Self-isolation and contact tracing
Information sheet for school and registered childcare settings
16 August 2021

When people test positive for COVID-19, or develop the symptoms of COVID-19, others who have been in close contact with them are asked to take certain actions to limit the potential for spread of the virus. These people are generally referred to as “contacts”.

From 9 August 2021, the approach to self-isolation and contact tracing for close contacts aged under 18, and for close contacts who are fully vaccinated adults, was updated. These changes were made to better reflect our understanding of the risks of infection and transmission, taking into account high levels of vaccination amongst adults and the evidence we have about infection and transmission in children and young people aged under 18.

Why these changes are being made

In summary, the health risks that arise when people are in contact with others who test positive have changed significantly, most notably due to vaccination. Vaccine uptake is very high, particularly among individuals who are at greater risk of harm from COVID-19, and the vaccines are highly effective at preventing severe disease (with 96% effectiveness against hospitalisation for the Delta variant – COVID-19 vaccine surveillance report. 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 COVID-19 to adults. This means that the risk environment has changed significantly, and our approach to managing COVID-19 is evolving to reflect that.

Changes to the self-isolation policy

The changes to self-isolation policy do not apply if you have had a positive test or if you have symptoms of COVID-19. In those circumstances, you must self-isolate in line with NHS Inform.

The action that close contacts of positive cases must take varies depending on age and vaccination status (see below for information on how close contacts will be identified and asked to take these actions). In summary:

- if you are a close contact aged more than 18 and 4 months who lives in the household of the positive case, OR who has been identified by Test and Protect as needing to take action, then:
    - if you are fully vaccinated (two doses, with at least 2 weeks having passed after your second dose), you should self-isolate and book a PCR test.
        - If the PCR test is negative and you remain without symptoms, you can end self-isolation and go about your daily life, including returning to work or school
        - If the PCR test is positive, you should continue to self-isolate in line with NHS Inform
        - If you subsequently become symptomatic you should self-isolate and book a PCR test
    - If you are unvaccinated, have only a single dose of the vaccine, or had a second dose less than two weeks previously, you should self-isolate and book a PCR test. You should continue to self-isolate regardless of the results of the test, in line with NHS Inform
- if you are a close contact aged between 5 years to 18 years and 4 months, who lives in the household of the positive case, OR who has been identified by Test and Protect as needing to take action, then:

- You should self-isolate and book a PCR test.

    - If the PCR test is negative and you remain without symptoms, you can end self-isolation and go about your daily life, including returning to work, school or childcare
    - If the PCR test is positive, you should continue to self-isolate in line with NHS guidance
    - If you subsequently become symptomatic you should self-isolate and book a PCR test

- if a close contact is aged under 5 years then they will not need to self-isolate if they remain without symptoms. This reflects the lower risk of transmission from very young children, as well as the challenges in tolerating testing that some very young children may experience. Although a PCR test is not required for this age group before returning to usual activities (including early learning and childcare), it is encouraged. It is recognised that this will not always be possible and parents/carers are the best judges of this

People who have had a positive PCR test in the previous 90 days do not require to repeat this. This is because after the infectious period is over, dead virus (with RNA) can still be present and picked up on testing, yet is not evidence of infectiousness.

Some people are exempt from having to take a PCR test to end self-isolation, due to medical reasons.

Some people who may previously have been asked to self-isolate as close contacts will no longer be asked to do so. However, they may be asked to be particularly vigilant for symptoms, and to ensure they continue to do regular at-home testing. This is due to our understanding of the risks of infection and transmission, and is explained further in the following section.

Contact tracing – overview

People who live in the same household as the person who has tested positive for/has symptoms of COVID-19 will be contacted by Test and Protect and advised to take the actions set out above. This is because much of the spread of COVID-19 takes place in household settings.

Test and Protect will also speak to the person who has tested positive for COVID-19 and identify close contacts where there is judged to be a higher likelihood of the virus being passed on. They will then get in touch with those close contacts and ask them to take the actions set out above.

Certain settings, including schools and registered childcare settings, will also be asked by Test and Protect or local Health Protection Teams to take action to "warn and inform" other potential contacts, where there is judged to be a lower likelihood of the virus being passed on.

Contact tracing in schools and registered childcare setting

Contact tracing will continue to operate in schools and registered childcare settings, but it will be done in line with the approach set out above. In practice, this means that when a person who attends tests positive, contact tracers will:

- contact the person or their parent/carer, and ask them to identify any **individual** contacts with very close contact and **high risk of transmission** and give them **individualised** messages about testing and self-isolation. There will be a particular focus on household contacts e.g. siblings or social settings involving prolonged contact (e.g. sleepover, intimate contacts), where we know there is a higher risk of transmission. Test and Protect will also ask the individual or their parents/carers whether there has been any <u>unusually</u> close or prolonged contact in the setting, with either adults or children and young people, that may mean there is a higher risk of transmission; and

- if indicated as necessary following a risk assessment based on the initial call, contact the school or childcare setting to:

    - inform them of the positive case; and

    - ask them whether they are aware of any unusually close or prolonged contacts the positive case may have had in the setting during a specified timeframe, that could have led to a higher risk of transmission. This will not involve “business as usual” contacts where the relevant mitigations are being followed – so, for example, simply being seated next to a positive case in class will not necessarily result in a requirement to self-isolate and take a PCR test. It may, for example, involve children who have slept in shared accommodation during school trips, or staff who have provided close personal care to children/pupils with additional support needs

If any additional individual close contacts are identified in this way, they will be contacted directly by Test and Protect and given individualised advice as set out above.

