**Haematology “plan on a page” What will it take to progressively resume full activity in an environment with ongoing COVID risk, maintaining a high standard of care whilst reducing risk of nosocomial transmission**

Commissioning: Many of the sub specialties of haematology come under the specialised commissioning umbrella but there is considerable overlap with local commissioning arrangements such that a plan dealing only with non-specialised commissioning is not practical. Where possible we have indicated those areas which are largely specialised.

Whilst the principles remain constant, the practice of haematology is likely to change as a consequence of the COVID epidemic.

(1.)Haematological malignancies (specialised with overlap): A large proportion of haematological malignancies have prolonged immunosuppression both from disease and consequences of treatment. Many such haematology patients fall into vulnerable groups and a large proportion are shielding. As a part of a strategy of risk management, hospital attendances have been restricted to essential admissions and visits, where possible combining these with necessary investigations such as biopsies or scans. Certain maintenance therapies have also been stopped but are largely now being re-instituted. The move to telephone or video consultation is likely to remain, albeit in a modified form.

(2.) Stem cell transplant and other cell therapy activity (specialised): deferred for all but high risk cases, but are being re-instituted. Such patients will however incur a higher risk of severe COVID infection for months to years after transplant. Protected inpatient and outpatient areas will need to be provided to reduce risk. Regular screening of staff to avoid inadvertent exposure has been advocated in this setting.

(3.)Haemoglobinopathies & rare anaemias (specialised with overlap): Many of these patients are shielding. They will need to continue to attend for essential treatments such as transfusions and will require in patient or day case care for acute episodes. Much of the routine outpatient work will be delivered via telephone clinics. Monitoring of iron overload requires MRI scanning. Alongside other investigations into acute and chronic complication these scans will need to be re-provisioned in low risk environments.

(4.) Haemostasis and Thrombosis(inherited disorders specialised, other areas non specialised) : This aspect of haematology includes inherited and acquired disorders. Acute and chronic complications have continued to be managed during the Covid outbreak. The workload of haemostasis teams has increased considerably during this period with supervision of transfer of many patents from warfarin to DOACs and the need for input into the thromboembolic aspects of severe covid infection. This workload will continue and represents additional commitment for these teams.

(5.) Haematological input into general medical conditions and obstetrics (non-specialised):The requirement for general haematology advice to primary care and other specialties has temporarily declined but is increasing again with a return to “business as usual”. This work goes largely

unrecognised but is essential to the safe running of core services. As an alternative to face to face attendance, advice and guidance is preferred for these general haematological issues.

(6.) Laboratory haematology is absolutely essential for the management of all patients in a hospital. More sophisticated molecular testing may compete with the push to drive SARSCoV2 testing back into local laboratories due to equipment needs and skill availability.

(7.) Paediatric haematology: Children with general haematological problems such as bone marrow failure, aplastic anaemia and neutropaenia have been shielding. Routine investigations such as bone marrow aspirates/trephines under GA have been deferred. These will all have to be restarted in designated low-risk environments. Other general haematology patients can continue with remote consultation and phlebotomy.

Throughout the current COVID outbreak haematological activity has been variably maintained at around 50%-75% of normal. Malignancies continue to be diagnosed, long term conditions must continue to be managed. COVID infections occurring in these groups have largely been cared for within the haematology units. Provisional data suggests a high risk to haematology patients.

Staffing: It should be noted that academic staff were typically drafted back to full-time NHS work during the crisis, so staffing considerations need to be re-evaluated for full opening. Many specialised trainees have stopped out of programme activities temporarily and will need to resume at some point. With travel restrictions there are fewer junior doctors planning to take a year out and so paradoxically, in the short term at least, we face fewer gaps in rotas than previously. Longer term we are aware that planned trainee numbers in haematology do not match the number of expected retirements and a BSH workforce survey predicts an impending consultant recruitment crisis within haematology over the next year or more.

Core themes :- To resume 75%-100% activity the following would need to be in place

* A regular COVID testing strategy with short turnaround for staff and patients appropriate to our highly immunosuppressed cohort
* Provision of low risk COVID facilities within inpatient, day case and outpatient areas
* Availability of critical care support in a low COVID risk environment
* Ability to provide “one stop shops” for investigation of potential new cases to reduce number of hospital visits
* Continued provision of enhanced transport and parking options to allow ‘shielded’ patients to safely visit the hospital
* Local commissioning arrangements for provision of advice and guidance which recognise the workload and do not act as a disincentive for secondary care
* Better IT solutions and alterations to job plans to allow robust auditable advice and guidance to other specialties and primary care
* Incentive to develop home or community hub services for delivery of therapies such as low intensity chemotherapy and possibly regular transfusions
* Better provision of out of hospital phlebotomy such as the drive through facilities.
* Continued delivery of outpatient medication to patients homes