Suspected sepsis: recognition, diagnosis and early management

Consultation on draft guideline - Stakeholder comments table
06/06/25 – 18/07/25

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Meningitis Research Foundation	EIA	001	000	Section 3.1 – Age is referenced as a consideration within this section but in reference to older age and frailty. We are concerned that the guidance does not refer specifically to the age 16-24 age group and that this creates an inequity in their care. This age group have multiple risk-factors that put them at a distinct disadvantage in their care if they are not considered to be an at-risk group in their assessments. They present to emergency departments relatively rarely, they are at an increased risk of invasive meningococcal disease and they are able to compensate until later stages of infection. Cumulatively, this means that if the same criteria are applied to them, they are at a disadvantage and are **more likely to have poorer outcomes.** We urge that these risks be clearly acknowledged in the Equality Impact Assessment and reflected throughout the guideline recommendations.	Thank you for your comment. The EIA has been updated to acknowledge the point you have raised regarding 16-24 year olds. The EIA notes that young adults and adolescents may initially compensate for the effects of sepsis more effectively than older adults potentially making early symptoms less obvious. However, the Committee agreed that as the 16-25 year old age group are a NEWS2 population specific reference to this group was not required. NICE's guideline on meningitis (bacterial) and meningococcal disease: recognition, diagnosis and management (NG240) has recommendations on recognising and investigating meningitis and meningococcal disease.
Meningitis Research Foundation	EIA	003	000	Section 3.3 – We were pleased to see reference to family and carers being consulted within the recommendations. To build further on this, it would be great to see specific reference to Martha's Law within the recommendations, to highlight the importance of seeking this input from the start.	Thank you for your comment. It is not entirely clear what section of the guideline your comments refer to but assuming it is recommendation 1.13 relating to vasopressors and monitoring and escalation (1.13.15 now 1.13.13). The committee discussed Martha's rule highlighting its focus in general patient safety and agreed that due to it not being sepsis specific, only recently being rolled out in English hospitals, and not yet fully implemented that it should not be referred to within this update.

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National Child Mortality Database (NCMD) Programme at the University of Bristol	Evidence review	000	000	The NCMD thematic report on Infection Related Deaths in Children and Young People, using data from the statutory child death review process in England, should be referenced. Evidence from the completed child death reviews of children who have died due to sepsis, shows that, where this information was known, in 85% (n=112/131) of deaths where the child presented to hospital, there were one or more red flag symptoms for sepsis, and these were recognised in 77% (n=101/131) of deaths. However, in 8% (n=11/131) one or more red flag symptoms were present but not recognised, and in 15% (n=19/131) of the deaths where the child presented to hospital, there were no red flag symptoms. We have made specific recommendations in this report to NICE to commission research with healthcare professionals and systems into the barriers to recognising and managing sepsis and review effectiveness and specificity of current sepsis guidance.	Thank you for your comment and the data provided. At this point we are only updating certain parts of the guideline, and your comment refers to children and young people who are out of scope for this update and as such was not considered by the guideline committee. We are therefore unable to amend this section of the guideline at present' Just to note NICE does not commission research.
Faculty of Pharmaceutical Medicine	Evidence Review D	General	General	Agree with the committee deliberations, conclusion & research recommendations, although we would recommend adding that the objectives of research should take into account the clinical context as well as antimicrobial stewardship and time taken.	Thank you for your comment. We think that you are referring to section K1.1 research. The 'why this is important' section notes the importance of people being given the appropriate antibiotic for their infection and timely diagnosis and treatment and better patient outcomes.
bioMérieux	Evidence Review D	051	000	We do not agree with the exclusion of Peri et al. 2022 (PMID: 36266641) on the basis of "PCR taken from culture not whole blood".	Thank you for your comment. The protocol for this review noted that the review only includes studies using whole blood sample and not culture. Tests using cultures would be

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				Some PCR diagnostic tests are designed to identify pathogens from blood cultures that have already tested positive, others are designed to detect pathogens directly from whole blood samples, potentially even before a blood culture becomes positive. The benefits of PCR testing in time-to-effective therapy, patient care optimisation, AMS, staff time, and hospital resource use, outweigh whether or not whole blood is used for the test.	unlikely to satisfy the definition of a 'rapid test' that is defined in this review as one where test results can be produced within 6 hours and is directly from patients' samples.
Faculty of Pharmaceutical Medicine	Evidence Review E	000	000	Agree with the committee conclusion & recommendations	Thank you for your comment.
Faculty of Pharmaceutical Medicine	Evidence Review F	000	000	Numerous studies have demonstrated a significant association between elevated lactate levels (either through increased production or reduced clearance) and higher odds ratios/hazard ratios for mortality. The committee acknowledged that, among various prognostic factors, lactate had the strongest evidence linking it to mortality outcomes. However, this emphasis is not adequately reflected in the current NICE guidance. While FPM recognizes the usual limitations inherent in cross-study comparisons and understand that no single prognostic marker should be used in isolation as indicated in the guidance, we believe that lactate warrants greater emphasis. *This is particularly important given the substantial body of supporting evidence,* especially when compared to the limited data available for other factors such as RAT/PCR rapid testing. The majority of studies	Thank you for your comment. Further detail on the decision making is in the rationale section which notes that the committee agreed that lactate could not be used in isolation and that those people assessed as high risk should be given IV fluids (unless contraindicated), using indicators such as lactate may unnecessarily delay treatments.

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				consistently show a correlation between elevated lactate and increased mortality risk. The recommendation to take people at moderate risk into high risk is welcome especially in younger patients whose NEWS2 may hold up and then deteriorate very rapidly when lactate levels may become important for tracking the deterioration.	
Faculty of Pharmaceutical Medicine	Evidence Review G	000	000	Agree with the committee conclusions & recommendations. It should note more clearly the impact of anti-infective treatment or other drug infusions that might also contribute to fluid overload.	Thank you for your comment. It was agreed that most infusions are delivered in relatively low volumes (20ml or 30ml), and this did not need to be considered in the context of fluid overload.
Faculty of Pharmaceutical Medicine	Evidence Review H	000	000	Agree with the committee conclusion & recommendations	Thank you for your comment.
Faculty of Pharmaceutical Medicine	Evidence Review I	000	000	Agree with the committee conclusions & recommendations, but perhaps some consideration should be given to iGAS especially in young adults with symptoms which may not fall in any of the current risk categories.	Thank you for your comment. This review was on factors associated with an increased risk of developing sepsis for example protected characteristics such as race or socioeconomic factors. Invasive Group A Streptococcus (iGAS) is not an associated factor as outlined in this review and is out of scope for this guideline update.
NHS England	Evidence review I	021	025	• The committee acknowledges that people with a learning disability, dementia and severe mental illness may be at greater risk of there being a delay in the recognition of sepsis due to the potential difficulties these people may have in communicating their symptoms and therefore a greater risk of delayed presentation or not being able to access services. This acknowledges delayed presentation but does not	Thank you for your comment. The EHIA has underpinned the committee's discussions for the areas within this update that are specific to suspected sepsis. Other NICE guidelines that consider the factors you highlight such as CG138 (Patient experience in adult NHS services) or NG108 (Decision-making and mental capacity) include recommendations on

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				acknowledge the *extensive evidence of poor care and health inequalities that may be faced once a patient has presented.* • It also attributes barriers to care to patient related factors, when there is extensive evidence, e.g. through LeDeR, that systemic and clinician related factors such as diagnostic overshadowing, unconscious bias, not recognising the significance of soft signs of deterioration, not offering reasonable adjustments under the Equalities Act, not adhering to the Mental Capacity Act etc can contribute to severe illness and death. • More proactive adjustments to care pathways are required for these patient groups in order to reduce inequalities, improve outcomes and reduce avoidable mortality, such as having a lower threshold for transferring immediately to acute hospital, offering reasonable adjustments to ensure required assessments (e.g. blood tests, blood pressure etc) are possible, using the MCA and acting in the patient's best interests when patients lack capacity, will all reduce vulnerability to severe illness and death. • Without a specific recommendation re management such as these, the knowledge of the increased vulnerability of these groups alone may have limited impact on practice and outcomes or the narrowing of inequality.	tailoring healthcare services for each patient and are outlined at the beginning of the guideline.

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Royal College of Nursing	General	General	General	Thank you for inviting the Royal College of Nursing to comment on the draft NICE guideline on Suspected sepsis: recognition, diagnosis and early management.	Thank you for your comment.
bioMérieux	Guideline	General	General	NICE should reference NHS England guidance, which is to collect two blood-culture sets (4 bottles) prior to antibiotics to maximise the likelihood of detecting the associated pathogen. NHS England Blood Culture Guidance (2022; https://www.england.nhs.uk/wp-content/uploads/2022/06/B0686-improving-the-blood-culture-pathway-executive-summary-v1-1.pdf.pdf) states that the standard is 2 sets of 8-10 mL per bottle, 4 bottles before antibiotics, and to incubate within 4 hours.	Thank you for your comment. Recommendation 1.13 (which was shaded in grey and outside the scope of this update) on 'Initial investigations to find the source of infection' refers to the UK standards for microbiological investigations with reference to taking microbiological and blood samples.
bioMérieux	Guideline	General	General	We understand that NICE have a developed method for evidence review. However, we believe that the NICE review for this update has missed key evidence from both RCTs and NHS real-world evaluations of BioFire® BCID2. Current conclusions are based on a single small Chinese study not representative of UK care (Li et al. 2023). We urge NICE to consider the publications and key results shared throughout this Comments Form. NICE has also not cited key NHS and Government guidance on AMS and blood culture best practices (including the AMR 5 year national action plan 'Confronting antimicrobial resistance 2024 to 2029' published in May 2024). Such best practices and	Thank you for your comment and additional information. Responses to the comments and publications elsewhere can be found beside those comments. The recommendation on 'Initial investigations to find the source of infection' refers to the UK standards for microbiological investigations with reference to taking microbiological and blood samples. Thank you for your comment. The study you have referred to (Li et al 2023) is in children and is on the detection of Bordetella pertussis which would not have been picked up in the searches for this sepsis guideline and would be excluded on population and topic area as this guideline focuses on NEWS2 populations. The Peri et al (2022) study which considered the performance of BioFire BCID2

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				guidelines directly support the workflow that rapid multiplex testing and rapid ID AST integrate into. For example, the digital vision for AMS in England, the NHS England AMS Vision (2025), is a 10-point framework that includes diagnostics-first policy, mandatory stewardship review at 48 – 72h, and the UKHSA/NHS Blood Culture Toolkit (2022) which advises a two-set draw protocol standard.	was identified for full paper review but excluded as PCR was taken from culture and not whole bloods which was an exclusion criteria in the corresponding review (Review D). Recommendation 1.13 (which was shaded in grey and outside the scope of this update) on 'Initial investigations to find the source of infection'. refers to the UK standards for microbiological investigations with reference to taking microbiological and blood samples.
bioMérieux	Guideline	General	General	Regarding the management of the condition while awaiting transfer, administering antibiotics prior to collecting blood cultures is known to significantly reduce the likelihood of obtaining a positive result, which can negatively affect the subsequent management of patients with sepsis (Scheer et al. 2029 PMID: 29879482). Therefore, if NICE recommends pre-hospital administration of antibiotics, it should also support the implementation of pre-hospital diagnostics to preserve the ability to identify causative pathogens and guide targeted treatment.	Thank you for your comment and additional information. This section of the guideline is out of scope for this update and as such was not considered by the guideline committee. We are therefore unable to amend this section of the guideline at present.
Royal College of Pathologists	Guideline	General	General	Overall this is a welcome document and we would support it.	Thank you for your comment.
Royal College of Midwives	Guideline	General	General	It is unclear if the majority of this guideline is aimed at Over 16s (not pregnant or recently pregnant) as per heading on line 20 page 8. There are very few references to management of pregnant or postnatal women elsewhere in the guidance.	Thank you for your comment. The scope of this update is only for people over the age of 16 (not pregnant or recently pregnant) and as such this is the population included in this consultation. As outlined in the consultation documents the sepsis guideline will be split into 3 guidelines by population: NEWS2 populations (aged 16 and over), pregnant or recently pregnant people, and children and young people.

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					This will make it easier to find relevant information quickly for each of these populations.
Thermo Fisher Scientific	Guideline	General	General	Procalcitonin (PCT) testing was identified as an area being monitored in the 'Final Scope' for the Guideline update (06 Mar 24) but is absent in the Draft Guideline. While we appreciate that NICE intend to wait for new UK evidence from the NIHR funded PRONTO trial, evidence on the utility of PCT in the management of sepsis patients has developed considerably since NICE DG18 was published in 2015. Multiple interventional randomised controlled trials have demonstrated that PCT is a safe and effective tool in the management of sepsis patients, highlighting the **importance of an early (<24hrs) sample** to establish a baseline, especially in patients with moderate to severe illness. **Evidence from several recent Randomised Controlled Trials (RCTs)** • **ADAPT-Sepsis Trial (Dark P et al., JAMA 2024)**: "Biomarker-Guided Antibiotic Duration for Hospitalised Patients With Suspected Sepsis: The ADAPT-Sepsis Randomised Clinical Trial" A multicentre double-blinded RCT involving 2,760 patients in 41 NHS intensive care units in the UK, comparing three arms: PCT-guided care, CRP-guided care, and standard care. Main findings: PCT-guided care was superior to standard care, significantly reducing antibiotic	Thank you for your comment and further information. PCT and CRP are out of scope for this update and as such was not considered by the guideline committee. We are therefore unable to amend this section of the guideline at present. NICE has existing guidelines that considers PCT in sepsis (DG18). Consideration is currently being given via NICE's prioritisation process on a possible update of this sepsis guideline or DG18.

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				duration by approximately 10% (0.88 days, p=0.01) without compromising patient safety. CRP did not show superiority over standard care for antibiotic duration and did not meet the non-inferiority safety margin. The ADAPT-Sepsis trial was designed to address evidence gaps identified by NICE and was funded by NIHR HTA following a specific commissioning brief call (15/99). In October 2020, the Chief Medical Officer/Deputy Chief Medical Officers recommended the ADAPT-Sepsis trial as NIHR Urgent Public Health (UPH) research. • **SAPS Trial (De Jong et al., Lancet Infect Dis 2016)**: "Efficacy and safety of procalcitonin guidance in reducing the duration of antibiotic treatment in critically ill patients: a randomised, controlled, open-label trial" A multicentre RCT conducted in 15 hospitals in the Netherlands with 1,575 critically ill patients in ICU (~80% sepsis or severe sepsis and 20% septic shock). Main findings: Significantly lower antibiotic exposure in the PCT group, with a 19% relative reduction (p<0.0001). The study demonstrated that the reduction in antibiotic exposure with the aid of PCT was not only safe but also resulted in lower mortality than the control group (-5.4% and -6.1% lower mortality in the PCT group at Day 28 and 1 year, respectively).	

