

Pay More Attention: A national mixed methods study to identify the barriers and facilitators to ensuring equal access to high quality hospital care and services for children and young people with learning disabilities and their families.

Statement of the problem

Despite comprehensive evidence of health inequalities for adults with learning disability (LD), including poor practice, discrimination and abuse in hospitals, there has yet to be a comprehensive review of how well hospital services are meeting the needs of children and young people (CYP) with LD and their families. Qualitative evidence of parental dissatisfaction with the quality, safety and accessibility of hospital care for CYP with LD exists. However, the extent to which their experience differs from that of parents of CYP without LD is not known. Moreover, the views and experiences of CYP with LD are missing. A major uncertainty is when the inequalities known to exist for adults with LD start to emerge - is it simply when CYP with LD make the transition to adult services or are they apparent as soon as they are first recognised as having LD? We aim to address this gap in our understanding by comparing how services are delivered to, and experienced by CYP with and without LD and their families to see what inequalities exist, for whom, why and under what circumstances. This information will:

- **provide evidence for the development of new interventions and improved use of existing ones;**
- **promote equality to be better target interventions to those who need them, when they need them;**
- **resulting in a more efficient and effective service that patients and parents are satisfied with.**

Summary of project plan

A transformative, mixed methods case study design¹, prioritising the voices of CYP and their parents. Each case will be represented by National Health Service (NHS) hospitals in England. Data will be gathered concurrently, over 4 phases as shown below:

Phase	Aims	Setting	Methods
1	-To describe the organisational context for healthcare delivery to CYP with LD and their families -To compare how equipped hospital staff feel they are to identify the needs of CYP with and without LD and their families and provide high quality care to effectively meet these needs.	18 hospitals in England	STAFF: Interviews with senior managers STAFF: Questionnaire to clinical teams Content analysis of hospital documents
2	-To compare how hospital care and services are experienced by CYP with and without LD and their families -To compare staff experiences of caring for CYP with and without LD and their families -To investigate differences in safety concerns between parents of CYP with and without LD -To investigate differences in access to hospital services between CYP with and without LD	4 hospitals in England sampled from Phase 1	CYP: Interviews using creative and digital research techniques PARENTS: Hospital 'blog', reports of safety concerns, home interview STAFF: Interviews HOSPITAL ACCESS: Retrospective mapping of hospital inpatient and out-patient activity
3	-To compare levels of satisfaction with hospital care between CYP with and without LD -To compare levels of satisfaction with hospital care between parents of CYP with and without LD	4 hospitals in England sampled from Phase 1	CYP: Satisfaction questionnaire PARENTS: Satisfaction questionnaire
4	-To synthesise study findings and develop content of a DVD for training staff and students	Suitable workshop setting that is accessible and has good facilities	A workshop involving study participants and experts in the field of LD

The study has been designed to meet the requirements of FINER:

Feasible: Parents of CYP with and without LD have reviewed the research questions and methods of data collection and their feedback has been incorporated into the project design. The research team has the relevant experience and expertise to deliver the project in a timely way. KO, FG, JW, MF and SK have collaborated on grants, including those funded by NIHR. KO (CI) has just completed a single site ethnographic study exploring the needs and experiences of CYP with LD and their families during hospitalisation, and the staff caring for them. One co-applicant (IWT) has recently completed a multi-site HS&DR funded project into healthcare provision for adults with LD in hospital. AH has extensive experience of LD related issues, multicentre methodologies and expertise in transition and adulthood related issues in those with LD.

Interesting: We will combine traditional, creative and digital methods to make the project interesting and accessible to participants. Hospitals can be very stressful for parents and leaving their child, even briefly, can generate anxiety. Hospital 'blogging' will enable parents to upload 'real time' data at their convenience.

Novel: The inclusion of CYP with LD, a vulnerable population who are frequently excluded from research. Our inclusive approach means interviews will be tailored to meet the individual learning, physical, communication and health needs of *all* participants. The research team has extensive skills in working with CYP of all ages, both with and without LD. One of the co-applicants (SK) is a parent of more than one CYP with LD.

Ethical: The team has good understanding of the ethical issues of involving this group of participants in research and has experience of gaining ethical approval for their inclusion. The funds requested will allow the appointment of skilled researchers and the use of appropriate resources to involve CYP in a meaningful way and ensure findings are disseminated in multiple formats. One co-applicant (FG) is alternate chair for an NHS ethics committee.

Relevant: This study supports the HS&DR mission of inclusive research, and bridging the gap between theory and practice. The voice of two groups of CYP with long-term health conditions, those with and without LD, will be heard. Through directly comparing their hospital experience and that of their parents and the staff who care for them, we will identify what facilitates and prevents the provision of an equitable service. A major gap in the evidence base, addressed through this study, is what CYP with LD and their families think about the hospital service they receive.

Background

Definition and prevalence of learning disability in children and young people

The term "learning disability" covers a wide spectrum of impairments. The presence of a low Intelligence Quotient is a defining feature. The definition does not include CYP who have learning *difficulties* that may impair educational attainment, e.g. processing problems, but who are within the average range of intelligence or those with developmental delay who are late in reaching some or all of their developmental milestones. Whilst LD is the preferred term of the Department of Health², terminology varies internationally, with 'intellectual disability' and 'mental retardation' also used. In the 10th international classification of diseases (ICD-10)³ mental retardation is defined as "... a condition of arrested or incomplete development of the mind, which is especially characterised by impairment of skills manifested during the developmental period, which contribute to the overall level of intelligence, i.e. cognitive, language, motor and social abilities". For a diagnosis to be considered '*definite*', reduced intellectual functioning must result in "diminished ability to adapt to the daily demands of the normal social environment", but notably there can be wide variations in the levels of skills developed by individuals.

Advances in technology have dramatically increased rates of survival and life expectancy for premature babies⁴, a significant proportion of whom will subsequently have intellectual impairment^{5,6} and life-long health problems⁷. Moreover, technological advancements in equipment have improved life expectancy for those with medical conditions and genetic disorders who previously would not have survived⁸. It is now widely acknowledged that the numbers of those with severe intellectual impairment and multiple/complex long term problems will continue to rise⁹. There are no definitive figures for the prevalence of LD. Whilst estimates indicate a worldwide prevalence similar to one of schizophrenia at 1.0%¹⁰, there are huge variants within that depending on the definition applied. Latest figures indicate that there are 286,000 CYP age 0-17 years with LD in England¹¹.

Health Inequalities for people with LD

It is widely recognised that people with LD have more health needs that often remain unmet than the general population. In 2007 Mencap published "Death by indifference"¹² detailing case histories of 6 people with LD who died in hospitals from avoidable conditions and calling on the government to take "serious action". An Independent Inquiry into access to healthcare for people with LD followed, revealing significant system failures and reporting that patients with LD were treated less favourably than others, resulting in prolonged suffering and inappropriate care. The report of this Inquiry, "Healthcare for All"¹³, identified the invisibility of people with LD within health services, and the lack of priority given to identifying their particular health needs. Training and education about LD was found to be very limited. Combined with ignorance and fear, lack of training was identified as reinforcing "negative attitudes and values towards people with learning disabilities and their carers" and "contributing significantly to a failure to deliver equal treatment, or to treat people with dignity or respect". A need to strengthen the systems for assuring equity and quality of health services for people with LD at all levels was identified.

The degree to which the experiences of CYP with LD or their families were included in this Inquiry is unclear. It was reported only that the 412 responses, included 76 from *family carers* and 100 from *people* with LDs. The limited direct reference to CYP with LD in the report presents a mixed picture. Services were praised for "providing all round care", yet access to general health care was reported as being "as problematic as it appears to be for adults". Accounts were provided of staff suggesting that "disabled children should be allowed to 'slip away' rather than resuscitated or treated", and communication about treatment and options was reported to be particularly poor. Furthermore, both parents and carers of adults *and* children with LD, "*find their opinions and assessments ignored by healthcare professionals ... They struggle to be accepted as effective partners in care by those involved in providing general healthcare; their complaints are not heard; they are expected to do too much of the care that should be provided by the health system and are often required to provide care beyond their personal resources*".

A Confidential Inquiry into premature deaths of people with LD (CIPOLD)¹⁴ including 14 CYP aged 4-17, followed. It emerged that “more people with LD died from causes that were potentially amenable to change by good quality healthcare”. All aspects of care provision, planning, coordination and documentation were found to be significantly less good for people with LD. A plethora of recommendations and guidelines are now available to support hospitals in ensuring that “people with LD are included as “equal citizens, with equal rights of access to equally effective treatment”¹³. Mencap has worked with healthcare professionals and Royal Colleges to develop the ‘Getting it Right Charter’¹⁵, highlighting key activities that all healthcare professionals should undertake to ensure that there is equal access to health, including the appointment of a Learning Disability Liaison Nurse (LDLN) in every hospital. Whilst 200 Trusts, hospitals and organisations have signed up to the Mencap Charter demonstrating their commitment to change, a current feasibility audit of adult LD care pathways found that only 56% of the 9 acute trusts that took part had a liaison nurse in place¹⁶. Providing reasonably adjusted services for people with LD is a legal requirement¹⁷. Yet, the largest study of its kind to date¹⁸ found that the delivery of reasonable adjustments in the adult hospital setting was haphazard, with a lack of a) effective systems for identifying patients with LD and b) clear lines of responsibility for implementing reasonably adjusted care to individual patients. Dr Tuffrey-Wijne and Baroness Hollins, Emeritus Professor and President of the British Medical Association, subsequently argue that, “the NHS is still failing patients with intellectual disabilities in all departments, all specialties and all services”¹⁹. Drawing on the findings of the recent Francis inquiry, they argue that those with LD perhaps more than any other patients “need special focus, knowledge and skill to ensure their healthcare needs are met”²⁰.

The direct relevance that current recommendations (detailed synthesis uploaded separately) about the care of ‘people’ with LD have to CYP, and guidance on the best way to implement them in the child health setting, is missing. The main thrust of initiatives aimed at reducing health inequalities faced by people with LD has been on improving access to healthcare among *adults* rather than the health inequalities faced by CYP²². Hence, we do not know:

- **The extent to which available recommendations *should* be applied to CYP with LD;**
- **To what extent they *are* being applied to CYP with LD;**
- **If they are being applied, what *difference* they are making to patients, parents and staff.**

CYP with LD and their families

CYP with LD routinely experience particularly poor health outcomes. A review of the evidence on the prevalence and determinants of health conditions and impairments among CYP with LD in the UK²¹ has found that the risk of children being reported by their main carer (usually their mother) to have fair/poor general health is 2.5-4.5 times greater for those with LD compared to their non-disabled peers^{22, 23} a finding only partially accounted for by differences in socio-economic status¹¹. As well as having intellectual impairment, these CYP may have sensory impairments and physical impairments e.g. cerebral palsy²⁴ that adversely affect their speech, feeding and mobility. CYP with LD are also almost twice as likely to report 3 or more health problems and more than 4 times as likely to suffer from a psychiatric disorder than children without LD^{23, 25}. Increasing numbers are dependent on technological equipment for their survival²⁶.

