Public Health England

Protecting and improving the nation's health

PHE NW COVID-19 Resource Pack for Schools

Version 4.0

(Cheshire West and Chester Council)

17th December 2020

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

Quality Assurance - SOP Consistency Group Sign-Off	
Sign-off is the responsibility of the NW Incident Lead	
Name	Alan Higgins
Signature	
Sign-Off Date (of current version)	25.08.2020
Comments (if applicable)	Alan Higgins signed-off as COVID-19 Incident Lead w/c
Review Date	Every six weeks, or earlier if appropriate
Any comments about the contents/implementation of this should be emailed to ICC Northwest: ICC.Northwest@phe.gov.uk	

Document Change History

Version	Status	Author	Details of Change/Superseded document
V2.0	**Draft**	**Emma Savage** **Martin Bewley**	Case definition updated Shielding advice updated Advice regarding facemasks added Single page algorithm for suspected/confirmed cases added Scientific evidence section added
V2.1	**Final**	**Emma Savage** **Martin Bewley** **Alex Stewart**	Extra information regarding specific scenario for face mask use added NW STAC Summary Guidance (including outbreak review) added Algorithm streamlined
V2.2	**Final**	**Emma Savage** **Martin Bewley** **Alex Stewart** **Sam Ghebrehewet**	Extra information regarding updated guidance on face coverings (announced on 25/08/20) was added.
V2.3	**Final**	**Martin Bewley** **Alex Stewart** **Sam Ghebrehewet**	Additional information re testing was added
V2.4	**Final**	**Martin Bewley** **Sam Ghebrehewet**	Planning for local restrictions section added Exemptions for face coverings added Link to RCOG advice for pregnant women added to FAQ question Advice regarding music lessons added to FAQ section Advice on school transport added
V2.5	**Final**	**Emma Savage** **Sam Ghebrehewet** **Martin Bewley**	Notification process for confirmed cases changed What to do if no testing added Q&A on diarrhoea and vomiting added Q&A on non-case definition respiratory symptoms added
V2.6	**Final**	**Emma Savage** **Sam Ghebrehewet** **Martin Bewley**	Advice on free from fever clarified Updated minimum dataset for confirmed cases
V2.7	**Final**	**Emma Savage** **Sam Ghebrehewet** **Martin Bewley**	Addition of Department of Education Helpline to contacts Change to Management of Confirmed Case Clarification of outbreak in section 5 Section added on delayed testing Q&A on free from fever clarified Q&A on using/reordering test kits Addition of template letter for close contacts (Appendix 3) Flowchart modified to include DoE helpline
V2.8	**Final**	**Emma Savage** **Sam Ghebrehewet** **Martin Bewley** **Alex Stewart**	Contacts: Signposting for SEND schools and residential schools Key Messages: Addition of information on self-isolation Section 4 title changed to management of a single confirmed case Section 5: title changed to management of multiple confirmed cases and possible outbreaks and paragraph order changed

			Q&A: Question added on what to do if more cases in a bubble Further clarification that schools should not be asking for negative tests if no COVID-19 symptoms Appendix 3: Letter for close contacts – recommend changed to must and added information on self-isolation and that contacts will not be contacted by NHS T&T Appendix 8: Link to exclusion periods for childhood illnesses added
V2.9	**Final**	**Emma Savage** **Sam Ghebrehewet** **Martin Bewley**	P.6 clarification of settings that the guidance applies to Consisent use of 48 hours and not 2 days Clarification of self-isolation period Q&A Ending of self-isoaltion
V3.0	**Final**	**Emma Savage** **Sam Ghebrehewet** **Martin Bewley**	Extension of DoE helpline hours Self-isolation period change and addition of graphic Updated guidance on face coverings Updated hierarchy of control Updated guidance on clinically extremely vulnerable FAQ on children with complex medical needs such as tracheostomies Removal of word advice from Annex 3 Letter to close contacts
V4.0	**Final**	**Emma Savage** **Sam Ghebrehewet** **Martin Bewley**	Change of isolation period from 14 days to 10 days throughout Removal of Section 6: Planning for Local Restrictions Removal of what to do if lab test delayed Change to QA: What can schools do to organise testing? Addition of QA on fever following immunisation and teething Inclusion of link to preliminary guidance on asymptomatic testing in schools from January Updated Appendix 3. letter to contacts Updated Appendix 8. flowchart

Contents

Please note that, as COVID-19 is a rapidly evolving situation, guidance may change with little notice.

Therefore we advise that, in addition to familiarising yourself with the content of this document, you refer to the relevant national guidance (links provided in Section 7)

This guidance applies to all education settings (excluding universities):

- **Early years settings including nurseries**
- **Schools including Infant, Junior, secondary, special, independent and boarding schools**
- **Further Education settings including colleges, independent training providers and other adult education**

Section 1: Local Area Key Contacts

For COVID-19 queries and notification of single confirmed COVID-19 cases related to educational settings

Cheshire West and Chester Council Test and Trace Team

Monday – Friday 8am – 7pm	0300 123 8123
Saturday – Sunday 9am-5pm	0300 123 7035

General COVID-19 related enquiries and submission of completed Risk Assessment (see Appendix 4):
healthprotectionsecure@cheshirewestandchester.gov.uk

Out of Hours PHE Contact:

Public Health England first on call via the Contact People	0151 434 4819

Section 2: COVID-19 Key messages

What are the symptoms?

The main symptoms of COVID-19 are:

- new continuous cough and/or
- fever (temperature of 37.8°C or higher)
- Loss of or change in, normal sense of taste or smell (anosmia)

What is the mode of transmission?

COVID-19 is passed from person to person mainly by large respiratory droplets and direct contact (close unprotected contact, usually less than one metre). These droplets can be directly inhaled by the person, or can land on surfaces which another person may touch which can lead to infection if they then touch their nose, mouth or eyes.

What is the incubation period?

The incubation period (i.e. time between exposure to the virus and developing symptoms) is between 1 and 14 days (median 5 days).

When is a person infectious?

A person is thought to be infectious 48 hours before symptoms appear, and up to ten days after they start displaying symptoms. 48 hours should be used to determine close contacts and not two days.

Are children at risk of infection?

Children of all ages can catch the infection but children make up a very small proportion of COVID-19 cases with about 1% of confirmed cases in England aged under 19 years. Children also have a much lower risk of developing symptoms or severe disease.

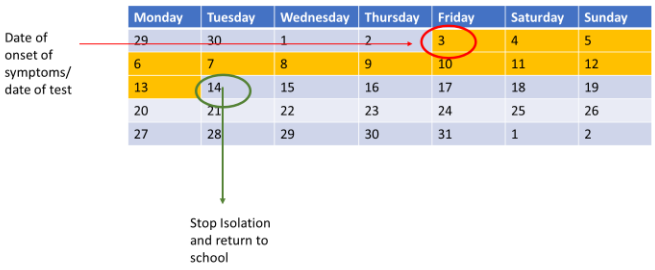
Can children pass on the infection?

There is some uncertainty about how much asymptomatic or mildly symptomatic children can transmit the disease but the evidence so far from a number of studies suggests children are less likely to pass it on and do not appear to play a major role in transmission. Most children with COVID-19 have caught the infection from adults and not the reverse.

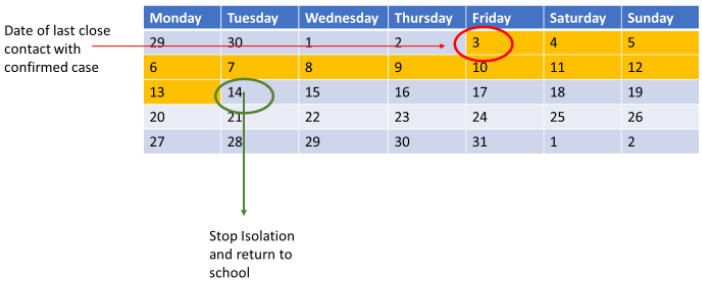
While the risk of transmission between young children and adults is likely to be low, adults should continue to take care to socially distance from other adults including older children/adolescents.

How long does self-isolation last?

- If a child or staff member is a confirmed case they must not leave home for 10 days from the onset of symptoms or the date of test if they have no symptoms. The isolation period includes the day their symptoms started (or the day their test was taken if they do not have symptoms), and the next 10 full days. This means that if, for example, their symptoms started at any time on the 15th of the month (or if they did not have symptoms but their first positive COVID-19 test was taken on the 15th), their isolation period ends at 23:59 hrs on the 25th.



- If the child or staff member has been identified as a close contact of a confirmed case they must not leave home for **10** days from the date they last had contact with the case.



Who is a close contact?

A contact is defined as a person who has had contact (see below) at any time from 48 hours before onset of symptoms (or time of test if asymptomatic) to 10 days after onset of symptoms (or test):

- a person who has had face-to-face contact (within one metre) with someone who has tested positive for coronavirus (COVID-19), including:
  - being coughed on, or
  - having a face-to-face conversation, or
  - having skin-to-skin physical contact, or
  - any contact within one metre for one minute or longer without face-to-face contact

- a person who has been within 2 metres of someone who has tested positive for coronavirus (COVID-19) for more than 15 minutes (either as a one-off contact, or added up together over 24hrs)

- a person who has travelled in a small vehicle *with* someone who has tested positive for coronavirus (COVID-19) or in a large vehicle *near* someone who has tested positive for coronavirus (COVID-19)

- people who spend significant time in the same household as a person who has tested positive for coronavirus (COVID-19)

What does self-isolation mean?

