NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Centre for Clinical Practice

Static list - candidate guidelines post consultation

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Purpose of the paper

1. In September 2013 the Senior Management Team approved a list of 27 clinical guidelines to be consulted on as the first candidates for a static list to be created in CCP.

2. Further to the consultation which was held for 4 weeks during October 2013 this paper sets out the final proposed list of topics for approval by Guidance Executive.

Background

3. A list of 27 clinical guidelines were identified as possible static list candidates based on the following criteria:

    - No quality standard commissioned or

    - A previous full review which yielded a no update decision and no major ongoing studies/research identified as due to be published in the near future (that is within the next 3-5 years)

4. Routine surveillance every 2 years would not be carried out on guidelines transferred to the static list. A high level surveillance review would be carried out on static list guidelines every 5 years.

5. GE are reminded that consideration to transfer a clinical guideline back to the active surveillance list may occur in the following circumstances:

    - The high level review at 5 years yields new evidence
    - Stakeholders notify NICE of relevant new evidence at any time point, for example safety data.
    - A quality standard is commissioned that relates to a guideline on the static list

Static list of clinical guidelines

6. Following consultation it is proposed that 25 of the 27 candidate guidelines are placed on the static list (see table below). Attached is a copy of the consultation comments for each guideline and CCP responses.

7. It is proposed that CG26 Post traumatic stress disorder and CG50 Acutely ill patients in hospital should remain on the active surveillance list with surveillance reviews conducted in March 2015 and July 2015.

8. For the following guidelines the majority of comments received were not in favour of placing the guideline on the static list. However, it is proposed these are transferred to the static list.

- CG53 CFS/ME – There is no quality standard planned and so it is not considered a priority for NICE to review at this stage. Issues raised relate mainly to similar issues raised during the consultation on the guideline itself. These relate mainly to the interpretation of the evidence and clinical definition/diagnostic criteria of CFS/ME which have been considered and addressed previously during development.

- CG64 Prophylaxis infective endocarditis – No quality standard has been planned and is therefore not a priority for NICE to review. Studies cited by consultees were not primary clinical studies. A recent Cochrane review also concluded no new evidence found.

- CG104 Metastatic malignant disease of unknown primary origin – Consultees cited molecular profiling as an area of development and offered a number of study and trial references, however, these are in the early stages and it is unlikely that these would help inform an update of the guideline within the next 3-5 years. This area will be considered again in 5 years when we review its inclusion on the static list. In addition no specific quality standard has been identified for this topic.

- CG116 Food Allergy - There is no quality standard planned and is therefore not a priority for NICE to review every 2 years. Consultees noted areas for consideration but cited no specific references, these will be considered at the 5 year review.

- CG16 Self harm: short-term management – It is proposed that this guideline transfers onto the static list but that the broader scope of this guideline and CG133 Self harm: long-term management are considered together at the next full review of CG133

- Mental health topics - The Royal College of Psychiatrists response to the mental health topics stated that the methodology for most of these guidelines was now old and out of date and these guidelines should therefore be updated. However there were few specific comments about the actual relevance of the recommendations or evidence base for each guideline. We do not believe that because the guideline development methodology is old is a reason in and of itself to make them a priority for NICE to automatically update them. It is proposed that these are transferred to the static list and will be considered again in 5 years.

Table: Proposed final static list

Guideline	Publication date	Last surveillance review date	Criteria for static list
Dental recall (CG19)	Oct 2004	Sept 2012	Both criteria
CFS/ME (CG53)	Aug 2007	Mar 2011	Both criteria
Surgical management of OME (CG60)	Feb 2008	Aug 2011	Both criteria
Prophylaxis against infective endocarditis (CG64)	Mar 2008	Sept 2011	Both criteria

Respiratory tract infections (CG69)	Jul 2008	Jun 2012	Both criteria
Critical illness rehabilitation (CG83)	Mar 2009	Jun 2012	Both criteria
Donor breast milk (CG93)	Feb 2010	Dec 2012	Both criteria
Self-harm(CG16)	Jul 2004	Feb 2012	No update & no evidence expected
OCD & BDD (CG31)	Nov 2005	Mar 2011	No update & no evidence expected
Faecal incontinence (CG49)	Jun 2007	Dec 2012	No update & no evidence expected
Drug misuse – opioid detoxification (CG52)	Jul 2007	Mar 2011	No update & no evidence expected
Antenatal care (CG62)	Mar 2008	May 2011	No update & no evidence expected
Metastatic spinal cord compression (CG75)	No 2008	Aug 2012	No update & no evidence expected
Antisocial personality disorder (CG77)	Jan 2009	Jan 2012	No update & no evidence expected
When to suspect child maltreatment (CG89)	Jul 2009	Aug 2012	No update & no evidence expected
Diarrhoea & vomiting in children under 5 (CG84)	Apr 2009	01/07/2012	No QS
Metastatic malignant disease of unknown origin (CG104)	Jul 2010	n/a – no surveillance review	No QS
Barrett's oesophagus – ablative therapy (CG106)	Aug 2010	n/a	No QS
A model of service provision for pregnant women with complex social factors (CG110)	Sep 2010	n/a	No QS
Sedation in children (CG112)	Dec 2010	n/a	No QS
Food allergy (CG116)	Feb 2011	n/a	No QS
Colonoscopic surveillance (CG118)	Mar 2011	n/a	No QS
Common mental health disorders (CG123)	May 2011	n/a	No QS
Urinary incontinence in neurological disease: management of lower urinary tract dysfunction in neurological disease (CG148)	Aug 2012	n/a	No QS
Neutropenic sepsis: prevention and management in cancer patients (CG151)	Sep 2012	n/a	No QS

Recommendation

9. Guidance Executive is asked to approve the above list of clinical guidelines to be placed on the static list.

Mark Baker – Director, Centre for Clinical Practice
December 2013

ID	Stakeholder	Guideline title and number	Agree / Disagree	Comments Please insert each new comment in a new row.	NICE Response Please respond to each comment
General Comments					
6	The Royal College of Surgeons of Edinburgh	General		The Royal College of Surgeons of Edinburgh supports the proposal to rationalise reviews. The College is mindful that, although a mechanism exists to allow a specific topic to be returned to 'active status', it can be very difficult to achieve this in practice. The College believes that the considerations to transfer a clinical guideline back to the active surveillance list seem reasonable, but, suspects that in practice this will be near impossible, or could take a significant amount of time, due to the infrastructure not being in place to facilitate it. The College assumes that it may be the second consideration, stakeholders notifying NICE, that will be the most important route and suggests that NICE should consider developing a specific mechanism for this, e.g. three different groups of stakeholder. This may mean that a mini-review would result when concerns were raised. An alternative may be for NICE to have a specific update from an appropriate specialist society.	Thank you for your comments. We agree that the identification of new ongoing evidnece by stakeholders will be a key stimulus for NICE to reconsider any topic placed on the static list. The Centre for Clinical Practice at NICE is developing a mechanism to consider future requests to remove topics from the static list. This will entail which criteria will be used to assess the rationality of such requests, and the subsequent measures to re-integrate topics to the regular guideline surveillance programme if it is found that the decision to put a topic on the static list is no longer valid. Details of this process will be made publically available on our website.

ID	Stakeholder	Guideline title and number	Agree / Disagree	Comments Please insert each new comment in a new row.	NICE Response Please respond to each comment
98	NeuroImmune Science	All	Disagree	The concept of a static list is inappropriate to medicine. Scientists need to be in a position to constantly inform guidelines in order to ensure quality of care and highlight any specific dangers. A static list would hinder any such influence and would not be in the interest of any patient.	Thank you for yoru comment. The Centre for Clinical Practice at NICE is developing a mechanism to consider future requests to remove topics from the static list. This will entail what criteria will be used to assess the rationality of such requests, and subsequent measures to re-integrate topics to the regular guideline surveillance programme if it is found that the decision to put a topic on the static list is no longer valid. Details of this process will be made publically available on our website.
17	Cochrane Pain, Palliative and Supportive Care Review Group	General	Agree	We are not aware of any on-going evidence that will affect the decision to add all of these proposed guidelines to the static list.	Thank you for your comment.
18	The Multiple Births Foundation	GENERAL		We agree with the proposal to put all the Guidelines suggested on the static list. However we strongly support points made regarding when consideration should be given to transferring a Guideline back to the active list particularly if new evidence is found and hope this would be activated as quickly as possible should this arise.	Thank you for your comment. The Centre for Clinical Practice at NICE is developing a mechanism to consider future requests to remove topics from the static list. This will entail which criteria will be used to assess the rationality of such requests, and the subsequent measures to re-integrate topics to the regular guideline surveillance programme if it is found that the decision to put a topic on the static

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					list is no longer valid. Details of this process will be made publically available on our website.
60	MPC	All proposed static list Clinical Guidelines	Agree	Is there a system to check if the information about medicines in a static guideline is still correct? For example the license status, products available, pricing changes etc. Will there be a review on accuracy of therapeutic advice at the 5 year review stage, even if there is not found to be sufficient new evidence to prompt a review of the guideline?	Thank you for your comment. The guideline surveillance review programme will check the licence status of products, and any generic drugs only as part of the 2 yearly rolling surveillance programme. If at 5 years review it is found that a topic should be taken off the static list it is the intention that it will fall back within this regualr review cycle
67	Faculty of General Dental Practice (UK)	General comments		We welcome the fact that the transfer of clinical guidelines to the static list is not an irreversible process, and that clinical guidelines can be considered for transfer to an active surveillance list if NICE is notified of relevant new evidence. The FGDP(UK) supports the aim of the creating a static list of clinical guidance to allow NICE to focus resources on the most rapidly developing clinical areas.	Thank you for your comment.
68	Johnson & Johnson Medical	General	Agree	Johnson & Johnson agrees with NICEs decision to create a static list for the review process for published clinical guidelines, and agrees specifically with the topics selected for the proposed list issued as part of this consultation. Following consultation on this proposal, once NICE has finalised the new process it would be helpful to provide advice to stakeholders on how to submit a request for the review of a guideline on the static	The Centre for Clinical Practice at NICE is developing a mechanism to consider future requests to remove topics from the static list. This will entail which criteria will be used to assess the rationality of such requests, and the subsequent measures to re-integrate topics to the regular guideline surveillance programme if it is found that

ID	Stakeholder	Guideline title and number	Agree / Disagree	Comments Please insert each new comment in a new row.	NICE Response Please respond to each comment
				list should new evidence that impacts on the recommendations becomes available.	the decision to put a topic on the static list is no longer valid. Details of this process will be made publically available on our website.
138	Royal College of Paediatrics and Child Health	All guidelines relevant to Children (CG29, 26, 53, 69, 93, 62, 89, 112)	Agree	All fulfil the criteria for the static list.	Thank you for your comment.
CG104 Metastatic Disease of Unknown Origin.					
5	Cancer of Unknown Primary Foundation – Jo's friends	CG104	Disagree	The very significant CUP Guideline of 2010, given impetus by Peer Review Measures of 2013, is starting to have an important impact on clinicians and patient management; but CUP MDTs are patchy nationally, not helped by uncertainties following the NHS re-organisation of Apr 2013. We understand that within cancer networks there are aspects that clinicians wish to change as they turn the guideline into their own operating protocols and gain operational experience. Our main pitch for keeping the Guideline from becoming 'static' is based on molecular profiling. In the Guideline we supported molecular profiling use for research and in this country it is an integral part of the CUP-One trial and is proposed in the Putative CUP-Two trial (supported by the UGI CSG of NCRI and presently under review by CTAAC). Independent of CUP-One we, as a charity, are funding a sequencing pilot project at Hammersmith	Thank you for your comment. Having considered the criteria again we do not feel that the evidence base warrants 2 yearly surveillance review.Whilst many trials are indicated most are still at a very early stage and at present do not provide a substantial evidence base at this time. . In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence before its next review in 5 years.

ID	Stakeholder	Guideline title and number	Agree / Disagree	Comments Please insert each new comment in a new row.	NICE Response Please respond to each comment
				Hospital to look at the DNA sequence of previously banked or stored tissue biopsies to uncover potential biomarkers (predictive and prognostic) of CUP. Next generation sequencing (NGS) is now being performed on a subset of the samples as a pilot that will help us to understand the disease and detect potentially “drug-able” mutations. A successful pilot will enable further research. In the Guideline we identified an average of 19 investigations per CUP patient and if, in the future, NGS/WGS can be used early to accelerate the diagnostic process, other investigations may be reduced significantly and there will be potential for cost savings as well as improved QOL. The tide is turning with regard to the overall value of molecular profiling. CUP has been selected by the CMO as a priority within cancer for the 100K Genome Project and this should develop our knowledge. Gene expression profiling is a fast moving area which could transform the management and treatment of CUP patients. (Recently we have seen the announcement of the use of Oncotype DX agreed by NICE for certain breast cancer cases so the whole profile of this form of science is rising). Surely we need to be able to review the Guideline asp when a sufficient evidence base accrues, not have it locked away inaccessible and hid from our eyes for 5 years. I accept that at the moment the problem is the lack of a substantive evidence base	

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				for a change in outcomes – and hence an economic case- for CUP patients in using gene expression profiling, although this is starting to build. The evidence base for the benefits in changing treatment and outcomes is strongest in the USA and much of this comes from the work of Greco and Hainsworth. Another linked factor that might speed the evidence base is the ability to extract DNA from circulating tumour cells. Our understanding is that this field is advancing fast and offers the possibilities of tracking DNA changes simply in the metastatic spread without invasive serial biopsies. This could help crack the biology of CUP. With incidence and mortality still running in parallel at over 10,000 cases pa in the UK it is too critical a topic to become 'static'.	
8	The Royal College of Surgeons of Edinburgh	CG104 - Metastatic malignant disease of unknown origin	Disagree	The Royal College of Surgeons Edinburgh disagree with the proposal to put metastatic malignant disease of unknown origin (MMDUO) on the static list. The College believes that MMDUO is an area of quite rapid change and the SAT guideline is very good. It is felt to be unlikely that this area will not require an update over a five-year period and as such, this guidance should not be removed from routine review.	Thank you for your comment. This guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. The issue of supporting research in this area that the consultee raises does not directly relate to the decision of NICE to move this topic to the static list based on the criteria laid out in the consultation. As

ID	Stakeholder	Guideline title and number	Agree / Disagree	Comments Please insert each new comment in a new row.	NICE Response Please respond to each comment
					such we are unable to comment on this matter.
13	Association for Palliative Medicine of Great Britain and Ireland	CG104	Disagree	Cancer of unknown primary is currently an evolving area of practice and things are likely to develop / change quite significantly in the next few years	Thank you for your comment. Having considered the criteria again we do not feel that the evidence base warrants a 2 yearly surveillance review. Whilst many trials are indicated most are still at a very early stage and at present do not provide a substantial evidence base at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence before its next review at 5 years.
31	Brain Tumour Research	CG104 - Metastatic malignant disease of unknown origin	Disagree	Brain tumours include metastatic malignant diseases of unknown origin. There is a vast disparity between cancer research funding and the figures on its impact. Despite causing more deaths in children (and under-40s) than any other cancer, brain tumours receive only 1% of the national spend on cancer research. It is not understood how brain tumours arise but what is all too painfully clear is that metastatic brain tumours come with particularly poor prospects and	Thank you for your comment This guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. The issue that the consultee raises does not directly relate to the decision of NICE to move this topic to the static list based on the criteria laid out in the consultation. As such we are unable to comment on this

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				high mortality rates. With incidences of metastases to the brain not being monitored effectively therefore they represent a potential 'tsunami' of new brain tumour diagnoses in the next five years. Moving these guidelines to a static list could adversely affect brain tumour research initiatives that desperately need the support from NICE. The level of funding and attention for brain tumours is such that to place this illness on a static list could see an extremely important and dangerous illness moved further from a possible cure. In the 2010 guidelines a number of issues are raised – the lack of clarity of the term itself, uncertainty about treatment, a lack of adequate structure and research – and these issues will only continue, possibly even worsening, with the proposed move. We propose the action NICE is considering should not be implemented. More not less attention should be paid to issues of research into this cancer, and the move to a five year review could halt much needed change and progress in tackling cancer.	matter. In addition NICE us scheduled to develop a clinical guideline on brain metasteses.
47	Greater Manchester Health Economy	Metastatic malignant disease of unknown origin (CG104)	Agree		Thank you .
81	The Royal College of Radiologists	Metastatic Malignant Disease of	Disagree	The RCR notes that CG104 has been a useful guideline and was particularly helpful in informing the 2013 cancer peer review measures. The RCR	Thank you for your comment. Thank you for your comment. Having considered the criteria again we

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	(RCR)	Unknown Primary Origin CG104		would have been content for CG104 to be moved to the static list if its next review date was in 2015 (that is, 5 years from when it was published) but we understand that it will not be reviewed until 2018 (that is, 5 years from the date at which it is placed on the static list). This is a matter of concern, particularly as we understand that routine surveillance every 2 years (as per the process for active guidelines) would not be carried out on guidelines transferred to the static list.	do not feel that the evidence base warrants a 2 yearly surveillance review. Whilst many trials are indicated most are still at a very early stage and at present do not provide a substantial evidence base at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence before its next review at 5 years.
105	NATIONAL COLLABORATING CENTRE FOR CANCER	CG104	Disagree	I do have worries about this particularly in relation to molecular profiling. This is a fast moving area which could transform the management and treatment of CUP patients. Surely we need to be able to review the Guideline as soon as possible when a sufficient evidence base accrues, not have it locked away, inaccessible and hid from our eyes for 5 years. I accept that at the moment the problem is the lack of a substantive evidence base for a change in outcomes – and hence an economic case- for CUP patients in using gene expression profiling, although this is starting to build. The evidence base for the benefits in changing treatment and	Thank you for your comments. Thank you for your comment. Having considered the criteria again we do not feel that the evidence base warrants a 2 yearly surveillance review. Whilst many trials are indicated most are still at a very early stage and at present do not provide a substantial evidence base at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently

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				outcomes is strongest in the USA and much of this comes from the work of Greco and Hainsworth. In the Guideline we supported molecular profiling use for research and in this country it is an integral part of the CUP-One trial and is proposed in the Putative CUP-Two trial (supported by the UGI CSG of NCRI and presently under review by CTAAC). Independent of CUP-One we, as a charity, are funding a sequencing pilot project at Hammersmith Hospital to look at the DNA sequence of previously banked or stored tissue biopsies to uncover potential biomarkers (predictive and prognostic) of CUP. Next generation sequencing (NGS) is now being performed on a subset of the samples as a pilot that will help us to understand the disease and detect potentially "drug-able" mutations. A successful pilot will enable further research. In the Guideline we identified an average of 19 investigations per CUP patient and if, in the future, NGS/WGS can be used early to accelerate the diagnostic process, other investigations may be reduced significantly and there will be potential for cost savings as well as improved QOL. A trial that has now started in Australia using NGS offers the hope of a significant leap forward. (Shown at the bottom of this page http://www.cupfoundjo.org/research_and_resources/trials.html for anyone who is interested).	than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence before its next review at 5 years.

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				Another linked factor that might speed the evidence base is the ability to extract DNA from circulating tumour cells. My lay understanding is that this field is advancing fast and offers the possibilities of tracking DNA changes simply in the metastatic spread without invasive serial biopsies. This could help crack the biology of CUP. The tide is turning with regard to the overall value of molecular profiling. CUP has been selected as one of the diseases to be part of the 100K Genome Project and this should develop our knowledge (how quickly I hope to find out at a Genomics England briefing next Thursday). Yesterday we saw the announcement of the use of Oncotype DX for certain breast cancer cases so the whole profile of this form of science is rising. My pitch for keeping the Guideline away from becoming 'static' is based on Molecular Profiling – the very significant Guideline, given impetus by Peer Review Measures, is starting to have an important impact on clinicians and patients; but CUP MDTs are patchy nationally, in my view, not helped by uncertainties following the NHS re-org. I sit on a (strategic) cancer network and I think that there are aspects that people might want to change as they gain operational experience which could be embraced in a review in a few years time	
106	NATIONAL	CG104	Disagree	I think most people would agree that the major	Thank you for your comment.

