

Report to: Infection Prevention and Control Group

From: Amanda Hemsley – Head of Infection Prevention and Control,

Date: 9 November 2022

Subject: LPT SARS CoV-2 Associated notification of Death Report

1. INTRODUCTION

Guidance issued to all NHS Trusts from National Health Service England and Improvement (NHSE/I) on 9 June 2020 required all NHS organisations to instigate formal outbreak management processes where outbreaks of SARS-CoV-2 were identified.

In the event of a COVID-19 outbreak, NHS organisations were to follow existing Public Health England guidance on defining and managing communicable disease outbreaks <https://www.gov.uk/government/publications/communicable-disease-outbreak-management-operational-guidance>

The purpose of this report is to provide an aggregated review of all patients in LPT who died within 28 days of a positive Covid-19 test result. This report covers the period of 26th March 2020 up until 31st October 2022. The number of deaths during this time was 81. This has also supported interpretation of the data, lessons identified for learning across the Trust and maintaining patient safety.

Approach to COVID-19 deaths

NHS England and NHS Improvement guidance defines a probable or definite hospital-onset healthcare associated COVID-19 infection death as:

a) the death of a patient who has a positive specimen result where the swab was taken within 28 days of death and/or COVID-19 is cited on either Part 1 or Part 2 of the death certificate (i.e., the death resulted from a COVID-19 clinically compatible illness with no period of complete recovery between the illness and death)

b) and the COVID-19 infection linked to the death meets the definition of 'probable' or 'definite' hospital-onset healthcare associated infection:

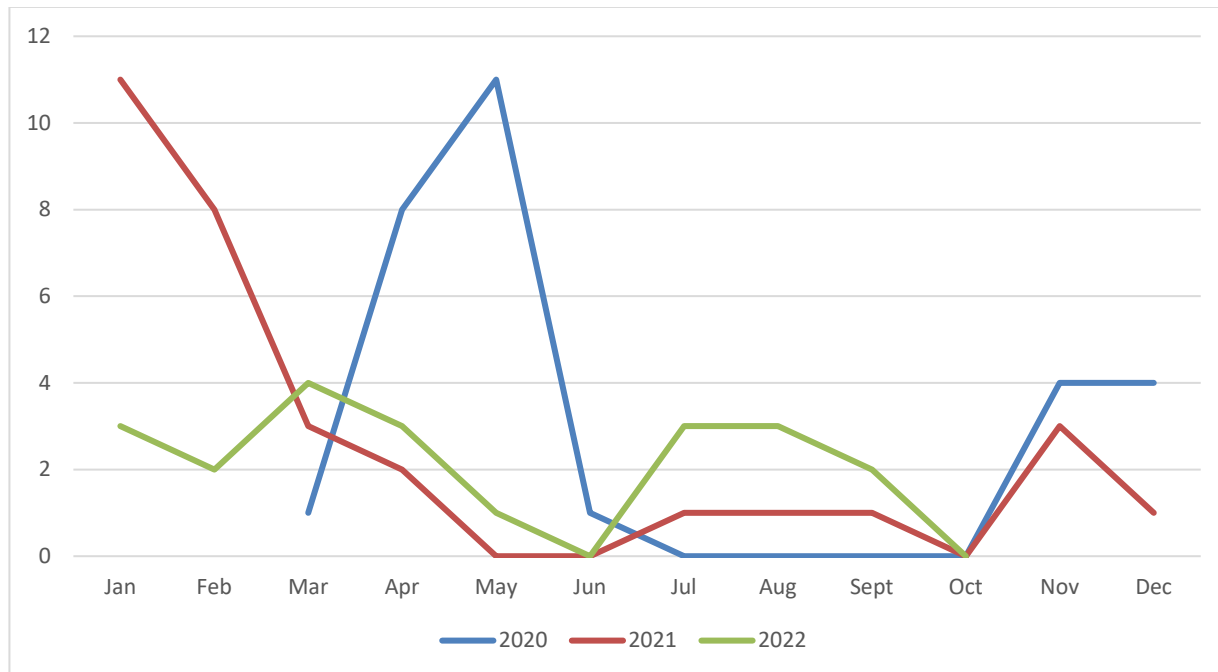
- Hospital-Onset Probable Healthcare-Associated - a positive specimen date 8-14 days after hospital admission
- Hospital-Onset Definite Healthcare-Associated – a positive specimen date 15 or more days after hospital admission

All probable or definite hospital-onset healthcare associated COVID-19 infection deaths are reported and investigated as patient safety incidents. Despite requests for the cause of death notification for the patients reviewed from the coroner's department, this information has not been received so is not included within this report.

