ADVICE FROM THE COVID-19 ADVISORY SUB-GROUP ON EDUCATION AND CHILDREN'S ISSUES

30 July 2020[1]

Physical distancing in early learning and childcare settings (ELC)

This advice is set with a Scottish context of currently low community transmission rates and a clear strategy towards driving case numbers continually towards zero. Given Scotland's current low prevalence, the advice given here on physical distancing in Early Learning and Childcare (ELC) settings is appropriate. If the further unlocking of restrictions, including indoor settings and tourism, results in an increase in cases, there will need to be flexibility in the use of this advice and variation among areas depending on transmission in their local community. This could mean that changes to distancing and greater use of face coverings may be required if prevalence increases. The advice is firmly based on an evaluation that risks are outweighed by the benefits to young children. However, the overall objective is to continue to push incidence and prevalence down across Scotland and for ELC settings to function as normally and fully as COVID-19 prevalence makes possible. Flexibility is necessary within local areas to make the best decisions based on local data on community transmission.

Key Messages

- Subject to continued suppression of the virus, and to surveillance and mitigations being in place, the balance of the evidence suggests that no distancing should be required between young children, and young children and adults in ELC settings. This advice is based on a balance of evidence, bringing evidence specifically about COVID-19 together with evidence relating to the wider wellbeing of young children.
- Two metre distancing does not need to apply between adults and children in ELC settings as, given the age-groups involved, maintaining two metre distance between adults and children is neither realistic nor appropriate. Maintenance of two metre distance in adult-to-adult interactions is still advised.
- Young children require to view faces and rely on non-verbal cues to learn effectively. Face coverings should not be required for most children and adults (those clinically advised to wear a covering would be an exception).
- Where adults who are interacting together cannot keep two metre distance, are interacting face-to-face and for about 15 minutes or more, face coverings should be worn. Young children may require additional reassurance about the wearing of face coverings by adults when these are required.
- No additional general protections are proposed for particular categories of children or staff, such as those with underlying health conditions. Instead, requirements should be put in place to reflect individual circumstances in line with specific clinical advice.
- The concerns within BAME communities must be recognised and individual requests for additional protections should be supported where possible. Care should be taken to ensure that BAME staff, children and families are involved in decisions about additional protections.
- ELC provision should maximise opportunities for high quality outdoor play, interaction and activities.
- Practitioners should be provided with support in how to assess and meet the needs of children who have experienced neglect during the period of ELC closures.

[1] As new evidence is published these advice notes will be reviewed regularly and revised if appropriate. These advice notes are current as at the date stated.

- A package of measures must be put in place to reduce the risk of transmission of the virus:
    - There should be an increased emphasis on teaching and practising good hand hygiene, respiratory hygiene (both indoors and outdoors) and surface cleaning.
    - Hand washing/sanitising should be required for everyone on every entry to the setting or moving of rooms. Young children will need assistance to wash/sanitise hands effectively. Young children will also need support to dry hands effectively. Care should be taken to ensure that any products which are being used are age appropriate and suitable for sensitive skin.
    - As close as possible to zero tolerance of symptoms should be in place, and strict compliance with the Test and Protect system.
    - The preference should be to avoid crowded indoor spaces and, as much as possible, to keep children within the same groups for the duration of the day.
    - Sharing of equipment/utensils/toys/books should be minimised; and smaller groups, more outdoor interactions and activities put in place.
    - Movement between settings of children should be reduced as far as possible. Movement between settings of temporary/ supply/peripatetic staff etc. should be kept to an absolute minimum.

