Witness Name: Professor Nicholas van As

Statement No.: 1

Exhibits:

INQ000371203

INQ000371204

INQ000371205

INQ000371206

INQ000371207

INQ000399440

INQ000399441

INQ000399442

Dated: 1 JULY 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF Professor NICHOLAS VAN AS

I, Professor Nicholas van As, will say as follows: -

I am the Medical Director at the Royal Marsden NHS Foundation Trust and the Professor of The Institute of Cancer Research. I am also a Consultant Clinical Oncologist. My qualifications are MBBCH MRCP FRCR MD (res).

I make this statement as requested by the Inquiry and in order to respond to the specific questions raised by the Inquiry.

1. The Royal Marsden NHS Foundation Trust ("RM") is a specialist cancer hospital and receives referrals from GPs, consultants and other hospitals when patients need care. RM provides specialist cancer care for the local population but is also a regional centre for rare cancers e.g. sarcoma accepting referrals from a wider geographical area. RM's referral geography varies by tumour group. The core standard referral area is Southwest London, Surrey Downs and part of Northwest London. However, the geography is much wider for several of our supra-regional tumour groups, in some cases covering much of the Southeast of England. In addition, there are several specialist treatments, such as Isolated Limb Perfusions (ILP), Total Pelvic Exenterations and clinical trials where RM has a wider/national remit. Other hospitals may be involved with the delivery of care at different points during a patient's treatment plan. For example, they may be referred to their local hospital for tests, receive care at RM for specific parts of a treatment plan, and then have follow-up care at a local hospital or with their GP. RM has sites at Chelsea, Sutton, Kingston and Cavendish Square, London, and does not provide acute medical care beyond oncology care.

2. During the pandemic, cancer services across London were coordinated by specialist 'Cancer Hubs' led by RM with Tour local cancer alliance RM Partners, University College London Hospitals NHS Foundation Trust and Guy's and St Thomas' Hospitals NHS Foundation Trust in close liaison with NHS England (NHSE).

3. NHSE formally commissioned the RM Cancer Hub on 25 March 2020. The Cancer Hub was established to help the wider system support giving time critical cancer surgery and treatment. It was made up of 10 hospitals and covered West London, providing access to urgent cancer care for a population of four million. The RM Cancer Hub worked collaboratively with several Trusts pan London. The following Trusts worked as part of the RM Cancer Hub: RM, St George's University Hospitals NHS Foundation Trust (St George's), Epsom & St Helier University Hospitals NHS Foundation Trust (ESTH), Croydon Health Services NHS Trust ("Croydon"), Chelsea & Westminster Hospital NHS Foundation Trust (CWFT), Imperial College Healthcare NHS Foundation Trust and London North West University Health NHS Trust (LNW).

4. The hub was able to secure operating theatres, which consisted of 5 theatres at RM Chelsea site, 2 theatres at RM Sutton site, and 5 theatres at The Cromwell Hospital, as well as intensive care and ward beds for patients needing urgent, time critical cancer surgery. The first complex cancer operation was on 30 March 2020, a significant accomplishment considering the complexities of healthcare management in the backdrop of a global pandemic.

5. By November 2020, The RM Cancer Hub had operated on over 3538 patients from 10 Trusts across London and c7,200 patients overall, all of which were performed under auspices of the RM Cancer Hub. This surgery would not have been possible without the RM Cancer Hub.

6. The RM Cancer Hub also supported other hospitals across the NHS and the independent sector to work together to maximise capacity and ensure that people receive the time critical cancer treatment that they needed. RM worked with the private sector and approached the Cromwell Hospital and the London Clinic who agreed to support, and patients were operated on across both sites. Prior to this, there was not an agreement between these hospitals and this agreement was for surgery only.

7. During this period patients operated on at the RM Cancer Hub remained under the care of their doctor or nurse specialist at the Trust where they were being cared for initially, however they moved to another site for surgery. The aim was to match patients who required urgent time critical cancer surgery with available capacity using the right expert clinical team and coordinating the specialist cancer workforce across the capital. Decisions about the best approach to treatment continued to be taken by specialist cancer doctors with their patients.

8. The RM Cancer Hub was in operation until May 2021.

9. RM worked with NHSE regional and national teams' throughput. As the first cancer hub to be established we were able to share details of our operating model and criteria that was then used to establish hubs both in London and across the country.

10. RM also advised other Trusts and networks in the UK on setting up similar cancer hub models and developing relationships with the private sector. This included pathways, protocols and Standard Operating Procedures to guide organisations and other Hubs with step-by-step instructions on how to set up and safely manage Cancer Hubs. There were Cancer Hubs set up and run by London South East, and North East as well as the RM partners Hub. Hubs were also established at The Christie, in Southampton, Frimley Park, Birmingham and other places in the country. Please see exhibit NVA/01 INQ000371203 for the Standard Operating Procedure and exhibit NVA /02 INQ000371204 for the RM Cancer Hub operating model.

11. For diagnostics (i.e. Endoscopy, colonoscopy) RM worked closely with Kingston Hospital, ESTH, Croydon Hospital, and St George's as a network to support diagnostic planning and recovery of services. Weekly network meetings were undertaken to share information and coordinate diagnostic activity across the sector.

12. During the initial stage of the COVID pandemic, endoscopy services were temporarily suspended for a 6-week period (with the exception of emergency situations - such as gastrointestinal bleeding) until staff were appropriately trained in the use of PPE, new national infection control policies were adopted and air flow in the endoscopy suite was restored to ensure safe resumption of endoscopy services. Once this was established, all endoscopy referrals were risk assessed on an individual basis by the GI Endoscopy Consultants and categorised based on priorities (D1-D4) in line with guidance from the NHS

England Clinical Prioritisation framework and British Society of Gastroenterology surgery.

