HOUSE OF COMMONS

Education Committee

Oral evidence: The impact of COVID-19 on education and children's services, HC 254

Tuesday 19 January 2021

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Watch the meeting

Members present: Robert Halfon (Chair); Fleur Anderson; Apsana Begum; Jonathan Gullis; Tom Hunt; Dr Caroline Johnson; Kim Johnson; David Johnston; Ian Mearns; David Simmonds; Christian Wakeford.

Questions 1147 - 1207

Witnesses

I: Dr Jenny Harries, Deputy Chief Medical Officer for England, Department for Health and Social Care; Professor Russell Viner, President, Royal College of Paediatrics and Child Health, and Professor of Adolescent Health, UCL Institute of Child Health; Osama Rahman, Chief Scientific Adviser, Department for Education; and Dr Dougal Hargreaves, Deputy Chief Scientific Adviser, Department for Education.

Written evidence from witnesses:

Examination of witnesses

Witnesses: Professor Russell Viner, Dr Jenny Harries, Osama Rahman and Dr Dougal Hargreaves.

Q1147 **Chair:** Good morning, everybody. Thank you very much for attending our Committee session today. For the benefit of the tape and those watching on the internet, could you introduce yourselves and your title, briefly, please?

Dr Harries: Good morning. My name is Dr Jenny Harries. I am the Deputy Chief Medical Officer at the Department of Health and Social Care.

Dr Hargreaves: Good morning, everyone. My name is Dougal Hargreaves. I am an academic paediatrician at Imperial College London and I am currently on a part-time secondment as Deputy Scientific Adviser at the Department for Education.

Osama Rahman: I am Osama Rahman. I am Chief Analyst and Chief Scientific Adviser at the Department for Education.

Professor Viner: Good morning. I am Russell Viner. I am a professor at the Institute of Child Health at UCL. I am also President of the Royal College of Paediatrics and Child Health.

Q1148 **Chair:** Thank you. When the Government announced the recent closure of schools they said hoped to reopen them after the half term. Is it your view that that is still going to happen?

Dr Harries: I think the ambition should always be that schools should be open wherever that is appropriate epidemiologically, because we know how important education is for children. There is a caveat with that around the current epidemiology and I know the Department for Education work closely with the Department of Health and Social Care to ensure that that information is fed in. The reason I gave a caveat is that I am sure that you and the public in general are very aware that we have very recently seen very high rates of infection in our community and, of course, we are dealing with trying to understand the implications of new variants of coronavirus. With that caveat, it is a timeframe that allows us to continue to monitor the infection rates and to see the direction of travel, but it will need to be observed and reviewed right up until that time.

Osama Rahman: To add to what Jenny said, I think Government in general will be looking at what the balance of risks is and monitoring them. There is a range of risks. Jenny has mentioned epidemiological risks. We also know that there are risks to children of not being in school. There is harm to them from not being in school. Government will continue to always monitor the situation and always look to make a judgment on where the balance of risks is at any point.

Q1149 **Chair:** Is there a prospect that there could be either a regional or a

phased system of opening?

Dr Harries: On the broad epidemiology, it is highly likely that when we come out of this national lockdown we will not have consistent patterns of infection in our communities across the country. As we had prior to the national lockdown, it may be possible that we need to have some differential application. But as Osama said, clearly schools will be at the top of the priority for trying to ensure that the balance of education and wellbeing is right at the forefront of consideration. The short answer is that I think it is likely that we will have some regional separation of interventions and as we are starting to see some glimmers of hope now in London, which was affected earlier by the new variant, that may move across the country.

Osama Rahman: In November the Government put out its plans for a contingency framework, which was prior to the tier approach. It is possible that that is an approach that is taken. I can't predict what Government will do in the future, but we currently have an approach that is aligned to the tier system so it may be that that is the approach that we will take.

Q1150 **Chair:** What you are saying is that the idea that the schools will reopen at half term is probably pretty unlikely, sadly. Is that the case?

Osama Rahman: No, that is not what I am saying. I am saying Government will make a judgment based on the evidence at the time.

Q1151 **Chair:** Can I ask about the transmission rates and bring in Russell Viner as well? Jenny Harries, you said—admittedly it was some months ago—that on the evidence that you have transmission of Covid-19 to children in schools is probably not a common route of transmission. As I understand it, there was a Public Health England survey done with the School of Hygiene and Tropical Medicine and published in late December or early January, which said that the effect on reducing transmission with school closures was relatively low. Has that evidence changed now? Russell Viner, you were one of the authors of a systematic review of whether school closures reduced community transmission. Your study concluded that the effectiveness of school closures remains uncertain and you suggested that school closures may have no effect on transmission. I will start with Russell Viner and then ask the others to comment.

Professor Viner: We remain in a situation of quite a lot of uncertainty about the role of schools in transmission. I think it is important to separate out school-aged children from schools. Without making too fine a point of that, clearly children and young people spend a lot of their time in schools but it is by no means all of their time. I have been looking at the literature on children and transmission right from the beginning and we have learned a huge amount over that time. Every time we thought we had some certainty, that has been slightly unsettled by getting more information about this virus.

We remain uncertain about the role of schools. The role of schoolchildren is clearer and we recognise that children of primary school and younger age groups, as we had thought before, play a relatively minor role in the transmission of this pandemic. They do play a role and it is foolish to think they do not. They absolutely play a role. Children do transmit this virus and they can bring it back from school to their households, but the role of primary schoolchildren and early years appears to be lesser. What we saw particularly from October, November onwards was high rates of viral prevalence of the frequency of the virus particularly among teenagers. What we see for transmission is a complex interaction of the biology, which is how likely a child or young person is to transmit, with social mixing and then with the environmental controls.

Without trying to be too detailed, we think that children under 12 are probably less susceptible to catching the virus and that can dampen the ability to pass it on. Children and young people are less likely to be symptomatic, they are less likely to have the cough and the fevers, and we think that will also help reduce transmission to some extent. But children, and particularly teenagers, socialise or socially mix a lot more than most adults, so you have a balance between the biology and the social mixing. We think that high level of social mixing, much of which occurs outside of schools, is responsible for teenagers being more involved in transmission than we have previously thought.

Going back to where I started, we don't yet have a clear answer to how much of this transmission is within schools or it is fairly uncontrolled mixing outside of schools, and that is clearly important. There is quite a lot of evidence around it. We know that schools are quite contained places. Of course they are places where a lot of teenagers and young people are brought together, but they are also places where their behaviour is contained and is containable. There is quite a lot of evidence that with good mitigations in place transmission can be reduced. I can talk at greater length on this if you wish but I hope that answers your question to some extent. We still remain unclear.

You mentioned the systematic review. That review identified 10 large papers on the impact of closing schools on community transmission. There were eight papers that suggested that there was a protected effect, that closing schools reduced transmission, but there were two papers that found no impact and they were the highest quality two papers. We concluded from that that we could not easily give an overall estimate and say definitely school closures work or that they don't work. I think the answer is that school closures as a straight-up, on/off thing is a bit of a simplistic way to think about it. We need to think about the ages of the children involved, how much of schools are closed, because we know at the moment our schools are dismissed or closed but there is about 14% of children and young people in schools, or that is the data I had from colleagues last week. What happens around schools is really important.

There is lots of evidence from previous influenza epidemics that if you close schools but then let children and young people mix freely in society, you can really reduce the impact of school closures. My take, for what it is worth, on that systematic review is that in one sense it is a no-brainer that if we close schools and stop children and young people mixing outside of schools you will reduce social contact and you will have an impact on community transmission. The point to the systematic review was that we can't just assume that anything we do will have an impact. We have to do it carefully.

