COVID-19 - 'shielding' guidance for children and young people

Health Policy team

This page provides advice to members on which paediatric patient groups are considered to be clinically extremely vulnerable during the COVID-19 outbreak and at very high risk of severe illness from coming into contact with the virus. It also provides frequently asked questions on how 'shielding' applies to children and families.

This updated RCPCH advice for clinicians is provided to help members in their discussions with children and young people who are shielding across the UK and their families.

This advice was developed in June 2020 in partnership with a wide range of paediatric specialty groups: British Association of Paediatric Nephrology, British Association of Perinatal Medicine, British Congenital Cardiac Assocation, British Inherited Metabolic Disease Group, British Paediatric Allergy, Immunity & Infection Group (working with the UK Primary Immunodeficiency Network), British Paediatric Neurology Association, British Paediatric Respiratory Society, British Society for Paediatric Endocrinology and Diabetes, British Society of Paediatric Gastroenterology, Hepatology and Nutrition, British Society for Rheumatology, Children's Cancer and Leukaemia Group, Paediatric Special Interest Group of British Haematology Society. Many specialties also worked with parents and patient groups as they developed their advice.

Status

Partnership

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Update on shielding: 18 August 2020

- It is now the responsibility of paediatricians to look at our patients who are on the current shielded patient list and to communicate any changes with families and children who are no longer clinically extremely vulnerable.
- Paediatricians should be updating their shielded patients lists now. Children and families should be at the centre of this process, and advised about how the changing advice on extreme clinical vulnerability affects them. Paediatricians can start this process through letters, phone calls or face-to-face discussions and consultations, as appropriate
- There are different operational arrangements across the UK to update shielded patient lists, and paediatricians should engage with local processes. It is essential that shielded patient lists are kept up to date in line with current clinical advice. While shielding advice is currently paused, if it were to restart, we need to ensure we don’t cause harm by keeping children isolated and unnecessarily away from school and other activities.

Update on shielding: 31 July 2020

From August, we expect that UK governments’ public health advice on shielding will be paused (except for local lockdowns). This means that children and young people who are clinically extremely vulnerable (CEV) will be advised to follow the same precautions as the rest of the population, such as hand hygiene and social distancing.

In England, Northern Ireland and Scotland, we expect advice on shielding to be paused from 1 August. In Wales, this is expected to happen on 16 August.

The shielded patient lists (SPL) will continue to be maintained while shielding is paused in case increases in prevalence mean governments reintroduce shielding measures in the future. It is important therefore to maintain an accurate list to ensure those children who do not need to be shielded are not left on the list if shielding was to return.

Therefore, over the summer, all children and young people currently on the SPL should be reviewed by their clinicians, to discuss whether they are still considered to be CEV before the return to school after the summer break.

For many children this may be their GP who may seek advice and guidance from us as paediatricians. This advice should be straightforward to give from the guidance below. Alternatively it will be the lead paediatrician to advice the family who may be in secondary or

tertiary care.

Children and young people who have been shielding, and their families and carers, may be anxious about attending health settings. This should be considered when putting in place measures to support safe service restoration and provide ‘COVID-protected’ environments. It should also be reflected in information provided to patients about attending appointments and visiting NHS sites.

Introduction

As part of the initial response to the pandemic several thousand children and young people were advised to shield because their pre-existing conditions meant they were felt to be at the highest risk of severe illness from COVID-19.

The original shielded patients list was intended to identify people with particular conditions which put them at highest clinical risk of severe morbidity or mortality from COVID-19, based on our understanding of the disease at the time. It was developed early in the outbreak when there were very little data or evidence about the groups most at risk of poor COVID-19 outcomes, and so was intended to be a dynamic list that would adapt as our knowledge of the disease improved and more evidence became apparent.

Our experience and knowledge of the impact of COVID-19 infection on children and young people with comorbidities has been developing over time. New evidence and research findings allow us to reconsider and update the advice about which children are at the highest risk of severe infection because they are ‘clinically extremely vulnerable’. For example:

- Research evidence summaries
- Service evaluation and audit on the care needs of children admitted to hospital (England)
- Systematic review of evidence about milder outcomes in children

During May and June, RCPCH worked with paediatric specialties to review this evidence and revise the advice on which children and young people are ‘clinically extremely vulnerable’ to COVID-19 infection.

