Witness Name: Professor M Douek
Statement No.: 1
Exhibits: MD1
Dated: [18th December 2023]

UK COVID-19 INQUIRY

WITNESS STATEMENT OF PROFESSOR MICHAEL DOUEK

I, **Professor Michael Douek**, of, 38-43 Lincoln's Inn Fields, London WC2A 3PE will say as follows: -

1. I am President of BASO~The Association for Cancer Surgery (BASO~ACS) and have held this position since 7th November 2023. Prior to this, I was the Vice President of BASO~ACS from 2021. Prior to that I was appointed as Honorary Secretary in November 2020 and I was the BASO~ACS Meeting Secretary from 2015 to 2021. I was an Ordinary Member from November 2011 and a member since 1997. I make this witness statement on behalf of BASO~ACS at the request of the UK Covid-19 Inquiry.

2. This witness statement was prepared on my behalf by Open Plan Law Limited who drafted it after discussing matters with me and my colleagues on BASO~ACS Council: Mr Hassan Malik, Mr Zaed Hamady, Professor Jayant Vaidya, Professor Jim Khan, Professor Anastasios Kanatas, and Associate Professor Edmund Leung.

3. The facts and matters set out in this witness statement are within my own knowledge and that of the colleagues on BASO~ACS Council named in paragraph 2 above, unless otherwise stated, and I believe them to be true.

4. Attached to this witness statement is a paginated bundle of exhibits known as **MD1** to which I will make reference.

Background

5. When BASO~ACS received the request to submit evidence to the Covid-19 Inquiry, it felt that it could make a useful contribution to the Inquiry, in particular with regard to recommendations as to how the UK can better prepare itself for a future pandemic.

6. Except for the above heading "Background", the headings in this statement relate to the questions as set out in Annex A of the rule 9 letter dated 31 May 2023 with which we were requested to comply in the letter from the Covid-19 Inquiry dated 30 August 2023. Unless otherwise specified, the statement covers the period between 1 March 2020 and 28 June 2022 ("the relevant period") as required under Annex B of the rule 9 letter.

The BASO~The Association for Cancer Surgery's role, function and aims.

A Brief Overview of the role, function, aims and membership of BASO~The Association for Cancer Surgery (BASO~ACS) across the United Kingdom and in England, Scotland, Wales and Northern Ireland individually:

7. BASO~ACS is a Charity founded in 1971. BASO~ACS provides support for its members and also independent advice on the delivery of cancer & cancer surgery treatment. BASO~ACS serves as an umbrella organisation for professionals in all surgical cancer specialties and cancer research. In addition, the Society focuses on innovation in cancer care, supports the training and development of the future workforce, and carefully considers the Charity Commission's guidance on public benefit when determining its activities. It is completely independent of the NHS and is not involved operationally with any aspect of the delivery of cancer care. By way of illustration, at page 1 of **MD1** is a diagram showing where BASO~ACS sits in respect of the NHS.

8. Our Council members and the wider membership represent the full range of cancer surgical subspecialties including:

- Breast surgery
- Colorectal surgery
- Upper gastrointestinal surgery & pancreatic surgery
- Hepatobiliary surgery
- Head & neck surgery
- Neurosurgery
- Urology
- Endocrine surgery

- Thoracic surgery
- Sarcoma surgery
- Gynaeco-oncological surgery
- Cancer specialist nurses, surgical trainees and medical students with an interest in cancer surgery

9. BASO~ACS aims to advance the science, practice, and art of surgical oncology for the benefit of patients with cancer and to promote research, training, and education in surgical oncology for the benefit of the public, patients and the medical community, and to disseminate the useful results of that research appropriately. It is not part of the NHS and the diagram at page 1 of **MD1** shows how we sit with regard to the NHS.

10. Modern cancer treatment is delivered by multidisciplinary teams and includes a combination of surgery, chemotherapy, immune treatment and radiotherapy. However, surgery is the most important treatment for almost all solid cancers.

11. In addition to dealing with the specific questions raised by the Covid-19 Inquiry, in the recommendations below we will address how the current healthcare structure in the UK does not allow or encourage a streamlined approach to the provision of cancer surgery and cancer treatment more broadly. There is little communication between the various health bodies and societies such as BASO~ACS. There is also little consistency in healthcare between regions. For example, whilst guidance is developed and disseminated by NHS England, each individual Trust operates independently. Taking the example of NICE (the National Institute for Care and Health Excellence), is usual for NICE to consult stakeholders, including BASO~ACS, in making decisions and issuing guidance. During the pandemic, I am not aware of NHS England consulting stakeholders and we believe that this led to poorer and less efficient decision making. The disparities in the availability and standard of treatment that this system creates became even more obvious during the pandemic.