Q1152 **Chair:** Thank you. Jenny, could you reply to that briefly and also to my mention of the survey that I think was late December or early January from Public Health England, suggesting that what you had found was that the school closures had a relatively negative effect, they didn't make that much difference on the effects of transmission?

Dr Harries: Russell has given a fairly comprehensive review of why there remains some uncertainty in the data. If we go right back to when SAGE first looked at or surmised what the impact of school closures might be, the modelling right at the start—going back to March last year—estimated that it would be less than 5% of the impact of the different social non-pharmaceutical interventions that could be applied. The work that Russell described has gone forward to try to understand whether that modelling estimate was correct or not. For all of the reasons he described, it still remains very difficult to put a figure on each of the different components, for example by age, type of establishment or size.

We are still learning and the caveat I would like to raise is that we have a new variant now. Some of the risks towards the end of the year and the rapid movement in decision-making linked very much to trying to understand a new variant that we know has different transmissibility, Therefore, all of those models and our understanding need to be adapted and reconsidered.

Q1153 **Chair:** Do you have evidence that the new variant is a different means to increase transmission in schools, given you have said in the past that they didn't?

Dr Harries: I want to go back to what Russell said, which is that if you look at the evidence that we have to date it is extremely difficult to draw out transmission that happens in school and transmission that happens in schoolchildren when schools are open. The latter point is very much because they are part of our community, so when children are in school parents tend to be in work. When you look at the evidence data that is accumulated, including from across the different devolved Administrations that have slightly different timings in school closures, you can see movements in transmission in children, in infection rates, but it is very difficult to interpret. I think what we should say overall is that schoolchildren definitely can transmit infection in schools. They can transmit it in any environment but it is not a significant driver as yet, as far as we can see, of largescale community infections. Rather it is the

other way round, that if there is a rise in community rates you will see a rise in children as well.

Q1154 **Chair:** when there were very high infections in Liverpool last year, the schools were open and yet you drove the transmission rates, the R rate, down eventually with all the testing programmes.

Dr Harries: You have raised another point, which is what else is happening at the same time. Testing is one of the ways of managing community transmission.

Q1155 **Chair:** The reason why I ask these questions is that you have said, and you have just said this again, that there is no special evidence about transmission of the new strain and that schools are not a driver of transmission rates, if I am correct in repeating what you said.

Dr Harries: This is quite early days for the new variant and I am sure there will be others. On our current evidence, it is more transmissible.

Q1156 **Chair:** But schools are not drivers; is that what you are saying?

Dr Harries: At the moment, there is no significant evidence. It is very much a closed community.

Q1157 **Chair:** Dougal, please put your hand up if you need to grab my attention if you want to answer. I know that Osama wants to come in. Given what has been said—and I know that Professor Russell Viner has been particularly active on this and has all the time talked about schools opening as much as possible—have you assessed the overall damage of school closures on children's mental health, academic attainment, wellbeing and safeguarding hazards? This applies to the DfE itself. When you weigh up these risks, given that you said that schools are not a driver of transmission, do you in your role, Jenny, weigh up those considerations as well?

Dr Harries: It is not me solely who does this. It is very much questions for SAGE, but I have been a director of public health previously so I am acutely aware of this whole broad area of education and the negative impact that school closures can have. That is why they have been only very much down the line where you can't control community transmission in other ways. There is work being done currently and it is considered broadly through SAGE discussions. There are behavioural considerations for SAGE as well as the pure epidemiological modelling. It is quite difficult to quantify that but clearly there is other evidence. The DELVE study and the Institute for Fiscal Studies have produced reports and SAGE will take acknowledgement of those as well.

Q1158 **Chair:** This is a question for the DfE, Osama and Dougal. We know that eating disorders, just to take one, among young people, according to the Royal College of Paediatrics and Child Health, has gone up by, I think, 400% over the past months partly because of social isolation and school closures. When you are making decisions about school closures, what risk

assessment do you do in the Department for Education as to whether or not the closure to deal with the virus makes the risk even worse for children and young people in mental health, education attainment and so on?

Dr Hargreaves: I will start off and respond about the science team in the Department for Education and maybe Osama can respond on some of the policy points.

I really appreciate you making those comments. I have been working as a paediatrician throughout the pandemic and I have had a lot of those very difficult conversations with my patients about mental health in general, access to physical health, falling behind in education, and specifically with a number of my patients about changes in eating patterns. It is absolutely on the agenda at the Department for Education and on the broader agenda. To be honest, our team is small and a lot of our focus has been on the transmission questions that you were asking about. We have heavily relied on working in partnership with outside bodies—RCPCH is a very important partner and there is a number of other important partners—understanding what is going on with children and young people's mental health and how we can best tackle that. There is some specific work looking at educational disadvantage and the extent to which children and young people are falling behind.

There is some specific work in DfE looking at mental health of children and young people. We are often a bit slower than some of the charities to get some of those findings out and that is something we can work on, but we are finding things that are broadly in line with some of the external partner organisations. To reassure you, it is very much on the agenda that over the next six months we are looking up to build up a more comprehensive database.

Q1159 **Chair:** But shouldn't this be done when the decision is made to close the schools? I will move on to Osama.

Osama Rahman: There is a range of survey evidence out there that points to a worsening mental health situation for children and young people. That is provided to my colleagues and also to Ministers. The information that is there is provided and the Department published jointly with SPI-B, which is one of the SAGE subgroups, a paper on the benefits of school and the losses from school on mental health and wellbeing. What we don't have is a single quantitative assessment of the total mental health impact. We have a range of survey evidence, which we provide to Ministers and my policy colleagues. That is taken into account when judging the balance of risks in making decisions, so Ministers definitely take that into account when making those decisions.

Q1160 **Chair:** Professor Viner, as I mentioned at the start, you have been incredibly actively in this and I have nothing but admiration for what the Royal College of Paediatrics and Child Health has done and has been saying over many months. Should there be much more assessment of

mental health and the other impacts on young people from school closures? Could you set out the situation as you see it?

Professor Viner: There are about 15 million children and young people under 20 in our population. They make up about 23.5% of our population. When we close schools we close their lives, not to benefit them but to benefit the rest of society. They reap harm when we close schools. There has been a lot of activity to try to quantify those harms, to be clear about what they all are. Much of the data we have comes from the first pandemic wave and, perhaps understandably, during that first pandemic wave from March to May it was very difficult to get data because most of our systems for gathering data were closed down. There has been some data collected over the summer and later.

I am aware of about 75 reasonable quality international publications on the harms to children and young people from the first wave of the pandemic. We have around 25 academic publications from the UK and there is 50 from elsewhere and they tell a very consistent story. It is a story of considerable mental health harms. Our data are not perfect. Probably the best study is the national children's mental health study that was done by NHS Digital and NHS England where in July they resurveyed a number of thousands of children and young people who had been surveyed in 2017. They found that the rate of serious mental health problems or very likely mental health problems had increased from one in nine in 2017 to one in six in July. Remember July was when we were opening up and things were looking better again. We can't specifically say that change was due to the pandemic because it could have been anything from 2017 to 2020. However, it is very suggestive. They are collecting new data from the same group. There is a range of other studies showing considerable mental health harms.

Not every study has shown that. A couple of studies have shown a reduction in anxiety in some children out of school and we have to recognise that for some children, hopefully a small group, schools can be a place of stress. But overall and I think some of the reports we are seeing from the UK and elsewhere are suggesting up to 30% to 40% of children having really significant problems when, of course, at a background level it is much lower than that at the 5% to 10% level. There is also quite a lot of evidence on child protection. There are two good studies from the UK and a study from the US suggesting that child protection referrals, or referrals for child abuse, fell by about 30% to 40% during the first pandemic wave. The assumption is that much of that is due to school closures because we believe that schools are responsible for about 40% of child protection referrals.

