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Scope details	**Questions for discussion**	**Stakeholder responses**
1.1 Who is the focus		
Groups that will be covered: • Adults and young people **(16 years and older)**	• What do the group think of the implications of changing the age cut off to age 16 and over?	All stakeholders agreed with age 16 and over, with the majority suggesting this reflects current practice of treating young people over 16 in the same way as adults. Hospital beds are also determined by this cut off and 16 year olds will be placed on adult wards. The majority of stakeholders highlighted the issue of prophylaxis drugs being licensed for 18 years and over, which should be taken into consideration in the guideline.
• Adults and young people (16 years and older) admitted to **hospital** as **inpatients**, including: - Around 18 separate groups for hospital inpatients, each considered as separate groups in GG92 - Additional groups include: ○ People on long term rehabilitation in hospital ○ Psychiatric patients but see next bullet point	• Are the population groupings still appropriate? • Are there other populations to consider? • Elective knee replacement • Elective hip replacement • Hip fracture • Knee arthroscopy • Other orthopaedic surgery • Gastrointestinal, gynaecological, laparasocopic, thoracic and urological surgery (i.e. any area of the abdomen) • Cranial or spinal surgery • Cardiac surgery • Vascular surgery • Day case surgery • Other surgery • Lower limb plaster casts and braces • Spinal injury • Major trauma • General medical admissions • Stroke patients • Acute coronary syndromes • Cancer	Discussions around population groupings concentrated on the relevance of listed groups and any additional group's considered important for consideration. On the whole the stakeholders agreed with the listed populations however some felt that a number of additional populations may be appropriate. This included: • Adding individuals undergoing bariatric surgery; • Adding liver surgery to the list and possibly separating it from gastrointestinal surgery due to the distinct coagulopathy of these patients; • Covering patients who are poorly mobile on a long-term basis/ individuals in hospital for a prolonged period; • Patients with obesity due to the issue of dose escalation. One group of stakeholders acknowledged that this group may be too broad as patients would require a risk assessment in the community. Further populations for consideration that were suggested by a minority of stakeholders included: • ENT; • Head injury (as a subset of trauma); • Inflammatory bowel disease (as at increased risk); • Patients with cancer undergoing surgery may be considered a separate group as they may be on dual prophylaxis; • Patients with central venous catheters. Some felt that this is too

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	• Patients with central venous catheters • Palliative care	broad as they are receiving treatment for a variety of conditions, and are unlikely to receive prophylaxis as it is ineffective in this group; • Renal transplant surgery could also be considered separately; • Frail patients should be included as a separate population as the risks/benefits of prophylactic anticoagulation may differ in this population. One consideration being that for some of this group the harms associated with anticoagulation may outweigh the benefits; • Patients with pre-existing bleeding conditions; • Dental surgery (if not captured in 'other surgery'); • Laparoscopic surgery should be separated from major abdominal surgery as the risk of VTE; • Individuals engaging in illicit IV drug use. A number of stakeholders discussed the importance of grouping populations as each subgroup has different clinical needs and therefore their management may be significantly different in each case. One option was to group populations by clinical speciality.
• Adults and young people (16 years and older) with **psychiatric** illness **admitted** to hospital and (other institutions?)	• Does the **term** 'hospitals' adequately cover the description of **institutions for psychiatric treatment** in the NHS or are there other institutions/terms that need to be included in the scope? • What about the settings (e.g. primary care, secondary care, community care)? • Are there **specific psychiatric conditions** to cover or all patients? Which are at increased risk?	There was consensus that this is an important group for the guideline to look at due to the potential increased risks of patients developing VTE i.e. through reduced mobility (sedation) and the types of anti-psychotic drugs taken within this population. It was also noted by a small number of stakeholders that psychiatric drugs are not currently part of VTE risk assessment. There was discussion around the terminology of the settings for this population. Some stakeholders suggested 'acute settings' or 'acute facilities' was more appropriate than 'hospitals', because it would include institutions such as hostels and halfway houses. Other stakeholders preferred the term 'community and mental health units' to describe all institutions for psychiatric treatments in the NHS whilst further suggestions included 'inpatient psychiatric units'.
• Adults and young people (16 years and older) attending hospital for **day**	• What other day procedures are there to consider	There were a number of suggestions relating to other day procedures which may be considered appropriate including lower limb surgery, abdominal surgery, some cardiovascular procedures and interventional radiology.