Analysis of Covid Deaths

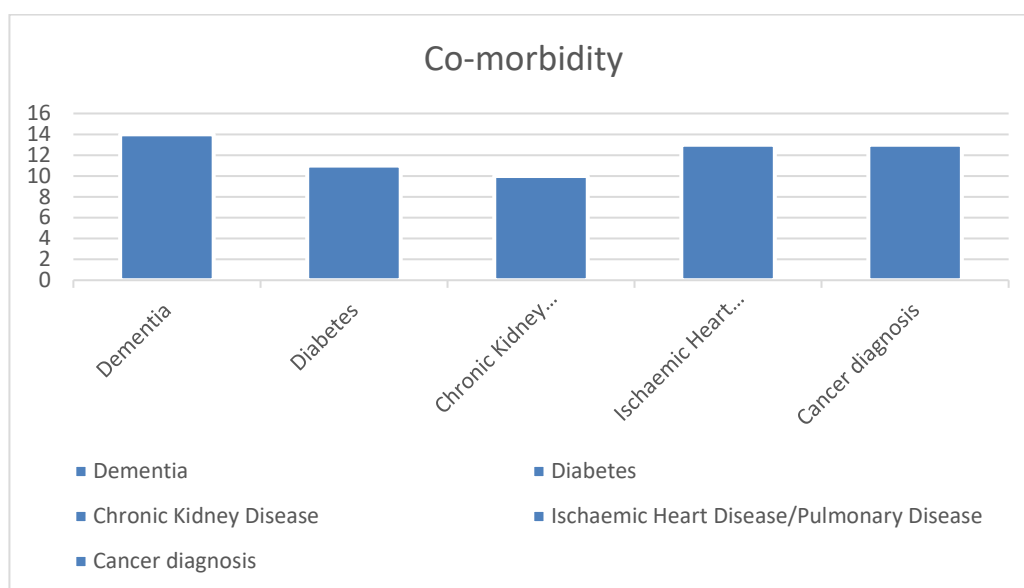
The majority of COVID-19 deaths occurred in April 2020 and January 2021 (Chart 1).

Chart 1: LPT COVID-19 patient deaths by month of death



Of the deaths involving COVID-19; there was at least one co-morbidity in every reported case. There appears to be similar numbers for the most common co-morbidity found in deaths involving COVID-19 (Chart 2). It is worth noting that a number of patients were diagnosed with more than one co-morbidity.

Chart 2



Male patients had a higher mortality due to COVID-19 when compared to female patients (Chart 3)

