



# Reflections on the UK COVID-19 Public Inquiry: Unveiling the Hidden Impact on Colorectal Cancer

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The UK COVID-19 Inquiry, launched in 2022 and led by Baroness Heather Hallett, is an extensive review of the country's handling of the pandemic, examining how well the government and health systems responded. The inquiry covers areas including the economy, education, and healthcare. The 10 modules cover preparedness, decision-making, healthcare impact, and vaccine rollouts. As part of this broad investigation, Module 3 focussed on the healthcare impact, assessing how the NHS managed essential services, including cancer care, during a period of enormous strain.

On October 31st 2024, I (Professor Aneel Bhangu) had the privilege of presenting evidence for colorectal cancer in Module 3 of the inquiry, co-authored with Dr Dmitri Nepogodiev. Our detailed written report focused on the hidden impact on colorectal cancer, taking a data-driven approach to evaluate the effects of the pandemic on cancer services<sup>1</sup>. We aimed to provide an objective view of how COVID-19 disrupted cancer diagnosis and care, evaluating the NHS's resilience across England, Scotland, Wales, and Northern Ireland. Among our findings, we noted the immense dedication and professionalism of healthcare staff, who continued delivering cancer care despite significant personal and professional risks. This commitment enabled the system to recover swiftly, with diagnostic services largely catching up by the end of 2021 after an estimated 4,725 patients went undiagnosed in 2020.

From our analysis, we identified several key recommendations to better prepare the healthcare system for future pandemics. Our top three highlighted recommendations are below:

First, it is crucial to maintain and adhere to cancer performance standards, including the 28-day Faster Diagnosis and 62-day Referral to Treatment targets, as they ensure accountability and keep patients moving quickly through the system. These standards

are underpinned by an administrative infrastructure of booking clerks, MDT coordinators, and supporting staff, which proved vital during the pandemic.

Second, strengthening diagnostic centres and elective surgical hubs will help create the ring-fenced capacity needed to maintain essential services even in times of crisis. Advanced preparedness of these elective hubs against future pandemics is critical<sup>2</sup>.

Third, it's essential that public communication during pandemics emphasizes that hospitals and GPs remain open to patients with red-flag symptoms, especially when screening can be stratified through methods like stool tests.

Our findings highlighted not only the gaps but also the swift adaptation of the healthcare workforce in overcoming those gaps. Before COVID-19, the UK's Department of Health had only limited plans to handle a pandemic's potential to overwhelm health systems and disrupt elective care. Though some systems anticipated pandemic-related pressures, operational preparedness was largely absent globally, not just in the UK. We indicated that had lockdowns not halted elective surgeries during the first wave, we might have seen an even higher number of missed diagnoses and potentially increased mortality from COVID-19 exposure in mixed hospital environments<sup>3</sup>.

The 5-year survival impact on the population remains uncertain. However, early signs indicate that the healthcare system's quick return to regular cancer care operations was a crucial factor in minimising potential harm<sup>4</sup>.

As a long-term solution, we recommended that NHS England develop a pandemic-specific operational toolkit, tailored for surgical preparedness and disseminated across the four UK nations. This toolkit should outline essential national roles (such as the Federation of



Surgical Specialty Associations and British Society of Gastroenterology) and provide a clear structure for mobilizing surgical specialties efficiently and equitably. At the local level, the toolkit should empower Clinical Service Leads and Trust managers to bolster their own services, including preparing elective hubs for a future that includes external threats. The experience gained from the pandemic is valuable, and without concerted efforts, there is a risk that knowledge could be lost as senior surgeons retire over the next decade.

To preserve and expand on these lessons, we recommend that hospitals use tools like the Surgical Preparedness Index to conduct annual self-assessments, identifying areas for improvement and building resilience within local surgical systems<sup>5</sup>. Such measures can reduce future surgery backlogs and ensure that the UK is well-prepared for any future pandemic. We hope these lessons are also useful for health systems beyond the UK borders.

## References

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