Managing common infections

Consultation on draft scope
Stakeholder comments table

01/11/16 to 28/11/16

Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Association of Directors of Public Health	General	General	'Common infection' needs to be defined. It may be useful to differentiate 'self-limiting' conditions from the other infections requiring antibiotic treatment. These new guidelines will need to address situations which contribute to antibiotics resistance. These situations need to be identified and defined so that the guidelines can focus on them. The risks of not treating with antibiotics need to be clearly spelled out, so that the practitioner can adapt his or her management. Prescribing guidelines should make the link with infection prevention control, such as hand hygiene.	Thank you for your comment. The definition of what a 'common infection' is varies depending on the setting where the infection is being managed. We have amended the wording following your comment. The aim of the guidelines is to address antimicrobial resistance. We will link to existing NICE guidelines on antimicrobial stewardship, such as Antimicrobial stewardship – systems and processes for effective antimicrobial use (NG15) and Antimicrobial stewardship – changing risk-related behaviours in the general population (publication expected January 2017). We will link to other relevant NICE guidelines as you have suggested.
Association of Directors of Public Health	3	71	Under "specific consideration", the guidelines should include patients with a chaotic lifestyle (for example intravenous drug users, those with mental health issues, and the homeless).	Thank you for your comment. These populations would be included under lines 69 – 70 (Groups that will be covered).
Association of Directors of Public Health	4	88	Under "factors that can affect" we would suggest that factors influencing the patient's demand for antibiotics should be included (for example employment patterns) and their lifestyle, which may impact on completion of treatment. The guidelines should also consider whether there is access to a rapid diagnostic tool.	Thank you for your comment. Please note that these guidelines will link to other relevant NICE guidelines, for example Antimicrobial stewardship – changing risk-related behaviours in the general population which will provide recommendations to address your comment. Thank you for your comment, diagnostics will be considered as advised by the committee for each topic area.
Association of Directors of Public Health	6	113	In relation to question 3, we would suggest that evidence of the impact on the risk of resistance of changing the antibiotic given for a specific infection should be considered.	Thank you for your comment. This is covered by key questions (section 3.4 point 9.11) relative impact of specific antimicrobials on the development of future resistance to that and other antimicrobials.
Association of Directors of	6	119	In relation to question 5 – this should include reviewing the clinical effectiveness of reducing exposure to air pollution in exacerbating	Thank you for your comment. Please see the draft NICE guideline on Air pollution - outdoor air quality

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Public Health			chronic respiratory conditions.	and health.
Primary Care Unit, Public Health England	3	69	I suggest concentrating on children and first secondary care.	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Primary Care Unit, Public Health England	3	80	I think there are many immune-suppressed patient groups, e.g. oral steroids so better to only exclude distinct groups. I agree cystic fibrosis and AIDS, not HIV, steroids.	Thank you for your comment. This bullet has been removed following your comment. The guidelines are covering all populations except those individuals in the first 72 hours of life (see section 3.1) of the final scope document. If the included evidence highlights any specific groups of patients that require different approaches for managing common infections this will be included in the guideline.
Primary Care Unit, Public Health England	4	Bone and joint	Add diabetic foot to ulcers – should be okay to broaden cover in those cases.	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Primary Care Unit, Public Health England	4	Dental	Add gingivitis, pericoronitis, acute necrotising gingivitis for dentists – although guidance – I don't think they have all references at guidance group.	Thank you for your comment. We will take these into account when selecting and prioritising our topics for development.
Primary Care Unit, Public Health England	4	Blepharitis	Gap in primary care, which has been requested but in current review	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Primary Care Unit, Public Health England	4	STIs	Many GPs treating esp. if viral and GC resistance, so add GC chlamydia, herpes including recurrent, trichomoniasis, PID.	Thank you for your comment. Please note that there is national guidance available from a NICE accredited guideline producer for pelvic inflammatory disease but in addition we will take this into account when selecting and prioritising our topics for development.
Primary Care Unit, Public Health England	5		Add oral candidiasis.	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Primary Care Unit, Public Health England	5	In Gastro	Add H.pylori – Note De Nol no longer available, diverticulitis, travellers' diarrhoea.	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Primary Care Unit, Public Health England	5	SEPSIS	Returning travellers PUO and resistance risk.	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Primary Care Unit, Public Health England	5	Skin	Mastitis including alternative treatment, not currently in primary care guidance.	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Primary Care	5	Skin	Scabies, shingles as contentious, and chicken pox as undertreated in	Thank you for your comment. We will take these into

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Unit, Public Health England			young adults, cold sores as easy and common. Acne as much over treatment with antibiotics. Dermatophyte nails, as future risk for cellulitis and poorly treated, skin dermatophyte.	account when selecting and prioritising our topics for development.
Primary Care Unit, Public Health England	5	URTI	Important to add otitis externa.	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Primary Care Unit, Public Health England	5	UTI	Important to add UTI in pregnancy, prophylaxis, recurrent, resistance risks.	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Primary Care Unit, Public Health England	5	111	Add NNT and NNH wherever data and GPs like this.	Thank you for your comment. We will take this into account when presenting the guideline evidence.
Primary Care Unit, Public Health England	6	113	Include degree of resistance risk for each infection.	Thank you for your comment. We will consider this when reviewing the evidence for each infection topic.
Primary Care Unit, Public Health England	6	124	Add first and second line antibiotics and also in pen allergic.	Thank you for your comment. We will take this into account when presenting the guideline evidence.
Primary Care Unit, Public Health England	6	121	Include antitussives in URTI, cranberry methenamine for UTI.	Thank you for your comment. We will consider these interventions when discussing the review protocols for the topic.
Primary Care Unit, Public Health England	6	131	Include symptom scores and when to use or not. Point of care tests to help target treatment.	Thank you for your comment. We will consider symptom scores and diagnostics as appropriate for each infection topic when discussing the review protocol with the committee.
Primary Care Unit, Public Health England	6	144	Include prophylaxis antibiotic vs other treatments vs standby for UTI and prophylaxis for COPD or not and when to use.	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development. In the key questions (section 3.4) we state that we will consider delayed [back-up] prescribing interventions (see point 9.9) and standby or rescue therapy (see point 9.10) in the final scope document.
Primary Care Unit, Public Health England	7	170	Clarify what you mean by resource – financial, staff?	Thank you for your comment. More information about resource impact can be found on the NICE website.
Primary Care Unit, Public Health England	General	General	Priority would be to produce guidance where it doesn't currently exist.	Thank you for your comment. We will take these into account when selecting and prioritising our topics for development.

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NTW NHS Foundation Trust	2	30	When considering delivery partners can special consideration be given to those mental health and learning disability trusts who struggle to engage clients. This is particularly relevant with the 'see saw' taking of medication I respect of antibiotics, failure to complete courses, early termination of treatment and difficulties with administration routes.	Thank you for your comment. Please see the NICE guideline on Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence.
NTW NHS Foundation Trust	3	62	The equality impact does not identify issues relating to the mental health and Learning disability groups as well as those within specialist settings such as prison, seclusion or specialist areas such as adult / adolescent forensic units. These have unique and challenging issues as well as having inherently vulnerable groups.	Thank you for your comment. Learning disability is a protected characteristic under the Equality Act 2010 (please see line 71 of the draft scope for consultation). As set out in the Equality Impact Assessment document the scope covers all adults and children in all care settings; this would include prisons and those people receiving care for mental health conditions either in the community or in a residential or secure setting. The committee will consider this when discussing the evidence for each infection topic.
NTW NHS Foundation Trust	3	74	More definition regarding chronic conditions is needed regarding clients on high dose antipsychotics, polypharmacy and those with multiple morbidities. May be on combination treatments for conditions that may negatively impact on treatment options and compliance.	Thank you for your comment. Please note that these are examples and the list is not intended to be exhaustive.
NTW NHS Foundation Trust	4	99	Can you expand on other options such as first line topical treatments rather than systemic. Particularly in respect of wound care many client receive systemic when critical colonisation may be adequately managed using topicals.	Thank you for your comment. Please see the footnote on page 3 of the final scope document.
NTW NHS Foundation Trust	5	Table 1	Skin and soft tissue – Can injuries associated with factitious wounds / self-inflicted or maintained be included as these can represent a risk area in mental health and Learning disability. Also Tattoo and piercings should be covered due to application issues and post application management.	Thank you for your comment. The issue of wound management is outside the remit of this guideline. Please see the NICE website for more information on Wound management and Injuries, accidents and wounds.
NTW NHS Foundation Trust	6	117	Many clinicians are 'risk adverse' when managing infection risks, can some thought be given to how we might empower them to take therapeutic risks with watchful waiting, first line topicals etc?	Thank you for your comment. NICE has developed guidelines on Antimicrobial stewardship – systems and processes for effective antimicrobial use (NG15) and Antimicrobial stewardship – changing risk-related behaviours in the general population (publication expected January 2017). These guidelines recommend antimicrobial stewardship interventions that address your comment. The common infections guidelines will link to these where relevant.

