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Fulfilling Children's Right to Play in the Hospital Setting: A Scoping Review of the Literature

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Abstract: There is growing recognition of the importance of fulfilling children's right to play under Article 31 of the United Nations Convention on the Rights of the Child within the context of the hospital setting. Methodologically, a scoping review approach was used to review the literature, with the aim of identifying and rapidly mapping the existing evidence related to children's fulfilment of Article 31. Scoping reviews are considered to be particularly useful when a body of literature has yet to be comprehensively covered or when the scope of the literature is not amenable to a systematic review of the evidence. In this research, a scoping review approach was chosen to summarize the research findings, including those from social media platforms, leading to the identification of gaps in the literature, which may in part, be due to limitations in the discoverability of information linked to children's right to play in the context of hospital settings. Guidance from Peters et al. was used to conduct and structure the scoping review under 10 clearly defined points and a number of key characteristics are discussed, using two broad questions: 1) How important is play for children's health, particularly when they are ill or have chronic health conditions? 2) How does current health service provision fulfil children's rights to play as defined by article 31 of the UNCRC? The review identifies a consistent lack of robust empirical evidence that makes play service delivery vulnerable due to fiscal challenges. However, the use of social media platforms to elicit the rich, qualitative narrative around play provision in hospital settings highlights advocacy for play provision by play teams and those who value and use their services.

Keywords: Play, Hospital, Rights, Health, Illness, Playworkers

1. Introduction

The United Nations Convention on the Rights of Child (UNCRC) sets out the rights that all children and young people have, up to the age of 18 years of age. These are designed to help children and young people meet their full potential and offer protection from harm, abuse and violence [45]. All the rights are considered equally important and connected [63]. This literature review is looking specifically at the fulfilment of Article 31 in the context of the provision of play in hospitals in the United Kingdom.

Article 31 from the UNCRC clearly states that all children have the right to "rest, relax, play and to take part in cultural and creative activities" [63]. Play is seen as a contributory factor to children's holistic health and wellbeing and as such, its promotion should be a priority [25]. However, for children who are unwell or have chronic health issues that restrict their access to play and recreational activities, additional support may be needed to enable them to fulfil their right to play [61]. Children and young people will periodically access healthcare, ranging from universal services available to all, to specialist targeted services and facilities that may, at some point, require access to hospital services and/or hospitalisation. Play carries great significance for children within the context of hospitals, as noted in Article 7 of the European Association for Children in Hospital [EACH] Charter which states, "children shall have full opportunity for play, recreation and education suited to their age and condition" [16]. This in turn helps to fulfil Article 24 of the UNCRC, which advocates the right to the "best health care possible" [63]. In recognition of both articles above, the provision of age-and-developmental-stage-appropriate play

opportunities and therapeutic activities is now integrated into the National Institute for Health and Care Excellence [NICE] [43] guideline titled *Babies, children and young people's experience of healthcare* [NG204], placing play firmly at the centre of the child or young person's hospital journey.

Within the National Health Service [NHS] [42] the provision of play within hospital settings is seen as a corporate service, where specialist staff support clinical and non-clinical areas; one such service is the Health Play Team [42]. Stonehouse [57] states that 'play is everybody's business and should not just be left to play specialists alone' and many play teams consist of 'both health play specialists and playworkers to support patients and their families during their hospital stay' [6, 50]. According to Walsh [66] 'Playworkers in hospital have the same primary purpose as all playworkers – creating conditions for play and supporting children to extend their play, keeping an awareness of the children's cues and subtle prompts', which can be particularly difficult within the restrictive environment of a hospital setting [62]. Walsh [66] elaborates on the playworker role in hospital settings, describing how 'a playworker understands developmental theories and with those and the Playwork Principles underpinning their practice, they facilitate opportunities for play…[which may need] the playworker to take a lead when energy levels are low, or a child's Illness is a barrier to their play'. Playworkers are an integral part of the play team [6, 50], and as such, the literature explored within this literature review incorporates the role of the playworker, and the roles of many other healthcare practitioners, as well as play specialists [57], all of whom contribute to the fulfilment of Article 31 in the hospital setting.

2. Methodology

Using a similar methodological approach to that taken in 2014, a scoping review was used to "scope the body of literature … to give an indication of the volume of literature … as well as a broad overview of its focus" [41]. Scoping reviews, as a specific method of conducting a literature review, allow for the identification and mapping of available evidence [41], which in this case, will help identify key characteristics related to children's fulfilment of Article 31 from the UNCRC. This scoping review was conducted "loosely" using guidance provided by Peters et al. [48] which pre-defined the objectives and methods and provided a proposed 10-point plan and structure for writing the review, which is utilised below.

