Acute Respiratory Infection (ARI) in over 16s: Initial assessment and management
Consultation on draft guideline - Stakeholder comments table
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Abbott Rapid Diagnostics	Guideline	005	011	Differently than in the current Pneumonia guidelines the recommendation regarding CRP testing is not mentioning point-of-care (POC) testing anymore. POC testing has the big advantage to deliver results within minutes, which can directly be discussed with the patients. The direct availability of test results may support the discussion with patients – in general and especially when patients ask for antibiotics. All the relevant publications about antibiotic prescribing for acute RTIs in primary care have been performed with CRP POC tests. They have been proven to safely reduce antibiotic prescribing for RTIs and are recommended by several meta-analysis, latest the Cochrane Review of Smedemark et al. published in Oct. 2022. Thus, the question is why is POCT not mentioned in the recommendation?	Thank you for noting this omission. The committee have amended the recommendation to match the pneumonia guideline. The NICE pneumonia guideline is in the process of being updated. If you would like to register as a stakeholder for this update please visit https://www.nice.org.uk/guidance/indevelopment/gid-ng10357
Abbott Rapid Diagnostics	Guideline	005	011	We are wondering why the recommendation for CRP testing is not stronger despite the overwhelming available evidence about its effectiveness to reduce antibiotic prescribing for RTIs in primary care? Why should CRP testing only be "considered"?	Thank you. The committee agreed that the evidence they saw supported the recommendation made by the pneumonia guideline, however they were also aware that the confidence in the evidence was low or very low. They also noted that CRP testing is likely to increase re-consultation rates, and were further concerned that not all NHS primary care sites had access to CRP point of care testing. Please see the committee discussion section of the evidence summary for further information about the limitations

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					of CRP measures the committee thought were important. Based on these factors the committee did not think it was appropriate to make a stronger recommendation.
Abbott Rapid Diagnostics	Guideline	005	012	The recommendation to perform a CRP test is limited to cases, when the physician is uncertain whether to prescribe antibiotics after the clinical assessment. We want to highlight that there may be a disconnect between confidence levels and appropriateness of antibiotic prescribing. Van Velden et al. found during an audit of nearly 5000 consultations with acute RTIs across 18 countries that GPs rated their level of confidence as certain or very certain in 90% of consultations. But GPs prescribed antibiotics overall more often than is considered appropriate (Van Velden AW et al. BJGP Open.202. Observed over prescription may further underline the potential disconnect between confidence levels and appropriateness of antibiotic prescription as outlined below (Dekker AR et al. Fam Pract. 2015; Pouwels KB et al. J Antimicrob Chemother 2018; Hopstaken R et al. Fam Pract 2006). CRP testing may enhance the quality of antibiotic prescribing decisions if it can safely reverse decisions confidently made on clinical grounds alone to prescribe antibiotics.	Thank you. While the evidence that the committee considered did show a reduction in antibiotic prescription using point of care CRP testing, the confidence in the evidence was low. Additionally, the committee noted that CRP POC testing probably increased re-consultation, and further that many primary care sites do not have access to these tests. On this basis they agreed to be consistent with the 2014 pneumonia guideline and recommend that CRP POCT should only be considered if the decision to prescribe antimicrobials is unclear. The NICE pneumonia guideline is in the process of being updated. If you would like to register as a stakeholder for this update please visit https://www.nice.org.uk/guidance/indevelopment/gid-ng10357. We will ensure these references are put forward as part of that update.

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				Thus the recommendation should be to perform a CRP test once antibiotic prescribing is considered. This is the chance to reduce antibiotic prescribing for acute RTIs. Details regarding the mentioned publications above: Van der Velden AW, et al. Point-of-care testing, antibiotic prescribing, and prescribing confidence for respiratory tract infections in primary care: a prospective audit in 18 European countries. BJGP Open.2022; 6:212. doi: 10.3399/BJGPO.2021.0212 Dekker et al. had a look at data obtained from a detailed registration of 2739 RTI consultations by GPs from 48 Dutch primary care practices. 46% of the antibiotics prescribed for adults with LRTIs were not indicated by guidelines. Dekker AR, Verheij TJ, van der Velden AW. Inappropriate antibiotic prescription for respiratory tract indications: most prominent in adult patients. Fam Pract. 2015; 32:401–7. doi: 10.1093/fampra/cmv019 Pouwels KB et al. compared actual condition-specific prescribing proportions in primary care in England with ideal prescribing proportions identified by experts (data extracted from The Health Improvement Network (THIN) database). They found that an	

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				antibiotic was prescribed in 41% of all acute cough consultations when experts advocated 10%. Pouwels KB et al. Actual versus 'ideal' antibiotic prescribing for common conditions in English primary care. J Antimicrob Chemother 2018; 73(2): ii19–ii26. doi:10.1093/jac/dkx502 Hopstaken et al. found that in 247 patients with LRTIs auscultation abnormalities (OR 11.5), and diarrhoea (OR>11) were strongly associated with antibiotic prescribing. An antibiotic was prescribed for 195 (79%) patients. Assuming that an antibiotic definitely needs to be prescribed only for patients with pneumonia, antibiotics may have been inappropriately prescribed for 166/193 (86%) of the patients. Antibiotics were not prescribed for 5 of the 32 (16%) patients with a radiographic diagnosis of pneumonia. The authors concluded that abnormal findings on auscultation in patients with LRTI strongly predict antibiotic prescribing and that this is probably inappropriate for most patients Hopstaken RM, Butler CC, Muris JW, Knottnerus JA, Kester AD, Rinkens PE, Dinant GJ. Do clinical findings in lower respiratory tract infection help general practitioners prescribe antibiotics appropriately? An observational cohort study in general practice. Fam Pract 2006;23(2):180-7. doi: 10.1093/fampra/cmi100	

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Abbott Rapid Diagnostics ltd.	Guideline	005	006	Rec 1.1.8 We are concerned that this recommendation does not aid clinicians to prescribe effectively when clinical assessments and early warning scoring (EWS) systems do not result in a clear solution and treatment pathway. Please, refer to Differentiating viral from bacterial pneumonia - The Centre for Evidence-Based Medicine (cebm.net) Assessment | Diagnosis | Chest infections - adult | CKS | NICE As a suggestion, please evaluate to add a statement around the following to support effective prescribing "for a person with moderate severity community-acquired pneumonia, clinicians may wish to take a nasal/throat swab in some circumstances to aid diagnosis" This above suggestion comes from p.3 in the 'FAQs for prescribers' section on PRN00247_Group-A-Streptococcus-reinstatement-of-NICE-sore-throat-guidance-for-children-and-young-people-and-wi.pdf (england.nhs.uk)	Thank you. Recommendation 1.1.8 is now recommendation 1.3.1. This guideline is focussed on initial triage of people with suspected ARI and therefore only assessed rapid point of care tests that can help with the initial triage decision.
Abbott Rapid Diagnostics ltd.	Guideline	005	020	Rec 1.1.10 For people who do not have a clinical diagnosis of	Thank you. Recommendation 1.1.10 has been amended and is now recommendation 1.3.2, and recommendation 1.3.5 recommends following

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				pneumonia, consider their ARI symptoms …when making decisions about treatment or referral for further assessment. We are concerned that extensive data on the benefit of rapid NAAT test to support effective patient triage and treatment was not included in the assessment. High-risk and other specific patient groups should be tested The IDSA and CDC provide detailed guidance on when suspected cases of influenza should be confirmed by testing. The CDC algorithm, shown in the below Figure and focused on influenza season, largely agrees with IDSA guidance. During influenza season, the IDSA recommends testing the following patient groups presenting with flu-like illness: • In the community: O High-risk patients o Those with acute respiratory symptoms and either exacerbation of chronic conditions or known complications of influenza, if the results influence management o Any other patients, if the diagnosis would avoid	seasonal advice from UKHSA on managing influenza-like illness. As detailed in the committee discussion in the evidence summary, the committee agreed that strategies for testing and treating for influenza were largely determined by the UKHSA communicable disease function. Overall, they did not find any evidence to convince them that testing for influenza over and above clinical assessment was useful at initial triage. They agreed to add a recommendation to follow UKHSA guidance during flu season (Recommendation 1.3.5) and have added a caveat to the recommendation to point out that their reservations are specifically about testing to inform prescribing decisions. Tests may be useful for surveillance and disease control.

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				further tests, avoid antibiotic prescription, or influence disease management • In hospital: o All patients requiring hospitalization with acute respiratory symptoms o Patients with acute worsening of chronic cardiopulmonary disease (e.g., chronic obstructive pulmonary disease, asthma, coronary artery disease, or heart failure) o High risk patients who present with acute onset of respiratory symptoms o Patients who, in hospital, develop acute respiratory symptoms, with or without fever, or respiratory distress, without a clear alternative diagnosis	

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				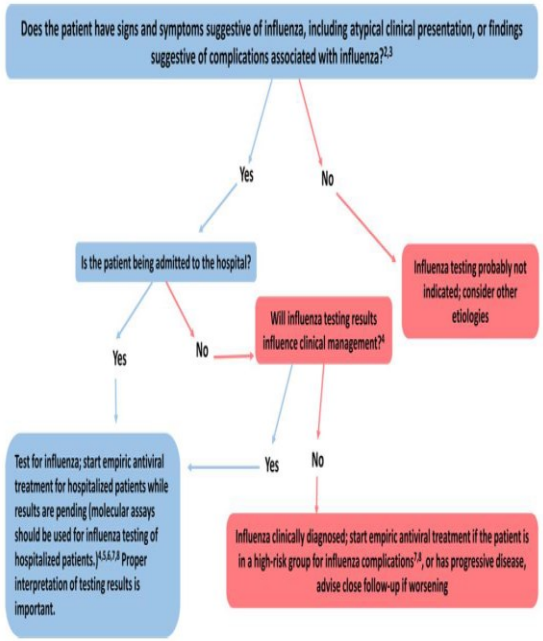 Outside influenza season, the IDSA recommends testing patients with acute respiratory symptoms, particularly if they are at high risk in the community setting. In the hospital setting, patients with acute respiratory illness should be tested where there is a link to a case of influenza, as well as those patients in risk groups with acute febrile respiratory illness. Testing should also be performed if results might	

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				influence treatment/prevention for high-risk household contacts. Please, evaluate the following evidence which has the intention to support rapid triage. https://www.globalpointofcare.abbott/gb/en/product-details/id-now.html?wvideo=phqucs0maz	
Abbott Rapid Diagnostics ltd.	Guideline	010	021	Recommendations 1.1.7 to 1.1.13 Why the committee made the recommendations For the statement "were accurate for ruling out these viruses but were less good at detecting them." We object this statement as our molecular POC assays have high performance at detecting their viral target pathogen. Our rapid* molecular ID NOW Influenza A&B 2 and RSV assays have high clinical performance, with high sensitivities for both: *Rapid: molecular results in less than 13 minutes. ID NOW Influenza A&B 2 VS PCR	Thank you. The recommendation numbering has been updated and this section now refer to recommendation 1.3.1 to 1.3.7. We have removed the statement.

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				Direct Swab Sensitivity Specificity Flu A 96.3% 97.4% Flu B 100% 97.1% Please, refer to ID NOW Influenza A & B 2 | Abbott Point of Care (globalpointofcare.abbott)- https://doi.org/10.1016/j.jiac.2020.10.009 ID NOW RSV Table 2: Performance of the ID NOW™ RSV assay vs real-time RT-PCR (31) % (95% CI) | Sensitivity | Specificity | NPV | PPV Direct NPS | 98.6 (94.4–99.7) | 98.0 (95.8–99.1) | 95.1 (89.8–97.8) | 99.4 (97.7–99.9) VTM NPS | 98.6 (94.4–99.7) | 97.8 (95.5–98.9) | 94.5 (89.1–97.4) | 99.4 (97.7–99.9) Abbreviations: CI, confidence interval; NPS, nasopharyngeal swab; NPV, negative predictive value; PPV, positive predictive value; RSV, respiratory syncytial virus; VTM, viral transport medium. Source: Hassan et al, 2018 (31) Please, refer to ID NOW RSV | Abbott Point of Care (globalpointofcare.abbott)	

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				https://doi.org/10.1128/JCM.01777-17	
Abbott Rapid Diagnostics ltd.	Guideline	010	021	Recommendations 1.1.7 to 1.1.13 Why the committee made the recommendations For the statement "The economic evidence for single pathogen tests was sparse and demonstrated no cost-effectiveness" We object this statement as our molecular POC has relevant economic evidence in the UK and globally. Molecular POCT for influenza can be cost-effective • In a decision-tree model set in Hong Kong, POCT-PCR was considered cost-effective, giving an ICER of 29,582 $/QALY (below the willingness-to-pay threshold of 43,497 $/QALY) The use of ID NOW™ is associated with cost and resource use savings • ID NOW™ can reduce the time and cost of medical care • Introducing ID NOW™ can lead to overall cost savings	Thank you. The recommendation numbering has been updated and this section now refer to recommendation 1.3.1 to 1.3.7. There are no references for the Hong Kong and German studies so the committee were unable to assess the methods however, the Hong Kong study is unlikely to be generalisable to a UK context and the German study would be excluded as it is a cost benefit study not a cost effectiveness study. With regards to the two UK studies neither are a cost effectiveness study and therefore, do not meet the inclusion criteria. There was one included study (Nicholson 2014) that did look at influenza testing which found that point of care testing was less expensive and more effective than traditional laboratory testing, but was not cost effective compared with PCR. Please see the evidence summary for further details.

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				• Introduction of ID NOW™ in the UK NHS could lead to savings of £242 per adult presenting with flu-like symptoms • A German cost-benefit analysis at primary care payer level predicts considerable savings through the introduction of ID NOW™ Testing for COVID-19 and influenza using ID NOW™ is cost-saving compared with RT-PCR testing at a centralized laboratory • ID NOW™ was associated with a saving of $267 versus RT-PCR per patient in the home quarantine scenario • ID NOW™ was associated with a saving of $629 versus RT-PCR per patient in the healthcare facility isolation scenario In a prospective study in four UK hospitals from December 2014 to March 2015 (N=827), ID NOW™ increased the cost of isolation and antiviral treatment in 1,000 patients by £15,330 over PCR	

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				testing when isolation resources were constrained (due to rapid isolation when influenza was identified), and reduced costs by £221,630 vs PCR testing when isolation resources were not constrained (by enabling patients to leave isolation more rapidly upon a negative test result). Onward transmission costs were £11,970 less per 1,000 patients with ID NOW™ testing than PCR when isolation resources were constrained (i.e., patients were not automatically isolated) or £6,590 more than PCR when isolation resources were available (i.e., patients were automatically isolated until negative test result. REF Davis S, Allen AJ, O'Leary R, et al. Diagnostic accuracy and cost analysis of the Alere™ i Influenza A&B near-patient test using throat swabs. J Hosp Infect. 2017;97(3):301-9. A cost consequence model was used to compare ID NOW™ Influenza A & B (an earlier generation of	

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				assays) with RT-PCR testing, for influenza-like illness in the setting of the UK NHS. Costs in 2017 GBP were modelled for a cohort of 1,000 patients, with a time horizon starting at admission to hospital with suspicion of influenza and finishing at the end of treatment (following influenza diagnosis or hospital discharge). The study found that hospitals with long delays in time to receive diagnostic results would benefit most from ID NOW™. Savings of £242,730 per 1,000 adults with influenza-like illness could be made by using nasal swab point-of-care testing. Isolation costs would be substantially cut by using ID NOW™ POCT (savings of £190,867 per 1,000 patients) because isolation upon arrival in hospital would be on an as-needed basis, when the rapid test result was obtained, rather than until an RTPCR result was obtained. REF	

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				Allen AJ, O'Leary RA, Davis S, et al. Cost implications for the NHS of using the Alere™ i Influenza A & B near patient test with nasal swabs. Diagn Progn Res. 2018;2:15.	
Association of Chartered Physiotherapists in Respiratory Care (ACPRC)	Guideline	005	008 - 010	Crackles on auscultation may be present in people with bronchiectasis/COPD without the presence of pneumonia. I feel these clinical signs in ADDITION to the presence of 1 or more symptoms in Box 1 would be useful. Not "OR" or instead of those listed in box 1.	Thank you. This recommendation has been reworded following stakeholder consultation.
Association of Chartered Physiotherapists in Respiratory Care (ACPRC)	Guideline	011	018	There is evidence that The DECAF (dyspnoea, eosinopenia, consolidation, acidaemia, atrial fibrillation) is useful in predicting clinical outcomes – albeit in COPD rather than all ARIs, in comparison to NEWS. Could this be considered as an additional screening tool, likely in ARI hubs rather than primary care due to the need for blood tests/ECG +CXRs.	Thank you. No evidence that met the inclusion criteria was found by the review teams of this tool during their searches. For details of the relevant review protocol see the protocol in evidence review A. The DECAF trial does not meet the inclusion criteria for the review because it is not a systematic review and because COPD is not an acute respiratory infection.
Association of Respiratory Nurses (ARNS)	Guideline	General	General	Variation in service provision dependant on locality and equity of step down/step up teams	Thank you. The committee was aware that care pathways will be different in different areas and therefore was careful not to be too prescriptive.
Association of Respiratory Nurses (ARNS)	Guideline	General	General	Out of hours service provision.	Thank you. Out of hours provision (for initial consultations) would be part of this guideline.
Association of Respiratory Nurses (ARNS)	Guideline	General	General	Workforce including ACPs and MDT consultant health care	Thank you. Any clinician or healthcare practitioner providing an initial assessment and triage of a person with a suspected ARI is included in this guideline.

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Association of Respiratory Nurses (ARNS)	Guideline	General	General	Professionals to deliver advice/ward round/equipment drop off.	Thank you. The committee do not understand this comment.
Association of Respiratory Nurses (ARNS)	Guideline	General	General	Alternatives to digital technology for those with Learning disabilities/difficulties.	Thank you. Recommendation 1.2.1 covers making sure that the person can use the technology and notes that people should be offered alternatives if they can't use it.
Association of Respiratory Nurses (ARNS)	Guideline	General	General	Oxygen titration/weaning guidelines to prevent unnecessary hospital delays/admission.	Thank you. Oxygen therapy is beyond the remit of this guideline which is focused on initial triage at first presentation. Please see the scope document for details.
Association of Respiratory Nurses (ARNS)	Guideline	005 & 006	023 & 001 - 010	Clarification on CRB-65/CURB-65 from step down to step up.	Thank you. This guideline does not cover discharge or 'step down'. The guideline focuses on initial triage of people with suspected ARI. Please see the scope document for details.
Association of Respiratory Nurses (ARNS)	Guideline	003	002	Consider Acute respiratory illness as opposed to acute respiratory infection	Thank you. NICE was specifically asked to look at respiratory infections rather than more broadly at respiratory illness. Please see the scope document for details.
British Infection Association (BIA)	Guideline	004		Box 1 I wonder about the specificity of using diarrhoea (type 5 or more) as a diagnostic indicator for pneumonia. Lots of people have loose stools for a multitude of non-infection reasons and I think this might not be discriminatory enough and will lead to over diagnosis of ARI. How many additional ARI patients would be captured by including diarrhoea in addition to the other features in Box 1 vs the collateral impact on further assessment/prescribing in those with unrelated diarrhoea?	Thank you. Box 1 has been removed following stakeholder consultation.

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British Infection Association (BIA)	Guideline	005	014 - 019	What is the evidence base behind these recommendations? References should be given.	Thank you. The evidence base for the recommendations can be found in evidence reviews A-C on the guideline webpage. There is also a summary of the evidence which includes details of the committees discussions of the evidence reviews.
British Medical Association	Guideline	General	General	Overall the guideline appears confused. Is the purpose to ensure when patients are assessed remotely, if there are any concerns (as per box 1 page 4), they should be assessed face-to -face? Is it also supposed to clarify that if there is more clinical concern that some patients could be directly escalated to an ARI hub, ambulance or A&E? This needs further clarification in the guidance.	Thank you. The purpose of the guideline is to support health care practitioners in deciding on the best care pathway for people at first presentation with a suspected acute respiratory tract infection. The committee have amended the title and initial narrative to try to better reflect this.
British Medical Association	Guideline	001	004	The nomenclature appears at odds to what is normally used. What is the aim? Is it about suspected LRTIs?	Thank you. This guideline covers the assessment and triage of people aged 16 and over when they first present to an NHS service with signs and symptoms of an acute respiratory infection (either bacterial or viral). It is intended to support health care practitioners in making sure that people are on the best care pathway for them.
British Medical Association	Guideline	003	003 & 004	Acute Respiratory Infection must include patients who have COVID-19 as there is no routine NHS access to testing in General Practice. Many Patients and their GPs do not know and therefore we cannot view COVID separately. In fact NICE CKS for Covid-19 Diagnosis states: 'If a person has symptoms suggestive of covid most people are no longer advised to get tested, and tests are no longer free.' The COVID-19 guidance also suggests that high temperature, cough, loss or change of taste/smell,	Thank you. The guideline excludes people with known COVID-19 as detailed in the scope document. The committee have amended the guideline to clarify this.

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				SOB, tiredness, headache, sore throat, diarrhoea, nausea/vomiting are likely symptoms. However, this guidance states it covers all patients with an acute illness affecting respiratory tract with symptoms such as cough, sore throat, fever, sputum production, breathlessness and no alternative explanation such as asthma - so there is a complete overlap with patients with COVID-19 who are not eligible for testing. This should be addressed and clarified.	
British Medical Association	Guideline	003	010	This guidance is completely at odds with NG120 on acute cough. This guidance does not clarify when you would use this guidance instead of NG120 for patients presenting with cough and cold symptoms, which are by the definition given here ARIs. NG120 talks about patients being systemically very unwell, whereas this uses a box of individual symptoms – this needs clarification.	Thank you. The cough guideline covers the management of acute cough associated with URTI or bronchitis. This guideline is focussed on the initial assessment of undifferentiated ARI, which may lead to using the cough guideline (for example). The Box of individual symptoms has been removed
British Medical Association	Guideline	004		**Box 1** Having reviewed the evidence wheeze is only mentioned on auscultation - this section is about remote contact therefore (unless the patient is or is with a medical professional) this should not be here as it is confusing. Patient reported wheeze is very different.	Thank you. Box 1 has been removed following stakeholder consultation.
British Medical Association	Guideline	004	001 & 002	Does this mean, patients with ARI and any of the symptoms in Box 1, should be seen face-to-face for a clinical assessment? This is not clear. Should it read 'In the presence of ARI and 1 or more of the	Thank you. Box 1 has been removed following stakeholder consultation.

