Public Health England

Protecting and improving the nation's health

PHE NW COVID-19 Template Resource Pack for Madrasahs

Procedures for suspected or confirmed case of coronavirus (COVID-19)

BwD Version 7

24th September 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.

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 4).

Section 1: Local Area Key Contacts

For COVID-19 queries related to educational settings including Madressah in BwD

For Covid related questions please contact the Education Response Team on 01254 588199 or email @ EdResponseTeam@blackburn.gov.uk

Education Response Team

- **Resilience:** Sarah Riley / Rachel Hutchinson / Adam Patel
- **HR:** Hellen Brooks
- **Health and Safety:** Helen Moran
- **Education Risk Advisor:** Julie Hemingway
- **Education Services:** Andrew Hutchinson
- **Public Health:** Iona Lyell / Liz Johnston

To notify outbreaks of COVID 19, please contact your local health protection team as detailed below:

Blackburn with Darwen, Blackpool and Lancashire	0344 225 0562

Out of Hours PHE Contact:

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

Please note, this is only to be used if really necessary, e.g an outbreak (more than two cases) in a school setting, that absolutely cannot wait until office hours.

For a confirmed case, the Madrasah should complete the minimum data set (Appendix 3) and send it to the local authority via BWD.COVID19@blackburn.gov.uk

Where Madrasahs are unable to contact the Education Response Team, the Department for Education Helpline for COVID-19 enquiries and support is now live. Helpline Number: **0800 046 8687** Select option for reporting positive case

Line is open Monday to Friday 8am to 6pm and Saturday to Sunday 10am to 4pm

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.

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. In Madrasahs this will be the responsibility of the lead teacher.

In BwD, in school settings where Year 7 (11) 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. This also applies to **adults** in primary schools. 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.** This advice applies to Madrasah settings also.

Please also see Section 5: Face coverings of FAQs which is now a separate document.

What are the protective measures that the Madrasah needs 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 the Madrasah

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 activities that have the potential for being in close proximity to other individuals. **This must be properly considered, and Madrasahs must put in place measures that suit their particular circumstances.**

6) Face covering should be worn as per BwD guidance (see above and Section 5 of FAQs document).

Section 3: Management of a suspected case

What to do if a child or staff member is unable to attend the Madrasah 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 the Madrasah and should follow the steps below:

- Parent/Carer or staff member should notify the Madrasah of their absence by phone immediately
- The Madrasah should record and keep minimum dataset which should be held in the Madrasah (see suggested template in Appendix 1): Reason for absence, date of onset of symptoms, symptoms, class, possible contacts 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 should get tested via NHS UK website 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 develop 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 Madrasah at this time, and no need to notify the Local Authority or Health Protection Team.**

If confirmation of laboratory diagnosis is delayed (failure to get a test appointment within 3 days of developing symptoms) the following actions should be followed:

  - The symptomatic child/staff member needs to be excluded for 10 days
  - Siblings from the same household who attend the Madrasah should be excluded for 14 days
  - Any other household contacts should self-isolate for 14 days
  - If the pupil/staff member with symptoms cannot get a test appointment within 3 days of onset of symptoms please contact the local authority via 01254 588199 or BWD.COVID19@blackburn.gov.uk for further advice.

What to do if someone falls ill while at the Madrasah

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

Adults / Staff members

- Decide on rooms within the setting which can be used as isolation rooms and identify with appropriate signage if in use;
- If it is a member of staff and they can drive themselves home, they should do so immediately.
- Where an adult needs to be collected they should be removed to a room where they can be isolated with the door closed and a window open for ventilation.
- All areas they have been used should be cleaned down using the Madrasah's usual cleaning materials following PHE guidance on cleaning non-healthcare settings.
- If it is not possible to isolate them, move them to an area that is at least 2 metres away from other people.

Children

- If a child is awaiting collection, they should be moved, if possible, to a room where they can be isolated behind a closed door (if the door has a window in it), 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.
- All PPE worn by the supervising adult should be removed as per the donning and doffing guidance. This, along with disposable cleaning cloths and tissues, should be put it in a plastic rubbish bag and tied when full. Place the plastic bag in a second bin bag and tie it. Put it in a suitable and secure place marked for storage for 72 hours. Waste should be stored safely and securely kept away from children. You should not put your waste in communal waste areas until the waste has been stored for at least 72 hours. Storing for 72 hours saves unnecessary waste movements and minimises the risk to waste operatives.