General comments

COVID-19 and children

- Risk relates to a combination of factors, and evidence about vulnerability to, transmission of, and protection from the virus continues to evolve, as does evidence about symptoms, virology, testing, treatment and immunity[2]. For all of these reasons there are limitations to the ability of science and evidence to definitively answer very specific questions about absolute risk. As evidence develops, advice may need to change.
- Globally, COVID-19 has been reported in children and young people of all ages, but there have been many fewer confirmed cases in children than adults.
- In Scotland, as at 26 July, 159 (0.9%) of a total 18,554 positive cases were among people aged under 15. This is a rate of less than 20 per 100,000 of the population in that age group[3]. There have been no deaths among people under 16 years of age[4], but in the absence of high quality sero-surveillance we cannot be certain how many children have ultimately been infected.
- Children in the age groups accessing early learning and childcare have a low susceptibility to COVID-19 infection, they also have a low likelihood of onward transmission[5,6]. The infection appears to take a milder course in children than in adults; clinical signs are very similar to other childhood respiratory infections, and very few infected children develop severe disease.[7]

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[2] https://www.theguardian.com/commentisfree/2020/jun/19/our-knowledge-of-COVID-19-changes-every-day-hindsight-is-misleading-when-it-comes-to-science
[3] https://www.nrscotland.gov.uk/covid19stats
[4] https://www.nrscotland.gov.uk/covid19stats
[5] Goldstein E., Lipsitch M & Cevik M *On the effect of age on the transmission of SARS-CoV-2 in households, schools and the community.* (Preprint.)
[6] https://www.nccmt.ca/uploads/media/media/0001/02/09e652c44a7de3cfcb8d85e093cd20d8d90dc2ba.pdf
[7] https://www.rcpch.ac.uk/resources/COVID-19-research-evidence-summaries

Overall approach

- Impacts resulting directly from COVID-19 need to be considered in relation to wider impacts on children and young people. This advice is based on a balance of evidence, bringing evidence specifically about COVID-19 together with evidence relating to the wider wellbeing of children.
- The pandemic and the consequences of lockdown have magnified existing inequalities. There is an anticipated high level of need for support for vulnerable children and families as lockdown eases and ELC settings reopen.
- ELC settings are not closed systems. The effects of decisions in these settings will not happen in isolation and need to be understood in the context of wider changes and levels of adherence.
- Decisions relating to ELC need to attend to the safety of the adults in these settings, as well as the safety of children.
- There is an evidence-base relating to *how* changes are introduced and communicated, which needs to be considered alongside the evidence on transmission and risk.
- The advice that follows is contingent on there being low levels of infection in the Scottish population and on systems being in place for close monitoring, rapid testing and tracing of suspected cases. Where incremental changes can be made and the impacts of these monitored, that would be recommended.
- Measures put in place as precautions may become more relaxed as the prevalence and incidence of COVID-19 in Scotland reduce. Conversely, measures may need to be strengthened or reintroduced if there is evidence of a resurgence, or in the light of localised outbreaks. Where other relevant new evidence has implications for this advice, it will also need to be taken into account.

1. Given the latest evidence/health analytics about the suppression of the virus and children's role in transmission, what implications does this have for our approach to physical distancing in early learning and childcare provision (ELC)?

- General evidence is clear that two metre distancing is significantly more protective than one metre[8]. This is particularly important for those at higher risk and is therefore more important for adults than for children. This point about heterogeneity of risk is set out in the COVID-19 Advisory Group's advice on physical distancing[9].
- Risk is also dependent on the level of infection in the population, and the consequent likelihood that an interaction will involve someone who may transmit the virus. Scottish Government modelling suggests there are currently between 30 and 60 new infections per day and an infectious pool of approximately 500 people (data for 17 July 2020)[10] . This is a much more positive position than was the case when the Strategic Framework for Reopening Schools and Early Learning and Childcare Provision in Scotland[11] was published on 21 May and the Coronavirus (COVID-19)

[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892043/S0484_Transmission_of_SARS-CoV-2_and_Mitigating_Measures.pdf
[9] https://www.gov.scot/publications/COVID-19-advisory-group-physical-distancing-advice/
[10] https://www.gov.scot/publications/coronavirus-covid-19-modelling-epidemic-scotland-issue-no-10/
[11] https://www.gov.scot/publications/excellent-equity-during-COVID-19-pandemic-strategic-framework-reopening-schools-early-learning-childcare-provision-scotland/

Phase 3: guidance on reopening early learning and childcare services was published on 15 June[12].