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				• **PROGRESS Trial (Kyriazopoulou et al., Am J Respir Crit Care Med, 2021)**: "Procalcitonin to Reduce Long-Term Infection-associated Adverse Events in Sepsis. A Randomised Trial" A prospective, multicentre, randomised trial in Greece involving 266 patients. Main findings: PCT-aided antibiotic reduction leads to long-term improved clinical outcomes, including reduced mortality. Comparing the PCT arm with standard care, the median length of antibiotic therapy was 5 days (range, 5–7) versus 10 days (range, 7–15) (P<0.001), while the rate of infection-associated adverse events until Day 180 was 7.2% versus 15.3% (P=0.045) and 28-day mortality was 15.2% versus 28.2% (P=0.02). **Evidence from recent meta-analyses of RCTs, including two at the patient level:** • **Schuetz et al., The Lancet 2018**: "Effect of procalcitonin-guided antibiotic treatment on mortality in acute respiratory infections: a patient level meta-analysis." An individual patient data analysis on 6,708 patients with acute respiratory infections from 26 eligible RCTs, 11 of which involved patients with sepsis and/or critically ill patients with suspected bacterial infections. It proves the safety of the PCT approach to reduce	

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				antibiotic exposure and the positive impact on patient survival. Main findings: 30-day mortality was significantly lower in the PCT group (9% vs. 10% in the control group). PCT guidance was also associated with a reduction in both antibiotic exposure (-2.4 days) and antibiotic-related side effects (16% vs. 22%). • **Wirz et al., Critical Care 2018**: "Effect of procalcitonin-guided antibiotic treatment on clinical outcomes in intensive care unit patients with infection and sepsis patients: a patient-level meta-analysis of randomised trials." An individual patient data meta-analysis of 11 RCTs with 4,482 sepsis patients with various types of infections. Main findings: Significantly shorter antibiotic treatment duration (9.3 vs. 10.4 days; $p<0.001$) without causing harm to patients. In fact, PCT-aided treatment in ICU patients resulted in improved 30-day survival compared to the control group (21.1% vs. 23.7%; $p=0.03$). • **Gutiérrez-Pizarraya et al., Expert Rev Anti Infect Ther. 2022**: "Clinical impact of procalcitonin-based algorithms for duration of antibiotic treatment in critically ill adult patients with sepsis: a meta-analysis of randomised clinical trials." A meta-analysis of 12 RCTs with a total of 4,292 patients assessing the safety of using PCT to guide	

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				antibiotic cessation in critically ill patients with confirmed sepsis or septic shock. Main findings: In critically ill adults with sepsis, using a procalcitonin-guided approach significantly reduces the duration of antimicrobial therapy by 1.98 days (95% CI: -2.76 to -1.21). This reduction was associated with a significant decrease in mortality, with a combined relative risk for 28-day mortality of 0.89 (95% CI: 0.79 to 0.99). We have also noted that the current guideline recommends the measurement of C-reactive Protein (CRP) for individuals aged 16 or over who are at risk of severe illness or death (Guideline, Page 16 and Page 20). Recommending CRP while not including a recommendation for PCT in this context overlooks important differences in their specificity, kinetics, and clinical utility. CRP is cheap and widely available, but it has low sensitivity and specificity for bacterial infection. The slow kinetics of CRP often mean that the biomarker can be falsely negative in patients presenting early making it unreliable in acute sepsis care and propagating the problem of overtreatment of antibiotics. Further the slower decrease in the course of bacterial infection often leads to misinterpretation, potentially prolonging or triggering unnecessary antibiotic use. PCT has consistently demonstrated superior clinical diagnostic performance in detecting sepsis and invasive	

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				bacterial infections across multiple studies, as evidenced by two meta-analyses in both adults and children (**Norman-Bruce et al., 2024; Simon et al., 2004**). These findings are reinforced by the aforementioned RCTs and meta-analyses conducted across different countries, including the UK (i**.e. the ADAPT-Sepsis study funded by NIHR HTA**), which consistently show that a PCT-guided approach to antibiotic management leads to reduced antibiotic exposure without compromising patient safety and potentially even decreasing all-cause mortality. This is of high clinical significance and stands in clear contrast to the level of evidence available for CRP. Moreover, PCT remains the only 'essential' biomarker recommended by the World Health Organization for the de-escalation of antibiotics in Sepsis & Respiratory Infection (**Second WHO Model List of Essential In Vitro Diagnostics – 2019**). Additionally, other international guidelines already recommend serial PCT testing along with clinical evaluation to decide when to stop antibiotics, namely: • **2023 ADLM (formerly AACC)** Guidance Document on the Clinical Use of Procalcitonin • **2021 Surviving Sepsis Campaign**: International Guidelines for Management of Sepsis and Septic Shock	

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				Based on this, we would like to request NICE to consider the accumulating evidence on PCT and update the current guidance to accommodate this and align with the most recent international standards.	
Royal College of General Practitioners	Guideline	General	General	We believe that the cost implications of early intravenous therapy and rapid conveyance to hospital may disproportionately impact community and out-of-hours services especially in rural settings. Additional training and resource allocation should be considered to support these pathways as well as clarity around the individual responsibilities of ambulance services. It is not the role of General Practice to stock and administer intravenous fluids and current training currently does not support this.	Thank you for your comment. These recommendations do not change when and where IV fluids are to be given. The recommendations are not suggesting IV fluids should be given by GPs. Ambulance settings already have the provision to administer fluids. The specification of fluids to be balanced crystalloids where possible was made to avoid a potential resource impact and need for additional training for ambulance services because they usually only stock 0.9% saline solution.
Aneurin Bevan University Health Board	Guideline	Implementation (General)	Implementation (General)	Rapid Microbiological Testing for future research recommendations and in answer to the implementation questions posed above: We perform a limited number of Blood Culture Identification (BCID) rapid PCR for positive blood culture isolate identification. A clear funding stream for this for blood culture positives needs to be agreed for all blood culture positives, also to necessitate antimicrobial stewardship in these, reducing glycopeptide use in particular and also carbapenem use. A nationally agreed requirement for BCID rapid PCR may help ensure local / national funding for its use.	Thank you for your comments and the additional information provided.

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				We see a lot of contaminants in blood cultures, and this would reduce the use of antibiotics where we can identify a coagulase negative *Staphylococcus* rather than *S. aureus*. CONS may still be significant in those at risk (long lines, cardiac implantable devices, endocarditis, ortho prosthesis, repeat cultures) but we see a lot of CONS in blood cultures where antibiotics are started empirically and could be avoided if we did a rapid ID in more of these. We also have high blood culture contamination rates – audit ongoing locally. Another challenge for the lab picking up more rapid antigen tests, would be that the lab already does *pneumococcal* antigen testing only if CURB score ≥3 due to resource and we do reject a lot. So, that would be a limitation. For orthopaedic infections there are also joint panel multiplex PCRs available to reduce broad spectrum antibiotic use. We don't have the access to the test locally due to lack of funding, although this could also be beneficial from an antimicrobial stewardship angle.	
Royal College of Emergency Medicine	Guideline	General	General	On splitting the guideline into age groups – this is useful for paediatricians and obstetricians, but EM and GP clinicians could end up reading the same guidance 3 times – could there be general advice for all adults with specifics for pregnant patient and general advice for all children and specific advice for where it differs between age groups of children?	Thank you for your comment. There were discussions with representatives from the RCEM prior to the decision to split the sepsis content into three guidelines. The content within the paediatric and maternity recommendations has not been updated (except some changes to ensure clarity and consistency) and as such has not been consulted on Consideration will be given via

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				RCEM Paediatric Emergency Medicine Professional Advisory Group were concerned that they could not review the separate guidance for age groups.	NICE's prioritisation process on any further updates of the NICE sepsis guidelines.
Royal College of Emergency Medicine	Guideline	General	General	RCEM Paediatric Emergency Medicine Professional Advisory Group response: National Institute for Health and Care Excellence (NICE) guidance provides a way of standardising evidence-based approaches to clinical care. While the application of guidance is not mandated it is used by regulators and coronial systems to highlight where care may be deficient or substandard. Updates to NICE guidance are necessary to ensure the available evidence is applied as effectively as possible. This is important to protect the public and patients from harm but also to ensure that the standards that healthcare professionals are held against are relevant and fair. This is an important principle as it is difficult to see how evidence as it applies to children and young people has been updated in this iteration of the NG 51 update. Previously sepsis has been defined as a suspected or proven infection associated with a Systemic Inflammatory Response (SIRS); Severe Sepsis is sepsis with organ dysfunction. (1,2). SIRS is the presence of at least 2 of the following: Core temperature > 38.5°C or < 36°C, tachycardia or tachypnoea for age and white cell count elevated or depressed. It is this approach that has been	Thank you for your comment. At this point we are only updating certain parts of the guideline, and your comment refers to children and young people who outside the scope of this guideline and was not considered by the guideline committee. Consideration will be given via NICE's prioritisation process on any further updates of the NICE sepsis guidelines.

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				essentially adopted by NICE in the sepsis guidance. This guidance screens patients into low, medium and high risk categories based on an expanded SIRS criteria (heart rate, respiratory and behavioural changes). There is no current evidence that the NICE screening is effective but there are multiple sources that demonstrate it is poorly specific (3-6) in children and young people. A further example of the poor practical applicability of the NICE sepsis guidance is that of children presenting with low-risk pneumonia (able to be discharged with oral antibiotics from an Emergency Department). In one study 54% (318/591) had high risk sepsis criteria. According to NICE guidance this requires prescription of a broad-spectrum antimicrobial at the maximum recommended dose, without delay (within 1 hour of identifying that they meet any high-risk criteria), admission and supportive care as required (such as fluids and oxygen). Of these 318 children only 4% (14/318) returned to the hospital within 7 days to be hospitalised (7). This demonstrates how poorly specific NICE sepsis guidance is, with implications for antimicrobial resistance and iatrogenic patient harm (through over-diagnosis). An argument might be that non-of these studies meet NICE's standards for academic quality or match the specific brief for the evidence reviews. The counter factual to this argument is that no study has been published demonstrating the effectiveness of the NICE Sepsis	

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				approach in Children and Young People. It is well demonstrated that physiological criteria alone do not predict outcomes for children and young people in emergency care yet the core guidance in the UK continues to recommend resources to be mobilised to review children on the basis of solitary vital signs. A poorly performing tool leads to over-investigation, alarm fatigue and contributes to poor antimicrobial stewardship. In 2024 the Society of Critical Care Medicine Paediatric Sepsis Definition Task Force (4) released a new definition of sepsis, the Phoenix criteria. This approach affirms the need to demonstrate organ dysfunction to confirm the presence of sepsis. We recognise a new definition of sepsis is useful for case ascertainment and audit purposes but does not solve the challenge of identification in acute settings such as primary care and emergency departments. However it appears in this current update of NICE guidance the specific challenges facing clinicians in recognising and managing sepsis have been ignored for children and young people. **References** 1. Goldstein B, Giroir B, Randolph A, International Consensus Conference on Pediatric Sepsis. International pediatric sepsis consensus conference: definitions for sepsis and organ dysfunction in pediatrics. Pedi Critic Care Med. 2005 Jan; 6(1):pp. 2–8.	

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				2. Weiss, S.L., Peters, M.J., Alhazzani, W. et al. Surviving sepsis campaign international guidelines for the management of septic shock and sepsis-associated organ dysfunction in children. Intensive Care Med 2020 46 (Suppl 1),10–67. 3. Nijman RG, Jorgensen R, Levin M, Herberg J, Maconochie IK. Management of Children With Fever at Risk for Pediatric Sepsis: A Prospective Study in Pediatric Emergency Care. Front Pediatr 2020 17;8:548154 4. Lim E, Suspected Sepsis: Summary of NICE Guidance. BMJ 2016;354:i4030 5. Gomes S, Wood D, Ayis S, Haliasos N, Roland D. Evaluation of a novel approach to recognising community-acquired paediatric sepsis at ED triage by combining an electronic screening algorithm with clinician assessment. Emerg Med J. 2021 Feb;38(2):132-138 6. Brennan L, Heal C, Brown S, Roland D, Rowland AG. Time to change the reference ranges of children's physiological observations in emergency care? A prospective study. J Paediatr Child Health. 2023 Mar;59(3):480-486 7. Roland D, Stohr W, Gibb D, Sturgeon K, Bielicki JA, Lyttle MD. Evidence of Poor Utility of Current Sepsis Screening Tools in an At-Risk Population of Children With Community-Acquired Pneumonia. Pediatr Infect Dis J. 2025 Feb 18. doi:	

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				10.1097/INF.0000000000004758. Epub ahead of print. PMID: 39970317. 8. Sanchez-Pinto LN, Bennett TD, DeWitt PE, et al. Development and Validation of the Phoenix Criteria for Pediatric Sepsis and Septic Shock. JAMA. Published online January 21, 2024. doi:10.1001/jama.2024.0196	
UK Health Security Agency	Guideline	General	General	Please clarify why the population under 16 years (and associated national work on PEWS) has been excluded from this guidance, despite individuals belonging to this group being listed as being at higher risk of developing sepsis. While this exclusion is not explicitly stated, recommendations start with "for people aged 16 or over". The omission is also not clear from the title of the document.	Thank you for your comment. Those who are pregnant or recently pregnant and those under 16 are outside of the scope of this update. As outlined in the consultation documents the sepsis guideline will be split into 3 guidelines by population, NEWS2 populations (aged 16 and over), pregnant or recently pregnant people, and children and young people. Consideration will be given via NICE's prioritisation process on a possible update of the children and young people and pregnant or recently pregnant split sepsis guideline, such as the incorporation of PEWS.
UK Health Security Agency	Guideline	General	General	Current NG51 online has information on those under 16 and those persons who are pregnant or recently pregnant, these appear to be missing from the Consultation and with no explanation as to why they are not present in the current document.	Thank you for your comment. Those who are pregnant or recently pregnant and those under 16 are outside of the scope of this update. As outlined in the consultation documents the sepsis guideline will be split into 3 guidelines by population, NEWS2 populations (aged 16 and over), pregnant or recently pregnant people, and children and young people – which will be published alongside this update which focuses on NEWS2 populations.
Royal College of Nursing	Guideline	General	General	Overall, there is little mention in the guideline what is children and young people (CYP) specific, and the only	Thank you for your comment.