2.1. Background

The original literature review in 2014 opened by acknowledging that:

> *Play and recreation are seen as essential for children's holistic development and participation in play related activities should form a daily part of every child's life (Committee of the Rights of the Child, 2013; International Play Association, 2013; Play Scotland, 2012). In fact, play is considered to be so important for children's holistic development, that it is a universal right for all children under article 31 of the United Nations Convention on the Rights of the Child [UNCRC] (Committee on the Rights of the Child, 2013). Enshrined in law, the UNCRC applies to all children aged 17 years and under, and requires States to promote and protect children's rights, which must be seen to be implemented within policy and practice* [61].

In 2019, the UNCRC, which is a global Convention, reached its 30th anniversary and to celebrate this landmark, UNICEF [63] co-produced with children and young people, a child friendly version of the UNCRC. This provided an opportunity to promote the UNCRC and remind state parties around the world, that although there is much to celebrate, there is also much to do, particularly in certain areas of activity. Hospitalised children or children who need to access hospital services are one such group [66], and therefore, additional help and support is required for these children to fulfil their right to "rest, relax, play and to take part in cultural and creative activities" [63].

In comparison to Japan where the very essence of play provision for children in hospital is questioned as non-scientific and "grandma's wisdom" [37], the literature on play in hospital continues to show strong advocacy for play provision and the "emotional value" of play is clearly evident [6]. However, progress in overcoming the difficulties in measuring the "value of play" in fiscal terms remain, particularly when the contribution of play to clinical outcomes is not measurable [23, 28]. This has been particularly important since the Health and Social Care Act 2012 introduced the most wide-ranging reforms of the NHS since it was introduced in 1948 [60].

One of the cornerstones of the *new* NHS was the introduction of Clinical Commissioning Groups (CCGs) which operate at a local level. Made up of mainly general practitioners (GPs) but also representatives from nursing, the public and hospital doctors, the CCGs remit was, through commissioning, "the buying and selling of services for their particular populations from a range of different organisations, including hospitals, community health services and the private and voluntary sectors" [58]. Today, NHS England, which was also introduced in 2013 as part of the reforms, is responsible for the selling and buying of NHS services, mainly through the CCGs. In 2014, the *NHS Five Year Forward View* advocated for more focus on prevention of ill health and most importantly, giving patients more control of their own care at a local level [59]. The complexity within the healthcare system continues to grow as shown in Figure 1, but what remains constant is the need for sustainability and the role of evidence of efficacy for the commissioning of services.

Figure 1. *Complexity of the NHS in England (reproduced by kind permission)* [59].

Evidencing efficacy can lead to sustainability and this provides the rationale for conducting a second scoping review of the literature, which aims to explore how the evidence base has changed since the original review conducted in 2014 [61]. The scoping methodology also allows a broadening of the accessible literature to incorporate the proliferation of social media content, which has 'changed the speed and depth of interaction between healthcare organizations and the public [70] providing new means of communication and the sharing of good practice [8].

The qualitative value of play is informally well evidenced, however the efficacy and fiscal benefits of play remain stubbornly hidden [23, 25, 68]. This makes play as a service vulnerable, particularly in times of fiscal constraint. Kennedy's assertion in 2010 that "the contribution of play provision to the clinical outcome is hard to measure" [61] is still evident: "drawing conclusions about the implementation of interventions remains difficult, as the existing literature is heterogenous with great variation in participants, comparator groups, study design and outcomes" [23].

The consequences of play's vulnerability can be seen in Table 1, which summarizes three questions from the third biannual *Children and young people's survey,* which was conducted in 2020. The responses show a downward trend in children's access to and engagement with activities, including play, while in hospital [15].

Table 1. *Findings from the Children and young people's survey 2020 [15].*

Survey statements	2016	2018	2020
Children and young people said that there were enough things for them to do in hospital	51%	50%	44%
Children (8-12 years) said staff did not play or do activities with them	-	-	41%
Parents and carers of children aged 0 to 7 said that their child 'definitely' had enough to do in hospital.	63%	61%	43%

The survey responses, gathered against the backdrop of the second wave of COVID-19 infections, collated data on the experiences of 27,374 children between the ages of 0-15 years of age who were hospitalized during November 2020 and January 2021. The results provide evidence, through a deficit model approach, of the importance of play services in relation to children's experiences of hospitalization [15] and as a consequence, the provision of play and activities has been identified as a "key area for improvement" for children who are hospitalized [15].