Self-isolation means the child/staff member should

- Not go to school, work or public places
- Not attend any other out of school activities or go around to a friends house
- Not use public transport or taxis
- Not go out to shop – order it online or ask a friend to bring it to your home
- Not have visitors in your home except for people providing essential care
- Not go out to exercise – exercise at home or in your garden, if you have one
- Inform GP practice or hospital or other healthcare setting that they are self-isolating if they must attend in person

What PPE is recommended for teachers and children?

From the 5th November, in schools where pupils in year 7 and above are educated, face coverings should be worn by adults and pupils when moving around the premises, outside of classrooms, such as in corridors and communal areas where social distancing cannot easily be maintained. This was already the case for pupils in year 7 and above, and staff and visitors for those schools that were in areas where local alert level ‘high’ and ‘very high

In primary schools and education settings teaching year 6 and below it is not mandatory for staff and visitors to wear face coverings but the Director of Public Health in Cheshire West and Chester highly recommends face coverings are worn particularly in situations where social distancing between adults in settings is not possible (for example when moving around in corridors and communal areas).

As in the general approach, it will not usually be necessary to wear face coverings in the classroom, where protective measures already mean the risks are lower, and they may inhibit teaching and learning.

Some individuals are exempt from wearing face coverings and adults and pupils should be sensitive to those needs.

Face coverings should also be worn by pupils in year 7 and above (all pupils in Cheshire West and Chester) when travelling on dedicated school transport to secondary school or college.

What are the protective measures that the schools need to put in place?

The following hierarchy of prevention and response measures should be put in place.

Prevention:

1) minimise contact with individuals who are unwell by ensuring that those who have coronavirus (COVID-19) symptoms, or who have someone in their household who does, do not attend school

2) where recommended, the use of face coverings in schools

3) clean hands thoroughly more often than usual

4) ensure good respiratory hygiene by promoting the ‘catch it, bin it, kill it’ approach

5) introduce enhanced cleaning, including cleaning frequently touched surfaces often, using standard products such as detergents and bleach

6) minimise contact between individuals and maintain social distancing wherever possible, i.e. maintain social distancing of 2 metres with individuals outside your bubble whenever possible and in school activities that have the potential for being in close proximity to other individuals.

This must be properly considered, and schools must put in place measures that suit their particular circumstances.

7) where necessary, wear appropriate personal protective equipment (PPE)

Section 3: Management of a suspected case

What to do if a child or staff member is unable to attend school because they have the following COVID-19 symptoms

- new continuous cough and/or
- fever (temperature of 37.8°C or higher)
- Loss of or change in, normal sense of taste or smell (anosmia)

Anyone who develops symptoms of COVID-19, or whose household member develops symptoms, should immediately self-isolate. They should not attend school and should follow the steps below.

- Parent/Carer or staff member should notify the school of their absence by phone
- School should record and keep relevant information (see suggested template in Appendix 1): Reason for absence, date of onset of symptoms, symptoms, class etc.
- Direct to Stay at home guidance for isolation advice for child/staff member and their households. The person with symptoms should isolate for 10 days starting from the first day of their symptoms and the rest of their household for 10 days.
- Advise that the child/staff member should get tested via NHS UK or by contacting NHS 119 via telephone if they do not have internet access This would also apply to any parent or household member who develops symptoms. If any staff contact develops symptoms then they can apply for a test via https://www.gov.uk/apply-coronavirus-test-essential-workers.
- **There is no further action required by the school at this time, and no need to notify the Local Authority or Health Protection Team.**

What to do if someone falls ill while at school

If anyone becomes unwell with a new continuous cough, a high temperature or a loss of or change in their normal sense of taste or smell they must be sent home as soon as possible

- If a child is awaiting collection, they should be moved, if possible, to a room where they can be isolated behind a closed door, depending on the age of the child and with appropriate adult supervision if required. Ideally, a window should be opened for ventilation. If it is not possible to isolate them, move them to an area which is at least 2 metres away from other people**.**

- If they need to go to the bathroom while waiting to be collected, they should use a separate bathroom if possible. The bathroom should be cleaned and disinfected using standard cleaning products before being used by anyone else.

- PPE should be worn by staff caring for the child while they await collection ONLY if a distance of 2 metres cannot be maintained (such as for a very young child or a child with complex needs).

- If a 2 metre distance cannot be maintained, then the following PPE should be worn by the supervising staff member:
  - Fluid-resistant surgical face mask

- If direct contact with the child is necessary, and there is significant risk of contact with bodily fluids, then the following PPE should be worn by the supervising staff member
  - Disposable gloves
  - Disposable plastic apron
  - Fluid-resistant surgical face mask
  - Eye protection (goggles, visor) should be worn ONLY if a risk assessment determines that there is a risk of fluids entering the eye from, for example, coughing, spitting or vomiting

- The school should record and keep the details of the incident in case it is needed for future case or outbreak management (see suggested template Appendix 2)

- **There is no need to notify the Local Authority or the Health Protection Team of the incident**

Section 4: Management of a single confirmed case

If a headteacher is informed by a parent or staff member that a child or staff member has tested positive they should use the guidance below to appropriately identify and exclude close contacts if appropriate.

The school should complete the Risk Assessment (Appendix 4) and submit the Risk Assessment securely to the Local Authority Test and Trace Team by emailing healthprotectionsecure@cheshirewestandchester.gov.uk

The school should follow the steps below:

- The confirmed case should be advised to self-isolate until the latest of:
    - 10 days after the onset of their symptoms

  or
    - 10 days after their test day if they asymptomatic

- If the case is isolating because of a positive test result but did not have any symptoms, and then develops COVID-19 symptoms within their 10 day isolation period, they should start a new 10 day isolation period by counting 10 full days from the day following their symptom onset.

- The headteacher or appropriate member of the leadership team should gather the following information to assist with identification of close contacts:
    - The cases's date of onset onset of their illness, the date on which they were tested, and their attendance record at school
    - The cases's year group/class/bubble

The INFECTIOUS PERIOD IS FROM 48 hours BEFORE ONSET OF SYMPTOMS (or the time of test if they don't have symptoms) UNTIL 10 DAYS AFTER SYMPTOMS STARTED

- **If the staff member or pupil has not been at school during the infectious period, the school does NOT need to take any further action.**

- **If the staff member or pupil has been at school during the infectious period**, the headteacher should identify direct and close contacts of the case during the 48 hours prior to the child or staff member falling ill. This is likely to be the classmates and teacher of that class. The social distancing measures put in place by educational settings outside the classroom should reduce the number of other direct/close contacts.

- All close contacts should be excluded from school for 10 days following their last contact with the case. For example, if the case tests positive on Thursday and was last in school on the previous Monday the first day of the 10 day period is on the Monday. Household members of contacts do not need to self-isolate unless the contact develops symptoms.

- **Close/direct contact is considered to be**:
  - being coughed on, or
  - having a face-to-face conversation within 1 metre, or
  - having unprotected skin-to-skin physical contact, or
  - travel in a small vehicle with the case, or
  - any contact within 1 metre for 1 minute or longer without face-to-face contact

- extended close contact: between 1 and 2 metres for more than 15 minutes with a case (either as a one-off contact, or added up together over a 24hr period)

See page 18 for a fuller description of a contact in a school setting.

- The school should send to the identified close contacts and their families a standard letter containing the advice (see Appendix 3).

- The school should complete the Risk Assessment (Appendix 4) and submit the Risk Assessment securely to the Local Authority Test and Trace Team by emailing healthprotectionsecure@cheshirewestandchester.gov.uk

Contacts will not be tested unless they develop symptoms If a contact should develop symptoms, then the parent/carer should arrange for the child to be tested via NHS UK or by contacting NHS 119 via telephone if they do not have internet access This would also apply to any parent or household member who develops symptoms. If any staff contact develops symptoms then they can apply for a test via https://www.gov.uk/apply-coronavirus-test-essential-workers.

The Department of Education has announced that from January testing for contacts of confirmed cases will be made available initially for certain year groups in secondary schools and Further Education colleges .
https://www.gov.uk/government/publications/coronavirus-covid-19-asymptomatic-testing-in-schools-and-colleges/coronavirus-covid-19-asymptomatic-testing-in-schools-and-colleges

Further information and guidance will be provided in due course. Materials to support schools on rapid COVID-19 testing including a link to the handbook is available here

If the school has any enquiries regarding the action that should be taken for a confirmed case of COVID-19 then they should contact the Cheshire West and Chester Council Test and Trace Team by emailing healthprotectionsecure@cheshirewestandchester.gov.uk with details of the query or to request a call back.

Section 5: Management of multiple confirmed cases and possible outbreaks

Schools should follow the steps outlined in section 4 to identify and exclude contacts of each subsequent confirmed case of COVID-19.

It is not unusual for self-isolating children or staff who have been identified as close contacts of a case to report a couple of days later that they have developed symptoms or test positive for COVID-19. If this person was self-isolating for 48 hours before they developed symptoms or were tested (if asymptomatic) there will be no further public health action for schools. If the person was in school in the 48 hours before onset of symptoms or testing, we would recommend that you confirm they did not have contact with anyone outside their bubble during that time. Household contacts will be managed as normal through NHS Test and Trace.

