



Public Health
England

Protecting and improving the nation's health

PHE NW COVID-19 Lancashire Resource Pack for Schools

Version 2.4

3rd September 2020

About Public Health England

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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Version	Status	Author	Details of Change/Superseded document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

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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 4).

Section 1: Local Area Key Contacts

For COVID-19 queries related to educational settings

Local contact details

Lancashire County Council Public Health
7 days a week, 9am to 5pm

Contact email address:

COVID19-
HealthProtection@lancashire.gov.uk

To notify confirmed cases of COVID 19 and suspected outbreaks, please contact your local health protection team via the relevant hub for your area as detailed below

Cheshire and Merseyside	0344 225 0562 (option 0 then option 1)
Cumbria	0344 225 0562 (option 0 then option 2)
Greater Manchester	0344 225 0562 (option 0 then option 3)
Blackburn with Darwen, Blackpool and Lancashire	0344 225 0562 (option 0 then option 2)

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)

Children may also display gastrointestinal symptoms.

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.

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.

What PPE is recommended for teachers and children?

From 1st September in England, the use of face coverings in schools by children in Year 7 or above is discretionary on the head teacher's decision.

However, in areas with local intervention (lockdown), 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. 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.

In the event of new local restrictions being imposed, schools and colleges will need to communicate quickly and clearly to staff, parents, pupils and learners that the new arrangements require the use of face coverings in certain circumstances. This updated guidance on face coverings for areas of national government intervention will come into effect on 1 September ([Face Covering Guidance](#)).

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) clean hands thoroughly more often than usual
- 3) ensure good respiratory hygiene by promoting the 'catch it, bin it, kill it' approach
- 4) introduce enhanced cleaning, including cleaning frequently touched surfaces often, using standard products such as detergents and bleach
- 5) 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.**
- 6) Face covering should be worn as per guidance (see above).

Section 3: Management of a suspected case

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

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 minimum dataset (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 14 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 confirmed case

If a child who attends or staff member who works at an educational setting tests positive for COVID-19 then the school will be contacted by a contact tracer. This contact tracer may be based either in the Local Authority or the local Health Protection Team. If a headteacher is informed by a parent or staff member that a child or staff member has tested positive and has not already been contacted by a contact tracer then they should notify both the Local Authority and their local Contact Tracing Team (see hub details at front of pack). Schools in Lancashire, Blackpool and Blackburn with Darwen should ring the local Health Protection Team on 0344 225 0562 option 3.

The headteacher or appropriate member of the leadership team at the educational setting will be asked to work with the contact tracer to 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.

- **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

See page 13 for a fuller description of a contact in a school setting.

All direct and close contacts will be excluded from school and advised to self-isolate for 14 days starting from the day they were last in 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 14 day period is on the Monday. Household members of contacts do not need to self-isolate unless the contact develops symptoms.

The contact tracer will provide a standard letter to the school containing the advice for contacts and their families; the school will be asked to send the letter to the identified contacts.

Contacts will not be tested unless they develop symptoms (contract tracer may provide advice on this). 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>.

Section 5: Arrangements for management of a possible outbreak

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

If a school has come across two or more confirmed cases, or there is a high reported absence which is suspected to be COVID-19 related, then the local health protection team or the local authority public health team should be notified promptly (see front page).

However, it is probable that some outbreaks will be identified by either the local health protection team or the local authority public health team and the school will then be contacted by one of these teams.

Section 6: Planning for local restrictions

Schools are expected to plan for the possibility of local restrictions (from national direction) and how they will ensure continuity of education in exceptional circumstances where there is some level of restriction applied to education or childcare in a local area.

Full guidance can be found [here](#).

Restrictions will be implemented in a phased manner. These 'tiers of restriction' will ensure that extensive limitations on education and childcare are a last resort, and that priority is given to vulnerable children and children of critical workers for face-to-face provision in all cases.

Tiers of restriction

Tier 1 – The default position for areas in national government intervention is that education and childcare settings will remain open. An area moving into national intervention with restrictions short of education and childcare closure is described as 'tier 1'. There are no changes to childcare, and the only difference in education settings is that 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.

Tier 2 - Early years settings, primary schools and alternative provision (AP) providers, special schools and other specialist settings will continue to allow all children/pupils to attend on site. Secondary schools move to a rota model, combining on-site provision with remote education. They continue to allow full-time attendance on site to vulnerable children and young people and the children of critical workers. All other pupils should not attend on site except for their rota time. Further education (FE) providers should adopt similar principles with discretion to decide on a model that limits numbers on site but works for each individual setting.