2.2. Identifying the Research Question

There were two research questions:

1) How important is play for children's health, particularly when they are ill or have chronic health conditions?
2) How does current health service provision fulfil children's rights to play as defined by article 31 of the

UNCRC?

2.3. Inclusion Criteria

An important point in relation to conducting a scoping review is inclusion can be considered regardless of quality [48] and this was particularly important when reviewing social media platforms and content.

Inclusion criteria included:

1) Time frame 2015-2021

This is an update on the previous review that was published in 2014, therefore this review provides an update on literature post 2014 to the present day.

2) Related to children aged 0-18 years of age

According to the UNCRC, Article 1 states a child is "any person under the age of 18" [63]. This review is linked to Article 31 and therefore the definition from the UNCRC was also used to define the age range being scoped.

3) Included "play" within the context of "hospital settings"

This was the key criteria for inclusion as the theme of the scoping review.

4) Written in the English language

The authors do not have facilities to translate literature written in other languages and therefore, only those written in English were accessed and used.

5) Any geographic region that specifically reports on "play in hospitals"

The review is looking at the fulfilment of Article 31 within the context of a hospital setting. Although the main context is the United Kingdom, any evidence of fulfilment for any area of the globe is considered useful.

6) For social media, content was accessible to the general public and compliant with all relevant rules and regulations [8].

2.4. Types of Participants

For both the academic and social media pathways, participants focused on children and young people between the ages of 0-18 years who were in hospital and receiving play-based activities and interventions. Studies or social media posts that featured providers of play (play workers, play specialists, child life specialists or other health staff) and caregivers (family including siblings and parents) who were involved in the child's hospitalisation were also included, as per the inclusion criteria above.

Practitioners were the other focal point, linked to the provision of play for children and young people aged 0-18 years of age. When used appropriately, social media platforms such as Facebook, Twitter and Instagram, allow practitioners and charities to communicate and share their work within an online community [64]. Social media provides evidence of the benefits of play in action, hearing 'directly from healthcare professionals who are getting their hands dirty' and informing medical professionals of new information and practice wisdom through channels that do not rely on medical journals or conferences [8].

2.5. Concept

There are two main concepts being explored.

1) The importance of play for children's health in general, but also specifically when they are hospitalised, which is known to increase developmental vulnerability [68].
2) Whether play and play-based strategies that are being utilised within the hospital context are deemed sufficient to fulfil children's right to play as defined in Article 31 of the UNCRC.

2.6. Context

The context is the hospital setting. This can be a dedicated children's hospital or a general hospital that caters for the needs of the whole age range of the population. The child may be attending the hospital as an outpatient (clinic appointments, investigations, etc.) or be admitted as an inpatient, with or without a family member being present or staying with the child (such as a parent, carer, grandparent or sibling).

2.7. Searching

The scoping review followed two main pathways using two distinct strategies for sourcing relevant literature:

1) Academic literature
2) Content on social media

Peters et al. [48] identify that a scoping review requires at least two reviewers - this review had three. Communication was through a variety of communication methods including verbal conversations, e-mail, WhatsApp and a Google Jamboard (with color coded themes as shown in Figure 2), that allowed us to share progress synchronously and asynchronously.

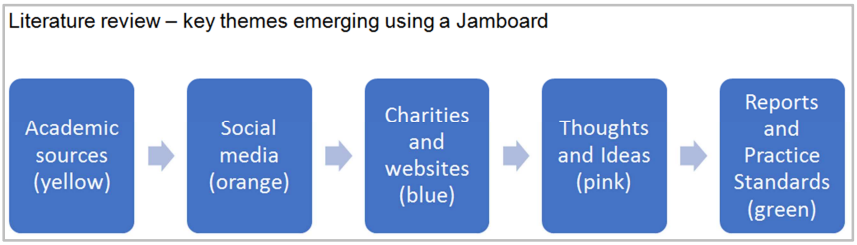

Figure 2. *Jamboard front frame for collaborative working on the scoping review.*

a) Searching for academic literature

The majority of the academic literature was accessed through electronic sources. The academic database CINAHL and the platform EBSCOhost were used to access Science

Direct and in particular Elsevier. The British Library Catalogue was also searched using key words and search terms in isolation or combined.

Key words included: play, health, hospital, children, young people, adolescents, preschool, infants, specialist, therapy, cost effectiveness, occupational, physiotherapy, nursing, radiography and radiotherapy.

Manual search using Google Scholar brought good results relating to hospitalised children's rights. This included the right not to feel pain. Searches often brought up literature from the USA, which was a rich source of valuable content.

