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

Phased return to in-person learning in schools and early learning and childcare (ELC) settings

3 February 2021

Key messages

- This paper provides an overview of evidence relating to the state of the epidemic in Scotland; children, schools, ELC settings and transmission; and wider impacts of the current restrictions on children and families. On the basis of this evidence it offers advice on the phased return to in-person learning in schools and ELC settings.
- Case numbers, levels of community transmission and test positivity rates are decreasing. However, projected ongoing pressures on the NHS, the emergence of new variants, continued uncertainties about the degree of greater transmissibility of the Variant of Concern B.1.1.7 and its health consequences, and recognition that progress in suppressing the virus to previous low levels will likely take some more weeks, mean that there is little headroom for releasing current restrictions.
- Any relaxation of measures should be undertaken in a staged/progressive way, enabling time for planning each step change and for monitoring its impacts, and should be cognisant of the need for stability and sustainability of the approach. Options involving younger children and those with fewer numbers of children returning are likely to have a smaller impact on R.
- For children to return to ELC and schools, there will need to be an ongoing focus on measures to prevent community transmission. It should be emphasised that any easing does not suggest a return to wider 'normality'.
- Prioritisation of the phases of return should be based on a combination of factors including transmission risks, educational and wider health harms/benefits, and confidence in mitigations.
- Evidence continues to confirm that younger children are at lower risk of transmission and of clinical disease from SARS-CoV-2 than are older children and adults. There is no evidence of any difference in the risk of severe Covid-19 among pre-school, primary and secondary school teachers, relative to other adults of a similar age. Where community prevalence is low, risks of cases and outbreaks in ELC and school settings are low, particularly in settings with younger children and when numbers are kept down.
- Staged return to in-person learning should be subject to continued reductions in prevalence and community transmission, no significant changes in the evidence, and reassurance that appropriate infection prevention and control mitigations are in place. Subject to these conditions, ELC, P1-P3 and small numbers of senior secondary pupils requiring practical in-school learning could return from 22 February.

Background

1. The First Minister announced on 4 January 2021 a legal requirement to stay at home except for essential purposes. Schools and ELC settings would remain closed for the majority of pupils, except vulnerable children and children of key workers. This was a precautionary measure, based on the increased number of COVID-19 cases in Scotland, the growing proportion of these being of the new variant of COVID-19, and the high level of community transmission taking place.

2. At the time, the First Minister made it clear that the priority was to reopen school buildings again for all children and young people, as quickly as possible, and to keep them open. The Scottish Government then commissioned the advisory sub-group on education and children's issues to advise on the best and safest way to return to in-person learning in schools and ELC settings.

3. The sub-group's deliberations have been supported by evidence from the Scientific Advisory Group for Emergencies (SAGE) and the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG), evidence from Public Health Scotland and Public Health England, wider published evidence and international experience.

4. The sub-group has reflected on:

- The state of the epidemic in Scotland and beyond, levels and trends in key indicators including community transmission, incidence and prevalence rates, test positivity, behaviour of the new variants, and consequential implications for hospital / ICU capacity;
- Evidence regarding age-group-specific risk associated with the new variant, and evidence about changes in transmission;
- Evidence regarding risks to staff or pupils of school/ELC-associated transmission and outbreaks, including risks associated with the new B.1.1.7 variant;
- Evidence regarding the impacts of loss of access to in-person provision on educational and developmental outcomes;
- The need to consider the impacts of remote learning and a phased return to in-person learning on children's rights and wellbeing;
- The need for a sustainable approach to a phased return, and a clear direction of travel to allow for forward planning by the education system. Changes should be made on an incremental basis, with the impact of each change being monitored before further changes are implemented. Infection prevention and control mitigations, not only within schools and ELC settings but more widely in society, will play a critical part in ensuring a sustainable and phased return.

The state of the epidemic

5. In the week from 23 to 30 December, the seven day incidence of cases per 100,000 of the population increased from 136 per 100,000 to 225 per 100,000 in Scotland. Test positivity had also risen sharply. This increase in cases was partially driven by the new B.1.1.7 variant, which appears to have substantially increased transmissibility compared to other variants and has grown quickly to become the dominant variant in much of the UK (rising in Scotland from 42.7% at 31 December[1] to 67% on 24-25 January[2]).

[1] Coronavirus (COVID-19): state of the epidemic in Scotland 4 January 2021 - gov.scot (www.gov.scot)
[2] Coronavirus (COVID-19): state of the epidemic in Scotland - 29 January 2021 - gov.scot (www.gov.scot)

6. In terms of severity, evidence suggests there is "a realistic possibility" that the new variant carries an increased risk of death, but the absolute risk of death per infection remains low[3]. This combination of a steeply rising trend of infections and increased severity of the variant has clear implications for the NHS and the potential for breach of NHS capacity. In the week from 23 to 30 December, modelling of the COVID-19 epidemic in Scotland[4] indicated that some areas were at risk of breaching their hospital bed capacities.