- Decisions about the operation of ELC facilities will be contingent on continued low incidence (new infections each day), low prevalence (proportion of the population infected) and low reproduction rate (indicating whether the epidemic is growing or shrinking) of COVID-19 in Scotland.
- Although children do transmit the virus, the role of children in transmission has been shown to be limited, both between children and from children to adults[13,14]. Most transmission is between adults.
- The small risks of infection associated with the absence of physical distancing measures between children and between children and adults are, in the sub-group's considerations, outweighed by the benefits to children of being able to interact naturally and play together.
- There is not yet evidence of the specific effects of Covid-related physical distancing on children's development, but the psychological literature unequivocally shows that children rely on social interaction with their peers to meet their broad developmental needs including learning, well-being and positive mental health outcomes[15].
- Childhood is also an important life stage for the foundations for good mental health – and conversely for the development of mental health difficulties. Concerns about mental health are at the top of the issues highlighted by children in response to the pandemic. Early onset of mental health difficulties is associated with more severe symptoms and lasting risk.
- Time away from ELC settings leaves at-risk families more vulnerable, and there is evidence that transitions further disadvantage already disadvantaged children and families[16]. These families and their needs require particular consideration.
- There are particular impacts for children with additional support needs, for whom opportunities to interact regularly with their peers are especially important to facilitate social skills development and personal wellbeing.
- There is also some evidence of increased domestic abuse and concerns about vulnerable children and their safety.[17]
- The level of enforced adult control that would be required to insist on physical distancing at all times with younger children could in our view cause emotional harm and impact on relationships. Young children are likely to be more susceptible to the unnatural feel of physical distancing and may already have fears about approaching others or being approached by others after several months of little contact.
- In summary, children's development and learning, peer relationships, safety, wellbeing and mental health are at risk from physical distancing and non-attendance at ELC settings. The risks of children acquiring and transmitting the virus are small.
- We conclude that - ***subject to continued suppression of the virus and to surveillance and mitigations being in place*** - the balance of the evidence suggests that no physical distancing should be required between children or between

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[12] https://www.gov.scot/publications/coronavirus-COVID-19-phase-3-guidance-on-reopening-early-learning-and-childcare-services/

[13] https://adc.bmj.com/content/105/7/618

[14] https://rs-delve.github.io/reports/2020/07/24/balancing-the-risk-of-pupils-returning-to-schools.html

[15] https://www.mentalhealth.org.uk/projects/right-here/why-focusing-relationships-vital-improving-young-people%E2%80%99s-mental-health-and-wellbeing

[16] Van Laere, K., Boudry, C., Balduzzi, L., Lazzari, A., S., Prodger, A., Welsh, C. Geraghty, S., Režek, M., Mlinar, M., (2019). *Sustaining Warm and Inclusive Transitions across the Early Years. Final report with implications for policies and practices. Ljubljana: ERI.*

[17] file:///C:/Users/z607920/Downloads/children-young-people-families-COVID-19-evidence-intelligence-report.pdf

children and adults. We also conclude that on balance two metre distancing should remain in place wherever possible between adults.

2. Can the sub-group advise in a more granular fashion on evidence of levels of infection in the youngest children (0-5 year olds), and also any evidence on transmission from children to adults?

- The younger the child the fewer the positive cases recorded. In confirmed cases of COVID-19 in Scotland, as at 26 July 2020, only 0.2% of total positive case numbers involved children under 5[18]. This almost certainly represents some undercounting of children in total case numbers as testing may have focussed on the most unwell, but in some countries which undertook widespread population testing, children still account for very low case numbers.
- Infants and young children are likely to experience a relatively mild illness if they are infected; critical illness is very rare. A significant proportion do not appear to develop any symptoms. Where symptoms are present there is little in the way to distinguish COVID-19 from other childhood respiratory infections. Understanding of symptomatology is still developing. At present, the most common presenting symptoms are cough and fever. Upper respiratory tract infections (including sore throat) are also relatively common; and about 10% of cases in children have vomiting and/or diarrhoea[19]. Children with exceptional healthcare needs are the most likely to need hospital care if they become infected.
- Because low numbers of young children have been infected, there is very little evidence of the role of the youngest children in transmission. Consistently, however, children under the age of 10 are shown to have relatively low infectivity and not to be significant drivers of the pandemic. It is unclear why, even where there are positive child cases, transmission from children to other children or adults is so infrequent.[20]

3. Further to this evidence, can the sub-group provide comment on the relative importance of continuation of the package of measures adopted in current Scottish guidance on children returning to nurseries, childminders and other early years providers?