A variety of web-based resources yielded significant sources of information. For example:

1) Play related websites and charities for advocacy and evidence demonstrating play efficacy.
2) International, U.K. and national government websites for reports and policy statements.
3) Books and e-books that had significant coverage of play within the health setting were also searched.

b) Searching on social media

Regular use of social media for professional networking formats provided the foundations for searching a variety of social media platforms.

When using social media, it is worth noting that what you get depends on how you search i.e., the use of hashtags # and @ in Twitter as well as an awareness of who to follow. Although this could introduce an element of bias, this was mitigated by the use of systematic searching across all social media platforms.

Two searches were conducted on social media platforms using the search terms "Health Play Specialist", "Hospital Play Specialist" and "Hospital Play". These terms were also "Googled" with "blog" added to each search term defined above.

The search initially involved Facebook, Instagram and Twitter which are three of the most well-known and popular social media platforms [75]. These initial searches were followed up by others using the same method on both Reddit and TikTok (which does not appear in the YouGov top 20 social media platforms) but is a widely accessed video-sharing social network [55].

Attention was given to hospital-play-linked individuals and organisations identified by these searches. This considered the nature of social media "presence" or "reach" - how many followers they have accumulated, what types of information are being shared and how many "likes" or responses these posts tend to yield. Specific hospital or health-based play teams known with social media pages or presence were also identified and their content considered.

During the initial process, it became clear that some online profiles are private or restricted and cannot be viewed without permission being sought and gained, or without seeking to join an online social networking group as a member. Due to the researcher's existing contacts in this area, quite a large number of these were already accessible having been through this process. Only social media content that was in the public domain was accessed to ensure compliance with confidentiality legislation as 'opinions and inferences are also personal data… if they directly or indirectly relate to [an] individual' [26]. Therefore, the searches were repeated using a different account belonging to another individual. This acted as a "proxy" in the search process and allowed for a "cold search". It also highlighted which accounts were not in the public domain and freely accessible to all who might be searching for more information in this area.

3. Results

This section forms the eighth of Peters et al [48] 10 defined points for conducting a scoping review.

3.1. Extracting the Data

This has been undertaken for the academic literature. A total of 44 studies/reports were accessed and reviewed: 40 research articles, 2 reports and 2 audits.

3.2. Charting the Results

The charting of the results provides a logical and descriptive summary [48]. Key information from the reviewed studies were charted chronologically and alphabetically for each year. Summary details from each study included: authors, date, title, aim of the research, country of origin, participants of the research, methodology, findings, thoughts about the study (as formal evaluation is not required) and a conclusion. Table 2 provides an overview of the prevalence of differing criteria that emerged from the reviewed academic literature.

Table 2. *Numerical summary of charted studies content.*

Research approach	**Quantitative - 7**	**Qualitative - 9**	**Systematic - 4 review**	**Literature - 3 review**
Play intervention	**Unstructured - 3**	**Preparation - 7**	**Distraction - 18**	**Clowning - 6**
Featured age range	**Aged 3 -10 years - 24**		**Aged 11 - 15 years - 15** **Two studies had a 17- and 19-year-old participant**	
Geographic location of study	Australia 2 Canada 3 Ireland 1 Sweden 1 United Kingdom 3	Belgium 1 Denmark 1 Netherlands 2 Turkey 4 United States 11	Brazil 1 Italy 3 Portugal 2 UAE 1 International 3	
Children voice documented	5	Children active participants in intervention		7
Use of technology	9	Research conducted as part of a clinical investigation or treatment		23
Environment	3	Pain management/coping strategies		11

For the social media content, summaries are used within the discussion.

4. Discussion

This section forms the ninth of Peters et al [48] 10 defined points for conducting a scoping review.

The themes used to structure the discussion replicate those from the original literature review that was conducted in 2014 [61], providing continuity and a means of comparison to see if there had been any changes in the evidence base. The first discussion point explores the first research question identified in section 2.

> *How important is play for children's health, particularly when they are ill or have chronic health conditions?*

The World Health Organization [WHO] [71] defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". This definition has not changed since its origin in 1948. Children's health often suffers when they are hospitalised and this may have long term adverse effects on a child's development due to their specific developmental stage [35, 68]. The authors argue that recreational programmes and developmentally appropriate strategies should be part of the treatment programme during a stay in hospital, as these programmes positively affect well-being and children's willingness to participate in medical treatment [22]. Due to the specifics of hospitalisation and medical conditions, social and collaborative play is difficult to implement in hospitals but it is desired and projects are developing technology aids such as "Lolli and Friends" [2] or Socially Assistive Robots (SARs) [40].