We also have a lot of evidence of reduced access to healthcare. Presentations to emergency departments and admissions to children's wards and to child and adolescent mental health units and presentations for mental health problems were right down. We had an increase in problems and a reduced access to care and a reduced surveillance

system—I don't want to talk about state surveillance but the protective safety net we put around our children was removed in that first pandemic wave. There are also concerns across sleep. There is evidence of reductions in physical activity. There is some evidence around diet—we don't have good evidence on that—and reduced wellbeing.

There is a range of harms that are quite consistent. It is not just the UK. This is very much international. If we close schools and when we close schools again, we must make sure we mitigate those risks.

Q1161 **Dr Caroline Johnson:** I should make a declaration of interest that I work as a consultant paediatrician and I am continuing to practise and I am also a member of the Royal College of Paediatrics and Child Health, from which we have witnesses today. Professor Viner, you talked about the increase in mental health but you also suggested that mental health admissions to hospitals was falling when last measured. Do you have any more recent figures? On a recent shift that I did at the hospital there were more acutely unwell children admitted for mental health presentations than there were acutely medically unwell children on the ward. Is that an unusual pattern or is that a pattern you are seeing in other parts of the country too?

Professor Viner: Yes, that is absolutely a pattern that our paediatricians around the country have told us about since the beginning of this pandemic. Social distancing has reduced other viruses and the transmission of other infections that often bring children into hospital. We have seen across all of our children's wards a bit of a shift towards more mental health problems being the reason that children come into children's wards, which is not necessarily, as you know, the best place for them.

Q1162 **Dr Caroline Johnson:** No, and on that note, what number of children are you seeing that are having to be nursed longer term on children's wards as a result of lack of availability of mental health beds?

Professor Viner: This has been a long-term problem and I don't have good data on whether that has been exacerbated by the pandemic, but it is a problem that we have seen across our children's wards. I recall that in 2016-17 the situation was that some of the major issues for long-staying patients in children's wards were those who could not get access to mental health beds. I know that NHS England has invested a huge amount of money or the Government have invested in the NHS and NHS England has invested a large amount of money since that time but clearly there is more work to do.

Q1163 **Dr Caroline Johnson:** Are you seeing any particular patterns of mental health conditions in children caused by the pandemic? Talking to local psychiatrists, they are seeing more children with eating disorders. I know the Royal College has produced a specific report about eating disorders in children and a greater number of problems in children who have autistic spectrum disorders for whom routine is quite important too. Is that

something that you are seeing or is that a more local problem?

Professor Viner: On the science, we don't have good data on that but anecdotally, absolutely. Our paediatricians and child and adolescent psychiatrists are saying that there is more pressure on eating disorder services, pressure on paediatricians who see children. Eating disorders can come from stress and distress across a range of areas, people feeling out of control, and I think that is perhaps, rather simplistically, part of the stress on our children during this pandemic. Those with learning difficulties or with autism have been affected in a range of different ways by the pandemic and school closures. For some children being at home can be less stressful but this brings its own set of risks for those who find change very difficult.

Q1164 **Dr Caroline Johnson:** What do you think can be done to help parents with children at home or to help schools to identity and mitigate the risks of this? What can we do? We are in the situation we are in. We have got the pandemic and we are doing our best to sort that out, but in the meantime while schools are closed for some children, what can be done to reduce the number of cases, the number of children who get to this level of mental health distress? What signs can parents watch out for; what potential mitigating steps can they take; what can schools do; and, specifically, what can or should Government be trying to do to reduce the burden of mental health problems?

Professor Viner: The easy answer, the first answer is to get children back into school as quickly as possible. The most important thing—and I say to the whole Committee—we can do for our children and young people's mental health is to get schools open again and get face-to-face learning and peer interaction happening. That is the most important thing we can do. Allied to that, we must think when we look at reopening schools of balancing the epidemiological risk with the benefits for children. I want to say again: we close schools to benefit the rest of the population; we must look at reopening to look at that balance across society.

On what can be done now, I think the messages to parents are that the NHS is open, the CAMHS services are open. A lot of money has been invested by mental health services in improving online and various bits of access, so those are there. We could argue that those children who are involved with CAMHS could be treated as vulnerable children in different ways. I am not necessarily suggesting that they all be given access to school as vulnerable children because the numbers in school could be complex, but there may be things that schools are able to do to support them in different ways now. We could accelerate the plans that the Government and NHS England have to improve the mental health provision in school. Those things are ramping up across the country but I think we could drive them much more quickly.

Q1165 **Tom Hunt:** I am not surprised but very concerned about that increase from one in nine to one in six over the last three years and I imagine that

a lot of it is due to the pandemic. With remote education there is a difference between live online lessons and prerecorded online lessons. I think most schools have a good mixture of the two but there are concerns that some schools don't have many live online lessons at all. Is there a point here, linked to the question about mental health, that for many young people experiencing loneliness during these periods, that having some live online lessons can be helpful in having at least some engagement, although virtual, with fellow pupils, teachers and so on? I am pleased that you have picked up on the slightly nuanced areas for those with special educational needs because I have spoken to some who have not minded being at home but others who really have. I was speaking to a head teacher yesterday about purely dyslexic students and fortunately for her they all have live online lessons because she was making the case that live online lessons are particularly important for them.

I think it will take a long time for young people's mental health to recover after this, even once we overcome the public health challenge in the short term. Do you think the Government should be quite hands on in making a stipulation that every school has a mental health practitioner trained, like many schools in my constituency already have such as Copleston High School?

Professor Viner: Were those questions for me? I assume they were but—

Tom Hunt: Yes, it is for you. In essence, should there be a mental health professional in every school, especially now, so that parents and kids can access them, as well the answer on remote learning.

Professor Viner: As I understand, the Government and NHS England have committed to doing that through the programme of rolling out mental health educational practitioners. I absolutely agree, we should accelerate that. They are not the only thing we should be doing. We should be looking carefully at the way schools are run and the way we build schools to make sure they promote mental health as well as give the most excellent education. There is quite a lot of evidence that the school culture and the way that children and young people are involved with school can help determine whether a school promotes mental health otherwise. On your other point, we are facing a longer-term issue on this and the College is calling for there to be a clear strategy and a major focus across Government on the health and wellbeing of this next generation, who in a sense paid so much during this pandemic.

Osama Rahman: I want to mention one thing about online learning. Local authorities and education providers have been allowed to deem certain students as vulnerable who otherwise wouldn't be. They can use this to deem some children as vulnerable if bringing them into school will help manage their mental health or access support more easily.

Dr Hargreaves: I completely agree with doing more and I agree with all that Russell said, but I think we need to recognise the incredible efforts that are going on in schools currently to support children and young people. Whenever I have a patient with mental health problems, the first thing we tend to do is get in touch with the school and it is incredible. Sometimes they have been able to support by having flexibility in classing that child or young person as a vulnerable person and attending. They have found ways of staying in touch with the family and supporting them in other ways. I think we need to recognise that and thank them for it.

Q1166 **David Simmonds:** I think the questions about advice that we had scheduled have been asked to some extent. I want to ask the panel about the evidence. There has been a lot of debate in the public domain about evidence-based decisions, following the science, what the evidence shows. While it feels to me that you are broadly giving the right advice and the right decisions are being taken, there seems to be a lack of transparency around the data and the evidence that is being used to inform this advice. I want to ask you about the primary source evidence. We have come across examples of a number of quite small studies. How good is the primary evidence data or other information about what is happening in schools and what is driving it, or are we in a situation where in reality that evidence is quite sketchy and, therefore, the evidence has to be based on professional experience rather than clear and definitive science?