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				symptoms below arrange for further assessment face-to-face', which would be clearer?	
British Medical Association	Guideline	004	011	This is too definite - there are circumstances where this may be appropriate a patient may be unwilling to travel yet have highly suggestive symptoms. The patient may have access to full assessment of the relevant symptoms and signs remotely such as being a GP themselves.	Thank you. The committee discussed this and agreed to make the recommendation less definite. They noted that there were circumstances where a remote prescription might be appropriate. Please see the rationale and impact section of the guideline for more details.
British Medical Association	Guideline	005	006 - 010	This is confused. This is the section on face-to-face assessment obviously if they have ARI they are being assessed for pneumonia and clinical judgement would be used. Eliciting the symptoms and signs in Box 1 and performing chest auscultation is the assessment for pneumonia, it is not the reason to assess for pneumonia. This risks confusing both the public and healthcare professionals.	Thank you. The wording was open to misinterpretation. The committee have amended it. Box 1 has been removed following stakeholder consultation.
British Medical Association	Guideline	005	011	CRP testing is not acutely available in General Practice and the evidence states specificity of raised CRP >100 is low, so we are not sure this helps (although it is fine in A&E where there is more likely to be true pneumonia presenting). This risks CRP being taken in lots of patients unlikely (states without suspected pneumonia) to have a bacterial infection and increasing antibiotic prescribing.	Thank you. The specificity of CRP>100 is 91% in the evidence seen by the committee, which is high. The recommendation specifies that CRP testing should only be considered when clinical assessment is unable to determine whether or not to prescribe an antimicrobial. The recommendation to consider CRP point of care testing comes from the 2014 NICE guidance on the assessment and management of pneumonia and is not a new recommendation. The data presented in the Gentilotti (2022) review were consistent with the conclusions reached by the 2014 pneumonia guideline. The committee took this as further evidence that the thresholds were useful and useable and agreed to keep them. For the evidence

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					underpinning the 2014 recommendation, please see the pneumonia full guideline, section 7.1. The committee discussed and recognised that many primary care sites do not have access to CRP testing, but they agreed that where this is available it should be considered as an option to support decision making' The NICE pneumonia guideline is in the process of being updated. If you would like to register as a stakeholder for this update please visit https://www.nice.org.uk/guidance/indevelopment/gid-ng10357
British Medical Association	Guideline	005	024	The evaluation and evidence according to the attached evidence papers is low in primary care. This risks admission being refused for patients with low scores that the GP may have significant concern about. Should be clarified this should not replace clinical judgement. Many areas have junior nurses 'stopping' admissions and relying on unvalidated scoring systems.	Thank you. The committee agreed and made this clear in the wording of the recommendations. The recommendations make clear that CRB65 is to "Use clinical judgment together with CRB65…"(recommendation 1.3.7)
British Medical Association	Guideline	009	018	It states that 75% of patients with ARI and 1 symptom from Box 1 are likely to have bacterial pneumonia. This is clearly not true, as there is no evidence in the attached papers to support this, it does not fit with common sense and review of the literature suggests fever, chest signs on auscultation and breathlessness only has an 11% positive predictive value of	This section has been rewritten following stakeholder consultation and box 1, to which it refers has been removed.

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				pneumonia in ARI. Where has this statistic come from?	
British Society for Antimicrobial Chemotherapy (BSAC)	Guideline	General	General	Thank you for your invitation to comment on this consultation. Members of The British Society for Antimicrobial Chemotherapy (BSAC) have no comments to make on this occasion.	Thank you for your response.
British Thoracic Society	Guideline	General	General	The purpose of the document is not clear as it contains little useful information, has significant flaws and is based on a minimal evidence base. It is surprising this was not established at the commissioning stage. As it stands, it may significantly embarrass NICE amongst the respiratory community and lower the standing of the organisation	Thank you. This guideline is intended to support healthcare practitioners in making initial triage decisions for people from undifferentiated populations with signs and symptoms that suggest an acute respiratory infection. The committee have amended the title and initial narrative to try to better reflect this. NICE's reputation rests its high quality methods and processes which were followed as usual and this includes consensus recommendations based on the committees expertise and experience where evidence is lacking. The committee believe the problem lies in the absence of primary data. There are no previous NICE guidelines regarding undifferentiated symptoms presenting in primary care, and especially to the wider variety of access points than in the past.
British Thoracic Society	Guideline	General	General	People suspected of having pneumonia should have an urgent CXR. This should be in the community if possible but this is needed to make a diagnosis and provide appropriate management	Thank you. This guideline only covers first contact with the NHS with a suspected chest infection, and any subsequent decision to perform a chest x-ray is outside the remit of the guideline. Current NICE guidelines recommend diagnosis (including x-rays) and treatment of community-acquired pneumonia within 4 hours of presentation to hospital.

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					The NICE pneumonia guideline is in the process of being updated. If you would like to register as a stakeholder for this update please visit https://www.nice.org.uk/guidance/indevelopment/gid-ng10357
British Thoracic Society	Guideline	General	General	Why is there no mention of end of life care and ceiling of treatment decisions which practically is vital for optimum decision making in the context of ARI	Thank you. End-of-life care is outside the scope of this guideline. Please see section 3.1 of the scope document.
British Thoracic Society	Guideline	003	019	1.1.4 etc Why are there repeated references to "such as asthma"? – there are many differential conditions for ARI and the guideline seems to suggest if not ARI this will be a presentation of asthma which is flawed and misleading	Thank you. Asthma was being used as an example in 2 places. The committee have removed it. Recommendation 1.1.4 is now recommendation 1.2.2.
British Thoracic Society	Guideline	004		Box 1 In people with pre-existing airway disease (asthma, COPD and bronchiectasis) wheezing is an expected symptom and does not indicate a higher likelihood of pneumonia	Thank you. Box 1 has been removed following stakeholder consultation.
British Thoracic Society	Guideline	004		Box 1 In the very elderly, saturations of 94% are normal (see reference equation for age adjustment of PaO2) regardless of cardiorespiratory disease so the threshold <95% is too high and will trigger unnecessary intervention	Thank you. Box 1 has been removed following stakeholder consultation.
British Thoracic Society	Guideline	005	006	1.1.8 The clinical signs of pneumonia are dullness to percussion, harsh crackles and bronchial BS. All	Thank you. Recommendation 1.1.8 is now recommendation 1.3.1. Box 1 has been removed following stakeholder consultation.

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				practitioners with clinical examination skills are taught this	
British Thoracic Society	Guideline	005	006	1.1.8 Lung sound transmission is increased in consolidated lung so "reduced BS" is wrong and nonsensical. This would be more likely to illustrate a pleural effusion	Thank you. Recommendation 1.1.8 is now recommendation 1.3.1. Box 1 has been removed following stakeholder consultation and the recommendation has been updated.
British Thoracic Society	Guideline	006	005	1.1.12 People with CRB65 scores of 3-4 should always be assessed in hospital – the word "consider" is wrong as some of the cohort will have mortality rates in excess of 20%. This is inconsistent with existing NICE guidance	Thank you. Recommendation 1.1.12 in now recommendation 1.3.7. The recommendation is a consider one because of the low confidence in the evidence and the possibility that CRB65 might overpredict pneumonia in low prevalence cohorts. The recommendation is consistent with NICE guidelines on the assessment and management of pneumonia.
British Thoracic Society	Guideline	009	025	Why the committee…. You have stated that anyone with ARI who requires antibiotics needs to be seen face to face. This contradicts other NICE guidance as well as standard clinical practice where people with airway disease (COPD, bronchiectasis, asthma) have rescue packs and are instructed and empowered to self-manage. This practice is patently safe and appropriate so that statement makes no sense	Thank you. The rationale section contains this text because the committee recommend not routinely prescribing antimicrobials remotely. This would not include people on self-management programmes. The committee have clarified this to ensure that it does not appear to contradict other guidelines.

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Cepheid	Guideline	General	General	The draft guidance is not incorporating all the content of the NICE's Final scope for the development of the guideline which included "symptoms that may indicate an acute respiratory infection" in its focus. The draft guidelines make significant reference to pneumonia and the existing Pneumonia guideline (CG191) with more limited reference to guidelines on COVID-19 (NG191) and Sore Throat (NG84). No rationale is provided for the bias to pneumonia. We believe that this is a missed opportunity and does not reflect the challenge provided by Influenza, SARS-CoV-2, and RSV as they often cause patients to present with similar symptoms. A microbiological test is needed to support clinical decision-making about optimal patient treatment and management.	Thank you. As detailed in the scope document, people with known COVID-19 infection are not included in this guideline. The recommendations have been updated following consultation and only 3 out of 15 recommendations in the final version relate to pneumonia specifically. The committee looked at evidence for microbiological tests for influenza virus and for RSV. However even though the evidence that they saw showed good sensitivity and specificity, they were probably not useful for immediate prescribing decisions, which were usually set by UKHSA. They agreed that these tests could be useful for surveillance and outbreak control, but that was beyond the remit of this guideline. It was an area where they felt further research was needed and made a research recommendation about microbiological point of care tests (see research recommendation 2 in the guideline). This is detailed in the rationale and impact section of the guideline under the heading "In-person contact with NHS services at first presentation".

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Cepheid	Guideline	General	General	In addition the NICE's Final scope for the development of the guideline which included "Specific consideration will be given to people with co-morbidities that will affect their risk, for example chronic obstructive pulmonary disease" in its focus. The draft guideline refers to co-morbidities limited to patients with pneumonia. No rationale is provided for this bias toward co-morbidities for patients suspected of having pneumonia. This is despite the established evidence that place people with specific co-morbidities at higher risk from Influenza and SARS-CoV-2. Recommending the use of a microbiological test for Influenza, SARS-CoV-2, and RSV for patients at the highest risk would help to support optimal clinical decision-making about patient treatment and management.	Thank you. As detailed in the scope document, people with COVID-19 infection are not included in this guideline. The recommendations have been updated following consultation and only 3 out of 15 recommendations in the final version relate to pneumonia specifically. The committee looked at evidence for microbiological tests for influenza virus and for RSV however even though the evidence that they saw showed good sensitivity and specificity, they were probably not useful for immediate prescribing decisions, which were usually set by UKHSA. They agreed that these tests could be useful for surveillance and outbreak control, but that was beyond the remit of this guideline. It was an area where they felt further research was needed and made a research recommendation about microbiological point of care tests (see research recommendation 2 in the guideline). This is detailed in the rationale and impact section of the guideline under the heading "In-person contact with NHS services at first presentation". The evidence review teams were alert to the possibilities of conducting subgroup analyses for people with specific co-morbidities alongside a suspected ARI but did not find any evidence.

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Cepheid	Guideline	General	General	The draft guidance should consider alignment with the new NHS England's Integrating in-vitro point of care diagnostics: guidance for urgent community response and virtual ward services published on 29 August 2023 which recommends the use of microbiological tests (Influenza and SARS-COV-2). The draft guidance in its current form may cause uncertainty among healthcare systems across England about the need for microbiological testing to support acute respiratory infection hubs and virtual wards.	Thank you. As detailed in the scope document, people with COVID-19 infection are not included in this guideline so the expectation is that practitioners will follow NHS guidance for the initial testing for Covid before entering this diagnostic pathway. Additionally, the guideline only covers people at first presentation to health services, so the use of near patient microbiological and biomarker tests and other investigations in virtual wards are also out of scope for this guideline.
Cepheid	Guideline	General	General	The draft guidance is a missed opportunity to consider the on-going changes to the testing infrastructure after the end of the SARS-CoV-2 pandemic including Maria Caulfield MP Under Secretary of State for Health's Letter to Professor Dame Jenny Harries Chief Executive of UKHSA sent on 16 August 2023 which stated that from 1 October 2023 testing that gives people at the "highest risk" from SARS-CoV-2 access to treatments will transfer to NHS England.	Thank you. As detailed in the scope document, people with COVID-19 infection are not included in this guideline so the expectation is that practitioners will follow NHS guidance for the initial testing for Covid before entering this diagnostic pathway.
eConsult Health Ltd	Guideline	004	011 - 013	I am writing on behalf of eConsult Health Ltd in response to the consultation on NICE Guidance for the initial management of Acute Respiratory Infections (ARIs) in individuals over 16. We acknowledge and appreciate the emphasis placed on antimicrobial stewardship, and the rationale provided that individuals exhibiting symptoms of pneumonia require a comprehensive face to face assessment. We agree that a thorough evaluation is paramount in ensuring appropriate management of	Thank you. The committee is aware of the great steps forward being made in terms of technology and competence to undertake remote consulting as this becomes more normal. They agreed that a growing number of approaches and models were springing up, and that practitioners needed to be adequately trained to use them effectively. In spite of this they agreed that antibiotics should not currently be routinely prescribed via a remote

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				such cases. However, we would like to express our reservations about the blanket recommendation against prescribing antimicrobials for ARIs via remote consultations. Our primary concern stems from the current evidence base on the impact of remote consulting on antibiotic prescribing. The available literature is limited, and what exists presents a mixed picture, with some studies suggesting a positive and some a negative impact of remote consulting on antimicrobial prescribing. A recent systematic review (Han SM et al., JMIR 2022) concluded that 'there is insufficient evidence to confidently conclude that remote consulting has a significant impact on antibiotic prescribing in primary care.' Furthermore, neither the existing research evidence, nor the proposed new guidance, include an appreciation for the wide range of different approaches and models that can be described as remote consulting. While we would agree that a single free-text query submitted by a patient via an online form is very unlikely to represent sufficiently rigorous clinical assessment to justify safe or appropriate antibiotic prescribing in the context of suspected ARI, we would argue that a remote consultation comprising patient responses to detailed clinical questions via an algorithm-based online consultation, perhaps in conjunction with a telephone and / or video call,	consultation and that good antimicrobial stewardship required a face-to-face assessment. The committee agreed to make the recommendation less categorical. They noted that there were circumstances where a remote prescription might be appropriate. Please see the rationale and impact section of the guideline for more details.

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				patient-supplied images, and even clinical measurements using patient-held health technologies (e.g. pulse oximetry), has the potential to provide a sufficiently thorough clinical assessment in a wide range of acute illness scenarios. While the intent behind the recommendation is commendable, we believe that a categorical exclusion of antimicrobial prescribing via remote consulting is likely to result in an unintended increase in unnecessary face to face appointments. This is likely to place additional strain on already highly stretched healthcare resources, particularly in primary care. We would argue for a more nuanced approach, where clinicians are equipped with clear guidance and training on remote assessment for ARIs. This would empower them to make informed decisions, with patients, on a case-by-case basis, balancing the need for antimicrobial stewardship with the practicalities of patient care in the current healthcare context. In conclusion, while we support the overarching goal of promoting responsible prescribing and use of antibiotics, we urge a reconsideration of this stance on remote consultations. We believe that with the right tools and training clinicians, already highly expert in making balanced and appropriate prescribing decisions with patients based on appropriate clinical assessment, can judiciously use remote consultations	

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				to manage ARIs without compromising patient care or antimicrobial stewardship, while meeting strong demand from patients for rapid and convenient access to health advice and maintaining efficiency in a highly pressured health system. Thank you for considering our feedback. We remain committed to collaborating with NICE and other stakeholders to ensure the best outcomes for our patients.	
MeMed Diagnostics Ltd.	Guideline	General	General	Question 1: Would it be challenging to implement of any of the draft recommendations? Please say why and for whom. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or national initiatives. Answer: As diagnostic manufacturer it is difficult for us to comment on this question. However, in terms of implementing CRP testing as part of the assessment of patients with suspected community acquired pneumonia, we believe this will be challenging for NHS services in primary care / GP practices. Implementation of any intervention requires a bundle of interventions and past studies have demonstrated that POCT-CRP might not impact antibiotic prescribing. In addition, utilization rate of such interventions fluctuates widely across different centres and is largely driven by local 'champions'.	Thank you. The committee discussed and recognised that many primary care sites do not have access to CRP testing, but they agreed that where this is available it should be considered as an option to support decision making. The committee noted that this has been a recommendation in NICE's 2014 pneumonia guideline and this is not a new resource impact.

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MeMed Diagnostics Ltd.	Guideline	General	General	Question 2: Would implementation of any of the draft recommendations have significant cost implications? Answer: As diagnostic manufacturer it is difficult for us to comment on this question.	Thank you for your response.
MeMed Diagnostics Ltd.	Guideline	General	General	Question 3: NEWS2 is being promoted for use in assessing severity of illness (and hence placement) in people with ARI in community settings, but the committee did not find evidence to support this. We would stakeholder comments on whether NEWS2 is an appropriate tool for use in this setting. Answer: As diagnostic manufacturer it is difficult for us to comment on this question.	Thank you for your response.
MeMed Diagnostics Ltd.	Guideline	005	011 - 019	We agree with the general outline of the draft guideline but we feel that more consideration should be given to the behavioural aspects of implementing CRP testing rather than solely focusing on diagnostic accuracy (i.e., systematic reviews) and utility data (i.e., RCT). When there is uncertainty on whether to prescribe antibiotics to patients with suspected community acquired pneumonia (or Acute respiratory Tract Infections [ARI] overall), additional clinical investigations are warranted. A recommendation for CRP, and no other microbiological test, is made based on the evidence review done with a focus on systematic reviews & RCT data. However, the effectiveness of CRP testing does not only dependent	Thank you. The final guideline recommends considering a CRP test in people with lower respiratory tract infection if a clinical assessment cannot determine the need for antibiotics. The committee discussed and recognised that many primary care sites do not have access to CRP testing, but they agreed that where this is available it should be considered as an option to support decision making' Professionals who offer any test need to be adequately trained in its use and NICE does not routinely recommend this. Clinicians have a duty to be competent in a procedure before they offer it.

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				on diagnostic accuracy and utility data. Additional influencing factors should also be considered: Prior work done in primary care has demonstrated that the implementation process of POCT-CRP testing can impact the relative effectiveness of the intervention (Tonkin-Crine S. et al. 2023: Implementing antibiotic stewardship in high-prescribing English general practices: a mixed-methods study | British Journal of General Practice (bjgp.org)). This is in line with findings on other microbiological tests indicating that clinician adherence, reinforced education & awareness is crucial to the success of any intervention. Often a bundle of interventions is needed to observe a clinical benefit. These factors should be considered in the evidence review and draft guideline to mitigate a risk of not improving routine clinical care through the single recommended diagnostic intervention (i.e., CRP testing). CRP testing might increase, rather than decrease, clinical uncertainty: in patients with suspected community acquired pneumonia, the CRP level might create additional uncertainty when the result does not align with the initial clinical impression after clinical assessment of the patient: i.e., CRP testing is not only performed to alleviate clinical uncertainty but also to reaffirm the initial clinical impression. When the result of the CRP test does not confirm the suspicion,	

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				adherence to the recommended course of action will likely decrease and potentially impact referral rates to other NHS services (e.g., from GP practice to ARI hubs and/or A&E). Care delivery for patients with suspected community acquired pneumonia presenting to different NHS services will greatly fluctuate as accessibility to CRP testing might be present (e.g., A&E), or not (e.g., GP practice). The absence/presence of CRP testing within different areas of a local health system consisting of community-based NHS services and hospital-based (A&E) services might thus influence health-seeking behaviour and the healthcare-referral process.	
MeMed Diagnostics Ltd.	Guideline	010 - 011	026 - 029 & 001-006	The limitations of CRP testing are taken into consideration by the guideline committee, yet the only focus is on the time lag for symptoms onset. However, there are several other limitations of CRP testing that are not taken into account: Elevated CRP levels in viruses causing acute respiratory infections (a.k.a. bacteria-mimicking viruses): adeno- and other respiratory viruses are known to cause an elevated CRP response (above the 100mg/l cut-off described in the draft guideline). Consequently, using CRP as a single biomarker might not promote appropriate antibiotic prescribing in the absence of additional clinical investigations. Furthermore, using the 20-100mg/l CRP rule for a	Thank you. The committee was aware that the evidence was not straightforward, not least because of quality issues, and for this reason they made the recommendation to 'consider' the use of CRP, and then only if a decision on prescribing could not be made based on clinical assessment alone. Further detail has been added to the evidence summary about the limitations of CRP testing. The evidence considered by the committee does contain evidence from reviews of multiple host response biomarkers, please see evidence review C for details.

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				'delayed prescription' if symptoms don't resolve will likely also contribute to less appropriate antibiotic prescribing. Although mild- to moderate viral acute respiratory infections with an elevated CRP response (between 20-1000mg/l) will mostly resolve without treatment, symptom discontinuation will take time (and thus create a risk for inappropriate prescriptions). Changed pathogen epidemiology; immunity-debt; emerging pathogens: acute respiratory infections caused by viruses can elevate CRP levels above the 100mg/l cut-off described to definitively prescribe antibiotics. The onset of the COVID-19 pandemic clearly demonstrated this as even non-severely ill patients displayed high CRP levels. Therefore, interpretation of a single CRP level only makes sense in the context of the patient's clinical presentation and additional knowledge of the etiological cause of the underlying infection. An alternative method that can overcome the limitations of CRP testing is using a combination of multiple host-response biomarkers (e.g., CRP + TRAIL + IP-10). Although more utility evidence is needed for such an approach, recent published evidence did demonstrate the utility of such an approach to overcome the limitations of 'time lag for symptom onset' ; and 'bacteria-mimicking viruses' (Stein M. et al. 2023; Frontiers | BV score	

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				differentiates viral from bacterial-viral co-infection in adenovirus PCR positive children (frontiersin.org)).	
MeMed Diagnostics Ltd.	Evidence review C	030		In table 2, the Carlton 2021 systematic review is cited for assessing the diagnostic accuracy of the TRAIL, IP-10 and CRP test that differentiates bacterial from viral infections (4 studies included in the systematic review). However, the Carlton 2021 systematic review cites diagnostic accuracy studies that were presented at conferences prior to the completion of the respective trials (e.g., the 'Mencaroni E. citation' in the Carlton 2021 systematic review refers to a clinical trial called 'Autopilot' that was only published in 2022 - A host signature based on TRAIL, IP-10, and CRP for reducing antibiotic overuse in children by differentiating bacterial from viral infections: a prospective, multicentre cohort study - ScienceDirect ; and the 'Shani L et al. citation' refers to a clinical trial called 'Observer' that was only published in 2023 - Host test based on tumor necrosis factor-related apoptosis-inducing ligand, interferon gamma-induced protein-10 and C-reactive protein for differentiating bacterial and viral respiratory tract infections in adults: diagnostic accuracy study - ScienceDirect). The latter conflicts with the methodology outlined in the evidence review C that specified to only include journal publications, and no conference abstracts. We would recommend to not consider the Carlton 2021 systematic review as representative for the TRAIL, IP-10 and CRP test diagnostic accuracy.	Thank you. The 8 diagnostic studies you refer to would not be eligible for inclusion in evidence review C which only looked at systematic reviews for this test. The 2021 systematic review would not have been included because it was not specific to ARI, which was one of the criteria in the protocol.

