Suspected Sepsis: recognition, diagnosis and early management (update)

Consultation on draft guideline - Stakeholder comments table
09/11/2023 – 23/11/2023

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Association of Ambulance Chief Executives (AACE)	Guideline	001	007	'This update covers management of suspected sepsis in acute hospital settings,'-the guideline then goes on to mention other settings such as ambulance services?	Thank you for your comment. This update under consultation is part of a series of updates of NG51 and focused in the main on making new and updating existing recommendation on managing suspected sepsis in acute hospital settings. The aim of this update was to align the risk stratification system in the recommendations on early non-antibiotic management to the NEWS2 risk strata. As outlined in the scope for this update other recommendations in NG51 may be revised to ensure consistency. These updated recommendations under consultation will be brought together with the other out of scope recommendations that were not part of this update of NG51 to create a full comprehensive guideline that applies to healthcare professionals working in primary, secondary and tertiary care.
Association of Ambulance Chief Executives (AACE)	Guideline	006	006	Should also take into account scores taken in pre hospital/ambulance setting?	Thank you for your comment. We think this comment refers to recommendations on 'Evaluating risk level: In acute hospital settings, acute mental health settings and ambulances'. As outlined on page 2 of the consultation draft of the guideline, areas shaded in grey indicate that this recommendation is outside the scope of this update of NG51, and we cannot accept comments on these areas which includes recommendations on 'Evaluating risk: In acute hospital settings, acute mental health settings and ambulances'. Whilst outside of the scope of this update consultation, recommendations on 'Evaluating risk: In acute

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					hospital settings, acute mental health settings and ambulances' outline taking into account any NEWS2 score calculated or intervention carried out before initial assessment in the emergency department indicating that 'any' NEWS2 score pre or otherwise should be accounted for when evaluating risk level in people with suspected sepsis in acute hospital settings, acute mental health settings and ambulances.
Association of Ambulance Chief Executives (AACE)	Guideline	007	017	Needs more clarity of what 'conveyance agreements' means-this is not a clearly defined term	Thank you for your comment. The wording has now been clarified as 'agreements on transfer to hospital'.
Association of Ambulance Chief Executives (AACE)	Guideline	007	019	Shouldn't the wishes of the patient or their advocate be also taken into account re. whether they do wish to be conveyed to hospital? There may be no advance care plan and the patient may not want to be taken to hospital.	Thank you for your comment The Committee noted that the guideline outlines at the start of the recommendations section that 'People have the right to be involved in discussions and make informed decisions about their care". The guideline cross refers to NICE's 'Information on making decisions about your care' and also refers and links to NICE resources on 'Making decisions using NICE guidelines' all of which emphasise the importance of discussions and informed decision making.
Association of Ambulance Chief Executives (AACE)	Guideline	008	014	Can the term ambulance crews be changed? Is it meaning registered health care professionals/clinicians-i.e. paramedics. Also, accessing senior clinical advice is poorly established in some areas and therefore may not be available. And should a registered paramedic need senior clinical advice to administer an antibiotic? The guidance is	Thank you for your comment. The Committee considered your comment and recommendations on 'Managing suspected sepsis outside acute hospital settings: Managing the condition while awaiting transfer' have been amended to specify paramedics who are thinking about giving antibiotics should follow local guidelines or seek

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				not very clear whether antibiotics should be given pre hospital.	advice from more senior colleagues, if needed. The recommendation is now preceded by a bullet point that highlights the need for ambulance services to consider having mechanisms in place to be able to give antibiotics to people at high risk of severe illness or death from sepsis if antibiotics have not been given before by a GP. As outlined on page 2 of the consultation draft of the guideline, areas shaded in grey indicate that this recommendation is outside the scope of this update of NG51, and we cannot accept comments on these areas which includes some of the recommendations on 'Managing suspected sepsis outside acute hospital settings: Managing the condition while awaiting transfer. However, recommendations on 'Managing suspected sepsis outside acute hospital settings: Managing the condition while awaiting transfer' outline that if transfer time to emergency department is routinely more than 1 hour ensure GPs have mechanisms in place to give antibiotics to people with high risk criteria in pre-hospital settings) and ambulance services have mechanisms in place to give antibiotics to people at high risk of severe illness or death from sepsis if antibiotics have not been given before by a GP.
Association of Ambulance Chief Executives (AACE)	Guideline	008	016	It is not very clear if the recommendations are for paramedics to give antibiotics pre hospital? This is not common practice currently.	Thank you for your comment. The Committee considered your comment and recommendations on 'Managing suspected sepsis outside acute hospital settings: Managing the condition while awaiting transfer' have been amended to specify paramedics who are thinking about giving antibiotics should follow local guidelines. The

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					recommendation is now preceded by a bullet point that highlights the need for ambulance services to consider whether they need to put mechanisms in place to be able to give antibiotics to people at high risk of severe illness or death from sepsis if antibiotics have not been given before by a GP.
Association of Ambulance Chief Executives (AACE)	Guideline	016	001	It is common for ambulance services to see patients in the pre hospital setting that are assessed as Low risk of severe illness or death from sepsis. Should this section be revised to say that it applies to patients outside hospital as currently it sits in the section titled: Managing suspected sepsis in acute hospital settings.	Thank you for your comment. The committee considered your comment and highlighted that these recommendations do not cover out-of-hospital settings. This section of the guidance is for people at low risk of severe illness or death from suspected sepsis in acute hospital settings.
Association of Ambulance Chief Executives (AACE)	Guideline	018	011	As above, re. Very low risk of severe illness or death from sepsis. These patients are seen in pre hospital settings- where is the advice for ambulance services/paramedics?	Thank you for your comment. This section of the guidance is for people at low risk of severe illness or death from suspected sepsis in acute hospital settings. The guideline has recommendations that were outside the scope of this update of NG51 that cover 'Management of suspected sepsis outside acute hospital settings'.
Association of Paediatric Emergency Medicine (APEM)	Guideline and algorithm	General	General	Many paediatric emergency and urgent care units see and treat children 16 years and over but do not use NEWS2, rather using sepsis scoring systems as recommended by NICE and the Sepsis Trust, bespoke PEWS and more recently, as it is rolled out, the national PEWS. We note from your previous consultation that you are considering including PEWS and MEWS in this guideline. Until this occurs however, we are keen to highlight the possible conflicts in sepsis scoring that may occur for units that do not use NEWS2 for their 16+ population. Would you consider reclassifying this guidance as being for 16-year-olds in units that use NEWS2 and refer to other guidance	Thank you for your comment. The Committee have considered your comments and understand the points made. This phase of the update of NG51 guideline under consultation sought to align previous risk stratification criteria with NEWS2 as it is already in use in most NHS acute care settings, Emergency Departments, ambulance services and mental health facilities in England. The Committee agreed that recommending its use to evaluate risk of severe illness or death from sepsis in these settings would further improve consistency in the detection of and response to acute illness due to sepsis (for people for whom the NEWS2 can be

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				for those that do not i.e. location-specific guidance rather than age-specific?	used), at no further cost. It is not possible to reclassify the guideline as you have outlined and as you have identified future work regarding PEWS and MEWS is being considered by NICE for a future update of NG51.
London Ambulance Service NHS Trust	Guideline	001	007	The document states that the update covers sepsis in acute hospital setting yet the main text mentions community settings, mental health, and ambulance services so this is not an accurate reflection of the breadth of the guideline and who it is relevant to.	Thank you for your comment. This update under consultation is part of a series of updates of NG51 and focused in the main on making new and updating existing recommendation on managing suspected sepsis in acute hospital settings. The aim of this update was to align the risk stratification system in the recommendations on early non-antibiotic management to the NEWS2 risk strata. As outlined in the scope for this update other recommendations in NG51 may be revised to ensure consistency. These updated recommendations under consultation will be brought together with the other out of scope recommendations that were not part of this update of NG51 to create a full comprehensive guideline that applies to healthcare professionals working in primary, secondary and tertiary care.
London Ambulance Service NHS Trust	Guideline	006	006	Take into account any NEWS2 score calculated or intervention carried out before initial assessment in the emergency department – why would this not apply to the attending ambulance crew too ?	Thank you for your comment. As outlined on page 2 of the consultation draft of the guideline, areas shaded in grey indicate that this recommendation is outside the scope of this update of NG51, and we cannot accept comments on these areas which includes recommendations on 'Evaluating risk'; 'Transfer by ambulance for people with a NEWS2 score of 5 or above' and 'Managing the condition while awaiting transfer'. For clarity, recommendations on 'Managing the condition while

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					awaiting transfer highlights that on taking over the care of an individual with a suspected sepsis from community or custodial settings that a NEWS2 score should be reevaluated which could include accounting for interventions carried out before initial assessment.
London Ambulance Service NHS Trust	Guideline	007	017	It is not clear what the phrase 'conveyance agreements' means	Thank you for your comment. The wording has now been clarified as 'agreements on transfer to hospital'.
London Ambulance Service NHS Trust	Guideline	008	014	It is not generally feasible for ambulance crews to routinely require senior clinical advice before drug administration – antibiotics will only be given by paramedics and if they are required there should be a clear guideline as with other areas of practice.	Thank you for your comment. The Committee considered your comment and recommendations on 'Managing suspected sepsis outside acute hospital settings: Managing the condition while awaiting transfer' have been amended to specify paramedics who are thinking about giving antibiotics should follow local guidelines or seek advice from more senior colleagues, if needed. The recommendation is now preceded by a bullet point that highlights the need for ambulance services to consider having mechanisms in place to be able to give antibiotics to people at high risk of severe illness or death from sepsis if antibiotics have not been given before by a GP.
London Ambulance Service NHS Trust	Guideline	016	008	Paramedics will frequently manage patients out-of-hospital with low risk of severe illness or sepsis without the requirement to refer to another clinician – this statement needs to acknowledge that and account for it.	Thank you for your comment. This section of the guidance is for people at low risk of severe illness or death from suspected sepsis in acute hospital settings and does not cover out-of-hospital settings.
London Ambulance Service NHS Trust	Guideline	018	021	As per comments above, paramedics who are not prescribers will manage low risk patients without onwards referral to another clinician.	Thank you for your comment. This section of the guidance is for people at low risk of severe illness or death from suspected sepsis in acute hospital settings. The guideline has recommendations that

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					were outside the scope of this update of NG51 that cover Management of suspected sepsis outside acute hospital settings.
London Ambulance Service NHS Trust	Guideline	025	016	This comment does not reflect the skills of paramedics and it is not clear why ambulances are singled out alongside mental health services here.	Thank you for your comment. We assume that you are referring to the rationale and impact section regarding 'evaluating risk level in people with suspected sepsis in acute hospital settings, acute mental health settings and ambulances' and specifically 'how the recommendations might affect practice'. As outlined on p.2 of the consultation draft of the guideline, this section has been shaded in grey indicating that this item is outside the scope of this update of NG51 and we cannot accept comments on this section. This section was developed in the first phase of the update of NG51 and has already been consulted on and is outside the scope of this update. However, to address your comments amendments have been made to the recommendations on 'Managing the condition while awaiting transfer' and corresponding rationale and impact sections to make more direct reference to paramedics and their ability to prescribe antibiotics. In terms of 'singling out' ambulances it's not clear what you mean. The section you are referring to is the rationale and impact section which seeks to outline the Committee's thinking when developing the recommendation which outlines that "NEWS2 is already in use in most NHS acute care settings, Emergency Departments, ambulance services and mental health facilities in England…" and the Committee were highlighting why recommending its use to evaluate risk of severe illness or death from

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					sepsis in these settings would improve consistency in the detection of and response to acute illness due to sepsis. The comment is not suggesting there are issues or problems in these areas but points to the Committees thinking behind the recommendation to use NEWS2.
Mencap	General	General	General	Sepsis has been recognised as one of the major causes of avoidable deaths in people with a learning disability by the LeDeR programme.	Thank you for your comment. The equality impact assessment (EIA) identifies and gives consideration to people with learning disabilities throughout the development of this update of NG51. People with a learning disability were identified through the EIA process and the committee aimed to ensure that the needs of this group were captured in the guidance. The guideline refers to the need for clinical judgement when interpreting NEWS2 scores and the recommendations on 'When to suspect sepsis'; 'Interpreting findings' and 'Communicating and sharing information' refer to the need to consider specific characteristics and characteristics that may impact certain groups over others including people with learning disabilities or autism.
Mencap	Guideline	General	General	We note that the guideline states that NEWS 2 scores should be taken in context with a patient's underlying physiology, however we are not sure that this is sufficient to make clear that some people's physiology and/or general presentation means that NEWS 2 scores are likely to be incomplete or may mask the signs of deterioration. For people with a learning disability for example with different presentation, it is important to compare any deterioration against the baseline for that person to accurately spot the clinical signs of deterioration.	Thank you for your comment. The Committee felt that the concerns you have raised regarding the consideration of people's physiology and/or general presentation and interpretation of NEWS 2 scores and the potential to miss signs and symptoms of a suspected sepsis in this, and other groups are addressed in relevant recommendations including 'People who are most vulnerable to sepsis' Risk factors for sepsis' which highlights several groups who are at higher risk of developing sepsis; 'Interpreting findings' which falls under a broader

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					title of 'Face to face assessment' which refers to accounting for the fact that some groups of people with sepsis may not develop a raised temperature for example people who are very old, frail, young infants and children. The committee agreed that people with learning disabilities are potentially at greater risk of sepsis. The guideline refers to the need for clinical judgement when interpreting NEWS2 scores and the recommendations refer to the need to consider specific characteristics and characteristics that may impact certain groups over others including people with learning disabilities or autism when suspecting sepsis, when interpreting the findings of NEWS2 scores and when communicating and sharing information
Mencap	Guideline	General	General	We would also like the guideline to make clear that in the case of someone who cannot communicate their symptoms, or who may present differently, it is often vital to listen to the person's family and/or supporters who may be describing the soft signs of deterioration. Some small numbers of family carers and support workers have been trained in using RESTORE2 MINI in an initiative by NHSE to prevent avoidable deaths from sepsis.	Thank you for your comment. The Committee felt that the concerns you have raised regarding the consideration of someone who cannot communicate their symptoms, someone who may present differently and the importance of listening to a person's family/supporters are addressed in these recommendations. As well as the frequent reference to the use of clinical judgement when interpreting NEWS2 scores, recommendations on 'When to suspect sepsis' 'Interpreting findings', and Evaluating risk refer to the need to interpret and not rely solely on indicators such as fever or hypothermia as indicators of sepsis in isolation and that any NEWS2 scores should be interpreted within the context of the persons underlying physiology and comorbidities. These recommendations highlight the need to take into

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					account that people with sepsis may have non-specific, non-localised presentations; the need to pay attention to concerns expressed by the person and their family or carers; and assess people who might have sepsis with extra care if they cannot give a good history. The committee have added to the recommendations on 'When to suspect sepsis' to make more specific reference to people with learning disabilities and autism in line with stakeholder comments.
Mencap	Guideline	General	General	We were unsure why RESTORE 2 was not mentioned in the document as our understanding is this also tracks the soft signs of deterioration. We would strongly advise the team to liaise with the Learning Disability and Autism Team at NHS England whose clinical team have done a large quantity of work in the recognition and early management of sepsis.	Thank you for your comment. This update under consultation is part of a series of updates of NG51. Some of the recommendations you refer to are outside of scope for this update but speak to the point you raise. Restore 2 was out of scope for this update. However, the committee considered your comments and were satisfied that the final guideline addresses the concerns you have raised regarding the consideration of people's physiology and/or general presentation and interpretation of NEWS 2 scores and the potential to miss signs and symptoms of a suspected sepsis in this, and other groups. The guideline refers to the importance of the use of clinical judgement when interpreting NEWS2 scores; recommendations on 'When to suspect sepsis'; 'Interpreting findings; and 'Evaluating risk refer to the need to interpret and not rely solely on indicators such as fever or

					hypothermia as indicators of sepsis in isolation and that any NEWS2 scores should be interpreted within the context of the persons underlying physiology and comorbidities. Recommendations on 'When to suspect sepsis' and 'Interpreting findings' speak to the need to take into account that people with sepsis may have non-specific, non-localised presentations; the need to pay attention to concerns expressed by the person and their family or carers, for example changes from usual behaviour; and assess people who might have sepsis with extra care if they cannot give a good history (for example, people with English as a second language or people with communication problems). The committee have added to recommendations on 'When to suspect sepsis' to make more specific reference to people with learning disabilities and autism in line with stakeholder comments. In addition, the equality impact assessment (EIA) which has been undertaken and its findings considered by the committee throughout the development of this guideline identifies and considers people with learning disabilities and autism. The EIA is undertaken as part of NICE duty to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations between particular population groups to support NICE's compliance with the Equality Act 2010 and the Human Rights Act 1998.