This indicated that not all those children and young people who were initially classed as clinically extremely vulnerable should continue to be so. The majority of children with conditions including asthma, diabetes, epilepsy, and kidney disease are not clinically extremely vulnerable. This includes many children with conditions such as cerebral palsy and scoliosis.

In principle,

- Children and young people who are cared for just in primary care are very unlikely to be clinically extremely vulnerable.
- A small group of children who are clinically extremely vulnerable due to their pre-existing condition will need to follow public health advice on shielding.
- A further larger group of children exists who due to their underlying condition may be clinically extremely vulnerable and the decision to follow public health advice on shielding would normally result from a discussion between the clinician, the child and their family.

The list below provides further details. We anticipate that all patients who need to continue to follow public health advice on shielding will be seen in a specialist centre before September 2020 (but not all those with specialist appointments will be clinically extremely vulnerable).

Any decision to follow public health advice on shielding should balance the clinical and social impact of shielding - weighing the benefit of keeping children and young people with underlying co-morbidities safe whilst protecting the most socially vulnerable, due to family and social circumstances, who may risk additional harm from continued shielding.

If a child is no longer clinically extremely vulnerable, clinicians should discuss with children and their families/carers their removal from the shielding list (see links below for further details). Patients can only be removed from the shielding patient list by their GP or specialist, following discussion/consultation with the child and their family, and other clinicians where appropriate.

We know that many children and young people and their parents/carers will feel cautious and uncertain at this time. We have developed this advice for clinicians to support them as they discuss the risks of COVID-19 infection with individual patients.

Revisions and updates

This advice reflects the current understanding of the risks associated with COVID-19 infection. We will continue to update and revise this advice as we learn more about the impact of COVID-19 infection on the health of children and young people with comorbidities and as public health advice is updated. If you have comments or questions about this guidance, please email health.policy@rcpch.ac.uk.

Children who are clinically extremely vulnerable

Our updated advice identifies two groups of children and young people (under 18 years of age) who are ‘clinically extremely vulnerable’, either due to the risk of severe infection, or the risk arising from complications of infection.

Group A lists conditions that mean a child is clinically extremely vulnerable. A child with a condition in Group A should be advised to follow public health advice on shielding.

Group B lists conditions that require discussion between the clinician and the child and their family/carer to establish whether they are clinically extremely vulnerable on a case by case basis. A child in Group B should have a discussion with their clinical team to establish whether on balance of risks they should follow public health advice on shielding. Not all

children and young people with conditions listed in Group B will need to do this. If following a discussion, they are advised not to shield, the child should maintain stringent social distancing.

Group A

Children and young people in the following categories are clinically extremely vulnerable and all should be advised to follow government public health advice on shielding.

Immunodeficiency and immunosuppression

- Children with risk of severe infection due to their primary immunodeficiency. More advice for clinicians is available from UK Primary Immunodeficiency Network (PDF). Advice for parents is available from PIDUK.
- Children at risk of severe infection due to immunodeficiency induced by their disease or their drugs as part of their therapy (ie some post-transplant immunosuppression, severe vasculitis). This means:
    - Those on cyclophosphamide and high dose steroids (the dose may vary depending on specialty – see below).
    - It may include children who are clinically vulnerable during the period before and after transplants. The duration of immunosuppression may differ for solid organ transplant and stem cell transplant.

Oncology

Children with very specific immunosuppression as part of their cancer therapy. This means those who:

- are receiving induction chemotherapy for acute lymphoblastic leukaemia (ALL) and Non-Hodgkins Lymphoma
- are receiving chemotherapy for acute myeloid leukaemia (AML)
- are receiving chemotherapy for relapsed and/or refractory leukaemia or lymphoma
- have received a donor stem cell transplant (allogeneic transplant) in the last 12 months
- have received their own stem cells back (autograft transplant) in the last 6 months
- are undergoing CAR-T therapy and for 6 months following CAR-T therapy

More advice is available from the Children's Cancer and Leukaemia Group.

Group B

Conditions listed in the categories below will require a case-by-case discussion to decide whether, on the balance of risks, a child should be considered to be clinically extremely vulnerable and advised to follow government public health advice on shielding. Not all children and young people in the categories listed below will need to do this.