If a school has come across two or more confirmed cases from **more than one household**, among students or staff who are known to have been in the same class or 'bubble' who were attending the school within 14 days of one another or there is a high reported absence which is suspected to be COVID-19 related, then the local authority should be notified promptly (see front page).

If there are more confirmed cases linked to the school the local authority will investigate and will advise the school on any other actions that may be required.

There is no need to notify multiple cases or possible outbreak directly to the Health Protection Team. The local authority will liaise with the local Health Protection Team as appropriate.

Section 6: Frequently Asked Questions

Cases and contacts

Should a child/staff member come to school if a member of their household is unwell?

No. If a member of the child's household is unwell with COVID-19 symptoms then the child/staff member should isolate for 10 days starting from the day the household member(s) became ill. If the child subsequently develops symptoms than they should isolate for 10 days from the date they developed symptoms. See Stay-at-home-guidance. The household member(s) should be tested within 5 days of symptom onset. If all symptomatic household members test negative, the child/staff member can return to work.

If I am notified by a parent that their child is ill do I need to exclude the other children in their class/bubble?

No, classmates and staff can attend school as normal. The child who is ill should stay at home (Stay-at-home-guidance) and be advised to get tested. If the child has any siblings who attend the school, they should also be self-isolating at home for 10 days. If the child tests positive for COVID-19, close contacts should be excluded for 10 days.

If a child with symptoms has difficulty getting tested do I need to exclude the other children in their class/bubble?

The child with symptoms must isolate for 10 days from onset of symptoms if they do not test negative for whatever reason (e.g. refuse testing, delays in testing). Siblings from the same household must also self-isolate for 10 days. If the child is unable to get a test appointment within 3 days please contact the local authority for further advice regarding the class/bubble.

Who is considered a contact in a school setting?

A person who maintained appropriate social distancing (over 2 metres) would not be classed as a contact.

A contact is defined as a person who has had contact (see below) at any time from 48 hours before onset of symptoms (or time of test if asymptomatic) to 10 days after onset of symptoms (or test):

- a person who has had face-to-face contact (within one metre) with someone who has tested positive for coronavirus (COVID-19), including:
    - being coughed on, or
    - having a face-to-face conversation, or
    - having skin-to-skin physical contact, or
    - any contact within one metre for one minute or longer without face-to-face contact

- a person who has been within 2 metres of someone who has tested positive for coronavirus (COVID-19) for more than 15 minutes (either as a one-off contact, or added up together over 24hrs)

- a person who has travelled in a small vehicle *with* someone who has tested positive for coronavirus (COVID-19) or in a large vehicle *near* someone who has tested positive for coronavirus (COVID-19)

- people who spend significant time in the same household as a person who has tested positive for coronavirus (COVID-19)

Which contacts need to self-isolate?

Where the child, young person or staff member *tests positive* and they had attended the school in the 48 hours prior to developing symptoms, direct and close contacts will be identified and advised regarding self-isolation by a contact tracer.

Please note: The other household members of that wider class or group do not need to self-isolate unless the child, young person or staff member they live with in that group subsequently develops symptoms.

If a further member of the household develops symptoms while the child/staff member is already in self-isolation does the child/staff member need to restart their self-isolation period?

No. If the child/staff member has already tested positive than the child/staff member only needs to self-isolate for 10 days from the date of onset of symptoms or the date of the test.

If the child/staff member is another household contact without symptoms then if the child/staff member remains well, they can return to their normal routine at the end of the 10-day period. The child/staff member does not need to isolate for longer than 10 days, even if other household members develop symptoms during this period.

After 10 days if any of the household members develop symptoms then the whole household needs to start a new 10 day self-isolation period.

Can the siblings of a child who has been excluded because they are a contact of a case attend school?

Yes, other household members of the contact do not need to self-isolate unless the child, young person or staff member they live with in that group subsequently develops symptoms

A child/parent reports to us that they have had contact with someone with symptoms – what should we do?

There is no action required of the school. No one with symptoms should be attending school and anyone who develops symptoms while at school should be isolated and sent home as soon as possible. Schools should regularly remind parents of the government guidance on staying at home and the importance of a household self-isolating if anyone in the household develops symptoms.

If a child has COVID-19 symptoms, gets tested and tests negative, can they return to school even if they still have symptoms?

If the child is NOT a known contact of a confirmed case the child can return to school if the result is negative, provided they have been fever free for 48 hours and feel well.

If the child is a contact of a confirmed case they must stay off school for the 10 day isolation period, even if they test negative. This is because they can develop the infection at any point up to day 10 (the incubation period for COVID-19), so if a child tests negative on day 3 they may still go on to develop the infection.

If a child who was a contact of a confirmed case tests negative, can they return to school?

No, the child should complete 10 days of isolation.

Does a child who was identified as a contact need to have a negative test before they can return to school?

No, schools should not request evidence of a negative test results or other medical evidence before admitting children after a period of self-isolation.

Any individual (staff / pupil) who remains asymptomatic within 90 days of testing positive needs no further test for clinical or public health reasons unless they develop symptoms.

If I get confirmed cases does the school need to close?

The school does not need to close on public health grounds. Schools will generally only need to close if they have staff shortages due to illness or being identified as contacts. It is expected that only the class of a confirmed case will need to be excluded. If there are a number of confirmed cases across different classes and year groups at the same time, then the school may be advised to close by the Health Protection Team in consultation with other partners.

If I get more cases in a bubble do I need to do anything further?

No. Further cases among contacts that have already been excluded are likely to arise and do not need any further action if appropriate action has already been taken and the child or staff member has no additional contacts in the 48 hours prior to developing symptoms.

Should children with diarrhoea and vomiting be considered possible cases of COVID-19?

No. The clinical definition for COVID-19 still remains the same; new and continuous cough, fever and loss of taste or smell. The case definition is kept under review and guidance will be updated if the case definition changes. If a child has diarrhoea and/or vomiting they should remain off school while symptomatic and are free of symptoms for 48 hours. They do not meet the case definition for testing for COVID-19.

Should children with respiratory symptoms not in the case definition (e.g. sore throat, congestion) be considered possible cases of COVID-19?

No. The clinical definition for COVID-19 still remains the same; new and continuous cough, fever and loss of taste or smell. The case definition is kept under review and guidance will be updated if the case definition changes. If a child has other respiratory symptoms then they should remain off while symptomatic. There is no need for the child to get tested unless they develop one of the COVID-19 symptoms and schools should not ask for evidence of a negative test as only those with COVID-19 symptoms should be tested. Guidance on exclusion periods for common childhood diseases can be found here

Testing

How can a parent arrange testing?
The parent can arrange for any child to be tested via NHS UK or by contacting NHS 119 via telephone if they do not have internet access.

Will the school be informed of any test results?
The school will be informed if a child or staff member tests positive as part of NHS Test and Trace. The school will not be informed of any negative results.

How can a staff member get tested?
All education and childcare workers can apply for a test if they are symptomatic via https://www.gov.uk/get-coronavirus-test

Can they be tested if they do not have symptoms?
No. People should only be tested if they have symptoms.

Can schools help to organise testing?
The Department of Education has announced that from January weekly testing of staff and for contacts of confirmed cases will be made available initially for certain year groups in secondary

schools and Further Education colleges . Further information and guidance will be provided in due course.

Materials to support schools on rapid COVID-19 testing including the handbook is available here

High risk groups

Should children or staff who are shielding (classed as clinically extremely vulnerable due to pre-existing medical conditions) attend school?

Children whose doctors have confirmed they are still clinically extremely vulnerable are advised not to attend school whilst the national restrictions are in place.

Staff whose doctors have confirmed they are still clinically extremely vulnerable are advised to work from home and not go into work whilst the national restrictions are in place

Parents of clinically extremely vulnerable children and staff who are extremely clinically vulnerable should have received a letter from the NHS or their GP.

Further advice on shielding is available at Current advice on shielding

What specific steps should be taken to care for children with complex medical needs, such as tracheostomies?

New guidance has been published and is available here which states that oral or nasal suction are no longer classified as Aerosol Generating Procedures (AGPs).

Can our pregnant members of staff work? What if staff have pregnant household members?

Pregnant women are in the “clinically vulnerable” category and can return to work at school.

All clinically vulnerable staff should take particular care to observe good hand and respiratory hygiene, maintain 2 metre distance from others and where this is not possible avoid close face to face contact and minimise time spent within 1 metres of others.

If a staff member lives with someone who is pregnant, they can work.

The Royal College of Obstetrics and Gynaecology (RCOG) has published occupational health advice for employers and pregnant women. This document includes advice for women from 28 weeks gestation or with underlying health conditions who may be at greater risk. The Department of Education guidance advises pregnant women and employers to continue to monitor for future updates to it. Pregnant women with no underlying health conditions should return to work as normal.

Should children or staff who have family in the shielding group be coming to school/work?

Children or staff who live with people who are clinically extremely vulnerable can continue to attend school/work.

Staff

We have staff who are asymptomatic but wish to be tested is this possible?

Currently, only people who are symptomatic can access a test via NHS UK or ringing 119

We have had a child confirmed as a case and had contact with other staff, including catering staff at lunch, do they need to be excluded?

