



**Children's
Health Scotland**

CHILDREN IN HOSPITAL

2018/19 SURVEY

**Parental Access,
Family Facilities,
Policies and Procedures**

October 2019

**We care about all children and young people
getting the healthcare and treatment they need.**

Children's Health Scotland

At Children's Health Scotland¹ our vision is 'for every child and young person in Scotland to realise their right to the best quality healthcare'.

We are the only charity in Scotland dedicated to informing, promoting and campaigning on the healthcare needs and rights of all children and young people. We do this by:

- informing children and young people, parents and carers of their rights and responsibilities, where to access advice and support and what they should expect from health service providers;
- empowering parents and carers to participate in decisions about the treatment and care of their children; and
- supplying information, resources and support with the aim of helping families access the best possible healthcare.

As an independent organisation – not part of any health board or hospital – we can give parents information on any aspect of the healthcare of children and young people. Since 1985, we have undertaken regular surveys of Scottish NHS hospitals admitting children to find out what provision they make for the children and young people they are caring for, and for their families. The results of these surveys, and the trends they identify, have helped shape the development of government policy around children's healthcare and prompted improvements to services for families when their children are in hospital.



Acknowledgements

Children's Health Scotland (CHS) wishes to express its thanks to the Scottish Government Health and Social Care Directorate for funding this survey and to the research team at Blake Stevenson Ltd. for undertaking this survey on behalf of CHS.

We are very grateful to the NHS professionals who took time out of their busy schedules to complete the survey questionnaires and facilitated the hospital visits.

Special thanks to those parents and carers who shared their views and experience of being in hospital with a child.

Final thanks go to the CHS team involved and, in particular, to the Project Steering Group: Richard Olver (Chair), Kay Fowlie, Gwen Garner, Helen Forrest, Catriona Johnson, Una Macfadyen, Sylvia Smith and Zoe Dunhill.

¹ <https://www.childrenshealthscotland.org>



Contents

Chapter	Page
Executive summary	4-6
1. Background and context	7-9
A children's health landscape in transition	7
A dynamic hospital setting	8
A moving sample	8
Research approach	8
Hospital visits	9
Report structure	9
2. Findings	10-27
Visiting	10
Staying overnight	11
Taking a break	12
Refreshments and meals	14
Support	15
Staying informed: information provision and translation services	17
Young people's services	19
Consent, choice and autonomy for 14-16 year olds	20
Ambulatory care, short stay and surgery	21
Mental health	22
Children's menus and nutrition	23
Education	24
Play provision	26
The role of the Child Health Commissioner	27
3. Progress report	28
4. Benchmarking against the EACH Charter	29-32
5. Recommendations	33-35
Parental access and facilities	34
Family support	34
Information	34
Young people: admissions and facilities	34
Surgery	34
Mental health	35
Children's meals	35
Education and play	35
The role of the Child Health Commissioner	35

Appendices:

Appendices are provided in a separate document and may be viewed online at www.childrenshealthscotland.org



Executive summary

Background

- i. Since 1985, Children's Health Scotland (CHS, formerly Action for Sick Children Scotland) has carried out periodic surveys of Scottish NHS hospitals admitting children. Funded by the Scottish Government, CHS commissioned this, its eighth survey, in 2018 to assess current parental access and family facilities provision, and the implementation of child healthcare policies and procedures. Its purpose is to highlight good practice and progress and to identify where improvements need to be made. Survey results have been benchmarked against the ten articles of the European Association for Children in Hospital (EACH) Charter, key standards for paediatric care.

Research method

- ii. We carried out a survey of paediatric wards, neonatal units and hospitals with adult wards that admit children and young people in hospitals across Scotland and, additionally, sent questionnaires to health board catering managers, lead paediatric dieticians and child health commissioners.

Findings

Visiting and accommodation

- iii. The small dip (11%) in provision in open visiting for parent/carers in paediatric wards notwithstanding, the provision of unrestricted visiting has remained high (88% or above) in paediatric, neonatal and adult wards that admit children, while there has been a substantial increase in open visiting for siblings in paediatric and neonatal wards (no sibling visiting data for adult wards was collected) (Figure 2.1).
- iv. High percentages (above 89%) of paediatric neonatal and adult wards/units can accommodate at least one parent at night and there have been substantial increases since 2012/13, by at least 25%, in the provision of accommodation for both parents in neonatal units and adult wards. In contrast, paediatric wards showed a much smaller, and possibly non-significant, increase (4%) (Figure 2.2).

Facilities, refreshments and meals for parents/carers

- v. Compared to 2012/13, there have been substantial increases (16-43%) in the provision of a sitting room, kitchen and laundry facilities in paediatric wards and neonatal units. The availability of washing and showering facilities has remained the same (80%) in paediatric wards but has increased in neonatal units from 50% to 80%. Adult wards generally do not provide any of these facilities (Figure 2.3).
- vi. Paediatric wards and neonatal wards report that café facilities are accessible for virtually all parents/carers but access to food at non-commercial prices at all times is restricted, particularly in neonatal units (40%). In both paediatric wards and neonatal units there have been substantial increases (47-57%) in the availability of self-catering facilities for resident and non-resident parents/carers (Figure 2.4).

Family support

- vii. Access to spiritual care is virtually universal in all wards/units surveyed, with the biggest increase (32%) in adult wards admitting children. However, access to family support/liaison workers remains low across all wards/units (44-60%). Access to a social worker is higher in paediatric wards (increase from 70% to 77%) and adult wards (increase from 84% to 100%); in neonatal units it has fallen to 67%. Three paediatric wards and two neonatal units do not provide any form of family support other than spiritual care and bereavement support (Figure 2.5).

Information

- viii. There has been a small increase (5%) in the provision of information to families about ward procedures in adult wards that admit children, but a general decline in the information given at the time of admission on ward procedures in paediatric wards (down 39%) and, for young people, on confidentiality, consent and complaints/feedback on both paediatric wards (down between 14% and 48%) and adult wards (down between 12% and 30%). There are no 2012/13 comparative figures for neonatal units providing information on ward procedures but in 2018/19, only 53% of units do this. (Figure 2.6).
- ix. All but one of the 15 neonatal units provide written information on reimbursement of travel costs and car parking for parents and carers, whereas in paediatric wards, the figure has dropped by 38% to 49%.



- x. Four out of five paediatric wards provide information about the language and translation services available to parents and how to access them.
- xi. Translation and interpretation of spoken communications is available to families in nine out of ten paediatric wards and to children and young people in eight out of ten paediatric wards. Figures for translation of written communications for families and for children are lower by 25% and 23%, respectively.

Young people's services

- xii. The age of children and young people admitted to adult wards is not recorded at national (ISD) or health board level. However, the survey has revealed that 16 general hospitals admit children and young people while 37% of paediatric wards reported that children under 16 years of age have, in the past, been accommodated on an adult ward.
- xiii. The proportion of 14-16 year olds offered a choice of admission to a children's ward or adult ward has dropped 14% to 9%, since 2012/13. In the same period, the number of wards reporting that young people are accommodated on a specialist adolescent unit or ward has increased - but it remains low, at 15%. (Figure 2.7).
- xiv. In nine out of ten wards young people can consent to treatment in their own right and be given the opportunity to be seen by clinical staff on their own at admission. (Figure 2.8).

Surgery

- xv. The ability of parents/carers to accompany their child to the theatre and stay with them until they are asleep, and to be with their child in the ward after surgery, is almost universal and in each case represents a small increase in these practices (7% and 3%, respectively) since 2012/13. However, in other respects, operating day practice appears to have gone backwards, with fewer wards reporting that there is a dedicated paediatric surgery list (down 12% from 87%), reduced access of parents to recovery to be with their child on waking (down 22% from 83%) and fewer families given a contact number on discharge (down 15% from 97%). (Figure 2.8).
- xvi. Three-quarters of paediatric wards that admit children for surgery have dedicated paediatric lists, down 12%. (Figure 2.8).
- xvii. The frequency of allocation of particular anaesthetists for children's surgery lists varies from 57% to 75% depending on the speciality and whether the procedure is elective or emergency. Children's hospitals are more likely than general hospitals to allocate particular anaesthetists and, in the case of emergency surgery, twice as likely (88%).



Mental health

xviii. Three-quarters of paediatric wards admit children with a mental health condition, such as self-harm or eating disorder, which may be the primary cause for the admission or a co-morbidity with a primary physical condition. Fewer than a half (48%) reported that a named Child and Adolescent Mental Health Service (CAMHS) professional is responsible for managing these patients and only a third indicated that CAMHS staff are available for these patients at all times. (Figure 2.10).

Children's meals and nutrition

xix. Nearly all (86-100%) paediatric and adult wards support special diets required for medical and cultural/religious reasons. While the proportion of paediatric wards providing specific menus for children has fallen by 14% from 97% in 2012/13, in adult wards there has been a small increase (6%) to 43% over the same period. (Figure 2.11).

xx. All respondents claim to follow the Scottish Government guidance 'Food in Hospitals', 2016, but a third of paediatric and adult wards do not adhere to nutritional and salt intake standards. (Figure 2.11). The average spend on children's meals is £3.32 per day.

xxi. The provision of age-appropriate cutlery and tableware in paediatric wards has fallen 14% since 2012/13 to 83%.

Education

xxii. While paediatric wards report improvements in the provision of dedicated classrooms and the provision of additional needs support teaching, in no case does this reach 40% of wards (Figure 2.12) and in respect of the teaching of children and young people from outwith the hospital's local authority area, there has been a fall of 28% to 45% of wards.

xxiii. Two-thirds of wards report that they adhere to the Scottish Government Guidance on Education for Children and Young People Unable to Attend School due to Ill Health (2015), but only 36% provide teaching within five days of admission (medical assessment permitting), a key recommendation of the guidance. (Figure 2.12).

xxiv. Only 25% of adult wards offer access to teaching for the children and young people they admit.

Play

xxv. Nearly all (94%) paediatric wards now have a dedicated play room (up 5%) while the provision of a full range of play for children has remained high in the 2-13 age group (94%) and 14-16 age group (91%). The equivalent figure for babies (0-1 years) is 85% (down 8%). Access to a trained Health Play Specialist is available in 73% of paediatric wards and in half the neonatal units surveyed. (Figure 2.13).

The role of the Child Health Commissioner

xxvi. Thirteen of the 14 Child Health Commissioners provided information on 24 hospitals in their health board areas. Only four (28%) were able to provide a complete set of data on the number of adult wards that admit children or, between April 2018 and March 2019, the number of children admitted to adult wards, the number of children admitted as day cases or the number admitted as in-patients.



Professor Richard Olver
Chair, Children's Health Scotland



1. Background and context

Purpose of the report

- 1.1 This is the eighth survey in the series and again looks at parental access and family facilities provision, and the implementation of child healthcare policies and procedures. Its purpose is to highlight areas of progress and identifying where improvements still need to be made. The findings will be used by Children's Health Scotland to share examples of good practice, encourage health boards to improve their services where problems are seen to exist and to provide the Scottish Government with evidence about the quality and standard of child health services and inform its future provision and planning.
- 1.2 This report compares the results of this latest survey against the ten articles of the European Association for Children in Hospital (EACH) Charter, recognised as a benchmark for paediatric care in hospitals by the Scottish Government.
- 1.3 EACH is an international umbrella organisation open to European non-governmental, non-profit national associations involved in the welfare of children in hospital and other healthcare services. All member associations promote the implementation of the EACH Charter which sets the standards for the quality of care and the rights of sick children and their families, spanning everything from involvement in decisions about the child's healthcare and the right to having a parent or carer present at all times, to continuity of care and the preservation of privacy.
- 1.4 The EACH Charter echoes many of the articles of the UN Convention on the Rights of the Child (UNCRC), soon to be incorporated into Scots Law. All children have an explicit right to achieve their developmental potential and to sustain the highest possible standard of health. They also have a right to appropriate health services to facilitate attainment of these goals.
- 1.5 Protecting and promoting the health of children is an important goal in itself. Since children's early experiences are central to shaping their long-term health and wellbeing, it is also critical to improving the health of the whole population and reducing inequalities in health over the longer term.
- 1.6 Neonatal units have access to their own benchmarking system. The BLISS Baby Charter was designed to set standards for high quality family-centred care for babies across the UK. It is based on seven core principles built around: social, developmental and emotional needs; decision making; specialist services and staff; benchmarking; unit information and support for families; feeding; and discharge. It enables units to audit their practices and develop meaningful plans to achieve changes that benefit babies and their families. Thirteen of the units involved in this survey operate under the principles of the charter, and the two not doing so are working towards it.
- 1.7 Both the EACH Charter and the relevant UNCRC articles that underpin it are outlined in Chapter 4, alongside an assessment of how current parental access and family facilities provision, and the implementation of child healthcare policies and procedures, compare with the aspirations of these standards.