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procedures including surgery and cancer		In addition to type of procedure, there were other factors which a number of stakeholders felt to be important including dividing procedures by those that require general anaesthetic and those which do not. It was felt length of surgery and subsequent level of immobility should also be a consideration. Stakeholders reported that in current practice there is often uncertainty as to when to conduct an individual risk assessment for day case procedures, and guidance on this would be helpful. A small number of stakeholders felt that the effectiveness of one dose of LMWH often given to day cases needed to be examined.
• Adults and young people (16 years and older) with **plaster casts and braces**		There was consensus that the terminology of devices for this group needed to be clarified and less ambiguous. Stakeholders suggested the need to specify 'lower limb' plaster casts or braces, or rename them 'immobilisation devices'. A number of stakeholders also noted that this could specify whether orthosis for neurological conditions is included.
Special consideration will be given to: • Pregnant women admitted to hospital and midwife or birth centre (and up to 6 weeks post-partum)	• Do the settings hospital and midwife / birth centres adequately cover the NHS institutions for the pregnancy and post – partum group? What about the settings (e.g. primary care, secondary care, community care)? • Is there a specific period during pregnancy when women are at risk? Should the guideline cover all this period? Would these all patients be described as NHS patients?	Although all stakeholders considered pregnant women an important group to be included, there was discussion, and mixed opinions, around what period during pregnancy should be covered. Whereas some stakeholders felt covering the whole period of pregnancy was needed, others suggested it should only focus on those women who are admitted to hospital. For a smaller group of stakeholders, it was felt that those being admitted to hospital for labour should be excluded. Further this group also felt that 6 weeks post-partum may not cover those with complications from birth, for example C-sections. One group questioned how home births would fit into the guidance. The majority of stakeholders referenced the RCOG guideline with a number questioning how the two guidelines will align. One stakeholder felt that it would be important to investigate cost-effectiveness.
• All patients in whom pharmacological prophylaxis is contraindicated • Patients requiring anticoagulants or	• Are there any specific subgroups that have not been mentioned (in either list)?	In addition to the groups listed, the following specific subgroups were considered to be appropriate by a small number of stakeholders: • Bridging therapy for lung resection surgery;

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antiplatelet for other reasons/bridging prophylaxis		• Those at risk of self-harm as a particular subgroup in whom pharmacological prophylaxis is contraindicated; • Patients in whom anticoagulants need to be used with extreme caution. A number of stakeholders also highlighted that mechanical prophylaxis should be included as a contraindicated method, and not only pharmacological methods.
Groups that will not be covered: • Young people and children (under 16 years) • People presenting to emergency departments without admission other than those treated with lower limb plaster casts and braces • People with suspected or confirmed VTE	• Are the exclusions appropriate for the guideline?	Stakeholders agreed with the groups not to be covered. No other groups were suggested.
1.2. Settings		
• Primary and Community care after hospital discharge • Secondary care including outpatient appointments • Tertiary care	• Are the listed settings appropriate? • Are there other settings that should be considered?	A number of stakeholders felt that specialist care in out-of-hospital settings may not be adequately covered by these definitions, for example, some of the cancer treatment pathways and high risk procedures such as arthroscopy procedures. They also felt that the language of primary and secondary care may become outdated in the near future with more care pathways being moved into the community. Some stakeholders felt that consideration should be given to people who have not been in hospital but may be at risk of VTE, for example people in nursing homes and those admitted directly to nursing homes. A majority of stakeholders felt that outpatient appointments should not be included as it is not a useful distinction.

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		Stakeholders also felt that tertiary care is not relevant terminology as it is seen as the same as secondary care by practitioners.
1.3 Activities, services or aspects of care		
This is a full update with particular attention given to orthopaedics, pregnancy, stockings in stroke and risk assessment. **Key areas that will be covered:** Risk assessment and risk factors: • Patient risk factors (for VTE) • Risk prediction tools (for bleeding or VTE) • Reassessment of risk	• Have any areas for risk assessment and risk factors not been mentioned? **NOTE:** specific questions about risk are discussed below. This relates to the broad issues.	A number of stakeholders felt that patient risk factors should include not just those for VTE but for the complications of prophylaxis. These include bleeding, ulcers and skin damage. In addition, a number of other risk factors were highlighted including: • Prolonged prophylaxis; • Thromboprophylaxis failure; • Sepsis; • Iron deficiencies.
Prophylaxis: • Prophylaxis for reducing the incidence of venous thromboembolism including pharmacological and mechanical prophylaxis • Timing of prophylaxis • Duration of prophylaxis • Bridging prophylaxis **Methods of prophylaxis to include:** • All methods included in CG92 (except those listed below in exclusions) • New interventions including new anticoagulants	• Are all issues relating to prophylaxis choice mentioned? **NOTE:** specific questions about risk are discussed below. This relates to the broad issues.	A number of stakeholders discussed the complex issue of bridging patients that were already on warfarin. Stakeholders agreed that this was an important aspect of practice to cover as there is uncertainty about how to do this and variation in practice. They also discussed that there was new evidence on bridging that would be helpful. Warfarin was discussed and stakeholders reported that although this is less commonly used now, it is still used in some cases. Another stakeholder said that aspirin use is on the increase and it would be useful to include this to ensure that it is not being used incorrectly. In terms of timing it was felt that when to stop or change prophylactic management was an important point to include.
Patient information: • Content of information provided to patients (prophylaxis methods and VTE)	• Are there any specific issues relating to patient information to consider?	A number of stakeholders discussed the importance of managing the expectations of patients in relation to the role of prophylaxis in reducing the risk of VTE rather than preventing it. A number of stakeholders felt it was important to explicitly report the failure rates for prophylaxis as part of the information for patients.