It depends on the level of contact. staff would need to be excluded only if they had face to face contact with a case for any length of time, including being coughed on or talked to. This includes exposure within 1 metre for 1 minute or longer OR the staff member had extended close contact with the case (within 2 metres for more than 15 minutes, either as a one-off contact, or added up together over one day). The contact tracer will advise and help the school to identify contacts that need to be excluded.

Can the school still have supply teachers come in if there has been multiple cases?

Local risk assessment should be undertaken and staff excluded if in direct contact with a symptomatic case according to the national guidance.

If a supply teacher has not been identified as a close contact in any of their workplaces then exclusion will not be necessary, and they should be able to work.

Can non-teaching staff, for example cleaners and caterers, work for 2 or more schools?

Local risk assessment should be undertaken and staff excluded if in direct contact with a symptomatic case according to the national guidance.

If a staff member has not been identified as a close contact in any of their workplaces then exclusion will not be necessary.

Schools are being advised to adopt preventative measures including small class sizes and social distancing to minimise contact between students and teachers.

Face coverings

It is reasonable to assume that staff and young people will now have access to face coverings due to their increasing use in wider society, and Public Health England has made available resources on how to make a simple face covering.

However, where anybody is struggling to access a face covering, or where they are unable to use their face covering due to having forgotten it or it having become soiled or unsafe, education settings should take steps to have a small contingency supply available to meet such needs.

No-one should be excluded from education on the grounds that they are not wearing a face covering.

The wearing of face covering should not replace other important infection prevention control measures which should be in place in all schools. These include:

- Minimising contact with individuals who are unwell by ensuring that those who have coronavirus (COVID-19) symptoms, or who have someone in their household who does, do not attend childcare settings, schools or colleges
- Cleaning hands more often than usual - wash hands thoroughly for 20 seconds with running water and soap and dry them thoroughly or use alcohol hand rub or sanitiser ensuring that all parts of the hands are covered
- Ensuring good respiratory hygiene by promoting the 'catch it, bin it, kill it' approach
- Cleaning frequently touched surfaces often using standard products
- Minimising contact and mixing by altering, as much as possible, the environment (such as classroom layout) and timetables (such as staggered break times)

When should children wear face coverings?

From the 5th November, in schools where pupils in year 7 and above are educated, face coverings should be worn by adults and pupils when moving around the premises, outside of classrooms, such as in corridors and communal areas where social distancing cannot easily be maintained. This was already the case for pupils in year 7 and above, and staff and visitors for those schools that were in areas where local alert level 'high' and 'very high

In primary schools and education settings teaching year 6 and below it is not mandatory for staff and visitors to wear face coverings but the Director of Public Health in Cheshire West and Chester highly recommends face coverings are worn particularly in situations where social distancing between adults in settings is not possible (for example when moving around in corridors and communal areas).

As in the general approach, it will not usually be necessary to wear face coverings in the classroom, where protective measures already mean the risks are lower, and they may inhibit teaching and learning.

Face coverings should also be worn by pupils in year 7 and above (all pupils in Cheshire West and Chester) when travelling on dedicated school transport to secondary school or college.

Pupils should remove their face covering before entering their classroom. They should place reusable face coverings in a plastic bag or dispose of temporary face coverings in a covered bin. Pupils should be instructed not to the touch the front of the face covering when removing it. Pupils should wash their hands after removing their facemask before going to the classroom.

If older pupils are leaving the grounds at lunchtime they should be reminded that face coverings need to be worn in shops or supermarkets.

Are there exemptions for certain pupils and staff?

Some individuals are exempt from wearing face coverings. This applies to those who:

- cannot put on, wear or remove a face covering because of a physical or mental illness or impairment or disability
- speak to or provide assistance to someone who relies on lip reading, clear sound or facial expression to communicate

The same exemptions will apply in education settings, and we would expect teachers and other staff to be sensitive to those needs.

Transport to and from school

Public Transport

Children who come to school via public transport are required to wear face coverings, and to observe social distancing.

Designated school transport

The approach to dedicated transport should align wherever possible with the principles underpinning the system of controls set out in this document and with the approach being adopted for your school. It is important, wherever it is possible, that:

- social distancing should be maximised within vehicles
- children either sit with their ‘bubble’ on school transport, or with the same constant group of children each day
- If the designated school transport includes children outside the ‘bubble’ then face coverings should be recommended
- children should clean their hands before boarding transport and again on disembarking
- additional cleaning of vehicles is put in place
- organised queuing and boarding is put in place

- through ventilation of fresh air (from outside the vehicle) is maximised, particularly through opening windows and ceiling vents

While waiting for school transport social distancing must be maintained

Immunisations

Should school-based immunisations take place?

It is really important that school-based immunisation programmes take place as normal. These programmes are essential for children's health and wellbeing and can also provide benefits for staff. Schools should engage early with their local immunisiation providers to facilitate this and advice should be sought from their Local Authority.

A child has developed a fever following vaccination do they need to isolate?

No. Vaccines may cause a mild fever in children. This is a common and expected reaction, and isolation is not required unless coronavirus (COVID-19) is suspected. Parents and carers should monitor side effects from a vaccination, and if they are concerned about their child's health, they should seek advice from their GP or NHS 111.

Is fever a side-effect of teething in young children?

No. Whilst teething can cause some known side effects such as flushed cheeks and sore gums, NHS guidelines state that fever is not a symptom of teething.

Music

Can music lessons go ahead?

When planning music provision for the next academic year, schools should consider additional specific safety measures. These include

- Playing instruments and singing in groups should take place outdoors wherever possible.
- Pupils should be positioned back-to-back or side-to-side when playing or singing
- Avoid sharing instruments and equipment (including scores and scripts). If instruments and equipment have to be shared, disinfect regularly (including any packing cases, handles, props, chairs, microphones and music stands) and always between users.
- Singing, wind and brass playing should not take place in larger groups such as choirs and ensembles, or assemblies unless significant space, natural airflow (at least 10l/s/person for all present, including audiences) and strict social distancing and mitigation as described below can be maintained

Physical Education

Schools have the flexibility to decide how physical education, sport and physical activity will be provided whilst following the measures in their system of controls.

Schools should refer to the following guidance:

- guidance on the phased return of sport and recreation and guidance from Sport England for grassroot sport
- advice from organisations such as the Association for Physical Education and the Youth Sport Trust
- guidance from Swim England on school swimming and water safety lessons available at returning to pools guidance documents

Cleaning

What additional cleaning is necessary following a symptomatic or confirmed case?

It is important to concentrate on regular cleaning of frequently touched items / surfaces. This is likely to be highly effective as high contact surfaces will present the main risk in terms of indirect transmission. So long as regular cleaning is thorough and maintained at all times there is no need for additional cleaning.

- Cleaning an area with normal household disinfectant after someone with suspected coronavirus (COVID-19) has left will reduce the risk of passing the infection on to other people.
- Wear disposable or washing-up gloves and aprons for cleaning.
- Using a disposable cloth, first clean hard surfaces with warm soapy water. Then disinfect these surfaces with the cleaning products you normally use. Pay particular attention to frequently touched areas and surfaces, such as bathrooms, grab-rails in corridors and stairwells and door handles.
- If an area has been heavily contaminated, such as with visible bodily fluids, use protection for the eyes, mouth and nose, as well as wearing gloves and an apron.
- All the disposable materials should be double-bagged, then stored securely for 72 hours then thrown away in the regular rubbish after cleaning is finished.
- Wash hands regularly with soap and water for 20 seconds, and after removing gloves, aprons and other protection used while cleaning.

Do toilets need to be cleaned after every use?

No. Toilets are frequently touched surfaces, so they need to be cleaned frequently throughout the day, but not after every use (except if used by a symptomatic person whilst waiting to go home).

Increase the frequency of cleaning toilets to at least five times a day:

before school starts
after morning break
after lunch
after afternoon break
at the end of day.

Apart from gloves and apron, there is no need for additional PPE.

Use disposable cloths or paper roll and disposable mop heads, to clean all hard surfaces, floors, chairs, door handles and sanitary fittings, following one of the options below:

- use either a combined detergent disinfectant solution at a dilution of 1,000 parts per million available chlorine

or

- a household detergent followed by disinfection (1000 parts per million available chlorine). Follow manufacturer's instructions for dilution, application and contact times for all detergents and disinfectants

or

- if an alternative disinfectant is used within the organisation, this should be checked and ensure that it is effective against enveloped viruses

Avoid creating splashes and spray when cleaning.

All the disposable materials should be double-bagged, then stored securely for 72 hours then thrown away in the regular rubbish after cleaning is finished.

Section 7: National Guidance Documents

This local guidance document has been based on national PHE, NHS and government guidance. Hyperlinks to key national guidance are displayed here for reference (click on the link to be taken to the relevant guidance/information online).

