC SCR Repository. **Reference [3.5] cited on p.24.** [Link to SCR]

S.7b Local Safeguarding Children Board email about **unpublished Serious Case Review Report, not available in the NSPCC repository which references [3.1].**

S.7c Summary report and graph of SCRs in the NSPCC repository referring to WNB.

S.8 Video animations promoting Was Not Brought message

S.8a 'Rethinking Did Not Attend' developed by Nottingham LSCB (2017). Youtube 75,258 views at 11.3.21. **It was developed in direct response to our WNB work.**

S.8b 'Missing Appointments Matter' commissioned by Nottingham CCG (2019), a follow on from [S.8a].

S.8c 'Was not Brought' created by the charity Inclusion Gloucestershire. Youtube 1,954 views at 11.3.21.