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		A smaller number of stakeholder also queried whether general public awareness about VTE and how people can reduce their risk could be covered in the guideline as they felt this is an important area. Stakeholders felt information on the signs and symptoms of VTE would be useful in reducing the risk. Furthermore, explaining the risks of non-compliance for prophylaxis methods was also considered important. There were a number of comments with regards to patient content, and patients understanding what they are consenting to, which this was seen as a potential area for patient information. This was particularly important and relevant for those patients with dementia/cognitive impairment. Most stakeholders felt that information about the origin of drugs (for example heparin as a porcine product) was a valid issue for this guideline, however a smaller number of stakeholders felt it was inconsistent to apply this rule to one drug without doing it for all drugs, and the feasibility of doing this was questionable.
Areas that will not be covered: Not updated but stay in guideline, prophylaxis by: • Early mobilisation and leg exercises • Physiotherapy • Hydration • Regional versus general anaesthetic Completely remove from guideline, prophylaxis by: • Leg elevation • Fixed dose warfarin Areas not covered at all: • Prophylaxis for secondary prevention of VTE	• Are the excluded areas appropriate? • Suggestion is to remove all reference to warfarin from the guideline as this is an outdated treatment option. Would you agree?	In the main, stakeholders agreed with the areas not to be covered. A small number of stakeholders felt that the general principles of mobilisation and hydration should be included in patient information as they were concerned that it should not be lost sight of in the guidance. There were mixed opinions as to whether to remove warfarin from the guideline. Stakeholders agreed that warfarin is less commonly used however some stakeholders felt that where practitioners continued to use it, there should be updated advice in this area.

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1.4 Economic Aspects		
An economic plan will be developed that states for each review question/key area in the scope, the relevance of economic considerations, and if so, whether this area should be prioritised for economic modelling and analysis.	• Which practices will have the most marked or **biggest health or cost** implications for the NHS? • Are there any **new practices** that might **save the NHS money** compared to existing practice? • Do you have any further comments on economics?	A number of areas were discussed to be important for the economic plan, including: • Pharmacological and mechanical prophylaxis; • Pregnancy; • Those patients who choose not to self-administer heparin and the cost of district nurse time for administering in these instances; • The use of stockings and examining the difference between thigh and knee length stockings; • IV filters.
1.5 Key issues and questions		
This section expands upon the areas mentioned in section 1.3. This section should therefore give more of the detail of what the key issues are within that area and what questions will be asked to address those issues.	• Are there any critical clinical issues that have been missed from the Scope that will make a difference to patient care? • Would you like to add any additional questions to this list? • Are there any areas currently in the Scope that are **irrelevant** and should be deleted?	Discussed as part of 1.3.

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1.6 Main Outcomes		
• All-cause mortality • Pulmonary embolism • Fatal pulmonary embolism • Deep vein thrombosis (symptomatic or asymptomatic) • Major bleeding • Fatal bleeding • Heparin-induced thrombocytopenia, HIT • Post-thrombotic syndrome • Pulmonary Hypertension • Quality of life (validated scores) • Hospital length of stay • Readmission • Neurological events (.e.g. haemorrhagic stroke)	**General** • Is the list of outcomes appropriate? Are any key outcomes missing? **DVT as an outcome:** • Should symptomatic DVT be analysed as an outcome in its own right? • Should Calf/distal DVT be included? • Should proximal and distal DVT also be included as separate outcomes? **Other** • Is the outcome 'neurological events' too broad? Perhaps be more specific? Ischaemic stroke? Haemorrhagic stroke? • Please identify the top 5 outcomes.	In the main the group agreed with the main outcomes. There was a divide in opinions about whether symptomatic and asymptomatic DVT should be analysed separately or should remain together. One groups of stakeholders also felt that proximal versus distal DVT should be analysed separately. Stakeholders agreed that 'neurological events' is too broad and should be divided into subcategories. On group felt that the example should haemorrhage and not haemorrhagic stroke. There were a number of additional outcomes in which stakeholders thought to be relevant: • Skin complications; • Pressure ulcers; • Tolerability of stockings for patients; • Non-major bleeding; • Line-related DVT was mentioned as an extra outcome for patients with venous catheters.
Guideline committee membership		
Full committee members	• Are any full members missing? • Could some of the listed members be expert advisors instead?	The suggestions from stakeholders with regards to the guideline committee membership were: • An obstetrician and a midwife rather than one or the other; • Cardiologist; • Radiologist; • 2 pharmacists (1 medical, 1 surgical); • Community based practitioner i.e. a district nurse or a GP. In relation to the patient members, a number of stakeholders discussed the range of experiences that would be beneficial to the committee, for example, orthopaedic experience in addition to the consequences of VTE and the consequences of contraindications and complications from prophylaxis. Where the guideline would cover all phases of pregnancy, it was suggested that patients who had recent experience of pregnancy, antenatal care and childbirth

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		would be important.
Expert advisors	• Are there any other expert advisors to consider? • Should any of the expert advisors be full committee members? • Are any of the expert advisors unnecessary? (perhaps other listed full members would cover their area?)	No further comments.
Orthopaedic subgroup	• Is there any specific expertise missing?	No further comments.