ADVICE FROM THE CMO's COVID-19 ADVISORY GROUP

8th May 2020 Confidential – not to be distributed out-with Scottish Government

COVID-19: Request to review the documents "Education Recovery Group – Phased Reopening and Physical Distancing in Schools and ELC Settings – Infrastructure and Organisation"
and
"EXCELLENCE AND EQUITY DURING THE COVID 19 PANDEMIC: - A strategic framework for the reopening of schools and early learning and childcare provision in Scotland"

1. The COVID-19 CMO's Advisory group has considered the request to review the documents "*Education Recovery Group – Phased Reopening and Physical Distancing in Schools and ELC Settings – Infrastructure and Organisation*" and "*EXCELLENCE AND EQUITY DURING THE COVID 19 PANDEMIC: - A strategic framework for the reopening of schools and early learning and childcare provision in Scotland*" and to comment on the following assumptions:

1. It will not be possible to return all children simultaneously due to needs to retain physical distancing (transmission rates not significantly different between children and adults)
2. We use the 2m (and 15 min) rule to calculate 4sqm per pupil (plus extra for e.g. staff and circulation) of space required and 'cap' class sizes accordingly.
3. The primary suppression policy comes from aforementioned physical distancing as opposed to reducing the size of networks. On that basis, we are willing to absorb the additional risk of having some individuals (e.g. staff, children of key workers) in on a full time basis while other pupils rotate around them"

2. We wish to note explicitly that in the very limited time available we have not had time to review thoroughly the papers provided so **do not provide comment on the detailed content.**

3. We thus **limit our responses to underlying areas of science and evidence** related to the topics addressed by the documents and explicitly to only the areas below.

There was broad consensus on the group on the following points:

4. Evidence suggests the vast majority of children are asymptomatic or have relatively mild disease.

5. We agree with a summarised position of SAGE that: evidence suggests that younger children (up to 11-13) are less susceptible to clinical disease than adults; there is not enough evidence to determine whether this is also the case for older children. Severity of infection still is very low in those under 18

6. We note there are concerns about a rare emerging syndrome in children that may be linked to COVID-19 that appears disproportionately to affect BAME children

7. There is a limited, relatively weak evidence base on transmission in children; It is not clear whether transmissibility by children is lower than in adults, but some variable evidence indicates that this may be the case for younger (up to age 11-13) children

We note:

8. Timing of reopening schools is extremely important to understand its impact on the spread of the virus. Even limited opening in May risks putting pressure on the NHS as it is re-establishing normal services. This is because there is a high level of current cases together with the expected increase in the rate of R. Doing this when the number of infectious people is expected to be significantly lower would have less impact, though would still have an effect on the rate of R.

9. Careful monitoring of the epidemic will be vital. If re-opening schools does lead to an increase in the overall transmission rate then this could be balanced by other interventions to reduce transmission (e.g. contact tracing) and/or by measures that reduce the risk of severe disease (e.g. shielding, however further consideration of this would be required).

In light of this we recommend:

10. any lifting of lockdown restrictions should be as part of an overall framework of action, but in a phased manner

11. it is essential to accompany any changing of restrictions with an appropriate monitoring program; improved data flows in Scotland could readily enable such evaluation

We note:

12. The hybrid model – whereby children who cannot study from home are taught in class with simultaneous live-streaming to those who can study from home – would enable a degree of physical distancing beginning with key years (transition and key exam)

13. This would likely need to be accompanied by:

    - Increased hand-washing facilities/hand sanitisers
    - Regular cleaning of surfaces
    - Protocols for what to do if a child/members of staff has suspected/confirmed COVID-19
    - Possible regular temperature screening of children and PPE for staff and children

We have the following observations in the context of behavioural science:

14. Preparing for return to school
    - Context is crucial: if schools are reopened before workplaces, people will be reluctant to send their children unless they understand why.
    - Messaging needs to emphasise reduction of harm to children as a key criterion
15. Organising the return to school
    - If the return is partial and some time is spent in home-working it is critical to ensure that all children have both the resources (computers and wifi) and the space to study
    - Attention needs to be paid to how children get to and from school as much as what happens at school (e.g. giving lifts, walking in groups, parents congregating at school gates). This must be addressed both through messaging and through environmental redesign
16. Developing the curriculum
    - Children can be used to spread positive norms of hygiene and distancing to parents and this may be particularly important for hard to reach demographics who may be missed by mainstream messaging. Appropriate teaching materials should be developed and integrated into the curriculum.
    - Schools can also serve as a therapeutic space where children can talk about their experiences and their anxieties can be dealt with. This too can be built into a curriculum for the 'new normal'

Statement on physical distancing:

17. We note that the 'Framework' document we are asked to review contains the statement in paragraph 13 that:

"TheChief Medical Officer's advisory group agree with the proposal for 4m2 distancing guidance in schools which will help to ensure that children will not be within 2m proximity for more than 15 mins with each other in class."

18. Given the noted weakness of evidence around the transmission in children we did not reach a unanimous view on this. There was a minority view that, once the timing was appropriate to enable opening of schools in any form, physical distancing in classrooms may not be a necessary measure and that fully re-opening schools should be considered.

19. For accuracy we thus ask that this be rephrased to:

"The majority view of the Chief Medical Officer's advisory group is that actions to support distancing guidance in schools in situations where children are in indoor environments for extended periods of time would be appropriate to consider"

General comments:

20. We recommend consideration of how such measures have been implemented internationally to allow sharing of experiences/insights/evaluations