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Mencap	Guideline	General	General	As we think is important with all NICE guidelines, we believe it is important to remind clinicians that they must remove barriers to care, make reasonable adjustments and meet their duties under the Mental Capacity Act to ensure that people with a learning disability (and other disabled people) are able to access care. Research has shown that failure to meet both of these duties is one of the contributors to the avoidable deaths of people with a learning disability.	Thank you for your comment. Making reasonable adjustments as required by the Equality Act is a statutory requirement and we expect that these are being implemented so this requirement would not need to be repeated in each individual NICE guideline and constituent recommendations. That said, this update under consultation is part of a series of updates of NG51. Some of the recommendations are out of scope for this update of NG51 but speak to the issue you raise. NG51 recommendations on 'When to suspect sepsis' outline the need to 'take into account that people with sepsis may have non-specific, non-localised presentations, for example feeling very unwell, and may not have a high temperature. The recommendations go on to say 'pay particular attention to concerns expressed by the person and their family or carers, for example changes from usual behaviour and 'assess people who might have sepsis with extra care if they cannot give a good history (for example, people with English as a second language or people with communication problems). These other recommendations will be brought together with the recommendations that are the focus of this consultation to form a comprehensive guideline on final publication.
Meningitis Research Foundation	Guideline	General	General	We are pleased to see that recommendations about monitoring NEWS2 scores are now included in the guidance	Thank you for your comment

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Meningitis Research Foundation	Guideline	General	General	There is no mention within the guidance about specific groups or circumstances in which NEWS2 scores should be interpreted with caution. We believe it would be helpful to provide clinicians with a list of groups/circumstances which might require increased clinical judgement over and above NEWS2 scores. In particular, young adults (i.e those aged between 16 and 24) we believe require a special mention because adult clinicians may not recognise compensated shock in this age group where hypotension can be a late sign due to the maintenance of blood pressure through vasoconstriction and tachycardia. We reiterate the points made in our initial consultation response when we say that 16-24 year olds with sepsis are a special case and should be specifically mentioned as such, with a warning in the guidance not to overly rely on NEWS2 for this age group because: • There is no evidence on what age, physiologically, one should move from using PEWS to NEWS2, so reliance on NEWS2 in adolescents is risky. • Young adults can display low NEWS2 scores despite being very unwell. At MRF we often hear of deaths that occur in adolescents aged 16 and over in which cardiovascular parameters and blood pressure are well preserved by teenagers and by the time they decompensate with meningococcal or any other type of sepsis, it's too late for them due to cardiac compensation. We have real concerns that over reliance on a NEWS2 assessment in this age group could lead to delays in treatment with antibiotics and subsequently result in more preventable deaths.	Thank you for your comment and references. The committee considered your comments and agreed that the role of clinical judgement is emphasised throughout the guideline as is the reference to NEWS2 in assisting clinical judgement; and in the situation you have outlined (the move from PEWS to NEWS2) clinical judgement would apply. Thank you for the references provided. However, these are not relevant to the guideline due to a lack of focus on a sepsis population.

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				• Junior Drs are fallible in their clinical assessments. Research looking at the effect of suboptimal healthcare delivery on outcomes of patients with IMD[1] found that: o Optimal early management of IMD at the admitting hospital can improve outcomes o Young people being looked after by doctors without paediatric training were at increased risk of dying. Often this was as a result of drs trained to recognise serious illness in adults failing to recognise compensated shock in children where hypotension can be a late sign due to the maintenance of blood pressure through vasoconstriction and tachycardia. Whilst the maximum age of children participating in this study we are in contact with families of fatal cases of young adults who presented similarly. We would like to see 16-24 year olds mentioned as a high risk group because: • A recent multicentre study which took place across Europe concluded that despite accounting for a relatively small fraction of all ED visits, febrile adolescents have an increased risk of serious bacterial infections, including sepsis/meningitis, in comparison with younger children[2]. The authors state that more research is needed to be able to provide detailed guidelines for this age group. • Recent data from UKHSA has shown a rapid increase in IMD during epidemiological year 21/22 in the 15 to 24 year old age group particularly as a result of group B meningococcal disease with the incidence in this age group now higher than in children aged 1 to 4. During the same year there were an estimated 12 deaths in all ages with at least 3 of	

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				these within the 19-22 year old age group[3,4]. Levels of disease in this age group are now similar to the levels we saw pre-pandemic, but if they continue to increase at this rate they could soon exceed this. The recent elevated levels of GAS infections in this age group also highlight the need for this group to be considered at increased risk. • IMD is rapidly fatal, especially in adolescents. An analysis of 8 years worth of deaths from IMD in England between 2008 and 2015 showed that around 90% of all deaths as a result of confirmed IMD took place within the first 24 hours of diagnosis. In the 15 to 24 year old age group this was even higher at 96%[5]. References 1) Ninis, Nelly, et al. "The role of healthcare delivery in the outcome of meningococcal disease in children: case-control study of fatal and non-fatal cases." Bmj 330.7506 (2005): 1475. 2) 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) Invasive meningococcal disease in England: annual laboratory confirmed reports for epidemiological year 2021 to 2022. Available from Invasive meningococcal disease in England: annual laboratory confirmed reports for epidemiological year 2021 to 2022 - GOV.UK (www.gov.uk) 4) JCVI minutes - Extraordinary JCVI meeting to discuss polio and meningococcal B Minute of the meeting held on 25 July 2022. Available from Extraordinary JCVI polio and meningococcal B meeting draft minute July 2022.pdf | Powered by Box	

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				5) Beebeejaun, Kazim, et al. "Invasive meningococcal disease: timing and cause of death in England, 2008–2015." Journal of Infection 80.3 (2020): 286-290	
Meningitis Research Foundation	Guideline	006	010 – 011	The advice to recalculate a NEWS score if someone's condition deteriorate implies that a NEWS2 score is considered more important that using clinical judgement. We would like it to be made clearer that action should be taken on the basis of clinical judgement/ the fact that the patient is deteriorating even in the absence of a NEWS2 which indicates prompt treatment. NEWS2 is an early warning score that can help clinicians decide how and when to treat, but should not be used to validate a noticeable deterioration in a patient.	Thank you for your comment. The Committee discussed the comment raised and highlighted that throughout the guideline it is stated that clinical judgement should be used in the interpretation of NEWS2 scores and that applies throughout. Recommendations on 'Evaluating risk: In acute hospital settings, acute mental health settings and ambulances' speaks to the periodic re-calculation of NEWS2 score in line with the AoMRC statement. The Committee have acknowledged your comment and have amended the recommendations on 'Evaluating risk: In acute hospital settings, acute mental health settings and ambulances' which now accounts for deteriorations and unexpected changes in the persons condition as an additional trigger to recalculate the NEWS2 score and a re-evaluate sepsis risk.
Meningitis Research Foundation	Guideline	010	047	People aged 16 or over who are at high risk of severe illness or death from sepsis should be seen by a consultant, not just discussed.	Thank you for your comment. The Committee discussed your comment and highlighted that recommendations on 'Managing suspected sepsis in acute hospital settings: High risk of severe illness or death from sepsis' outline that) a clinician with core competencies in the care of acutely ill patients (FY2 level or above) will assess the person's condition. There would be a venous blood test undertaken and antibiotics given with a referral to the senior clinical decision maker undertaken. The recommendation regarding a discussion with a consultant has been amended to the use of 'clinical

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					judgement to decide whether to discuss with a consultant' in recognition of the importance of clinical judgement in decision making, patient needs and the balance of consultant resource and need.
Meningitis Research Foundation	Guideline	023	017 - 028	It is helpful to see some comments about how NEWS2 scores should be interpreted, but we would like to see these comments mentioned within the guideline itself rather than in the write up about why the committee made their recommendations. We would like to see a section within the guidance itself which alerts clinicians to the possibility of compensated shock in young adults.	Thank you for your comment. This update under consultation is part of a series of updates of NG51. Some of the recommendations outside the scope of this update of NG51 acknowledge the points you raise regarding 'compensated shock' and physiological considerations. As well as the frequent reference to the use of clinical judgement when interpreting NEWS2 scores, recommendations on When to suspect sepsis, Interpreting findings, and Evaluating risk refer to the need to interpret and not rely solely on indicators such as fever or hypothermia as indicators of sepsis in isolation and that any NEWS2 scores should be interpreted within the context of the persons underlying physiology and comorbidities. These other NG51 recommendations will be brought together with the recommendations that are the focus of this consultation to form a comprehensive guideline on final publication.
Napp Pharmaceuticals Limited	Guideline	General	General	The incidence of invasive fungal disease is increasing. Invasive fungal infections have a high mortality rate (estimates in excess of 40%) despite there being treatments available. General awareness of invasive fungal disease is poor We suggest adding some guidance for invasive fungal disease to be considered in patients with risk factors and appropriate guidance to be provided to ensure timely investigation, diagnosis, management, and fungal	Thank you for your comment. The committee considered your comment and did not make any changes. The committee agreed that incidence of invasive fungal disease in the context of suspected sepsis is very low and, it would be unusual to treat a person with suspected sepsis with an anti-fungal as an initial management strategy because the

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				antimicrobial stewardship at all levels of risk and in all settings. This will help with general awareness of the increasing disease and improve management and outcomes.	treatments are known to sometimes have toxic side effects.
Napp Pharmaceuticals Limited	Guideline	General	General	Throughout the document antibiotic treatment is referred to. As this is a general sepsis guideline and sepsis may be secondary to viral and fungal pathogens. We suggest the term antimicrobial may be more appropriate in some instances when not referring to antibacterial treatments specifically.	Thank you for your comment. The committee considered your comment and did not make any changes. The committee agreed that incidence of invasive fungal disease in the context of suspected sepsis is very low. The term antimicrobial is used throughout the guideline where appropriate, and the committee felt this was sufficiently clear.
Napp Pharmaceuticals Limited	Guideline	018	004	Some more detail about blood volumes to be taken when collecting blood cultures could be added. This is to ensure blood cultures are sufficient to increase the chance of culturing difficult to culture organisms such as fungi.	Thank you for your comment. This update under consultation is part of a series of updates of NG51. Some of the recommendations are outside the scope of this update of NG51. Recommendations that were out of scope for the update were removed from the consultation version of the guideline. Within the recommendations on 'Initial investigations to find the source of infection' reference is made to the UK standards for microbiological investigations with reference to taking microbiological and blood samples which the Committee agreed were adequate and appropriate felt that this reference to the UK standards was appropriate. These other recommendations will be brought together with the recommendations that are the focus of this consultation to form a comprehensive guideline on final publication.
National Spinal Injuries Centre	Algorithm	General	General	At present the algorithm references the use of clinical judgment with inference only to additional clinical signs such as meningococcal disease. There is a concern that the reference made to underlying physiology and co-	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope. For

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				morbidities outlined in the guideline at page 5, line 6 is not reflected in the algorithm, when the algorithm is more likely to be used as an aide-memoir in the acute situation. Furthermore, it is felt that the reference to underlying physiology and co-morbidities in both the guideline and algorithm should be strengthened by explicitly stating the conditions of spinal cord injury, heart or lung disease.	reference, the algorithms are designed to provide an overview of the recommendations to aid implementation but can't include all the content from the guideline as that would make them unreadable. The committee strived to strike a balance between detail and pragmatism. On the point around spinal cord injury, this detail was added to the guideline following consultation for the previous update in March 2023. See the consultation comments and responses from the March 2023 consultation.
National Spinal Injuries Centre	Guideline	005	006	Rec 1.5.1 I would ask that the caveat added to the "Suspected Sepsis: recognition, diagnosis and early management (update)" guideline of "NEWS2 can be less accurate in people with certain conditions, such as people with spinal injury or heart or lung disease, because of their altered baseline physiology" be reflected in this section, thus making spinal injury explicitly stated for those practitioners that may be unfamiliar with the condition and less likely to consider it alongside NEWS2 score.	Thank you for your comment. As outlined on page 2 of the consultation draft of the guideline, areas shaded in grey indicate that this recommendation is outside the scope of this update and we cannot accept comments on these areas which includes recommendations on 'Evaluating risk'.. We think your point speaks to a broader issue which the committee has considered in the development of this update which is outlined under "Interpreting NEWS2 scores" where we acknowledge the importance of clinical judgement in interpreting NEWS2 scores and acknowledged that NEWS2 can be less accurate in people with certain conditions, such as people with spinal injury or heart or lung disease, because of their altered baseline physiology. Some of the recommendations, which are outside the scope of this update of NG51, acknowledge the points you

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					raise regarding 'compensating ' and 'abnormal physiology'. As well as the frequent reference to the use of clinical judgement when interpreting NEWS2 scores, recommendations on When to suspect sepsis, Interpreting findings, Evaluating risk refer to the need to interpret and not rely solely on indicators such as fever or hypothermia as indicators of sepsis in isolation and that any NEWS2 scores should be interpreted within the context of the persons underlying physiology and comorbidities. These other recommendations will be brought together with the recommendations that are the focus of this consultation to form a comprehensive guideline for publication.
Newcastle upon Tyne Hospitals NHS Foundation Trust	Guideline	005	008	1.5.2 - There is a summary in 1.5.1 when to suspect severe sepsis and categorisation of prognosis with high risk with NEWS >7, moderate risk 5-6 etc with highlighting of the fact that if a single parameter e.g. BP <30 this should be high priority – this seems to be practical and sensible	Thank you for your comment.
Newcastle upon Tyne Hospitals NHS Foundation Trust	Guideline	005	023	1.5.3 - Even in those with low NEWS need to consider severe disease in those with mottled or ashen appearance, non-blanching rash and cyanosis of skin lips or tongue – ashen is very non-descript and not entirely sure this should be in a guideline- I would strongly recommend removing. I would potentially add capillary refill reduced- this is certainly more objective than 'ashen' and there is some evidence base for cap refill with specificity for severe sepsis and correlation with lactate around 70-90% and sens	Thank you for your comment. As outlined on page 2 of the consultation draft of the guideline, areas shaded in grey indicate that this recommendation is outside the scope of this update of NG51 and we cannot accept comments on these areas which includes recommendations on 'Evaluating risk'.

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				40-50%. I would also clarify in those with concern about meningitis or meningococcal disease a full body examination for rash should be undertaken. In addition, examination for cellulitis and other sources of infection should be routine.	
Newcastle upon Tyne Hospitals NHS Foundation Trust	Guideline	005	029	1.5.4 - consider evaluating the persons risk of severe illness or death as being higher than suggested by NEWS2 if there is deterioration or lack of response- again this is vague and I would be keen for more specific e.g. I would be more concerned if lactate was not improving, acidosis was not improving, or BP was not improving with fluid resus than I would PR was still high as this is likely to be physiological and appropriate. I think there is evidence for this.	Thank you for your comment. As outlined on page 2 of the consultation draft of the guideline, areas shaded in grey indicate that this recommendation is outside the scope of this update of NG51, and we cannot accept comments on it.
Newcastle upon Tyne Hospitals NHS Foundation Trust	Guideline	006	012	1.5.6 is about recalculating NEWS 2 and this seems to be in line with wait NEWS2 would say. There is also a link to Statement_on_the_initial_antimicrobial_treatment_of_sepsis_V2_1022.pdf (aomrc.org.uk) this document is complex (excellent) and points out UK resistance patterns and also discusses the evidence for and against Abx within 1hr improving mortality. It is a good document but it is not very helpful in the context of the NICE guidance but the link here is a bit confusing and not needed should be in supporting documents at the end of the document.	Thank you for your comment. The Committee considered your comment but were in agreement that whilst recommendation on 'Evaluating risk: In acute hospital settings, acute mental health settings and ambulances' provides the specific actions required in terms of the recalculation and re-evaluation of NEWS2 score derived from the AoMRC statement, that it was prudent and helpful for the reader to provide a hyperlink to the AoMRC statement in the recommendation for those who may require it given the direct reference to it in the recommendation.
Newcastle upon Tyne Hospitals NHS Foundation Trust	Guideline	009	018	1.5 To 1.8 Is about transfer to hospital There does not seem to be a 1.9 ? why. Goes straight to 1.10 High risk from severe illness or death from sepsis	Thank you for your comment. This update under consultation is part of a series of updates of NG51. Recommendations that were out of scope for the update were removed from the consultation version of the guideline. These other recommendations will

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					be brought together with the recommendations that are the focus of this consultation and future consultations updates to form a comprehensive guideline on final publication..
Newcastle upon Tyne Hospitals NHS Foundation Trust	Guideline	010	002	1.10 Is about high risk of severe illness or death from sepsis- defined as NEWS2>7 (NEWS2 Chart 1_The NEWS scoring system_0_0.pdf) this is really the most severe you would probably need multiple parameters scoring >1- I generally look at whether an exarcerbation of COPD would get you Abx within 1hr and it wouldn't !! OR NEWS 5 or 6 with a single parameter of 3 contributing to this +/- any other clinical reason for concern The link here to antibiotic choice takes you to a part of the document that is not helpful and should take you to 1. 10.2- the link is pointless. Overall investigations at this point are very reasonable. I would always add that other appropriate cultures should be taken at this point e.g. throat swab but accept that this may not be appropriate to put in the guidelines here for the sickest patients. In addition there needs to be some consideration of source and source control even at an early stage e.g necrotising fasciitis.	Thank you for your comment. The hyperlink has now been updated to navigate the reader to the correct part of the guideline. Recommendations on 'Managing suspected sepsis in acute hospital settings: High risk of severe illness or death from sepsis: antibiotics has hyperlinks to recommendations on 'Initial investigations to find the source of infection' and links to recommendations on 'Finding the source of infection'. . The recommendations on 'When to suspect sepsis' outline the need to assess for source of infection when there is any suspected sepsis infection; the recommendations on 'Choice of antibiotic therapy for people with suspected sepsis outline when the source of infection is clear that existing local antimicrobial guidance should be used; and the recommendations on 'Finding the source of infection' outline the clinical examination for sources of infection which includes references to surgical drainage, consideration of patient history, urine analysis, chest x-ray, imagining of abdomen and pelvis. The committee did not feel that throat swabs were appropriate to recommend to those identified as being at high risk of severe illness or death from sepsis.
Newcastle upon Tyne Hospitals NHS	Guideline	011	003	**Section 1.10.2 is about antibiotics** This is excellent- in essence it is suggesting Abx within 1hr for thise with high risk (NEWS2 >7 OR >3 in one parameter with clinical	Thank you for your comment. We have amended all hyperlinks throughout the guideline.