A children's health landscape in transition

- 1.8 The standards and expectations for children's healthcare are set out in various guidance documents from the Scottish Government, NHS Scotland and health boards, and underpinned by ambitions set by the Children and Young People (Scotland) Act 2014² and 'Getting it right for every child' (GIRFEC)³, the national approach to supporting the wellbeing of children and young people in Scotland.
- 1.9 The Scottish Government is currently "undertaking work to bring together an overarching narrative of the national policy priorities and Scottish Government actions being undertaken to improve outcomes for children, young people and families; building on extensive engagement with children, young people, parents and professionals about how best to support and improve the health and wellbeing of children and young people. The resulting document setting out the Scottish Government's vision, priorities and actions will be published in early 2020." (Children and Families Directorate, Scottish Government, October 2019).
- 1.10 NHS Scotland has conducted research into the improvement of maternity and neonatal care services. Its focus is to place the current and future needs of women, babies and families, as well as person-centred, relationship-based care, at the centre of redesigned services. In 2017, this research culminated in The Best Start, a five-year forward plan setting out the future vision for delivery of high quality and safe maternity and neonatal services across Scotland.

² <http://www.legislation.gov.uk/asp/2014/8/contents>

³ <https://www.gov.scot/policies/girfec/>



A dynamic hospital setting

- 1.11 It has been seven years since the previous survey and much has changed in the children's health landscape, with a new children's hospital in Glasgow providing regional and national services, and changes elsewhere.
- 1.12 Not only has the policy framework under which health boards operate changed since the last report – so too has the operational setting and approach at many of the hospitals surveyed.
- 1.13 Nearly three-quarters of the wards involved in the current survey reported that there had been major changes since 2012/13 and a third indicated that there were major changes planned for children and young people's healthcare in the next 12 months.
- 1.14 The changes that have taken place, or that are planned, centre around moving to different units and/or hospital sites; improvements in unit and/or hospital design and facilities; increasing the upper age limit of patients admitted for care in children's wards to 16 years; staffing and organisational changes.

A moving sample

- 1.15 The timing of this current survey provides an opportunity to evaluate the impact on service provision since 2012/13 of the changing policy landscape of children's healthcare, the service developments in hospitals at a regional and local level, and the opening of the large new children's hospital (RHC Glasgow).
- 1.16 However, since the response rate in 2018/19 has been considerably higher than in 2012/13, with additional wards and units included for the first time, caution should be exercised when making comparisons between the two surveys. Rather, the trends and differences identified serve as a snapshot of children's health services as they stand now and offer a marker for broad comparisons and benchmarking against EACH Charter standards.
- 1.17 In addition, this survey asked about service provision for 14-16 year olds whereas the previous survey referred to those aged 12-16, so the comparative responses around these areas will be indicative rather than definitive.

Research approach

- 1.18 We carried out a survey of paediatric wards (35 wards responded, a response rate of 97%), neonatal units (15 units; 100% response rate) and hospitals with adult wards that admit children and young people (19 hospitals; 95%⁴ response rate), along with catering managers and lead paediatric dieticians (17; 89% response rate) and Child Health Commissioners (CHCs) (13; 93%⁵ response rate) and in the process have built up a picture of the facilities on offer for children, young people and their families in hospital. The topic areas covered were informed by the EACH Charter and the UNCRC and included:
 - information about the ward or unit admissions;
 - parental access, including visiting arrangements;
 - family facilities and accommodation, including sleeping arrangements, family support, refreshments and meals;
 - young people's services, including facilities for young people, the provision of information and access to technology;
 - acute assessment for ill children admitted for less than 24 hours (excluding surgery);
 - children admitted for surgery and care on operating day;
 - children and young people admitted to paediatric wards with mental health conditions;
 - arrangements for providing feedback and accessing records;
 - any recent or planned changes in service provision;
 - travel, including provision of information relating to travel costs and car parking;
 - education, such as the provision of staffing and facilities for education; and
 - play, including workforce provision, play facilities and equipment.

⁴ Three of these 19 hospitals reported that they do not admit children and young people to their adult wards, so it was not appropriate for them to complete the majority of the survey. Consequently, the analysis in this report presents findings from the responses of the 16 hospitals whose wards admit children and young people.

⁵ The 13 CHCs completed individual surveys relating to 24 hospitals.



- 1.19 Facilitated through contact with CHS, survey respondents were identified by the Nurse Director in each territorial health board. The survey opened at the beginning of October 2018 and closed in early December 2018. Reminder emails and telephone calls during the survey period prompted people to take part.
- 1.20 In respect of the paediatric ward survey, information was obtained about the types of specialist units contained in each paediatric ward. In some cases, the ward itself was a specialist unit. Sixteen paediatric wards have combined medical and surgical units.

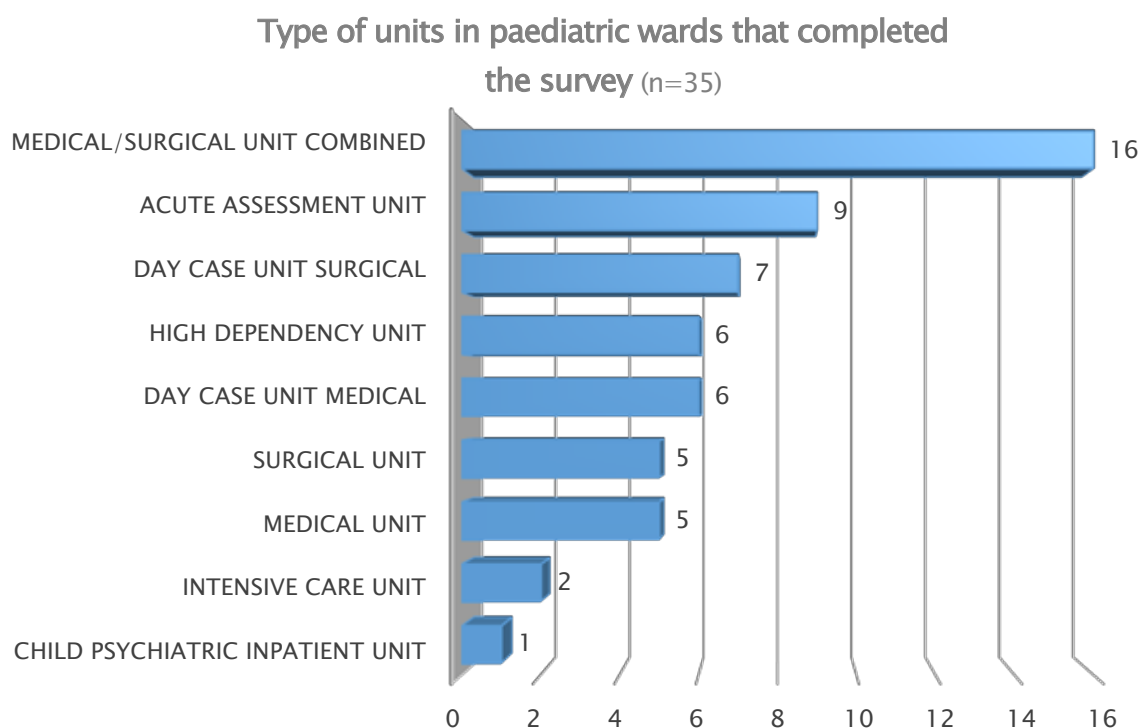


Figure 1.1

Hospital visits

- 1.21 Following the completion of the online survey, we visited two children's hospitals and two district general hospitals, one rural and the other urban, to explore some of the issues in greater detail with staff, parents and carers. Information from these visits are captured in the boxed examples.

Report structure

- 1.22 The remainder of the report is structured as follows:
- Chapter 2 outlines the main findings from the survey.
 - Chapter 3 summarises progress on some key areas since the 2012/13 survey.
 - Chapter 4 benchmarks the survey results with the articles of the EACH Charter.
 - Chapter 5 provides recommendations based on the findings of the survey.

2. Findings

- 2.1 The study looks at factors that might impact on a family with a child in hospital: when they can visit; if and where they can stay; where they can take a break; when and where they can eat and drink. It also looks at the child's experience of hospital; if they have a say in their treatment and who looks after them; whether they have a chance to play, learn, and use technology; what they eat and drink; and if they are kept fully informed about their rights and what is happening to them.
- 2.2 Responses for paediatric wards and neonatal units were made at the ward/unit level and the quoted percentages are based on the number of wards/units responding to a particular question⁶. However, responses to questions about adult wards admitting children were made 'per hospital' and the figures quoted for adult wards are percentages of the 16 hospitals with adult wards that admit children (see footnote four on page four). Throughout, the term 'adult wards' is used as shorthand for the hospitals with adult wards admitting children and young people.
- 2.3 This section summarises the findings from the surveys conducted in 2018/19 and, where possible, offers comparisons with the 2012/13 survey. Where the charts provided do not provide 2012/13 data, this is either because the questions asked in the two surveys were not directly comparable, or because the question was not asked in 2012/13.

Visiting

A reduction in open visiting for parents and carers but greater access for siblings

- 2.4 A small minority of paediatric wards (11%) surveyed placed restrictions on when parents can visit their children. The four paediatric wards that reported restricted visiting in the current survey were not surveyed in 2012/13 and, of these, three cited clinical priorities. The restricted times mentioned were during meals, doctors' rounds or school lessons. In contrast, the neonatal units which participated in the survey placed no restrictions on parents visiting. For siblings and family friends, the overall trend is an improvement in unrestricted visiting.
- 2.5 Eighty-eight per cent of the adult wards surveyed indicated that the friends of young people are allowed to visit on

Parents we spoke to were, in general, positive about visiting arrangements and feel able to come and go as they please.

"You can come up any time you want - there's no time limit." - Parent

Some, however, noted difficulties related to visiting. For example, at one of the children's wards we visited, parking is free, but it is really difficult to find a space.

the same terms as adult patients' visitors. Those that do not allow open visiting judge when friends can visit using: the discretion of staff; the need to maintain the privacy and dignity of other patients; the age of visitors; the child or young person's wishes; and the child or young person's condition.

- 2.6 Most respondents stated that staff apply the 'rules' around visiting consistently.

One parent appreciated that she was able to stay overnight but commented that it **"would be a lot easier"** if her partner could stay as well.

The majority of children have a say in who stays

- 2.7 Of the paediatric wards surveyed, most (94%) allow children to have a say in who visits them, similar to the findings of the 2012/13 survey (93%), and who they choose to stay with them (86%), a slight (7%) decrease since 2012/13.

Most neonatal units do not have rapid entry arrangements in place

- 2.8 Only two units (13%) reported having a rapid entry system. These two units used a key card or fingerprint system

"It's up to me who visits, and I restrict if they have coughs and colds." - Parent

⁶ In some cases, wards did not respond to a question because it was not relevant to them, for example questions about education were not relevant for intensive care units.