Tier 3 - Childcare, nurseries, primary schools, AP, special schools and other specialist settings will continue to allow all children/pupils to attend on site. Secondary schools, FE colleges and other educational establishments would allow full-time on-site provision only to vulnerable children, the children of critical workers and selected year groups (to be identified by Department for Education). Other pupils should not attend on site. Remote education to be provided for all other pupils.

Tier 4 – All nurseries, childminders, mainstream schools, colleges and other educational establishments allow full-time attendance on site only to our priority groups: vulnerable children and the children of critical workers. All other pupils should not attend on site. AP, special schools and other specialist settings will allow for full-time on-site attendance of all pupils. Remote education to be provided for all other pupils.

Section 7: 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 14 days starting from the day the household member(s) became ill. If the child subsequently develops symptoms then 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?

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 14 days. If the child tests positive for COVID-19, direct and proximity contacts should be excluded for 14 days. The school will be contacted by contact tracers to support with contact identification and provision of advice.

If I am notified by a parent that their child has had a positive test do I need to exclude the other children in their class or notify anybody?

The school should notify the local HPT/contact tracing hub as per contact details on page 5. The health protection team/contact tracer will advise on identifying and excluding contacts appropriately.

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 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
- 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.

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 feel well and they have not had a fever for 48 hours.

If the child is a contact of a confirmed case they must stay off school for the 14 day isolation period, even if they test negative. This is because they can develop the infection at any point up to day 14 (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 14 days of isolation.

Does a child 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 and the child is fever free for 48 hours.

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.

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?

All schools and Further Education providers will receive an initial supply of 10 home test kits. Home test kits should only be offered if you believe an individual may be unable to access testing elsewhere. The full guidance from DfE regarding access to testing can be found here [accessing tests in schools](#)

High risk groups

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

Since the 1st August 2020 shielding measures have been paused as rates of community transmission of COVID19 are now much lower. Therefore, children or staff who have previously been shielding can return to school so long as the school has put in place the preventative measures on page 7. If the school is in an area of local lockdown due to a rise in infections, then people may be advised to shield again. The school should check with their local authority.

Further advice on shielding is available at [Current advice on shielding](#)

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 were previously in the shielding group can return to 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 (within 2 metres for more than 15 minutes) with the case. 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](#). Here is a [BBC video on how to wear one safely](#).

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?

Where the transmission of the virus is high (areas with local intervention) face coverings are recommended for staff and pupils in year 7 and above in line with [national guidance](#).

Where the transmission of the virus is not high (areas without local intervention), schools and colleges will have the discretion to require face coverings in communal areas where social distancing cannot be safely managed, if they believe that it is right in their particular circumstances.

Examples of where education leaders might decide to recommend the wearing of face coverings - for pupils and staff - in communal areas of the education setting include:

- where the layout of the school or college estate makes it particularly difficult to maintain social distancing when staff and pupils are moving around the premises
- where on top of hygiene measures and the system of controls recommended in the full opening guidance to schools and FE colleges and providers, permitting the use of face coverings for staff, pupils or other visitors would provide additional confidence to parents to support a full return of children to 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 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 immunisation providers to facilitate this and advice should be sought from their Local Authority.

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 grassroots 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 8: 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 COVID19](#)

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](#)

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 9: 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 3**.

The European Centre for Disease Control has also published its finding on COVID19 transmission in schools on 6 August 2020, and this is summarised in **Appendix 4**.

In addition, a brief review of the specific evidence on face covering is summarised in **Appendix 5**.

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 – 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 Sage¹, Public Health England² and The European Centre for Disease Control³. 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 transmission¹⁻¹¹. 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 rebound², although there is some disagreement about this³. Closures of childcare and educational institutions are unlikely to be an effective single control measure for community transmission³.