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				real link is to the Babies, children and young people (BCYP)'s Experience of healthcare experience documentation which does not seem to be specific to Sepsis management. There is also no direct reference to under 16s which was clearer in the previous iteration of NG51. It is not clear that the term 'people' refers to babies, children, young people and adults.	The scope of this update focuses on rapid antigen testing and PCR tests, indicators of organ hypoperfusion, intravenous fluid therapy, vasopressors in NEWS2 populations, and risk factors for sepsis across all populations. The consultation documents include the updated recommendations and additional contextual recommendations; it does not include all sections of the guideline. As outlined in the consultation documents the sepsis guideline will be split into 3 guidelines by population, NEWS2 populations (aged 16 and over), pregnant or recently pregnant people, and children and young people.
Royal College of Nursing	Guideline	General	General	It is not clear enough in the draft guideline that some young people between 16 years to over 18 years may still be primarily cared for in the paediatric settings due to co-morbidities or physical/developmental/cognitive impairment and would use a paediatric early warning score to reflect this. Does this need to be acknowledged in hospital settings where sepsis is suspected?26	Thank you for your comment The hospital setting within this guideline refers to acute hospital settings and does not specify if these are adult or paediatric. NEWS2 refers to those aged 16 and over and PEWS includes a chart for those ≥13 years, clinical judgement will inform the use of these for those between 16 and 18 years. Consideration will be given via NICE's prioritisation process on a possible update of this sepsis guideline, such as the incorporation of PEWS.
Royal College of Nursing	Guideline	General	General	We note that there is mention of NEWS2 throughout the draft guideline, but this is not used in paediatrics settings. National Paediatrics Early Warning Score (PEWS) is the expected standard for use in CYP settings and there is no mention of it within the document.	Thank you for your comment. At this point we are only updating certain parts of the guideline, and your comment refers to children and young people who are outside the scope of this guideline and was not considered by the guideline committee.

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					Consideration will be given via NICE's prioritisation process on a possible update of this sepsis guideline, such as the incorporation of PEWS.
Royal College of Nursing	Guideline	General	General	The parameters for fluid resuscitation could not be applied in the under 16 age group as this is not weight dependent.	Thank you for your comment. Amendments have been made to the paediatric IV fluids recommendations within the under 16s recommendations in the sepsis guideline, with the addition of a 250mls volume cap.
Royal College of Nursing	Guideline	General	General	The Sections on vasoactive medications could indicate that for those with neurodivergence / Mental Health issues / cognitive impairment etc., monitoring of lines needs to be more vigilant to reduce the risk of extravasation.	Thank you for your comment. Close monitoring of the cannula and infusion is specified for everyone who is receiving vasopressors peripherally. The need to consider the needs of those with 'neurodivergence / Mental Health issues / cognitive impairment etc' is outlined throughout the guideline and further considered in the accompanying equalities impact assessment (EIA).
Royal College of Nursing	Guideline	General	General	It seems there is only mention of people over 16 years in the document. Perhaps we may have misunderstood the patient group that this guideline is intended for and / or there is a section missing as we cannot see any section which is CYP specific? We are aware there is information on this in the previous iteration of NG51. If the guideline is not intended for children and young people under 16 years, it should be made specifically clear in the document and refer CYP healthcare professionals to the relevant guidance for managing this group of patients.	Thank you for your comment. Children and young people are out of scope for this update. As outlined in the consultation documents the sepsis guideline will be split into 3 guidelines by population, NEWS2 populations (aged 16 and over), pregnant or recently pregnant people, and children and young people.

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Royal College of Nursing	Guideline	General	General	This document would not be suitable as a resource for CYP focused healthcare professionals as it currently stands. We look forward to clarification in the final guideline in case we may have misinterpreted this from a CYP perspective.	Thank you for your comment. Children and young people are out of scope for this update. As outlined in the consultation documents the sepsis guideline will be split into 3 guidelines by population, NEWS2 populations (aged 16 and over), pregnant or recently pregnant people, and children and young people – which will be published alongside this update which focuses on NEWS2 populations.
Maternity & Newborn Safety Investigations	Guideline	General	General	We propose the term '**birth**' is used instead of [caesarean] 'section' and 'delivery', in line with other NICE guidance e.g. Caesarean birth, and other NHS guidance.	Thank you for your comment. The recommendations relating to this are in a section is greyed out as it is out of scope for this guideline update. If there are additional updates in these sections of sepsis recommendations the terminology used can be updated.
Maternity & Newborn Safety Investigations	Guideline	General	General	We acknowledge that NICE guidance will be updated to incorporate MEWS in future guidance. We highlight that many clinical areas outside the maternity setting (for example emergency departments, general surgical and medical wards) are still using NEWS2 for pregnant or recently pregnant people. We recommend that the current update is an opportunity to highlight that a maternity-specific early warning score is recommended for people who are pregnant or recently pregnant. National MEWS consider that this should be used from conception to 4 weeks after the end of pregnancy, and this has been incorporated into the clinical tools (UK Sepsis Trust: Acute Hospital Women Who are Pregnant or up to 4 Weeks Post-Partum) for sepsis in pregnant/recently pregnant people.	Thank you for your comment. As outlined in the consultation documents the sepsis guideline will be split into 3 guidelines by population, NEWS2 populations (aged 16 and over), pregnant or recently pregnant people, and children and young people – which will be published alongside this update which focuses on NEWS2 populations. Consideration will be given via NICE's prioritisation process on a possible update of the children and young people and pregnant or recently pregnant split sepsis guideline, such as the incorporation of MEWS.

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Maternity & Newborn Safety Investigations	Guideline	General	General	The use of the terms 'moderate' and 'high' in relation to risk criteria (of severe illness or death) may be confusing; clinical teams commonly use tools which have 'amber' and 'red' flags. We recommend consistent terminology is used across guidelines and clinical tools, to aid communication within clinical teams and to facilitate a shared understanding of the clinical situation. We suggest high risk (red) and moderate risk (amber) would be suitable compromise, given that the Royal College of Obstetricians and Gynaecologists (RCOG) Identification and Management of Maternal Sepsis During and Following Pregnancy guidance was updated in 2024. It uses the same terminology as the UK Sepsis Trust, which is 'amber' and 'red' flags respectively for moderate or high risk, in relation to clinical symptoms, signs and risk factors suggestive of sepsis. Their amber and red flags appear to be aligned to NICE moderate and high risk criteria. The RCOG guidance does cross-reference the current NICE NG51 moderate and high risk criteria in its recommendations, so swapping these terms to amber and red may not be optimal.	Thank you for your comment. This guideline update reviewed the recommendations on stratifying risk of severe illness or death from sepsis to incorporate the National Early Warning Score (NEWS2) for evaluating risk level in people with suspected sepsis. The categories moderate and high align with the terms utilised in NEWS2.
Maternity & Newborn Safety Investigations	Guideline	General	General	We welcome the splitting of NG51, which will then have a separate section for Pregnant or recently pregnant people. This will align with early warning scores and make it easier for clinicians to navigate the guidance.	Thank you for your comment.
South Eastern Health and	Guideline	General	General	Adults and children over 16 now get boluses in 250 mL aliquots. We are now in a funny situation where a 50 kg	Thank you for your comment. Amendments have been made to the paediatric IV fluids recommendations within the under 16s recommendations

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Social Care Trust				under 16 receiving 10 mL / kg would be getting boluses of double the recommended over 16 dose.	in the sepsis guideline, with the addition of a 250mls volume cap.
South Eastern Health and Social Care Trust	Guideline	General	General	Fluids are now recommended to be balanced crystalloids in preference over normal saline. I believe that other units are moving towards Plasma-Lyte in children. This is quite different to our current practice, but we would be due a review. APLS still teach either fluid as acceptable.	Thank you for your comment. At this point we are only updating certain parts of the guideline, and your comment refers to Children and young people under 16 which outside the scope of this update and was not considered by the guideline committee. We are therefore unable to amend this section of the guideline at present but the current guideline for under 16's recommends 'use glucose-free crystalloids that contain sodium in the range 130 to 154 mmol/litre'. PLasmaLyte and N Saline would both fit that description.
South Eastern Health and Social Care Trust	Guideline	General	General	Antibiotic timing – immediate antibiotics are only for high-risk children. Moderate risk can be delayed for up to 3 hours, provided senior review is available. This is different from APLS/Sepsis Six/our current practice and I think some will feel uneasy with this.	Thank you for your comment. At this point we are only updating certain parts of the guideline, and your comment refers to Children and young people under 16 which outside the scope of this update. The current recommendations for managing suspected sepsis in acute hospital settings in children and young people under 16 state that • If there are 2 or more moderate to high risk criteria there would be a review by a clinician arranged within 1 hour for children under 12 and for children aged 12-15; with those with a lactate over 2 mmol/litre being treated as if they met one or more high risk criteria and for those with a lactate of 2mmol/litre or lower being assessed at least hourly and a senior clinical decision maker review undertaken within 3 hours regarding their antibiotic needs.

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					• If there is 1 moderate to high risk criterion there would be a clinical review arranged for within an hour with repeated structured assessment undertaken at least hourly and a senior clinical decision maker reviewing the child or young persons need for antibiotics within 3 hours. Consideration will be given via NICE's prioritisation process on any possible update of other areas of sepsis recommendations.
South Eastern Health and Social Care Trust	Guideline	General	General	Blood culture before antibiotics – always better anyway but more emphasis on that practice now	Thank you for your comment.
South Eastern Health and Social Care Trust	Guideline	General	General	It's a bit surprising to see CRP, procalcitonin and WCC not recommended for including or excluding sepsis	Thank you for your comment. The scope of this update reviewed the evidence on rapid antigen testing and PCR tests, indicators of organ hypoperfusion, intravenous fluid therapy, vasopressors, and risk factors for sepsis. CRP, procalcitonin and WCC are not within the scope of this guideline update. NICE has existing guidelines that considers procalcitonin (DG18). Consideration will be given via NICE's prioritisation process on a possible update of this sepsis guideline or DG18
South Eastern Health and	Guideline	General	General	No use of PEWS charts, and the included observation tables have different age cutoffs than our PEWS charts.	Thank you for your comment.

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Social Care Trust					Children and young people under 16 are outside the scope of this guideline update. As outlined in the consultation documents this guideline will be split into 3 guidelines by population and will cover NEWS2 populations, pregnant and recently pregnant populations, and children and young people. Consideration will be given via NICE's prioritisation process on a possible update of the proposed children and young people sepsis guideline, such as the incorporation of PEWS.
Society for Acute medicine	Guideline	General	000	While the inclusion of peripheral vasopressor use reflects a welcome development in the management of sepsis with hypotension, the 2025 draft lacks safeguards to prevent **inappropriate use in ward environments** and **does not provide enough detail around timeliness of assessing response, the need for involvement of enhanced or critical care and the clarification of escalation plans**. Clarifying these points would support patient safety, promote early critical care involvement, and reduce the risk of treatment failure or complications.	Thank you for your comment. This recommendation has been updated to more clearly include the critical care team (if available) in decision making about the peripheral administration of vasopressors. The recommendation on shared decision making and escalation in relation to vasopressor administration has also been moved to sit with the vasopressor recommendations.
NHS England	Guideline	General	000	Replace "broad-spectrum antibiotics" with "antibiotics" throughout – there are infection specific causes of sepsis where narrow spectrum antibiotic therapy is superior to broad-spectrum and patient groups (e.g. recent C diff infection) where the balance of risks and benefits will favour narrow spectrum use. To continue to recommend broad-spectrum antibiotics even in those at low risk of severe illness or death from sepsis as in page 22, lines 11-	Thank you for your comment. he antibiotic recommendations are outside the scope of this update and was not considered by the guideline committee. We are therefore unable to amend this section of the guideline at present. Consideration will be given via NICE's prioritisation process on any possible update of other areas of sepsis recommendations.

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				14 seems out of place with antimicrobial stewardship principles.	
NHS England	Guideline	General	000	It would support best practice to develop some tools for clinicians to share with patients and carers in sections 1.19-1.23 rather than giving a list of things to discuss with them.	Thank you for your comment. Visual summaries to help decision making will be published alongside the guidelines. Specific tools for clinicians to share with patients are outside the remit of this update.
British Infection Association	Guideline	General	000	Rapid antimicrobial susceptibility testing (RAST) of blood cultures from patients with suspected sepsis is neither recommended nor mentioned. This is now a validated method from EUCAST permitting reporting of AST results within 4-20 hours after a positive blood culture. If blood cultures are considered to be important for sepsis management then getting rapid AST results should also be encouraged. The diagnostic accuracy and potential clinical impact of rapid antimicrobial susceptibility testing (RAST) of blood cultures from patients with suspected sepsis should be reviewed.	Thank you for your comment and further information. Rapid antimicrobial susceptibility testing is not in scope for this update. Consideration will be given via NICE's prioritisation process on any possible update of other areas of sepsis recommendations.
Group B Strep Support	Guideline	General	000	We are concerned to see that the sole obstetrician on the guideline committee resigned in September 2024 and was not replaced. We would be keen to understand what specialist obstetric input was sought after this date to ensure the guidance includes the best possible guidance for health professionals caring for pregnant, birthing and recently postpartum women and people.	Thank you for your comment. Those who are pregnant and recently pregnant are not within the scope for this update. For any future updates that may include pregnant or recently pregnant populations NICE will ensure appropriate committee representation.
The Faculty of Intensive Care Medicine	Guideline	General	000	The guidelines are not particularly easy to read and it is not clear which staff groups the document is actually aimed at. There is clear value in creating definitions and setting standards for institutions to use in local audit and QI work,	Thank you for your comment. Visual summaries to help decision making will be published alongside the guidelines.