- The highest risks of transmission are in crowded spaces for prolonged periods of time. Where physical distancing cannot be achieved or is not desirable, prevention and mitigation measures should consider all transmission routes of the virus and be bespoke to the setting and the activities carried out therein. [21]
- In addition to adults wearing face coverings where a 2 metre distance cannot be achieved in adult-to-adult interactions, strategies such as teaching and practising effective handwashing/drying and respiratory hygiene, ensuring spaces are well ventilated, and surfaces regularly cleaned will be key to supressing the prevalence of the virus in ELC settings. Guidance exists on how these should be considered in ELC settings[22].
- Hand washing and drying/sanitising should be required for everyone on every entry, and prior to eating. It will be important to teach all children good hand hygiene

[18] https://beta.isdscotland.org/find-publications-and-data/population-health/covid-19/covid-19-statistical-report/
[19] https://dontforgetthebubbles.com/evidence-summary-paediatric-COVID-19-literature/
[20] https://pediatrics.aappublications.org/content/early/2020/07/08/peds.2020-004879
[21] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892043/S0484_Transmission_of_SARS-CoV-2_and_Mitigating_Measures.pdf
[22] https://www.gov.scot/publications/coronavirus-COVID-19-physical-distancing-in-education-and-childcare-settings/pages/hygiene-measures-including-ppe/

technique, and emphasise the importance of putting it into practice. Very young children will need to be supported to do this effectively. Care should be taken with the choice of hand washing and sanitising products to ensure they are appropriate for young children and others with similarly sensitive skin.

- Children who experience neglect may also need additional support in practising these hygiene measures. Provision for washing of clothing may be beneficial.
- As close as possible to zero tolerance of symptoms should be in place – anyone with a high temperature, new continuous cough, loss of (or change in) sense of smell or taste, or who has had contact with a family/community member with symptoms should not attend/should be asked to return home and be tested. The established Test and Protect process should be followed[23]. Contact tracing should be undertaken, and this will have implications for all children and families attending the setting. It will be important that ELC providers keep clear records of children, adults and staff attending their settings, and of the composition of groups undertaking activities. These records will help to ensure rapid response and contact tracing should a positive case occur.
- Sharing of equipment/utensils/toys/books should be minimised with a focus on individual alternatives, and smaller groups and more high quality outdoor activities should be put in place.
- It will be important that staff and families are actively engaged in agreeing and establishing new practices and routines; and that public health (including good hygiene) becomes a core part of ELC processes.
- Inductions for new staff should include guidance on the setting's approach to ensuring distancing by adults as well as routines to ensure good infection prevention and control.

4. Similar issues apply in ELC and other age childcare. Can the sub-group advise if evidence supports a need for different/additional mitigation approaches for children under 5 and children aged 5 -12?

- The sub-group advice is that no physical distancing is required for children under 5 nor for those aged 5 -12. It is important that children in ELC settings and at the early stages of primary are treated similarly.
- This assumes that the level of infection remains low, appropriate surveillance, test and protect and all the other appropriate mitigations and measures are in place.
- Assuming that the schools open as planned, young children going into P1 and P2 will have missed significant periods of learning and development. This needs to be taken into account when playful pedagogy is being planned.
- For young children, very close physical interactions such as holding hands and hugging are important. This is less important as children increase in age and should be actively discouraged as children approach the end of primary school.

5. Can the sub-group advise if evidence supports a need for different/fewer mitigation approaches in indoor and outdoor contexts?