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NTW NHS Foundation Trust	6	125	Please consider MH / LD access to services / compliance issues.	Thank you for your comment. The committee will consider this when discussing the evidence for each infection topic. Please also see the NICE guideline on Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence.
NTW NHS Foundation Trust	6	132	Include MH / LD / Forensic	Thank you for your comment. This would be covered by comorbidity and location (see section 3.4, point 9.3 of the final scope document).
NTW NHS Foundation Trust	6	138	Don't forget to consider where clients receive their treatment – community versus hospital, prison, forensic etc, these play a important part in clients engaging, being concordant with treatment and completing courses.	Thank you for your comment. The guidelines will cover all care settings (see section 3.2 of the final scope document).
NTW NHS Foundation Trust	7	156,161, 167	Please consider 'parity of esteem' to ensure client with MH / LD / Specialist issues have access to care	Thank you for your comment. The remit of this guideline is to focus on the management of common infections, if relevant evidence is found for issues around parity of esteem for those persons with mental health or learning disability this will be taken into consideration.
NTW NHS Foundation Trust			Out of the guidance the NHS is likely to do another campaign, can funding be looked at to tailor these to other none mainstream client groups as the message may be the same but delivery options may be vastly different.	Thank you for your comment. This is outside the remit of the guideline.
Royal College of Nursing	General	General	The Royal College of Nursing welcomes proposals to develop guidelines for the management of common infections. We invited our members who work in this area to review and comment on our behalf. The comments below include the views of our members.	Thank you for your comment.
Royal College of Nursing	1	4 -5	Consider changing the title to: *Managing common infections: antimicrobial prescribing guidelines*. This would put the emphasis on managing common infections as the main intervention first and prescribing on a clinical judgement.	Thank you for your comment. We have amended the wording following your comment.
Royal College of Nursing	2	43 & 44	The draft document states that users of the document are to provide users of services (including the public) with information on AMR, self-help etc. We are not sure these guidelines have reach into the community. NICE guidance is used by healthcare professionals rather than the general public so a strategy will be required to deliver this information to	Thank you for your comment. All NICE guidelines are publically available on our website, and are also linked to from other accessible sources such as NHS Choices. From the calls to our enquiry service, we know that members of the public do use NICE guidance. We use a variety of public-facing channels to communicate about our guidelines, including the

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			the public. Many information from PHE is available for the public so please consider if it is the role of NICE to provide information for public and service users specifically around this subject or if this is already done by others.	NICE Facebook page and Twitter. Our media team also publishes news stories on the NICE website. The final scope for the guideline will take PHE priorities into account to ensure that the NICE and PHE work complement each other. We will work closely with PHE and others to make the public aware of what NICE has said.
Royal College of Nursing	3	68	What about people undergoing acute treatment which alters their immune status for example chemotherapy etc? We suggest that the guidelines also cover this group.	Thank you for your comment. This bullet has been removed following your comment. The guidelines are covering all populations except those individuals in the first 72 hours of life (see section 3.1) of the final scope document. If the included evidence highlights any specific groups of patients that require different approaches for managing common infections this will be included in the guideline.
Royal College of Nursing	4	88	The document does not seem to cover the importance of infection prevention and the role it has in breaking the chain of infection. Should emphasis also be provided on how this can help treat and prevent common infections e.g. hand washing, using a tissue if one has a cold?	Thank you for your comment. It is not the remit of this guideline to address infection prevention and control please see the NICE guidelines on Healthcare-associated infections: prevention and control (PH36), Healthcare-associated infections: prevention and control in primary and community care (CG139), Surgical site infections: prevention and treatment (CG74) and the upcoming guideline on Antimicrobial stewardship – changing risk-related behaviours in the general population as well as our quality standard on Infection prevention and control (QS61).
Royal College of Nursing	4	Table 1	This should also include people undergoing acute treatment which alters their immune status- chemotherapy.	Thank you for your comment. We have amended the wording following your comment. The guidelines are covering all populations except those individuals in the first 72 hours of life (see section 3.1) of the final scope document. If the included evidence highlights any specific groups of patients that require different approaches for managing common infections this will be included in the guideline. The guidelines cover all people, except neonates (in the first 72 hours of life).
Royal College	4	Table 1	Some of the descriptors are not fully inclusive	Thank you for your comment. We have amended the

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of Nursing				wording following your comment.
Royal College of Nursing	4	Table 1	bone and joint - consider joint replacement infections and poly-trauma/ complex trauma infections	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Royal College of Nursing	4	Table 1	Dental- consider other non-abscess infections	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Royal College of Nursing	4	Table 1	Genital - consider broader inclusive term - pelvic inflammatory disease	Thank you for your comment. Please note that there is national guidance available from a NICE accredited guideline producer for pelvic inflammatory disease.
Royal College of Nursing	4	Table 1	Consider intra-abdominal	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Royal College of Nursing	5	Table 1	Infectious diarrhoea - consider listing organisms, gastroenteritis or norovirus is infectious but as a viral diarrhoea, will not ordinarily require antibiotics	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Royal College of Nursing	5	Table 1	Sepsis- suggest link to sepsis guidance	Thank you for your comment. We will link to other relevant NICE guidelines as you have suggested.
Royal College of Nursing	5	Table 1	Consider the challenges presented by gram negative organisms. (Cabapenem resistant gut bugs)	Thank you for your comment. We have amended the wording following your comment. We will also take this into account when selecting and prioritising our topics for development.
Royal College of Nursing	6	Line 122	Add articulate the risk / benefit to inform clinical judgement	Thank you for your comment. We will take this into account when presenting the guideline evidence.
Royal College of Nursing	7	Line 147	Consider highlight nursing responsibility/ multidisciplinary responsibility in prescribing, management and stewardship of antimicrobials	Thank you for your comment. Antimicrobial stewardship is everyone's responsibility, NICE has produced 2 guidelines on antimicrobial stewardship: Antimicrobial stewardship – systems and processes for effective antimicrobial use (NG15) and Antimicrobial stewardship – changing risk-related behaviours in the general population (publication expected January 2017).
Royal College of Nursing	General	General	Consider dealing with outbreak situations	Thank you for your comment. The purpose of the guideline is to provide recommendations on the management of common infections. Handling outbreaks would be outside the remit of these guidelines.
Royal College of Nursing	General	General	Consider standardized audit tools	Thank you for your comment. The purpose of the guidelines is to provide antimicrobial prescribing

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				guidance on managing common infections. Audit tools would be considered tools for implementation. NICE are always looking for tools that can be reviewed through the NICE endorsement programme to help support the implementation of guidance.
Royal College of Nursing	General	General	Would there be benefit in directly observed therapy (DOT) for some populations- including fit for purpose packs and public health messages regarding left over antimicrobials?	Thank you for your comment. NICE have published a guideline on medicines adherence.
Royal College of Nursing	General	General	Consider cross-referencing / linking to other available guidance within the text including inserting relevant links	Thank you for your comment. Wording and formatting was considered by the NICE publishing team. Related NICE guidance is listed in section 4 of the final scope document.
Royal College of Nursing	General	General	Should the guidelines also include information on viruses as antimicrobials are often given to treat viral infections?	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Royal College of Nursing	General	General	A comprehensive guideline, will strengthen the role of nurses in managing common infections; - nurses are at the coal face of patient care and can influence antimicrobial management in the different settings they work.	Thank you for your comment.
Royal College of Nursing	General	General	Suggest the document be mapped against the Public Health England (PHE) document and also look at some conditions that were excluded, including the ones we mentioned earlier.	Thank you for your comment. The final scope for the guideline will take PHE priorities into account to ensure that the NICE and PHE work complement each other. We will work closely with PHE and others to make the public aware of what NICE has said.
Primary Care Respiratory Society UK	General		As there is already a clinical guideline focused on respiratory infections, *CG69: Respiratory tract infections (self-limiting): prescribing antibiotics*, can you clarify whether this guideline in development will replace/ supersede CG 69 or be in addition to it?	Thank you for your comment. NICE clinical guidelines often do not make specific medicine prescribing recommendations. Therefore these guidelines will be additional to earlier guidelines although we will link to relevant existing NICE guidelines wherever possible.
Primary Care Respiratory Society UK	P4 Line 102 Table 1		From a respiratory perspective, we are comfortable with the proposed respiratory content of this guideline.	Thank you for your comment.
Primary Care Respiratory Society UK	P4 Line 102 Table 1		We would like to highlight a research paper from 2004 which suggested that reduced use of antibiotics in lower respiratory tract (LRTI) infections was followed by an increase in deaths from pneumonia in England and Wales. (http://www.resmedjournal.com/article/S0954-6111(03)00293-2/abstract?cc=y=) It concluded that the challenge is to identify the patients with LRTI who would benefit from antibiotics.	Thank you for your comment. We will consider this in line with our processes for reviewing the evidence for the infection area.