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Foundation Trust				concern as per above) – excellent and fully supportive. The links to recommendation on finding source do not work	
Newcastle upon Tyne Hospitals NHS Foundation Trust	Guideline	011	015	1.10.3 this is about fluids, ionotropes and vasopressors- there is no mention of guidance on inotropes or vasopressors in this section and 1.10.4 repeats 1.10.3 apart from missing out BP <90	Thank you for your comment. Thank you for your comment. The area of intravenous fluids was outside the scope of this update of NG51. The recommendations on intravenous fluids and vasopressors will be considered and updated in the next update of NG51 as outlined in the scope for the next update here. .
Newcastle upon Tyne Hospitals NHS Foundation Trust	Guideline	013	001	1.11 is a section on moderate risk (NEWS 5 or 6 OR NEWS 1-4 with one parameter contributing 3 points. The recommendation here is to defer IV broad spectrum Abx for 3hrs unless NEWS2 of 5 or 6 with one parameter contributing 3 (as above)- I think this time is crucial the only caveat is I would be concerned if someone had a NEWS2 of 4 and this was mainly due to BP <90 in a younger person or had a high lactate with no clear cause this would make me worried that they are approaching shock but compensating and I would be keen for antbiotics to be given early.	Thank you for your comment. The guideline outlines throughout the need for clinical judgement when interpreting NEWS2 scores. The pre-amble to recommendations on 'Managing suspected sepsis in acute hospital settings' and those at 'Moderate risk of severe illness or death from sepsis' highlights the importance of 'any other clinical reasons for concern' when considering a NEWS2 score of 1 to 4. The scenario that you have outlined regarding concerns of a NEWS2 score of 4 and the impact of BP<90 or a high lactate with no clear cause in a younger person and the action you would take would fall into the use of clinical judgement when interpreting a NEWS2 score.
Newcastle upon Tyne Hospitals NHS Foundation Trust	Guideline	016	001	1.12 is a section on low risk NEWS 1-4 or NEW o and clinical concern. The recommendation is to gather information prior to giving antibiotics for up to 6hrs. Would be supportive of this. The only issue is that 1.12.3 repeats the moderate guidance	Thank you for your comment. The committee have considered your comment and highlighted that whilst there is some repetition between these recommendations, they do speak to different NEWS2 risk strata (low-risk and moderate risk of severe illness or death from sepsis). They considered combining these recommendations but felt that it is important that escalation pathways are clear, and that it would be better to keep

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					recommendations for low and moderate risk groups separate despite some elements of repetition across actions as you have identified. The committee highlighted that the recommendations align with the AoMRC statement, the RCPs guidance and their discussions regarding the action to take when considering the 3 points in one parameter for NEWS2 scores in those identified as either at low-risk or moderate risk of severe illness or death from sepsis.
Newcastle upon Tyne Hospitals NHS Foundation Trust	Guideline	019	004	Regarding the rest 1.14 does not provide any detailed information. There is advice on when to contact critical care. I think there needs to be a sentence here about assessing whether escalation is appropriate, and it should say that a consultant grade should review a deteriorating patient and assess suitability for escalation where there is no prior decision In practice patients do not need to be discussed with critical care if there has been a senior decision that escalation would be inappropriate. There needs to be some emphasis on the importance of finding source and considering if there needs to be source control, this could be in the section on deterioration after initial management. It would be important to outline that consideration needs to be given to TSS and sources of infection including tampons, cellulitis/necrotising fasciitis, deep seated infection- abscess and imaging for this where there is not a clear source of infection. There is a link to 'recommendation on finding a source of infection' and this does not work and I cannot find any recommendation within the guidance. I think this is	Thank you for your comment. As outlined on p.2 of the consultation draft of the guideline, the recommendation has been shaded in grey indicating that this recommendation is outside the scope of this update of NG51 and we cannot accept comments on this recommendation.. The comment made refers to 'when to contact critical care' it is unclear what recommendation or section of the guideline this refers to. We think you are referring to recommendations on 'Monitoring and escalation' . The prompt to refer to or discuss with a critical care specialist of team would be triggered if the individual who is at high risk of severe illness or death from sepsis does not respond within 1 hour of intravenous fluid resuscitation. It is also important to note that this recommendation is preceded by recommendations which instructs the recalculation of the NEWS2 score and where a person has been identified as being at high risk of severe illness or death from sepsis they would be seen by a clinician with core competencies in the care of acutely-ill patients (FY2

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				important and there needs to be some consideration of baseline Ix CXR, Throat examination, examination for rash including cellulitis, assessment for meningitis, abdominal, chest and heart examination and cultures should be taken according to suspected infection. I agree with the further statements- e.g. when to count from time zero should be when NEWS2 is calculated in emergency department, the only thing I would say is that there needs to be recommendation that observations are done quickly in anyone with suspected infection.	level or above) as a matter of urgency, undergone a venous blood test, received antibiotics and potentially intravenous fluids; and a discussion with a consultant would have been undertaken. All of these items would contribute to the clinical judgement made regarding a decision to refer to or discuss with a critical care specialist or team. This update under consultation is part of a series of updates of NG51. Recommendations that were out of scope for the update were removed from the consultation version of the guideline. These other recommendations will be brought together with the recommendations that are the focus of this consultation to form a comprehensive guideline on final publication.
NHS England	Guideline	General	General	We strongly suggest the document makes reference to making reasonable adjustments. This is a legal requirement for disability. as stated in the Equality Act 2010. Adjustments aim to remove barriers, do things in a different way, or to provide something additional to enable a person to receive the assessment and treatment they need. Possible examples include; taking blood samples by thumb prick rather than needle, providing a quiet space to see the patient away from excess noise and activity. Considering an individual's sensory needs such as lighting, offering early or late appointment, providing plain English or easy read information on the tests or diagnoses can all help support a better experience and therefore outcome from healthcare interactions. Reasonable adjustments can help to maximise engagement in physiological assessment for the purposes of NEWS2	Thank you for your comment. Making reasonable adjustments as required by the Equality Act is a statutory requirement and we expect that these are being implemented so this requirement would not need to be repeated in each individual NICE guideline and constituent recommendations. This update under consultation is part of a series of updates of NG51. Some of the recommendations are outside of scope for this update of NG51 but speak to the issue you raise. NG51 recommendations on 'When to suspect sepsis' outline the need to 'take into account that people with sepsis may have non-specific, non-localised presentations, for example feeling very unwell, and may not have a high temperature. The recommendations go on to say 'pay particular attention to concerns expressed by the person and

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				score calculation must be provided for people with a learning disability and autistic people. These include (but are not limited to): o Numbing cream to improve engagement with blood tests o Involving carers in assessments to better understand what is usual communication or level of function. o Asking whether a health and care passport (can be known as hospital passport) is available to also gain insight into a patient's baseline functioning Involve hospital learning disability liaison nurses (where available)	their family or carers, for example changes from usual behaviour and 'assess people who might have sepsis with extra care if they cannot give a good history (for example, people with English as a second language or people with communication problems).
NHS England	Guideline	General	General	We recommend including reference to the importance of Communication: Check with the person themselves, their family member or carer or in their hospital or communication passport for the best way to achieve this. Using simple, clear language, avoiding medical terms and 'jargon' wherever possible. Some people may be non-verbal and unable to describe verbally how they feel. Pictures may be a useful way of communicating with some people, but not all. Plain English text may be helpful for those who would not find pictures appropriate.	Thank you for your comment. The committee have considered your comment and agreed that the points you raised are considered in the guideline. Recommendations on 'Communicating and sharing information' outline that when sharing information with people with a suspected sepsis or their family or carers that NICE guidelines on patient experience in adult NHS services (CG138) and babies, children and young people's experience of health care (NG204) should be followed. CG138 and NG204 consider and make recommendation regarding the points you raise and make recommendations regarding shared decision making. This update under consultation is part of a series of updates of NG51. Recommendations that were out of scope for the update were removed from the

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					consultation version of the guideline. These other recommendations will be brought together with the recommendations that are the focus of this consultation to form a comprehensive guideline on final publication.
NHS England	Guideline	General	General	Please note recent LeDeR research: NHS England » Clinical guide for front line staff to support the management of patients with a learning disability and autistic people – relevant to all clinical specialties	Thank you for your comment. The committee agreed that people with learning disabilities are potentially at greater risk of sepsis. However, please note this update under consultation is part of a series of updates of NG51. Some of the recommendations are outside of scope for this update of NG51 but speak to the issue you raised regarding the more explicit consideration of people with a learning disability and/or autism. The guideline refers to the need for clinical judgement when interpreting NEWS2 scores and the recommendations refer to the need to consider specific characteristics and characteristics that may impact certain groups over others including people with learning disabilities or autism in recommendation on 'When to suspect sepsis'; 'Interpreting findings'; and when 'Communicating and sharing information'. In addition, the equality impact assessment (EIA) which has been undertaken, and its findings considered by the committee, throughout the development of this guideline identifies and considers people with learning disabilities and autism.
NHS England	Guideline	General	General	We know that avoidable mortality for people with a learning disability or autistic people is much higher than for the general population. There are a number of factors which mean the level of risk of severe illness or death from sepsis	Thank you for your comment. The committee agreed that people with learning disabilities and autism are potentially at greater risk of sepsis. This update under consultation is part of a series of

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				may be underestimated for people with a learning disability and autistic people. These include: o NEWS2 scores may be skewed for people with a learning disability as baseline scores may be different for people with a learning disability compared with the general population. o NEWS2 scores may be difficult to calculate for those people with a learning disability and autistic people that struggle to cope with physiological assessments such as blood pressure or blood tests. o There is a high risk of diagnostic overshadowing for people with a learning disability, which can lead to a high risk of premature, avoidable mortality. This means that symptoms of signs in presentation may be considered as part of their usual functioning or it is assumed that individuals would not tolerate/wish to undergo tests or procedures or it would not be in their best interests, but without a full Mental capacity act process being considered. Due to the risks outlined above, there is a strong argument for lowering the threshold for escalation for people with a learning disability and autistic people with suspected sepsis (e.g. alerting a consultant, refer/or discuss with a critical care specialist team, discuss with a senior clinical decision maker etc).	updates of NG51. Recommendations that were out of scope for the update were removed from the consultation version of the guideline. These other recommendations will be brought together with the recommendations that are the focus of this consultation to form a comprehensive guideline on final publication. The guideline refers to the need for clinical judgement when interpreting NEWS2 scores and the recommendations refer to the need to consider specific characteristics and characteristics that may impact certain groups over others including people with learning disabilities or autism when suspecting sepsis, when interpreting the findings of NEWS2 scores and when communicating and sharing information. Whilst these recommendations do not constitute a 'lowering of thresholds' the Committee acknowledged within the guideline the need to consider these factors when applying and interpreting NEWS2 scores and assessing a person with a suspected sepsis.
NHS England	Guideline	General	General	We recommend there is reference made to the importance of the Assessment of soft signs of deterioration is likely to	Thank you for your comment. The committee agreed that people with learning disabilities and

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				be vital for people with a learning disability and some autistic people, to gain sufficient insight into how the current presentation compares with baseline functioning.	autism are potentially at greater risk of sepsis. This update under consultation is part of a series of updates of NG51. Recommendations that were out of scope for the update were removed from the consultation version of the guideline. These other recommendations will be brought together with the recommendations that are the focus of this consultation to form a comprehensive guideline on final publication. The guideline refers to the need for clinical judgement when interpreting NEWS2 scores and the recommendations refer to the need to consider specific characteristics and characteristics that may impact certain groups over others including people with learning disabilities or autism in recommendations on 'When to suspect sepsis'; Interpreting findings' and 'When communicating and sharing information'. Whilst these recommendations do not constitute a 'lowering of thresholds' the Committee acknowledge within the guideline the need to consider these factors when applying and interpreting NEWS2 scores and assessing a person with a suspected sepsis.
NHS England	Guideline	General	General	We recommend reference to the importance of the Mental Capacity Act. People with a learning disability and autistic people should be assumed to have capacity in line with the principles of the Mental Capacity Act. Assess their capacity to make a decision about their treatment or care in line with the principle of the Mental Capacity Act in making appropriate efforts and adjustment to enable decision making wherever	Thank you for your comment. As following the Mental Capacity Act is a statutory requirement we expect that it is being implemented, so this requirement would not need to be repeated in each individual NICE guideline and constituent recommendations.

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				possible. Remember that capacity is time and decision-specific. Refer to the MCA Code of Practice for guidance.	
NHS England	Guideline	General	General	Where is the community/primary care guidance, many GPs and community settings use NEWS2. There needs to be the option to use similar criteria to that used in ambulances and hospitals. There will be push back from RCGP, but at the end of the day having dangerously low BP, high heart rate etc. has the same predictive value wherever the patient is.	Thank you for your comment. On page 1 of the guideline, it outlines that the guideline is for 'healthcare professionals working in primary, secondary and tertiary care'. Recommendations that were out of scope for the update were removed from the consultation version of the guideline. These other recommendations will be brought together with the recommendations that are the focus of this consultation to form a comprehensive guideline on final publication. Some of these recommendations refer to primary and community settings and address the issue you raised. Until NEWS2 is validated in primary care settings, the previous recommendations from NG51 still apply.
NHS England	Guideline	General	General	Recurrent presentations to healthcare facilities with the same acute illness is a severe sign, was this considered as a potential red flag.	Thank you for your comment. The Committee have considered your comment and have added to recommendations on Initial assessment and examination to include a reference to asking individuals about recent presentations of symptoms or signs that could indicate sepsis.
NHS England	Guideline	010	019	Blood cultures should signpost national guidance (2 bottles, properly filled, urgent carriage for incubation)	Thank you for your comment. As outlined on page 2 of the consultation draft of the guideline, areas shaded in grey are outside the scope of this update of NG51, and we cannot accept comments on these areas. Recommendations on 'Initial investigations to find the source of infection'. refer to the UK standards for microbiological investigations with reference to taking microbiological and blood samples and Committee

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					felt that this reference to the UK standards was appropriate.
NHS England	Guideline	015	019	This comes across as discharging home patients with a NEWS2 between 5-6 and suspected infection acutely. I'm sure that is not what you are trying to say.I would remove 19-23 it could be dangerously misinterpreted.	Thank you for your comment. The Committee have considered your comment and are in agreement. The recommendation has been removed. The committee created a new recommendation on 'Discharge' to be implemented later in the care pathway, at the time of discharge, which signposts to the section on information that should be provided at discharge. This includes safety netting advice to ensure people seek medical attention if they experience certain symptoms that may be indicative of suspected sepsis. This new recommendation was developed by consensus in response to (and in agreement with) stakeholder comments, recognising that for people assessed as being at moderate and low risk of severe illness or death from sepsis that the initial management period was not the right time to consider discharge.
NHS England	Guideline	018	006	Again, I would avoid commenting on discharging any patients. This is not the scope of sepsis guidance; and could be interpreted poorly.	Thank you for your comment. The Committee have considered your comment and are in agreement. The recommendation has been removed. The committee created a new recommendation on 'Discharge' to be implemented later in the care pathway, at the time of discharge, which signposts to recommendations on 'Information that should be provided at discharge'. This includes safety netting advice to ensure people seek medical attention if they experience certain symptoms that may be indicative of suspected sepsis.