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				Instead we propose to either conduct a search for relevant diagnostic accuracy studies and include those as part of the evidence assessment: i.e., include the 8 completed diagnostic accuracy studies on TRAIL, IP-10 and CRP published up to May 2023. Alternatively, there is another systematic review on this topic published by FIND in 2021: i.e., Fernandez-Carballo B.L. et al. - Distinguishing bacterial versus non-bacterial causes of febrile illness – A systematic review of host biomarkers - ScienceDirect	
MENCAP	Guideline	General	General	Evidence shows that people with a learning disability are at higher risk of respiratory infection, and also die in significantly higher numbers from respiratory infections than the general population. In 2019 41% of deaths reported to the LeDeR programme were due to pneumonia. It is difficult to compare the most recent LeDeR reports due to the changes in leadership of the programme and some reporting changes, however, the most recent LeDeR report (2022 reporting on 2021) suggests the number of deaths due to pneumonia may be falling, yet also notes that some pneumonia deaths may be masked as COVID. We note that overall in the latest report, 49% of all deaths of people with a learning disability were rated as avoidable for (compared to 22% in the general population), with 17% of these avoidable deaths being linked to respiratory conditions (it is unclear if this includes COVID). Due to likelihood of presentation, and high risk of barriers to care, we	Thank you. The equality impact assessment (EIA) conducted for this guideline captured the points you have raised regarding people with a learning disability, and this has been considered by the committee in the development of this guideline. At the start of the recommendations section the guideline acknowledges that people have the right to be involved in discussions and make informed decisions about their care. In this section the committee link to NICE's information on making decisions about your care which provides NICE's resources on Shared decision making which seek to address the issue you raise and support those using the guidelines to address them. The committee have also added people with learning disabilities and autism to the rationale and impact section to highlight them as people who are more likely than average to have poor outcomes from an ARIm and that it may be difficult to assess confusion

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				recommend that this guideline be specifically reviewed to ensure there is always an appropriate pathway for people with a learning disability, which should be noted in the guidance.	(for the CRB65) in some people with learning disabilities or autism.
MENCAP	Guideline	003 - 004	016 - 007	It has been well evidenced that people with a learning disability can experience barriers to care using remote services, including NHS 111, and remote consultations. In our own unpublished research (2022) on access to GP services we found that most people agreed they needed someone to physically check their (or the person they support's) body because they find it hard to explain what is wrong, and most people also agreed that phone consultations were harder than face to face consultations. Research from NDTi (2021) showed a mix of experiences using 111, but some people reported not getting the reasonable adjustments they needed, or difficulties with communication. During the height of the COVID pandemic, the LeDeR programme highlighted difficulties accessing care through 111. In addition, our own case work has suggested there may sometimes be similar issues using 999. In addition to communication barriers, many people with a learning disability may have complex health needs, and/or present differently from what may be typically expected either for basic observations due to either physical differences or different ways of	Thank you. The equality impact assessment (EIA) undertaken for this guideline identifies and acknowledges the points you raise, and the committee have considered them in the development of the guideline. At the start of the recommendations section the guideline acknowledges that people have the right to be involved in discussions and make informed decisions about their care. In this section the committee link to NICE's information on making decisions about your care which provides NICE's resources on Shared decision making which seek to address the issue you raise and support those using the guidelines to address them. The committee have also added people with learning disabilities and autism to the rationale and impact section to highlight them as people who are more likely than average to have poor outcomes from an ARI and that it may be difficult to assess confusion (for the CRB65) in some people with learning disabilities or autism.

				recognising and responding to pain/discomfort. Others may not be able to recognise or explain symptoms. This can make remote communication very difficult, even with the support of a carer or supporter. Whilst many people can have positive experiences using services like 111 or remote consultations, it is important that services are able to recognise when people are likely to have difficulties and make adjustments as needed. It also means that it will be harder to spot people using symptom checkers (including those listed in Box 1, page 4). Whilst we appreciate that the guidance specifies that if an adequate assessment cannot be made remotely the person should be referred for face to face assessment, in practice we know that this is not always recognised for people with a learning disability and that difficulties in spotting deterioration in people with a learning disability is a major issue contributing to the health inequality people experience. It should also be noted that there can be issues during face to face consultations, particularly when with a healthcare professional that is unknown to the person. This is why it is important to ensure consistency wherever possible, and to ensure that carers and supporters are listened to when an individual is unable to relay information themselves.	

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				It would be helpful to specifically state particular risks for people with a learning disability, and that if there are communication difficulties, or differences in presentation that it is important to seek more thorough input, and the importance of listening to family and supporters if they are telling professionals that something is wrong, or different with the person.	
MENCAP	Guidance	005	023	We are concerned that the CRB65 score may not be suitable for all people with a learning disability and may not show appropriate levels of risk. It may be harder for professionals to recognise/diagnose confusion or delirium in people with a learning disability. Due to the health inequality people with a learning disability experience, most people with a learning disability die before the age of 65, including very high rates of deaths due to avoidable respiratory conditions. We recommend linking with the learning disability and autism team at NHS England to seek clinical advice on which tools to recommend and that the guidance notes that this tool may not be suitable for all patients.	Thank you. The committee think your comment relates to p.7-8 where CRB65 is referred to. Recommendations suggest that CRB65 is used to support clinical judgement and would not be used in isolation. The equality impact assessment (EIA) undertaken for this guideline identifies and acknowledges the points you raise, and the committee have considered it in the development of the guideline. At the start of the recommendations section the guideline acknowledges that people have the right to be involved in discussions and make informed decisions about their care. In this section the committee link to NICE's information on making decisions about your care which provides NICE's resources on Shared decision making which seek to address the issue you raise and support those using the guidelines to address them. The committee acknowledged that further research is needed to validate CRB-65 in primary care and community settings and have made a research recommendation to explore this further.

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					The committee have added to the rationale and impact section to remind clinicians that people with learning disabilities and autism may have an increased risk of deterioration and have added the specific example you give about assessing confusion in people with learning disability or autism..
MENCAP	Guidance	005 006	020 011	"For people who do not have a clinical diagnosis of pneumonia, consider 21 their ARI symptoms in the context of their overall health and frailty when 22 making decisions about treatment or referral for further assessment." "When deciding on treatment, take into account the patient's social 12 circumstances and preferences" We are concerned that both of these statements require context in order to support clinicians to safely make decisions about people with a learning disability. Attitudes to learning disability can sometimes skew judgement about a person's quality of life, and/or priorities for the treatment of that individual. In addition, we still have concerns that people may be using the level of people's support needs or dependence on others to make judgements about frailty (as in the CFS). In addition to this, there can also be barriers to treatment itself, particularly if a service or clinician is not experienced in making reasonable adjustments. We recommend the guidance points out the risk of relying on assessment tools for people who may	Thank you. The committee think your comments relate to p.7 and p.8 respectively. The equality impact assessment (EIA) undertaken for this guideline highlights the issues you have raised, and they have been considered by the committee in the development of this guideline. During discussion regarding the EIA the decision to include reference to "all remote consultations should be holistic and person-centred" in recommendation 1.2.1 was made. A discussion was had as to whether a similar item should feature in recommendations regarding 'In-person first contact' but the Committee felt that this is already part of the clinicians' job and is already mandated by law and there would be no additional benefit or purpose to adding this to recommendations. At the start of the recommendations section the guideline acknowledges that people have the right to be involved in discussions and make informed decisions about their care. In this section the committee link to NICE's information on making decisions about your care which provides NICE's resources on Shared decision making which seek to address the issue you raise and support those using the guidelines to address them.

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				present/communicate differently and also stresses the importance of ensuring access to care for people with a learning disability and avoiding making assumptions about people's quality of life etc. We would prefer the statement page 5 to provide more context about what it means. Particularly to ensure that it cannot be interpreted as encouraging a decision not to treat and/or refer a disabled person either due to a conflation of support needs and frailty, or disability and health status. We would prefer the statement on page 6, line 11 to focus on delivering person centred care, including how to treat and where to treat based on preferences etc, as with current wording it could easily be interpreted as whether to treat.	
MENCAP	Guidance	General	General	May it be appropriate to suggest consideration of contributing factors to the infection and in addition to assessment/treatment, considering the benefit subsequent referrals to services such as SALT teams and/or support with keeping warm at home?	Thank you. The guideline scope includes the specific consideration of people with co-morbidities that will affect their risk. This guideline focuses on settings where people make a first presentation to the NHS. Recommendation 1.2.1 highlights the need for all remote consultations to be approach in a holistic and person-centred way which would include the consideration of contributing factors to symptoms and signs of ARI. The consideration of ongoing clinical care beyond the initial assessment and prevention strategies which could include subsequent referrals is outside the scope of this guideline.

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Multiple System Atrophy Trust	Guideline	General	General	Need to add somewhere Referral to SLT during admission to hospital to assess for aspiration pneumonia and ongoing treatment/prevention	Thank you. Aspiration pneumonia is outside the remit of this guideline. Please see the scope document.
Multiple System Atrophy Trust	Guideline	004		Box 1 • fever (more than 38 degrees Celsius) Need to add People with autonomic dysfunction caused by a neurological condition such as MSA are likely to be apyrexial	Thank you. Box 1 has been removed following stakeholder consultation.
Multiple System Atrophy Trust	Guideline	006		Box2 • Confusion Need to add Someone with MSA may experience short term confusion/hallucinations with an acute infection- their Neurologist team must be contacted to discuss treatment options as many antipsychotic medications will make the person worse • low blood pressure Need to add Someone with autonomic dysfunction such as MSA may have low blood pressure as a symptom prior to	Thank you. All of the factors mentioned are important and should form part of the clinical judgment of the person implementing the CRB65 test. The test itself is validated on the 4 components listed in the box and cannot be changed. Hence the importance of clinical judgment and shared decision making alongside the test itself. The committee have added some text to the rationale and impact section to make this point and to the recommendation to clarify that CRB65 scores can be affected by other factors.

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				infection, but infection may make this worse Risk of death • 3 or 4: high risk (more than 10% mortality risk). Neurological disease/autonomic dysfunction should be included in this category	
NHS England	Guideline	General	General	We strongly suggest the document makes reference to making reasonable adjustments. This is a legal requirement as stated in the Equality Act 2010. Adjustments aim to remove barriers, do things in a different way, or to provide something additional to enable a person to receive the assessment and treatment they need. Possible examples include allocating a clinician by gender, taking blood samples by thumb prick rather than needle, providing a quiet space to see the patient away from excess noise and activity. We recommend including reference to the Reasonable Adjustment Digital Flag (RADF) and the RADF Information Standard which mandates all providers and commissioners of health services and publicly funded social care to identify, record, flag, share, meet and review Reasonable Adjustments, including details of their underlying conditions.	Thank you. All recommendations in NICE guidelines have a text box at the beginning of the recommendations with a link to resources to support people in accessing and understanding NHS and social care. Please see NICE's information on making decisions about your care. We have added the point about offering alternatives to recommendation 1.2.1.

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				DAPB4019: Reasonable Adjustment Digital Flag - NHS Digital	
NHS England	Guideline	General	General	We recommend including reference to the importance of Communication: Using simple, clear language, avoiding medical terms and 'jargon' wherever possible. Some people may be non-verbal and unable to describe verbally how they feel. Pictures may be a useful way of communicating with some people, but not all.	Thank you. All recommendations in NICE guidelines have a text box at the beginning of the recommendations with a link to resources to support people in accessing and understanding NHS and social care. Please see NICE's information on making decisions about your care.
NHS England	Guideline	General	General	It remains unclear what gap in current management guidance this guideline covers. It contains inconsistencies and non-evidence-based statements and is nowhere near the quality of other clinical guidelines. We think it risks reputational issues for NICE if published in its current form and question whether it will have much practical use. We would of course be happy to work with NICE and feel it's really important that this is right given it will underpin the forthcoming Quality Standard and because there are also other related pieces of work in the pipeline, such as guidance NHS England is developing on virtual ward care for people with acute respiratory infection.	Thank you. This guideline is intended to support healthcare practitioners in making initial triage decisions for people from undifferentiated populations with signs and symptoms that suggest an acute respiratory infection. The committee have amended the title and initial narrative to try to better reflect this. NICE's reputation rests its high quality methods and processes which were followed as usual, and this includes consensus recommendations based on the committees expertise and experience where evidence is lacking. The committee believe the problem lies in the absence of primary data. There are no previous NICE guidelines regarding undifferentiated symptoms presenting in primary care, and especially to the wider variety of access points than in the past.
NHS England	Guideline	General	General	Content relating to self-care, safety netting and monitoring for ARI is missing from the guideline.	Thank you. The committee agreed that this was an important omission since the majority of people with an ARI do not need further intervention and can be given self-care and safety netting advice. They added a recommendation to reflect this.

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NHS England	Guideline	General	General	I applaud the approach by NICE to consider an undifferentiated approach to those presenting with ARI symptoms. This is a sea change in guidance, and a vital one; and will produce something that will be clinically credible and well utilised. I think there needs to be appropriate balance within the guidance to also considering non-pneumonic ARI presentations (particularly around symptoms of concern- synergised with those of sepsis), which make up the vast majority of suspected ARI community presentations.	Thank you for your support. The recommendations have been updated following consultation and only 3 out of 15 recommendations in the final version relate to pneumonia specifically.
NHS England	Guideline	General	General	Please note, some people with a learning disability and autistic people may have a healthcare passport, giving information about the person and their health needs, preferred method of communication and other preferences. Ask the person or their accompanying carer if they have one of these. Learning disabilities - Support if you are going into hospital - NHS (www.nhs.uk)	Thank you. All recommendations in NICE guidelines have a text box at the beginning of the recommendations with a link to resources to support people in accessing and understanding NHS and social care. Please see NICE's information on making decisions about your care. The committee have also added people with learning disabilities and autism to the rationale and impact section to highlight them as people who are more likely than average to have poor outcomes from an ARIm and that it may be difficult to assess confusion (for the CRB65) in some people with learning disabilities or autism.
NHS England	Guideline	General	General	Please note recent LeDeR research: kcl.ac.uk/ioppn/assets/fans-dept/leder-main-report-hyperlinked.pdf	Thank you. All recommendations in NICE guidelines have a text box at the beginning of the recommendations with a link to resources to support people in accessing and understanding NHS and

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					social care. Please see NICE's information on making decisions about your care. The committee have also added people with learning disabilities and autism to the rationale and impact section to highlight them as people who are more likely than average to have poor outcomes from an ARIm and that it may be difficult to assess confusion (for the CRB65) in some people with learning disabilities or autism.
NHS England	Guideline	001	004	The title should say "Acute respiratory tract infection in patients aged 16y and over…" rather than "over 16s". The scope included patients aged 16y.	Thank you. NICE routinely uses 'Over 16s' to refer to people age 16 and over. As soon as a person has had their 16th birthday they are over 16.
NHS England	Guideline	003	001	ARI needs to be defined earlier in the document. What is included e.g. An acute illness affecting either the upper and lower respiratory tracts caused by bacterial or viral pathogens. This is a snapshot of the most common reasons for seeking help in OOH community	Thank you. NICE guidelines follow a specific format. ARI is defined in the 'Terms used in this guideline' section.

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				settings: For reference: NHUC – top reasons for calling (same day OOH) 	
NHS England	Guideline	003	003	This guideline does not cover people with COVID-19. So, this implies all people presenting with ARI symptoms would need to do a COVID-19 test to determine which guideline should be followed? Are we asking everyone to be tested for COVID-19 first? If so, then this should be made explicit. If not, then suggest	Thank you. The guideline excludes people with known COVID-19 as detailed in the scope document. The committee have amended the guideline to clarify this.

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				tweak wording e.g. This guideline does not cover people with COVID-19. If COVID-19 is suspected based on (insert hyperlink to most relevant guidance or COVID-19 symptoms and what to do - NHS (www.nhs.uk) then a COVID-19 rapid lateral flow test can be done. However, this is no longer required if a patient presents with COVID-19 symptoms. If COVID-19 is confirmed then see NICE's guidelines on COVID-19 for advice on managing COVID-19 infection.	
NHS England	Guideline	003	005	The phrase "people with a suspected acute respiratory infection" is used. It would be significantly helpful for implementation of these recommendations and monitoring of adherence, if clinicians were encouraged to create a digital record of this patient cohort using a SNOMED code for "suspected acute respiratory infection". Can NICE please promote this digital coding?	Thank you. This is beyond the remit of this guideline. Please see the scope document for details.
NHS England	Guideline	003	006	Suggest explaining how "seriously ill" should be assessed or provide link to relevant guidance to highlight or signpost to red flag symptoms. This is important given the increasing number of non-medical staff who might be reviewing patients/members of the public who may not have undergone the same level of clinical assessment training as medical staff.	Thank you. The committee have changed the wording of this recommendation to be more consistent with the "think sepsis" approach set out in NICEs sepsis guideline (NG51)
NHS England	Guideline	003	008	The phrase "people with a suspected upper respiratory infection" is used. It would be significantly helpful for implementation of these recommendations and monitoring of adherence, if clinicians were encouraged to create a digital record of this patient	Thank you. This is beyond the remit of this guideline. Please see the scope document for details.

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				cohort using a SNOMED code for "suspected upper respiratory infection", unless a more specific diagnosis is evident (such as sore throat). Can NICE please promote this digital coding?	
NHS England	Guideline	003	008	In people presenting with a suspected upper respiratory tract infection, see NICE's guidelines on antimicrobial prescribing for acute sore throat and acute cough. Suggest including NICE guidelines for Sinusitis (acute): antimicrobial prescribing	Thank you. The committee have added this.
NHS England	Guideline	003	010	Acute cough guidelines covers much of the ARI.	Thank you. The cough guideline covers the management of acute cough associated with URTI or bronchitis. This guideline is focussed on the initial assessment of undifferentiated ARI, which may lead to using the cough guideline (for example).
NHS England	Guideline	004		Box1 fever (more than 38 degrees Celsius) Consider amending to the BTS pneumonia symptom definition which aligns clinical guidance. At least one systemic feature (either a symptom complex of sweating, fevers, shivers, aches and pains and/or temperature of 38°C or more).	Thank you. Box 1 has been removed following stakeholder consultation.
NHS England	Guideline	004	001	The box is unhelpful to determine if an individual has pneumonia, is this about ARI and not pneumonia? Wheeze is not a feature of pneumonia (may be ARI if background COPD in an exacerbation). This feature of box 1 is more around sepsis and loose stool is also more of a sepsis feature.	Thank you. Box 1 has been removed following stakeholder consultation.

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				Difficult to determine these symptoms remotely, especially when the patient will not have the equipment, so becomes confusing.	
NHS England	Guideline	004	002	Focusing on pneumonia is not as helpful and conflates the aim of a broad guidance on acute respiratory infections (including but not limited to pneumonia). I would include a box focusing on red flags of severe ARI instead, as these are the patients that should be seen face to face rather than only those with suspected pneumonia.	Thank you. Box 1 has been removed following stakeholder consultation.
NHS England	Guideline	004	002	Clinicians are advised to "Use the presence of 1 or more of the symptoms and signs in box 1 to assess for possible pneumonia." This decision rule is likely to be highly sensitive for detecting pneumonia (low risk of false negative in disease-positive cohort) but is also likely to have low specificity (high risk of false positives in disease-negative cohort), which will lead to over-prescribing of antibiotics. Can NICE provide information within the guideline on the sensitivity and specificity of this decision rule? How does NICE propose to mitigate the risk of over-prescribing of antibiotics?	Thank you. Box 1 has been removed following stakeholder consultation.
NHS England	Guideline	004	003	Really clear criteria for high risk of pneumonia for patients with ARI	Thank you. Box 1 has been removed following stakeholder consultation.
NHS England	Guideline	004	003	Box 1 is titled: "Symptoms and signs with high probability of indicating pneumonia in people with suspected ARI." Please can NICE add a case definition for "suspected ARI"? This is important to improve the specificity of the list of symptoms and signs in box 1 for "high probability of indicating	Thank you. Box 1 has been removed following stakeholder consultation.

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				pneumonia". Please also make it clear in the title that the listed symptoms or signs can indicate "bacterial or viral pneumonia" as discussed on p9, line 23.	
NHS England	Guideline	004	004	Clear guidance for moving to a face-to-face consultation which supports the making of a more accurate diagnosis and avoiding unnecessary antibiotics.	Thank you.
NHS England	Guideline	004	004	Confusing lengthy statement. Should a patient have any of the features in box 1 then they should have a face-to-face appointment.	Thank you. Box 1 has been removed following stakeholder consultation. The committee have reworded recommendation 1.1.5 make it more readable. Recommendation 1.1.5 is now recommendation 1.2.3. Presence/suspicion of pneumonia is not the only reason for a face-to-face assessment.
NHS England	Guideline	004	011	Needs to be qualified with the evidence around increased antibiotic prescribing when patients have remote consultations alone. What about deferred prescriptions?	Thank you. NICE recommendations do not include direct reference to the evidence. Recommendation 1.2.4 outlines that antimicrobials should not be prescribe routinely based on a remote assessment but now outlines scenarios where this could be an option. Deferred prescriptions are introduced as an option in recommendation 1.3.1 and 1.3.4.
NHS England	Guideline	004	011 - 013	Do not prescribe antimicrobials for ARIs based on a remote consultation alone. If antimicrobials may be needed, refer the person for a face-to-face assessment. Welcome and support this statement.	Thank you for your support.
NHS England	Guideline	005	002 - 003	…who present in-person at NHS services, including GP practices and walk-in centres. Suggest edit to who present in-person at sites that provide an NHS	Thank you. The committee have amended this.

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				service, including GP practices, walk-in centres and community pharmacies. Community pharmacies are increasingly being promoted as a first point of contact for minor ailments including many ARIs and should be explicitly included in this guideline to recognise and support their role.	
NHS England	Guideline	005	004	When will covid be excluded from this?	Thank you. Known COVID-19 is excluded from this guideline. Please see the scope document for details.
NHS England	Guideline	005	006	Again, too much focus on pneumonia and not the wider causes of ARI.	Thank you. The committee have rearranged the recommendations to highlight those for people with and without pneumonia.
NHS England	Guideline	005	006	For people with symptoms and signs of an ARI, use clinical assessment to make a diagnosis and decide whether to prescribe antibiotics. Consider include guidance for antiviral for flu prescribing also as ARI may be flu.	Thank you. We have broadened the term to 'antimicrobials' so that it covers both antibiotics and antivirals.
NHS England	Guideline	005	006	For recommendation 1.1.8, please provide a case definition for "people with symptoms and signs of an ARI", What does NICE consider to be symptoms and signs of an ARI and is one symptom or sign sufficient to constitute a diagnosis or is more than one symptom/sign or are specific combinations required? If a patient is short of breath due to heart failure and has cough due to pulmonary oedema and happens to present with diarrhoea, will this be considered "high probability" of pneumonia? Is it possible for NICE to be more specific about what should constitute a "clinical assessment to make a diagnosis and decide whether to prescribe antibiotics."? What symptoms	Thank you. Recommendation 1.1.8 is now recommendation 1.3.1. ARI is defined in the 'terms used in this guideline' section of the guideline as 'An acute illness (present for 21 days or less) affecting the respiratory tract with symptoms such as cough, sore throat, fever, sputum production, breathlessness, wheeze or chest discomfort or pain) *and no alternative explanation'*. The list of symptoms in box 1 has been removed following stakeholder consultation.