7. This prompted the decision to move to remote learning for the majority of children and young people following the Christmas break. This decision, together with the wider stay at home restrictions, has led to case numbers, levels of community transmission and test positivity rates decreasing in recent weeks. In the week from 24 to 30 January the seven day incidence of cases per 100,000 of the population decreased from 167.8 per 100,000 to 133.5 per 100,000[5]. Test positivity also decreased over this period, from a weekly average of 7.7% on the 24th to 6.5% on the 30th.

8. The growth rate for Scotland is currently estimated as being between -5% and -1%. The reproduction rate (R) in Scotland is currently estimated as being between 0.7 and 1.0 – a decrease compared to the previous week. The number of new daily infections for Scotland on 27 January is estimated as having been between 63 and 104, per 100,000 people. This level of daily infections is similar to the peak of infections in mid-October.

9. Children continue to show comparatively lower rates of positive infection. In the week ending 24 January 2021, the identified COVID-19 positive cases in Scotland reflected a rate of:

- 50.5 cases per 100,000 2 to 4 year olds,
- 57.7 cases per 100,000 5 to 11 year olds,
- 64.7 cases per 100,000 12 to 13 year olds
- 72.9 cases per 100,000 14 to 15 year olds, and
- 127.1 cases per 100,000 16 to 17 year olds.

In the same week, across the whole population of Scotland, the rate was 167.8 cases per 100,000.[6]

10. The near closure of schools along with the wider stay at home restrictions has helped to support the reduction in positive cases in Scotland. This reduction can be seen in Figures 1 and 2, which modelling shows should continue to show a decline in pressure or a plateau for the NHS. The decision on when and how to reopen the education system is taking the modelling into account by looking at the level of infections in the future at the point in time education system reopening may occur, alongside the level of hospital pressure at that time. The 'better' projections include population impacts flowing from vaccination; the 'worse' are without the effects of vaccination.

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/955239/NERVTAG_paper_on_variant_of_concern__VOC__B.1.1.7.pdf)
[4] https://www.gov.scot/publications/coronavirus-covid-19-modelling-epidemic-issue-no-36/
[5] COVID-19 Daily Dashboard - PHS COVID-19 | Tableau Public
[6] https://beta.isdscotland.org/find-publications-and-data/population-health/covid-19/covid-19-statistical-report/27-january-2021/

Figure 1: *Medium term projections of modelled total new infections, adjusting positive tests to account for asymptomatic and undetected infections (positive test data up to 23 January[4])*