Children with disabilities experience more frequent and lengthier hospital admissions than children without disabilities²⁷ and have contact with numerous professionals, often attending the same hospital many times in a week²⁸. They are also more likely than other children to be absent from school. In those with profound multiple learning difficulties, 62% of absences were accounted for by illness and 13% from attending medical/dental appointments¹¹. The ability for CYP with LD of *all* ages to understand information about hospital care and treatment will be limited, they may not be able to communicate their needs verbally, and may need additional support with all aspects of hospital life. Whilst many CYP will find it hard to cope emotionally when they are in an unfamiliar hospital environment, those with LD who have challenging behaviour²⁹ may find it particularly difficult.

The physical, emotional, social and financial impact on parents caring for a child with LD are well documented and have been acknowledged for decades³⁰⁻³². They are more likely than other parents to suffer from stress and depression, marriage breakdown, social isolation, poverty, and poor physical health¹¹. Whilst parents of all children may find it stressful accompanying their child into hospital, we know that parents of CYP with LD can find it particularly challenging especially when they do not have confidence in the staff caring for them or they feel they have to fight to get the services their child needs (see below). In the CI’s most recent study, aimed at understanding the needs and experiences of CYP with LD and their families in hospital, some nursing staff revealed concerns that this population of parents were not given sufficient opportunity to have a break from their care-giving responsibilities. They felt that some staff relied too heavily on them, in part because they did not have the time or confidence to negotiate responsibilities³³. A nurse working in a local hospital that we consulted about our proposed project expressed similar concerns about this group of mothers “being left to do everything”.

Within the National Service Framework (NSF) for CYP in hospital³⁴ the distinct service requirements of ‘disabled’ children are recognised, as is their greater need for personalized, child-centred care. However, the NSF framework precedes the latest evidence on the care of people with LD in hospital and may no longer be fit for purpose for

meeting the specific intellectual, emotional, social and physical needs of CYP with LD. A number of children's hospitals have introduced nursing posts with a specific focus on improving care for CYP with LD but provision varies geographically and over time and has not been formally evaluated. In one tertiary paediatric hospital for example, there has been sustained commitment and support for improving care to CYP with *autism* and their families. However, this work does not include the wider population of CYP with LD. **This example highlights the repeated issue of CYP with LD falling between the gap in research and provision. Many will have specific needs that are very different to other disabled children, those with autism and adults with LD.**

Expressed Need

Many reports have expressed the need to review NHS services for *disabled* children and their families. The most consistent message is that services need to be tailored to meet the individual needs of these patients and it is imperative that their views are incorporated at every level of service delivery. This message applies equally, if not more so to CYP with LD, whose struggle to get their views heard is widely recognised. The National Children's Bureau³⁵ refer to them as "*an invisible group in society*", arguing that, "*the more complex their needs, the more invisible they appear to become*". A review of children's services within the NHS²⁸, identified that care and services for disabled CYP were frequently overlooked and in need of attention. The battle that parents of these children feel they face in getting access to suitable health services was highlighted, as was their frustration at the lack of co-ordination between services. Kennedy (2010) described the "often hostile environment" they had to navigate through to get help for their child. He also drew attention to the lack of streamlining of hospital appointments, in particular them being scheduled on consecutive days at multiple locations at great time and cost to families. **Two recommendations from the Kennedy report have direct relevance to this study – first, that there should be a single criterion for measuring the quality of NHS services for CYP – that being satisfaction with the outcome achieved (Recommendation 29) and second, that NHS services for CYP should be designed, organised and delivered from the perspective of the CYP and parent or carer (Recommendation 33).**

Concerns about inequality in the health system have been recognised by the CYP's Health Outcomes Forum³⁶, who draw attention to the fact that disabled children "face even poorer health outcomes" not just in their health, but also in their social and economic potential. It was further identified that these CYP and their families "really struggle to get their voices heard and to be involved in decisions about their own health". The way services are commissioned and provided to CYP with a disability and their families has also been found to be variable, leading to calls for work "across the range of services ... covering the standard of, access to, co-ordination of and continuity of care". The CQC³⁷ strongly recommend that commissioners "take the lead in establishing a real, local understanding of the needs of children with disabilities and their families, and respond by ensuring the most suitable provisions are in place".

In the CMO's latest annual report³⁸, it was recommended that a range of measures to reduce barriers to the participation of disabled children and their families were needed to ensure their individual needs were met. In particular, provision for CYP with LD and mental health issues, including challenging behaviour was described as "very unsatisfactory" and evidence of their needs lacking. There was further endorsement that "at every level services should be shaped by the needs, wishes and aspirations of both children and their families". Few researchers have explored the hospital experience of parents of CYP with LD to see how acceptable and effective services are in meeting their individual needs. Hitherto, the focus has been on improving the organisation and delivery of services in the community. With the introduction of Education, Health and Care Plans there is greater emphasis on looking at *all* the needs a child has across education, health and social care, with hospital Trust's having a clearly defined role. Our proposed national study will provide evidence of what prevents and supports CYP with LD, including those with mental health issues and challenging behaviour from receiving equal access to high quality hospital care. It will provide an opportunity for CYP with LD and their families to explain how their needs can be met when they are in hospital. **As Professor Dame Sally Davies states³⁸, "children are different from adults ... children need different approaches". That message applies equally to hospital services and we have a responsibility to ensure that CYP with LD are not facing the same, or different inequalities as have been identified in the adult setting.**

Generating new knowledge

This inclusive study will provide evidence of whether, and what, inequality exists, for whom and why. A key strength is that is has been designed to generate evidence of what issues affect *all* CYP with long-term conditions and what are particular to those with LD. This evidence is needed to understand the context for making reasonable adjustments for particular populations of CYP on the basis of their specific intellectual, emotional, social and physical needs. This should help address the gap resulting from the focus of policy and research being on two key areas: a) providing safer hospital care for adults with LD and b) providing more integrated healthcare services for disabled CYP. CYP with LD have unique needs that must be taken into account by commissioners and providers of hospital services. Implementing the practical suggestions and guidelines resulting from this study will help to ensure that resources and interventions that promote equality are better targeted to those who need it, when they need it, with the potential for multiple improvements:

- | | |
|--|--|
| 1. Fewer unmet needs | 6. Increase in staff confidence & satisfaction |
| 2. Reduction in adverse health outcomes and long-term damage to CYP from poor practice | 7. Increase parental trust in staff and confidence in care |
| 3. Reduction in seriousness of complaints and numbers of clinical incidents | 8. Reduction in numbers of patient hospital visits |
| 4. Increase in patient & parent satisfaction | 9. Reduction in delayed discharge |
| 5. Improved patient & parent experience | 10. Reduction in financial cost to NHS and families |

Paying more attention to the needs of our most vulnerable CYP will help get it right for all.

Increased acceptability and effectiveness of services

Few researchers have focused on how acceptable and effective hospital services are in meeting the needs of CYP with LD and their families. More importantly, the voice of CYP with LD is largely non-existent. Conversely, there has been some research conducted with CYP without LD, including those with long-term conditions, to understand the hospital experience from their perspective³⁹⁻⁴³. We know from this body of work the range of fears and anxieties that CYP can have about being in hospital, as well as some understanding of what supports them to feel safer, happier and more positive about their experience. What we do not know is whether CYP with LD have the same needs and experience. A recent review of qualitative studies reporting on the experience of *disabled* children as inpatients⁴⁴ led to the conclusion that their experience was “variable and not always optimal” and that providing information ... would improve their experience. **Importantly, of the 8 studies included in this review, only 2 focused specifically on the care of children with LD and within these, only two individual CYP were interviewed.** Of significance, is that these 2 CYP, despite talking positively about nursing staff, were reported to be “less positive in general about their hospital stay than their parents”. Similarly, in a small Australian study⁴⁵ exploring the views of four children with cerebral palsy about their experience of the medical consultation, it was reported that, “whilst children and mothers had similar views about communication, there were obvious differences in what was perceived to be important.” Children described wanting to be included even if they did not understand what was being said, and expressed a desire to be informed of any tests or procedures before they happened, rather than having things ‘done’ to them. From this small body of evidence we can draw 3 important conclusions:

- 1. Evidence of what CYP with LD think about hospital and what they want from hospital services is lacking**
- 2. Given opportunity, some CYP with LD are able to share views about hospital and what is important**
- 3. CYP with LD do not necessarily view hospital in the same way as their parents**

We will address this major gap in the evidence base by placing CYP with LD at the centre of the study and ensuring, where at all possible, that their voice is heard. We know from our own experience and that of Sharkey et al.⁴⁶ that recruiting CYP with LD into research whilst they are in hospital can be challenging. However, this should not preclude their involvement and we have taken steps to enhance recruitment (see table of risk p20).

A small body of qualitative research has been conducted with parents of CYP with LD to understand their own and their child’s experience of hospitalisation^{47,48}. Avis and Reardon⁴⁷ explored parents’ perceptions of nursing care and attitudes and how their child’s experience could be improved. They report parental feelings of stress, anxiety and fear, an expectation to care for their child, a lack of trust and confidence in staff and a lack of information and preparedness. Communication with staff was reported as the biggest issue that needed addressing. More recently Sharkey et al.⁴⁶ have reported on the barriers and facilitators to communicating with disabled children when inpatients. Interviews with parents and professionals revealed that, “communication with disabled children on the ward was perceived as less than optimal” and that “staff perceived time pressures and lack of priority given to communicating directly with the child as major barriers”. They found that parents could feel a “weight of responsibility” concerning their child’s communication that could make them reluctant to go home and leave their child alone. A large qualitative study³³ carried out by the CI as part of her PhD supports these findings. Parents described a sense of devoted protection towards their child with LD, which meant they were simply not willing to take any risk by leaving their child in the care of someone they did not have complete confidence in. Moreover, on the rare occasions when they felt they had no option but to leave their child, the occurrence of any problems could devastate trust in the overall system, with some refusing to access those particular services again. Ultimately parents felt they had to take complete responsibility for their child’s health and well-being, even in hospital. The general tone was one of apprehension that other care-providers lacked the specialist knowledge they held about their child; anger that their advice was often ignored; and concern that others did not share their dedicated commitment to the child. A feeling that professionals devalued both them and their child with LD was also reported.

Why this research is needed now

1. The numbers of CYP with LD and complex, long-term health needs who are more likely to need hospital services is growing, which means ensuring equitable access to hospital care and services is of ongoing concern.
2. We have the benefit of being able to learn from the costly mistakes that have occurred in the adult hospital setting and have an opportunity to prevent CYP with LD and their families from experiencing the same fate.
3. There is currently a lack of comprehensive evidence of how well *hospital* services are meeting the needs of CYP

with LD and their families. They have unique needs that are different from adults with LD and the wider population of disabled children that need investigating.