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				and signs should be elicited by what means? What is the diagnostic threshold for an acute RTI? How should a patient with symptoms of coryza (common cold) and confusion due to dementia be managed for example? Can NICE specify a clinical threshold for offering antibiotics? This would meet an important unmet need, exemplified by the wide variation between UK primary care clinicians in antibiotic prescribing for episodes of RTI. [Palin V et al. J Antimicrob Chemother 2019; 74: 2440–2450 doi:10.1093/jac/dkz163]	It was not possible for the committee to specify signs and symptoms that should drive clinical assessment since the evidence for these was poor and largely ambivalent. See evidence review A for further detail.
NHS England	Guideline	005	011	Again, too much focus on pneumonia and not the wider causes of ARI.	Thank you. This recommendation has changed following stakeholder consultation to cover all people with lower respiratory tract infection.
NHS England	Guideline	005	011	CRP is a good tool to use to support the clinical decision-making process but near patient testing such as this very unlikely an option for majority of GPs.	Thank you. The committee discussed and recognised that many primary care sites do not have access to CRP testing, but they agreed that where this is available it should be considered as an option to support decision making. The committee noted that this has been a recommendation in NICE's 2014 pneumonia guideline and this is not a new resource impact. The NICE pneumonia guideline is in the process of being updated. If you would like to register as a stakeholder for this update please visit https://www.nice.org.uk/guidance/indevelopment/gid-ng10357
NHS England	Guideline	005	011	Recommendation 1.1.9 has significant resource implications for the NHS associated with the	Thank you. Recommendation 1.1.9 is now recommendation 1.3.4. This recommendation comes

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				introduction of routine CRP testing in primary care settings, although it is acknowledged the recommendation is "Consider" rather than "Offer". What is the medico-legal position if NICE recommends a clinician should "Consider" using a CRP test but is unable to "Consider" that test because it is not available within the care setting?	from the 2014 NICE guidance on the assessment and management of pneumonia and is not a new recommendation. The data presented in the Gentilotti (2022) review were consistent with the conclusions reached by the 2014 pneumonia guideline. The committee took this as further evidence that the thresholds were useful and useable and agreed to keep them. For the evidence underpinning the 2014 recommendation, please see the pneumonia full guideline, section 7.1. The committee discussed and recognised that many primary care sites do not have access to CRP testing, but they agreed that where this is available it should be considered as an option to support decision making The NICE pneumonia guideline is in the process of being updated. If you would like to register as a stakeholder for this update please visit https://www.nice.org.uk/guidance/indevelopment/gid-ng10357
NHS England	Guideline	005	011 - 013	Suggest rephrasing for clarity "Consider a C-reactive protein (CRP) test if, after the clinical assessment, it is unclear whether to prescribe antibiotics to people without suspected pneumonia:" to "For people without suspected pneumonia, consider a C-reactive protein (CRP) test if, after the clinical assessment, it is unclear whether to prescribe antibiotics."	Thank you. The committee have amended this recommendation to make it clearer.

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NHS England	Guideline	005	011 - 013	Noting what the committee discussed about the timing of CRP testing (page 10-11) "so a sample taken early in the course of infection could be falsely reassuring", it would be advisable to include this consideration into the main guideline and include reference.	Thank you. The rationale and impact section of the guideline currently reports that "They discussed the limitations of CRP testing because of the time lag for onset of symptoms with infections (which corresponds to presence of CRPs), so a sample taken early in the course of infection could be falsely reassuring.". It has been amended to report other reservations the committee had about the usefulness of CRP testing at first assessment.
NHS England	Guideline	005	014	offer antibiotics if their CRP level is more than 100 mg/litre. Suggest amending to use term 'offer immediate antibiotic prescription' which is a term used in other NICE guidance to differentiate from a back-up antibiotic prescription.	Thank you. The committee have amended this as you suggest.
NHS England	Guideline	005	015	consider a delayed antibiotic prescription Suggest amending to use the term back-up antibiotic which is used in other NICE guidance.	Thank you. The committee have amended this as you suggest.
NHS England	Guideline	005	015	...consider a delayed antibiotic prescription. Suggest "back-up (delayed)" antibiotic prescription in line with many other NICE resources such as Recommendations | Sore throat (acute): antimicrobial prescribing | Guidance | NICE; Quality statement 2: Back-up (delayed) prescribing | Antimicrobial stewardship | Quality standards | NICE; Overview | Otitis media (acute): antimicrobial prescribing | Guidance | NICE	Thank you. The committee have amended this as you suggest.
NHS England	Guideline	005	015	The term "delayed antibiotic prescription" can be misinterpreted as an inevitable eventual antibiotic prescription. Please use the term "back-up antibiotic prescription" to avoid this misunderstanding. If the	Thank you. The committee have changed this throughout the guideline.

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				word delayed is considered necessary, please use the term "back-up (delayed) antibiotic prescription". Using "prescription/supply" rather than "prescription" facilitates the supply of antibiotics under patient group direction at a later date if the patient does not improve.	
NHS England	Guideline	005	020	A pneumonia diagnosis does not determine if patients require on referral or further assessment alone. There are many other factors.	Thank you. This was an important consideration for the committee and led them to make the recommendation 1.1.10 (now recommendation 1.3.2) about taking people's social circumstances into account.
NHS England	Guideline	005	020 - 022	It seems advice for those who do not have pneumonia stops here but there are various other ARI resources that would be useful to signpost e.g. Overview | Otitis media (acute): antimicrobial prescribing | Guidance | NICE; Overview | Cough (acute): antimicrobial prescribing | Guidance | NICE; Overview | Chronic obstructive pulmonary disease (acute exacerbation): antimicrobial prescribing | Guidance | NICE Also need to provide self-care and safety netting info (currently missing)	Thank you. The committee have made clearer links with the antimicrobial prescribing guidelines and have added a recommendation about self-care and safety netting (1.1.2). Links are provided in the guideline to all of the relevant antimicrobial prescribing guidelines. A link is not included for otitis media in children because the scope of this guideline was over 16s.
NHS England	Guideline	005	023	I worry about encouraging the use of CRB65 in this undifferentiated ARI group. This is particularly important in community settings where diagnosing a pneumonia is incredibly challenging. Indeed, even in hospital and with the benefit of CXRs, recurrent BTS audits have demonstrated a v low accuracy with correctly diagnosing pneumonia. NEWS2 is possibly as useful as CRB65 in predicting outcomes in	Thank you. The guideline does not recommend the use of CRB65 in undifferentiated ARI groups. It recommends the use of CRB65 in people with a clinical diagnosis of pneumonia. This is consistent with the 2014 NICE pneumonia guideline and new evidence contained in evidence review A. The committee noted that there were concerns about the validity of CRB65 in low prevalence settings and in

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				pneumonia, and a lot more useful in non-pneumonic ARI. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7517400/	different populations (which thy added to the recommendation) and were careful to frame the recommendation to prioritise clinical judgment and only use CRB to 'inform' decisions about care. They also made a research recommendation to validate both NEWS2 and CRB65 in low prevalence cohorts (research recommendation 1). The NICE pneumonia guideline is in the process of being updated. If you would like to register as a stakeholder for this update please visit https://www.nice.org.uk/guidance/indevelopment/gid-ng10357
NHS England	Guideline	005	023	If a clinical diagnosis of pneumonia has been made (see box 1). Up until now, reference to box 1 has always been about using these as prompts to assess for pneumonia NOT as a diagnostic checklist. Suggest remove "(see box 1)".	Thank you. The committee have removed this.
NHS England	Guideline	006		Box 2: CRB65 score for risk assessment of pneumonia in primary care. First time mention primary care. Does this mean this guideline does not apply to those presenting in hospital A&E depts? Can "primary care" be removed from the box?	Thank you. The committee have removed primary care, but the committee note that the CURB65 test is more commonly used in emergency departments.
NHS England	Guideline	006		Box Are we happy for intermediate risk with a 10% mortality not to be evaluated in hospital?	Thank you. The committee agreed that clinical judgment and shared decision making were key factors in this decision, along with contextual factors such as the persons social circumstances (recommendation 1.3.2). The committee agreed that some people in this category would need hospital assessment, some might be managed in alternatives

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					to hospital care such as virtual wards, and some might be managed at home if their home circumstances were suitable.
NHS England	Guideline	006	001	CRB56 scoring helps to make correct decision for onward referral. It would be good to maybe in addition to the mortality risk add in something about patients with LD&A who have an increased risk of deterioration and fatality as often overlooked-COULD BE ADDED AS AN ADDITIONAL POINT IF PATIENT IS LD&A?	Thank you. The committee have added some text to the rationale and impact section to make this point.
NHS England	Guideline	006	001	In Box 2, please clarify to what time period the risk of death applies (e.g., risk of death within 30 days). This is important to help clinicians contextualise the urgency implied by CRB65 score.	Thank you. The committee have added this.
NHS England	Guideline	006	007 - 009	Suggest adding another example in addition to "virtual ward".	Thank you. The committee agreed to add a further example and have included community intervention teams.
NHS England	Guideline	007		To reiterate, the scoring system utilised needs to be wide angled to not miss other ARI that are not pneumonias and other pathologies that present with suspected ARI symptoms e.g., PE, Acute MI	Thank you. The CRB65 is only recommended here for use in people with a clinical diagnosis of pneumonia. Further research is needed to validate both CRB65 and NEWS2 in face-to-face assessments in primary care, community settings and ARI hubs, and that the committee made a research recommendation on using early warning scores in different settings.
NHS England	Guideline	007	004	ARI no comment about sinusitis.	Thank you. The committee have added a cross reference to the NICE guideline on antimicrobial prescribing for acute sinusitis.
NHS England	Guideline	007	009	Research recommendations: appropriate but shows how little evidence we have in promoting a guideline that has limited evidence. It seems as if there are	Thank you for your observation. The committee agreed that they were hoping for better evidence to make stronger recommendations. Hopefully the

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				more recommendations for research than there are for clinical care.	research recommendations will lead to more evidence being available next time this guidance is reviewed.
NHS England	Guideline	007	012	e.g., An acute illness affecting either the upper and lower respiratory tracts caused by bacterial or viral pathogens.	Thank you. The committee have added a reference to ARI into the research recommendation.
NHS England	Guideline	007	013 - 016	Suggest adding community pharmacies.	Thank you. The committee have added this.
NHS England	Guideline	007	017	Please include within the research recommendation "initiating antibiotics" as an important example of a care pathway that scores may be able to help support clinical decisions.	Thank you. The committee did not search for evidence on the effectiveness of initiating antibiotics as this was outside the scope of this guideline, which was focused on triage at first presentation.
NHS England	Guideline	008	016 - 023	Why do we focus on bacterial pneumonia when this is a guideline covering sore throat and sinusitis as well as acute bronchitis? We have lost the guideline focus as the paragraph further concentrates on viral or bacterial pneumonia and not ARI.	Thank you. The paragraph you refer to has been rewritten following consultation.
NHS England	Guideline	009	012	Consider a broader approach rather than just a pneumonia based one. Red flags should determine who is seen face to face, not necessarily limited to those listed. this is the national ambulance ARI tool. Nearly all used NEWS2 and standardised symptom lists:	Thank you. The committee searched for evidence for the use of NEWS2 in primary care settings for ARI but was unable to find any study validating NEWS2 in these populations. The committee have added to the rationale and impact section of the guideline to make clear that it is broader than pneumonia.

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				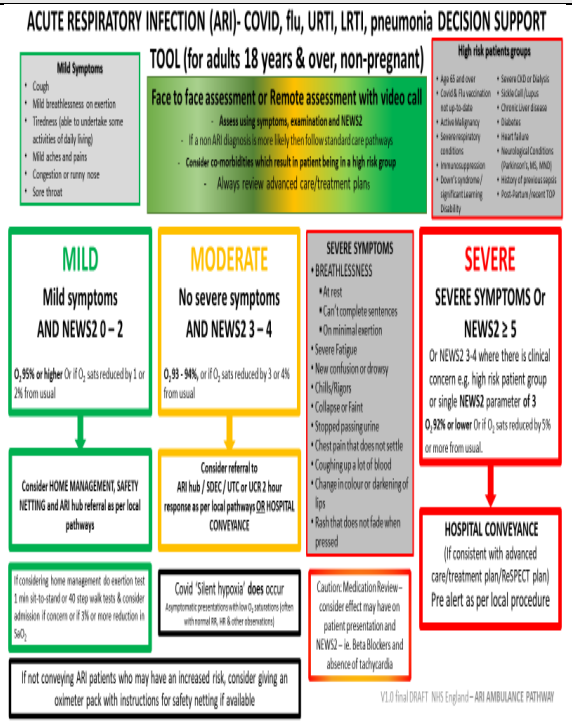 Allowance for risk factors for severe illness needs to be included, and then clear advice on what constitutes mild v severe symptoms to help non-clinical triage in primary care settings (see the mild and severe symptom boxes). Note also the current national guidance for mild, moderate, and severe based on NEWS2 and oxygen saturations.	

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				We are hoping to have a consistent set of ARI resources and guidance across community, ambulance and hospital settings outlining assessment, treatment, admission, and discharge criteria. A lot of the 363 ARI hubs that operated during winter 2022-3 used pathways like this:	

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				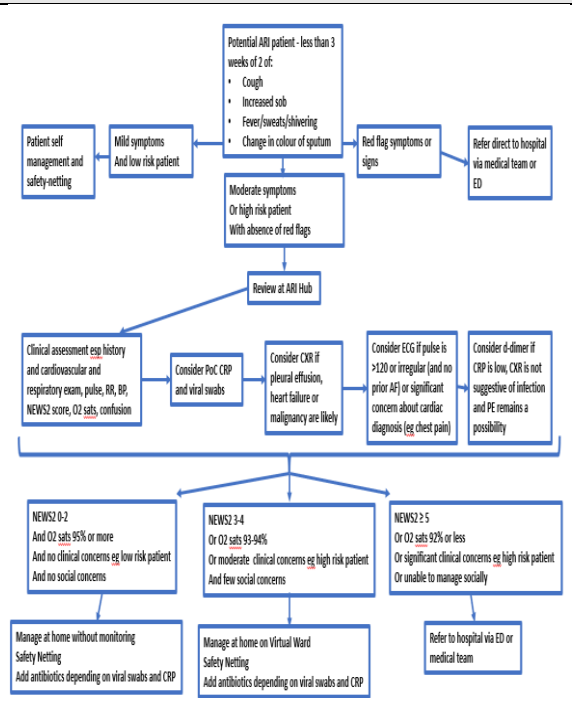	
NHS England	Guideline	009	015	Not sure why the remote assessment has morphed into checking from pneumonia, this is an ARI guideline.	Thank you. This section has been rewritten following stakeholder consultation and box 1, to which it refers has been removed.
NHS England	Guideline	010	007	Not sure you can state that guideline will help recognition of pneumonia. No evidence for this statement.	Thank you. The committee have amended this.

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NHS England	Guideline	010 - 011	026 - 010	This is not a guideline to aid management but a discussion on CRP testing. Very unfocused.	Thank you. This guideline focuses on the initial triage of people with a suspected ARI. For most people the management is covered by other NICE guidelines. The committee have updated the title of the guideline to reflect this and tried to make it clearer in the introduction.
NHS England	Guideline	011	015	Repetition of research agenda above.	Thank you. This is intentional because the committee are keen to explore the usefulness of NEWS2 and CRB65 in both face to face and remote consultations.
NHS England	Guideline	011	027	Certainly, may reduce Abx prescribing but this new guidance likely to increase demand for F2F in primary care which is at a crisis point in terms of capacity. Recommendations should also include that ICBs look to a rapid 'demand and capacity' assessment of primary care and implement strategies to support additional demand such as ARI Hubs, VWs etc. Also, the increased conversion from telephone to F2F will have implications for health inequalities, transport availably, vulnerable adults and children, socially deprived etc. More likely those without the means to get to a F2F won't get to be examined and may result in inequality of access to appropriate antibiotics with subsequent deterioration and use of emergency services or worst-case scenario fatalities, hence the need to risk score for LD&A and other health inequalities may need to be considered.	Thank you. Recommendations on ICB strategies for managing demand are outside NICEs remit. The recommendation for not prescribing remotely has been modified in the final version of the guideline to allow for remote prescribing in certain circumstances.
NIHR Health Protection Research Unit (HPRU) in	Guideline	General	General	I struggled to understand the main overarching purpose for the guideline since there already exist guidelines for COVID, Influenza and Pneumonia and this seems to be a watered-down version of each.	Thank you. As you say the main purpose of this guideline is to assess people at first presentation with a suspected acute respiratory infection and to triage them on to the correct care pathway, either in remote

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Respiratory Infections, Imperial College London.				This from what I gather should in fact be entitled " Acute Respiratory Infection in over 16s. how to triage virtually." I assume this is being delivered in response to the call for virtual wards across the UK.	or face-to-face first consultations. The committee have amended the title of the guideline to clarify this.
NIHR Health Protection Research Unit (HPRU) in Respiratory Infections, Imperial College London.	Guideline	001	General	Title of consultation, All titles through documents A,B,C,D Barely any mention of viruses, apart from exclusion of COVID 19. Need to change the title or include viral infections more explicitly. Based on content this consultation should be about…… Acute bacterial infection in the over 16s	Thank you. The committee have updated the recommendations since consultation. Most of the recommendations are equally applicable to bacterial or viral ARI and therefore just refer to ARI.
NIHR Health Protection Research Unit (HPRU) in Respiratory Infections, Imperial College London.	Guideline	004		BOX 1. Lists Wheeze as a symptom of concern but does not include cough/sputum production. The evidence reviewed provides equal weight for these symptoms as it does for Wheeze. I am therefore unclear why cough/sputum production are not included within the box since these are more common than wheeze outside of patients with underlying airways disease and wheeze reflects airway exacerbation which may be due to reasons other than an ARI/pneumonia. I would also suggest that the addition of the word "New" symptoms and signs is added to the overall title since many of the signs and symptoms may characterise chronic respiratory disease.	Thank you. Box 1 has been removed following stakeholder consultation.
NIHR Health Protection Research Unit	Guideline	004	002	Box 1 I suggest including (new) focal chest examination	Thank you. Box 1 has been removed following stakeholder consultation.

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(HPRU) in Respiratory Infections, Imperial College London.				findings in box 1 instead of text (or as well as) for reasons of clarity	
NIHR Health Protection Research Unit (HPRU) in Respiratory Infections, Imperial College London.	Guideline	005	004	1.1.7 and general There is little in relation to viral infections and the importance of testing for these on a seasonal basis. The blanket statements in 1.1.7 about not utilising Point of care testing ignores the benefit in certain seasons or times of rising incidence when they in fact have lots of benefit both clinically and for surveillance purposes.	Thank you. Recommendation 1.1.7 is now recommendation 1.3.3. This recommendation focuses on the inability of tests to distinguish between bacterial and viral infection, and therefore their lack of usefulness in making decisions about whether to prescribe an antimicrobial agent. Surveillance was outside the remit for this guideline however the committee have added a recommendation to follow UKHSA seasonal advice for managing influenza like illness..
NIHR Health Protection Research Unit (HPRU) in Respiratory Infections, Imperial College London.	Guideline	005	004	1.1.7 In addition to importance of testing for viral infections, I think there should be some challenge to not sending sputum for analysis especially in the rise of growing infection. If sputum is purulent and symptoms not improving sputum should be sent for analysis. AMR relies upon appropriate use of diagnostics to inform decision making. The stance of this guideline appears to use clinical impression alone with little input from testing.	Thank you. Recommendation 1.1.7 is now recommendation 1.3.3. Because this guideline is about the initial triage of patients, the tests that were considered in the evidence reviews were point of care type tests, that is they were near patient tests that delivered results in less than 45 minutes since that was the time the committee agreed was reasonable to inform initial triage and decision making. Sputum cultures take much longer than 45 minutes and, while useful for making a definitive diagnosis, they do not inform initial assessment and management decisions. The committee have clarified that this refers specifically to rapid, point-of-care tests for the purposes of prescribing, and not to slower diagnostic

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					tests such as sputum cultures or the use of POCT for surveillance or disease control.
NIHR Health Protection Research Unit (HPRU) in Respiratory Infections, Imperial College London.	Guideline	005	004 - 005	1.1.7 "Do not offer microbiological tests or influenza tests to people with suspected ARI".....this implies that pathogen diagnostic tests have no value, and also takes no account of seasonal epidemic variation in causes of ARI. During influenza epidemics, there are periods of 6-12 weeks where influenza tests will be very informative about cause of ARI. It is acceptable to have clinical presentation as primary driver for antibiotic choice, but testing still has a role, and this NICE guidance does not speak to clinical best practice	The committee have clarified that this refers specifically to rapid, point-of-care tests for the purposes of prescribing, and not to slower diagnostic tests such as sputum cultures or the use of POCT for surveillance or disease control. Recommendation 1.1.7 is now recommendation 1.3.3.
NIHR Health Protection Research Unit (HPRU) in Respiratory Infections, Imperial College London.	Guideline	005	006	1.1.8 - Does "clinical assessment" mean a face-to-face assessment. I would suggest that this indeed what is needed in place of a virtual review especially when considering prescribing an antimicrobial therapy.	Thank you. Recommendation 1.1.8 (now recommendation 1.3.1) refers to face-to-face assessment at an in-person presentation, this has now been made clearer. Also of note, recommendation 1.2.4 acknowledges stakeholder comments and committee discussion points that whilst "antimicrobials should not be routinely prescribed based on remote assessment alone" that in certain scenarios flexibility to prescribe remotely is required so have added that remote prescribing could occur if "the person knows when and how to seek further medical help and there is a sound reason to prescribe remotely" with some example scenarios provided.

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NIHR Health Protection Research Unit (HPRU) in Respiratory Infections, Imperial College London.	Guideline	006	010	Depending on scope of the guideline, I suggest being more prescriptive about recommending hospital admission to patients who have a low Curb score but in whom an infection has significantly impacted other comorbidities, prompting health care providers to consider these comprehensively eg an infection that has significantly disrupted diabetes control	Thank you. The committee have added to the rationale and impact section to clarify that part of the clinical judgment involves assessing red flags.
NIHR Health Protection Research Unit (HPRU) in Respiratory Infections, Imperial College London.	Guideline	007	005 - 006	"terms" The guidance acknowledges the pneumonia and covid guidance, but ARI takes into account symptoms noted for 3 weeks and therefore I would assume should also mention exploring risk factors for TB also and link to that guidance also if patients have significant risk factors.	Thank you. The committee have added a cross reference to the NICE guideline on tuberculosis.
NIHR Health Protection Research Unit (HPRU) in Respiratory Infections, Imperial College London.	Guideline	010 - 011	026 - 009	I am concerned with such a CRP threshold of 100 and assuming the appropriate timepoint taken. This result will need to be PoC as a test to allow this to work and note it allows a delayed antibiotic option.	Thank you. This recommendation does refer to a point of care test. The committee have amended the wording to reflect this.
NIHR Health Protection Research Unit (HPRU) in Respiratory Infections,	Evidence review C	009	012	Section C Signposting to Tables appears to be incomplete…should state Table 4	Thank you. We have contacted the external reviewers who note that the caption is there but during the conversion to pdf form it has moved onto the previous page.

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Imperial College London.					
NIHR Health Protection Research Unit (HPRU) in Respiratory Infections, Imperial College London.	Evidence summary	General	General	Section C and D General tone of NICE approach to use of PoC tests seems out of alignment with the reported user feedback which HPRU and UKHSA have been party to, through events that have been run by the HPRU …see as another example "Pathology In Practice May 2023. The Power to Disrupt "..point of care testing in the NHS p29-32. The NICE process insistence on the rigid approach to pre specified RCT does not take account of user experiences in the usefulness of PoC testing for managing patient flows, where there may never be a model study write up. Does not seem to be reflected in the discussions, but should be as managing winter pressures is critical for the NHS	Thank you. There are no sections C&D in the evidence summary so the committee are unclear what you are referring to. NICEs approach is widely known and recognised as being a robust management of the evidence base. Details of NICEs methods and process are available in the NICE manual, which has recently been updated and was widely consulted on. NICE is committed to taking user experience into account and has at least 2 lay members on each NICE committee. NICE also consults widely on its guidelines, including with patient organisations.
NIHR Health Protection Research Unit (HPRU) in Respiratory Infections, Imperial College London.	Evidence summary	065	023 - 029	Section D Concern about the way in which technical performance of PoC rapid antigen devices for individual viruses is described and assessed. The search strategies for the included studies does not explicitly consider data which assesses technical performance of individual devices. This should be listed as a limitation of the consultation preparation. Search and text do not distinguish between rapid PoC antigen tests and very rapid PCR tests Typically it is clear that PoC antigen devices for influenza and RSV have high specificity (>90%), but lower sensitivity. Sensitivity may vary on the day of illness, which is	Thank you. Greater detail of the individual devices for which data were found is contained in evidence review C.