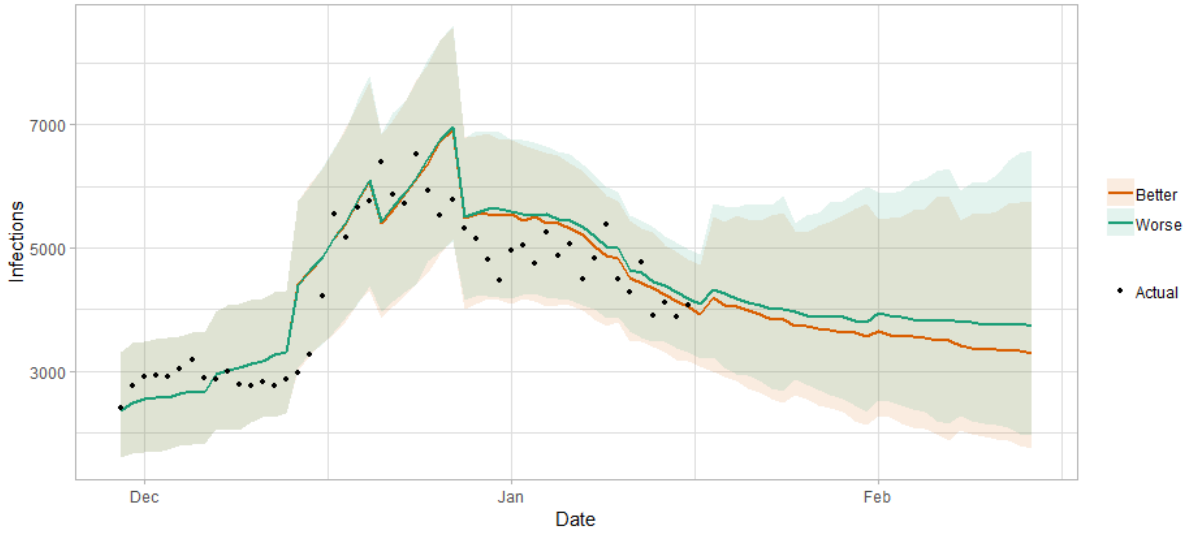
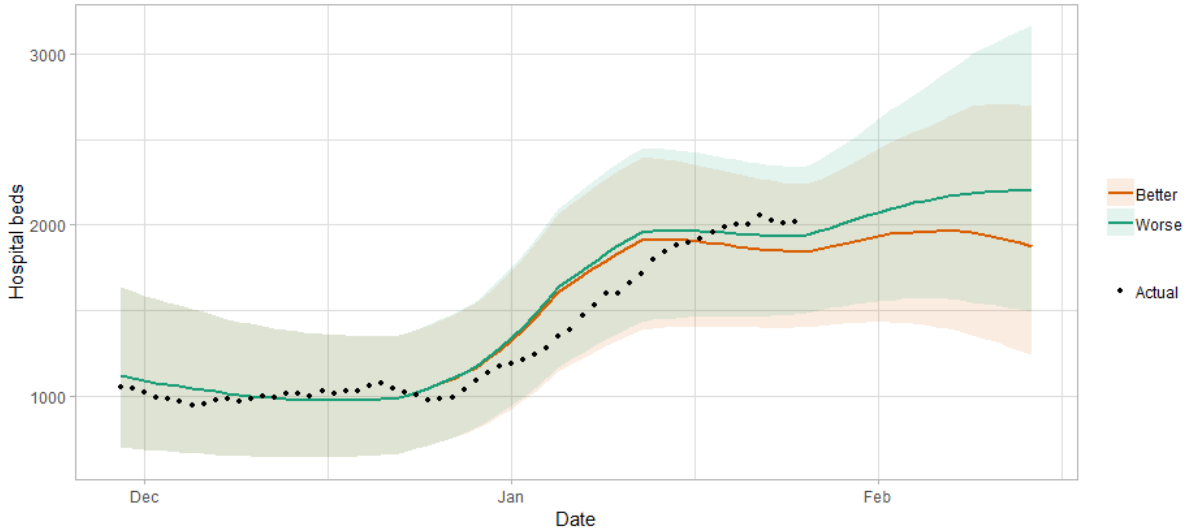


Figure 2: *Medium term projections of modelled hospital bed demand, from Scottish Government modelling[4].*



The sub-group continues to monitor carefully the incidence and prevalence of the new variant of COVID-19 in Scotland, and in children and young people in particular.

Transmission: children and young people

11. Transmission rates are determined by characteristics of the virus, characteristics of the population of interest, and characteristics of the environment and exposure.

12. The new variant is now the dominant variant in Scotland. It has been prevalent for longer in England than in Scotland, and the Public Health England Technical Briefing 3[7] provides information drawn from the analysis of contact tracing data in England up to 5 January 2021. A higher secondary attack rate for the new variant (compared to the wild type) was seen across all age groups and was highest among those aged 30 to 80+

[7] Investigation of novel SARS-CoV-2 variant: Variant of Concern 202012/01 (publishing.service.gov.uk)

years. It was lowest (9%) for those aged 0-9 years, followed by 10-19 year olds (11.8%). This indicates that, as was the case for the previously dominant strains, children and young people transmit the new variant at lower rates than do adults.

13. Younger children appear to be less susceptible to acquiring COVID-19 than adults and older teenagers. Viner et al's meta-analysis found evidence that children and adolescents have lower susceptibility to SARS-CoV-2, with an odds ratio of 0.56 for being an infected contact compared with adults. Contact tracing studies indicate that the risk of a child being infected from a case in their household is approximately half the risk for an adult[8]. They are also more likely to be asymptomatic, with serological screening with symptom surveys suggesting that approximately 50% of children may be asymptomatic[9]. Asymptomatic cases are more likely not to be self-isolating and can still be infectious, but they are generally significantly less likely to transmit the virus than symptomatic cases.

14. In the week ending 23 January 2021, the ONS COVID-19 infection survey[10] showed that infection rates (based on statistical modelling of nose and throat swab test results) remained high but decreased in all ages, except for the group of children age two years to school Year 6, which showed early signs of levelling off. School Year 7 to Year 11 showed a substantial decrease in recent weeks. Caution should be taken in over-interpreting small movements in the narrower age groups, which have wider credible intervals.

15. The number of children being tested for COVID-19 in Scotland in the third week of January was similar to the previous week, with 3,302 2 to 17 year olds tested (18 lower than the previous week). Test positivity decreased overall for 2 to 17 year olds, with 13.2% test positivity in week 3, compared to 15.5% in week 2. In addition, the overall number of children and young people who test positive has decreased in recent weeks.