Suspected Sepsis: recognition, diagnosis and early management (update)

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NHS England	Guideline	021	014	This lack of epi robustness and lack of a gold standard test, makes the argument for instead measuring the number of infection admissions where there is a 'suspicion of sepsis'. https://bmjopen.bmj.com/content/7/6/e014885 instead. I would advise using ONS death cert data for deaths. The data needs to come from administrative databases that are already collected.	Thank you for your comment. We assume that you are referring to research recommendation 1. As outlined on p.2 of the consultation draft of the guideline, research recommendation 1 has been shaded in grey indicating that this item is outside the scope of this update of NG51 and we cannot accept comments on this research recommendation. This research recommendation was developed in the first phase of the update of NG51 and has already been consulted on and is outside the scope of this update.
NHS England	Guideline	022	009	Sepsis cases are also missed in primary care and ED would be helped by better recording and response to abnormal NEWS2 scores. There is good evidence in ED of the predictive value of NEWS2 for death. There are multiple studies. There are less in primary care, but please be careful; the consequences of not reinforcing the value of physiology in primary care could lead to much unintended harm. NEWS2 does predict hospital outcomes in primary care https://bjgpopen.org/content/4/2/bjgpopen20X101071	Thank you for your comment. We assume that you are referring to research recommendation 3. As outlined on p.2 of the consultation draft of the guideline, research recommendation 3 has been shaded in grey indicating that this item is outside the scope of this update of NG51 and we cannot accept comments on this research recommendation. This research recommendation was developed in the first phase of the update of NG51 and has already been consulted on and is outside the scope of this update.
NHS England	Guideline	027	015	But single 3's have less predictive value on death and can lead to increased calls. Please reflect on https://www.rcplondon.ac.uk/file/8636/download and this article on NEWS2 and sepsis https://www.rcpjournals.org/content/clinmedicine/22/6/514 single 3 v aggregate https://pubmed.ncbi.nlm.nih.gov/37195103/	Thank you for your comment. As outlined on p.2 of the consultation draft of the guideline, this section has been shaded in grey indicating that this item is outside the scope of this update of NG51 and we cannot accept comments on this section.
NICE Medicines	Guideline	017	017	This is very difficult for users to follow what antibiotic to give. The rec says Give a broad spectrum antibiotic, in line with rec 1.10.2. Rec 1.10.2 repeats Give a broad spectrum	Thank you for your comment. As outlined on p.2 of the consultation draft of the guideline, this recommendation has been shaded in grey

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optimisation team				antibiotic… and also see 'choice of antibiotic'. Choice of antibiotic then tells you to review the choice when the causative organism is known. So none of this tells users which antibiotic to give – which I assume is ceftriaxone? It's very important from an AMR perspective, and because this is a serious condition, that users know which antibiotic to give.	indicating that this recommendation is outside the scope of this update of NG51.. The committee noted that this recommendation asks the reader to 'see recommendations on 'Choice of antibiotic therapy' which as you have outlined highlights the need to review antibiotic choice and use a narrower-spectrum antibiotic if appropriate. The committee have now amended the positioning of recommendations so that advice on antibiotic choice is provided.
Nottingham University Hospitals NHS Trust (NUH)	Algorithm	Acute healthcare settings	Moderate and low risk	Not sure re wording about suggest we consider discharging the patient if safe to do so once we have identified the definitive condition? The writing here just seems odd – we have gone to this algorithm with a new NEWS2 5-6 and suspected infection – it would be a rarity to discharge someone home with a NEWS2 5-6, even if managed the condition.	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope. In response to your comment, the Committee agreed. Reference to discharge in recommendations regarding NEWS2 scores of 5 to 6 have been removed. The committee created a new recommendation to be implemented later in the care pathway, at the time of discharge, which signposts to the section on 'Information that should be provided at discharge. This includes safety netting advice to ensure people seek medical attention if they experience certain symptoms that may be indicative of suspected sepsis. .
Nottingham University Hospitals NHS Trust (NUH)	Algorithm	Acute healthcare settings	High risk	Time zero – is not "the first set of obs" in ward or ED – it is the time when the first NEWS2 trigger occurs where infection suspected as the cause.	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope. In response to your comment, to guide the appropriate timing for delivering antibiotics, the committee discussed what constitutes time zero. After careful

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					consideration, they agreed to define it as 'a first NEWS2 score calculated on initial assessment in the emergency department or on ward deterioration' and accompanied by suspected or confirmed infection. This is in line with the AoMRC report.
Nottingham University Hospitals NHS Trust (NUH)	Algorithm	Acute healthcare settings	High risk	High risk pathway says give Abs <1hr, then see what lactate and systolic BP is, then a further box to decide whether to consider giving, or to give Abs…what is the first box of 'give Abs <1hr within first hour of…' for?? Specify first NEWS2 score that led to risk stratification for sepsis? Would be helpful to include NEWS2 scores in risk headings on page 6.	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope.
Nottingham University Hospitals NHS Trust (NUH)	Algorithm	Acute healthcare settings	Moderate and low risk	Why has signs of meningococcal disease been given as the example…odd compared to those suggested by AMRoC	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope.
Nottingham University Hospitals NHS Trust (NUH)	Algorithm	Acute healthcare settings	High risk	Give antibiotics within one of first NEWS2 score – not when meets criteria?	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope. In response to your comment regarding antibiotics. Recommendations on 'Managing suspected sepsis in acute hospital settings:1 or more high risk criteria – Assessment, blood tests and antibiotics' in the guideline specifies within 1 hour of identifying that they meet any high risk criteria.

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Nottingham University Hospitals NHS Trust (NUH)	Algorithm	Acute healthcare settings	Moderate risk	Moderate arm only leads to high risk in flow chart if raised lactate or AKI not deteriorating condition, raised NEWS2 etc. Would it be useful to include clinical judgement box from Low risk group in moderate too?	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope.
Nottingham University Hospitals NHS Trust (NUH)	Algorithm	Acute healthcare settings	Moderate risk	'clinician with core competences in the care of the acutely ill?? How are clinicians aware of who has core competences? Should this read doctor at registrar level.	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope. In terms of your comment, the Committee discussed your comments and have amended the recommendation to refer to 'a clinician with core competencies in the care of acutely ill patients (FY2 level or above). .
Nottingham University Hospitals NHS Trust (NUH)	Algorithm	Acute healthcare settings		Is there any scope to include relative worry or concern especially regarding altered mental status in the high, moderate and low risk.	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope. In terms of your comment, this is covered in the recommendation on 'Evaluating risk level' and outlines that for anyone below high risk, healthcare professionals should use clinical judgement to decide risk level if there is an additional cause for concern. This is in line with recommendations on 'Evaluating risk level' :In acute hospital settings, acute mental health settings and ambulances' in the guideline. It was also noted that recommendations on 'Interpreting findings: Confusion, mental state and cognitive state in suspected sepsis' which were outside the scope this update of NG51 provide advice regarding the consideration of 'confusion,

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					mental state and cognitive state in suspected sepsis.
Nottingham University Hospitals NHS Trust (NUH)	Algorithm	004		For moderate risk, why question whether the patient is 16 years?	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope
Nottingham University Hospitals NHS Trust (NUH)	Algorithm	006		In 'high-risk' column, 'urgently' misspelt. 'Obtain venous blood, and include tests for:'	Thank you for your comment and observation. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope
Nottingham University Hospitals NHS Trust (NUH)	General	General	General	Clearly there has been a lot of work here with regards to the evidence review, and writing the guideline. Unfortunately it just has not translated into the sensible, unifying, credible and easy to read guideline update that was anticipated. From previous comments, again these guidelines seem to have shoehorned sepsis into NEWS2 protocols. The guideline is disjointed and very difficult to read and this makes it difficult to operationalise and standardise let alone measure compliance or any potential future difference. Furthermore it leaves the physician vulnerable to criticism should there be an untoward outcome from sepsis with regards to defending medical practice.	Thank you for your comments. NICE recognises this is a complex guideline and has worked closely with the committee to make the pathway of care as clear as possible. NICE is also developing algorithms to accompany the full guideline which, when published, aim to aid clinicians when implementing the recommendations.
Nottingham University Hospitals NHS Trust (NUH)	General	General	General	There are sections of the guideline that have been marked "to be completed awaiting guideline content" so it is difficult to support this guideline revision when it is presented as incomplete.	Thank you for your comment. This update under consultation is part of a series of updates of NG51. Recommendations that were out of scope for the update were removed from the consultation version of the guideline. These other recommendations will be brought together with the recommendations that

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					are the focus of this consultation to form a comprehensive guideline on final publication.
Nottingham University Hospitals NHS Trust (NUH)	General	General	General	In summary, the algorithm is good, the guideline is very confusing and done piecemeal and hard to read (and can't comment on 2023(a) again. In new 2023b can't see anything too controversial from micro point of view apart from how the Ambulance bit will get interpreted – concern will get antibiotics in the ambulance and then rush is no longer there to transfer in and sepsis management isn't just giving timely antibiotics !	Thank you for your comment. This update under consultation is part of a series of updates of NG51. Recommendations that were out of scope for the update were removed from the consultation version of the guideline. These other recommendations will be brought together with the recommendations that are the focus of this consultation to form a comprehensive guideline on final publication. The committee considered your comments and did not feel a change was necessary. The recommendation highlighted is about 'Managing suspected sepsis outside acute hospital settings'. Prior to ambulance notification the people in question would be at high risk of severe illness or death from sepsis and the use of antibiotics by ambulance services would only occur if transfer time to an acute hospital setting is potentially >1 hour and seeks to manage the condition whilst awaiting transfer.
Nottingham University Hospitals NHS Trust (NUH)	Guideline	006	012	1.5.6 - NICE says to use AoMRC guideline – why not just not have NICE CG51?	Thank you for your comment. The Committee outlined that recommendations on 'Evaluating risk: In acute hospital settings, acute mental health settings and ambulances' do not state to use AoMRC but refers to it whilst also providing the details of what should be considered from the statement in the recommendation. The Committee agreed that it was important to make reference to the AoMRC statement here for consistency for healthcare professionals implementing the recommendation.

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Nottingham University Hospitals NHS Trust (NUH)	Guideline	007	004	1.6.3 - Why is NEWS2 not used here, it was understood that NEWS2 would have been a universal language for aggregate physiology scores, it is accepted that the risk of sepsis is increased in those with mental ill heath due to delayed presentation	Thank you for your comment. These recommendations are about 'When to transfer immediately to acute hospital settings' from other settings. In the case of recommendations on 'Managing suspected sepsis outside acute hospital settings: In mental health settings' this would be in acute mental health settings and those requiring 'transfer immediately' are outlined as being at 'high risk of severe illness or death from sepsis' in line with local emergency protocols on treatment and ambulance transfer. It was unclear to the Committee to what extent NEWS2 is being used in these settings and to suggest that they do use it without that knowledge was seen to be unhelpful. It was considered more appropriate to refer to high risk of severe illness or death from sepsis as this could be defined via NEWS2 if used or via a local mechanism for assessment.
Nottingham University Hospitals NHS Trust (NUH)	Guideline	008	014	1.7.3 - 'Ambulance crews should strongly consider early administration of (intravenous) antibiotics in cases of high-risk sepsis, and are encouraged to seek senior support to achieve this, if required.' Reword suggestion.	Thank you for your comment. The Committee considered your comment and the recommendations on 'Managing suspected sepsis outside acute hospital settings: Managing the condition while awaiting transfer' have been amended to specify paramedics who are thinking about giving antibiotics should follow local guidelines. The recommendation is now preceded by a bullet point that highlights the need for ambulance services to consider whether they need to put mechanisms in place to be able to give antibiotics to people at high risk of severe illness or death from sepsis if antibiotics have not been given before by a GP.

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Nottingham University Hospitals NHS Trust (NUH)	Guideline	009	006	1.8.3 - Unsure whether ambulance staff can be expected to make a diagnosis? If this section isn't referring to ambulance staff - need to specify who this expectation refers to.	Thank you for your comment. Recommendations on 'Managing suspected sepsis outside acute hospital settings: Managing the condition while awaiting transfer' 1focuse on when immediate transfer is not required in acute mental health settings. It does not refer to ambulance staff.
Nottingham University Hospitals NHS Trust (NUH)	Guideline	009	011	1.8.4 - NEWS2 should indeed be used in women whom are or have recently been pregnant, as it is universal, the definition for pregnancy or recently pregnant should be here rather than as a footer for this guideline to be clinically useful. If NEWS2 is not going to be used then an alternative pathophysiology scoring system should be suggested here rather than leaving a blank space.	Thank you for your comment. As outlined in the scope and the title of the guideline this update focuses on people aged 16 or over who are not and have not recently been pregnant. People who are or who have recently been pregnant may be considered in future updates of NG51.
Nottingham University Hospitals NHS Trust (NUH)	Guideline	010	013	1.10.1 - "Senior decision maker" what are the core competencies of care of the acutely ill patient? This should be specified, or just say ST3 doctors, noting that sepsis is difficult to diagnose, physiology difficult to interpret and respond to, and using words like "clinicians" or "prescribers" would perhaps result in response from staff without the necessary knowledge, skills and attitudes to deliver care appropriately. For paediatrics this is specified as ST4, but adults the ability to have a registrar review within 30 minutes is operationally a huge challenge. AMRoC are very clear about the level of doctor / clinician required – but this NICE guidance is very unclear regarding expectation – and does not appear to align with AMRoC. I suggest a junior doctor with competence / experience would suffice for initial review of patient – with senior input sought if no improvement or further deterioration.	Thank you for your comments. The Committee discussed your comments and have amended the recommendation to refer to 'a clinician with core competencies in the care of acutely ill patients (FY2 level or above).

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Nottingham University Hospitals NHS Trust (NUH)	Guideline	010	018	1.10.1 - I think addition of 'consider arterial blood gas analysis if concerns around hypoxaemia or hypercapnia'	Thank you for your comment. Recommendations on 'Managing suspected sepsis in acute hospital settings: High risk of severe illness or death from sepsis outlines that a venous blood test should be undertaken and that blood gas including glucose and lactate measurements could be assessed. The committee considered the point you raised but were in agreement that there was no need to add 'consider arterial blood gas analysis if concerns around hypoxaemia or hypercapnia' to the non-exclusive list of tests/measures and agreed that not having it on the list did not preclude its use if clinical judgement dictated it.
Nottingham University Hospitals NHS Trust (NUH)	Guideline	010	019	1.10.1 - I would query usefulness of stating blood cultures before any other blood test on the list.	Thank you for your comment. The recommendation does not present a prioritised list of tests and states "carry out a venous blood test" within which you could test for blood gas, blood culture, full blood count and so forth. No evidence was identified that suggested an order in which to undertake tests.
Nottingham University Hospitals NHS Trust (NUH)	Guideline	011	003	1.10.2 – Very little detail on antibiotics which are the cornerstone of treating sepsis.	Thank you for your comment. As outlined on page 2 of the consultation draft of the guideline, areas shaded in grey are outside the scope of this update of NG51, and we cannot accept comments on these areas which includes recommendations on 'Antibiotics'.
Nottingham University Hospitals NHS Trust (NUH)	Guideline	011	015	1.10.3 - No detail on the fluid bolus, could well be worth a suggested volume, and infusion time, and rationale for giving eg fluids to restore oxygen delivery by correcting relative hypovolaemia from vasodilation and increase ventricular pre-load, reasonable to give salt rich fluid 500ml over 10-15 minutes if no risk factors for heart failure, or 250ml if there is…	Thank you for your comment. The area of intravenous fluids was outside the scope of this update of NG51. The recommendations on intravenous fluids and vasopressors will be considered and updated in the next update of NG51 as outlined in the scope for the next update here.

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Nottingham University Hospitals NHS Trust (NUH)	Guideline	011	017	1.10.3 - reword 'give intravenous fluid bolus as soon as possible, but within 1 hour of...'	Thank you for your comment. The area of intravenous fluids was outside the scope of this update of NG51. The recommendations on intravenous fluids and vasopressors will be considered for update in the next update of NG51 as outlined here.
Nottingham University Hospitals NHS Trust (NUH)	Guideline	012	004 – 007	1.10.4 - is this section required in addition to 1.10.3? Is it referring to maintenance IV fluid not bolus? If so, it might be more clear to state 'if lactate is less than 2mmol/L...	Thank you for your comment. The area of intravenous fluids was outside the scope of this update of NG51. The recommendations on intravenous fluids and vasopressors will be considered for update in the next update of NG51 as outlined here.
Nottingham University Hospitals NHS Trust (NUH)	Guideline	013	010	1.5.4 - State recalculation of NEWS2 dependent on minimum frequency of NEWS2 guideline (or is this different across trusts/ providers?) and level of clinical concern. I also think likely able to combine 1.5.5 and 1.5.6 - could easily combine I think...	Thank you for your comment. As outlined on page 2 of the consultation draft of the guideline, areas shaded in grey indicate that this recommendation is outside the scope of this update of NG51, and we cannot accept comments on these areas which include recommendations on 'Evaluating risk level: In acute hospital settings, acute mental health settings and ambulances' . For clarification the recommendations your comment refers to are linked but speak to different items and the committee felt that combining them would not aid clarity.
Nottingham University Hospitals NHS Trust (NUH)	Guideline	013	016	1.11.1 - again, consider blood cultures first on this list (HF perspective!)	Thank you for your comment. The recommendation does not present a prioritised list of tests and states that to "carry out a venous blood test" within which you could test for blood gas, blood culture, full blood count and so forth. The committee noted that recommendations on 'Managing suspected sepsis in acute hospital settings' (which was outside the scope of this update of NG51) highlights that

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					'microbiological and blood samples' should be taken before giving antimicrobials in line with the UK standards for microbiological investigations. ..
Nottingham University Hospitals NHS Trust (NUH)	Guideline	013	018	1.10.6 - Add in monitoring re-check lactate (eg via VBG)	Thank you for your comment. The committee considered your comment and did not think that a re-checking of lactate via venous blood gas as part of this recommendation needed to be specified. .
Nottingham University Hospitals NHS Trust (NUH)	Guideline	014	002	1.11.2 - I think possibly useful to bold risk categories throughout document - although there are titles present for high, moderate, low etc., they all span multiple pages and could easily be missed if accessing in a rush. Another idea to support HF when reading would be to colour the background of the pages related to high-risk red, moderate risk amber, etc. for quick visual confirmation of section.	Thank you for your comment. The guideline has been written in line with NICE style guide and accessibility guidance which is applied to all NICE produced products.
Nottingham University Hospitals NHS Trust (NUH)	Guideline	014	005	1.11.2 - Consider in guideline and algorithm replacing the word deferring to delaying	Thank you for your comment. As outlined on page 2 of the consultation draft of the guideline, areas shaded in grey indicate that this recommendation is outside the scope of this update of NG51, and we cannot accept comments on these areas which include this recommendation.
Nottingham University Hospitals NHS Trust (NUH)	Guideline	015	018	1.11.6 - I don't find it easy to understand what is meant by 'definitive condition' in the context of a sepsis guideline. I wonder whether 'manage the underlying infection' might be clearer.	Thank you for your comment. The committee discussed your comment but were in agreement to keep the term 'definitive condition' recognising that not all cases of suspected sepsis could be caused by an underlying infection. The reference to 'definitive condition' has been moved to a new recommendation focused on information provision before discharging people who have been assessed for suspected sepsis. This new recommendation was developed by consensus in response to (and in agreement with) stakeholder comments, recognising that for people assessed as

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					being at moderate and low risk of severe illness or death from sepsis that the initial management period was not the right time to consider discharge.
Nottingham University Hospitals NHS Trust (NUH)	Guideline	018	011	1.13 - is discharge advice required here too (as per low-risk)?	Thank you for your comment. The Committee have considered the feedback from stakeholders about discharge and have removed the current recommendation on discharge and created a new recommendation to be implemented later in the care pathway, at the time of discharge, which signposts to recommendations on 'Information that should be provided at discharge'. This includes safety netting advice to ensure people seek medical attention if they experience certain symptoms that may be indicative of suspected sepsis.
Nottingham University Hospitals NHS Trust (NUH)	Guideline	019	003	1.14 - Definition of Sepsis - Sepsis is a life threatening organ dysfunction due to a dysregulated host response to infection. But infection is confirmed *or suspected* presence of pathogenic microorganisms in a morally sterile location, so therefore the term suspected sepsis contains a suspicion of a suspicion which is suspicious and unnecessary. Consider changing 'suspected sepsis' to 'sepsis'	Thank you for your comment. We think your comment refers to 'Terms used in this guideline' and not the recommendation outlined.. As outlined on p.2 of the consultation draft of the guideline, the definition of sepsis in the 'Terms used in this guideline' section has been shaded in grey indicating that these items are out of the scope of this update of NG51 and we cannot accept comments on this section of the guideline. This definition was developed in the first phase of the update of NG51 and has already been consulted on and is outside the scope of this update.
Nottingham University Hospitals NHS Trust (NUH)	Guideline	019	017	1.14 - might be best to state 'fluid resuscitation'	Thank you for your comment. As outlined on p.2 of the consultation draft of the guideline, this recommendation has been shaded in grey indicating that this recommendation is outside the scope of this update of NG51 and we cannot accept comments on this recommendation.