Social distancing for different groups

- Stay at home: guidance for households with possible coronavirus (COVID-19) infection
- Guidance on social distancing for everyone in the UK
- Guidance on shielding and protecting people who are clinically extremely vulnerable from COVID-19

Guidance for contacts

- Guidance for contacts of people with possible or confirmed COVID-19

Specific guidance for educational settings

- Guidance for schools and other educational settings
- Guidance for full opening of schools
- Opening schools and educational settings to more pupils: guidance for parents and carers
- COVID-19: implementing protective measures in education and childcare settings
- Safe working in education, childcare and children's social care settings including the use of PPE
- Guidance on isolation for residential educational settings
- E-bug online resource, including COVID-19 specific information

Testing

- NHS: Testing for coronavirus

Infection prevention and control

- Safe working in education, childcare and children's social care settings including the use of PPE
- Cleaning in non-healthcare settings
- 5 moments for hand hygiene: with how to hand rub and how to handwash. Posters
- Catch it. Bin it. Kill it. Poster

Coronavirus Resource Centre posters

- Available Here

Section 8: Scientific Evidence

Public Health England have reviewed the data for June 2020 on outbreaks in schools in England and concluded that outbreaks are usually small, starting more often from infected staff than students, and transmission is more likely to happen in communities than in schools.

A recent evidence review on schools and COVID-19 transmission, which builds on previous work is summarised in **Appendix 4.**

The European Centre for Disease Control has also published its finding on COVID-19 transmission in schools on 6 August 2020, and this is summarised in **Appendix 5**.

In addition, a brief review of the specifc evdience on face covering is summarised in **Appendix 6**.

APPENDIX 1 – Template to record school absences

In the event of a COVID-19 outbreak, the table will ensure that important information is recorded in one place and is easily accessible

Date	Name	Class	Reason for absence*	Date of onset of symptoms	Symptoms **	Has the child/staff been assessed by GP, NHS 111 etc? Y/N/NK	Has the child/staff been tested? Y/N/NK	Is the child/staff reporting a positive test result? Y/N/NK	Is the child/staff in hospital? Y/N/NK

Reason for absence*: Ill, Household member ill, contact of a confirmed/suspected case, Shielding, Other e.g. dental appointments

Symptoms * T = Temp (>=37.8 C), C = Cough, D = Diarrhoea, V = Vomiting, ST = Sore Throat, H = Headache, N = Nausea, LST = Loss of smell/taste, Other

APPENDIX 2 – Template to record illness at school

In the event of a COVID-19 outbreak, the table will ensure that important information is recorded in one place and is easily accessible

Date	Name	Class	Date/Time of onset of symptoms	Symptoms*	Time between detection of symptoms and isolation at school	Did staff member wear PPE?** Y/N

Symptoms * T = Temp (>=37.8 C), C = Cough, D = Diarrhoea, V = Vomiting, ST = Sore Throat, H = Headache, N = Nausea, LST = Loss of smell/taste, Other

**** Only required if social distancing could not be observed**

APPENDIX 3 – Letter for close contacts

Date: DD/MM/YYYY

FOR PARENTS OF CLOSE CONTACTS OF COVID-19 at XXXXX

Dear Parent,

We have been advised by Public Health England that there has been a confirmed case of COVID-19 within the school.

We have followed the national guidance and have identified that your child (name) has been in close contact with the affected child. In line with the national guidance your child must now stay at home and self-isolate until ADD DATE (10 days after contact). Please note that you will not necessarily be contacted by NHS Test and Trace as the school has been asked to identify all school contacts.

Self-isolation means the child/staff member should

- Not go to school, work or public places
- Not attend any other out of school activities or go around to a friends house
- Not use public transport or taxis
- Not go out to shop – order it online or ask a friend to bring it to your home
- Not have visitors in your home except for people providing essential care
- Not go out to exercise – exercise at home or in your garden, if you have one
- Inform GP practice or hospital or other healthcare setting that they are self-isolating if they must attend in person

Further advice on self-isolation is available from:https://www.nhs.uk/conditions/coronavirus-covid-19/self-isolation-and-treatment/when-to-self-isolate-and-what-to-do/

We are asking you to do this to reduce the further spread of COVID-19 to others in the community.

If your child is well at the end of the 10 days period of self-isolation, then they can return to usual activities.

Other members of your household can continue normal activities provided your child does not develop symptoms within the 10 day self-isolation period.

Please see the link to: Guidance for contacts of people with confirmed coronavirus (COVID-19) infection who do not live with the person

https://www.gov.uk/government/publications/guidance-for-contacts-of-people-with-possible-or-confirmed-coronavirus-covid-19-infection-who-do-not-live-with-the-person

What to do if your child develops symptoms of COVID-19

If your child develops symptoms of COVID-19, they should remain at home for at least 10 days from the date when their symptoms appeared. Anyone with symptoms will be eligible for testing and this can be arranged via https://www.nhs.uk/ask-for-a-coronavirus-test or by calling 119 .

All other household members who remain well must stay at home and not leave the house for 10 days. This includes anyone in your 'Support Bubble'.

The isolation period includes the day the first person in the house became ill (or the day their test was taken if they did not have symptoms, whether this was an LFD or PCR test), and the next 10 full days.

Household members should not go to work, school or public areas and exercise should be taken within the home. If you require help with buying groceries, other shopping or picking up medication, or walking a dog, you should ask friends or family. Alternatively, you can order your shopping online and medication by phone or online.

Household members staying at home for 10 days will greatly reduce the overall amount of infection the household could pass on to others in the community

If you are able can, move any vulnerable individuals (such as the elderly and those with underlying health conditions) out of your home, to stay with friends or family for the duration of the home isolation period

Please see the link to the PHE 'Stay at Home' Guidance:
https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection

Symptoms of COVID 19

The most common symptoms of coronavirus (COVID-19) are recent onset of:

- new continuous cough and/or
- high temperature and/or
- a loss of, or change in, normal sense of taste or smell (anosmia)

For most people, coronavirus (COVID-19) will be a mild illness.

If your child does develop symptoms, you can seek advice from NHS 111 at https://www.nhs.uk/conditions/coronavirus-covid-19/check-if-you-have-coronavirus-symptoms/ or by phoning 111.

How to stop COVID-19 spreading

There are things you can do to help reduce the risk of you and anyone you live with getting ill with COVID-19

Do

- wash your hands with soap and water often – do this for at least 20 seconds
- use hand sanitiser gel if soap and water are not available

- wash your hands as soon as you get home
- cover your mouth and nose with a tissue or your sleeve (not your hands) when you cough or sneeze
- put used tissues in the bin immediately and wash your hands afterwards

Further Information

Further information is available at
https://www.nhs.uk/conditions/coronavirus-covid-19/

Yours sincerely

Headteacher

APPENDIX 4– COVID-19 Risk Assessment

Please email a copy of this risk assessment to:
healthprotectionsecure@cheshirewestandchester.gov.uk

<table>
<tr><td colspan="3">Notification Record - Please keep a copy of this risk assessment for your school records</td></tr>
<tr><td colspan="2">Date: xx</td><td>CW&C Officer: xx</td></tr>
<tr><td colspan="3">Notifying person and organisation details:</td></tr>
<tr><td colspan="2">Name: xx

Job Title: xx</td><td>Contact Details: xx
Telephone: xx
Mobile: xx
Email: xx</td></tr>
<tr><td colspan="2">Total number of students in school: xx</td><td>Name and address of school: xx</td></tr>
<tr><td colspan="3">Confirmed case details:</td></tr>
<tr><td>Name: xx
Date of Birth: xx

Year group: xx
Staff or pupil: xx</td><td colspan="2">Address: xx
Contact number: xx
Telephone: xx
Mobile: xx
Email: xx</td></tr>
<tr><td><u>Symptomatic case</u>

Date of symptom onset: xx
Symptoms: xx
Date of PCR test: xx
Date of results: xx

Was the case in school in the 48hrs prior to symptom on-set or in the 10 days after symptom onset?

Yes/No</td><td><u>Asymptomatic case</u>
(case who did not have one of the three COVID symptoms)

Date of PCR test: xx
Date of results: xx

Was the case in the setting in the 48hrs prior to PCR test or in the 10 days after PCR test?

Yes/No</td><td><u>Asymptomatic case</u>
(case who did not have one of the three COVID symptoms)

Date of LFT test: xx
Date of results: xx
Date of PCR test: xx
Date of results: xx

Was the case in school in the 48hrs prior to LFT test or in the 10 days after LFT test?

Yes/No</td></tr>
<tr><td colspan="3">Does the case have any links to an existing case in the school? Yes/No

If yes, please give details: xx</td></tr>
<tr><td colspan="3">Case Contact tracing risk assessment (see definition on page 3) of a contact 48hrs before and 10 days after symptom on-set or date of swab if asymptomatic:</td></tr>
<tr><td colspan="3">Household contacts of case: Advise all household contacts to continue self-isolation for 10 days from the on-set of the cases symptoms.</td></tr>
<tr><td colspan="3">Pupils and staff (including visiting and contracted staff) who meet the definition of a contact
All contacts should self-isolate for 10 days from the last time they had contact with the case.

1. Contacts travelling to school (including transport staff, driver from another household, other children): xx

2. Contacts when entering the school: xx

3. Classroom based contacts: xx

4. Break and lunch contacts (including canteen and yard area): xx</td></tr>
</table>

5. **Activity contacts (music, sport):** xx

6. **Contacts when leaving school:** xx

7. **Contacts when travelling home** (including transport staff, driver from another household, other children)**:** xx

8. **Does the case attend any after school clubs, childcare or activities?** Yes/No

   If yes secure contact details if the provider is not the school.