12. Whilst challenges were created by the strain that the COVID-19 pandemic put on our healthcare system it also led to innovations which were created and implemented in a short time-period. It provided an opportunity for novel models of work, including remote working within multi-disciplinary tumour boards and telephone/video clinics (virtual consultations). It is important that

the lessons learned are carried forward both to allow better preparation for a future pandemic and to enable us to improve the healthcare system in the UK.

Summary of Guidance

A summary and list of any guidance for its professional members or to NHS Trusts or other bodies which BASO~ACS formulated or to which it contributed during the relevant period. For each piece of guidance or advice listed:

a. A summary of the advice or guidance provided.
b. The date it was issued.
c. The date and nature of any changes or updates to guidance.
d. How this was communicated to the BASO~ACS's members.

13. During the relevant period BASO~ACS was not approached for advice by the NHS or by any government body despite the fact that it is a stakeholder in a number of health related organisations including NICE & NIHR (National Institute for Health Care and Research). For example, as mentioned above NICE will send out its draft comments to BASO~ACS and other associations for their comments. In addition, BASO~ACS as chair of the Cancer Services Committee of the Royal College of Surgeons of England was in a unique position to disseminate information to colleagues within the surgical community [*Afsana Elanko, Jim Khan, Zaed ZR. Hamady, Hassan Malik. Cancer surgery sustainability in the light of COVID-19 pandemic. Eur J Surg Oncology. 46 (2020) 1174-1175*]. It supported the development of the COVID-SURG CANCER initiative which provided data to support policy decisions. BASO~ACS also contributed to the Specialty-guide-Essential-Cancer-surgery-and-coronavirus, as well as producing its own guidance in April 2020: "Strategy for Cancer Surgery sustainability and recovery in the COVID 19 pandemic" [*Afsana Elanko, Jim Khan, Zaed ZR. Hamady, Hassan Malik. Cancer surgery sustainability in the light of COVID-19 pandemic. Eur J Surg Oncology. 46 (2020) 1174-1175*]. At pages 2-10 of **MD1** is a copy of the guidance entitled Strategy for Cancer Surgery sustainability and recovery in the COVID 19 pandemic. This was issued on 9 April 2020 and was made available on our website and by email to our members. To summarise this advice: The COVID-19 Pandemic had created unprecedented pressure on the healthcare system, creating a need to conserve critical resources (e.g. ventilators, ICU beds) and to provide the PPE (Personal Protection Equipment) that is essential for protecting both patients and staff from intra-hospital transmission and unnecessary exposure. This guidance was intended to support frontline clinicians, who were witnessing an increasing burden of COVID-19 patients, so that they could continue to provide essential cancer surgery. Cancer surgery treats life threatening diseases, and where practicable, it need to go ahead within the SAFE practice framework, as advised by the NHS England (NHSE) document/guidance.

14. We also issued, and in the case of the NHS Guidance contributed to, the following guidance which was sent to our members by email and was also available on our website where it is available to anyone visiting our website.

- **BASO~ACS guidance: Pragmatic Management of Breast Cancer during COVID-19**

  (https://BASO~ACS.org.uk/media/98159/covid_19_and_breast_cancer_march_2020.pdf)

  Summary: During the COVID-19 crisis, difficult decisions were being taken about management of other diseases and even the management of cancer was being altered. At such time, there can be a temptation to use unproven treatments, often without consultation with patients. Having considered the evidence, and keeping the length and quality of life as the primary outcomes that patients would care about, we made some recommendations, in consultation with Professor Jeffrey Tobias, Professor of Clinical Oncology, and Professor Bob Leonard, Professor of Medical Oncology, to be used in conjunction with the guidance already issued by Association of Breast Surgery (ABS) for the management of breast cancer patients during Covid-19. Date Issued: 25th March 2020. A copy of this advice is at page 11 of **MD1**.

- **BASO~ACS contributed to the NHSE guidance: Clinical guidance for the management of essential cancer surgery for adults during the coronavirus pandemic – BASO~ACS volunteered to contribute.**

  (https://BASO~ACS.org.uk/media/99217/BASO~ACS_guidance_for_cancer_surgery_9th_april_2020_v7.pdf)

  Summary: Cancer surgery treats life threatening diseases, and where practicable, it should go ahead within the SAFE practice framework. BASO~ACS's recommendations on screening, self-isolation of patients and shielding of patients were included in the "Advice on maintaining cancer treatment during the COVID-19 Response" document sent to NHS trusts on 30th March 2020 (Publications approval reference: 001559).

  Date Issued: 23rd March 2020. A copy of this guidance and the documents referred to within that guidance are at pages 12-25 of **MD1**.