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British Infection Association	4	Table 1	Section on CNS infection could include brain abscess	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
British Infection Association	4	Table 1	Section on bone and joint infection should include diabetic foot infection	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
British Infection Association	5	Table 1	Section on Skin & Soft tissue infection should include otitis externa	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
British Infection Association	5	Table 1	Be very careful in defining catheter associated UTI.	Thank you for your comment. We will take this into account when considering terms used in the guideline.
British Infection Association	general	general	The scope is huge. They are pretty much planning to cover all of infectious diseases. The NICE guidelines on meningitis alone are a couple of hundred pages long. Is this realistic? The scope seems very broad, but they will have to focus on particular aspects of care eg choice of antibiotics.	Thank you for your comment. The focus of the guideline is antimicrobial prescribing guidelines for managing common infections. We have amended the wording following your comment. We will link to relevant existing NICE guidelines wherever possible.
British Infection Association	general	general	The range of infections includes common GP issues sore throat, sinusitis, otitis media and some very serious but less common infections meningitis, peritonitis etc. Would it not be better to concentrate on a few of the key GP areas where antibiotics often not required and rapid point of care testing etc might help eg sore throat.?	Thank you for your comment. We will take these into account when selecting and prioritising our topics for development.
British Infection Association	general	general	There are already guidelines available for some of the conditions does NICE intend to have two competing guidelines eg for meningitis?	Thank you for your comment. NICE clinical guidelines often do not make specific medicine prescribing recommendations. Therefore these guidelines will be additional to earlier guidelines although we will link to relevant existing NICE guidelines wherever possible.
British Infection Association	general	general	Interested that they are doing acute septic arthritis and osteomyelitis. Will you be covering whole management or just antibiotics?	Thank you for your comment. The detail for each infection topic will be considered by the committee when developing and agreeing the review protocols.
British Infection Association	General	general	This consultation is too broad and therefore difficult to comment on clearly.	Thank you for your comment.
Renal Association	General	General	All clinicians both in primary and secondary care will increasingly be involved in prescribing antibiotics for patients with chronic kidney disease. It would be helpful to specifically consider this group of patients throughout the guidelines. Dose amount, frequency and duration are frequently different in patients with CKD. Certain antibiotics such as aminoglycosides are best avoided in patients with	Thank you for your comment. The committee will consider this (and other specific patient subgroups where therapeutic management may differ to the general population) when discussing the evidence for each infection topic.

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			chronic kidney disease because of the increased risks of toxicity. Others require a dose reduction according to GFR. Others, such as trimethoprim, are associated with an acute rise in creatinine due to inhibition of creatinine tubular secretion without any change in real GFR. This results in unnecessary acute referral to renal units because of a lack of awareness. There is a real opportunity for improving antibiotic prescribing in CKD patients in this guideline.	
Renal Association	General	General	It would be best if patients receiving renal replacement therapy such as dialysis or renal transplantation were specifically excluded from this guideline. They are a unique group of patients requiring specific management that is very different from standard patients. For example, peritonitis in a patient receiving peritoneal dialysis is caused most commonly by gram +ive bacteria (in contrast to gram –ive organisms in standard patients). The choice of antibiotic and its mode of administration is very different and outside the scope of these general guideline. Most renal transplant patients receive chronic immunosuppression with calcineurin inhibitors (CnIs). There are important pharmacokinetic interactions between CnIS and a range of antibiotics most importantly the macrolide antibiotics which if unrecognised result in a large increase in CnI level with concomitant harmful nephrotoxicity.	Thank you for your comment. The committee will consider this when discussing the evidence for each infection topic. For some topics the committee may advise that a topic specialist is required to attend the meeting to advise on specific infection management issues such as this.
Renal Association	3	78-80	Solid organ transplant recipients or patients receiving immunosuppressive treatment should be specifically excluded by name in the same group as those with HIV etc.	Thank you for your comment. The wording has been amended following your comment.
Renal Association	General	General	It would be helpful if guidelines were provided on recording medications in primary care because of important interactions between certain antibiotics and CnIs. It should be mandatory for primary care to record all chronic medications that the patient is taking irrespective of the source of the prescription i.e. including chronic medications provided by hospital prescription. This would ensure that the electronic prescribing systems used in primary care would pick up important interactions with these agents when attempts are made to prescribe certain antibiotics and other agents.	Thank you for your comment. The detail in your comments applies to other guidelines and not just this. NICE has developed a guideline on medicines optimisation which provides recommendations on 'medicines-related communication systems when patients move from one care setting to another' and 'medicines reconciliation'.
Renal Association	General	General	It would be helpful if the guidelines could recognise the increasingly frequent problem with the supply of medications including antibiotics. For example, the licensed intravenous formulation of co-trimoxazole is currently unavailable. Secondary care is therefore required to use an	Thank you for your comment. The supply of medicines is outside the remit of this guideline and NICE. The Medicines and Healthcare products Regulatory Agency regulates medicines in the UK

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			unlicensed product accepting the risks associated with doing this. Guidance on an acceptable approach to the use of unlicensed products because of supply difficulties would be welcome.	and has responsibility for ensuring that the supply chain for medicines is safe and secure.
Renal Association	General	General	The risk of using high dose flucloxacillin in malnourished hospitalised patients receiving concomitant treatment with paracetamol needs to be highlighted. This common combination risks the development of pyroglutamic acidaemia particularly in patients with CKD or liver disease and is currently under recognised.	Thank you for your comment. The committee will consider this when discussing and agreeing the review protocols and the evidence for each infection topic.
British Thoracic Society	3	79-80	Presumably these will be developed for each infection? However HIV is the cause of AIDS so having both in the document is confusing.	Thank you for your comment. The wording has been amended following your comment.
British Thoracic Society	general	general	No mention of identifying a pathogen prior to commencing antibiotics where appropriate.	Thank you for your comment. This is covered by the NICE guideline on Antimicrobial stewardship. These guidelines will link to existing NICE guidelines wherever possible.
British Thoracic Society	3	78	It is not clear which chronic respiratory comorbidities will be excluded. Cystic fibrosis is mentioned, but bronchiectasis due to other causes is not. This list of exclusions should be more exhaustive.	Thank you for your comment. The wording has been amended following your comment.
British Thoracic Society	4	98	This point is a duplicate	Thank you for your comment. The wording has been amended.
The British Society for Antimicrobial Chemotherapy (BSAC)	GENERAL		Is the scope of this guideline feasible – ie all infections, all ages. It can be argued that septic arthritis, osteomyelitis, meningitis, intra-abdominal abscesses, febrile neutropenia, ventilator associated pneumonia are not common infections. It may be better to focus on common infections that present (and are managed) in primary care or front of house hospital (ED) rather than conditions that require an in-patient admission for some/all of the management.	Thank you for your comment. We have amended section 3.3 of the scope following your comment. We will take this comment into account when selecting and prioritising our topics for development.
The British Society for Antimicrobial Chemotherapy (BSAC)	98		Repetition - remove	Thank you for your comment. The wording has been amended.
The British Society for Antimicrobial Chemotherapy (BSAC)	136		The scope should also include some clear guidance to diagnosing a penicillin/beta-lactam allergy- has a huge impact on choice of Ab and the inappropriate use of macrolides that can drive resistance.	Thank you for your comment. The wording has been amended and a link to the NICE guideline on Drug allergy added in section 4 of the final scope document.
The British Society for Antimicrobial	GENERAL		The scope should include some pragmatic advice about Ab prescribing in young children i.e. not prescribing Ab suspensions that taste awful (flucloxacillin, clindamycin, pen V) and being mindful of the frequency of	Thank you for your comment. The committee will consider this when discussing and agreeing the review protocols and the evidence for each infection

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Chemotherapy (BSAC)			dosing i.e. adherence likely to be poor if >3 times per day dosing and child needs to be woken overnight.	topic.
The British Society for Antimicrobial Chemotherapy (BSAC)	GENERAL		Need to include a section in the scope about the importance of guidelines that promote consistent prescribing (or not) for common conditions prescribing to primary care or front of house hospital – inconsistency can drive Ab seeking behaviour and impact of patient Ab expectations.	Thank you for your comment. This detail would not normally be included in the scope. However, we will take this into account as we develop the guidelines.
Alere	General	General	Alere is a leader in rapid point of care diagnostics and supports working toward better clinical and economic healthcare outcomes globally. Alere welcomes the opportunity to respond to this draft scope consultation on management of common infections. In line with key existing NICE guidance, we recommend that these guidelines should incorporate a topic area on the effectiveness of diagnostic testing in ascertaining the clinical need for an antimicrobial (both point-of-care and laboratory). Inclusion of this new topic area is supported by the following areas of existing NICE guidance: 1. **Pneumonia in adults: diagnosis and management (2014) NICE CG191, recommendation 1.1.1:** *'Consider a point of care C-reactive protein test if after clinical assessment a diagnosis of pneumonia has not been made and it is not clear whether antibiotics should be prescribed. Use the results of the C-reactive protein test to guide antibiotic prescribing in people without a clinical diagnosis of pneumonia'* 2. **Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use (2015) NG15**, **recommendation 1.1.30:** *'Consider point-of-care testing in primary care for patients with suspected lower respiratory tract infections as described in the NICE guideline on pneumonia.'* C-Reactive Protein Point of Care Testing (CRP POCT) represents an example of a proven and cost-effective Point of Care diagnostic that can be used in primary care and pharmacy settings to support the management of common infections, as well as contribute to efforts to	Thank you for your comment. Diagnostics will be considered only for those topics areas as relevant and we will be advised by the committee.