- The supervising adult should wash their hands thoroughly for 20 seconds with soap and warm water. At this point, they do not need to go home.

- Record which staff have looked after/had contact with the symptomatic child.

- In an emergency, call 999 if the person is seriously ill or injured or their life is at risk. Do not visit the GP, pharmacy, urgent care centre or a hospital.

- The isolation room, toilet and anywhere else the symptomatic person has been should be cleaned after they have left following PHE guidance.

- Consider removing the rest of the children and staff to a different part of the Madrasah while cleaning takes place.

- PPE must be worn by staff caring for the child while they await collection 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 must 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

N.B. The member of staff will still be considered a contact if the case tests positive. The PPE will reduce the risk of transmission.

- In exceptional circumstances, where it is not possible for a child or young person to be collected and the Madrasah needs to take responsibility for transporting the child home, they should use:
    - A vehicle with a bulkhead (partition between the driver and passenger);
    - The driver and passenger should be 2m apart;

  The driver should wear PPE and the passenger should wear a fluid resistant surgical facemask if old enough to do so.

- **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 the Madrasah 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 Madrasah should complete the minimum dataset (Appendix 3) and submit it securely to the Local Authority via BWD.COVID19@blackburn.gov.uk

The Madrasah 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

- The teacher or appropriate adult from the Madrasah should gather the following information to assist with identification of close contacts:
  - The case's date of onset of their illness, the date on which they were tested, and their attendance record at the Madrasah.

The INFECTIOUS PERIOD IS FROM 2 DAYS BEFORE ONSET OF SYMPTOMS (or the date of test if they don't have symptoms) UNTIL 10 DAYS AFTER SYMPTOMS STARTED

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

- **If the staff member or pupil has been at the Madrasah during the infectious period**, the lead teacher 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 the Madrasah outside the classroom should reduce the number of other direct/close contacts.

- All close/direct contacts should be excluded from the Madrasah for 14 days following their last contact with the case. For example, if the case tests positive on Thursday and was last at the Madrasah 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.

- **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

N.B. This is irrespective of whether the contact was wearing PPE at the time

- The Madrasah should send to the identified close contacts and their families a standard letter containing the advice (see Appendix 8).

- The Madrasah should complete the minimum dataset (Appendix 3) and send it to the local authority via BWD.COVID19@blackburn.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.

If the Madrasah has any enquiries regarding the action that should be taken for a confirmed case of COVID19 then they should contact the Education Response Team on 01254 588199 / edresponseteam@blackburn.gov.uk or the Department for Education helpline on 0800 046 8687 (Monday to Friday 8am to 6pm, Saturday to Sunday 10am to 4pm).

Section 5: Arrangements for management of a possible outbreak

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

If a Madrasah 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 Madrasah within 14 days of one another or there is a high reported absence which is suspected to be COVID-19 related, then the local health protection team should be notified promptly (see front page).

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 COVID19. 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 the Madrasah. If the person was in the Madrasah 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.

Section 6: Planning for local restrictions

Madrasahs 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 in a local area.

Full guidance for schools can be found **here.**

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 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
- Safe working in education, childcare and childrens 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 childrens 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 COVID19 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 Madrasah absences (keep in the Madrasah for your records)

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	Pupil /Class	Staff/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.

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 the Madrasah (keep in the Madrasah for your records)

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	List of potential contacts

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 – COVIV-19 Minimum Data Set for the Madrasah

To be completed and used to inform the LA when there is a confirmed positive case via BWD.COVID19@blackburn.gov.uk

Name of person completing form:	**Date:**	
1. Name of Madrasah		
2. Postcode of Madrasah		
3. Local Authority area of Madrasah		
4. Name/Date of Birth/Postcode of case		
5. Age of child		
6. Date of onset of symptoms (n/a if asymptomatic)		
7. Date of test		
8. Date last in the Madrasah		
9. Was case in the Madrasah while infectious?	YES/NO	
10. Number of close contacts identified and advised to exclude	STAFF:	PUPILS:
11. Date contacts asked to isolate from		
12. Name of class or bubble with positive case		
13. When is this class due to come back?		
14. Are all contacts in the same class?	YES/NO	
15. If no, number and name of classes affected		
16. Total number of children in the Madrasah		
17. Total number of confirmed cases in the Madrasah broken down into classes		
18. Any other information		

APPENDIX 4 – 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 for 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:

- Those who are shielding (confined to the house) should remain shielding
- 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].