Guidance can be found under (April 2020): https://www.bsa.ora.uk/covid-19-advice/bsa-auidance-on-recommencina-ai-endoscopy- in-the-deceleration-earlv-recoverv-phases-of-the-covid-19-pandemic/

Second wave COVID (Oct 2020): https://www.bsa.ora.uk/covid-19-advice/endoscopy- services-durina-covid-19-second-wave/

Followed by restoration and recovery of endoscopy services (Jan 2021): https://www.bsq.orq.uk/covid-19-advice/an-update-to-information-and-quidance-for- endoscopv-services-in-the-covid-19-pandemic-2/

NHS England Clinical Prioritisation framework (June 2021): https://www.enqland.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/05/C1328- clinical-prioritisation-of-waitinq-lists-for-endoscopy-and-diaqnostic-procedures- quidance June2021 v2.pdf

13. The Pan-London Guidance on the Principles for Infection Prevention and Control (in the context of COVID 19 to reduce the risk to patients being provided with planned and emergency care in all healthcare settings) V1 11/5/2020 via NHSE&I London CAG; V2 18/5/2020 via NHSE&I London CAG; 11/6/2020 via NHSE&I London CAG were followed.

14. Staff from RM met regularly with the COVID-19 London Colorectal Working Group which had representation from NHSE, Transforming Cancer Services Team (TCST), North Central & East London, North Central London, South East London, RMP, central screening teams, and included patient representatives.

15. The Hub and Spoke model was proposed in the context of the crisis as it was suggested and supported by the UN WHO to continue essential services while also managing the crisis response directly. The Hub and Spoke model is a way of maintaining clinical activities either to increase efficiency or in a disaster / crisis situation. It is the preferred UN WHO model for continuation of non-disaster related services. Hub is the central clinical establishment and spoke hospitals feed into the Hub. It was chosen as it is the tried and trusted model that has been used for numerous international crises. There were no other models proposed by NHS England. RM suggested it due to prior experience of some in managing disasters.

16. Trust staff attended meetings with a number of senior UK Government officials, including with the then Cabinet Secretary, and key policy makers in March 2020, to discuss various aspects of the national response to COVID-19 and these discussions included the potential impact on cancer (and other) services nationally. Staff were also contacted by members of the Cabinet Office Health team for advice regarding other aspects of providing capacity to maintain non COVID-19 healthcare services.

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

17. Referrals for colorectal surgery, endoscopy and colonoscopy were screened by clinicians and prioritised to minimise the impact on patients' cancer treatment and diagnostic pathways. Patients who required urgent time critical treatment were prioritised.

18. The colorectal group had regular Multi-Disciplinary Team (MDT) meetings and Clinical Prioritisation Group (CPG) meetings during which the group determined the appropriate recommendation and subsequently to decide the urgency and order of procedures to be undertaken. The Preventing Viral Pandemic Associated Risk of Cancer Death (PREVAIL) model was used to help with prioritisation and staff met with representatives of all the spoke hospitals where the urgency of cases was discussed and collectively agreed. Please see exhibit NVA / 03 INQ000371205.

19. Cancer surgery was greatly affected in the early phase of the initial COVID-19 peak; elective surgery across the NHS was suspended with an estimated 43000 operations being cancelled. Markers of care quality in colorectal surgery are typically related to process (usually surgical) and have often not been validated, yet it is widely accepted that tumours can respond to treatment in different ways, and incorporating i-PREVAIL into personalised MDT treatment plans should surpass current standards as optimal care.

20. Two-week referrals to secondary care decreased during the coronavirus peak. Anecdotal reasons for this were patients not coming forward because of anxieties of what would happen if they are diagnosed with cancer. This immediate fear of the unknown was compounded in the COVID-19 environment by a fear of wasting NHS resources, reported delays in access to treatment and potential sub-optimal treatments.

21. Following the initial COVID-19 peak, national guidelines assigned procedures to four categories. Most elective procedures for cancer were classified as priority 3 (surgery delayed up to 3 months) unless symptomatic in which case they were priority 2 (surgery delayed up to 4 weeks).

22. PREVAIL aimed to provide reassurances of a safe and effective approach where individual patients get the right treatment for them personally at the right time. The PREVAIL system incorporates individual tumour characteristics and complexity of surgery which taken together with patient overall health status

(including anaesthetic risk) as a tool for the MDT to help to prioritise surgery based on risk of progression and treatment related risks.

23. PREVAIL utilises the existing structure of NHS Tumour Specific Cancer MDT's and facilitates combined assessments by specialist radiologists, oncologists, surgeons, pathologists and clinical nurse specialists. It further ensures that patients are diagnosed and appropriately risk stratified for treatment through surveillance, non-surgical therapy with surveillance or urgent surgery. This stratification moves away from time-based cancer treatment decisions and promotes individual treatment plans based on objective prognostic markers of cancer behaviour.

24. A virtual multidisciplinary consultation model, clinical prioritisation framework and screening protocols for colorectal surgery were a key element of this new referral pathway and were necessary to ensure patients referred could receive treatment within a set timeframe. This logistical challenge was streamlined and managed through the RM Cancer Hub ensuring efficient and appropriate use of NHS resource by matching the patient to the surgeon, anaesthetic and theatre staff expertise alongside the correct critical care and bed capacity.

25. Clinical governance was a key element ensuring safety was paramount and ensuring audit and outcomes across the Hub were measured and presented to ensure risk was managed and clinical excellence continued throughout. RM held weekly MDT meetings to discuss RM colorectal cancer patients' management plans and weekly Hub meetings with representation from each of the referral (spoke) hospitals for the purpose of prioritisation and logistics to help coordinate patient flow. RM developed the models, framework and protocols as generic documents jointly for all specialities and used the PREVAIL model to help with prioritisation.

26. The overall Trust response to the COVID-19 pandemic overseen by Gold Command which was chaired by the Chief Executive and attended by Executive Directors which met daily following the silver meeting. Gold's main responsibilities were to oversee internal and external communications (ensuring consistent and frequent communications), liaison with external bodies and forming the strategic Trust response. Output of Gold would feed into the daily STR call.