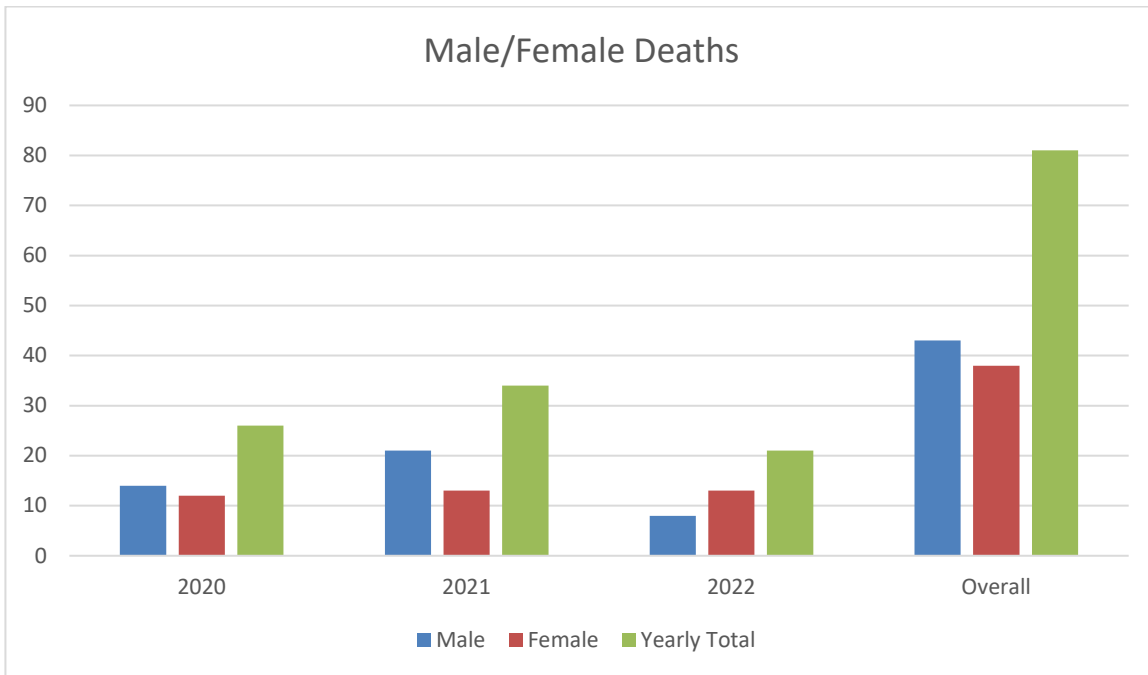


Chart 3: COVID-19 deaths – male compared to female patients

The majority of COVID-19 deaths were reported in patients over 80 years of age (Chart 4). The average age at death overall was 86 years. For males it was 85 and females 87 years.

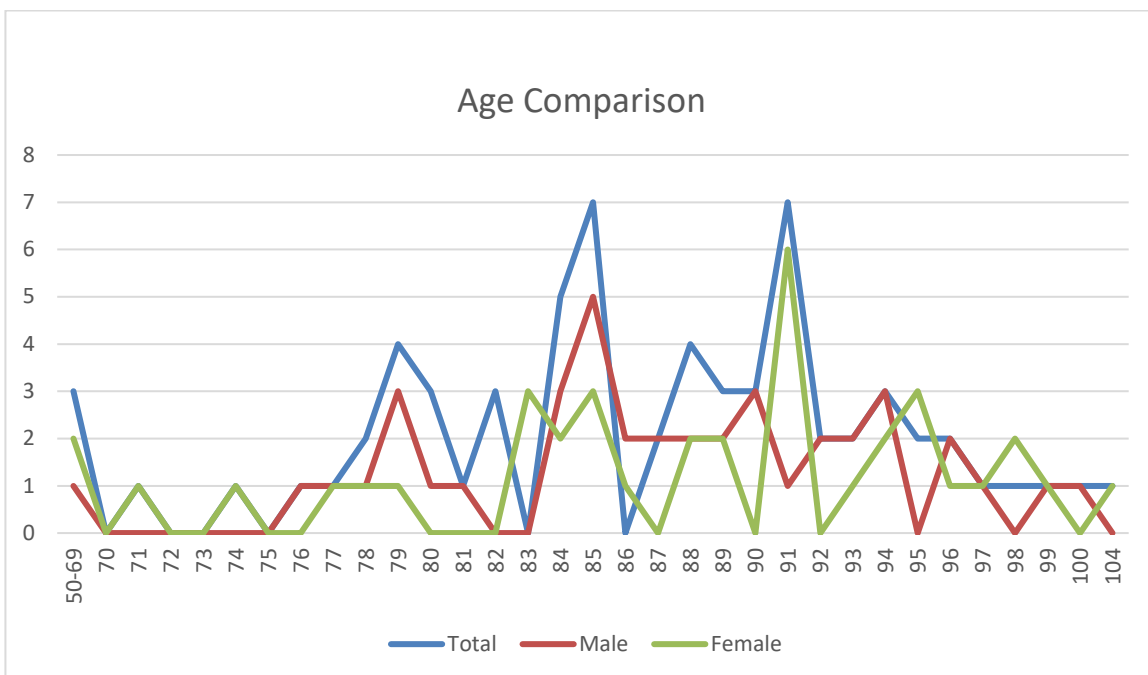
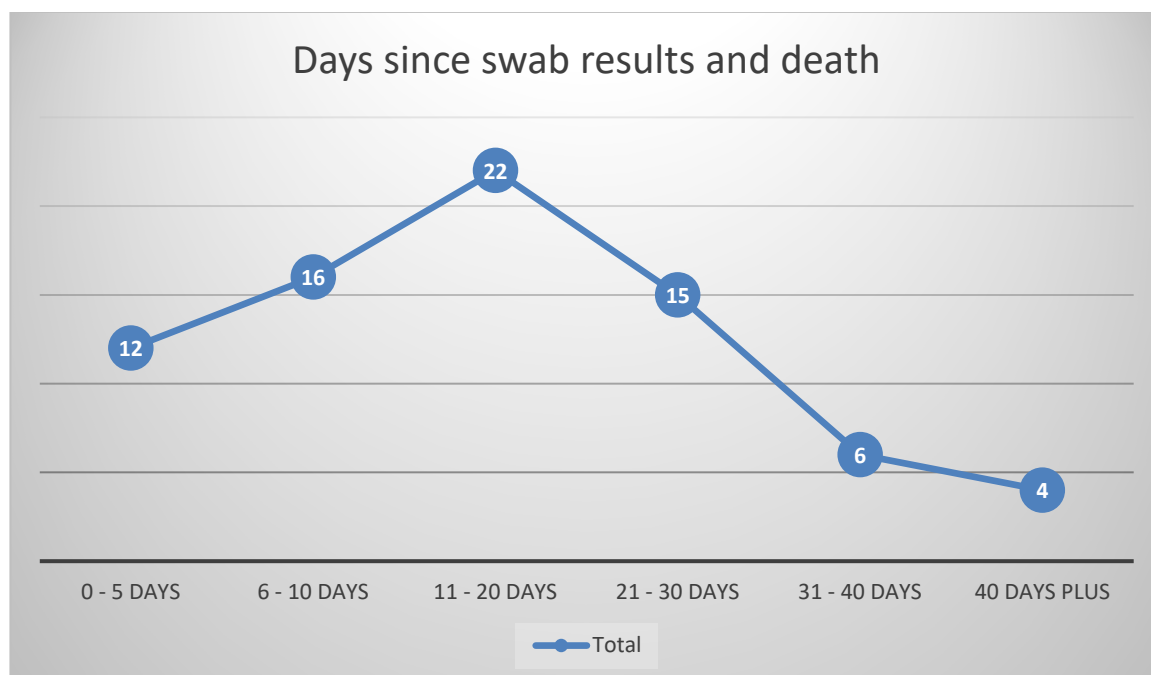