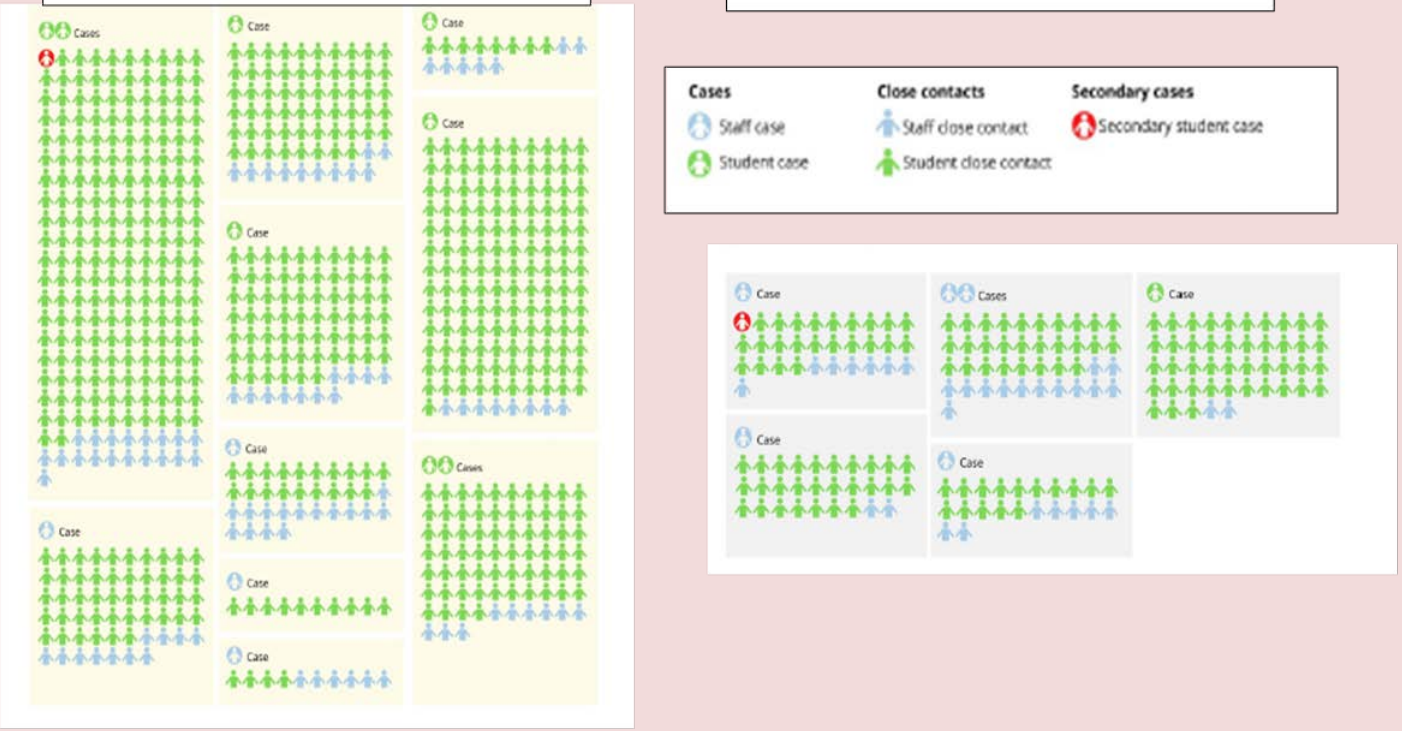
In New South Wales, Australia, 18 covid-19 cases (nine students, nine staff) across 10 secondary schools and five primary schools were followed up, with 735 students and 128 staff who were close contacts (**Figure**). No adult staff member contracted the disease from any of the initial cases; one child 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

Figure a: Cases and close contacts among teachers and students in 10 NSW high schools showing one secondary case in a student

Figure b: Cases and close contacts among teachers and students in 5 NSW primary schools showing one secondary case in a student



References

1 SAGE. Children's Task & Finish Group: Risks associated with the reopening of education settings in September. 8 July 2020. https://www.gov.uk/government/publications/tfc-risks-associated-with-the-reopening-of-education-settings-in-september-8-july-2020

2 Public Health England. Transmission of COVID-19 in school settings and interventions to reduce the transmission: a rapid review. August 2020. Internal document.

