Department for Education

Overview of scientific advice and information on coronavirus (COVID-19)

Since 23 March, nurseries, schools and colleges have remained open only to children of critical workers and vulnerable children. We have been clear that we would review this arrangement in line with scientific advice.

The Department's response to the issues raised regarding the science on coronavirus (COVID-19) draws on information from the Scientific Advisory Group for Emergencies (SAGE) and its sub-group the Children's Task and Finish Working Group, as well as the broader advice from engagement with Public Health England. Responses have been grouped by topic. Evidence from SAGE and the Children's Task and Finish Working Group is being published separately and full details are not included in this response.

Spread and vulnerability to disease

1. Infectivity and transmission in children

The exact rates of infectivity and transmission of children is not fully known yet; this is a novel virus and the scientific understanding is developing all the time. However, the current understanding is that:

- There is a high degree of confidence[1] that the **severity of disease** in children is lower than in adults.
- There is a moderate to high degree of confidence that the **susceptibility to clinical disease** of younger children (up to age 11 to 13) is lower than for adults. For older children there is not enough evidence yet to determine whether susceptibility to disease is different to adults.
- The susceptibility to **infection** of younger children (up to age 11 to 13) might be lower than for adults, but the degree of confidence in this is low. For older children there is not enough evidence yet to determine whether susceptibility to infection is different to adults.
- There is no evidence to suggest that children **transmit the virus** any more than adults. Some studies suggest younger children may transmit less, but this evidence is mixed and provides a low degree of confidence at best.

2. Advice from SAGE on education settings

The papers from SAGE meetings are being published in tranches. The first batch was released on 20 March 2020 and further batches will be released every couple of weeks. The list of papers to be released to date is available by following the link below, including a number of schools-related papers. This list will be updated to reflect papers considered at future meetings:

[1] The language used here reflects that in the advice given to us, for the purposes of consistency.

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https://www.gov.uk/government/groups/scientific-advisory-group-for-emergencies-sage-coronavirus-covid-19-response

3. The impact of reopening on transmission within settings and the population

The transmission rate of coronavirus (COVID-19) has decreased and testing capacity has increased in preparation for the rollout of contact tracing. We anticipate that by the week commencing 1 June a greater number of children can return to education and childcare settings, provided that the five key tests set by government justify the changes at the time, including that the rate of infection is decreasing. As a result, we are asking schools and childcare to plan on this basis.

The changes proposed from 11 May are expected to allow R to remain below 1 if adherence rates to social distancing measures do not drop. Any changes in adherence rates or behavioural changes could have a much larger impact on R. This is why it is critical that we continue to monitor and review the scientific advice on transmission rates before we ask education and childcare settings to invite a greater number of children to return on 1 June.

To continue monitoring transmission, staff and pupils in all settings will be eligible for testing if they become symptomatic, as will members of their households. A negative test will enable children to get back to childcare or education, and their parents to get back to work In the event of a child or member of staff testing positive for coronavirus (COVID-19), the relevant group of people within the school with whom the child has mixed closely (their cohort) should be sent home and advised to self-isolate for 14 days. For further information, read Coronavirus (COVID-19): implementing protective measures in education and childcare settings.

Risks to different groups

4. Clinically vulnerable groups

Shielded and clinically vulnerable children and young people

For the vast majority of children and young people, coronavirus is a mild illness. Children and young people (0 to 18 years of age) who have been classed as clinically extremely vulnerable due to pre-existing medical conditions have been advised to shield. We do not expect these children to be attending school or college, and they should continue to be supported at home as much as possible. Clinically vulnerable (but not clinically extremely vulnerable) people are those considered to be at a higher risk of severe illness from coronavirus. A small minority of children will fall into this category, and parents should follow medical advice if their child is in this category.

Shielded and clinically vulnerable adults

Clinically extremely vulnerable individuals are advised not to work outside the home. We are strongly advising people, including education staff, who are clinically extremely vulnerable (those with serious underlying health conditions which put them at very high risk of severe illness from coronavirus and have been advised by their clinician or through a letter) to rigorously follow shielding measures in order to keep themselves safe. Staff in this position are advised not to attend work. For more advice, read COVID-19: guidance on shielding and protecting people defined on medical grounds as extremely vulnerable.

