COVID-19 Guidance for health protection teams
Including contact tracing guidance
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Version 1.2
## Version history

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<tr>
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<td>First published on SHPIR only. Includes updated contact tracing guidance (follow-up and self-isolation of contacts)</td>
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| V1.1    | 07/09/2021 | Published on SHPIR only  
Section 1: Addition of Scottish Government documents on coronavirus legislation  
Section 2: Addition of headache to symptoms  
Section 3: Addition of NIPCM updates to physical distancing section; contact tracing via test and protect to section on reducing risk associated with social mixing; good ventilation added to measures to reduce risk in workplaces  
Section 4: Vaccination text reworded for clarity and to include reference to relevant articles and further information for the public  
Section 5: Addition around results from non NHS laboratories to be risk assessed or repeated if not aligned with local NHS laboratories  
Section 6.2: Clarification that contact tracing of a PCR positive test will be either digitally or by telephone.  
Section 6.3: Clarification that anyone with symptoms of COVID-19 shouldn’t use LFD tests as there is a risk of false negative results  
Section 8.2.1: clarification around self-isolation periods being 14 days in some settings due to vulnerabilities. Added mention of the further conditions which apply to anyone working in health and social care settings and linked out to the section of the guidance with more information and link to further advice on NHS inform on reducing risk for anyone who has shortened their self-isolation period.  
Section 8.2.2: Clarified sentence stressing that testing doesn’t replace self-isolation especially in people who are not vaccinated and a sentence clarifying that people with a positive PCR in the previous 90 days do not need to undertake another PCR test  
Section 8.2.3: Health and social care worker contacts section updated to include links to and a summary of the director’s letter |
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<td>“isolation exemptions for health and social care staff” DL 2021/24)</td>
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<td>Section 8.2.4: “Unusually close” added to definition of high risk contacts in children and young people. Additional clarification around contacts under 5 not needing testing or self-isolation because they are considered to be at low risk of illness and transmission</td>
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<td>Section 9.3: Addition of childcare settings throughout; the need for a proportionate response taking into account the impact of mitigations on the learning and outcomes of children and young people; links added to Scottish Government educational resources for school ages and childminding settings; sentence suggesting that targeting warn and support inform letters to the class of the case is more helpful than sending these to wider year groups or whole schools; reinforcement of provision and promotion of LFDs for asymptomatic testing added to control measures for HPTs to consider</td>
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<td>Section 9.3.1: Heading changed to “other out of school settings”</td>
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<td>Section 10.3: Clarification around persistent positive results due to remnant RNA in an asymptomatic person with a positive PCR within 90 days of their initial infection</td>
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<td>Appendix 3: Self-isolation periods for cases and contacts updated to include fully vaccinated contacts, health and social care staff exemptions and updated travel regulations</td>
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<td>use a face covering in public places to reduce the risk of spreading COVID-19.</td>
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1. Purpose and scope

This guidance aims to support those working in health protection teams (HPTs) across Scotland. It provides an overview of the public health measures required to prevent and manage COVID-19, and general recommendations for the management of cases, contacts, clusters and outbreaks in various settings. This document should be read together with:

- PHS COVID-19 guidance documents for specific settings
- PHS COVID-19 variants and mutations (VAMs) reference document for HPTs
- Scottish COVID-19 infection prevention and control addenda for acute settings, care homes and community health and care settings.
- PHS/SHPN management of public health incidents (MPHI) guidance
- The Public Health etc. (Scotland) Act 2008
- Scottish Government collection of documents relating to coronavirus legislation.

This guidance is based on what is currently known about COVID-19. Public Health Scotland (PHS) will update this guidance as needed, and as additional information becomes available. See Appendix 1 for details on guidance development. Comments on this guidance can be sent to PHS guidance cell. Contact details for local HPTs can be found in Appendix 2.

Out of scope

This guidance does not cover the following:

- The clinical management of COVID-19. Guidelines for this can be found on the Scottish intercollegiate guidance network (SIGN) website.
- Management of other respiratory viruses e.g. influenza, parainfluenza, respiratory syncytial virus (RSV).
2. Introduction

The disease COVID-19 is caused by an RNA virus, SARS-CoV-2, which is mainly spread through respiratory droplets/aerosols, when an infected person coughs or sneezes. There is also evidence of airborne transmission \(^1\). People may also acquire the infection through direct contact with an infected case or by contact with contaminated objects and surfaces. The virus can survive on surfaces for periods ranging from a few hours to days. However, the amount of viable virus declines over time and it may not always be present in sufficient quantities to cause infection.

Symptoms of COVID-19 vary in severity from having a fever, cough, headache, sore throat, altered sense or absence of taste or smell, general weakness, fatigue and muscular pain to pneumonia, acute respiratory distress syndrome and other complications \(^2\) (cardinal symptoms are outlined in section 5). Mortality is an unfortunate potential outcome in those with severe disease. Up to 1 in 3 cases can be asymptomatic \(^3\), making detection of transmission challenging. The infectious period begins two days before symptom onset to 10 days after, but people are most infectious during their symptomatic period, usually in the first 3 days. The incubation period is estimated to last for up to 14 days \(^4\).

After being infected with SARS-CoV-2, most people recover quickly, usually starting to feel better in a few days; unfortunately, some people take longer and symptoms can affect the whole body. SIGN has produced a booklet for anyone with ongoing signs and symptoms of COVID-19 and NHS inform provides a variety of useful information.

PHS provides a daily updated dashboard with the latest available data including, but not limited to, the numbers of positive cases reported, the number of tests carried out, the number of vaccinations administered and percentage of Scotland's population who are vaccinated.

All viruses change through mutation; the term "variants and mutations" (VAMs) describes a group of selected SARS-CoV-2 variants and mutations that are predicted to be responsible for the changes in properties of the virus. VAMs are the result of natural changes that happen when viruses transmit between people. They are maintained within a population when they provide some advantage to the virus. These advantages include increased transmission, virulence and immune escape. Due to the potential for future
VAMs to circumvent current mitigation measures through improved transmissibility, pathology or immune escape, practitioners should be cautious that public health mitigations, including vaccination, may require future re-evaluation.

See PHS COVID-19 VAMs reference document for HPTs for further information as well as technical briefings and risk assessments available from Public Health England. In addition, risk assessments for individual VAMs are also available.

3. General prevention measures

Hand hygiene

As for other pathogens, hand hygiene is a key mitigation measure for the prevention and management of SARS-CoV-2. Regular hand hygiene can break the chain of infection between infected and non-infected people, and should be followed by everyone. Further information on effective hand washing can be found on the PHS website and NHS inform.

Physical distancing

Physical distancing measures are a key mitigation in the prevention and management of SARS-CoV-2 by reducing the likelihood of droplet and airborne transmission between people. People should aim to keep close contact to a minimum and continue to avoid crowded areas, where face coverings are useful mitigation, in particular where high levels of ventilation are not possible, such as indoors and in residential settings. Further information is available from NHS inform.

Physical distancing of either 1 or 2 metres is required in healthcare settings, depending on the particular area. Details of this are provided in the NIPCM addenda for acute settings, care homes and community health and care settings. As the NIPCM addenda highlight, these changes to physical distancing do not mean a return to pre pandemic practices. NHS Boards and independent contractors must continue to adapt processes to ensure risk of transmission is minimised. This is the minimum guidance –
local policy and guidelines should be followed, in particular where local risk assessment has identified a need for increased physical distancing.

Physical distancing by staff should be followed in all areas of the workplace, including non-clinical areas in line with local policy and risk assessment. A local review of existing practice may need to be considered to introduce measures, such as staggered staff breaks, to limit the density of staff in specific areas. Other measures such as use of Perspex (or similar) screens may be considered to reduce risk in non-clinical encounters. Particular attention must be given to staff break times, car-sharing and other non-clinical/work interactions when implementing physical distancing in relation to workplaces.

"Personal or work travel and physical distancing" should be followed as per the PHS information and guidance for general (non-healthcare) settings guidance. PHE also provide guidance on safety screens for taxis or private hire vehicles (PHV).

Specific guidance for each of these settings, including business, health, education and housing, are available on the Scottish Government website.

**Reducing risk associated with social mixing**

Ensuring that social mixing is kept to a minimum can reduce SARS-CoV-2 transmission by reducing exposures, as well as subsequently minimising the number of people identified as contacts, should transmission occur. General advice emphasising the need to minimise social mixing, where possible, is available from NHS Inform. Contact tracing via Test and Protect (TaP) is a key public health intervention to support management of the pandemic, aimed at reducing social mixing in a targeted way.

**Personal protective equipment (PPE) in workplaces**

PPE protects the user against health or safety risks at work. Workplaces should continue to use any PPE required as per local policies (business as usual) to mitigate against non-COVID-19 risks in their setting. The risk of COVID-19 should be managed by hygiene measures, physical distancing, wearing of face coverings and good ventilation. See section 11 for further information on PPE, noting that the use of PPE for COVID-19 (out with healthcare or specific residential settings) is out with the scope of this guidance.
Face coverings

Everyone needs to be aware of and follow the Scottish Government guidance on face coverings. Note that face coverings are not considered clinical PPE but do serve to mitigate person-to-person transmission in the general population.

Improving ventilation

Ensuring good ventilation in indoor spaces will help to reduce the risk of SARS-CoV-2 spreading. The amount of fresh air entering a room should be maximised, wherever possible.

Natural ventilation can be achieved by opening windows, vents and doors (excluding fire doors). Some buildings may have mechanical ventilation systems, these should maximise the amount of fresh air being introduced and minimise the recirculation of air in rooms and throughout buildings.

HSE ventilation and air conditioning during the coronavirus (COVID-19) pandemic guidance provides practical steps on improving ventilation; carbon dioxide monitors are being assessed for their utility in identifying poorly ventilated areas. Scottish Government also provide ventilation guidance in a variety of settings, alongside guidance on reducing the risks of far-field aerosol transmission in schools.

Vulnerable populations

Some groups of people are at the highest risk of severe illness if they catch coronavirus (COVID-19). People who are in the highest risk group will have received a letter from the Chief Medical Officer telling them so. This includes some children and young people. The Scottish Government have published further guidance which identifies these groups and provides advice to help individuals make informed decisions and access support services. Further, up to date information can also be found on the NHS inform website.

Inequalities in both risk and outcome of COVID-19 are described by age, sex, ethnicity and deprivation. People from minority ethnic groups and socioeconomically more deprived areas are more likely to experience harm from COVID-19. Those living in more deprived areas are more likely to be admitted to hospital with serious illness and have higher
mortality rates. Additionally, the interventions designed to suppress viral transmission have an unequal impact across the population, with this differential impact most adversely affecting those in more deprived populations (e.g. overcrowded housing preventing adequate self-isolation from others, financial barriers to seeking a test or self-isolating, etc.)

Staff (such as health and social care workers) with underlying health conditions that place them at increased risk of severe illness from COVID-19, should discuss this with their line manager or local occupational health service. The COVID-19 occupational risk assessment guidance can be used to support managers to undertake an individual occupational risk assessment. Pregnant staff should also seek advice from their line manager or local occupational health service. Further information for at-risk or pregnant healthcare workers can be found in Guidance for NHS Scotland workforce staff and managers on coronavirus.

Further information in support of the above mitigation measures is available in the European Centre for Disease Prevention and Control's (ECDC) Guidelines for the implementation of non-pharmaceutical interventions against COVID-19.

4. Vaccination

The COVID-19 vaccination programme commenced in the UK in December 2020. COVID-19: the green book, chapter 14a provides information on COVID-19 vaccines in the UK, the vaccine schedule for the UK and recommendations for use of the vaccines.

Evidence of vaccine effectiveness across adult age groups is increasingly available. The observed reduction in both symptomatic and asymptomatic infections suggests that all the vaccines licensed for use in the UK have the potential to reduce transmission as well as hospitalisation, severe disease and mortality. A summary of the most recent data on real world effectiveness is published on a weekly basis as part of PHE COVID-19 vaccine surveillance reports and regularly updated into the COVID-19: the green book, chapter 14a.