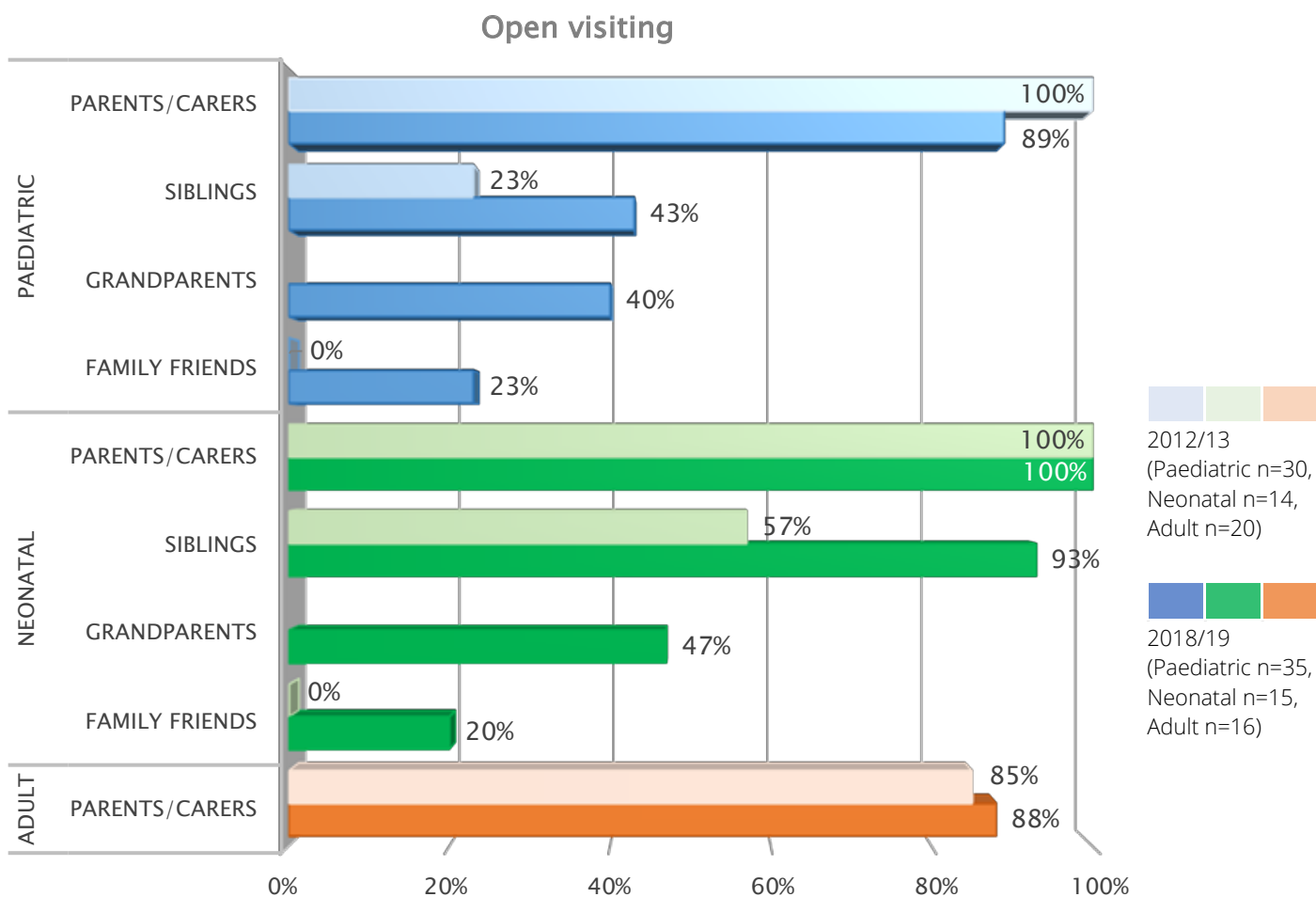


Figure 2.1

Most neonatal units encourage parents to stay with their babies at all times

2.9 Approximately nine in ten units (87%) encourage parents to stay with their baby at all times. Those that did not reported that parents are not encouraged to stay when other babies are being discussed during medical rounds or when procedures are being carried out on another baby in the same room.

Staying overnight

One in ten paediatric wards cannot accommodate parents overnight

2.10 Parents are able to stay overnight in 89% of paediatric wards, a very similar figure to the last survey (90%). Both parents can stay in half the wards (49%) and two-thirds of all paediatric wards allow another child to stay with their parents in the hospital.

All adult wards and neonatal units provide accommodation for at least one parent

2.11 All the adult wards and neonatal units surveyed could accommodate parents overnight. Most neonatal units (93%) can accommodate both parents overnight, an improvement from 2012/13 (64%); the corresponding figure for adult wards is 75%.

Percentage of wards/units where parents can be accommodated overnight

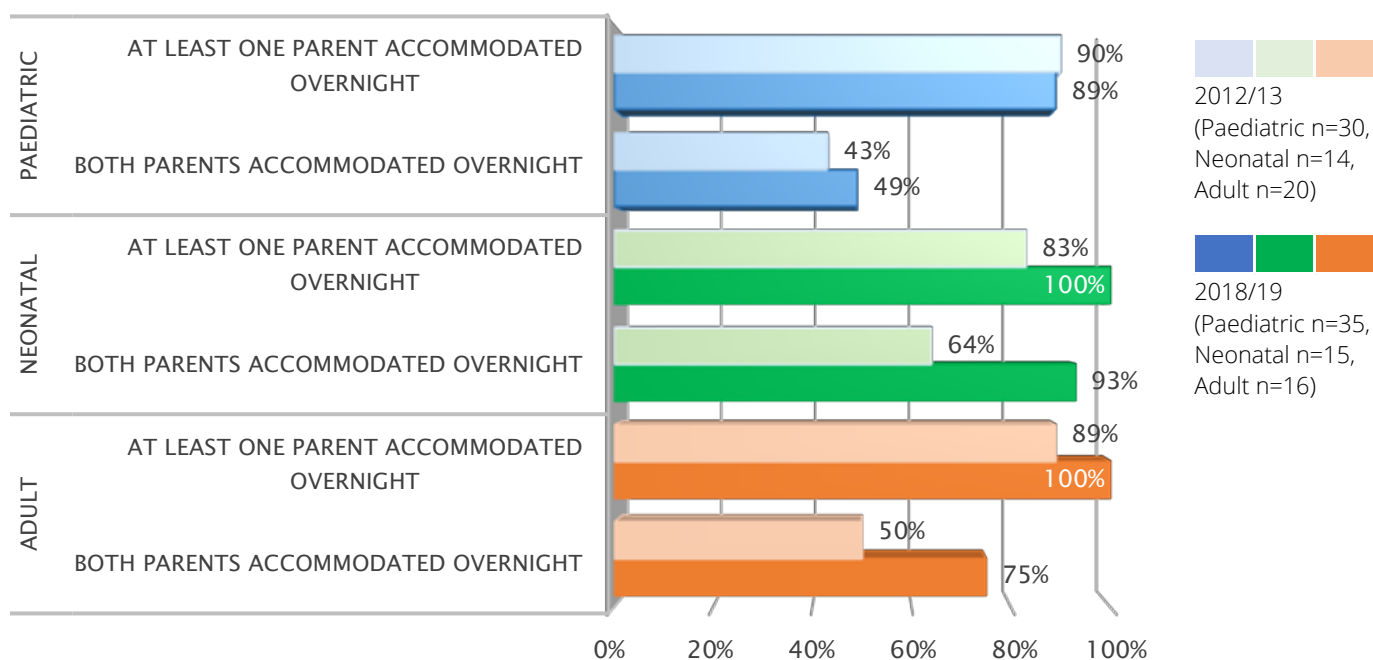


Figure 2.2

Most wards let parents stay next to their child

2.12 Just over four fifths of paediatric wards report that parents can stay beside their child in a bed. The figure is slightly higher in neonatal units – 87% – and slightly lower in adult wards – 75%. If parents are not in a bed beside their child, they can stay beside the child in a chair or off the ward. The adult wards that cannot accommodate both parents explained that this is due to a lack of space and accommodation, and one respondent emphasised that “every effort is made to ensure that parents/carers are supported to stay overnight should they and the young person wish.”

Parents at a new children’s hospital were impressed with the design of the ward, describing it as “peaceful” and “relaxed”.

There were some mixed views on the use of single rooms, however. Parents appreciated the privacy that this provides, particularly when discussing their child’s care with a doctor or nurse - “it’s nice to have your own privacy” - but one missed being able to strike up conversations with other parents on the ward, which is easier in a multi-bedded room.

A parent noted that, although she is not staying on the ward, she is able to stay at the nearby Ronald McDonald House. She thinks this is “brilliant” because it is close to the hospital and has room for her partner and other children to stay too.

Sometimes parents are turned away due to lack of space

2.13 In two wards at children’s hospitals (6%), parents had been turned away between April 2017 and March 2018 due to a lack of accommodation, and just over a quarter (27%) of neonatal units indicated that they have had to turn a parent away through lack of accommodation in the same period. For neonatal units, this is an improvement on 2012/13, when this figure was 50%.

Taking a break

Access to rest facilities for families on wards has improved

2.14 Almost nine in ten (86%) of paediatric wards now have a sitting room for families – up from 63% of those surveyed in 2012/13. Provision is even higher in neonatal units at 93%.



2.15 Four out of five (80%) neonatal units and paediatric wards offer washing and showering facilities for parents but only a quarter of neonatal units (27%) and under half of paediatric wards (43%) offer dedicated laundry facilities for parents. Nevertheless, both represent a notable increase since the last survey when there were laundry facilities in just over a quarter of paediatric wards and none in neonatal units.

Facilities available on ward for parents/carers

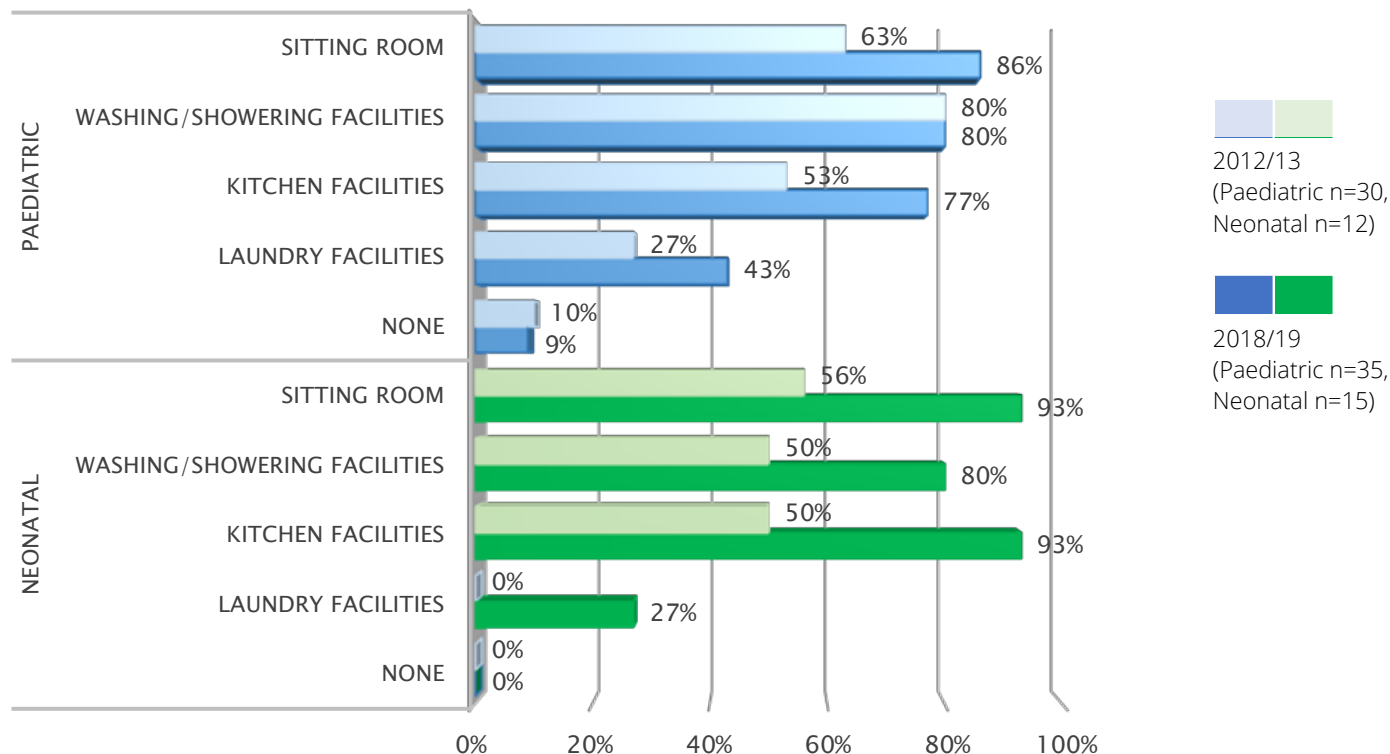


Figure 2.3

Three wards offer no facilities at all

2.16 Three wards (9%), all at children’s hospitals, indicated that they do not provide washing or showering facilities, laundry facilities, kitchen facilities or a sitting room.

One of the children’s hospitals we visited has a laundry room (with soap powder provided), parents’ lounge, and kitchen with microwave and basic provisions. Parents often leave food for others to use.

“We have very much a whole family approach. We provide lots of practical things if families need them like tissues, orange juice, water, toiletries, hairdryer.” - Member of staff

In another hospital, there are no laundry facilities on-site for parents to use, but the Family Support and Information team can arrange for a local launderette to collect laundry.

The facilities for families staying at one of the children’s hospitals we visited are excellent, with many areas to relax. Individual patient rooms have pull down beds, en-suite facilities and a TV. Small ward areas also have pull down beds. Only one parent can stay on the ward but families can also use the accommodation in another unit in the hospital.

Another hospital has similarly good facilities, but parents and staff reported that many of the televisions did not work. The hospital can lend DVD players to children, but there are not enough for every child to have one.

At the children’s ward in a district general hospital we visited, the two single rooms on the ward appear to be problematic as there are no windows/ventilation and feel very claustrophobic. Everyone questioned would like a toilet on the ward. Despite this, most people thought there were good facilities for a small unit; the commitment and helpfulness of the staff seemed to make up for any perceived shortfalls in facilities.

“The toilet is outside the ward. Makes it very difficult as you need to leave child and then get back in.” - Parent

Refreshments and meals

Access to hot and cold drinks is better in neonatal units than paediatric wards

2.17 All neonatal units offer access to hot or cold drinks for parents, day and night: only 89% of paediatric wards do the same during the day, dropping to 63% at night.

Wards generally offer improved access to meals

2.18 All neonatal units offer access to café facilities for parents, and almost all paediatric wards (97%) do the same. Around three-quarters (73%) of neonatal units indicated that meals are available for parents between 9am and 8pm and a third reported that meals are available day and night for parents.