Chart 4: COVID-19 deaths – patient age

In line with national guidance, all patients who died with a probable or definite diagnosis of nosocomial COVID-19 (see 4b, above, for definitions), are part of an aggregated review using the root cause analysis process.

This report covers all deaths of patients between the identified timeline that were diagnosed with Covid-19. However, in line with the national reporting guidance the chart below identifies the number of days between being diagnosed with Covid-19 and the date of death.

The greatest number of patients died within the timescales considered to be a nosocomial infection of 15 plus days since admission



5. Learning and actions from Covid-19 reviews

Covid-19 audits were completed in inpatient areas weekly and daily for those with increased incidents of Covid or ongoing outbreaks. The audits include Personal Protective Equipment (PPE), adhering to social distancing, ventilation, staff testing, patient testing and vaccination status. The results were reviewed in conjunction with the Infection Prevention and Control Team and discussed at the outbreak meetings. Lessons identified for learning were shared with all services within LPT as learning boards.

Covid-19 PCR tests were carried out for inpatients on the day of admission, day 3, day 7 and then weekly. Testing for non-symptomatic patients was ceased in August in line with national guidance. Testing for symptomatic patients continues.

Ventilation risk assessments were conducted with risks added to the organisational risk register and a ventilation programme has been developed, which will continue to be progressed and managed by the trust's ventilation group.

None of the deaths from covid were associated with travel to a foreign country or patients who may be displaced from their country of birth.

Information regarding the patients cause of death listed on the death certificates was requested from the coroner's team on a number of occasions to provide further learning however at the point of completing this report this information had not been received.