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| **Checklist for submitting comments**   * Use this comments form and submit it as a **Word document (not a PDF)**. * **Do not submit further attachments** such as research articles, or supplementary files. We return comments forms that have attachments without reading them. You may resubmit the form without attachments, but it must be received by the deadline. You are welcome to include links to research articles or provide references to them * Complete the disclosure about links with, or funding from, the tobacco industry. * Include **document name,** **page number and line number** of the text each comment is about. * Combine all comments from your organisation into 1 response form. **We cannot accept more than 1 comments form from each organisation**. * **Do** **not** paste other tables into this table – type directly into the table. * Ensure each comment stands alone; **do not** cross-refer within one comment to another comment. * **Clearly mark any confidential information or other material that you do not wish to be made public with underlining and highlighting. Also, ensure you state in your email to NICE, and in the row below, that your submission includes confidential comments.** * **Do not name or identify any person or include medical information about yourself or another person** from which you or the person could be identified as all such data will be deleted or redacted. * Spell out any abbreviations you use. * **We do not accept comments submitted after the deadline stated for close of consultation.**   **Note:** We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate. Where comments contain confidential information, we will redact the relevant text, or may redact the entire comment as appropriate.  Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees. |

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|  | **Please read the checklist above before submitting comments.** **We cannot accept forms that are not filled in correctly.**  We would like to hear your views on the draft recommendations presented in the guideline, and any comments you may have on the rationale and impact sections in the guideline and the evidence presented in the evidence reviews documents. We would also welcome views on the Equality Impact Assessment.  In addition to your comments below on our guideline documents, we would like to hear your views on these questions. **Please include your answers to these questions with your comments in the table below.**   1. Would it be challenging to implement of any of the draft recommendations? Please say why and for whom. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or national initiatives. 2. Would implementation of any of the draft recommendations have significant cost implications?   See [[Developing NICE guidance: how to get involved](https://www.nice.org.uk/process/pmg20/resources/developing-nice-guidelines-how-to-get-involved-2722986687/chapter/commenting-on-a-draft-guideline)](https://www.nice.org.uk/process/pmg20/resources/developing-nice-guidelines-how-to-get-involved-2722986687/chapter/commenting-on-a-draft-guideline) for suggestions of general points to think about when commenting. |
| Organisation name (if you are responding as an individual rather than a registered stakeholder please specify). | Royal College of General Practitioners |
| Disclosure (please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry). | **None** |
| Confidential comments (Do any of your comments contain confidential information?) | No |
| Name of person completing form | Michael Mulholland/Adrian Hayter |

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| **Comment number** | **Document**  [e.g. guideline, evidence review A, B, C etc., methods, EIA] | Page number  **‘General’** for comments on whole document | Line number  **‘General’** for comments on whole document | Comments  * Insert each comment in a new row. * Do not paste other tables into this table, because your comments could get lost – type directly into this table. * Include section or recommendation number in this column. |
| Example | Guideline | 016 | 045 | Rec 1.3.4 – We are concerned that this recommendation may imply that ………….. |
| Example | Guideline | 017 | 023 | Question 1: This recommendation will be a challenging change in practice because …… |
| Example | Guideline | 037 | 016 | This rationale states that… |
| Example | Evidence review C | 057 | 032 | There is evidence that … |
| Example | Evidence review C | 063 | 012 | CONFIDENTIAL: Our unpublished study has shown that [X] is more effective than [Y] |
| Example | Methods | 034 | 010 | The inclusion criteria … |
| Example | Algorithm | General | General | The algorithm seems to imply that … |
| Example | EIA | 010 | 002 | We agree with the barriers to access listed, and would also like to add …. |
| 1 | Guideline | General |  | We believe that the cost implications of early intravenous therapy and rapid conveyance to hospital may disproportionately impact community and out-of-hours services especially in rural settings. Additional training and resource allocation should be considered to support these pathways as well as clarity around the individual responsibilities of ambulance services. It is not the role of General Practice to stock and administer intravenous fluids and current training currently does not support this. |
| 2 | Guideline | 5 |  | We believe this could benefit from explicitly including 'profound fatigue' and 'new confusion' as commonly seen early markers in primary care presentations. |
| 3 | Guideline | 9 |  | We believe it would be helpful to provide clearer pathways or decision support for community management when high-risk features are absent, but there is still clinical concern. This could reduce inappropriate hospital conveyance. |
| 4 | Guideline | 13 and 17 |  | The emphasis on antibiotics and IV fluids within 1 hour is challenging in community and non-hospital settings, given that transfer time to emergency departments, even in urban areas is often more than one hour for category 2 responses. We believe, it would be useful to include practical advice on safe and timely transfer or initiation of antibiotics, particularly when intravenous access is not immediately possible. |
| 5 | Guideline | 19 |  | We suggest adding a reminder for clinicians to ensure clear documentation of escalation plans and ceilings of care, particularly for patients with increased vulnerability such as those living with significant frailty, comorbidities, or learning disability. |
| 6 | Guideline | 25 |  | We recommend including a research question on the diagnostic accuracy of clinical decision tools for sepsis in community and pre-hospital settings, where most initial contacts occur. |

Insert extra rows as needed

**Data protection**

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By submitting your data via this form you are confirming that you have read and understood this statement.

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