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			reduce levels of inappropriate antibiotic prescribing, without increasing the risk of complications or missed diagnoses. It can therefore represent an important tool to healthcare practitioners and patients in the management of common infections.	
Alere	4	100	Review of protocols should be aligned with NICE evidence already provided to ensure there is no confusion regarding guidelines. Examples are Pneumonia Guideline CG 191 and Antimcirobial Stewardship Guideline NG 15.	Thank you for your comment. We will link to relevant existing NICE guidelines wherever possible
Alere	6	115	Non-pharmacological strategies should include use of rapid diagnostic tests such as point of care CRP for lower respiratory tract infection (see NICE Pneumonia Guideline CG191 and Antimicrobial Stewardship Guideline, NG15).	Thank you for your comment. We will link to relevant existing NICE guidelines wherever possible and we will consider these interventions when discussing the review protocols for the topic.
Somerset Partnership NHS Foundation Trust	2	32	Does the phrase "primary" and "secondary" care cover the "health care wide system" especially with the development of new models of care in line with the NHS five year forward view. For example: • where do virtual wards in patients homes, ambulatory care and assessment beds in the community sit? They are not necessarily covered by current primary care guidelines or secondary trust guidelines? • How do you treat a "step up" or "step down" patients in community hospitals with a chest infection – do you follow primary care guidelines or secondary care guidelines? They may have a HAP, which is not in current primary care guidance. Community care cannot automatically adopt secondary care guidance due to prescriber competency/experience with secondary care antibiotics and consultant medical microbiologist resources for developing "community hospital or virtual ward" antibiotic guidance is not readily available if at all. Potentially a more patient pathway approach has to be considered so that a patient can get the appropriate treatment regardless of their healthcare setting. A revolving door secondary care patient being treated within new models of care to avoid hospital admission, may not receive appropriate care if empiric primary care guidance is followed.	Thank you for your comment. The scope covers all publicly funded health and social care settings. We will consider your comments when we are presenting the guideline evidence.
Somerset Partnership NHS Foundation	2	47	As service provision moves from traditional settings (GP led primary care and prescriber led secondary care), PGDs are more frequently being used to provide care closer to patients homes in community hospitals, ambulatory care, assessment beds, virtual wards. PGDs are	Thank you for your comment. Patient group directions are not routinely recommended for supply of antimicrobials in line with recommendation 2.1.10 of NICE guideline on Patient group directions (MPG2).

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Trust			increasingly being used. There would be merit in including PGD users in the guideline scope as they are often used for sexual health, podiatry prescribing and MRSA suppression therapy currently and may be necessary for empiric treatment of sepsis in non traditional settings.	The wording used in the scope is intended to capture all types of service provision.
Somerset Partnership NHS Foundation Trust	4	91	Current resistance reports are frequently separated into primary care and secondary care. These do not facilitate guideline development or antibiotic choice for new models of care where acute patients are treated in alternate settings.	Thank you for your comment. We will consider your comment when discussing the review protocols and the presentation of the final guidelines.
Somerset Partnership NHS Foundation Trust	4	100	"all care settings" needs to be clearly defined.	Thank you for your comment. Section 3.2 of the final scope document outlines the settings to be covered. We feel that all care settings is self-explanatory.
Somerset Partnership NHS Foundation Trust	4	102	All these conditions are potentially provided in: • secondary care • "step down" and "step up" new models of care (virtual wards in patients homes, community hospital beds, ambulatory care beds, assessment beds in community hospitals, minor injury units/urgent care units), • primary care • Other settings Guidelines are required which ensure the patient receives the most appropriate treatment and not treatment which fits into either a "primary" or "secondary" care guideline, and can be treated appropriately when A&E and secondary care beds are full. Appropriate consultant medical microbiologist input/resource will be required to develop these guidelines. This resource is currently limited and often not available in the non traditional care settings, especially when mutli organisation facing.	Thank you for your comment. Section 3.2 of the final scope document outlines the settings to be covered. We will consider your comment when discussing the presentation of the final guidelines. The guideline committee has 2 consultant microbiologists on it along with other experts in the field.
Somerset Partnership NHS Foundation Trust	6	113	The resistance reports based on "primary" and "secondary" care may not provide the information to inform a truly "local" picture. It is based on silo information and not the patient pathway.	Thank you for your comment. We will take this into account when reviewing the information.
Somerset Partnership	6	124	The antibiotic should be based on clinical need and not location of treatment, although risk assessment of use needs to be considered in	Thank you for your comment. We will consider your comment when reviewing the evidence and

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NHS Foundation Trust			line with location, staff skill mix and availability of antibiotics e.g. gentamicin use when levels can't be utilised in the traditional way. "primary " and "secondary" care choices can introduce false treatment categories. There should be more a treatment pathway which includes if the infection is thought to be community acquired or healthcare associated.	discussing the presentation of the final guidelines.
Somerset Partnership NHS Foundation Trust	6	125	Optimal route of administration may need to be varied depending on the location of the patient being treated, the availability of the drug and the skill mix of the staff prescribing /administering. A patient may require an IV but if they are to be treated outside of an acute trust an alternative may be required.	Thank you for your comment. We will consider your comment when reviewing the evidence and discussing the presentation of the final guidelines.
Somerset Partnership NHS Foundation Trust	6	131	The location of the treatment of "severe" infections may be variable as new models of care my result in more treatment outside of the "acute" setting where in the patients bests interests.	Thank you for your comment. We will consider your comment when reviewing the evidence and discussing the presentation of the final guidelines.
Somerset Partnership NHS Foundation Trust	6	132	Inclusion of "location" is very important.	Thank you for your comment. We will consider your comment when discussing and reviewing the review protocols, subsequent evidence and presentation of the final guidelines.
Somerset Partnership NHS Foundation Trust	6	146	Consideration is required of the optimal treatment of patients where ever the setting e.g. oral levofloxacin has recently been reintroduced to treat HAP in an acute hospital. However, if the patient is a step down patient from an acute trust or has HAP in a non acute hospital they may not receive the same therapy due to the need to reduce the use of quinolones in the "community". The same may happen with meropenem – if best practice is to use meropenem, a patient may receive as per guidance it in an acute trust but not in another setting and hence may require transfer or a suboptimal therapy.	Thank you for your comment. We will consider your comment when discussing and reviewing the review protocols, subsequent evidence and presentation of the final guidelines.
Somerset Partnership NHS Foundation Trust	7	148	"hospital" requires definition and is often misinterpreted as "acute" hospitals, whereas it could be:	Thank you for your comment. These are examples and are not intended to be an exhaustive list.
Somerset Partnership NHS Foundation	7	149	"hospital" as in 11 above.	Thank you for your comment. These are examples and are not intended to be an exhaustive list.

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Somerset Partnership NHS Foundation Trust	7	160	Resistance reports will need to take into account new models of care and setting of treatment provision rather than just be "primary" and "secondary" care.	Thank you for your comment. We will consider your comment when discussing and reviewing the review protocols, subsequent evidence and presentation of the final guidelines. NICE will not be producing resistance reports this is the remit of Public Health England.
Somerset Partnership NHS Foundation Trust	7	169	Please consider the consultant medical microbiologist resource required to provide equitable appropriate care to patients regardless of treatment location. This resource is often unavailable outside of traditional "primary" and "secondary/acute" care models	Thank you for your comment. We will consider your comment when discussing and reviewing the review protocols, subsequent evidence and presentation of the final guidelines.
Somerset Partnership NHS Foundation Trust	9	229	Clarity required on "hospital" prescribing. I believe the data only includes "acute" trusts. Current NICE does not cover non acute hospitals which are starting to treat more and more complex infection patients.	Thank you for your comment. Please note that the section referred to in the comment is a quote from Public Health England's 2014 English surveillance programme antimicrobial utilisation and resistance (ESPAUR) report. The final scope document outlines that all settings will be covered (see section 3.2).
Somerset Partnership NHS Foundation Trust	10	251	Where will new models of care sit i.e. acute treatments in the community?	Thank you for your comment. Section 3.2 of the final scope document outlines the settings to be covered. We will consider your comment when discussing the presentation of the final guidelines.
Somerset Partnership NHS Foundation Trust	4	102	Guidelines for dental infections need to consider the complex provision of dental care, it can include GPs prescribing for dental infections as an emergency last resort before referral to dental services (current primary care guidance), private dental provision in the community, specialist dental service provision (prisons, complex patients at home as unable to attend acute care settings e.g learning difficulties, infirm) and acute settings.	Thank you for your comment. We will consider your comment when discussing and reviewing the review protocols and subsequent evidence.
RCPCH	Full document		Our commenter agrees with the content of draft document so far.	Thank you for your comment.
Smith & Nephew	4	95	Please add: Consider the use of effective topical antiseptics to manage local infections where appropriate i.e. wounds	Thank you for your comment. Please see the footnote on page 3 of the final scope document which provides a definition for the term 'medicine'.
Smith & Nephew	5	Table 1	Within the soft tissue infections section please add: Pressure ulcers, diabetic foot ulcers and surgical wounds	Thank you for your comment. We will take this into account when selecting and prioritising our topics for