Meal facilities available on the ward for parents/carers

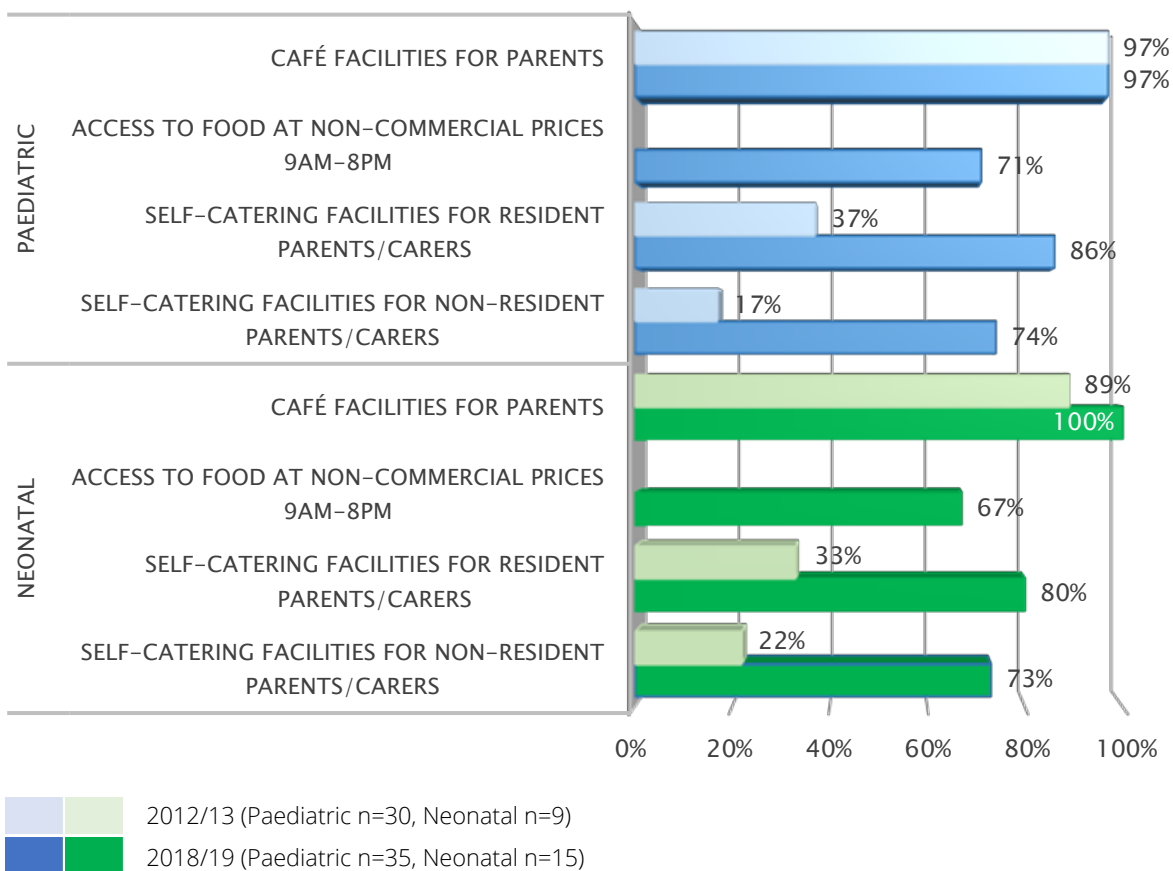


Figure 2.4

2.19 Most paediatric wards (94%) and neonatal units (87%) allow parents to use the staff canteen but only 71% of paediatric wards and 67% of neonatal units give parents access to food at non-commercial prices between 9am-8pm.

At one of the children's wards we visited, meals are limited but parents receive discount vouchers for the staff canteen. The staff café at a children's hospital which parents have access to is only open from 7.30am until 3.30pm and visitors and parents pay 50% more than staff. They do not get reduced rates even if their child is in hospital long term. Parents find it very expensive if their child is in hospital for a long period.

"Food in the canteen is too expensive. We tend to bring in our own but as we are miles from home with limited shopping and cooking facilities it's really expensive. However, the facilities are good where you can make tea and coffee and heat things up." – Parent

Access to self-catering facilities has improved markedly

- 2.20 Kitchen facilities for parents to make drinks and heat food are available in around three-quarters (77%) of paediatric wards, up from 53% in 2012/13 and in nine out of ten (93%) of neonatal units, up from 50% in 2012/13. Eighty-six per cent of paediatric wards offer self-catering facilities, giving parents the chance to make their own meals in their own accommodation, up from 37% in the last survey.

A parent at another hospital made a similar observation, that buying food at the hospital can be **“expensive”** and the cost **“soon mounts up if you are in here and not working... it’s an added worry”**. She also noted that she is reluctant to leave her child alone, so it can be **“awkward”** to find time to go off the ward to buy food.

We found food on the wards of a children’s hospital we visited to be excellent. The lunch trolley has fresh produce which can be made into filled rolls or served with baked potatoes to order at the bedside. Evening meals are reportedly good as well. However, meals are only provided for the child and only one parent can purchase a meal ticket.

More wards allow parents to eat with their child

- 2.21 Around two thirds (63%) of paediatric wards offer parents the opportunity to eat with their child on the ward, a noteworthy increase from the previous survey when the figure was just 20%. A third of neonatal units allow parents to eat with their child on the unit. Nine out of ten paediatric wards (86%) reported that parents can eat their own meals at their child’s bedside; the wards where this is not possible are in children’s hospitals.

Access to food and refreshment for siblings has improved

- 2.22 Nearly half the paediatric wards surveyed (49%) allow siblings to eat with their brother or sister, an increase since the last survey when the figure was 20%. Although only 20% of neonatal units allow this, it too represents an increase since 2012/13 when no siblings were allowed to eat in the units.
- 2.23 Self-catering facilities are available to resident siblings in four out of five (80%) neonatal units and three in five (63%) paediatric wards. The same facilities for non-resident siblings are available in 67% of neonatal units and 54% of paediatric wards. All of these represent an increase since the survey of 2012/13.
- 2.24 Eighty-seven per cent of neonatal units and 83% of paediatric wards offer siblings the use of café facilities.

Support

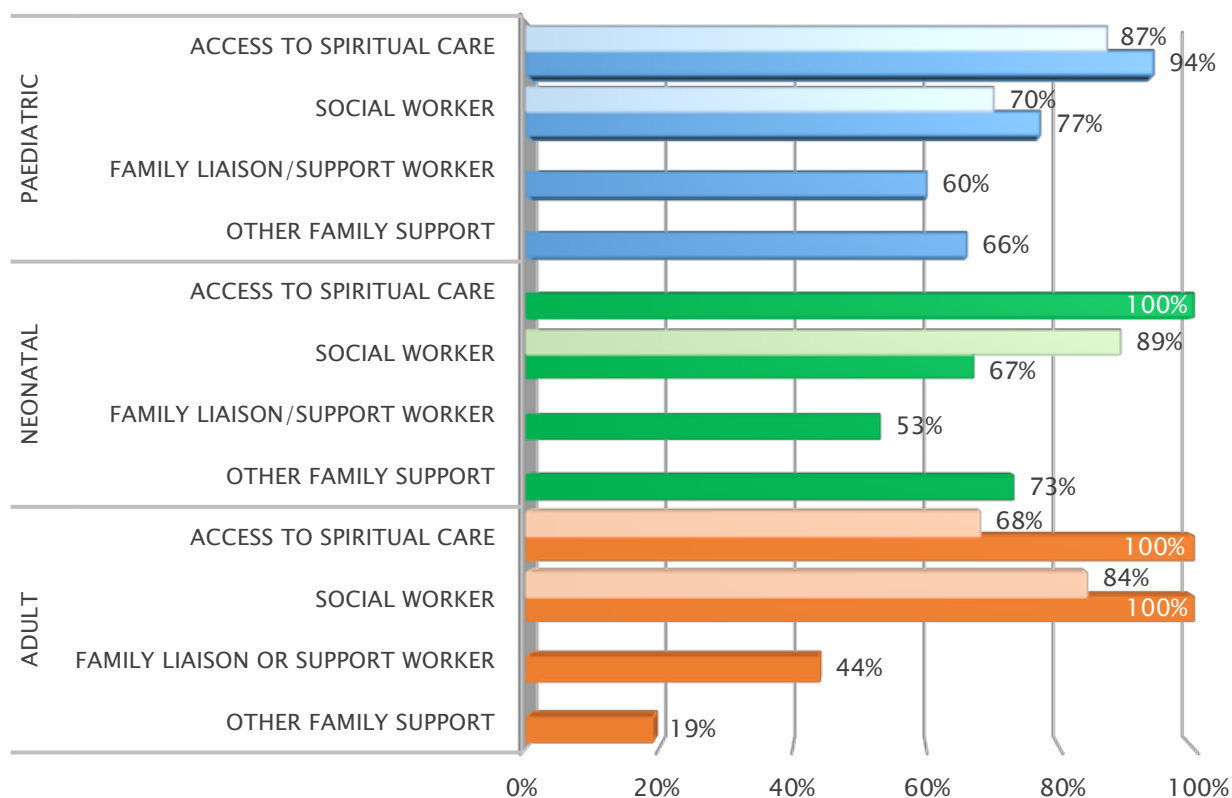
Around half the wards surveyed provide access to family support workers

- 2.25 Three in five (60%) paediatric wards give families access to a family liaison or family support worker. The figure is slightly less for neonatal units – 53%. These services are more likely to be available at children’s hospitals than in other types of hospital. For example, 70% of children’s hospitals have a family liaison or support worker, compared with a quarter (25%) of district general hospitals. Less than half of the adult wards surveyed (44%) provide access to a family liaison or support worker.

Access to a social worker has decreased in neonatal units

- 2.26 All adult wards that admit children have access to a social worker while three-quarters (77%) of paediatric wards and two thirds (67%) of neonatal units offer the same service – a decrease in neonatal unit provision from the 89% of the previous survey. Around two-thirds of paediatric and three-quarters of neonatal units have access to another type of family support service such as money advice, help with literacy difficulties and/or psychological support. The figure for adult wards is lower, at 19%.
- 2.27 Three paediatric wards out of 35 (9%) and two neonatal units out of 15 (13%) do not provide access to a social worker, a family liaison/support worker or any other form of support (other than bereavement and spiritual support).

Family support



2012/13 (Paediatric n=30, Neonatal n=9, Adult n=19)
 2018/19 (Paediatric n=35, Neonatal n=15, Adult n=16)

Figure 2.5

Spiritual care is readily accessible in most care settings

- 2.28 All adult wards and all neonatal wards offer access to spiritual care. The figure of 94% for paediatric wards offering access to spiritual care represents a modest increase from 87% in 2012/13.
- 2.29 All neonatal units and four out of five (83%) of paediatric wards offer access to bereavement services following the loss of a child.
- 2.30 Most respondents explained that spiritual care is provided through the on-site spiritual care team, chaplaincy service or a nominated spiritual care lead. A few respondents identified a specific area of the hospital where spiritual care is provided, such as a “spiritual care centre” or “sanctuary”.

“We ask about spiritual care/religion at admission. My experience is they usually approach us about these issues if they want some spiritual support.” - Member of staff

All neonatal units provide support and equipment for breastfeeding mothers

- 2.31 All units provide facilities, equipment or skilled support for mothers to express breast milk when they are in the unit, and all provide mothers with the free loan of a breast pump when expressing milk.

Only half of the neonatal units surveyed provide meals for breastfeeding mothers

- 2.32 Fifty-three per cent (8) of neonatal units provide breastfeeding mothers with meals; seven provide these for free, while one provides subsidised meals. This is up from 44% in 2012/13. When breastfed babies are admitted on to paediatric wards, the mother is provided with meals in 57% of wards, all free of charge.



Staying informed: information provision and translation services

Nearly all wards provide information about available facilities before or on admission

2.33 Four in five (83%) paediatric wards make written information about parent and carer facilities available for emergency admissions, while 89% provide this information for elective admissions. Ninety three per cent of neonatal units offer written information about the facilities available to parents, an improvement on 2012/13, when only 25% provided this information.

One of the children's wards we visited has good information on notice boards including a feedback tree to actively encourage comments from parents.

A patient's brother at another hospital said that staff had provided all the information they needed and there had been **"nothing unanswered."**

A general decline in the provision of information about confidentiality, consent and ward procedures

2.34 On paediatric wards, fewer young people are routinely made aware of their right to confidentiality or offered information about consent (76% and 74% respectively) than in 2012/13. Nevertheless, this is still higher than the provision of information about the complaints procedure which, at 32%, represents a notable drop from 2012/13, when 80% of paediatric wards told young people how they could complain.