Play can offer many additional health benefits for children in hospital and these are summarised in Table 3 with reference to six aspects of health.

Table 3. *Benefits of play for children who are ill, have chronic illness or hospitalised.*

Aspect of health	Additional health benefits
Physical	Physical pain is a common factor described in many of the studies scoped (11 out of 38). Aiming to reduce pain and anxiety provides a powerful rationale for researching the efficacy of play-based strategies. Friedrichsdorf et al. [21] state that access to pain management is a fundamental human right and not treating or managing pain is a violation of that right [10]. At the same time, pain in children undergoing medical treatment continues to be a common, under-recognised and undertreated issue [21]. When pain is treated appropriately, anxiety level is reduced and compliance with treatment regimens increases, as well as enhancing consistency of long-term self-care, thereby reducing the need for regular hospitalisation [32, 35, 46]. Hospitalisation often correlates with reduced mobility and/or with reduced motivation to do any physical activity [38]. As technology becomes part of children's playful experience, it is more frequently used as part of hospital recreational play [39] and can also be used to increase motivation to engage in physical activity [38]. In recent years, the focus on serious games (games designed for non-recreational purpose with emphasis on added educational value of fun and competition) can also be used for education about treatment as well as being part of the treatment [36]. Playing digital games during chemotherapy reduces feeling of pain and nausea [36]; using humanoid robots and music during physiotherapy increases motivation to exercise and reduces fatigue [38]. The idea that Virtual Reality (VR) distraction reduces pain begins to be supported by emerging scientific research on brain activity during this process, although more research is needed [20, 52].
Social	Capurso et al. [14] highlights the "power of play" in narratives of children for whom "feeling ill or well" is influenced by their ability to form relationships with others, be active and "feel alive within the hospital environment". Capurso et al. [14] argue that play is capable of "pushing the illness completely into the background". The importance of social interaction for the holistic health of children and improvements in family involvement in children's care is visible when exploring the role of Clown Doctors [3, 4, 31]. Interaction with Clown Doctors allows for a more personalised approach to support at different stages of treatment and hospital stay, strengthening children's competence in pain management and ability to cope [32] as well as replacing "forceful compliance with patient empowerment and agency" [69]. Seeing their children playing in hospital during stressful and painful encounters is important for parents/carers and improves their ability to interact with children, giving confidence to support children's needs and care [68, 35, 3, 40, 1]. Developments in technology are part of children's play culture so digital play has its use on hospital wards. The introduction of SARs and their benefits is reviewed by Moerman et al. [40]. Using SARs in children's free play improved their mood during hospital stay and their interaction with other children and nurses. Family members were also found to relax more and improve their engagement with children. These interactions with pet-like social robots has a positive effect on a child's well-being, reduces anxiety and pain through distraction, increases engagement and promotes a positive impulse to communicate [40]. Direct social interaction with others is often limited due to medical restrictions and the use of technology could be used when supporting social behaviours and interactions [22]. Apps have been developed that encourage collaboration, help to overcome isolation and loneliness, particularly in children who are located in single rooms [2, 36]. The importance of access to Wi-Fi for the maintenance of contacts and networks is pivotal for children and young people when they are in hospital and ensuring free internet access is a recommendation in the NICE [43] *Guideline on Babies, children and young people's experience of healthcare.*
Emotional	Children's negative experiences in the hospital may have long term effects on their well-being. There is now enough clinical evidence that these experiences are retained in episodic memory and children may need future therapy to remove these anxieties/trauma [53]. Play not only provides distraction and reduces anxiety [5, 12, 23, 29, 56, 67, 68], but also supports the development of coping strategies [19, 32, 54, 69, 74]. Play is fun and improves children's mood and happiness, which is essential for "effective coping and resilience in paediatric hospital environment" [22]. Positive and playful experiences in the hospital help to establish good self-care behaviours and reduce feelings of