4. The proposed study builds directly on the methodology and findings of research conducted by the applicants. As discussed earlier, the CI's PhD research revealed that rather than seeing hospitals as a place of safe care, parents tended to view them with trepidation. Her more recent ethnographic research conducted in a single tertiary paediatric hospital setting, revealed that meeting the specific non-medical needs of CYP with LD presented a challenge to hospital staff where the focus was on providing highly specialist, complex medical care for all its patients. Key 'barriers' included a lack of clear understanding of a) which CYP had LD b) how much CYP with LD could understand and c) how best to communicate with CYP with LD. Staff identified that having more time, resources and training would help them provide the individualised approach to care that these patients needed⁴⁹. Through this research we learnt how to meaningfully engage CYP with LD in hospital-based research, as well as the practicalities of involving their parents and hospital staff⁵⁰. A co-applicant (ITW) has recently completed an NIHR funded, mixed methods study into hospital provision for people with LD. We have benefitted from knowing what worked well in delivering that project as well as the key challenges¹⁸.

5. The recently launched Children and Families Act⁵¹ places new duties on a) NHS Trusts to inform parents and the local authority if they believe a child under compulsory school age is disabled or has a special educational need and on b) partner commissioning bodies including the NHS commissioning Board to plan and jointly commission the education, *health* and care provision for disabled children and those with special educational needs. It is specified that CYP must receive any health care provision specified in their education, health and care plan.

Aims and objectives

Primary aim:

1. To identify the cross-organisation, organisational and individual factors in NHS hospitals that facilitate CYP with LD and their families receiving equal access to high quality care and services.
2. To identify the cross-organisation, organisational and individual factors in NHS hospitals that prevent CYP with LD and their families receiving equal access to high quality care and services.

Secondary aim: To develop guidance for NHS Trust's about the implementation for successful and effective measures to promote equal access for CYP with LD and their families.

Research Questions

From the perspectives of the families and clinical staff:

1. Do CYP with and without LD and their families have equal access to high quality hospital care that meets their particular needs?
2. Do CYP with and without LD, assisted by their families, have equal access to hospital appointments, investigations and treatments?
3. Are CYP with and without LD and their families equally involved as active partners, in their treatment, care and services?
4. Are CYP with and without LD and their families equally satisfied with their hospital experience?
5. Are safety concerns for CYP with and without LD the same?
6. What are the examples of effective, replicable good practice for facilitating equal access to high quality care and services for CYP with LD and their families at the study sites?
7. What indicators from the data and the literature suggest the findings may be generalisable to adults with LD and other CYP with long-term conditions in the hospital setting?

Theoretical/conceptual framework

This study takes a systematic approach to an empirical identification of the factors that affect access to high quality hospital care for CYP with LD and their families. Building on Tuffrey-Wijne et al.⁵² a theoretical framework for understanding the range of factors at the organisational and individual level that might impact on the delivery of hospital care to CYP with LD and their families has been devised (Figure 1). A synthesis of existing literature and the team's expertise and research informed its development. Included, are outcomes that might be associated with effective measures for promoting equal access. We intend to re-populate this framework with barriers and facilitators to promoting equal access to safe, high quality hospital care for CYP with LD and their families identified by systematically testing the theoretical and empirical framework throughout this study. From this theoretical framework we will construct a detailed research framework, comprising specific research questions.

Design

A transformative, mixed methods case study design¹ will be used. Case study research provides "a voice to the powerless and voiceless"⁵³ and so will enable the views of CYP and their parents to be prioritised. Case study design is "an empirical inquiry that investigates contemporary phenomena in depth and within its real-life context"⁵⁴. In this study, a single hospital site represents each case and 4 cases will be included. In each hospital, for every CYP with LD recruited, a CYP without LD will be recruited as a comparator case, thereby allowing the experience of the 2 groups of patients to be compared. This is a complex study, requiring data to be gathered concurrently,

over 4 distinct phases (Figure 2). Case study design is characterised by a convergence of diverse sources of quantitative and qualitative data (Figure 3) and is therefore well-suited to evaluating the multiple elements likely to shape and influence whether CYP with and without LD and their families receive equal access to high quality hospital care and services. The production of rich descriptions of the phenomena, through in-depth interviews and digital research methods will allow the many complexities of the situation and factors that can contribute to those complexities to emerge⁵⁵. FG will provide specific expertise in the use of case study design.

Operational definition of LD

The theoretical definition of LD is not always easily operationalised in practice. Among very young children, only severe LD is likely to be apparent⁵⁶ and some never receive a formal diagnosis of LD but remain categorised as having 'developmental delay' or a 'syndrome without a name'. Moreover, as highlighted hospital staff do not always know what is meant by LD or which CYP on their ward have this diagnosis. For our purposes, a CYP will be classified as having a LD if any **ONE** of the following is documented in the medical notes:

- a) The CYP has a LD
- b) The CYP has a condition, which is always accompanied by some degree of LD, e.g. Down syndrome
- c) The CYP has global developmental delay (GDD) and they are aged over 10 years old*
- d) The CYP attends a special needs school and their parent verbally confirms the child has a LD

*GDD refers to CYP who are late in reaching their developmental milestones, which can be an indication of LD but may also be caused by factors such as inadequate stimulation, malnutrition, psychological and familial situations. In practice, some CYP will remain labelled as having GDD, even when other causative factors have been ruled out and a diagnosis of LD is assumed by process of elimination - we want to make sure these patients are not excluded from taking part solely on the basis of terminology.

A broad approach is taken when recruiting CYP with LD because it is entirely those issues around the identification of this population that need exploring. If a CYP is recruited to the study does not have a LD they will remain in the study as a comparator case. In this way, we maximise the diversity of the sample and minimise sampling bias (see Table of risk p20).

CYP with LD will be broadly matched with another CYP with a long-term condition. They will be matched on four criteria: 1) age, 2) number of co-morbidities, 3) expected length of stay, 4) reason for admission. The aim is to recruit two samples of CYP with and without LD who are of similar age, with equal complexity of health needs and who are admitted to the same hospital during the study period. It is important to include a range of CYP with varying degrees of LD. For those with severe or profound LD who are unable to participate in an interview, all other data will be collected. Definitions for all of the matching criteria will be agreed prior to data collection. The aim is to recruit 2 groups of CYP with long-term conditions, one with LD and one without LD, who are of similar age, with equal complexity of health needs and admitted to the same hospital during the data collection period. We will use real life case examples to train staff at the study sites about recruitment and they will have these case examples to refer to.

Selection of hospital sites

Phase 1: Mapping of organisational context and staff questionnaire

18 hospitals in England will take part in Phase 1.

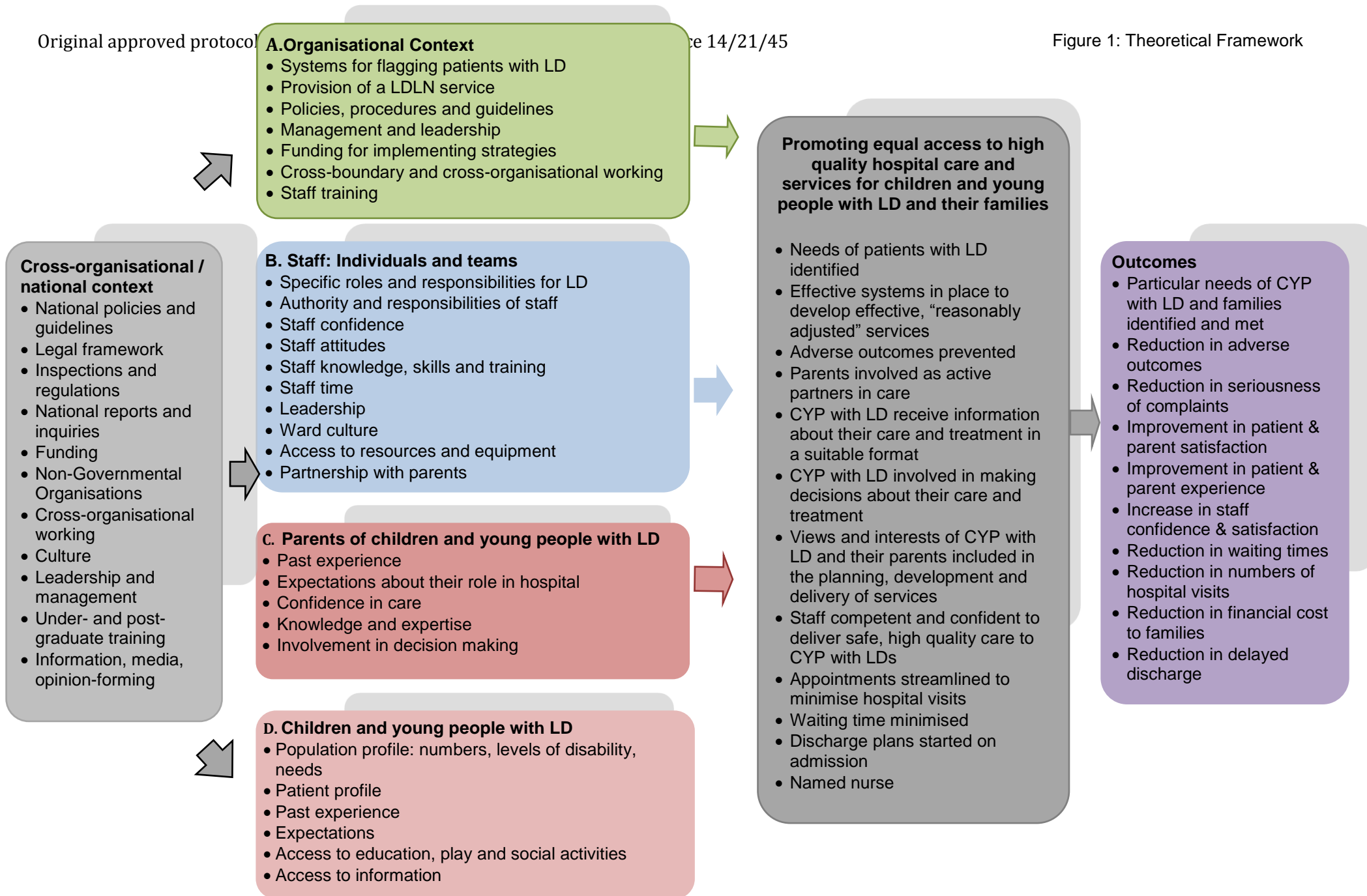
Phase 2: Case studies

To ensure successful study completion, the 18 hospital sites from Phase 1 will become eligible for Phase 2 if they fulfil 2 criteria as ascertained during the mapping exercise: 1) Accessibility to sufficient numbers of CYP with and without LD, 2) Good hospital engagement

Eligible hospitals will be grouped according to whether they have a lot, a little, or no initiatives/appointments of an LD professional with a remit to improve care for CYP with LD. This important step in the selection process will ensure variability in amount of provision provided. Members of the SSC will be asked to design scoring criteria to enable objective selection of the 4 sites for phase 2 based on:

1. The strength of organisational context for delivery care to CYP with LD
2. Staff's perceived ability to identify and meet the needs of CYP with LD
3. Initiatives/appointments of an LD professional with a remit to improve care for CYP with LD

Sites will be anonymised to prevent selection bias.



