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ACUTE PERSPECTIVE

David Oliver: Deaths from hospital acquired covid are everyone's problem

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Last month the *Guardian* reported that, since March 2020, "Up to 8700 patients died after catching covid-19 in English hospitals."[1] The question is whether any of these cases could have been avoided and what we need to do better in future, rather than just seeking to apportion blame.

The story was based on freedom of information requests sent to all 126 acute hospital trusts, with 81 replying. A total of 32 307 patients admitted with other conditions had contracted covid-19 while in hospital, and 8747 (27%) died within 28 days, showed figures supplied by the trusts themselves.

In response to the *Guardian*'s story, NHS England stated that the root cause was a rising infection rate in the community, adding that hospitals consistently outperformed other settings in preventing and controlling outbreaks. My immediate personal reaction as a doctor who looked after busy acute covid wards in the pandemic, alongside many other staff who put themselves at risk, is to defend our colleagues and workplaces. We must, however, acknowledge how this death toll looks to people outside the NHS, including bereaved parties, survivors, and campaign groups.

We should bear in mind that some NHS hospitals had much lower rates of hospital acquired infections than others[2] —even during pandemic peaks—and that some other countries and health systems adopted systematic approaches to make hospital acquired covid far rarer.[3] We also have objective evidence from independent reports by the Healthcare Safety Investigation Branch and the Health and Safety Executive of some basic failings in procedures for preventing nosocomial covid spread.[4 5] Failings in the quality and supply of personal protective equipment (PPE) for staff or rapid access to mass covid-19 testing have also been amply documented.

Hospitals undoubtedly introduced substantial changes to identify covid-19 patients as they were admitted, to divide streams into high and low risk; to cancel elective procedures, tests, and operations; to restrict visiting; and to move much outpatient work online. But outbreaks still occurred, and patients were moved repeatedly between hospital wards, sometimes before covid could be excluded, or they were placed in bays or wards with infected patients.

The UK has among the fewest hospital beds per 1000 of the population among developed countries, and our hospitals routinely run "hot" at over 90% capacity,[6] although bed occupancy actually fell during the first few months of the pandemic because elective procedures were cancelled and some acute non-covid patients stayed away.[7] We also face a major workforce crisis where around one in eight nursing posts and one in 11 medical vacancies are unfilled, with morale and retention worsened by the pandemic.[8 9]

We had official guidance on PPE that focused on aerosol generating procedures, even though we now know that covid-19 has airborne routes and that staff working in general ward areas were at much greater risk than staff working with such procedures.[10 11]

We have an ageing hospital estate[12] with a relatively low percentage of single side rooms in all but the newest facilities, with close bed spacing in bays shared by four to six patients. Ventilation to prevent airborne transmission is often suboptimal. Staff areas for meeting, rest, or eating and drinking are inadequate and crowded, and staff share computers and desks. Specialist teams for infection prevention and control may be short staffed and overwhelmed, and the reports mentioned above showed variability in rigorously applying correct procedures.

Many of the factors behind hospital acquired covid infections and deaths are beyond the remit of overstretched clinical teams already putting their own health and lives on the line. Many of the solutions lie elsewhere. But we all—from government to NHS trust management down to the shop floor—own some of the solutions, and we have a responsibility to deliver what we can and to implement lessons from the past 14 months. If we don't, we risk future pandemics and outbreaks surging unchecked through hospitals, putting future patients at avoidable risk.

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