Aspect of health	Additional health benefits
	being fearful of follow-up care [46]. Recreational play reduces boredom, which improves quality of experience [29, 54, 68].
Mental	Play in the hospital setting is also beneficial for parents/carers as seeing children happy and smiling, despite their illness, reduces their own anxiety; this subsequently improves family dynamics and coping abilities [3, 4, 34, 35, 68]. Children see play as a way of dealing with illness, pain and hospitalisation [29, 32, 54]. Play also allows children to understand their illness and the treatment [14, 34, 35] – both of which are protective factors for mental health. Children's views about their treatment and care are often not listened to [9]; play empowers children and gives them a voice [29] improving, at least in the short term, their well-being and reducing long term adverse outcomes [68]. Playfulness and humour when interacting with Clown Doctors improves positive outlook in oncological patients [3]. By providing distraction kits for children undergoing painful needle related procedures, they can gain a sense of being in control over their pain [5].
Spiritual	Allowing children to be children and enabling them to play and interact with others, gives children hope for the future and a sense of well-being [14, 54].
Environment	When children find themselves in a rich and stimulating environment, they feel alive and can make sense of their reality [14]. NICE [43] identify the importance of providing a healthcare environment that feels welcoming and comfortable in the NICE Guideline NG204 for 'Babies, children and young people's experience of healthcare', which has been presented as a single page summary, incorporated as part of a visual summary titled "My healthcare experience checklist". Play is featured throughout the recommendations, particularly in relation to the provision and location of play and recreational facilities.

The second theme that is discussed comes from the original literature review conducted in 2014, exploring the scope and variety of play that is accessible within the hospital context.

What types of play are provided within health service delivery?

Gjærde et al. [23] state that previous papers and non-systematic reviews have not used rigorous methods to categorise or define types of play in the context of hospital settings. The articles in this scoping review show significant crossover in how play was applied, although, as shown in Table 2, most related to the role of play and distraction (n=18) while preparation (n=7) and clowning (n=6) were also heavily featured. Gjærde et al. [23] comment on the importance of unstructured play for children's general health and wellbeing but note that structural and cultural factors present difficulties when providing unstructured play within hospital settings, something that was noted in just two studies that mentioned the role of routine/unstructured play [14, 29].

Gjærde et al. [23] propose their own conceptual model that maps play into four clinical contexts:

a) Play in procedure and diagnostic testing

Includes the use of play for "distraction, preparation and support … to alleviate pain, stress and anxiety" (p. 6).

The majority of articles in this review were linked to clinical interventions or investigations (n=23), showing how play is used as a tool with defined outcomes as opposed to pure play that is child-led and freely chosen.

As noted above, the use of technology is growing. Apps [31] VR [11, 20, 30, 52] and robots [40, 39] are now being used for preparation, distraction and socialization. This increased use of technology through the use of digital media is consistently identified as a type of play in all four clinical contexts [23].

b) Play in patient education

Includes the use of play for "age-appropriate communication and to increase understanding and motivation" [23]. Motivation was identified by Majid et al. [36] when discussing the role of "serious games" (games designed for non-recreational purposes) in a literature review linked to paediatric cancer patients. Used pre, during and post cancer treatment, technology was a focal point, while also noting the importance of socioeconomic considerations and access to technology for patients within a hospital context. Ortiz La Banca et al. [46] provide an overview of 16 years of play-based interventions by Child Life Specialists entitled "Teachable moments for youth with type 1 diabetes". Over 43,000 interventions were grouped into six categories, two of which were play-based: medical play and developmentally-appropriate recreational play. For younger children, coping strategies for managing procedural fear and pain include educational programmes such as a Teddy Bear Clinic [19] where modelling and rehearsal can help to prepare children for needle-based procedures.

Medical play, when play specialists explain the treatment, procedures and wider elements of hospital stays, are proven to benefit children and are recommended to be a standard treatment for hospitalised children [19, 34, 51]. Providing more information through developmentally-appropriate activities and providing opportunities for emotional expression is not only beneficial for paediatric patients but also for their families; carers distress often has a negative effect on children [67]. so alleviating this is beneficial for all involved.

c) Play as treatment and recovery

According to Gjærde et al. [23], this is where "play could supplement and occasionally replace conventional treatment". For example, there is concern about the general rates of physical activity undertaken by children globally [72]. For children with oncological disorders, this can be even more difficult, as defined by Meyns et al. [38], who used a humanoid robot and music to motivate children to participate in physical activity. Brown et al. [11] discuss the cost effectiveness of a tailored, hand-held computerized intervention for dampening pain perception during burn wound care and rehabilitation, noting a reduced time to re-epithelialize in comparison to standard interventions. Sposito et al. [54] identify the benefits of children being encouraged

to share their coping strategies when undergoing chemotherapy and provide a rare intervention that actually elicits the views of children themselves. Of the 38 studies scoped, Kleye et al. [29] were the only other authors who specifically identified the importance of children articulating their coping strategies for adequate pain management when undergoing hospital treatment. Both of these studies have relatively low participant numbers and demonstrate the difficulties of undertaking robust qualitative research with children in the hospital context.