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				related to the Limit of detection performance of the devices	
NIHR Health Protection Research Unit (HPRU) in Respiratory Infections, Imperial College London.	Evidence summary	067	043	Section D The reference to the notification from UKHSA about triggering antiviral treatment for influenza is apposite for the consultation, but it is surprising that throughout the documents there is so little mention of the very big swings in consultation and admissions for respiratory infections by season, with much more illness seen in the winter months, than the summer months. This would be worth highlighting, and considering the statement in the context of peak epidemic weeks of the annual influenza season. The recommendation does not really distinguish between presentation to hospitals or primary care	Thank you. The committee discuss seasonality and ARI highlighting that information from UKHSA about national pattern of these diseases is important in deciding diagnosis and treatment. The committee have added a recommendation to highlight that clinicians should follow updates from UKHSA and advice from them about diagnosis and prescribing during seasons of high ARI prevalence. This guideline focuses on first presentation with a suspected ARI so self-referral hospital sites such as emergency departments would be included. The focus is on first presentation and initial triage rather than setting.
Nuffield Department of Primary Care Health Sciences University of Oxford	Guideline	005	005 - 010	Section 'In-person contact with NHS services at first presentation' under 1.1.8. The sentence here 'use the presence of 1 or more of the symptoms and signs in box 1, or reduced breath sounds or crackles on auscultation, to assess for possible pneumonia' is problematic. It suggests that simply fulfilling one symptom or sign is justification for a clinical diagnosis of (possible) pneumonia and hence an antibiotic prescription. Box 1 is useful for screening/ remote consultation (not	Thank you. Recommendation 1.1.8 has been amended and is now recommendation 1.3.1. Box 1 has been removed following stakeholder consultation.

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				for diagnosis or whether to prescribe an antibiotic or not).	
Nuffield Department of Primary Care Health Sciences University of Oxford	Guideline	005	005 - 010	The reliance on auscultation is unreliable. Primary care clinicians tend to 'overestimate' their skills in diagnosis of 'pneumonia'. 'Noise on the chest' is the most important reason to prescribe an antibiotic. One of the consequences is that by labelling an acute cough illness as pneumonia, antibiotics seem to be justified. i.e. in the study by Hopstaken et al. [Do clinical findings in lower respiratory tract infection help general practitioners prescribe antibiotics appropriately? An observational cohort study in general practice. Fam Pract. 2006 Apr;23(2):180-7. doi: 10.1093/fampra/cmi100], they found that auscultation abnormalities (OR 11.5; 95% CI 5.4-24.7), and diarrhoea (OR>11) were strongly associated with antibiotic prescribing. An antibiotic was prescribed for 195 (79%) patients. If we assume an antibiotic needs to be prescribed only for patients with pneumonia, antibiotics may have been inappropriately prescribed for 166/193 (86%) of the patients. Antibiotics were not prescribed for 5 of the 32 (16%) patients with a radiographic diagnosis of pneumonia. The conclusions of this study suggest that abnormal findings on auscultation in patients with LRTI strongly predict antibiotic prescribing and this is probably inappropriate for most patients seen in a primary care setting. These results should prompt	Thank you. Box 1 has been removed following stakeholder consultation.

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				GPs to consider the extent to which finding 'crackles/rhonchi on auscultation' influences their decisions to prescribe antibiotics for their patients with LRTI, and to consider the (other) predictive value of individual clinical signs in reaching evidence-based prescribing decisions.	
Nuffield Department of Primary Care Health Sciences University of Oxford	Guideline	005	010 - 019	Section 1.1.9 Consider a C-reactive protein (CRP) test if, after the clinical assessment, it is unclear whether to prescribe antibiotics to people without suspected pneumonia. This statement is unclear and potentially ambiguous. As it stands one should only do a CRP POCT if I have ruled out 'pneumonia' clinically, and one is still concerned. However, as outlined in Example 2 above, the clinical diagnosis of pneumonia in general practice is often over-diagnosed. In addition, we should acknowledge that we are not able to confidently decide which patients would benefit from an antibiotic based on clinical examination alone. It is for this reason that performing a CRP POCT can confirm (or refute) the antibiotic prescribing decision in suspected LRTIs. In addition, I am concerned that the corollary of the statement above suggests that patients with a LRTI should (automatically) be prescribed an antibiotic. Rather, in general practice, it is the severity of the LRTI that should determine whether an antibiotic is	Thank you. Recommendation 1.1.9 is now recommendation 1.3.4. This recommendation is from the 2014 pneumonia guideline and has been part of NICE guidance since 2014. The NICE pneumonia guideline is in the process of being updated. If you would like to register as a stakeholder for this update please visit https://www.nice.org.uk/guidance/indevelopment/gid-ng10357 The committee believe that your argument is consistent with what the guideline says and have reworded to make this clearer. Antibiotic prescribing should follow from the clinical assessment of the severity of the disease. If after clinical assessment the clinician is still unsure about the prescribing decision then a CRP test can add additional support to their decision. The evidence showed that the use of CRP testing did reduce the number of antibiotic prescriptions, but it also had a negative impact on the number of re-consultations (see evidence review C).

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				prescribed or not. Bearing in mind the diagnostic difficulties prescribers face in GP, using a CRP POCT to help assess the severity of a potential LRTI and reduce diagnostic uncertainty as part of their clinical assessment.	The committee discussed and recognised that many primary care sites do not have access to CRP testing, but they agreed that where this is available it should be considered as an option to support decision making. The committee noted that this has been a recommendation in NICE's 2014 pneumonia guideline and this is not a new resource impact.
Nuffield Department of Primary Care Health Sciences University of Oxford	Guideline	005	010 - 019	The authors outline that (p33 ln 13), CRP POCT reduces the risk of antibiotic prescribing within 14 or 28 days compared to usual care (RR 0.79 (95% CI 0.73 to 0.85, I2=24.4%; 6 RCTs/cluster-RCTs, n=2,251)'. However, this evidence is not appreciated in statement 1.1.9 (above). A flow chart here would be useful to illustrate the decision-making process and clearly illustrate where CRP-POCT (or other POCT) might be useful in general practice.	Thank you. The evidence showed that the use of CRP testing did reduce the number of antibiotic prescriptions, but it may also have a negative impact on the number of re-consultations (see evidence review C). However, the committee discussed and recognised that many primary care sites do not have access to CRP testing. Overall, they agreed that where CRP testing is available it should be considered as an option to support decision making. The committee noted that this has been a recommendation in NICE's 2014 pneumonia guideline and this is not a new resource impact. NICE are undertaking internal discussions about the possibility of producing an algorithm to support this guideline.
Nuffield Department of Primary Care Health Sciences University of Oxford	Guideline	005	010 - 019	Minor point. The Evidence Review B is problematic in that outcomes are compared without acknowledging the different context of prescribing in resource-poor settings e.g. in Do 2016 study in Vietnam and Althaus 2029 Myanmar compared to high-income countries.	Thank you for raising this valid point. The committee have added it to the committee discussion section of the evidence summary to acknowledge the potential issues with comparing outcomes from low and middle income countries with the UK.

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Nuffield Department of Primary Care Health Sciences University of Oxford	Guideline	005	023 - 025	Section 1.1.11 'If a clinical diagnosis of pneumonia has been made (see box 1)…'. Suggest delete Box 1 here. Box 1 refers to a remote consultation/screening and not specific to a diagnosis of pneumonia.	Thank you. Recommendation 1.1.11 is now recommendation 1.3.6. The committee have removed this.
PMD Device Solutions Limited	Guideline	006	002 - 010	Recommendation 1.1.12 indicates that patients with a CURB>=1 may be considered for Virtual Wards. Given the point above it should be strongly recommended that patients admitted to Virtual Ward and who meet the criteria above should also be indicated for use for continuous respiratory rate monitoring.	Thank you. Recommendation 1.1.12 in now recommendation 1.3.7. The management of patients on virtual wards is outside the scope of this guideline.
PMD Device Solutions Limited	Guideline	007	012 - 019	Regarding recommendations for research, the range of respiratory rate has been shown to be incidental for the severity or deterioration of a patient due to respiratory disease or infection. In fact, it is the change of respiratory rate which is key, in the context of deviations from the patient's normal breathing range. Patients who have respiratory related co-morbidities, e.g. COPD, will naturally have a higher respiratory rate as high as 27 breaths per minute (or a NEWS2 single parameter weighting of 3). Given initial assessments, if respiratory rate is 'discounted' as being naturally high, this leads to a reliance on lagging indicators of deterioration (Pulse Oximetry, Pulse Rate). Further research should be completed to use	Thank you. This guideline only focuses on the initial triage and assessment of people with a suspected ARI. Longer term management is outside the scope of this guideline and therefore the committee are unable to make this research recommendation.

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				continuous respiratory rate for a 48hour observation to establish both a baseline breathing profile for the patient (range of respiratory rate, mean respiratory rate) and also to evaluate if deterioration in present (higher nocturnal mean respiratory rate than diurnal mean respiratory rates, increasing slope of mean respiratory rate over 24 hours). Research underpinning these physiological markers include McCartan2021, Crooks2023, Lynn 2011(https://pubmed.ncbi.nlm.nih.gov/21314935/) , Badawy2017 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5812442/), Lagadec2023 (https://www.sciencedirect.com/science/article/pii/S1036731423000814)	
PMD Device Solutions Limited	Guideline	011	010 - 026	It has been well established that Respiratory Rate, when manually measures, shows clinically significant errors in Early Warning Scores (including NEWS2 and CURB65) where 80% of recorded rates are incorrect, of which 41% of the time the early warning score would change leading to a change in clinical care (McCartan2021: https://www.researchgate.net/publication/351923244_The_effectiveness_of_continuous_respiratory_rate_monitoring_in_predicting_hypoxic_and_pyrexic_events_A_retrospective_cohort_study). Fogarty et all in 2023 demonstrated that continuous respiratory rate can align with changes in arterial blood gas chemistry – the biomarker for deterioration due to respiratory	Thank you. This guideline is focused on the initial triage of people with suspected ARI and does not cover their management. As a result, continuous respiratory rate measurement and pulse oximetry are outside the remit of this guideline. Please see the scope for further information. NICE has published its health technology evaluation on virtual ward platform technologies for acute respiratory infections.

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				failure and metabolic acidosis e.g. Sepsis (Crooks2023: https://pubmed.ncbi.nlm.nih.gov/37399900/). Furthermore, there is a risk of overreliance on Pulse Oximetry which may lead ot more delayed interventions leading to patient harm. McCartan et al in 2021 showed that in patients with respiratory failure (Type 1 and Type 2), increasing trends of respiratory rate, continuously measured, predicted Hypoxia (SpO2<92%) 12hrs earlier. Furthermore, the NICE Early Value Assessment for Virtual Wards for Acute Respiratory Infections (GID-HTE10006) highlighted the inequality and reliability of pulse oximetry in patients of colour or with poor perfusion due to age or underlined cardiopulmonary comorbidities compounds the risk of not including accurate respiratory rate. It is a significant patient safety issue to not accurately measure respiratory rate. There is significant evidence to illustrate it is a real daily issue for healthcare providers. In addition, there is clinical value in using continuous respiratory rate for patients given its value to non-invasively indicate changes in blood chemistry during a deterioration trend. Of course, this will need to be balanced as 'technology loading' all patients is not viable or reasonable. Therefore, the suggestion is to have the indications for use of Objective and/or Continuous	

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				respiratory rate to be for patients: With a NEWS score >=4 or With a CURB65 score >=2 or A patient with an existing respiratory or cardiac co-morbidity e.g. COPD of Gold E severity Continuous respiratory rate is being evaluated by the NICE Early Value Assessment for Virtual Wards for Acute Respiratory Infection (GID-HTE10006) and a novel device, RespiraSense (NICE MIB 299), has been reviewed by the NICE Medtech Innovation Brief team in 2022.	
Primary Care Respiratory Society (PCRS)	Guideline	General	General	Question 2: Would implementation of any of the draft recommendations have significant cost implications. PCRS Answer: PCRS is unaware of any cost implications within the draft recommendations.	Thank you for your response.
Primary Care Respiratory Society (PCRS)	Guideline	003	005, 006, 007	Question 3: NEWS2 is being promoted for use in assessing severity of illness (and hence placement) in people with ARI in community settings, but the committee did not find evidence to support this. We would stakeholder comments on whether NEWS2 is an appropriate tool for use in this setting PCRS Answer:	Thank you for your response. The committee agreed that further assessment was needed and hope the research recommendation they made will encourage this.

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				PCRS can see the potential value of this tool, particularly for patients with multiple co-morbidities as the score result may aid the primary care physician in persuading the hospital admitting service to receive the patient. However, at this stage PCRS does not support the use of NEWS2 in assessing severity of illness in community settings and recommend that it needs evaluating formally in a primary care setting before becoming a NICE guideline recommendation.	
Primary Care Respiratory Society (PCRS)	Guideline	004	011, 012, 013	Question 1: Would it be challenging to implement of any of the draft recommendations? Please say why and for whom. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or national initiatives). PCRS Answer: PCRS overall agree with the recommendation, that antimicrobials for ARIs should not be prescribed based on a remote consultation and that people should be seen first face to face. However, whilst remote prescribing of antimicrobials should be the rare exception to such a rule, there are scenarios where an additional face to face visit would not alter the patient outcome versus a remote assessment and in that situation would not represent the best use of overall primary care resources. A change to the absolute nature of the language used	Thank you. The committee discussed this and agreed to make the recommendation less definite. They noted that there were circumstances where a remote prescription might be appropriate. Please see the rationale and impact section of the guideline for more details.

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				in the recommendation we think should be considered.	
Royal College of General Practitioners (RCGP)	Guideline	004	002	Rec 1.1.4 – We would question if using the presence of 1 or more of the symptoms and signs to assess for possible pneumonia is suitable. Pneumonia is usually a radiological diagnosis, and many times individuals present relatively few or no signs and symptoms.	Thank you. Recommendation 1.1.4 is now recommendation 1.2.2. This guideline is focused on initial assessment and triage of people with suspected ARI and does not cover definitive diagnosis. The committee did not consider the evidence for x-ray since this is not usually available at the point of presentation (for example a general practice). People with suspected pneumonia should be assessed and managed in accordance with NICEs guideline on the assessment and management of pneumonia.
Royal College of General Practitioners (RCGP)	Guideline	004	006	Rec 1.1.5 – We are concerned that this recommendation may put at risk the most deprived parts of the population as some individuals may not have the means to visit a face-to-face service. The need for face to face does not reflect how General practice is now delivered (a mixture of telephone digital and face to face appointments). A statement expecting face to face assessment would in some cases increase pressure on primary care when demand is greater than capacity e.g., in winter, which would risk some patients not having any assessment or needing A&E. Additionally, this could remove shared decision making with patients given that being housebound, elderly, in rural locations, having health inequalities or social challenges would make face to face assessments difficult. The preferred option for them is often a remote assessment with sometimes	Thank you. Recommendation 1.1.5 is now recommendation 1.2.3. The committee discussed this and agreed to make the recommendation less definite. They noted that there were circumstances where a remote prescription might be appropriate. Please see the rationale and impact section of the guideline for more details

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				antibiotics prescribed after shared decision making, knowing the risks of treatment or not in their context.	
Royal College of General Practitioners (RCGP)	Guideline	005	007	Rec 1.1.8 – We are concerned this recommendation suggests prescribing antibiotics as it is common for many people with a flu and a cough to have a fever of 38 degrees Celsius.	Thank you. Recommendation 1.1.8 has been amended and is now recommendation 1.3.1. The recommendation focuses on clinical assessment to decide on the severity of illness and the decision to prescribe an antimicrobial. The committee have reworded the recommendation.
Royal College of General Practitioners (RCGP)	Guideline	005	011	Rec 1.1.9 – We are concerned that if a GP organisation starts performing CRP tests routinely as proposed, there are organisational issues including financial cost as to who pays for the CRP test, the clinical time workload, and other organisational issues. A generic organisational impact assessment should be considered.	Thank you. Recommendation 1.1.9 is now recommendation 1.3.4. The committee was aware of the issues with providing point of care CRP testing in general practice, and this was one of the reasons they recommended that it should be 'considered' rather than 'offered' and then only in circumstances where an antimicrobial prescribing decision could not be made based on clinical judgment alone.
Royal College of General Practitioners (RCGP)	Guideline	005	024	Rec 1.1.11 – This recommendation will be a challenging in practice because CRB 65 has not been validated in primary care. Individuals with new onset of confusion could score much more than 1 i.e., significantly likely to be septic.	Thank you. Recommendation 1.1.11 is now recommendation 1.3.6. The committee discussed this and noted that a person over 65 with confusion would already be at intermediate risk. Therefore, they further developed a recommendation (1.3.7) that recommends using CRB65 alongside clinical judgment to inform decisions about care, and also made a recommendation for further research to validate early warning scores like CRB65 and NEWS2 in low prevalence populations. The committee was clear that sepsis should be foremost in the mind of a clinician assessing someone

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					with a suspected ARI and therefore the first recommendation is to 'think sepsis'.
Royal College of General Practitioners (RCGP)	Guideline	005	025	Rec 1.1.11 – This recommendation is challenging given that if an adult has a respiratory rate 30 breaths per minute and has otherwise been previously well, then immediate hospital admission for further assessment should be recommended, regardless of any other CRB65 factors, unless there is a clear reason not to arrange admission.	Thank you. Recommendation 1.1.11 is now recommendation 1.3.6. A further recommendation (1.3.7) has been developed that suggest CRB65 is used to support clinical judgement and would not be used in isolation when making decision on an individual's care
Royal College of General Practitioners (RCGP)	Guideline	006	002	Rec 1.1.12 – It is important to consider when a CRB65 score should not be done as potentially all 65-year-olds and above should be admitted to hospital on the stated basis of 10% mortality risk.	Thank you. Recommendation 1.1.12 is now recommendation 1.3.7. Recommendations suggest that CRB65 is used to support clinical judgement and would not be used in isolation when making decision on an individual's care
Royal College of General Practitioners (RCGP)	Guideline	011	004	Rec 1.1.6 – We are concerned that this recommendation will have a big impact as we come to flu and covid season and respiratory illness peaks. Additionally, some patients with mild symptoms may be unable to access a face-to-face consultation in a timely manner due to significant demand in general practice or out of hours.	Thank you. Recommendation 1.1.6 is now recommendation 1.2.4. The committee discussed this and agreed to make the recommendation less definite. They noted that there were circumstances where a remote prescription might be appropriate. Please see the rationale and impact section of the guideline for more details
Royal College of General Practitioners (RCGP)	Guideline	General	General	Individuals with frequent recurrent ARI presentations or where the response to antibiotic therapy is slow or atypical should invoke consideration of other underlying conditions such as malignancy, bronchiectasis, pulmonary fibrosis, cystic fibrosis (even in adults), COPD, etc A NICE recommendation as about the active consideration in such situations would be beneficial.	Thank you. The scope does highlight that specific consideration will be given to people with co-morbidities that will affect individuals risk of acute respiratory infection, however prevention strategies and ongoing clinical care beyond the initial assessment is outside of the scope of this guideline.

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Royal College of General Practitioners (RCGP)	Guideline	General	General	It will be important to clarify who will be staffing the virtual wards and who will be conducting the face-to-face assessments, particularly given the staff shortages and resource pressures in general practice.	Thank you. Issues regarding staffing of virtual wards are outside the scope of this guideline. Please see the scope document for details.
Royal College of Nursing	Guideline	004	002	Box 1 – suggest adding 'productive cough with green sputum'.	Thank you. Box 1 has been removed following stakeholder consultation.
Royal College of Nursing	Guideline	004	002	We are unsure how tachypnoea can be measured remotely. Can shortness of breath or difficulties in completing sentences/ speaking be also included as an indicator in Box 1?	Thank you. Box 1 has been removed following stakeholder consultation.
Royal College of Nursing	Guideline	004	004	1:1:5 This advice seems to contradict the advice in 1:1:6. If pneumonia is suspected this should trigger a face-to-face assessment.	Thank you. In both 1.1.5 and 1.1.6 a face-to-face assessment is suggested. Recommendation 1.1.5 is now recommendation 1.2.3. Recommendation 1.1.6 is now recommendation 1.2.4.
Royal College of Nursing	Guideline	005	003	It would be more inclusive to say 'general practice' rather than "GP" practice. Also, would be good to include Out of hours services.	Thank you. The committee have amended to general practice throughout the guideline.
Royal College of Nursing	Guideline	007	016	Suggest changing to Community diagnostic hubs and Same day emergency care services.	Thank you. These would be examples of low prevalence settings and the committee cannot make the list exhaustive.
Royal College of Nursing	Guideline	009, 011, 012	028, 016, 011	Suggest changing this to an 'acute respiratory infection pathway' which might be facilitated by Same day emergency care, a community diagnostic hub, virtual ward, or another commissioned service. This would be more in keeping with the NHSE respiratory programme planning.	Thank you. The committee discussed this and agreed to refer to general practice and the acute respiratory infection pathway.
Royal College of Nursing	Guideline	010	009	Please use 'general practice' rather than "GP". That is more inclusive of the workforce including those practising at an advanced level who are likely to be reviewing these patients and are often on multi-	Thank you. The committee have amended this throughout.

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				professional rotas covering on the day emergency clinics within general practice.	
Royal College of Nursing	Guideline	010	021	Should there be proactive testing during the winter periods as both bacterial and viral infections coexist? In our opinion, this will support some of the economic evidence, in terms effective infection prevention and control.	Thank you. As noted in the committee discussion of the evidence section of the evidence summary, the committee discussed this and agreed that in general these proactive testing and treatment periods were mandated by UKHSA as part of their communicable disease strategy. The committee agreed that this was important enough to add a recommendation (1.3.5).
Royal College of Nursing	Guideline	011	003	The threshold is high, and we agree that it supports the antimicrobial stewardship. One concern is that many patients will call at the initial phase of the infections, hence their initial CRP testing will be lower than the 100mg/L threshold. So additional safety netting should be there especially if a fever is already present so that those patients should be added to the virtual wards or hubs to receive a follow up call even if their CRP is low.	Thank you. The committee was aware that the evidence was not straightforward, not least because of quality issues, and for this reason they made the recommendation to 'consider' the use of CRP, and then only if a decision on prescribing could not be made based on clinical assessment alone. Safety netting is in place with the recommendation to consider back up prescribing at CRP>20 mg/l. At these levels, CRP testing is 83% sensitive for infection and further safety netting advice has been added to the final guideline.
Royal College of Nursing	Guideline	011	023	We agree with this approach for lowering the threshold for individuals at greater risk in terms of frailty, comorbidities and smoking history including vaping.	Thank you.
Society for Acute Medicine	Guideline	005	006	1.1.8 For people with symptoms and signs of an ARI, use clinical assessment to make a diagnosis and decide	Thank you. Recommendation 1.1.8 is now recommendation 1.3.1. Box 1 has been removed following stakeholder consultation. The committee were unable to make a research recommendation

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				whether to prescribe antibiotics. Use the presence of 1 or more of the symptoms and signs in box 1, or reduced breath sounds or crackles on auscultation, to assess for possible pneumonia. we are not aware reduced breath sounds or crackles have particularly good discriminatory value to make or exclude diagnosis of pneumonia - it would be good to know on what basis NICE have made that recommendation? In the same vein, there is fairly clear evidence that ultrasound can help make or exclude a diagnosis of CAP and I would have thought it incumbent on NICE to evaluate that as part of their recommendations? It is increasingly available in non-hospital settings so should be covered by this guidance wevwould have thought at the very least, they should consider it as a future recommendation / research recommendation?	about the use of ultrasound in primary care to detect CAP because they did not search for evidence about this and therefore cannot be certain it is an evidence gap.
The Health Foundation	Evidence summary	067 065 066	024 - 029 037 - 041 001 - 002	The Health Foundation welcomes the opportunity to contribute to the development of this guideline. Our response relates to the section of the evidence summary that underpins section 1.1.6 of the draft guideline (Draft guideline page 004 line 11): "Do not prescribe antimicrobials for ARIs based on a remote consultation alone. If antimicrobials may be needed, refer the person for a face-to-face assessment". The committee agreed that antibiotics should not be prescribed for ARIs based on a remote consultation	Thank you for providing this information, which appears to support the committees view that antibiotics might be over-prescribed in remote consultations. It would not have been included in our evidence reviews, which only included systematic reviews. Recommendation 1.1.6 is now recommendation 1.2.4.