The second part of the question is I get asked a lot, as I am sure we all do, by teachers what the numbers are for transmission in schools and what the numbers are for transmissibility between staff versus between students and staff across the different age groups. The evidence in the public domain about that seems to be extremely sketchy. Is there good evidence that answers those questions that could be published or do we need to be very clear with people that the evidence and advice you are giving is on the basis of professional experience but not on the basis of definitive data?

Dr Harries: I think the answer is it is a mixed picture. The advice that is being given is based on the best available evidence and the evidence is accruing. It will change with the new variant, as I have highlighted, because we will have to keep reassessing. At the start of the pandemic we did not have good strong evidence at all but now we have growth in the routine surveys, for example the ONS survey, community surveyance, some specific educational surveys, the schools survey that PHE does. They all accumulate data and they are all considered in updated SAGE advice.

The bit that is more difficult is the point that Russell and I mentioned earlier, which is that every child goes to school and they are also part of their community. Trying to get absolute clarity of an individual case in a school causing an outbreak, potentially, as opposed to a child arriving in school, at the same time that they have recently, for example, had a

weekend outing, with a school friend and they both have cases that were community acquired is much more difficult. To do that definitively you would have to do genomic studies and trace the particular virus through its roots through the outbreak. Each local health protection team will follow potential school outbreaks and will have a good idea and those are monitored routinely by Public Health England and are reported in and included in the information, but in many of them it will not be possible to say definitively where transmission occurred, and that would be the same in workplaces of all sorts.

Information is good; all the scientific evidence is accrued; it gets stronger as the pandemic goes on because we have increased numbers of tests. We are finding now that there is more information because of the use of testing in schools, focused in schools, allows for more information on asymptomatic transmission, which is one of the things that was unknown at the start of the pandemic. I think that is an important and growing area of knowledge.

Q1167 **David Simmonds:** When the likes of the NEU are telling head teachers that schools need to close because teachers are at a particularly marked risk of Covid, can we be confident that they are wrong in rebutting that? Especially in respect of these studies, is there in prospect some wider publication of that data to address the understandable anxieties that some people feel?

Dr Harries: On the first point about potential risk to teachers, we look at a number of sources. If we are doing lateral flow testing in schools, any particular individual outbreak or information will be assessed by PHE in the way it would be for any outbreak. But I think the really important one for unions is the ONS data and there is a very clear review—and that is done fairly routinely—that at the moment there is no evident increased risk to the teaching profession or educational staff in schools. I think that is a really important one and it fits with the information that Russell has described earlier about transmission in and around schools.

Q1168 **Fleur Anderson:** My question very much follows on from this to talk about early years specifically. To declare an interest, I am one of the volunteers for the ONS study as well as having a child next door and two university students at home.

You said earlier that there is a separation between schoolchildren and the transmission between children and then the public health community transmission and that is why primary schools were closed. Could you answer the questions from early years teachers about if a state maintained nursery is having to stay open but the nursery in a school next door is having to close, what is the difference in the science about the risk? Dr Harries, you were talking about lateral flow tests being done with teachers, but my early years teachers are telling me that they can't get hold of those lateral flow tests and they are not being able to do them. Is there enough evidence about the risk for early years teachers, not the transmission between young children, which I acknowledge is

very low? Why are early years settings being told to stay open when the early years of primary schools are being told to close?

Dr Harries: I will start that one and perhaps bring in Department for Education colleagues on the actual policy decisions for opening and closing. I think the science here—and Russell may wish to comment, as he has highlighted earlier—is the transmissibility and the risk seems to stem down. If we think of secondary schoolchildren more as young adults and similar transmission routes there, but as you come down to very small children the social connections and the infection risks appear to be much lower. I think that is the distinction between early years.

If we pick out the elements of the balance of risk and harm, one of the things that, of course is absolutely critical for early years is that you can't do online learning with very small children in the same way that you perhaps can with secondary schoolchildren. The balance in favour of maintaining establishments open is very much towards keeping face-to-face learning whereas some of that difficulty in the harm that potentially happens in education terms can be managed for older children.

I can't answer the question, I am afraid, about the actual distribution of lateral flow tests but I think Dougal may be able to pick up that one. This is an area that is changing quickly. My understanding is that the plan is that the early years workforce and the primary school workforce will all be included in the twice-weekly testing programme. But that is my understanding. It is a rapidly changing picture.

Q1169 **Fleur Anderson:** Is that a change from last week, when the Secretary of State told us that the schools workforce was in one stream and the early years workforce was in the community testing cohort and so being treated differently?

Dr Hargreaves: Correct. Published on the DfE website yesterday was a new plan for testing in the primary care and early years workforces. There may be more details to work out on the operational aspects of that but that is certainly the current policy.

Q1170 **Fleur Anderson:** That is welcome. Is it like that you would open foundation years, reception and year one earlier because of nurseries or that you are reviewing the science of nurseries being open and may close them, especially with the new strain and the increase of transmission in the community?

Dr Harries: On that broader point about transmission, the key message is that everybody wants certain planning and dates for opening and closing. Unfortunately, that is not how the virus works. It is highly likely that all countries are going to see changes, mutations and new variants of this virus over coming months and potentially years.

That does not mean that schools are going to have to stay in the position that they are now—far from it for reasons like the importance of wanting to keep them open—but it does mean that it is difficult to say with

certainty at any one point. We have to keep monitoring and responding to the epidemiology and also those risks the Chair has been highlighting and getting the balance right.

One of the differences perhaps—and this is for the Department for Education—from my own perspective is that I am aware there are operational issues for teachers and schools. Where you have early years provision attached to a school, it may be different. There is an organisational issue about how to open institutions safely and the lead times to do that.

Q1171 **Chair:** If you say you cannot give dates, why on earth say that the schools most probably will open at half terms when we know, especially from what you said today, that it is looking unlikely?

Dr Harries: It is a Department for Education policy date, but it seems a perfectly reasonable assumption. If you are looking at the epidemiology, you are watching a wave of virus come across the country. We can see it is hopefully starting to level off now in the original areas where the new variant arose. We have a national lockdown and we can see that those numbers are starting to be contained. You can get a sense of the timeframe in which those waves might come down and we could potentially open schools.

I cannot guarantee that there would not be, in the interval between now and February, another variant or we may find some other epidemiological change. These are sensible time estimates but they need to be understood as not fixed dates. That applies to anything in any Department in relation to the pandemic.

Q1172 **Fleur Anderson:** This question is about new strains. It is important to know this and to get the facts right about the sequencing and the timing of your knowledge about the new strain in December and also to know how that decision-making will work for, as you said, Dr Harries, potential new strains in the future. When did you know about the new strain and have evidence about its increase in transmission? When the Secretary of State issued the court injunction for the Greenwich schools to stay open in the last week of December, did you know about the new strain then and did the Secretary of State have information from you and evidence about the new strain?

Osama Rahman: The letter to Greenwich was written at about 1.50 pm, although it was sent a bit later. It was a bit later in the day when the Secretary of State for Health stood up and mentioned this new variant of concern. At the SAGE on 17 December, which I was at, it was discussed that this new variant may—and at the time it was just may—be more transmissive. On 21 December, the Government's Chief Scientific Adviser called together quite quickly in the afternoon a meeting with fellow departmental chief scientific advisers. Later that day, we were sent the first technical report from Public Health England, which gave the actual detail and confirmed that this new variant was about 50% more

transmissive across all age groups. That is the sequencing of our knowledge.

