Measles Infection Prevention

Department/ Service:	Infection Prevention and Control Team
Originator:	Emma Fulloway IPC Nurse Manager
Accountable Director:	DIPC Liz Watkins
Approved by:	TIPCC
Approved by Medicines Safety Committee:	8th October 2025
Date of approval:	22nd May 2025
Revision due: This is the most current document and should be used until a revised version is in place	8th October 2028
Target Organisation(s):	Worcestershire Acute Hospitals NHS Trust
Target Departments:	Clinical Services
Target Staff Categories:	Drs, Nurses

Policy Overview:

- Consider measles in any patient with a high fever and rash.
- Measles is more likely if the patient also has conjunctivitis.
- Cases of suspected or confirmed measles must be isolated immediately with respiratory precautions.
- Contacts of cases of measles must be followed up to assess whether they are immune.
- Contacts who are non-immune are offered post-exposure prophylaxis with MMR vaccine or human normal immunoglobulin.
- Measles is a notifiable disease.

Key Amendments to this Document

Date	Amendment	Approved by:
Oct 2025	New document approved	MSC/TIPCC

Contents page:

1. Introduction

Measles is the most infectious of all diseases transmitted via the respiratory route. Measles is a potentially serious condition in any individual but can be particularly severe in immunosuppressed individuals and young infants. Measles is also more severe in pregnancy, and increases the risk of miscarriage, stillbirth or preterm delivery.

The most effective way to control measles is by achieving high uptake of two doses of measles, mumps, rubella (MMR) vaccine. However, in England overall coverage has never reached the ≥95% World Health Organisation (WHO) target, and fell during the COVID-19 pandemic, so that currently around 10% of children starting school in England are unprotected from measles. At the same time, falling vaccine uptake rates globally have contributed to large outbreaks in countries in South Asia and Africa, increasing the risk of imported infections.

As well as an unvaccinated, and therefore non-immune, population of all ages, it is important to remember that patients who are immunocompromised may be non-immune to measles, even if they have a positive vaccination history.

2. Scope of this Document

To describe the infection prevention management of measles within the Trust.

3. Definitions

Definition	Description
Contact	A person: patient or health care worker who has been in contact with a case of measles. Who is at risk of infection.
Immunoglobulin	Immunoglobulins, or antibodies, are proteins that are a key part of the immune system, produced by plasma cells (a type of white blood cell) to identify and neutralize foreign substances called antigens, such as bacteria, viruses, or allergens. Which can be used to reduce the risk of measles infection.
Measles	A highly infectious viral illness that can be very unpleasant and sometimes lead to serious complications.

4. Responsibility and Duties

It is the responsibility of all clinical staff to ensure that patients with suspected or confirmed measles are appropriately managed.

The Infection Prevention & Control Team (IPCT) provides support to clinical staff in the implementation of this guidance.

The Occupational Health Service ensures that staff are protected against measles.

4.1. Identification of Stakeholders

The stakeholders of this guidance are all clinical staff who may have, or encounter patients or persons outside hospital, with any of these infections. For the purposes of producing the guidance they are represented by the members of the Trust Infection Prevention & Control Committee IPCC).

5. Policy detail: Clinical & epidemiological features of measles

5.1 Transmission

Highly infectious via respiratory secretions. Most transmission events require face-to-face and/or prolonged contact, but transmission through more casual contact can occur.

5.1.2 Infectious period

From four days before, to four days after, onset of the rash.

5.1.3 Incubation period

7-21 (usually 10-12) days to onset of prodromal illness (high fever, coryzal symptoms, cough and conjunctivitis).