16. There is no evidence at present that the new variant has a more severe impact on children and young people than on adults. The President of the Royal College of Paediatrics and Child Health issued a statement in January[11] "As cases in the community rise there will be a small increase in the number of children we see with COVID-19, but the overwhelming majority of children and young people have no symptoms or very mild illness only. The new variant appears to affect all ages and, as yet, we are not seeing any greater severity amongst children and young people."

17. In terms of severity, the risk of poor clinical outcome for children and young people remains extremely low. UK[12] data shows no significant increase in the proportion of deaths in children under 19 years old when comparing wave 1 (Jan 17th-July 3rd 2020) with a time period including wave 2 (Jan 17th - Dec 31st 2020). For wave 1, 651 (0.94%) of 69,516 hospitalised patients of all ages were under 19 years; of these there were 8 deaths.

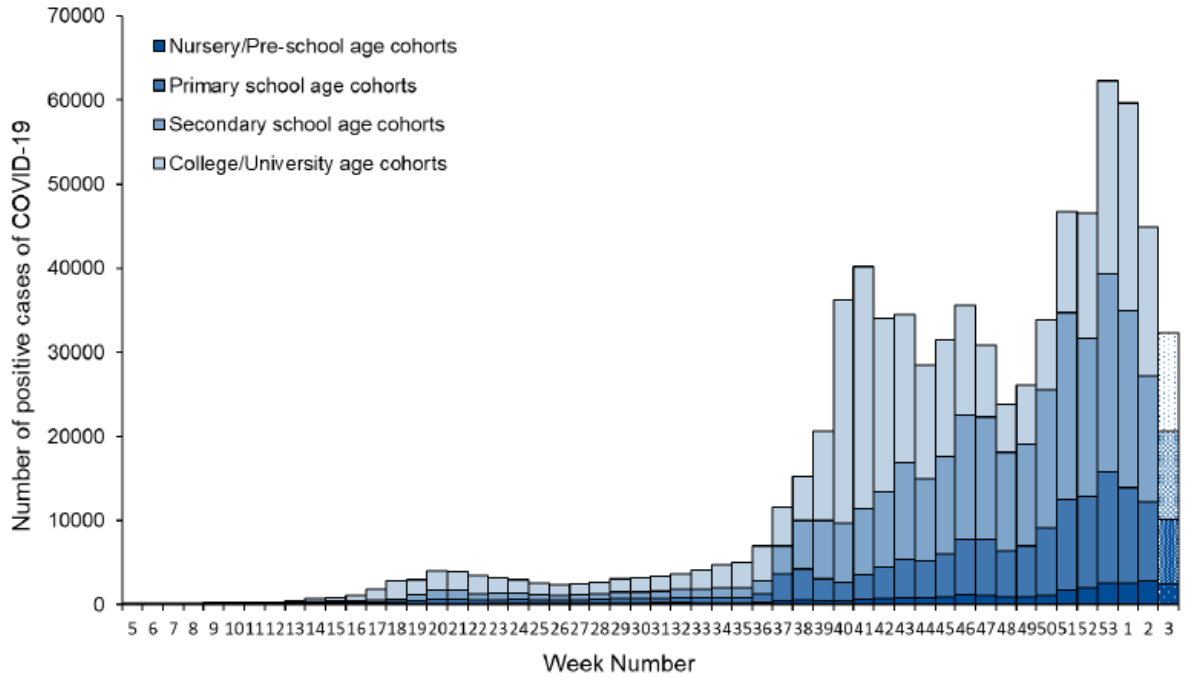
[8] https://pubmed.ncbi.nlm.nih.gov/32975552
[9] https://dontforgetthebubbles.com/evidence-summary-paediatric-covid-19-literature/).
[10] Coronavirus (COVID-19) Infection Survey, UK - Office for National Statistics
[11] RCPCH responds to media reports of increased admissions of children and young people with COVID-19 | RCPCH
[12] Clinical characteristics of children and young people admitted to hospital with covid-19 in United Kingdom: prospective multicentre observational cohort study | The BMJ

Transmission: ELC and school settings

18. In-school/ELC transmission does happen and there is a growing body of evidence relating to the factors with which it is associated. Community prevalence is a major determinant: school/ELC outbreaks are relatively uncommon when there is low-moderate population prevalence of COVID-19. Incidence of COVID-19 in school settings appears to be mainly affected by levels of community transmission. Widespread transmission of more highly transmissible variants of SARS-CoV-2 is therefore more likely to increase the COVID-19 cases in school settings, even if these variants are not disproportionately more transmissible among children and young people.[13] Cases are less common in primary schools than secondaries[14], partly reflecting the lower susceptibility of younger children and partly the greater degree of mixing/contact networks in secondary schools.