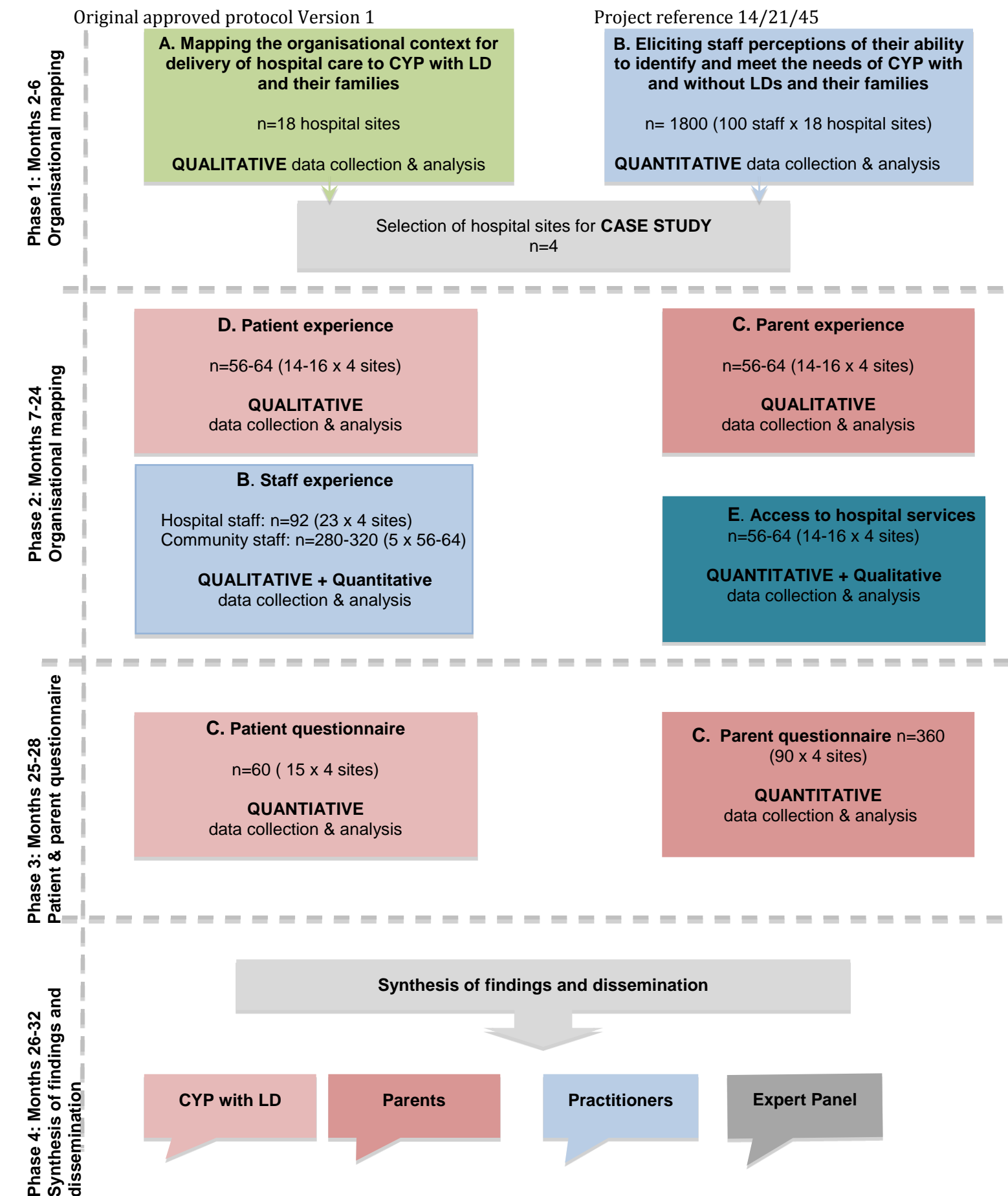
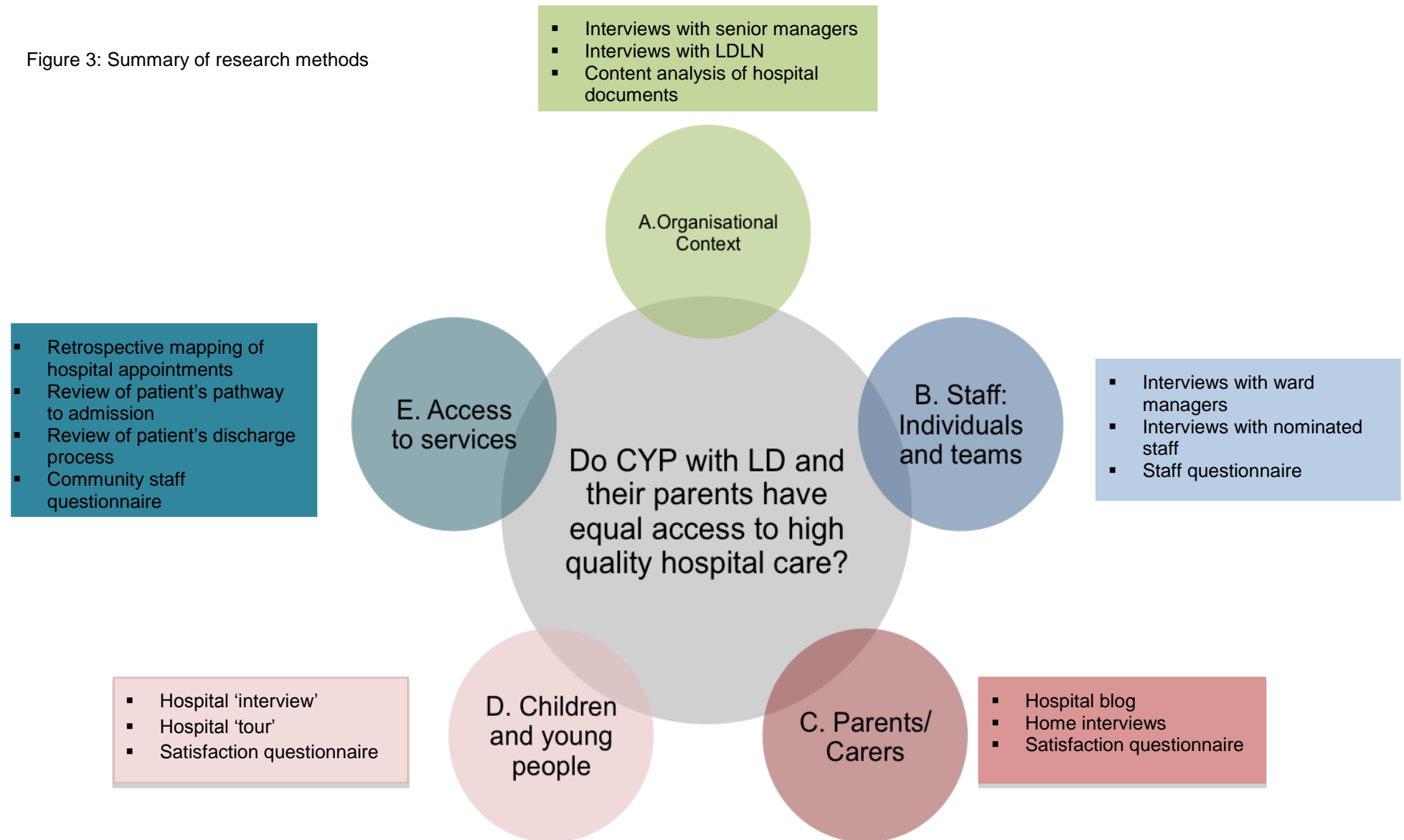


Figure 3: Summary of research methods



PHASE I: MONTHS 2-6**Aims**

- 1) To describe the organisational context for healthcare delivery to CYP with LD and their families
- 2) To compare staff perceptions of their ability to identify the needs of CYP with and without LD and their families and provide high quality care to effectively meet these needs.

Setting

18 NHS hospitals in England.

Recruitment and consent

The CI will liaise closely with the Chief Nurse and local investigator at each site to identify senior managers and staff with a specific remit for LD care to ensure sample diversity according to professional background (as recommended by a senior nurse at one hospital site who was consulted about the study design). Staff will be provided with written information about the study prior to consent.

Methods***Semi-structured interviews with senior managers and LDLN (Research questions 1-7)***

Semi-structured face-to-face or telephone interviews will be held with up to 3 senior managers at each site. Interviews, will be directed to those identified by the chief nurses or their deputies, giving important internal support for this activity. In the first instance we will be seeking interviews with 2 managers per site, at Trust, unit (collection of services) or similar level, with executive or strategic decision making /informing capacity. This may include LD leads and one member on, or directly reporting to, the executive board (likely to be a senior nurse). If time and capacity permit, we will continue and interview an additional recruit per site. The focus of interviews will be on the delivery of services to CYP with LD at the organisational level and should last no more than 20-30 minutes.

The information collected will provide the *context* for answering all of the research questions.

KO, FG, ITW, LC will provide expertise for this part of the study.

Content analysis of hospital documents (Primary aim)

Hospital documents will be collected electronically from each site and a content analysis conducted. The following documents, which are directly relevant to the research questions, will be included: Communication Policy, Admission and Discharge Policy, Complaints Policy, Child Protection Policy, the latest Patient experience/satisfaction surveys and any specific LD Policy. A search and find exercise using predefined terminology (learning disability, special needs, intellectual disability, developmental delay) will be used to ascertain references to CYP with LD and create a thematic framework based on content. Once the first set is retrieved, they will be examined in detail and a simple coding frame developed to use on subsequent documents. .

JW will provide expertise for this part of the study

Staff questionnaire: (Research Questions 1-3)

All clinical and non-clinical staff with patient contact at each hospital site will receive an anonymised semi-structured questionnaire using 'survey monkey'. It is essential that a full range of hospital staff, including for example hospital porters, technicians and canteen staff are represented. A total sample size of 1800 participants across the 18 sites was calculated based on recent evidence of response rates of approximately 100 participants per hospital site using similar staff questionnaires about the care of patients with LD ^{52,57}. The questionnaire will be devised to elicit staff perceptions of their ability to identify the needs of CYP with and without LD and their families and provide high quality care to effectively meet these needs. The questionnaire will be piloted to ensure it is acceptable and relevant to staff. Qualitative data from the CI's recent research with hospital staff about their care of CYP with LD, and other relevant literature, will inform the design of the questionnaire and will focus on 6 key areas: staff knowledge, skills, training, confidence, time and resources. The Chief Nurse (or other nominated senior manager) at each site will email all staff to inform them about the study and invite them to participate. To incentivise participation, a league table will be devised and shared weekly between hospital sites indicating how many of each staff group have returned questionnaires. This method of incentivisation has been used successfully by two of the co-applicants (MF FG).

JW, ITW, MF, LC will provide expertise for this part of the study.

PHASE 2: MONTHS 7-24**Aims**

This Phase forms the main part of the study and has a number of aims:

- 1) To compare how hospital care and services are experienced by CYP with and without LD and their families.
- 2) To compare staff experiences of caring for CYP with and without LD and their families.
- 3) To investigate differences in safety concerns between parents of CYP with and without LD.
- 4) To investigate differences in access to hospital services between CYP with and without LD. .

Setting

Participants will be recruited from 4 NHS hospitals in England. In order to keep the study manageable, and to focus data collection where it is likely to yield the most insightful findings, participant recruitment will be limited to 3 wards in each hospital. Ward managers will be asked to nominate their ward as a site for data collection to increase staff ownership of the study and maximise success. Inclusion criteria to volunteer: the ward would be expected to admit 10 CYP with LD for a stay of 3 nights within a 6 month period (allowing for a 50% recruitment rate).