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	COLLABORATING CENTRE FOR CANCER			benefit arising from CG104 has been the re-organisation of services meaning that MUO patients have the same sort of benefits of "site-specific" care as enjoyed by those with identified primary cancer. In particular, the requirement to act rapidly when MUO is identified means these patients are beginning to get care which rivals that of other groups. One logical outcome may be that an increasing number of patients will be assigned a diagnosis of MUO (instead of "possible x cancer"), with consequences for the capacity and function of CUP Teams. The ongoing review / revision of the NICE Referral for Suspected Cancer guideline will inevitably have an impact on referral practice and pathways, and my hunch is that this will increase the need for referral pathways for generic investigation when a primary site is uncertain. Unless there is a formal process for refining the nature and remit of CUP Team work, increased demand may not be handled efficiently, and health services may fail to provide for this increased need. Accordingly, a timely review of at least that part of the CUP Guideline that deals with service provision will be desirable in a couple of years time, when evidence about referral pathways will be available on which to base changes in recommendations. For this reason, I would argue that the CUP guideline should not be placed on the static list, but instead would suggest a halfway house where a	Having considered the criteria again we do not feel that the evidence base is substantially evolving in this area at this time. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence or guidelines that impact on the recommendations within the guideline before the next 5 year review.

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				small group decided on its status perhaps a year after the new Referral Guideline is published. As a second point, you will be aware that the Government's 100k Genome Project is particularly focussing on CUP, meaning that a wealth of data about the genetic makeup of this entity will become available this decade. It seems inconceivable that there will be no actionable findings - I particularly expect data to emerge relating to early use of molecular diagnostics, and to treatment selection based on "molecularly-defined" syndromes. Review of CG104 would seem the logical way to assess the value, and hopefully implement these new developments.	
143	British Association of Dermatologists	CG104 – metastatic malignant disease of unknown origin	Disagree	Management of metastatic disease of unknown origin will be affected by changes in genetic diagnosis of cancer. Genetic tests on a metastasis of unknown origin could open up potential therapies (e.g. the presence of a BRAF mutation). Currently, only vemurafenib would keep this guideline OFF the static list.	Thank you for your comment. Having considered the criteria again we do not feel that the evidence base is substantially evolving in this area at this time. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence. NICE issued a technology appraisal guidance TA269 in December 2012 on the use of Vemurafenib for treating locally advanced or metastatic BRAF

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					V600 mutation-positive malignan melanoma.It would appear that this agent is currently recommended for the treatment of a very specific metastatic cancer.
CG106 Barrett's oesophagus – ablative therapy					
86	NICE – Health and Social Care Quality Programme	CG106 – Barrett's oesophagus	Disagree	This may relate to the QS referral on GORD.	Thank you for your comment. CG106 specifically excludes individuals with GORD from its scope.
36	Greater Manchester Health Economy	Barrett's oesophagus – ablative therapy (CG106)	Agree		Thank you.
100	Royal College of Physicians (RCP)	Barrett's oesophagus – ablative therapy (CG106)	No objections raised		Thank you.
CG110 A model of service provision for pregnant women with complex social factors					
32	Greater Manchester Health Economy	A model of service provision for pregnant women with complex social factors (CG110)	Agree		Thank you.

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CG112 Sedation in children					
54	Greater Manchester Health Economy	Sedation in children (CG112)	Agree		Thank you.
66	Faculty of General Dental Practice (UK)	CG112 - Sedation in children	Agree	No comments.	Thank you..
CG116 Food allergy					
137	Royal College of Paediatrics and Child Health	CG116 – food allergy	Disagree	Whilst we agree that the criteria for the static list are fulfilled, since 2011 there have been considerable advances in understanding of non-IgE mediated reactions to foods. There has been a recent submission of a review on Eosinophilic oesophagitis for publication. There are now better diagnosis and management algorithms.	Thank you for your comment. Having considered the criteria again we do not feel that the evidence base is substantially evolving in this area at this time. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence before the next 5 year review.
46	Greater Manchester Health Economy	Food allergy (CG116)	Agree		Thank you..
139	Phadia Ltd – (now Thermo Fisher Scientific)	CG116 - Food Alergy	Disagree	The current guideline states that updates will be required as the field and evidence for molecular allergy diagnostics evolves, therefore should not be put on the static list	Thank you for your comment. Having considered the criteria again we do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not

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					scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence before the next 5 year review.
140	Phadia Ltd – (now Thermo Fisher Scientific)	CG116 - Food Alergy	Disagree	Increased evidence on advantages on using component resolved diagnostics has grown substantially.	Thank you for your comment. Having considered the criteria again we do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review.By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence before the next 5 year review.
141	Phadia Ltd – (now Thermo Fisher Scientific)	CG116 - Food Alergy	Disagree	Identified more than ten ongoing trials nationally in the UK and 100 internationally on component resolved diagnostics (molecular-based allergy diagnostics) in food allergy.	Thank you for your comment. Having considered the criteria again we do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality

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					Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence.
142	Phadia Ltd – (now Thermo Fisher Scientific)	CG116 - Food Alergy	Disagree	A new WAO - ARIA - GA2LEN consensus document on molecular-based allergy diagnostics (Canonica GW, Ansotegui IJ, Pawankar R, Schmid-Grendelmeier P, van Hage M, Baena-Cagnani CE, Melioli G, Nunes C et al. World Allergy Organization Journal 2013, 6:17 (3 October 2013)	Thank you for providing this reference. This guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review.
CG118 Colonoscopic surveillance					
9	The Royal College of Surgeons of Edinburgh	CG118 - Colonoscopic surveillance	Agree	The proposal to put colonoscopic surveillance on the static list is supported. The College believes that this proposal is reasonable and that most clinicians are usually guided by British Society of Gastroenterology.	Thank you for your comment.
28	Merck Sharp & Dohme	CG118 – Colonoscopic surveillance	Agree	MSD agrees with the proposal to add this guideline to a static list.	Thank you for your comment
38	Greater Manchester Health Economy	Colonoscopic surveillance (CG118)	Agree		Thank you for your comment

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71	British Society of Gastrointestinal and Abdominal Radiology (BSGAR)	CG118 – Colonoscopic surveillance	Disagree	The main problem from an imaging point of view is that in the current version of CG118 gives barium enema (BE) as well as CT colonography (CTC) as alternatives to colonoscopy in those cases where colonoscopy is not possible/appropriate eg 1.1.11 Consider computed tomographic colonography [1] (CTC) as a single examination if colonoscopy is not clinically appropriate (for example, because of comorbidity or because colonoscopy cannot be tolerated). 1.1.12 Consider double contrast barium enema as a single examination if CTC is not available or not appropriate. 1.1.13 Consider CTC or double contrast barium enema for ongoing surveillance if colonoscopy remains clinically inappropriate, but discuss the risks and benefits with the person and their family or carers. This is somewhat in conflict from the current NHS Bowel Cancer Screening Program (NHSBCSP) guidelines (November 2012) which state that BE should not be used for polyp/cancer detection as part of the program when colonoscopy is not appropriate – a CTC should be performed and if CTC is not available locally the patient should be transferred to a centre that does offer the study. Though CG131 (November 2011) does still	Thank you for your comment and for bringing the SIGGAR trial to our attention. We understand there is an issue with barium enema. However, having considered the body of the evidence and the fact that the position of CT colonoscopy in the hierarchy of treatments is retained over barium enema in the current guideline and on the balance of commenst receieved we propose to transfer this to the static list and it will be considered again at 5 years.

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				mention BE as an option, the RCR (Royal College of Radiologists) is in the process of issuing guidance regarding the phasing out of the BE in favour of CTC. This has already happened in many centres. CG118 may need to be revised to take in more recent evidence of changes in best practice. For example the SIGGAR trial of CTC vs colonoscopy and CTC vs BE from earlier in 2013 in not included in the reference base of CG118.	
73	Ferring Pharmaceuticals Ltd.	CG118 - Colonoscopic surveillance	Agree	No comments	Thank you for your comment.
101	Royal College of Physicians (RCP)	Colonoscopic surveillance (CG118)	No objections raised		Thank your for your comment.
113	Bowel Cancer UK	CG118 – Colonoscopic surveillance	Agree	Bowel Cancer UK welcomes the opportunity to respond to this consultation on the transference of CG118 Colonoscopic surveillance to the NICE static list.	Thank you for your comment.
114	Bowel Cancer UK	CG118 – Colonoscopic surveillance	Agree	A colonoscopy is one of the most common techniques used to detect bowel cancer at the earlier stages of the disease when it is more treatable. If detected at the earliest stage, early the five-year survival rate is over 90% compared to a five year survival rate of only 9% if detected at the latest stage. High-quality colonoscopic surveillance is therefore vital to those who have a higher risk of	Thank you for your comment.

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				developing bowel cancer due to being predisposed to the disease either through having a strong family history of colorectal cancer or through having a genetic condition such as Familial Adenomatous Polyposis.	
115	Bowel Cancer UK	CG118 – Colonoscopic surveillance	Agree	Bowel Cancer UK strongly believes that, given the importance of colonoscopic surveillance, those at a higher risk of developing bowel cancer should receive the best standard of care based on the most up-to-date research and evidence.	Thank you for your comment.
116	Bowel Cancer UK	CG118 – Colonoscopic surveillance	Agree	As there is no data imminently due to be published that could impact upon the guidance, Bowel Cancer UK supports the decision to transfer CG118 to the static list. However, we would strongly recommend that NICE review this decision promptly if new evidence and research comes to light. This would ensure that the NICE guidance is consistent with future updates to the British Society of Gasteroenterology guidelines for screening and surveillance for people at moderate to high risk.	Thank you for your comment; we agree with your suggestion. As part of the interim guideline surveillance programme the Centre for Clinical Practice at NICE has proposed that guidelines where the evidence base is less dynamic should be reviewed less frequently. This is to ensure that resources available to the surveillance programme are focused more productively.
117	Bowel Cancer UK	CG118 – Colonoscopic surveillance	Agree	We would further argue for the development of a quality standard for colonoscopic surveillance. Research has demonstrated that higher detection rates for bowel cancer are reliant upon the colonoscopy being of the highest quality and not upon undertaking colonoscopies more frequently. With the added pressures that the expected increase in the demand for colonoscopic procedures will bring, ensuring services continue to be of the highest quality is paramount to preventing people from dying prematurely.	Thank you for your comment. The issue raised does not directly relate to the decision of NICE to move this topic to the static list based on the criteria laid out in the consultation. Decisions to refer a Quality standards to NICE rests with NHS England. However, the Centre for Clinical Practice at NICE is developing a mechanism to consider future requests to remove

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				A quality standard which outlines what constitutes best practice in relation to the appropriateness of colonoscopic surveillance, frequency, risk groups and method for high risk individuals would contribute to improving the effectiveness, quality and patient experience of the procedure, as well as ensuring variation in clinical practice is minimised. If such a quality standard is produced before the publication of any research findings that could impact upon the guidance, we would strongly recommend that NICE transfer CG118 back to the active surveillance list.	topics from the static list. This will entail what criteria will be used to assess the rationality of such requests, and subsequent measures to re-integrate topics to the regular guideline surveillance programme if it is found that the decision to put a topic on the static list is no longer valid. Details of this process will be made publically available on our website.
CG123 Common mental health disorders					
39	Greater Manchester Health Economy	Common mental health disorders (CG123)	Agree		Thank you for your comment.
87	NICE – Health and Social Care Quality Programme	CG123 – Common mental health disorders	Disagree	Recommendations from CG123 underpin quality statements in the draft quality standards on mental wellbeing of older people in care homes and anxiety.	Thank you for your comment. The recommendations in CG123 are underpinned by recommendations and evidence drawn from other clinical guidelines on depression and anxiety. Therefore whilst CG123 relates to the draft quality standards on mental wellbeing of older people in care homes and anxiety, we do not feel that this impacts on the decision to transfer this guideline to the static list as the evidence base will be reviewed through surveillance on CG90, 91 and 113 which remain on the active surveillance list.

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CG148 Urinary incontinence in neurological disease					
57	Greater Manchester Health Economy	Urinary incontinence in neurological disease: management of lower urinary tract dysfunction in neurological disease (CG148)	Agree		Thank you.
75	Ferring Pharmaceuticals Ltd.	CG148 - Urinary incontinence in neurological disease: management of lower urinary tract dysfunction in neurological disease	Agree	No comments	Thank you..
83	Coloplast	CG148 – Urinary incontinence in	Agree	We have no objections to the proposal to place this guidance on the static list at the present time.	Thank you for your comment.

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		neurological disease: management of lower urinary tract dysfunction in neurological disease			
104	Royal College of Physicians (RCP)	Urinary incontinence in neurological disease: management of lower urinary tract dysfunction in neurological disease (CG148)	No objections raised		Thank you for your comment.
130	Allergan Ltd	CG148	Disagree	The treatment of NDO is an area of active research and Allergan does not believe it appropriate that it be placed on a static list.	Thank you for your comments. Whilst we understand that this is an area of active research, we do not feel that there is any new evidence at this time that would impact on the guideline. Clinical guidelines placed on the static list will continue to be reviewed every 5 years to determine if they should remain on the static list. However, NICE would welcome being informed of the

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					publication of any additional new evidence that is likely to impact on the guideline before the next 5 year review.
131	Allergan Ltd	CG148 NICE	Disagree	Botox™ was licensed for the treatment of neurogenic detrusor overactivity (NDO) with urinary incontinence due to subcervical spinal cord injury (traumatic or non-traumatic) or multiple sclerosis in the UK on 24 Sept 2012, just after the publication of CG148. Since Botox™ is generally considered one of the key options for the treatment of urinary incontinence associated with these conditions we believe it is important that the guideline be updated to reflect not only its approval (footnote in p11 of the NICE guidance, Section 4.2 on p31-) but also significant completed and ongoing clinical research in this area. By way of example only, there have been two publications in 2013 alone on the use of Botox™ in NDO • Ginsberg et al, 2013; on BOTOX being effective in NDO regardless of concomitant anticholinergic use or neurologic aetiology, • Kennelly et al, 2013; data from an interim analysis of the long term extension study (094) in which data are presented for 5 BOTOX cycles Further publications based on the long term extension study are planned for the near future which will inform clinicans' decisions on treatment of this important disease.	Thank you for your comments and for highlighting new areas relating to this guideline. Having considered the criteria again, we do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence which might impact on the guideline before the next 5 year review.

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CG151 Neutropenic sepsis: prevention and management in cancer patients					
49	Greater Manchester Health Economy	Neutropenic sepsis: prevention and management in cancer patients (CG151)	Agree		Thank you for your comment.
76	The Royal College of Radiologists (RCR)	Neutropenic sepsis: prevention and management in cancer patients CG151	Agree	The RCR is not aware of any new data that would have a significant impact on this guideline	Thank you for your comments.
CG16 Self-harm					
55	Greater Manchester Health Economy	Self-harm (CG16)	Agree		Thank you..
69	Department of Health	CG16 – Self-harm	Disagree	I am concerned with the proposal to move CG16 - Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care – onto a static list. This is complicated, in that CG133 (long-term management of self-harm published in November 2011) was a partial update of CG16 (which focussed on short-term management).	Thank you for your comments. It is proposed that this guideline is transferred to the static list but that we will consider the broader scope of both this guideline and CG133 when undergoes its full surveillance review..

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				This led to the decision not to revisit CG16 in February 2012. However the criteria 'no significant ongoing research identified' was not met. There is quite a lot of active research going on in this area. My understanding was that next time the self-harm guidelines came up for review, consideration would be given to merging the short and long-term management into a single guideline (and also possibly decoupling physical healthcare management of overdose and self-injury from psychological care). In this context, moving CG16 to the static list might be a bit premature, unless it will automatically be considered when CG133 comes up for review.	
135	College of Psychiatrists	CG16 - Self Harm	Disagree	*The College welcomes this opportunity to convey its views about the proposed 'static list' of Clinical Guidelines. It is of course right and proper that NICE conducts its clinical guideline review programme in a manner that is both efficient and sustainable, and the College supports the principle of some guidelines being reviewed less frequently when this is appropriate. However, we would urge NICE to consider two key aspects of how this may work in practice.* *Firstly, the methodology that the NCCMH employs to produce NICE mental health guidelines has changed considerably over recent years. Contemporary guidelines are produced using sophisticated network meta-analysis, which when*	Thank you for your comments. We appreciate your comments relating to changes to the methodology for developing guidelines, however, this does not directly relate to the decision of NICE to move this topic to the static list based on the criteria laid out in the consultation about limited research being identified or due in the near future. With regard to the name 'static guidelines', we hope that the supporting information conveys the message that such guidelines will continue to be reviewed, albeit less frequently than

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				combined with GRADE assessments to rate the quality of evidence have made it possible to make highly rigorous, accurate recommendations with a remarkable degree of confidence. Although there has been incremental improvement in the quality of guidelines over the past 12 years, these new techniques represent a sea-change in the quality of clinical recommendations produced. These techniques have been developed relatively recently, and have only been available to the NCCMH since 2009. The College therefore strongly recommends that the mental health guidelines published before this year (and which have been selected for the proposed 'static list') automatically go through another round of guideline publication before being reconsidered for a longer review period. This will ensure that the latest iteration has been produced using the most robust methodology available. Even if there is no 'new' evidence as such, the significantly improved methodology could well result in a more nuanced, comprehensive interpretation of the existing data, with implications for subsequent recommendations, the quality of clinical care, patient safety and ultimately health outcomes. This cannot be ignored as a consideration. *Secondly, the College suggests that NICE reconsider the suggested term 'static list'. This term gives the misleading impression that no research is taking place in the respective guideline areas on the list, and also does not reflect the fact that guidelines will still be reviewed (albeit at a less*	other guidelines. The Centre for Clinical Practice at NICE is developing a mechanism to consider future requests to remove topics from the static list. This will entail what criteria will be used to assess the rationality of such requests, and subsequent measures to re-integrate topics to the regular guideline surveillance programme if it is found that the decision to put a topic on the static list is no longer valid. Details of this process will be made publically available on our website

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				frequent rate). Both of these misconceptions could be distressing for patients, who may infer that their condition is not being taken seriously. Alternatives could perhaps include 'long review cycle' or 'intermittent review' etc. *The College would also like to point out that mental health guidelines seem to be overrepresented in the proposed list, particularly in terms of topics where no significant research is ongoing. This is sadly symptomatic of the lack of parity of esteem accorded to mental health research, and the College will take this point up with the NIHR as a matter of urgency.*	
CG19 Dental Recall					
10	The Royal College of Surgeons of Edinburgh	CG19-Dental Recall	Disagree	It is not felt appropriate to put dental recall on the static list. The UK population is ethnically diverse and is changing rapidly as such, new evidence regarding disease processes is produced more frequently than a five-year review could embrace, especially in respect of periodontal disease and, in particular regarding the benefits of scaling and polishing as well as oral hygiene in different populations. Furthermore, research on dental caries and its management and the care and management of oral cancer (and particularly pre-cancerous lesions) are still developing. Guidance on dental recall and the cost-effectiveness of different treatment modalities may change too rapidly to allow a transfer to a static five-year period of review, especially regarding 'who delivers what' to patients. An	Thank you for your comments. This guideline was reviewed in September 2012 where the decision was that it should not be updated at this time as no new evidence was identified which would suggest a significant change in clinical practice. The decision to move this guideline to the static list reflects the result of the review in 2012 not to update. Having considered the criteria again, we do not feel that the evidence base is substantially evolving in this area at this time which would contradict the decision to move this guideline onto the static list. In addition this guideline is not scheduled to form part of a Quality