19. It should be noted that evidence on transmission of the new variant in ELC and school settings is limited due to the reduced numbers of children and young people currently attending. In Scotland, the proportion of cases in educational settings and the proportion of cases among the educational workforce, remain at low levels in January 2021 compared to those observed in the period September-December 2020, but there has been a slight increase in comparison to the very low levels over the holiday period.[15] Figure 3 b shows case numbers amongst school and ELC aged cohorts in England throughout the pandemic. Note that early years settings remain open in England (estimated attendance around 57%)[16].

Figure 3: *Weekly number of laboratory confirmed COVID-19 cases in nursery/preschool, primary, secondary and college/university age cohorts (England)[17]*



[13] Risk of spread of new SARS-CoV-2 variants of concern in the EU/EEA - first update (europa.eu)
[14] COVID-19 infections among school pupils in Scotland - Enhanced surveillance of COVID-19 in education settings - COVID-19 data and intelligence - COVID-19 - Our areas of work - Public Health Scotland
[15] COVID-19 statistical report 27 January 2021 - Data & intelligence from PHS (isdscotland.org)
[16] Attendance in education and early years settings during the coronavirus (COVID-19) outbreak, Week 5 2021 – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk)
[17] PHE Influenza Surveillance graphs (publishing.service.gov.uk)

20. Trend data from the ONS infection survey show that when wider restrictions are eased in society, incidence increases first among adults and older teenagers; children's rates follow thereafter . The WHO report on COVID-19 transmission in schools, published on 21 October 2020[18], showed that few outbreaks had been reported in schools since early 2020, and that most infections or COVID-19 cases reported in children were acquired at home. In school outbreaks, transmission between adults was most common, with transmission among students, or between students and adults, being less common. The available evidence from the European Union suggests that the return of children to school does not seem to have been the driving force behind the increase in cases which began to be seen in September and October, although the paper from the European Centre for Disease Control[19] was published on 23 December 2020 and does not include evidence in relation to the new variant.

21. A review of observational studies which provided a quantitative estimate of the impact of school closures on community transmission of SARS-CoV-2 was carried out by the University of Cambridge and the East of England Population Health Research Hub. [20] The studies spanned a range of countries and were heterogenous in design. The studies at lowest risk of bias reported no association between school closure and community transmission. The review was unable to examine differences between primary and secondary schools as no studies distinguished between them, despite the different transmission patterns for younger and older children. The studies were also unable to distinguish between the direct and indirect effect of school closures. Indirect effects might include parents staying at home (reducing workplace contacts), and the signalling effect that closing schools sends to the general population to be cautious and reduce social contacts.

22. A study from Duke University[21] found that fewer than one in 20 COVID-19 infections among students and staff were acquired in schools and there were no recorded instances of child-to-adult transmission in school, even when the virus was widespread in the community. An important factor in the lack of within-school transmission was felt to be the safety measures in place in the participating school districts, which included:

    - Mask wearing at all times for all children aged five and over, apart from during meals or when sufficiently distanced outside.
    - Two metre physical distancing, and regular handwashing.
    - Daily screening of students and staff, transparency in reporting new cases, and efficient contract tracing.

23. A study in Norway[22] systematically tested almost all contacts of 5 to 13 year olds with COVID-19. The study concluded that transmission of SARS-CoV-2 from children under 14 years of age was minimal in primary schools in Oslo and Viken, the two counties with the highest COVID-19 incidence.

[18] update39-covid-and-schools.pdf (who.int)
[19] COVID-19 in children and the role of school settings in transmission - first update (europa.eu)
[20] Do school closures reduce community transmission of COVID-19? A systematic review of observational studies | medRxiv
[21] peds.2020-048090.full.pdf (aappublications.org)

[22] Eurosurveillance | Minimal transmission of SARS-CoV-2 from paediatric COVID-19 cases in primary schools, Norway, August to November 2020

Impact of COVID-19 on staff

24. Public Health Scotland published data on 16 December[23] that showed there were no differences between men and women, or by age group, in the proportion of participants working in education that had coronavirus antibodies detected. The proportion of staff working in secondary school settings that had antibodies detected was slightly lower than staff in early learning and childcare and primary school settings. Among staff groups, a slightly higher proportion of non-teaching staff had antibodies detected than teaching and teaching support staff. There was no difference between teaching and teaching support staff, and early learning and childcare staff. While no direct comparison data are available, the results show that the proportion of education staff who had antibodies detected in this period is similar to the proportion of the general adult population in Scotland estimated to have antibodies. This is based on the data from the ONS Infection survey of a random sample of households.

25. A data linkage study also published by Public Health Scotland on 16 December which was undertaken with the support of the General Teaching Council for Scotland (GTCS) and Scottish Government Education Analytical Services provides a robust way of comparing risk between groups and time periods. Importantly, it takes into account differences in age, sex, ethnicity, deprivation and pre-exiting health conditions, that might otherwise contribute to the differences in risk.