- There is evidence that transmission of COVID-19 is more likely indoors than outdoors[24]. Other evidence indicates that sunlight may rapidly inactivate COVID-19 on surfaces, suggesting that persistence, and subsequently exposure risk, may vary significantly between indoor and outdoor environments. Studies suggest that

[23] https://www.nhsinform.scot/campaigns/test-and-protect
[24] https://www.medrxiv.org/content/10.1101/2020.04.04.20053058v1

infectious virus can persist for some time on nonporous surfaces indoors[25]. Natural sunlight may be effective as a disinfectant for contaminated nonporous materials.[26]

- Given that the risks of transmission are much lower outdoors, ELC provision should maximise opportunities for outdoor play and activities. The Covid-related benefits of being outdoors provide a stimulus to maximise the use of high quality outdoor learning. There is a strong link between outdoor learning and health outcomes, and some evidence regarding positive impact on academic performance[27]. Infection control in these contexts is well understood by outdoor nurseries. Guidance is already in place for these[28].
- For some young children with complex needs this may be a particular priority because of the increased physical contact that is unavoidable in this field of work. Too sedentary an environment does not serve young children, nor ELC practitioners well. Outdoor clothes should not be shared between children and should be washed daily to reduce risks.
- Sharing of equipment/utensils/toys/books should be minimised; and if reasonable smaller consistent groupings put in place.
- There should be an increased emphasis on hand hygiene when moving from outdoors to indoors. Hand washing/drying and/or sanitising should be required for every child and adult on every entry to the setting. Teaching and building these routines and helping young children follow them will be essential.
- There is much to learn from the Danish model in relation to use of smaller groups, outdoor activity and approaches to hygiene[29].

6. Can the sub-group advise if their recommendation is that two metre distance between children and adults should be maintained if possible? If no distancing is required for children in ELC settings, is it reasonable remove this measure? Does the context of a suite of mitigations in ELC settings affect this recommendation?

- Given the current trajectory of infection in Scotland, the evidence of low levels of transmission from children, and the balance of evidence overall (including the importance of children being able to interact and play freely, and to feel loved), we recommend that no physical distancing should be required between children or between children and adults. Two metre distancing is advised in adult-adult interactions.
- As stated above, establishment of good hygiene routines, enhanced cleaning and ventilation, use of smaller groups, maintenance of good records, and greater use of quality outdoor activity are all important in ongoing suppression of the virus.

[25] https://www.nejm.org/doi/full/10.1056/nejmc2004973
[26] https://academic.oup.com/jid/article/222/2/214/5841129
[27] https://policyscotland.gla.ac.uk/wp-content/uploads/2020/06/PSOutdoorLearningBriefingPaper.pdf
[28] https://www.gov.scot/publications/coronavirus-COVID-19-fully-outdoor-childcare-providers-guidance/
[29] https://policyscotland.gla.ac.uk/wp-content/uploads/2020/04/PSBriefingPaperReopeningOfSchoolsInDenmark.pdf

7. Can the sub-group clarify if it would be recommended that face coverings should be worn in this case in ELC settings, given the package of measures in place and the evidence around transmission in young children, and potential detrimental impact on young children?

- Evidence is becoming clearer about the role of face coverings in reducing transmission[30, 31]. They are important where the risk of transmission is increased (for example in crowded indoor spaces, where distancing cannot be applied, and where people are interacting face-to-face).
- Face coverings should not normally be required for most children (those clinically advised to wear a covering would be an exception). Adults in ELC settings (including at the entrance) should not need to wear face coverings as long as they can retain two metre distancing with other adults. Where adults cannot keep two metre distance, are interacting face-to-face and for about 15 minutes or more, face coverings should be worn. Some children may need additional support/ reassurance about the reasons for adults wearing face coverings when they are required to do so.
- In addition, any adults wishing to wear face protection should be enabled to do so. As the wearing of face coverings/masks becomes more commonplace in Scotland, it is possible that more people may choose to wear a face covering.
- The wellbeing and needs of the child should remain a focus of attention, recognising that face coverings limit communication, and the wearing of masks could cause distress to some young children who may need additional support/reassurance about the reasons for adults wearing face coverings. More generally, viewing of faces facilitates brain development in children, and in learning to speak/phonics. It is noted that a systematic review of literature relating to non-verbal communication in teaching success found a strong link between the combined use of verbal and non-verbal communication and learning effectiveness[32].
- Clear and detailed information should be provided to support the correct use of face coverings. There are risks that people do not apply face coverings correctly, that their use increases face touching and that their safe removal/disposal needs further attention. Any such information needs to be culturally sensitive and recognise that, alongside their role in reducing transmission, there are pre-existing cultural and religious reasons behind the wearing of some face coverings.
- Should the prevalence of the virus in the population start rising, nationally or in parts of Scotland, we would advise that consideration be given to encouraging the wearing of face coverings more routinely, especially among adults in ELC settings, as part of an enhanced system of approaches to reduce transmission.