27. The Trust's operational response was overseen at the tactical command meeting which was chaired each morning by an Executive Director and attended by other Executive Directors, workstream leads and other members of staff overseeing key elements of the Trust's response, including the Infection Control Lead. During the peak of the pandemic a second meeting took place in the afternoon to follow up progress on actions raised in the morning meeting, and actions were also followed up outside the meeting by the Command Centre, he agenda for each daily meeting was agreed at a pre-meet on the morning of the meeting, and the output and key decisions were escalated to Gold Command by the Chair.

28. The Command Centre (staffed full time by staff seconded from the Finance function and overseen by the Deputy Chief Operating Officer) was central to the Trust's response, supporting daily tactical meetings and manning the Trust's Covid inbox to respond to queries from staff and other key stakeholders. Each workstream was led by a clinician, groups reported into the daily tactical meeting and took actions away to local meetings where appropriate.

29. Supplementing the updates from workstream leads was a daily sitrep report produced by the Command Centre which details levels of stock of key PRE items, levels of sickness across the Trust, and numbers of patients that had been tested for COVID-19. The frequency of the tactical meeting was reduced during the recovery phase to three times per week then twice per week, and responsibilities of the Command Centre were distributed back out across the Trust as appropriate in an exercise approved at the tactical meeting.

30. Testing patients for COVID-19 prior to surgery was a new step in the surgical process. Minimally invasive surgery was stopped for a period of 2 months due to the perceived risk of aerosol related COVID-19 transmission in line with emerging practice. Laparoscopic/robotic surgery was reinstated after the AirSeal® device was procured to minimise aerosol spread.

31. During the COVID pandemic there was concern that use of minimally invasive techniques such as during laparoscopic and robotic surgery could result in viral transmission due to aerosolisation of virus contained in CO2 gas used to insufflate the abdomen. The AIRSEAL® system, unlike conventional insufflators used in laparosopic and robotics feature unidirectional flow and cyclical inflation, which momentarily stops for pressure sensing function. The AirSeal® has a filtered circulatory flow design (particles of size equal to 0.01 pm) which not only enables simultaneous in-sufflation and pressure sensing but also provides constant smoke evacuation thus technically reducing the risk of viral transmission. The AIRSEAL® device was procured by RM directly and was implemented in May 2020.

32. Please see exhibit NVA/04 INQ000371206 which summarises the number of patients treated for colorectal cancer from 2018-2022.

33. The choices of which treatment modality to offer The Royal Marsden patients remained the same throughout most of the COVID-19 pandemic; surgery, chemotherapy, radiotherapy, chemo-radiotherapy and immunotherapy, depending on the nature, biology and extent of disease. The PREVAIL model was used to help with prioritisation of patients. Teams involving surgeons, specialist nurses, oncologists and radiologists met with representatives of the Spoke hospitals where the urgency of colorectal cases was discussed and collectively agreed. For a short period (2 months) during the period MarchMay 2020, RM were unable to perform endoscopic procedures, CT pneumocolons (virtual colonoscopies) or laparoscopic / robotic procedures due to concerns about aerosolisation documented in the COVID-19

literature at the time.

34. Although telephone clinics were already utilised for some clinic appointments, such as pre assessment, this was extended, and some outpatient appointments were changed to virtual consultations to reduce footfall and protect our vulnerable patients. These virtual consultations were more widely commenced in March 2020. Hospital throughfare was minimised and patients had restrictions in the number of relatives or friends they could bring to appointments where they may have done before or after the pandemic. The proportion of consultations taking place virtually substantially increased in March 2020 as the Trust worked to ensure patients only attended on site where absolutely necessary.

35. Due to the nature of our patient population, we already have low Did Not Attend (DNA) rates (circa 5%) but these dropped to a low of 2% in April and May 2020, however the reduced DNAs were not only seen for virtual appointments, but there was also a reduction of DNAs in face-to-face appointments. As such it is not possible to determine whether DNAs were reduced due to introduction of virtual appointments, or whether this reduction was due to more societal reasons such as a general increased awareness of the importance of healthcare etc and patients having fewer conflicting commitments such as social engagements or work.

36. One improvement in the pathway was the use of the Faecal Immunochemical Test (FIT) which was almost completely accepted in Network and more widely in the country as a primary screening tool to aid with prioritisation of referrals. Q-FIT testing had started a few years before the Pandemic. There had been various studies demonstrating its efficacy at identifying the presence of microscopic blood in faeces in a home-testing kit. It was decided that a cut-off of 10 ng haemoglobin (Hb/ml). This allowed RM to prioritise investigations on the basis of an objective measurement, rather than the standard 2-week referral (2-WW) criteria.

37. RM followed guidance from NHSE and the Royal College of Surgeons England (ROSE) and used the Priority 1 to 4 clinical prioritisation system which assesses patients based on their clinical need to receive treatment This was subsequently expanded with a more sophisticated model (PREVAIL) which was used to predict who was likely to progress and who could remain on active surveillance. This helped with determining priorities and also with communication to patients and families who were able to understand the risks of any potential delays to surgical interventions.

38. A Clinical Prioritisation Group was set up via RM Partners and met weekly. This was headed by me as Medical Director for the RM, and the group was responsible for reviewing all decision from a governance and ethical perspective, particularly if treatment was delayed. This was a pivotal body responsible for governance of clinical activity. The membership included surgeons from RM, Imperial, St George's Hospital, partner Trust's and 2 oncologists as well as optional input from surgeons and oncologists, including the referring clinicians from partner trusts. The Clinical Prioritisation Group SOP has been provided at exhibit NVA/05 INQ000371207 and examples of the work conducted of the group have been provided at exhibit NVA/06 **INQ000399440**

39. It is difficult to comment on patients accessing primary care services or the impact on reduction of screening as RM may not be able to work out how many diagnoses were delayed or not made. Clinical prioritising of bowel cancer screening was undertaken, and referrals were screened by the introduction of the FIT which allowed us to stratify acceptance and prioritisations of referrals. This continues to be used.