Issues Brought to BASO~ACS's Attention

Any issues brought to the attention of BASO~ACS regarding advice or guidance issued during the relevant period (whether issued by BASO~ACS or by other bodies), including but not limited to:

a. The communication of changes to guidance during the relevant period;
b. Implementation of the guidance.

15. None except for those referred to in para 14 above.

Impact of Covid-19 on the diagnosis and treatment of colorectal cancer

The impact of the use of private healthcare providers, if any, on the care and treatment that NHS patients with colorectal cancer received during the relevant period.

16. Covid-19 has had a significant impact on the diagnosis and treatment of colorectal cancer for a number of reasons:

a. After 23rd of March 2020, during the national lockdown, routine clinical care and routine operations for cancer were deferred when possible. This involved individual surgeons and individual Trusts triaging patients for outpatient consultations and for operations and deferring all those that could be deferred.
b. Although social distancing was in place during the first lockdown, there was a lack of Covid-19 testing and shortage of FFP3 masks suitable as PPE for cancer surgeons and nursing staff.
c. Although some guidance was provided by NHS England this was not always put into practice and individual trusts were making their own decisions on cancer treatment delivery and availability of PPE.
d. After the first lockdown and over a period of time, NHS hospitals across the UK resumed some surgical delivery but also commissioned operating lists at private hospitals. The latter practice was widespread.
e. The outsourcing of NHS operating lists into private hospitals must have impacted on the delivery of private cancer treatment. BASO~ACS is not aware of what changes, if any, were made to the provision of private treatment for those patients with private insurance, in terms of restricting private cover or part-reimbursement of insurance premiums by medical insurance companies, given the inevitable restrictions in the delivery of cancer care even privately.
f. It is not clear why this extra operating capacity was needed by the NHS and the reasons for this expansion need to be identified in order to render the NHS more resilient in a future pandemic. Potential causes for outsourcing surgical care

include inadequate operating capacity within the existing NHS and co-location of cancer surgery with emergency/Covid delivery. This co-location caused the prioritization of the pandemic over the delivery of cancer surgery to the detriment of cancer patients. Any shortages of operating capacity need to be quantified and urgently addressed.

g. Specifically for colorectal surgery, sterilization of laparoscopic, robotic and endoscopic equipment is needed as well as adequate PPE , because of the risk of aerosol transmission of the virus to staff and patients.

Inequalities

Any issues that BASO~ACS identified or were made aware of around inequalities, relating to any protected characteristics under the Equality Act 2010, in the diagnosis, treatment or follow-up care for colorectal cancer patients during the relevant period.

17. The only issue that we identified was that breast reconstruction for women undergoing mastectomy was withdrawn. We believed that this was unnecessary and detrimental to the patients' mental health and addressed this in our own guidelines (*https://BASO~ACS.org.uk/media/98159/covid_19_and_breast_cancer_march_2020.pdf).*

Staffing Capacity

Details of any changes in the availability of surgeons specializing in colorectal cancer during the relevant period. If there was a change, what BASO~ACS considers the reason(s) to have been for the reduction and whether it impacted:

a. The capacity of the NHS to provide treatment for colorectal cancer;
b. The quality of treatment that was provided;
c. The physical and/or mental health and wellbeing of the BASO~ACS members.

If applicable, please also comment on whether this varied by geographical location of the cancer service.

18. The lack of expeditious and effective COVID-19 testing meant that more staff had to be isolated and periods of absence were longer than necessary. This negatively impacted on delivery of care exacerbating delays in routine outpatient appointments. Some surgeons were redeployed to cover staff shortages elsewhere or to look after COVID-19 patients.

19. Prior to the first lockdown, lack of social distancing restrictions led to some surgeons being off sick and we were notified through our members of surgeons who were sick and could not be tested for COVID-19 because routine lateral flow tests were unavailable and routine antibody testing was only available weeks later. However, we would not have received any formal

notifications from colorectal surgeons about their concerns as these would normally be reported directly to the NHS.

Infection prevention and control

Details of any concerns raised by members of BASO~ACS in relation to infection prevention and control ("IPC") measures in healthcare settings and the impact on care pathways for colorectal cancer during the relevant period. This includes those relating to aerosol generating procedures, from the perspective of health and safety in the workplace as well as patient safety.

20. None of these issues would have been reported to BASO~ACS. These operational matters are normally reported to the NHS directly. However, we would have expected a detailed report of such concerns to be produced by NHS England and to be circulated widely to stakeholders for comment. This has not happened.

Issues Reported to BASO~ACS by its Members

A summary of any issues reported to BASO~ACS by its members about:

a. *The availability of staff testing for Covid-19;*
b. *The availability and suitability of personal protective equipment (PPE);*
c. *The fitting of and training in the use of PPE;*
d. *Any issues with PPE due to the physical attributes of staff according to their age, sex, ethnic background, disability or other reasons such as facial hair or wearing glasses;*
e. *Delays in providing emergency treatment due to the putting on and taking off of PPE.*

Details of any impact on the quality of care or treatment of the patient these issues may have caused or contributed to.