Total contacts – please note if a previous case has been notified and no additional contacts are identified please do not record any further contacts.	
Total number of pupil contacts: xx	Total number of staff contacts: xx
Total number of additional transport contacts: xx	Total number of visitor contacts: xx

Letters to contacts
Have letters been issued to all contacts? Yes/No

End of self-isolation and return to school date
Return to school date (case): xx
Return to school date (contacts): xx

Are there any vulnerable pupils required to self-isolate?
Yes/No

If yes, please follow the CW&C Monitoring Absence of Vulnerable Children and Young People Process

Are there any children entitled to free school meals who are required to self-isolate?
Yes/No

If yes, please make arrangements for food delivery/parcels

APPENDIX 5 – Updated review of (25/8/2020) of scientific evidence to support decision making in schools

COVID-19 North West Science and Technical Advice Cell [STAC]
Schools and Re-opening after Covid-19 Lock Down
UPDATED REVIEW (25/8/2020) OF SCIENTIFIC EVIDENCE TO SUPPORT DECISION MAKING
Updated schools' information 20 August 2020 V 2.0

Overall, there is no change to the scientific principles or the infection prevention and control measures which NW STAC issued in May 2020, arising from more recent scientific reports on Covid-19 related to schools.

1. Challenges in schools

The challenges of this pandemic are acknowledged, particularly for the school environment. Re-opening schools is challenging and harder and less clear than closing schools or introducing lock down. However, the risks from transmission of the virus remain the same.

Extra risks around re-opening are unclear, and it is recognised that covid-19 is not just a health crisis, but also a social and economic one, bringing into sharp focus pre-existing socio-economic and racial inequalities.

This document does not address social and educational issues which also influence decisions about school opening, such as the need ongoing education of children, issues around free school meals for many families, the contribution of schools to child care, the size of classes post-lock down, the effect of inequalities on educational provision, or older children being potentially off school March-Sept and with a lack of diversionary activities leading to possible behavioural issues.

We are also mindful of wider issues, such as concerns around the cumulative impacts of opening schools on the provision of other linked services, e.g. catering, road crossings, nearby shops.

2. Infection prevention and control

• This document supplements the national safe working guidance for educational settings and the indications therein for the use of PPE (personal protective equipment). The NW STAC has raised school issues nationally, but we give our opinion until we receive further guidance.

The principles remain the same:

- Maintaining social distancing of 2 metres (3 steps, 6 feet) is important
- Hand hygiene remains key, with regular washing with soap and water for 20 seconds
- Respiratory etiquette is important to be maintained always
- Increased cleaning between classes should be undertaken
- Daily checks should be made of everyone, to verify that they are well and able to attend school
- In situations where social distancing cannot be maintained, e.g., a child or a staff member become unwell, then PPE should be used as per DoE guidance

3. The scientific principles

- Children are less likely than adults to spread covid-19, both at home and school
- Most children with covid-19 acquired it from adults and not the reverse
- Adherence to social distancing is far more important than which pupils are in school
- Transmission is affected by age: younger children transmit less than older children
- The disease in children is usually mild and self-limiting, lasting 7–10 days
- Children may present with gastrointestinal symptoms with or without respiratory symptoms (dry cough, sore throat, breathlessness); fever may be absent
- Rarely, toxic shock like syndrome / atypical Kawasaki disease in children has been reported but does not affect the risk of transmission
- Early identification of cases, clusters and outbreaks is vital to reduce spread
- Current UK guidance stipulates that face masks should not be universally worn in educational settings, as it is known that children will have a lower tolerance and/or may not be able to use the mask properly
- Social distancing should be observed by staff and other service providers in schools and by parents who are collecting children
- Any child or adult who is unwell for any reason should not attend or visit school

4. Evidence (updated 25/6/2020)

Relevant evidence is still limited due to the short time that the disease has been studied. There have been several reviews around educational settings: in particular by Sage[1], Public Health England[2] and The European Centre for Disease Control[3]. We have taken these reviews and other papers into account. These reviews have not changed the overall conclusions of the earlier NW STAC summary, as above.

4.1. School outbreaks June 2020 – PHE report

Public Health England reviewed all Covid-19 outbreaks (≥ 2 confirmed cases) in English schools occurring during June 2020 (partial reopening: nursery, reception, year 1 and year 6 in primary schools; years 10 and 12 in secondary schools)[4]. The outbreaks were recorded in routine public health data collection. The full article can be found here.

4.1.1. Key Findings

Out of 170 reports, there were 67 (39%) single confirmed cases with no transmission, 4 (2%) situations with co-primary cases (siblings), and 30 (18%) Covid-19 outbreaks; 69 (40%) other investigations did not identify Covid-19 infections. In the 101 confirmed situations, 70 children and 128 staff members were confirmed cases.

There was a strong correlation between number of outbreaks and relevant regional COVID-19 incidence. Larger outbreaks were mainly in the early-years settings (7, 23%) and primary schools (18, 60%) as more children attended these settings. Secondary schools (2, 7%) and SEND schools (3, 10%) had fewer outbreaks. Outbreaks were small: 53% had only one confirmed case and one secondary case. Of the 18 primary school outbreaks, 9 involved only staff (affecting 32 members), including 5 in which only 2 staff members were affected.

Staff (22 outbreaks) were the source of infection more often than students (8): staff to staff (15), staff to student (7), student to staff (6), student to student (2). Where a potential source was identified, for the 30 student cases the commonest source was staff (for 17), then household (8) then a fellow student (2); for the 91 staff cases school transmission was commonest: staff (46), student (6), with 9 from a household source.

4.1.2. Public Health conclusions

- Outbreaks of Covid-19 can occur in schools but are usually small.
- The number of school outbreaks in an area reflect the transmission of Covid-19 in that region.
- While transmission can arise from an infected child, more transmission in schools arises from staff.
- It is important to keep symptomatic staff and students out of the school.
- Informing the local Health Protection Team early will help control an outbreak more quickly.

5. Previous reports

Children of all ages can contract the disease[1-3 5 6] but do not appear to play a major role in transmission[1-11]. There is consistent (limited, weak) evidence that transmission of Covid-9 in schools is low; modelling suggests that re-opening schools at reduced capacity, particularly for younger children, might not be associated with an epidemic rebound[2], although there is some disagreement about this[3]. Closures of childcare and educational institutions are unlikely to be an effective single control measure for community transmission[3].

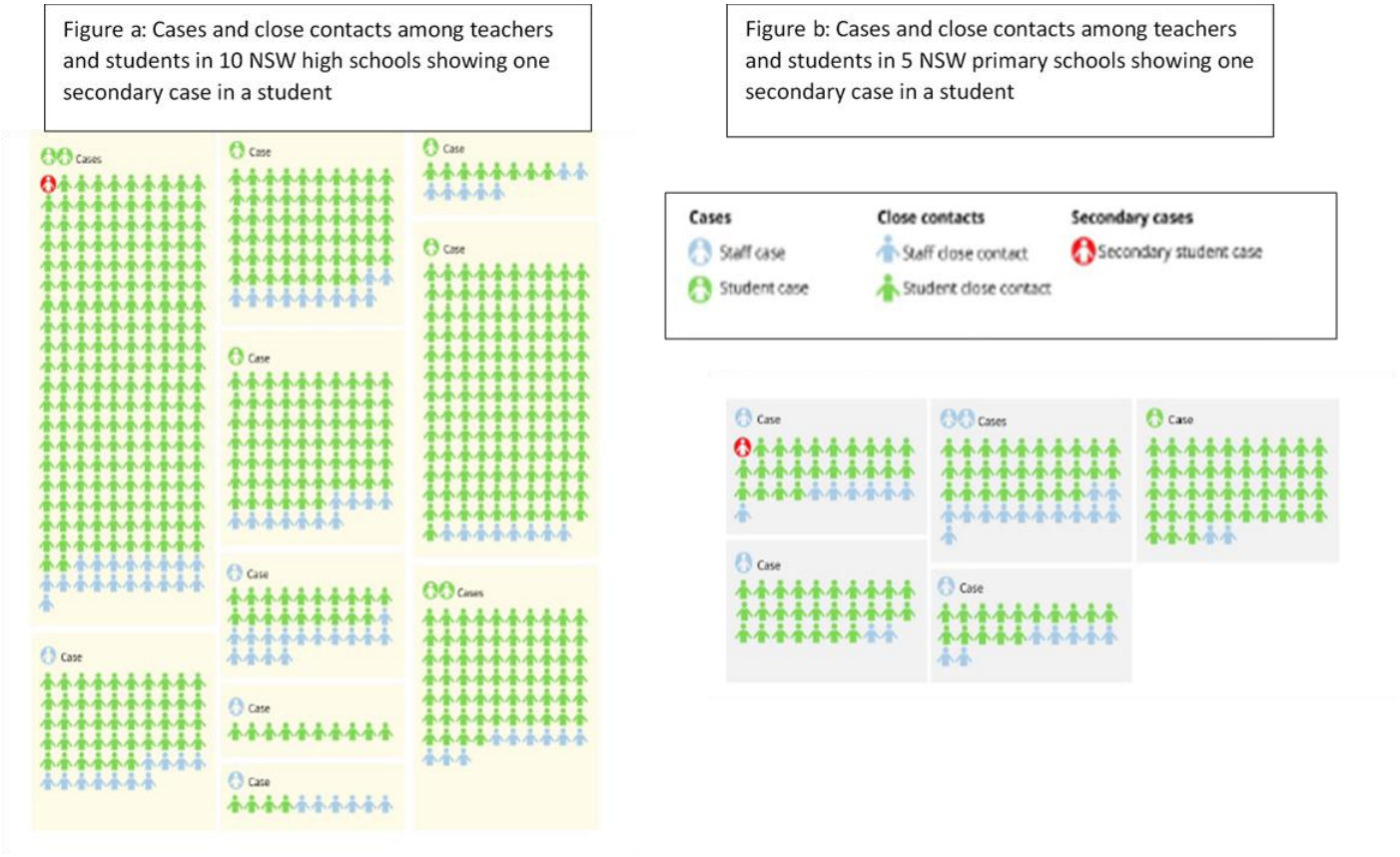
Follow up of the 1,938 contacts of 335 cases in Guangzhou, China, showed that within household transmission was higher than outside, although schools are not mentioned[12]. Children in the UK and elsewhere are a small percentage of covid-19 cases (1% UK)[5] or hospital patients[13]. There may be a risk of faecal-oral spread from children[14].