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				example of this may be the cost-effectiveness of care delivery from dental care professionals rather than dentists.	Standard at this time and is therefore not considered a priority for NICE to review. Clinical guidelines placed on the static list will be reviewed every 5 years to determine if they should remain on the static list. However, NICE would welcome being informed of the publication of any additional new evidence that is likely to impact on the guideline.
19	Scottish Dental Clinical Effectiveness Programme	CG19 – Dental Recall	Agree	Relevant research is ongoing to evaluate the effectiveness and cost effectiveness of several dental recall strategies by assessing their impact on maintaining oral health (https://viis.abdn.ac.uk/hsru/interval/default.aspx; http://www.nets.nihr.ac.uk/projects/hta/063599). The results of this research are not expected within the next 3-5 years. At this point, a review of the Dental Recall guideline is likely to be appropriate.	Thank you for your comments. We are aware of this ongoing research and will consider it as part of the high level review process for static list guidelines at the next 5 year point.
41	Greater Manchester Health Economy	Dental recall (CG19)	Agree		Thank you for your comments.
77	The Royal College of Radiologists (RCR)	Dental Recall CG19	Agree	The RCR is not aware of any new data that would have a significant impact on this guideline	Thank you for your comments.
118	British Dental Association	CG 19 Dental recall	Disagree	The oral health group of the Cochran collaboration is currently updating the relevant review 'Recall intervals for oral health in primary care patients' which was published in 2008. The revised version is due to be published later in 2013.	Thank you for your comments. This guideline previously underwent surviellacnereviewin September 2012 where the decision was that it should not be updated at this time as no new

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					evidence was identified which would suggest a significant change in clinical practice. The decision to move this guideline to the static list reflects the result of the review in 2012 not to update. We understand that no new studies have been included in the update to the Cochrane review and that the conclusions of this review will remain essentially unchanged. NICE is not aware of any other new evidence that is likely to impact on the guideline at this time. Clinical guidelines placed on the static list will be reviewed every 5 years to determine if they should remain on the static list. However, NICE would welcome being informed of the publication of any additional new evidence prior to this that might impact on the guideline recommendations.
65	Faculty of General Dental Practice (UK)	CG19 – Dental Recall	Agree	However, a Cochrane dental recall review is currently being updated – this is expected to be published before the end of 2013. Also, an INTERVAL Dental Recalls Trial (University of Dundee) is currently in progress and not due to end until July 2014. The results of this trial could necessitate a review of the dental recall guidance, although the trial outcomes may not be reported until 2015 at the earliest.	Thank you for your comments. We understand that no new studies have been included in the update to the Cochrane review and that the conclusions of this review will remain essentially unchanged. As a static list guideline, it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the

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					publication of any additional new evidence where it arises.
119	British Dental Association	CG 19 Dental recall	Disagree	The results of the INTERVAL Dental Recalls Trial are likely to inform current guidance. This trial is funded by Health Technology Assessment programme of the NIHR. It is a 4-year, multi-centre, parallel-group, randomised controlled comparison of three different arrangements for the timing of dental check-up recall intervals on oral health: 6-month fixed-period recall, risk-based recall, and 24-month fixed-period recall. The trial is started as on a pilot basis in 2011.	Thank you for your comments. This guideline was reviewed in September 2012 where the decision was that it should not be updated at this time as no new evidence was identified which would suggest a significant change in clinical practice. The decision to move this guideline to the static list reflects the result of the review in 2012 not to update. Clinical guidelines placed on the static list will be reviewed every 5 years to determine if they should remain on the static list. NICE is aware of the current INTERVAL trial and its potential impact on the current guideline. However, we understand that this review isn't due to report until 2017/18 when this guideline would be due for a 5 year review. However, NICE would welcome being informed of the publication of any additional new evidence that is likely to impact on the guideline. The Centre for Clinical Practice at NICE is developing a mechanism to consider future requests to remove topics from the static list. This will entail what criteria will be used to assess the rationality of

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					such requests, and subsequent measures to re-integrate topics to the regular guideline surveillance programme if it is found that the decision to put a topic on the static list is no longer valid. Details of this process will be made publically available on our website.
CG26 PTSD					
16	Birth Trauma Association	PTSD	Disagree	PTSD around childbirth is making enormous advances. There is actually a UK Birth Research Network devoted to co-ordinating the huge amount of research in this area. Contact Dr Susan Ayers at Sussex University for more information or follow this link for a list of the current large studies being undertaken. http://www.sussex.ac.uk/affiliates/ukbrn/research.html PTSD around childbirth is a major contributor to the total numbers of PTSD cases each year – recent research suggests that there has been widespread misdiagnosis of PND as PTSD. We would like to see the addition of PTSD to the static list delayed until these issues are examined. Women are a 'protected group' in terms of equality legislation and it is therefore important that an issue that only affects them is not dismissed simply because there are no advances in PTSD diagnosis and treatments that affect both sexes equally.	Thank you for your comment and the link provided. Following consultation, this topic will not be transferred to the static list and will remain on the active list for 2 yearly reviews.
52	Greater Manchester Health	PTSD (CG26)	Agree		Thank you..

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	Economy				
84	NICE – Health and Social Care Quality Programme	CG26 – PTSD	Disagree	Recommendations from CG26 underpin quality statements in the draft quality standard on anxiety currently in development.	Thank you for your comment. Following consultation, this topic will not be transferred to the static list and will remain on the active list for 2 yearly reviews.
	Tees Esk and Wear Valley NHS Foundation Trust	CG26 - PTSD	Disagree	For some PTSD sufferers, it may initially be very difficult and overwhelming to disclose details of their traumatic events. In these cases, healthcare professionals should consider devoting several sessions to establishing a trusting therapeutic relationship and emotional stabilisation before addressing the traumatic event. NICE Guideline, recommendation 1.9.2.5	Thank you for your comment. Following consultation, this topic will not be transferred to the static list and will remain on the active list for 2 yearly reviews.
	Tees Esk and Wear Valley NHS Foundation Trust	CG26 - PTSD	Disagree	Non-trauma-focused interventions such as relaxation or nondirective therapy, which do not address traumatic memories, should not routinely be offered to people who present with chronic PTSD. B NICE Guideline, recommendation 1.9.2.6	Thank you for your comment. Following consultation, this topic will not be transferred to the static list and will remain on the active list for 2 yearly reviews.
	EMDR Association UK & Ireland		Disagree	The EMDR Association recommend that the guidance for PTSD be reviewed as soon as possible and, due to rapid developments in the research in this area, the PTSD guidance should not be placed on the static list. NICE is already recommending EMDR as one of the two treatments of choice for adults with PTSD and, in fact, since the last major review in 2005, further evidence for the efficacy of EMDR for the treatment of PTSD has been published, For example a recent RCT showed that EMDR results	Thank you for your comment and for providing references. In light of this, and following consultation, this topic will not be transferred to the static list and will remain on the active list for 2 yearly reviews.

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				in faster recovery as compared with brief eclectic psychotherapy (similar to Trauma Focussed CBT - TF-CBT) in the treatment of PTSD (Nijdam, Gersons, Reitsma, de Jongh, & Olff, 2012). In addition, it is now clearer that the utilisation of Eye Movements (EMs) are a crucial active ingredient in EMDR. For example, Lee & Cuijpers (2013) meta-analysis of the contribution of eye movements in processing emotional memories shows that EMs have an additional value in EMDR treatment, that EMs alter the processing of emotional memories and the processes involved in EMDR are different from other exposure based therapies. In addition Schubert, Lee & Drummond (2011) showed that the EM component in EMDR is beneficial, and is coupled with distinct psychophysiological changes that may aid in processing negative memories. Since the last review in 2005 a considerable amount of evidence for the efficacy of EMDR for children with PTSD has been published. A crucial paper is the meta-analysis by Rodenburg et al. (2009). We have been informed by Cath White that the Rodenburg study was 'excluded from their review as it was not clear from the abstract what methodology was used for the meta-analysis and how included studies were identified whilst no specific results or data were reported in the abstract'. We accept that the abstract alone is rather brief and does not include this information. However the main paper itself is very clear about the methodology and shows very strict inclusion	

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				criteria for the meta-analysis. Rather than explaining that here, I am attaching the Rodenburg paper which shows in detail what the inclusion criteria are and provides a detailed explanation of the methodology used. More recently, an RCT compared EMDR with a waiting list control for children with PTSD. The PTSD reduced to 25% in the EMDR group whilst remaining at 100% in the control group (Kemp, Drummond, & McDermott, 2009). Another study which directly compared CBT and EMDR for children with post-traumatic stress symptoms, showed that both interventions produced significant improvements but for EMDR this was achieved in fewer sessions (de Roos et al., 2011). Our colleague Carlijn de Roos (Psychotrauma Centre for Children and Youth, Leiden, The Netherlands) informs us that two large EMDR child studies (N > 150 in total) looking at EMDR compared with TF-CBT and 'writing therapy' are expected to be published early in 2014. In addition, it should be pointed out that, after careful consideration of the up to date available evidence, the World Health Organisation (WHO) have recommended EMDR as one of the two treatments of choice for PTSD in adults and children (WHO, 2013). It is therefore the recommendation of the EMDR	

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				Association that PTSD guidelines be reviewed at the earliest opportunity. de Roos, C., Greenwald, R., den Hollander-Gijsman, M., Noorthoorn, E., van Buuren, S., & de Jongh, A. (2011). A randomised comparison of cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) in disaster exposed children. European Journal of Psychotraumatology, 2, 5694. doi: 5610.3402/ejpt.v5692i5690.5694. Kemp, M., Drummond, P., & McDermott, B. (2009). A wait-list controlled pilot study of eye movement desensitization and reprocessing (EMDR) for children with post-traumatic stress disorder (PTSD) symptoms from motorvehicle accidents. Clinical Child Psychology and Psychiatry, 15, 5-25. Lee, C. W., & Cuijpers, P. (2013). A meta-analysis of the contribution of eye movements in processing emotional memories. Journal of Behavior Therapy and Experimental Psychiatry, 44, 231-239. Nijdam, M., Gersons, B., Reitsma, J., de Jongh, A., & Olff, M. (2012). Brief eclectic psychotherapy v.eye movement desensitisation and reprocessing therapy in the treatment of post-traumatic stress disorder: randomised controlled trial. British Journal of Psychiatry, 200, 224–231. Rodenburg, R., Benjamin, A., de Roos, C., Meijer,	

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				A., & Stams, G. (2009). Efficacy of EMDR in children: A meta-analysis. Clinical Psychology Review, 29, 599-606 Schubert, S., Lee, C., & Drummond, P. (2011). The efficacy and psychophysiological correlates of dual-attention tasks in eye movement desensitization and reprocessing (EMDR). Journal of Anxiety Disorders,, 25, 1-11. World Health Organisation. (2013). Guidelines for the management of conditions specifically related to stress. Geneva.	
132	Royal College of Psychiatrists	CG26 - PTSD	Disagree	*The College welcomes this opportunity to convey its views about the proposed 'static list' of Clinical Guidelines. It is of course right and proper that NICE conducts its clinical guideline review programme in a manner that is both efficient and sustainable, and the College supports the principle of some guidelines being reviewed less frequently when this is appropriate. However, we would urge NICE to consider two key aspects of how this may work in practice.* *Firstly, the methodology that the NCCMH employs to produce NICE mental health guidelines has changed considerably over recent years. Contemporary guidelines are produced using sophisticated network meta-analysis, which when combined with GRADE assessments to rate the quality of evidence have made it possible to make highly rigorous, accurate recommendations with a remarkable degree of confidence. Although there has been incremental improvement in the quality of*	Thank you for your comments. We appreciate that there have been changes to the methodology for developing guidelines in the past few years. However, this does not directly relate to the decision of NICE to move this topic to the static list based on the criteria laid out in the consultation. However, following consultation, this topic will not be transferred to the static list and will remain on the active list for 2 yearly reviews.

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				guidelines over the past 12 years, these new techniques represent a sea-change in the quality of clinical recommendations produced. These techniques have been developed relatively recently, and have only been available to the NCCMH since 2009. The College therefore strongly recommends that the mental health guidelines published before this year (and which have been selected for the proposed 'static list') automatically go through another round of guideline publication before being reconsidered for a longer review period. This will ensure that the latest iteration has been produced using the most robust methodology available. Even if there is no 'new' evidence as such, the significantly improved methodology could well result in a more nuanced, comprehensive interpretation of the existing data, with implications for subsequent recommendations, the quality of clinical care, patient safety and ultimately health outcomes. This cannot be ignored as a consideration. *Secondly, the College suggests that NICE reconsider the suggested term 'static list'. This term gives the misleading impression that no research is taking place in the respective guideline areas on the list, and also does not reflect the fact that guidelines will still be reviewed (albeit at a less frequent rate). Both of these misconceptions could be distressing for patients, who may infer that their condition is not being taken seriously. Alternatives could perhaps include 'long review cycle' or 'intermittent review' etc.*	

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				The College would also like to point out that mental health guidelines seem to be overrepresented in the proposed list, particularly in terms of topics where no significant research is ongoing. This is sadly symptomatic of the lack of parity of esteem accorded to mental health research, and the College will take this point up with the NIHR as a matter of urgency.	
CG31 OCD & BDD					
14	London Autistic Rights Movement and Committee member, Hoarding Peer Support Group	OCD & BDD (CG31)		Dear NICE, Not at all sure that original consultation was received. I have ccd in the Hoarding Peer Support Group email in. The new diagnosis of Hoarding Disorder makes it essential that the OCD/BPD guidelines are revised urgently and that clinical guidance on Hoarding Disorder is introduced as a matter of urgency. We will be discussing this as a matter of urgency on Sunday at our Committee meeting (Hoarding Peer Support Group) in Tower Hamlets (after our monthly support group meeting). I will also be raising it at a Conference on Hoarding in Hammersmith on Wednesday. Yours sincerely,	Thank you for your comment and for bringing this to our attention. However, we do not feel that the evidence base is evolving substantially in this area at this time. This issue will be considered at the next review of the guideline.

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				Adrian Whyatt, Vice-Chair, London Autistic Rights Movement and Committee member, Hoarding Peer Support Group (as well as a member of the Hammersmith and Fulham Mind Hoarding Group).	
50	Greater Manchester Health Economy	OCD & BDD (CG31)	Agree		Thank you..
85	NICE – Health and Social Care Quality Programme	CG31 – OCD/BDD	Disagree	Recommendations from CG31 underpin quality statements in the draft quality standard on anxiety currently in development. It will also be included within the topic overview of the eating disorders quality standard that will go out for stakeholder engagement in January 2014.	Thank you for your comment. However, a guideline being placed on the static list does not preclude its use to underpin a quality standard(s). Having considered the guideline against the criteria again in light of the comments recieved we do not feel that the evidence base is evolving substantially in this area at this time and therefore continues to fulfil one fo the two main criteria for its inclusion on the static list.
133	Royal College of Psychiatrists	CG31 - OCD/BDD	Disagree	*The College welcomes this opportunity to convey its views about the proposed 'static list' of Clinical Guidelines. It is of course right and proper that NICE conducts its clinical guideline review programme in a manner that is both efficient and sustainable, and the College supports the principle of some guidelines being reviewed less frequently when this is appropriate. However, we would urge NICE to consider two key aspects of how this may work in practice.* *Firstly, the methodology that the NCCMH employs to produce NICE mental health guidelines has changed considerably over recent years.*	Thank you very much for your comments. This guideline was reviewed in December 2010 where the decision was that it should not be updated at this time as no evidence was identified which would suggest a significant change in clinical practice. The decision to move this guideline to the static list reflects the result of the review in 2010 not to update. Having considered the criteria again in light of the comments received we do

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				Contemporary guidelines are produced using sophisticated network meta-analysis, which when combined with GRADE assessments to rate the quality of evidence have made it possible to make highly rigorous, accurate recommendations with a remarkable degree of confidence. Although there has been incremental improvement in the quality of guidelines over the past 12 years, these new techniques represent a sea-change in the quality of clinical recommendations produced. These techniques have been developed relatively recently, and have only been available to the NCCMH since 2009. The College therefore strongly recommends that the mental health guidelines published before this year (and which have been selected for the proposed 'static list') automatically go through another round of guideline publication before being reconsidered for a longer review period. This will ensure that the latest iteration has been produced using the most robust methodology available. Even if there is no 'new' evidence as such, the significantly improved methodology could well result in a more nuanced, comprehensive interpretation of the existing data, with implications for subsequent recommendations, the quality of clinical care, patient safety and ultimately health outcomes. This cannot be ignored as a consideration. *Secondly, the College suggests that NICE reconsider the suggested term 'static list'. This term gives the misleading impression that no research is taking place in the respective guideline areas on*	not feel that the evidence base is substantially evolving in this area at this time. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises.

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				the list, and also does not reflect the fact that guidelines will still be reviewed (albeit at a less frequent rate). Both of these misconceptions could be distressing for patients, who may infer that their condition is not being taken seriously. Alternatives could perhaps include 'long review cycle' or 'intermittent review' etc. *The College would also like to point out that mental health guidelines seem to be overrepresented in the proposed list, particularly in terms of topics where no significant research is ongoing. This is sadly symptomatic of the lack of parity of esteem accorded to mental health research, and the College will take this point up with the NIHR as a matter of urgency.*	
CG49 Faecal incontinence					
82	Coloplast	CG49 – Faecal incontinence	Disagree	While we accept that the previous review of the faecal incontinence guidance in 2010 did not find significant new evidence, we do feel that the current guidance is not fully comprehensive in relation to rectal irrigation. Under the previous system, where guidance was revisited every three years, the faecal incontinence guidance was originally due to be considered for review this year. We had most recently been told by NICE that the guidance would now be considered for review in 2015. With this in mind, we would be keen to gain clarity when exactly NICE will next give consideration to as review of the guidance.	Thank you very much for your comments. With regard to the issue relating to rectal irrigation, this does not directly relate to the decision of NICE to move this topic to the static list based on the criteria laid out in the consultation. As a static list guideline it will be reviewed every five years therefore the next planned review date for this guideline would be 2018. However, NICE would welcome being informed of the publication of any additional new evidence which may arise before this date.

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				We would also be interested in further detail on the process of drawing new evidence to the attention of NICE, should such evidence be published in the middle of a five year cycle, including the process by which NICE will make decisions on whether to remove guidance from the static list.	The Centre for Clinical Practice at NICE is developing a mechanism to consider future requests to remove topics from the static list. This will include what criteria will be used to assess the rationality of such requests, and subsequent measures to re-integrate topics to the regular guideline surveillance programme if it is found that the decision to put a topic on the static list is no longer valid. Details of this process will be made publically available on our website.
7	The Royal College of Surgeons of Edinburgh	CG49 - Faecal incontinence	Disagree	The Royal College of Surgeons of Edinburgh do not think that faecal incontinence (FI) is suitable to be removed from routine review. FI was the subject of a very comprehensive review in 2010. FI is the subject of considerable clinical research and evaluation of new techniques, such as neuromodulation and surgical correction of occult rectal prolapse. The College believes that an update to NICE guidelines will be required before the five-year period and it would potentially deprive many patients of optimum care if these changes were not assessed for inclusion into the relevant guidelines. An early review by the Association of Coloproctology could be a useful compromise, provided the advice was acted upon. Assessment	Thank you very much for your comments. This guideline underwent a surveillance review in December 2010 where the decision was that it should not be updated at this time as no evidence was identified which would suggest a significant change in clinical practice. The decision to move this guideline to the static list reflects the result of the review in 2010 not to update. Having considered the criteria again in light of all comments received we do not feel that the evidence base is substantially evolving in this area at this time. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would

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				and management of FI are the subject of a large NIHR project and this may affect practice. In addition, FI comes under specialist commissioning in England and this group may need support in their decision making in this area.	welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.
25	Uroplasty	CG49 – Faecal Incontinence	Disagree	We comment that there are ongoing randomized controlled trials that might give evidence to implement the Percutaneous Posterior Tibial Nerve Stimulation treatment modality as a specialized minimally invasive management for faecal incontinence. We ask to remain the CG49 active being subjected for review on new relevant clinical data.	Thank you very much for your comments. Whilst we understand that this is an area of active research, we do not feel that there is any new evidence at this time that would impact on the guideline. Clinical guidelines placed on the static list will continue to be reviewed every 5 years to determine if they should remain on the static list. However, NICE would welcome being informed of the publication of any additional new evidence that is likely to impact on the guideline before the next 5 year review.
26	Uroplasty	CG49 – Faecal Incontinence	Disagree	In the current CG49 the PTNS treatment is not described for treating faecal incontinence although there is evidence on safety and efficacy of the treatment, described in IPG395, Percutaneous tibial nerve stimulation (PTNS) for faecal incontinence. Also longer-term data on PTNS are and will come available to justify an update of the CG49.	Thank you very much for your comments. Having considered the criteria again in light of the comments received we do not feel that the evidence base is substantially evolving in this area at this time. Clinical guidelines placed on the static list will continue to be reviewed every 5 years to determine if they should remain on the static list.