26. The results indicate that that for the whole period, and for the period following the re-opening of schools:

    - teachers were not at an increased risk of hospitalisation with COVID-19 than the general population; and
    - at lower risk of severe COVID-19.

27. Following the re-opening of schools, teacher's risk of testing positive was higher than the general population. More detailed assessment of these data[24], by age and sex, shows that, over the whole period, the relative risk of testing positive was generally lower for female teachers compared to male teachers:

    - Among teachers aged 31-40 years, the risk of being a positive case was higher for men, compared to women.
    - Among female teachers aged 41-50 years and 51-65 years, and male teachers aged 51-65 years, there was no difference in the risk of testing positive compared to the general population.

28. Office of National Statistics data for England and Wales published on the 25 January[25] notes for both sexes, rates of death involving COVID-19 for teaching and educational professionals were statistically significantly lower than the rate of death involving COVID-19 among those of the same age and sex.

29. Of the individual occupations, it was only possible to calculate a reliable rate for secondary education teaching professionals. Rates of death involving COVID-19 in secondary education teaching professionals were not statistically significantly different to those of the same age and sex in the wider population. The data also found that rates of

[23] COVID-19 Antibody Survey of education Staff (CASS) Report 1 (publichealthscotland.scot)
[24] Report of record linkage study of COVID-19 among Teachers, Healthcare workers and other working-age adults (publichealthscotland.scot)
[25] Coronavirus (COVID-19) related deaths by occupation, England and Wales - Office for National Statistics (ons.gov.uk)

death involving COVID-19 in all teaching and educational professionals were not statistically significantly different to the rates seen in professional occupations as a whole. This was the case for both males and females. Of the specific teaching and education professions, the rate of death involving COVID-19 in male secondary education teaching professionals was statistically significantly higher than the rate of death involving COVID-19 in professional occupations in men of the same age.

Wider health/educational implications

30. Children's rights and wellbeing matter now, more than ever. A children's rights approach is being embedded into the Scottish Government's response to COVID-19 and the approach to recovery and renewal. Children and young people's mental health and wellbeing has consistently been identified as at risk of being negatively impacted by school closure, both during closures and/or in the arrangements for return.

31. The UK Chief Medical Officers (CMOs)[26] have been clear that school attendance is very important for children and young people, and is critical to reduce inequality, improve life chances, and enhance physical and mental health. Schools also play an essential role in safeguarding vulnerable children.

32. The impact of the pandemic and the public health control measures on children and young people's physical and mental health continues to be a field of considerable research activity. Studies carried out in the early stages of the pandemic may not reflect the longer term effects as the pandemic continues and restrictions are lifted and, then, re-imposed.

33. The NSPCC published a briefing based on insights from Childline counselling sessions and message boards from the beginning of April to the end of October 2020, to highlight the experiences of children and young people of being away from and returning to school during the pandemic[27]. Children talked about missing the social interaction, support and security that school offered. Learning during lockdown had been a challenge for some children as they had struggled to adapt to new routines. Some children were concerned about falling behind in their school work. Others had found it hard to take part in online lessons as it had brought back distressing memories of online abuse. As restrictions were lifted, some children were looking forward to going back to school, catching up with work and getting back into a routine.

34. In November 2020, Young Scot published the results of a survey of over 6,000 young people from across Scotland asking what young people in Scotland thought about their lives as lockdown restrictions changed. This updated Lockdown Lowdown[28] showed that two in five (38%) of young people disagreed that they felt good about their mental health and wellbeing. Compared with the original survey, which was carried out in April 2020[29], there was a greater proportion of respondents strongly disagreeing with this statement. The April survey also showed that over two-fifths of young people were concerned about school closures. In the latest survey, over two thirds (67%) of those who had returned to in-person learning were happy to be back. A similar proportion (63%) thought that their establishment had re-opened in a safe way.

[26] Statement from the UK Chief Medical Officers on schools and childcare reopening - GOV.UK (www.gov.uk)
[27] The impact of the coronavirus pandemic on child welfare: schools (nspcc.org.uk)
[28] Long-term impacts of COVID-19 on young people in Scotland - Young Scot Corporate
[29] lockdown-lowdown-final-report.pdf (syp.org.uk)

35. The Education Endowment Foundation has published a study on the impact of school closures and subsequent support strategies on attainment and socio-emotional wellbeing[30]. The study, which looks at pupils in Key Stage 1 in England (age 5-7) confirms that children in this age group have fallen behind and that disadvantage gaps have widened. In particular, the disadvantage gap in reading and maths was around seven months progress.