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				development.
Smith & Nephew	6	114	Please add an additional key question: Role of biofilms in chronic infections: Antibiotic therapy tolerance and failure (not resistance), recurrent infections, delayed healing (in the case of wounds)	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development. This level of detail will be considered when the committee is discussing and agreeing the review protocols.
Smith & Nephew	6	121	Would question why antiseptics are considered under the non-antimicrobial section? These are potent broad spectrum antimicrobials that attack bacterial cells in multiple ways thereby minimising the development of resistance compared to antibiotics. There is also evidence to suggest use of topical antiseptics can minimise the need for antibiotics in localised infections therefore reducing use – they also play a role in spreading/ systemic infections working alongside systemic antibiotic therapy to manage infection locally (particularly where reduced perfusion of limbs/ infected tissue leads to minimal antibiotic reaching the infected site). We would advise to list antiseptics in a separate key question and can support this section with evidence.	Thank you for your comment. The wording has been amended following your comment. We will consider this intervention when discussing the review protocols for the topic.
Optical Confederation and Local Optical Committee Support Unit	4	102	Table 1 – Eye – Conjunctivitis The Optical Confederation represents optometrists and dispensing opticians, both of whom use antibiotics as part of their professional practice. The Confederation is fully committed to minimising antibiotic use and to the overarching strategy to eliminate unnecessary prescribing. Eye care practitioners are trained in the recognition of ocular disease. Most are conveniently located and easily accessible to patients, and have both the equipment to comprehensively examine eyes and the skills to make a differential diagnosis of ocular infections. Optometrists and dispensing opticians use antibiotics for treatment, for example to manage patients suffering from bacterial conjunctivitis. However, they are aware that this condition is generally self-limiting, often requiring no treatment. Eye care practitioners are skilled at making that differentiation and are therefore cautious prescribers, only treating those infections that are not self-limiting or are - on rare occasions - causing the patient significant discomfort.	Thank you for your comment. We will consider this information during the development of the guidelines. For some topics the committee may advise that a topic specialist is required to attend the meeting to advise on specific infection management issues such as this.

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			Optometrists can also use antibiotics for prophylactic purposes, following a corneal insult for example. All registered optometrists currently have exemption access to two antibiotics, Chloramphenicol and Fucithalmic, and dispensing opticians to Chloramphenicol. Optometrists with additional therapeutic qualifications or who work within a Patient Group Direction have access to a wider range of antibiotics and Independent Prescriber optometrists may manage a wide range of anterior segment ocular infections, including conjunctivitis, and prescribe autonomously in their clinical practice. NB: Fucithalmic is no longer available in generic form and has recently seen a significant increase in price. We would urge the committee therefore, to support a change to an alternative antibiotic for optometrist prescribing to reduce costs for the NHS. We support the development of the guideline and, in so far as the draft scope currently applies to our sector, are happy with the content proposals. In addition, primary eye care practitioners are increasingly providing a wider range of extended primary eye care services outside hospital, for instance to manage patients with urgent eye conditions (e.g. via Minor Eye Care Services, or MECS) and to carry out surgical follow-up (e.g. for cataract). Across England, there are currently 70 commissioned MECS. MECS direct patients to primary eye care practitioners with the necessary skills and equipment to assess minor eye conditions, such as foreign matter in the eye, thus freeing up resource in GP surgeries and in secondary care eye departments, both of which are currently facing severe capacity issues. All urgent eye condition services include the assessment and management of red eyes and inflammation caused by conjunctivitis and have been shown to be clinically effective and positively received by patients A optometrist prescriber would make a meaningful contribution to the work of the guideline development committee and we urge the Committee to make a co-opted appointment to assist in the discussion	

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			of conjunctivitis and other eye conditions.	
Faculty of General Dental Practice (UK)	3	78	We disagree that people with disorders of the immune system (e.g. patients undergoing chemotherapy) should be excluded from the scope of the guidelines. This group are at high risk of presenting with common infections and are just as likely to be treated by generalists and independent contractors.	Thank you for your comment. This bullet has been removed following your comment. The guidelines are covering all populations except those individuals in the first 72 hours of life (see section 3.1) of the final scope document. If the included evidence highlights any specific groups of patients that require different approaches for managing common infections this will be included in the guideline.
Faculty of General Dental Practice (UK)	4	102	In the third row of Table1, "dental abscess" is the only listed 'Infection topic' under 'Area of infection: Dental'. However, there are a number of common dental infections which are not accurately defined by the term "dental abscess". We suggest that either the description of the 'Infection topic' be changed to "dental infections", or that common dental infections are listed individually, including: • Dento-alveolar infections • Pericoronitis • Acute necrotising ulcerative gingivitis	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Faculty of General Dental Practice (UK)	5	104	In the management of dental infections, the use of antibiotics differs substantially from that in relation to the other common infections listed in Table 1, and a number of the key questions are not relevant. The diagnosis (cause) is the most important. Where there is no evidence of systemic disease, removal of the cause by definitive dental treatment will lead to resolution of the infection without antibiotics.	Thank you for your comment. The committee will consider this when discussing and agreeing the review protocols and the evidence for each infection topic.
Faculty of General Dental Practice (UK)	Generl	General	We are concerned at the lack of dental expertise within the person specification for the Development Group you are recruiting for this guideline. As noted in comment 3, the use of antibiotics in the management of dental infections differs substantially from that of the other common infections (such as those listed in Table1 of the draft scope). In particular, where there is no systemic disease, dental treatment will in most cases lead to resolution of a dental infection without the need for antibiotics.	Thank you for your comment. For some topics the committee may advise that a topic specialist is required to attend the meeting to advise on specific infection management issues such as this.

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			Excluding dental input from the GDG risks the group taking insufficient account of the oral health context, and making medically-based recommendations which are clinically inappropriate for common dental infections. This could result in NICE guidance which is out of step with existing evidence-based guidance, and could legitimise prescribing in circumstances which experts in infection management within the oral health professions and their regulators currently consider inappropriate. Such a situation could halt or reverse the considerable progress already made in improving antibiotic stewardship in dentistry, which would be opposite to the intended effect of the guidelines (as outlined on page 1, lines 6-9). We therefore strongly recommend that NICE seeks to recruit to the GDG an expert in the use of antimicrobials within dentistry, or failing that seeks expert dental advice for the group - above and beyond that which can be delivered by written consultation responses – when it is formulating guidelines on the management of dental infections.	
Royal College of General Practitioners	General	General	There is nothing in the scope about the use of decision aids and tools and about shared decision making more broadly. Key question number 4 is about non-pharmacological treatments but a further key question is how can clinicians be supported to help patients make decisions about when to opt for these? There are a number of decision tools that have been developed specifically for the management of common infection, including the TARGET antibiotic toolkit that was produced by the RCGP with partners. It would be useful if this guideline was able to provide recommendations about the use of these decision aids and about the use of shared decision making more broadly. (AR)	Thank you for your comment. We will link to existing NICE guidelines on antimicrobial stewardship, such as Antimicrobial stewardship – systems and processes for effective antimicrobial use (NG15) and Antimicrobial stewardship – changing risk-related behaviours in the general population (publication expected January 2017). These guidelines include recommendations on shared decision making. NICE's programme for Endorsement seeks to use existing implementation tools to support the implementation of guidance recommendations. We aim to work with partner organisations wherever possible to ensure the guidelines are implemented.
Royal College of General Practitioners	General		The scope is well defined. It is generally concerning acute infections many of which will be self limiting. The relevance of therapeutic blood levels in determining practice is of importance-and for how long and at	Thank you for your comment. NICE has produced a guideline on Tuberculosis, which includes specific prescribing recommendations. However, we will take

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			what level. It is unclear whether TB treatment and long term penicillin for Rheumatic fever/ Sickle cell will be considered. The duration and dosage are critical and in particular whether a single large dose, administered by the clinical team orally or intramuscularly/depot would be sufficient. The problem of compliance and the co-operation of prescriber/patient for the duration of treatment is crucial to success. Often the duration of therapy is arbitrary and not particularly related to clinical response or microbiological "clearance". (PS)	your comments into account when selecting and prioritising our topics for development.
British Dental Association	4	Table 1	Necrotising periodontal diseases should be included in the "dental" category. These conditions occur commonly in, for example, young otherwise healthy adults, and require treatment with specific antibiotics alongside clinical intervention.	Thank you for your comment. We will take your comments into account when selecting and prioritising our topics for development.
British Dental Association	6	124	Guidance is needed by prescribers on managing patients who report drug allergies. For example, some patients might incorrectly identify themselves as allergic to a particular antimicrobial; this could influence the choice of treatment thereafter if recorded unquestioningly in their notes.	Thank you for your comment. The wording has been amended in section 4 of the final guideline scope document - a link to the NICE guideline on Drug allergy has been added.
British Dental Association	7	169-173	The management of dental infections requiring operative intervention should be prioritised for resource impact analysis. The current NHS dental contract, in England, Wales and Northern Ireland, perversely incentivises the unnecessary prescription of antibiotics for patients with dental abscess, because it fails to acknowledge the unpredictability of patients presenting with dental emergencies. In particular, the contracts for services that specifically provide unscheduled care should take into account that surgical/clinical intervention can take at least 45 minutes and that where, for example, a contractual target is to treat four patients an hour, appropriate care in antimicrobial stewardship terms becomes impossible. Dentists working within normal hours also require funded time for the appropriate treatment of unscheduled emergencies. Studies have shown that this time and resource pressure is a substantial driver of antibiotic prescribing in dentistry.* The cumulative cost of repeated visits by patients who do not initially receive appropriate surgical intervention should make the provision of funded emergency treatment time cost-effective, in addition to promoting antimicrobial stewardship.	Thank you for your comment. We will take your comments into account when selecting and prioritising our topics for development and discussing and agreeing the review protocols.