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					In the meantime, NICE would welcome being informed of the publication of any additional new evidence that is likely to impact on the guideline.
45	Greater Manchester Health Economy	Faecal incontinence (CG49)	Agree		Thank you.
102	Royal College of Physicians (RCP)	Faecal incontinence (CG49)	No objections raised	The RCP has liaised with the BSG and has no objections to this guideline being moved to the static list. We understand from expert feedback that there may be a need to provide some guidance or position statements on a few discrete areas of the topic, in the short term. However, we would envisage that this might be progressed via the specialist society until a full review of CG49 by NICE takes place.	Thank you for your comments.
CG50 Acutely ill patients in hospital					
3	Patients and Relatives Committee, Intensive Care Society	CG 50 Acutely ill patients.	Agree	There is little new evidence related to this Clinical Guideline but the relevance of the Guideline remains very pertinent particularly in the like to the findings of the enquiry into the Mid Staffordshire Hospital. This Guideline needs to be maintained as live but it is not necessary to be regularly reviewed.	Thank you very much for your comments. In light of information provided through the consultation process, we propose to not transfer this topic to the static list, and the guideline will continue to undergo regular 2 yearly surveillance.
29	Resuscitation Council (UK)	CG50 - Acutely ill patients in hospital	Disagree	We have major reservations about your plan to move CG50 on to a static list for the following reasons: • Following its publication there was evidence	Thank you very much for your comments. In light of information provided through the consultation process, we propose to not transfer this topic to the static list, and the guideline

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				of failure of implementation, exemplified by the events at Stafford Hospital and by the findings reported in the NCEPOD report on cardiorespiratory arrests in hospitals “Time to Intervene” and in the CIPOLD report. • As a result there is widespread public concern about the care of patients in hospitals, including those who are acutely ill. • There is a lot of work being done to try to improve the quality of acute hospital care, particularly but not exclusively in response to the Francis report and the other reports referred to above. • Over the coming months and years this topic will be a focus of active attention for healthcare professionals, for hospital managers, for the government and the Department of Health, and for the public. • Since the publication of CG50 there have been other interventions, such as the publication of the NEWS score, which may contribute to improved acute care, and which would be expected to generate new evidence of relevance to any review of CG50. • Over the coming months and years various aspects of acute hospital care are likely also to generate publication of clinical data and other scientific evidence that would inform any review of CG50.	will continue to undergo regular 2 yearly surveillance

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				We believe that the content of this guideline and effective implementation thereof is of such importance to the promotion of high-quality care in NHS hospitals that it should be kept under active review by NICE at intervals of substantially less than 5 years, to demonstrate clearly to all that its recommendations remain current,.	
33	Greater Manchester Health Economy	Acutely ill patients in hospital (CG50)	Agree		Thank you for your comment.
99	Royal College of Physicians (RCP)	Acutely ill patients in hospital (CG50)	Strongly disagree	The RCP strongly disagrees with the proposal to move CG50 to the static list. We would like to make the following comments • CG 50 was issued in 2007 with planned review in 2010 - when it was decided not to proceed. The proposal to transfer the guidance to the static list in 2013 would therefore considerably extend the period to the next review. • CG 50 is a core NICE standard for acute patient care in hospital. It crosses all specialties and is fundamental to generic high quality medical care. This is highly topical given the failings in care identified by Francis and the recommendations in the Future Hospital Commission report to RCP about enhancing care provided by generalists in hospital. Furthermore, there is concern about maintaining standards of acute care across all hospitals and wards within individual hospitals and CG50 is at the heart of these standards.	Thank you very much for your comments. In light of the information provided through consultation, we propose to not transfer this topic to the static list, and the guideline will continue to undergo regular 2 yearly surveillance.

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				• In the period that CG 50 has not received a detailed revision the RCP has launched NEWS (National Early Warning Score) which has been adopted widely and has generated significant audit and research activity. We also believe that there is far more research activity centred on this subject than the NICE review of the situation suggests.	
CG52 Opiod Detoxification					
44	Greater Manchester Health Economy	Drug misuse – opioid detoxification (CG52)	Agree		Thank you for your comment.
70	Department of Health	CG52 – Opioid detoxification (	Agree	Confirming that we have no problem with opioid detoxification being moved to the static list.	Thank you for your comment.
134	Royal College of Psychiatrists	CG52 - Opiod Detoxification	Disagree	*The College welcomes this opportunity to convey its views about the proposed 'static list' of Clinical Guidelines. It is of course right and proper that NICE conducts its clinical guideline review programme in a manner that is both efficient and sustainable, and the College supports the principle of some guidelines being reviewed less frequently when this is appropriate. However, we would urge NICE to consider two key aspects of how this may work in practice.* *Firstly, the methodology that the NCCMH employs to produce NICE mental health guidelines has changed considerably over recent years.*	Thank you very much for your comments. While we appreciate your comments relating to changes to the methodology for developing mental health guidelines, this does not directly relate to the decision of NICE to move this topic to the static list based on the criteria laid out in the consultation which is based on the changes to the evidence base and likelihood of relevant evidence being published in the near future. The Centre for Clinical Practice at NICE

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				Contemporary guidelines are produced using sophisticated network meta-analysis, which when combined with GRADE assessments to rate the quality of evidence have made it possible to make highly rigorous, accurate recommendations with a remarkable degree of confidence. Although there has been incremental improvement in the quality of guidelines over the past 12 years, these new techniques represent a sea-change in the quality of clinical recommendations produced. These techniques have been developed relatively recently, and have only been available to the NCCMH since 2009. The College therefore strongly recommends that the mental health guidelines published before this year (and which have been selected for the proposed 'static list') automatically go through another round of guideline publication before being reconsidered for a longer review period. This will ensure that the latest iteration has been produced using the most robust methodology available. Even if there is no 'new' evidence as such, the significantly improved methodology could well result in a more nuanced, comprehensive interpretation of the existing data, with implications for subsequent recommendations, the quality of clinical care, patient safety and ultimately health outcomes. This cannot be ignored as a consideration. *Secondly, the College suggests that NICE reconsider the suggested term 'static list'. This term gives the misleading impression that no research is taking place in the respective guideline areas on*	is developing a mechanism to consider future requests to remove topics from the static list. This will entail what criteria will be used to assess the rationality of such requests, and subsequent measures to re-integrate topics to the regular guideline surveillance programme if it is found that the decision to put a topic on the static list is no longer valid. Details of this process will be made publically available on our website.

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				the list, and also does not reflect the fact that guidelines will still be reviewed (albeit at a less frequent rate). Both of these misconceptions could be distressing for patients, who may infer that their condition is not being taken seriously. Alternatives could perhaps include 'long review cycle' or 'intermittent review' etc. *The College would also like to point out that mental health guidelines seem to be overrepresented in the proposed list, particularly in terms of topics where no significant research is ongoing. This is sadly symptomatic of the lack of parity of esteem accorded to mental health research, and the College will take this point up with the NIHR as a matter of urgency.*	
CG53 CFS/M.E.					
20	Action for M.E.	CG53 – CFS/M.E.	Disagree	Action for M.E. emphatically disagrees with the proposal to add the NICE guideline CG53 for CFS/M.E. to the static list.	Thank you for your comment. This guideline was reviewed in March 2011 where the decision was that it should not be updated at that time as no new evidence was identified which would suggest a significant change in clinical practice. The decision to move this guideline to the static list reflects the result of the no to update decision from the review in 2011. Since that review NICE is not aware of any important new studies likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Having considered the criteria again in light of all comments received

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					we do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.
21	Action for M.E.	CG53 – CFS/M.E.		Patients have told us that they feel ignored and neglected, and any further delay in reviewing the guidelines would exacerbate this. Their comments include: • "Putting it back to only reviewing every 5 years is just another example of how we are shoved to the background and ignored by the medical profession." • "So much research is now happening into M.E. that a two year reassessment would be best. Knowledge of our illness is progressing rapidly compared to 10-20 years ago. Please don't let NICE keep us in the past" • "This outrageous proposal seems designed	Thank you for your comment. This guideline was reviewed in March 2011 where the decision was that it should not be updated at that time as no new evidence was identified which would suggest a significant change in clinical practice. The decision to move this guideline to the static list reflects the result of the no to update decision from the review in 2011. Since that review NICE is not aware of any important new studies likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Having considered the criteria again in light of all comments received

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				to perpetuate the totally inappropriate status quo for this neglected neuroimmune disorder. Don't let them keep pushing us to the side lines."	we do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.
22	Action for M.E.	CG53 – CFS/M.E.		We are also very concerned that reducing the frequency of the review process would mean that patients face an unacceptable wait for new research to be taken into account when considering treatment. As one of our members who got in touch about this consultation emphasised: "I think most people with M.E. think that medical practice needs to evolve somewhat. I would see changes to NICE guidelines as a trigger for progress, and can only assume that lengthening the period between reviews would slow progress down."	Thank you for your comment. This guideline was reviewed in March 2011 where the decision was that it should not be updated at that time as no new evidence was identified which would suggest a significant change in clinical practice. The decision to move this guideline to the static list reflects the result of the no to update decision from the review in 2011. NICE is not aware of any important new studies likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Having considered the criteria again in light of all comments received we still do not feel

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					that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.
23	Action for M.E.	CG53 – CFS/M.E.		It also sends the erroneous message to GPs and other healthcare professionals using the guidelines that little new research is being done. But the field of M.E. research is attracting more interest than ever before, particularly with the launch of the UK CFS/M.E. Research Collaborative (UK CMRC) in April this year, of which Action for M.E. is an executive board member.	Thank you for highlighting that the UK CFS/ME Research Collaborative has funded CFS/ME research. However, as these studies are laboratory or small-scale pilot studies the results of this research are unlikely to contradict the decision to move this guideline onto the static list. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review.

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					By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.
24	Action for M.E.	CG53 – CFS/M.E.		A similar body, the UK Respiratory Research Collaborative, was established in 2006 with the aim of driving forward the respiratory research agenda. This resulted in a three-fold increase in research funding in this field including research projects, programmes, centres, networks, Fellowships and PhD studentships. We have every reason to hope that the Collaborative will also attract new researchers into the field of M.E. research, grow our knowledge about the condition and stimulate much-needed investment in high quality, peer-reviewed research. To choose this time, therefore, to reduce the frequency with which the NICE guideline for CFS/M.E. is reviewed, may counteract the much-needed progress that is finally being made.	Thank you for highlighting that the UK CFS/ME Research Collaborative has funded CFS/ME research. However, the issue of increasing research activity and funding in this field whilst encouraging is unlikely to impact significantly within the near future so that a 5 year review is still considered appropriate by NICE. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the

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					publication of any additional new evidence when it arises before the next 5 year review.
37	Greater Manchester Health Economy	CFS/ME (CG53)	Agree		Thank you.
59	FORWARD-ME	CG53	Disagree	We are writing to you as members of the Forward ME Group – an alliance of national patient support and research funding organisations for people with ME and CFS . At our meeting on Tuesday 15 October at the House of Lords we discussed a proposal to place the NICE Guideline on CFS/ME (CG53) into the static list. We express our extreme concern over this proposal and strongly feel that the guideline must remain on the active list for the following reasons. Medical and scientific advances in relation to ME and CFS are taking place very rapidly. We therefore believe this is completely the wrong time to remove this guideline from the active list when these developments need to be regularly reviewed. When Professor Peter Littlejohns attended the meeting of the All Party Parliamentary Group on ME in February 2007 it is minuted that: “He explained that he had been responsible for clinical guidelines at NICE since their inception. All NICE guidelines were produced on the basis of best available evidence and on a process based on transparency, active consultation and review. He	Thank you for your comment. This guideline was reviewed in March 2011 where the decision was that it should not be updated at that time as no new evidence was identified which would suggest a significant change in clinical practice. The decision to move this guideline to the static list reflects the result of the no to update decision from the review in 2011. Since that review NICE is not aware of any important new studies likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list

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				added that guidance however robust is not set in stone; medical advances can happen very quickly and NICE aims to make guidance as up to date as possible. A total of 118 guidelines, including 51 of clinical guidance, have been produced over the past 18 months. NICE was the biggest guideline production unit in the world. Any organization affected by a guidance should be part of the development of that guideline." (None of which has ever materialised). Individual members of the Forward ME Group who are also stakeholders will be sending submissions which will cover our concerns in more detail. However, as a united group representing people with ME and CFS in the United Kingdom, we feel so strongly about this proposal that we are sending in this joint response.	it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.
61	The ME Association			**Proposal by NICE to move the guideline on ME/CFS to the static list** **Submission from The ME Association** The ME Association is strongly opposed to the proposal to place the current (2007) NICE guideline on ME/CFS into the newly created static list. We do so for the following four reasons: 1. Along with most other ME/CFS charities, and people with ME/CFS, we have been unable to endorse the current NICE guideline. We believe	Thank you for supplying evidence relevant to the guideline CG53. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than

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				the ME/CFS guideline can only become fit for purpose following fundamental changes to the sections covering clinical assessment, investigation, diagnosis and management. 2. Important evidence from published sources, and from people with ME/CFS, has been either ignored or missed by NICE. 3. New and emerging evidence relating to clinical assessment, diagnosis and management of ME/CFS needs to be included in a comprehensive review. 4. Whilst accepting that there is a good case for placing conditions that already have a settled diagnosis and successful forms of treatment into a static list, ME/CFS is a condition that is still in a state of flux involving uncertainty and debate over diagnosis, cause and management. Based on the content of the *Quick Reference Guide* that was produced by NICE for health professionals we highlight some key areas of concern relating to the above four points. The list is not complete – it simply summarises a sufficient number of examples, along with references to relevant sources of published evidence, to justify a review.	other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.

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				Introduction (Page 3) The guideline fails to adequately demonstrate that ME/CFS covers a wide range of clinical presentations/phenotypes and disease pathways. Consequently, it is inappropriate for NICE to recommend that two specific forms of treatment (ie CBT/cognitive behavior therapy and/or GET/graded exercise therapy) are going to be safe and effective for everyone who comes under the ME/CFS umbrella. We will cover this key point in more detail later in the submission. **Symptoms (Page 7, Box 1)** Having produced a new and inappropriate clinical definition for the diagnosis of ME/CFS in the guideline, and one that extends the heterogeneity even further, the symptom list has serious omissions, especially in relation to characteristic symptoms associated with autonomic dysfunction – eg orthostatic intolerance and/or hypotension and postural orthostatic tachycardia syndrome (POTS). Evidence: Hoad A *et al:*	

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				SUBJECTS: *Fifty-nine patients with CFS/ME (Fukuda criteria) and 52 age- and sex-matched controls underwent formal autonomic assessment in the cardiovascular laboratory with continuous heart rate and beat-to-beat blood pressure measurement (Task Force, CNSystems, Graz Austria). Haemodynamic responses to standing over 2 min were measured. POTS was defined as symptoms of orthostatic intolerance associated with an increase in heart rate from the supine to upright position of >30 beats per minute or to a heart rate of >120 beats per minute on standing.* ***RESULTS:*** *Maximum heart rate on standing was significantly higher in the CFS/ME group compared with controls (106 +/- 20 vs. 98 +/- 13; P = 0.02). Of the CFS/ME group, 27% (16/59) had POTS compared with 9% (5) in the control population (P = 0.006). This difference was predominantly related to the increased proportion of those in the CFS/ME group whose heart rate increased to >120 beats per minute on standing (P = 0.0002). Increasing fatigue was associated with increase in heart rate (P = 0.04; r(2) = 0.1).* ***CONCLUSION:*** *POTS is a frequent finding in patients with CFS/ME. We suggest that clinical evaluation of patients with CFS/ME should include response to standing. Studies are needed to determine the optimum intervention strategy to manage POTS in*	

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				those with CFS/ME. At the same time, the diagnostic list of symptoms produced by NICE includes symptoms such as palpitations that can occur in ME/CFS but are not characteristic of the condition. And the fact that palpitations have to occur in the absence of identified cardiac pathology would appear to exclude those caused by autonomic dysfunction or POTS. When Professor Peter Littlejohns came to talk to the All Party Parliamentary Group on ME in February 2007, the Minutes record that he stated: *"…although NICE considered definitions, NICE was not in a position to define conditions".* Yet what is widely perceived to be a new clinical definition of ME/CFS, that has been produced by NICE, appears in the guideline. **Differential diagnosis (Page 7, Box 2)** There is a significant problem with the misdiagnosis of ME/CFS – even where patients are being referred to specialist centres: Evidence: Newton JL et al: *Of the 40% of patients subsequently found not to*	

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				have CFS the most common diagnosis was fatigue associated with a chronic disease (47% of all alternative diagnoses); 20% had primary sleep disorders, 15% psychological/psychiatric illnesses and 4% a cardiovascular disorder. Thirteen per cent remained unexplained (5.2% of the total referrals). This study found a significant increase in the proportion of patients referred to National Health Service (NHS) CFS services diagnosed with CFS. A large proportion of patients presenting with fatigue are not eligible for referral to the Department of Health specialist fatigue services, which represents an unmet need in terms of symptom management in current NHS services This section therefore needs to include examples of conditions that are being misdiagnosed as ME/CFS in both adults and children – eg coeliac disease, primary biliary cirrhosis, joint hypermobility syndrome, systemic lupus erythematosus – and not just consist of a list of six very obvious 'red flag' symptoms and signs that are strongly suggestive of other possible explanation. **Investigations (Page 8, Box 3)** Following on from the previous point, the provision of information on the differential diagnosis of ME/CFS in this section needs to also provide examples of investigations that do not need to form part of the essential list of investigations but should be seriously considered, where appropriate, in the	

ID	Stakeholder	Guideline title and number	Agree / Disagree	Comments Please insert each new comment in a new row.	NICE Response Please respond to each comment
				clinical assessment of someone with ME/CFS. For example: **Vitamin D** levels in people with moderate to severe ME/CFS who are mainly or totally housebound and are obviously at risk of developing vitamin D deficiency due to lack of exposure to sunlight. Evidence: Berkovitz S et al: ***INTRODUCTION:*** *Patients with chronic fatigue syndrome (CFS) may be at risk of osteoporosis due to their relative lack of physical activity and excessive time spent indoors, leading to reduced vitamin D synthesis. We hypothesized that serum 25-OH vitamin D levels are lower in CFS patients than in the general British population.* ***SUBJECTS AND METHODS:*** *We performed a retrospective survey of serum 25-OH vitamin D levels in 221 CFS patients. We compared this to a group of patients attending the hospital for other chronic conditions and to a large British longitudinal survey of 45-year old women, using a variety of appropriate statistical approaches.* ***RESULTS:*** *25-OH vitamin D levels are moderately to severely suboptimal in CFS patients, with a mean of 44.4 nmol/L (optimal levels >75 nmol/L). These levels*	