40. During the period of March-May 2020 there was a short pause in colonoscopy services while new protocols and procedures were instituted in the endoscopy suite (one way flow) and preadmission screening, air handling, PRE secured, and training of staff was undertaken to ensure safe resumption of endoscopy services. This was followed by a period of several months in 2020 where there was a reduction on the number of colonoscopies that could be undertaken per session. This was necessary to allow sufficient time to don and doff PRE and facilitate pause times between cases to prevent COVID-19 spread in line with British Society of Gastroenterology and national (NHS England, NICE, Infection Prevention & Control (IPC)) guidance at the time. This reduction in capacity is likely to have had an effect in terms of diagnostics and earlier treatment, but this is difficult to quantify.

41. The number of patients accessing outpatient and endoscopy services and DNA's (patients that did not attend appointments) increased during this period due to the perceived fear by patients of attending hospitals which was markedly heightened for most of 2020 and 2021, and some of 2022. This was not unique to The Royal Marsden and seen sector wide. To support this, remote consultations were introduced, and patient COVID-19 information leaflets were distributed from May 2020 and included information on how to keep safe during cancer treatment. Please see exhibit NVA/ 07 **INQ000399441**

42. There was a reduction in referrals seen across all specialties. As well as a reduction in patients accessing services due to the perceived fear of attending hospitals in general. There were also more DMAs particularly within endoscopy as patients did not want to attend for routine surveillance. This was seen across sector and not unique to The Royal Marsden. Virtual outpatient consultations and preassessment were introduced and leaflets and patient information was distributed for patients to help reassure patients

FIT testing was also introduced.

43. There was a 2-week period at the start of the pandemic beginning 30th March 2020 where all (except P1) surgery was halted nationally whilst the PRE and IPC implications for surgery was understood and staff training for PPE donning and doffing (including mask fit testing of all staff) as well as safe policies and procedures were introduced in theatres and endoscopy to resume safe running of services (air handing in theatres and endoscopy, pause times between cases, one way flow of patients, PPE).

44. The Trust followed the Infection prevention and control COVID-19 management checklist which was first introduced in May 2020 and NHS England board assurance framework. All policies and procedure updates followed the national guidelines. This included new presurgery screening for COVID-19 prior to surgery and the introduction of isolation requirements prior to elective surgery as well as guidance on safe management of COVID-19 patients in line with emerging evidence in the literature and national guidance. RM staff received training for donning and doffing and mask fit testing. Front line staff working in critical care, theatre and anaesthetic staff were prioritised.

45. Types of surgery that were halted were primarily P3/P4 cases e.g. plastic reconstructive procedures, risk reducing mastectomies, reversal of stomas, robotic prostatectomies and some P2 procedures e.g. total abdominal hysterectomies Laparoscopic keyhole procedures were temporary suspended while the Airseal device was procured. Length of hospital stays following surgery and length of recovery time were not specifically affected.

46. With regards to follow up care, some in-person consults were changed to phone consultations. Follow up care for cancer patients were undertaken locally for non-RMH patients. Relatives could not visit patients as in patients or attend for consultations. This was challenging when breaking bad news or explaining complex situations.

47. During the pandemic, Cancer services across London were coordinated by specialist 'Cancer Hubs' led by RM with our local cancer alliance RM Partners, University College London Hospitals NHS Foundation Trust and Guy's and St Thomas' Hospitals NHS Foundation Trust. This was led in conjunction with major teaching hospitals including the Royal Free NHS Foundation Trust, Barts Health NHS Trust and Imperial College Healthcare NHS Trust, as well as local hospital partners in close liaison with NHS England.

48. Cancer Hub hosted by Royal Marsden Partners (RMP) enabled urgent surgical cancer cases to continue during the pandemic. NHSE commissioned theatres at the Royal Marsden NHS Foundation Trust (RM) and Bupa Cromwell Hospital (BCH) to deliver the Cancer Hub. The Cancer Hub worked collaboratively with several Trusts pan London. The following Trusts worked as part of the Cancer Hub: RM, St George's University Hospitals NHS Foundation Trust, Epsom & St Helier University Hospitals NHS Foundation Trust (ESTH), Croydon University Hospital, Chelsea & Westminster Hospital NHS Foundation Trust

(CWFT), Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust.

49. By Nov 2020, The Royal Marsden hub operated on over 3547 patients from 10 Trusts across London. This surgery would not have been possible without the Cancer Hub.

50. The aim was to continue to deliver anti-cancer treatments and outpatient care when needed but with reduced hospital visits and appointment duration for both NHS and Private Patients. This was achieved by:

- delivering certain anti-cancer treatments to patients via courier to home and teaching them to self-administer where required.
  adjusting intravenous treatments and radiotherapy regimens to allow for less hospital visits.
  Social distancing in medical day unit areas.
- Increased use of the Mobile Chemo Unit from 3-5 days with extended hours.
- Increased use of information videos to replace face to face visits e.g. consent and treatment information.
- Videos to teach self-management e.g. PICC line flushes and pump disconnections
- the introduction of telephone and virtual clinics.
- Remote consent for Systemic Anti-Cancer Treatment (SACT).

51. There was an increase in virtual consultations and use of MS teams for MDT meetings.

52. The Treatment Escalation Plan (TEP) was rolled out at the start of the COVID-19 pandemic in April 2020 to ensure that ceilings of care of treatment were clearly documented for inpatients. The TEP used at this time was tailored to some of the expected clinical features being seen as part of the clinical course of COVID-19 infection - such as a being able to indicate appropriateness for use of high flow oxygen. Treatment Escalation Plans (TEP) were formally embedded at The Royal Marsden during the COVID-19 pandemic. This ensured that patients admitted to The Royal Marsden had clear plans and discussions of ceilings of care documented on admission.

53. The TEP is now a standard part for the admission process for non-elective medical admissions to the trust. The initial form developed at the start of the COVID-19 pandemic has been refined and developed. It is an example of a quality improvement initiative from COVID-19 which we have taken forward into current standard practice. It now forms a key part of the electronic patient record.