21. At the outset of the pandemic, and for several months into the pandemic our experience was that cancer surgeons were functioning without proper information or equipment. As at March 2020 I, as a Consultant surgeon could not obtain a COVID-19 test. Whilst in Italy and China for example cancer services continued (Liu C et al. Delayed diagnosis and treatment of cancer patients during the COVID-19 pandemic in Henan , China: An interrupted time series analysis, Frontiers in Public Health, 2022: article 881718; Girardi F et al. The Impact of COVID-19 on Treatment Practices for Patients With Early Breast Cancer: A Cross-Sectional Study From a Large Cancer Center in Italy, The Oncologist 2023; 28: e1179-1184;). Although there was a significant reduction in diagnosis and treatment of cancer in China during lockdown (Jan to March 2020), given cancer care is delivered via specialist cancer institutes, the number of cancer operations recovered after lockdown and

in 2020 was similar to 2019 & 2021 (Liu C et al. Delayed diagnosis and treatment of cancer patients during the COVID-19 pandemic in Henan , China: An interrupted time series analysis, Frontiers in Public Health, 2022: article 881718). In addition, chemotherapy treatments that would otherwise have been implemented as a matter of routine were avoided because of the effect of chemotherapy on immunity and the fear that the risk of COVID-19 infection exceeded any potential benefit from cancer treatment.

22. As a result of the lack of testing, aerosol procedures such as endoscopy and laparoscopy became challenging because practitioners were not able to test themselves or the patients or to protect themselves with proper PPE equipment.

IPC Guidance

In relation to IPC guidance in healthcare settings during the relevant period, a summary of any issues reported to BASO~ACS including:

a. *The communication of changes to guidance during the relevant period.*
b. *The interpretation of the guidance.*
c. *Any disparities in the guidance issued to the four nations of the UK.*
d. *Details of any negative effects that IPC measures may have had on BASO~ACS's members, patients or their family members.*

23. No requests and no reports

Summary of Submissions and Reports

A summary and list of any submissions, reports, or other communications from BASO~ACS to the NHS England (NHSE), the Department of Health and Social Care, or other relevant bodies regarding the impact of the IPC measures in healthcare settings during the relevant period, including the date of such communications and any response or steps taken as a result.

24. Apart from information already provided in this statement, specific information, data and statistics are held by the NHS. We would like to be able to access such information, data and statistics in order to provide an expert opinion (subject to having the funding to do so) in specific areas and on the wider operating capacity within the NHS over time, any independent assessment of capacity required in the future, in order to avoid out-sourcing operating lists into the private sector during a pandemic and any central NHS England assessment of operating capacity requirements in order to address the waiting-list crisis.

COLORECTAL CANCER

Impact of Covid-19 on the diagnosis and treatment of colorectal cancer

Details of the main issues which were brought to the attention of BASO~ACS in relation to the treatment of colorectal cancer during the relevant period. This may include, but is not limited to:

- *a. a reduction in the number of cases referred for treatment in cases of confirmed colorectal cancer;*
- *b. cancellations of or delays to treatment for colorectal cancer, including:*
  - *i. surgery;*
  - *ii. laparoscopic (key-hole) procedures;*
  - *iii. anastomoses (bowel join lines) procedures;*
  - *iv. radiotherapy;*
  - *v. chemotherapy;*
- *c. a change in the number of stoma-forming procedures;*
- *d. deviation from the standard patient care pathways;*
- *e. increased use of pre-operative radiotherapy;*
- *f. the length of hospital stays following surgery or the length of recovery time;*
- *g. delayed or cancelled follow-up care;*
- *h. changes in the number of patients and/or waiting periods for treatment for colorectal cancer.*

25. Apart from information already provided in this statement, specific information, data and statistics are held by the NHS. We would like to be able to access such information, data and statistics in order to provide an independent expert opinion (subject to our obtaining funding to do this).

Cancellations and Delays

Any reported issues around the cancellation, delay or de-escalation of surgery for Colorectal cancer, including, but not limited to:

- *a. an increase in patients requiring more complex or advanced surgery in the absence of early surgical intervention;*
- *b. any increase in the number of patients and/or waiting periods for surgery.*

26. Apart from information already provided in this statement, specific information, data and statistics are held by the NHS. We would like to be able to access such information, data and statistics in order to provide an expert opinion (subject to our obtaining funding to do this).