Q1173 **Fleur Anderson:** On reflection, does there need to be faster decision-making on new strains coming up and schools opening or closing and the impact that will have on them?

Dr Harries: To set the background context to this, we have variants of interest and variants of concern. We hear about an individual variant—and you will hear it called the "UK variant" or the "Kent variant"—but there are hundreds of variants arising all the time across the world. Clearly, we cannot have an individual meeting for every variant that our clever virologists discover and so there is this sequenced timeframe of monitoring a change in the genetic makeup of the virus and then linking that with information from the UK or overseas as to what impact that might have and its characteristics of transmission and disease severity in the community. That is an ongoing situation and will continue that way.

It moves from a variant of interest to a variant of a concern if we start to get individual sequences that might cause concern in transmissibility or there could be a suggestion, for example, that vaccines could potentially become less effective. It is very difficult to put an individual pinpoint timeframe at this point.

Q1174 **Ian Mearns:** Following up on Fleur's point, the Secretary of State before Christmas issued court injunctions against Greenwich and Islington. Is there something that can be done about the timeliness of advice from the likes of SAGE to Cabinet members about decisions they might be taking to tip them off about that?

Professor Viner, to go back to your earlier point about mental health, is CAMHS ready for this challenge? Prior to going into the pandemic, the quality and levels of frontline children's mental health provision were hardly uniformly high across the country. Therefore, we have identified that there are additional problems coming from this for young people and children. Are they ready for the challenge? What needs to be done to beef up these services to get them ready to meet this challenge? Otherwise, we are going to have what we have had for an awfully long time and that is significant levels of unmet need.

Osama Rahman: On the point about moving rapidly from SAGE discussions to advice to Ministers, both the SAGE secretariat and my science team will normally within 48 hours of a SAGE meeting have summarised the key papers that are relevant for Education and circulated them internally both to our policy colleagues and also to Ministers and their offices. It is not instantaneous but it is pretty rapid.

Professor Viner: I cannot necessarily speak on behalf of NHS England and CAMHS directly. We know that as a country we had underinvested in child and adolescent mental health services for the last 10 to 20 years. That was starting to be recognised in about 2015-16. There has been

increased investment. There has been a rapid upward trajectory, but I think everybody would agree with what the honourable member said, that things are not where we want them to be. We need an accelerated improvement package, undoubtedly.

This is not just about clinical services. We need a society and a school system that support children and young people's mental health in a different way. That is where we need a broader conversation across the Government to work out how we put that in place after the pandemic.

Q1175 **Ian Mearns:** Are you talking about a comprehensive rollout of a mental health first aid package for the population and young people in particular?

Professor Viner: I am talking about stopping the problems happening to start with. The clinical services are at the sharp end when people have significant problems. Schools need to deal with the first aid issues, the cuts and bruises of mental health, but we need to have a system that stops children and young people getting into this place.

Q1176 **Ian Mearns:** You talked about a clear strategy needed by the Government. Will your organisation, the Royal College, be making recommendations to the Government about what will be needed from your perspective?

Professor Viner: The Royal College was part of a group of organisations that wrote a letter recently calling for a broader commission—call it what you will—to focus on promoting the health of our next generation.

Q1177 **Ian Mearns:** Dr Harries, the SAGE minutes of 22 December noted that keeping schools open would be "highly unlikely" to maintain R below 1 at that point. Was it inevitable that a decision would be made to close schools immediately after that meeting?

Dr Harries: There is a balance of risk and harm in keeping schools open and closed. It is with great reluctance that they are closed. It is only when the epidemiology shows that growth rates are rising so rapidly that we have to try to pull in the school element. Of course, there is a difference between whether it is all schools or whether it is sequentially those we think are contributing the most to community transmission. We see a change in secondary schools and then primary schools with reluctance because of the importance of this and potentially even early years. These are simply stepped control mechanisms to do that.

Over the Christmas period, we looked at five key areas of epidemiology, including case detection rates in all our age groups and in the over-60s and the rate at which cases are rising and falling and positivity rates. A key point that occurred over Christmas and in the run-up to the New Year particularly and on 4 January when we moved alert level was the strain on the NHS. Although schools are impacted, of course this is a community control mechanism. The rate of growth, particularly in London and the south-east, was significant. It was unprecedented for this country.

Q1178 **Ian Mearns:** We know that the new variant was out there and of course we know to our cost in the north-east of England that probably the spread of the new variant was not helped by the escape from London in the immediate run-up to Christmas. People were packing trains to get out of London.

My DPH last week was suggesting that she believed that 55% of the new cases here in the north-east were of that new variant. It has now become the dominant variant here in the north-east as well. That is quite concerning. I am glad to say that numbers are now levelling off, but they are levelling off at a high level compared to where we were in early December before Christmas. What significantly changed over 1, 2 and 3 January for the major change in policy to be announced on Monday, 4 January?

Dr Harries: Monday, 4 January was the day that the four UK CMOs recommended that the alert level should move from 4 to 5. That has never happened. In the first wave of the pandemic, that never occurred. It signalled the significant risk to life of the potential overwhelming of health services. Basically, that was a signal that said we have an exponential growth rate but, interestingly, that was not the case in the north-east at the time. The north-east has been relatively spared. I am sure it does not feel like that locally but if you look across the transmission rates you can see that the proportion of this new variant in cases in all areas was starting to rise significantly. It was a different epidemiological pattern than we had before.

Q1179 **Ian Mearns:** Yes, I accept that we are not at the levels that London has been at, but before the new variant we were talking about levels of 450 per 100,000 population being acceptable. You would have been blanching at that, I would have thought.

Dr Harries: Yes, you are right that the rates changed. We were down to 10 per 100,000 in some areas in the summer. Then we saw some rises and some stubbornness in community transmission rates and you are right that the north-west, the north-east and some parts of the East Midlands had some problems. Then we saw a completely changing pattern, which we can see in the data now, with rapid growth in the new variant.

One of the problems with this issue of awareness is that we have to be able to detect the new variants. We have good testing capacity now, which allows us to use a proxy testing mechanism. Other countries potentially have similar variants but perhaps do not have the capacity to detect them in quite the same way.

Q1180 **Ian Mearns:** Professor Viner, you have talked about an awful lot of uncertainty about what is happening in schools or among the schools population because it is different things. I wonder if we need to do some in-depth work on young people in schools. Young people are still attending schools. You mentioned 14% being the current attendance

rate. That was a snapshot on Monday, 11 January. But here in my own locality, demand for places is much higher than that and schools are regularly opening with 20% to 30% attendance by vulnerable children and key workers' children. The advice has come from DfE about keyworkers and vulnerable children and the demand is much higher than in many schools.

Do we need to do some intensive work with the children's population to get some definitive advice out there about what should be done after half term or after Easter if this virus is still persisting in its mutated forms?

Professor Viner: In one sense, you are absolutely right that we need better studies that are connected across schools in the community, using genomics or genetic analysis, as Dr Harries has said, to pin this down. That cannot be done by half term, but I am aware that the DfE and others are looking at how things are operating at the moment. I am not the best person to answer that.

Q1181 **Kim Johnson:** Good morning, panel. How would you approach the decision-making around prioritisation of phase 2 vaccines and should school staff be prioritised as a group as a whole? How would you identify which staff are most at risk, taking into account occupational risk of exposure as well as characteristics including age, ethnicity and sex, which will have been flagged as risk factors?