54. There was a 2-week period at the start of the pandemic where all (except P1) surgery was halted nationally whilst the PPE and IPC implications for surgery was understood, and staff could be trained

in donning and doffing of PPE as well as the wards and the critical care unit reconfigured to support safe management of cancer patients. This included creation of separate pathways for care for COVID-19 suspected/COVID-19 infection and non-C0VID19 patients, zoning of clinical areas (green/yellow/orange and red) to allow for separation of patients known to be COVID-19 free, re-organisation of the oncology workforce to separate staff into COVID-19 vs non-COVID-19 teams and implementation of broader testing criteria for patients.

55. Patients also required isolation prior to surgery and national guidance in pre-operative isolation was followed as well as emerging literature. This meant some delays in surgery for patients who required isolation prior to elective surgery. Patients had their surgery postponed if they tested positive for COVID-19 and for these patients a risk assessment was undertaken to decide whether surgery should proceed or not taking account of the patient's symptoms, co-morbidities and risks of cancer progression.

56. This followed guidance endorsed by the Association of Anaesthetists, Centre of Perioperative care, Royal College of Anaesthetists and Royal College of Surgeons. Timing of surgery for adults after COVID-19 guidance was followed. This guidance was followed and endorsed by the centre of perioperative care, The Royal College of Anaesthetists, The Royal College of Surgeons of England, association of anaesthetist and federation of surgical speciality associations.

Document: https://www.cpoc.org.uk/sites/cpoc/files/documents/2022-02/Timina%20of%20elective%20suraerv%20and%20risk%20assessment%20after%20SARS%E2%80%90CoV%E2%80%902%20infection%20%20an%20update.pdf

57. The Pan-London Guidance on the Principles for Infection Prevention and Control (in the context of COVID 19 to reduce the risk to patients being provided with planned and emergency care in all healthcare settings) V1 11/5/2020 via NHSE&I London CAG; V2 18/5/2020 via NHSE&I London CAG; 11/6/2020 via NHSE&I London CAG were followed PPE guidance for COVID 19 patients: full PPE (gloves, fluid resistant long sleeve gown, FFP3 masks, eye protection to be worn by staff in theatres) and theatre down time 30 mins between cases and cleaning of the theatre between cases Turnaround of cases in theatre was impacted due to requirement of down time in between cases and this resulted in fewer patients being able to be booked per list. This meant that patients across all specialties were prioritised based on clinical need (P1-P4) and PREVAIL resulting in a backlog of P4 patients. The combined result was an increase in number of P3 and P4 patients waiting for surgery. The P1-4 was disseminated by the Royal College of Surgeons (RCS) and the Federation of Surgical Speciality Associations (FSSA).

Clinical guide to surgical prioritisation during the coronavirus pandemic - Update 8 June 2020 IRCSEd Prioritisation - Master 240720 (fssa.org.uk)

Coronavirus » Freguently asked guestions about surgical prioritisation (england.nhs.uk) https://fssa.org.uk/ userfiles/pages/files/covid19/developing safe surgical services dsss fo r the covid19 era mav2020updated.pdf

58. We are unable to comment on how many patients would on average be place on a list prepandemic versus post pandemic as this depended entirely on the type of list. As per national infection control guidance, at the time pause times were required in between surgical cases to avoid the risk of aerosol transmission of viral particles between cases. The pause period would vary depending on whether the patient was deemed low (no pause time), medium (12 minute pause) or high risk (30 min pause between cases); the patient woulS be cstegorised based on their isolation period, COVID-19 test result and risk of exposure. During this period use of the anaesthetic room as discontinued therefore impacting on overall turnaround times between cases. For lists with multiple cases e.g. urology lists there could be a 20% reduction of list capacity. Lists with involved only 1-2 cases on the list *were* less affected.

59. RM would agree with the Lancet paper on the "Impact of the Covid-19 pandemic on the detection and management of colorectal cancer in England: a populatism based study". This is a population-based study which included an analysis of NHS England data. It would be difficult for us to comment on the populationwide data but it is clear that patients went to see GPs less with red-flag symptoms of cancers due to the fear of contracting COVID-19. Hospitals were stopped from undertaking either of the two diagnostic tests for colorectal cancer - colonoscopy and CT pneumocolon (virtual colonoscopy) due to the perceived concern about aerosol transmission of the virus. Inevitably, as fewer people were accessing healthcare with symptoms and less diagnostic procedures were undertaken, this would have likely reduced the number of patients treated.

Please also refer to the following studies:

Feasibility and usability of a regional hub model for colorectal cancer services during the COVID-19 pandemic. Open Access. Published: 03 March 2022. volume 74, pages619-628 (2022).

Summary

60. The outbreak of the COVID-19 pandemic produced unprecedented challenges, at a global level, in the provision of cancer care. With the ongoing need in the delivery of life-saving cancer treatment, the surgical management of patients with colorectal cancer required prompt significant transformation. The aim of this retrospective study is to report the outcome of a bespoke regional Cancer Hub model in the delivery of elective and essential colorectal cancer surgery, at the height of the first wave of the COVID-19 pandemic.

168 patients underwent colorectal cancer surgery from April 1st to June 30th of 2020.

61. Approximately 75% of patients operated upon underwent colonic resection, of which 47% were left-sided, 34% right-sided and 12% beyond total mesorectal excision surgeries. Around 79% of all resectional surgeries were performed via laparotomy, and the remainder 21%, robotically or laparoscopically. Thirty-day complication rate, for Clavien-Dindo IIIA and above, was 4.2%, and 30-day mortality rate was 0.6%. Re-admission rate, within 30 days post-discharge, was 1.8%, however, no patient developed COVID-19 specific complications post-operatively and up to 28 days post-discharge.

62. The established Cancer Hub offered elective surgical care for patients with colorectal cancer in a centralised, timely and efficient manner, with acceptable post-operative outcomes and no increased risk of contracting COVID-19 during their inpatient stay. We offer a practical model of care that can be used when elective surgery "hubs" for streamlined delivery of elective care needs to be established in an expeditious fashion, either due to the COVID-19 pandemic or any other future pandemics.