Reduction in Number of People Referred, Diagnosed or Treated for Colorectral Cancer

The Inquiry is aware of research conducted and published in The Lancet on the 'Impact of the COVID-19 pandemic on the detection and management of colorectal cancer in England: a population based study', March 2021 [INQ000191135] which analysed NHS England data and concluded that the COVID-19 pandemic led to a sustained reduction in the number of people referred, diagnosed, and treated for colorectal cancer. Please provide details of any reduction in the number of people referred, diagnosed, and / or treated for colorectal cancer that BASO~ACS

identified, or that was brought to their attention, and what steps, if any, BASO~ACS took in response.

27. BASO~ACS was not approached to undertake specific work on this.

Work with Other Associations
Details of BASO~ACS's work with the other member associations and/or the Royal Colleges relevant to the areas of colorectal cancer during the relevant period and a brief summary of such work or collaborations if they took place.

28. BASO~ACS offered grant support of £3,000 to the COVIDSurg – Cancer, an international cohort study, designed by the team in Birmingham to assess the safety of surgery for all types of cancer during COVID-19 pandemic and the impact of the pandemic on cancer diagnostic delay and on treatment pathways. It was envisaged that the data from this study would help to make key service changes feasible during the pandemic. The study was presented at the May 2020 CSC (Cancer Stem Cell) Meeting.

Impact on Scientific Research
Any impact that BASO~ACS identified the Covid-19 pandemic had on scientific research in the area of colorectal cancer and any long-term consequences. Please provide details of any action taken by BASO~ACS in response, for example, its contribution to the development of the "COVID-SURG CANCER initiative".

29. BASO~ACS supported the development of the COVID-SURG CANCER initiative which provided data to support policy decisions. The research project received some funding from BASO~ACS but it was conducted entirely independently of BASO~ACS. Several landmark papers have been published.

Other Issues and Concerns
Any concerns or issues not covered above which the BASO~ACS identified in relation to the impact of the Covid-19 pandemic on its members during the relevant period.

30. Overall, the population restrictions introduced at the time aimed to control the community transmission of COVID-19 [*Hale T, Angrist N, Goldszmidt R. A global panel database of pandemic policies (Oxford COVID-19 Government Response Tracker) Nat Hum Behav. 2021;5:529–538*]. In the first COVID-19 wave (i.e.,31st January to 6th September 2020), at least 21 million elective operations were cancelled globally, partly due to concerns over postoperative SARS-CoV-2 infection and partly due to capacity issues within hospitals [*COVIDSurg Collaborative. Effect of COVID-19 pandemic lockdowns on planned cancer surgery for 15 tumour types in 61 countries: an international, prospective, cohort study. Lancet Oncol. 2021 Nov;22(11):1507-1517. doi: 10.1016/S1470-2045(21)00493-9*].

Guidance from health ministries and national surgical associations prioritised time-dependent cancer surgery to continue during societal restrictions related to COVID-19 [*Burki TK. Cancer guidelines during the COVID-19 pandemic. Lancet Oncol. 2020;21:629–630*]. To support delivery of surgical services throughout the pandemic, prioritisation of different procedures had been undertaken [*Burki TK. Cancer guidelines during the COVID-19 pandemic. Lancet Oncol. 2020;21:629–630*].

31. This prioritization of surgical care, and deferral of treatment of many patients including cancer patients, was caused by bed shortages and staff shortages as a result of the pandemic.

32. However, during the decades preceding the pandemic a central innovation across all surgical specialties within the NHS, was a move towards day-case surgery and a drastic reduction in hospital beds, nationally. This may well have further exacerbated the impact of COVID-19 on cancer surgery delivery within the NHS.

33. We are not aware whether NHS England has a strategy on surgical operating capacity within the NHS and any independent assessment of the number of operating theatres required across England including the need to consider weather cancer surgery should in future be delivered within separate Institutes that would not compete with other medical specialties for hospital beds and avoid exposing cancer patients, many of whom receive immune-compromising chemotherapy and radiotherapy, direct exposure to potentially infected patients.

Recommendations
Any recommendations that BASO~ACS would seek to make in order to improve healthcare services in the event of a future pandemic.

34. Please note that BASO~ACS is making these recommendations in the absence of data from the NHS. We would welcome the opportunity to have access to the data we would require in order to be able to carry out a fuller and independent analysis, if we are funded to do so, so that we can make more detailed and focused and independent recommendations.

35. There have been obvious inequalities in delivery of care for patients with cancer in comparison to patients with COVID-19. The lack of hospital beds during peak infection periods, referred to above, led to widespread cancellation of cancer operations across the UK. This caused delay to diagnosis and surgical treatment which inevitably caused delay to subsequent chemotherapy & radiotherapy treatments. In patients requiring chemotherapy, before we could

routinely test for COVID-19 and before the availability of the vaccine, oncologists had to decide whether chemotherapy could be administered in light of its effect of impairing the patient's immunity and in many cases it was not. This evidently impacted negatively on quality of life and other cancer outcomes including survival.