Sampling

Participants	Sampling strategy	Sample size
CYP and Parents	-A purposive sampling strategy using a sampling matrix to ensure diversity according to level of LD, age, ethnicity	56-64 CYP
Hospital staff	-Ward manager on each study ward -Nominated hospital staff	12 ward managers 112-128 hospital staff
Community staff	-Community health and social care professionals directly involved in the care of CYP	280-320 (Estimated at 5 professionals for each family)

Participants	Inclusion criteria	Exclusion criteria
CYP with LD	Aged 4-18 years, Known LD (as defined above) Expected minimum in-patient stay of 3 nights	Acute health problem only
CYP without LD	Aged 4-18 years Expected minimum in-patient stay of 3 nights	Acute health problem only
Parents	Is able to speak English	None
Hospital staff	Is known to the family who has nominated them for interview	None
Community staff	More than 1 contact with the CYP in previous 12 months	None

Recruitment and consent

CYP and Parents

A small group of senior staff working on the ward and the local investigator at each site will identify eligible families from admission lists according to inclusion criteria. Eligible participants will be provided with the relevant parent and CYP information sheet in an accessible format, including a purposefully made 'talking photo album' and interactive choice button previously used by the CI to successfully recruit CYP with LD (See Figure 3). Study information will be delivered in person or posted. Parents will be asked to contact the researcher if they are interested in taking part or have any questions. Once contact has been made, the researcher will explain to parents what would be expected of them and their child if they were to participate, including the voluntary nature of the study and the ability for them to withdraw without explanation. Confirmation will be sought that parents have discussed the project with their child. Families will only be recruited where parents and CYP both agree to take part. With permission, the researcher will meet participants prior to their involvement at a place of their choosing, likely to be out-patients or the family home. The CI's previous experience of recruiting CYP with LD into research underlined the need to allow considerable time to become familiar with each CYP's level of understanding and usual method of communication to enhance the assent process and ensure their involvement is valuable and meaningful. Once recruited, the researcher will arrange to meet families on the ward during their admission, where consent will be reconfirmed.

Figure 3: Resources for assenting CYP



Hospital staff

Staff will be provided with a study information leaflet and where relevant, informed that they have been nominated for interview. They will be provided with the researcher's contact details and asked to make contact for more information or to take part. Despite being nominated, they need to agree or not to participating. The researcher will meet them at their convenience.

Community based staff

Staff will be sent information about the study and an anonymised questionnaire in the post. Return of the questionnaire will be taken as consent to participate.

Methods

- **To meet the aim of comparing how hospital care and services are experienced by CYP with and without LD and their families the following methods will be used:**

Interviews with CYP: (Research Questions 1-3)

The Mosaic approach^{58,59}, combining the “traditional methodology of observation and interviewing with the introduction of participatory tools”⁵⁸ will be used to guide interviews with CYP. This multi model approach to data collection is underpinned by a view that CYP are experts on their own lives. The aim is to have a toolkit of creative and digital techniques available that draw on each individual's strengths, thereby enabling them to share their experience and preferences in whatever ways they are able and comfortable with. As Davis et al.⁶⁰ suggests, “it is unlikely that any one research activity or tool will be accessible to all young children with different skills, cultural backgrounds and personalities” and this is even more so for CYP with LD.

The primary method of data collection will be ‘Talking Mats’, a communication symbols tool based on extensive research and designed by Speech and Language Therapists. It consists of a pictorial framework based on 3 sets of picture symbols - **issues** relevant to the topic, **factors** relating to each issue and **emotions** to allow participants to indicate feelings about each factor. Talking Mats has been shown to be a powerful tool to allow CYP with different degrees of LD to communicate their views. In a study about making choices at the time of transition for YP with LD, Cameron and Murphy⁶¹ found that participants were able to indicate their likes/dislikes and express views about choices available to them. Some YP with LD raised sensitive issues about transition and revealed opinions that were previously unknown to those caring for them. The method is suitable for CYP of all ages and communication abilities and can therefore be offered to all participants irrespective of whether they have a LD.

Arts-based activities, photography and hospital tour⁶²⁻⁶⁵ are other ways that CYP will be able to share their views. The CI has previously used arts based activities to help CYP with LD share their hospital experience⁵⁰. A 3rd person craft activity enabled them to project their fears and concerns, as well as what they found helpful; choice boxes enabled them to share preferences and a simple questionnaire enabled them to give their opinion (See Figure 4).

Figure 4: Possible methods for collecting data with CYP with LD



Where appropriate, CYP will be offered the opportunity to ‘tour’ the hospital with the researcher, identifying areas they have accessed during their admission and what those spaces mean to them. They will be offered a digital camera to use during the tour to take photographs of people, places and objects of importance to them.

Photography has been used in research with CYP with and without LD as a way of giving them control over what is talked about and as a visual prompt for discussion⁶⁵. In a project involving CYP with LD, Cook and Hess⁶⁶ reported that the method revealed more complex and in-depth conceptualisations than they had imagined, introduced unexpected topics and offered new suggestions as to what might be meaningful for children in certain situations.. Through a process of photo-elicitation, the photographs will be printed and used to facilitate discussion with the researcher about who, what and where is important to them during their hospitalisation. Photo-elicitation is a well-established research method that uses images to prompt and guide discussion. It allows participants to give meaning to the pictures they take and explain these, thereby giving them an element of control over the process. It is recognised as being non-threatening¹¹ and as Whiting (2015) suggests the method “can be a positive experience for children, and one that is not only fun and engaging, but that is also empowering and valuing of their contributions”. The use of digital photography is therefore particularly useful in a context in which we want to hear from a group of vulnerable children whose opinions about hospital are seldom heard. Moreover, some CYP with LD, such as those with Autism, relate particularly well to photographs and may prefer this method of communication above all others.

The skill throughout Phase 2 will be on tailoring data collection activities to each individual CYP, whilst ensuring the research questions are addressed. As Mason⁶⁷ said in relation to CYP with LD, “*Listening can mean going for walk with someone and noticing what captures their interest. It can mean learning to recognise situations in which a person becomes upset, or becomes animated; it can mean watching a person's movements, or the activities they choose over others*” Our flexible, multi-method approach to data collection is crucial to ensuring that CYP of all ages and abilities are truly listened to.

Data collection sessions will take place in a quiet room on or close to the ward (apart from the hospital tour), depending on each CYP's personal preference and health needs. Some CYP, including those with LD, may find it

difficult concentrating for long periods of time and in these circumstances a few short sessions may be preferred to one longer session. The researcher will be guided by CYP and parents as to what would be most appropriate. CYP's preference for their parent(s) to be present or absent during the sessions will be respected.

KO, FG, CJ, SK will provide expertise for this part of the study.

Parent Blog: (Research Questions 1-3)

Parents will be given an android 'tablet' (password protected and security tagged) and invited to complete a hospital blog during their child's in-patient admission using a pre-installed 'Evernote' application, a virtual notebook for simply and instantly uploading audio and video files, photographs and written comments. Parents will be encouraged to document their thoughts and feelings in relation to key events during their hospital stay such as admission, discharge and their child's investigations and treatments. With 'Evernote', parents have a choice about whether and when to share their uploads, thereby giving them control about what becomes data. Parents will not be sharing their thoughts/feelings with other parents in real time. Parents will be able to have a paper copy of their blog and both parents will be invited to blog.

The CI's previous experience revealed some parent's reluctance to leave their child to be interviewed, even for short periods. Blogging offers parents flexibility in how they tell their story and can be completed at any time of the day/night. The researcher will spend time showing parents how to use 'Evernote' and will provide a simple crib sheet and FAQ page to refer to. They will also 'check-in' with parents to answer their questions and resolve any technical issues. Parents will be able to use 'Evernote' on their mobile phone should they prefer. Importantly, the parent's blog will be used to facilitate discussion during a follow-up home interview (see below) that has been designed as the primary method for answering the research questions. By incorporating the use of novel, digital research methods we aim to give parents flexibility and enhance the findings through the capturing of 'live data', but the success of the study is not dependent on its use. Parents will also be offered a paper diary as an alternative to the 'tablet'

CJ will provide expertise for this part of the study

Home interviews with parents: (Research Questions 1-3, 5)

Home interviews will be conducted with parents as soon as possible after the CYP's discharge from hospital, preferably once they have returned to school. The CI previously found home interviews to be more conducive to the collection of rich data. Parents appeared less distracted and more at ease in their own environment and conversations were interrupted less frequently than in the hospital setting. Moreover, conducting home interviews with parents will free the researcher to focus on working closely with CYP during the hospital admission. The CI found that collecting data with parents and patients during the same hospital admission had challenges, sometimes resulting in the voice of CYP being overshadowed. The interview guide will focus on parents' experience of accessing and using hospital care and services for themselves and their child. Data recorded on the parent blog will be used as a further prompt. Questions about the child's pathway to admission and their experience of discharge will be included. Parents will also be asked to nominate 5 staff who made a 'difference' (positive or negative) during their child's admission, 1-2 of whom will be randomly invited for interview. Details of community professionals in contact with their child will also be collected. Parent interviews are expected to last one-two hours.

KO, FG, SK will provide expertise for this part of the study

- **To meet the aim of comparing staff experiences of caring for CYP with and without LD and their families the following methods will be used:**

Interviews with hospital staff: (Research Questions 1-3, 5,7)

Interviews with hospital staff will be face-to-face or telephone and semi-structured. They are expected to last 30-60 minutes. Flexibility will be provided as to the timing and location to minimise staff burden. The CI has experience of interviewing hospital staff about their experience of caring for CYP with LD and received a positive response to requests to participate.

KO, FG, ITW, MF, LC will provide expertise for this part of the study

- **To meet the aim of investigating the differences in safety concerns between parents of CYP with and without LD the following methods will be used:**

Completion of the 'Daily Safety Reporting Tool':(Research Question 5)

In light of qualitative evidence that parents of CYP with LD can lack confidence that their child is receiving high quality hospital care and subsequently feel responsible for monitoring their care, parents will be asked to complete the daily safety reporting tool⁶⁸ – a six item tool which asks parents to identify their safety concerns from a choice of: medication, communication and information, equipment, unexpected complications of care, hygiene/cleanliness, other safety problems. Completion of the tool will enable perceptions of safety between the two groups of parents to be compared. Information collected will be used as a prompt during home interviews.

LC will provide expertise for this part of the study.

- **To meet the aim of investigating the differences in access to hospital services for CYP with LD, compared with CYP without LD the following methods will be used:**

Retrospective mapping of hospital appointments: (Research Question 2)

For each CYP, a retrospective mapping will be conducted of all in-patient stays and out-patient appointments for the previous 2 years using the electronic hospital appointment system to retrieve the following data:

In-patient stay – a) age of patient b) diagnosis c) date of admission d) ward e) admitting team f) reason for admission g) anticipated date of discharge h) date of discharge i) discharge location.

Out-patient appointments – a) age of patient b) diagnosis c) date of appointment d) time of appointment e) admitting team f) 'Did not attend' status and reason given.