Surgical Treatment and Outcomes of Colorectal Cancer Patients During the COVID-19 Pandemic: A National Population-based Study in England *Ann Surg Open 2021 Jun 10;2(2):e071. 2021 Jun*

Summary

63. The pandemic has affected the diagnosis and treatment of colorectal (CRC) patients worldwide. Little is known about the safety of major resection and whether creating "cold" sites (COVID-free hospitals) is effective. A national study in England used administrative hospital data for 14,930 CRC patients undergoing surgery between October 1, 2019, and May 31, 2020. Mortality of CRC resection was compared before and after March 23, 2020 ("lockdown" start).The number of elective CRC procedures dropped sharply during the pandemic (from average 386 to 214 per week), whereas emergency procedures were hardly affected (from 88 to 84 per week).

64. There was little change in characteristics of surgical patients during the pandemic. Laparoscopic surgery decreased from 62.5% to 35.9% for elective and from 17.7% to 9.7% for emergency resections. Surgical mortality increased slightly (from 0.9% to 1.2%, $P = 0.06$) after elective and markedly (from 5.6% to 8.9%, $P = 0.003$) after emergency resections. The observed increase in mortality during the first phase of the pandemic was similar in "cold" and "hot" sites ($P > 0.5$ elective and emergency procedures). The pandemic resulted in a 50% reduction in elective CRC procedures during the initial surge and a substantial increase in mortality after emergency resection. There was no evidence that surgery in COVID-free "cold" sites led to better outcomes in the first 2 months.

65. Aside from capacity constraints seen nationally (but seen less at RM due to the presence of the Cancer Hub) there were no specific concerns regarding the ability of access to operating theatres. Staff sickness due to COVID-19 and staff isolation requirements did impact on operating theatres with cancellations on the day and the requirement to rebook patients. This was not unique to The Royal Marsden and was an issue nationally. Critical care capacity was maintained by surging critical care beds (from a baseline of 16 beds to 24 beds) and increasing patient to nursing ratios. Availability of PRE did not limit activity but procurement of the Airseal device meant that laparoscopic surgery had to be temporarily suspended.

66. Critical care and theatre capacity was managed by careful scheduling of cases to avoid cancellations on the day or the requirement for non-clinical transfers. Critical care capacity was increased from a baseline of 16 beds (to at peak 24 beds) with expanded nursing ratios. RM were able to able to respond to service delivery according to need and capacity when impeded by staffing issues etc and this included extended day and weekend operating prioritisation was undertaken as discussed in previous sections to manage any capacity constraints. A structured Cancer Hub Operating Policy based on best-evidence, clinical risk, prioritisation and maximisation of patient flow was developed.

67. As RM were coordinating the flow of patients from a few other Trusts, communication was key between the Trusts. It was necessary to have cover over both the RM and Cromwell sites for 24/7 cover. Local surgeons and their teams came across to operate on their own patients, so a robust communications and handover process was required to ensure patient safety. The theatre utilisation meeting took place weekly and confirmed lists for the following week. The meeting was chaired by the Cancer Hub Matron and attended by the theatre team, anaesthetic co-ordinator and CBU managers/schedulers who represent the RM and Pan London surgical teams. Additional theatre capacity requests were directed to the CBU manager, Theatres and Acute Inpatients as this enabled the theatre scheduling team to manage theatre and CCU capacity to avoid overlooking and ensure best utilisation of theatre and critical care resources.

68. Critical care capacity was maintained and increased from baseline of 16 beds up to 24 beds (during the peak of the pandemic) to support cancer care and specifically cancer surgery. Critical care at The Royal Marsden was mainly focussed on supporting the Cancer Hub, maximising its ability to support cancer patients undergoing surgery. The critical care unit worked with the wider SWL critical care sector to support the COVID-19 pandemic with the reallocation of The Royal Marsden doctors and nurses to other sites within the South West London sector. And South West London Elective Orthopaedic Centre (SWLEOC) This did not have direct impact on the treatment pathway for patients with colorectal cancer. RM did not need to undertake to non-clinical transfers during this period for critical care capacity constraints.

69. Immunocompromised patients were asked to shield in line with national guidance and a letter was sent

out by RM to patients advising them about shielding. Virtual consultations were offered to patients who were shielding. Staff who were immunocompromised were recommended to shield (as per national guidance). Letters were sent to vulnerable staff by their GP and staff were then supported by the Trust and were offered the option to work remotely. This meant that staff who were immunocompromised and had to shield were not able to provide direct clinical care. This however increased workforce pressures for those members of staff not shielding. Vaccination was prioritised in immunocompromised patients and staff who were shielding.

70. During the pandemic RM worked with The Cromwell Hospital to provide additional surgical capacity and associated inpatient beds. It is RM's view that the private healthcare sector was used to full potential within the workforce constraints. The need to secure anaesthetists was an issue.

16. Any issues that the RM identified or brought to their attention relating to inequalities in the diagnosis, treatment or follow-up care for colorectal cancer patients during the relevant period

71. I am not aware of any specific inequalities in respect of the diagnosis, treatment or follow up care for colorectal cancer patients at this time. COVID-19 patient information leaflets were also translated into Arabic to minimise inequalities in care. For patients where communication was a barrier to virtual consultations they were brought into hospital for a face-to-face consultation.

Staffing capacity

72. Staff sickness due to COVID-19 and the associated isolation period was the largest impact on staffing. Lists and outpatient appointments had to be cancelled on occasion if the surgeon or anaesthetist tested positive for COVID-19 or had to isolate due to exposure and the relevant expertise was not available on the day. Immunocompromised staff who were shielding were supported to work remotely but resulted in an increase in pressure on staff not shielding with at time expanded nurse/doctor to patient ratios and long clinic wait times. This did not directly impact RM ability to provide treatment for colorectal cancer.

73. There was also a particular effect on mental health as there was significant fear among clinicians in the early phases when there was limited knowledge and cases were being reported of staff contracting and dying or suffering major morbidity secondary to COVID-19 infections. This was particularly relevant to those dealing with patients with COVID-19.