Osama Rahman: Decisions on vaccine prioritisation are made by the Joint Committee for Vaccination and Immunisation based on the most relevant risk factors. That is an independent decision completely separate from the Government. However, in saying that, the Secretary of State has made it clear that in phase 2 he would like to see education staff prioritised for vaccinations.

Q1182 **Chair:** If schools could be opened sooner rather than later if teachers and support staff were vaccinated, given what has just been said in the session by you and Professor Viner particularly, would that be a number one case for getting teachers and support staff vaccinated as a priority?

Osama Rahman: It would certainly be a case that the DfE would put forward, but the ultimate decision as to where that ranks with other cases is with the JCVI.

Q1183 **Kim Johnson:** Osama, what conversations has the DfE had with the Department of Health regarding these issues?

Osama Rahman: Dr Harries and I and others meet quite regularly. I am not sure about what other discussions have been had. Also, these issues are discussed at SAGE.

Dr Harries: The decisions on vaccination are an entirely independent consideration.

Q1184 **Chair:** That is a separate question. We get that. We understand the bureaucracy and the decision-making. Is it the case that if you vaccinate

school and support staff as a priority, the schools will open sooner? Does that surely make the case much more for them being made a priority?

Dr Harries: The rationale for why the JCVI had prioritised certain groups was based on the risk of mortality and the protection of health and care staff. It is very much a clinical vulnerability risk. From all the conversations we had earlier, we are not suggesting—and we have reasonable evidence at the moment—that schoolteachers and educational staff are not at increased risk.

The other important point here is that we do not yet understand the characteristics of the vaccine outcomes. We are confident it will protect the individuals. We do not yet—and we will in due course—understand what impact it has on transmission risk. Can somebody have mild illness and still be transmitting to somebody else?

The underlying point here is that whereas schoolteachers and education staff are a vital part of our key worker service, they are not at increased risk. Any of those who might be from underlying conditions, if they are extremely vulnerable or have other vulnerabilities, they will be prioritised with the age and clinical vulnerability list.

Q1185 **Kim Johnson:** How does the decision to close schools until mid-February fit with the timescale for phase 2 vaccinations? You discussed earlier that we could be looking to Easter for schools to reopen. What decisions will you be looking at for the reopening of schools sooner rather than later?

Dr Harries: On that first one, by the middle of February, hopefully, across the country, any educational staff who are in those first four clinically extremely vulnerable groups or who fit in the older age group—unlikely for teaching staff—would be vaccinated. It will not come through until that period. It will take a while to get to phase 2.

Osama might be better on the reopening, but I highlight that the dates cannot be set in concrete going forward because we cannot be absolutely sure of the virus. We are learning about it all the time.

Osama Rahman: I reiterate that we cannot set the dates in concrete. Throughout, we will monitor the epidemiological information and other things. The Government will make a decision based on the balance of risks.

Q1186 **Kim Johnson:** Dr Harries, we know that Covid-19 has a disproportionate impact on black people. What studies have been undertaken on the consequences for the mental health of black kids and whether there are any correlations with adults?

Dr Harries: If I start with some of the ethnicity elements, Professor Viner can pick up on the clinical side.

The ethnicity question is tricky in the sense that we get different signals in different places. There is not a pure ethnicity. There is a whole load of

different social, occupational and general lifestyle interventions. If we look at the data now, there was a heightened potential impact on black ethnic groups in the first wave, but that is not what we are seeing in the second wave at all. It is very much a manifestation in families of Pakistani and Bangladeshi origin. It is not as clear-cut as that. The important thing is that we are monitoring impacts, infection rates and possible opportunities to mitigate risk in those groups. There is an ethnicity subgroup in SAGE that looks at all of this individual variation. As soon as there is a strong signal, an intervention or specific recommendation is made with advice to different groups.

Finally, as we have gone through, I hope that the way the advice has gone out is utilising many more community leaders, faith leaders, different languages and different routes of community to try to support that.

Professor Viner: This is a useful question. The relationship between ethnicity and mental health in children and young people is complex.

The national mental health survey looked at the change between 2017 and 2020. It did not find any increased risk for black and minority ethnicity young people. Maybe it did not have the power to pick it up, but it is a complex area. Some studies find that children from some ethnic groups have a lower risk overall of mental health problems than the background population.

We know that for children it is likely that some of the same issues apply around ethnicity and Covid-19 as we have seen in the adult population, although at a much lower level.

Q1187 **Tom Hunt:** With about 1 million staff in schools alone, how should staff from different education phases be prioritised for vaccination? For example, should special education staff be prioritised given that they are often providing personal and clinical care?

I am also interested in a letter sent by HMC and a few other educational organisations last week to the Prime Minister and the Health Secretary about the possibility of certain schools organising their own vaccination programmes in specific areas and providing facilities. One school in my constituency has the trained staff to be able to carry out vaccinations itself. Essentially, they just need the vaccine. A lot of this could be practically done without detracting too much from the wider vaccination programme. What are your thoughts on that?

Dr Harries: You have probably spotted the big problem with this, which is the supply of vaccine. That is the limiting factor at the moment. The NHS is doing a fabulous job of rolling out the vaccine as quickly as possible. Despite the fact that the UK has sufficient orders in, the production of the vaccine is the limiting factor. That is important.

When we go back to who is being vaccinated among health and care workers, staff who may potentially be offering direct care in a health or

care approach would be included within the health and care worker grouping. But for other staff, there is no evidence currently of increased mortality or serious infection rates. Therefore, they would not be prioritised on the JCVI guidance but would be considered within that phase 2 response. Anybody providing direct care in a clinical capacity, which I know happens in some educational settings, would be included within the health and social care staff group.

Q1188 **Chair:** Going back to vaccination, I understand what you say about how teachers are at no more risk than any other profession and I understand absolutely that the elderly and clinically vulnerable must be prioritised. I have no issue with that at all.

My question is that even though teachers are at no greater risk, when teachers are sick it means that whole year groups or bubbles of children are sent home, even before the school closures. If it could be shown that school openings could happen sooner rather than later, would that make the case for vaccinating teachers and support staff as a priority once the clinically vulnerable and the elderly had been done?

Professor Viner: I am not sure I can comment in a helpful way on vaccine prioritisation or the vaccination of adults. I need to defer to Dr Harries.

Dr Harries: Yes. The vaccination of staff is not the limiting factor to opening schools. It is community transmission rates. Once we start to see that decline, we will be stepping back, probably, to some sort of tiered approach and schools will reopen. They were not shut because there was a specific risk in that setting. While I recognise that teachers will be concerned, of course that concern is shared across a number of our key workers across the country.

Q1189 **Chair:** I completely understand all that. It is difficult to prioritise one group of workers over another, absolutely. If it is correct that it means schools can open sooner rather than later, even though teachers and support staff are at no greater risk than any other profession, would that make the case for them to be a priority for vaccination?

Dr Harries: It is a JCVI decision but I cannot see the link between vaccinating staff and a decision to open schools sooner or later. They are not running in the same vein. One is to protect people at clinical risk of severe disease and fatality and the other is about the epidemiology and getting our children back to school as quickly as possible.

Q1190 **Chair:** The problem is that even if it is a few, when teachers have to go home or self-isolate, it means that either schools close or year groups close and it means that children are not learning.

Dr Harries: I recognise that, but to my mind from a professional perspective that is a different issue about how we maintain schools to stay open. It is not a vaccination issue in many ways. You are thinking that if more people are vaccinated, there should be less illness and

infection, but at the moment we still need to understand in much more detail what the impact of the vaccination is. It will protect an individual from becoming seriously ill themselves but it does not necessarily yet stop transmission. In situations with bubbles, a teacher could potentially still be a transmission risk and therefore we would have to rethink the public health system and the control measures around it.