After the first set of paired notes have been reviewed at each site, we will ask the SSC to determine whether the data collected is sufficient and any practical considerations such as time taken to collect the data.

JW will provide expertise for this part of the study.

Questionnaires by community-based professionals: (Research Questions 1-3)

Community professionals nominated by parents will be sent an anonymised questionnaire in the post, with a stamped address return envelope. The questionnaire will be a modified version of the hospital staff questionnaire from Phase 1 with a particular focus on access to secondary and tertiary care for CYP with and without LD.

JW and ITW will provide expertise for this part of the study.

PHASE 3: MONTHS 25-28

Aims

To compare levels of satisfaction with hospital care between: a) CYP with and without LD, b) Parents of CYP with and without LD.

Setting and sample

All parents and patients who are discharged from the study wards at each of the 4 hospital sites for a period of 3 months will be eligible for participation. Respondents will be asked to tick whether they/their child has a) LD, b) a long-term condition, c) neither and d) both. A total sample size of 360 parents and 60 CYP has been calculated based on a conservative estimated return rate of 30 questionnaires per hospital per month for parents and 5 questionnaires per hospital per month for CYP. These estimates are based on the research team's experience of collecting this type of data in a hospital setting.

Method

Questionnaire: (Research Question 4)

There is a lack of validated patient/parent satisfaction questionnaires, particularly for CYP and those with LD. Drawing on the best available tools (<http://www.chimat.org.uk/default.aspx>) a questionnaire will be purposefully designed to answer the research question. Multiple versions of the questionnaire will be developed for CYP across the age range and with differing levels of cognitive functioning. Questionnaires will be piloted with a group of CYP with and without LD and their parents beforehand.

Questionnaires will be given to parents and CYP prior to discharge. Parents will be asked to indicate on the form if their child has a) LD b) a long-term health condition c) both d) neither (Definition of long-term health condition and LD will be provided on the form). A sealed box will be available on the ward for participants to leave their completed questionnaire prior to discharge and free post envelopes will also be available for return by post.

JW, ITW will provide expertise for this part of the study.

Data analysis

A model for mixed methods data analysis¹ will be used. Qualitative and quantitative data will be analysed within each phase using appropriate methods before merging and connecting them through a period of data synthesis.

Qualitative

Multiple sets of qualitative data will be generated from this study that are best analysed using the Framework method. This matrix based analytic method facilitates rigorous and transparent data management "such that all the stages involved in the 'analytic hierarchy' can be systematically conducted"⁶⁹. The method involves five distinct, but highly interconnected stages: familiarisation; identifying a thematic framework; indexing; charting; mapping and interpretation. The strengths of using framework is that it allows easy access to the synthesised data so that it can be continually revisited, which is important when conducting multi-centred, mixed methods research over 4 phases. The approach enables data to be examined within cases across a range of different themes, thereby facilitating

comparisons to be made both between and within case study sites. Furthermore, the process is well-suited to research involving group and individual level analysis. The data will be managed using NVivo, a qualitative data analysis programme.

Quantitative

Separate quantitative analyses will analyse:

- (i) Hospital staff questionnaire data (Phase 1).** Analyses will follow previous studies of staff questionnaires of patients with LD in hospitals¹⁸. Descriptive comparisons for each of the 6 key areas of the questionnaire between responses pertaining to CYP with and without LD will be presented (e.g., frequencies, percentages, means and standard deviations, medians and inter-quartile ranges). Comparisons will also be presented for sub-groups of respondents categorised by staff group (e.g., doctors, nurses, professions allied to medicine, non-clinical staff), staff grade and site.
- (ii) 'Safety concerns' data using the daily safety reporting tool (Phase 2).** Number and type of safety concerns will be compared and analysed descriptively.
- (iii) Community-based staff questionnaire (Phase 2).** Responses to this questionnaire will be compared descriptively and analysed in the same way as for the hospital staff data, described above in (i).
- (iv) Parent and patient satisfaction with hospital care (Phase 3).** Responses to this questionnaire will be compared descriptively and analysed in the same way as for the hospital staff data, described above in (i).

PHASE 4: MONTHS 26-32

Aim

To synthesise and disseminate findings and develop the content of a DVD and/or training package for students/staff

Method

The amount of qualitative and quantitative data generated by the study will be large. During the stage of data synthesis, the research team will use quantitative data to explain and illustrate qualitative findings, and look for congruence and incongruence between qualitative and quantitative findings. In particular, the team will look for instances where there is incongruence between policy and practice, using specific queries within the Nvivo programme to address these issues and explain any incongruence. It is at the stage of data synthesis that barriers and facilitators to ensuring CYP with LD and their families receive equal access to high quality hospital care and services, will be highlighted, looking for specific examples of successful and effective measures that promote equal access. The final analytical framework will be compared with our Theoretical Framework and the initial common analytical framework, in order to generate a final Empirical Framework of factors that affect the promoting of equal access to high quality hospital care for CYP with LD and their families.

Four workshops will be held towards the end of the study, one for CYP, parents, professionals and an expert panel. The aim of these workshops will be to disseminate findings back to participants and known experts to promote discussion regarding the content of a DVD and/or training package that will be used in practice to guide students and staff of the barriers and facilitators to the delivery of high quality care for CYP with LD and their families. **It is only the content of this training package that will be decided during the project duration. Additional funding will be sought elsewhere for its development and implementation.** In the adult setting, a similar training initiative has been used to ensure staff have a good understanding of the issues faced by patients with dementia so they can recognise and support care for these vulnerable patients. So far, 12,500 staff at Guys and St Thomas' hospital have attended a training session, the main focus of which is a short film about Barbara and her experiences during a hospital visit.

FG, ITW, MF will provide expertise for this part of the study.

Patient and public involvement

This study has directly evolved from 4 substantial pieces of work involving the CI and/or other co-applicants to understand: 1) how to manage pain in non-verbal children with LD, 2) parental perspectives of caring for a child with LD, 3) the needs and experiences of CYP with LD, their families and staff in hospital, 4) how to create a safe hospital environment for adults with LD. Key to each of these was hearing what matters most to participants. We believe strongly that it is crucial to involve patients and public in all aspects of the research process, particularly when the research involves marginalised groups of people, such as those with LD, whose views are rarely heard. One of the co-applicants is a parent (SK) with nearly 20 years experience of using NHS hospitals within and outside London for her children with LD. SK has previously worked with the CI on a related LD project. Our aim is to ensure that any data collection involving parents is carried out in an appropriate, accessible, sensitive and ethical manner. SK will play a crucial role in advising on data collection so that methods are acceptable to parents and likely to be completed.

Parents, hospital and community based clinicians and LD experts have been consulted about the research questions, design, methods and dissemination to ensure they are acceptable, feasible and of importance. Parents identified the need to consider raised parental stress, illness of child, possibility of parents having a LD and benefit of collecting data online, using a LD nurse to support CYP involvement in the project and collecting data from multiple hospital sites. 3

parents of CYP with LD have agreed to sit on the SSC and we will invite a similar number of parents of CYP without LD to also join the SSC. We will offer relevant training in the form of a workshop to all parents on the SSC and research team prior to the study start date. Training will include a session on roles and responsibilities, providing parents with clear guidance of what is expected of them and who to contact with any questions or concerns. Two members of the research team with particular expertise in PPI, FG and MF, will act as mentors to parents, acting as a point of contact for them throughout the study and providing relevant advice and support as needed. We will also offer SK the opportunity to attend an external training session on qualitative data analysis in preparation for her involvement in this element of the project.

The well-established Young People's Advisory Group (YPAG), run by the Medicines for Children Research Network, will act as a reference group. This group of young people aged 9-19 review and discuss information materials, ethical issues and study designs to ensure they are appropriate for young patients. Members have a range of health conditions, experience of being an inpatient or outpatient and/or an interest in research. The YPAG does not currently have any representation from CYP with LD but the CI is working with the Nurse Consultant for LD to change this, to ensure their views are heard more widely. We will invite one or two representatives of the reference group to provide feedback to the SSC, at each meeting, on the wider views of the group. CYP and parents on the SSC will have the opportunity to be involved in presenting at proposed conferences. We will recruit an NHS manager to the SSC.

MF, FG will provide expertise in PPI

Outputs and dissemination

There will be at least one output from each part of the study, led by different team members with relevant expertise:

What	When
Comprehensive mapping of the systems and structures in place for the delivery of hospital care to CYP with LD and their families across 18 hospitals in England	December 2016
Comparison of staff's perception of their ability to meet the needs of CYP with and without LD and their families	December 2016
The hospital experience of CYP with and without LD	November 2018
The hospital experience of parents of CYP with and without LD	November 2018
Hospital staff's experience of caring for CYP with and without LD	November 2018
Community staff's perception of hospital access for CYP with and without LD	November 2018
In-patient and out-patient activity for CYP with and without LD	November 2018
Comparison of safety concerns of parents of CYP with and without LD	November 2018
Patient satisfaction with hospital care and services	November 2018
Parent satisfaction with hospital care and services	November 2018

The primary output will be guidance for commissioners and providers of NHS hospital services for CYP with LD and their families. Other outputs include:

- Report to CYP/parent participants in a range of accessible formats, accounting for the needs of those with LD.
- On-line report for lay audiences, including those with LD, at GOSH and Contact a Family, BILD,
- Presentation back to staff participants to share examples of good practice
- Published abstracts and papers in international peer-reviewed journals including an e-journal for healthcare students and professionals 'www.intellectualdisability.info' which is accessed by more than 500 people daily
- Presentations through national and international conferences, including those that reach different professional groups such as nurses (Royal College of Nursing International Research Conference), doctors (Royal College of Paediatrics and Child Health) and Allied Health Professions (Royal College of Speech and Language Therapists) as well as the International Association of Scientific Study of Intellectual Disabilities (IASSIDD).
- Separate funding will be sought, from a 3rd sector organisation, for the making of the DVD and disseminating it widely into practice. The aim is to replicate the impact that Barbara's Story has had at Guys and St Thomas' Hospital in changing care and attitudes towards patients with dementia. 12,500 staff have currently seen the film and been trained. Once made the training DVD will also be available for trained staff.

http://www.youtube.com/watch?v=DtA2sMAjU_Y&feature=share&list=UUBJBH2MFKrX6lf8bJ7_ZGW_Q

Working in partnership with the Foundation for People with Learning Disabilities, the British Institute of Learning Disabilities, Contact a Family and NHS England will strengthen our dissemination strategy, ensuring the findings are shared in a variety of accessible formats and reach a wide range of parents, professionals and CYP with and without LD, as well as academics and policy makers helping drive support for change. Through inclusive dissemination this research will bridge the gap between NHS management and users.

We will develop a social media strategy to ensure ongoing dissemination of findings and user engagement throughout the project, and to build a network/community of interested users/stakeholders. We will set up a project website, blog,

and twitter for the project. This will enable key research narratives to be disseminated and will provide a creative way to engage directly with potential users and testing ideas and contributing to relevant debates as they evolve. The web site will be maintained by the researcher team and will be a 'read only' site. The research team will provide an accessibly written project post on a key issue related to the project once every two weeks, and a twice-yearly study newsletter. Only the project team will be able to post information. Twitter will be used to regularly connect with major stakeholders, policy makers and key players about ongoing debates and ideas. All participants will be provided with information about the social media.