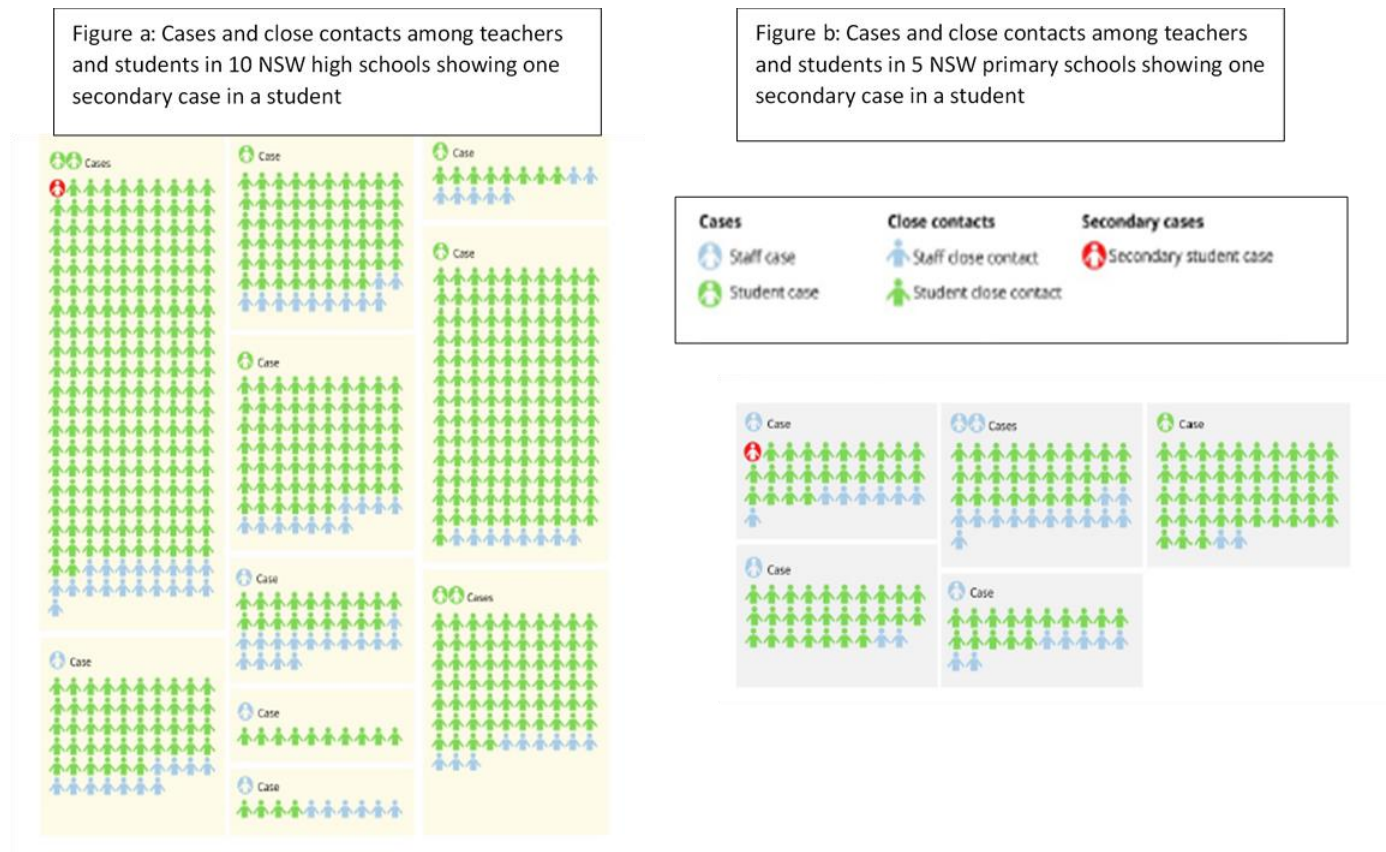
Follow up of the 1,938 contacts of 335 cases in Guangzhou, China, showed that within household transmission was higher than outside, although schools are not mentioned¹². Children in the UK and elsewhere are a small percentage of covid-19 cases (1% UK)⁵ or hospital patients¹³. There may be a risk of faecal-oral spread from children¹⁴.

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 school¹⁵, 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 contacts¹⁶.

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 4 – 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 5 – 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 maintain¹.

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 covering¹ in crowded places², 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 (droplets³ and aerosols⁴). 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 distance⁵.

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 makers⁵. A large-scale WHO supported systematic meta-analysis⁹ 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-19⁹. Reduced transmission of proven Covid-19 has also been observed in health-care settings in the pandemic through the use of face coverings¹⁰.

Wearing face coverings is acceptable and feasible in communal settings^{6 9} but must not be over-relied on, instead they 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 inhalation¹¹.

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 Wells¹² 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 breathing¹³. Coughing produces the largest droplet concentrations and nose breathing the least, although considerable inter-subject variability has been observed¹⁴.

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 2y¹⁵; they may be challenging for older children, with risks of contamination with inappropriate use.

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APPENDIX 6 – Flowchart for dealing with suspected and confirmed COVID—19 cases