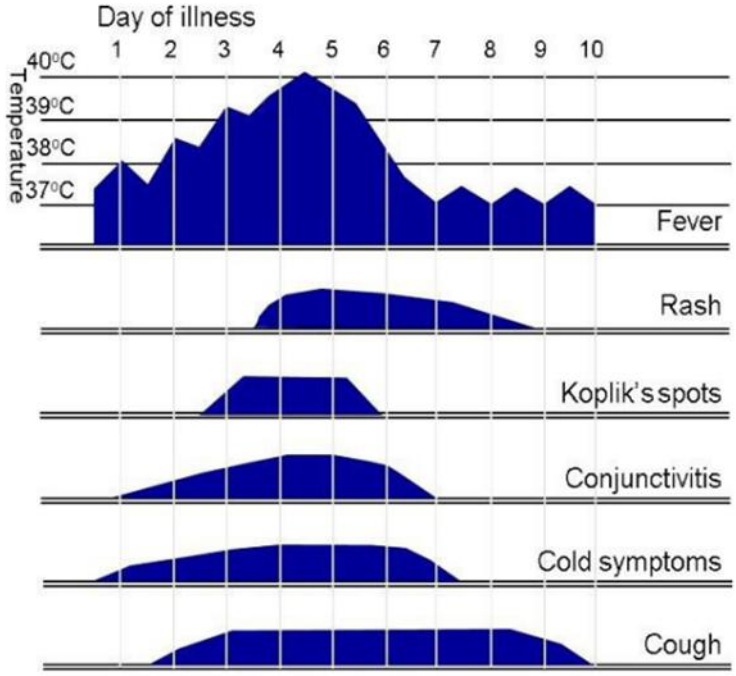
5.1.4 Clinical progression

Disease starts with a 2–4-day prodromal illness, with fever, coryza, cough, conjunctivitis.

Maculopapular rash appears on the 3rd to 7th day of illness. The rash generally starts on the face and behind the ears. The number of lesions/spots generally increase in the first 2 – 3 days, and their distribution expands further to the face, trunk, and can sometimes be generalised. Lesions can become confluent, particularly on the face and the trunk. The rash is red, blotchy, maculopapular (i.e. non-vesicular), not itchy, and generally lasts for 3 - 7 days, fading gradually.

Koplik spots may appear around the time of the rash, sometimes one day before, and last for 2 – 3 days after the rash appears. These are small spots with white or bluish-white lesions, of about 2-3mm in diameter, on an erythematous base on the buccal mucosa.

The clinical course of measles is presented diagrammatically here:



5.1.5 Period of infectivity

From four days before until four days after onset of rash. The day of onset of the rash is day 0. Note that immunosuppressed individuals may be infectious for longer.

5.1.6 Diagnosis

For hospitalised patients a viral throat swab for PCR testing is the preferred sample, if this is collected within 6 days of the onset of the rash.

A serum sample for IgM testing may be useful but note that serum samples may still be IgM negative within 3 days of onset of rash.

Oral saliva test kits used by UKHSA (Public Health) are the most useful single approach, but these kits are only provided by UKHSA once a case of possible measles has been notified to them.

Note that a negative local result does not necessarily exclude measles, as it will depend upon the timing and adequacy of the sample and the tests undertaken.

5.2 IPC management of cases of suspected or confirmed measles

Immediate source isolation with respiratory precautions:

5.2.1Staff

Staff must wear FFP3 for all care while the patient is considered infectious.

Only staff who have been assessed as immune to measles should enter the isolation room.

Staff who are pregnant should not care for patients with suspected or confirmed measles.

5.2.2 Patients

If able, the patient should wear a fluid-resistant surgical mask before staff enter the isolation room.

Any movement of the patient around the hospital must be carefully planned in conjunction with the IPCT. Where possible the patient should always wear a fluid-resistant surgical mask when outside the isolation room.

5.2.3 Visitors

Asymptomatic non-resident visitors do not need to take any special IPC precautions. Asymptomatic resident parents/carers who can confirm that they are immune (i.e. that they have received two doses of a measles-containing vaccine) do not need to take any special IPC precautions.

Asymptomatic resident family members/parents/carers who are unable to confirm that they are immune and who are asymptomatic must remain with the patient in their cubicle. If they do need to leave the cubicle (e.g. to use the toilet or washing facilities) they should wear a fluid-resistant surgical mask.

Symptomatic visitors should not visit the hospital, if they are at the hospital they must be asked to wear a fluid-resistant surgical mask and leave the hospital. If a symptomatic resident/carer is unable to leave the hospital, please contact the IPCT for advice.

5.3 Identification & management of contacts

5.3.1 Defining significant contact

For immunocompetent individuals significant contact is contact with an infectious case (from four days before, to four days after, appearance of the rash) as:

- Household contact
- Face to face contact of any length
- More than 15 minutes in a small, confined area, e.g. a room in a house, or a four-bedded bay in hospital
- More than 30 minutes in a larger area within the hospital, e.g. ED, Triage or outpatient waiting areas

For immunocompromised individuals even more limited exposure to an infectious case may be significant.

5.3.2 Identification of contacts

Contacts need to be urgently assessed to that those who need IVIG are identified and treated as soon as possible (ideally within 72 hours of exposure: see section Management of contacts below).