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				alone (Evidence summary page 067 lines 24-29) but noted (Evidence summary page 065 lines 37-41 & page 066 lines1-2) that the quality of the evidence to support this was poor. In particular: that 'none of the evidence from studies that included remote consultations' and therefore the committee had had to extrapolate from the evidence about face-to-face consultations to remote consultations. We would like to point NICE to additional evidence for consideration that does include remote consultations. The Health Foundation conducted a quasi-experimental evaluation using electronic health records in English general practice of the association between consultation mode (remote vs. face-to-face) and antibiotic prescribing for acute respiratory infections (ARIs) between April 2021 and March 2022. Our evaluation using nationally representative data found that adults had a 23% (odds ratio: 1.23, 95% confidence interval: 1.18 -1.29) higher chance of being prescribed an antibiotic for an ARI in a remote consultation compared with a face-to-face consultation. We found no evidence of any association between consultation mode and antibiotic prescribing for ARIs in children. Our analysis controlled for a wide variety of demographic, socioeconomic and clinical variables. In our study, we were unable to examine whether prescribing was clinically appropriate and note that further research is	

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				required to understand the cause for increased prescribing rates in remote consultations. We discuss the implications of these findings including that they should be used to inform guidelines for prescribing in remote consultations. This work has been peer reviewed and accepted for publication (13/09/2023) in eClinical medicine. A preprint of the report is available at https://www.medrxiv.org/content/10.1101/2023.03.20.23287466v1.	
The UK Sepsis Trust	Guideline	General	General	Page one of the draft states, "this guideline covers the initial assessment and management of suspected acute respiratory infection in over 16s". Page 2, section 3.1 of the final scope document states the following groups will be covered, "People aged 16 and over with symptoms that might indicate an acute respiratory infection, for example cough, sore throat, shortness of breath, or runny nose. Specific consideration will be given to people with co-morbidities that will affect their risk, for example chronic obstructive pulmonary disease". Despite this, the guideline itself does not seem to address acute respiratory infections in general, instead focusing on pneumonia, there is no mention of "runny nose" in the draft (but it is mentioned in the scope, implying conditions such as the common cold will be addressed) and the scope states specific consideration will be given to people with certain co-morbidities such as COPD but this appears not to	Thank you. NICE routinely uses 'Over 16s' to refer to people age 16 and over. This is clarified in the following box, the guideline covers people aged 16 years and over. It is clear the guideline applies to people once they have had their 16th birthday. The guideline covers the initial assessment and management of people with suspected ARI and provides advice on assessing for ARIs both remotely and in-person. The recommendations have been updated following consultation and only 3 out of 15 recommendations in the revised version relate to pneumonia specifically. Most respiratory tract infections do not require medical intervention unless the person has co-morbidities such as COPD or frailty. The evidence reviewers searched the included studies for more detail about the impact of ARI on subgroups of people with COPD,

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				have been done clearly (COPD is briefly mentioned once in the draft guideline). The scope of the guideline and what appears in the draft seem rather different. Please consider explaining in the rationale section of the guideline how and why a decision was made to focus on pneumonia, when this was not part of the scope (any reasons to explain the difference between the scope (what people were expecting to see in the guideline) and what the guideline delivers should be stated clearly). If the focus is indeed on pneumonia, please may the committee clarify how these guidelines fit with the current NICE pneumonia guidelines: are they to be used in conjunction with each other or will these replace the current pneumonia guidelines? Did the committee consider the practical implications and possible cognitive fatigue caused by too many guidelines on the same subject?	however there was limited evidence and they were unable to perform any specific analysis for these groups. The NICE pneumonia guideline is in the process of being updated. If you would like to register as a stakeholder for this update please visit https://www.nice.org.uk/guidance/indevelopment/gid-ng10357
The UK Sepsis Trust	Guideline	General	General	This text was identified as confidential and has been removed.	Thank you for submitting these links.
The UK Sepsis Trust	Guideline	General	General	1. "Would it be challenging to implement of any of the draft recommendations? Please say why and for whom. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or national initiatives."-The majority of primary care services do not have access to point of care CRP testing. -The guideline states 'this guideline does not cover people with COVID-19'. Based on the current testing	Thank you. The committee agree and recognised that not all primary care services have access to point of care CRP testing but they agreed that where this is available it should be considered as an option to support decision making. The committee noted that this has been a recommendation in NICE's 2014

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				strategy, most of the time clinicians will not know whether the patient in front of them presenting with acute respiratory symptoms has coronavirus or not.	pneumonia guideline and this is not a new resource impact. The scope document lists people with known COVID-19 and the committee have amended the guideline to clarify this.
The UK Sepsis Trust	Guideline	General	General	2. Would implementation of any of the draft recommendations have significant cost implications? Unclear how recommendation 1.1.9 re CRP testing will be funded for those practices that do not have point of care equipment.	Thank you. This recommendation is now numbered 1.3.4. The committee discussed and recognised that many primary care sites do not have access to CRP testing, but they agreed that where this is available it should be considered as an option to support decision making. The committee noted that this has been a recommendation in NICE's 2014 pneumonia guideline and this is not a new resource impact.
The UK Sepsis Trust	Guideline	General	General	There is significant uncertainty regarding which patients this guideline is for and what the purpose of the guideline is. The guideline appears to be intended to be for people presenting with acute respiratory infections but other than pneumonia, there is no clear guidance on any other acute respiratory infection (either within the guideline itself or signposts to all other relevant guidelines, except for those with acute cough and sore throat). If the committee intends for the focus of the guideline to be pneumonia (or lower respiratory tract infections), this should be clear in the title of the guideline and the "who is it for?" section but this would contradict the scope of the guideline, which indicates it is for all forms (upper and lower respiratory tract) of acute respiratory infection. It would be helpful	Thank you. The recommendations have been updated following consultation and only 3 out of 15 recommendations in the final version relate to pneumonia specifically. Searches were undertaken for a broad range of ARI, however most of the evidence found related to pneumonia. The definition of ARI is contained in the Terms used in this guideline section of the guideline. The committee agree that the guideline does not provide very specific advice for different ARIs. This is because the evidence for this is lacking and they were unable to make strong recommendations. The committee made research recommendations that they

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				if the committee addressed/explained this. Furthermore, the guideline does not clearly state which conditions NICE considers examples of "acute respiratory infections" and which are covered by this guideline. There should be brief mention of this to give clinicians clarity about whether the guideline is applicable for the patient they have in front of them or not. In time-pressed 10-minute primary care consultations, primary care clinicians would likely prefer to see a section at the beginning of the guideline which makes it clear what the guideline is for e.g. in the "who is it for?" section the committee may wish to put a comment along the lines of "use this guideline in cases of acute respiratory infection when considering diagnoses of x, y, z" and "this guideline is not for patients with a, b, c". It would also be reasonable for readers to expect a summary to provide context, such as "acute respiratory infections consist of upper and lower respiratory tract infections. Examples of possible diagnoses include… This guideline focuses on….". In general, when we see the term "acute respiratory infection", we think of infections that predominantly affect the upper respiratory tract above the vocal cords and those that affect the lower respiratory tract. In those aged 16 and over, upper respiratory tract infections include (but are not limited to) the common cold, pharyngitis/tonsillitis, laryngitis, glandular fever,	hope will improve the evidence base for the management of undifferentiated ARI at first presentation. The committee noted the point about whooping cough being more prevalent in adults in recent years and therefore not a 'childhood illness', however they noted that the incidence of whooping cough is very low and adult presentations are usually atypical so they would have been unlikely to make a recommendation about it.

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				sinusitis, influenza and otitis media; lower respiratory tract infections include (but are not limited to) pneumonia, bronchitis and whooping cough. In its current form, the guideline focusses on pneumonia and there is brief mention of influenza (to state not to test for it to decide if antibiotics are needed in a patient with acute respiratory infection). There is a link to the guidelines on sore throat and acute cough. There is no clear discussion or link to the other conditions listed above, including the common cold, sinusitis, otitis media, laryngitis, glandular fever and whooping cough but these all fall within the remit of "acute respiratory infection" and many of them were included in the review question populations defined in Evidence Review A (page 5, table 1). There is no discussion on how to e.g., differentiate between pneumonia and influenza and/or other acute respiratory conditions. Thus, there needs to be clarity on what the purpose of this guideline is, particularly whether it is for all forms of acute respiratory infection (which it seems not to be, but the title suggests it is) or a subset of acute respiratory infections (or specifically, pneumonia, in which case the title should be changed to accurately reflect this). There should be links to all other relevant NICE guidelines, if this guideline does not address those other acute respiratory infections. This would improve the usability and efficiency of the guideline.NB: we have included whooping cough above because	

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				sources consider it common in teens and adults and incorrect to classify it as a childhood illness (see BMJ 2019;365:l1623; doi: https://doi.org/10.1136/bmj.l1623). The UKHSA report on laboratory confirmed cases of pertussis in England from July to September 2022 showed the while few cases were diagnosed, the majority were in those aged 15 and over, and not in children (https://www.gov.uk/government/publications/pertussis-laboratory-confirmed-cases-reported-in-england-2022).	
The UK Sepsis Trust	Guideline	General	General	3. "NEWS2 is being promoted for use in assessing severity of illness (and hence placement) in people with ARI in community settings, but the committee did not find evidence to support this. We would stakeholder comments on whether NEWS2 is an appropriate tool for use in this setting." NEWS is a set of physiological parameters. These can be quickly and easily measured in primary care. The main question is how these values are to be interpreted. It is likely the values should be age-specific, and the scoring system will probably be different to that used in secondary care (e.g., we do not know if the same parameter value which may score 2 points in secondary care would score the same in primary care). These are questions for future research.	Thank you for this information. The committee agreed these were important research questions and made a research recommendation about them.
The UK Sepsis Trust	Guideline	General	General	This is a guideline primarily aimed at primary care practitioners. 2/15 of the committee are GPs. Please	Thank you. The committee includes a range of professionals who work in settings where first contact

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				provide clarity on how many of the committee members work in the community and may use the guideline in their own day-to-day work? Does the committee feel primary care practitioners have been proportionately represented on the committee and how important do they consider it for a particular speciality to be properly represented in a guideline predominantly to and for that speciality?	is made with the NHS, including NHS 111, the ambulance service, community pharmacy, emergency departments and general practice. Of the 14 committee members, 2 are lay members and 7 work directly with patients on their first contact with services.
The UK Sepsis Trust	Guideline	001	004	The title of the guideline (line 4) and the "this guideline covers" section (line 7) suggest the guideline is for those over 16 (>16) but the "who is it for?" section suggests the guideline is for those aged 16 and over (=16). The guideline, including the title, should clearly and consistently identify whether it is for those over 16 (>16) or those aged 16 and over (=16). This will give clinicians clarity, as well as researchers who may screen guidelines rapidly from title alone.	Thank you. NICE routinely uses 'Over 16s' to refer to people age 16 and over. As soon as a person has had their 16th birthday they are over 16.
The UK Sepsis Trust	Guideline	003	005	Recommendation 1.1.1 advises to assess for sepsis in those "with a suspected acute respiratory infection who appear seriously ill". Sepsis is a life-threatening medical emergency. Approximately 50% of cases of sepsis are thought to be precipitated by pneumonia so most cases of sepsis, considering other respiratory infections alongside pneumonia, may be precipitated by respiratory infections in general (see: https://sepsistrust.org/wp-content/uploads/2022/06/Yellow-Manual-6th-Edition.pdf). We are concerned the wording of the recommendation may result in delay in diagnosing some people with sepsis and potentially further a false	Thank you. The committee agreed and have amended the wording of the recommendation to be more consistent with NG51

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				narrative that all patients with sepsis can be expected to appear "seriously ill". The guideline attempts to deal with a with a vastly heterogenous population of anybody aged 16 and over (a younger adult with sepsis will likely present differently to a post-partum patient to an elderly patient with multi-morbidity, especially in the early stages). Many people may not be "seriously ill" in the early stages of sepsis, only reaching this stage once sepsis has become manifest for some time. Some people - especially those who are younger, without comorbidities and with higher levels of fitness - may have signs of sepsis but compensate for a significant period before they appear "seriously ill". Early intervention - well before such patients become "seriously ill" - may be lifesaving and reduce progression to severe sepsis, septic shock and risk of other complications. Waiting until patients are "seriously ill" to consider or assess for sepsis is too late. In our opinion the wording of recommendation 1.1.1 should be revised to ensure clinicians not only consider sepsis in people who appear "seriously ill", as this approach may introduce significant delays to such patients receiving prompt diagnosis and intervention, which is vital in sepsis. Sepsis guidelines produced by NICE (NG51) advise clinicians to ask, 'could this be sepsis?' in anybody presenting with a	

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				possible infection: "Sepsis is difficult to diagnose with certainty. Although people with sepsis may have a history of infection, fever is not present in all cases. The signs and symptoms of sepsis can be very non-specific and can be missed if clinicians do not think 'could this be sepsis?'. In the same way that healthcare professionals consider 'could this pain be cardiac in origin?' when presented with someone of any age with chest pain this guideline aims to make 'could this be sepsis?' the first consideration for anyone presenting with a possible infection." We suggest recommendation 1.1.1 be reworded to be consistent with NG51 and to along the lines of, "In anybody with a suspected acute respiratory infection, think "could this be sepsis?" and assess for sepsis in line with the section on identifying people with suspected sepsis in NICE's guideline on sepsis." We consider this a safer approach than only assessing for sepsis in people who appear "seriously ill", as currently implied by the guideline. Consistently encouraging clinicians to always ask themselves "could this be sepsis?" when faced with any infection may contribute to increased rates of earlier diagnosis and treatment for patients with sepsis. The assessment outlined in NG51 can be done rapidly and is practical. NG51 already advises how to assess those out of hospital and those in hospital.	

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The UK Sepsis Trust	Guideline	003	008	Recommendation 1.1.2 implies the acute cough guidelines are specifically for people presenting with suspected upper respiratory tract infection. However, they are relevant for those with suspected lower respiratory tract infection, also (see section on bronchitis). Please consider an additional note to indicate the acute cough guidelines are not only for people with suspected upper respiratory tract infection, but lower also. Similarly, it is unclear how the acute respiratory infection guideline will relate to the acute cough guidelines, as there seems to be considerable overlap between the two i.e., does it need to be made clear they should be used in conjunction with each other, or will one replace the other? Has it also been considered that multiple guidelines on similar topics with significant overlap may cause uncertainty and confusion among clinicians regarding which to use and when? E.g., in a patient with acute cough, how does a clinician rapidly identify (in the context of a busy 10-minute primary care consultation) whether they should refer to the acute cough or acute respiratory infection guideline, considering both are applicable? Please consider adding a sentence in the guideline to indicate/explain when this guideline is applicable or is to be used over others.	Thank you. The cough guidelines specifically cover acute cough associated with an upper respiratory tract infection or acute bronchitis. The purpose of the ARI guideline is to set out the assessment pathway that would lead to use of, for example, the cough guideline. Recommendation 1.1.2 has been amended with additional narrative added just before the start of recommendations section to map this out more clearly.
The UK Sepsis Trust	Guideline	003	008	Recommendation 1.1.2 refers readers to other documents "in people presenting with a suspected upper respiratory tract infection" therefore implying this guideline does not deal with those who have	Thank you. The remit of the guideline is acute respiratory infections. Recommendation 1.1.2 has been amended. The committee have reworded this

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				upper respiratory tract infection. If this is the case, it is a misnomer to title the guideline "acute respiratory infections" because it only deals with one type of acute respiratory infection and not the other. The Evidence Reviews included studies investigating upper respiratory tract infections (and the scope document does not list upper respiratory tract infection in the "groups that will not be covered"). If a decision was made to deviate from the protocol agreed in the final scope and evidence reviews, please consider addressing the reason(s) for this in the rationale for decisions section of the guideline.	section with additional narrative added just before the start of recommendations section to make it clearer.
The UK Sepsis Trust	Guideline	003	011	These comments relate to the "remote contact with NHS services at first presentation" section. Please consider explaining why the committee decided to categorise all forms of remote communication into one single category when the different forms of communication are so heterogenous (i.e., assessing somebody through a video or telephone consultation is vastly different to an email or text message) and each method is utilised with very different frequencies. If the committee has concerns about assessments being made through a certain method (e.g., text or email) or has reviewed evidence to show certain methods are associated with poorer outcomes (such evidence was not seen in any of the three evidence reviews), these concerns should be made clear and/or it should be explained why there is not a review question to investigate this.	Thank you. The committee was unable to make recommendations about specific modes of remote consultation. As detailed in the committee discussion of the evidence section of the evidence summary, none of the evidence found was from remote consultations, and therefore these recommendations are based on the committee using their expertise and experience to extrapolate from the evidence and make general statements about remote consultations.

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				We note data from NHS England (https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice) summarising appointments in General Practice in July 2023 (data for August 2023 was not available at the time of completing this comment form): there were a total of over 27 million appointments in the month. 68% of these (i.e., the majority) were face-to-face, 26.5% were by telephone consultation and less than 2% were categorised "video/online". This highlights there is a priority to ensure guidelines focus on how to approach telephone consultations, as these are far more prevalent than any other remote form of consultation. Will the committee consider formulating separate recommendations for patients assessed through telephone/video consultation compared to those who contact the NHS via app, email or text, considering the level of assessment made in each format is vastly different?	
The UK Sepsis Trust	Guideline	003	019	Recommendation 1.1.4 – suggests clinical assessment should be used to make a diagnosis. When presented with a patient with suspected acute respiratory infection and consulting remotely by telephone or video we suspect most primary care clinicians will have two main questions in mind: can the patient be safely managed based solely on telephone or video assessment (i.e. are there any red flags to indicate high risk of serious illness that require face-to-face review) and if they cannot be safely	Thank you. The committee have reworded recommendation 1.1.4 taking into account your comment. Recommendation 1.1.4 is now recommendation 1.2.2. Recommendation 1.1.6 is now recommendation 1.2.4.

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				management based on telephone or video assessment, when and where does the patient need to be seen face-to-face for further assessment (e.g. same day, next day, within a few days and in a GP surgery, same day emergency care unit or respiratory hub etc). Regardless of whether there is an alternate explanation for a patient with signs and symptoms of an acute respiratory infection, a clinical assessment will be made. Thus, the committee may wish to consider clarifying the rationale for including the comment "and no alternative explanation (such as asthma)" because a clinical assessment is still going to be made even if asthma is the suspected cause of the symptoms (so the comment seems redundant). It may be helpful to re-word the first sentence of recommendation 1.1.4. An alternative may be "Assess people with signs and symptoms of acute respiratory infection to identify any red flags suggestive of serious illness, such as sepsis and/or pneumonia, to help determine whether the suspected cause of symptoms can be safely managed by telephone or video assessment or if face-to-face assessment is required. If any red flags or significant biopsychosocial concerns are present, consider the need for urgent same day face-to-face assessment. Use clinical judgement, consider illness severity and rate of deterioration to determine the location of this	

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				assessment." This wording may also replace recommendation 1.1.6.	
The UK Sepsis Trust	Guideline	003	019	Recommendation 1.1.4 suddenly introduces (for the first time in the document) pneumonia and 4 out of the remaining 9 subsequent recommendations (44%) focus on pneumonia. This may be confusing to readers and/or inadvertently create tunnel vision where only pneumonia is thought about and no other conditions/causes of acute respiratory infection. Up until this point the guideline implies it is for those with acute respiratory infections in general and the reader is expecting a far broader discussion than the one which takes place. Did the committee consider structuring the guideline differently to bring together all the recommendations relating to pneumonia while also making it clear that the focus is on pneumonia and not all acute respiratory infections? Will the committee consider updating the title and corresponding sections to ensure there is no misunderstanding regarding the conditions dealt with in the guideline?	Thank you. The recommendations have been updated following consultation and only 3 out of 15 recommendations in the final version relate to pneumonia specifically. Recommendation 1.1.4 is now recommendation 1.2.2.
The UK Sepsis Trust	Guideline	003	019	The second sentence of recommendation 1.1.4 advises using the presence of certain signs and symptoms to assess for possible pneumonia in a remote consultation. Many of the listed signs and symptoms cannot be assessed remotely, most of the time. The box lists eight bullet points. Most remote consultations done in primary care are via telephone consultation: data from NHS England showed in July 2023, 68% of consultations were face-to-face, 26.5%	Thank you. Recommendation 1.1.4 has changed substantially following stakeholder consultation. Recommendation 1.1.4 is now recommendation 1.2.2. The committee have removed the box.

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				were by telephone consultation and less than 2% were "video/online". Therefore, the signs and symptoms listed in the box will generally not be helpful for a clinician making a remote assessment because most of the time, they cannot see the patient and most patients do not have clinically validated or calibrated equipment to use at home to measure the signs listed in the box. From the signs and symptoms listed, realistically, a clinician may only be able to assess for two or three of the eight items listed, namely diarrhoea, confusion and audible wheeze (not wheeze heard on auscultation). The committee may wish to remove this box from the "remote contact with NHS services at first presentation" and place it elsewhere, as a list of things to consider in general when assessing for pneumonia regardless of whether that assessment is face-to-face or remote.	
The UK Sepsis Trust	Guideline	003	019	Recommendation 1.1.4 refers to Box 1. The symptoms and signs listed in the box have not been validated in any of the studies included in Evidence Review C as being predictive of pneumonia so the statement "symptoms and signs with high probability of indicating pneumonia…" is incorrect. We are concerned this may unintentionally mislead clinicians and result in delay or missed diagnosis of pneumonia (and its complications, including sepsis – note pneumonia precipitates approximately half of cases of sepsis, so it is vital this section is accurate). The probability of a sign or symptom to indicate a	Thank you. Recommendation 1.1.4 has changed substantially following stakeholder consultation. Recommendation 1.1.4 is now recommendation 1.2.2. The committee have removed the box.