Expected Impact

The NHS is striving to improve quality of care while also increasing the efficiency of resource use. This study has the capacity to meet both these goals through identifying inequalities in hospital care for CYP with LD and their parents and determining how resources and interventions that enable equality can be targeted more effectively to the right patients at the right time and be reconfigured to ensure care is preventative rather than reactive, thereby increasing efficiency. The guidance produced will enable commissioners and service providers to improve the way that hospital services are organised and delivered to CYP with and without LD and their families ensuring equality for all. There is potential to see improvements in staff awareness of what matters to these CYP and their families as well as their ability and confidence to identify and meet their needs, leading to improved satisfaction for everyone.

Through identifying inequality and offering strategies to eradicate it, there is the potential to see a reduction in:

- 1) Financial costs to the NHS and families through the delivery of a more efficient and effective service**
- 2) Health costs to CYP and parents through better understanding of their physical needs and focus on risk prevention, leading to improved quality of care**
- 3) Emotional costs to CYP and parents as a result of reduced stress and greater confidence in care**
- 4) Social costs to CYP and parents through reduced hospital contact**

It is key that we make findings accessible and they are widely disseminated so that the relevant people are given the opportunity to 'take notice' of them and respond.

Failure to identify inequalities in hospital care for adults with LD has led to preventable deaths and damage to the reputation of the NHS, as well as on-going costs from reviews and inquiries. Through identifying inequalities in access to high quality hospital care for CYP with LD and what action is needed to remove them, these extensive human and financial costs can be avoided, thereby making the proposed study extremely good value for money.

Success Criteria

1. 20% response rate for the staff questionnaire
2. All staff groups represented by completed questionnaires
3. The target of 36-54 interviews with senior managers will be met
4. 100% of CYP with LD will be matched with a comparator case
5. 50% of parents complete a hospital blog
6. 75% of parents complete the daily safety reporting tool
7. 100% of parents complete the home interview
8. 40% response rate of the parent satisfaction questionnaire
9. Workshops will have representatives from each of the four stakeholder groups.

Research Management

Dr Kate Oulton (KO) is the CI and will act as project manager. KO has experience of project managing a 4 site randomised controlled trial, including supporting clinical nurses to recruit and deliver an intervention to parents in the neonatal intensive care setting. KO is currently leading or collaborating on a number of projects, each one involving CYP and/or their families in the hospital setting. She has recently led and completed a study to understand the needs and experiences of CYP with LD in hospital, the results of which have reinforced the need for the proposed research. KO is a Visiting Fellow at South Bank University and is linked to the Department of Children's Nursing Team. She also has an NIHR funded post as the clinical academic programme lead for nursing and allied health professions research at Great Ormond Street Hospital NHS Foundation Trust (GOSH). KO will provide day to day supervision for the research team and lead regular team meetings, assist with day to day management of the project as needed, monitor progress, guide data analysis, and communicate with the joint applicants. All research activities will be based at GOSH; researchers will travel to the research sites as needed.

In addition to being a core member of the research team (see below) Prof Gibson (FG) will provide mentoring support for KO through the provision of weekly face to face 'meetings' which provide regular opportunity to listen, share experiences, offer support and encouragement, as well as provide a framework to explore options for career development; including identifying and supporting opportunities for teaching and training and drawing on existing

networks to maximise opportunities for KO to reach out into the research community in child health. Mentoring in terms of a research career already features in the relationship between the CI and FG, both are based at GOSH, thus regular contact is possible. FG currently mentors a number of nurse academics, and offers at a distance guidance to two NIHR post doctoral fellows. It is this process of getting information to people, through people that will lead to changes in practice. Professor David Richards, a nurse and Professor of Mental Health Services Research at University of Exeter Medical School, will provide additional mentoring to KO externally. Prof Richards is CI on NIHR-HTA and MRC/EME funded projects, a NIHR Senior Investigator and the NIHR Academic Training Advocate for Nursing. He will be an excellent role-model for KO and will support her leadership development.

The research team comprises individuals from different professional backgrounds that have extensive experience of researching the field of child and adult health and significant expertise in the delivery of time-limited projects, involving hard-to-reach participants. As a team we are aware of the challenges and burdens for families for participating in research and have the necessary skills to minimise and manage these. The core research team and researchers will meet weekly to discuss and address current issues and progress. In all cases, face to face meetings will be encouraged where there is no significant time or travel cost, but teleconferencing will be used to minimise time and funding required. The wider research team will meet monthly to oversee the study at an operational level.

Name	Professional background	Research expertise	Primary population
Dr Oulton (KO)	Paediatric nurse	Qualitative research methods	CYP with LD
Prof Gibson (FG)	Paediatric nurse	Qualitative research methods/ case study design	CYP
Prof Fletcher (MF)	Paediatric nurse	Patient and public involvement	CYP
Dr Wray (JW)	Health psychologist	Quantitative research methods	CYP
Dr Tuffrey-Wijne (ITW)	Adult nurse	Health services delivery research	Adults with LD
Dr Hassiotis (AH)	Consultant psychiatrist	Applied health services research	LD/mental health
Dr Carr (LC)	Consultant neurologist	Expert clinician	CYP with epilepsy
Prof Jewitt (CJ)	Education and technology	Digital research methods	CYP
Mrs Kerry (SK)	Expert Parent	Expert parent	CYP with LD

A SSC has been set up to provide overall supervision and ensure the project is conducted to the standards set out in the "Department of Health's Research Governance Framework for Health and Social Care and the Guidelines for Good Clinical Practice" (NIHR). The SSC is necessarily large, as this study involves multiple research sites and strands, requiring wide-ranging expertise and viewpoints from a range of academics, clinicians and lay people.

Ethical issues

This study includes data collection involving vulnerable CYP. The research team has longstanding expertise in conducting research in sensitive areas. The research team feels strongly that ethical considerations for this study need to be given attention above and beyond any requirements of Research Ethics Committees. Therefore, a range of steps will be taken in order to safe guard all informants from undue harm in accordance with the principal of beneficence. We will pay particular attention to obtaining assent from research participants with LD, using a range of accessible study information materials, including a talking photo album, and ensuring sensitivity to the various ways in which people with LD may express withdrawal of consent. Ethical approval for the study will be obtained via IRAS. All data collection tools and participant information materials need to be submitted at the point of REC application – we have allowed 2 months for the development of these materials. We have allowed 3 months for obtaining ethics and R&D approvals. We propose to commence the study in Dec 2015.

Summary of study risks

Potential risk	Action to limit or resolve risk
Delayed approval from NHS Ethics committee	<p>We are well aware that our application may present to the ethics committee challenges in relation to the population and research methods. We will ensure clarity and offer fuller explanations to assist the members to fully understand:</p> <ul style="list-style-type: none"> • The need for the research • The sample and sampling framework used • The need to be flexible in our approach with CYP that will best reveal a yes or no to participation • The range of methods of data collection used with CYP and evidence of our expertise in using them • The challenges associated with using digital photography in a hospital setting and evidence of our expertise in this area

	<ul style="list-style-type: none"> • What the burden of being in a study can mean to families, our aim will be to sensitive to this and keep it to a minimum • Our approach to PPI that ensures we have a robust and achievable study • Our skills in managing large and complex data sets • Our relationships within the child healthcare settings that enable multi-site working
Protracted period for local R&D approvals	Our experience to date would suggest we might be delayed, similar to NHS ethics, as we are presenting local approval teams with a challenge in terms of population and data collection. We have experience of multiple conversations to provide additional information about the creative approaches to data collection we use with CYP to R&D departments. Similar to ethics we will ensure fuller descriptions of our work in the SSI form are given, making clear the role of local PI, and their role in identifying families, approaching and recruiting. The role of their staff, and time to be given on the study will be made very clear: anticipating questions in advance based on our experience to date in multi-site complex studies like this.
Low recruitment rate: CYP	<ul style="list-style-type: none"> -Experienced network of parents and professionals on SSC -Parent of CYP with LD as a co-applicant -Small sample size for Case Study during Phase 2 -Mixed methods allows other sources of data to add to the voice of CYP -Costs included for local investigator time at each site -Costs included to allow for suitably trained researchers -Tailored assent information and recruitment materials -Home visit to facilitate rapport and understand CYP's individual needs -Ongoing feedback to sites through project Newsletter and support for local investigators
Low recruitment rate: staff	Telephone interviews will be offered as an alternative to face-to-face interviews
Identifying CYP with LD	A broad definition of LD will maximise potential success of recruiting families and minimise risk of patient identification problems disrupting recruitment or study processes. Accommodating and including families where the child has an uncertain diagnosis, which by definition may change over time, is an important aspect of the inclusivity of this study.
Site reluctance to include 'Daily safety reporting tool'	We will liaise closely with study sites to ensure they have complete understanding of the reasons for including the tool and how we will use the data collected. Maintaining confidentiality of study sites will be a crucial element of the study.
Responding to patient safety concerns	As part of the ethics approval process, the research team, SSC and local investigators will agree an appropriate plan of action in response to parent's reporting of safety concerns to ensure staff are alerted to incidents of 'actual harm' and parents have appropriate avenues of support to discuss their concerns.
Maintaining patient and site confidentiality	Information pertaining to participants and sites will be kept strictly confidential and used solely for the purpose of the study. Strict coding procedures will be adhered to at all times.
Dissemination of findings	We are well aware of the complexities of disseminating to families and professionals sensitive information. We are mindful of published work that offers suggestions about how to approach this sensitively, whilst still ensuring we inform study participants about what we found out. Having a parent of children with LD on the research team will help us here. In addition, the research team have significant experience in producing dissemination materials, the development of the DVD will ensure we reach as many people as need to know.