Q1191 **Chair:** To turn my question on its head completely, if it is the case that teachers and support staff are at no greater risk than any other profession and that schools are not drivers of transmission even of the new variant, would it have been better to keep the schools open, given the effects on children that Professor Viner has highlighted?

Dr Harries: First, I am caveating everything with current evidence. We have to keep accruing this and so this is the position now. Personally, from a public health perspective, I am absolutely supportive of maintaining schools open whenever we can. But it has become evident that our health services were becoming overwhelmed to the extent that not only could we not manage Covid cases but that there was a risk that we could not manage other serious illnesses, heart attacks and so on as well. In fact, there has been a pause in societal transmission through the lockdown and we would be looking to open that as quickly as possible to minimise and mitigate those potential harms to children from lack of face-to-face education.

Q1192 **Apsana Begum:** I want to ask about the criteria for reopening schools. Dr Harries mentioned the potential unlikeliness of schools not being able to reopen after the February half term. I want to go into that a little further.

How did you come to that conclusion scientifically? Also, what are the mitigation measures that would be recommended scientifically for schools and early years settings to adopt to reduce transmission?

Dr Harries: I may sound a bit repetitive and so my apologies if I do. For absolute clarity, the Department of Health and the scientists do not set the opening and closing dates for schools. We work closely with colleagues in the Department for Education through the JCVI to look at the data and the epidemiology and highlight what is likely to happen and where risks might be.

The date that has been suggested around February fits logically and reasonably with as much as we know currently about where the epidemic is. I am not suggesting that schools will or will not reopen but that appears to be a reasonable timeframe for seeing a wave of this virus come through and settle.

The additional measures put in across the country, effectively a national lockdown, are dampening our community transmission. In the event that we can open schools because that dampening has happened, schools have good systems of control. The Department for Education sought

advice from Public Health England and in fact I see that guidance as well. Those systems of control, on our current evidence, are exactly those that should be in schools before.

We have seen large numbers of children isolating because it is public health practice to try to minimise infection risk, but we have not seen vast numbers of schools with major outbreaks closing or huge transmission chains. We can be reasonably reassured that those systems of control, if they are implemented, are pretty effective at keeping children and staff safe.

Q1193 **Apsana Begum:** Do the measures that have been in place within school settings need to change compared to what they were a few months ago before we went into this lockdown?

Dr Harries: The mechanism of transmission of the virus has not changed. It is still potentially coming in aerosol or droplet forms. Those basic mechanisms are still the same, so the measures the Department for Education recommended for schools previously still apply.

There are two points. One is that this new variant is more transmissible and so all of those interventions will be continuously monitored. It is possible that changed advice could come but we are still trying to understand this new variant and why it is more transmissible. If there is a strong signal in one direction, that advice might change. At the moment, it is what it is. The second point is to highlight that schools were not closed because the schools were found to be inherently less safe. They were closed to support the dampening of community transmission rates.

Q1194 **Apsana Begum:** Going forward, for schools and educational settings, are there some measures that have shown through scientific evidence that they can be backed up as recommended more highly; for example, ensuring physical distance and separating tables in classrooms compared with having closed-in common play areas? Are there mitigation measures that are seen to be more effective in school settings? I appreciate that school settings are not responsible for the rates of transmission that led to this lockdown, but what mitigation measures are seen as effective in educational settings? Is there anything you can share about what has happened in other countries that we could learn from in this area?

Dr Harries: The measures are exactly the same as we would apply in any workplace setting because we are trying to interrupt the spread of the virus—distancing, not mixing in communal areas and that sort of thing.

Osama Rahman: There are various interventions that there is good scientific evidence for around distancing, ventilation and cleaning surfaces. Those are the three major interventions for the system of control. Narrowing down on specific ones like the value of closing playgrounds where surfaces might be touched by multiple children versus keeping physical distance is almost impossible to get the degree of

differentiation between the interventions you might use in your system of control.

Q1195 **Dr Caroline Johnson:** I have questions about the lateral flow testing. We know that when children go back to school, hopefully sooner rather than later, a key feature that will be different from last time is the regular lateral flow testing, particularly for school-age children. Dr Harries, you said that lateral flow tests are accurate, but the BMA has said that the INNOVA test is not fit for mass testing. As medics, you are used to the idea that testing is part of a clinical picture. What information or evidence do you have that can give confidence to teachers, other staff, children and parents about the safety and use of lateral flow testing?

Dr Harries: I said that they were effective rather than accurate, although they are accurate but with provisos. Lateral flow tests are an addition to the armoury to try to detect asymptomatic cases. These are cases that we would not find if we were not applying these tests. The Department for Education and NHS Test and Trace have done a number of studies looking at the additional pickup with children and how many more cases we can find.

In the same way that we are, for example, in care homes or with healthcare staff, which you will be familiar with, we are trying to find those asymptomatic tests. From the modelling that feeds into the advice that Dr Hargreaves highlighted earlier, because of the rapid turnaround of this and the engagement of staff—it is a 30-minute maximum for most of these now—two lateral flow tests a week has the equivalent effectiveness and accuracy as one PCR. That is a combination of the speed and the fact that we can immediately take somebody who is positive out of circulation and prevent them being a transmission risk.

A lot of the sensitivity—so this accuracy of the test in detecting disease—has perhaps been misunderstood in some circles. We are finding that it is highly effective, probably around 80% to 85%, at picking up cases in their most infectious period. A PCR test will pick up viral fragments but over a much longer period of time when people are probably not infectious. For picking up infectious cases, particularly if they are asymptomatic, on a routine basis, they are highly effective in removing people who are infectious out of that environment and stopping chains of transmission.

Dr Hargreaves: I agree with everything Dr Harries said. It is exactly right. The point you started with is a key one that is often missed. No test is perfect. We need to find the appropriate use for lateral flow tests in schools and in a way that the benefits of doing that outweigh the potential risks and potential harms from doing that.

The two arguments are different and have often been a bit conflated. One use of lateral flow tests is to pick up additional cases. We are doing that in my hospital. I have been testing myself twice a week for the last six weeks or so using lateral flow tests. It gives me confidence that I am not

infecting my patients. It gives me confidence when I come back from the hospital that I am not putting my family at risk. There is broad consensus that that can be useful.

The concern is about not overinterpreting a negative test. If you get a negative test, it does not mean that you can ignore the usual mitigation procedures. You still need to be doing the social distancing, the handwashing and the mask-wearing where appropriate. However, there is broad consensus that it does have a use and there has been broad support from teacher unions for doing that in schools as long as we can get the training right and all the logistics up and running.

The concern is around the separate programme of daily testing for those who have been in contact with a proven case. There the aim is different. The aim is to improve attendance and there is at least a hypothetical risk of increasing transmission. We do have data, but there is also a huge issue of professional judgment that reasonable experts weigh up differently.

It is often presented as quite a polarised debate. We have been in touch with experts from a full range of different perspectives and we are all broadly agreed that there are potential benefits. We are all agreed that there are potential risks in doing this. If you in a high prevalence area, people are nervous about the idea that staff or pupils who have been in contact with infected cases are still attending school. Against that, we have to get the balance right. There was evidence from the Children's Commissioner's Office before Christmas that sometimes just one case in a school can mean up to 100 children and young people losing 10 days of schooling. There was a strong feeling that that balance was not right and was a little bit disproportionate.

Now we need to look at a more detailed evaluation process. We have the time until half term to do that. That will take a number of forms. It will look at the performance of lateral flow testing in school settings because it has been tried and evaluated in lots of other settings but we need useful information about how it performs in these specific settings.