3 COVID-19 in children and the role of school settings in COVID-19 transmission, 6 August 2020. Stockholm: ECDC; 2020. https://www.ecdc.europa.eu/en/publications-data/children-and-school-settings-covid-19-transmission

4 Ismail SA, Saliba V, Bernal JL, Ramsay ME, Ladhani SN. SARS-CoV-2 infection and transmission in educational settings: cross-sectional analysis of clusters and outbreaks in England. 23/8/2020. https://www.gov.uk/government/publications/sars-cov-2-infection-and-transmission-in-educational-settings

5 Lu X, Xing Y, Wong GW. COVID-19: lessons to date from China. Archives of Disease in Childhood. Online First: 12 May 2020. https://doi.org/10.1136/archdischild-2020-319261
6 Ladhani SN, Amin-Chowdhury Z, Davies HG, et al. Arch Dis Child. Epub ahead of print. https://doi.org/10.1136/archdischild-2020-320042
7 Zhu Y, Bloxham CJ, Hulme KD, et al. Children are unlikely to have been the primary source of household SARS-CoV-2 Infections. The Lancet preprint. http://dx.doi.org/10.2139/ssrn.3564428
8 Danis K, Epaulard O, Bénet T, et al. Cluster of coronavirus disease 2019 (Covid-19) in the French Alps, 2020. Clinical Infectious Diseases. 11 April 2020; ciaa424. https://doi.org/10.1093/cid/ciaa424
9 Gudbjartsson DF, Helgason A, Jonsson H, et al. Spread of SARS-CoV-2 in the Icelandic population. NEJM. 14 April 2020. https://doi.org/10.1056/NEJMoa2006100
10 Lavezzo E, Franchin E, Ciavarella C, et al. Suppression of COVID-19 outbreak in the municipality of Vo, Italy. Preprint. medRxiv 2020.04.17.20053157. https://doi.org/10.1101/2020.04.17.20053157
11 van Dissel J. COVID-19. Technical briefing to Parliament. Rijksintituut voor Volksgezondheid en Milieu. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/886997/s0291-dutch-parliament-role-of-children-in-transmission-220420-sage31.pdf
12 Jing Q-J, Liu M-J, Yuan J, et al. Household secondary attack rate of COVID-19 and associated determinants. medRxiv 2020.04.11.20056010 pre-print. https://doi.org/10.1101/2020.04.11.20056010
13 Annemarie BD, Ewen MH, Christopher AG, et al. Features of 16,749 hospitalised UK patients with COVID-19 using the ISARIC WHO Clinical Characterisation Protocol. medRxiv. 2020.04.23.20076042; https://doi.org/10.1101/2020.04.23.20076042
14 Theodoratou E, Dozier M, Li X, Xu W, He Y, Kirolos A. Review: What is the evidence for transmission of COVID-19 by children [or in schools]? UNCOVER. Usher Network for COVID-19 Evidence Reviews. V001-03. Edinburgh: Usher Institute, University of Edinburgh. 6 May 2020. https://www.ed.ac.uk/usher/uncover/completed-uncover-reviews
15 National Centre for Immunisation and Surveillance. COVID-19 in schools – the experience in NSW, 2020. Available: http://ncirs.org.au/sites/default/files/2020-04/NCIRS%20NSW%20Schools%20COVID_Summary_FINAL%20public_26%20April%202020.pdf
16 Heavey L, Casey G, Kelly C, Kelly D, McDarby G. No evidence of secondary transmission of COVID-19 from children attending school in Ireland, 2020. Eurosurveillance. 28/May/2020; 25(21): pii=2000903. https://doi.org/10.2807/1560-7917.ES.2020.25.21.2000903
17 Robert Koch Intitut. Wiedereröffnung von Bildungseinrichtungen –Überlegungen, Entscheidungsgrundlagen und Voraussetzungen. [Reopening of educational institutions - considerations, basis for decisions and requirements] Epidemiological Bulletin 19/2020. https://www.rki.de/DE/Content/Infekt/EpidBull/Archiv/2020/19/Tabelle.html
18 Munro APS, Faust SN. Children are not COVID-19 super spreaders: time to go back to school. Archives of Disease in Childhood. Published Online First: 05 May 2020. https://doi.org/10.1136/archdischild-2020-319474

APPENDIX 5 – Review of current (August 2020) scientific advice by The European Centre for Disease Prevention and Control

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 COVID19 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 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 6 – 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.