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				condition is its positive predictive value. The positive predictive value has not been calculated in any of the consultation documents, including Evidence Review C. Please may the committee clarify how and based on what data they have concluded the listed signs and symptoms have "high probability of indicating pneumonia"? 1. The sensitivity and specificity of the signs/symptoms listed in Box 1 are shown in Evidence Review C but these do not provide information on probability of a patient having pneumonia in an undifferentiated population (sensitivity and specificity are measures of the validity of a diagnostic test [or symptom/sign, in this case] when the disease status of a patient is already known – sensitivity and specificity alone do not give information about the predictive abilities of the presence or absence of a symptom or sign in a 'real-world' setting). Please may the committee clarify if they based their comment "symptoms and signs with high probability of indicating pneumonia" on the specificity values shown in Evidence review C?2. All the items listed in Box 1 appear to have been extracted from one single study (Gentilotti et al 2022). None of the included studies in this systematic review consisted of a population of patients based in the UK, there is no information about basic population demographics of participants in the included studies, including biological sex, age and comorbidities, for example. Thus, we cannot comment on how representative the study population is of the target population of this guideline. Did the	

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				committee discuss these omissions and what consideration did they give to the generalisability of the findings from this single systematic review to a UK population when deciding to include various signs and symptoms from this study in Box 1 and indicating they are suggestive of high probability of pneumonia? 3. The committee has focussed on specificity (values in Evidence Review C) when deciding whether to include a sign or symptom in Box 1. Consequently, the signs and symptoms listed in Box 1 have low sensitivity i.e., they will fail to identify pneumonia in somebody who actually does have it. This contradicts the committee's statement that the symptoms and signs have "high probability of indicating pneumonia". Based on the sensitivity/specificity values the committee has, we believe wrongly, chosen, the signs and symptoms in Box 1 will fail to identify up to 90% of cases of pneumonia (see the example of diarrhoea which has a sensitivity of 10.8% meaning in a cohort of people known to have pneumonia, using diarrhoea to assess for the presence of pneumonia will only identify 10.8% of people as having it. This low proportion is unacceptable, considering pneumonia is potentially life-threatening, closely linked with sepsis (also life-threatening) and its treatment is time sensitive. 4. In all but one case, the certainty of the body of evidence for the signs and symptoms in Box 1 was	

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				graded as low or very low (see pages 20 – 26 of evidence review C: tachypnoea - very low, wheezing - very low, Sp02 - low, fever - very low, systolic blood pressure - low, tachycardia - very low, diarrhoea - low, impaired consciousness – moderate). In our opinion, when the overwhelming classification of certainty of the body of evidence is low or very low, none of the signs and symptoms listed in Box 1 can be considered as evidence-based indications of high probability of pneumonia. Please may the committee justify why they chose the contents of Box 1 when the certainty of evidence was almost entirely low or very low? 5. The number of participants who had the symptoms listed in Box 1 are generally small. Did the committee have any concerns about sample size? (see pages 20-26 of evidence review C: tachypnoea, n = 10,351, wheezing, n = 2403, Sp02, n = 2821, fever n = 11219, systolic BP, n = 3262, tachycardia n = 9474, diarrhoea, n = 4268, impaired consciousness, n = 3208). Based on the above, good quality data with at least moderate or good certainty of the body of evidence has not been presented to support the use of the signs and symptoms listed in Box 1 and the evidence does not indicate these signs/symptoms have "high probability of indicating pneumonia in people with suspected ARI"; the evidence indicates the opposite of this. Therefore, based on inadequate evidence to support this claim, we believe Box 1 needs to be	

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				removed or significantly altered. Many of the signs/symptoms listed (5/8) relate to derangement in vital signs and may be found in any unwell patient, regardless of cause of illness, being indications of organ stress and/or dysfunction. The guideline should support clinicians in identifying unwell patients or those at risk of becoming unwell by having a list of red flags. The Evidence Reviews have not clearly shown what these red flags are in the context of acute respiratory illness. It is a question for further research but for the purpose of this section, the committee may wish to re-word the second sentence of recommendation 1.1.4 and the caption of Box 1 to along the lines of "Use the presence of 1 or more of the symptoms and signs in box 1 to assess for serious illness, causes of which include sepsis and pneumonia" and "Box 1: Symptoms and signs which may indicate high risk of serious illness in people with suspected acute respiratory infection". We suggest the contents of this box (the actual signs/symptoms listed) needs to be changed, considering the above points. The Box should be consistent with sepsis red and amber flags (see the moderate to high risk and high-risk criteria in Table 1, page 58 of NG51) and also include other concerning clinical features, including inability to complete sentences in one breath, sudden reduction in ability to carry out activities of daily living and the clinician's own clinical impression. Some of these may not have a clear	

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				evidence base, but few would argue they are inappropriate to include in such a list, as they are common-sense approaches to clinical assessment and basic parts of the history.	
The UK Sepsis Trust	Guideline	004	002	At the end of Box 1 it is stated, "Note: Some of these symptoms and signs will require the person to have access to equipment for measuring vital signs". Not all oximeters, thermometers and blood pressure monitors patients have for home use will be clinically validated, nor will everybody be using them correctly (e.g., is it known how many patients use an appropriately sized cuff to measure blood pressure at home? There are several studies which indicate concern e.g. https://pubmed.ncbi.nlm.nih.gov/18568690/ "In conclusion, inaccurate devices have been used in home BP measurements frequently and frequency of device-related errors can be decreased by awareness and training of the patients"). It is often said 'no test is better than a bad test'. Did the committee consider this and if they do wish for clinicians to encourage home monitoring, does it need to come with a caveat or reminder to ensure equipment is validated and used appropriately? We are aware some NHS services specifically provide equipment for patients to use at home, but most patients (of the small number who have equipment) would have purchased their own and the clinician will have no information on the accuracy and reliability of such equipment. It would also add clarity if the	Thank you. Box 1 has been removed following stakeholder consultation.

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				committee explained why there was not a review question for the Evidence Review team to look into the reliability of patients measuring their own vital signs at home when the scope document mentions "Assessment of people aged 16 and over with suspected acute respiratory infection in remote and face-to-face settings" as a key area that will be covered by the guideline	
The UK Sepsis Trust	Guideline	004	004	Recommendation 1.1.5 - Pneumonia is not the only serious acute respiratory infection. The committee may wish to consider re-wording this recommendation e.g. If a serious cause of acute respiratory infection, such as pneumonia, is suspected, or if adequate assessment cannot be made remotely....."	Thank you. This has been amended. Recommendation 1.1.5 is now recommendation 1.2.3.
The UK Sepsis Trust	Guideline	004	004	Recommendation 1.1.5 – The committee may wish to consider adding "signs of sepsis and/or other red flags" in the list of examples for "cause for concern".	Thank you. This is covered by recommendation 1.1.1. Recommendation 1.1.5 is now recommendation 1.2.3.
The UK Sepsis Trust	Guideline	004	004	Recommendation 1.1.5 – The committee may wish to consider the wording of this recommendation. Instead of "refer the patient for face-to-face assessment", "arrange or refer for face-to-face assessment" may be preferable because most of the remote consultations will be conducted by primary care clinicians in GP surgeries, and they do not need to refer to arrange face-to-face review in their own practice. We appreciate the referral element is relevant in other settings e.g., when remote consultations are conducted out of hours or by 111. "Refer" implies "refer to some other organisation e.g. from GP to hospital or hub or virtual ward". For a GP or other	Thank you. This has been amended. Recommendation 1.1.5 is now recommendation 1.2.3.

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				primary care clinician working in a practice, they may wrongly interpret this as meaning a patient must be referred elsewhere e.g., hub/virtual ward/hospital, which, we assume is not what the committee intends.	
The UK Sepsis Trust	Guideline	004	004	Recommendation 1.1.5 - Consider alternative wording for the sentence regarding where to refer e.g. "The decision about where to arrange face-to-face review or refer should be based on severity of symptoms, rate of deterioration and the presence of any red flags (for example, signs of sepsis) or serious co-morbidities (for example, chronic cardiovascular conditions such as COPD and heart failure) or multi-morbidity."	Thank you. NICE prefer to limit lists of examples so they are not perceived as exhaustive. Sepsis is covered in recommendation 1.1.1. Recommendation 1.1.5 is now recommendation 1.2.3.
The UK Sepsis Trust	Guideline	005	003	Is "walk in centre" the correct/up-to-date terminology? Does this need to be changed to "walk-in or urgent care centres"?	Thank you. This has been removed.
The UK Sepsis Trust	Guideline	005	004	Recommendation 1.1.7 – the committee suggests not offering microbiological tests or influenza tests to determine whether to prescribe antibiotics but are there any cases when these should be done for other reasons e.g., if a patient is suspected of having super-added or co-infection with influenza and bacterial disease, if a patient is at high risk of complications from influenza, if associated with an outbreak e.g. in a nursing home? Does this need to be clarified and/or is there a risk this recommendation could be misunderstood or misinterpreted and lead to an inappropriate reduction in number of microbiological/influenza tests?	Thank you. Recommendation 1.1.7 is now recommendation 1.3.3. The recommendation is specifically about using tests to determine whether or not to prescribe antimicrobials. It does not cover outbreak management, which is beyond the remit of this guideline. The committee have clarified that this refers specifically to rapid, point-of-care tests, and not to slower diagnostic tests such as sputum cultures, and that it only refers to POCT for making prescribing decisions, not for surveillance or disease control.

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The UK Sepsis Trust	Guideline	005	006	Recommendation 1.1.8 – mentions "crackles" and "reduced breath sounds" as signs suggestive of pneumonia. The certainty of the body of evidence (evidence review C, page 25) for these two signs is "very low" and "low" respectively. Did the committee consider this grading of evidence when deciding to include these signs over others in the recommendation? According to the sensitivity values shown, crackles will fail to identify approximately 60% of known cases of pneumonia and reduced breath sounds will fail to identify approximately 75% of known cases of pneumonia. Clinical experience/acumen suggests these abnormal physical findings may add to the overall clinical impression indicating presence of pneumonia or serious illness, but they are not the only findings which do so. Others – not included in the evidence reviews – include increased work of breathing (assessed separately to tachypnoea), ability to complete sentences, dullness on percussion. Does the committee acknowledge these are important aspects of the clinical assessment and the lack of evidence in such factors predicting pneumonia may simply mean the evidence is not there/studies have not been done, not that they are poor tests/signs?	Thank you. Recommendation 1.1.8 is now recommendation 1.3.1. Box 1 has been removed following stakeholder consultation.
The UK Sepsis Trust	Guideline	005	011	Recommendation 1.1.9 – is there context to this recommendation and is it referring to standard venepuncture or point of care testing? If it refers to point of care testing, can the committee clarify the proportion of primary care centres (whether	Thank you. Recommendation 1.1.9 is now recommendation 1.3.4. This recommendation comes from the 2014 NICE guidance on the assessment and management of pneumonia and is not a new recommendation. In the context of this guideline, it

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				GP surgeries, urgent care centres [not emergency departments] or out of hours providers) that currently have access to point of care CRP testing and how many are projected to have access in the short to medium term and how long do these tests take to do? Most GP appointments are 10 minutes long and patients often have multiple, different things to discuss in this period (so realistically, a clinician is unlikely to only be assessing a patient for acute respiratory illness but some other problem during the consultation, also). Such tests, even if they take 2-3 minutes, account for 20-30% of consultation time, adding significant inefficiency into the consultation. If the recommendation refers to standard venepuncture, in many cases, the result may not come back for at least a few days, potentially harming the patient due to delay. Did the committee consider the above practicalities when making this recommendation and what is the committee's comment on this?	refers to point of care CRP testing. The committee have amended the recommendation to reflect this. The committee discussed and recognised that many primary care sites do not have access to CRP testing, but they agreed that where this is available it should be considered as an option to support decision making. The committee noted that this has been a recommendation in NICE's 2014 pneumonia guideline and this is not a new resource impact.
The UK Sepsis Trust	Guideline	005	011	Recommendation 1.1.9 – the following CRP thresholds have been used <20, 20 – 100, >100. These thresholds are based on findings from one single systematic review (Gentilotti 2022). In all but two of the individual studies in this systematic review, the type of LRTI investigated was pneumonia. Despite this, the recommendation has extrapolated the data to "people without suspected pneumonia". This seems inappropriate and arguably a misrepresentation of the	Thank you. Recommendation 1.1.9 is now recommendation 1.3.4. This recommendation comes from NICE's 2014 pneumonia guideline and is not a new recommendation. It was based on data from 3 European RCTs comparing CRP with usual care that covered LRTI and URTI, and an economic analysis. This guideline details how the threshold decisions

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				data (pneumonia vs non-pneumonia are likely to have very different CRP thresholds). Please can the committee explain the rationale for using these thresholds for patients without suspected pneumonia when the thresholds were studied in populations that almost exclusively had pneumonia? Is this a typo in the recommendation and does the recommendation apply to people with pneumonia, rather than without? Furthermore, none of the patients in the studies included in the systematic review were based in the UK (relevant because there is ethnic variation of CRP), no information is provided regarding the age of participants (baseline CRP and ability to mount a CRP response may change with age and a young, fit healthy patient with a CRP of 50 may be as unwell, or worse, than an elderly patient with a CRP of 100 [or vice versa]), there are no details about other characteristics of patients included in the studies that may have influenced CRP level e.g. comorbidities and evidence review C (page 28) classified the certainty of the body of evidence for a CRP of >100 as low. The evidence review also states, "It is likely that many people with bacterial pneumonia will not have a CRP level >100mg/L". Thus, this threshold will miss "many people with bacterial pneumonia" and prevent them from receiving antibiotics (the actual proportion of missed cases is 48% - almost half). Pneumonia is a potentially life-threatening illness and accounts for	were made by that guideline committee (table 16 in section 7.5 of the guideline). The data presented in the Gentilotti (2022) review were consistent with the conclusions reached by the 2014 pneumonia guideline. The committee took this as further evidence that the thresholds were useful and useable and agreed to keep them. For the evidence underpinning the 2014 recommendation, please see the pneumonia full guideline, section 7.1. The limitations and variations in CRP were of concern to the committee and were one of the reasons that CRP testing was only recommended as a way to support decision making. The limitations of CRP testing are discussed in the evidence summary and further detail has been added in response to your points. The committee have changed the wording from 'without suspected pneumonia' to 'someone with a lower respiratory tract infection' The committee was aware that the evidence was not straightforward, not least because of quality issues, and for this reason they made the recommendation to 'consider' the use of CRP, and then only if a decision on prescribing could not be made based on clinical assessment alone.

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				approximately 50% of cases of sepsis. We do not consider it acceptable or in the interests of patient safety to miss "many people with bacterial pneumonia" ("many people" here is referring to almost half of such cases). What is the rationale for including these thresholds and this recommendation, considering the above concerns? The evidence appears of such low quality that it seems preferable to not make a recommendation on this but mention it as an area for future research.	It is also important to note that the recommendation suggests a backup antibiotic prescription for people with CRP>20mg/l. At 20mg/l the Gentilotti review finds the CRP test 83% sensitive, which means more than 8 out of 10 people with pneumonia would receive an antibiotic. Antibiotics are not precluded at levels less than 20mg/l, the recommendation says that they should not 'routinely' be offered but the recommendation makes clear that clinical judgment is more important than CRP level. The NICE pneumonia guideline is in the process of being updated. If you would like to register as a stakeholder for this update please visit https://www.nice.org.uk/guidance/indevelopment/gid-ng10357
The UK Sepsis Trust	Guideline	005	020	Recommendation 1.1.10 – please consider adding multimorbidity to the list of considerations. Frailty is mentioned but patients may be frail and not have multimorbidity. Furthermore, multimorbidity is rising not only in older adults, but younger people.	Thank you. The committee have added this. Recommendation 1.1.10 is now recommendation 1.3.2.
The UK Sepsis Trust	Guideline	005	023	Recommendation 1.1.11 – in our opinion, there should be strong emphasis that CRB65 is only an adjunct and not a replacement for clinical judgement. It provides support in making decisions but cannot be used by itself to make a decision. Furthermore, it is imperative there is mention that CRB65 may underestimate disease severity in some populations (e.g., younger people or those with higher levels of physical fitness). E.g. The only, and potentially	Thank you. Recommendation 1.1.11 is now recommendation 1.3.6 and a further recommendation (1.3.7) has been developed to address the point you have raised. The committee agreed and believe this is now reflected in the wording of recommendation 1.3.7 "Use clinical judgement together with the CRB65 score to inform decisions about…"

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				earliest, sign of a seriously unwell patient in their 20s with pneumonia could be a heart rate that is relatively higher than their baseline. If their baseline is 50 and their pulse is 90 at assessment (this itself is potentially serious, as it represents an 80% increase in heart rate), they cannot complete sentences, have increased work of breathing, crackles and reduced breath sounds, all of these are very serious causes for concern yet the CRB65 may be 0. If too much emphasis is placed on CRB65 in this case, or CRB65 is not used appropriately, the result may be inadequate or delayed treatment, increasing risk of complications, including sepsis and septic shock. This issue will disproportionally affect and disadvantage some groups eg younger people and those with higher levels of fitness. There are several studies that highlight CURB-65 may underestimate disease severity in some cohorts, such as younger people and we consider it vital for the committee to include a clear caveat reminding readers of this, to protect such patients from potentially fatal delays in diagnosis and treatment. See here: https://thorax.bmj.com/content/65/11/971, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4796818/, https://academic.oup.com/qjmed/article/102/6/379/1527479 - note there are many other examples in the literature).	They were aware of the lack of validation for CRB65 in low prevalence cohorts and made a research recommendation about this (research recommendation 1).

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The UK Sepsis Trust	Guideline	006	002	Recommendation 1.1.12 – please consider expanding the "clinical judgement" phrase and providing examples (independent of CRB65 score) when hospital assessment may be needed e.g., if there is concern about serious illness, rapid deterioration, signs of sepsis (or other red flags), a complication of pneumonia such as empyema.	Thank you. Recommendation 1.1.12 in now recommendation 1.3.7. The committee have expanded on this in the rationale and impact section.
The UK Sepsis Trust	Guideline	007	012	The first recommendation for research includes clarifying how accurate CRB65 is when applied to primary care, non-hospital and low prevalence settings, as well as ARI hubs. If this is not known or clearly shown in the evidence reviews, why has CRB65 been encouraged in recommendation 1.1.12? This implies the guideline is advising using a scoring system whose accuracy in the setting it is to be applied is unknown. Has the committee considered how this (using an unvalidated score whose accuracy is unknown) may unintentionally harm patients? If the committee insists this scoring system is used, does there need to be a clear caveat to explain the accuracy in the setting it is to be used is unknown? (But that raises serious questions about why it should be used in the first place).	Thank you. Recommendation 1.1.12 in now recommendation 1.3.7. The use of CRB65 for assessing people with pneumonia is already recommended in NICE guidelines on the assessment and management of pneumonia. The committee recommend using CRB65 as an adjunct to clinical judgment to help to inform the decision about the right care pathway for the patient. Because of the low confidence in the evidence this is framed as asking clinicians to 'consider' an option depending on CRB65. The committee agreed that CRB65 was likely to overestimate risk in suspected community diagnoses of pneumonia and therefore would be unlikely to misclassify severity to a lower risk category.
The UK Sepsis Trust	Guideline	007	017	In the recommendations for research it is stated, "How can the scores help to make clinical decisions about care pathways, for example, sending people home, to ARI virtual wards, or to same day emergency care?". If this is unknown, and not validated, on what basis has the committee advised using CRB65 in recommendation 1.1.12 to help decide on admission,	Thank you. Recommendation 1.1.12 in now recommendation 1.3.7. The use of CRB65 for assessing people with pneumonia is already recommended in NICE guidelines on the assessment and management of pneumonia. The committee recommend using CRB65 as an adjunct to clinical judgment to help to inform the decision about the right

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				virtual ward and home-based care? This will likely raise questions among readers about the utility of the CRB65 in primary care and the veracity of recommendation 1.1.12? Has the committee considered if any potential harm may be caused to patients if the scoring system is wrong and misclassifies patients in terms of mortality/severity (at best it is currently unproven in primary care to make the above decisions)?	care pathway for the patient. Because of the low confidence in the evidence this is framed as asking clinicians to 'consider' an option depending on CRB65. The committee agreed that CRB65 was likely to overestimate risk in suspected community diagnoses of pneumonia and therefore would be unlikely to misclassify severity to a lower risk category.
The UK Sepsis Trust	Guideline	009	001	Regarding the "rationale and impact" section – the section is difficult to follow. In our opinion, there will be greater clarity, transparency and accountability if the section was re-structured. We suggest each recommendation is listed separately in this section, under each recommendation should be the rationale for that specific recommendation, including specific reference to the evidence used/what the evidence showed, the quality of that evidence and if the recommendation was based only on the opinion of the committee. Currently the recommendations have been grouped and it is difficult to see the rationale for a specific recommendation (or the reader must make their own inference, which should not be the case).	Thank you. The rationale and impact section only provides a brief overview of the reasons the committee made the recommendations. Fuller discussion is contained in the evidence summary document.
The UK Sepsis Trust	Guideline	009	001	Regarding the "rationale and impact" section – the rationale should make specific reference to the evidence reviews because at present many of the claims appear unsubstantiated and independent of the evidence reviews, perhaps being the view/opinion of the committee, and not a reflection of the findings of the evidence reviews. If any decision has been made	Thank you. The rationale and impact section only provides a brief overview of the reasons the committee made the recommendations. Fuller discussion is contained in the evidence summary document.

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				on opinion/consensus of the committee and not based on the findings of the evidence reviews, this should be made clear. Where a decision has been made based on the evidence review, a comment on the quality of evidence should appear so that clinicians know how deeply rooted (or not) the recommendations they are following are in evidence. Most clinicians using this guideline in a real-world setting will not be able to look through each of the evidence reviews themselves (and doing so in the middle of a 10-minute primary care consultation when the guidance is needed to support 'live' decision making is impractical) hence the need for the aforementioned.	NICE guidelines are produced in accordance with the NICE guideline manual, which is available here. All of the evidence in the evidence reviews is assessed using GRADE or GRADE CERQual to determine the confidence the committee can have in the evidence and this is reported in the committee discussion section of the evidence summary.
The UK Sepsis Trust	Guideline	009	008	The committee agreed "people contacting NHS services remotely might not have equal access to digital technology and the skills needed to use it". In our opinion, this should be clarified to state "some people contacting…". Furthermore, most people contacting NHS services remotely do so by telephone. We suspect the comment "equal access to digital technology" mainly refers to other methods of communication (which form the minority of remote services) such as app, email or text. This should be clarified in the text. The committee should also clarify why there was not a review question to investigate whether there are inequalities in people accessing healthcare remotely.	Thank you. The committee was content with the wording. The investigation of inequalities in accessing healthcare remotely is beyond the remit of this guideline, which is focused on initial triage of people with a suspected ARI. Please see the scope document for details.
The UK Sepsis Trust	Guideline	009	009	Regarding the sentence, "They might also have difficulties communicating if they are suffering symptoms of an ARI, such as wheezing or	Thank you. The committee did not agree with this statement. They agreed it was more difficult to understand a patient who was short of breath over the

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				breathlessness." What is the relevance and implication of this for the guideline? Whether the patient is reviewed remotely or face-to-face, the difficulties in communicating remain the same – a patient struggling to communicate over the telephone will have the same struggle to communicate face-to-face? We agree some signs are more effectively addressed face-to-face than remotely, some cannot be assessed remotely, and subtle signs may be at greater risk of being missed remotely than face-to-face. If this is what the committee meant, it should be made clearer.	telephone than in person. This is partly because of the quality of telephony and partly because body language, gestures and other means of communication are available in face-to-face settings.
The UK Sepsis Trust	Guideline	009	010	Consider replacing the word "suffering" with "have" as not everybody who has a certain symptom may consider themselves to "suffer" from it.	Thank you. The committee have amended this.
The UK Sepsis Trust	Guideline	009	015	Instead of "…appropriate and to assess for pneumonia" consider "…appropriate and to assess for signs and symptoms of serious illness including pneumonia and sepsis".	Thank you. This section has been rewritten following stakeholder consultation and box 1, to which it refers has been removed. Sepsis awareness is covered elsewhere in this guideline (recommendation 1.1.1).
The UK Sepsis Trust	Guideline	009	016	It is stated, "The evidence identified a range of symptoms and signs that can help to identify bacterial pneumonia". There is no such clear evidence in any of the evidence reviews which identified this. Please clarify which evidence and statistics the committee has seen to enable to them to conclude this. As far as we can tell, Evidence Review C identified some signs and symptoms with very low and low certainty of body of evidence that the committee have selected	Thank you. NICE guideline recommendations are based on the best available published evidence combined with the expertise and experience of guideline committee members. This section has been rewritten following stakeholder consultation and box 1, to which it refers has been removed.