Contacts should be identified in the following order of priority:

1. Immunosuppressed contacts
2. Pregnant women and infants <12 months
3. Healthcare workers
4. Healthy individuals

When identifying contacts (especially immunosuppressed contacts) of a case of measles in hospital it is important to consider the possibility that isolated patients may not have been entirely confined to their isolation room.

All contacts should be provided with information to ensure early detection of symptoms, and exclusion from schools or other settings.

5.3.2.1 Poorly defined contacts

There may be situations in ED or other waiting areas several individuals may have been exposed, but the level of contact is unclear. In this situation:
Any immunosuppressed individuals that are identified should be managed as close contacts.

Where there is a defined list of contacts, but it is not clear if the group contains immunosuppressed individuals warn and inform letters or messaging should be issued to all potential contacts.

5.3.2.2 Defining the time window for receiving post-exposure prophylaxis

For household contacts, or other contacts with ongoing exposure, the time window should be calculated from the date of onset of the rash in the index case.
For other contacts, the last day of exposure to the infectious source should be used.

5.3.3 Management of immunosuppressed contacts

All immunosuppressed patients should be considered for intravenous immunoglobulin (IVIG).

1. If the individual receives on regular IVIG replacement, and the most recent dose was administered ≤3 weeks before exposure, additional IVIG is not required.
2. All other immunosuppressed individuals are then assessed according to their ability to maintain adequate antibody from past exposure or vaccination as follows:

5.3.3.1Group A

Includes most immunosuppressed individuals. These individuals should be able to develop and maintain adequate antibody from any prior successful vaccination or infection and can therefore be managed based on evidence of protection at any time (prior to or since the diagnosis or treatment end).

Group A. Individuals who should develop and maintain adequate antibody from past exposure or vaccination

- Patients receiving or within 6 months of completing immunosuppressive chemotherapy or radiotherapy for malignant disease (other than those with all, a lymphoproliferative disorder or who have had haematopoietic stem cell transplantation, HSCT).
- Patients with human immunodeficiency virus (HIV) infection aged >5 years and with a CD4 count <200 cells/µl (but without a diagnosis of AIDS) ***or*** aged ≤5 years with a CD4 count <500 cells/µl
- Patients with chronic immune mediated inflammatory disease who are receiving or have received immunosuppressive therapy as follows:
-
    - Moderate to high dose corticosteroids (equivalent ≥20mg prednisolone per day; children 1 mg/kg/day) for >10 days in the previous month
    - Long term moderate dose corticosteroids (equivalent to ≥10mg prednisolone per day; children ≥0.5 mg/kg/day for >4 weeks) in the previous 3 months
    - Adults on non-biological oral immune modulating drugs, e.g. methotrexate >20mg per week (oral & subcutaneous), azathioprine >3.0mg/kg/day; 6-mercaptopurine >1.5mg/kg/day, mycophenolate >1g/day, in the previous 3 months
    - Adults receiving certain combination therapies at individual doses lower than stated above, including those on ≥7.5mg prednisolone per day in combination with other immunosuppressants (other than hydroxychloroquine or sulfasalazine) and those receiving methotrexate (any dose) with leflunomide in the previous 3 months
    - Children on any dose of non-biological oral immune modulating drugs
    - Individuals who have received a short course of high dose steroids (equivalent >40mg prednisolone per day; children >2 mg/kg/day for >1 week) for any reason in the previous month.

Note: Individuals who received brief immunosuppression (≤40mg prednisolone per day) for an acute episode (for example, asthma, COPD or COVID-19) and individuals on replacement corticosteroids for adrenal insufficiency are not considered severely immunosuppressed.

5.3.3.2 Group B

Includes individuals who are unlikely to have developed or maintained adequate antibody levels from past exposure or vaccination.

This group can be further subdivided into:

- **B** (i) individuals who can be managed based on a measles IgG test at the time of exposure or at any point since the end of treatment or diagnosis
- **B** (ii) individuals who require IVIG following an exposure without the need for testing

Group B. Individuals who lose or may not maintain adequate antibody levels from past exposure or vaccination

B (i)

- Patients on or after completion of immunosuppressive chemotherapy for acute lymphoblastic leukaemia (ALL)
- Patients with lymphoproliferative disorders (including haematological malignancies such as indolent lymphoma, leukaemia and plasma cell lymphoma)
- Patients who have received a solid organ transplant
- Patients more than 12 months after receiving a haematopoietic stem cell transplant (HSCT)
- Patients receiving or within 6 months of completing biological therapies (alone or in combination with steroids); these include: monoclonal antibodies (e.g. alemtuzumab, ofatumumab, rituximab) and cytokine inhibitors (e.g. etanercept)
- Patients with a diagnosis of acquired immunodeficiency syndrome (AIDs)