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				it is unclear how helpful frontline staff will find them. In particular they could benefit from being translated into clinical decision support tools or infographics that will be more effective at guiding management	As outlined in the consultation documents the sepsis guideline will be split into 3 guidelines by population, NEWS2 populations (aged 16 and over), pregnant or recently pregnant people, and children and young people. Splitting the sepsis guideline into these three sections will make it easier to find relevant information quickly for each of these populations.
The Faculty of Intensive Care Medicine	Guideline	General	000	It would be easier to read if the guideline was split into the sections of pre-hospital, transfer and acute hospital with each section containing the relevant risk assessment, management and monitoring standards	Thank you for your comment. The guideline has been structured by population rather than setting as the sepsis guideline will be split into 3 guidelines by population, NEWS2 populations (aged 16 and over), pregnant or recently pregnant people, and children and young people with each guideline corresponding with the population specific early warning score. On discussion a focus on population rather than setting was considered to be the best way to keep the guideline centred on the individual rather than where their condition is managed. Splitting the sepsis guideline into these three sections will make it easier to find relevant information quickly for each of these populations.
UK Health Security Agency	Guideline	General	000	It is good to note the expansion of the patients at higher risk and that these are a consideration especially as the AOMRC had no considerations at all for patients with factors associated with inequalities	Thank you for your comment.
National Child Mortality Database (NCMD)	Guideline	015-016	000	1.13 – Managing Suspected Sepsis in Acute hospital settings. –	Thank you for your comment. The committee discussed Martha's rule highlighting its focus on general patient safety and agreed that due to it not being sepsis specific and only recently being rolled in

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Programme at the University of Bristol				We are concerned that Martha's Rule is not referenced. Martha's Rule is age-blind and has predominantly been introduced in adult health care settings. While it is about the 'deteriorating patient', it definitely also encompasses sepsis. We think NICE should be referencing this.	English hospitals and not yet fully implemented that it should not be referred to in this update.
National Paediatric Pharmacy Group (NPPG) and British Association of Perinatal Medicine (BAPM).	Guideline	000	000	Not quite sure what is going on with the numbering. It appears to go from 1.1 to 1.2 then 1.11	Thank you for your comment. The numbering corresponds to the specific sections in the guideline. Not all sections are included in the scope of this update which focuses on primarily on NEWS2 populations with recommendations 1.1 and 1.2 considering all populations.
National Paediatric Pharmacy Group (NPPG) and British Association of Perinatal Medicine (BAPM).	Guideline	000	000	You have stated that the document is being split into: NEWS 2 population, Pregnant people, and Children and young people. However, the consultation document only appears to cover the NEWS 2 population. It appears that these will become three separate guidelines, which will be much better.	Thank you for your comment. The scope of this update was within the NEWS2 population which is the area in this consultation. On final publication the three separate guidelines will be published.
National Paediatric Pharmacy Group (NPPG) and British Association of	Guideline	000	000	Can you confirm that this is going to link to NG195 for neonates?	Thank you for your comment. Children are outside of the scope of this update and was not considered by the guideline committee. We are therefore unable to amend this section of the guideline at present'

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Perinatal Medicine (BAPM).					
National Paediatric Pharmacy Group (NPPG) and British Association of Perinatal Medicine (BAPM).	Guideline	000	000	Section 1.15 as a missed opportunity to include young children, infants and neonates in the group mentioned where communication difficulties may make history taking more difficult.	Thank you for your comment. Recommendation 1.15 which focuses on children under 16 is outside the scope of this guideline update which focuses on NEWS2 populations (those aged 16 years and above) and was not considered by the guideline committee. We are therefore unable to amend this section of the guideline at present'
The Faculty of Intensive Care Medicine	Guideline	0000	000	Points 1.11.6 and 1.11.7 would read better if combined	Thank you for your comment. The recommendations you refer to are outside the scope of this guideline update. If these sections of the guideline are updated we can consider further whether to combine recommendations in this section.
The Faculty of Intensive Care Medicine	Guideline	000	000	1.11.8 and 1.11.9 should be combined so that all the instructions on NEWS2 scoring are read concurrently	Thank you for your comment. The recommendations you refer to are outside the scope of this guideline. If these sections of the guideline are updated we can consider further whether to combine recommendations in this section.
The Faculty of Intensive Care Medicine	Guideline	000	000	In 1.13.11 (Vasopressors) - starting vasopressors should mandate a discussion with the Critical Care team not just a senior decision maker as many senior decision makers may have little to no experience in how to begin and safely prescribe/monitor this therapy in practice.	Thank you for your comment. This recommendation has been updated to more clearly include the critical care team (if available) in decision making about the peripheral administration of vasopressors.

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The Faculty of Intensive Care Medicine	Guideline	000	000	1.13.12 (If starting vasopressors peripherally) this would be a good place to specify that the location of ongoing care, not just monitoring should be considered. There are concerns about peripheral vasopressors being started on wards without the capability to continue safely administering them –the Faculty is aware of incidents have been reported reflecting this.	Thank you for your comment. This recommendation around the decision making has been updated to more clearly include the critical care team (if available) in decision making about the peripheral administration of vasopressors. The location of care may vary across hospitals with different facilities and staff available.
The Faculty of Intensive Care Medicine	Guideline	000	000	In 1.14 (when to suspect sepsis) you have behaviour, circulation or respiration but it would be better to keep these in the ABCD order that most doctors are familiar with so respiration, circulation and behaviour.	Thank you for your comment. This recommendation is outside the scope of this update and was not considered by the guideline committee.
The Faculty of Intensive Care Medicine	Guideline	000	000	1.3.15 – It's not clear what "starting critical care" means in this context. Does refer to admission to an Intensive Care Unit or initiation of organ support?	Thank you for your comment. The recommendation has been clarified to note that before starting vasopressors there should be a shared decision about escalation.
				COMMENTS MOVED TO THE CORRECT SECTIONS	
Royal College of General Practitioners	Guideline	005	000	We believe this could benefit from explicitly including 'profound fatigue' and 'new confusion' as commonly seen early markers in primary care presentations.	Thank you for your comment. This recommendation is outside the scope of this update and was not considered by the guideline committee.
Royal College of Pathologists	Guideline	005	038	Should it read "neurodiversity" instead of autism? There are a wide range of neurodiverse conditions that may result in challenges in communication.	Thank you for your comment. This has been changed.
UK Sepsis Trust	Guideline	006	General	We are concerned that this new extended list of risk factors feels problematic. The inclusion criteria are now so broad that we estimate around 70–80% of the emergency department population would meet at least one risk factor—likely a similar story in general practice. Our	Thank you for your comment. This recommendation has been revised, and the list has been grouped into overall categories with some examples. This should improve the usefulness of the recommendation.

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				concern is that the value of the list is diluted: either it will be ignored or inconsistently applied, or conversely over-interpreted and lead to unnecessary treatment. We're not quite sure what can be done about this, but both directions carry risk. This could be very tricky to operationalise.	
National Child Mortality Database (NCMD) Programme at the University of Bristol	Guideline	006	000	1.2.1. People at higher risk of developing sepsis. – Should include 'Asian/Asian British, especially children of Pakistani background, and black/black British ethnicity and children with learning disabilities as per the evidence in the NCMD reports Infection Related Deaths in Children and Young People and Learning from deaths: Children with a learning disability and autistic children aged 4 – 17 years.	Thank you for your comment. This recommendation has been revised, and the list has been grouped into overall categories with some examples. This should improve the usefulness of the recommendation.
NHS England	Guideline	006	003	There needs to be an accompanying algorithm / clinical pathway in order for this to be useful (and used. The AoMRC sepsis guidance had a very helpful table that is used in many hospitals) When to suspect sepsis 1. Suspect sepsis in a patient with suspected infection who is acutely unwell, with physiological abnormalities (e.g. elevated NEWS2 score. This should be the starting point as the acute physiological compromise must be present. 2. Is there any difference between factors that increase the risk of sepsis V risk of infection? 3. If a patient has any risk factors where does that place them with regard to their NEWS2 (or equivalent)- does that bump them up one category as per Academy of Medical Royal Colleges' sepsis	Thank you for your comment. Visual summaries to help decision making will be published alongside the guidelines.

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				guidance or is it just something to influence clinical judgement?	
Royal College of Midwives	Guideline	006	009	In this section 1.2 People at higher risk of developing sepsis it does not list pregnant women. It is good that there is a separate section devoted to the unique vulnerabilities of pregnant and recently pregnant women, however it would be good to add a bullet point pertaining to pregnant and recently pregnant women in the list. In practice, there may be occasions where clinicians consult the list of people at higher risk and, not seeing pregnant women listed, do not read on to the next section that details pregnant women's risks. A bullet point could read 'pregnant and recently pregnant women – see next section for more details'.	Thank you for your comment. As outlined in the consultation documents the sepsis guideline will be split into 3 guidelines by population, NEWS2 populations (aged 16 and over), pregnant or recently pregnant people, and children and young people. Splitting the sepsis guideline into these three sections will make it easier to find relevant information quickly for each of these populations. Not including pregnant and recently pregnant people within 1.2 was appropriate as there will be a separate guideline for this population.
Meningitis Research Foundation	Guideline	006	009	Rec 1.2 – As one of the leading UK charities focused on defeating meningitis, we are particularly concerned that young adults aged 16–24 remain under-recognised as a group at heightened risk of severe outcomes from sepsis, particularly when caused by meningococcal disease. A stronger focus on this group throughout the guideline would significantly enhance early recognition and reduce mortality. This age group are at heightened risk for the following reasons: 1. Young adults in this age bracket are at increased risk of meningococcal disease: https://assets.publishing.service.gov.uk/media/674	Thank you for your comment. The EIA has been updated to acknowledge the point you have raised regarding 16-24 year olds. The EIA notes that young adults and adolescents may initially compensate for the effects of sepsis more effectively than older adults potentially making early symptoms less obvious. However, the Committee agreed that as the 16-25 year old age group are a NEWS2 population specific reference to this group was not required. NICE's guideline on meningitis (bacterial) and meningococcal disease: recognition, diagnosis and management (NG240) has recommendations on recognising and investigating meningitis and meningococcal disease

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				6098dda210676b4ffe1c5/hpr1024-IMD-ann-fig2.png 2. Research has shown that this age group accounts for a relatively small proportion of all emergency department visits, yet when they do present, they have an increased risk of a serious bacterial infection. (Borensztajn, Dorine, et al. "Characteristics and management of adolescents attending the ED with fever: a prospective multicentre study." BMJ open 12.1 (2022): e053451). 3. Adolescents are able to maintain cardiovascular parameters until late decompensation. Evidence has shown that they can display low NEWS2 scores, despite being critically unwell with sepsis. They are therefore more likely to be misdiagnosed. It is essential that health care professionals who are unlikely to encounter these individuals very often, have this increased risk in mind when assessing them. Paediatricians are aware of these factors; however, doctors who primarily treat adults are far less aware and therefore more likely to miss the signs until too late. Including a sentence to raise awareness of this group being at risk could potentially save lives. Tragically, we have seen many high-profile preventable deaths from sepsis that involved delayed treatment. Given the devastating outcomes for these families, it is vital that	

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				we do all we can to help health professionals to 'think sepsis' in this age group. William Hewes, aged 22 died due to meningococcal infection: https://www.bbc.co.uk/news/articles/cglyw36z0l4o Aoife Johnston, aged 16, died due to meningococcal infection: https://www.irishtimes.com/health/2024/09/20/aoife-johnston-report-circumstances-around-teens-death-at-limerick-hospital-almost-certainly-avoidable/ Sophie Ward, aged 20, died due to meningococcal infection: https://www.itv.com/news/london/2025-02-21/inquest-failings-at-barnet-hospital-contributed-to-death-of-20-year-old-woman Tim Mason, aged 21, died due to meningococcal infection: https://www.bbc.co.uk/news/uk-england-kent-45896753 Ellie Penrose, aged 18, died due to meningococcal infection: https://www.theguardian.com/uk-news/2017/jan/16/immediate-antibiotics-might-have-saved-triathlete-ellie-penrose-inquest Mia Ginever, aged 19, died due to meningococcal infection: https://www.itv.com/news/meridian/2024-06-10/teen-told-she-had-boring-virus-died-from-meningitis	

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				Awareness of this age group as more at risk could save lives.	
UK Health Security Agency	Guideline	006	009	You do not mention learning difficulties, but we know from the paediatric group A strep review (4 Nations rapid review of iGAS deaths in children) and the NCMD review (Infection-related deaths in children and young people)	Thank you for your comment. The recommendation relating to increased risk of developing sepsis now makes specific reference to people with learning difficulties, the recommendation relating to assessment notes the importance of considering any potential difficulties in taking a history and includes those with learning disabilities in the example in this recommendation. Both groups are also included in the EIA for this guideline.
UK Health Security Agency	Guideline	006	010	People at higher risk of sepsis – risk groups for sepsis omit homeless people yet in NICE own equality impact assessment (https://www.nice.org.uk/guidance/gid-ng10412/documents/equality-and-health-inequalities) the committee agreed people experiencing homelessness should be considered in the update. The assessment cites evidence that people experiencing homeless are at higher risk of death from sepsis (partly in relation to delayed healthcare seeking).	Thank you for your comment. This recommendation has been revised, and the list has been grouped into overall categories with some examples. This should improve the usefulness of the recommendation. Homelessness has been added as a specific example within this revision.
UK Health Security Agency	Guideline	006	010	People at higher risk of sepsis – in this section there is no reference to current/prevailing outbreaks and groups that might be particularly impacted. In 2022/2023, UKHSA declared a national enhanced incident due to the unusually high levels of Group A Streptococcus (GAS) and associated deaths, particularly in children. There followed endorsement to lower antibiotic prescribing thresholds for children. During incidents, the index of clinical suspicion	Thank you for your comment. This recommendation focuses on individual factors that a practitioner may want to consider. At times of increased disease prevalence individual factors may be even more important. Current or prevailing outbreaks are not an individual factor and would be communicated through other channels such as the UK Health Security Agency.

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				may be lowered. Suggest adding a line to alert practitioners that infectious disease outbreaks can disproportionately elevate risk of groups not on this list, for instance children over 1 years of age.	
Blackpool Teaching Hospitals	Guideline	006	012	Patients at high risk need to include also: Patients with hereditary immune deficiency states People with distorted anatomy like horseshoe kidney and paraphimosis	Thank you for your comment. This recommendation has been revised, and the list has been grouped into overall categories with some examples. People with hereditary immune deficiency, horseshoe kidney and paraphimosis would be considered under clinical features.
NHS England	Guideline	006	012	Organ transplantation needs to be referenced	Thank you for your comment. This recommendation has been revised, and the list has been grouped into overall categories with some examples. People with organ transplantation would be considered under clinical features.
NHS England	Guideline	000	014	Currently having treatment.	Thank you for your comment. This recommendation has been revised, and the list has been grouped into overall categories with some examples. People currently having treatment would be considered under clinical features.
NHS England	Guideline	000	015	Are patients with 'diet controlled' diabetes at increased risk? The risk factors need to be better ranked to signify the degree of risk. I.e. splenectomy is a much higher risk factor than having diabetes.	Thank you for your comment. This recommendation has been revised, and the list has been grouped into overall categories with some examples. People with diet-controlled diabetes may be considered under clinical features. There was no evidence to support this group being added as a specific increased risk. This recommendation does not seek to rank the risk but to note groups who may be at increased risk of sepsis.

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NHS England	Guideline	000	020	And communicating significant antibiotic allergies, and if known previous growth of organisms from cultures,	Thank you for your comment. This recommendation has been revised, and the list has been grouped into overall categories with some examples. People with repeated antibiotic use are in the examples under clinical features.
NHS England	Guideline	006	018	Is there a steroid dose threshold? Having 1 mg Prednisolone daily (for PMR) does not immunosuppress to the same degree has 50 mg for example. How is long term defined?	Thank you for your comment. This recommendation has been revised, and the list has been grouped into overall categories with some examples. People with impaired immune function because of medical treatment use are in the examples under clinical features. This recommendation considers factors that may increase the risk of developing sepsis for clinicians to be aware of it did not consider specific levels of risk within these factors.
NHS England	Guideline	006	023	• Recognition of increased vulnerability of people with a learning disability is extremely valuable however LeDeR has identified that delayed diagnosis is not solely attributable to communication difficulties but also to other factors including diagnostic overshadowing, unconscious bias, clinicians not recognising the significance of soft signs of deterioration, not offering reasonable adjustments under the Equalities Act and not adhering to the mental capacity act (MCA). • These guidelines would benefit from a specific recommendation re management of these high risk groups, not just recognition of their vulnerability. E.g. for people with a learning disability, as well as mental health conditions and dementia, having a lower threshold for transferring immediately to acute hospital, offering reasonable adjustments to ensure required	Thank you for your comment. The EHIA has underpinned the committee's discussions for the areas within this update that are specific to suspected sepsis. Other NICE guidelines that consider the factors you highlight such as CG138 (Patient experience in adult NHS services) or NG108 (Decision-making and mental capacity) include recommendations on tailoring healthcare services for each patient and are outlined at the start of this guideline.