The joint committee for vaccination and Immunisation (JCVI) provides details on the groups that are to be prioritised for COVID-19 vaccination. There is evidence of better
immune response and/or protection where longer intervals between doses are used; hence the JCVI recommends a minimum interval of eight weeks between doses of the COVID-19 vaccines used in the UK where a two-dose primary schedule is used, to ensure a good balance between achieving rapid and long-lasting protection. Recommended minimal intervals between doses might vary for individuals commencing immunosuppressive treatment.

It is important to note that vaccination does not change the need to continue all current COVID-19 mitigation measures (valid for both vaccinated and unvaccinated people) until more evidence of effectiveness of the vaccination programme has been established; emphasising the following has therefore become particularly important:

- The safety profile for COVID vaccination remains good

- A person’s vaccine status is altering the requirement for self-isolation with specific conditions applied for mitigation but compliance with IPC mitigation measures need to continue.
  - For the general population, being fully vaccinated can support a risk assessment approach in determining if an individual requires to self-isolate after having been identified as a close contact. Self-isolation requirements for close contacts or returning travellers may vary in certain circumstances based on setting, vaccine status or age, in particular for health and social care workers. See section 8 for more details.

- Vaccinated people should continue to comply with ALL testing regimes as per unvaccinated people. There is no evidence that the currently approved vaccines for use in the UK affect PCR test results for COVID-19. This may not be the case for other vaccines with different structures, as they are developed.

- It is advisable that for people who have a current diagnosis of COVID-19, vaccination is deferred for four weeks after onset of symptoms or four weeks from the first confirmed positive specimen in those who are asymptomatic.

- Vaccination is not as yet used as a tool in managing outbreaks, where the risks and benefits of a vaccination session during an outbreak must be carefully considered, in particular the ability to vaccinate whilst maintaining IPC measures. The lack of an
established evidence base on this means that the local HPT can be contacted to undertake a risk assessment in order to determine the appropriate next steps in such situations.

Evidence for vaccination across adult age groups shows protection against symptomatic disease, infection (including in healthcare workers and in care home residents) and against hospitalisation and mortality, for all vaccines licensed for use in the UK. The observed reduction in both symptomatic and asymptomatic infections suggests that vaccination has the potential also to reduce transmission. Inequalities in vaccination uptake have the potential to widen the existing inequalities in COVID-19 risk and outcomes. Therefore, it is important that HPTs and NHS Boards consider how inequalities in local vaccination uptake might be proactively addressed. HPTs should draw on experience from existing vaccination programmes to ensure barriers to accessing vaccination are mitigated for people living in areas of greater deprivation and those in groups identified that have lower uptake within their local area. COVID-19 vaccine surveillance work is being carried out by PHS, MHRA, NHS Scotland, Scottish Government and academic partners to monitor and evaluate the vaccines against a broad range of outcomes including inequalities and barriers to vaccine uptake.

In the UK, there is variation in the reporting of vaccine hesitancy between different population groups. Differences have been described based on age, ethnicity, religion and deprivation, with younger adults, people living in more deprived areas and some black and minority ethnic groups being more likely to report vaccine hesitancy.

However, this is not an exhaustive list. HPTs and NHS boards should consider the potential role of vaccine hesitancy within their local population, and should ensure local plans for vaccine delivery seek to address it to improve vaccine uptake.

Additional sources of information for COVID-19 vaccination are available:

- More information on the COVID-19 vaccine is available on NHS inform.
- Workforce education materials are available on the Turas learn site.
- Leaflets explaining why the COVID-19 vaccine is being offered and how, when and where it will be given, are available on NHS inform.
• Resources from PHS are available to promote the COVID-19 immunisation programme to frontline healthcare worker staff and to social care worker staff.

• More information on the COVID-19 vaccine is available on NHS inform and a helpline for the public has been set up on 0800 030 8013.

5. Case definitions

For the purposes of public health management, COVID-19 cases can be classified as below.

Confirmed COVID-19 case

A person with laboratory confirmed detection of SARS-CoV-2 by PCR in a clinical specimen

Things to note:

• It is important to know where a PCR test is processed (e.g. tests may have been carried out in non-NHS laboratories. A list of non-NHS laboratories which have agreements in place with their local NHS laboratory can be accessed by emailing nss.nlpq@nhs.scot). Results from non-NHS laboratories that are not aligned with their local NHS laboratories or UK-accredited need to be risk assessed or the test repeated.

• A positive PCR test may be due to fragments of the virus being present despite the person not being infectious. See section 6.2 for further details of interpreting a positive test within 90 days of a previous positive and section 0 which relates to reinfections.

More information on testing for SARS-CoV-2 is provided in section 6 of this guidance.
Probable COVID-19 case

A person with a positive LFD test

Things to note:

- Beyond recommending a confirmatory PCR, from a public health management perspective, there is no difference between how a probable or a confirmed case of COVID-19 is to be managed. Therefore, contact tracing and other public health actions should take place after a positive LFD test, i.e. a probable COVID-19 case.

Possible COVID-19 case

A person presenting recent onset of one or more of the following cardinal COVID-19 symptoms:

- new continuous cough
- fever / temperature ≥37.8°C
- loss of, or change in, sense of smell (anosmia) or taste (ageusia).

A wide variety of additional clinical signs and symptoms have also been associated with COVID-19. Fever may not be reported in all symptomatic people⁹ and cases may also be asymptomatic¹⁰.

Public health professionals should be alert to the possibility of atypical and non-specific presentations in children, older people with frailty, those with pre-existing conditions and those who are immunocompromised. People with epidemiological links to COVID-19 outbreaks or clusters should also be considered with a high degree of suspicion. People must be assessed for other infectious or non-infectious causes of symptoms as appropriate.
6. Testing for SARS-CoV-2

There are currently various tests available for the detection of SARS-CoV-2. This section focusses on the indications for and interpretation of polymerase chain reaction (PCR) and lateral flow device (LFD) tests only. Vaccination status does not change the requirement for testing.

More information on testing is provided in the following guidance:

- COVID-19 guidance for sampling and laboratory investigations
- COVID-19 laboratory frequently asked questions
- COVID-19 SARS CoV-2 virus detections testing within Scotland: a guide for non-NHS laboratories

Ideally, testing should be undertaken in the first 3 days of symptom onset, but can be undertaken at any time during illness that is suspected of being COVID-19, on clinical or public health grounds.

6.1 PCR testing

Anyone in Scotland who is experiencing any of the cardinal symptoms of COVID-19 should be tested by PCR through UK government testing sites. Further guidance on eligibility and access to testing is available on NHS inform and the Scottish government website. PCR is the main diagnostic test used in Scotland in NHS laboratories and UK government Lighthouse laboratories.

PCR testing is also recommended for certain asymptomatic people including contacts of confirmed cases (see section 8.2.1) and health and social care staff working with clinically vulnerable patients.
6.2 Interpreting PCR test results

A positive PCR test result indicates that someone is infected with SARS-CoV-2 and needs to be managed as a confirmed case. See section 7 for the public health management of cases.

Everyone who has a positive PCR test result should be contact traced either by telephone or digitally.

A negative PCR result in an asymptomatic person with no known exposure suggests no infection.

If an asymptomatic person is inadvertently re-tested and tests positive by LFD or PCR within 90 days of a previous positive PCR result, a risk assessment will likely conclude there is no need to do a confirmatory PCR, isolate or contact trace again, as long as the person with the repeat positive test:

- remains asymptomatic;
- is not a contact of a confirmed case;
- is not required to isolate having returned from travel to a non-exempt country;

Repeat positive tests (asymptomatic or symptomatic) after 90 days should result in the usual public health action, i.e. isolation of the person with the positive test and contact tracing.

However, if someone develops the cardinal symptoms of COVID-19 at any time, they should get a further PCR test.

Participants in surveillance studies (e.g. SIREN, ONS survey) will undertake regular repeat testing regardless of symptoms, in accordance with study protocols. First positive tests amongst surveillance study participants should be managed in accordance with routine guidance, including isolation of the person with the positive result and contact tracing. This applies similarly to screening interventions, e.g. health and social care workers and inpatients as part of hospital admission protocols.
In certain situations, for example, an outbreak, risk of re-infection with a new variant, specific clinical or travel risks, the HPT may conduct a risk assessment and recommend action such as self-isolation or whole genome sequencing for all individuals testing PCR positive, without exemption.

6.3 LFD testing

LFD tests are rapid self-administered tests that can be used quickly to identify asymptomatic cases with a high viral load. These tests are being widely used both at home and within workplaces and where this is happening, it is recommended that asymptomatic people test themselves twice weekly. See COVID-19: asymptomatic staff testing in NHS Scotland and COVID-19: getting tested in Scotland for further information.

Anyone with symptoms of COVID-19 should not use LFD tests since there is a risk of false negative and they must access a PCR test. If a symptomatic person has had a negative or positive result using an LFD, they should self-isolate and arrange a PCR test.

More information on accessing LFD tests is available on NHS inform, and anyone without access to digital services can access LFDs from community pharmacies and other settings.

6.4 Interpreting LFD test results

People who receive a positive test result from an LFD should undertake a confirmatory PCR test, and they should isolate whilst awaiting the result of the PCR test. Repeated false positive LFD results can occur in the same individual. In these circumstances, where a PCR test shows that a person does not have SARS-CoV-2, they should be advised that false positive LFD results may continue to be obtained. If LFD testing is essential, tests from a different manufacturer can be considered, although there is no guarantee that false positive results will not continue to arise.

People who receive a negative LFD result must not regard themselves as definitively free from infection – the test could be a false negative – as they may still be incubating the virus and could also go on to acquire the infection in the period before the next test.
Everyone must remain vigilant to the development of COVID-19 symptoms and continue to follow existing general control measures appropriate to the setting, for example IPC measures.

6.5 Testing for respiratory pathogens other than SARS-CoV-2

Consider where testing for pathogens other than SARS-CoV-2 such as influenza A and B, human metapneumovirus (hMPV) and adenovirus should be undertaken in discussion with the local virologist, as necessary. This may be particularly important if testing of SARS-CoV-2 is negative during investigation of a cluster. Discussion may also be needed with the local laboratory as to whether a single swab will be sufficient, if pathogens other than SARS-CoV-2 are to be tested for.

7. Public health management of cases

See section 5 for information on confirmed, probable and possible case definitions.

- **Possible** cases should be advised to seek a confirmatory PCR test and self-isolate in the meantime.

- **Probable** cases should also be advised to seek a confirmatory PCR test and be treated as a confirmed case whilst awaiting the test result; or in the absence of a PCR test, should be treated as a confirmed case.

The following applies to both confirmed and probable cases:

- Cases (whether or not they have symptoms) should be provided with the current Scottish isolation advice for households with coronavirus infection and self-isolate in line with appendix 3 and appendix 4.

- Cases can return to their usual activities on the 11th day from the onset of cardinal symptoms, if they feel better and have not had a high temperature in the previous 48 hours.
  - A number of symptoms including cough or change in sense of smell/taste may persist for several weeks in some people, even though the infection has
cleared. Cases do not need to continue to self-isolate for more than 10 days in these instances.

- For cases who are asymptomatic when tested, isolation should be for 10 days from the date the positive sample was taken. If cardinal symptoms develop subsequently, isolation should be re-started from the date of cardinal symptom onset.

- For cases who had an initial positive LFD followed by confirmatory positive PCR test, isolation should be for 10 days from the date of the initial positive LFD test.

- When contact tracing is commenced based on a positive LFD result alone, and a negative PCR test is received later, but within the isolation period, the cases will be automatically flagged to the local HPT via the case management system (CMS), who will conduct a risk assessment to decide whether contact tracing will be reversed.

  o Every person with a positive LFD result and a subsequent negative confirmatory PCR result should be contacted and told whether they can stop self-isolation.

- If a case who tested positive has recovered, and then develops cardinal symptoms again out with the original self-isolation period, they should re-isolate and have a PCR test again.