36. The pandemic affected patients and clinical staff at all stages of care, from diagnosis to treatment and hospital discharge. All aerosol-prone procedures were avoided (e.g., endoscopy) and alternative means were used: FIT testing (Faecal Immunochemical Test- a test for colon cancer), CT colonography (a computed tomography examination to look at the bowel), contrasted / PET CT (a type of test that may be used in cancer diagnosis or treatment) [*COVIDSurg Collaborative. Effect of COVID-19 pandemic lockdowns on planned cancer surgery for 15 tumour types in 61 countries: an international, prospective, cohort study. Lancet Oncol. 2021 Nov;22(11):1507-1517. doi: 10.1016/S1470-2045(21)00493-9*]. All non-urgent research was delayed by the NHS (without consultation with BASO~ACS and we are not aware of other stakeholders being consulted), several trials were terminated-and staff were mobilised for COVID-19 diagnostic or vaccination programmes. Procedures such as reconstructive surgery e.g. breast or head and neck reconstruction were avoided. Laparoscopic surgery was avoided unless it significantly enhanced hospital discharge, for e.g. transverse incision for right hemicolectomy [*J Khan, G van Boxel, S Mercer, Is minimal access surgery possible and safe during the COVID-19 pandemic?,* British Journal of Surgery*, Volume 107, Issue 8, July 2020, Page e268, https://doi.org/10.1002/bjs.11731*].

37. The recommendations set out in this statement are designed to address the above matters and would be best addressed, in our view, by the establishment of Institutes for Cancer Care. This would enable proper communication of advances in treatment between the NHS, the RCS, BASO~ACS and other organisations leading to the most up to date treatments being available to patients across the country. In addition, with dedicated cancer institutes, should another pandemic arise, we would be in a better position to offer cancer treatments even if testing and the availability of equipment such as PPE take time to become available.

38. In conjunction with a specialized Institute, BASO~ACS recommends that an independent expert multidisciplinary group of cancer surgeons, oncologists and other cancer disciplines should be set up (independently of the NHS). This would be able to provide advice on:

a. Areas of risk for cancer delivery including co-location of cancer services with emergency services.

b. Bed capacity & protection of capacity for cancer care
c. Operating theatre capacity across UK
d. Cancer itself & cancer treatments negatively impact the immunity of patients putting them at risk of contracting various infections. The NHS should look at delivery of cancer treatment away from medical emergency treatment. Analysis of operating capacity provision, overtime & an estimation of operating capacity required for long waiting lists.

39. BASO~ACS believes that in similar emergencies in the future, secondary care organisations should follow three basic principles:

1: **Care for all patients** – pathways should be in place to provide effective planned and un-planned care for all. For cancer surgery, this should consist of a defined local surgical hub within each cancer alliance footprint, with established pathways for patient flow and continuity of care. Where there is the need for highly specialised cancer care, which may not be appropriate for a "surgical hub", mechanisms should be put in place for the organisation hosting such services to institute infection-prevention pathways to facilitate safe care. In addition, for lower volume, highly complex surgery e.g. Hepato-pancreatico biliary, oesophago-gastric and abdominal sarcoma surgery, consideration should be given to a national surgical waiting list and patients being transferred for care to other centres of expertise if one region is particularly compromised by a future pandemic.

2: Care for all staff – need for effective PPE policies as well as staff emotional support during such emergencies. BASO~ACS does not have the expertise to provide advice on PPE and we fully support the position on PPE requirements by Public Health England.

3: Care for the community – need for hospitals to maintain stringent infection control policies to prevent well patients developing nosocomial infections. Safe discharge policies to prevent infective patients from spreading the illness to vulnerable members of the community. BASO~ACS~ACS does not have the expertise to provide advice on infection control and hospital discharge policies. However, stringent infection control and safe hospital discharge policies would be crucial to preventing nosocomial infections spreading within secondary care as well as from secondary care to the community.

40. It is particularly important that surgery, as one of the few curative options for patients with

solid organ tumours, is maintained throughout any future crisis. To this end, we would make a number of further recommendations on which the multidisciplinary group recommended in paragraph 33 above would be able to advise. These are inevitably linked and overlap each other.

a. **Independent advice on long term cancer treatment strategy**.

   The UK electoral system's cycle of 5 years is too short for decision on long term planning and the NHS is run by the Department of Health. There is an urgent need for independent advice on provision of cancer care and how best to improve the NHS cancer treatment strategy in the future.

b. **Greater Connectivity Between Healthcare Organisation**.