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				assessments (e.g. blood tests, blood pressure etc) are possible, using the MCA and acting in the patient's best interests when patients lack capacity, will all reduce vulnerability to severe illness and death. • Without a specific recommendation re management such as these, the knowledge of the increased vulnerability of these groups alone may have limited impact on practice and outcomes or the narrowing of inequality. Learning from Lives and Deaths – people with a learning disability and autistic people (LeDeR) | King's College London Annual reports | School for Policy Studies | University of Bristol	
First Community Health and Care	Guideline	006	023	Should this be dementia or people with cognitive impairment.	Thank you for your comment. This has been changed.
NHS England	Guideline	000	025	Please would you consider dividing all of these risk factors into two main groups: 1. Those with genuine risk due to underlying medical conditions e.g. hypogammaglobulinaemia or treatment e.g. chemotherapy 2. Delayed/poor access increasing the risk of sepsis e.g. Deprived., LD, MH populations have delayed access and presentations.	Thank you for your comment. This recommendation has been revised, and the list has been grouped into overall categories with some examples. This should improve the usefulness of the recommendation.
NHS England	Guideline	000	025	Living with deprivation is possibly a better term. You can be rich but live in a deprived area.	Thank you for your comment. This has not been changed as the committee agreed that while a rich person could live in a deprived area that this

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					factor encompassed more than individual agency but also issues of lack access to services, as well as the underlying health conditions experienced and environmental stressors within that area.
First Community Health and Care	Guideline	006	025	Deprived is ambiguous term. Can this be defined?	Thank you for your comment. This recommendation has been revised, and the list has been grouped into overall categories with some examples. This recommendation considers factors that may increase the risk of developing sepsis for clinicians to be aware of it did not consider specific definitions of risk within these factors.
UK Health Security Agency	Guideline	006	025	"people living in deprived areas" – does a definition of this need to be provided?	Thank you for your comment. This recommendation has been revised, and the list has been grouped into overall categories with some examples. This recommendation considers factors that may increase the risk of developing sepsis for clinicians to be aware of it did not consider specific definitions of risk within these factors.
First Community Health and Care	Guideline	006	029	Clarify repeated antibiotic prescriptions – how many are classed as repeated and does this include people on prophylactic treatment regimes?	Thank you for your comment. This recommendation has been revised, and the list has been grouped into overall categories with some examples. People with repeated antibiotic prescriptions are in the examples under clinical features. The committee considered that what repeated would mean would vary for different individual circumstances. This recommendation considers factors that may increase the risk of developing sepsis for clinicians to be aware of it did not consider specific levels of risk within these factors.

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UK Health Security Agency	Guideline	006	029	"people with a history of repeated antibiotic prescriptions" is a vague line – it does not specify over what time, nor whether the indication matters e.g. treatment courses or prophylaxis	Thank you for your comment. This recommendation has been revised, and the list has been grouped into overall categories with some examples. People with repeated antibiotic prescriptions are in the examples under clinical features. This recommendation considers factors that may increase the risk of developing sepsis for clinicians to be aware of it did not consider specific levels of risk within these factors.
NHS England	Guideline	000	029	Define repeated?	Thank you for your comment. This recommendation has been revised, and the list has been grouped into overall categories with some examples. People with repeated antibiotic prescriptions are in the examples under clinical features. This recommendation considers factors that may increase the risk of developing sepsis for clinicians to be aware of it did not consider specific levels of risk within these factors.
NHS England	Guideline	000	030	Should this be unstable chronic conditions? Well controlled diabetes has minimal risk compared to uncontrolled for instance.	Thank you for your comment. This recommendation has been revised, and the list has been grouped into overall categories with some examples. This recommendation seeks to raise awareness of general areas for consideration with some examples for practitioners to bear in mind when someone presents to them as unwell who could be at greater risk of developing sepsis.
UK Health Security Agency	Guideline	006	030	"severe chronic comorbidity" – does a definition of this need to be provided?	Thank you for your comment. This recommendation has been revised, and the list has been grouped into overall categories with some examples. This recommendation seeks to raise awareness of general areas for consideration with some examples for

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					practitioners to bear in mind when someone presents to them as unwell who could be at greater risk of developing sepsis.
NHS England	Guideline	007	002	Include chronic wounds e.g. diabetic foot ulcers, venous or arterial ulcers	Thank you for your comment. This recommendation has been revised, and the list has been grouped into overall categories with some examples. This recommendation seeks to raise awareness of general areas for consideration with some examples for practitioners to bear in mind when someone presents to them as unwell who could be at greater risk of developing sepsis.
NHS England	Guideline	007	005	Bizarre that people with indwelling lines/catheters is at the bottom of the list of higher risk conditions. It should be near the top. The ordering of the whole list needs to reflect those at most risk at the top...	Thank you for your comment. This recommendation has been revised, and the list has been grouped into overall categories with some examples. This is not a ranked list. This recommendation seeks to raise awareness of general areas for consideration with some examples for practitioners to bear in mind when someone presents to them as unwell who could be at greater risk of developing sepsis.
NHS England	Guideline	007	006	Suggest moving link to recommendation 1.1.10 on when to suspect neutropenic sepsis to text on page 6 (lines 12-20) as this is where the detail around the at-risk population is	Thank you for your comment. This recommendation seeks to raise awareness of general areas for consideration with some examples for practitioners to bear in mind when someone presents to them as unwell who could be at greater risk of developing sepsis. It has been retained in the could this be sepsis section of the guideline.
Maternity & Newborn	Guideline	007	010	We propose changing '…who are pregnant, have given birth or had a termination of pregnancy or miscarriage in	Thank you for your comment.

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Safety Investigations				the past 6 weeks are in a high risk group' to '…who are **pregnant or recently pregnant** are in a high risk group…' (recently pregnant is defined in comment 4)	Those who are pregnant are not within the scope of this update. As outlined in the consultation documents the sepsis guideline will be split into 3 guidelines by population, NEWS2 populations (aged 16 and over), pregnant or recently pregnant people, and children and young people.
Maternity & Newborn Safety Investigations	Guideline	008	013	We propose that '…onset of labour' should be amended to '…**birth**' as we feel 'labour' is not the relevant time point, when considering either maternal or early neonatal infection risks.	Thank you for your comment. Those who are pregnant are not within the scope of this update. As outlined in the consultation documents the sepsis guideline will be split into 3 guidelines by population, NEWS2 populations (aged 16 and over), pregnant or recently pregnant people, and children and young people.
Group B Strep Support	Guideline	008	019	It's great to see the cross reference to the Neonatal Infection guideline for risk for early-onset infection. Please would you consider adding the risk factors and clinical indicators for late-onset infection and a link to the relevant table too (section 1.8 of ng195).	Thank you for your comment. The onset to neonatal infection recommendation is not within the scope of this update and was not considered by the guideline committee. We are therefore unable to amend this section of the guideline at present.
Royal College of General Practitioners	Guideline	009	000	We believe it would be helpful to provide clearer pathways or decision support for community management when high-risk features are absent, but there is still clinical concern. This could reduce inappropriate hospital conveyance.	Thank you for your comment. Visual summaries to help decision making will be published alongside the guidelines. The recommendations on page 9 are not within the scope of this update and were not considered by the guideline committee. We are therefore unable to amend this section of the guideline at present.
Royal College of Emergency Medicine	Guideline	009	028	RCEM supports the use of NEWS2 and are pleased that there is the phrase "use clinical judgement to interpret NEWS2" as it is possible can get caught out in the elderly	Thank you for your comment

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				and underestimate sickness with NEWS2. E.g. normal BP is 160/90 and pt has BP 120/80 which is low for them. We also recognise that sepsis remains difficult to identify in young, fit individuals, so NEWS2 criteria have many limitations.	
Royal College of Midwives	Guideline	011	015	In this whole section 'Managing suspected sepsis outside acute hospital settings' it does not specify that this is not for pregnant or recently pregnant women. Therefore, when referring to NEWS2 scores it would be pertinent to also include reference to maternity specific tools such as MEOWS score. This has not been noted up to this point in the guideline, so in the above pregnancy section it could be helpful to include a sentence there outlining for any woman who is pregnant or recently pregnant their EWS should be calculated using an appropriate maternity tool.	Thank you for your comment. Pregnant and recently pregnant populations are outside the scope of this update and was not considered by the guideline committee. We are therefore unable to amend this section of the guideline at present' Consideration will be given via NICE's prioritisation process on a possible update of the planned split sepsis guideline for pregnant and recently pregnant people, such as the incorporation of MEWS.
NHS England	Guideline	011	019	Please note the criteria are based on single parameter readings (akin to previous NICE criteria) and that these were not evidenced. A lot of community facilities, including prisons, care homes and primary & community care, are using NEWS2 and therefore the option of using similar thresholds to the hospital guidance should be put in place.	Thank you for your comment. This recommendation is not in the scope of this update.
NHS England	Guideline	012	001	The added step of a community assessment leading to a GP pre alert for a hospital referral would waste time and I would just focus on direct communications with the ambulance and ED	Thank you for your comment. The greyed out recommendations on page 12 are not within the scope of this update.
British Infection Association	Guideline	012	006	Rec 1.12.3, 1.12.1 & 1.12.12 – The updated recommendation for patient assessment in mental health settings with recommendation for early medical input and/or early transfer all seem sensible.	Thank you for your comment

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Royal College of Emergency Medicine	Guideline	012	008	When NICE states refer for "Emergency Medical Care" this could mean send to ED or refer to a specialty – anyone high risk for sepsis should be referred directly to the Emergency Department as that is where resus facilities are. Moderate risk patients could be seen by a specialty team, lower risk patients could use a number of pathways	Thank you for your comment. The committee discussed your comment and were in agreement that 'emergency medical care' was the correct term which as you have identified includes the emergency department but also other options if the emergency department is not accessible.
NHS England	Guideline	012	013	Consecutive needs defining. Does an instant repeat qualify? What if the patient has an abnormal NEWS2 baseline- ie a patient on long term oxygen who is usually hypoxic and tachycardic (which will give a score of 5 even when well)	Thank you for your comment. This recommendation is not in the scope of this update.
Royal College of General Practitioners	Guideline	013	000	The emphasis on antibiotics and IV fluids within 1 hour is challenging in community and non-hospital settings, given that transfer time to emergency departments, even in urban areas is often more than one hour for category 2 responses. We believe, it would be useful to include practical advice on safe and timely transfer or initiation of antibiotics, particularly when intravenous access is not immediately possible.	Thank you for your comment. These recommendations are not in the scope of this update.
NHS England	Guideline	013	001	It would be preferable to prioritise moving the most acutely unwell patients from ambulances to ED to support optimal management of sepsis where handover delays take time to beyond one hour rather than recommending giving antibiotics in the ambulance as a single intervention, when a bundle approach is optimal for patient care.	Thank you for your comment. This recommendation is not in the scope of this update.
NHS England	Guideline	013	014	There have been significant delays with ambulance transfer, due to a lack of ambulances or queuing. Should ambulance services consider ambulance cars to administer	Thank you for your comment. This recommendation is not in the scope of this update.

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				antibiotics to patients waiting hours for ambulance conveyance?	
Blackpool Teaching Hospitals	Guideline	013	019	For paramedics to follow local policy there needs to be clue to the source of infection otherwise they will realistically treat empirically with broad spectrum antibiotics. That is very challenging before obtaining any investigations – need more clarification and also highlighting that the allergy status will be thoroughly checked	Thank you for your comment. This recommendation is not in the scope of this update.
NHS England	Guideline	013	027	Add a NEWS2 of 7 or more as a criteria for urgent transfer as many community facilities now use NEWS2.	Thank you for your comment. This recommendation is not in the scope of this update.
Royal College of Emergency Medicine	Guideline	014	023	Again, "Emergency Medical care" will often default to the ED, but Mental health patients fare better if they are sent to a medical admissions unit to be seen directly by a specialty.	Thank you for your comment. The committee discussed your comment and were in agreement that 'emergency medical care' was the correct term which as you have identified includes the emergency department but also other options if the emergency department is not accessible or not the optimal place of referral.
NHS England	Guideline	015	General	Please could you include NHSE guidance on blood culture processing on page 15 https://www.england.nhs.uk/wp-content/uploads/2022/06/B0686-improving-the-blood-culture-pathway-executive-summary-v1-1.pdf.pdf	Thank you for your comment. This recommendation is outside of the scope of this update. It does include the UK standards for microbiological investigations with reference to taking microbiological and blood samples.
NHS England	Guideline	015	003	This NICE guidance needs a really clear table/pathway to visually describe the criteria in a very succinct way. Please look at the AoMRC sepsis tables within the guidance. These are very popular with clinicians Statement_on_the_initial_antimicrobial_treatment_of_sepsis_V2_1022.pdf	Thank you for your comment. Visual summaries to help decision making will be published alongside the guidelines. Consideration will be given via NICE's prioritisation process on a possible update of the children and young

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				Figure 1: Clinical Decision Support framework for initial evaluation of sepsis in adults ≥	people and pregnant or recently pregnant split sepsis guideline, such as the incorporation of PEWS.