Clinically vulnerable individuals who are at higher risk of severe illness (for example, people with some pre-existing conditions as set out in the staying at home and away from others (social distancing) guidance have been advised to take extra care in observing social distancing and should work from home where possible. Education and childcare settings should endeavour to support this, for example by asking staff to support remote education, carry out lesson planning or other roles which can be done from home. If clinically vulnerable (but not clinically extremely vulnerable) individuals cannot work from home, they should be offered the safest available on-site roles, staying 2 metres away from others wherever possible, although the individual may choose to take on a role that does not allow for this distance if they prefer to do so. If they have to spend time within 2 metres of other people, settings must carefully assess and discuss with them whether this involves an acceptable level of risk.

Living with a shielded or clinically vulnerable person

If a child, young person or a member of staff lives with someone who is clinically vulnerable (but not clinically extremely vulnerable), including those who are pregnant, they can attend their education or childcare setting.

If a child, young person or staff member lives in a household with someone who is extremely clinically vulnerable, as set out in the COVID-19: guidance on shielding and protecting people defined on medical grounds as extremely vulnerable, it is advised they only attend an education or childcare setting if stringent social distancing can be adhered to and, in the case of children, they are able to understand and follow those instructions. This may not be possible for very young children and older children without the capacity to adhere to the instructions on social distancing. If stringent social distancing cannot be adhered to, we do not expect those individuals to attend. They should be supported to learn or work at home.

5. Evidence on other groups vulnerable to COVID-19

ONS published analysis of coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020. This provisional analysis has shown that the risk of death involving coronavirus (COVID-19) among some ethnic groups is significantly higher than that of those of White ethnicity. Further research is needed to understand why some ethnic groups have higher death rates from coronavirus (COVID-19) than others.

The exact reasons for the increased risk associated with coronavirus (COVID-19) in BAME populations are not known, and there are a number of factors that could underlie this. Schools should be especially sensitive to the needs and worries of BAME members of staff, BAME parents and BAME pupils.

ONS data from week ending 1 May also shows that deaths registered from coronavirus (COVID-19) are higher in older age groups. There have been two female deaths in the 1 to 14 years age group but no male deaths, and no deaths in the under 1 year age group.

The highest number (1,494) of COVID-19 deaths were among those aged 90 years and over, but the highest proportion of deaths involving coronavirus (COVID-19) out of all causes was among those aged 80 to 84 years (36.7%). Overall, there have been more deaths for males than females.

Social distancing

6. Social distancing in education settings

Social distancing has not been factored into the models considered by SAGE. Although it is difficult to put some of these measures into place in practice in schools, particularly with younger children, protective measures are possible. Hygiene will continue to be important in schools.

We know that, unlike older children and adults, early years and primary age children cannot be expected to remain 2 metres apart from each other and staff. In deciding to bring more children back to early years and schools, we are taking this into account.

To help prevent the spread of the coronavirus (COVID-19), a range of approaches and actions should be employed. These can be seen as a hierarchy of controls that, when implemented, creates an inherently safer system, where the risk of transmission of infection is substantially reduced. These include:

- minimising contact with individuals who are unwell by ensuring that those who have coronavirus symptoms, or who have someone in their household who does, do not attend childcare settings, schools or colleges
- cleaning hands more often than usual - wash hands thoroughly for 20 seconds with running water and soap and dry them thoroughly or use alcohol hand rub or sanitiser ensuring that all parts of the hands are covered
- ensuring good respiratory hygiene by promoting the 'catch it, bin it, kill it' approach
- cleaning frequently touched surfaces often using standard products, such as detergents and bleach
- minimising contact and mixing by altering, as much as possible, the environment (such as classroom layout) and timetables (such as staggered break times)

See implementing protective measures in education and childcare settings.

Settings are best placed to understand the risks in their individual circumstances, so we are asking every setting to carry out a risk assessment before opening. The assessment should directly address risks associated with coronavirus (COVID-19), so that sensible measures can be put in place to control those risks for children and staff.