74. In addition, the guidance regarding PRE evolved in the early phases of the crisis. Due to the lack of evidence, all aerosol-generating procedures were stopped. It was not clear whether open procedures carried a similar risk of aerosol generation due to diathermy and other energy devices and this raised a further degree of mental stress. The risks of contracting COVID-19, requirements for regular testing and isolation when testing positive, and workload on existing staff with stretched nursing/doctors' ratios on the

ward and on critical care affected staff mental health and wellbeing. Psychological and staff support services were offered and are still available to staff.

75. Staff from The Royal Marsden were deployed to SWLEOC and The Nightingale Hospital. Patient care was maintained during this period at The Royal Marsden. Nursing ratios on the ward and on critical care were increased in line with the SWL sector with nursing to patient ratios on critical care stretched from the normal 1:2 ratios for level 2 patients to 1:3 in line with the rest of the South West London sector. Staff were deployed from non-clinical roles to clinical roles to support safe running of the hospital.

76. Ward and theatre staff were deployed to help support critical care. The internal nursing and medical staff that were moved to clinical roles underwent a refresher training undertaken by the practice education team; this included simulation training; the anaesthetists and Specialist Registrars (SpR's) that went to work at the SWLEOC were all already clinical working in the ITU environment at the RMH therefore they had a short induction by the team at SWLEOC and they were covered by the NHS COVID-19 indemnity.

77. Staff members required to shield, based on medical advice, were supported to work from home. If they were in a clinical role usually delivering face to face patient care they undertook an alternative non-clinical role. Rapid roll out of a variety of information technology (IT) to minimise patient and staff exposure. The Trust sped up the planned rollout of Microsoft 365 and Teams to enable better remote working as provided laptops and remote access for staff. Meetings including multi-disciplinary team (MDTs) and Tactical Command became virtual via MS Teams.

78. Agile and remote working was encouraged where staff were not physically required on site. RM ensured that all staff that required to isolate at home during the shielding periods were supported. In wave one this was twelve weeks and in wave two it was fifteen weeks. The RM enabled shielding staff to work from home which provided valuable support to colleagues on site. Welfare checks were undertaken by line managers and supported by Occupational Health and staff support.

79. Staff sickness due to COVID-19 and the associated isolation period was the largest impact on staffing. Lists and outpatient appointments had to be cancelled on occasion if the surgeon or anaesthetist tested positive for COVID-19 or had to isolate due to exposure and the relevant expertise was not available on the day.

80. Staff were risk assessed, in line with national guidance and additional support was provided as required. Immunocompromised and pregnant staff were risk assessed and recommended to shield in line with national guidance. This impacted on training for doctors and nurses who needed to shield. A Covid-19 risk assessment was developed by RM in May 2020 and reviewed with the occupational health team. The risk assessment consists of 2 parts.

1- Shielding form completed by the ward manager / occupational health
2- Staff positive management form, this form completed on staff members being positive and reviewed the contacts and what actions were required if needed.

81. Front line staff and staff exposed to aerosol generating procedures (e.g. anaesthetists, critical care nursing staff) and staff looking after COVID-19 patient had a greater risk of COVID-19 exposure and this causes increased anxiety amongst this workforce group. Please see **NVA/08 INQ000399442** for the risk assessment.

Infection Prevention & Control (IPC)

82. IPC measures were followed in line with national guidance and updated regularly.

83. Theatre and anaesthetic turnaround times were increased impacting on the number of cases that could be booked for theatres. Staff time to don and doff PPE also resulted in an increase in the time required for each case. Air exchanges in theatres, critical care and endoscopy had to be adjusted and one way flow was created in theatres and on wards including critical care.

84. Optiflow use was discontinued on the ward. Aerosol generating procedures could not be undertaken on the ward and needed to be undertaken in theatres, critical care or specific side rooms. Optiflow is a form of high flow nasal oxygen support used to manage patients with acute respiratory failure. This was considered an aerosol generating procedure and concerns were raised about viral transmission if Optiflow was undertaken on an open ward. It was required, as per national infection control guidance at the time, for patients on Optiflow to be in a side room. Patients were transferred to critical care for close monitoring and isolation. This change in case allowed for close observation of patients at risk of respiratory deterioration but also allowed for compliance with national IPC guidance.

85. New standard operating procedures for theatres and critical care were developed during the COVID-19 pandemic in line with national guidance and latest research evidence. These were updated regularly and ratified by our 'silver command'. These included the requirement for PPE, pause time between theatre and endoscopy cases, segregation between COVID-19 and non-COVID-19 pathway for

patients on the ward and critical care, adaptation in theatres (e.g. one way system of patient flow, air exchanges, anaesthetic rooms were not used for a short period of time with all patients being anaesthetised in theatre), isolation requirements for surgery and COVID-19 testing prior to hospital admission for create a safe environment for diagnostics (I.e. colonoscopies) and surgery to be undertaken.

86. RM rapidly deployed COVID-19 testing for both patients and staff using a combination of outsourced and inhouse PCR testing. This was rolled out in March 2020 and began with asymptomatic testing of both groups and ensured that RM could isolate both staff and patients at the earliest opportunity. RM was supported with a combination of onsite and offsite laboratory support which included:

- Onsite - Rapid COVID-19 PCR testing for urgent patients, Onsite - COVID-19 Serology (antibody)
- Offsite - all other testing for COVID-19 PCR provided by the Crick via TDL for both patients (symptomatic & asymptomatic) and staff (asymptomatic & symptomatic)

87. Internal Rapid PCR testing was available on site due to the purchase of a Cepheid machine which was used for patients suspected of COVID-19 as well as pre-operative COVID-19 screening. Asymptomatic staff and symptomatic COVID-19 testing was performed at the Francis Crick Institute. RM also adopted a robust test and trace model for both staff and patients to manage any outbreak. The Occupational Health and I PC team developed an assessment tool to manage the risk following staff and patient exposures. The risk assessment determined what actions where required when either a staff member was positive and the risk to contacts with an action plan attached recorded as evidence by the department. The assessment allowed for transparency and consistency with clear actions on cleaning, duty of candour and with guidance on isolation measures.