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Nottingham University Hospitals NHS Trust (NUH)	Guideline	020	013	confirm 'levels'... might be best to state 'pre-pregnancy baseline'?	Thank you for your comment. When developing this definition of 'recently pregnant' the Committee established that what constitutes pre-pregnancy levels is individual, widely variable and is dependent on several factors that have not yet been established more widely. In conclusion attempting to go any further than what is outlined was not felt to be useful in the context of the guideline being updated and the Committee agreed that no further change was to be made.
Nottingham University Hospitals NHS Trust (NUH)	Guideline	021	024	Notes no evidence for NEWS2 available so why is there such reliance on this scoring system to literally underpin the whole guideline, would it be better to continue with current physiological criteria and investigate NEWS2 before updating the guideline as such.	Thank you for your comment. We assume that you are referring to research recommendation 2. As outlined on p.2 of the consultation draft of the guideline, research recommendation 2 has been shaded in grey indicating that this item is outside the scope of this update of NG51 and we cannot accept comments on this research recommendation. This research recommendation was developed in the first phase of the update of NG51 and has already been consulted on and is outside the scope of this update. NEWS2 has been endorsed by NHS England and also the AoMRC and one of the drivers for the update to NG51 was to bring the guideline in line with current practice.
Nottingham University Hospitals NHS Trust (NUH)	Guideline	027	021	'by definition sepsis'	Thank you for your comment. It is unclear what your comment is referring to or what action you would like us to consider.
Nottinghamshire Healthcare	Guideline	008	006	1.7.2 - The recommendation states: *In remote and rural locations where transfer time to emergency department is*	Thank you for your comment. As outlined on page 2 of the consultation draft of the guideline, areas

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NHS Foundation Trust				*routinely more than 1 hour, ensure GPs have mechanisms in place to give antibiotics to people with high risk criteria in pre-hospital settings*. There is no mention of settings where GP access is not available. This needs to be changed to 'appropriately trained clinician to reflect all clinical settings.	shaded in grey are outside the scope of this update of NG51, and we cannot accept comments on these areas which includes the recommendations on 'Managing suspected sepsis outside acute hospital settings: Managing the condition while awaiting transfer'. However, we have logged this for consideration in a future update of the guideline.
Royal College of Emergency Medicine	Guideline	004	002	We would welcome additional description in the text box regarding one of NICE's key documents and an explanation of how this might apply to this topic (Sepsis). We feel this overarching guidance on shared decision making is often overlooked despite it's significant merits. Eg. …..This guidance is of particular value when undertaking conversations with patients about escalation of care and ensuring their wishes are respected eg. completion of RESPECT forms.	Thank you for your comment. The text box your refer to is found in all NICE guidelines and is added to ensure that people are aware they have the right to be involved in discussions and make informed decisions about their care. The guideline makes specific reference to the point you raised within recommendations on 'Communicating and sharing information', which outlines that when sharing information with people with a suspected sepsis or their family or carers that NICE guidelines on patient experience in adult NHS services (CG138) and babies, children and young people's experience of health care (NG204) should be followed. CG138 and NG204 consider and make recommendation regarding the points you raise and make recommendations regarding shared decision making.
Royal College of Emergency Medicine	Guideline	004	011 – 012	Please consider removing the words 'women and' they are unnecessary; I am sure the intention is not to suggest NEWS2 should only be used for males.	Thank you for your comment. We have assumed this refers to the box of text on p.5. This has now been amended in line with your comment.
Royal College of Emergency Medicine	Guideline	009	018	Please consider removing the words 'women and' they are unnecessary; I am sure the intention is not to suggest NEWS2 should only be used for males.	Thank you for your comment. The wording has been changed in line with your comment.

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Royal College of Emergency Medicine	Guideline	010	027	'discuss with a consultant' there is no indication as to the timing eg. in the event of no response to initial therapy. There is no reference to the expected outcome or rationale for this discussion at this stage	Thank you for your comment. The Committee discussed your comment and have amended the recommendation which now refers to the use of 'clinical judgement to decide whether to discuss with a consultant' in recognition of the importance of clinical judgement in decision making, patient needs and the balance of consultant resource and need.
Royal College of Emergency Medicine	Guideline	011	017	'fluid bolus' is undefined in terms of volume and there may be merit in highlighting both the need to be cautious in those patients with poor cardiac function as well highlighting the need to be aggressive 30ml/kg in those with presumed 'septic shock'. The impact is likely to be multiple unnecessary calls to critical care teams if 'fluid bolus' is not qualified.	Thank you for your comment. The area of intravenous fluids was outside the scope of this update of NG51. The recommendations on intravenous fluids and vasopressors will be considered for update in the next update of NG51 as outlined here.
Royal College of Emergency Medicine	Guideline	013	022 – 024	There is an opportunity to simply the guideline and improve compliance by amalgamating moderate and severe categories guidance with the only difference between the two being the antibiotic target and both requiring a senior clinical decision maker for the assessment.	Thank you for your comment. The Committee considered your suggestion but agreed to retain the existing format. They felt that merging the high and moderate risk recommendations may reduce the clarity of advice for busy clinicians when implementing the recommendations.
Royal College of Emergency Medicine	Guideline	015	008	The rationale for introducing AKI as a modifier in the categorisation of moderate and severe sepsis is appreciated, however given the strict definition of AKI this does not lend itself particularly well to clinical settings such as the emergency department particularly with time based measurements (eg.urine output over 6 hours) this may lead to an increased in patient admissions, prolonged stays in EDs, delayed discharges	Thank you for your comment. The recommendation outlines to treat moderate risk of severe illness or death from sepsis as high risk if either lactate is over 2 mmol/litre or there is evidence of acute kidney injury (AKI) making AKI one of two measure that would trigger a raising of risk strata. The recommendation does not suggest a time limit within which presence or absence of an AKI is confirmed but when test results are available which could be from previous medical notes or tests or when from the venous blood tests undertaken as

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					part of recommendations on 'Managing suspected sepsis in acute hospital settings' in those at 'Moderate risk of severe illness or death from sepsis'. .
Royal College of Emergency Medicine	Guideline	016	010	Clinician review within 1 hour for patients with a NEWS2 score of less than 4 seems at odds with the NEWS2 escalation chart and likely to be extremely challenging in most emergency departments	Thank you for your comment. We think your comment refers to recommendations on 'Managing suspected sepsis in acute hospital settings' in those at 'Low risk of severe illness or death from sepsis' which now refers to arranging for a registered health practitioner review within 1 hour of the person being assessed as at low risk. The Committee has reviewed your comment in light of the AoMRC statement on the initial antimicrobial treatment of sepsis (2022) which outlines that a low NEWS2 score (1-4) should prompt assessment by a competent registered nurse or equivalent within 1 hour who should decide whether a change to frequency of clinical monitoring or an escalation of clinical care is required. As a registered healthcare practitioner could include a nurse, the committee are satisfied that it does not contradict the AoMRC statement.
Royal College of Nursing (RCN)	Guideline	General	General	We agree and welcome the use of NEWS2 for assessment of patients with suspected sepsis for the intended group of patients outlined.	Thank you for your comment.
Royal College of Nursing (RCN)	Guideline	012	011	Point 1.10.6: Critical care outreach should have been made aware as soon as the NEWS is calculated and not wait after the fluid challenge. In fact NEWS >7 warrants Urgent or emergency response.	Thank you for your comment. The committee considered this and made some amendments to the recommendation to specify that if a person who is at high risk of severe illness or death from sepsis does not respond with 1 hour of any intervention that the senior clinical decision maker attends in person, that a referral to or discussion with a critical

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					care specialist or team should occur and the responsible consultant should be informed. .
Royal College of Nursing (RCN)	Guideline	014	002	Point 1.11.2: Welcome emphasis on gathering information for a more specific diagnosis and deferring administration of antimicrobial for up to 3 hours for moderate risk group.	Thank you for your comment
Royal College of Nursing (RCN)	Guideline	023	General	We welcome that the guideline is aligned with AoMRC guidance which RCN was part of its development.	Thank you for your comment.
Royal College of Pathologists (RCPath)	Algorithm	General	General	I welcome the algorithms as a separate document as this makes them much clearer. The colour grading is extremely helpful and sends a consistent message.	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope
Royal College of Pathologists (RCPath)	Algorithm	006		All boxes have "start looking for the source of infection" as the last line in the first box. This should be followed by and achieve source control as soon as possible if able to as this will reduce the mortality associated with sepsis. Reitz et al (Jama Surg 2022 157 (9): 817-826) showed that source control within 6 hours of sepsis onset was associated with a 29% reduction in the risk-adjusted odds of 90-day mortality compared with delayed source control.	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope The committee considered your comment and revised the new recommendation on involving the surgical team early if surgical or radiological intervention is suitable for the source of infection recommendation to say that action should be taken as soon as possible and have amended the algorithm to reflect this. The committee felt that the decision to undertake an intervention for source control would most likely be dependent on the patient in front of them and specifying a timeframe was not in alignment with that. The committee

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					preferred to recommend that source control be achieved as soon as is possible.
Royal College of Pathologists (RCPath)	Guideline	General	General	We welcome this update and are pleased to see the stratification of severity according to the NEWS scores with the caveat of the importance of the clinical condition.	Thank you for your comment
Royal College of Pathologists (RCPath)	Guideline	General	General	The guideline is much more comprehensive than the previous guidelines and the rationale for antimicrobial administration timeframes clear and welcomed.	Thank you for your comment
Royal College of Pathologists (RCPath)	Guideline	General	General	The guideline has a lot of hyperlinks which is understandable given the length of the document, but which would be hard to read if looking for advice in a hurry. The algorithms and Trust specific sepsis tools should help with this if available.	Thank you for your comment.
Royal College of Pathologists (RCPath)	Guideline	011	003 – 009	It is disappointing that "broad spectrum" has not been further defined; in practice many non-infection specialists will give what they believe is a "stronger" antibiotic namely piperacillin tazobactam or meropenem which may then be difficult to narrow down as looking for the source of infection is often neglected. This could contribute to antimicrobial resistance (AMR) and/or acquisition of healthcare associated infection such as *Clostridioides difficile*.	Thank you for your comment. As outlined on page 2 of the consultation draft of the guideline, areas shaded in grey are outside the scope of this update of NG51, and we cannot accept comments on these areas which includes recommendations on 'Antibiotics'. NG51 has recommendations on Antibiotic treatment in people with suspected sepsis and outlines for people "who need an empirical intravenous antimicrobial for a suspected infection but who have no confirmed diagnosis, use an intravenous antimicrobial from the agreed local formulary and in line with local (where available) or national guidelines".
Royal College of Pathologists (RCPath)	Guideline	011	011 – 013	It appears as if there is a hyperlink for "recommendations on finding the source of infection" but this does not work. It is disappointing that there is not a separate section on source control; if source control is not managed then antibiotic along may not be successful in treating the sepsis. I would like to see a separate section on source	Thank you for your comment. The recommendations under consideration here are part of a series of updates of NG51. There are source control recommendations in NG51 and the hyperlink will link to these when this update is brought together with existing NG51

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				control as it is an important part of the management of sepsis.	recommendations. Recommendations on 'When to suspect sepsis' outline that assessment of people with any suspected infection should seek to identify the possible source of infection. Recommendations on 'Initial assessment and examination' goes on to outline that as part of the initial assessment thorough clinical examinations should look for sources of infection, including sources that might need drainage or other interventions. Recommendations on 'Initial investigations to find the source of infection' highlight the importance of starting to look for the source of infection and recommendation on 'Choice of antibiotic therapy for people with suspected sepsis' highlights the role of a confirmed source of infection in directing antibiotic review and choice. All of these recommendations hyperlink to recommendations on 'Finding the source of infection' which is focused on finding the source of infection, and the committee expanded the recommendation to highlight that the relevant surgical team should be involved early on if surgical or radiological intervention is suitable for the source of infection.
Royal College of Pathologists (RCPath)	Guideline	019	007 – 011	This is quite short; while this is not the initial management of sepsis it is important to prevent AMR. There should be at least a reference to following local antimicrobial guidelines according to the source, iv to oral switch, and de-escalation of treatment.	Thank you for your comment. As outlined on p.2 of the consultation draft of the guideline, this recommendation has been shaded in grey indicating that this recommendation is outside the scope of this update of NG51 and we cannot accept comments on this recommendation..

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Royal College of Physicians (RCP)	Evidence review	022	010	We suggest review of the following evidence which looks at the distribution of NEWS2 values in primary care Scott, L.J., Redmond, N.M., Tavaré, A., Little, H., Srivastava, S. and Pullyblank, A., 2020. Association between National Early Warning Scores in primary care and clinical outcomes: an observational study in UK primary and secondary care. *British Journal of General Practice*, *70*(695), pp.e374-e380.	Thank you for your comment and sharing this evidence. In early 2023, NICE 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 aim of this update was to align the risk stratification system in the recommendations on early non-antibiotic management to the NEWS2 risk strata. We have checked the study you provided and it was identified but excluded as it focused on critically ill patients and not sepsis..
Royal College of Physicians (RCP)	Guideline	General	General	CKD 4 and 5 patients should be considered as the same risk as AKI since sepsis is likely to precipitate AKI with the associated increased risk. The presence of a dialysis catheter (or any other central venous catheter raises the possibility of sepsis from a line infection and blood cultures should be taken from the catheter as well as peripheral blood cultures. The development of AKI requires an early referral/escalation to a renal team.	Thank you for your comments. This area was out of scope for this update which aimed to align the risk stratification system in the recommendations on early non-antibiotic management to the NEWS2 risk strata. We have logged this area for further consideration in any future update to the guideline.
Royal College of Physicians (RCP)	Guideline	004 – 005	013	1.5.1 - **Evaluation**: Omission of importance of **travel history** in presentation of acutely unwell patients with high NEWS2 scores presenting as sepsis (to reduce the chance that severe malaria or other serious imported illness is overlooked). Could add "<u>Consider could this be malaria or other imported illness?</u> (every patient with severe malaria presents as severe sepsis)	Thank you for your comment. As outlined on page 2 of the consultation draft of the guideline, areas shaded in grey indicate that this recommendation is outside the scope of this update of NG51 and we cannot accept comments on these areas which includes recommendations on 'Evaluating risk'. However, the recommendations on 'Evaluating risk: In acute hospital settings, acute mental health settings and ambulances' includes reference to

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				1.5.1 In people aged 16 or over, grade risk of severe illness or death from* *sepsis using the person's:* *history ,* *physical examination results (especially symptoms and signs of 1 infection)* *NEWS2 score.* *[2023a]***	'history', which could include travel history, as well as physical examination results and NEWS2 scores (and their interpretation within the context of the persons' underlying physiology and comorbidities) as being criteria used to grade risk of severe illness or death from sepsis.
Royal College of Physicians (RCP)	Guideline	005 017 023	023 – 027 001 026 – 028	**Caveats about specific presentations**: mottled skin etc (see two sections below) are heavily focussed on meningococcal disease but such skin changes are <u>not specific to that infection</u>, and are perhaps more relevant to e.g. invasive group A streptococcal infection that results in far more deaths than meningococcal disease?- (~500 in the last year). Page 5. There is an omission here, which is <u>that severe soft tissue pain that is greater than might be expected</u> should be added to this list because necrotising fasciitis in adults can present like this, sometimes without obvious skin changes at first. Although rare, this is life threatening and early recognition saves lives. Could add <u>"Severe soft tissue pain that is greater than expected"</u> as one of the bullet points listed in section 1.5.3 Page 17. What about the patient with a non-blanching rash and low NEWS2 and antibiotics? Would usually expect NEWS2 to be raised but if a young person with 'usual' low BP and low pulse rate they may move into normal ranges when become they become unwell	Thank you for your comment. As outlined on page 2 of the consultation draft of the guideline, areas shaded in grey indicate that this recommendation is outside the scope of this update of NG51, and we cannot accept comments on these areas which includes recommendations on 'Evaluating risk' and the section on 'Interpreting NEWS2 scores' in 'Why the committee made the recommendations' section. Non-blanching rash is outlined in recommendations on 'Evaluating risk' as a factor that would need to be considered when interpreting a person's NEWS2 score and would be a factor that could indicate a higher risk of severe illness or death from sepsis than the NEWS2 score might suggest. Recommendation on 'managing suspected sepsis in acute hospital settings' outlines the need for clinician review and the periodic recalculation of NEWS2 scores. Given the variability of potential scenarios regarding a person with a suspected sepsis the committee felt that the scenario you have outlined is covered within the guideline.