2.35 A comparable decline in information about confidentiality, consent and complaints for children and young people has occurred on adult wards while, at 44%, the provision of ward information to families about ward procedures represents a small (9%) increase.

2.36 A third (34%) of paediatric wards offer written information to families at the time of admission about ward procedures, including how to access their child's records. This is a decrease since from 73% in 2012/13. Just over half (53%) of neonatal units provide this information.

Wards routinely providing information

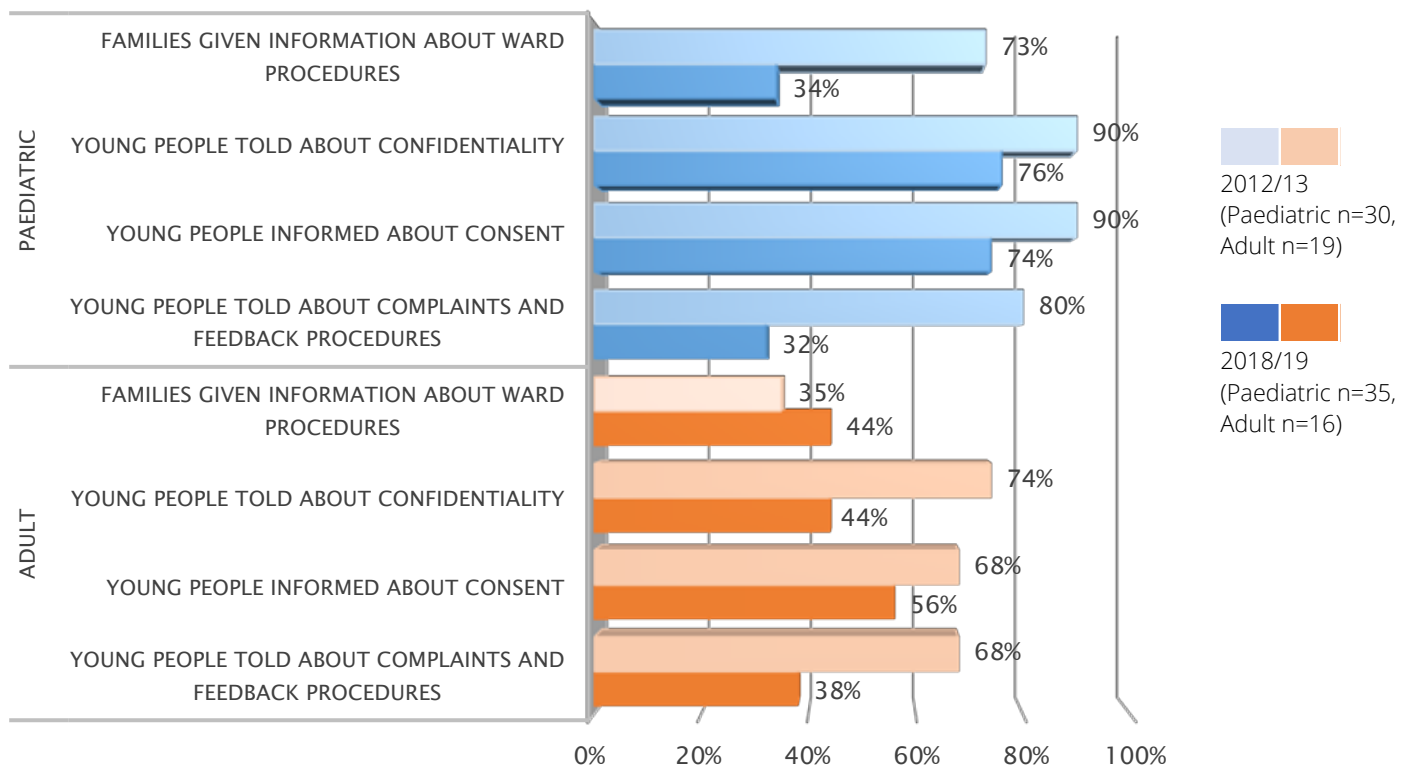


Figure 2.6

- 2.37 The proportion of wards allowing children to access their own records on request has also fallen from a half (47%) in 2012/13 to a third (31%) in 2018/19.

At a children's hospital we visited, there is a welcome folder in the wards but very few parents seem to be aware of it and not all staff seem to know about it – so it does not get used much.

At one of the children's wards at a DGH we visited, it appears that written information about ward routines and facilities is not always provided.

Feedback from parents with children at another DGH children's ward is that staff are good at giving lots of information. However, both parents and staff agree that written information about the ward would be good, and they are putting this together at present. There is lots of information in the parents' room on confidentiality, consent and how to give feedback – the latter is also displayed above patients' beds – but interestingly most parents questioned had not noticed this information.

A parent, whose son had been admitted for surgery, said that the ward **“needs to be more forthcoming with information to make it easier for parents”**. Staff had told her that he would be taken to the theatre early the following morning, and she would be staying with him on the ward the night before the operation, but she had not been given any information about visiting times. As a result, she was unsure if her partner would be able to visit immediately before the operation. Also, she knew that her son would be taken to ICU following the operation, but had not been given any information about visiting arrangements or facilities for parents' accommodation on that ward.

Fewer wards have a named nurse policy

- 2.38 Fifty-one per cent of paediatric wards reported that they use a named nurse approach; 43% use a team nurse approach. This is a drop from 2012/13 when 77% of wards reported using a named nurse approach. The same trend is evident in neonatal practice, where 33% of units use a named nurse, a decrease from 56% in the previous survey. This trend reflects a change in policy favouring the use of a team approach.

Most wards tell families about food and drink availability

- 2.39 All neonatal units and 86% of paediatric wards provide parents and carers with information about arrangements for food and drink either on or before admission.

The provision of information about travel costs has remained high in neonatal units but decreased in paediatric wards

- 2.40 The survey took place during the first year of the Scottish Government's Neonatal Expenses Fund, which includes travel expenses, and which staff are expected to promote to parents and carers. All but one neonatal unit (93%) provide written information on reimbursement of travel costs and car parking for parents and carers, whereas in paediatric wards, the figure has dropped to 49% from 87%.

All wards encourage feedback

- 2.41 All neonatal units state that they encourage parents to provide feedback. This is the same in paediatric wards, where all parents are encouraged to provide feedback on their stay, including decision making, service design and service evaluation - an increase compared with 90% in 2012/13. Thirty-three paediatric wards (94%) indicated that children are encouraged to do the same.

The information provided to children on adult wards has decreased

However, further research at a children's hospital we visited suggests that while there is a formal feedback process in place, very few parents and not all staff are aware of it and so it is not routinely offered. One parent said **“I wouldn't know how to do it formally, but I am able to talk easily to staff”** and that staff are **“all very supportive and good at listening”**.

- 2.42 Just over half of the adult wards that admit children and young people (56%) provide age-appropriate information about consent for children and young people when they are admitted to an adult ward. Forty-four per cent provide information about confidentiality and the same percentage provide children and young people with information about the ward itself.
- 2.43 Forty-four per cent of adult wards do not provide information on confidentiality, consent, complaints, about the ward or access to health records. Two-thirds of wards in rural general hospitals and half in district general hospitals do not provide this information or access to health records.
- 2.44 Nearly two thirds (63%) of adult wards ask the 'What Matters to Me?' questions when a child or young person is admitted in order to find out about their likes, dislikes, needs and preferences.

A parent said that What Matters to Me is **“fun for them [children] to do”** and she was impressed that the ward staff **“talk more to [my daughter] than me”**.

Language and translation services are more readily available to parents than children

- 2.45 Just over four-fifths (83%) of paediatric wards provide information about the language and translation services available to parents and how to access them. Translation and interpretation of written communications is available to families in two-thirds of wards and of spoken communications in 91% of wards.
- 2.46 More than half (57%) of paediatric wards offer translation of written communications to children and young people, and more – 80% – offer translation of spoken communication. Two-thirds of wards offer communications via British Sign Language to families, children and young people.

Young people’s services

Most adolescents are treated on children’s wards, not in specialist adolescent facilities

- 2.47 All but one (97%) of the 35 paediatric wards surveyed accommodate young people aged 14 and above. Of these, 29 (85%) accommodate young people between 14 and 16 on the children’s ward and the remaining 5 accommodate them in specialist adolescent facilities, such as an adolescent unit. Although this number is low, at 15% it still represents an increase from the previous survey when only 3% of wards accommodated 14-16 year olds in a specialist unit. However, 3 of the 5 wards that accommodate young people in a specialist adolescent unit have, on occasion, had to place young people on children’s wards when the unit was full.
- 2.48 A third (37%) of paediatric wards reported that in the period between the 2012/13 and current survey, patients have been accommodated on an adult ward before their 16th birthday. Respondents explained that this might happen if their ward is at full capacity, if the child or young person’s medical needs cannot be fully met on the children’s ward, or where the child displays challenging behaviour that makes it inappropriate for them to be on a paediatric ward.

Most paediatric wards are flexible about the age of young people they admit

- 2.49 Four out of five wards (79%) also mentioned that there are exceptions to their upper age limit, depending on the local arrangements for transitioning young people to adult wards and on the individual’s health condition.

“[The ward] admits children over 16 if they have a chronic or life-limiting condition and are not ready to transition to an adult ward for some reason.” - Staff member, paediatric ward

Adult wards do not generally have a policy for the care of children

- 2.50 Only one (6%) of the adult wards consulted stated they have a written policy or guidelines for the care of children and young people while just over half (56%) of adult wards surveyed offer children and young people access to paediatric medical/nursing advice and support. Roughly two-thirds (63%) of wards reported that children and young people admitted to an adult ward are not always nursed in a single room.

Consent, choice and autonomy for 14-16 year olds

The majority of paediatric wards allow young people to consent to treatment and be seen on their own

2.51 Respectively, 32 (94%) and 31 paediatric wards (91%) permit young people to consent to treatment in their own right and give young people the opportunity, where appropriate, to be seen by nursing or medical staff on their own and without their parents during the admissions procedure. Nevertheless, in a quarter of wards, young people are not routinely made aware of their right to confidentiality or offered information about consent on admission. In two thirds (68%) of wards they are not informed about the complaints procedures – a substantial drop from 80% in 2012/13.

Ward choice and autonomy for young people aged 14–16

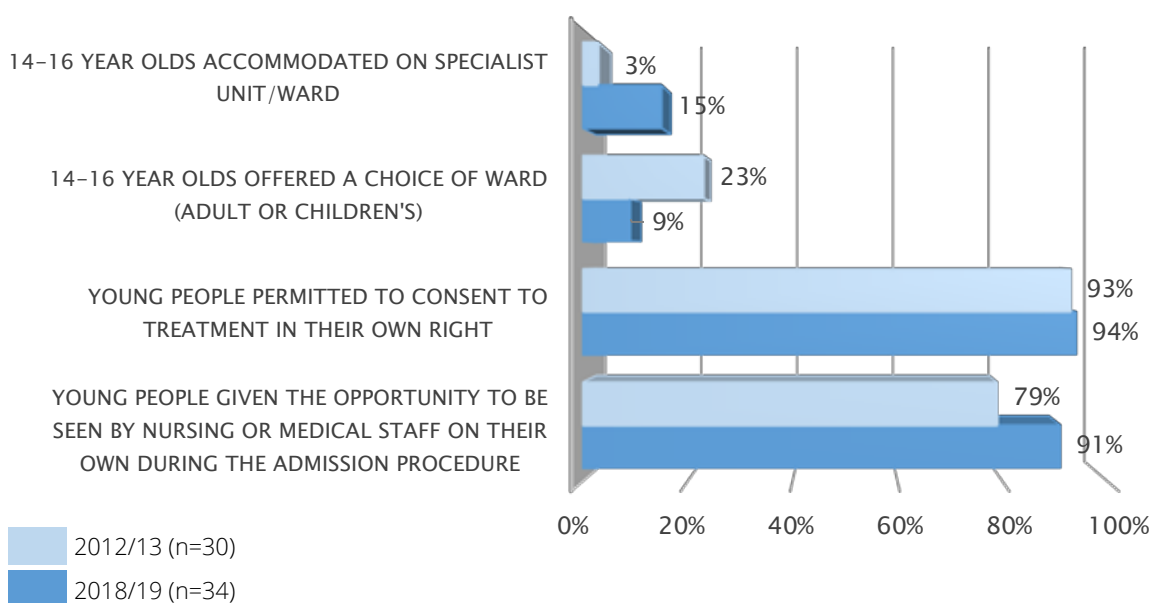


Figure 2.7

2.52 Only three wards (9%) offer those aged 14-16 a choice of ward (children's or adult) upon admission.

2.53 Thirty-two paediatric wards (94%) accommodating 14-16-year olds reported that there are facilities for young people with profound disabilities to have their carers resident while they are in hospital. This has more than doubled since the last survey when it was 40%.