- See section 6.2 for information on re-testing within 90 days of a positive result.

- If the case resides with any vulnerable people (such as the elderly or those with underlying health conditions) they should consider how to best separate themselves. Further information to support those at highest risk of illness who are residing in a household with COVID-19, is available from NHS inform. The local authority is responsible for deciding whether to provide publically funded alternative accommodation, taking into account the public health risk assessment.

- Where a case is associated with a complex setting such as a hospital or care home (see section 8.2.3), local risk assessment may be required. Additional information for assessing staff contacts in acute healthcare settings is also available.
- It is expected that providers of healthcare services will follow recommendations on identifying possible cases of COVID-19, isolate patients with respiratory illness and follow appropriate guidance, as outlined in the NIPCM COVID-19 IPC acute setting addendum, from the outset. For community settings, see COVID-19 IPC community health and care setting addendum.

- In hospital settings, there may be occasions, however, when COVID-19 was not considered to be a possible diagnosis initially. Actions may include identifying exposed patients and assessing them in a one-to-one basis. Where there is more than one case and these may be linked, investigation and management of such a scenario will usually be led by the NHS board IPCT with involvement of the local HPT and occupational health where appropriate.

- Symptomatic cases should be advised that if their symptoms do not get better after 7 days, or their condition gets worse, they should look for further advice on NHS inform or call NHS 24 (dial 111). For a medical emergency, they should dial 999 and tell the call handler they have confirmed COVID-19. They should not go to a GP surgery, pharmacy, or hospital without calling first for advice.

### 7.1 Case reporting

HPTs do not need to report cases to PHS; data for national surveillance is taken from laboratory reports in ECOSS.

Clusters and outbreaks should be managed using the outbreak management module (OBM) or HPzone to provide PHS with an accurate national picture for surveillance and reporting purposes.

The local HPT is not required to complete the modified acute respiratory illness (ARI) surveillance form (available on SHPIR) for COVID-19 confirmed outbreaks.
8. Contact tracing

Contact tracing is an effective public health intervention aimed at reducing or breaking transmission links. It relies on good understanding and compliance. **Support** is available for those identified as contacts.

Everyone who tests positive for SARS-CoV-2 will be contacted by an **NHS contact tracer** to identify their contacts, either through digital routes or by direct phone call.

In addition to contact tracing individuals, settings (such as workplaces, transport, public venues, other households, or schools) can be identified through engagement with the case. All settings where the index case has spent significant time during the infectious period (from 48 hours prior to the onset of symptoms, or positive test if asymptomatic; and for 10 days from date of onset of symptoms, or positive test if asymptomatic) should be recorded.

Retrospective contact tracing 7 days prior to symptom onset (or date of test, if asymptomatic) may be useful to identify the source of clusters of cases or higher risk events (health and social care settings, crowded events). In addition, any history of travel should be recorded from the 14 days before symptom onset (or date of test, if asymptomatic).

The case should be told that there may need to be a discussion held with others in these settings to identify potential contacts and to ensure appropriate measures are taken. A contact name, e.g. owner, manager, occupational health professional, etc. should be obtained where appropriate.

Communication between PHS, local HPTs and other local partners (including local authorities and local health services) is necessary to reduce further onward transmission, encourage testing to find additional cases, reinforce adherence to COVID-19 control measures and minimise the dissemination of inaccurate information and media handling.

Contacts who live elsewhere in the UK should be passed to the relevant national public health agency (see **appendix 5**), or to PHS for follow-up. Details of any identified contacts who live outside the UK should be passed to PHS, who will liaise with the relevant public health authority or national focal point.
8.1 Definition of a contact

A contact is a person who has been close to someone who has tested positive (using PCR or LFD) for SARS-CoV-2, any time from 2 days before the person who tested positive developed their symptoms and up to 10 days after, as this is when they can pass the infection on to others (their infectious period). If the person who tested positive is asymptomatic, onset date should be taken as the date of the test.

More information can be found in appendix 6. A contact is defined as:

- Anyone who lives in the same household as another person who has tested positive for SARS-CoV-2, or in shared accommodation (such as university accommodation) that involves sharing a kitchen or bathroom, or has stayed overnight.

- Anyone who has had any of the following types of contact with someone who has tested positive for SARS-CoV-2:
  
  o face-to-face contact for any length of time including having a face-to-face conversation within 1 metre
  
  o any contact within 1 metre for 1 minute or longer without face-to-face contact
  
  o been within 2 metres of someone for more than 15 minutes (either as a one-off contact, or cumulatively over one day)
  
  o spending lots of time in the same household, e.g. cleaners

- Anyone who has travelled in the same small vehicle (e.g. a car) as a person who has tested positive for SARS-CoV-2, or in a large vehicle (e.g. a bus) close to a person who has tested positive for SARS-CoV-2.

- Flight passenger cases returning from red, amber and green listed countries will be followed up by PHS:
  
  o Single cases are contact traced for two seats in all directions;
  
  o Multiple cases are contact traced similarly, with further risk assessment for potential whole flight isolation.
A secondary contact is a person who meets one of the types of contact defined above with a primary contact in the primary contact's potential infectious period, i.e. in the 10 days following the primary contact's last exposure to the index case. Follow up of secondary contact tracing is not routinely required, but may be implemented rarely and after careful consideration at the discretion of the HPT in response to a specific need. More detailed definitions are provided in appendix 6.

The below would typically **not** be considered as a contact:

- An interaction through a Perspex (or equivalent) screen with a case, as long as there has been no other contact such as those listed above.

- Where clinical PPE has been used, such as visors, masks, gloves etc., an individual risk assessment will have to be undertaken by the HPT or the IPCT, as relevant to decide whether there has been an exposure risk sufficient to require contact isolation.

- Those having partaken in outdoor sporting activities with a case, although risk assessment of activities prior to and after the sporting activity may be required, e.g. changing rooms, meals, travel.

**8.2 Self-isolation advice**

Some individuals may be exempt from self-isolation or their period of self-isolation can be shortened, based on the contact's age, vaccination status and any history of recent infection.

Relevant age groupings are defined as:

- **Adult contact**: all people aged more than 18 years and 4 months.

- **Child and young person contact**: all people aged 5 years to 18 years and 4 months. This additional four-month period is to allow young people to arrange and receive vaccination before they are considered as adult contacts. With the changing eligibility for vaccination, this will be kept under review.

- **Under 5 years contact**: all people aged under 5 years.
Where the case or contact is aged under 18 years and 4 months, advice on contact testing and self-isolation differs on whether a high-risk or a low-risk contact has occurred. See section 8.2.4 for definitions.

A vaccinated contact is defined as a person who has completed a course of approved vaccine at least 14 days prior to the date the contact took place (note, day 1 is the day of final dose of the schedule, e.g. second dose for two dose vaccination, or first dose for single). All others are considered unvaccinated for the purposes of self-isolation requirements.

Where an individual has been fully vaccinated while participating in a formally approved COVID-19 vaccine clinical trial, they should be treated as those who are fully vaccinated with approved vaccines.

Recent infection is defined as having tested PCR positive in the 90 days before the contact took place.

Each contact should be dealt with in line with the relevant guidance for their age, vaccination status and past infection. Where a case has contacts of mixed ages for example, this may result in differing isolation requirements for different contacts.

All the following self-isolation guidance also applies to those in the highest clinical risk group and pregnant women.

A public facing guide to when and how long to self-isolate due to coronavirus is available on NHS inform.

8.2.1 Vaccinated adult contacts

The self-isolation period for adult contacts of a case of COVID-19 is 10 days for most settings, however for some settings, contacts must self-isolate for 14 days, due to particular vulnerabilities for that setting. See appendix 3 and appendix 4 for more details on the self-isolation period for cases and contacts.

Self-isolation can be shortened for contacts who meet all of the following criteria:

- they are fully vaccinated as defined above
- they are not currently self-isolating as a case or for travel-related reasons
- they remain asymptomatic
- they have a negative PCR test
  - The sample should be taken at any time after the contact occurred; or in the case of ongoing contact e.g. a household member, on or after their symptom onset date or test date in asymptomatic cases
  - Those with recent PCR confirmed infection (in the last 90 days) do not need a recent, post-contact PCR as a condition of exemption.
- they have not been advised to continue to isolate for any other reason by Test and Protect or a HPT.
- further conditions apply for anyone working in health and social care settings (see section 8.2.3 on exemptions); resident in a care home; or a hospital inpatient; where additional restrictions apply

The criteria to shorten self-isolation outlined above apply even where there is ongoing exposure to a case, e.g. household contacts (see appendix 4). Further advice on reducing risk for those who have shortened their self-isolation period is available on NHS inform. The option to work from home should be considered before enacting the exemption from self-isolation for contacts, as relates to the workplace.

Although testing should be recommended to contacts after the case's result is received, where a negative test result for the contact is received prior to the case's positive result, but subsequent to their contact with each other, isolation can be shortened.

If a person is identified on serial occasions as a contact of a person in their household (i.e. they are contacted by Test and Protect more than once during the same household situation), then they do not need to have a new negative PCR test each time to be exempt from self-isolation. If a person is identified on serial occasions as a contact of a person outside their household, then each occasion is a new ‘contact episode’ and they need to have a new negative PCR test in order to be exempt from self-isolation.
The criteria for shortening self-isolation do not currently apply to residents of care homes, hospital inpatients or prisoners (under Rule 41). These contacts should be reviewed on a case-by-case basis by the HPT (or IPCT as required), e.g. in an outbreak.

**8.2.2 Unvaccinated adult contacts**

Contacts who are not fully vaccinated should seek a PCR test and self-isolate for 10 days, even if they have a negative PCR test. Testing does not replace self-isolation, especially in those who are not vaccinated, as they may still be incubating the SARS-CoV-2 virus. They are not exempt from self-isolation.

- Those with recent PCR confirmed infection (in the last 90 days) do not need to undertake a PCR as this may misidentify them as a recent case, leading to further unneeded contact tracing.

- Those who are **medically unable to be vaccinated** should get a PCR test as soon as possible. If the PCR test result is negative and they remain asymptomatic, they may end self-isolation.

- Those who are medically unable to be vaccinated or participating in **vaccine trials** are eligible for the adult contact self-isolation exemption in line with the general population (this exception does not apply in health and social care settings).

Contacts who test positive are confirmed cases and therefore need to self-isolate for an additional 10 days from the date of their symptom onset or the day the sample for the test was taken, if asymptomatic.

Advice on household isolation of cases and contacts is available in **appendix 4** and on **NHS inform**.

**8.2.3 Health and social care worker contacts**

For health and social care workers (HSCW) the guidance for adults as above applies for general activities (i.e. outwith the health and social care setting). HSCWs are generally advised to limit contact in line with the COVID-19 mitigation advice issued to the general population.
Due to the potential transmission to vulnerable people additional mitigations are required for HSCW staff returning to work. The Scottish Government have issued a Director’s Letter and Policy Framework on ‘Isolation Exemptions for Health and Social Care Staff’ (DL 2021 / 24) which sets out these requirements. HSCW who are medically exempt from vaccination are not eligible for this exemption from contact self-isolation.

HSCW exemption can only apply to those who are exempt from isolation under the conditions outlined in the Director’s letter and policy framework - i.e. fully vaccinated, asymptomatic and with a negative PCR test following exposure and with further mitigations:

- Daily LFD tests are required for 10 days following last exposure.
  - If the index case is a household member then for 10 days from the date of onset, or test date if case is asymptomatic.
  - If a contact is exempt from the initial PCR test due to a positive PCR in the previous 90 days, a LFD before return to work and daily LFDs are still required.
  - The staff member must register the results of the daily LFD online and inform their manager. Adherence and reporting of daily LFD tests should be supervised by the line manager of the staff member.

- If the LFD result is positive, the staff member should isolate and seek a confirmatory PCR, whether or not they have had a previous positive PCR in the last 90 days.