In New South Wales, Australia, 18 covid-19 cases (nine students, nine staff) across 10 secondary schools and five primary schools were followed up, with 735 students and 128 staff who were close contacts (**Figure**). No adult staff member contracted the disease from any of the initial cases; one child in primary and one in secondary school may have contracted the disease in school[15], although not all contacts were

tested, and asymptomatic cases may have been missed. In Northern Ireland, among 1,001 child contacts of six cases there were no confirmed cases of Covid-19. In the school setting, there were 924 child contacts with an additional 101 adult contacts. There were no confirmed cases of covid-19 in these 1,025 school contacts[16].

Advice for schools in European situations is similar to that in the UK: slow opening of schools with careful surveillance of anyone with COVID-19 and their contacts[3 17 18].

Figure: Cases with Covid-19 and contacts in 15 New South Wales schools, March–April 2020 15



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APPENDIX 6 – Review of current (August 2020) scientific advice by The European Centre for Disease Prevention and Control

COVID-19 North West Science and Technical Advice Cell [STAC]

Schools and Re-opening after Covid-19 Lock Down

REVIEW OF CURRENT (August 2020) SCIENTIFIC EVIDENCE TO SUPPORT DECISION MAKING

This document summarises a review from the European Centre for Disease Prevention and Control. The full article (*ECDC. COVID-19 in children and the role of school settings in COVID-19 transmission. 6 August 2020*) and associated references can be found here.

KEY FINDINGS

- A small proportion (<5%) of overall COVID-19 cases reported in the EU/EEA and the UK are among children (those aged 18 years and under).
- Children are more likely to have a mild or asymptomatic infection, meaning that the infection may go undetected or undiagnosed.
- Investigations of cases identified in school settings suggest that child to child transmission in schools is uncommon and not the primary cause of SARS-CoV-2 infection in children whose onset of infection coincides with the period during which they are attending school, particularly in preschools and primary schools.
- If appropriate physical distancing and hygiene measures are applied, schools are unlikely to be more effective propagating environments than other occupational or leisure settings with similar densities of people.
- Current evidence from contact tracing in schools, and observational data from a number of EU countries suggest that re-opening schools has not been associated with significant increases in community transmission.

PUBLIC HEALTH INTERPRETATION

- Closures of childcare and educational institutions are unlikely to be an effective single control measure for community transmission of COVID-19 and such closures would be unlikely to provide significant additional protection of children's health.
- Decisions on control measures in schools and school closures/openings should be consistent with decisions on other physical distancing and public health response measures within the community.
- IPC measures in the community, such as physical distancing, cancellation of mass gatherings, hand hygiene and staying home if symptomatic, remain integral to preventing schools from becoming a setting for accelerating onward transmission.
- If these measures are in place in the community, and if infection control policies - including practising hand hygiene and staying at home for students and staff with symptoms are also applied in schools themselves, the likelihood of COVID-19 transmission in the school setting is not higher than the likelihood in the community at-large.

1. Epidemiology and disease characteristics of COVID-19 in children

- As of 26 July 2020, children made up a very small proportion of the 744 448 cases reported in the EU/EEA and in the UK; 31 380 (4%) were children aged under 18 years. Of these, 7044 (24% of children) were below five years of age, 9 645 (32%) between five and 11 years and 13 020 (44%) between 12 and 18 years.
- COVID-19, like SARS and MERS, is observed less frequently in children, who tend to present milder symptoms and have a better overall outcome than adults
- Other symptoms include gastrointestinal symptoms, sore throat/pharyngitis, shortness of breath, myalgia, rhinorrhoea/nasal congestion and headache, with varying prevalence among different studies
- Among children reported by EU/EEA countries and the UK, the proportion of cases hospitalised were lowest in the age groups 5-11 years and 12-18 years (3% and 4% respectively) and highest among 0-4 year olds (10%).
- Pre-existing medical conditions have been suggested as a risk factor for severe disease and ICU admission in children and adolescents
- Several countries affected by the COVID-19 pandemic reported cases of children who were hospitalised in intensive care units due to a rare paediatric inflammatory multisystem syndrome (PIMS) or multisystem inflammatory syndrome in children (MIS-C), characterised by a systemic disease involving persistent fever, inflammation and organ dysfunction following exposure to SARS-CoV-2

2. Viral shedding of SARS-CoV-2 among children

- The detection of viral RNA by PCR does not directly indicate infectivity.
- Based on the limited case data, shedding of viral RNA through the upper respiratory tract may be of shorter duration in children than adults.
- In contrast, children show prolonged viral shedding via the gastrointestinal route after clearing the virus from the respiratory tract.
- There does not appear to be a significant difference in viral RNA load between symptomatic children and symptomatic adults, indicating that children shed viral RNA (whether viable or not) in a similar manner to adults - this does not, however, indicate whether children transmit the infection to an equal extent, given that the exact load of viable virus is unknown and that it will depend on the specimen from which the virus is identified.

3. Infectiousness of children in household settings

- A non-peer reviewed Italian study showed the attack rate among contacts of 0-14 year old cases was 22.4%
- In South Korea, a study showed the attack rate among household contacts of index cases aged 0-9 years and 10-19 years was 5.3% and 18.6%, respectively, indicating transmission potential in both children and adolescents, and possibly more effective transmission in adolescents than in adults.
- These results, consistent with unpublished data from EU/EEA and UK contact tracing efforts, support the transmission potential of children, in household settings.

4. Evidence relating to the role of childcare and school settings in COVID-19 transmission

4.1 What is the evidence of transmission between children within the school setting?

- Available evidence appears to suggest that transmission among children in schools is less efficient for SARS-CoV-2 than for other respiratory viruses such as influenza
- A number of studies have evaluated secondary transmission in school settings. In summary, in children where COVID-19 was detected and contacts followed-up, only one child contact in the school setting was detected as SARS-CoV-2 positive during the follow-up period.
- The conclusion from these investigations is that child-to-child transmission in schools is uncommon and not the primary cause of SARS-CoV-2 infection of children whose infection onset coincides with the period during which they are attending school.

4.2 What is the evidence of transmission from children (students) to adults (teacher/staff) within the school setting?

- In studies where COVID-19 in children was detected and contacts followed-up, no adult contacts in the school setting have been detected as SARS-CoV-2 positive during the follow-up period. The conclusion from these investigations is that children are not the primary drivers of SARS-CoV-2 transmission to adults in the school setting.

4.3 What is the evidence of transmission from adults (teacher/staff) to children (students) within the school setting?

- In Ireland, three adult cases had a total of 102 child contacts that did not result in detection of any secondary child cases although, only symptomatic individuals were referred for follow-up testing
- In Australia, a contact tracing study in 15 primary and high schools where nine staff-member-COVID-19 cases were detected found one secondary positive case in a secondary school student (among 735 child close contacts who were followed up)
- In summary, while there is evidence of transmission from adults to children in household settings, there is little evidence of this occurring within the school setting.

4.4 What is the evidence of transmission between adults (teacher/staff) within the school setting?

- In Sweden, where schools for children younger than 16 years remained open, the Public Health Authority analysed occupational groups within the school and found that teachers were at no higher risk of COVID-19 than the general public
- Recommendations for Swedish schools were that everyone with mild symptoms remain at home, to practise physical distancing, to cancel mass gatherings within the school setting, and to practise hand hygiene while in the school setting

4.5 What is the effect of school openings on community transmission?

- There is limited evidence that schools are driving transmission of COVID-19 within the community, however there are indications that community transmission is imported into or reflected in the school setting.
- Given that all countries have implemented additional non-pharmaceutical interventions in addition to school closures, it is difficult to assess the true impact of school closure/opening on transmission of SARS-CoV-2 within the community from the school setting itself

5. IPC Measures

5.1 Social distancing

- Physical distancing is considered to be the most effective measure for reducing the risk of COVID-19 transmission.
- In childcare and educational facilities, this measure can definitely be considered and approaches implemented to establish it, taking into account the feasibility and appropriateness of the measures for the age group.
- Clusters and outbreaks of COVID-19 during choir practice and performances or potentially associated with speaking loudly or shouting point towards the need for stricter implementation of physical distancing, avoiding gatherings of children and adolescents and particular activities entailing shouting, such as indoor athletic practice, indoor choir, singing contests or theatrical rehearsals.