[30] https://voxeu.org/article/unmasked-effect-face-masks-spread-COVID-19

[31] https://drive.google.com/file/d/1ZMJ_UD1lwiYX2WS8KSBE7O1PQ1yeT8Jr/view

[32] Bambaeeroo, F., & Shokrpour, N. (2017). The impact of the teachers' non-verbal communication on success in teaching. *Journal of advances in medical education & professionalism*, *5*(2), 51–59.

8. **Can the sub-group provide their view of the relative importance of restricting staff movement between settings, and the evidence of impact of this on transmission risk? In particular, is there strong evidence to support requirement of continuation of a blanket prohibition on all such movement, or would developing evidence about transmission in children support a partial or complete removal of the prohibition?**

- Evidence from other settings, including care homes, highlights the role played in transmission by people moving between institutions.[33] Attendance at multiple settings risks joining up chains of transmission. The close contact/intimate care provided in ELC settings may increase this risk further. This would make the management of outbreaks potentially more challenging, as children, parents/grandparents and staff at different settings would potentially need to be traced and isolated.
- The learning from care homes should be applied to decisions about ELC settings, highlighting the need for particular attention to students and other professionals (social workers, psychologists, voluntary organisation staff etc) who come in and out of the ELC estate on an interim basis and move between settings.
- The sub-group supports the view that movement of children between settings should be reduced as far as possible, but recognises that the benefits and reduction in harm to children of being in childcare outweighs the risks involved.
- It will also be important to recognise the amount of movement in early childhood, including between settings, and travelling with siblings to and from school. Consideration will need to be given to how to mitigate that by e.g. implementing staggered pick up and drop off times. The number, and consistency, of adults involved in accompanying/ transporting children between venues should be minimised.
- At least initially, movement between settings of temporary/ supply/peripatetic staff etc should be kept to an absolute minimum, including the attendance at ELC settings of those who visit, including psychologists, nurses, social workers. Recognising the importance of holistic support for children, every effort should be made to secure these wider inputs through lower risk methods such as digital/virtual means or use of outdoor settings.

9. **Can the sub-group advise if the emerging evidence base supports ongoing restrictions on size of cohorts in ELC, given the move to effectively larger cohorts in primary?**

- The evidence base and the advice of the sub-group would be to support a move to cohort sizes for children under five in line with those aged 5-12 assuming the level of infection remains low, appropriate surveillance, test and protect and all the other appropriate mitigations and measures are in place. [34]
- As far as possible, groups of children should be kept consistent – again with an eye to minimising bridges of transmission and facilitating tracing of contacts should that be required.

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[33] National Clinical and Practice Guidance for Adult Care Homes in Scotland during the COVID-19 Pandemic https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2020/03/coronavirus-COVID-19-clinical-and-practice-guidance-for-adult-care-homes/documents/clinical-guidance-for-nursing-home-and-residential-care-residents/clinical-guidance-for-nursing-home-and-residential-care-residents/govscot%3Adocument/National%2BClinical%2BGuidance%2Bfor%2BCare%2BHomes%2BCOVID-19%2BPandemic-%2BMASTER%2BCOPY%2B-%2BFINAL%2B-%2B15%2BMay%2B2020.pdf?forceDownload=true

[34] Space to Grow https://hub.careinspectorate.com/media/1623/space-to-grow.pdf