Play is also a way children make sense of their world and communicating with children at the stage-appropriate level is extremely important. This was highlighted by a panel of 44 international, inter-disciplinary specialists working on the development of Clinical Practice Guidelines when treating children with cancer [35]. This literature review suggests that children's voices are not often heard and not enough is done to explain to them what is happening to their bodies but also about their treatment. When this is done well through age-appropriate activities, the benefits for children and families are well recognised [21, 29, 46, 51, 68]. This approach is recommended as an individualised approach that meets children's interests, developmental stage and medical needs [32].

d) Play as adaptation

Adaptation relates to "diversional or recreational activities or activities designed to help [children] cope with being hospitalised" [23]. A notable increase in the role of clowns has occurred over the past six years and clowning featured in six of the articles. All identified a reduction in anxiety as a key feature of the intervention [4, 31, 32, 65] as well as empowering children and restoring their agency [69]. Capurso et al. [14] explored children's narratives from 379 children aged 3-14 years of age, noting that play for children was a social mechanism as well as enabling children to cope with their illness. Andries and Robertson [2] describe the use of an app for reducing social isolation, particularly for occupants of single rooms, while Gillard [22] describes the benefits of a recreational programme for overcoming boredom which enhanced children's mood, enabling the development of resilience in the paediatric hospital environment. Williams et al. [68] specifically explores the role of play as an adaptive coping response that helps mitigate long-term adverse outcomes linked to hospitalisation. Although based on a single case story, Williams et al. [68] highlight the paucity of evidence examining the efficacy of play through "methodologically rigorous empirical studies". This provides the rationale of charitable organizations discussed in the background section who are now actively engaged in the research process, in an attempt to generate rigorous, quantifiable evidence of the benefits of all types of play for children within the hospital setting.

One of the biggest changes since the original literature review in 2014, has been the emergence of social media as a means of raising awareness and 'expanding the reach of existing resources and promoting civic engagement' [8]. The third theme looks at the influence of social media for promoting the value of play in the hospital setting.

The influence of social media

Due to the volume of social media posts and the formatting of different platforms, it is not feasible to present the information in a similar manner to academic literature. The following provides a summary overview of social media output and how it publicises the uses and benefits of play for children and young people in hospital.

Hospital play that is beneficial to children's health is visible within wider play narratives observed across social media sites. Since the original review conducted in 2014, the majority of qualitative narrative around hospital play has been conducted through social media. Anecdotally, the number of specifically created sites, pages, handles and individuals using and accessing social media to share and discuss play in healthcare has increased in that time. The work and service provision of play teams are visible on social media, sharing examples and explanations of their work – either as individuals or on behalf of their workplace/healthcare teams. The majority of content shared are examples of play normalising or general play activities in the form of photographs bearing in mind the strict rules around the use of images that include children and/or hospital settings, particularly in relation to other people's privacy) [44] and the need to comply with relevant rules and regulations [8].

A considerable number of hospital play teams have set up online "pages" or "handles" (an identifying name used on specific or across multiple social media sites) specifically for posting information about and examples of their day-to-day work. The effect of this is that their work is easily accessible and visible to people searching for examples of hospital play. Hospitals seem to be keen to include children's services as part of their online presence, encouraging a wider understanding of how hospitals provide a person-centred approach, as advocated in the NHS reforms in 2012 [59]. For example, the following tweet clearly directs interested parties to the Play Team Instagram site, stating "You can get the deep dive in Hospital Playworkers. What they do and how they support children to access their rights to play and recreation, rest and the arts. #SummerofPlay won't happen by accident…" [33].

Discussions around children's experiences of healthcare, their needs and the ways that play can be used in response to those needs, occur online with some regularity between health play specialists, other healthcare professionals, play academics and others. Terms used in these discussions are regularly observed to include reference to children's experiences of care, their needs and their rights. Play is broadly accepted as important to children's health and their healthcare experiences [23, 25]. Typically, these discussions occur on Twitter. This social media platform allows for thoughts, opinions, questions and examples of practice to be

posted, with key individuals, perhaps those considered to be influential can be "tagged".

Posts can also be "retweeted" by those who see it and consider it worth sharing more widely (potentially tagging more individuals). This process of sharing can increase the "reach" – the visibility – and longevity of a single post many times over. The visibility of items shared on Twitter (and arguably all social media sites) is dependent on individuals gaining and maintaining followers.

Hospital play – particularly oncology and accident and emergency cases – is often seen as "good news" content for news sites and hospital success stories online. Local BBC news stories shared/retweeted often include children but don't always include "hospital play" or "play specialist" in their wording or narration of video footage [7].

The second research question specifically addresses the link between play in hospitals to children's fulfilment of Article 31.