Young people can use their phones in all wards and most have access to Wi-Fi

2.54 Young people are allowed to use their mobile phones in all paediatric wards where 14-16 year olds are admitted, an increase from 86% in 2012/13, while roughly four out of five (82%) paediatric wards give young people access to Wi-Fi and half allow young people to access the internet via a computer.

2.55 All adult wards allow children and young people to use their mobile phones, an increase from 80% in the 2012/13 survey. Free Wi-Fi coverage is almost universal (94%) in adult wards, although the availability of an internet-connected computer for children is low at 31%.

2.56 Although the permitted use of mobile phones is widespread, not all children and young people have access to one and neither do all parents and carers. This, combined with the fact that the strength of phone signals in hospital often varies, means that the availability of written information remains important.

At a children's hospital we visited, there is a room near the ward with two computers that families can use. They are given a code to do so, but there is no Wi-Fi provision.

Ambulatory care, short stay and surgery

2.57 All but one (96%) of the 24 wards that provide acute assessment of ill children (less than 24 hours) reported admitting children and young people for procedures, with the same number also reporting that they have a short stay ward or unit (under 24 hours). Seventy-nine per cent indicated that all acute referrals are seen by a consultant or specialty doctor (at Registrar/ST4 level or above).

Operating day practice

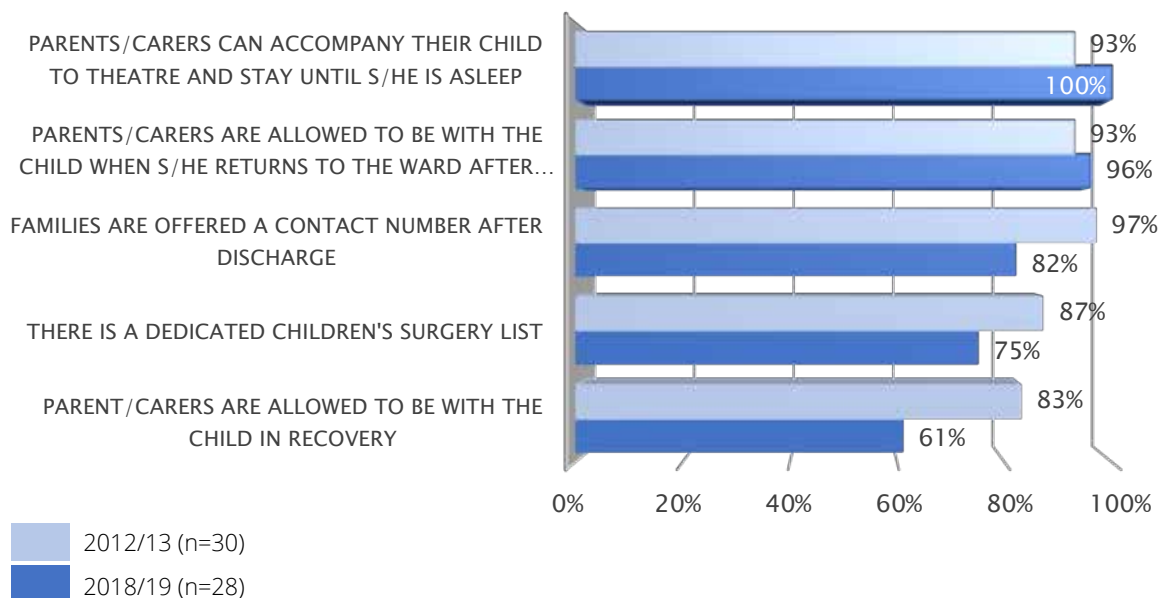


Figure 2.8

The majority of paediatric wards report that particular anaesthetists are allocated for children's lists

2.58 Four-fifths (80%) of the paediatric wards surveyed admit children and young people for surgery and three-quarters (75%) of them have a dedicated children's surgery list with particular anaesthetists allocated for children's elective surgery. However, only 64% report that particular anaesthetists are allocated for general paediatric surgery, 61% for emergency surgery, and 57% for dental surgery.

2.59 Children's hospitals are more likely than district general hospitals to have particular anaesthetists allocated for children's surgery. Nine out of 10 (88%) of children's hospitals allocate anaesthetists for emergency children's surgery, compared to 43% of district general hospitals.

Family focussed operating day practice has improved in some areas but declined in others

2.60 All paediatric wards that admit children for surgery now allow parents and carers to accompany their child to and from theatre and to stay with them until they are asleep, and in all but one ward (96%), parents can be with their child when they return to the ward after surgery. However, parents and carers are less likely to be allowed to be with their child in recovery – only 61% of wards reported that this is allowed, compared to 83% in 2012/13 – and fewer wards offer families a contact number after discharge.

Mental health

A third of paediatric wards that admit children and young people (CYP) with mental health conditions have Child and Adolescent Mental Health Services (CAMHS) staff available 24/7

2.61 Three-quarters (77%) of paediatric wards admit children and young people with mental health conditions. Over half (54%) admit children with eating disorders.

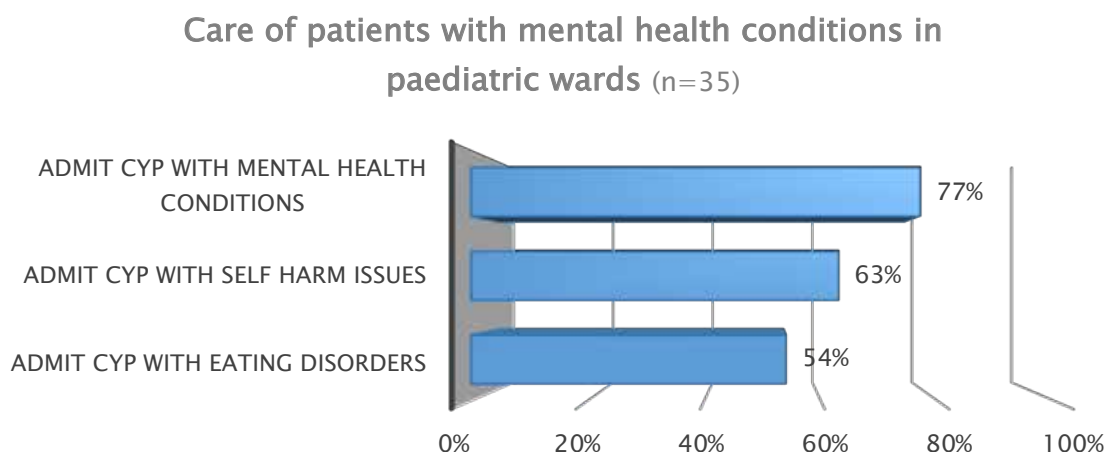


Figure 2.9

2.62 A third (33%) of paediatric wards that admit children and young people with mental health conditions reported that CAMHS staff are available for these patients at all times, while just under half (48%) indicated that a named CAMHS professional is responsible for managing these patients.

Policies and procedures in paediatric wards which admit CYP with mental health conditions (n=27)

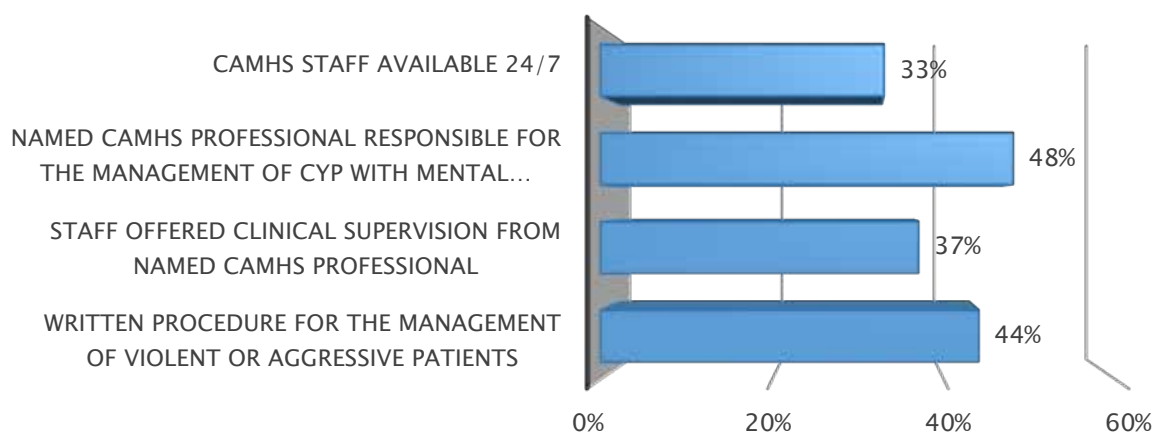


Figure 2.10

2.63 In 37% of these wards, paediatric nursing and medical staff are provided with clinical supervision from a named CAMHS professional when caring for children and young people with mental health conditions. Forty four per cent have a written procedure for managing violent or aggressive children and young people.

Children's menus and nutrition

Fewer children's wards have menus designed for children and young people

- 2.64 The survey with catering staff suggested that fewer children's wards have specific menus for children now than in 2012/13 – 83%, down from 97%. Three-quarters (75%) report having a children's menu planning group with paediatric dietetic input in place to serve children's wards.
- 2.65 In contrast, only 43% of adult wards admitting children have a specific menu for them.

A children's ward based in a DGH has no specific children's menu which many see as an issue, but they do provide an additional snack menu which the staff, children and parents seem to like. Parents receive a discount in the staff canteen and there are vending machines out of hours.

A third of paediatric and adult wards do not adhere to nutritional standards for children

- 2.66 Three-quarters (75%) of paediatric wards use a validated tool to assess nutritional risk or nutritional status and 67% report that they adhere to the recommended nutritional intake and salt standards in children's wards.

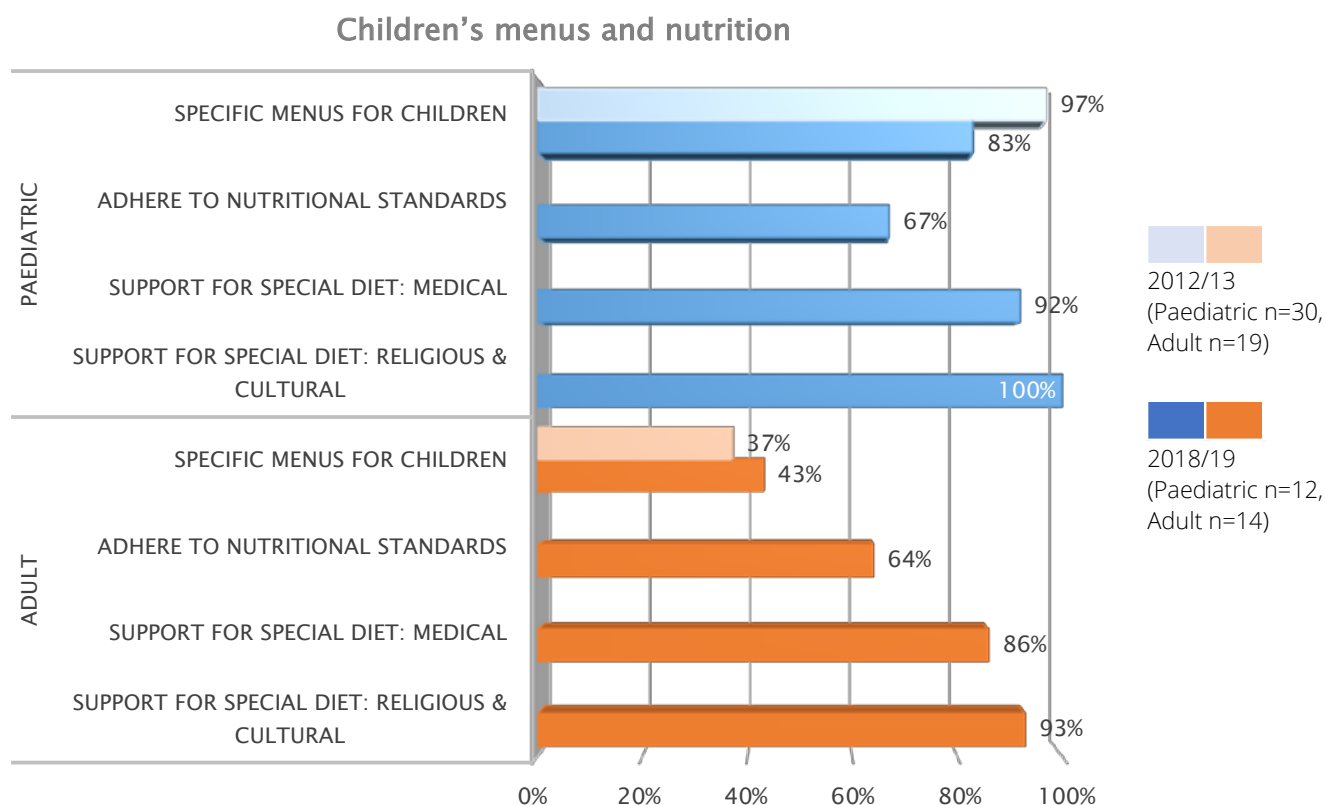


Figure 2.11

- 2.67 In adult wards caring for children and young people, only 57% use a validated tool to assess nutritional risk or nutritional status while 64% adhere to the recommended nutritional intake and salt standards for children and young people.