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				Page 23. Suggest remove reference 'can be signs of meningococcal disease'.	
Royal College of Physicians (RCP)	Guideline	006	009 – 011	Consider need to reassess ABCDE and note changes in disability. Note any intervention that improves or resolves NEWS2 score without addressing underlying risk of sepsis (i.e. fluid challenge that improves SBP and HR, paracetamol that induces normothermia).	Thank you for your comment. We think your comment refers to recommendations regarding 'When to recalculate a NEWS2 score'. As outlined on page 2 of the consultation draft of the guideline, areas shaded in grey indicate that this recommendation is outside the scope of this update of NG51, and we cannot accept comments on these areas. However, to improve clarity, this section of the recommendations have been reordered and amended to account for deteriorations and unexpected changes in the persons condition as a trigger to recalculate the NEWS2 score and re-evaluate sepsis risk which would include the assessment of 'ABCDE'. The committee noted the reference to change in 'disability' and were satisfied that any change would be captured under the amended recommendation and would constitute a 'unexpected change in the person's condition' as well as part of the consideration of history, physical examination, NEWS2 score and the interpretation of these within the context of the persons underlying physiology and comorbidities as outlined in recommendations.
Royal College of Physicians (RCP)	Guideline	007	004	Recommendation is of limited use for out of hospital clinicians reading the guidance to recommend follow local protocols and give no suggestion what should be included in the protocol. RCGP recommends full sets of observations https://www.rcgp.org.uk/representing-you/policy-areas/news2#:~:text=NEWS2%20score%20for%20assessing%20the,primary%20care%20setting%20is%20required.	Thank you for your comment. The Committee discussed your comment and recognised the point you make. The Committee did not think it was useful or appropriate to specify what should and should not be outlined in local protocols as these will be specific to local needs. The committee noted that the recommendations on 'Managing suspected

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				Does the guidance need clarity on calling 999 based on more than 1 high NEWS2 score and in the absence of other clinical signs suggestive of sepsis.	sepsis outside acute hospital settings: In mental health settings' already cross-refers to the section in the guideline on evaluating risk of severe illness or death from sepsis and felt this was sufficient.
Royal College of Physicians (RCP)	Guideline	008	014 – 015	Many ambulance services do not include intravenous antibiotics (Abx) in their formulary. Does this point need to clarify oral vs parenteral Abx? Also need to consider the use of Patient Group Directions (PGDs) and availability of prescribers within a governance framework where delegation of medicines may be required.	Thank you for your comment. The Committee considered your comment and given the variability in local settings in remote and rural locations, being more specific was not possible and was not considered helpful in the context of the recommendation being made. Recommendations on 'Managing suspected sepsis outside acute hospital settings: Managing the condition while awaiting transfer' have been amended to specify paramedics who are thinking about giving antibiotics should follow local guidelines. The recommendation is now preceded by a bullet point that highlights the need for ambulance services to consider whether they need to put mechanisms in place to be able to give antibiotics to people at high risk of severe illness or death from sepsis if antibiotics have not been given before by a GP. This mechanism could include a Patient Group Direction.
Royal College of Physicians (RCP)	Guideline	011	015 – 017	Needs clarity that this section follows the management of in-patient care or is applicable to all healthcare settings.	Thank you for your comment. We think your comment refers to recommendations on intravenous fluids, inotropes and vasopressors. The committee considered your comment and highlighted that these recommendations on 'Managing suspected sepsis in acute hospital settings' in those identified as at 'High risk of severe illness or death from sepsis', and are satisfied that this makes it clear in which setting (acute hospital)

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					and for whom (those identified as being high risk) these recommendations apply.
Royal College of Physicians (RCP)	Guideline	012	004 – 007 014	If this section does apply to all settings, clarity needed re: Point of Care Testing (POCT) for lactate vs using clinical signs for Abx if time to hospital is >1 hour. This should be a consideration rather than a mandate to alert the consultant. In many instances the ongoing management after initial (unsuccessful) resuscitation will be competently undertaken by the resident team below a consultant. If Critical Care is correctly involved again there may be nothing a medical Consultant will add. We need to be cognisant of the resource burden to mandating 'consultant alerts' for conditions they may not add value to. *Please note that this was not universally agreed.*	Thank you for your comment. We think your comment refers to recommendations on intravenous fluids, inotropes and vasopressors. The committee considered your comment and highlighted that these recommendations focus on 'Managing suspected sepsis in acute hospital settings' and those at 'High risk of severe illness or death from sepsis', and are satisfied that it is clear in which setting (acute hospital) and for whom (those identified as being high risk) these recommendations apply. This guideline update did not investigate the comparative diagnostic accuracy of different outcomes for example lactate vs clinical signs to inform decision making in people identified as being at high risk of severe illness or death from sepsis, as this was out of scope for this update of NG51. We will be considering indicators of organ hypoperfusion in the next update of NG51 as outlined here . With regarding to your second comment, the committee considered the comment and amended recommendations on 'Managing suspected sepsis in acute hospital settings' and those at 'High risk of severe illness or death from sepsis' to include the 'use clinical judgment to decide whether to discuss with a consultant'. In recommendations on 'Managing suspected sepsis in acute hospital settings' and 'Monitoring and escalation' the committee have added that the responsible consultant should be informed because in this situation, the person at high risk of severe

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					illness or death from sepsis is not responding within 1 hour to an intervention.
Royal College of Physicians (RCP)	Guideline	014	019	It is not unusual for young people to have a systolic BP≤ 90 so score a 3 and therefore this should be viewed in context of patients' usual vital signs and the other parameters making up NEWS2 and not consider always at moderate risk.	Thank you for your response. This update under consultation is part of a series of updates of NG51. Recommendations that were out of scope for the update were removed from the consultation version of the guideline. Some of these recommendations acknowledge the points you raise. As well as the frequent reference to the use of clinical judgement when interpreting NEWS2 scores, recommendations on When to suspect sepsis; Interpreting findings; and 'Evaluating risk' refer to the need to interpret and not rely solely on indicators such as blood pressure as indicators of sepsis in isolation and that any NEWS2 scores should be interpreted within the context of the persons underlying physiology and comorbidities. These other NG51 recommendations will be brought together with the recommendations that are the focus of this consultation to form a comprehensive guideline.
Royal College of Surgeons of England AND Royal College of Surgeons of Edinburgh	Guideline	General	General	The Royal College of Surgeons of England (RCSEng) and The Royal College of Surgeons of Edinburgh (RCSEd) welcome the opportunity to comment on the NICE (draft) limited update to NG51 (last updated September 2017).	Thank you for your comment and we welcome the RCSEng and RCSEd comments.
Royal College of Surgeons of England AND Royal College	Guideline	General	General	While it is understood that NICE are currently proposing further changes to sepsis guidance in GID-NG10412, we note that many patients, particularly those at high risk of severe illness or death from sepsis due to an infection for	Thank you for your comment. This update under consultation is part of a series of updates of NG51. Recommendations that were out of scope for the update were removed from the consultation version

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of Surgeons of Edinburgh				which a **surgical (or radiological**) source control procedure is required, will need this treatment at the **same time** as resuscitative measures (and antibiotic therapy) are being undertaken. The current draft guidance (as with previous versions) fails to include urgent consideration of the need for (and timing of) source control procedures in relevant patients. RCSEng and RCSEd believe that these issues should be addressed (at least in principle) in the updated NG51. Rather than wait for a further update, we urge NICE to consider modifying the current updated guidance to specifically include the need to consider source control and (where appropriate) implement it in a timeframe appropriate to the patient's level of physiological instability as indicated by NEWS2 score.	of the guideline. Source control was out of scope for this update of NG51 and was planned to be covered in the next update of NG51. However, based on the stakeholder feedback received during this consultation, that improving the guidance around source control could improve patient outcomes, the changes have been made in this update. The changes have been made by committee consensus and include: • Recommendations on 'initial assessment and examination' were expanded to note that clinical examination should be carried out in initial assessment to look for sources of infection that might need drainage or other interventions • A subsection was added to recommendations on 'Managing suspected sepsis in acute hospital settings' which covers initial investigations to find the source of infection to increase the prominence of taking action to find a source of infection early in initial management • Recommendations on 'Finding the source of infection' focused on 'Everyone' were revised by committee consensus, that sepsis can be caused by surgically treatable infection at other sites of the body. So, this recommendation was broadened to ensure that the relevant surgical team is involved early on if intervention is needed to control the source of infection
Royal College of Surgeons of	Guideline	032	023	Para 1.5.5 - The NEWS2 score is of prime importance in assessing (and communicating) the level of physiological	Thank you for your comment.

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England AND Royal College of Surgeons of Edinburgh				instability in patients with sepsis and both Colleges support the recommendation that NEWS2 score should be (re) calculated if there is an unexpected deterioration in a patient's condition.	
Royal College of Surgeons of England AND Royal College of Surgeons of Edinburgh	Guideline	033	023	Paras 1.10.1 - RCSEng and RCSEd also support the recommendation that a "senior clinical decision maker" should be involved in assessing patients at high risk of severe illness or death.	Thank you for your comment.
Royal College of Surgeons of England AND Royal College of Surgeons of Edinburgh	Guideline	033	023	Paras 1.10.1 / 1.10.3 - The reference to both "18 or over" in the 2016 guidance and "16 or over" is unnecessary and confusing. It is unnecessary to have both terms, so the Colleges support simplification to assessment in persons under (or over) 16 years old.	Thank you for your comment. This identified inconsistency has been noted and will be amended and aligned as we continue the process of updating NG51.
Royal College of Surgeons of England AND Royal College of Surgeons of Edinburgh	Guideline	033	023	Para 1.10.1 - While the Colleges support the recommended change in timeframe from "immediate" to "urgent", we believe that "immediate" has a clear connotation and "urgent" does not. We suggest that the timeframe of assessment is aligned with the standards set out in the 2022 guidance of the Academy of Medical Royal Colleges (AoMRC 2022).	Thank you for your comment. The Committee have considered your comment and are satisfied that the wording of the recommendation conveys their intention.
Royal College of Surgeons of England AND Royal College of Surgeons of Edinburgh	Guideline	035	023	Para 1.10.4 - The principal concern that the RCSEng and RCSEd wish to communicate to NICE is the failure, in light of specific recommendations made in AoMRC 2022, to consider amendments to the section on source identification in NG51 (Para 1.10.4). This is currently limited to "*consider imaging of the abdomen and pelvis if no likely source of infection is identified after clinical examination and initial tests*" (recommendation 120 of the 2016/2017 version of the guidance). It has not yet been revised further.	Thank you for your comment. NG51 has recommendations on 'Finding the source of infection in people with suspected sepsis'. Source control was out of scope for this update of NG51 and was planned to be covered in the next update of NG51. However, based on the stakeholder feedback received during this consultation, that improving the guidance around source control could improve patient outcomes, the changes have been

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					made in this update. The changes have been made by committee consensus and include: • Recommendations on 'initial assessment and examination' were expanded to note that clinical examination should be carried out in initial assessment to look for sources of infection that might need drainage or other interventions • A subsection was added to recommendations on 'Managing suspected sepsis in acute hospital settings' which covers initial investigations to find the source of infection to increase the prominence of taking action to find a source of infection early in initial management • Recommendations on 'Finding the source of infection' focused on 'Everyone' were revised by committee consensus, that sepsis can be caused by surgically treatable infection at other sites of the body. So, this recommendation was broadened to ensure that the relevant surgical team is involved early on if intervention is needed to control the source of infection.
Royal College of Surgeons of England AND Royal College of Surgeons of Edinburgh	Guideline	036, 037, 040	023	Paras 1.11.1 / 1.11.4 / 1.12.4 - We note that NICE are not seeking stakeholder comment on the definition of a "senior clinical decision maker" but we think that the term "*core competencies in the care of acutely ill patients"* is unlikely to be of help or value unless it is defined. We accept that it may fall to other responsible bodies rather than NICE to set out the minimum standards in that regard, but feel that the current potential for uncertainty should at least be recognised by NICE.	Thank you for your comment. The committee agree with the comments made and have added further clarification regarding who we mean in the recommendations highlighted which now refer to 'clinician with core competencies in the care of acutely-ill patients (FY2 level or above)'.

Suspected Sepsis: recognition, diagnosis and early management (update)

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St George's University Hospitals NHS FT – Sepsis Task Force	Guideline	006	010	1.5.5 - Re-calculation of the NEWS2 score is appropriate in light of any clinical change	Thank you for your comment. The Committee have considered your comment and have amended the recommendation which now accounts for deteriorations and unexpected changes in the persons condition as a trigger to recalculate the NEWS2 score and a re-evaluation of sepsis risk.
St George's University Hospitals NHS FT – Sepsis Task Force	Guideline	007	004	1.6.3 - Following local policy is appropriate. No comment beyond this as it is outside our remit.	Thank you for your comment.
St George's University Hospitals NHS FT – Sepsis Task Force	Guideline	008	014	Response to this question is outside our remit.	Thank you for your comment.
St George's University Hospitals NHS FT – Sepsis Task Force	Guideline	009	002 – 017	1.8 - Response to this question is outside our remit.	Thank you for your comment.
St George's University Hospitals NHS FT – Sepsis Task Force	Guideline	010	013	1.10.1 - Liver Function Tests are essential for the diagnosis of sepsis under the international consensus definition (SOFA score). In addition, a low albumin in a well-recognised predictor of mortality.	Thank you for your comment. The Committee have considered your comments and have added liver function tests (which would cover albumin) to the list of tests for people at high and moderate risk of severe illness or death from sepsis.
St George's University Hospitals NHS FT – Sepsis Task Force	Guideline	012	004	Intravenous fluids should not be limited to those who are 'high-risk' and hypotensive or raised lactate. Most hypotensive patients with sepsis would warrant intravenous fluids, irrespective of their NEWS2 score.	Thank you for your comment. The area of intravenous fluids was outside the scope of this update of NG51. The recommendations on intravenous fluids and vasopressors will be considered for update in the next update of NG51 as outlined here .

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St George's University Hospitals NHS FT – Sepsis Task Force	Guideline	013	012	1.11.1 - LFTs are essential for the diagnosis of sepsis under international consensus definition (SOFA score). In addition, a low albumin level is a known independent predictor of mortality in sepsis.	Thank you for your comment. The Committee have considered your comments and have added liver function tests (which would cover albumin) to the list of tests for people at high and moderate risk of severe illness or death from sepsis.
St George's University Hospitals NHS FT – Sepsis Task Force	Guideline	015	007	1.11.5 - We believe it is impractical for a clinician to be confident of the presence or absence of an AKI within 1h of admission because of limitation in resources to get a sample to the laboratory and a result in this timeframe.	Thank you for your comment. The recommendation outlines to treat moderate risk of severe illness or death from sepsis as high risk if either lactate is over 2 mmol/litre or there is evidence of acute kidney injury (AKI). The recommendation does not suggest that the presence or absence of an AKI is confirmed within an hour but when test results are available which could be from previous medical notes or tests or when the venous blood tests undertaken as part of recommendations on 'Managing suspected sepsis in acute hospital settings' in those at 'Moderate risk of severe illness or death from sepsis'..
St George's University Hospitals NHS FT – Sepsis Task Force	Guideline	015	014	1.11.6 - The recommendation that a patient who is deemed 'moderate risk' (NEWS2 score 5-6) with a lactate <2mmol/l and no AKI can be discharged, is concerning. There are many patients who are very sick and do not elevate their lactate. Also, many patients develop an AKI after they are admitted. This recommendation around discharging patients is concerning and should be removed.	Thank you for your comment. The Committee have considered your comment and are in agreement. This recommendation has been removed. The committee created a new recommendation on 'Discharge' to be implemented later in the care pathway, at the time of discharge, which signposts to the section on information that should be provided at discharge. This includes safety netting advice to ensure people seek medical attention if they experience certain symptoms that may be indicative of suspected sepsis. This new recommendation was developed by consensus in response to (and in agreement with) stakeholder comments, recognising that for people assessed as

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					being at moderate and low risk of severe illness or death from sepsis that the initial management period was not the right time to consider discharge
St George's University Hospitals NHS FT – Sepsis Task Force	Guideline	017	003	1.12.2 - Delaying antibiotics for up to 6 hours is not advisable simply because the NEWS2 score is 0 to 4. There are many patients who for example have a rising oxygen requirement or are actually sicker than the NEWS2 score predicts. It also implies that delaying antibiotics for up to 6 hours is acceptable for the management of patients who do not have sepsis but do have an infection that requires timely antibiotics.	Thank you for your comment. As outlined on p.2 of the consultation draft of the guideline, the recommendation highlighted has been shaded in grey indicating that this recommendation is outside the scope of this update of NG51, and we cannot accept comments on this recommendation. However, it was consulted on in April/March 2023 when a similar comment was made, the responses to which are available here. In summary the response outlines that the purpose of deferring antibiotic delivery after calculating the first NEWS2 score is to facilitate the gathering of more information for a more specific diagnosis allowing for a more targeted treatment. The committee highlighted that the 6 hour limit is a maximum rather than an aim and that clinical judgement is key when considering someone's specific care needs, which is also frequently outlined in the guideline.
St George's University Hospitals NHS FT – Sepsis Task Force	Guideline	017	010	1.12.3 - The guidelines recommend that patients with a NEWS2 score of 3 in one vital sign should receive antibiotics within an hour. We are not aware of the evidence to support this.	Thank you for your comment. The recommendation outlines that if someone has a NEWS2 score of 3 or 4 and a single parameter contributing 3 points to their total NEWS2 score that clinical judgement should be used to determine the likely cause of the 3 points in one parameter, and based on that clinical judgement, if the likely cause is the current infection manage as moderate or high risk and give broad-spectrum antibiotics. This advice is in line with AoMRC statement on NEWS2 with the focus on clinical judgment.