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			*Cope *et al.*, 2015: http://onlinelibrary.wiley.com/doi/10.1111/cdoe.12199/abstract	
British Dental Association	General	General	Published evidence-based guidance already exists for dentists in the UK .** The scope of this NICE guidance under development for the treatment of dental infections must be appropriate for GPs and A&E staff, taking into account the extant published guidance. Dental patients commonly present in both of these medical settings (for many reasons including perceived patient charge avoidance). The key issue is one of the need for correct diagnosis and referral to the appropriate provider of clinical intervention. **British National Formulary Dental Practitioners' Formulary: https://www.evidence.nhs.uk/formulary/bnf/current/dental-practitioners-formulary Palmer, N.O.A., Longman, L., Randall, C. and Pankhurst, C.L. (2012) Antimicrobial prescribing for general dental practitioners. FGDP(UK), London: http://www.fgdp.org.uk/OSI/open-standards-initiative.ashx SDCEP *Drug prescribing for dentistry*: http://www.sdcep.org.uk/published-guidance/drug-prescribing/ FDS National Clinical Guidelines, 1997: https://www.rcseng.ac.uk/dental-faculties/fds/publications-guidelines/clinical-guidelines/	Thank you for your comment. We will consider your comments when discussing the review protocols for the topic. The BNF provide prescribing information for all antimicrobials and does not take into account priorities for selection of a specific antimicrobial for a named infection.
British Dental Association	General	General	The BDA notes with alarm that the call for expert members of the Guideline Development Group for this topic did not include a dentist. It is essential that a dental expert be included, and we have written separately to NICE on this issue, as follows: *The BDA is concerned that a dental expert has not been included in the list of professionals being recruited to the NICE committee developing this guideline. The draft scope recognises that dental infections occur commonly and must be managed "in all care settings" in which they present. We strongly believe this requires expert dental input.* *Guidance already exists for dentists on the treatment of dental infections, but dental patients often present to GPs or A&E departments for a variety of reasons. Indeed, recent research commissioned by the BDA indicated that 600,000 dental patients per year are attending GP surgeries with conditions that doctors are not equipped to treat. A dental expert will be able to advise the NICE guideline development group on how such patients should be managed.*	Thank you for your comment. For some topics the committee may advise that a topic specialist is required to attend the meeting to advise on specific infection management issues such as this. We will contact those names provided for specialist input.

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			The BDA would recommend Dr and Dr as appropriate experts to contribute to the guideline development group for this topic, both of whom have been involved extensively in antimicrobial stewardship work within dentistry and attended the NICE stakeholder meeting on 17 November.	
Meningitis Research Foundation	6	141	We would also like the guidance to specifically address when to provide patients with safety netting information. This would align with the NICE guidance on Sepsis, Feverish illness in children and Bacterial meningitis in children	Thank you for your comment. We will consider your comment when discussing and reviewing the review protocols, subsequent evidence and presentation of the final guidelines.
Meningitis Research Foundation	8	199	Include NICE guidance on Meningitis (bacterial) and meningococcal septicaemia in under 16s: recognition, diagnosis and management (CG102)	Thank you for your comment. The wording has been amended in the final scope document (see section 4).
NHS England	general	general	Inclusion of diagnostics is imperative to ensure appropriate targeted treatment with antibiotics. NHS England would encourage inclusion of diagnostics and reduction in empirical treatment towards targeted treatment based on the active infection.	Thank you for your comment. Diagnostics will be considered only for those topic areas as relevant and we will be advised by the committee.
NHS England	general	general	Inclusion of consideration of antimicrobial resistance or susceptibility and stewardship in managing common infections. Use of diagnostics to monitor infection and ensure appropriate treatment and antimicrobial stewardship and review are included (For example in the management of UTIs and sepsis).	Thank you for your comment. Diagnostics will be considered only for those topic areas as relevant and we will be advised by the committee.
Royal College of Physicians of Edinburgh	General		The draft scope of this document is enormous, challenging and ambitious but in light of the pressing concerns regarding Antimicrobial Resistance (AMR), it is very welcome. There inevitably will be overlap with many other guideline groups including SIGN UTI, BTS CAP and HPA C. difficile guidance. The College would appreciate clarification on how this will relate to PHE's widely used primary care antibiotic guidance – to inform or replace?	The final scope for the guideline will take PHE priorities into account to ensure that the NICE and PHE work complement each other. We will work closely with PHE and others to make the public aware of what NICE has said. We will also take your comments into account when selecting and prioritising our topics for development.
Royal College of Physicians of Edinburgh	5	102, table 1	Dysentery could be removed as not distinct form infectious diarrhoea as a syndrome.	Thank you for your comment. We have amended the wording following your comment and we will take this into account when selecting and prioritising our topics for development.
Royal College of Physicians of Edinburgh	5	102, table 1	"Septicaemia" should be removed as it is not a recognised entity any more.	Thank you for your comment. We have amended the wording following your comment and we will take this into account when selecting and prioritising our topics for development.
Royal College	5	102, table	Staph aureus bacteraemia could be included as an area where practice	Thank you for your comment. We will take this into

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of Physicians of Edinburgh		1	is often suboptimal and where there is emerging evidence for best practice.	account when selecting and prioritising our topics for development.
Royal College of Physicians of Edinburgh	5	102, table 1	Infectious diarrhoea and Clostridium difficile should be separated as distinct clinical entities (there will be significant cross over with HPA guidance here).	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Royal College of Physicians of Edinburgh	5	102, table 1	Cholecystitis could be included as a distinct clinical entity within the GI section as behave very differently from others included here. Similarly liver abscess may be considered as a common entity in hospitals.	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Quinolone Toxicity Support UK	3.4 Q 9.8	136	First, second and third line therapy (including for those with allergic 137 reactions to certain antimicrobials) are very important criteria. The Quinolone antibiotics are generally considered to be third line therapy but their use in urgent situations before a culture can be taken often means they are given unnecessarily. All medical professionals must be aware that the BNF advisory statement "tendon damage (including rupture) has been reported rarely in people receiving quinolones" (BNF 58, 2009) is actually an understatement. Many hundreds of people have been affected by Quinolones with multi-system symptoms, not just tendon problems, but these are rarely associated with the Quinolone as they can manifest themselves not only while the course is being taken but up to many weeks or months after – long after the association with the Quinolone is forgotten. http://casereports.bmj.com/content/2015/bcr-2015-209821.full Golomb et al. Fluoroquinolone-induced serious, persistent, multisymptom adverse effects – which states "Physicians and patients should be alert to the potential for FQ-induced severe disabling multisymptom pathology that may persist and progress following FQ use. See also: http://bmjopen.bmj.com/content/5/11/e010077.full Daneman"Fluoroquinolones and collagen associated severe adverse events" 18.11.2015 The MHRA drug analysis sheets reveal that numbers of Adverse Reactions (ADRs) to Quinolones reported to them via the Yellow Card scheme increased by 1,140 between January 25th and Aug 21st this year (2016). More worryingly the number of reported fatalities rose by 17 in the same period. They have informed me that they estimate only 10 -15% of ADRs are reported so there may be over 10,000 people who	Thank you for your comment. We will consider your comment when discussing and reviewing the review protocols, subsequent evidence and presentation of the final guidelines.

