

LTHT Measles Outbreak Debrief and Key Learning

Infection Prevention and Control (IPC) Sub-Committee 20th August 2025

Presented for:	Information
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Previous Committees:	NONE.

Our Annual Commitments for 2025/26 are:	
Recognise and act upon moments that matter to our patients	✓
Support our patients to get home a day sooner	
Be in the top 25% for patient experience and efficiency in outpatients	
Support each other to act with kindness and compassion	
Reduce our carbon footprint by creating greener patient pathways	
Support our staff to manage every £ wisely	
Make best use of our estate, equipment and digital assets	

Risk Appetite Framework				
Level 1 Risk	(✓)	Level 2 Risks	(Risk Appetite Scale)	Impact
Workforce Risk		Workforce Retention Risk - We will deliver safe and effective patient care, through providing a supportive culture, training, development and H&WB to our staff to retain the appropriate level to continue to meet the patient demand for our clinical services	Choose an item	Choose an item.
Operational Risk		Choose an item.	Choose an item	Choose an item.
Clinical Risk		Infection Prevention & Control Risk - We will manage the risks related to infection prevention and control to reduce the transmission of infection in our hospitals.	Minimal	Moving Towards
Financial Risk		Choose an item.	Choose an item	Choose an item.
External Risk		Choose an item.	Choose an item	Choose an item.

Key points	
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1. To evaluate the effectiveness of the Trusts response to an outbreak of Measles in Leeds.	Information
2. To identify learning and recommend actions required to continuously improve future responses.	Information

1. Summary

An outbreak of measles in Leeds occurred with the first case likely to have been a returning traveller in September 2024. From September 2024 to April 2025, there were over 120 confirmed cases in Leeds and likely many more unreported. While there was an initial gap before cases escalated, community transmission was observed in early October, and by the end of November LTHT was receiving a number of predominantly paediatric cases through acute assessment areas.

Learning from the outbreak, especially regarding the risks of emergency department (ED) transmission and the challenges in delivering post exposure prophylaxis within 72 hours are being fed back to UK Health Security Agency (UKHSA) to help inform future national policy.

2. Background

Measles is a highly contagious respiratory disease caused by a virus that spreads through the air via respiratory droplets produced when an infected person coughs or sneezes. It can also be transmitted by touching a contaminated surface and then touching your face. Measles is extremely contagious, with up to 90% of susceptible people contracting the disease after close contact with an infected individual.

Measles is typically diagnosed based on clinical symptoms and confirmed with a diagnostic laboratory test; however symptoms can be similar to other respiratory illness in the early stages and without an understanding of community transmission, specific symptoms such as conjunctivitis, and a characteristic measles rash, detection can be problematic.

Measures to reduce the risk of transmission include the wearing of respiratory virus personal protective equipment for healthcare workers and immediate isolation of potentially infective individuals.

UKHSA informed the trust and system partners about an increase in measles in [REDACTED]. The outbreak included 131 probable and confirmed cases, including 15 schools and 4 nurseries. A combined city-wide incident management team met regularly.

From December an emergency preparedness response (EPR) response was triggered and subsequently a weekly meeting with the Medical Director for operations supported the trust response, and the community outbreak closed 6th April 2025.

3. Proposal

A Trust debrief meeting was held June 2025 with all the Trust stakeholders to review the response to the recent measles outbreak. The meeting assessed the key lessons learned, evaluated what measures were effective, identified where challenges arose, and

understood where response strategies could be refined for greater efficiency in similar situations.

There was recognition that the hard work and professionalism demonstrated throughout the incident reduced the number of onward transmissions of infection that could have occurred. The organisational collegiate response was exceptional with teams going above and beyond to reduce harm from measles and demonstrating a shared commitment to continuous improvement. This was further enhanced by the collaborative system response.

3 key areas for celebration were identified. This included the dynamic development of the Measles Vaccination and Epidemiological Tracker (MVET) which was a critical turning point, ensuring a standardised approach across departments. The MVET tool helped streamline case recognition at the front door, enabling earlier isolation and reducing transmission risks.

The second area was the temporary process that was stood up to support the delivery of Human Normal Immunoglobulin (HNIG) to susceptible immunocompetent infants and pregnant women within 72hrs, it rapidly became clear that systems were not in place in the community to support this role.