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				are lower and the difference is statistically significant (p<0.0004) than those of the general British population from a recent national survey, but similar to those in patients with other chronic conditions. *A retrospective study of serum 25-OHD levels in 221 ME/CFS patients found moderately to severe suboptimal levels, with a mean level of 44.4nmol/L.* Vitamin D deficiency often goes unrecognised and can cause bone or muscle pain and muscle weakness. It can co-exist with ME/CFS. Levels < 25ng/ml may be associated with symptoms. **Short synacthen test** where there are symptoms, signs or laboratory test results which indicate that there is significant hypocortisolaemia **Tilt table testing** where there are symptoms and signs suggesting significant autonomic dysfunction or POTS. Evidence: Lewis I et al: *Research aimed at characterising ME/CFS patients with and without POTS found that those with POTS were younger, less fatigued, less depressed, and had reduced daytime somnolence. They also had greater orthostatic intolerance and autonomic dysfunction. Those with POTS may require further investigation and consideration for therapy to*	

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				control heart rate. At the same time the guideline is in effect banning one investigation that could be of wider benefit: ***Do not do: ……tests for serum ferritin in adults, unless other tests suggest iron deficiency* (page 8)** This recommendation is over-restrictive and misleading because serum ferritin can be the first laboratory marker to change when iron deficiency/depletion is present. Evidence: Guidelines for the Management of Iron Deficiency Anaemia: British Gastroenterology Society Iron deficiency/depletion without anaemia (as proven by a low serum ferritin – hypoferritinaemia) is three times as common as iron efficiency anaemia and may cause fatigue, cognitive dysfunction and restless legs - all of which occur in ME/CFS. Iron deficiency can also be a 'red flag' warning sign for conditions that are misdiagnosed as ME/CFS – coeliac disease for example. **Symptom management (page 11)** In addition to omitting any reference to orthostatic intolerance and/or hypotension, there is no	

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				information on the clinical assessment, self-help management and possible pharmacological management of orthostatic intolerance and hypotension, or POTS. **Education and employment (page 12)** ME/CFS is recognised to be a disability under section A6 of the 2010 Equality Act. This should be included in this section because the Act legislates for important adjustments in working hours and duties that could be used to help keep someone with ME/CFS in employment or at school/college/university. Evidence: *A6. A disability can arise from a wide range of impairments which can be impairments with fluctuating or recurring effects such as rheumatoid arthritis, myalgic encephalitis (ME)/chronic fatigue syndrome (CFS), fibromyalgia, depression and epilepsy* **Strategies that should not be used for CFS/ME (Page 13)** We would accept that there is no indication at present to positively recommend the use of antiviral and immunomodulatory drugs. However, the recommendation to in effect ban the prescribing of antiviral drugs needs to be balanced with an	

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				acknowledgement that there is new and emerging evidence to indicate that antiviral medication using valganciclovir (Watt T et al) and B cell depletion using Rituximab (Fluge O et al) could be an effective form of treatment in at least a sub-group of people with ME/CFS – possibly those with evidence of reactivation of human herpes virus infection (ie valganciclovir) or where there is an autoimmune component (Rituximab). **Treatment approaches (Page 14)** The implication here is that any form of vitamin supplementation should not be prescribed or recommended. As already noted, people with moderate to severe ME/CFS are at increased risk of developing vitamin D deficiency. Consequently, they should be treated with a vitamin D supplement when appropriate. For those at increased risk, consideration should be given towards the use of a prophylactic vitamin D supplement. **CBT, GET and Pacing (Page 18 onwards)** Our principle reason for opposing this proposal and requesting a fundamental review of the guideline relates to the recommendation that CBT and GET should be automatically offered to everyone with mild or moderate ME/CFS.	

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				This is coupled with the continuing failure of NICE to take note of highly consistent patient evidence, dating back to evidence that was published in the 2002 Chief Medical Officer's report on ME/CFS, regarding the efficacy and safety of these two behavioural treatments. The largest ever survey of patient evidence relating to all aspects of the management of ME/CFS was carried out by The ME Association and published in 2010 (ME Association). The report provided important evidence regarding concerns over the efficacy of CBT and the safety of GET. **For CBT** (997 responses) Greatly improved: 2.8% Improved: 23.1% No change: 54.6% Slightly worse: 11.6% Much worse: 7.9% **For GET** (906 responses) Greatly improved: 3.4% Improved: 18.7% No change: 21.4% Slightly worse: 23.4% Much worse: 33.1% **For Pacing** (2137 responses) Greatly improved: 11.6% Improved: 59.6%	

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				No change: 24.1% Slightly worse: 3.5% Much worse: 1.2% The MEA is currently in the final stages of preparing a further report covering the use of CBT, GET and Pacing – but this time in much greater depth. The report will be based on the answers to questions on the above three treatments that were provided through 3142 responses given by 1429 respondents during 2012. Overall, the patient evidence contained in this new MEA report is very similar to the evidence contained in the 2010 report. The two MEA surveys show a total of 6599 responses about the effect of treatments on symptoms, and a total of 6838 responses about appropriateness of courses, effectiveness of self management and helpfulness of consultations and general satisfaction. However, to date NICE has failed to consider any of this patient evidence and both MEA reports support the findings from patient surveys referred to in the Chief Medical Officer's Working Group report into ME/CFS. We are therefore looking at a consistent picture from patients with regard to all three approaches to management going back over at least a decade and the picture has not improved.	

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				As a result of growing concern amongst people with ME/CFS about the efficacy and safety of CBT and GET, we will be making a number of radical recommendations regarding the future use of CBT and GET in ME/CFS in this report. This is clearly important new evidence that cannot be ignored by NICE. **The PACE trial and the March 2011 surveillance review** Finally, in relation to CBT and GET and Pacing, we assume that the guideline surveillance review that took place in March 2011, and which followed publication of the PACE trial in February 2011, simply 'rubber stamped' the 2007 NICE guideline recommendations on the basis that the PACE trial had supported the recommendations relating to CBT and GET. However, there has been widespread and valid criticism about the way in which the PACE trial was carried out, as well as the way in which the results were presented and reported (Shepherd CB). In addition, it should be noted that the cost effectiveness paper (McCrone P *et al*) reported that take up of state sickness benefits had increased during the PACE trial for all four treatments (ie CBT, GET, Pacing and Standard Medical Care). The MEA report will also contain similar information	

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				on benefit status. **Conclusion** ME/CFS is a condition that is still in a state of flux involving uncertainty and debate over diagnosis, cause and management. We have provided examples of existing or emerging evidence that fully justify a review of the NICE guideline on ME/CFS. In addition, we do not believe that there is any justification for NICE to continue to recommend that everyone with mild or moderate ME/CFS requires CBT and/or GET. The NICE guideline should therefore be thoroughly reviewed and there is no justification in the current circumstances to place it in a static list. The MEA would be very willing to provide additional information, clarification or references. We will send a copy of our new report on CBT, GET and Pacing on completion. We are aiming to complete this work by the end of 2013. When Professor Littlejohns came to the APPG in February 2007 he stated:	

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				"All NICE guidelines were produced on the basis of best available evidence and on a process based on transparency, active consultation and review". **He added that*:*** *"Guidance however robust is not set in stone; medical advances can happen very quickly and NICE aims to make guidance as up to date as possible. Any organization affected by a guideline should be part of the development of that guideline".* We do not believe that NICE has been listening to people with ME/CFS – the vast majority of whom do not endorse this current guideline – and we do not believe that patient support organisations are being allowed to playing a meaningful role in the on-going development of this guideline. So we hope and expect that NICE will listen to the people with ME/CFS and their representatives on this occasion. **References** **All Party Parliamentary Group on ME** Minutes for meeting dated 22 February 2007: http://appgme.org.uk/Downloads/minutes/appgmins2007/APPG_minutes_22_February_07.pdf	

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				Berkovtiz S *et al.* Serum 25-hydroxy vitamin D levels in chronic fatigue syndrome: a retrospective study. *International Journal for Vitamin and Nutrition Research,* 2009, 79, 250-254. **Fluge O *et al.*** Benefit from B-lymphocyte depletion using the anti-CD20 antibody Rituximab in chronic fatigue syndrome. A double-blind and placebo-controlled study. *PLoS One,* 2012, 6, e26358. **Guidelines for the Management of Iron Deficiency Anaemia** British Society for Gastroenterology, May 2005. **Hoad A *et al.*** Postural orthostatic tachycardia syndrome is an under- recognized condition in chronic fatigue syndrome. *Quarterly Journal of Medicine,* 2008, 101, 961-965. **Lewis I *et al.*** Clinical characteristics of a novel subgroup of chronic fatigue syndrome patients with postural orthostatic tachycardia syndrome. *Journal of Internal Medicine,* 2012. **MEA Association**. Managing my M.E. What people with ME/CFS and their carers want from the UK's health and social services (2010): http://www.meassociation.org.uk/wp-content/uploads/2010/09/2010-survey-report-lo-res10.pdf	

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				McCrone P *et al.* Adaptive pacing, cognitive behavior therapy, graded exercise, and specialist medical care for chronic fatigue syndrome: A cost effectiveness analysis. *PLoS One,* 2012, 7, e40808. **Newton JL *et al.*** The Newcastle NHS Chronic Fatigue Syndrome Service: not all fatigue is the same. *Journal of the Royal College of Physicians of Edinburgh,* 2010, 40, 304 – 307. **Report of the CFS/ME Working Group:** Report to the Chief Medical Officer of an Independent Working Group. January 2002. http://www.erythos.com/gibsonenquiry/docs/cmoreport.pdf **Shepherd CB.** Problems with the PACE trial. *Psychological Medicine,* 2013, 43, 1790 – 1791. **Watt T *et al.*** Response to valganciclovir in chronic fatigue syndrome patients with human herpesvirus 6 and Epstein-Barr virus IgG antibody titres. *Journal of Medical Virology,* 2012, 84, 1967 - 1974. Ends	
88	NeuroImmun	CG53 –	Disagree	There is no study published in a peer reviewed	Thank you for your comment. The GDG

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	e Science	CFS/ME		journal where patients were recruited into studies using the internationally agreed consensus "Fukuda" criteria which demonstrates any superiority over no treatment for Cognitive Behaviour therapy (CBT) or Graded exercise therapy (GET) on any objective measure. Current guidelines are therefore inappropriate.	noted that the diagnostic criteria for CFS/ME varied among studies and that the evidence base for existing case definitions of CFS/ME was not robust. The criteria for inclusion of studies in the guideline included adults or children aged 5 years or more with a diagnosis of CFS/ME based on any criteria. Therefore, any studies recruiting patients based on the Fukuda criteria would have been considered for inclusion during guideline development and in the 2011 review of the guideline. NICE is not aware of any important new studies likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Please note that clinical guidelines placed on the static list will be reviewed every 5 years to determine if they should remain on the static list. However, if you become aware of any new evidence or information from clinical practice that is likely to impact on the guideline, please contact NICE with the appropriate details.
89	NeuroImmune Science	CG53 – CFS/ME	Disagree	A large publically funded study, known as the FINE trial, also failed to find any benefit in the use of CBT over and above routine doctors visits. http://www.ncbi.nlm.nih.gov/pubmed/20418251	Thank you for your comment. The FINE trial was considered at the 3 year review of the guideline conducted in March 2011. Through an assessment of the abstract it was concluded that this trial of pragmatic rehabilitation, supportive

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					listening and General Practitioner treatment as usual reported inconclusive results and was unlikely to impact on the guideline recommendations. NICE is not aware of any important new studies likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.
90	NeuroImmune Science	CG53 – CFS/ME	Disagree	A large publically funded study, known as the PACE trial, was funded to looked at CBT and GET offered by the NICE guidelines. The primary mechanism for selection of patients into the PACE study was a semi structured	Thank you for your comment. This guideline was reviewed in March 2011 where the decision was that it should not be updated at that time as no new evidence was identified which would suggest a significant change in clinical

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				questionnaire constructed by Sharpe et al., 1991 (http://www.ncbi.nlm.nih.gov/pubmed/1999813). This is not an internationally recognized method for diagnosing patients with chronic fatigue syndrome. In fact no internationally recognized criteria were used in this study. Notably the current International consensus criteria set out in Fukuda et al., 1994 (http://www.ncbi.nlm.nih.gov/pubmed/7978722) were not used, as can be seen from the following extracts from the paper: "Participants were also assessed by international criteria for chronic fatigue syndrome,12 requiring four or more accompanying symptoms, and the London criteria13for myalgic encephalomyelitis (version 2)," http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3065633/ As can be seen below reference 12 refers to the unvalidated "Reeves" criteria and not the internationally recognized "Fukuda" criteria. The so called Myalgic Encephalomyelitis criteria (ref 13) refers to unpublished unvalidated criteria primarily drawn up by an individual Health Psychologist with no medical training. 12. Reeves WC, Lloyd A, Vernon SD, Klimas N, Jason LA, Bleijenberg G, Evengard B, White PD, Nisenbaum R, Unger ER, International Chronic Fatigue	practice. The results of the PACE trial were considered at this review point. The decision to move this guideline to the static list reflects the result of the no to update decision from the review in 2011. The issue raised relating to recruitment for the PACE trial does not directly relate to the decision by NICE to move this topic to the static list based on the criteria laid out in the consultation. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.

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				Syndrome Study Group BMC Health Serv Res. 2003 Dec 31; 3(1):25. 13. The London criteria Report on chronic fatigue syndrome (CFS), post viral fatigue syndrome (PVFS) and myalgic encephalomyelitis (ME) The National Task Force; Westcare, Bristol: 1994. Therefore we have a publically funded study costing some 5 million pounds purporting to examine the effects of graded exercise and CBT as "treatments" for Chronic Fatigue Syndrome where the patients were not diagnosed using any internationally agreed research criteria.	
91	NeuroImmune Science	CG53 – CFS/ME	Disagree	The meaning of standard medical care in the PACE study In this study Standard Medical care equates to clinic visits, non specific advice, and, if required, drug treatment for comorbid conditions. In short this equates to no treatment as far as the illness is concerned. The complete section is outlined below "Standardised Specialist Medical Care SSMC will be given to all participants. This will include visits to the clinic doctor with general, but not specific advice, regarding activity and rest management,	Thank you for your comment. The issue that the consultee raises does not directly relate to the decision by NICE to move this topic to the static list based on the criteria laid out in the consultation.

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				such as advice to avoid the extremes of exercise and rest, as well as pharmacotherapy for specific symptoms and comorbid conditions. SSMC is standardised in the SSMC Doctor's Manual. As well as this, SSMC participants, like all other participants, will already have received the Patient Clinic Leaflet (PCL). The PCL is a generic leaflet explaining what CFS/ME is, its likely causes, and available treatments." http://www.biomedcentral.com/1471-2377/7/6	
92	NeuroImmune Science	CG53 – CFS/ME	Disagree	Conflict between subjective and scientific measurements in the PACE study. Patients recruited into the study displayed horrendous levels of disability both when measured subjectively(SF-36) and scientifically (distance walked in 6 mins). See Table 6 in http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3065633/ Table 6 average figures: No treatment arm (standard medical care) • Baseline distance (m) = 326 • 52-week distance (m) = 348 Graded exercise therapy	Thank you for your comment. This guideline was reviewed in March 2011 where the decision was that it should not be updated at that time as no new evidence was identified which would suggest a significant change in clinical practice. The results of the PACE trial were considered at this review point. The decision to move this guideline to the static list reflects the result of the no to update decision from the review in 2011. The issue that the consultee raises relating to the PACE trial does not directly relate to the decision by NICE to move this topic to the static list based on the criteria laid out in the consultation.

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				• Baseline distance (m) = 312 • 52-week distance (m) = 379 Cognitive behaviour therapy • Baseline distance (m) = 333 • 52-week distance (m) = 354 After 52 weeks GET and CBT produced a change in patients perceptions and beliefs about their disability but not the reality of their disability. CBT was no better at improving the distance walked in 6 minutes than doing nothing at all (standard medical care). GET produced an increase in distance walked in 6 minutes of 45 metres compared to doing nothing at all. The difference is statistically significant but clinically and practically insignificant. 31% of the GET data remains unpublished (See Table 6 in http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3065633/). Following a year of GET and CBT the reality of the patients quite horrendous levels of disability had not changed at all.	Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.
93	NeuroImmune Science	CG53 – CFS/ME	Disagree	Inappropriate use of the term randomization in the PACE study. Participants in the PACE study were not randomised according to the normal meaning of the	Thank you for your comment. This guideline was reviewed in March 2011 where the decision was that it should not be updated at that time as no new evidence was identified which would

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				term in randomised controlled trial, as can be seen from the following extracts from the paper. Minimisation with a random component is not randomization. "Once an eligible participant has completed the baseline assessment and given written informed consent, the RN will contact the MH&N CTU for treatment allocation by facsimile, giving the criteria needed for randomisation." http://www.biomedcentral.com/1471-2377/7/6 "Allocation will be stratified by centre, CDC Criteria (met or unmet), London Criteria (met or unmet) and depressive disorder (major, minor depressive episode and dysthymia being present or absent) using minimisation with a random component [45]" http://www.biomedcentral.com/1471-2377/7/6	suggest a significant change in clinical practice. The results of the PACE trial were considered at this review point. The decision to move this guideline to the static list reflects the result of the no to update decision from the review in 2011. The issue that the consultee raises relating to the method of randomisation used in the PACE trial does not directly relate to the decision of NICE to move this topic to the static list based on the criteria laid out in the consultation. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.

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				45. Pocock SJ, Simon R: Sequential Treatment Assignment with Balancing for Prognostic Factors in the Controlled Clinical Trial. Biometrics 1975, 31(1):103-115. http://www.biomedcentral.com/1471-2377/7/6 Randomisation should not depend on criteria in any way or it is not unrestricted randomization. Otherwise patients do not have an equal chance of being randomised into each of the four groups. In short randomisation is biased by preordained but unstated criteria.	
94	NeuroImmune Science	CG53 – CFS/ME	Disagree	Observer patient bias and conclusion in the PACE study. This is an open label study and the primary end point is entirely based on the subjective viewpoint of the patient. The following passages from the study highlight the issues with participant and observer biases and the danger of drawing conclusions from untrustworthy information. "Because masking of research assessors to treatment allocation after randomisation was impractical, we relied on participant ratings to keep observer bias to a	Thank you for your comment. This guideline was reviewed in March 2011 where the decision was that it should not be updated at that time as no new evidence was identified which would suggest a significant change in clinical practice. The results of the PACE trial were considered at this review point. The decision to move this guideline to the static list reflects the result of the no to update decision from the review in 2011. The issue that the consultee raises relating to the methodology used in the PACE trial does not directly relate

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				minimum." "The research assessors did the assessments, usually face-to-face in clinic. Most measures were self-rated by the participant." http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3065633/ It is noteworthy that the participants had been briefed on the nature of their treatment and the opinion of the trialists as the cause of their condition. The data could easily be little but the product of the expectation bias of the patients and the cognitive biases of the researchers and hence is untrustworthy. This is particularly so when the results of this portion of the study are in total conflict with the scientific evidence regarding the 6 minute walking distance. The normal quality control measures which minimize the untrustworthy nature of Qualitative information were absent in this study. In conclusion, we have a very expensive publically funded study where internationally recognized diagnostic criteria for chronic fatigue syndrome were not used, the study was unblinded throughout and true randomization was not used. Additionally quality control measures needed to improve the reliability of subjective information were not employed and this subjective information was given	to the decision of NICE to move this topic to the static list based on the criteria laid out in the consultation Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.