Vital signs	Vital signs: NEWS-2 'Physiology first'	0	1-4	
Initial assessment	History, examination, lab results	***If clinical or carer concern, continuing deterior evidence of organ dysfunction, including eleva***		
	Comorbid disease, frailty, patient preferences?	*Consider influence of comorbid disease, frail inten*		
Initial (generic) actions	**Monitoring and escalation plan**	Standard observations	• Registered nurse review <1 h • Obs 4-6 hrly if stable. • Escalate if no improvement	
	Initial treatment of precipitating condition	Standard care	<6 hr	
Likelihood of infection & specific actions	Unlikely	Standard care	Review daily and reconsider infecti	
	Possible	Review at least daily	**< 6 h** • Source identification & control plan documented.	
	Probable or definite	**< 6 h** • Diagnostic tests & R plan	**< 6 h** • Microbiology tests • Antimicrobials: administer or revise • Source identification & control plan. • D/w ID/micro if uncertain, & review	

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				The consultation document contains nothing new for paediatrics and given the length of time this guideline has been out for, it would be likely there is new evidence in which to refine paediatric guidance on sepsis. In addition, the NPEWS now exists as a validated paediatric equivalent of NEWS.	
NHS England	Guideline	015	006	Lik to section on 'Finding and controlling the source of infection' does not list blood culture as a type of test required	Thank you for your comment. This section is out of scope of the current update. At this point we are only updating certain parts of the guideline, and your comment refers to a section that is not being updated and was not considered by the guideline committee. We are therefore unable to amend this section of the guideline at present
UK Standards for Microbiology Investigations	Guideline	015	10	Please change the UK SMI link to UK Standards for Microbiology Investigation This link takes the user to the Syndromic document page where the Sepsis standard UK SMI 12 is located.	Thank you for your comment. We have updated this with the correct hyperlink.
NHS England	Guideline	015	010	Link goes to general SMI page instead of SMI for Sepsis (SMI12), and date should be 2025, as this is the latest update	Thank you for your comment. We have updated this with the correct hyperlink.
NHS England	Guideline	015	010	SMI Guidance on Sepsis and disseminated infections has been last amended in 2025 April- https://www.rcpath.org/static/3f51b8e5-1ebe-469d-a79f3a3323bfaec9/uk-smi-s-12i1-1-sepsis-and-systemic-or-disseminated-infection-april-2025-pdf.pdf	Thank you for your comment. We have updated this with the correct hyperlink.
NHS England	Guideline	015	012	Does this terminology lead to any confusion? Should sepsis be a binary diagnosis- you either have sepsis or you do not? And if you have sepsis you have high risk of a severe illness/death by definition.	Thank you for your comment. This section is out of scope of the current update. At this point we are only updating certain parts of the guideline, and your comment refers to a section that is not being

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				Instead, would it be simpler to define sepsis as a NEWS2 of 7 or more and suspected infection. By definition sepsis has to be accompanied by significant physiological compromise.	updated and was not considered by the guideline committee. We are therefore unable to amend this section of the guideline at present The remit of this guideline includes the recognition, early assessment, and initial treatment of suspected sepsis, including the use of NEWS2.
NHS England	Guideline	016	000	Is it possible to add the blood culture pathway standards to NICE guidelines to support improvements in practice?	Thank you for your comment. This recommendation is outside the scope of this update. It does include the UK standards for microbiological investigations with reference to taking microbiological and blood samples.
Royal College of Emergency Medicine	Guideline	016	003	A patient with a NEWS2 of 7 would usually get escalated to a senior Dr in most EDs so it is concerning to recommend an FY2 or above to see the patient – especially as most EDs have rapid assessment and treatment processes now staffed by ST3 and above or senior clinical fellows	Thank you for your comment. This recommendation is outside the scope of this update, this recommendation was updated in 2024.
Royal College of Pathologists	Guideline	016	008	Good to see blood cultures mentioned but NHSE guidance is for 2 sets of blood cultures to increase yield of pathogens (with 8-10mls of blood in each bottle) in adults and this should be mentioned so that all national guidance aligns. B0686-improving-the-blood-culture-pathway-executive-summary-v1-1.pdf.pdf	Thank you for your comment. This recommendation is outside of the scope of this update. It does include the UK standards for microbiological investigations with reference to taking microbiological and blood samples.
NHS England	Guideline	016	010	Why has PCT not been evaluated for inclusion? There appears to be no evidence synthesis for this biomarker, or indeed any other biomarkers, only rapid microbiological tests. Should consider Biomarker-Guided Antibiotic Duration for Hospitalized Patients With Suspected Sepsis: The ADAPT-Sepsis Randomized Clinical Trial - PubMed	Thank you for your comment. PCT is out of scope for this update. NICE has existing guidelines that considers PCT (DG18). Consideration will be given via NICE's prioritisation process on a possible update of this sepsis guideline or DG18.
British Infection Association	Guideline	016	010	Rec 1.13.2 – Although not addressed in the current update, we recommend that the guideline should include evidence-	Thank you for your comment.

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				based recommendations for minimum blood culture volumes, and for the minimum number of blood culture sets, to be obtained from patients with suspected sepsis. NHS England issued evidence based guidance on this issue in 2023, see link here: Blood culture pathway	This section is out of scope of the current update. At this point we are only updating certain parts of the guideline, and your comment refers to a section that is not being updated and was not considered by the guideline committee. We are therefore unable to amend this section of the guideline at present The recommendation that focuses on initial investigations to find the source of infection refers to the UK standards for microbiological investigations with reference to taking microbiological and blood samples.
UK Health Security Agency	Guideline	016	015	At this point can we repeat the recommendation to take microbiological samples that are relevant to the suspected source or possible sources, prior to commencing antibiotics. It is stated on the previous page but would be useful to repeat in this section, where we have repeated the antibiotic recommendation. This is often missed or given less importance in clinical practice, meaning that clinicians cannot focus antimicrobial therapies later in the treatment pathway.	Thank you for your comment. This section is out of scope of the current update. These recommendations include a hyperlink that refers you back to recommendation on the need to do initial investigations to find the source of infections.
British Infection Association	Guideline	017	002	Rec 1.13.4 – Whilst the general recommendation to give fluids in those at high risk of severe illness or death seems an appropriate pragmatic decision given the poor accuracy of clinical features to indicate hypoperfusion, we think that it is important to ensure that contraindications to intravenous fluid resuscitation were clearly stated here (rather than later p32, line 8). As well as cardiac and renal failure, BIA members wanted to highlight that individuals with low body weight might also be at risk of fluid overload.	Thank you for your comment. The committee agreed that a list of the possible contraindications in the recommendations could be misconstrued as an exhaustive list of all possible contraindications for fluid administration.

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British Infection Association	Guideline	032	007	We agree with the statement that "people assessed as being at high risk should be given intravenous fluids, unless giving fluids is contraindicated (for example in people with cardiac or renal failure)." However these contraindications should be more explicitly stated in recommendation 1.13.4.	Thank you for your comment. The committee agreed creating a list of the possible contraindications in the recommendations could be misconstrued as an exhaustive list of all possible contraindications for fluid administration.
Royal College of Nursing	Guideline	17	002	We approve of the recommended changes to this Section. The rationale is sound. The information is easy to understand and implement.	Thank you for your comment.
Society for Acute medicine	Guideline	017	010	**1. Concern: Risk of Delay Due to Fragmented Fluid Resuscitation** The proposed shift from 500 ml to 250 ml boluses risks *delaying timely fluid resuscitation* in patients with suspected sepsis, particularly those presenting with hypotension and hypoperfusion. • In urgent cases of distributive shock, rapid volume expansion is essential. • Requiring multiple reassessments after each 250 ml bolus may inadvertently delay reaching a clinically effective volume (e.g. 1000 ml), especially in busy or resource-limited settings. • The emphasis on reassessment after each 250 ml bolus is operationally difficult and could contribute to **under-resuscitation or treatment delays**, particularly out-of-hours or in non-acute environments.	Thank you for your comment. The committee discussed that there may be increased nurse workload from more frequent monitoring after every 250ml bolus. They considered that these patients should already be being closely monitored given the severity of their condition, as such there shouldn't be an inadvertent delay in reaching a clinically effective volume. Therefore, this recommendation should not lead to a large change in practice. The committee also considered that whilst the recommendation is to reassess after every 250ml of fluid that is given, this is still possible with larger bolus sizes. Even if 250ml boluses are used, it would not be expected for a line change to occur with every additional bolus. Therefore, the committee considered there would be minimal additional costs associated with the additional monitoring and more frequent line changes and giving sets would not be required. Given no specification is being given to the size of the fluid bag which should be used, no additional

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				2. Inconsistency with NICE NG174 (IV Fluids for Adults in Hospital) The updated sepsis guidance is **not aligned** with existing NICE NG174 recommendations on intravenous fluid therapy. **3. Financial and Operational Implications** The rationale states that switching to 250 ml boluses is cost neutral. This is not accurate in practice. • **Smaller boluses require additional giving sets**, increasing equipment cost per litre of fluid delivered. • **Increased nursing workload** due to more frequent line changes and bolus reassessments. • Requires additional documentation and monitoring effort. • NG174 advises: *"Initial fluid resuscitation should usually be with a 500 ml bolus of crystalloid solution, repeated if needed."* • The draft NG51 departs from this standard **without presenting convincing evidence**, despite acknowledging that the evidence supporting smaller boluses is **low or very low quality**.	environmental impact is anticipated as a result of these recommendations. The committee discussion of the evidence has been updated to reflect these considerations by the committee. The consideration of additional staff time has also been added into the impact section of the guideline.

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				• This inconsistency risks **confusing clinicians**, especially junior staff or those working across multiple areas of care. **4. Environmental Sustainability Impact** The guidance does not adequately consider the environmental consequences of increasing fluid bag usage. • Moving from 500 ml to 250 ml bags effectively **doubles the plastic waste** (bags, packaging, and potentially extra giving sets). • This increase conflicts with the **NHS Net Zero strategy** and should be explicitly evaluated in the cost and impact rationale. **Suggested Amendment** We recommend NICE revert to the **existing NG174-aligned approach**, unless high-quality evidence becomes available to support smaller, slower titration in the early resuscitation phase. Specifically: • Recommend an **initial 500 ml crystalloid bolus**, with reassessment before further fluids • Retain option to reduce bolus size in patients at risk of fluid overload (e.g. cardiac/renal disease) • If 250 ml boluses are retained, NICE should:	

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				○ Explicitly clarify that **speed is critical**, and smaller boluses should **not delay reaching total resuscitation volume** ○ Provide updated cost modelling that includes equipment and environmental factors	
Royal College of Emergency Medicine	Guideline	017	010	EM clinicians are concerned with giving only 250 ml as standard. This would be the case for the elderly but we would mostly prescribe 500ml for younger patients. We recognise that this guidance is in line with teaching elsewhere, but the risk in a busy ED is that the patient is only given 250ml, not reviewed soon enough, the nurses are busy, they insist on giving through a pump, repeat boluses are then delayed as doctors can't operate the pumps. We strongly suggest moving to **boluses of 250 to 500 ml depending on the age, size and cardiovascular status of the patient.** If the evidence for how big a bolus is poor, then it is preferable to give as practical advice as possible.	Thank you for your comment. The committee considered the evidence reviewed and discussed this with their expertise and have recommended a 250ml bolus stepped approach up to 1000ml total (excluding any previous fluids given) with reassessment was appropriate. The committee discussed that whilst there may be increased nurse workload from more frequent monitoring after every 250ml bolus, they did not consider the expected increase to be large because it was these patients should already be being closely monitored given the severity of their condition (high risk of severe illness or death from sepsis). The consideration of additional staff time has also been added into the impact section of the guideline.
UK Sepsis Trust	Guideline	017	012	This is easy to operationalise. In line with best practice although for a larger adult a total of 1000 ml is very low.	Thank you for your comment. The recommendation outlines that if the person has not improved enough after 1000mls advice from a senior clinical decision maker should be sought.
British Infection Association	Guideline	017	012	Rec 1.13.7 – Some members were concerned that in the context of busy emergency departments with high patient demand, the recommendation to re-assess fluid status	Thank you for your comment. The committee considered the evidence reviewed and discussed this with their expertise and have

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				after each 250mL bolus might delay the timely fluid resuscitation in those individuals with marked hypoperfusion. Suggest recommendations on volume of fluid boluses might be individualised based on the initial fluid status assessment.	recommended a 250ml bolus stepped approach up to 1000ml total (excluding any previous fluids given) with reassessment was appropriate. They considered that these patients should already be being closely monitored given the severity of their condition, as such there shouldn't be delay in timely fluid resuscitation in those with marked hypoperfusion. The consideration of additional staff time has also been added into the impact section of the guideline.
Blackpool Teaching Hospitals	Guideline	017	015	Needs more clarification about the criteria for improvement (e.g MAP 65 mmHg, monitor urine output	Thank you for your comment. The recommendation has been amended to provide some examples of what improvement could involve. The committee emphasised that this is not an exhaustive list and that clinical assessment of the individual patient should always be used.
British Infection Association	Guideline	017	015	Rec 1.13.9 – Members were concerned that as currently phrased, the recommendation was ambiguous. How is 'not improved enough' defined? Could this be expressed in terms of changes in NEWS2 score, for example.	Thank you for your comment. The recommendation has been amended to provide some examples of what improvement could involve. The committee emphasised that this is not an exhaustive list and that clinical assessment of the individual patient should always be used.
UK Sepsis Trust	Guideline	017	015	We do agree that patients needing more than a litre should trigger prompt senior review.	Thank you for your comment.
Society for Acute medicine	Guideline	017	021	• **1.13.11 to 1.13.12**: Use of **peripheral vasopressors** in patients with suspected sepsis • Associated rationale section on **vasopressors** (page 30–31)	Thank you for your comment. The recommendation has been amended to say that there should be discussion with the critical care team on whether vasopressors should be given and whether they

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					should be started peripherally if central access is not available. The recommendation has been clarified to note that before starting vasopressors there should be a shared decision about escalation. Recommendations do not usually include details on the site of initiation of therapies as different hospitals may have different levels of care available in different areas, and local policies will be followed on these.
				1. Concern: Peripheral Vasopressor section should be clearer The draft guidance supports peripheral administration of vasopressors before central access is available, but does **not explicitly warn against delays in escalation or transfer** to enhanced care or critical care. • In particular, there is no recommendation as to **where** peripheral vasopressors should or can be administered, and no recommendation to involve an expert decision maker before initiation. We would suggest a senior decision maker is not experienced enough to initiate peripheral vasopressor use except in an emergency. • As a new recommendation with no standardised practice across the UK, we also feel it would be beneficial to suggest some consensus standards of care regarding timeliness of assessing response to vasopressors, need for escalation, involvement of Critical Care etc. You recommend assessing reponse to fluid bolus but there is no similar recommendation for response to peripheral vasopressors, for example	

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				Suggested Amendment We recommend strengthening the guidance as follows: **A. Add explicit trigger for expert decision maker involvement:** "Initiation of vasopressor therapy should be following discussion and / or review by an expert decision maker with competencies in enhanced or critical care." **B. Site of initiation:** "The use of peripheral vasopressors should only occur in appropriately resourced and monitored environments, such as resuscitation areas of the Emergency Department, Enhanced Care Units or Critical Care areas; they should not be used in standard ward environments. Bolus peripheral vasopressor use may be considered as a bridging therapy to support safe transfer to such an area" **C. Emphasise that vasopressors initiation must trigger escalation decisions:** "The initiation of vasopressors should mandate a decision regarding appropriate site of care (usually Enhanced or Critical Care areas) and the escalation plan should response not be adequate. This will often require the involvement of expert Critical Care decision makers which should occur early." This recommendation would mirror that in NIV, for example, where it is accepted practice that at the point of initiation of NV a plan should be made for what happens if there is a lack of satisfactory response	
British Infection Association	Guideline	017	021	Rec 1.13.11 – We are concerned that the implication of this guidance is that vasopressors may be started without review by the critical care team. As written the guidance	Thank you for your comment. The recommendation has been amended to say that there should be discussion with the critical care team on

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				tacitly sanctions the use of peripherally administered vasopressors, following discussion with (not necessarily even review by) a non-critical care ST3+ doctor. We acknowledge the rationale for the suggested use of vasopressors without delay, but use outside of a critical care setting requires greater involvement by experienced staff members rather than less. We would recommend that vasopressors are only started following review by the critical care team. Since intensivists have their own guidance on the use, type and route of vasopressors in sepsis, the recommendations within this NICE guidance - developed for a generalist audience – may be of limited use. We recommend that the main message should be if patients are not improving then discuss with critical care rather than attempting vasopressors without their input.	whether vasopressors should be given and whether they should be started peripherally if central access is not available. The recommendation has been clarified to note that before starting vasopressors there should be a shared decision about escalation.
University hospitals Sussex, Royal Sussex County Hospital, Eastern Road, Brighton	Guideline	017	022	Page 17 of 38. 1.13.11 If a patient is to be considered for peripheral vasopressors this needs to be discussed with critical care and not just a senior clinical decision maker which has been defined as (page 25/38) a clinician of ST3 or above. There are many factors which need to be taken into consideration including has the patient been sufficiently fluid resuscitated, are vasopressors and escalation of therapy in the patients best interests, where will the patient be managed and how will their response to vasopressors be monitored as the document does not mandate the need for invasive blood pressure monitoring.	Thank you for your comment. The recommendation has been amended to say that there should be discussion with the critical care team on whether vasopressors should be given and whether they should be started peripherally if central access is not available. The recommendation has been clarified to note that before starting vasopressors there should be a shared decision about escalation.