The third area was the effectiveness of the whole IPC team in stepping up to deliver a robust approach to case tracking and coordination.

What became clear during the debrief meeting was the amount of extra work required to manage the measles outbreak safely, resulting in resource being diverted from other areas and a tremendous amount of discretionary effort, which was not sustainable.

6 key areas of learning emerged.

- **Clear escalation frameworks and predefined intervention triggers need to be established to support timely decision-making.**
- **A strategy for accommodating a surge in isolation capacity in ED is required.**
- **There is a need to assess contingency plans for sample processing, to be able to respond to future outbreaks and avoid delays.**
- **Explore options for a Trust contract tracing response model that can be triggered in the event of a major outbreak.**
- **Incorporate medical immunity assurance into supervision conversations between consultants and resident doctors, covering vaccination, fit testing, and High Consequence Infectious Disease (HCID) training.**
- **Support a proactive communication campaign to raise awareness of staff vaccination requirements and encourage all staff to verify their immunisation status in anticipation of future outbreaks.**

In addition

The group recognised the need for a more structured approach to information sharing between community and hospital teams in future outbreaks and there was agreement for a follow-up meeting with the team responsible for writing national guidance to share our meaningful learning and advocate for improved outbreak communications frameworks in future.

4. Financial Implications

Whilst there are no negative financial implications from this paper alone further scooping work will need to occur to understand the cost if all recommendations are adopted. This paper has the potential to support the 2025/26 commitment - recognise and act upon moments that matter to our patients.

5. Risk

The Trust IPC governance structure provides a robust approach to identifying, mitigating and managing risk of transmission of infection in hospital. The HCAI Group provides assurance to the IPC Sub-Committee, and Quality Assurance Committee and provides quality updates on position at the Quality safety and Assurance Group. There was no material change to the risk appetite statement related to the level 2 risk category (Healthcare Associated Infection) and the Trust continues to operate within the risk appetite for the level 1 risk category (clinical risk) set by the Board.

6. Communication and Involvement

All Trust infection incident meetings are discussed through the HCAI Group which feeds into the internal LTHT communications team, the OIPC group and the IPC Sub-Committee. This report was developed by the Operations and Infection Prevention and Control Team following a debrief meeting with all key stakeholders who delivered the Trust measles response. Review, assurance, and actions where agreed are undertaken at Trust and CSU level and where required, monitored through the various boards and committees outlined above.

7. Equality Analysis

The Leeds Teaching Hospitals NHS Trust is committed to ensuring that the way that we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group.

8. Improving Health Equity

As part of the patient safety incident response framework (PSIRF), there is an ambition to identify patient risk factors for HCAI at the point of patient admission to target interventions to reduce risk of infection in vulnerable individuals.

Certain specialties, including acute medicine, elderly care and haematology carry a greater risk of HCAI. This is not necessarily a greater risk compared to patients in these specialties in other hospitals but just compared to other specialties at LTHT which have lower HCAI risks and rates. Age distribution is not the same for all HCAs, with *C difficile* and *E coli* characterised in older patients but *MSSA* and *Pseudomonas aeruginosa* seen more evenly across age categories. Patients 0-4 and >65 years old are represented at higher rate in HCAI data sets.

9. Publication Under Freedom of Information Act

- This paper is exempt from publication under Section 22 of the Freedom of Information Act 2000, as it contains information which is in draft format and may not reflect the organisation's final decision.

10. Recommendation

The IPCSC is asked to support the following recommendations.

- I. Clear escalation frameworks and predefined intervention triggers need to be established to support timely decision-making.
- II. A strategy for accommodating a surge in isolation capacity in ED is required.
- III. There is a need to assess contingency plans for sample processing, to be able to respond to future outbreaks and avoid delays.
- IV. Explore options for a Trust contract tracing response model that can be triggered in the event of a major outbreak.
- V. Incorporate medical immunity assurance into supervision conversations between consultants and resident doctors, covering vaccination, fit testing, and HCID training.
- VI. Support a proactive communication campaign to raise awareness of staff vaccination requirements and encourage all staff to verify their immunisation status in anticipation of future outbreaks.

11. Supporting Information

None

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28.07.2025