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			have been affected since I first wrote to them in January with possibly well over a hundred Quinolone-related deaths! (http://www.mhra.gov.uk/drug-analysis-prints/drug-analysis-prints-a-z/index.htm)	
Quinolone Toxicity Support UK	Table 1	Urinary Tract – Acute Prostatitis.	The NICE guidelines for managing prostatitis state the following: Start antibiotic treatment immediately, while waiting for the urine culture results. • A quinolone (ciprofloxacin 500 mg twice daily, or ofloxacin 200 mg twice daily) for 28 days is recommended. If ciprofloxacin and ofloxacin cannot be taken, trimethoprim 200 mg twice daily for 28 days is recommended (off-label use). Treat the pain: • Paracetamol and/or ibuprofen (taken regularly) is recommended first-line. • https://cks.nice.org.uk/prostatitis-acute#!scenario The advice to give the Quinolone while waiting for the culture is poor and possibly dangerous advice given the severity of possible side effects due to mitochondrial damage (see refs in point 1 above). The advice to treat the pain with "and/or Ibuprofen" is even worse advice given that Ibuprofen and other NSAIDS along with corticosteroids (e.g. Prednisolone) can exacerbate the symptoms."Taking an NSAID while you take CIPRO or other fluoroquinolones may increase your risk of central nervous system effects and seizures" http://www.accessdata.fda.gov/drugsatfda_docs/label/ Also see "Advice to avoid the use of nonsteroidal anti-inflammatory drugs with quinolones, because of an increased risk of convulsions". BNF 58, 2009]	Thank you for your comment. We will link to other relevant NICE guidelines as appropriate. We will also consider your comment when discussing and reviewing the review protocols and subsequent evidence. Safety alerts will be considered along with the included evidence.
Quinolone Toxicity Support UK	General	General	Similar advice is given in the epididymo-orchitis section of the NICE guidelines: If epididymo-orchitis is thought to be due to chlamydia or other non-gonococcal organism (no risk factors for gonorrhoea):	Thank you for your comment. We will link to other relevant NICE guidelines as appropriate. We will also consider your comment when discussing and reviewing the review protocols and subsequent evidence. Safety alerts will be considered along with the included evidence.

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			Treat without waiting for test results with doxycyline 100 mg by mouth twice daily for 10–14 days, *or* ofloxacin 200 mg by mouth twice daily for 14 days. If epididymo-orchitis is thought to be due to an enteric organism (for example, *Escherichia coli*): • Treat without waiting for test results with ciprofloxacin 500 mg by mouth twice daily for 10 days, *or* ofloxacin 200 mg by mouth twice daily for 14 days. Avoid quinolones in people with a history of tendon disorders related to quinolones, or a history of seizures or conditions that predispose to seizures. Advise: • Bed rest, scrotal elevation (such as with supportive underwear), and analgesia. • If ciprofloxacin or ofloxacin is prescribed, avoid nonsteroidal anti-inflammatories, and discontinue treatment and seek immediate medical advice if joint or tendon pain occur. https://cks.nice.org.uk/scrotal-swellings#!scenario:2 (Interesting that advice to avoid NSAIDs is given in this section yet not in the prostatitis section above!) Although perhaps not under the umbrella of this scoping exercise, I feel I have to make this point again as many men who have joined our group for support have had their lives ruined by a course (or sometimes multiple courses) of Ciprofloxacin or Ofloxacin. Too often they have found they are suffering agonising aches and pains – and are then told the good news that they didn't have an infection after all! This cavalier attitude of checking if a patient has a history of tendon disorders but not checking if they have an infection in the first place is shocking when one considers just how damaging these drugs can be. Just one example is that one member of the group was given Cipro and Ibuprofen 10 years ago for suspected prostatitis, has suffered terribly since (especially with derealisation disorder), yet no doctor has ever tried to help him. He says *"All they've tried to do is make out it's all in my head".* (Testimonials from or interviews with group members can be arranged)	

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Quinolone Toxicity Support UK	General	General	Whilst preparing this submission I found this statement: "Very limited evidence from the only randomized, controlled trial of antibiotics for epididymo-orchitis identified by CKS that, for men older than 40 years of age with epididymitis, ciprofloxacin is more effective than pivampicillin, and has a lower risk of adverse effects." https://cks.nice.org.uk/scrotal-swellings I hope you will forgive me for drawing your attention to this trial published in 2011: 6-day intensive treatment protocol for refractory chronic prostatitis/chronic pelvic pain syndrome using myofascial release and paradoxical relaxation training. http://www.ncbi.nlm.nih.gov/pubmed/21334027 Anderson RU et al. The purpose of the study was set out thus: "Chronic prostatitis/chronic pelvic pain syndrome continues to elude conventional therapy. Evidence supports the concept that phenotypes of pelvic muscular tenderness and psychosocial distress respond to myofascial trigger point release and specific relaxation training. This case series reports long-term outcomes of a 6-day intensive combination of such therapies in refractory cases." The study concluded that: "Men with chronic pelvic pain refractory to traditional treatment benefit from intensive myofascial trigger point therapy and concomitant paradoxical relaxation training. Education in techniques for self-administered trigger point release and continued pelvic muscle relaxation help patients reduce pain and dysfunction. Refinement of clinical phenotyping and selection of patients with pelvic muscle tenderness should enhance the success rate with this treatment modality". The problem with these 'male pelvic area' conditions is that a diagnosis is often made on the symptoms of pain alone. M*ost men presenting with 'prostatitis' have a negative urine culture, indicating that bacteria may not be the cause of their symptoms. In 2004, a double-blind trial on men suffering from CP/CPPS, concluded that, "Ciprofloxacin and tamsulosin did not substantially reduce symptoms in men with long-standing CP/CPPS who had at least moderate symptoms", saying "..the*	Thank you for your comment. We will consider your comment when discussing and reviewing the review protocols and subsequent evidence. We also note that the evidence review for scrotal swellings on the NICE CKS website was conducted prior to 2011.

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			cause of CP/CPPS is unknown". "Ciprofloxacin or tamsulosin in men with chronic prostatitis/chronic pelvic pain syndrome: a randomized, double-blind trial." *Annals of Internal Medicine*, 2004 Oct 19;141(8):581-9. *Perhaps in these times of antimicrobial stewardship, methods other than antibiotic treatment for this condition should be considered – especially if no infection is found.*	
MSD	General	General	MSD supports the principles of good antimicrobial stewardship (AMS) and believe these guidelines will be supported by the documents referenced. We appreciate being given the opportunity to attend the workshop and believe some of the key points identified e.g., access to diagnostics/testing, pathogen-drug combinations and incorporation of local resistance data will help to inform good AMS.	Thank you for your comment.
MSD	General	General	MSD supports increasing the awareness of antimicrobial resistance (AMR) by utilising local resistance rates and epidemiology, and providing toolkits to enable trusts to be aware of their local epidemiology.	Thank you for your comment.
MSD	General	General	It is our interpretation based on the scoping workshop that consideration will be given per indication and therapeutic options recommended for each. MSD supports the use of the right product at the right time in the right patient based on clinical circumstances and feel that this would be enhanced based on availability of testing, local epidemiology and access to clinically appropriate treatment choices.	Thank you for your comment.
MSD	General	General	Having attended the workshop we feel that the draft scope is broad but understand there is the possibility that subsequent consideration will be given per indication/pathogen, and MSD welcomes any further clarity that can be provided on these in line with good AMS.	Thank you for your comment. Registered stakeholders will have opportunity to provide comments on draft guidelines when they are out for consultation.
MSD	4	81	The draft scope does not currently take into account the differences between primary and secondary care pathways and the possibility of harmonisation of the two in a sustainable pathway for a given condition.	Thank you for your comment. The guidelines will cover all care settings (see section 3.2 of the final scope document). We will consider your comment when discussing and reviewing the review protocols, subsequent evidence and presentation of the final guidelines.
MSD	4	85	MSD believes that it is critical for the guidelines to look at admission avoidance and early discharge and address potential mechanisms for monitoring and auditing these outcomes.	Thank you for your comment. We will consider your comment when discussing and reviewing the review protocols.
MSD	4	102	It is our belief that clinical practice reflects pathogen and drug/bug combinations rather than indication and we would support guidance that	Thank you for your comment. We will consider your comment when discussing and reviewing the review

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			follows current clinical practice.	protocols, subsequent evidence and presentation of the final guidelines.
Association of Clinical Oral Microbiologists (ACOM)	3	78	There are some concerns that people with disorders of the immune system or pre-existing conditions are excluded from this guideline. We recommend that the management of the common infections in all medically compromised patients including patients who have compromised immune system should not be ignored. Emphasis on preventive measures, timely diagnosis and management of infections along with the appropriate utilisation of diagnostic services should be made.	Thank you for your comment. This bullet has been removed following your comment. The guidelines are covering all populations except those individuals in the first 72 hours of life (see section 3.1) of the final scope document. If the included evidence highlights any specific groups of patients that require different approaches for managing common infections this will be included in the guideline.
Association of Clinical Oral Microbiologists (ACOM)	4	102 Third row: "Dental: dental abscess"	While dental abscess is the most common dental infections, there are other infections that are seen frequently in primary and secondary care settings such as: Periodontal abscess Aggressive periodontitis Refractory cases of periodontitis Necrotising ulcerative gingivitis/periodontitis (NUG/NUP) Pericoronitis Bacterial sialadenitis Oral candida infections Osteonecrosis and osteomyelitis	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Association of Clinical Oral Microbiologists (ACOM)	6	113	In the whole UK, there are only eight Clinical Oral Microbiologists (COMs) registered with the General Dental Council. To ensure patient safety in managing oral and dental infections, each dental hospital should have access to the expertise of one of the COMs. Currently, there is a lack of antimicrobial resistance surveillance scheme for oral pathogens in the UK. Taking good quality specimens and performing appropriate laboratory investigations is essential for informed decisions on guidance of empiric use of antibiotics. A national co-ordinated plan should be developed for an appropriately funded national surveillance scheme for antimicrobial resistance pattern in oral pathogens.	Thank you for your comment. Please note that your suggestion is outside the remit of the scope for these guidelines.
Association of Clinical Oral Microbiologists (ACOM)	6	115	ACOM members support the emphasis on the non-pharmacological strategies in managing dental infections. Antibiotics are often inappropriately prescribed for the treatment of	Thank you for your comment. We will consider your comment when discussing and reviewing the review protocols. Diagnostics will be considered only for those topic areas as relevant and we will be advised