How does current health service provision fulfil children's rights to play as defined by Article 31 of the UNCRC?

The U.K. Children's Commissioners Report [17] proposes that the "UK government does not prioritise children's rights or voices in policy or legislative processes". The report covers play and leisure and notes vulnerability as an issue for consideration but does not link illness or hospitalisation as a special area of concern that requires additional support or promotion [17].

Within all the literature surveyed, only Przybylska et al. [51] and Gjærde et al. [23] specifically discuss children's right to rest, play and relaxation, as defined in Article 31 from the UNCRC [63]. However, the World Health Organization Regional Office for Europe [73] have produced a set of rapid assessment checklists to ensure children's rights in hospital can be reviewed and improved. Linked to standards from the *Children's Rights in Hospital: Manual and Tools for assessment and improvement* [73], Standard 3 "evaluates how play and learning are planned and delivered to all children". Significant progress towards achieving the standard requires a range of measures to be in place including:

1) Evidence of opportunities for age/stage-appropriate play.
2) Other supportive activities are provided – clown, music or art.
3) All staff, including doctors and nurses utilise play within therapeutic care.
4) Children's views are collected in the planning and/or use of play spaces.
5) Evidence of satisfaction form children and their parents.
6) Hospital promotion of research about benefits of play – published and shared [73].

Evidence and research about the efficacy of play is lacking, as stated by Williams et al. [68] and this is perhaps the biggest issue facing the advocacy for play provision and the fulfilment of Article 31 in hospital settings [23].

The charity sector provides some positive examples of how play is promoted in accordance with Article 31 of the UNCRC and as funding mechanisms rely on evidencing the efficacy of provision, play is increasingly reliant upon charitable organisations such as Oxford Hospitals Charity [47] and Glasgow Children's Hospital Charity [13] for the provision of play resources- including human resources. As well as funding play provision, Starlight Children's Foundation and Great Ormond Street Hospital Charity are also undertaking research to demonstrate efficacy, which will in turn aid fulfilment of children's right to play in hospital settings [25]. This includes the impact of COVID-19 on hospital play, which has had a detrimental impact on play provision in hospitals [25]. In many ways, the deprivation of play highlights its potency, as noted in Table 1 [15]. Limited access to play equipment, play spaces shut down and play staff redeployed [25] have all meant play has been marginalised to the detriment of children and young people in hospital settings at a time when it is needed more than ever.

Limitations of the search strategy

The scoping review undertaken by Gjærde et al. [23] provides an excellent overview of existing literature that has been published between the years 2000 and 2019, updated 2020. An impressive range of 64 sources have been cited and the search strategy and selection criteria are described in detail. When comparing the list of sources to those that have been accessed for this scoping review, there is just one reference that occurs in both scoping reviews and that is for methodological considerations when undertaking a scoping review [48].

This scoping review of the literature only covers 2015-2021 so the earlier sources have not been featured, but this does raise an interesting methodological question in relation to how research linked to play interventions are published and how accessible play-based research in a hospital context may be. This clarifies previous concerns that not only is literature linked to play interventions scarce, but the literature that is available is not discoverable when systematic searching takes place.

5. Conclusion

The final part of Peters et al [48] 10 point process provides Conclusions and Implication for future research and practice.

The value of play and play-based strategies for children and young people in hospital is well known, mainly through qualitative narratives in the academic literature and

particularly on social media. A number of literature reviews were identified when scoping and the absence of high quality, robust empirical evidence was noted by the authors of each one. The difficulty in defining play and the many contexts in which it is used, contributes to a lack of clarity, which, when coupled with an inability to clearly define the contribution play makes to clinical procedures and treatments, makes the commissioning of play services difficult.

Government action in relation to fulfilling children's right to play and leisure does not feature the additional needs of children within the context of hospitalisation. More emphasis needs to be placed on the development of policy frameworks that emphasise and promote the value of play for hospitalised children. This has become even more important since the impact of COVID-19, which has illustrated the detrimental effect on children's experience of healthcare, which may negatively affect children's future use of hospital services.

A solid evidence base that clearly promotes the role of play for children in hospital needs to be generated. With limited studies being published in the academic literature that originate in the United Kingdom, this is an area that needs to be developed. Although charities are becoming more involved in the financing of resources for play and undertaking research themselves, this is not enough. If the benefits of play are to be taken seriously within the context of hospitals, then generating an evidence base becomes a priority. Until this happens, it is unlikely that fulfilling children's right to rest, play and relaxation, as defined under Article 31 of the UNCRC, will become a reality.

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