References

1 Fischer EP, Fischer MC, Grass D, Henrion I, Warren WS, Westman E. Low-cost measurement of facemask efficacy for filtering expelled droplets during speech. Science Advances. 7 August 2020. 2020eabd3083. https://doi.org/10.1126/sciadv.abd3083

2 European Centre for Disease Prevention and Control. Using face masks in the community Reducing COVID-19 transmission from potentially asymptomatic or pre-symptomatic people through the use of face masks. 2020. https://www.ecdc.europa.eu/sites/default/files/documents/Cloth-face-masks-in-case-shortage-surgical-masks-respirators2020-03-26.pdf

3 Public Health England. COVID-19: infection prevention control guidance. Transmission characteristics and principles of infection prevention and control. Updated 21 May 2020. https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/transmission-characteristics-and-principles-of-infection-prevention-and-control

4 WHO. Transmission of SARS-CoV-2: implications for infection prevention precautions; Scientific brief. 9 July 2020. https://www.who.int/news-room/commentaries/detail/transmission-of-sars-cov-2-implications-for-infection-prevention-precautions

5 Siegel J, Strausbaugh L, Jackson M, Rhinehart E, Chiarello LA. Draft guidelines for isolation precautions: preventing transmission of infectious agents in healthcare settings; Recommendations of the Healthcare Infection Control Practices Advisory Committee. 2004. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7119119/

6 Ma Q-X, Shan H, Zhang H-L, Li G-M, Yang R-M, Chen J-M. Potential utilities of mask wearing and instant hand hygiene for fighting SARS-CoV-2. J Med Virol. 2020. Accepted Author Manuscript. https://doi.org/10.1002/jmv.25805

7 Greenhalgh T, Schmid MB, Czypionka T, Bassler D, Gruer L. Face masks for the public during the covid-19 crisis. BMJ. 2020; 369: m1435. https://doi.org/10.1136/bmj.m1435

8 Mills M. Face masks and coverings for the general public: Behavioural knowledge, effectiveness of cloth coverings and public messaging. The Royal Society / British Academy. 26 June 2020. https://royalsociety.org/-/media/policy/projects/set-c/set-c-facemasks.pdf?la=en-GB&hash=A22A87CB28F7D6AD9BD93BBCBFC2BB24

9 Chu DK, Akl EA, Duda S, Sols K, Yaacoub S, Schunemann HJ, for COVID-19 Systematic Urgent Review Group Effort. Physical distancing, face masks, and eye protection to prevent person-to-person transmission of SARS-CoV-2 and COVID-19: a systematic review and meta-analysis. The Lancet. 1 June 2020; https://doi.org/10.1016/S0140-6736(20)31142-9

10 Wang X, Ferro EG, Zhou G, et al Dean. Association between universal masking in a health care system and SARS-CoV-2 positivity among health care workers. JAMA. 2020; 324(7): 703-704. https://doi.org/10.1001/jama.2020.12897

11 Stutt ROJH, Retkute R, Bradley M, Gilligan CA, Colvin J. A modelling framework to assess the likely effectiveness of facemasks in combination with ‘lock-down’ in managing the COVID-19 pandemic. Proc. R. Soc. A. 10 June 2020; 476: 20200376. http://doi.org/10.1098/rspa.2020.0376

12 Wells WF. On air-borne infection. Study II. Droplets and droplet nuclei. Am. J. Hyg. 1934; 20: 611–618.

13 Xie X, Li Y, Chwang ATY, Ho PL, Seto WH. How far droplets can move in indoor environments – revisiting the Wells evaporation–falling curve. Indoor Air. 2007; 17(3): 211-225. https://doi.org/10.1111/j.1600-0668.2007.00469.x

14 Papineni RS, Rosenthal FS. The size distribution of droplets in the exhaled breath of healthy human subjects. J Aerosol Med. 1997; 10: 105–116. https://doi.org/10.1089/jam.1997.10.105

15 Esposito S, Principi N. To mask or not to mask children to overcome COVID-19. Eur J Pediatr. 2020; https://doi.org/10.1007/s00431-020-03674-9

APPENDIX 7 – Management of suspected and confirmed cases of COVID 19 in Educational Settings – two page summary

Member of staff or child is showing one of more symptoms of COVID-19 (temperature of 37.8°C or above, new continuous cough, change to or loss of sense of taste/smell)

Has the individual been in the setting whilst a) showing symptoms or b) in the 48 hours beforehand?