Staff members must adhere to infection prevention and control appropriate to the setting in which they work. PPE should be worn in accordance with the relevant guidance. Fluid resistant surgical masks (FRSMs) are required to be worn at all times during the working day except when eating or drinking. FFP3 mask use applies in AGP situations.

Where conditions cannot be fulfilled for exemption from self-isolation as a close contact, the staff member must not attend for work and is expected to complete self-isolation for 10 days following exposure. Where a staff member declines daily LFD testing, they should not work in any clinical setting during the isolation exemption period.

During a period of exemption from isolation the staff member should not work with high clinical risk patients or service users. High clinical risk groups would include patients on
chemotherapy, immune-suppressants such as pre/immediately post-transplant, those who have profound immune-deficiency and other high clinical risk patients who are not vaccinated. This list is not exhaustive and local line managers may determine other groups as fitting within the high clinical risk category. Staff can however be asked to return to work in roles to care for and support people who are not deemed at high clinical risk.

In an outbreak situation the local Health Protection Team can override exemption from self-isolation as per the Scottish Government guidance on management of public health incidents.

8.2.4 Child and young person contacts

Self-isolation requirements for children and young people differ by the relative risk of the contact with the confirmed case. This applies for both adult and child cases.

High risk contact is defined as children and young people who are household contacts, e.g. siblings and social contacts involving unusually close or prolonged exposure (e.g. sleepover, intimate contacts).

- High risk contacts should be identified through routine contact tracing by Test and Protect.

- Where the high risk contact is an adult they should be managed in line with the guidance for adult contacts, based on their vaccination status, as set out above.

- Where the high risk contact is another child or a young person, e.g. a sibling, they should be advised to seek a PCR test and isolate until the result is known.
  
  o If the PCR test is negative, and they remain asymptomatic, they can end self-isolation (see appendices 3 and 4).

  o If the PCR test is positive (and more than 90 days since last positive PCR test if previously positive), they become a confirmed case and must continue their self-isolation as set out in this guidance (see appendices 3 and 4)

- Where the high risk contact is aged under 5, e.g. a sibling, they should be advised to take a PCR test but are exempt from isolation, without the requirement to do so.
This is because they are at such low risk of illness and/or transmission that insisting on a PCR test is not required unless they are symptomatic.

- This advice on self-isolation exemption is the same for clinically vulnerable and vaccinated contacts.

**Low risk contact** is defined as all other children and young people who meet the definition of contact, for example those who had contact in classrooms, early learning and childcare, communal dining, common entry and exit points, general playground contacts, sharing transport to school including cars and buses, friendship groups, cuddling or having nappies changed.

Low risk contact between child and young person cases of COVID-19 and adults, e.g. teachers, early learning and childcare staff, scout leaders, after-school club staff, should be managed in line with the same approach as for low risk contact between children.

TaP may be involved in contacting settings to inform them of the case, but in the first instance parents will be advised to inform the setting directly. A frequently asked question document has been produced by Scottish Government to support schools in the identification and notification of low risk contacts.

Low risk contacts, as described above, should be identified by the setting in which the contact occurred and be issued with a ‘warn and inform’ support notification from the owner/manager of that setting. A template letter has been provided by (appendix 8 and appendix 9). This applies to schools, educational settings, early learning and childcare and all other settings and situations for children, such as holiday clubs, youth groups (e.g. cubs, brownies, guides, scouts), sports clubs, etc.

Where Test and Protect identify complex setting or situation, HPTs may need to conduct a risk assessment to determine whether the nature of the contact presents a high risk of transmission. See section 9.3 for further details on the management of outbreaks and clusters in schools and other educational settings.
8.2.5 Contacts aged under 5 years

All contacts under the age of 5 are exempt from self-isolation unless they develop symptoms. They should be encouraged to take a PCR test, but this is not mandatory.

This advice is the same for clinically vulnerable contacts aged under 5.

8.3 People who are unwilling to self-isolate

Local teams can refer to the Public Health etc. (Scotland) Act 2008 if a case or contact is unwilling to co-operate with providing information for contact tracing, or unwilling to self-isolate. Local procedures for such circumstances should be followed.

9. Public health management of clusters and outbreaks

Management of COVID-19 clusters and outbreaks should follow existing, well-established principles and practice of outbreak management. This can be found in the SHPN Management of Public Health Incidents: guidance on the roles and responsibilities of NHS led incident management teams.

Cluster definition

Two or more unlinked test-confirmed cases of COVID-19 among people associated with a specific setting within 14 days.

Outbreak definition

Two or more linked test-confirmed cases of COVID-19 among people associated with a specific setting within 14 days.
9.1 Clusters or outbreaks in community-based and workplace settings

Settings who identify a cluster or outbreak should be advised to contact their local HPT (see appendix 2) as defined above. Proactive messaging should be undertaken by HPTs to ensure partners are aware of the need to report clusters and outbreaks.

The process of management of clusters is at the discretion of the local HPT, led by an appointed competent person under the Public Health Etc.(Scotland) Act 2008, in collaboration with the local authority. Responses to each incident should be proportionate to the public health impact. The purpose of asking settings to report clusters to HPTs is for surveillance, awareness and risk assessment.

The majority of community-based and workplace settings, clusters or outbreaks can be managed through routine approaches by the HPT. A generic checklist for preparation and management of clusters and outbreaks is provided in appendix 7 to support this. Actions to support outbreak management will consider measures and mitigations that are already in place or that require improvement and should be adapted to fit with local arrangements, for example on arranging testing, and should be adapted with setting-specific actions, as required.

Additional guidance on higher risk settings and any recommended specific actions are provided in the following guidance:

- Further information can be found in: COVID-19 information and guidance for non-health and care settings
- Sector specific advice can be found here: Coronavirus (COVID-19): Scottish workbook 2020 - gov.scot (www.gov.scot)
- PHS guidance for prevention and management of cases of COVID-19 on offshore installations
Further specific guidance exists for food businesses. Suspected / confirmed outbreaks and clusters in food processing premises should be reported to food standards Scotland (FSS). FSS also provide guidance for food business operators and their employees.

9.2 Clusters or outbreaks in higher risk settings

In some settings, there is a higher risk of transmission or potential higher impact of a cluster/outbreak. Once an outbreak is identified in a setting, a risk assessment should be undertaken to ascertain whether there is a risk of large scale spread or of spread to vulnerable populations. This should take into account the physical setting (e.g. the density of the setting), the characteristics of the population in terms of vulnerability (e.g. vaccination coverage and clinical vulnerability) and also the potential for intervention.

Setting-specific guidance exists for the following settings:

- PHS COVID-19 guidance for healthcare settings (due to be published soon)
- Scottish COVID-19 IPC community and healthcare addendum
- PHE COVID-19 guidance on management of exposed staff and patients in health and social care settings
- PHE COVID-19 guidance for first responders
- COVID-19: information and guidance for care home settings (adults and older people) and Scottish COVID-19 IPC care home settings addendum
- COVID-19: information and guidance for social, community and residential care settings (excluding adult and older people care home settings)
- COVID-19 guidance for prison settings
- Core COVID-19 sectoral information and guidance for homelessness settings
- PHS guidance for prevention and management of cases of COVID-19 on offshore installations.
There may be additional higher risk settings in addition to those identified above.

IPC and occupational health should have a system to identify clusters/outbreaks in healthcare settings. Communication and collaboration between HPTs and IPCTs is essential because frequently a combined response is required for hospitalised cases, as contacts and cases can move between the community and hospital.

### 9.3 Clusters or outbreaks in schools, childcare and other educational settings

The health risks that arise when people are in contact with others who test COVID-19 PCR positive have changed significantly, most notably due to high vaccination coverage and effectiveness. Children and young people have a very low risk of health harm from COVID-19, and children and young people with asymptomatic infection are at a relatively low risk of transmitting SARS-CoV-2 to adults. This means that the risk environment in schools has changed significantly, and our approach to managing COVID-19 in schools should evolve to reflect that.


These settings do not need to inform HPTs of each individual case and should send out the locally agreed version of the SG template ‘warn and inform’ support letters to all identified low risk contacts (see [appendix 8](https://www.gov.scot/publications/sgeic-covid-19-guide-reducing-risk-childcare-setting-19/)) and [appendix 9](https://www.gov.scot/publications/sgeic-covid-19-guide-reducing-risk-childminding-setting-19/). Template letters and processes must be agreed between local authorities and the health protection team. For childcare settings there is a [warn and inform information sheet for parents/carers and staff](https://www.gov.scot/publications/sgeic-covid-19-guide-reducing-risk-childcare-setting-19/), Schools do not need to send repeat warn and inform support letters to the same low risk contacts if there are serial cases in the same school during the same incident.

Feedback suggests that targeting such support letters at pupils in a class/es with a case
rather than wider year groups or whole schools avoids repetitive lettering to the same people and may induce less unwarranted parental concern.

Where significant (i.e. not just 2 or 3 cases) clusters or outbreaks are identified, schools, childcare settings and local authorities should be advised to undertake the following actions. This may be supported through existing local arrangements such as regular liaison between HPTs and education colleagues.

- Reinforcement of all controls are set out in the guidance above, produced by SG with input from PHS. This includes cleaning, ventilation, hand hygiene, symptom vigilance and physical distancing. In addition, the following controls could be reviewed and if necessary reinforced:
  - Reintroduction of previous control measures such as staggered start times, staggered use of shared spaces and other approaches to minimise mixing
  - Restricting external visitors to and from the setting, including minimising the use of peripatetic staff
  - Maximise the use of outdoor spaces, particularly for higher risk activities (e.g. physical activity, wind instruments, singing)
  - Cancelling any overnight trips / excursions and shows or wider assemblies.

- Encouragement of asymptomatic testing and use of face coverings for children and young people in secondary schools, as well as staff in all schools and early learning settings as outlined in the guidance above.

- Encouragement of all who are eligible to attend for vaccination.

Different health boards will have different ways of being informed of cases in education settings so the threshold for escalation to HPTs will need to be agreed locally in response to the local context. In some situations, it may be necessary for HPTs to become directly involved in managing such incidents. Factors that may indicate the need for escalation to a PAG or IMT include:

- risk to normal function of the setting due to high numbers of pupils or staff isolating
- unusually high levels of symptomatic cases, or severe illness
- higher risk settings such as schools for people with additional needs
- identification of variants or mutations (VAMs) - these may need HPTs to carry out a risk assessment and determine the approach required

In such situations HPTs may consider control measures such as:

- Encouraging testing of people with milder / wider range of symptoms e.g. flu-like symptoms
- Reinforcement of provision and promotion of LFDs for asymptomatic testing
- Further promotion of vaccination for all who are eligible.
- Request for an Environmental Health Officer (EHO) visit

Usually schools and childcare settings would be expected to continue to operate during outbreaks. On occasion, it may be necessary to move to remote learning approaches or to temporarily close a setting or part of a setting in order to implement control measures or for operational or staffing reasons. Any decision on this should be determined through the IMT taking full account of safety and wider public health considerations in line with their statutory duties. Similar decisions may need to be taken by local authorities in conjunction with schools/childcare settings where staffing constraints (e.g. due to self-isolation) make such a move unavoidable.

### 9.3.1 Other out of school settings

The principles above (section 9.3) also apply in out-of-school (non-household) settings for under 18 year olds, e.g. holiday clubs, youth groups such as cubs, brownies, guides scouts, sports clubs etc.in outbreak situations.

Local HPTs are likely to need to support these settings with text for a ‘warn and inform’ support letter (see appendix 8 and appendix 9) where this is indicated.
10. Investigation and management of suspected reinfections

Reinfection refers to a new infection with SARS-CoV-2 following a previous PCR confirmed infection. It is distinct from persistent infection and relapse of infection. Reinfection with SARS-CoV-2 remains rare although cases occasionally occur especially in the context of high prevalence.

10.1 When to consider a reinfection

- A positive SARS-CoV-2 PCR test 90 days or more after a previous positive PCR test.
- New COVID-19 symptoms in a person with previous SARS-CoV-2 PCR positive infection after apparent full recovery (resolution of previous symptoms) and a positive SARS-CoV-2 PCR test (including within 90 days of a previous positive PCR test).