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				From the wording in the document, a less experienced clinician may start vasopressors after a litre of fluid therapy. The limited safety evidence and lack of licencing for peripheral administration of vasopressors make the need to involve critical care in decision making even more important.	
University hospitals Sussex, Royal Sussex County Hospital, Eastern Road, Brighton	Guideline	017	023	With regards to fluid administration, we do not agree that lactate and SBP should be removed. A patient with a chronic pleural effusion and low grade temperature may have a high news based on RR and compensatory tachycardia and not require aggressive fluid therapy	Thank you for your comment. As described in the related rationale section which noted that although evidence was available for lactate, the committee agreed that these could not be used to guide treatment decisions in isolation. Using indicators such as lactate to make decisions may unnecessarily delay treatments. Systolic blood pressure is assessed as part of NEWS2, it will be being assessed as part of the NEWS2 reassessment.
UK Sepsis Trust	Guideline	018	General	Our view is that this needs more nuance. It seems to suggest that a decision for escalation is binary regarding whether to refer to Critical Care or not. This is at odds with clinical practice. Suggest feedback here to include a full escalation plan e.g. for vasopressors peripherally but not centrally, e.g. for non-invasive ventilation but not invasive ventilation.	Thank you for your comment. The recommendation has been clarified to note that before starting vasopressors there should be a shared decision about escalation.
UK Sepsis Trust	Guideline	018	002	We support the early use of vasopressors, including peripheral administration. But operationalising this in real life is going to be challenging. These recommendations	Thank you for your comment.

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				have been made before and rarely get absorbed rapidly into clinical practice.	
Maternity & Newborn Safety Investigations	Guideline	018	012	We recommend that recent Royal College of Obstetricians and Gynaecologists recommendation (Good Practice Point) stating 'In a critically ill pregnant woman, birth of the baby can be expedited if it would be beneficial to the woman or the baby or to both. A decision on the timing and mode of birth should be made by a senior obstetrician following discussion with the woman and/or family if her condition permits. [GPP]' could be added as an additional bullet point here, in the section which is titled 'Monitoring and escalation' Identification and Management of Maternal Sepsis During and Following Pregnancy	Thank you for your comment. Pregnant or recently pregnant populations are outside the scope of this guideline update.
Meningitis Research Foundation	Guideline	018	020	Rec 1.13.15 – Family and carers can be crucial in flagging sepsis. This recommendation is referring to treatment at the point of critical care, ideally this would happen earlier in patient assessment, but this gives another opportunity to give family members or carers an opportunity to flag concerns they may have about sepsis. Bereaved families supported by the Meningitis Research Foundation frequently report that their concerns were not acted upon early enough. We would like there to be reference to Martha's Rule to highlight the importance of this factor. Embedding the principles of Martha's Rule into the guideline would help empower carers and potentially avoid further preventable deaths.	Thank you for your comment. This recommendation relates to shared decision making around escalation to vasopressors not the provision of ways to seek an urgent review. The committee discussed Martha's rule highlighting its focus on general patient safety and agreed that due to it not being sepsis specific and only recently being rolled in English hospitals and not yet fully implemented that it should not be referred to within this update.

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British Infection Association	Guideline	018	020	Rec 1.13.15 – We agree with the principle of shared decision making on escalation before initiating critical care interventions, but it is currently ambiguous as to what interventions are regarded as 'critical care' within this guideline. This is particularly relevant when interventions like peripherally-administered vasopressors (presumably delivered outside of the critical care setting) are being suggested.	Thank you for your comment. The recommendation has been clarified to note that before starting vasopressors there should be a shared decision about escalation.
Royal College of General Practitioners	Guideline	019	000	We suggest adding a reminder for clinicians to ensure clear documentation of escalation plans and ceilings of care, particularly for patients with increased vulnerability such as those living with significant frailty, comorbidities, or learning disability.	Thank you for your comment. The consideration of the documentation of escalation plans and ceilings of care is outside the scope of this update. This recommendation notes taking into account existing advance care or treatment escalation plans.
British Infection Association	Guideline	019	007	Rec 1.13.15 – We think that as phrased the current recommendation is unclear. Does it mean 'If there is no time to discuss clearly with the patient then escalate to critical care for consideration of admission?' We would emphasise that patients may frequently be too unwell to engage in discussion; whilst that this might be obvious for those with overt delirium, sometimes cognitive changes may be more subtle but nonetheless result in patients may making decisions they would not usually make. We would recommend that if there is any uncertainty about the need for - or potential to benefit from – patients should be referred to critical care for consideration of admission.	Thank you for your comment. The recommendation has been clarified to note that it refers to the decision making around the possible starting of vasopressors, and that there should be a shared decision about this. The recommendation allows for flexibility as it notes to take into account the individuals overall condition, advance care or treatment escalation plans and the urgency to which the individual may need critical care.
UK Health Security Agency	Guideline	020	017	Can we add in here again a line on taking and sending microbiological samples from suspected or possible sources.	Thank you for your comment. This recommendation is outside the scope of this update.

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UK Health Security Agency	Guideline	021	021	Can we add in here a line on taking and sending microbiological samples from suspected sources.	Thank you for your comment. This recommendation is outside the scope of this update.
UK Health Security Agency	Guideline	022	007	Can we add "and take any relevant microbiological samples".	Thank you for your comment. This recommendation is outside the scope of this update.
NHS England	Guideline	022	013	Consideration should be had to developing a supporting quality standard for sepsis, as many audits align to quality standards and this would be one embedded method by which the less experienced clinicians would be able to build upon focusing on areas where there is the evidence and consensus, as the risk is to go without and continue as before with inconsistent application of sepsis guideline to ensure quality. This case is strengthened with both large numbers of NHSR reported claims, coroner regulation 28s and preventable deaths learning coupled with the opposite of inappropriate prescribing and potential for driving AMR	Thank you for your comment. Quality standards are being developed for this guideline.
Royal College of Nursing	Guideline	024	012	We also note that there is no mention of MEOWS which is the Maternity Early Warning Score. Should this be considered within the "Recently pregnant" Section of the guideline? As this is the Score that will be used in this setting and has different parameters for escalation from NEWS2 to reflect the altered physiology of the pregnant/newly birthed mother. There are risks identified for early neonatal infections but, there appears to be no links to guidance on how to manage it.	Thank you for your comment. Pregnant and recently pregnant populations are outside the scope of this guideline update. Consideration will be given via NICE's prioritisation process on a possible update of this sepsis guideline, such as the incorporation of MEOWS.

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Maternity & Newborn Safety Investigations	Guideline	024	014	We feel that '…in the 24 hours following a termination of pregnancy or miscarriage…' and the statements in lines 016-018 do not support clinical teams to consider secondary sepsis which can occur after 24 hours in woman who have termination of pregnancy or miscarriage. We propose that the two bullet points are amended to reflect that the term 'recently pregnant' refers • **up to 4 weeks after the end of pregnancy (birth, termination of pregnancy or miscarriage)** This is also in line with physiological early warning score for maternity, MEWS, which should be used up to 4 weeks after the end of pregnancy. We note that 1.2.2 states that 'people who are pregnant, have given birth or had a termination of pregnancy or miscarriage in the past 6 weeks are in a high risk group for sepsis'. We feel that **6** weeks is also an acceptable time frame, but this timeframe should apply to the end of pregnancy (including termination and miscarriage, as well as births). We recommend a consistent timeframe (at least 4 weeks) would help clinical teams to consider sepsis, including delayed sepsis, in these women.	Thank you for your comment. Pregnant and recently pregnant populations are outside the scope of this guideline update. Consideration will be given via NICE's prioritisation process on a possible update of this sepsis guideline, such as the incorporation of MEWS.
Group B Strep Support	Guideline	025	General	Recommendations for research – we would strongly encourage further research into pregnancy infections generally that can lead to sepsis (e.g. chorioamnionitis), as well as the contribution of group B Streptococcus to maternal infection and infectious causes of stillbirth	Thank you for your comment. Pregnant and recently pregnant populations are outside the scope of this guideline update.

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Royal College of General Practitioners	Guideline	025	000	We recommend including a research question on the diagnostic accuracy of clinical decision tools for sepsis in community and pre-hospital settings, where most initial contacts occur.	Thank you for your comment. Research recommendations are related to the areas of evidence reviewed in the update. This area is outside the scope of this update and was not considered by the guideline committee. We are therefore unable to amend this section of the guideline at present.
National Child Mortality Database (NCMD) Programme at the University of Bristol	Guideline	025	000	3 Recommendations for research 1. Epidemiological study on presentation and management of sepsis in England – The NCMD thematic study on Infection Related Deaths in Children and Young People updates the epidemiological evidence base in children presenting data on incidence, ethnicity and deprivation.	Thank you for your comment and for providing the NCDM thematic study which we will pass on to our surveillance colleagues for consideration.
Meningitis Research Foundation	Guideline	025	018	Rec 2 – We fully support the recommendation for the research into the association between NEWS2 bands and risk of severe illness or death. We would like to see reference to the specific 16-24 age group as a distinct physiological cohort to analyse as part of this research since they are at high-risk of severe infections such as meningococcal sepsis. There is currently a lack of evidence to support treatment protocols in this age group (Borensztajn, Dorine, et al. "Characteristics and management of adolescents attending the ED with fever: a prospective multicentre study." BMJ open 12.1 (2022): e053451).	Thank you for your comment and the additional information. As this research recommendation relates to a previous update of this guideline it is out of scope for this consultation. At this point we are only updating certain parts of the guideline, and your comment refers to a section that is not being updated and was not considered by the guideline committee. We are therefore unable to amend this section of the guideline at present

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Meningitis Research Foundation	Guideline	026	008	Rec 3 – We know that young people aged 16-24 are more difficult to assess for sepsis using standard measures, due to their ability to compensate when seriously ill. When combined with their increased risk for invasive meningococcal disease, they are a particularly high-risk group. In light of this, we would like to see reference to considerations for this age group included when developing clinical decision rules or a predictive tool to rule out sepsis. There is currently a lack of evidence to support clinical decision making for this age group: (Borensztajn, Dorine, et al. "Characteristics and management of adolescents attending the ED with fever: a prospective multicentre study." BMJ open 12.1 (2022): e053451).	Thank you for your comment and the additional information. As this research recommendation relates to a previous update of this guideline it is out of scope for this consultation. At this point we are only updating certain parts of the guideline, and your comment refers to a section that is not being updated and was not considered by the guideline committee. We are therefore unable to amend this section of the guideline at present
British Infection Association	Guideline	026	020	Section - Other recommendations for research - Rapid microbiological testing. We agree with the recommendation on rapid microbiological testing. However, there is a notable absence of recommendations for research on improving antibiotic treatment for those with suspected or confirmed sepsis. This is an omission. We would continue to advocate for research aiming to optimise the use (i.e. timing, selection, combination, administration route, duration) of antibiotics for patients with sepsis.	Thank you for your comment. Research recommendations are related to the areas of evidence reviewed in the update. This area is outside the scope of this update. At this point we are only updating certain parts of the guideline, and your comment refers to a section that is not being updated and was not considered by the guideline committee. We are therefore unable to amend this section of the guideline at present
UK Health Security Agency	Guideline	026	021	Can we include here point of care (POC) diagnostics, as well as microbiological sampling – for example with Group A Strep there is an available test for routine use in Wales and Northern Ireland for diagnosis in primary care, which has not been rolled out in England – this should be reviewed, alongside other POC tests	Thank you for your comment. Research recommendations are related to the areas of evidence reviewed in the update. This area is outside the scope of this update and was not considered by the guideline committee. We are therefore unable to amend this section of the guideline at present

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bioMérieux	Guideline	026	022	We welcome the recommendation for further research, and propose that NHS Trusts collaborate with industry to assess the use of rapid PCR and antimicrobial susceptibility testing to assess AMS performance, time-to-optimal therapy, and economic impact, thus filling the evidence NICE calls for. In the absence of UK NHS data in patients with sepsis, we urge NICE to consider relevant research data from other countries, as well as research conducted in patients with a bloodstream infection (BSI). BSIs may lead to sepsis, and the burden associated with BSIs and sepsis is exacerbated by delays in diagnosis, which delay initiation of optimal therapy. This could prolong exposure to empiric antimicrobial therapy and result in poorer survival rates, for example, patient survival declined by 7.6% for every hour of delay in optimal therapy for patients who progressed from sepsis to septic shock (Kumar et al. 2006 PMID: 16625125). Effectively and swiftly treating a BSI could lead to a reduction in the number of patients who would have continued on to develop sepsis and septic shock without any intervention. Devrim et al. 2024 (PMID: 38150026) evaluated the clinical impact of the BioFire® BCID2 Panel in children with sepsis (aged 15 days to 18 years) across 36 septic episodes. Key findings:	Thank you for your comment and additional information. The protocol for the reviews included OECD countries and was not restricted to UK evidence. Paediatric evidence is not in scope for this update and was not considered by the guideline committee. We are therefore unable to amend this section of the guideline at present. The systematic review considers blood stream infections; the research recommendation developed in this update is for testing in those with suspected sepsis.

