

Submission from:

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We are right at the heart of understanding of the current COVID-19 pandemic both nationally and globally. On the global front we are leading the UICC (The Union for International Cancer Control) taskforce with other colleagues from around the world to understand and mitigate the impact of national responses to the pandemic in some very complex ecosystems. This work broadly has relevance to the WHO, UNHCR and domestically DFID. For example, at the end of this week we will be publishing the economic impact of cancer on Syrian refugees in the Lancet Oncology.

Domestically we are one of three major groups looking to see what the excess mortality will be from the pandemic. Unlike the other two groups who have based their estimates on generic models we have focused on building our models around the already observed changes that we have seen to presentation and provision of cancer care in the NHS across four major site specific cancers. We have looked specifically at the delay that patients experience before they even get to definitive treatments such as radiotherapy. The excess mortality just from delays arising in the diagnostic pathways are seriously significant, and this is using a conservative approach. Added together with sub-optimal and deferred treatment from radiotherapy and surgery and the situation is likely to be far worse. This will result in premature death and increased morbidity at every year from cancer diagnosis.

The solutions are interlocking. Broadly speaking they include 1. Significant easing of lockdown with a greater balance of perspective regarding the risks of COVID-19 relative to other severe disease types (the messaging has been far too extreme and patients and health care workers have become very scared). 2. Confidence building measures amongst public and health care workers. This includes hospital and community level PPE and rapid antigen testing. In addition, accurate data on the true nosocomial risk of COVID-19 and how this varies depending on the type of interaction with the health service (eg. Outpatient consultation versus diagnostic procedure). 3. What is the infection fatality of cancer patients, particularly with comorbidities and advanced age. This will greatly improve risk management which has become very risk averse in the absence of robust health intelligence.