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			localised odontogenic abscesses instead of delivering the appropriate dental care in the absence of acute appointments. The importance of early surgical intervention (early tooth extraction of the source of infection, root canal treatment, incision and drainage) has been highlighted in several studies. Commencing antibiotic treatment does not prevent spread of infection and should not allow postponing the appropriate surgical intervention. Stopping this unnecessary prescribing should be strongly emphasised. This could be achieved by a timely access to diagnostic and treatment services. Furthermore, the time allocated for emergency dental appointments should allow the delivery of the appropriate intervention.	by the committee.
Association of Clinical Oral Microbiologists (ACOM)	7	171	As we mentioned above in comment number 3, there is shortage in Clinical Oral Microbiology service nationally and there is a need for a national plan for antimicrobial resistance surveillance in oral pathogen. This topic needs to be prioritised for a resource impact analysis. Also, investigating care pathways that led to patients being admitted to hospitals with severe oral infections should be a priority to identify common patterns and possible solutions.	Thank you for your comment. Please note that your suggestion is outside the remit of the scope for these guidelines.
Association of Clinical Oral Microbiologists (ACOM)	11	268	Please add resource: Dental antimicrobial stewardship: toolkit https://www.gov.uk/guidance/dental-antimicrobial-stewardship-toolkit	Thank you for your comment. The wording has been amended following your comment (see section 6).
Association of Clinical Oral Microbiologists (ACOM)	11	289	Please add resource: Faculty of General Dental Practitioners (FGDP-UK), Antimicrobial Prescribing for General Dental Practitioners Guidelines.	Thank you for your comment. Unfortunately this resource is not freely publicly available so cannot be added to the scope.
Royal Pharmaceutical Society	General	General	Guidelines for the whole patient pathway would be helpful – currently most guidelines seem to be organisational guidance, with best example current PHE primary care guidance.	Thank you for your comment. The guidelines will cover all care settings (see section 3.2 of the final scope document). We will consider your comment when discussing and reviewing the review protocols, subsequent evidence and presentation of the final guidelines.
Royal Pharmaceutical Society	General	General	Will there be linkage between primary & secondary care pathways?	Thank you for your comment. The guidelines will cover all care settings (see section 3.2 of the final scope document). We will consider your comment when discussing and reviewing the review protocols, subsequent evidence and presentation of the final guidelines.
Royal	General	General	Managing symptoms and patient behaviours could be integrated into	Thank you for your comment. We will consider your

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Pharmaceutical Society			the pathway guidance – for example use of PHE TARGET Treating Your Infection leaflet, along with a resource for contact tracing.	comment when discussing and reviewing the review protocols, subsequent evidence and presentation of the final guidelines.
Royal Pharmaceutical Society	General	General	Could infection prevention and control be included in the pathway content, for example vaccination where it is appropriate such as all patients with diabetes, COPD, children etc. This joins up the elements of the UK AMR strategy. A specific guideline on non-childhood vaccination would be beneficial.	Thank you for your comment. Immunisations and vaccinations are outside the scope of these guidelines.
Royal Pharmaceutical Society	General	General	Should include diagnostics and clinical decision tools into the guidance.	Thank you for your comment. Diagnostics will be considered only for those topic areas as relevant and we will be advised by the committee. We will link to existing NICE guidelines on antimicrobial stewardship, such as Antimicrobial stewardship – systems and processes for effective antimicrobial use (NG15) and Antimicrobial stewardship – changing risk-related behaviours in the general population (publication expected January 2017). In addition to medicines optimisation (NG5) which includes specific recommendations around clinical decision support.
Royal Pharmaceutical Society	General	General	Could drug-bug resistance data be included and joined up.	Thank you for your comment. Resistance data will be considered during the development of these guidelines.
Royal Pharmaceutical Society	General	General	Need to consider responsiveness and how guidance can be kept up to date in light of resistance patterns.	Thank you for your comment. This will be considered as part of the reviewing and updating process for the guidelines.
Royal Pharmaceutical Society	General	General	What is the definition of a common infection?	Thank you for your comment. The definition of what a 'common infection' is varies depending on the setting where the infection is being managed. We have amended the wording following your comment.
Royal Pharmaceutical Society	General	General	Should OPAT/admission avoidance be included?	Thank you for your comment. The guidelines will cover all care settings (see section 3.2 of the final scope document).
Royal Pharmaceutical Society	General	General	How much is this guidance intended to rigidly harmonise condition management across the UK, bearing in mind other potential drivers for antimicrobial choice within individual institutions?	Thank you for your comment. Guidelines are intended to support clinical practice and to help prescribers with their decision making. Guidelines are only one part of decision making but are based on evidence and are intended to reduce unwarranted variation.

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Royal Pharmaceutical Society	General	General	How might this impact on antimicrobial availability if the end product limits diversity & so reduces usage of certain agents? Will agents be lost from the market or will there be significant price rises because manufacturers will lose market share?	Thank you for your comment. The supply of medicines is outside the remit of this guideline and NICE. The Medicines and Healthcare products Regulatory Agency regulates medicines in the UK and has responsibility for ensuring that the supply chain for medicines is safe and secure.
Royal Pharmaceutical Society	General	General	What post-implementation monitoring will be considered to look for unintended consequences?	Thank you for your comment. Post-implementation is outside the remit of this guideline and also outside the remit of NICE.
Royal Pharmaceutical Society	2	43-45	Appropriate language should be used if this guidance will be used for the public as well as for prescribers	Thank you for your comment. Wording and formatting will be considered by the NICE publishing team.
Royal Pharmaceutical Society	3	78-79	What is the definition of 'pre –existing conditions that need specialist management'? Would this include diabetes, vascular grafts etc., or would they not be considered 'specialist management' What would be excluded here and why?	Thank you for your comment. The wording has been amended following your comment.
Royal Pharmaceutical Society	4	96-97	This is repetition of the statement below.	Thank you for your comment. The wording has been amended following your comment.
Royal Pharmaceutical Society	4-5	Table 1	In comparison with other primary care guidance, the scope does not appear to cover many infections included within each category, e.g. the skin & soft tissue section does not include mastitis, acne, scabies etc.	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Royal Pharmaceutical Society	4-5	Table 1	Why are many areas included that already have existing guidelines that have been produced by NICE accredited bodies - e.g. NGU & chlamydia produced by BASHH in late 2015?	Thank you for your comment. The Department of Health has referred this suite of guidelines to NICE with the purpose of tackling antimicrobial resistance. We will link to existing NICE guidelines on antimicrobial stewardship, such as Antimicrobial stewardship – systems and processes for effective antimicrobial use (NG15) and Antimicrobial stewardship – changing risk-related behaviours in the general population (publication expected January 2017). We will link to other relevant NICE guidelines wherever possible.
Royal Pharmaceutical Society	5	Table 1	Surgical site infection needs consideration. In particular for pathway management after hospital discharge. In primary care, audit of antibiotic use has identified co- amoxiclav use for a variety of post-surgical procedures for which no national guidance exists	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.

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Royal Pharmaceutical Society	5	Table 1	Will more complicated skin & soft tissue infection e.g. diabetic foot infection be included in skin and soft tissue guideline? Diabetic feet are not specifically mentioned and are a particular area of high antibiotic use. This is a pathway issue with need for accurate & appropriate diagnostics. These patients often have HCAIs as well so is a high priority for multiple reasons	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Royal Pharmaceutical Society	5	Table 1	Spontaneous bacterial peritonitis -will this be included in the peritonitis guideline? What about viral infections - e.g. herpes simplex/herpes zoster	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Royal Pharmaceutical Society	5	Table 1	Lower respiratory tract is missing non CF bronchiectasis	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
Royal Pharmaceutical Society	6	124	'Which antimicrobial; should be prescribed if one is indicated?' Will this be specific rather than class-limited (e.g. macrolides or tetracyclines) like other NICE guidance?	Thank you for your comment. The intention is that this will be specific rather than class-limited.
Royal Pharmaceutical Society	9	218	2016 ESPAUR report is now available.	Thank you for your comment. We will be using the most up-to-date ESPAUR report when developing the guidelines.
Royal Pharmaceutical Society	12	294	2017/19 Quality Premium is now available	Thank you for your comment.
The College of Podiatry	Table 1	102	We believe that this should cover a specific section on diabetic foot ulceration as opposed to leg ulcers in general. These patients often require high dose, prolonged and multiple courses of antibiotics.	Thank you for your comment. We will take this into account when selecting and prioritising our topics for development.
The College of Podiatry	4	93	We believe that the term antimicrobial should be defined; is it restricted to antibiotic use or widened to cover other agents used topically such as silver and irrigation washes?	Thank you for your comment. Please see the footnote on page 3 of the final scope document which provides a definition for the term 'medicine'.