This decision will depend on the severity of the condition and knowledge that the secondary and tertiary care clinical teams have of the particular circumstances of the child. If following a discussion, a child is advised they are not clinically extremely vulnerable, they should maintain stringent social distancing.

Although many diseases are treated with similar immunomodulatory drugs, advice regarding shielding may differ as an assessment of clinical vulnerability is based on a combination of the drug effect and the underlying disease.

Note: there may be other patients who do not fit these categories below, but secondary care clinicians feel that, after discussions with families, that a child is clinically extremely vulnerable. We advise contacting their tertiary specialists for advice.

Cardiology

- Fontan, single ventricle physiology, especially with evidence of 'failure', and or end organ damage.
- Persistent cyanosis.
- Pulmonary Arterial Hypertension (PAH) especially those on pulmonary vasodilator therapy.
- Severe and or symptomatic heart failure, particularly those on heart failure therapy.

More information is available from the BCCA.

Dermatology

- Those on high dose steroids, defined as ? 0.5mg/kg/day, for 4 or more weeks, within the last 4 weeks.
- Clinician decision for individual patients, considering overall health status (including unstable / flaring disease and immunosuppression) and social circumstances.

Haematology

- For children with sickle cell disease, this means those
    - with additional co-morbidities causing concern from their clinicians (for example, progressive critical neurovasculopathy, severe or symptomatic heart failure)
    - with a history, within the preceding 12 months, of either one or more chest crisis requiring intensive care treatment or two or more chest crises requiring treatment
- For children with thalassaemia, this means those with severe iron overload (T2 *< 10 ms) and additional co-morbidity causing concern
- For children with Diamond Blackfan Anaemia, this means those who have an associated immunodeficiency, severe iron overload (as per thalassaemia definition) or are on prednisolone (or equivalent) ?0.5 mg/kg/day.
- For children with other rare inherited anaemias, e.g. pyruvate kinase deficiency, congenital dyserythopoietic anaemia, if they are at particularly high risk due to iron overload as per thalassaemia guidelines above

NOTE: alone, asplenism due to surgery or functional asplenism is not a reason to shield, but could be considered if other co-morbidities

Immunodeficiency

- **HIV:** Only children and young people who have a CD4 count less than 50 or who have had an opportunistic illness within the last 6 months are advised to shield (or who have one of the other conditions listed for which shielding is advised). We recommend discussion with tertiary specialist if any doubt. Note that advice differs from that for primary immunodeficiency.

More advice for clinicians is available from CHIVA, as well as advice for parents.

- **Primary Immunodeficiency:** Patients with more common primary immunodeficiencies such as IgA deficiency will not need to shield.

More advice for clinicians available from UK Primary Immunodeficiency Network. Advice for parents is available from PIDUK.

Neonatal

- Ex-premature infants with oxygen and/or intermittent non-invasive ventilation requirements.

Neurology

- Patients with significant difficulty with swallowing (e.g. myotonic dystrophy patients).
- Patients at significant risk of decompensation during infection (e.g. mitochondrial disease).
- Patients with symptomatic heart failure, particularly those on heart failure therapy (e.g. Duchenne muscular dystrophy).
- Patients with myasthenic syndromes.

More advice is available from the British Paediatric Neurology Association.

Paediatric Gastroenterology, Hepatology & Nutrition

Paediatric inflammatory bowel disease (IBD) patients who meet one or more of the following criteria:

1. Intravenous or oral steroids ?20mg prednisolone (or >0.5mg/kg) or equivalent per day (only while on this dose).
2. Commencement of biologic therapy plus immunomodulatory or systemic steroids within previous six weeks.
3. Moderate to severely active disease not controlled by moderate risk treatments who may require an increase in treatment.

Intestinal failure patients requiring Home Parenteral Nutrition (HPN) who meet one or more of the following criteria:

1. Primary immunodeficiency or immunodeficiency induced by drugs as part of their therapy.
2. Other significant conditions or other organ involvement (renal, haematology, cardiac, GI, respiratory, diabetes mellitus).
3. Social cofactors (eg heavily reliant on support from healthcare professionals/ carers).

Liver disease who meet one of more of the following criteria:

1. Decompensated liver disease.
2. Receiving post-transplant immunosuppression or on Liver/small bowel/multivisceral transplant waiting list.
3. Liver disease and other significant conditions or other organ involvement (renal, haematology, cardiac, GI, respiratory, diabetes mellitus).
4. Active or frequently relapsing autoimmune liver disease where they are likely to need increase in treatment.