36. Research evidence from Scotland highlights that closure of ELC settings has a range of impacts on children – including: social and emotional development; wellbeing; behaviours; and social interaction with peers. The impact of closure appears to be more severe for less well-off households. Closure has also been assessed as having a disproportionate impact on other social groups – including single adult householders and households where children had long-term health conditions.[31]

37. Likewise, primary and secondary school leaders in England felt that pupils' learning losses had been extensive.[32] In primary schools, younger pupils were said to be more adversely affected. In some cases, pupils had regressed in their skills, for example returning to school unable to hold a pencil when they had been able to do so previously. In both primary and secondary school, more undesirable behaviours were being seen.

38. A paper looking at the impact of COVID-19 on families, children and young people in South Lanarkshire highlights that the pandemic has exacerbated the social and economic vulnerabilities of families, with those living in areas with the highest level of poverty most affected. It emphasises the increased isolation and reduced access to services for those in rural areas, where areas of high poverty may be masked by current measurement approaches.[33]

39. It will be important, therefore, to look urgently at what can be done to support children's learning and development and address inequalities while during this period of remote learning, and the subsequent phased return to in-person learning.

Phased return

40. Any relaxation of measures should be undertaken in a staged/progressive way, enabling time for the education system to plan for each step change and to monitor its impacts, and should be cognisant of the need for stability and sustainability of the approach.

41. Decisions on the nature and timing of each new phase of return to in-person learning will depend on the balance of harms, ongoing assessment of the risks associated with the new variant, and consideration of the benefits and risks to, and needs of, different groups of children and young people to return. However, the cycle of COVID-19 infection and hospitalisation necessitates a period of 3 weeks between each phase of return to in-person learning, in order to assess the impact fully.

42. Decisions made about other restrictions and sectors are also critical. For children to return to school and ELC, there will need to be an ongoing focus on measures to prevent community transmission, and clear messaging about the rationale for school and ELC restrictions being the first to be eased. It should be emphasised that any easing does not suggest a return to wider 'normality' and it will be crucial to maintain other restrictions

[30] Best evidence on impact of school closures on the attainment gap | Education Endowment Foundation | EEF
[31] COVID-19 Early Years Resilience and Impact Survey, Public Health Scotland, 2020
[32] COVID-19 series: briefing on schools, November 2020 (publishing.service.gov.uk)
[33] CNS-COVID-19-SL-research-report-final.pdf (childrensneighbourhoods.scot)

in broader society. Employers should be encouraged to continue to support parents of children to work from home once pupils return.

43. Given the increased risk of transmission of the new variant of the virus, there should also be an increased emphasis on the need for adherence with current restrictions more widely within the community. There is a direct correlation between community transmission rates and reported cases in schools. Encouraging adherence with the wider "stay at home" message will reduce the risk of infection and, therefore, of it being brought into schools and ELC settings.

Mitigations to support a safe return

44. International studies[34] have found that with the effective implementation of infection and control (IPC) measures there is low to no transmission from SARS-CoV-2–infected children in primary schools. The researchers conclude that this finding strengthens national guidelines to adjust measures according to the community transmission levels rather than closing primary schools for on-site teaching.

45. Given the new variant and the high current prevalence of COVID-19, the consensus view of the senior clinicians within Scottish Government relating to physical distancing is as follows:

    - 2m distancing should be put in place at the current time for secondary-aged pupils, in addition to continuing to be in place for staff
    - 2m distancing should also form part of the arrangements for return to secondary schools
    - 2m distancing should continue to be in place between staff in ELC and primary schools, and consideration should be given on how to further support and enable this
    - 2m distancing should continue to not be required for children in ELC, between primary school pupils, and between pupils and staff – in line with the general guidance for this age group

    As part of the process of phased return, every possible step should be taken to ensure the safety and wellbeing of children, young people and staff within school and ELC settings.

46. NERVTAG published advice on Mitigations to Reduce Transmission of the New Variant SARS-CoV-2 Virus in December 2020.[35] The advice concluded that previously identified personal, procedural, engineering and societal mitigations to reduce transmission of SARS-CoV-2 virus all continue to apply to the new variant, a step change in rigour of application is likely to be required given the increased transmission risk associated with the new variant. Primary actions to reduce transmission remain essential. These include: reduced social contacts; effective testing and tracing; robust outbreak identification and control; support to ensure effective isolation and quarantine; and population vaccination. As there remains uncertainty as to the *mechanisms* for increased transmission, enhanced mitigation measures are also likely to be necessary. NERVTAG advises that these might include reinforcing the importance of wearing face coverings, including in settings where they are not currently mandated, and in crowded outdoor spaces. The need for clear communication to the public about the importance of reducing the risk of transmission by adhering to the rules was also emphasised.