10.2 Public health management of reinfections

- People with suspected reinfection should be managed as for a new or first infection (see section 7 on public health management) and should be instructed to self-isolate pending further investigation and clinical risk assessment.
- Inform the person that COVID-19 due to reinfection (if confirmed) may not necessarily follow the same clinical course as the last time they had the infection; the illness could range from asymptomatic to severe and they should seek medical support as appropriate for their clinical condition.
10.3 Risk assessment of reinfections

The following factors should be considered in a risk assessment:

- Index of clinical suspicion for reinfection (considering onset and nature of symptoms relative to previous confirmed infection).

- The PCR result cycle threshold (Ct) value if available. The Ct value is the number of PCR cycles that it takes before the virus is first detected; the lower the Ct value the higher the level of virus in the original sample. More information is available from PHS guidance on lab testing and frequently asked questions and PHE’s guide to understanding Ct in SARS-CoV2 RT-PCR for HPTs.

- Epidemiological factors which might increase suspicion of reinfection such as: close contact with a recently confirmed case or a history of recent travel.

- Related factors such as prior vaccination (prior vaccination should not rule out further investigation, however should the case be confirmed as reinfection, further steps may be required).

The following factors make reinfection much less likely:

- If the second PCR test is within 90 days of the initial infection and the person is asymptomatic, it is more likely to be a persistent positive result (e.g. remnant RNA or severely immuno-compromised).

- Persistent rather than new symptoms (aside from fever) since the previous positive test.

If after risk assessment SARS-CoV-2 reinfection is still suspected, further investigation is indicated, e.g. whole genome sequencing.
11. PPE

The general principles when considering potential exposures amongst health and social care (HSCW) staff are:

- Where a HSCW tests positive for SARS-CoV-2 and has been on duty during their infectious period, a risk assessment of exposure to other HSCWs and patients must be undertaken.

- During routine care and working activities, where the SARS-CoV-2 positive HSCW has been wearing a fluid resistant surgical mask (FRSM), there should be no significant exposure risk to other staff and patients. This is providing that the mask was worn correctly and consistently, the positive HSCW adhered to all other standard IPC precautions and the other HSCWs to whom the SARS-CoV-2 positive HSCW was exposed were wearing FRSMs, in line with extended use of facemask policy.

- If the exposure was during an aerosol generating procedure (AGP) and the SARS-CoV-2 positive HSCW was wearing a filter face piece (FFP3) valved respirator, it is possible that some exhaled breath/droplets may have posed a risk to surrounding staff and the patient. If a visor was worn on top of the FFP3 valved respirator, this would provide a physical barrier directing air flow downwards and intercepting any respiratory droplets. There is a theoretical risk of exhaled breath from the wearer of a valved respirator transmitting SARS-CoV-2 where asymptomatic carriage is present however, this risk is likely to be low. A risk assessment must be undertaken to establish the level of any exposure to others from the exhaled breaths. The risk assessment should include whether the positive staff member was symptomatic or not and whether the person to whom they were exposed was wearing the appropriate PPE (if other staff members were wearing FFP3 respirators, exclusion from work is not necessary).

The above would also apply to all those present in a care environment e.g. allied health professional, visitor or family member, if they are following instructions for that institution. Any decision to deviate from the advice to self-isolate would be for local decision makers based on their risk assessment.
Settings other than health and social care

Guidance on measures to reduce transmission of SARS-CoV-2 in non-health and care settings is available on the PHS website, in specific sectoral guidance published by the Scottish Government and in the community health and care settings infection prevention and control addendum.

Where PPE has been used, such as visors, masks, gloves etc., an individual risk assessment will have to be undertaken by the HPT to decide whether there has been an exposure risk sufficient to require contact isolation.

Assessment of appropriateness of PPE should include:

- whether the PPE is as recommended in approved guidance applicable to the setting and the task being undertaken; in settings where national guidance is not available, HPTs should undertake risk assessments and convene IMTs as needed
- whether the PPE meets technical and quality standards
- whether staff have been trained to use the PPE properly
- whether the PPE is adequate to protect in the situation e.g. eye protection and FRSM should be in use if the exposure is from spitting in the face

Situational risk assessment may result in the recommendation of further measures, such as self-isolation and wider testing determined by local circumstances.

12. International travel and managed isolation (quarantine)

Whilst every effort has been made to ensure that the information below is up-to-date, changes occur frequently. Please refer to the Scottish Government's travel website for further details.

All travellers to the UK must complete a passenger locator form (PLF) and have a negative PCR taken in the 72 hours prior to arrival.
There is a requirement for travellers returning to Scotland who have travelled in or through red-list countries in the 10 days before arrival that they enter **self-isolation in a managed quarantine facility** (MQF). If they arrive in the UK at one of the named Scottish ports, then they will enter MQF in Scotland. If they arrive in the UK at an English airport, then they will enter MQF at that airport. More information is provided in **appendix 10**. Particular arrangements are in place regarding isolation and testing requirements for unaccompanied minors travelling from red-list countries, further information is available from **Scottish Government**.

As required under travel regulations, a managed accommodation and testing package needs to be purchased prior to travel to the UK, facilitating quarantine/isolation and post-arrival PCR testing. TaP will be informed of all positive PCR test results via CMS in line with standard processes. As complex cases, returning travellers must be escalated to the local HPTs for contact tracing.

Further regulations are in place for travellers from green- and amber-listed countries, these are detailed on the [Scottish Government's website](https://www.gov.scot).

### 13. Associated legislation

This guidance is of a general nature and employers should consider the specific conditions of each individual place of work and comply with all applicable legislation, including the [Health and Safety at Work etc. Act 1974](https://www.legislation.gov.uk).

### 14. Confidentiality

The name or other identifiable details of confirmed cases should not be shared with contacts without the stated permission of the case. Cases should be advised that there is a risk of deductive disclosure, i.e. of the contact being able to work out who the case is, on the basis of the date of last contact, the settings the contact has attended, and people present, all of which may have to be shared with contacts in order to assess isolation requirements and protect public health.
15. Further information

- Further information for public health professionals can be found on the PHS COVID-19 page and on SHPIR.

- Information for the general public including self-isolation advice can be found on NHS inform.

- Pre-travel guidance can be found on fitfortravel for the public, and on TRAVAX for health professionals.

- Further information on COVID-19 and pregnancy can be found on the RCOG website. Pregnant staff should also seek advice from their line manager or local Occupational Health service. Information for at risk or pregnant HCWs can be found in Guidance for NHS Scotland workforce staff and managers on Coronavirus.
Appendices

Appendix 1- Guidance development process

V1.0 of this guidance was produced by a short life guidance development group (GDG) - membership below. HPTs in Scotland contributed to its development and feedback comments have been considered, prior to publication. Minor revisions of this guidance, as required, will be carried out by PHS.

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- Kathy Kenmuir, Primary care advisor, PHS
- Alex Sánchez-Vivar, Principal healthcare scientist (HCS), PHS
- Adriana Zalewska, Advanced HCS, PHS
- Faiza Hansraj-Jackson, HCS, PHS
- Alexander Ian Watts, HCS, PHS
- Joe Crossland, Health protection advanced practitioner, PHS
- Jackie Hyland, CPHM, NHS Lanarkshire
- Seeta Reddy, Consultant in public health, NHS Lothian
- Jenni Strachan, Health protection nurse (HPN), NHS Grampian
- Mary Morrissey, HPN, NHS Lothian
## Appendix 2 - Contact details for local Health Protection Teams

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Office Hours Telephone Number</th>
<th>Out of Hours Telephone Number Ask for Public Health On Call</th>
<th>Health Protection Team Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>01292 885 858</td>
<td>01563 521 133 Crosshouse Hospital switchboard</td>
<td><a href="mailto:hp.team@aapct.scot.nhs.uk">hp.team@aapct.scot.nhs.uk</a></td>
</tr>
<tr>
<td>Borders</td>
<td>01896 825 560</td>
<td>01896 826 000 Borders General switchboard</td>
<td><a href="mailto:Healthprotection@borders.scot.nhs.uk">Healthprotection@borders.scot.nhs.uk</a></td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>01387 272 724</td>
<td>01387 246 246</td>
<td><a href="mailto:dg.hpt@nhs.scot">dg.hpt@nhs.scot</a></td>
</tr>
<tr>
<td>Fife</td>
<td>01592 226 435</td>
<td>01592 643 355 Victoria Hospital switchboard</td>
<td><a href="mailto:fife.hpt@nhs.scot">fife.hpt@nhs.scot</a></td>
</tr>
<tr>
<td>Forth Valley</td>
<td>01786 457 283 Ask for CPHM on call</td>
<td>01324 566 000 Ask for CPHM on call</td>
<td><a href="mailto:Fv.healthprotectionteam@nhs.scot">Fv.healthprotectionteam@nhs.scot</a></td>
</tr>
<tr>
<td>Grampian</td>
<td>01224 558 520</td>
<td>03454 566 000</td>
<td><a href="mailto:gram.healthprotection@nhs.scot">gram.healthprotection@nhs.scot</a></td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td>0141 201 4917</td>
<td>0141 211 3600 Gartnavel switchboard</td>
<td><a href="mailto:phpu@ggc.scot.nhs.uk">phpu@ggc.scot.nhs.uk</a></td>
</tr>
<tr>
<td>Highland</td>
<td>01463 704 886</td>
<td>01463 704 000 Raigmore switchboard</td>
<td><a href="mailto:hpt.highland@nhs.scot">hpt.highland@nhs.scot</a></td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>01698 752 952</td>
<td>01236 748 748 Monklands switchboard</td>
<td><a href="mailto:healthprotection@lanarkshire.scot.nhs.uk">healthprotection@lanarkshire.scot.nhs.uk</a></td>
</tr>
<tr>
<td>Lothian</td>
<td>0131 465 5420/5422</td>
<td>0131 242 1000 Edinburgh Royal switchboard</td>
<td><a href="mailto:health.protection@nhslothian.scot.nhs.uk">health.protection@nhslothian.scot.nhs.uk</a></td>
</tr>
<tr>
<td>Orkney</td>
<td>01856 888 034</td>
<td>01856 888 000 Balfour Hospital switchboard</td>
<td><a href="mailto:ORK.publichealth@nhs.scot">ORK.publichealth@nhs.scot</a></td>
</tr>
<tr>
<td>Health Board</td>
<td>Office Hours Telephone Number</td>
<td>Out of Hours Telephone Number Ask for Public Health On Call</td>
<td>Health Protection Team Email</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------</td>
<td>------------------------------------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Shetland</td>
<td>01595 743340 (answer phone only) 01595 743060 (Board HQ who will pass on to appropriate PH person)</td>
<td>01595 743 000 Gilbert Bain switchboard</td>
<td><a href="mailto:shet.publichealthshetland@nhs.scot">shet.publichealthshetland@nhs.scot</a></td>
</tr>
<tr>
<td>Tayside</td>
<td>01382 596 976/987</td>
<td>01382 660 111 Ninewells switchboard</td>
<td><a href="mailto:tay.healthprotectionteam@nhs.scot">tay.healthprotectionteam@nhs.scot</a></td>
</tr>
<tr>
<td>Western Isles</td>
<td>01851 708 033</td>
<td>01851 704 704</td>
<td><a href="mailto:wi.healthprotection@nhs.scot">wi.healthprotection@nhs.scot</a></td>
</tr>
</tbody>
</table>
Appendix 3- Self-isolation periods for cases and contacts

The below should be read alongside section 8.2 In the majority of instances, the self-isolation period for identified contacts can be shortened dependent on their age and vaccination status.

