RECOMMENDATIONS FOR ORGANISATIONS WHERE SURGICAL SERVICES ARE PROVIDED FOR PEOPLE WHO MAY HAVE ANAEMIA

Commissioning bodies should:

- Work collaboratively with providers to develop a system wide approach to support patients undergoing surgery who have anaemia. This will require cross boundary working with community, primary and secondary care services to develop the necessary pathways of care
- Work with providers to ensure mechanisms are in place for screening, assessing and optimising anaemia in patients undergoing surgery as early in the surgical pathway as possible
- Work with providers to develop a standardised referral form, so that requests for a surgical consultation include an FBC if the patient or possible procedure would require an FBC in accordance with NICE preoperative testing guidelines[2]

Developing clinical services; hospitals should:

- Appoint a clinical lead for perioperative patients with anaemia (this may be the same lead as for diabetes or frailty in the perioperative setting, see previous CPOC guidance)
- Support the clinical lead in developing, implementing and auditing policies and processes of care to ensure quality perioperative care for people with anaemia
- Support the clinical lead to:
  - Work with data or information from national initiatives such as HQIP (Healthcare Quality Improvement Partnership) audits and GIRFT (Getting It Right First Time) teams and ensure linkage
  - Support service development by working across primary and secondary care (surgery, anaesthetic, haematology, gastroenterology and general/geriatric medicine services)
  - Signpost local teams to relevant education and training resources (anaemia and blood transfusion)
  - Establish and lead multidisciplinary and multispecialty governance, audit, and morbidity and mortality meetings. Use SHOT (UK serious harm of transfusion) reports as a powerful educational tool
  - Standardise primary care referrals and if appropriate include latest Hb (if available), perform a frailty score if aged over 65 years using a recognised tool such as the Clinical Frailty Score (CFS) or the Electronic Frailty Index (eFI) and HbA1c if diabetes present
  - Ensure preoperative assessment occurs as soon after the decision to operate as possible to maximise the time available for optimisation
  - Work with pathology departments that receive blood tests from patients due to undergo surgery and develop pathways to:
    - formalise the additional tests they will undertake automatically preoperatively (eg including renal/eGFR, CRP, ferritin, Transferrin saturation, B12 and folate, with CHr and reticulocytes) if anaemia is identified
    - accept add-on requests for other tests if clinically appropriate
  - Develop a clear policy whereby abnormal test results are highlighted to a named senior clinician. They are responsible for further Shared Decision Making with the patient, considering all options, including whether to delay or talk through alternatives to operation, and for recommending or prescribing a treatment plan if needed
  - Ensure the transfusion committee at each Trust/Heath Board includes anaemia and PBM in their remit

Supporting infrastructure; hospitals should:

- Promote use of Enhanced Recovery programmes incorporating this guidance for all surgical patients with anaemia
- Allow necessary variation in the perioperative pathway, when clinically appropriate, eg pauses to the cancer pathways to optimise anaemia. This will facilitate patient assessment, optimisation and shared decision making prior to surgery
- Invest in technologies to support identification of people with anaemia on patient administration electronic systems that can be accessed across primary and secondary care.