B (ii)

- Patients who have received a haematopoietic stem cell transplant (HSCT) within the past 12 months
- Patients with persistent agammglobulinaemia (IgG less than 3g/L) due to primary immunodeficiency (e.g. common variable immunodeficiency) or secondary to disease or therapy (this group may already be on long term IVIG replacement, which should provide equivalent protection to post exposure immunoglobulin)

Table 1: Assessing measles susceptibility in pregnant women and immunosuppressed contacts of measles

Age group	History	Pregnant	Immunosuppressed Group A	Immunosuppressed Group B
All ages	Previous measles IgG positive	Assume immune	Assume immune	In all cases **Group B (i):** If measles IgG positive since diagnosis or treatment completed assume immune; do not retest & do not give IVIG. If IgG negative or equivocal, or unknown, since treatment or diagnosis, test[1] and offer IVIG within 3 days if measles antibody negative. If not possible to test within 3 days of exposure, give IVIG **Group B (ii):**
Born before 1970	Of measles infection	Assume immune	Assume immune	
	No measles infection	Test[1] & offer HNIG within six days only if measles antibody negative	Test[1] and offer IVIG if measles antibody negative or equivocal. If not possible to test within 6 days of exposure, assume immune & do not give IVIG	
Born between 1970 and 1990	Of measles infection or vaccination	Assume immune	Test[1] and offer IVIG if measles antibody negative or equivocal. If not possible to test within 6 days of exposure, assume immune & do not give IVIG	

	No measles infection or vaccination	Test[1] & offer HNIG within six days only if measles antibody negative	Test[1] and offer IVIG if measles antibody negative or equivocal. If not possible to test within 6 days of exposure, assume immune & do not give IVIG	Give IVIG regardless of status
Born after 1990	One measles vaccine	Test[1] and offer HNIG within six days only if measles antibody negative	Test[1] and offer IVIG within six days if measles antibody negative. If not possible to test within 6 days of exposure, give IVIG	
	Two measles vaccines	Assume immune	Test[1] and offer IVIG within six days if measles antibody negative. If not possible to test within 6 days of exposure, assume immune & do not give IVIG	
	Unvaccinated	Test[1] & offer HNIG within six days only if measles antibody negative. If not possible to test within 6 days of exposure, give HNIG	Give IVIG	

Table 2: Post exposure prophylaxis in infants

Age group	**Household exposure**	**Exposure outside hospital**
<6 months	Assume susceptible and administer HNIG, ideally within 72 hours but up to 6 days, regardless of maternal status	
6-8 months	Administer HNIG, ideally within 72 hours but up to 6 days if necessary.	Administer MMR, ideally within 72 hours
9 months and older	Administer MMR, ideally within 72 hours	

5.3.4 Immunoglobulin dosage

For immunosuppressed individuals, the protective dose should be provided using intravenous immunoglobulin (IVIG). This is available through NHS hospital pharmacies and not from UKHSA stockholders.
The dose is 0.15 g/kg.

For immunocompetent infants and pregnant women, who are normally managed in the community where IVIG is not practical, intramuscular HNIG is recommended. Subgam® can be issued from UKHSA stockholders on request. Other HNIG products available in the NHS are available from local hospital pharmacies.
The following doses are recommended:

Pregnant women: approximately 3,000mg
Infants: 0.6ml/kg up to a maximum of 1,000mg

Ideally IVIG should be administered within 72 hours of exposure, although it can be given up to 6 days following exposure. For immunosuppressed patients whose exposure was 6-18 days earlier, whether to give IVIG to attenuate rather than prevent infection should be assessed on a case-by-case basis.
Where a second measles exposure occurs more than 3 weeks after a first dose of IVIG a further dose will need to be considered.

5.4 Staff

All healthcare workers (HCW) (including receptionists, ambulance workers etc.) should have satisfactory evidence of protection against measles to protect both themselves and their patients. Satisfactory evidence of protection includes documentation of having received two or more doses of measles containing vaccine and/or a positive measles IgG antibody test.

Health care workers with satisfactory evidence of protection can continue to work normally but must stay off work, and should be advised to seek medical attention, if they develop prodromal symptoms or a fever between 7 days after the first exposure and 21 days after the last exposure.