More information is available from the British Society for Paediatric Gastroenterology, Hepatology and Nutrition.

Renal

- Those with recent kidney transplants – first three months immediately after transplant.
- Those on a high level of immunosuppressive medication for active disease undergoing induction treatment: those who are currently receiving or completed treatment within 6 weeks of high dose steroids of 20 mg/day or above (or 30 mg/m2 /day) AND cyclophosphamide or rituximab or other very powerful immunosuppression.
- The kidney team determines with the family that the child is at high risk.

More information available from the British Association for Paediatric Nephrology and the Renal Association.

Respiratory

- Children with significant impairment in ability to cough and to clear airway secretions due to disease severity. This will include those children with severe neurological diseases including severe cerebral palsy, neuromuscular disabilities, severe motor impairment and those with severe metabolic disease.
- Children who otherwise require a cough assist device to help with clearance of airway secretions.
- Children who are life-dependent on long term ventilation, both invasive (via tracheostomy) and non-invasive (CPAP and BiPAP).
- Children with severe lung disease requiring continuous or overnight supplementary home oxygen and/or intermittent non-invasive ventilation.
- Children with:
    - Cystic fibrosis and Primary ciliary dyskinesia.
    - Severe bronchiectasis

    - Severe restrictive lung disease such as interstitial lung disease or obliterative bronchiolitis
    - Severe asthma: children treated with biological agents or maintenance oral steroids. NOTE: Many children with asthma including those treated with biological agents and daily prednisolone will not need continued shielding
    - Children with repaired congenital thoracic abnormalities such as congenital diaphragmatic hernia / trachea-oesophageal fistula only if significant airway or lung problem.

Rheumatology / Paediatric ophthalmology

- Those on cyclophosphamide and/or high dose steroids, defined as ? 0.5mg/kg/day, for 4 or more weeks, within the last 4 weeks.
- Clinician decision for individual patients, considering overall health status (including unstable / flaring disease) and social circumstances.

More information available from the British Society for Rheumatology.

Notes on other conditions

Diabetes

There is no evidence that children with diabetes are more likely to be infected with COVID-19 compared to children without diabetes. More information is available from the Association of Children's Diabetes Clinicians.

Endocrinology

Children and young people who have hormone problems and in particular who are taking steroids (hydrocortisone, prednisolone, dexamethasone) because their adrenal glands do not work properly (steroid replacement therapy) are at no more risk of catching COVID-19 than other children. More information is available from the British Society of Paediatric Endocrinology and Diabetes.

Inherited metabolic diseases (IMD)

Children with an IMD who as a consequence fulfil one of the criteria in Group A will be advised to shield. Children with an IMD who fulfil one of the criteria in Group B may be advised to shield depending on discussion with the multidisciplinary team and parental assessment of the individual circumstances. Children with an IMD who do not fulfil Group A or B criteria should follow the advice given to the general population.

Communication with children and families

Clinicians most closely involved in the care of the child and family can help in decision-making (eg lead clinician within a tertiary centre, local clinician and / or GP) around extreme clinical vulnerability and 'shielding'. Clinicians can advise on 'shielding' to parents of children, though parents themselves hold the responsibility for the child and family.

If a child is no longer clinically extremely vulnerable, clinicians should discuss with children and their families/carers their removal from the shielding list (see links below for further details). Patients can only be removed from the shielding patient list by their GP or specialist, following discussion/consultation with the child and their family, and other clinicians where appropriate.

If there are uncertainties in primary care about whether a child is clinically extremely vulnerable, paediatricians can support GP colleagues with advice and support.

Children who are clinically extremely vulnerable should still attend hospital for essential treatment as recommended by their clinical teams, following risk assessment. The need for this should be discussed with families and young people in a sensitive and reassuring manner. It is understandable that parents may be apprehensive about attending hospitals even when it is clinically important to do so. The clinical team should do all they can to encourage attendance. If however, non-attendance becomes a clinical concern (despite all attempts at reassurance) and there is a concern for the child, then for the safety of the child, further steps need to be taken. On occasion, non-compliance with treatment recommendations may amount to significant neglect of medical needs and will require discussion with the local safeguarding team, particularly the Named Doctor for Safeguarding Children, and may meet threshold for referral to children's social care.