Table 3a: Self-isolation periods for cases and contacts - care home settings

<table>
<thead>
<tr>
<th>Case or Contact</th>
<th>Staff or Residents</th>
<th>Self-isolation period (days) *</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19 cases</td>
<td>Residents</td>
<td>14</td>
</tr>
<tr>
<td>COVID-19 cases</td>
<td>Staff</td>
<td>10</td>
</tr>
<tr>
<td>Contacts of cases</td>
<td>Residents</td>
<td>14</td>
</tr>
<tr>
<td>Contacts of cases</td>
<td>Staff**</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 3b: Self-isolation periods for cases and contacts - healthcare settings

<table>
<thead>
<tr>
<th>Case or Contact</th>
<th>Staff or Residents</th>
<th>Self-isolation period (days) *</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19 cases</td>
<td>In-patients (case) remaining in the hospital</td>
<td>14</td>
</tr>
<tr>
<td>COVID-19 cases</td>
<td>Patient (case) discharged/transfered to any residential/care home/hospice setting</td>
<td>14</td>
</tr>
<tr>
<td>COVID-19 cases</td>
<td>In-patients (case) discharged to own home</td>
<td>14</td>
</tr>
<tr>
<td>COVID-19 cases</td>
<td>Staff</td>
<td>10</td>
</tr>
<tr>
<td>Contacts of cases</td>
<td>In-patients (contact) remaining in the hospital</td>
<td>14</td>
</tr>
<tr>
<td>Contacts of cases</td>
<td>Patient (contact) discharged/transfered to older adult residential setting/care home</td>
<td>14</td>
</tr>
<tr>
<td>Contacts of cases</td>
<td>In-patients (contact) discharged to residential setting other than older adult</td>
<td>Requires risk assessment with regards to 10 or 14 days</td>
</tr>
<tr>
<td>Contacts of cases</td>
<td>In-patients (contact) discharged to own home</td>
<td>10</td>
</tr>
<tr>
<td>Contacts of cases</td>
<td>Staff**</td>
<td>10</td>
</tr>
</tbody>
</table>
### Table 3c: Self-isolation periods for cases and contacts - prisons/custody settings

<table>
<thead>
<tr>
<th>Case or Contact</th>
<th>Staff or Residents</th>
<th>Self-isolation period (days) *</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19 cases</td>
<td>People in prisons/custody settings</td>
<td>10</td>
</tr>
<tr>
<td>COVID-19 cases</td>
<td>Staff in prisons/custody settings</td>
<td>10</td>
</tr>
<tr>
<td>Contacts of cases</td>
<td>People in prisons/custody settings</td>
<td>10</td>
</tr>
<tr>
<td>Contacts of cases</td>
<td>Staff in prisons/custody settings***</td>
<td>10</td>
</tr>
</tbody>
</table>

### Table 3d: Self-isolation periods for cases and contacts - general public

<table>
<thead>
<tr>
<th>Case or Contact</th>
<th>Self-isolation period (days) *</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19 cases</td>
<td>10</td>
</tr>
<tr>
<td>Adult contacts of cases</td>
<td>10***</td>
</tr>
<tr>
<td>Contacts of cases- 5-18 years and 4 months</td>
<td>10***</td>
</tr>
<tr>
<td>Contacts of cases &lt; 5 years</td>
<td>Exempt from self-isolation (unless symptoms develop)</td>
</tr>
<tr>
<td>Contacts (fully vaccinated) of cases (any age) who have had a positive PCR test in the previous 90 days</td>
<td>Exempt from self-isolation (unless symptoms develop); NB: adults must also be doubly vaccinated</td>
</tr>
</tbody>
</table>

### Table 3e: Self-isolation periods for cases and contacts - returning travellers

<table>
<thead>
<tr>
<th>Case or Contact</th>
<th>Self-isolation period (days) *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traveller arriving in Scotland via air travel from outside the common travel area *</td>
<td>For managed quarantine: 10 days self-isolation counting day 1 as the first full day after the traveller arrives in Scotland. Day 0 is considered day of arrival to Scotland. For home isolation (amber-listed): 10 days self-isolation counting Day 1 as the first full day after the traveller departed from or transited through an non-exempt country. Day 0 is considered day of departure from or transited through the non-exempt country * Fully vaccinated travellers (according to accepted UK vaccines) are exempt from 10-day self-isolation. No self-isolation required for travellers from green-listed countries.</td>
</tr>
</tbody>
</table>
Additional points to note

- For cases, day 1 of isolation is the first day of symptoms (or the date that a positive test was taken, if asymptomatic); travel regulations manage days of isolation differently.

- For contacts, day 1 of isolation is the last day exposure occurred (with a case) or the case's day 1.

- Isolation ends at 23h59 on the 10th or 14th day of isolation (as appropriate) *; travel regulations manage days differently.

- For travellers who are required to enter isolation for quarantine purposes:
  
  o Where isolation is in a managed quarantine facility (MQF) then day 1 is established in Scottish regulations and relates to the day after arrival in Scotland, where the traveller has travelled in or through a non-exempt country in the previous 10 days.

  o Where isolation is at home then day 1 is established in Scottish regulations and relates to the day after departure from a non-exempt country.

  o In both cases, regulations require that for any positive test result, the traveller should remain in quarantine until the end of the 10th day after the test was taken.

  o If the traveller's day 2 test result is positive there is no requirement to submit a second test on day 8.

*These are minimum isolation periods and should be extended in line with guidance if the following apply prior to the end of the stated isolation period:

- A case has not recovered (e.g. is still not well and has not had a fever-free period for 48 hours without anti-pyretics)

- A contact develops symptoms or has a positive COVID-19 test result.

- A case who tested positive whilst asymptomatic who then develops symptoms within the isolation period.

- A returned traveller develops symptoms during the quarantine period.

- Considerations made by an IMT in the course of an outbreak.
** Self-isolation is required for ALL close contacts, however health and social care staff may be exempt from contact self-isolation, if certain conditions are met (e.g. asymptomatic, fully vaccinated, COVID testing negative, further daily LFD testing) – see section 8.2. The days outlined in column relate to default self-isolation timeframe, if conditions do not apply.

***Self-isolation is required for ALL close contacts, however, self-isolation can be shortened for contacts in the general population who meet certain criteria – see Scottish Government COVID-19 staying safe and protecting others guidance for details.

Further information can also be found in COVID-19: international travel and managed isolation (quarantine) guidance.
**Appendix 4- COVID-19 self-isolation for a household**

**Table 1: Symptomatic index case**

<table>
<thead>
<tr>
<th>Day</th>
<th>Symptom(s) start</th>
<th>Kate</th>
<th>Billy</th>
<th>Daisy</th>
<th>George</th>
<th>Roberto</th>
<th>Johanna</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No symptoms. Begin 10-day isolation and book PCR test</td>
<td>Kate</td>
<td>Billy</td>
<td>Daisy</td>
<td>George</td>
<td>Roberto</td>
<td>Johanna</td>
</tr>
<tr>
<td>2</td>
<td>Positive PCR</td>
<td>Billy</td>
<td>Daisy</td>
<td>George</td>
<td>Roberto</td>
<td>Johanna</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Negative PCR Complete 10-day isolation</td>
<td>Kate</td>
<td>Billy</td>
<td>Daisy</td>
<td>George</td>
<td>Roberto</td>
<td>Johanna</td>
</tr>
<tr>
<td>4</td>
<td>Negative PCR Isolation ends If no symptoms</td>
<td>Billy</td>
<td>Daisy</td>
<td>George</td>
<td>Roberto</td>
<td>Johanna</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Symptoms start Restart 10-day isolation</td>
<td>Billy</td>
<td>Daisy</td>
<td>George</td>
<td>Roberto</td>
<td>Johanna</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>Kate</td>
<td>Billy</td>
<td>Daisy</td>
<td>George</td>
<td>Roberto</td>
<td>Johanna</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>Kate</td>
<td>Billy</td>
<td>Daisy</td>
<td>George</td>
<td>Roberto</td>
<td>Johanna</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>Kate</td>
<td>Billy</td>
<td>Daisy</td>
<td>George</td>
<td>Roberto</td>
<td>Johanna</td>
</tr>
<tr>
<td>9</td>
<td>Isolation ends If no temperature in previous 48 hours</td>
<td>Kate</td>
<td>Billy</td>
<td>Daisy</td>
<td>George</td>
<td>Roberto</td>
<td>Johanna</td>
</tr>
<tr>
<td>10</td>
<td>Isolation ends If no symptoms</td>
<td>Kate</td>
<td>Billy</td>
<td>Daisy</td>
<td>George</td>
<td>Roberto</td>
<td>Johanna</td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>Kate</td>
<td>Billy</td>
<td>Daisy</td>
<td>George</td>
<td>Roberto</td>
<td>Johanna</td>
</tr>
<tr>
<td>12</td>
<td></td>
<td>Kate</td>
<td>Billy</td>
<td>Daisy</td>
<td>George</td>
<td>Roberto</td>
<td>Johanna</td>
</tr>
<tr>
<td>13</td>
<td></td>
<td>Kate</td>
<td>Billy</td>
<td>Daisy</td>
<td>George</td>
<td>Roberto</td>
<td>Johanna</td>
</tr>
<tr>
<td>14</td>
<td>Isolation ends If no high temperature in previous 48 hours</td>
<td>Kate</td>
<td>Billy</td>
<td>Daisy</td>
<td>George</td>
<td>Roberto</td>
<td>Johanna</td>
</tr>
</tbody>
</table>
Table 2: Asymptomatic index case

<table>
<thead>
<tr>
<th>Day</th>
<th>Faiza</th>
<th>Joe</th>
<th>Carrie</th>
<th>Anne</th>
<th>Tiago</th>
<th>Chucky</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Positive PCR</td>
<td>Contact</td>
<td>Contact</td>
<td>Contact</td>
<td>Contact</td>
<td>Contact</td>
</tr>
<tr>
<td>1</td>
<td>Begin 10 day self-isolation</td>
<td>Over 18 Fully vaccinated</td>
<td>Over 18 One dose vaccine</td>
<td>Over 18 Unvaccinated</td>
<td>Under 18</td>
<td>Under 18</td>
</tr>
<tr>
<td></td>
<td>No symptoms. Begin 10-day isolation and book PCR test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Positive PCR</td>
<td>Complete 10-day isolation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Negative PCR</td>
<td>Complete 10-day isolation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Negative PCR</td>
<td>Positive PCR</td>
<td>Negative PCR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Isolation ends If no symptoms</td>
<td>*Restart 10-day isolation due to onset of symptoms in index case</td>
<td>Symptoms start Restart 10-day isolation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Symptoms start Re-start 10-day isolation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Isolation ends If no high temperature in previous 48 hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Isolation ends If no high temperature in previous 48 hours</td>
<td>Isolation ends If no symptoms</td>
<td>Isolation ends If no high temperature in previous 48 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Carrie is an unvaccinated adult, therefore when the index case in the household develops symptoms and has to re-start their 10-day self-isolation, Carrie also has to re-start her 10-day self-isolation.
Additional points to note

- The cardinal symptoms of COVID-19 are new, continuous cough, fever or high temperature (37.8°C or greater) and loss of, or change in, sense of smell (anosmia) or taste (ageusia).

- Any reference in the table to “positive PCR test” and date corresponds to the date the sample was taken.

- A negative PCR result implies COVID-19 is unlikely at that moment in time, this test will need to be repeated if symptoms develop. The reason for this is that the test may have been done too early or could be a false negative.

- Note that contact tracing starts from 2 days before cardinal symptoms onset OR positive test, if asymptomatic, and for the next 10 days.

- The vaccination status for contacts under 18 (e.g. Roberto and Johanna in table 1 and Tiago and Chucky in table 2) makes no difference as vaccination is not a criterion for exemption from self-isolation for the under 18s.

- "Fully vaccinated" implies that the person had their second dose of approved vaccine at least 14 days prior to the date of exposure, noting that day 1 is the day of vaccination.

Regarding isolation

- A person with one of the cardinal symptoms of COVID-19 must isolate for 10 days from the date of onset of the symptoms; they do not isolate from the date of a positive PCR test.
  
  o For example, if a person (e.g. George in table 1) has a positive PCR test and develops symptoms the next day, they must isolate for 10 days from the day of onset of symptoms.

