**Information sheet for social care providers**

**Background**

# The Scottish Government have agreed that in extremis, where criteria is met, double vaccinated social care staff who are self-isolating can voluntarily return to work.

# This will include staff who have been contacted as a close contact of a case of COVID-19 by NHS Test and Protect, or advised to self-isolate by the NHS Scotland covid app.

# The decision has been taken in response to social care services/providers asking for the measure to ease critical staff pressures and support safe services.

# Public Health Scotland (PHS) support this measure and have concluded that where robust mitigations are in place, and clear daily testing requirements, staff can return to work with low risk. . The PHS assessment is included in Annex A.

1. It is not a mandatory policy, staff must volunteer to return aimed at protecting the safety of those dependent on services and supporting staff who wish to return to work.
2. The staff member has to be a passing close contact(except in extreme circumstances) and not a contact of an ongoing case within their own household. A passing close contact is described as a “contact” a staff member has encountered that is Covid positive but who is out-with their immediate household. An extreme circumstance for example could be when there is a small service with particular vulnerable clients where the risk of bringing in all new staff would be distressing.

**When does the policy apply?**

# The policy will apply when a service is facing extreme pressures due to staff shortages where there is a significant risk to the health, safety and well-being of service users or staff through the inability to meet an essential service.

# What is deemed as “extremis” is likely to vary within and across services but may include: care at home services unable to be provided; care homes facing acute staff shortages: the inability for care services to meet care and support for those medically fit to be discharged from hospital.

# The service will have exhausted all normal business contingency planning for example, asking existing staff to work additional hours; reaching out to other services within the same organisation; accessing bank/agency staff.

**What should I do as a provider who faces a “extremis situation”?**

# If a provider faces a extremis situation and all business contingency/continuity plans have been exhausted then they should contact their local Health and Social Care Partnership (HSCP).

# The HSCP will aim to support the provider through mutual aid. The HSCP will have the advantage of having an overview of care and support in their geographical area.

# If the HSCP cannot provide mutual aid then they will support the provider to assess whether double vaccinated staff returning to work where certain conditions are met could help.

# **What does a provider need to do to support staff returning to work?**

# A provider can ask staff who are fully vaccinated and self-isolating to voluntarily return to work. This is not mandatory and staff should be supported to make an informed decision.

# If the staff member agrees then the provider must ensure the following: (full details in the recommended section of the PHS assessment in Annex).

* the contact is fully vaccinated, defined as at least two weeks (14 days) post a FDA approved vaccine at the point of exposure.
* Where records on immunisation are not as available, e.g. agency staff for care at home, reliance on staff to provide their vaccination status in the circumstances is reasonable.
* the contact is, and remains, asymptomatic
* the contact undertakes initial PCR testing and the result is negative.
* the contact has a negative LFD result prior to starting work each day up until day 10 following the day of the last exposure;
* all negative test results should be reported to the contact’s line manager as well as logging them through the NSS portal. <http://www.covidtestingportal.scot/>
* the contact continues to adhere with IPC and relevant PPE.
* the staff member agrees to minimise contacts out-with the work situation for 10 days after initial exposure to covid.

# While the policy is place the staff member can access a PCR test if a member of their household has been advised to undertake one. For example, if a child of a staff member is asked to self-isolate and take a PCR then the staff member should also take a PCR test. If the child and staff member both have a negative test then the staff member can volunteer to return to work. If the child’s test is positive (even if the staff member is negative) then they cannot return to work (except in extreme circumstances see para 6). Accessing a PCR test at the same time as a household contact is to help staff who want to come back to work and reduce delays.

**What information is available to support providers and staff?**

# The following has been developed to support providers and staff.

* A provider checklist has been prepared to support this policy
* A staff factsheet has been developed and will ensure staff can have an informed discussion with their line manager/designated manager.
* A checklist to aid discussion with manager/employee

**Provider checklist Staff factsheet Manger/employee checklist**

  

**Annex A**

**Appendix A SBAR – self isolation guidance following double vaccination**

**SBAR V5 FINAL– July 11th 2021**

**Self - isolation guidance following double vaccination**

**Health and Social Care workers**

1. **Situation**

The large number of new COVID19 cases and associated self-isolation of close contacts is placing pressure on public, independent and third sector services. This issue has resulted in a number of boards experiencing critical problems with some acute services (having to cancel elective surgery) and with some social care services (care homes and care at home packages unable to be delivered) due to staff shortages as a result of isolation of contacts.