It will also look at some of those behavioural impacts, how we get the messaging right and how we can be clear that this is not for symptomatic people. If you are symptomatic, you need to be getting a PCR test and following other procedures. If you get a negative lateral flow test, it does not put you in the clear. You still need to follow all the other advice.

Q1196 **Tom Hunt:** I have a couple of quick questions. First, I assume that the majority of you think that the decision to go ahead with the BTEC exams was the right one. Secondly, I would like some clarity on face masks in classroom settings and your views on whether they should be mandatory in the classroom as well as when pupils are walking between lessons and in other parts of the school. Also, the National Deaf Society communicated to the Committee about the importance of being clear if we have teachers wearing face masks so that pupils can lip read.

Professor Viner: I will not comment on exams. That is not my area. Masks is a complex area because our evidence on masks and children and young people is practically zero. The World Health Organisation issued some advice in August, which has expert consensus. We tend to rely on that when we do not have information. It is disappointing to be at this stage of the pandemic and have so little information.

There is little evidence that masks make a significant difference for children and young people. Of course, we have to rely on the adult evidence, which I will let Dr Harries summarise. The balance is about the educational harms and the harms to child development and language development that come from wearing masks against the potential epidemiological benefits.

I recognise that countries internationally have a range of different scenarios. There are few countries in which primary school or younger children are wearing masks. There are more countries in which secondary schoolchildren and young people are wearing masks. Dr Harries is certainly more up on the overall literature, which almost entirely comes from adults.

Dr Harries: Public Health England has been looking at this recently and will continue to do so in light of the new variants. Again, these are very much the old studies. As we have highlighted, teenagers behave in infection terms much more like adults. For areas where social distancing cannot be maintained, such as in communal areas where kids tend to be more sociable and less controlled than in classrooms perhaps, there is a reasonable case for doing that. That in fact is what the Department for Education has recommended and the same for staff.

As we go down the age groups, it becomes less obvious that this is an overall benefit. The transmission risks drop and the potentially harmful impacts on education will increase as we go down that list. Face coverings are very much a source reduction mechanism rather than a protection mechanism.

Finally, I highlight that as we get more testing, the likelihood of having an asymptomatic transmitter in an educational environment starts to drop. We need to think of the balance of using face coverings and the impact on education alongside the other ways we can potentially reduce the risk of transmission. Lateral flow devices will help to mitigate that risk as well.

Q1197 **Tom Hunt:** There is definitely not a strong case for them to be used in the classroom while teaching is going on?

Dr Harries: Again, I am caveating about the new variant because it is more transmissible and so we need to keep that under review. For older children, there is a different case. As you go down to primary schoolchildren, the potential harm-benefit balance starts to move in the opposite direction. For small schoolchildren, the educational impact is

severe from wearing face coverings and the risk of infection transmission is very much reduced.

Dr Hargreaves: Last term we had, broadly, a system that was working. Schools were largely open and the R rate transmission went down across most of the country. That is not to underestimate the challenges of that and it took a lot of work to do that, but we did have a system that was working.

Face coverings can be an additional mitigation. The big question is whether the new variant changes that position. We will know more about that within the next few weeks. At the moment, the emphasis is on doing all the things we were doing last term but doing them better because we have a little bit less margin for error with the new variant. Hopefully, things like testing will also have had some improvement over time.

Q1198 **Chair:** Osama, you said the Department was making the case for teachers and support staff to be higher up the priority list for vaccination. Is that correct?

Osama Rahman: The Secretary of State and some of the Ministers have said that they would like to see that.

Q1199 **Chair:** What is the reasoning for that that you are making to the relevant bodies that Jenny set out?

Osama Rahman: I cannot speak for Ministers.

Q1200 **Chair:** No, but you advise Ministers of the DfE.

Osama Rahman: As Jenny has said, it is not on a science risk basis.

Q1201 **Chair:** I am trying to understand the reasoning that the Department for Education is making for teachers and support staff to move up the priority list for vaccinations that you set out earlier.

Osama Rahman: It is alongside that of other critical workers who are in frontline positions that other Departments are making for and the Government will be considering phase 2 prioritisation in due course.

Q1202 **Chair:** I know, but you will be making specific reasoning for making the case. What is the case that you are making?

Osama Rahman: I will be advising the Secretary of State on that when we get there.

Q1203 **Chair:** The Secretary of State has already said that he is making the case. You have said that too. Is it possible you could supply the Committee with the case that the Department is making for teachers and support staff to be up the priority list for vaccination?

Osama Rahman: I can write.

Q1204 **Chair:** Do you have anything extra to add?

Dr Hargreaves: No, I have nothing to add. It is how Osama has described it.

Q1205 **Chair:** Professor Viner, given everything you have said about school closures, is there anything else the Government could have done rather than have the closures that were announced a few weeks ago? If you were in charge of that, what would you have been recommending?

Professor Viner: I supported the school closures with a heavy heart. Our believe in the College and my personal belief is that schools should be the last things to close and the first to open. I have talked before about the evidence. We have talked about the harms. This is a drug that has potential benefits. We do not know the side effects. We know some of the side effects are bad and so it is used as a last resort. That is what was done. When our back is against the wall we close schools, but schools need to be the first to open.

When we reopen schools, it is important to think about what happens to the rest of society at the same time. We can open schools earlier if we maintain restrictions in other parts of society. If I take you back to 1 June when primary schools and some secondary schools reopened after the first pandemic wave, many of the other restrictions had been reduced on 26 May. We should be thinking differently this time about the potential for us to go back to a November style of partial lockdown. Whether it is done by regions or differently is up to the politicians, although that will be modelled as well, but we should be thinking about the schools being first to open and not opening as part of a broader reopening. That way, we may get all of our schools opened earlier. We also need to think about a differential opening. Are there some years and classes that can open earlier?

Q1206 **Chair:** I happen to be of a similar belief. Would you have a partial un-lockdown, so to speak, with schools as the priority and in doing so leave other parts of society and the economy closed to ensure schools are opened first?

Professor Viner: That is consonant with the "last to close, first to open" view. We saw in November that we could have a national partial lockdown with schools open and the R would fall. It rose in London and of course that was related to the new variant and it rose at the end of the month. There has been a lot of uncertainty about the new variant and whether it has changed our understanding. It is early days but we appear to be controlling this pandemic. We need to think about how we carefully step away from it without stepping away from it all at once.

Q1207 **Chair:** Dr Harries, do you agree with the approach Professor Viner has set out?

Dr Harries: Yes, broadly, from a public health perspective. Also, the Government have signalled that, but it will be for Department for Education colleagues to do. With all of education, there is a balance of public health risk and harm. Schools have already been prioritised

through this. It was only in this last element when we have had an exponential rise in cases that we have closed schools for a second term.

Osama Rahman: The Joint Committee has asked the Department for Health and Social Care to consider occupational vaccination and has asked it to work with other Departments. We have been working with the DHSC to ensure that the education and children workforce is considered as part of that prioritisation, mainly to reinforce our messaging about the importance of including education and childcare in this. It is to keep on reinforcing that message that there is an argument for prioritising.

Chair: If you could send us the detailed reasoning, if we are allowed to see that, it would help us understand the case being made for teachers and support staff to move up the priority list for vaccination.

I genuinely give heartfelt thanks to all of you. Dr Harries, I see you on the news all the time and I have nothing but respect for what you have to deal with, the pressure you are all under and the public service that you all give in the DfE, in the Royal Society and as the Deputy Chief Medical Officer. Thank you for being accountable and for answering question after question. It is appreciated. We wish you every success and all good health in what you are trying to do.