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				• BCID2 reduced time to actionable microbiology by approx.82 hours (mean: 82.2 ± 45.4h vs. conventional blood cultures) • Treatment was altered in 69.4% of episodes based on BCID2 results • De-escalation achieved in 36.1% of episodes (n = 13) • Broad-spectrum antibiotics like glycopeptides and piperacillin/tazobactam were stopped in multiple cases • BCID2 enabled rapid detection of resistance, informing safe shifts to targeted antimicrobials To conclude, BCID2 significantly impacted antimicrobial decision-making in paediatric sepsis, enabling faster, more precise treatment while supporting antimicrobial stewardship goals. The American Society for Microbiology's 2025 systematic review and guidelines (Wolk et al. 2025 PMID: 40522178) provide the strongest pooled clinical outcomes data to date on rapid testing in bloodstream infections. Their meta-analysis of 51 studies demonstrated an approx. 19 hour faster time to targeted therapy, a 1.5 to 2 day reduction in hospital LOS, and a 35% reduction in 30 day mortality where rapid diagnostics were embedded within AMS frameworks. These findings directly address NICE's concern about the clinical utility of rapid tests and strongly support implementation of syndromic multiplex diagnostics	

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				and antimicrobial susceptibility testing (AST) within the NG51 framework. Additionally, the NHS England Digital Vision for AMS (https://www.england.nhs.uk/long-read/digital-vision-for-antimicrobial-stewardship-in-england/) in 2025 emphasizes the use of digital systems to support rapid diagnostics and timely antimicrobial reviews, particularly within 48-72 hours of starting treatment. This vision aims to enhance the efficiency and effectiveness of AMS practices by integrating digital tools into clinical workflows.	
UK Sepsis Trust	Guideline	026	022	We endorse this.	Thank you for your comment.
bioMérieux	Guideline	027	006	We agree with this statement, and are disappointed that this isn't reflected in the overall recommendation for NG51. Multiplex testing such as BioFire® BCID2 enables sub-1h detection of 43 pathogens and 10 resistance genes, and when combined with rapid AST, aspects such as AMS, optimal therapy decisions, and patient care are accelerated. In the absence of UK NHS data in patients with sepsis, we urge NICE to consider relevant research data from other countries, as well as research conducted in patients with bloodstream infections (BSI). BSIs may lead to sepsis, and the burden associated with BSIs and sepsis is exacerbated by delays in diagnosis, which delay initiation of optimal therapy. This could prolong exposure to empiric antimicrobial therapy and result in poorer survival rates, for	Thank you for your comment and additional information. The protocol for the reviews included OECD countries and was not restricted to UK evidence. The focus of this guideline and the research recommendations developed in this update is for testing in those with suspected sepsis.

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				example, patient survival declined by 7.6% for every hour of delay in optimal therapy for patients who progressed from sepsis to septic shock (Kumar et al. 2006 PMID: 16625125). Banerjee et al. (2015; PMID: 25972018) conducted a 617-patient RCT evaluating the clinical impact of rapid multiplex PCR (rmPCR) for identifying pathogens and resistance genes directly from positive blood cultures. Patients were randomized into three groups; Standard care (control), rmPCR with templated result comments, and rmPCR plus real-time stewardship audit/feedback (rmPCR/AS). Key findings: • Pathogen ID time dropped from 22.3 to 1.3 hours in rmPCR groups ($p < 0.001$) • Broad-spectrum antibiotic use (piperacillin-tazobactam) was reduced by >10 hours in rmPCR arms ($p = 0.01$) • Narrow-spectrum β-lactam use increased significantly ($p = 0.04$) • Treatment of contaminants fell from 25% to 8% with rmPCR/AS ($p = 0.015$) • Antibiotic de-escalation occurred 13 hours faster in rmPCR/AS (21h vs. 34h; $p < 0.001$) • No difference in LOS, mortality, or cost To conclude, rmPCR alone improved antibiotic targeting; when combined with stewardship, it significantly accelerated de-escalation and reduced overtreatment.	

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				MacVane and Nolte (2016, PMID: 26197846) evaluated the clinical impact of the original BioFire® BCID Panel combined with AMS in a large U.S. hospital. The study compared patients with BSIs before and after BCID implementation. Results showed that pairing BCID with stewardship interventions reduced the time to optimal antimicrobial therapy by 19 hours (from 38.3 to 19.1 hours; $p < 0.001$) and cut the time to de-escalation by 14 hours ($p < 0.01$). Notably, the combination also led to fewer unnecessary broad-spectrum antibiotics and improved therapy precision, demonstrating clear clinical value when molecular diagnostics are integrated into stewardship workflows. Senok et al. (2023, PMID: 37510177) conducted a multicentre ICU study comparing conventional blood culture diagnostics with the BioFire® BCID2 Panel in patients with confirmed BSIs. BCID2, cut the time to optimal antibiotic decision-making from 92 hours to just 28 hours ($p < 0.0001$). It also improved pathogen detection rates (98.8% vs. 87.9%; $p = 0.003$) and was linked to a significant reduction in 30-day mortality (17.3% vs. 31.6%; $p = 0.019$).	
Royal College of Emergency Medicine	Guideline	027	010	Research into peripheral vasopressors is a top priority for RCEM	Thank you for your comment.
UK Sepsis Trust	Guideline	027	011	We endorse this.	Thank you for your comment.

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UK Health Security Agency	Guideline	028	009	People at higher risk of sepsis – Risk groups for sepsis omit homeless people yet in NICE own equality impact assessment (https://www.nice.org.uk/guidance/gid-ng10412/documents/equality-and-health-inequalities) the committee agreed people experiencing homelessness should be considered in the update. The assessment cites evidence that people experiencing homeless are at higher risk of death from sepsis (partly in relation to delayed healthcare seeking).	Thank you for your comment. This recommendation has been revised, and the list has been grouped into overall categories with some examples. This should improve the usefulness of the recommendation. Homelessness has been added as a specific example within this revision.
UK Health Security Agency	Guideline	029	020	"would not have the facilities to **diagnose** or care for people with a high risk of sepsis." In this section you are explaining why you have made changes for acute mental health care facilities; however, the statement may be slightly contradictory as you are expecting mental health care practitioners to identify that patients are at various levels of risk of sepsis but have stated that they should "diagnose" them (highlighted in the quote from line 20), but also that they lack the facilities to do so.	Thank you for your comment. This guideline relates to the identification of suspected sepsis and in this section relates to the decisions about transfer of people with suspected sepsis from mental health settings. Decisions that will be being made in the mental settings will be around the risk of sepsis, not diagnosis.
bioMérieux	Guideline	030	003	Multiplex PCR testing is used throughout the healthcare system in the UK and beyond. Recent evidence from RCTs, meta-analyses, conference posters, NHS studies, and Trusts strongly support rapid PCR for improved clinical outcomes and antimicrobial stewardship. In the absence of UK NHS data in patients with sepsis, we urge NICE to consider relevant research data from other countries, as well as research conducted in patients with	Thank you for your comment and additional information. The protocol for the reviews included had not limited the evidence review to RCTs. The study design considered for the diagnostic tests were systematic reviews of diagnostic accuracy tests and diagnostic accuracy studies. The protocol for the reviews included OECD countries and was not restricted to UK evidence.

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				bloodstream infections (BSI). BSIs may lead to sepsis, and the burden associated with BSIs and sepsis is exacerbated by delays in diagnosis, which delay initiation of optimal therapy. This could prolong exposure to empiric antimicrobial therapy and result in poorer survival rates, for example, patient survival declined by 7.6% for every hour of delay in optimal therapy for patients who progressed from sepsis to septic shock (Kumar et al. 2006 PMID: 16625125). Timbrook et al., 2017 (PMID: 27678085) conducted a meta-analysis of 31 studies involving 5,920 patients with BSIs, comparing outcomes between molecular rapid diagnostic testing (mRDT) and conventional methods. Key findings: • Mortality was significantly reduced with mRDT (OR 0.66; 95% CI: 0.54-0.80); number needed to treat (NNT) = 20 • Mortality reduction was only significant when paired with antimicrobial stewardship programs (ASPs) (OR 0.64 with ASP vs. 0.72 without; non-significant) • Time to effective therapy improved by 5 hours (mean difference: -5.03h) • Length of stay decreased by approx.2.5 days (-2.48 days; 95% CI: -3.90 to -1.06) • Mortality benefits were observed in both Gram-positive (OR 0.73) and Gram-negative (OR 0.51) infections, but not yeast	Given the limitations of the evidence identified, the committee agreed they could not make any recommendations for practice, the committee made a recommendation for further research in this area.

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				To conclude, mRDT significantly improves survival and accelerates effective treatment in BSIs when integrated with a stewardship program. This supports including platforms like BCID2 as part of standard care in sepsis.	
bioMérieux	Guideline, Evidence Review D	General	General	We urge NICE to reconsider the role of rapid syndromic multiplex PCR diagnostics as an essential adjunct tool in the diagnosis of infections in specific patient groups. While we understand that some of the currently available evidence may not meet traditional thresholds for review; particularly in the form of large randomized controlled trials (RCTs), this should not be a barrier to their wider adoption. RCTs are rarely conducted for infectious disease diagnostics due to several practical and methodological challenges. Diagnostic tools, unlike therapeutics, do not directly modify disease outcomes, but instead influence clinical decision-making, patient pathways, and healthcare resource utilization. As such, their benefits are often indirect, difficult to isolate, and deeply embedded within broader care delivery models, making them poorly suited for standard RCT methodologies. In real-world settings, timely and accurate diagnostics like the BioFire® BCID2 panel (a syndromic multiplex PCR panel test capable of rapidly detecting 43 pathogens and resistance genes) are instrumental in optimal treatment, improving patient triage, reducing unnecessary antimicrobial use, and guiding more efficient use of NHS services and budgets. These tools enable clinicians to	Thank you for your comment and additional information. The protocol for the reviews included had not limited the evidence review to RCTs. The study design considered for the diagnostic tests were systematic reviews of diagnostic accuracy tests and diagnostic accuracy studies. The protocol for the reviews included OECD countries and was not restricted to UK evidence. Given the limitations of the evidence identified, the committee agreed they could not make any recommendations for practice, the committee made a recommendation for further research in this area.

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				make faster, more confident decisions; an objective that is clearly aligned with the NHS Long Term Plan's focus on improving out-of-hospital care, expanding same-day care, and supporting virtual wards and community healthcare models. Moreover, the value of such diagnostics goes beyond individual patient care, they directly contribute to national antimicrobial stewardship (AMS) goals, help alleviate pressure on laboratory services and hospital beds, and support government priorities around modernizing the NHS through technological innovation. Investing in diagnostics is a strategic enabler for achieving NHS Key Performance Indicators (KPIs) such as reducing time to appropriate treatment, and optimizing use of scarce clinical resources. It also aligns with the UK Government's 5-Year Action Plan on antimicrobial resistance and its broader Life Sciences Vision. Given the real-world evidence and the systemic benefits of syndromic multiplex PCR testing, we believe there is a strong case for supporting the rapid microbiological testing within NHS diagnostic pathways for specific patient groups. The absence of traditional RCTs or large robust studies should not be misinterpreted as a lack of value or clinical impact; rather, it reflects a long-standing evidence gap in diagnostics evaluation, which must be bridged with pragmatic, context-aware decision-making.	

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NHS England	Other recommendations for research	026	025	"The clinical and cost effectiveness of the test" should say – "cost effectiveness of the test and the subsequent benefits gained through the test informing timely, optimal, safer sepsis care. This is because for community onset sepsis, this can ensure the appropriate use of more broad spectrum antibiotics though informing clinical judgement. Quickly particularly when there is diagnostic uncertainty. Additionally, in order to prevent severe infection becoming sepsis, consideration should be made to us or rapid microbiology testing further up the infection pathway. NHS-R claims, Learning from death reports and regulation 28 reports have common themes often related to a sepsis death where a person severely ill from infection, presented multiple times before onset of sepsis occurred. Future guideline iterations of sepsis should include more reference to the guidelines needed to prevent reaching non-severe infections becoming sepsis	Thank you for your comment. The research recommendation here includes rapid microbiological testing to guide management; this is in this research question and the inclusion of clinical effectiveness. Prevention of sepsis is not in the scope of this guideline.
NHS England	Research recs	026	021	Can this research recommendation be expanded to include biomarkers in addition to microbiological tests? The presence of bacteria in a non-sterile clinical specimen is expected and not necessarily indicative of infection or sepsis. For most infections, the causative organism and antibiotic susceptibilities can be reasonably well predicted from existing epidemiology and empirical treatment guidelines are designed to consider likely pathogens and their susceptibility profile. What is equally important is predicting which patients are more likely to deteriorate without antibiotics and which patients can be safely managed with a watch-and-wait antibiotic avoidance	Thank you for your comment. Research recommendations are related to the areas of evidence reviewed in the update. This area is outside the scope of this update. At this point we are only updating certain parts of the guideline, and your comment refers to a section that is not being updated and was not considered by the guideline committee. We are therefore unable to amend this section of the guideline at present

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				strategy and this is where biomarkers can potentially add value to clinical findings and microbiological tests.	
NHS England	Research recs	026	025	Please include the phrase 'clinical utility' along with cost-effectiveness and clinical effectiveness. It is important to confirm whether the test changes clinical management of the patient, such as escalation of care, cohorting/isolation, antibiotic treatment or no antibiotic treatment. This can influence health resource utilisation and antibiotic exposure and thereby contribute to the health economic assessment of the value of diagnostic tests.	Thank you for your comment. The research recommendation here includes rapid microbiological testing to guide management which encompasses areas including decisions around escalation of care or antimicrobial prescribing. This is in this research question via the inclusion of clinical and cost effectiveness.
National Child Mortality Database (NCMD) Programme at the University of Bristol	Scope for guideline update	General	General	We are concerned that the scope for this update is focused on people > 16 years old and that the NICE committee only had 1 co-opted paediatrician. There is a missed opportunity to discuss the introduction of Martha's Rule which has changed the landscape relating to escalation of patient/ parental concerns. We are also concerned that there is a missed opportunity to discuss the introduction of the National paediatric early warning score (PEWS) in 2023. This update talks extensively about the adult score (NEWS) but no mention is made of the paediatric equivalent.	Thank you for your comment. The focus of the guideline was NEWS2 populations which does not include those under 16 and the committee membership reflects the needs of the guideline which focus predominantly on adults. Those on the committee have a wide range of experiences. The committee discussed Martha's rule highlighting its focus on is a general patient safety initiative and agreed that due to itis not being sepsis specific and only recently being rolled in English hospitals and not yet fully implemented that it should not be referred to within this update. Consideration will be given via NICE's prioritisation process on a possible update of this sepsis guideline, such as the incorporation of PEWS.
NHS England	Terms Used	024	018	Please clarify what is meant by "return to pre-pregnancy levels". Levels of what?	Thank you for your comment. This has been clarified and physiology added.

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Organisation name – Stakeholder or respondent	Disclosure on tobacco funding / links	Comments/Action
Royal College of Pathologists	No	
Royal College of Midwives	No	
Thermo Fisher Scientific	No	
Royal College of General Practitioners	No	
Blackpool Teaching Hospitals	No	
UK Sepsis Trust	No	
NHS England	No	
UK Standards for Microbiology Investigations	No	
bioMérieux	No	
National Child Mortality Database (NCMD) Programme at the University of Bristol	No	
First Community Health and Care	No	
Meningitis Research Foundation	No	
Society for Acute medicine	No	
Aneurin Bevan University Health Board	No	
University hospitals Sussex, Royal Sussex County Hospital, Eastern Road, Brighton	No	
Royal College of Emergency Medicine	No	
British Infection Association	No	
National Paediatric Pharmacy Group (NPPG) and British Association of Perinatal Medicine (BAPM)	No	
Group B Strep Support	No	
The Faculty of Intensive Care Medicine	No	
Faculty of Pharmaceutical Medicine	No	
UK Health Security Agency	No	
Royal College of Nursing	No	
Maternity & Newborn Safety Investigations	No	
South Eastern Health and Social Care Trust	No	