Testing, contact tracing and PPE

7. Testing and contact tracing in education and childcare settings

Testing is already available for all school staff and their household members.

When the wider cohort of children are invited to return to their education settings, all those children eligible to attend, and members of their households, will have access to testing if they display symptoms of coronavirus (COVID-19).

To access testing parents should use the 111 online coronavirus service if their child is 5 or over. They should call 111 if the child is under 5.

This will enable them to get back into childcare or education, and their parents or carers to get back to work, if the test proves to be negative.

In the event of a child or member of staff testing positive for coronavirus (COVID-19), the relevant group of people within the school with whom the child has mixed closely (their cohort), should be sent home and advised to self-isolate for 14 days.

As part of the national test and trace programme, if other cases are detected within the cohort or in the wider setting, Public Health England's local health protection teams will conduct a rapid investigation and will advise schools and other settings on the most appropriate action to take.

8. Testing and tracing beyond education and childcare settings

The Government is developing a new test and trace programme and has announced a target of 200,000 tests a day by the end of May. Its goal is for anyone who needs a test to access one. The programme will bring together an app, expanded web and phone-based contact tracing, and swab testing for those with potential coronavirus (COVID-19) symptoms. This programme will play an important role in helping to minimise the spread of coronavirus (COVID-19) in the future. It will also include more traditional methods of contact tracing if a child, parent or other household member tests positive. This could include, for example, direct discussion with parents or carers and schools on recent contacts. The Government is recruiting 18,000 contact tracers to support contact tracing and will recruit more if needed. They will play an important part in tracing the contacts of those with coronavirus (COVID-19), including children.

Anyone who develops symptoms compatible with coronavirus (COVID-19) is advised to self-isolate for 7 days, and their fellow household members should self-isolate for 14 days.

9. Timeframes for testing and contact tracing

We expect the app to be rolled out more widely within weeks. The integrated test and trace programme is highly complex and will need to evolve and improve over time. The test and trace programme is not a solution on its own. It is one part of a package of measures that will be needed in the months ahead to keep new infections at the lowest level possible and avoid a second peak of infection.

10. International comparisons on testing and contact tracing

We are always looking to learn from other countries but our approaches need to take into account our own specific circumstances including our local systems as well as an appreciation of our cultural and societal differences. We have developed a test and trace programme that we think will work best for the UK and for the NHS.

11. PPE in education settings

Wearing a face covering or face mask in schools or other education settings is not recommended. Face coverings may be beneficial for short periods indoors where there is a risk of close social contact with people you do not usually meet and where social distancing and other measures cannot be maintained, for example on public transport or in some shops. This does not apply to schools or other education settings, as protective measures will be in place ensuring children and staff only will with a small consistent group.

The majority of staff in education settings will not require PPE beyond what they would normally need for their work, even if they are not always able to maintain distance of 2 metres from others. PPE is only needed in a very small number of cases:

- Children, young people and students whose care routinely already involves the use of PPE due to their intimate care needs should continue to receive their care in the same way.

- If a child, young person or other learner becomes unwell with symptoms of coronavirus (COVID-19) while in their setting, and needs to be cared for until they can return home, a facemask should be worn if a distance of 2 metres cannot be maintained. If contact with the child or young person is necessary, then gloves, an apron and a facemask should be worn. If a risk assessment determines there is a risk of splashing to the eyes, for example from coughing, spitting, or vomiting, then eye protection should also be worn.

For further guidance on safe working and the use of PPE, read Safe working in education, childcare and children's social care.

International comparisons

12. International approaches

Our approach is in line with other countries across Europe, who have begun to bring pre-school and school-age children back in a phased way and are focusing on primary schools and younger children. Approaches between countries will vary slightly based on different public health circumstances.

13. Approaches taken by Devolved Administrations

Education is a devolved matter and it is for the Devolved Administrations to take their own decisions about when and how to invite more children to return to education settings. The Department is in regular contact with its counterparts with the Devolved Administrations. They will sometimes want to take their own decisions, according to local circumstances, which could include different transmission rates or term dates.