If, based on the initial call with the person testing positive, contact tracers assess there is no requirement for a direct call to the setting, they will nevertheless request that the pupil/parent/carer informs the setting of the case.

When a school or childcare settings is informed of a positive case, whether by Test and Protect or by the individual or their parents/carers, they should also identify **groups** (e.g. class, school year, school trip) of other potential contacts in the school or childcare environment, and give them a “warn and inform” letter, which is similar to the approach taken with other infectious diseases in schools. A template warn and inform letter has been provided to all local authorities for agreement with local health protection teams, and sets out the steps required of these lower risk potential contacts. A warn and inform information sheet for use by registered childcare settings is available. In summary, they are not required to self-isolate, but they should: continue with any regular testing programme e.g. the secondary school LFD programme; stay vigilant for symptoms; and take precautions to limit any potential spread.

It is the school/childcare setting that is responsible for issuing these letters. The setting may exercise its judgement as to which groups this letter should be sent to. They may opt to take a precautionary approach and issue it to the whole year or whole community. If in doubt, they can contact their local health protection team or local authority for advice.

In this way, all potential close contacts (whether higher or lower risk) will be identified and provided with appropriate, risk-based advice on the action that should be taken. This approach also means that blanket isolation of whole classes will no longer be routine. Far fewer children and young people are likely to be asked to self-isolate, and when they do it will be for a shorter period of time while they await their PCR result.

Does this mean the definition of "close contacts" has changed?

No – the definition of close contacts remains the same. However, what has changed for close contacts under 18 is the threshold for intervention, based on our understanding of the risks of infection and transmission in different scenarios and involving different people over the past year. Throughout the pandemic, contact tracing has evolved in relation to levels of risk in particular settings or to particular groups of people. High vaccination rates have had an important influence on judgements around risk as we move beyond Level 0.

For example, previously, higher risk settings have been triaged to receive manual contact tracing, with lower risk contacts receiving SMS or digital contact tracing. This approach to risk-based interventions is reflected in the approach to contact tracing in schools set out above. A similar approach is also expected to be delivered in England and in Wales. Our approach to contact tracing will continue to evolve based on the evidence we gather about infection and transmission, including adjustments to reflect any higher or lower risk settings identified.

What this means for the risks of infection and transmission in schools

The changes above reflect the significant changes in the public health impact of COVID achieved through high vaccination coverage. They also reflect what evidence from Public Health Scotland and other expert sources tells us about the risks of infection and transmission amongst children and young people and staff in schools and registered

childcare settings, versus the educational harms that resulted from requiring large numbers of children and young people to self-isolate under the previous approach. As with all public health interventions, the approach to contact tracing and self-isolation must be proportionate to the risks both of transmission and wider harms.

Vaccination

As noted above, vaccination has significantly changed the risk environment in wider society and in schools and registered childcare settings, and vaccination rates are expected to increase further in the coming weeks. The vaccines are highly effective at preventing severe disease. Amongst school staff, it is estimated that around 85% of teachers who have taken up the offer of a first dose of vaccination will have been offered both doses of the vaccine and developed a second dose response by 16th August (79% of the teacher population in Scotland), and this will increase to 90% by 23rd August (85% of the teacher population). Further, of those who have only received one dose, the vast majority will be under 40 and are likely to have received the Pfizer or Moderna which have a relatively high level of protection from a first dose. Projections indicate a timeline of near-complete vaccination of over 18 year olds by late September.

Infection and transmission in school/childcare setting outbreaks

Children and young people as a group have relatively low risk of direct COVID-19 harm, but are at particularly high risk of wider – and long-term – social, educational, economic and wellbeing harms. In advance of schools finishing before the summer holidays, under the previous approach to self-isolation, approximately 26,000 children and young people were in isolation. This meant that on average, for each positive pupil identified who was infectious while in school, 19 other children in the same school year were required to isolate in primary schools, and 20 children/young people in the same school year were required to isolate in secondary schools. Although transmission can occur in school settings, recently published analysis from across schools and early years settings in England found that in almost two thirds (64%) of COVID cases in schools there were no secondary cases among the contacts. Where transmission may have occurred, outbreaks were small with the median number of secondary cases being one, and the large majority of outbreaks being less than 5 cases. The study provided further evidence that cases in children and young

people follow patterns in communities, which will be further reduced by higher vaccination coverage. Children and young people with asymptomatic infection are at a relatively low risk of transmitting COVID-19 to adults.

Mitigations in schools and registered childcare settings

We recognise that these are significant changes and that some staff and pupils may be anxious about the move to a more risk-assessed approach. Measures such as physical distancing, face coverings, one-way systems, etc., many of which are expected to be removed in wider society, will be retained in schools and registered childcare settings for a period of 6 weeks and will be kept under review. This cautious approach reflects the unique features of the school environment, and will allow time to monitor the impacts of the changes to self-isolation and contact tracing and adjust where necessary, as well as ensuring higher proportions of staff have time to become fully vaccinated.