References

1. J.W. Creswell, V.L. Plano Clark. Designing and Conducting Mixed Methods Research. 2nd ed. London: Sage; 2010.
2. Department of Health. Valuing People: A New Strategy for Learning Disability for the 21st Century. London: DH, 2001.
3. World Health Organisation. International Statistical Classification of Diseases and Related Health Problems - 10th Revision. Geneva, Switzerland: WHO; 2011.
4. BLISS. Special Care for Sick Babies - Choice or Chance? London: BLISS; 2005.
5. N. Marlow, E. M. Hennessy, M. A. Bracewell, D. Wolke, E. PICure Study Group. Motor and Executive Function at 6 Years of Age after Extremely Preterm Birth. *Pediatrics*. 2007;120(4):793-804.
6. S. Johnson, J. Fawke, E. Hennessy, V. Rowell, S. Thomas, D. Wolke, N. Marlow. Neurodevelopmental Disability through 11 Years of Age in Children Born before 26 Weeks of Gestation. *Pediatrics*. 2009;124(2):e249-57.
7. S. Saigal, L. W. Doyle. An Overview of Mortality and Sequelae of Preterm Birth from Infancy to Adulthood. *Lancet*. 2008;371(9608):261-9.
8. Nuffield Council on Bioethics. Critical Care Decisions in Fetal and Neonatal Medicine: Ethical Issues. London: Nuffield Council on Bioethics, 2006.
9. Prime Ministers Strategy Unit. Improving the Life Chances of Disabled People. London: Strategy Unit, 2005.
10. V. A. Morgan, H. Leonard, J. Bourke, A. Jablensky. Intellectual Disability Co-Occurring with Schizophrenia and Other Psychiatric Illness: Population-Based Study. *Br J Psychiatry*. 2008;193(5):364-72.
11. E. Emerson, C. Hatton, J. Robertson, H. Roberts, S. Baines, F. Evison, G. Glover. People with Learning Disabilities in England 2011. Improving Health and Lives Learning Disability Public Health Observatory, 2012.
12. Mencap. Death by Indifference. London: Mencap; 2007.
13. J. Michael. Healthcare for All: Report of the Independent Inquiry into Access to Healthcare for People with Learning Disabilities. London: DH; 2008.
14. Improving Health and Lives Learning Disabilities Observatory. Confidential Inquiry into Premature Death of People with Learning Disabilities. Bristol: IHAL; 2012.
15. Mencap. Getting It Right Charter. 2010.
16. The Joint Health and Social Care Learning Disability Self Assessment Framework: How Local Learning Disability Communities Rate Themselves [press release]. Learning disabilities observatory 2014.
17. Disability Discrimination Act 2005. London: DH; 2005.
18. I. Tuffrey-Wijne, L. Goulding, N. Giatras, E. Abraham, S. Gillard, S. White, C. Edwards, S. Hollins. The Barriers to and Enablers of Providing Reasonably Adjusted Health Services to People with Intellectual Disabilities in Acute Hospitals: Evidence from a Mixed-Methods Study. *BMJ Open*. 2014;4(4):e004606.
19. S. Hollins, I. Tuffrey-Wijne. Improving Hospital Care for Patients with Intellectual Disabilities. *Br J Hosp Med (Lond)*. 2014;75(6):304-5.
20. S. Hollins, I. Tuffrey-Wijne. Meeting the Needs of Patients with Learning Disabilities. *BMJ*. 2013;346:f3421.
21. L. A. Allerton, V. Welch, E. Emerson. Health Inequalities Experienced by Children and Young People with Intellectual Disabilities: A Review of Literature from the United Kingdom. *J Intellect Disabil*. 2011;15(4):269-78.
22. E. Emerson, C. Hatton. Contribution of Socioeconomic Position to Health Inequalities of British Children and Adolescents with Intellectual Disabilities. *Am J Ment Retard*. 2007;112(2):140-50.
23. E. Emerson, C. Hatton. Poverty, Socio-Economic Position, Social Capital and the Health of Children and Adolescents with Intellectual Disabilities in Britain: A Replication. *J Intellect Disabil Res*. 2007;51(Pt 11):866-74.
24. E. Emerson, C. Hatton, D. Felce, G. Murphy. Learning Disabilities: The Fundamental Facts. London: The Foundation for People with Learning Disabilities, 2001.
25. E. Emerson. Prevalence of Psychiatric Disorders in Children and Adolescents with and without Intellectual Disability. *J Intellect Disabil Res*. 2003;47(Pt 1):51-8.
26. C. Glendinning, S. Kirk, A. Guiffreda, D. Lawton. Technology-Dependent Children in the Community: Definitions, Numbers and Costs. *Child Care Health Dev*. 2001;27(4):321-34.
27. M. Mahon, M. S. Kibirige. Patterns of Admissions for Children with Special Needs to the Paediatric Assessment Unit. *Arch Dis Child*. 2004;89(2):165-9.
28. I. Kennedy. Getting It Right for Children and Young People: Overcoming Cultural Barriers in the NHS So as to Meet Their Needs. London: DH; 2010.
29. E. Emerson, C. Kiernan, A. Alborz, D. Reeves, H. Mason, R. Swarbrick, L. Mason, C. Hatton. Predicting the Persistence of Severe Self-Injurious Behavior. *Res Dev Disabil*. 2001;22(1):67-75.
30. C. Glendinning. Unshared Care: Parents and Their Disabled Children. London: Routledge Kegan Paul; 1983.
31. S. Baldwin, J. Carlisle. Social Support for Disabled Children and Families. A Review of the Literature. Edinburgh: HMSO; 1994.
32. J. Read. Disability, the Family and Society. Listening to Mothers. Buckingham: Open University Press; 2000.
33. K. Oulton, B. Heyman. Devoted Protection: How Parents of Children with Severe Learning Disabilities Manage Risk. *Health Risk Soc*. 2009;11:303-19.
34. Department of Health. National Service Framework for Children, Young People and Maternity Service. Disabled Children and Young People and Those with Complex Health Needs. London: HMSO; 2004.
35. K. Martin. Making Ourselves Heard: Exploring Disabled Children's Participation. London: National Children's

Bureau Enterprises Ltd 2009.

36. Department of Health. The Children's and Young People's Health Outcomes Forum: Report of the Long Term Conditions, Disability and Palliative Care Subgroup. London: DH; 2013.
37. Care Quality Commission. Health Care for Disabled Children and Young People. Newcastle: CQC; 2012.
38. Annual Report of the Chief Medical Officer 2012. Our Children Deserve Better: Prevention Pays. London: DH; 2013.
39. M. Brady. Hospitalized Children's Views of the Good Nurse. *Nurs Ethics*. 2009;16(5):543-60.
40. I. Coyne. Children's Experiences of Hospitalization. *J Child Health Care*. 2006;10(4):326-36.
41. I. Coyne. Consultation with Children in Hospital: Children, Parents' and Nurses' Perspectives. *J Clin Nurs*. 2006;15(1):61-71.
42. T. Carney, S. Murphy, J. McClure, E. Bishop, C. Kerr, J. Parker, F. Scott, C. Shields, L. Wilson. Children's Views of Hospitalization: An Exploratory Study of Data Collection. *J Child Health Care*. 2003;7(1):27-40.
43. S. A. Sartain, C. L. Clarke, R. Heyman. Hearing the Voices of Children with Chronic Illness. *J Adv Nurs*. 2000;32(4):913-21.
44. V. Shilling, V. Edwards, M. Rogers, C. Morris. The Experience of Disabled Children as Inpatients: A Structured Review and Synthesis of Qualitative Studies Reporting the Views of Children, Parents and Professionals. *Child Care Health Dev*. 2012;38(6):778-88.
45. B Garth, R. Aroni. "I Value What You Have to Say". Seeking the Perspective of Children with a Disability, Not Just Their Parents. *Disability and Society*. 2003;18(5):561-76.
46. S. Sharkey, C. Lloyd, R. Tomlinson, E. Thomas, A. Martin, S. Logan, C. Morris. Communicating with Disabled Children When Inpatients: Barriers and Facilitators Identified by Parents and Professionals in a Qualitative Study. *Health Expect*. 2014.
47. M. Avis, R. Reardon. Understanding the Views of Parents of Children with Special Needs About the Nursing Care Their Child Receives When in Hospital: A Qualitative Study. *J Child Health Care*. 2008;12(1):7-17.
48. F. Jackson-Brown, J. Guvenir. The Experiences of Children with Learning Disabilities, Their Carers and Staff During a Hospital Admission. *British Journal of Learning Disabilities*. 2009;37:110-5.
49. K. Oulton, S. Kerry, L. May, D. Sell, C. DeSousa, F. Gibson. How to Meaningfully Include Children and Young People with learning disabilities in Research. *Journal of Applied Research in Intellectual Disabilities*. 2014;27(4):361.
50. K. Oulton, S. Kerry, L. May, D. Sell, C. DeSousa, F. Gibson. Hospital Staff Experiences of Caring for Children and Youth with Id and Their Families: It's the Little Things That Make the Difference! *Journal of Applied Research in Intellectual Disabilities*. 2014;27(4):316.
51. Children and Families Act 2014. In: Office Stationery, editor. London 2014.
52. I. Tuffrey-Wijne, N. Giatras, L. Goulding, E. Abraham, L. Fenwick, C. Edwards, S. Hollins. Identifying the Factors Affecting the Implementation of Strategies to Promote a Safer Environment for Patients with Learning Disabilities in Nhs Hospitals: A Mixed-Methods Study. London: NIHR, 2013.
53. W. Tellis. Application of a Case Study Methodology. *The Qualitative Report*. 1997;3(3).
54. R. K. Yin. Enhancing the Quality of Case Studies in Health Services Research. *Health Serv Res*. 1999;34(5 Pt 2):1209-24.
55. D. E. Howard, C. Lothen-Kline, B. O. Boekeloo. Using the Case-Study Methodology to Teach Ethics to Public Health Students. *Health Promot Pract*. 2004;5(2):151-9.
56. Health and Social Care Information Centre. Learning Disabilities Census Report. England: hscic, 2013.
57. J. Blair. Staff Experience, Knowledge and Skills When Working with Children and Young People with Learning Disabilities in Hospital. 2013.
58. A. Clark, P. Moss. Listening to Young Children. The Mosaic Approach. London: National Children's Bureau, 2011.
59. A. Clark. The Mosaic Approach and Research with Young Children. In: Lewis V., Kellet M., Robinson C., Fruser S., Ding S., editors. *The Reality of Research with Children and Young People*. London: Sage; 2003. p. 157-61.
60. J. Davis, N. Watson, S. Cunningham-Burley. Disabled Children, Ethnography and Unspoken Understandings: The Collaborative Construction of Diverse Identities. In: Christensen P.M., James A., editors. *Research with Children: Perspectives and Practices*. New York, USA: Routledge; 2008. p.220-38.
61. L. Cameron, J. Murphy. Making Choices at the Time of Transition. Scotland: University of Stirling, 2000.
62. J. Coad, G. Plumridge, A. Metcalfe. Involving Children and Young People in the Development of Art-Based Research Tools. *Nurse Res*. 2009;16(4):56-64.
63. M. Horstman, S. Aldiss, A. Richardson, F. Gibson. Methodological Issues When Using the Draw and Write Technique with Children Aged 6 to 12 Years. *Qual Health Res*. 2008;18(7):1001-11.
64. K. Knighting, N. Rowa-Dewar, C. Malcolm, N. Kearney, F. Gibson. Children's Understanding of Cancer and Views on Health-Related Behaviour: A 'Draw and Write' Study. *Child Care Health Dev*. 2011;37(2):289-99.
65. B. Carter, K. Ford. How Arts-Based Approaches Can Put the Fun into Child-Focused Research. *Nurs Child Young People*. 2014;26(3):9.
66. T. Cook, E. Hess. What the Camera Sees and from Whose Perspective. *Fun Methodologies for Engaging Children in Enlightening Adults*. *Childhood*. 2007;14:29-45.
67. M. Mason. *Incurably Human*. London: Working Press, 2000.
68. H. Clausen. Doctors in Training Leading Quality Improvement: Families Reporting Critical Incidents and near

Misses in a Children's Hospital. London: The Health Foundation, 2014.

69. J. Ritchie, J. Lewis. Qualitative Research Practice - a Guide for Social Science Students and Researchers. London: Sage; 2003.

Copyright 2015, Great Ormond Street Hospital for Children NHS Foundation Trust