ID	Stakeholder	Guideline title and number	Agree / Disagree	Comments Please insert each new comment in a new row.	NICE Response Please respond to each comment
				primacy over scientific evidence. These methodological shortcomings, coupled with the fact that 31% of the efficacy data of GET on 6 minute walking distance remains unpublished, means that making treatment recommendations based on the results of this study is profoundly unsafe and would be a huge disservice to physically and or mentally disabled patients suffering from Chronic fatigue Syndrome.	
95	NeuroImmune Science	CG53 – CFS/ME	Disagree	The recommended interventions in the guideline are based on unsound evidence and hence should not be set in stone. On the contrary they should be reviewed and this time full note of the scientific evidence should also be included, which was not the case last time. When the scientific evidence as well as the qualitative evidence is consulted the picture is entirely different. Omitting any consideration of a huge body of scientific published papers produces an irrational treatment guideline and this omission should be rectified so that the total weight of evidence qualitative and scientific and not just qualitative should be considered as is right just and fair. NICE would not produce guidelines on the treatment of Multiple Sclerosis (MS) based on the results of a study where patients were not diagnosed according to international consensus Guidelines and people suffering from G93.3 Myalgic Encephalomyelitis/Chronic fatigue	Thank you for your comment. This guideline was reviewed in March 2011 where the decision was that it should not be updated at that time as no new evidence was identified which would suggest a significant change in clinical practice. The decision to move this guideline to the static list reflects the result of the no to update decision from the review in 2011. NICE is not aware of any important new studies likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a

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				syndrome surely deserve equal respect.	priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.
96	NeuroImmune Science	CG53 – CFS/ME	Disagree	The original guideline was created without any review of the scientific literature on ME (G93.3). Therefore a new review that does look at the scientific literature is needed.	Thank you for your comment. The issue that the consultee raises does not directly relate to the decision of NICE to move this topic to the static list based on the criteria laid out in the consultation.
97	NeuroImmune Science	CG53 – CFS/ME	Disagree	This entire exercise of determining whether CG53 should be reviewed has already deprived people of a review which should have been conducted and concluded in August 2013.	Thank you for your comment. As part of the interim guideline surveillance programme the centre for clinical practice at NICE has proposed that guidelines where the evidence base is less dynamic should be reviewed less frequently. This is to ensure that resources available to the surveillance programme are focused more productively. Please note that clinical guidelines placed on the static list will be reviewed every 5 years to determine if they should remain on the static list. However, if you become aware of any new evidence or information from clinical practice that is likely to impact on the

ID	Stakeholder	Guideline title and number	Agree / Disagree	Comments Please insert each new comment in a new row.	NICE Response Please respond to each comment
					guideline, please contact NICE with the appropriate details.
107	Welsh Association of ME & CFS Support (WAMES)	CG53 – CFS/ME	Disagree	The Welsh Association of ME & CFS Support strongly disagree with the decision to include the CG53 – CFS/ME Guidelines in the Static List of Clinical Guidelines. We feel this will lead to an increase in the feeling of isolation and dejection that is already felt by people with CFS/ME and their carers.	Thank you for your comment. This guideline was reviewed in March 2011 where the decision was that it should not be updated at that time as no new evidence was identified which would suggest a significant change in clinical practice. The decision to move this guideline to the static list reflects the result of the no to update decision from the review in 2011. NICE is not aware of any important new studies likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next

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					5 year review.
108	Welsh Association of ME & CFS Support (WAMES)	CG53 – CFS/ME		The MRC has funded a number of projects relating to CFS/ME. The full list including researchers can be found at http://www.mrc.ac.uk/Ouresearch/ResearchInitiatives/ CFSME/index.htm#P97_6648 and include research into: Mitochondial dysfunction, Muscle function, Fatigue research, Gene expression, Exercise-Induced fatigue. All these projects are due to report their findings at the latest in 2015. Any findings which come from these MRC funded projects could lead to new treatments to help both patients and clinicians alike but they could also impact on the cost to the NHS in managing CFS/ME patients but will be subject to insufferable delays if CFS/ME is put on the 'static list'.	Thank you for highlighting ongoing trials that may potentially be relevant to the guideline CG53. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.
109	Welsh Association of ME & CFS Support (WAMES)	CG53 – CFS/ME		A CFS/ME Research Collaborative (CMRC) has been set up to look into research which includes a combined membership of CFS/ME charities, the MRC, the National Institute of Health Research and the Wellcome Trust. Any research findings which come from this collaborative could be subject to an insufferable delay if CFS/ME were to be put on the static list which could impact on the care of patients and also impact on the cost to the NHS if a	Thank you for highlighting that the UK CFS/ME Research Collaborative has funded CFS/ME research. NICE is not aware of any important new studies likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Having considered the criteria again in light of all comments received we still do

ID	Stakeholder	Guideline title and number	Agree / Disagree	Comments Please insert each new comment in a new row.	NICE Response Please respond to each comment
				treatment were to come out of this collaborative.	not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review. The Centre for Clinical Practice at NICE is developing a mechanism to consider future requests to remove topics from the static list. This will entail what criteria will be used to assess the rationality of such requests, and subsequent measures to re-integrate topics to the regular guideline surveillance programme if it is found that the decision to put a topic on the static list is no longer valid. Details of this process will be made publically available on our website.
110	Welsh Association of ME &	CG53 – CFS/ME		If CFS/ME were put on the static list then it could send the wrong message to clinicians that nothing new was coming forward and this could impact on	Thank you for your comment. This guideline was reviewed in March 2011 where the decision was that it should not

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	CFS Support (WAMES)			the way they manage their patients to the detriment of both the clinician and patient.	be updated at that time as no new evidence was identified which would suggest a significant change in clinical practice. The decision to move this guideline to the static list reflects the result of the no to update decision from the review in 2011. NICE is not aware of any important new studies likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.
111	Welsh Association of ME &	CG53 – CFS/ME		Patients already feel as though they are misunderstood and badly managed by GPs and Hospital Consultants and if CFS/ME were put on	Thank you for your comment. This guideline was reviewed in March 2011 where the decision was that it should not

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	CFS Support (WAMES)			the static list this could send the wrong message to GPs and Hospital Consultants that no new research was being undertaken and therefore there was nothing they could do to help their patients. It could also deter new Researchers and funders from coming into the field of CFS/ME as they would get the erroneous message that no new research was being undertaken and they could take their money and expertise elsewhere.	be updated at that time as no new evidence was identified which would suggest a significant change in clinical practice. The decision to move this guideline to the static list reflects the result of the no to update decision from the review in 2011. NICE is not aware of any important new studies likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.
112	Welsh Association of ME &	CG53 – CFS/ME		At present funding is being sought by a UK charity into a small drug trial in the UK into Rituximab which has helped 67% of ME patients who took	Thank you for your comment. This guideline was reviewed in March 2011 where the decision was that it should not

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	CFS Support (WAMES)			part in a study in Norway. Better results were found in a second study and a third and larger study is due to start in Norway in January 2014. If the same results are found in the UK then it is imperative for both CFS/ME patients and clinicians that these findings are given a prominent place in any updates to CG53 and putting the CFS/ME guidelines on the static list because it is erroneously thought that no new studies are taking place would increase the neglect and dejection that people with CFS/ME feel.	be updated at that time as no new evidence was identified which would suggest a significant change in clinical practice. The decision to move this guideline to the static list reflects the result of the no to update decision from the review in 2011. NICE is not aware of any important new studies likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.
124	INVEST in ME	CFS/ME (CG53)	DISAGREE	In order to comment on the recommendation by NICE not to perform a review of the guidelines it is not sufficient merely to look for new evidence which	Thank you for your comment. Having considered the criteria again in light of all comments received we still do not feel

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				has come about in recent years - one necessarily needs to look back on the original guidelines to understand what a failing they were and what they missed. We use the comments from our original submission in this document. To comment on why a review of the guidelines is required it is necessary to repeat that the original guidelines were at fault and they were rejected almost unanimously by the patient community. This left the NICE guidelines in a state where they became, and have become, of little use to anybody – neither to patients nor to healthcare staff. NICE state – "Putting patients and the public at the heart of NICE's work NICE is committed to involving patients, carers and the public in the development of its guidance and other products. By involving the very people for whom the guidance will be relevant, we put the needs and preferences of patients and the public at the heart of our work." [1] It was no small matter that the very population for whom the NICE guidelines were supposedly intended to benefit were instead forced to take NICE to a Judicial Review, such was the dissatisfaction with the guidelines and it was plain for all to see that patients were not listened to. Over twenty internationally renowned ME/CFS	that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.

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				experts provided Statements in support of the Claimants‟ case for the Judicial Review of the National Institute for Health and Clinical Excellence (NICE) Clinical Guideline on “CFS/ME” that was brought by ME/CFS sufferers [2] IiME concluded that the basis of the NICE Guidelines was in viewing as broad a section of fatigue states as possible, where high quality biomedical research into ME was ignored. Essential research showing the multi-system nature of ME was not considered or discussed. There was little in the guidelines that would persuade a GP to conduct a proper and full medical examination before diagnosis. This was a major failing. There was almost universal condemnation of the guidelines by patients, patient support groups, most ME charities and even healthcare providers. The only organisations who agreed with the guidelines were those who had accepted government money in the past to support government policies on ME or those who had vested interests and gained from promoting ME as a behavioural illness. 1] http://www.nice.org.uk/getinvolved/patientsandpublic/patientandpublichome.jsp	

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				2] Statements of Concern about CBT/GET provided for the High Court Judicial Review of February 2009 http://www.investinme.org/Article-361%20Statements%20of%20Concern%20-%20CBT-GET%20JR%20Feb09.htm	
125	INVEST in ME	CFS/ME (CG53)	DISAGREE	NICE state in the original guidelines – "There is a lack of epidemiological data for the UK, so population estimates are based on extrapolations from other countries. Overall, evidence suggests a population prevalence of at least 0.2–0.4%. This means that a general practice with 10,000 patients is likely to include up to 40 people with CFS/ME; half of these people will need input from specialist services." [3] This would place the number of patients to be approximately 240,000 – if the higher estimate were taken. This figure is what the NICE guidelines was based on. Recently (a month ago) the National Institute of Health Research (NIHR) awarded £1.2 million to Bristol University, including Dr Esther Crawley for research into CFS/ME. On their web site they state that –	Thank you for highlighting relevant trials in this area. However, as these trials are not likely to publish for at least 3 years they are unlikely to contradict the decision to move this guideline onto the static list. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.

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				"Two new research projects that aim to advance treatment for people with Chronic Fatigue Syndrome [CFS] or Myalgic Encephalopathy [ME], which affects an estimated 600,000 adults and children in the UK, have been awarded funding totalling nearly £1.2 million from the National Institute for Health Research [NIHR]." [4] There is, therefore, a difference between the original NICE guidelines prevalence figure of 240,000 and the recent NIHR-awarded Bristol University projects' figure of 600,000 – a difference of over 350,000. This must mean either that – - an epidemic is occurring to explain the 100% + increase in patients in seven years; - or that Bristol University/Dr Esther Crawley's figures are wrong (in which case the NIHR may like to revisit their grant award); - or the original NICE figures are wrong. As the newly formed Science Media Centre/ Medical Research Council CFS Collaborative (formed in April 2013) has already stated that the prevalence is 600,000 then we must assume that the original NICE figures were incorrect or that we have an epidemic occurring.	

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				Either of these facts means new guidelines are necessary. Certainly these figures demand that the original NICE guidelines premise of one size fits all management strategies cannot be beneficial for such a range of patients. One needs to separate different conditions currently under the CFS umbrella and not lump them all together. A new review is necessary now. 3] http://www.nice.org.uk/nicemedia/live/11824/36193/36193.pdf 4] http://www.bris.ac.uk/news/2013/9741.html	
126	INVEST in ME	CFS/ME (CG53)	DISAGREE	At a recent meeting organised by Invest in ME with Dr Martin McShane, Director of Domain Two, NHS Commissioning Board [5], was presented with evidence of families of ME patients being prosecuted due to their children having ME and the healthcare staff dealing with the cases not understanding the disease process sufficiently. This is far from uncommon. Dr McShane stated that he understood the family's anger and said he would feel exactly the same if he was in their situation. He expressed his apologies and acknowledged the	Thank you for your comment. The issue that the consultee raises does not directly relate to the decision by NICE to move this topic to the static list based on the criteria laid out in the consultation therefore, NICE is unable to comment on this matter. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not

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				need to balance the system to ensure that situations such as this would not occur and that a major task was to alleviate stress for patient and carer. He said he heard what the parents were saying This means that the NICE guidelines have failed as the guidelines still allow this intolerable situation to occur. We need to address the major flaw in the NICE guidelines – namely its bias toward promoting a predetermined one-size fits all approach to ME by continually highlighting CBT and GET therapies despite widespread derision from ME patients. 5] http://www.investinme.org/IIME-Newslet-1303-04.htm	scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.
127	INVEST in ME	CFS/ME (CG53)	DISAGREE	In stating that the guidelines for ME will be placed on a static list NICE state – The following criteria have been applied to identify suitable guidelines to be placed on the static list: · No quality standard commissioned or · A previous full review which yielded a 'no update' decision and at that time no major ongoing studies/research was identified as due to be published in the near future (that is within the next 3-5 years)	Thank you for highlighting ongoing trials that may potentially be relevant to the guideline CG53. Having considered the criteria again we do not feel that the evidence base is substantially evolving in this area at this time. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence that may impact on the guideline recommendations.

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				When that decision regarding a “no update” was made then NICE failed (again) to recognise biomedical research into ME. New research has and is being carried out with conclusions to be reached. Yet new research has been performed since [6] and is scheduled to begin again with a multi-centre clinical trial [7]. This research will be completed well within the next 3-5 years. Also research being funded by Invest in ME has and is being started and the results will be available well within the next 3-5 years – IiME/UCL Rituximab clinical trial [8] and IiME/UEA gut microbiome study [9]. This therefore is another reason for a review and nullifies the NICE statement that “no major ongoing studies/research was identified as due to be published in the near future (that is within the next 3-5 years)”; 6] http://www.plosone.org/article/info:doi/10.1371/journal.pone.0026358 7] B-lymphocyte depletion with rituximab induction and maintenance in CFS / ME. A multicenter,	

ID	Stakeholder	Guideline title and number	Agree / Disagree	Comments Please insert each new comment in a new row.	NICE Response Please respond to each comment
				randomized, double-blind, placebo-controlled study. Project: flug, Oystein Project coordinator: Haukeland University Hospital, Helse Bergen http://bit.ly/111BQ6D 8] A UK Rituximab Clinical Trial for ME http://bit.ly/HeOfRu 9] A role for a leaky gut and the intestinal microbiota in the pathophysiology of myalgic encephalomyelitis http://bit.ly/11etHil	
128	INVEST in ME	CFS/ME (CG53)	DISAGREE	NICE state – "Clinical guidelines placed on the static list will be reviewed every 5 years to determine if they should remain on the static list. Routine surveillance every 2 years (as per the process for active guidelines) would not be carried out on guidelines transferred to the static list. " This is negligence by a body that refers to its own "excellence" Dr Clare Gerada (chair of Royal College of GPs) stated that GPs know very little about ME [10]. Therefore to leave the current outdated and	Thank you for your comment. This guideline was reviewed in March 2011 where the decision was that it should not be updated at that time as no new evidence was identified which would suggest a significant change in clinical practice. The decision to move this guideline to the static list reflects the result of the no to update decision from the review in 2011. NICE is not aware of any important new studies likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Having considered the criteria again in light of all comments received we still do not feel

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				unusable NICE guidelines for ME for another 5 years, just sitting on the shelf with no updates reflecting the current poor education regarding ME and without any knowledge of the biomedical research performed/about to be performed, would effectively mean that no clinical guidelines for ME will have been reviewed for 12 years. That is unacceptable. This would show not only contempt for the patients and families suffering from the effects of this disease – it would also show gross incompetence and negligence by NICE. Patients are currently being misdiagnosed, mis-treated and healthcare staff are being mis-informed and the current unsatisfactory status cannot be left for another generation. GPs are left in a situation where their patients have rejected NICE, they do not understand enough about the disease, they are not familiar with the real effects and consequences of ME or of the possible research producing data. The chair of the GPs organisation admits that GPs do not know enough about ME – seven years after the NICE guidelines were published! 10] Invest in ME International ME Conference (IIMEC8) London May 2013	that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.

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				http://bit.ly/10VfRhu	
129	INVEST in ME	CFS/ME (CG53)	DISAGREE	NICE state – "Consideration to transfer a clinical guideline back to the active surveillance list may occur in the following circumstances: · The high level review at 5 years yields new evidence which may impact on the guidance · Stakeholders notify NICE of relevant new evidence which may impact on guidance at any time point, for example safety data. · A quality standard is commissioned that relates to a guideline on the static list " We submit that – New evidence is available for ME A quality standard needs to be commissioned urgently The PACE trial [11] demonstrably proved that CBT and GET (the primary treatment recommendations of the NICE guidelines) do not work. Many articles have proven the PACE Trial to show that CBT and GET do not benefit ME patients and do not back up the original NICE guidelines' recommendations [12], [13]. NICE guidelines should be updated to reflect recent evidence that the recommended therapies in the existing guidelines (CBT and GET) do not lead to	Thank you for your comment. This guideline was reviewed in March 2011 where the decision was that it should not be updated at that time as no new evidence was identified which would suggest a significant change in clinical practice. The results of the PACE trial were considered at this review point. The decision to move this guideline to the static list reflects the result of the no to update decision from the review in 2011. Please note that clinical guidelines placed on the static list will be reviewed every 5 years to determine if they should remain on the static list. However, if you become aware of any new evidence or information from clinical practice that is likely to impact on the guideline, please contact NICE with the appropriate details. Decisions to refer a Quality standards to NICE rests with NHS England.