This guidance, for the Health and Social Care sector, offers NHS Boards and Health and Social Care Partnerships an approach to be taken in extremis under the conditions and governance as laid out in the SG framework [insert final title and link], in which fully vaccinated asymptomatic staff, in some settings and situations, are exempted from self-isolation when they are identified as close contacts. This guidance is founded in the application of a risk-management approach for certain health and social care settings and does not alter broader isolation guidance at this stage.

1. **Background**

The COVID-19 epidemiological picture now shows a transitional pandemic phase where the clinical and public health characteristics of SARS-CoV-2 infection have significantly changed over time, as a result of the ongoing population vaccination programme and the emergence of variants with greater transmissibility. Compared to earlier waves, the current wave is now characterised by ongoing significant transmissibility to unvaccinated (younger) populations and relatively sparing of older age groups who have largely received two doses of COVID vaccine. Consequent to this pattern of population vaccination protection, there has been an observed reduction in significant morbidity requiring hospitalisation and overall mortality linked to COVID-19 disease in older and susceptible populations.

Isolation after contact with a known positive COVID-19 case rightly continues to be recommended to reduce the risk of onward transmission. There is strong evidence that contacts of cases have higher positivity rates than the general population.

However there is an emerging issue in the Scottish Health and Social Care workforce that high community transmission rates are contributing to unmanageable pressure on these services. This issue arises where the requirements of close contact self-isolation are applied in a workforce that is well-vaccinated and adhering to Infection Prevention and Control protocols. Staff absence due to household caring for other members identified as contacts and over the summer period are also contributing to the staffing strains at the same time that elective activity is aiming to increase and COVID incidence is rising.

The recommendation below provides an agreed variation to the current policy position in Scotland and would be implemented at service level on a case-by-case basis whenever a staff member identifies themselves to their line manager as a close contact of an infected individual. Local NHS Boards will lead on which service areas to target in order to mitigate the potential harms deriving from staff absence in such settings during this transitional phase.

1. **Assessment**

Based on the emerging evidence-base, 2nd dose COVID-19 vaccine uptake rates for frontline NHS staff (excluding private contractors), care home residents, care home staff and the general population (18+ yrs old) are good at 89%, 94%, 100%, 64% respectively (at 8th July 2021)[[1]](#footnote-1). With the mounting evidence of effectiveness of current vaccines in terms of reduced transmission[[2]](#footnote-2), symptomatic disease[[3]](#footnote-3), hospital admission[[4]](#footnote-4) and deaths**[[5]](#footnote-5),** and some evidence of daily contact testing proving useful in sustaining key services[[6]](#footnote-6), **Health and social care workers who are effectively double vaccinated and identified as asymptomatic, close contacts can continue to work with any residual risk being mitigated through PCR testing and daily LFD (up until day 10 following the day of last exposure).**

1. **Recommendation**

A health and social care workforce contact of a case can be exempt from isolation if the following criteria are met:

* the circumstances under which exemption would be justified, as outlined in the Scottish Government Framework, are applicable
* the contact is fully vaccinated, defined as at least two weeks (14 days) post completion of a full course of MHRA, EMA or FDA approved vaccine at the point of exposure. Where records on immunisation are not as available, e.g. agency staff for care at home, reliance on staff to provide their vaccination status in the circumstances is reasonable.
* the contact is, and remains, asymptomatic
* the contact undertakes initial PCR testing and the result is negative
* the contact has a negative LFD result prior to starting work each day up until day 10 following the day of the last exposure; all negative test results should be reported to the contact’s line manager as well as logging them through the relevant reporting digital process. Any contact who has a positive LFD test during their follow up should self-isolate and arrange a PCR test.
* the contact does not work with immunocompromised patients (e.g. within oncology settings). Re-deployment to other clinical areas would be permitted.
* the contact continues to adhered with the guidance contained within National Infection Prevention and Control Manual, Scottish COVID-19 Addenda specific to the social care setting
* for contacts in adult care homes this is the [National Infection Prevention and Control Manual: Scottish COVID-19 Care Home Infection Prevention and Control Addendum](https://www.nipcm.hps.scot.nhs.uk/scottish-covid-19-care-home-infection-prevention-and-control-addendum/) and the following sections in particular
  + correct [use of PPE](https://www.nipcm.hps.scot.nhs.uk/scottish-covid-19-care-home-infection-prevention-and-control-addendum/#a2766)
  + extended [use of FRSM](htthttps://www.nipcm.hps.scot.nhs.uk/scottish-covid-19-care-home-infection-prevention-and-control-addendum/#a2766)
  + Compliance with [appropriate hand hygiene](https://www.nipcm.hps.scot.nhs.uk/scottish-covid-19-care-home-infection-prevention-and-control-addendum/#a2764)
  + Adherence with [Car sharing advice](https://www.nipcm.hps.scot.nhs.uk/scottish-covid-19-care-home-infection-prevention-and-control-addendum/#a2772)
* for contacts in children’s residential settings, care at home, supported accommodation settings, sheltered housing, respite and short stay services, and community based social care settings this is the [National Infection Prevention and Control Manual: Scottish COVID-19 Community Health and Care Settings Infection Prevention and Control Addendum](https://www.nipcm.scot.nhs.uk/scottish-covid-19-community-health-and-care-settings-infection-prevention-and-control-addendum/) and the following sections in particular
  + correct [use of PPE](https://www.nipcm.scot.nhs.uk/scottish-covid-19-community-health-and-care-settings-infection-prevention-and-control-addendum/#a2785)
  + extended [use of FRSM](https://www.nipcm.scot.nhs.uk/scottish-covid-19-community-health-and-care-settings-infection-prevention-and-control-addendum/#a2785)
  + Compliance with [appropriate hand hygiene](https://www.nipcm.scot.nhs.uk/scottish-covid-19-community-health-and-care-settings-infection-prevention-and-control-addendum/#a2783)
  + Adherence with [Car sharing advice](https://www.nipcm.scot.nhs.uk/scottish-covid-19-community-health-and-care-settings-infection-prevention-and-control-addendum/#a2792)
* contacts in all social care settings should also strictly adhere to the [additional guidance on staff use of FRSMS](https://www.gov.scot/publications/coronavirus-covid-19-use-of-face-coverings-in-social-care-settings-including-adult-care-homes/pages/what-you-should-do/)  in these settings
* there is no ongoing exposure to an infected case outside work (e.g. within the household). Only in exceptional circumstances where there is no resilience (e.g. highly specialised service), the local risk assessment may justify those with ongoing exposure being exempt.
* the HSCW agrees to minimise contacts out with the work situation until day 10 following the day of the last exposure

If any of the criteria above **are not** met, the member of staff should self-isolate for 10 days from last exposure to a case as per current advice for self-isolation

1. [COVID-19 Daily Dashboard | Tableau Public](https://public.tableau.com/app/profile/phs.covid.19/viz/COVID-19DailyDashboard_15960160643010/Overview) [↑](#footnote-ref-1)
2. [Effect of vaccination on transmission of COVID-19: an observational study in healthcare workers and their households **(preprint)**](https://www.medrxiv.org/content/10.1101/2021.03.11.21253275v1) [↑](#footnote-ref-2)
3. [Effectiveness of COVID-19 vaccines against the B.1.617.2 variant | medRxiv](https://www.medrxiv.org/content/10.1101/2021.05.22.21257658v1) [↑](#footnote-ref-3)
4. [Effectiveness of COVID-19 vaccines against hospital admission with the Delta variant - Public library - PHE national - Knowledge Hub (khub.net)](https://khub.net/web/phe-national/public-library/-/document_library/v2WsRK3ZlEig/view/479607266) [↑](#footnote-ref-4)
5. [PHE\_Variants\_of\_Concern\_VOC\_Technical\_Briefing\_16.pdf](file:///C:\Users\mariar04.PHS\Documents\PHE_Variants_of_Concern_VOC_Technical_Briefing_16.pdf) [↑](#footnote-ref-5)
6. [Liverpool Covid-SMART Community Testing Pilot Evaluation Report, 17 June 2021](https://www.liverpool.ac.uk/media/livacuk/research/Mass,testing,evaluation.pdf) [↑](#footnote-ref-6)