- If an index case has no cardinal symptoms of COVID-19, isolation is for 10 days from positive test.

  o A fully vaccinated adult household contact of such a case (e.g. Billy in table 1) can end isolation if his post-exposure PCR is negative and no symptoms develop. If he becomes symptomatic, he must get a PCR test.
- An under 18 household contact of such a case (e.g. Roberto in table 1) can also end his isolation if his PCR is negative and no symptoms develop.

- A fully vaccinated, PCR negative, household contact with no symptoms who is already in their 10-day isolation period does not need to re-start isolation if another member of the household becomes a case and does not need to re-do a PCR test as long as symptom-free.

- Note that contacts aged over 18 (not including people aged between 18 and 18 years and 4 months) must self-isolate if not fully vaccinated.

- If the index case was initially asymptomatic (e.g. Faiza in table 2) and their symptoms start later
  - Any household adult contacts who are not fully vaccinated (e.g. Carrie in table 2) need to restart their 10-day self-isolation along with the index case.
  - Any household adult contact who is fully vaccinated and PCR negative does not need to retest or re-start self-isolation if symptom free.

- A confirmed case does not need to re-start isolation if another member of the household tests positive during the full incubation period (14 days) from onset of the household case.
  - However, if at any time there is contact with a confirmed case from outside the household then the 10-day isolation period must restart. N.B a fully vaccinated contact would be exempt from self-isolation and would not need to be tested.
  - If a household contact has a positive PCR, the other household members do not need to be retested or restart isolation unless they develop symptoms.

- A person who has tested PCR positive in the previous 90 days does not need to be re-tested as a contact without symptoms.
  - In order to be exempt from self-isolation, a person who has tested PCR positive in the previous 90 days needs to be fully vaccinated but they do not need a negative PCR.
  - For HSCWs, if a subsequent daily LFD is positive, a PCR should be done at that stage even if PCR has been positive in the past 90 days; if negative a risk
assessment should be done to confirm that exemption for self-isolation applies; if this PCR is positive, the staff member must continue 10 days self-isolation as a case from the date of LFD positivity.
Appendix 5- Contact tracing points of contact for UK public health agencies and UK armed forces

<table>
<thead>
<tr>
<th>Country</th>
<th>Organisation</th>
<th>Contact number</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>Public Health England (PHE)</td>
<td>Tel: 0208 495 5403</td>
<td><a href="mailto:phe.da@nhs.net">phe.da@nhs.net</a></td>
</tr>
<tr>
<td>Wales</td>
<td>Public Health Wales (PHW)</td>
<td>Tel: 0300 0030032</td>
<td><a href="mailto:phw.Covid19ContactTracing@wales.nhs.uk">phw.Covid19ContactTracing@wales.nhs.uk</a></td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>Public Health Agency (PHA)</td>
<td>Weekdays 9am-5pm: 0300 555 0119 Out of hours: 028 9040 045</td>
<td><a href="mailto:pha.dutyroom@hscni.net">pha.dutyroom@hscni.net</a> Monday to Friday 9am-5pm only</td>
</tr>
<tr>
<td>Outside of UK</td>
<td>PHS acting as focal point</td>
<td>0141 300 1414</td>
<td><a href="mailto:phs.hpscoronavirus@nhs.net">phs.hpscoronavirus@nhs.net</a> It is not advised to ‘reassign’ cases/contacts to PHS on CMS unless asked to do so</td>
</tr>
</tbody>
</table>

UK armed forces personnel

Where a case is identified as someone who works or resides in a military establishment, and they are reluctant to divulge any contact details, movements or locations, HPTs may request the support of the Ministry of Defence (MOD) Public Health Team to interview the case (email: SG-DMed-Med-DPHU-GPMailBox@mod.gov.uk). This mailbox should not be used to transfer personal identifiable information but as a first point of contact for these scenarios. Responsibility for the follow up of contacts once identified can be determined on a case-by-case basis, whether HPT or MOD.
Appendix 6 - Definition and classification of contacts

The below should be read alongside section 8.3. In the majority of instances, the self-isolation period for contacts can be shortened dependent on age and vaccination status.

Table 6a: Classification of contact - household

<table>
<thead>
<tr>
<th>Type of contact</th>
<th>Definition</th>
<th>Isolation Period</th>
</tr>
</thead>
</table>
| Household contacts living with the case      | Those who are living in the same household as a case e.g. those that live and sleep in the same home, or in shared accommodation such as university accommodation that share a kitchen or bathroom. | - Contacts sharing the same household as the index case should isolate at home for 10 days from the date of onset of cardinal symptoms in the index case.  
  - Isolation should commence as soon as symptoms develop in the index case, whilst awaiting the result of testing.  
  - Exceptions to this are  
    - asymptomatic household contacts aged under 5  
    - those with a history of PCR-confirmed infection in the last 90 days (who do not need to isolate and do not need a follow-up PCR test, but do require double vaccination if adult)  
  - In situations where the index case is asymptomatic, isolation should be for 10 days from the index date of test. If cardinal symptoms develop subsequently, isolation should be re-started from the index date of symptom onset.  
  - If further cases arise within the household during the isolation period, there is no requirement to re-start the 10-day isolation of those resident within the household from symptom onset of any subsequent cases.  
  - Advice on household isolation is available on NHS inform. |
<table>
<thead>
<tr>
<th>Type of contact</th>
<th>Definition</th>
<th>Isolation Period</th>
</tr>
</thead>
</table>
| Household contacts not living with the case                                     | - Those that have spent a significant time in the home (cumulatively equivalent to an overnight stay and without social distancing e.g. 8 hours or more) with a case during the infectious period.  
- Sexual contacts who do not usually live with the case.  
- Cleaners (not using appropriate PPE) of household settings during the infectious period, even if the case was not present at the time. | - Contacts from outside the household of the case should be told to self-isolate at home for 10 days from the date of last exposure to the case.  
- Other members of the contact’s household do not need to isolate unless the contact becomes symptomatic. |

N.B. Temporary guidance for contacts of cases may exceptionally be introduced to manage an incident or based on specific geographical measures. In such situations, contacts should follow the advice provided by the local Test & Protect team.

**Table 6b: Classification of contact - non-household**

<table>
<thead>
<tr>
<th>Type of contact</th>
<th>Definition</th>
<th>Isolation Period</th>
</tr>
</thead>
</table>
| Direct contact | - Face to face contact with a case for any length of time, within 1 metre including being coughed on, a face to face conversation, unprotected physical contact (skin to skin). This includes exposure within 1 metre for 1 minute or longer without face-to-face contact.  
- A person who has travelled in a small vehicle (e.g. car or van) with someone who has tested positive for SARS-CoV-2 or in a large vehicle | - Contacts from outside the household of the case should be told to self-isolate at home for 10 days from the date of last exposure to the case.  
- Other members of the contact’s household do not need to isolate unless the contact becomes symptomatic. |
<table>
<thead>
<tr>
<th>Type of contact</th>
<th>Definition</th>
<th>Isolation Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>near someone who has tested positive for SARS-CoV-2.</td>
<td></td>
</tr>
</tbody>
</table>
| Proximity contact | • Extended close contact (less than 2 metres for more than 15 minutes) with a case.  
                   • The duration of contact should be considered cumulatively over a 24 hour period, where exposure is within the infectious period (48 hours prior to symptom onset, or positive test if the case is asymptomatic, for 10 days from the date of symptom onset, or positive test if the case is asymptomatic). | • Contacts from outside the household of the case should be told to self-isolate at home for 10 days from the date of last exposure to the case.  
                   • Other members of the contact’s household do not need to isolate unless the contact becomes symptomatic. |

N.B. Temporary guidance for contacts of cases may be introduced to manage an incident or based on specific geographical measures. In such situations, contacts should follow the advice provided by the local Test & Protect team.
Appendix 7 - Checklist for health protection team management of COVID-19 outbreaks

**Initial risk assessment**

Following notification of a cluster, an initial risk assessment should be undertaken by the Health Protection Team. As far as is possible, this risk assessment should be undertaken in collaboration with the setting owner, such as a manager or owner of the business/setting where the cluster/outbreak has occurred. A standardised approach to risk assessment should be developed to assist with this. This approach should take into account:

**Severity**

- Has anyone in the setting been reported as having been admitted to hospital, ICU or known to have died as a result of COVID-19 during this incident?
- Are the setting population particularly vulnerable e.g. unvaccinated adults, elderly, immunocompromised?

**Spread**

- OBM should be used to collate and review case and contact data.
- Produce a basic line-list summarising current known cases, contacts, onset dates, symptomatic / asymptomatic.
- Assess initial links between cases and the suspected attack rate within the setting.

**Uncertainty**

- Assess the potential for extensive spread, number of contacts / case; closeness of contacts in the setting e.g. shared sleeping accommodation
- Reflect on the strength of collaboration: Is the setting experienced and engaged with the management of incidents such as this?
- Assess the potential for those in the setting to spread infection to other settings, including higher risk settings e.g. medical students.
Control measure

- Assess actions taken to date and number of cases and contacts already self-isolating or undertaking contact testing, interrogate compliance, infection control, handwashing, current physical distancing measures in place, setting layout, consider likely adherence to any potential additional measures.

Context

- Any communications already issued, any operational issues due to staffing anxieties or absence, anxiety or misinformation circulating in staff or others in setting; social media context; press interest; ages and cohorts affected.

Management

Following risk assessment, the HPT should consider the need for a Problem Assessment Group (PAG) or Incident Management Team (IMT) meeting in line with Management of Public Health Incidents: Guidance on the roles and responsibilities of NHS led incident management teams.

Where the HPT is managing multiple simultaneous situations, it is recognised that it may not be practicable or possible to convene an IMT for each one and that alternative management approaches are in place across HPTs.

Whether through an IMT or other approach, the HPT should work in partnership with key stakeholders including the setting owner in order to make recommendations on ongoing assessment and control of the incident. Where relevant, Environmental Health Officers or the Health and Safety Executive or Food Standards Scotland should be invited to attend. PHS and Scottish Government (as observer) can also be invited to join IMTs for significant incidents.

A checklist for further investigation and control is provided below.

Updated assessment

- Maintenance and update of line list.
  
- Consideration of operational implications of the incident for the setting.
Investigations

- Linkages between cases: Consider layout of setting and establish linkages between cases, both in setting and outside the setting e.g. social events.
- Testing (PCR / LFD): Promote routine testing, if already established; consider how access can be maximised.
- Vaccination coverage: Assess coverage and consider approaches to maximise vaccination uptake in response to the incident.

Control Measures

- Review implementation of appropriate guidance e.g. non-healthcare settings and sector specific guidance
- Cohorting of population / minimising contact between groups
- Physical distancing: policy / guidance and adherence. Include discussion of car sharing, communal areas, changing rooms, breaks including smoking
- Reminder to population re symptom vigilance and indications for self-isolation and testing
- Personal Protective Equipment use: use of face coverings, compliance
- Personal hygiene: Hand and respiratory hygiene
- Environmental cleaning
- Ventilation

Communications and wellbeing

- Consider wellbeing and the impact of incident and any enhanced mitigations on those involved in or using the setting including financial impact on cases and contacts. Consider support required.
- Inform other stakeholders and widening participation as required.
- Assess the need for a proactive or reactive media statement.
Chairing of PAG/IMTs

- HPT to chair
- Consent for supportive recording, if useful for minute-taking
- If new attendees, explain PAG/IMT process briefly, acronyms
- Confidentiality reminder regarding reporting back organisationally generally and for personal identifiable information (PII)
- FOI reminder for documentation, etc
- Declarations of potential conflicts of interest, e.g. private owners, service managers or otherwise connected to the situation (e.g. link to specific school, business, service)
- Review membership
- Review case definition
- If company or setting manager invited to provide an update or support risk assessment, this should be only to part of the PAG/IMT in order to enable PAG/IMT members to discuss final conclusions.
- Establish plans for next meeting

Conclusion

An outbreak investigation should be concluded when there have been no new cases for a minimum of 14 days from the last potential exposure to a confirmed case and no further follow-up actions are required to mitigate the potential for future outbreaks.
Appendix 8 - Template letter – “warn and inform” letter for parents and carers

N.B. These template letters must be discussed between local authorities and the local health protection team before being issued to schools i.e. there should be an ongoing agreement in place between the HPT and local authority such that they do not need to be discussed for each individual case or school. Schools do not need to send additional ‘warn and inform’ support letters if there are serial cases in the same school in quick succession.