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				objective improvements in physical activity (6min walking test in PACE), increased employment rates or reduce service costs. [PACE] References: 11] Comparison of adaptive pacing therapy, cognitive behaviour therapy, graded exercise therapy, and specialist medical care for chronic fatigue syndrome (PACE): a randomised trial http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)60096-2/fulltext 12] The PACE Trial - Recovery Rates Published Observations from the PACE recovery study http://www.investinme.org/IIME-Newslet-1302-02.htm 13] The PACE Trial: An Expression Of Concern -A Summary http://www.investinme.org/Article430%20The%20PACE%20Trial-Expression%20Of%20Concern%20A%20Summary.htm	
144	Blue Ribbon for the Awareness of Myalgic	CG53: CFS/ME	Disagree	Re NICE guideline on CFS/ME – CG53 We are gravely concerned at the recommendation of NICE's Senior Management Team, in August	Thank you for your comment. This guideline was reviewed in March 2011 where the decision was that it should not be updated at that time as no new

ID	Stakeholder	Guideline title and number	Agree / Disagree	Comments Please insert each new comment in a new row.	NICE Response Please respond to each comment
	Encephalomyelitis (BRAME)			2013, that the NICE Guideline on CFS/ME - CG 53 should be one of the first to be put on the static list 'to ensure sustainability and efficiency of the programme'. We cannot agree with this, and strongly believe that it should remain on the active list. There is a wealth of biomedical research, both recent and currently on-going into the complex neurological diseases Myalgic Encephalomyelitis (ME) and Chronic Fatigue Syndrome (CFS), as classified by WHO ICD10 G93.3, and it is an entirely inappropriate time for NICE to take this proposed action. When Professor Peter Littlejohns attended the meeting of the All Party Parliamentary Group on ME in February 2007 it is minuted that: "He explained that he had been responsible for clinical guidelines at NICE since their inception. All NICE Guidelines were produced on the basis of best available evidence and on a process based on transparency, active consultation and review. He added that guidance however robust is not set in stone; medical advances can happen very quickly and NICE aims to make guidance as up-to-date as possible. Any organisation affected by a guidance should be part of the development of that guideline" (None of which has ever materialised)	evidence was identified which would suggest a significant change in clinical practice. The decision to move this guideline to the static list reflects the result of the no to update decision from the review in 2011. NICE is not aware of any important new studies likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.
145	Blue Ribbon for the Awareness	CG53: CFS/ME Continued	Disagree	<u>Biomedical Research</u> Much of the relevant biomedical research into ME	Thank you for highlighting published studies that may potentially be relevant to the guideline CG53. Having

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	of Myalgic Encephalomyelitis (BRAME)			was never looked at when the NICE Guideline was being developed, due to the restrictions that had been written into the initial scope eg the Group could only look into Graded Exercise Therapy and Chronic Fatigue Syndrome, instead of being able to look at all aspects, such as exercise and ME or CFS, which would have identified the adverse reaction to exercise, and the mitochondrial dysfunction, which are experienced by people with neurological ME and CFS. Tanya, as the severely affected patient representative on the Group, repeatedly highlighted these papers, and the patient research showing adverse reactions to GET and CBT. As Professor Stephen Holgate of the MRC emphasised at the launch of the ME Research Collaborative at Wellcome Collection, London on 22 April 2013, and again at his meeting with Forward ME (of which BRAME is a member) in the House of Lords on 2 July 2013, this is a most exciting time for biomedical research into ME, to identify the aetiology and pathogenesis of ME, especially with the revolutionary emergence of new science, enabling researchers to delve deeper into the complex cellular functions, identify where there is dysfunction, and then to develop possible treatments. Over the past decade there has been a wealth of biomedical research and this continues with new research being published regularly. Our own	considered the criteria again we do not feel that this evidence base is within the scope of the guideline which covered diagnosis, treatment and management of CFS/ME. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence that may impact on the guideline recommendations.

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				research advisor Professor Puri has identified changes in the brain ie: *Regional grey and white matter volumetric changes in Myalgic Encephalomyelitis (chronic fatigue syndrome) Br J Radiol 2012 Puri et al* Our previous research advisor Dr Jonathan Kerr, who sadly has now left research into ME, was the researcher who made the ground breaking discovery of genetic abnormalities with people with ME. His research on gene expression identified the possibility of seven sub-groups, which may explain why some patients present/react differently, and also identified 85 upregulated and 3 downregulated genes. These differential genes were related to haematological disease and function, immunological disease and function, cancer, cell death, immune response, and infection: *Seven genomic subtypes of chronic fatigue syndrome/myalgic encephalomyelitis: a detailed analysis of gene networks and clinical phenotypes. J Clin Pathol 2008 Kerr et al* also *Gene expression subtypes in patients with chronic fatigue syndrome/ myalgic encephalomyelitis. J Infect Dis 2008 Kerr et al* ME Research UK (MERUK) and the CFS Research Foundation have been funding biomedical research into ME and CFS for many years, and no doubt they will be presenting their own evidence to NICE. In the past 2 years MERUK, ME Association and Action for ME have helped to fund the Biobank,	

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				which will be a very useful source of information and research. At the time of the development and writing of the NICE guideline, Tanya as the severely affected patient representative on the Group, repeatedly presented biomedical research evidence, as well as patient evidence, including the case of Sophia Mirza, who sadly died due to her ME, and whose post mortem showed inflammation in the basal/dorsal root ganglia.	
146	Blue Ribbon for the Awareness of Myalgic Encephalomyelitis (BRAME)	CG53: CFS/ME Continued	Disagree	NICE Review and PACE Trial NICE, announced on 14th March 2011 that there will be no review of CG53 until 2013: "…*interventions recommended in the original guideline, such as CBT and GET, were described as the interventions for which there is the clearest evidence-base of benefit. This is supported by the recently published PACE trial….The results of the study are in line with current NICE guideline recommendations on the management of CFS/ME….There are no factors…which would invalidate or change the direction of the current guideline recommendations. The CFS/ME guideline should not be updated at this time".* The PACE trial has been overwhelmingly disputed by ME groups, and people with ME, across the UK, and continues to be challenged to this day. The authors are still refusing to publish/make available their methodology and data, and have yet to justify	Thank you for your comment. This guideline was reviewed in March 2011 where the decision was that it should not be updated at that time as no new evidence was identified which would suggest a significant change in clinical practice. The results of the PACE trial were considered at this review point. The decision to move this guideline to the static list reflects the result of the no to update decision from the review in 2011. The issue raised relating to recruitment for the PACE trial does not directly relate to the decision by NICE to move this topic to the static list based on the criteria laid out in the consultation. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality

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				how they reached the figures they published. The authors of the PACE trial via a letter, sent on their behalf by Sir Peter White, to the Editor-in-Chief of the Lancet, Dr Richard Horton, stated "*The PACE trial paper refers to chronic fatigue syndrome (CFS) which is operationally defined; it does not purport to be studying CFS/ME"*. The sentence continues by stating that the PACE Trial studied: "*CFS defined simply as a principal complaint of fatigue that is disabling, having lasted six months, with no alternative medical explanation (Oxford criteria)"*. The people they were studying only fitted the Oxford criteria, not even the Fukuda criteria needed to define CFS, therefore they were studying people with Chronic Fatigue, not ME, CFS or CFS/ME. Despite the assertion by Sir Peter White et al that they were not studying ME or CFS/ME, throughout their research paper and Lancet articles they refer to these conditions, therefore giving the impression to the readers, and therefore the reviewers for NICE, that ME and CFS/ME were the conditions being studied eg: • The two versions of the PACE Trial Protocol (both the Full Protocol and short version that was published in BMC Neurology 2007:7:6) are equally clear; the PACE Trial was: "*A randomised controlled trial of adaptive pacing,*	Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.

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				cognitive behaviour therapy, and graded exercise as supplements to standardised specialist medical care versus standardised specialist medical care alone for patients with the chronic fatigue syndrome/myalgic encephalomyelitis or encephalopathy". • In the PACE Trial Patient Clinic Leaflet, Professor White et al state: "*This illness is also known as post-viral fatigue syndrome, myalgic encephalomyelitis (ME) and myalgic encephalopathy (ME). Medical authorities are not certain that CFS is exactly the same illness as ME…but we will be calling this illness CFS/ME".* • Moreover, in the authors' reply published in the Lancet on 17th May 2011 (The PACE trial in chronic fatigue syndrome – Authors' reply), Peter White is unambiguous: "*…however we defined CFS and myalgic encephalomyelitis, we found that cognitive behaviour therapy and graded exercise therapy provided a significant and clinically useful advantage…."*.	
147	Blue Ribbon for the Awareness of Myalgic Encephalomyelitis (BRAME)	CG53: CFS/ME Continued	Disagree	NICE Review & PACE Trial Continued The management section of the NICE Guideline, and the misleading references to the patient cohort they were studying in the PACE trial, are having an overwhelming negative impact on people with ME or CFS, their health and their well-being, as the	Thank you for your comment. This guideline was reviewed in March 2011 where the decision was that it should not be updated at that time as no new evidence was identified which would suggest a significant change in clinical practice. The results of the PACE trial

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				inappropriate GET and CBT continues to be advocated/recommended by NICE for people with neurological ME and CFS. As the authors of the PACE Trial themselves have stated that they were not studying ME or CFS/ME (as now asserted by Professor White et al), then the results cannot be used by NICE to support its Clinical Guideline 53 for CFS/ME. Therefore the PACE trial, should not have been used to recommend no review of the guideline, in fact the above comments by the authors support what ME Groups and patients have understood for years; that the research these authors, and others, have done into GET and CBT by studying patients who fulfilled only the Oxford Criteria; they were not studying patients with neurological ME or CFS (WHO ICD10 G93.3) or CFS/ME, but those who have Chronic Fatigue. This brings into question the legitimacy of all the research used as a basis for the NICE Guideline management section, which should be re-examined immediately in the light of these new assertions.	were considered at this review point. The decision to move this guideline to the static list reflects the result of the no to update decision from the review in 2011. NICE is not aware of any important new studies on management of CFS/ME that are likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.
148	Blue Ribbon for the Awareness	CG53: CFS/ME Continued	Disagree	Diagnostic Criteria and ME IC Primer Apart from the very relevant, and important, recent	Thank you for highlighting the International and Consensus Primer for Medical Practitioners that may

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	of Myalgic Encephalomyelitis (BRAME)			and on-going biomedical research, and the admittance that the PACE trial was not studying people with ME or CFS/ME, the key documents that should result in the NICE Guideline on CFS/ME CG53 being reviewed are: • the Myalgic Encephalomyelitis – Adult and Paediatric – International and Consensus Primer for Medical Practitioners published in October 2012 (ME IC Primer), and • the previously published new International Consensus Criteria for ME (July 2011). Both of these important documents were written by an International Consensus Panel of doctors and researchers specialised in neurological ME, who between them have: • diagnosed and/or treated more than 50,000 patients who have ME; • more than 500 years of clinical experience; • approximately 500 years of teaching experience; • authored hundreds of peer-reviewed publications, as well as written chapters and medical books; and • several members have co-authored previous criteria. The UK ME specialists on the panel who authored these documents were Dr Terry Mitchell and Dr	potentially be relevant to the guideline CG53.. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.

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				Nigel Speight, both of whom are medical advisors to BRAME, and both have decades of experience of diagnosing and treating patients with ME. We also know Dr Anne Gerkin well, who has a good understanding of the neurological illness ME, and the overwhelming impact this most complex and debilitating condition has on people. In the ME IC Primer (2012) there are 154 research papers referenced, and on page 7 and 8 can be found the international clinical and research criteria for Myalgic Encephalomyelitis (published July 2011). This clearly differentiates people with ME from CFS and other fatigue states, and therefore the NICE Guideline on CFS/ME – CG53 – should be reviewed to take into account these new diagnostic criteria. The reason for these new criteria, which are designed for both clinical and research settings, is explained in the ME IC Primer 2012 – page ii *International Consensus Criteria (ICC)* *Problem* *The label 'chronic fatigue syndrome' (CFS), coined in the 1980s, has persisted due to lack of knowledge of its etiologic agents and pathophysiology. Misperceptions have arisen because the name 'CFS' and its hybrids ME/CFS, CFS/ME and CFS/CF have been used for widely diverse conditions. Patient sets can include those who are seriously ill with ME, many bedridden and*	

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				unable to care for themselves, to those who have general fatigue or, under the Reeves criteria, patients are not required to have any physical symptoms. There is a poignant need to untangle the web of confusion caused by mixing diverse and often overly inclusive patient populations in one heterogeneous, multi-rubric pot called 'chronic fatigue syndrome'. We believe this is the foremost cause of diluted and inconsistent research findings, which hinders progress, fosters scepticism, and wastes limited research monies.	
149	Blue Ribbon for the Awareness of Myalgic Encephalomyelitis (BRAME)	CG53: CFS/ME Continued	Disagree	<u>Diagnostic Criteria and ME IC Primer continued</u> *Solution* *The rationale for the development of the ICC was to utilize current research knowledge to identify objective, measurable and reproducible abnormalities that directly reflect the interactive, regulatory components of the underlying pathophysiology of ME. Specifically, the ICC select patients who exhibit explicit multi-systemic neuropathology, and have a pathological low threshold of physical and mental fatigability in response to exertion. Cardiopulmonary exercise test/retest studies have confirmed many post-exertional abnormalities. Criterial symptoms are compulsory and identify patients who have greater physical, cognitive and functional impairments. The ICC advance the successful strategy of the Canadian Consensus Criteria (CCC) of grouping coordinated patterns of symptom clusters that*	Thank you for highlighting the International and Consensus Primer for Medical Practitioners that may potentially be relevant to the guideline CG53. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new

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				identify areas of pathology. The criteria are designed for both clinical and research settings. *1. Name: Myalgic encephalomyelitis, a name that originated in the 1950s, is the most accurate and appropriate name because it reflects the underlying multi-system pathophysiology of the disease. Our panel strongly recommends that only the name 'myalgic encephalomyelitis' be used to identify patients meeting the ICC because a distinctive disease entity should have one name. Patients diagnosed using broader or other criteria for CFS or its hybrids (Oxford, Reeves, London, Fukuda, CCC, etc.) should be reassessed with the ICC. Those who fulfill the criteria have ME; those who do not would remain in the more encompassing CFS classification.* *2. Remove patients who satisfy the ICC from the broader category of CFS. The purpose of diagnosis is to provide clarity. The criterial symptoms, such as the distinctive abnormal responses to exertion can differentiate ME patients from those who are depressed or have other fatiguing conditions. Not only is it common sense to extricate ME patients from the assortment of conditions assembled under the CFS umbrella, it is compliant with the WHO classification rule that a disease cannot be classified under more than one rubric. The panel is not dismissing the broad components of fatiguing illnesses, but rather the ICC are a refinement of patient stratification. As other identifiable patient*	evidence when it arises before the next 5 year review.

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				sets are identified and supported by research, they would then be removed from the broad CFS/CF category. When the NICE guideline was being written, and the 'list of symptoms' was being compiled during the NICE Guideline Development Group meetings, xxxx constantly raised her concerns about this, saying that 'the list' would be read as, or be misinterpreted as, diagnostic criteria. They kept being reassured that it would not, but if it was, to let NICE know, and they will put out a statement to clarify that this was meant as just 'a list of possible symptoms', not diagnostic criteria. After the NICE guideline was published, and the 'NICE criteria' began to be used by Health Professionals (HPs), xxxx wrote to NICE to inform them that her fears had been realised, and asked NICE to put out there promised statement of clarity – needless to say, NICE did not do anything to correct the situation, which has led to people continuing to be incorrectly diagnosed, and people with ME or CFS being offered/given inappropriate management/treatment. With the 'NICE criteria' basically being fatigue and one other symptom (no different to the erroneous Oxford criteria) this has continued to 'muddy the waters', lead to misdiagnosis, and perpetuate the misunderstanding of what complex, debilitating and serious conditions ME and CFS can be, especially for those who are severely affected.	

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150	Blue Ribbon for the Awareness of Myalgic Encephalomyelitis (BRAME)	CG53: CFS/ME Continued	Disagree	<u>Conclusion and Impact on People with ME and CFS</u> The NICE Guideline on CFS/ME – CG53 has resulted in perpetuating the misunderstanding amongst HPs of the complex and debilitating neurological illnesses ME and CFS. Due to NICE not correcting the misunderstanding that this 'list of symptoms to consider whether someone may have ME or CFS' is not criteria, and was never meant to be, has led to clinicians and researchers erroneously using the 'NICE criteria' for diagnosis and research selection. NICE has also not corrected this being used on the Map of Medicine, which we have been constantly trying to get corrected over the past years, as it is giving Health Professionals erroneous information and leading to incorrect diagnoses. HPs following NICE guidance, continue to recommend inappropriate GET and CBT for patients with neurological ME and CFS. These NICE recommendations were based on flawed research. A review of the Guideline was refused, based on research misleading NICE, and other readers, to believe the research was on people with ME, CFS or CFS/ME – as NICE stated on 14 March 2011 there will be no review of CG53 until 2013 as "…*interventions recommended in the original guideline, such as CBT and GET, were*	Thank you for your comment. This guideline was reviewed in March 2011 where the decision was that it should not be updated at that time as no new evidence was identified which would suggest a significant change in clinical practice. The decision to move this guideline to the static list reflects the result of the no to update decision from the review in 2011. NICE is not aware of any important new studies likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.

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				described as the interventions for which there is the clearest evidence-base of benefit. This is supported by the recently published PACE trial…" The NICE Guideline on CFS/ME has had, and continues to have, not only an adverse effect on the health system/HPs, but also on DWP Guidance on ME/CFS, and on DWP Medical Assessment Providers, leading to further misunderstanding about neurological ME and CFS, and HPs assessments and recommendations to DWP decision makers, with many people with ME and CFS having to go to appeal before being awarded benefits. The inaccurate information in the NICE guideline also has an adverse effect on those people with neurological ME and CFS when claiming health insurance and early retirement due to ill health claims. In order to justify a review of the NICE Guideline on CFS/ME, or indeed not to be placed on the static list and be kept on the active list we feel that: a) the existing, current and emerging biomedical research/evidence has been overlooked/ignored b) there is important recent and emerging research/evidence to be considered relating to: clinical assessment – diagnosis and diagnostic criteria – management eg the ME International Consensus Primer 2012 is relevant	

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				c) the Guideline continues to contain advice and information, in particular on management, that is based on flawed and/or misleading research d) the Guideline, as it stands, is having an overwhelming adverse effect on people with neurological ME or CFS, their health, their quality of life, as well as their carers and family.	
151	Blue Ribbon for the Awareness of Myalgic Encephalomyelitis (BRAME)	CG53: CFS/ME Continued	Disagree	<u>Conclusion and Impact on People with ME and CFS continued</u> For all of these reasons NICE has severely let down patients with neurological ME and CFS, and it has a responsibility to these patients, their cares/families, and the HPs caring for them, to ensure that the information NICE has in their Guideline is accurate, not harmful, and truly reflective of the reality of the conditions, and that the correct and most up-to-date diagnostic criteria is included in the Guideline, and relevant information sites. The ME IC Primer (2012), and new criteria, as well as the wealth of biomedical research, should have already triggered a review. None of this will be addressed if the NICE Guideline on CFS/ME – CG53 is put on the static list. We strongly believe that the NICE Guideline on CFS/ME - CG 53 should most certainly be kept on the active list, and in fact should be urgently	Thank you for your comment. This guideline was reviewed in March 2011 where the decision was that it should not be updated at that time as no new evidence was identified which would suggest a significant change in clinical practice. The decision to move this guideline to the static list reflects the result of the no to update decision from the review in 2011. NICE is not aware of any important new studies likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. In addition this guideline is not scheduled to form part of a Quality Standard at this time and is therefore not considered a priority for NICE to review.

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				reviewed.	By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.
CG60 Surgical management of OME					
1	Cleft Lip and Palate Association	Surgical Management of OME (CG60)	Disagree	There is currently an HTA funded feasibility study in progress into conducting research on the treatment of OME in children with cleft lip and palate. If this leads to a full research project then this might change the guidelines on surgical management of OME	Thank you for your comment. Having considered the criteria again we do not feel that the evidence base is substantially evolving in this area at this time. The study that you reference aims to ascertain the current treatment methods in the UK using a survey of the clinicians who work in the UK Cleft Lip and Palate Centres, obtain qualitative data on the willingness of parents/carers and clinicians to take part in an RCT of the most commonly used treatments and to identify a core outcome set. This study will therefore not provide evidence that will impact on any recommendations within CG60. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than

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					other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence.
56	Greater Manchester Health Economy	Surgical management of OME (CG60)	Agree		Thank you.
CG62 Antenatal Care					
11	Swansea university	Antenatal care (CG62)	agree	We are happy to agree with this.	Thank you for your comment.
15	Birth Trauma Association	Antenatal	Disagree	We feel it would be unwise to put the antenatal guideline on the static list. Failure to keep up to date with developments in antenatal care could result in avoidable neonatal mortality and morbidity. The potential downsides in terms of human tragedy and litigation are so substantial that we think this guideline should continue to be reviewed. Advances in antenatal care – particularly identifying women who may encounter difficulties delivering vaginally - are making considerable progress. Eg Fundus measurements to identify macrosomia . This is an area that is too high risk to be on the static list.and we believe review in the normal way would be cost effective.	Thank you for your comment. Having considered the criteria again in light of all comments received we still do not feel that the evidence base is substantially evolving in this area at this time. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence when it arises before the next 5 year review.
34	Greater Manchester Health	Antenatal care (CG62)	Agree		Thank you.