   BASO~ACS is linked to the Royal College of Surgeons of England (RSCE) but neither the RSCE nor BASO~ACS are part of the NHS. This means that whilst the RSCE and BASO~ACS can disseminate guidance to their members, this will not reach other practitioners in the NHS and may not be compatible with guidance issued by the NHS. In addition, each NHS Trust operates independently from NHS England. Again, this creates a lack of consistency for patients and practitioners and, inevitably, gives rise to inequality of access to services and treatments. The guidance referred to above clearly required that cancer services would be provided separately to other services in order to maintain these to the fullest extent possible. However, NHS England was powerless to ensure that Trusts implemented the guidance or were sufficiently funded and supported in doing so.

   Secondary care organisations (i.e. NHS Hospitals) which primarily deal with cancer surgery, were severely affected in the early phases of the pandemic due to uncertainties in critical care requirements, the need to re-deploy surgical staff to support ITU/acute medicine and uncertainty about the safety of undertaking of surgery during the pandemic. Considering the immense implications of the pandemic, it was difficult to obtain reliable data rapidly. Some of the guidelines and recommendations, that had a huge impact on the service, required more evidence. One such proposal was about avoiding laparoscopy and reverting to open cancer surgery. There was advice and guidance from various surgical societies at the beginning of the pandemic with advice to avoid the use of minimal access surgery in patients to reduce the risk of cross contamination. This guidance was based on limited data and had consequences for the teams and the patients

with a rise in stoma rates, increased length of hospital stay and increased morbidity. [*Facts Views Vis Obgyn, 2020, 12 (1): Epub ahead of print -Covid 19 pandemic and gynaecological laparoscopic surgery: knowns and unknowns R. Mallick1, F. OdejinMi2, T.j. claRk3 - 1Princess Royal Hospital, Brighton and Sussex University Hospitals NHS Trust, Lewes Road, Haywards Heath, RH16 4EX, UK; 2Whipps Cross Hospital, Barts Health NHS Trust, Whipps Cross Road, Leytonstone, London, E11 1NR, UK; 3Department of Obstetrics and Gynaecology, Birmingham Women's and Children's Hospital, Birmingham, B15 2TG, UK*] and [[*https://www.asgbi.org.uk/userfiles/file/covid19/acpgbi-statement-on-covid-19.pdf*]. We gave advice and guidance to our surgical community, based on safety protocols, due to lack of evidence which continued to be the case during the period of pandemic (BASO~ACS's recommendations with regards providing safe cancer surgery were in line with government guideline and parts of our guidelines was incorporated into NHS-E statements, "Maintenance of Essential Cancer Surgery for Adults During the Covid-19 Emergency"). Data from selected centres who choose to continue with minimal access surgery showed that the risk of infection transmission from the aerosol generating procedures was extremely low [J Khan, G van Boxel, S Mercer, Is minimal access surgery possible and safe during the COVID-19 pandemic?, *British Journal of Surgery*, Volume 107, Issue 8, July 2020, Page e268, https://doi.org/10.1002/bjs.11731 and [*Vicky Maertens, Samuel Stefan, Emma Rawlinson, Chris Ball, Paul Gibbs, Stuart Mercer, Jim S. Khan, Emergency robotic colorectal surgery during the COVID-19 pandemic: A retrospective case series study, Laparoscopic, Endoscopic and Robotic Surgery, Volume 5, Issue 2, 2022, Pages 57-60, ISSN 2468-9009, https://doi.org/10.1016/j.lers.2022.03.001. (https://www.sciencedirect.com/science/article/pii/S2468900922000226)*]. These factors impacted the ability of the healthcare system to offer time critical cancer surgical treatments. As a result of this, extensive multidisciplinary work resulted in a number of consensus documents [*El-Boghdadly K, Cook TM, Goodacre T, Kua J, Blake L, Denmark S, McNally S, Mercer N, Moonesinghe SR, Summerton DJ. SARS-CoV-2 infection, COVID-19 and timing of elective surgery: A multidisciplinary consensus statement on behalf of the Association of Anaesthetists, the Centre for Peri-operative Care, the Federation of Surgical Specialty Associations, the Royal College of Anaesthetists and the Royal College of Surgeons of England. Anaesthesia. 2021 Jul;76(7):940-946. doi: 10.1111/anae.15464*] and [*El-Boghdadly K, Cook TM, Goodacre T, Kua J, Denmark S, McNally S, Mercer N, Moonesinghe SR, Summerton DJ. Timing of elective surgery and*

risk assessment after SARS-CoV-2 infection: an update: A multidisciplinary consensus statement on behalf of the Association of Anaesthetists, Centre for Perioperative Care, Federation of Surgical Specialty Associations, Royal College of Anaesthetists, Royal College of Surgeons of England. Anaesthesia. 2022 May;77(5):580-587. doi: 10.1111/anae.15699]. However, there was no centralized system through which expertise could be gathered, reviewed and disseminated, which led to inconsistency and confusion.