88. The capacity and performance of testing was monitored via a daily situation report (SitRep) and a weekly scorecard. The Microbiology laboratory monitored all incoming COVID-19 PCR results daily and followed up results that were invalid or had a longer than turnaround time. RM had a comprehensive staff testing model in place where all staff were able to and encouraged to have weekly COVID-19 PCR swabs and were offered a COVID-19 Serology (antibody) test. A robust test and trace model for both staff and patients was adopted to ensure that RM could manage any outbreak. This test and trace model was overseen with outbreak meetings. A risk-based staff deisolation approach was adopted to ensure staff were able to return to work safely minimising adverse impact on services and safety due to absence.

89. Availability of the correct masks was challenging at the beginning of the pandemic and stock level of different types of disposable FFP 2/3 masks and respirators was limited. This made it difficult for staff who did not fit the standard mask or had beards. This was confounded by conflicting and rapidly changing national IPC guidance.

90. Front line staff were prioritised, and mask fit testing roll out took 3-4 weeks before all frontline staff were mask fit tested and education was rolled out on the correct donning and doffing of PPE. Due to procurement and supply chain issues, a variety of different PPE was available and different periods of the pandemic with some PPE of better quality than others e.g., visors, gloves, gowns. A daily SitRep report was produced with clear metric. Reciprocal arrangements were established with neighbouring hospitals to ensure stock was distributed equitably when required.

91. At no time did the RM run out of any essential stock, however we regularly had to put in substitute products from those we normally use. This included alcohol hand sanitisers and surface wipes which were not always of a similar standard. Reciprocal arrangements were established with neighbouring hospitals including Chelsea and Westminster, The Royal Brompton and Epsom St Helier to ensure stock was distributed equitably where required. The Trust also accepted deliveries seven days a week and twenty-four hours a day to maintain stock levels.

92. An emergency list was produced of the PPE equipment required for predicted low stock levels. Stocks of essential equipment were kept secure with monitored distribution to the clinical areas and the use of a RAG rating system to ensure stock levels were maintained at safe levels. This was reported as part of the twice daily SitRep and reviewed at Tactical. Some masks were deemed unfit for purpose and sent back to procurement. At one-point FFP3 masks expiry dates were extended by NHS Supply Chain followed by a letter of confirmation to state the safety and efficacy of the products. A strategic framework was developed in preparation of short supply of PPE.

93. Fit test training was rolled out over a period of 3-4 weeks. Initial roll out was conducted by the IPC team, then supported by volunteers from the critical care team and operating theatres. Recording of staff undergoing fit testing was recorded on Healthroster with mask type. Training for the donning (application) and doffing (removal) of PRE was managed by the IPC Team and identified staff in the Critical Care Unit (CCU) and Operating Theatres. Individual training was supported by the PHE video materials made available on the intranet and in-house posters. Fit testing record was recorded on RM's Health roster system and compliance with use of PPE was monitored within clinical areas.

94. Changes to ventilation were made to critical care, endoscopy, theatres and outpatient dental areas to align with national guidance and was recognised as a risk on the Trust Risk Register. A ventilation baseline of air changes was agreed at the South West London IPC forum and set as a minimum of 6 air changes for Ward areas and higher levels of exchange in theatre, critical, endoscopy and dental rooms. Some adjustments had to be undertaken to ensure adequate levels of air changes were being made.

95. Every member of staff had a risk assessment in line with national guidance this was recorded with the Occupational Health department. The risk assessment included an action plan relevant to the staff

members workplace and included remote working.

96. Mask fitting was challenging for staff with beards and different facial shapes. Wearing of mass with staff who had glasses caused misting of glasses and this caused difficulty during surgery and anaesthesia. RM provided different types of masks to ensure staff could be fitted with the most appropriate type. Sundstrom® respirators were also provided for staff where disposable masks could not provide a suitable seal.

97. Communication with the use of PPE was more difficult both between staff and between staff and patients. This caused difficulty during communication during surgery. Clinical staff had a badge made that was a large head shot in order that patients/carers could see their face.

98. Visitor restrictions were applied in line with national guidance; however, 'End of Life' patients were supported to have visitors. The restrictions undoubtably were not a positive experience for patients and their families but was necessary to safeguard other patients. Please see **NVA/05 INQ000371207** for the Standard Operating Procedure on Facilitating compassionate care for patients dying with COVID-19 which came into effect in April 2020.

Other concerns or issues

99. Recovery of P4 Breast/Plastics DIEP surgery was required as P1,2 and 3 surgeries were prioritised.

100. I have considered recommendations that the RM would seek to make in order to improve cancer care and/or conditions for its patients and staff members in the event of a future pandemic:

- At times the national guidance and communication was unclear therefore caused confusion. Timely and clear guidance, communication and dissemination of information is needed for both key workers and the general public.
- Having clear consideration of non-Pandemic service provision consistent with UN WHO guidelines
- Dissemination of national Pandemic plan.
- As this was an unprecedented situation that no one had experienced before, there was very little guidance or understanding around how to response to this. Training for management and staff in emergency response with an emphasis on an infectious disease outbreak is recommended to prepare in the event that this situation arises again.

- Pre-positioning of supplies and equipment and stockpiles
- Clear dissemination of information to the general public
- Clear national messaging for staff and managers (IPC guidance etc.) and avoiding information overload, mixed messages.
- Pre-determination of allocated “clean" and infective sites.
- Discussion and agreement of healthcare priorities within the healthcare sector
- RM worked collaboratively with The Clatterbridge Cancer Centre and The Christie Hospital to determine how long we should continue mask wearing in a clinical setting for immunocompromised patient. However, the post-acute phase of the COVID-10 outbreak guidance on mask wearing is recommended so that there is consistency across specialist cancer hospitals.

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: **Personal Data**

Dated: 1 JULY 2024