Where an HCW is exposed to a confirmed or likely case of measles and they do not have satisfactory evidence of protection they should be excluded from work from the 5th day after the first exposure to 21 days after the final exposure. If possible, obtain a blood sample for testing for measles antibodies as soon as is practicable. If the HCW is confirmed to be measles IgG positive within 7 days of exposure (this is too early for antibody to be due to infection from the recent exposure) the HCW can return to work immediately.

Where MMR vaccine is given post-exposure, if the HCW remains symptom-free for at least 14 days after MMR was given, they can return at that stage. Note that where MMR is given post-exposure it is more likely to attenuate than prevent development of measles.

All HCW contacts of a case of measles should be advised to report to Occupational Health or their GP if they develop prodromal symptoms or a fever between 7 days after the first exposure and 21 days after the last exposure.
Exposed HCWs that develop fever, or rash should be excluded from all work until 4 full days after onset of the rash.

5.5 Template Warn & inform letter

This can be downloaded from the UKHSA website as required: https://www.gov.uk/government/publications/national-measles-guidelines <Accessed 17.07.2025>.

6. Implementation

6.1. Plan for Implementation

Policy will be periodically reviewed by the Infection Prevention and Control Team to ensure its up to date and in line with national guidance, it will be shared with attendees of the Trust Infection Prevention and Control Committee for comments, following ant additions or

changes it will then go back to TIPCC for approval, it will then be shared on the trust source page under policies, it will also be publicised via the infection prevention link network.

6.2. Dissemination

The policy will be available on the trust source page under the policies section to allow it to be available for clinical staff to use. It will be publicised via TIPCC and Trust link worker network.

6.3. Training and Awareness

All staff must undertake mandatory training in line with training needs analysis Appendix A of the Trust's Mandatory Training Policy.

7. Monitoring and Compliance

[This section should identify how the Trust plans to monitor compliance with, and the effectiveness of, this policy. It should include auditable standards and/or key performance indicators (KPIs) and details on the methods for monitoring compliance.

The NHSLA requirements are:

Organisations should measure, monitor and evaluate compliance with the minimum requirements within the NHSLA Risk Management Standards. This should include the use of audits and data related to the minimum requirements. The organisation should define the frequency and detail of the measurement, monitoring and evaluation processes.

Monitoring demonstrates whether the process for managing risk, as described in the approved documentation, is working across the entire organisation. Where failings have been identified, action plans must have been drawn up and changes made to reduce the risks. Monitoring is normally proactive - designed to highlight issues before an incident occurs - and should consider both positive and negative aspects of a process. The table below should help to detail the 'Who, What, Where and How' for the monitoring of this policy.]

Section / page no:	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out?	Responsible for carrying out the check:	Results of the check reported to: *(Responsible for also ensuring actions are developed to address areas of non-compliance)*	Frequency of reporting:
No.	**WHAT?**	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
P. 5	These are the 'key' parts of the process that we a relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends,	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the Policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within	Use terms, such as, '10 times a year' instead of 'monthly'.

		monitoring of attendance at training.)			its terms of reference.	
	Promoted identification and isolation of cases. Correct diagnostic samples have been taken. Staff caring for patient wear correct PPE - FFP3 face masks. Prompt identification of patient and staff cases, assessment for post exposure prophylactic treatment and correct treatment given if deemed necessary.	IPC Team will perform compliance checks in the event of measles cases.	IPC Team will perform compliance checks in the event of measles cases	IPC Team will perform compliance checks in the event of measles cases	Compliance will be monitored through measles case incident meeting which is then reported into TIPCC	IPC Team will perform compliance checks in the event of measles cases
	Availability of immunoglobulin	Pharmacy to be contacted by IPC	Annually	IPCT	TIPCC	Annually

8. Policy Review

[This section should state the frequency of the review of the policy and which person(s) or group will be responsible]

9. References

UKHSA National measles guidelines, July 2024, https://assets.publishing.service.gov.uk/media/66a0ce1449b9c0597fdb03a6/20240704_national-measles-guidelines-July-2024.pdf

10. Background

10.1. Equality requirements

[A brief description of the findings of the equality assessment Supporting Document 1]

10.2. Financial risk assessment

[A brief description of the financial risk assessment Supporting Document 2]

10.3. Consultation

This policy has be consulted through Trust Infection Prevention and Control Committee which has representation from all Trust clinical Divisions.