The template may be amended on the advice of local health board/health protection team representatives, for example to remove unnecessary information or to incorporate local messaging (e.g. around local services). Please ensure you note the version number in the header of this template letter.

Dear Parent/Carer,

**COVID-19 information letter to parents and carers**

This is to inform you that a case of confirmed COVID-19 (Coronavirus) has been reported in a person with links to (OR WORKS AT*) (INSERT SCHOOL).

All contacts of the case who need to take specific actions have been identified, contacted and advised to follow the latest guidance on self-isolation and testing.

From 9 August 2021, these procedures have been updated for:

- adults who are fully vaccinated, who do not have symptoms and who have not tested positive; and

- children and young people aged under 18 who do not have symptoms and who have not tested positive.

Further information on the latest self-isolation requirements can be found on the [NHS inform website](#), with [translations available](#) for accessible, easy read formats or other languages.

**What you need to do:**

There is no requirement for you or your child to self-isolate unless you are contacted by Test and Protect. This could happen if the contacts your child has had in the school environment or
other settings – most likely social or overnight settings – are assessed as requiring targeted action.

The school has multiple control measures in place against COVID-19, supported with regular testing of staff, to limit the risk of onwards transmission within the school environment.

If there are any further cases of COVID-19 in the school, Test and Protect and the local NHS Health Protection Team will work to ensure these individuals, and any of their relevant contacts, are advised to self-isolate and follow the latest guidance.

The school remains open in line with current Scottish Government guidelines and if there are any further updates we will communicate this to the school community. If your child has not been advised that they are a relevant contact and remains well, they can continue to attend school as per your school’s current arrangements. Anyone with COVID symptoms of a new and persistent cough, fever, altered or absent sense of taste or smell should stay at home and get a PCR test.

If you have been advised by Test and Protect that your child has been identified as a relevant contact of someone who has tested positive for COVID-19, please follow the guidance they have provided.

The information below is general information for parents/carers whose children have not been identified as a contact where targeted action is required.

- Please encourage your child to test twice-weekly, and to record all positive, negative or void results on the online reporting portal. Reporting results helps public health experts understand what is happening with COVID-19 in your area, so they can take early action to address any problems.

  If your child is at secondary school, they can access free LFD tests from the school, to allow them to test twice-weekly at home as long as they have no symptoms. Please contact the school directly to ask about this if your child is having problems accessing tests.

- In addition, you and the rest of your family, including primary school-aged children, can access free test kits through the Universally Accessible Testing programme, which is available to everyone in Scotland. Free at-home LFD test kits are available for collection from COVID test centres or pharmacies, or delivery by ordering online. More information can be found on the Scottish Government website.
What to do if your child develops symptoms of COVID-19:

Please be particularly vigilant for symptoms of COVID-19 in the coming weeks. If your child develops any symptoms of COVID-19 they must not come to school. They should stay at home from when their symptoms started, self-isolate, and get tested for COVID-19. Find out more on NHS Inform. The symptoms of coronavirus (COVID-19) are:

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

All other household members of your child (including yourself) must also stay at home and follow the latest guidance, which can be found on NHS Inform. In the event of a positive result, Test and Protect will contact you to provide tailored advice on what to do.

Booking a test if you develop symptoms:

- Book a test at NHS Inform for your nearest COVID-19 test site. There are drive-through, walk-through, mobile testing units across Scotland which are open from 8-am until 8pm, 7 days a week. Small scale test sites have also been set up in Highland, Grampian and Argyll & Bute to provide access to testing within local communities. A full list of sites can be found on the Scottish Government website.

- Order a home PCR test kit online, or by calling 119. A test will then be delivered to your home. To return you can either drop the test at your nearest priority post box, or if you are unable to go out, you can also call 119 to book a courier collection from your home.

It is important that anyone with one or more of the COVID-19 symptoms gets tested, so that anyone who tests positive knows to continue to stay at home and self-isolate. This will help stop the spread of coronavirus.

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

If your child develops symptoms you can seek advice from NHS inform.

How to stop COVID-19 spreading:

There are things you can do to reduce the risk of you and anyone you live with getting ill with COVID-19. Do:
• get vaccinated if you haven't already done so and are eligible. Vaccination is our best defence against COVID-19 causing anyone to become seriously unwell. If anyone who is eligible in your family or home have not yet been vaccinated, then they should arrange vaccination as soon as possible. This could also help you avoid having to self-isolate in the future. Information on how to arrange a vaccination can be found on NHS inform.

• regularly wash your hands with soap and water 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 straight in the bin and wash your hands.

• open windows/doors regularly to ventilate your home

• be vigilant for COVID symptoms

• self-isolate when you have COVID symptoms or have been advised to by Test and Protect

• avoid crowded settings and use a face covering if it is difficult to physically distance in public places.

Further Information

NHS inform provide Coronavirus frequently asked questions and information

If you would like to speak to someone or if you have any questions, please contact [INSERT CONTACT DETAILS]. I look forward to seeing your child return to school in line with the guidance in this letter.

Yours sincerely,

Head teacher
Appendix 9 - Template letter – “warn and inform” letter for school staff

N.B. These template letters must be discussed by local authorities and the local health protection team before being issued to schools i.e. there should be an ongoing agreement in place between the HPT and local authority such that they do not need to be discussed for each individual case or school. Schools do not need to send additional warn and inform letters if there are serial cases in the same school in quick succession.

The template may be amended on the advice of local health board/health protection team representatives, for example to remove unnecessary information or to incorporate local messaging (e.g. around local services). Please ensure you note the version number in the header of this template letter.

Dear colleague,

COVID-19 information letter to school staff

This is to inform you that a case of confirmed COVID-19 (Coronavirus) has been reported in a person with links to (OR WORKS AT*) (INSERT SCHOOL).

All contacts of the case who need to take specific actions have been identified, contacted and advised to follow the latest guidance on self-isolation and testing.

From 9 August 2021, these procedures have been updated for:

- adults who are fully vaccinated, who do not have symptoms and who have not tested positive; and

- children and young people aged under 18 who do not have symptoms and who have not tested positive.

Further information on the latest self-isolation requirements can be found on the NHS inform website, with translations available for accessible, easy read formats or other languages.

What you need to do:

Unless you have COVID symptoms, there is no requirement for you to self-isolate unless you are contacted by Test and Protect. This could happen if the contacts you have had in the school...
environment or other settings – most likely social or overnight settings – are assessed as requiring targeted action.

The school has multiple control measures in place against COVID-19, supported with regular testing of staff, to limit the risk of onwards transmission within the school environment.

If there are any further cases of COVID-19 in the school, Test and Protect supported when needed by the local NHS Health Protection Team will work to ensure these individuals, and any of their relevant contacts, are advised to self-isolate and follow the latest guidance.

The school remains open in line with current Scottish Government guidelines and if there are any further updates we will communicate this to the school community. If you have not been advised that you are a relevant contact and remain well, you can continue to attend school. Anyone with COVID symptoms of a new and persistent cough, fever, altered or absent sense of taste or smell should stay at home and get a PCR test.

If you have been advised by Test and Protect that you have been identified as a relevant contact of someone who has tested positive for COVID-19, please follow the guidance they have provided. The information below is general information for people who have not been identified as a contact where targeted action is required.

- Keep testing regularly, even without symptoms

- Regular testing even when you don’t have symptoms can help keep you and your school community safe.

- As a member of school staff, you can access free LFD tests from the school, to allow you to test twice-weekly at home as long as you have no symptoms. Please contact the school directly if you are having problems accessing tests.

- You are encouraged to test twice weekly, and to record all positive, negative or void results on the online reporting portal. Reporting results helps public health experts understand what is happening with COVID-19 in your area, so they can take early action to address any problems.

**What to do if you develop symptoms of COVID-19:**

Please be particularly vigilant for symptoms of COVID-19 in the coming weeks. If you develop any symptoms of COVID-19 you must not come to school. You should stay at home from when
symptoms started, self-isolate, and get tested for COVID-19. Find out more on NHS Inform.
The symptoms of coronavirus (COVID-19) are:

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

All other household members must also stay at home and follow the latest guidance, which can be found on NHS Inform. In the event of a positive result, Test and Protect will contact you to provide tailored advice on what to do.

**Booking a test if you develop symptoms:**

- Book a test at NHS Inform for your nearest COVID-19 test site. There are drive-through, walk-through, mobile testing units across Scotland which are open from 8-am until 8pm, 7 days a week. Small scale test sites have also been set up in Highland, Grampian and Argyll & Bute to provide access to testing within local communities. A full list of sites can be found on the Scottish Government website.

- Order a home PCR test kit online, or by calling 119. A test will then be delivered to your home. To return you can either drop the test at your nearest priority post box, or if you are unable to go out, you can also call 119 to book a courier collection from your home.

It is important that anyone with one or more of the COVID-19 symptoms gets tested, so that anyone who tests positive knows to continue to stay at home and self-isolate. This will help stop the spread of coronavirus. For most people, coronavirus (COVID-19) will be a mild illness. If you develop symptoms you can seek advice from NHS Inform.

**How to stop COVID-19 spreading:**

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

- get vaccinated if you haven’t already done so and are eligible. Vaccination is our best defence against COVID-19 causing anyone to become seriously unwell. If anyone who is eligible in your family or home have not yet been vaccinated, then they should arrange vaccination as soon as possible. This could also help you avoid having to self-isolate in the future. Information on how to arrange a vaccination can be found on NHS inform.
• regularly wash your hands with soap and water 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 straight in the bin and wash your hands.

• open windows/doors regularly to ventilate your home.

• be vigilant for COVID symptoms

• self-isolate when you have COVID symptoms or have been advised to by Test and Protect.

• avoid crowded settings and use a face covering if it is difficult to physically distance in public places.

Further Information

NHS inform provide Coronavirus frequently asked questions and information

If you would like to speak to someone or if you have any questions, please contact [INSERT CONTACT DETAILS].

Yours sincerely,

Head teacher
Appendix 10 - Travel areas and public health actions

Whilst every effort has been made to ensure that the information below is up-to-date, please refer to the [Scottish Government's travel website](https://www.gov.scot) for the latest risk status and restrictions of each country.

<table>
<thead>
<tr>
<th>Region</th>
<th>Public Health Action</th>
</tr>
</thead>
</table>
| Common Travel Area (CTA)                    | • Advice as for UK citizens/residents  
• No specific isolation or testing                                                                                                                                                                                                                                                                                                                   |
| Non-exempt countries that are Acute Risk Countries (ARC) (Red list) | • Required to enter managed isolation if arrive in Scotland or other part of UK (except if exempt for occupation etc)  
• Day 2 and day 8 PCR tests required  
• Additional actions may be required if variants and mutations (VAMs) are identified                                                                                                                                                                                                                                           |
| Non-exempt countries that are not Acute Risk Countries (ARC) (Amber list) | • Required to isolate at home or another specified premises if arrive direct to Scotland (except if exempt for occupation OR because person is fully vaccinated (has received final dose of a COVID-19 vaccine through approved sources, at least 14 days before arrival in Scotland)  
• Day 2 and day 8 PCR tests required if not exempt from self-isolation; only day 2 test required if exempt.  
• If arrive in other part of UK, can travel on to Scotland and isolate at home address but require testing package  
• If VAM identified, then further actions may be required.                                                                                                                                                                                                                                           |
| Exempt countries (Green list)               | • No requirement to self-isolate  
• Day 2 PCR test required  
• If VAM identified, then further actions may be required.                                                                                                                                                                                                                                                                                      |
References