ID	Stakeholder	Guideline title and number	Agree / Disagree	Comments Please insert each new comment in a new row.	NICE Response Please respond to each comment
	Economy				
62	The Royal College of Midwives	Antenatal care (CG62)	Disagree	RCM do not consider this is appropriate for the static list as there is a considerable body of new evidence that could influence the recommendations eg Sandall J, SoltaniH,Gates S, Shennan A,DevaneD.Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews* 2013, Issue 8. We also think it is important to revisit the evidence behind the recommendation that "Repeated weighing during pregnancy should be confined to circumstances where clinical management is likely to be influenced". Many clinicians consider routine weighing to be helpful in sensitively initiating the discussion about weight management.	Thank you for your comments. We have considered the evidence you have presented and do not feel that the evidence presented would indicate a change at present to the recommendations within the guideline. The Cochrane review concluded that most women should be offered midwife-led continuity models of care and women should be encouraged to ask for this option although caution should be exercised in applying this advice to women with substantial medical or obstetric complications. This is broadly in line with current guideline recommendations: Rec-4.1. Midwife- and GP-led models of care should be offered for women with an uncomplicated pregnancy. Routine involvement of obstetricians in the care of women with an uncomplicated pregnancy at scheduled times does not appear to improve perinatal outcomes compared with involving obstetricians when complications arise. With regards to weight measurement the there is no suggestion that the evidence base has changed substantially form that presented in the guideline. It should

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					be noted that measuring maternal weight routinely during pregnancy may produce unnecessary anxiety with no added benefit. However, the guideline already states that for pregnant women where nutrition is of concern then repeated weight measures may be appropriate. This would clearly provide any clinician an opportunity to address weight concerns with their patients. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence.
72	Ferring Pharmaceuticals Ltd.	CG62 - Antenatal care	Disagree	In the current guidelines, Table F.17 'Downstream' outcome costs for Induction of labour are stated as £20 and the references cited are from *Davies and Drummond (1991) and (1993).* The prices are updated to 2006 using Retail Price Index published by Office of National Statistics. Ferring requests for an update of the outcome costs for induction, based on the availability of current pharmacological agents for induction of labour and latest published price indices, given that the references cited in the current guidelines are 20 years old.	Thank you for your comment. We are aware that costs overtime will go out of date however there is no significant evidence that indicates that at present this is influencing the recommendtions within the guideline.

ID	Stakeholder	Guideline title and number	Agree / Disagree	Comments Please insert each new comment in a new row.	NICE Response Please respond to each comment
CG64 PIE					
12	Barnet & Chase Farm Hospitals NHS Trust	Prophylaxis against infective endocarditis (CG64)	Disagree	Sufficient debate and confusion in literature to review the guidance. Please see email also with abstract and references: Knowledge versus consensus: the endocarditis prophylaxis paradigm Author(s): Grisoli, D.; Raoult, D. Source: CLINICAL MICROBIOLOGY AND INFECTION Volume: 19 Issue: 3 Pages: 207-208 DOI: 10.1111/1469-0691.12121 Published: MAR 2013 A case of insufficient evidence equipoise: the NICE guidance on antibiotic prophylaxis for the prevention of infective endocarditis Author(s): Mohindra, R. K. Source: JOURNAL OF MEDICAL ETHICS Volume: 36 Issue: 9 Pages: 567-570 DOI: 10.1136/jme.2010.036848 Published: SEP 2010 A case of insufficient evidence equipoise: the NICE guidance on antibiotic prophylaxis for the prevention of infective endocarditis Author(s): Mohindra, RK (Mohindra, R. K.) Source: JOURNAL OF MEDICAL ETHICS Volume: 36 Issue: 9 Pages: 567-570 DOI: 10.1136/jme.2010.036848 Published: SEP 2010 Times Cited: 4 (from Web of Science) Cited References: 34 Abstract: This paper argues that the National Institute for Health and Clinical Excellence should	Thank you for your comment and for providing references to the Grisoli 2013, Mohindra 2010, Dhoble 2009, Knudsen 2009, Delahaye 2009 and Herring 2008 papers. However, none of these publications is a primary research study; hence they do not meet our criteria for inclusion under our current process. NICE is not aware of any important new studies likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Please note that clinical guidelines placed on the static list will be reviewed every 5 years to determine if they should remain on the static list. However, if you become aware of any new evidence or information from clinical practice that is likely to impact on the guideline, please contact NICE with the appropriate details.

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				not offer guidance in situations where there is insufficient evidence equipoise about the potential benefit of the treatment in question. This is broadly for two reasons. First, without knowing if the treatment is effective no cost-effectiveness judgement can be logically made. Second, the implementation of a population wide change in treatment where there is equipoise amounts to a de facto clinical trial that falls outside the Clinical Trials Regulations. As such there are strong ethical and possibly legal grounds for preventing such an outcome. Title: Prophylaxis to Prevent Infective Endocarditis: To Use or Not to Use? Author(s): Dhoble, Abhijeet; Vedre, Ameeth; Abdelmoneim, Sahar S.; et al. Source: CLINICAL CARDIOLOGY Volume: 32 Issue: 8 Pages: 429-433 DOI: 10.1002/clc.20583 Published: AUG 2009 Times Cited: 2 (from Web of Science) [View abstract] Prophylaxis to Prevent Infective Endocarditis: To Use or Not to Use? Author(s): Dhoble, A (Dhoble, Abhijeet)[1] ; Vedre, A (Vedre, Ameeth)[1] ; Abdelmoneim, SS (Abdelmoneim, Sahar S.)[2,3] ; Sudini, SR (Sudini, Srikar Reddy)[1] ; Ghose, A (Ghose, Amit); Abela, GS (Abela, George S.)[1] ; Karve, M	

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				(Karve, Milind)[4] Source: CLINICAL CARDIOLOGY Volume: 32 Issue: 8 Pages: 429-433 DOI: 10.1002/clc.20583 Published: AUG 2009 Times Cited: 2 (from Web of Science) Cited References: 19 Abstract: The American Heart Association (AHA) published their revised guidelines in 2007 in which they markedly limited the recommendations for the use of antimicrobial prophylaxis for the prevention of infective endocarditis (IE), except for patients who are at highest risk of adverse outcomes, A recent focused update on valvular heart diseases changed the recommendation for antibiotic use for patients with many underlying heart conditions including mitral valve prolapse (MVP) which were considered as "low risk" heart defects. In this article, we argue that antibiotic prophylaxis should be considered until concrete clinical evidence is provided to dispute against the use of this strategy, especially for patients with MVP. This approach is cost efficient, and provides a chance to prevent a dreadful disease. We have also enlisted 2 clinical cases to support our argument. These are not uncommon clinical scenarios, and emphasize that IE can be fatal in spite of optimum treatment. Patients have the right to make the final decision, and they should be allowed to participate in choosing for or against this approach until adequate clinical evidence is available.	

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				20. Title: Infective Endocarditis: A Continuous Challenge. The Recent Experience of a European Tertiary Center Author(s): Knudsen, Jane B.; Fuursted, Kurt; Petersen, Eskild; et al. Source: JOURNAL OF HEART VALVE DISEASE Volume: 18 Issue: 4 Pages: 386-394 Published: JUL 2009 Times Cited: 3 (from Web of Science) [View abstract] Title: Recommendations on prophylaxis for infective endocarditis: Dramatic changes over the past seven years Author(s): Delahaye, Francois; Harbaoui, Brahim; Cart-Regal, Virginie; et al. Source: ARCHIVES OF CARDIOVASCULAR DISEASES Volume: 102 Issue: 3 Pages: 233-245 DOI: 10.1016/j.acvd.2009.01.002 Published: MAR 2009 Title: Nice on infective endocarditis - A call for national monitoring of antibiotic prophylaxis Author(s): Herring, Neil; Sprigings, David C. Source: BRITISH MEDICAL JOURNAL Volume: 336 Issue: 7651 Pages: 976-976 DOI: 10.1136/bmj.39563.556343.80 Published: MAY 3 2008	
51	Greater Manchester	Prophylaxis against	Agree		Thank you..

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	Health Economy	infective endocarditis (CG64)			
64	Faculty of General Dental Practice (UK)	CG64 - Prophylaxis against infective endocarditis	Agree	Note: A Cochrane review, assessed January 2013 and published Oct 2013, titled 'Antibiotics for the prophylaxis of bacterial endocarditis in dentistry' (A-M Glenny *et al*), concluded that there remains no evidence about whether antibiotic prophylaxis is effective or ineffective against bacterial endocarditis in people at risk who are about to undergo an invasive dental procedure. Therefore, the guidance remains current.	Thank you for your comment.
120	British Dental Association	CG 64 Prophylaxis against infective endocarditis	Disagree	The existing guidelines do not appear to reflect the latest evidence. The most recent Cochrane review on the topic, published in January 2013 concludes as follows '*There remains no evidence about whether antibiotic prophylaxis is effective or ineffective against bacterial endocarditis in people at risk who are about to undergo an invasive dental procedure. It is not clear whether the potential harms and costs of antibiotic administration outweigh any beneficial effect. Ethically, practitioners need to discuss the potential benefits and harms of antibiotic prophylaxis with their patients before a decision is made about administration*.' Glenny AM, Oliver R, Roberts GJ, Hooper L,Worthington HV. Antibiotics for the prophylaxis of	Thank you for your comment and for providing the reference to the Glenny et al. 2013 Cochrane review. This publication is an update of the Oliver 2004 Cochrane review that was included in the guideline. The Glenny 2013 review did not find any new (recently published) studies and essentially had the same conclusion as the 2004 review. Thus, having considered the criteria again we do not feel that the evidence base is substantially evolving in this area at this. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would

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				bacterial endocarditis in dentistry. (2013). Cochrane Database of Systematic Reviews Issue 10. Art. No.: CD003813. DOI: 10.1002/14651858.CD003813.pub4.	welcome being informed of the publication of any additional new evidence.
121	British Dental Association	CG 64 Prophylaxis against infective endocarditis	Disagree	There is published evidence that clinicians are not generally following the current NICE guidelines. Instead many appear to be following the current guidelines from the American Heart Association (AHA) which suggests that antibiotic prophylaxis should still be given the most at risk patients. Dayer, MJ, Chambers, JB, Prendergast, B, Sandoe, JA and Thornhill, MH. (2013). NICE guidance on antibiotic prophylaxis to prevent infective endocarditis: a survey of clinicians' attitudes. QJM. 106(3):237-43. doi: 10.1093/qjmed/hcs235. Epub 2013 Jan 3. Thornhill, M.H. (2012).Infective endocarditis: the impact of the NICE guidelines for antibiotic prophylaxis. Dent Update. 39(1):6-10, 12. Impact of the NICE guideline recommending cessation of antibiotic prophylaxis for prevention of infective endocarditis: before and after study. Thornhill MH, Dayer MJ, Forde JM, Corey GR, Chu VH, Couper DJ, Lockhart PB. BMJ. 2011 May 3;342:d2392. doi: 10.1136/bmj.d2392. A similar situation exists in the United States where clinicians appear to continue prescribing	Thank you for your comment and for providing references. Having considered the criteria again we do not feel that the evidence base is substantially evolving in this area. Moreover, this appears to be an implementation issue and does not directly relate to the decision of NICE to move this topic to the static list based on the criteria laid out in the consultation. By moving the guideline to the static list it will continue to be reviewed periodically, but less frequently than other guidelines. However, NICE would welcome being informed of the publication of any additional new evidence.

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				prophylaxis in groups no longer recommended to receive antibiotics by the AHA. Lockhart, P.B, , Nicholas B. Hanson, N.B, Ristic, H., Menezes, A.R and Baddour, L. (2013). Acceptance among and impact on dental practitioners and patients of American Heart Association recommendations for antibiotic prophylaxis JADA 144(9): 1030-1035.	
122	British Dental Association	CG 64 Prophylaxis against infective endocarditis	Disagree	There have been a number of relevant primary research publications on this topic since the publication of the current guidance including: Chambers J.B, Dayer M., Prendergast B.D, Sandoe J., Westaby S. and Thornhill M. (2013). Infective endocarditis beyond antibiotic prophylaxis: the problem of dental surveillance. *Heart* 99(6):363-364. Lockhart P.B., Brennan M.T., Thornhill M.H., Michalowicz B., Noll J., Bahrani-Mougeot F.K. and Sasser H.C. (2009) Poor oral hygiene is a risk factor for infective endocarditis-related bacteremia. *JADA* 140(10):1238-1244.	Thank you for your comment and for providing references. The Chambers 2013 study is not a primary research study, hence does not meet our criteria for inclusion under our current process. Moreover, the authors' conclusion is in line with current guideline recommendations. The Lockhart 2009 study was considered at the 3 year review of the guideline conducted in July 2011. Through an assessment of the abstract it was concluded that insufficient evidence was identified to change the direction of current guideline recommendations. NICE is not aware of any important new studies likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Please note that clinical

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					guidelines placed on the static list will be reviewed every 5 years to determine if they should remain on the static list. However, if you become aware of any new evidence or information from clinical practice that is likely to impact on the guideline, please contact NICE with the appropriate details.
123	British Dental Association	CG 64 Prophylaxis against infective endocarditis	Disagree	There have been several recent research grants awarded to investigate this topic. The researchers involved include Prof Martin Thornhill, University of Sheffield : 'An investigation of whether a guideline to end antibiotic cover for patients at risk of infective endocarditis has led to an increase in cases of infective endocarditis'. Funded by Heart Research UK/Simply Health (£100K) 'A before and after study of the effect of ceasing to give antibiotic prophylaxis for dental procedures to prevent infective endocarditis.' Funded by the National Institute for Dental and Craniofacial Research at the National Institutes for Health in the United States. ($108K).	Thank you for your comment and for bringing this to our attention. However, we are unable to get any further information as to when these studies are likely to conclude or publish. NICE is not aware of any important new studies likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Please note that clinical guidelines placed on the static list will be reviewed every 5 years to determine if they should remain on the static list. However, if you become aware of any new evidence or information from clinical practice that is likely to impact on the guideline, please contact NICE with the appropriate details.
CG69 Respiratory Tract Infection					
53	Greater Manchester Health Economy	Respiratory tract infections (CG69)	Disagree	Given the launch of the 'UK Antimicrobial Resistance Strategy' published on 12th September 2013 https://www.gov.uk/government/news/uk-	Thank you for highlighting the recent launch of the UK Antimicrobial Resistance Strategy. Having considered the strategy we feel that the key areas

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				antimicrobial-resistance-strategy-published--2 particularly section 2.7 which indicates that research will be commissioned and published before 2015 regarding prescribing strategies. This could change the assertion that no knowledge or research will change within 5 years.	for future action on promoting rational prescribing supports the guideline recommendations. In addition, other aspects of the strategy including point of care tests and antimicrobial stewardship are outside of the scope of this guideline and may be covered by future guidelines on antibiotic prescribing.
63	British Thoracic Society	Respiratory Tract Infections CG69	Yes with proviso	This is an odd choice for the static list given its importance and the likelihood of important new studies being published over the next few years; however, this area is partially covered by other guidelines eg pneumonia guideline that will be published in 2014.	Thank you for your comment. NICE is not aware of any important new studies likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Please note that clinical guidelines placed on the static list will be reviewed every 5 years to determine if they should remain on the static list. However, if you become aware of any new evidence or information from clinical practice that is likely to impact on the guideline, please contact NICE with the appropriate details.
80	The Royal College of Radiologists (RCR)	Respiratory Tract Infections CG69	Agree	The RCR is not aware of any new data that would have a significant impact on this guideline	Thank you for your comment.
103	Royal College of Physicians (RCP)	Respiratory tract infections (CG69)	Agree with proviso	The RCP wishes to endorse the comments submitted by the BTS on this guideline proposal.	Thank you for your comment.
CG75 Metastatic spinal cord compression					
48	Greater	Metastatic	Agree		Thank you.

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	Manchester Health Economy	spinal cord compression (CG75)			
74	Ferring Pharmaceuticals Ltd.	CG75 - Metastatic spinal cord compression	Agree	No comments	Thank you.
CG77 Antisocial personality disorder					
27	Merck Sharp & Dohme	CG77 – Antisocial personality disorder	Agree	MSD agrees with the proposal to add this guideline to a static list.	Thank you for your comment.
35	Greater Manchester Health Economy	Antisocial personality disorder (CG77)	Agree		Thank you..
CG83 Rehabilitation following critical illness					
4	Patients and Relatives Committee, Intensive Care Society	CG83 Rehabilitation following critical illness.	Disagree	The potential psychological and physiological consequences of critical illness continue to be poorly recognised particularly after a patient has been discharged from hospital. The Guideline continues to be very relevant and in need of regular review as evidence continues to emerge of the implications of these consequences and of strategies to help address them. Placement on a static list may discourage active consideration of the Guideline resulting in a failure to incorporate late improvements in patient care and professional understanding. It should be noted that conformity	Thank you for your comment. This guideline was reviewed in April 2012 where the decision was that it should not be updated at that time as no new evidence was identified which would suggest a significant change in clinical practice. The decision to move this guideline to the static list reflects the result of the no to update decision from the review in 2012. NICE is not aware of any important new

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				with this guideline is being actively considered as a CQUIN funding opportunity.	studies likely to publish over the next few years which would contradict the decision to move this guideline onto the static list. Please note that clinical guidelines placed on the static list will continue to be reviewed every 5 years to determine if they should remain on the static list. However, if you become aware of any new evidence or information from clinical practice that is likely to impact on the guideline, please contact NICE with the appropriate details.
40	Greater Manchester Health Economy	Critical illness rehabilitation (CG83)	Agree		Thank you.
CG84 Diarrhoea and vomiting in children					
42	Greater Manchester Health Economy	Diarrhoea & vomiting in children under 5 (CG84)	Agree		Thank you.
79	The Royal College of Radiologists (RCR)	Diarrhoea and vomiting in children CG84	Agree	The RCR is not aware of any new data that would have a significant impact on this guideline	Thank you for your comment.
136	Royal College of Paediatrics and Child Health	CG84	Disagree	Whilst we agree that the criteria for the static list are fulfilled, diarrhoea and vomiting in pre-school children is a very common reason for resort to unscheduled care. The Allergy, Immunology and Infectious Diseases audit of attendances to	Thank you for your comment. The issue raised does not directly relate to the decision of NICE to move this topic to the static list based on the criteria laid out in the consultation.

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				paediatric A&E revealed 800 cases in 1 year. This has very considerable health economic impact and urgently requires review and a standard.	However, the Centre for Clinical Practice at NICE is developing a mechanism to consider future requests to remove topics from the static list. This will entail what criteria will be used to assess the rationality of such requests, and subsequent measures to re-integrate topics to the regular guideline surveillance programme if it is found that the decision to put a topic on the static list is no longer valid. Details of this process will be made publically available on our website.
CG89 When to suspect child maltreatment					
30	Resuscitation Council (UK)	CG89 - When to suspect child maltreatment	Disagree	Several members of our Executive Committee raised concerns about movement of CG89 on to a static list. As we are not stakeholders for this guideline one of those members has directed those concerns to the Royal College of Paediatrics and Child Health.	Thank you for your comment. We did not receive any specific comment regarding the placing of CG89 When to suspect Child Maltreatment on the static list from the Royal Collage of Paediatrics and Child Health. .
58	Greater Manchester Health Economy	When to suspect child maltreatment (CG89)	Agree		Thank you.
78	The Royal College of Radiologists (RCR)	When to suspect child maltreatment	Agree	The RCR is not aware of any new data that would have a significant impact on this guideline	Thank you for your comment.

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		CG89			
CG93 Donor breast milk					
43	Greater Manchester Health Economy	Donor breast milk (CG93)	Agree		Thank you.