CYP who have been shielding and their families and carers may be anxious about attending health settings. This should be considered when putting in place measures to support safe service restoration and provide 'COVID-protected' environments. It should also be reflected in information provided to patients about attending appointments and visiting NHS sites.

The shielded patient lists (SPL) will continue to be maintained while shielding is paused (see links below). If there is an increase in community transmission of COVID-19 children and young people who are clinically extremely vulnerable may be advised to shield again. All children and young people currently on the SPL should be reviewed by their clinicians, to discuss whether they are still considered to be CEV before the return to school after the summer break.

England: maintaining the shielded patients list

- On 8 July, the Chief Medical Officer and the NHS Medical Director wrote to Trusts and Primary Care outlining the approach to implementing this guidance and maintaining the SPL.
- Further details on maintaining the SPL are available on NHS Digital's website for GPs and specialists. This also provides a link to a template letter for those not considered to be clinically extremely vulnerable.
- Advice for Trusts.

Northern Ireland

- Advice for patients who are shielding.

Scotland

- Advice for clinicians about shielding.

- Health Protection Scotland COVID-19 search criteria for shielding.
- Scottish Government advice on shielding.
- NHS Scotland information on shielding.

Wales

- Welsh Government information on shielding.
- Advice for patients.

Frequently asked questions on 'shielding'

What does the pause on 'shielding' mean?

In England, Northern Ireland and Scotland, shielding is paused from 1 August. In Wales, shielding is being paused from 16 August. This means that children and young people who are clinically extremely vulnerable (CEV) will be advised to follow the guidance issued for the general population to manage their risk of contracting coronavirus. Further information is available here:

PHE guidance on shielding and protecting extremely vulnerable people from COVID-19.

PHE guidance on supporting children and young people's mental health and wellbeing.

NHS England advice and signposts for patients (PDF).

Northern Ireland advice for patients who are shielding.

NHS Scotland advice for patients who are shielding.

Scottish Government advice for patients who are shielding.

Welsh Government advice for patients who are shielding.

What happens if there is a local lockdown?

If local lockdowns are introduced, children and young people who are clinically extremely vulnerable may be advised to resume shielding. 'Shielding' is defined by Public Health England (PHE) as a measure to protect clinically extremely vulnerable people by minimising interaction between those who are clinically extremely vulnerable and others. Those adults and children who are classed as clinically extremely vulnerable or most at risk are strongly recommended to take additional precautions to avoid COVID-19 infection.

What does 'shielding' mean for a child?

If the advice from public health agencies and governments is to shield, children and young people who are clinically extremely vulnerable must stay at home.

If children receive regular health or social care from any organisation, either through local authority or paid for by the family, care providers should be informed that they are shielding and agree a plan for continuing care at home. Carers and care workers must not enter the home if they have any symptoms of COVID-19.

What does 'shielding' mean for families?

If the family is able to practice social distancing at home by separating out the family's roles at home, this may allow some family members to continue to work (including within high risk occupancies which may encounter COVID-19, eg front life healthcare). However, they should support the 'shielding' process by following guidance on stringent social distancing when outside the home.

It is important to maintain a normal family life as far as is possible whilst protecting all members of the family. Each family situation will be different and decisions will need to be taken individually. Families with older children should be able to follow advice on social distancing and their decision-making may be easier. Those with younger children will have more difficult decisions and they will need to consider the necessity of following social distancing advice and the needs of other children in the family.

Will hospital and GP appointments continue during the 'shielding' period?

Where possible, healthcare services are making provisions for remote consultations (eg telephone or video consultations). However, some consultations will need to be face-to-face and in these scenarios healthcare providers will follow the latest guidance for the safety of both staff and patients.

Is support available for families that are advised to shield?

Shielding advice is being paused in August. At this point access to centrally provided home food and medicine deliveries will be stopped.

Latest updates to this page

Updates in this version 14 September

- Update to Renal section under Group B.

28 August 2020 : New section at top of page to emphasise need for paediatricians to review and update the shielded patient list

17 August 2020: Correction to name of Association of Children’s Diabetes Clinicians

13 August 2020: Update to 'What does 'shielding' mean for a child?'

31 July 2020: Widespread changes to align with update on shielding, 31 July, as described at the top of the page