A parent at a children's hospital had brought food with them to cater for their son's allergies, and had been to McDonald's to get the child some lunch, but the nursing staff had told them they hoped to be able to provide dinner.

Another carer felt that **"the meals need improved"**.

The majority of hospital wards cater for special diets

2.68 Ninety-two per cent of the hospitals with paediatric wards that took part in the catering survey indicated they provided special diets for medical reasons; the corresponding figure for adult wards was 86%. All paediatric wards and 93% of adult wards provide support for special meals for cultural or religious reasons.

Hospitals spend less than £4 per day on feeding each child in their care

2.69 Eight hospitals that have children's wards were able to provide data about the daily spend per child on children's meals in children's wards in their hospital. This indicated that these hospitals spend on average £3.52 per day per child.

Education

Just over a third of children admitted receive education in accordance with Scottish Government guidance

2.70 Twelve out of the 33 wards (36%) of paediatric wards indicated that all children in their ward, medical assessment permitting, receive education within five days of admission, while another 12 wards (36%) responded that children receive education no later than 15 working days after admission.

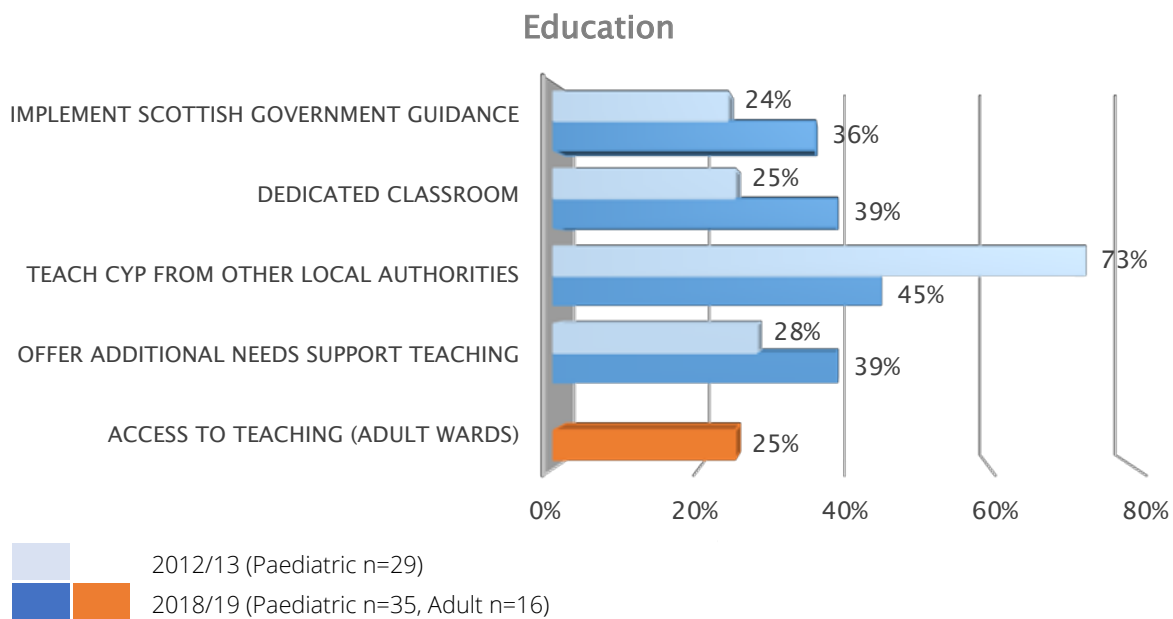


Figure 2.12

2.71 Just over half of paediatric wards (55%) have criteria for the teaching of children and young people. The criteria focus most commonly on length of hospital stay but some wards also take into account factors such as the individual's state of health and/or parental wishes.

2.72 One ward at a children's hospital noted that privately arranged tutors, paid for by parents, are available to children and young people of all ages.

At a children's hospital we visited, there appears to be some inconsistency regarding access to classroom and teachers: some patients are offered both and some are not. Staff are unsure how the system works and what should happen.

"Teacher is here every morning." – Parent

"We have been in hospital many times and no teaching is offered." – Parent

A parent at another hospital found it reassuring that their child could access education while in the ward as **"you worry about them missing too much school"**.

Teachers work with children from other local authorities in less than half of paediatric wards

2.73 Just under half (45%) of paediatric wards reported that their teachers work with children admitted from local authorities beyond the hospital's local authority area. This is a substantial decrease since 2012/13 when the figure was just under three-quarters (73%). In 80% of wards where teachers work with 'out of area' children, the teachers are based in the hospital. However, in one ward at a children's hospital, the teachers are sent in by the local authority and another uses both hospital-based and local authority based teachers.

The number of teachers available for children with additional needs has increased

2.74 Nearly two-fifths of paediatric wards (39%) indicated that there are teachers qualified to provide additional support for learning to children with particular needs, such as learning disabilities, sensory impairments or to children who use English as an additional language, an increase from 28% in 2012/13.

The majority of adult wards admitting children do not offer them access to education

2.75 Forty-four per cent of adult wards questioned reported that they are aware of the Scottish Government's guidance on education provision for children and young people in hospital, which states that local authorities must make special arrangements for children unable to attend school due to ill health without undue delay. However, three-quarters (75%) reported that their adult wards do not offer children and young people access to support for their education. This is particularly notable in rural district general hospitals, where none of their adult wards offer educational support.

Play provision

Nearly all paediatric wards have a dedicated play room

2.76 More than nine out of ten (94%) paediatric wards have a dedicated play room for children and young people. There are few or no play facilities on adult wards that treat children, but comments from respondents indicate that children treated there can access games and play elsewhere in the hospital.

Play provision in paediatric wards

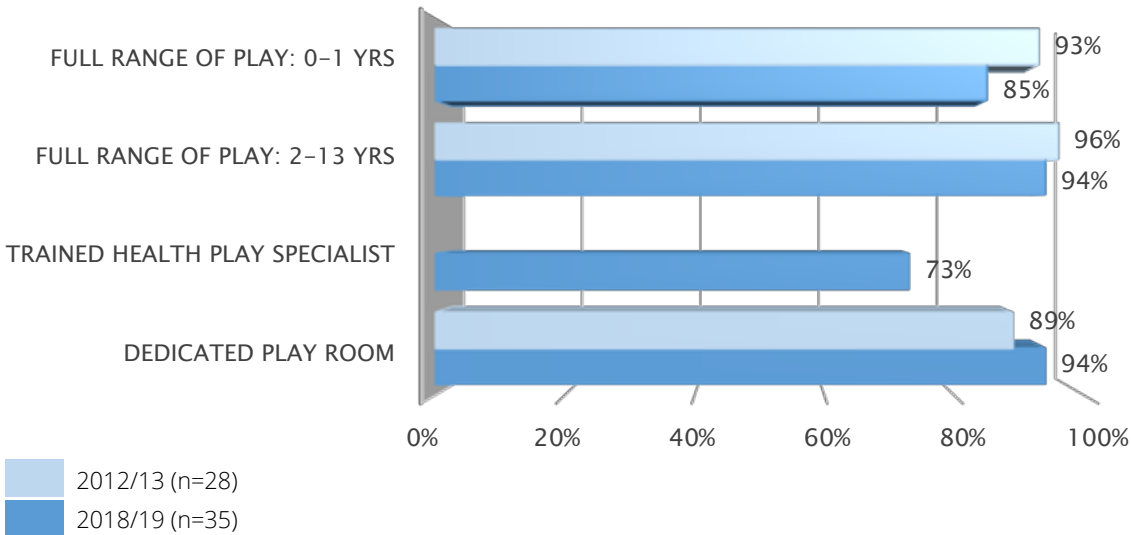


Figure 2.13

“The playroom is good. When a child is in isolation, they bring toys in.” – Parent

“We have children with different needs and make sure we tailor to needs - a range of activities and entertainment -it’s a vital distraction and also involves siblings.” – Play coordinator

“The sensory room is amazing.” - Parent

“There’s lots of stuff to keep the children entertained.” - Parent

“The Play Specialists are a godsend - they’re worth their weight in gold.” - Parent

Supervised play is widely available in paediatric wards and most have access to a trained Health Play Specialist

2.77 Nearly all paediatric wards surveyed (32 out of 33, 97%) offer supervised play for the children in their care, all of it on the ward itself. In 61% of wards, play staff also carry out non-play activities.

2.78 Nearly three-quarters (73%) of paediatric wards and approximately half (53%) of neonatal units can access the services of a trained Health Play Specialist. Ninety one per cent of paediatric wards offer particular play opportunities for babies, children and young people with additional support needs.



Supervised play goes beyond paediatric wards

- 2.79 Play staff offer outreach to other departments, such as the Emergency Department, Radiography or neonatal unit. Sixty one per cent of all paediatric wards offer the outreach services of trained Health Play Specialists, 18% play assistants, 15% nursery nurses and 9% play volunteers.
- 2.80 The paediatric day care wards and units are the most likely to take up these outreach services, followed by outpatient departments.

A parent at a children's hospital was impressed with the range of play facilities available on the ward, including provision for older children.

However, she was disappointed that there was no outdoor space easily accessible from the ward. She said there is a large play park near the main entrance to the hospital, but she was reluctant to take her daughter there in case they missed a doctor's round while they were away: **"it would make a huge difference to get into the fresh air"**.

Siblings can play together in nine out of ten wards

- 2.81 Siblings are included in play opportunities in 88% of children's wards, a small increase since 2012/13 (82%). On neonatal units the figure is 47%.

Access to play has remained broadly unchanged except for babies 0-1 years

- 2.82 A full range of supervised play for age and stage of development is available in 31 of 33 paediatric wards (94%) for children aged 2-13 years and in 30 of 33 wards (91%) for children aged 14-16 years. For babies aged 0-1 years, the figure is 85%, down from 93% in 2012/13.
- 2.83 The availability of play opportunities for young people aged 14-16 is broadly the same as those offered to children aged 2-13.

A children's ward in a DGH we visited had a well-equipped playroom and DVDs for children to watch in bed. What stood out were the comments from parents about the supportiveness of the staff and their willingness to help and be flexible.

The role of the Child Health Commissioner

Child Health Commissioners do not appear to have ready access to admission data for children and young people admitted to adult wards

- 2.84 Thirteen of the 14 Child Health Commissioners provided information on 24 hospitals in their health board areas. Only four (28%) were able to provide a complete set of data on the number of adult wards that admit children or, for the period April 2018 to March 2019, the number of children admitted to adult wards, the number of children admitted as day cases or the number admitted as in-patients.
- 2.85 The commonly used resources for monitoring service provision in adult wards where children and young people are admitted are the EACH Charter, the UN Convention on the Rights of the Child and the Royal College of Physicians of Edinburgh's 'Think Transition'.
- 2.86 Child Health Commissioners reported that the most common resource used to monitor service provision in children's wards in hospitals in their areas is (63%) the RCPCH's 'Facing the Future: Standard for Acute General Paediatric Services'; 2015, while 58% reported using the UNCRC, 54% the EACH Charter and 38% 'Think Transition'.

3. Progress report

- 3.1 This section looks at progress against a sample of 2012/13 statistics. Although the sample size and profile differ between this, the 2018/19 survey and the 2012/13 survey, where similar questions have been asked, comparisons have been made to highlight areas where improvements have been made, areas which have remained the same and areas where there has been some reduction in service provision.
- 3.2 The data are presented as individual statistics for paediatric wards, neonatal units and adult wards (percentage of hospitals with adult wards admitting children).
- 3.3 Some key results are presented in Table 3.1, with upward arrows indicating improvements in 2018/19 compared with 2012/13, downward arrows indicating a reduction in provision and a horizontal arrows denoting where there has been little or no change (defined as a difference of plus or minus 5% between 2012/13 and 2018/19).