10.4. Approval Process

This policy was approved via Trust Infection Prevention and Control Committee

11. Appendices

11.1. Appendix 1 – NHS Herefordshire and Worcestershire - Access to Immunoglobulin Following Measles Contact

Appendix 1: NHS Herefordshire and Worcestershire - Access to Immunoglobulin Following Measles Contact

Notification from UKHSA of measles contact within risk category. Information included within the National Measles Guidelines

UKHSA contact tracing identified at risk contacts who need HNIG. Data to be shared with provider – patient name; contact number; date of measles contact; NHS number; Risk factors; Date by which HNIG must be given

Worcestershire

Paediatrics

Referrals via 676 bleep holder (through switchboard 01905 763333)

Arrange admission to Riverbank Ward for either HNIG or IVIG

Adults -Immunosuppressed

Access is via ED. Contact Nurse in charge (ED) via switchboard (01905 763333)
Administration via ED utilising the ID room.

Adults – Pregnant women

Individual to contact either own GP or community midwife who will in turn contact Maternity Triage. Duty Obstetrician will assess immunity & significance of contact. If serology results indicate, administer HRIG utilising side room in maternity.

Administration -no dedicated prescription available. Stock of IVIG product is held within the Emergency Drug Cupboards at WRH and AH sites.

Contact pharmacy within Hrs. and the on-call pharmacist via Switchboard to confirm appropriate to remove stock. Record full details of patient and product taken on the forms provided within the EDC.

Herefordshire

Paediatrics

Contact on-call Consultant paediatrician on Bleep 071 (via switchboard 01432 355444)

Administered via Paediatric Assessment Unit in ED, including weekends.

IVIG – risk assess and may be administered on the Children's Wards, both within and out of hours

Adults – Pregnant and/or immunocompromised

Key personal in WVT notified wvt.cmdu@nhs.net

(Hospital at Home, H@H) Cheryl.tyler@wvt.nhs.uk & wvt.pharmacy@nhs.net

Liaise with Clinical Site Manager via switchboard (01432 355444) Bleep 040/368 to access paediatric Assessment Unit Consult Room 1 for treatment administration

CSM to inform WVT Level 3 Manager. If day 5-6 post contact, staff to wear FFP3. *NB Pharmacy closes at 6pm. Last order for prescription 4pm. Exceptions agreed with H@H.*

Administration – Dedicated prescription form for IV immunoglobulin, plus supplementary PRN medication available. Admin 1-2 hours. Prescription to be prescribed by Specialty e.g. Obstetrician on call or Medic in SDEC.

Hospital @ Home to contact via switchboard

H@H collect from pharmacy (adults only)

Email completed proforma/px to wvt.pharmacy@nhs.net and phone ext 4424/2200 to confirm receipt.

Individuals who develop symptoms within 10 days of receiving post-exposure vaccination should be assumed to have true measles unless the index case has been discarded. Oral Fluid samples should be sent for confirmation and genotyping.

12. Supporting Document 1 – Equality Impact Assessment Form

To be completed by the key document author and included when the document is submitted to the appropriate committee for consideration and approval.

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Emma Fulloway	**IPC Nurse Manager**	**e.fulloway@nhs.net**
Date assessment completed	**11th August 2025**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Measles Infection Prevention Policy			
What is the aim, purpose and/or intended outcomes of this Activity?	To give direction to clinical team on how to manage measles cases and measles contacts to prevent further cases within patients and staff populations.			
Who will be affected by the development & implementation of this activity?	❑ Y	Service User	T ❑	Staff
		Patient		Communities
	❑ Y	Carers	❑	Other _____
		Visitors	❑	

Is this:	Y Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	Persons who have not had measles infection or have not received MMR vaccine are vulnerable to acquiring measles infection. This could include patients or staff.
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Consultation is not required as there are no perceived negative impacts for implementation of this policy.
Summary of relevant findings	

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age	x			Managing measles will reduce the risk of paediatric patients from contracting the disease
Disability		x		
Gender Reassignment		x		
Marriage & Civil Partnerships		x		
Pregnancy & Maternity	x			Managing measles will reduce the risk of pregnant staff members from contracting the disease
Race including Traveling Communities		x		
Religion & Belief		x		
Sex		x		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Sexual Orientation		x		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)	x			Managing measles will reduce the risk of vulnerable groups from contracting the disease
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)	x			Managing measles will reduce the risk of health inequality groups from contracting the disease

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.
1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	
Date signed	
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

13. Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and included when the document is submitted to the appropriate committee for consideration and approval.

ID	Financial Impact:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
Other comments:		