5.1 Face masks

- In the school setting, it is challenging to implement the permanent wearing of masks, as it is known that children will have a lower tolerance and/or may not be able to use the mask properly
- A number of countries have introduced the requirement to wear face masks in schools, with variations in recommendations depending on the age groups. Most commonly the requirement to wear a face mask starts in the >12-year age group, with teachers and other staff also required to do the same
- Current UK guidance stipulates that face masks should not be universally worn in educational settings

5.2 Hand hygiene

- SARS-CoV-2 is believed to be transmitted mainly via respiratory droplets and by direct contact. However, indirect contact with contaminated fomites is also believed to play a role in transmission.
- Frequent and meticulous hand washing and disinfection plays a key role in mitigating the risk of COVID-19 transmission.
- Hands should be washed/sanitized regularly, especially after contact with frequently touched surfaces, before eating, drinking, and after using the toilet

5.3 Respiratory etiquette

- Similar to hand hygiene, respiratory etiquette is an essential measure aimed to reduce the risk of COVID-19 transmission. It includes mainly covering of nose and mouth with a paper tissue when sneezing or coughing to help reduce the spread of potentially infectious droplets.
- Used paper tissues should be disposed of immediately, ideally into no-touch bins (handsfree), and hands should be washed/sanitised immediately afterwards.

5.4 Ventilation

- Poor ventilation in indoor spaces is associated with increased transmission of respiratory infections, particularly if confined. Transmission of COVID-19 has been associated with closed spaces, including some from pre-symptomatic cases
- It is therefore important that proper ventilation – preferably with fresh air (i.e. by opening windows and doors) – is practiced, whenever possible, in all the school areas visited by children and adults (e.g. classrooms, corridors, canteen, etc.).
- Heating, ventilation, and air conditioning (HVAC) systems may have a complementary role in decreasing transmission in indoor spaces by increasing the rate of air exchange, decreasing recirculation of air and increasing the use of outdoor air when well maintained.
- It is important that HVAC systems are properly maintained and operated to fulfil their role, according to manufacturer’s instructions.

APPENDIX 7 – Review of face covering evidence – updated 26/08/2020

COVID-19 North West Science and Technical Advice Cell [STAC]

Face coverings – updated 26/8/2020

1. Background

Face coverings are mandatory in England in indoor settings where maintaining social distancing is difficult (e.g. transport, shops). The use of face coverings in schools by children in Year 7 or above is discretionary on the head teacher's decision. However, from 1st September in England, in local intervention (lockdown) areas, in education settings where Year 7 and above are educated, face coverings should be worn by adults and pupils when moving around, such as in corridors and communal areas where social distancing is difficult to maintain[1].

Advice from PHE on making a face covering and a BBC video on how to wear one safely are available.

In addition to the physical barrier presented by a good face covering[1] in crowded places[2], times of possible contamination abound, including when putting a face covering on or off, and packaging one for reuse, disposal or washing. The need to wash hands correctly before and after touching a face covering, and the complete and continuous covering of the mouth and nose when wearing the face covering, must be remembered.

Transmission of Covid-19 is believed to be largely airborne (droplets[3] and aerosols[4]). Respiratory droplet and aerosol travel depend on the velocity and mechanism of expulsion from their source, the density of respiratory secretions, environmental factors (e.g. temperature, humidity), and the pathogen's ability to maintain infectivity over that distance[5].

2. How strong is the underlying science for the use of face coverings?

There are two sides to the science, epidemiology of coronavirus transmission, and the physics of droplet / aerosol spread from the mouth and nose.

2a. Epidemiology

Various reviews of the effectiveness of face coverings have been published[6 7 8] although the primary literature has been inconsistently interpreted by policy makers[5]. A large-scale WHO supported systematic meta-analysis[9] of relevant studies in all languages for Covid-19, MERS-CoV and SARS identified 172 observational studies across 16 countries and six continents, with no randomised controlled trials, and 44 relevant comparative studies in health-care and non-health-care settings (n=25,697 patients). It concluded that wearing face coverings can reduce the transmission of Covid-19[9]. Reduced transmission of proven Covid-19 has also been observed in health-care settings in the pandemic through the use of face coverings[10].

Wearing face coverings is acceptable and feasible in communal settings6 9 but must not be over-relied on, instead thy should be used in conjunction with other infection prevention and control measures[7 9].

The protection offered by face coverings appears less to the wearer than to those around, being more effective in reducing exhalation droplet spread than reducing inhalation[11].

2b. Wider evidence

The epidemiology of Covid-19 is in line with the physics of droplet spread from the upper airways and mouth. The classic 1934 study of Wells[12] has recently been repeated and extended, concluding that large droplets expelled from the upper airways and mouth are carried by exhaled air more than 6 m at a velocity of 50 m/s by sneezing, more than 2 m at a velocity of 10 m/s by coughing, and <1 m at a velocity of 1 m/s by breathing[13]. Coughing produces the largest droplet concentrations and nose breathing the least, although considerable inter-subject variability has been observed[14].

3 Conclusion

Face coverings in public settings are an adjunct to, but are not a replacement for, social distancing (which remains more effective), hand hygiene and other infection prevention measures. No measure is 100% effective at preventing transmission, but the measures together may prove additive.

Face coverings are not recommended for children under 2y[15]; they may be challenging for older children, with risks of contamination with inappropriate use.

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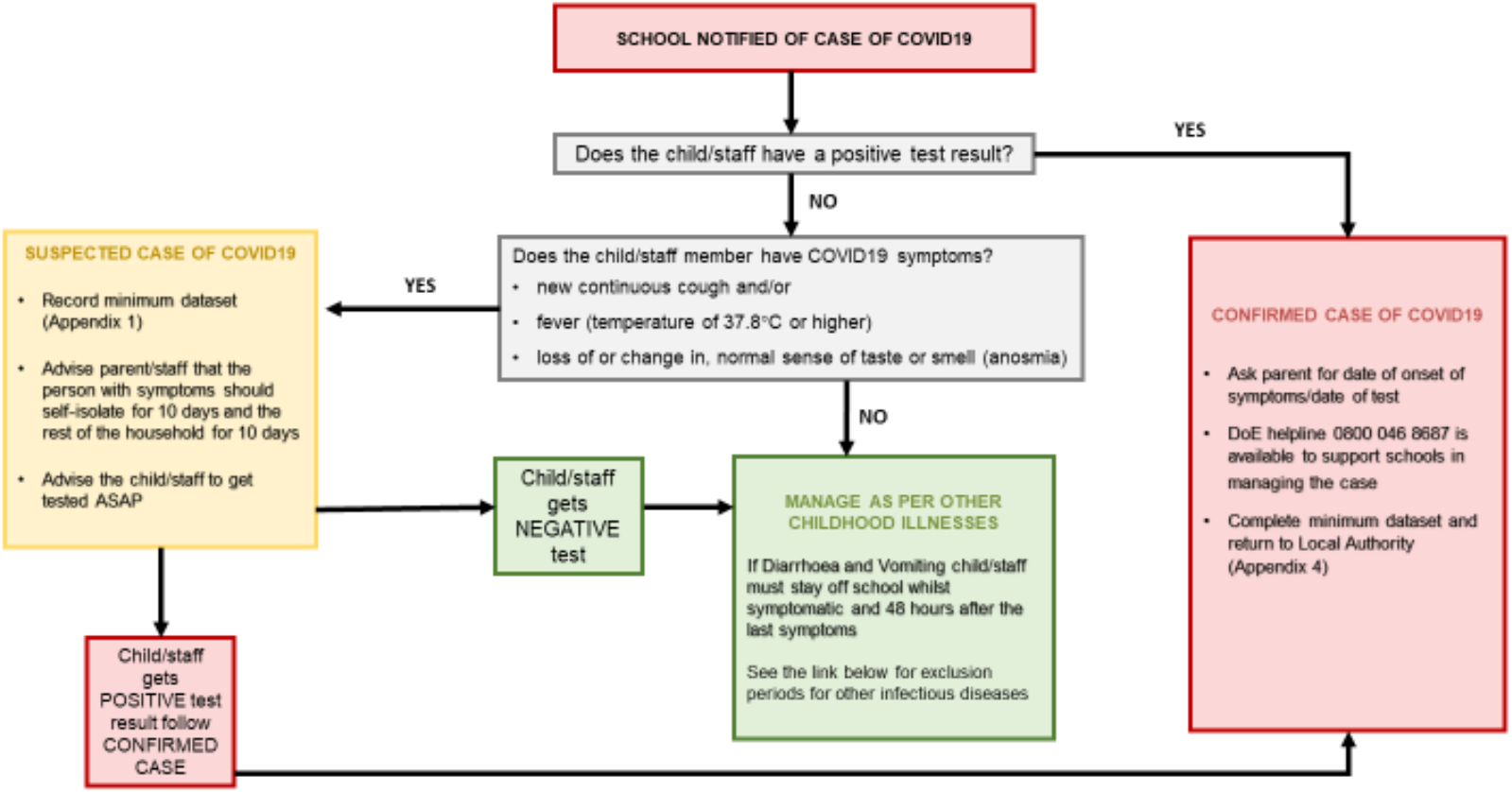
APPENDIX 8 – Flowchart for dealing with suspected and confirmed COVID—19 cases



Guidance on exclusion periods for common childhood diseases can be found here