[34] Eurosurveillance | Minimal transmission of SARS-CoV-2 from paediatric COVID-19 cases in primary schools, Norway, August to November 2020
[35] Mitigations to reduce transmission of the new variant SARS-CoV-2 virus, 22 December 2020 (publishing.service.gov.uk)

47. Schools and ELC settings should therefore place a high priority on reinforcing the current mitigations designed to reduce the risk for staff and pupils, including two metre distancing in secondary schools and between adults in all settings, the use of face coverings in line with existing guidance for schools and ELC settings, respiratory hygiene, ventilation, improved cleaning regimes within schools and ELC (including regular cleaning of surfaces) and regular handwashing with greatest emphasis on hand hygiene etc.[36] The sub-group agreed that its next meeting should focus on consideration of potential additional and/or enhanced mitigations that may be advised.

48. Parents should also be reminded of the need to comply with the restrictions when dropping off or collecting their children from school or ELC settings, and to ensure they maintain strict two metre distancing from other adults, and wear a face covering at these times (unless exempt from doing so).

49. Everyone should be very alert to the core symptoms of COVID-19 which remain the same, even for the new B.1.1.7 variant: new, continuous cough; high temperature; loss or change to sense of smell; loss or change to sense of taste. People should not go to work or school/ELC if they have even mild symptoms. Contact tracing in school settings remains an important mitigation, in particular for cases suspected to be infected with the virus variants.[37]

50. In addition, given the geographical spread of the new variant, there should be increased emphasis placed on the importance of not travelling between areas, and of quarantining following international travel.

51. Schools and ELC settings are important venues for science education and learning about good hygiene practices, such as handwashing. Children and young people are effective advocates for disease prevention and control in their homes, the school and the community at large.

52. Schools and ELC settings should consider whether additional guidance, practical demonstrations, or communications for staff and pupils to support the correct wearing, storage and disposal of face coverings, including the use of hygiene products when doing so, would support better efficacy of face coverings.

Testing

53. The use of Lateral Flow Device (LFD) home testing by senior phase pupils and staff, is a potential additional measure to help manage associated risks.

54. At-home testing using Lateral Flow Devices will identify asymptomatic individuals in school and childcare environments so that they and their close contacts can self-isolate, minimising the likelihood of passing on the virus. This will help further reduce risks in school and ELC settings, and enhance the confidence of school communities.

55. Any testing should be voluntary. Nobody should be required to undergo testing without consent, or be excluded from school if they do not wish to take a test. Staff and senior phase pupils should be actively encouraged to participate and contribute to the wellbeing of their school communities. Any staff or pupils who choose to decline to participate

[36] Coronavirus (COVID-19): Advisory Sub-Group on Education and Children's Issues - advice on face coverings, physical distancing and related matters - gov.scot (www.gov.scot)
[37] Risk of spread of new SARS-CoV-2 variants of concern in the EU/EEA - first update (europa.eu)

should follow the usual national guidelines on self-isolation. It is critical that everyone gets a test if they show symptoms of COVID-19.

Recommended approach

56. **The sub-group's advice is subject to continued reductions in prevalence and community transmission, no significant changes to the evidence, and reassurance that mitigations are in place and are being adhered to.** Planning for phased re-opening of schools and ELC should continue, with attention paid to ensuring that the conditions for effective infection prevention and control (including the role of testing, contact tracing and isolation) are maximised.

57. The advice that follows reflects the lower risk of transmission associated with young children and the benefits of having smaller numbers of people in school at any time. It is subject to continued reductions in prevalence and community transmission, no significant changes to the evidence, and reassurance that mitigations are in place and are being adhered to.

58. Based on the current balance of evidence, ELC and early primary could reopen in full from 22 February, subject to a continued decrease in the levels of community transmission and in the prevalence of the virus. This reflects the key developmental stage of this age-group, for socialisation as well as learning and development; the evidence that young children are less likely to transmit the virus and to have serious health effects from it; recognition that these children are less likely to successfully engage with remote learning than are older children; and that vulnerable children at this stage are less able to access other resources for their protection and wellbeing than are many older children.

59. In ELC settings, current guidance allows blended placements to continue, supported by appropriate risk assessments. (This could include for example, a child spending mornings in a school nursery and afternoons with a childminder.) However this increases the number of people with whom children have contact. The sub-group considers that such placements should be discouraged until transmission levels can be reduced, although it recognises that this may not be possible in all cases.

60. The most recent modelling also suggests that there would be a low risk of breaching NHS capacity if a very small cohort of senior phase pupils also returned from 22 February on a limited basis for the purpose of practical assessment for the alternative certification model for national qualifications. This limited return of senior pupils recognises the criticality of in-person learning and assessment for these young people. The use of Lateral Flow Device (LFD) home testing by these pupils, and staff, is a potential additional mitigation. Work to make test kits available to schools at the earliest opportunity in parallel with the return of this group would help manage associated risks.

61. The effects of these initial steps should be carefully monitored before any further decisions are made about future phases of return.