There is evidence that adults have higher susceptibility to infection (low confidence) and clinical disease (high confidence) than children. It follows that staff in educational settings have a higher risk of experiencing severe symptoms than students. There is some, but limited evidence, that children play a lesser role in transmission than adults (moderate confidence). There is little direct evidence of transmission from pupils to teachers.

This suggests that any risk to teachers may be less associated with contact with students, and more associated with potential contacts with other school staff, or parents/carers. For many school staff the risk of severe health outcomes will be lower than people of retirement age. However, the specific situations where there may be an increased risk associated with any transmission (for example if a child is living with a vulnerable adult, or a staff member has an indicator of increased risk) will require further consideration.

In terms of the risk of increasing community transmission, schools and universities should not be considered in isolation from wider measures. Which sectors to open or keep closed in order to keep R below one is clearly a policy choice. It should be noted that, given the evidence on the reduced severity of disease among children, reopening schools carries fewer risks to those who will attend than settings which have already been opened, that result in more frequent adult interactions. As policy makers work to strike a balance between opening up different sectors of the UK, the ready reckoners work[3] will be important in highlighting the trade-offs that will need to be made. This group would strongly support the opening of schools being prioritised, maintaining sufficient latitude in wider transmission to make that possible in September.

Section 3 presents scientific advice on the most important measures to have in place in educational establishments in any COVID-19 scenario. Section 4 discusses the concept of 'bubbles' and segmentation; Section 5 presents considerations around approaches to reduce risk associated with the use of transport.

Based upon the conclusions below, the key messages are:

- There is **relatively low immediate risk** to children's health from SARS-CoV-2 (high degree of confidence), with evidence indicating that **children/adolescents have lower susceptibility to SARS-CoV-2 infection** (low confidence) **and clinical disease** (high confidence) than adults.
- There is some (but limited) evidence that children play a lesser role in transmission than adults.
- **In countries where schools have been open for some time, data suggests that school opening has made little difference to community transmission.**
- Measures to reduce transmission should consider a hierarchy of risk, address the **three transmission routes (close-range droplet, surface contacts, aerosol)**, and **duration of exposure**.
- **Ensuring good ventilation** and **designing physical layouts to maximise distancing**, together with administrative controls such as **regular cleaning of high touch and shared surfaces** are key.
- Risk mitigation plans should consider the range of interactions over a school day, and identify situations / locations **that pose a higher risk of transmission through the activity and environment**. Extra consideration needs to be given to **interactions between adult staff**, given their greater risk of disease and likely more significant role in transmission.
- The use of facemasks for children is likely to be unfeasible for younger children. Among older children there are still risks that this will increase face touching and risk substitution, but these may be mitigated through education. Given the low risk of transmission between children, the detrimental developmental impacts of extended face mask use by children (including affecting

[3] SPI-M-O: Comments on Social Distancing Measures – publication pending; SAGE 43 Minutes 23 June – publication pending