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St George's University Hospitals NHS FT – Sepsis Task Force	Guideline	018	006	1.12.5 - We are not aware of the evidence for discharging patients if they are low risk (NEWS2 score is 1-4). It is important to note that these patients still have the potential to deteriorate.	Thank you for your comment. The Committee have considered your comment and are in agreement. This recommendation has been removed. The committee created a new recommendation on 'Discharge' to be implemented later in the care pathway, at the time of discharge, which signposts to recommendations on 'Information that should be provided at discharge'. This includes safety netting advice to ensure people seek medical attention if they experience certain symptoms that may be indicative of suspected sepsis.
St George's University Hospitals NHS FT – Sepsis Task Force	Questions	Q1		Overall, the guideline is complex, and as such, it would not be possible to implement safely. It would be difficult to audit as there is always a different route a clinician could take. There is a lack of robust evidence to support the delivery of antibiotics within an hour in all patients with a NEWS2 score of ≥7 and so we do not support this approach. The Surviving Sepsis Campaign Guidelines are far simpler and that is what we currently follow. The proposed NICE guidance endeavour to incorporate clinical judgement, but this results in undue complexity.	Thank you for your comment. NICE recognises the guideline is long and complex and has developed algorithms to aid healthcare practitioners with implementation of the recommendations.
St George's University Hospitals NHS FT – Sepsis Task Force	Questions	Q2		Implementation of the guidelines regarding the time to antibiotics based on the NEWS2 score will have cost implications as the sepsis module in our IT system will need to be re-configured	Thank you for this feedback.
St George's University Hospitals NHS	Questions	Q3		Response to this question is outside our remit.	Thank you for responding.

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FT – Sepsis Task Force					
St George's University Hospitals NHS FT – Sepsis Task Force	Questions	Q4		Response to this question is outside our remit.	Thank you for responding.
Thermo Fisher Scientific	Guideline	013	014	When performing the venous blood test in patients presenting with severe (1.10.1) or moderate risk (1.11.1), procalcitonin could be offered as an alternative to C-reactive protein. Our recommendation would be to suggest c-reactive protein AND/OR procalcitonin	Thank you for your comment. Procalcitonin (PCT) testing is covered by the NICE diagnostics guidance on procalcitonin testing for diagnosing and monitoring sepsis (DG18). The ongoing PRONTO trial is comparing PCT supported assessment with standard care for suspected sepsis in adults at emergency departments, to measure whether this approach reduces antibiotic prescriptions without increasing mortality. We will decide whether to update our recommendations on PCT testing once this trial completes.
Thermo Fisher Scientific	Guideline	013	014	Work package 1 of the 2021 NIHR funded PEACH study (Procalcitonin Evaluation of Antibiotic use in COVID-19 Hospitalised patients) found that of the 98% acute hospitals in England and Wales who submitted a survey response in 84.4% of hospitals used PCT in the ICU and 50.7% of hospitals used PCT in ED/AMU. Procalcitonin is routinely available & used in the NHS. (*Powell N, Howard P, Llewelyn MJ, Szakmany T, Albur M, Bond SE, Euden J, Brookes-Howell L, Dark P, Hellyer TP, Hopkins S, McCullagh IJ, Ogden M, Pallmann P, Parsons H, Partridge DG, Shaw DE, Shinkins B, Todd S, Thomas-Jones E, West R, Carrol ED, Sandoe JAT. Use of*	Thank you for your comment and the additional information and references. Procalcitonin (PCT) testing is considered in NICE diagnostics guidance on procalcitonin testing for diagnosing and monitoring sepsis (DG18) and is out of scope for this update of NG51. We are unable to consider the study by Powell et al because this is specific to use of PCT for people with COVID-19 as opposed to guiding management of suspected sepsis. We have added the ongoing PEACH study you have highlighted to our surveillance log for consideration as part of NICE's approach to living guidelines.

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				Procalcitonin during the First Wave of COVID-19 in the Acute NHS Hospitals: A Retrospective Observational Study. Antibiotics (Basel). 2021 May 1;10(5):516. doi: 10.3390/antibiotics10050516. PMID: 34062898; PMCID: PMC8147337.)	
Thermo Fisher Scientific	Guideline	013	014	Evidence already exists related to the clinical utility of Procalcitonin in addition to Sepsis early warning scores in Emergency Medicine. LifePOC 2021 study – Diagnostic Performance of Procalcitonin for the Early Identification of Sepsis in Patients with Elevated qSOFA Score at Emergency Admission. The authors demonstrated that the early measurement of PCT in a patient population with elevated qSOFA score served as an effective tool for the early identification of sepsis in ED patients. The study recruited 742 patients of which 202 were diagnosed with sepsis in the first 96 hours. The authors commented "*In a cohort of ED patients selected based on current guideline-recommended clinical criteria, PCT exhibited excellent diagnostic performance. PCT can improve early sepsis identification in EDs by 40%, especially for the majority of patients presenting with qSOFA scores of at least 1 upon admission. Thus, PCT can support clinicians in the early application of targeted measures to improve clinical courses and outcomes. PCT can thus serve as an ideal biomarker for point-of-care measurement in EDs*." AND	Thank you for your comment, the additional information, and references. Procalcitonin (PCT) testing is considered in NICE diagnostics guidance on procalcitonin testing for diagnosing and monitoring sepsis (DG18) and is out of scope for this update of NG51. Therefore, we are unable to consider the study highlighted. . We have added the study you have highlighted to our surveillance log for consideration as part of NICE's approach to living guidelines.

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				"*highlighted the diagnostic abilities of PCT on top of qSOFA, proving that PCT acts independently of other established risk markers like CRP and lactate*" Bolanaki M, Möckel M, Winning J, Bauer M, Reinhart K, Stacke A, Hajdu P, Slagman A. Diagnostic Performance of Procalcitonin for the Early Identification of Sepsis in Patients with Elevated qSOFA Score at Emergency Admission. J Clin Med. 2021 Aug 28;10(17):3869. doi: 10.3390/jcm10173869.	
Thermo Fisher Scientific	Guideline	013	014	The NIHR funded PRONTO trial closed recruitment on the 1st of November, the trial investigators expect the results to be available in Q2 2024. The primary aim is to compare PCT supported assessment with standard care of suspected sepsis in adults presenting to the ED, and measure whether this approach reduces prescriptions of antibiotics without increasing mortality by decreasing uncertainty in the group who may not need IV antibiotics urgently within 1 hour, or not need antibiotics at all. PRONTO is a parallel two-arm open-label individually RCT set in up to 20 NHS EDs in the UK with a target sample size of 7676 participants. Participants will be randomised in a ratio of 1:1 to standard clinical management based on NEWS2 scoring or standard clinical management based on NEWS2 scoring plus PCT-guided risk assessment. We will compare whether the addition of PCT measurement to NEWS2 scoring can lead to a reduction in intravenous antibiotic initiation in ED patients managed as suspected sepsis, with at least no increase in 28-day mortality	Thank you for your comment. Procalcitonin (PCT) testing is considered in NICE diagnostics guidance on procalcitonin testing for diagnosing and monitoring sepsis (DG18) and is out of scope for this update of NG51. It is NICE's intention to decide whether to update our diagnostics guidance on procalcitonin testing for diagnosing and monitoring sepsis (DG18) once the PRONTO trial publishes.

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				compared with NEWS2 scoring alone (in conjunction with local standard care pathways). We request that the guideline committee will consider the results of this study as soon as they are available"	
UK Health Security Agency (UKHSA)	Guideline	General	General	can they add safety netting for community where sepsis is not considered at plat at current examination but patients have likely viral or bacterial infection	Thank you for your comment. This update under consultation is part of a series of updates of NG51. Recommendations that were out of scope for the update were removed from the consultation version of the guideline. NG51 has recommendations that provide safety netting advice including recommendations on 'Information at discharge for people assessed for suspected sepsis, but not diagnosed with sepsis' and 'Information at discharge for people at increased risk of sepsis' and 'Information at discharge for people who have had sepsis' which provide safety netting advice. These other NG51 recommendations will be brought together with the recommendations that are the focus of this consultation and to form a comprehensive guideline. On considering this comment, the committee also agreed that the initial assessment is an important opportunity to identify those most at risk of suspected sepsis. However, they noted that some people may present with non-specific feelings of being unwell and may not be considered at risk of suspected sepsis. They therefore agreed, by consensus, to add a recommendation to acknowledge that recurring recent presentation to a GP or hospital with the same signs and symptoms

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					was an important risk factor to consider when assessing people for suspected sepsis.
UK Health Security Agency (UKHSA)	Guideline	004	013	1.3.1 - Can they include some degree of epidemiological assessment or exposure e.g. if you are household risk of iGAS patient risk is much greater for sepsis.	Thank you for your comment. As outlined on page 2 of the consultation draft of the guideline, areas shaded in grey indicate that this recommendation is outside the scope of this update of NG51 and we cannot accept comments on these areas which includes recommendations on 'initial assessment and examination'..
UK Health Security Agency (UKHSA)	Guideline	005	029	1.5.4 - Can they include something about representation to services, for example if 3rd attendance for clinical concern	Thank you for your comment. The Committee have considered your comment and have added to recommendations on 'Initial assessment and examination' to include a reference to asking individuals about recent presentations of symptoms or signs that could indicate sepsis.
UK Health Security Agency (UKHSA)	Guideline	010	019	Fill volume of blood cultures is critical to improve detection of bacteriaemia therefore we think this is not specific enough and should quote the following from the NHSE document on 'Improving the blood culture pathway executive summary' - "NHS England and NHS Improvement therefore recommend the collection of two sets of blood cultures (two aerobic and two anaerobic bottles) from patients with suspected sepsis. These two sets should provide a volume of 8- 10mL per bottle." 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. As outlined on page 2 of the consultation draft of the guideline, areas shaded in grey are outside the scope of this update of NG51, and we cannot accept comments on these areas. 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 and the Committee felt that this reference to the UK standards was appropriate..

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UK Health Security Agency (UKHSA)	Guideline	011	015	1.10.3 - Is there a recommendation of crystalloid versus colloid intravenous fluid	Thank you for your comment. The area of intravenous fluids was outside the scope of this update of NG51. The recommendations on intravenous fluids and vasopressors will be considered and updated in the next update of NG51 as outlined in the scope for the next update here.
UK Health Security Agency (UKHSA)	Guideline	013	016	Fill volume of blood cultures is critical to improve detection of bacteriaemia therefore we think this is not specific enough and should quote the following from the NHSE document on 'Improving the blood culture pathway executive summary' - "NHS England and NHS Improvement therefore recommend the collection of two sets of blood cultures (two aerobic and two anaerobic bottles) from patients with suspected sepsis. These two sets should provide a volume of 8- 10mL per bottle." 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 update under consultation is part of a series of updates of NG51. Recommendations that were out of scope for the update were removed from the consultation version of the guideline including recommendations on 'Initial investigation to find the source of infection' .Within this recommendation reference is made to the UK standards for microbiological investigations with reference to taking microbiological and blood samples. The Committee felt that this reference to the UK standards was sufficient..
UK Health Security Agency (UKHSA)	Guideline	015	005 – 006	Lines state a 'clinician with core competencies in the care of an acutely ill patient should assess'. Would be helpful if the grade of the clinician can be clarified. Does it mean a consultant, or can a junior doctor assess too? As a FY 2 doctor will have competencies in managing an acutely unwell patient.	Thank you for your comment. The committee considered your comment and have amended the recommendations to refer to a clinician with core competencies in the care of acutely-ill patients (FY2 level or above).
UK Health Security Agency (UKHSA)	Guideline	020	007 – 013	Does not mention the level of clinical input (would be useful to clarify).	Thank you for your comment. We assume that you are referring to recommendations on 'Choice of antibiotic therapy for people with suspected sepsis'. As outlined on p.2 of the consultation draft of the guideline, this recommendation has been shaded in grey indicating that this recommendation is outside

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					the scope of this update of NG51 and we cannot accept comments on this recommendation..
UK Sepsis Trust	Guideline	General	General	We welcomed the language around the importance of clinical judgement being considered alongside NEWS2 and empowering a 'trumping' of NEWS2 in the earlier 2023 draft guideline update. A lot of this language seems to have been lost in the latest update. We suggest that there are groups of patients, significant in number, who will compensate well and not demonstrate significantly abnormal physiology until the very late stages of disease, for example a young patient with pneumococcal or meningococcal sepsis. We strongly suggest that to omit prioritisation of clinical judgement and to fail to empower clinicians who are extremely worried about a patient to act is a major safety issue.	Thank you for your comment. This update under consultation is part of a series of updates of NG51. Recommendations that were out of scope for the update were removed from the consultation version of the guideline. These other recommendations will be brought together with the recommendations that are the focus of this consultation to form a comprehensive guideline on final publication. The committee acknowledged the points raised regarding 'compensating' and 'abnormal physiology' but felt these were covered by the frequent reference to the use of clinical judgement when interpreting NEWS2 scores The committee also noted that recommendations that were out of scope for this update including recommendations on When to suspect sepsis, Interpreting findings, Evaluating risk which refer to the need to the use of clinical judgment and not rely solely on indicators such as fever or hypothermia as indicators of sepsis in isolation and that any NEWS2 scores should be interpreted within the context of the persons underlying physiology and comorbidities.
UK Sepsis Trust	Guideline	General	General	Similar to the above, our patient on public panel have serious concerns about the omission of the importance of listening to families and carers, particularly in the recent context of the Martha Mills case and Martha's Rule	Thank you for your comment. This update under consultation is part of a series of updates of NG51. Recommendations that were out of scope for the update were removed from the consultation version of the guideline. Recommendations on 'When to suspect sepsis' speak to the points you raised regarding the need to take into account that people

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					with sepsis may have non-specific, non-localised presentations; the need to pay attention to concerns expressed by the person and their family or carers, for example changes from usual behaviour; and assess people who might have sepsis with extra care if they cannot give a good history (for example, people with English as a second language or people with communication problems).
UK Sepsis Trust	Guideline	005	023 – 028	Rec. 1.5.3: We accept that this is a 2023a recommendation. However the revisions do appear to have removed some of the previously welcomed language around clinical gestalt: we would strongly urge a revision here to include "a patient who looks seriously unwell to a health professional" This phrase is used throughout (Rec 1.11.3; or similar	Thank you for your comment. As outlined on page 2 of the consultation draft of the guideline, areas shaded in grey indicate that this recommendation is outside the scope of this update of NG51 and we cannot accept comments on these areas which includes recommendations on 'Evaluating risk' which makes reference to the use of clinical judgement to interpret the NEWS2 score and reference to the importance of clinical judgement in decision making is made throughout and speaks to the point regarding clinical gestalt.
UK Sepsis Trust	Guideline	008	012 - 015	Rec. 1.7.3: We find this to be very ambiguous: the use of vague language such as "more senior", "if needed" does not help. Administration of antibiotics by Ambulance staff would need to be covered by a Patient Group Directive and as such this recommendation should contain details of the patient group by definition along with more direct instruction. As delays to disposition of ambulances and prolonged handoff times at hospitals increase, we welcome this addition but it needs to be clarified.	Thank you for your comment. The Committee considered your comment and given the variability in local settings in remote and rural locations, being more specific was not possible and was not considered helpful in the context of the recommendation being made. Recommendations on 'Managing suspected sepsis outside acute hospital settings: Managing the condition while awaiting transfer' have been amended to specify paramedics who are thinking about giving antibiotics should follow local guidelines or seek advice from more senior colleagues, if needed. The

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					recommendation is now preceded by a bullet point that highlights the need for ambulance services to consider having mechanisms in place to be able to give antibiotics to people at high risk of severe illness or death from sepsis if antibiotics have not been given before by a GP.
UK Sepsis Trust	Guideline	010	002 - 012	Rec. 1.10: We do welcome inclusion of individual parameters scoring three as a cause for concern. We also welcome the ongoing importance of lactate in risk ratification. However, the original guidelines highlighted recent chemotherapy as a risk factor, which we would propose it clearly is. If it is felt that this is clearly included in another guideline then perhaps signposting/cross-referencing would be of utility?	Thank you for your comments. This update under consultation is part of a series of updates of NG51. Recommendations that were out of scope for the update were removed from the consultation version of the guideline. These other recommendations will be brought together with the recommendations that are the focus of this consultation and future consultations updates to form a comprehensive guideline on final publication.. NG51 has recommendations on 'Risk factors for sepsis' and outlines that people who have impaired immune systems which would include those being treated for cancer with chemotherapy as a risk factor..
UK Sepsis Trust	Guideline	012	004 - 007	Rec. 1.10.4: We suggest that there might have been an oversight here. Should this not also ensure the absence of critical hypotension, for example "….death from sepsis, lactate of 2 mmol/litre or lower and systolic blood pressure greater than or equal to 90mmHg"?	Thank you for your comment. The areas of intravenous fluids and organ hypoperfusion were outside the scope of this update of NG51. These areas will be considered for update in the next update of NG51 as outlined here.
UK Sepsis Trust	Guideline	014	005 - 007	Rec. 1.11.2: We believe that within this recommendation there should be reference to the level of clinical suspicion of serious bacterial infection, for example: "consider deferring if a bacterial infection is not strongly suspected'"	Thank you for your comment. As outlined on page 2 of the consultation draft of the guideline, areas shaded in grey indicate that this recommendation is outside the scope of this update of NG51, and we cannot accept comments on these areas which include this .
UK Sepsis Trust	Guideline	015	007 - 013	Rec. 1.11.5: Whilst we welcome the retention of other makers of organ dysfunction than NEWS2 in risk	Thank you for your comment. The recommendations on indicators of organ