Yes	No
• If the individual is still in the setting, isolate them and arrange for them to go home immediately. It is recommended that staff wear Personal Protective Equipment (PPE) if supporting a symptomatic child and 2 metres distance cannot be maintained. Send all siblings/other household members home too. • Advise that individual needs to isolate at home for 10 days (other household contacts 14 days) from the day symptoms started and follow stay at home guidance. • Thoroughly clean any areas the individual has been in contact with • Advise the staff member or parent/carer to arrange testing. They can book online via https://www.nhs.uk/conditions/coronavirus-covid-19/testing-and-tracing/get-a-test-to-check-if-you-have-coronavirus/ or call 119. • Ask the member of staff or parent/carer to keep you informed of when they have their test and also the result of the test. • Record absence details. Also make a note of any staff or children who had close contact (e.g. within 2 metres for 15 minutes or more) with the individual whilst they were showing symptoms or during the 48 hours before they developed symptoms – use Appendix 2 - this is your 'close contact list' and you will need it if a test comes back positive. • **Hold Appendix 1 in the Madrasah**. • Contact parents of children who may have had close contact e.g. those in same bubble/class to make them aware staff/children have developed symptoms and remind them of the symptoms to look out for. Reassure that bubble/setting currently remains open pending test results. ***Please note – you do not need to send any contacts home or shut any bubbles/the setting at this stage. You only need to consider further actions like this if a positive test result is reported. This is why it is important that individuals with symptoms get tested as soon as possible.***	• Contact staff member or parent/carer - ensure the individual is isolating at home (for 10 days, other household contacts 14 days) and advise to follow the stay at home guidance • Advise the staff member or parent/carer to arrange testing. They can book online via this link or by calling 119. • Ask the member of staff or parent/carer to keep you informed of when they have their test and also the result of the test. • Record absence details. • **Hold Appendix 1 in the Madrasah.**

If you have a query about a suspected case, please contact the Education response team on 01254 588199

Individual receives their test result and informs the school leader/office

Test result is positive	Test result is negative
• Advise that the individual needs to continue with their 10 day isolation at home. They can return to the setting after 10 days if they have not had a high temperature for 48 hours. Others in their household need to continue with their 14 day 'isolation at home' period and should get tested if they develop symptoms. • Any close/direct contacts (definitions below) from the bubble/setting will need to go home and isolate for 14 days from the date they were last in contact with the individual who has tested positive (their wider household do NOT need to isolate). • **Close/direct contact is considered to be**: o being coughed on, or o having a face-to-face conversation within 1 metre, or o having unprotected skin-to-skin physical contact, or o travel in a small vehicle with the case, or o any contact within 1 metre for 1 minute or longer without face-to-face contact o extended close contact (between 1 and 2 metres for more than 15 minutes) with a case **N.B This is irrespective of whether the contact is wearing PPE** • Inform all parents within the bubble/setting to ensure they watch for symptoms. • Testing will not routinely be offered to individuals who do not have symptoms, so contacts do not need to be tested, unless informed otherwise via health protection services. • Email Appendix 3 to BWD.COVID19@blackburn.gov.uk to inform them of the positive result. • A contact tracer from a local health protection service may then get in touch with you, the staff member or the parent/carer to provide advice and identify further contacts. Further local follow up may take place in order to manage local incidents/outbreaks.	• Inform staff and parents/carers of the result. • Agree the return date with the staff member/parent. The individual can return to the setting straight away as long as they: - have not had a high temperature for 48 hours - have not been told to isolate because they have been identified as a close contact of a positive case or a household contact of a possible/ confirmed case. • No need to inform LA or HPT of negative result.

APPENDIX 8 – Letter for close contacts

Date: DD/MM/YYYY

FOR PARENTS OF CLOSE CONTACTS OF COVID 19 at XXXXX

Advice for Child to Self-Isolate for 14 Days

Dear Parent,

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

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 we recommend that your child now stay at home and self-isolates until ADD DATE (14 days after contact).

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 14 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 14 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 MUST 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 14 days. This includes anyone in your ‘Support Bubble’.

The 14-day period starts from the day when the first person in the house became ill.

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 14 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