BASO~ACS is the only representative body for cancer surgeons in the UK. It is linked to other societies in Europe, but not to the NHS. We believe that this is a waste of expertise which could be harnessed to improve cancer surgery throughout the UK and especially during times of stress such as a pandemic.

c. **Co-Location**

Much of the delay in cancer treatment during the pandemic arose from the co-location of services. The treatment of cancer sufferers alongside patients suffering from other diseases including infectious diseases meant that cancer treatments such as chemotherapy and surgery could not always be safely delivered and the cancer treatments were postponed with inevitably detrimental consequences.

One of the challenges of surgery during the COVID-19 pandemic was the peri-operative risk of morbidity and mortality to patients with active SARS-CoV-2 infection. Evidence suggested a 19.1% 30-day mortality in elective (planned) and 26.0% 30-day mortality in emergency surgical patients, with around half of patients having surgery when infected with SARS-CoV-2 experiencing postoperative pulmonary complications [*COVIDSurg Collaborative. Mortality and pulmonary complications in patients undergoing surgery with perioperative SARS-CoV-2 infection: an international cohort study. Lancet 2020; 396: 27–38*]. In addition, given the scale of the pandemic, peri-operative outcomes after a previous SARS-CoV-2 infection were an important concern, as a significant number of patients who have previously been infected (estimated at 15–20% of the UK population required surgery [Office for National Statistics. Coronavirus (COVID-19) roundup. 2021.https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/coronaviruscovid19roundup/2020-03-26)]

The consequences of the COVID-19 pandemic continued during the second wave (i.e. 7th September 2020 to 12th April 2021). Some hospitals were overwhelmed and were unable to offer essential cancer surgery. The second wave of the pandemic also had a detrimental effect on cancer services. Data from head and neck [*Shaw R; COVIDSurg Collaborative. UK Head and neck cancer surgical capacity during the second wave of the COVID-19 pandemic: Have we learned the lessons? COVIDSurg collaborative. Clin Otolaryngol. 2021 Jul;46(4):729-735. doi: 10.1111/coa.13749*] indicated that 50% of UK HN cancer patients requiring surgery were having a compromised treatment; 28% delayed, 12% de-escalated, 10% received radiotherapy instead. In the worst third of hospitals, 82% of HN cancer patients needing surgery had compromised treatment. This restriction in capacity was no better than the first wave response, despite advanced warnings for winter 2020/21, and 6-months lead-time to prepare the NHS strategic response[6].

d. **Testing and PPE**

At the outset of the pandemic, and for several months into the pandemic surgeons were functioning without proper information or equipment. The UK was particularly badly hit compared to other countries such as Italy and China because surgeons and patients could not be tested for COVID-19 and isolated appropriately. As mentioned at paragraph 21 above, in March 2020 I could not obtain a COVID-19 test. This meant that precautions had to be taken which were not based on accurate information which led to the precautionary cancellation of an excess number of procedures and treatments. In addition, chemotherapy treatments that would otherwise have been implemented as a matter of routine were suspended because of the effect of chemotherapy on immunity.

As a result of the lack of testing, aerosol procedures such as endoscopy and laparoscopy became challenging because practitioners were not able to test themselves or the patients or to protect themselves with proper PPE equipment.

e. **Surgical Oncology as a recognized specialism**.

Currently surgical oncology is not recognized by the GMC. Cancer surgery should be dealt with separately from other surgery. This is crucial so that in circumstances

such as the COVID-19 pandemic, patients can be safely and properly treated. Currently, cancer patients are treated alongside other patients, including those with infections, regardless of the particular nature of cancer and its treatments such as lower immunity. There is competition for beds in the NHS. The availability of beds was reduced as a result of the move away from in-patient surgery as a matter of policy as referred to in paragraph 32 above. Cancer patients, even those requiring urgent surgery, have their operations cancelled if there is no bed available for them at the time when their surgery is due to take place. This could have been avoided if, alongside our other recommendations, cancer surgery was recognized as a specialist field.

41. The delays to cancer surgery and treatment during the pandemic arising from the issues set out above led to unnecessary deaths and were a great source of stress and anxiety to patients and staff. BASO~ACS is aware of this from the experience of its members who were seeing the effects of the delays first hand. However, as set out above, we would welcome access to the data obtained by the NHS in order that we can provide a more considered analysis.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: **Professor Michael Douek**

President, BASO~ACS
Professor of Surgical Sciences and Breast Cancer, University of Oxford

Signature

Dated: ___18th December 2023_____