Table 3.1: Some key findings: comparison with 2012/13 survey

Facility / Procedure	2018/19		
	Paediatric	Neonatal	Adult
Parental access			
Provision of open visiting for parents/carers	89% ↓	100% ↔	88% ↔
Parental facilities and accommodation			
Parents' overnight accommodation at bedside in a bed or chair	90% ↑	87% ↑	100% ↑
Availability of a sitting room for parents/ carers	86% ↑	93% ↑	n/a
Self-catering facilities for parents/carers	86% ↑	80% ↑	n/a
Showering/washing facilities for parents/carers	80% ↑	80% ↑	n/a
Family support			
Access to a social worker	77% ↑	67% ↓	100% ↑
Young people's services			
14-16 year-olds accommodated in a specialist unit or ward	15% ↑	n/a	n/a
Choice of children's or adult wards for young people	9% ↓	n/a	n/a
Children admitted for surgery			
Dedicated surgery lists	75% ↓	n/a	n/a
Allowing parents to stay with child until anaesthetised	100% ↑	n/a	n/a
Allowing parents to be with their child in recovery	61% ↓	n/a	n/a
Information, records and feedback			
Information for parents on reimbursement of travel costs	49% ↓	93% ↔	n/a
Availability of written information for families about ward procedures on admission	34% ↓	53% ↓	n/a
Young people given information about consent	74% ↓	n/a	56% ↓
Young people given information about confidentiality	76% ↓	n/a	44% ↓
Education			
Compliance with Scottish Government guidelines on education ¹	36% ↑	n/a	n/a
Provision of teaching for children from other local authority areas	45% ↓	n/a	n/a
Catering			
Specific menus for children and young people	83% ↓	n/a	43% ↑

¹ Implementation assessed as provision of education within five days, medical assessment permitting

² n/a = comparative data not available

4. Benchmarking against the EACH Charter

EACH Charter

Article 1

Children shall be admitted to hospital only if the care they require cannot be equally well provided at home or on a day basis.

Relates to UNCRC Article 24

4.1 This issue was not addressed.



Article 2

Children in hospital shall have the right to have their parents or parent substitute with them at all times.

Relates to UNCRC Articles 3; 9; 18

4.2 Nine in ten (89%) paediatric wards in the survey place no restrictions on parents visiting their child in hospital. The one in ten wards that restricted visiting times did so when children were eating, during medical rounds and school lessons.

4.3 All adult wards and neonatal units allow unrestricted access. In neonatal units, parents are encouraged to stay with their babies at all times in 13 of the 15 units questioned; those that did not, asked parents to stay away when other babies were being discussed or when a procedure was being carried out on another baby.

4.4 Of the 28 paediatric wards that admit children and young people for surgery, all report that parents are allowed to stay with their child until they fall asleep before an operation and accompany them to and from theatre. Almost all wards (27 out of 28) allow parents to be with their child when they return to the ward after surgery. However, only 17 (two-thirds) of the paediatric wards report that parents are allowed to be with their child in recovery.



Article 3

(1) Accommodation should be offered to all parents and they should be helped and encouraged to stay. (2) Parents should not need to incur additional costs or suffer loss of income. (3) In order to share in the care of their child, parents should be kept informed about ward routine and their active participation encouraged.

Relates to UNCRC Articles 3; 9; 18

4.5 Thirty-one out of 35 paediatric wards (89%) reported that one parent can be accommodated overnight and half can accommodate two parents at the same time. The four that do not provide access to accommodation overnight are a paediatric intensive care unit, a day care ward, a haematology-oncology ward and a psychiatric in-patient unit.

4.6 All neonatal units can accommodate one parent overnight and in 14 out of 15 (93%) both parents can stay at the same time. Most parents (87% of units) are accommodated in rooms on the neonatal units themselves. However, just over a quarter of the units surveyed had to turn parents away due to a lack of overnight accommodation in the twelve-month period between April 2018 and March 2019.

4.7 All adult wards allow parents to stay overnight, mostly in a chair or bed next to their child; two general hospitals provide accommodation for parents off-ward, within the hospital grounds. Three-quarters of the adult wards can accommodate both parents at the same time; those that couldn't pointed to a lack of space and accommodation.



Article 4

(1) Children and parents shall have the right to be informed in a manner appropriate to age and understanding. (2) Steps should be taken to mitigate physical and emotional stress.

Relates to UNCRC Articles 5; 12; 18

- 4.8 There has been a decrease in information provided to children and young people on adult wards. Provision of information about confidentiality has dropped from 74% to 44% and about consent from 68% to 56%. Under half (44%) of adult wards provide no information at all on ward procedures, confidentiality, consent, complaints, or access to health records.
- 4.9 On paediatric wards, there has been a dramatic drop in the proportion of children informed about their right to complain; down to 32% from 80%.
- 4.10 Access to information about routines on paediatric wards has decreased. Only a third (34%) of provide this information, down from 73% in 2012/13. Just over half of neonatal wards provide information about ward routines.
- 4.11 Language and translation services are more readily available to parents than children. Two-thirds of paediatric wards translate and interpret written communications for families and 91% of wards do the same for spoken communications. In contrast, 57% of paediatric wards offer translation of written communications for children and 80% for spoken communications.
- 4.12 Parents are told about reimbursement of travel costs and car parking in 14 out of the 15 (93%) of neonatal units, but in only half (49%) of paediatric wards.
- 4.13 Spiritual support for families is almost universal but practical support is not. Practical support is provided by family liaison workers, family support workers and social workers but three out of the 35 paediatric wards and two of the neonatal units do not provide any.
- 4.14 All adult wards that admit children provide access to a social worker but only 44% provide access to a family liaison or family support worker.



Article 5

(1) Children and parents have the right to informed participation in all decisions involving their healthcare. (2) Every child shall be protected from unnecessary medical treatment and investigation.

Relates to UNCRC Articles 5; 12; 13; 17

- 4.15 Three in five (63%) of adult wards ask the 'What Matters to Me?' questions when a child or young person is admitted in order to find out about their likes, dislikes, needs and preferences. All neonatal wards encourage parents to provide feedback as do paediatric wards, where parents are encouraged to comment on decision making, service design and service evaluation. Thirty-three paediatric wards (94%) indicated that children are encouraged to do the same.
- 4.16 Nearly all (94%) paediatric wards permit young people to consent to treatment in their own right.



Article 6

(1) Children shall be cared for together with children who have the same developmental needs and shall not be admitted to adult wards.

(2) There should be no age restrictions for visitors to children in hospital.

Relates to UNCRC Article 3

- 4.17 Only three of the 35 paediatric wards (9%) give adolescents (14-16) a choice of where they are admitted.
- 4.18 Only five (15%) paediatric wards accommodate young people aged between 14 and 16 in a specialist facility, such as an adolescent unit.
- 4.19 There are no records held at national (ISD) or health board level to show the number of children and young people under 18 admitted to adult wards. However, 37% of paediatric wards reported that children under 16 years of age have, in the past, been accommodated on an adult ward.
- 4.20 While there are no age restrictions in place for visitors to children in hospital, siblings and wider family and friends have more restricted access than parents. Siblings can visit any time in less than half of the wards surveyed (43%) – still a marked increase from 2012-13 when only 23% of wards allowed siblings unlimited access. Forty per cent of paediatric wards allow open visiting for grandparents and 23% allow the same for family friends.
- 4.21 Eighty-eight per cent of adult wards surveyed indicated that young people's friends are allowed to visit on the same terms as adult patients' visitors.



Article 7

Children shall have full opportunity for play, recreation and education suited to their age and condition and shall be in an environment designed, furnished, staffed and equipped to meet their needs.

Relates to UNCRC Articles 3; 29; 31

- 4.22 Fifty-six per cent of paediatric wards have designated areas or facilities for play in place for children. In contrast, there are few or no play facilities for children treated on adult wards. 18% of these facilities are staffed at all times and 70% some of the time.
- 4.23 Nearly all paediatric wards offer supervised play for children on their wards (32 out of the 33 wards). Seventy-three per cent of paediatric wards and 53% of neonatal wards can access the services of a trained Health Play Specialist.
- 4.24 Just over a third of paediatric wards (36%) implement the Scottish Government Guidance on Education for Children and Young People Unable to Attend School due to Ill Health (2015) by providing education within five days of admission, medical assessment permitting.
- 4.25 Three-quarters (75%) of adult wards admitting children do not offer access to education.



Article 8

Children shall be cared for by staff whose training and skills enable them to respond to the physical, emotional and developmental needs of children and families.

Relates to UNCRC Article 2; 19; 25

- 4.26 Only 6% of adult wards that admit children have a written policy or guidelines for the care of children. Just over half (56%) have access to paediatric medical/ nursing advice and support.
- 4.27 Of the 27 paediatric wards that admit children and young people with mental health conditions, just under half (48%) reported that a named CAMHS professional is responsible for managing these patients and only a third indicated that CAMHS staff are available for these patients at all times.
- 4.28 Of the 28 wards that admit children and young people for surgery, 21 (75%) report that there is a dedicated paediatric list and that particular anaesthetists are allocated for children's elective surgery (all specialities). The rates for general paediatric surgery and emergency surgery are 64% and 61% respectively.



Article 9

Young people should be provided with continuity of care for as long as required even after their stay in hospital.

Relates to UNCRC Article 24

- 4.29 This issue was not addressed.

Article 10


Young people should be treated with the respect, understanding and privacy they need at all times.

Relates to UNCRC Article 16; 24

- 4.30 Thirty one of the 34 paediatric wards surveyed (91%) report that young people can be seen on their own, without their parents, by nursing or medical staff on admission.



5. Recommendations



5.1 This section provides recommendations that highlight issues which should be addressed to ensure further improvement in the provision of services for families, children and young people in accordance with the EACH Charter.

Parental access and facilities

5.2 All wards admitting children and young people should offer to parent/carers:

- overnight accommodation and unrestricted visiting;
- a sitting room close to the ward with self-catering facilities;
- subsidised meals in the hospital café/staff cafeteria;
- laundry facilities for the parent/carers of long stay patients, and
- washing and showering facilities.

Family support

5.3 In addition to spiritual care, all wards that admit children should provide access to:

- a family support/liaison worker or social worker, and
- translation services for spoken and written communications for parents/carers, children and young people.

Information

5.4 Ward staff should ensure that the following information is understood by patients and carers (not just made available), both for elective and emergency admissions:

- Arrangements for overnight accommodation for parent/carers;
- Availability of family support, including help with travel expenses;
- The named nurse or team, as appropriate;
- Accommodation, facilities and access for carers;
- The right to confidentiality and informed consent, and
- Complaints, accessing health records and feedback procedures.

Young people: admissions and facilities

- Children and young people under the age of 16 should not be admitted to adult wards;
- Young people between 16 and 18 should be given the choice of ward type to which they are admitted;
- Where admission to an adult ward is unavoidable, there must written guidelines for the care of young people and access to paediatric medical/nursing advice and support;
- Information Services Division Scotland should report the admission rates of 14-16 year olds and 15-18 year olds at the ward level;
- Adolescents should be cared for with others of a similar age in a specialist unit or separate ward area, and
- There should be access to free Wi-Fi.

Surgery

- Surgery should be provided on dedicated lists with particular anaesthetists allocated to children's surgery;
- All children should have the right to have their parents/carers stay with them until anaesthetised prior to surgery, and
- be present in recovery after surgery, theatre facilities permitting.



Mental health

- 5.5 Paediatric wards which admit children and young people with mental health conditions should have:
- access at all times to a named CAMHS professional responsible for managing a patient when the mental health condition is the primary reason for admission, or to provide advice when it is impacting on the care of a physical disorder, and
 - a written procedure for managing violent or aggressive children and young people.

Children's meals

- 5.6 There should be:
- healthy menus and attractively presented food specifically designed for children and young people;
 - adherence to nutritional guidelines as set out in the Scottish Government guidance 'Food in Hospitals', 2016;
 - information regarding the nutritional value of meals, possibly using a 'traffic lights' system to guide healthy choices, and
 - age-appropriate cutlery and tableware.

Education and play

- 5.7 All children and young people, whether admitted to children's wards or adult wards, should have access to:
- education provision no longer than five days after admission, irrespective of the location of the hospital relative to the local authority area where the child normally resides (medical assessment permitting);
 - provision of education immediately if it is known on admission that the child will be in hospital for longer than five days, and
 - qualified play staff and recreational facilities appropriate to age and development.

The role of the Child Health Commissioner

- 5.8 The health of its children determines the future health of the Scottish population and the effectiveness of each health board's Child Health Commissioner is crucial.
- 5.9 To be effective, there needs to be clarity about the role of the Child Health Commissioner (CHC) and consistency across health boards. To this end, the CHC must:
- have a clear job description;
 - take the lead in the development of the Child Health Strategy, planning and commissioning child health services, and
 - have appropriate information systems in place to ensure the provision and monitoring of child health services.

Prepared by:

Blake Stevenson Ltd
3 Boroughloch Square
Edinburgh EH8 9NJ

 0131 667 2919

 admin@blakestevenson.co.uk

 www.blakestevensonresearch.co.uk

Registered office:

Children's Health Scotland
22 Laurie Street, Edinburgh EH6 7AB

 enquiries@childrenshealthscotland.org

 www.childrenshealthscotland.org



Find us on:



Scottish Government
Riaghaltas na h-Alba
gov.scot

We acknowledge the support of the Scottish Government
through CYPFEIF and ALEC Fund Grant.

Children's Health Scotland. A charitable company limited by guarantee.
Scottish Charity No. SC006016. Registered Company No. 100114.
All materials © Children's Health Scotland 2019.