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				stratification we do find this part difficult to operationalise as it comes after initial assessment/ risk stratification. We propose that using language as in the Academy of Medical Royal Colleges Statement preferable, in which criteria such as these increase the risk stratification immediately. We do not believe that the guideline in general properly addresses fluctuations in physiology particularly those driven by treatment: e.g. if IV fluid boluses transiently increase blood pressure, it should be reinforced that the patient remains high risk.	hypoperfusion will be considered and updated in the next update of NG51 as outlined here.
UK Sepsis Trust	Guideline	015	014 - 023	Rec. 1.11.6: We suggest that this recommendation could be misinterpreted as offering permission to discharge those at moderate risk: we recognise the inclusion of the line " definitive condition or infection can be identified and treated" (this is actually an extremely small subset) - how will anyone know definitively? Oh is that this should be amended to ensure that repeated assessment demonstrates improvement with physiology returning to low risk levels over a sustained period of, for example, 4 hours. We suggest that to not do this introduces significant patient risk.	Thank you for your comment. The Committee have considered your comment and are in agreement. This recommendation has been removed. The committee created a new recommendation on 'Discharge' to be implemented later in the care pathway, at the time of discharge, which signposts to the section on information that should be provided at discharge. This includes safety netting advice to ensure people seek medical attention if they experience certain symptoms that may be indicative of suspected sepsis. This new recommendation was developed by consensus in response to (and in agreement with) stakeholder comments, recognising that for people assessed as being at moderate and low risk of severe illness or death from sepsis that the initial management period was not the right time to consider discharge.
University Hospitals Bristol and Weston NHS	Algorithm	General	General	We welcome the addition of algorithms to supplement the guideline, as a potentially useful decision aid.	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope

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Foundation Trust					
University Hospitals Bristol and Weston NHS Foundation Trust	Algorithm	General	General	We appreciate the potential complexity, but we suggest it may better to have a **single algorithm** that combines the separate 'Evaluating risk of severe illness or death from sepsis in acute healthcare settings with NEWS2' and 'Managing risk of severe illness or death from sepsis in acute hospital settings with NEWS2' algorithms you've produced	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope
University Hospitals Bristol and Weston NHS Foundation Trust	Algorithm	003		You use the phrase 'Carry out a high priority **clinical assessment**' in two places on this page. However, in the source 5th bullet point of the underpinning draft recommendation 1.5.2 – this is referred to as 'a **medical review** should be requested with high priority'. It would be good to have consistency of language between the guideline recommendations and algorithms, including making it clear whether this assessment/review can only be performed by a medical practitioner, if that is your intention.	Thank you for your comment. We agree with the comments you have made but we have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope. .
University Hospitals Bristol and Weston NHS Foundation Trust	Algorithm	003		In the best designed algorithms, steps that are processes are visually different and separate to steps that are questions/decision points – and such questions are often visualised as a diamond box. You have two light-blue shaded boxes 'Carry out a high priority clinical assessment to determine whether this factor is likely to be because of the current infection' and underneath each you have white boxes repeating the question with yes/no options, and then additional yes/no lineout arrows to the suggested risk category.	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope.
University Hospitals Bristol and Weston NHS	Algorithm	003		At first glance there appears to be an element of duplication in the content of this algorithm to that on page 3 – specifically the 'Is the current infection the likely cause of	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope

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Foundation Trust				the 3 points from 1 factor?' question and in the moderate risk column. Is that intended?	
University Hospitals Bristol and Weston NHS Foundation Trust	Guideline	General	General	We welcome the opportunity to comment on this second draft, and broadly agree with the guideline's detailed recommendations.	Thank you for your comment.
University Hospitals of Leicester NHS trust	Algorithm	General	General	Perhaps the document would be easier to use if t was organised by setting so community evaluation followed by community management, then acute health care settings evaluation then management etc	Thank you for your comment. We agree with your suggestions but we have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope.
University Hospitals of Leicester NHS trust	Algorithm	001	High risk and moderate risk criteria	Behaviour – this isn't anywhere in the guidance whether it is objective or not – surely everything in the algorithm should be in the guidance somewhere? We fear objective evidence may mask altered mental state especially in those with learning disabilities or dementia where the baseline may only be known by those giving a collateral history opposed to the individual assessing the patient they may never have met before or may have had a sustained decline since they were last seen by a medical professional	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope. The relevant sections of the guideline were removed from the consultation version, to make it easier to find the updated content. At publication, these will be added back in.
University Hospitals of Leicester NHS trust	Algorithm	001	Moderate risk criteria	Impaired immune system – concern that this may be interpreted as including chemotherapy and the patient could then be managed inappropriately (noting there is separate NICE guidance for neutropenic sepsis)	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope The relevant sections of the guideline were removed from the consultation version, to make it easier to find the updated content. At publication, these will be added back in.

Suspected Sepsis: recognition, diagnosis and early management (update)

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University Hospitals of Leicester NHS trust	Algorithm	001	Moderate risk criteria	Signs of potential infection – where is this in the main body of guidance? Does this not have the potential for all cellulitis to be treated as moderate to high risk?	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope. The relevant sections of the guideline were removed from the consultation version, to make it easier to find the updated content. At publication, these will be added back in. This particular wording has not changed since the original 2016 guideline published.
University Hospitals of Leicester NHS trust	Algorithm	002	Is there an additional cause for concern box?	This doesn't match with the written guidance. There is no mention of meniginococcal disease in the written guidance (nor chemotherapy – which in AoMRC suggestion would bump up a risk category). However, in the full guidance mottled/ashened appearance, non-blanching rash (assuming this meant to be the reference to meningococcal disease) cyanosis of skin/lips/tongue are mentioned but aren't on the algorithm. Also no reference in algorithm or guidance of NICE meningococcal guidance	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope In response to your comments on the recommendations. Recommendations on 'Evaluating risk level: In acute hospital settings, acute mental health settings and ambulances' covers signs of meningococcal disease. For chemotherapy, the relevant sections of the guideline were removed from the consultation version, to make it easier to find the updated content. At publication, these will be added back in. References to other NICE guidance have not been included in the algorithm because we want to save space and keep the algorithm to a printable page size throughout
University Hospitals of	Algorithm	005	General	Very difficult to read due to font size	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new

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Leicester NHS trust					algorithms to accompany the guideline that will result from the updates listed in the scope
University Hospitals of Leicester NHS trust	Algorithm	005	Risk boxes	As well as high/moderate/low very low it would be helpful to have the accompanying news2 range for clarity as we expect in reality the majority of the time it will be the algorithms that are looked at rather than the full guidance	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope
University Hospitals of Leicester NHS trust	Algorithm	005	Low risk assessment box	Clarify what a clinician with core competencies means. Deferring antibiotics for up to 6hrs – the wording of this makes it sounds like you should wait as long as possible to give antibiotics as opposed to you have up to 6hrs to identify the source and prescribe appropriate antibiotics. The likely cause of any single parameter scoring 3 – it adds nothing in this box as its covered by the next 2 boxes so could be removed.	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope. The Committee discussed your comments and have amended the recommendation to refer to 'a clinician with core competencies in the care of acutely ill patients (FY2 level or above). . On deferring antibiotics, the guideline (Managing suspected sepsis in acute hospital settings: Low risk of severe illness or death from sepsis') is clear that antibiotics should not be deferred for up to 6 hrs. The purpose of deferring antibiotic delivery is not to delay treatment, but to have extra time to gather information for a more specific diagnosis, allowing for more targeted treatment.
University Hospitals of Leicester NHS trust	Algorithm	005	Low risk recalculate news2 box	This could be misleading in that this is the next box off no definitive condition identified – we are concerned that this could be misinterpreted that if you haven't identified the source of the infection don't do anything until the next news2 is done in 4-6hrs – is this what you meant?	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope. We think that your comment refers to the recommendations on 'Evaluating risk: When to recalculate a NEWS2 score' and 'Managing suspected sepsis in acute hospital settings: low risk of severe illness or death

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					from sepsis'. The 'When to recalculate a NEWS2 score' recommendations states that in alignment with the AoMRC statement those at low risk of severe illness or death from sepsis should have their NEWS2 score recalculated and their risk of sepsis re-evaluated every 4 to 6 hours; and also states that recalculation of NEWS2 and a re-evaluation of sepsis risk should occur if there is any deterioration or an unexpected change in the person's condition. The committee highlighted that this recommendation is about re-calculation and that they would be preceded by the recommendations on 'Low risk of severe illness or death from sepsis' which highlights the need to arrange registered health practitioner review within 1 hour of the person being assessed as at low risk and to perform blood tests if indicated. This recommendation goes on to state that an assessment by a clinician with core competencies in the care of acutely ill patients (FY2 level or above) should occur to consider whether to defer antibiotic treatment for up to 6 hours post calculation of an individual's first NEWS2 score and that this time should be used to gather more information for a more specific diagnosis. This recommendation goes on to cross refer to the recommendation on 'When to recalculate NEWS2' further emphasising that a recalculation should occur if there is a deterioration or no improvement and that care should be escalated to a clinician with core competencies in the care of acutely ill patients (FY2 level or above).

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University Hospitals of Leicester NHS trust	Algorithm	005	Low risk Escalate care box	What does escalate care mean? Discuss with,?in person review or are you happy with either. Again what does core competencies mean do you mean a senior decision maker? Is the point being made that the patient needs a review or that the patient needs a review by a different doctor?	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope. Throughout the guideline, we have included definitions of what is meant by a clinician with core competencies in care of the acutely ill. This will be reflected in the revised algorithms, where appropriate. **Escalation of care in this context refers to the moving of care of a deteriorating or not improving patient at low risk of severe illness or death from sepsis to someone with the appropriate competencies (FY2 level or above) to manage.**
University Hospitals of Leicester NHS trust	Algorithm	005	Moderate risk recalculate news2 box	The positioning of this box makes this algorithm read as if lactate is <2 and no AKI and source of infection is unknown (even if its obvious there is an infection such as temp, wcc etc) then antibiotics aren't given, news2 are just monitored – is this what you meant?	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope.
University Hospitals of Leicester NHS trust	Algorithm	005	High risk if no response box	The not responded is indicated by any of list does not match what is in the full guidance and should	Thank you for your comment. We have withdrawn the 2016 algorithms. We are developing new algorithms to accompany the guideline that will result from the updates listed in the scope.
University Hospitals of	Guideline	009	010	Should this read protocols on assessment rather than treatment – as a definitive diagnosis has not been made	Thank you for your comment. The Committee discussed your comment and noted that recommendations on 'Managing suspected sepsis

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Leicester NHS trust					outside acute hospital settings: Managing the condition while awaiting transfer' refer specifically to those 'who are at moderate risk of severe illness and death from sepsis, has suspected sepsis but immediate transfer is not required. The preceding bullet points within the recommendation outline that there should be an assessment to establish a definitive diagnosis of their condition and decide if their condition can be treated safely outside hospital. The reference to following local emergency protocols on treatment was considered by the committee to be in alignment with the steps outlined in the recommendation.
University Hospitals of Leicester NHS trust	Guideline	010	015	We are concerned that the wording/placement surrounding the urgent assessment of the patient by a senior decision maker inadvertently suggests that this assessment should occur before antibiotics are given which may inadvertently cause harm if for any reason the SDM assessment was delayed	Thank you for your comment. The committee discussed your comment and highlighted that in practice the actions outlined in the recommendations would occur simultaneously and that the delivery of antibiotics to someone at high risk of severe illness or death from sepsis would not be delayed by the instructions to carry out a venous blood test. The Committee were clear that the intention was for all of the recommendations to be considered and implemented if appropriate and in line with patient needs and did not represent a sequential process.
University Hospitals of Leicester NHS trust	Guideline	012	009 – 010	This does not read well, please consider rephrasing, perhaps: recommendations on when to recalculate the NEWS2 score should be followed (with hyperlink)	Thank you for your comment. The committee did not think a change to the recommendation was needed because it is signposting to an earlier recommendation with the details of when to recalculate a NEWS2 score.
University Hospitals of	Guideline	013	022	A clinician with core competencies - is unclear what is meant – later in the document it suggests a senior decision	Thank you for your comment. The Committee discussed your comments and have amended the

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Leicester NHS trust				maker is a doctor with core competencies this suggesting moderate risk patients should be assessed by a senior decision maker, please see general comments about feasibility but also if this is what is meant this is what should be written. Please also consider whether an ACP who has been accredited so signed off for core competencies but is not a senior decision maker can do this assessment/review.	recommendation to refer to 'a clinician with core competencies in the care of acutely ill patients (FY2 level or above).
University Hospitals of Leicester NHS trust	Guideline	015	005	What does escalate care mean? Discuss with,?in person review or are you happy with either. Again what does core competencies mean do you mean a senior decision maker? Is the point being made that the patient needs a review or that the patient needs a review by a different doctor?	Thank you for your response. This recommendation has been amended to provide clarity that a clinician with core competencies in the care of acutely-ill patients is FY2 or above. Escalation of care refers to the moving of care of a deteriorating or not improving patient at moderate risk of severe illness or death from sepsis to someone with the appropriate competencies (FY2 level or above) to manage.
University Hospitals of Leicester NHS trust	Guideline	015	007	Should point 1.11.5 actually be 1.11.2 as this caveat changes the management of care	Thank you for your comment. The committee have reviewed your comment and can confirm that the sequence of the recommendations is correct.
University Hospitals of Leicester NHS trust	Guideline	015	009 – 010	This does not read well, please consider rephrasing, perhaps: recommendations on when to recalculate the NEWS2 score should be followed (with hyperlink)	Thank you for your comment. The committee did not think a change to the recommendation was needed because it is signposting to an earlier recommendation with the details of when to recalculate a NEWS2 score.
University Hospitals of Leicester NHS trust	Guideline	017	023 – 024	This does not read well, please consider rephrasing, perhaps: recommendations on when to recalculate the NEWS2 score should be followed (with hyperlink)	Thank you for your comment. The committee did not think a change to the recommendation was needed because it is signposting to an earlier recommendation with the details of when to recalculate a NEWS2 score.
University Hospitals of	Guideline	018	001	What does escalate care mean? Discuss with,?in person review or are you happy with either. Again what does core	Thank you for your response. The recommendation outlines that in those at low risk of severe illness or

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Leicester NHS trust				competencies mean do you mean a senior decision maker? Is the point being made that the patient needs a review or that the patient needs a review by a different doctor?	death from sepsis their NEWS2 score should be recalculated every 4 to 6 hours and if they deteriorate or do not improve their care should be undertaken by clinician with core competencies in acutely ill patients (FY2 level or above). Escalation of care refers to the moving of care of a deteriorating or not improving patient at low risk of severe illness or death from sepsis to someone with the appropriate competencies to manage these changes. The escalation may not be necessary if the individual doing the recalculation of NEWS2 score already has those competencies.
University Hospitals of Leicester NHS trust	Guideline	018	018 – 019	This does not read well, please consider rephrasing, perhaps: recommendations on when to recalculate the NEWS2 score should be followed (with hyperlink)	Thank you for your comment. The committee did not think a change to the recommendation was needed because it is signposting to an earlier recommendation with the details of when to recalculate a NEWS2 score.
University Hospitals of Leicester NHS trust	Guideline and algorithm	019 – 020	017 – 006	These don't match the separate algorithm document	Thank you for your comment. The algorithms will be updated to align with the guideline before publication.
University Hospitals of Leicester NHS trust	Questions	Q1		These draft recommendations would be difficult to implement with respect to all patients stratified as low risk or above, so NEWS2 score >0, need to be assessed withing the hour by a clinician with core competencies, within this document a doctor with core competencies is defined as a senior decision maker(SDM). The sheer volume of patients in the ED with a NEWS2 score of >0 makes it impossible for them all to have a SDM review within the hour. Similarly out of hours on the wards it would not be possible for SDM to review all patients with a news2 >0 within the hour. Surely the assessment could be performed by a clinician (also	Thank you for your comment. The Committee have considered your comments and recognise the potential resource and implementation challenges. In response the guideline has been amended and recommendations on 'Managing suspected sepsis in acute hospital settings' refer to a registered health practitioner review rather than a clinician for people at low or very low risk of severe illness or death from sepsis. The Committee also highlighted that it would only require the arrangement for a registered health practitioner review within 1 hour in

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				defined in the document) with involvement of SDM within the hour for moderate and high risk (perhaps high risk should be an in person assessment)	the case of a person with a NEWS2 score of 0 if there was also a cause for clinical concern as outlined in the grey box preceding recommendations on those at 'Low risk of severe illness or death from sepsis'.
University Hospitals of Leicester NHS trust	Questions	Q3		1.73 Long waits for handover at acute trusts due to capacity, whilst trying to be avoided,are relatively common and predictable. It would be helpful for this guidance to cover this situation – in particular with regard to administering antibiotics in high or moderate risk patients by ambulance crews (rather than the acute trust) if there are delays getting the patient into the hospital setting. Likewise some clarity regarding where patients who are stranded in ambulances outside hospitals should continue to be evaluated using the community risk assessment model or the acute setting model – or local agreement to which might be useful	Thank you for your comment. As outlined on p.2 of the consultation draft of the guideline, areas shaded in grey indicate that this recommendation is outside the scope of this update of NG51 and we cannot accept comments on this recommendation. Recommendation on 'Managing suspected sepsis in acute hospital settings' outline actions to consider when managing the condition while awaiting transfer with recommendations highlighting that where transfer or handover time to emergency departments is more than 1 hour that ambulances should consider whether they need to put mechanisms in place to be able to give antibiotics to people at high risk of severe illness or death from sepsis (if not provided beforehand) and instructs paramedics who are thinking about giving antibiotics to so in line with local guidelines or if required seek advice from more senior colleagues.