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				because of high specificity (at the expense of sensitivity, indicating a willingness to accept that many people with pneumonia will not be picked up by the symptoms and signs – an approach we strongly disagree with). The authors of the Gentilotti 2022 review itself write in their paper, "Overall, the diagnostic accuracy of stand-alone signs and symptoms was poor to distinguish bacterial and viral causes of infection". If the authors of the study the committee have cited refer to the signs and symptoms as "poor to distinguish bacterial and viral causes" why has the committee described it as otherwise? Has the committee seen other evidence that is not cited or included in the evidence reviews?	
The UK Sepsis Trust	Guideline	009	017	It is stated, "If a person with a suspected ARI has 1 or more of these symptoms, they are at least 75% likely to have bacterial pneumonia". Please clarify which statistics this is based on and where these statistics appear in the evidence reviews. Box 1 lists 8 signs and symptoms. These have all been extracted from one, single systematic review (Gentilotti 2022). The generalisability of the studies in this review is limited (see patient demographics) and the certainty of the body of evidence is almost entirely low or very low (see Evidence Review C). The signs and symptoms have not been widely validated for diagnostic accuracy and in their paper, the authors themselves write, "Overall, the diagnostic accuracy of stand-alone signs and symptoms was poor to	Thank you. NICE guideline recommendations are based on the best available published evidence combined with the expertise and experience of guideline committee members. This section has been rewritten following stakeholder consultation and box 1, to which it refers has been removed. It was not possible to calculate predictive values since the committee did not have reliable prevalence data, and because prevalence of respiratory infections is subject to large seasonal fluctuations.

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				distinguish bacterial and viral causes of infection". The committee appears to have chosen signs and symptoms from Evidence Review C (pages 20-26) that have a point estimate of specificity of over 75% (though some confidence intervals are broad, indicating an imprecise measurement) and this appears to be source of the above claim ("If a person with a suspected ARI has 1 or more of these symptoms, they are at least 75% likely to have bacterial pneumonia"). This is incorrect for several reasons. Firstly, specificity is not a predictive value. It cannot be used to state somebody who has a certain symptom is at least 75% likely to have bacterial pneumonia, just because that symptom has a specificity of 75%. Such a claim can only, in part, be made based on positive predictive value. Positive predictive value depends on prevalence. If we assume – only as an example – a modest prevalence of pneumonia of 10% among those presenting with acute respiratory infection in primary care, then the positive predictive values of the signs and symptoms listed in Box 1 are far from 75%. We have calculated these below. The values show how likely somebody is to have bacterial pneumonia if the prevalence of pneumonia is 10% and have been calculated using the point estimates of sensitivity and specificity provided in Evidence Review C: Tachypnoea – 13.5%,	

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				Wheezing – 12.4%, Low oxygen saturations – 15.9%Fever – 19.2%Systolic BP – 17.6%Tachycardia – 16.1%Diarrhoea – 10.3% Impaired consciousness – 15.5% None of these predictive values are close to 75%, as claimed in the guideline. We are concerned some readers of the draft guideline may have taken this at face value and be under the impression the signs/symptoms in Box 1 are truly at least 75% predictive of pneumonia, negatively impacting clinical practice. Will the committee and/or NICE correct this and release an urgent communication so that any misunderstanding can be clarified and review why this misunderstanding of sensitivity/specificity/predictive values was not identified prior to approval of the draft guideline?	
The UK Sepsis Trust	Guideline	009	018	It is stated, "Although some of these symptoms can be assessed remotely, many require the person to have access to the correct equipment." Please consider adding that not only is the correct equipment required but the person using it must do so correctly and the equipment itself must be validated/calibrated.	Thank you. This section has been rewritten following stakeholder consultation and box 1, to which it refers has been removed. A recent NICE technology evaluation has assessed virtual ward platform technologies for ARI.
The UK Sepsis Trust	Guideline	009	020	It is stated, "The committee acknowledged that pneumonia can be caused by a viral infection, and it is difficult to distinguish it from a bacterial infection". Many different types of people with varying levels of experience will read this guideline. We suggest this	Thank you. This section has been rewritten following stakeholder consultation and box 1, to which it refers has been removed.

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				sentence needs to be more precise as pneumonia may be e.g., viral, bacterial, fungal or mixed. This also contradicts the statement on page 9, line 16 which states, "The evidence identified a range of symptoms and signs that can help to identify bacterial pneumonia". Please reconcile this inconsistency.	
The UK Sepsis Trust	Guideline	009	021	It is stated, "they agreed that the symptoms and signs in box 1 could be used to identify viral pneumonia too". If this is the case, any reference to the signs and symptoms in Box 1 being indicative of specifically of bacterial pneumonia must be removed, otherwise such statements (such as "Symptoms and signs with high probability of indicating pneumonia in people with suspected ARI") are incorrect and arguably misleading.	Thank you. This section has been rewritten following stakeholder consultation and box 1, to which it refers has been removed.
The UK Sepsis Trust	Guideline	009	024	It is stated, "The committee agreed that people with symptoms of pneumonia need to be seen face-to-face so a more thorough assessment can be carried out". Pneumonia is one example of a serious acute respiratory infection. In our opinion, anybody with suspected acute respiratory infection with red flags or signs of serious illness, including signs of sepsis, should be seen face-to-face, not just those with pneumonia. Please consider updating this accordingly.	Thank you. The committee agreed and have made this clearer in the recommendations and rationale and impact section.
The UK Sepsis Trust	Guideline	009	025	It is stated, "This is also the case for people with other ARIs who may need antibiotics." Please clarify the rationale for this. The discriminating factor for face-to-face review following remote telephone or video assessment should not be whether antibiotics may be	Thank you. The committee agreed and have made this clearer in the rationale and impact section where they note that "some people are unable or find it difficult to attend face-to-face appointments. There might also be cases where the prescriber was

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				needed. The discriminating factor should be, in our opinion, whether there are any signs or symptoms of serious illness such as sepsis or pneumonia or red flags as specified by the high and moderate to high-risk criteria in sepsis guideline NG51. This is a more holistic and safer approach to decide who to see face to face than whether somebody may need antibiotics.	confident in their diagnosis and the need for antimicrobials and so a face-to-face assessment was not required".
The UK Sepsis Trust	Guideline	009	027	The language used here ("For many people, a referral to a GP or an ARI hub would be the right solution….) is not appropriate for the predominant target audience of this guideline. The guideline is directed towards primary care assessment. Most of such assessments will be done by primary care clinicians from GP surgeries. Some such assessments – a minority compared to the aforementioned – will be done by out of hours services/111. For the average user of this guideline, "a referral to a GP" is not the most appropriate language because a GP/advanced nurse practitioner/physician associate/paramedic et al who is working in a GP surgery and has completed a remote consultation and feels face-to-face review is now needed, will not refer the patient, but arrange review at the practice they already work at. Furthermore, they may not necessarily need to seek the advice of a GP. Alternative wording may be "for many people, face-to-face assessment at a general practice or an ARI hub…"	Thank you. The committee have amended this.
The UK Sepsis Trust	Guideline	009	028	Link to "ARI hub" is broken.	Thank you. The link has been fixed.

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The UK Sepsis Trust	Guideline	010	003	It is stated, "The committee were keen to explore whether any of the established early warning scores such as NEWS2 or CRB65 could help with this decision making and they made a research recommendation on using early warning scores in different settings." If it has not been established whether CRB65 can help with this decision making, please clarify the basis on which the recommendations involving CRB65 have been made? Has the committee assumed, based on experience of use of CURB65 in secondary care that CRB65 will be just as effective in primary care? Has the committee considered any potential risk of harm to patients if this assumption is wrong and CRB65 turns out to misclassify severity in a primary care cohort?	Thank you. The use of CRB65 for assessing people with pneumonia is already recommended in NICE guidelines on the assessment and management of pneumonia. The committee recommend using CRB65 only as an adjunct to clinical judgment to help to inform the decision about the right care pathway for the patient. Because of the low confidence in the evidence this is framed as asking clinicians to 'consider' an option depending on CRB65. The committee agreed that CRB65 was likely to overestimate risk in suspected community diagnoses of pneumonia and therefore would be unlikely to misclassify severity to a lower risk category'.
The UK Sepsis Trust	Guideline	010	009	It is stated, "These recommendations will help healthcare practitioners recognise bacterial pneumonia". Please refer to the evidence the committee has used to make this statement. It appears to contradict a comment in the Evidence Summary, which states, "This position was supported by the lack of evidence for the usefulness of symptoms and signs to distinguish between bacterial and viral infections in evidence review".	Thank you. We have amended this.
The UK Sepsis Trust	Guideline	010	009	It is stated, "…should improve antimicrobial stewardship by reducing the number of antibiotics prescribed without a face-to-face assessment." This implies a proportion of antibiotics prescribed without face-to-face review are inappropriate. None of the evidence reviews support this but they were also not	Thank you. This is the opinion of the committee based on their expertise and experience.

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				designed to investigate this because it was not a review question (the reason for this omission should be made clear). Please clarify if this is the opinion of the committee and how this reconciles with the evidence base which shows a much less certain view: some studies show higher antibiotic prescribing rates in remote consultations compared to face-to-face, others show lower antibiotic prescribing, others show no difference (see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7655728/, https://pubmed.ncbi.nlm.nih.gov/36168456/ and https://pubmed.ncbi.nlm.nih.gov/34497096/).	
The UK Sepsis Trust	Guideline	010	026	It is stated, "The evidence showed that using a high CRP test result of 100mg/l or more as a threshold for giving antibiotics means that most people who test positive will have an infection". Please provide clear reference to the evidence that showed this. Our reading of the evidence suggests this was not shown. Evidence Review C page 28 states, "It is likely that many people with bacterial pneumonia will not have a CRP level >100mg/L" and the certainty of the body of evidence for a CRP > 100 was "low". Furthermore, the evidence investigated CRP levels in people with pneumonia, but the committee has applied the same thresholds to those without pneumonia (people with pneumonia [the study population] are very different to those without pneumonia so the recommendation could only be applicable to those of the study population i.e., with pneumonia, not without).	Thank you. This recommendation comes from the 2014 NICE guidance on the assessment and management of pneumonia and is not a new recommendation. It was based on data from 3 European RCTs comparing CRP with usual care that covered LRTI and URTI, and an economic analysis. This guideline details how the threshold decisions were made by that guideline committee (table 16 in section 7.5 of the guideline). In the context of this guideline it refers to point of care CRP testing. The committee have amended the recommendation to reflect this. The committee was aware that the evidence was not straightforward, not least because of quality issues, and for this reason they made the recommendation to 'consider' the use of CRP, and then only if a decision

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				The committee should explain why they have considered it appropriate to apply thresholds studied in people with pneumonia to those without pneumonia and if they consider them equivalent. Furthermore, the CRP thresholds in the Gentilotti 2022 paper were based on categorical, not continuous analysis, and in forming such categories, valuable information about the most appropriate threshold to use is inherently lost by the very nature of the variable being categorical. Thus, we cannot agree that the stated threshold is evidence-based, and it is not appropriate to use in those without suspected pneumonia because they were established almost exclusively in studies that investigated people with pneumonia. Instead of serving as a basis for a recommendation, this evidence (and its associated poor quality) should alert the committee to a research question and in particular, CRP should be analysed as a continuous variable in such future studies that attempt to assess diagnostic accuracy of thresholds.	on prescribing could not be made based on clinical assessment alone. It is also important to note that the recommendation suggests a backup antibiotic prescription for people with CRP>20mg/l. At 20mg/l the Gentilotti review finds the CRP test 83% sensitive, which means more than 8 out of 10 people with pneumonia would receive an antibiotic. Antibiotics are not precluded at levels less than 20mg/l, the recommendation says that they should not 'routinely' be offered but the recommendation makes clear that clinical judgment is more important than CRP level. The NICE pneumonia guideline is in the process of being updated. If you would like to register as a stakeholder for this update, please visit https://www.nice.org.uk/guidance/indevelopment/gid-ng10357
The UK Sepsis Trust	Guideline	010	029	It is stated, "However, it also means that some infections might be missed". This implies only a few infections may be missed. For transparency, please clarify what statistic this statement is based on and quote the exact proportion of infections, and what type of infections, that may be missed. In Evidence Review C (page 28) the point estimate for sensitivity is 52% for CRP > 100. This means if 100 people were already known to have pneumonia and they had a CRP test, only 52 people with pneumonia would have	Thank you. This recommendation comes from NICE's 2014 pneumonia guideline and is not a new recommendation. It was based on data from 3 European RCTs comparing CRP with usual care that covered LRTI and URTI, and an economic analysis. This guideline details how the threshold decisions were made by that guideline committee (table 16 in section 7.5 of the guideline).

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				a CRP >100 and 48 people with pneumonia would have a CRP lower than this. In other words, this threshold would miss almost half (48%) of cases of pneumonia. This is very different to the statement "some infections might be missed". This should be clarified in the text. In our opinion, we cannot accept missing almost half of all cases of such a serious and potentially life-threatening infection like pneumonia, which itself is responsible for approximately half of all cases of sepsis (another life-threatening infection). Such patients certainly require prompt antibiotics and using this threshold may prevent them from receiving prompt, life-saving treatment. The chosen threshold would not identify almost half of some people with pneumonia, who would therefore not be given antibiotics, would therefore likely deteriorate and once they eventually re-present to seek further medical attention, require broader-spectrum antibiotics and more protracted medical attention than they would have initially needed, negatively impacting quality of life, antimicrobial stewardship and cost-effectiveness.	The data presented in the Gentilotti (2022) review were consistent with the conclusions reached by the 2014 pneumonia guideline. The committee took this as further evidence that the thresholds were useful and useable and agreed to keep them. For the evidence underpinning the 2014 recommendation, please see the pneumonia full guideline, section 7.1. The limitations and variations in CRP were of concern to the committee and were one of the reasons that CRP testing was only recommended as a way to support decision making. The The committee was aware that the evidence was not straightforward, not least because of quality issues, and for this reason they made the recommendation to 'consider' the use of CRP, and then only if a decision on prescribing could not be made based on clinical assessment alone. It is also important to note that the recommendation suggests a backup antibiotic prescription for people with CRP>20mg/l. At 20mg/l the Gentilotti review finds the CRP test 83% sensitive, which means more than 8 out of 10 people with pneumonia would receive an antibiotic. Antibiotics are not precluded at levels less than 20mg/l, the recommendation says that they should not 'routinely' be offered but the

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					recommendation makes clear that clinical judgment is more important than CRP level. The committee discussed this at length and discussed the trade offs of a difficult decision. They noted not only good antibiotic stewardship but also the negative effects of antibiotics, for example in frail elderly people who they could make very sick. The NICE pneumonia guideline is in the process of being updated. If you would like to register as a stakeholder for this update please visit https://www.nice.org.uk/guidance/indevelopment/gid-ng10357
The UK Sepsis Trust	Guideline	011	002	It is stated, "The committee agreed that a higher threshold was better in terms of antimicrobial stewardship". The chosen higher threshold comes at a cost of lower sensitivity i.e., a greater proportion of people with bacterial disease will not be treated with antibiotics because they will be misclassified as being well. These people are likely to get worse without antibiotics, deteriorate and as they develop more severe/protracted illness with or without complications, they will likely require more broad-spectrum antibiotics than they initially would have needed, thus negatively impacting antimicrobial stewardship. It may be "better" in terms of antimicrobial stewardship from a point of reducing antibiotic prescription, but this reduction would largely	Thank you. This recommendation comes from NICE's 2014 pneumonia guideline and is not a new recommendation. It was based on data from 3 European RCTs comparing CRP with usual care that covered LRTI and URTI, and an economic analysis. This guideline details how the threshold decisions were made by that guideline committee (table 16 in section 7.5 of the guideline). The data presented in the Gentilotti (2022) review were consistent with the conclusions reached by the 2014 pneumonia guideline. The committee took this as further evidence that the thresholds were useful and useable and agreed to keep them. For the

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				be artificial, through preventing access to antibiotics in people who need them (the evidence for this is the low sensitivity – almost half of people with pneumonia will not be picked up). This is a false economy. The trade-off for the perceived "better" antimicrobial stewardship here is a greater proportion of people who do genuinely require antibiotics not receiving them. This may include patients with non-specific signs of sepsis. Did the committee consider this, and do they deem it acceptable? In our opinion this is unacceptable.	evidence underpinning the 2014 recommendation, please see the pneumonia full guideline, section 7.1. The limitations and variations in CRP were of concern to the committee and were one of the reasons that CRP testing was only recommended as a way to support decision making. The committee was aware that the evidence was not straightforward, not least because of quality issues, and for this reason they made the recommendation to 'consider' the use of CRP, and then only if a decision on prescribing could not be made based on clinical assessment alone. It is also important to note that the recommendation suggests a backup antibiotic prescription for people with CRP>20mg/l. At 20mg/l the Gentilotti review finds the CRP test 83% sensitive, which means more than 8 out of 10 people with pneumonia would receive an antibiotic. Antibiotics are not precluded at levels less than 20mg/l, the recommendation says that they should not 'routinely' be offered but the recommendation makes clear that clinical judgment is more important than CRP level. The committee discussed this at length and discussed the trade offs of a difficult decision. They noted not only good antibiotic stewardship but also the negative

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					effects of antibiotics, for example in frail elderly people who they could make very sick. The NICE pneumonia guideline is in the process of being updated. If you would like to register as a stakeholder for this update please visit https://www.nice.org.uk/guidance/indevelopment/gid-ng10357
The UK Sepsis Trust	Guideline	011	003	It is stated, "They discussed the limitations of CRP testing because of the time lag for onset of symptoms with infections (which corresponds to presence of CRPs), so a sample taken early in the course of infection could be falsely reassuring". None of the evidence reviews refer to studies which show CRP lags clinical onset of symptoms of acute respiratory infection. This is often quoted in clinical environments; please provide clear references to the evidence which shows CRP lags. If this is based on clinical experience (i.e., anecdotal evidence) this should be made clear, rather than being presented as fact.	Thank you. The committee have amended this wording.
The UK Sepsis Trust	Guideline	011	010	It is stated, "The evidence showed that CRB65 might be a useful tool to estimate mortality risk and can serve as a useful check on clinical judgement when assessing the severity of pneumonia after a clinical diagnosis has been made". Please clarify which evidence showed this. CRB65 was assessed in Evidence Review A. This showed "further studies are needed in outpatient cohorts", "CRB65 has not been validated sufficiently in primary care settings", "it's	Thank you. This is consistent with the 2014 NICE pneumonia guideline and new evidence contained in evidence review A. The committee noted that there were concerns about the validity of CRB65 in low prevalence settings such as primary care and community pharmacies (where the tool has not been validated) and were careful to frame the recommendation to prioritise clinical

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				[CRB65] value as a prognostic indicator in the community remains unclear", but one review with high risk of bias concluded CRB65 can be used to estimate mortality risk and support physician judgement. "In summary, it appears that further research is needed to validate the PSI and CRB-65 in primary care/community settings". Line 10 on page 11 of the guideline claims CRB65 "might" be a useful tool but equally, Evidence Review A indicates it might not. In the absence of clear evidence, on what basis/evidence has the committee suggested using it?	judgment and only use CRB to 'inform' decisions about care. However, they note that CRB65 is well validated and widely used in higher prevalence settings. They also made a research recommendation to validate both NEWS2 and CRB65 in low prevalence cohorts (research recommendation 1). The NICE pneumonia guideline is in the process of being updated. If you would like to register as a stakeholder for this update please visit https://www.nice.org.uk/guidance/indevelopment/gid-ng10357
The UK Sepsis Trust	Guideline	011	012	It is stated, "The committee noted that further research is needed to validate CRB-65 in primary care and community settings". Considering this, the committee should explain why they have decided to encourage the use of CRB65. Have there been previous examples of unvalidated scoring systems later being found to cause patient harm and is it appropriate to incorporate CRB65 into recommendations when it has not been validated?	Thank you. This is consistent with the 2014 NICE pneumonia guideline and new evidence contained in evidence review A. The committee noted that there were concerns about the validity of CRB65 in low prevalence settings such as primary care or community pharmacy and were careful to frame the recommendation to prioritise clinical judgment and only use CRB to 'inform' decisions about care. However they note that CRB65 is well validated and widely used in higher prevalence settings. They also made a research recommendation to validate both NEWS2 and CRB65 in low prevalence cohorts (research recommendation 1).

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					The NICE pneumonia guideline is in the process of being updated. If you would like to register as a stakeholder for this update please visit https://www.nice.org.uk/guidance/indevelopment/gid-ng10357
The UK Sepsis Trust	Guideline	011	014	It is stated, "There was evidence for using the NEWS tool for predicting severe illness, but not in primary care". Similar applies to CRB65 and Evidence Review A confirms the evidence shows CRB65 needs to be validated in primary care. If the committee decided not to make recommendations using NEWS2 because of lack of evidence in primary care, and CRB65 also lacks evidence in primary care, why did the committee consider it acceptable for CRB65 to be included in a recommendation but not NEWS2? They both lack evidence, but one has been favoured over another for reasons which should be made clear.	Thank you. CRB65 is recommended for this indication based on evidence contained in evidence review At. No evidence was found for NEWS2 as a predictor of severity in acute respiratory infection. The committee noted that there were concerns about the validity of CRB65 in low prevalence settings such as primary care and community pharmacy and were careful to frame the recommendation to prioritise clinical judgment and only use CRB to 'inform' decisions about care. However they note that CRB65 is well validated and widely used in higher prevalence settings. They also made a research recommendation to validate both NEWS2 and CRB65 in low prevalence cohorts (research recommendation 1). The NICE pneumonia guideline is in the process of being updated. If you would like to register as a stakeholder for this update please visit https://www.nice.org.uk/guidance/indevelopment/gid-ng10357
The UK Sepsis Trust	Guideline	011	019	Regarding the paragraph on lines 19-23, may be helpful to add those with multimorbidity (a different	Thank you. The committee have added this.

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				group of people to those who have just co-morbidity) may also be at high risk.	
The UK Sepsis Trust	Guideline	011	019	Regarding the paragraph on lines 19-23, suggest clarifying and being more precise regarding referral – referral to where/for what?	Thank you. The criteria for deciding where to refer is covered in the recommendations.
The UK Sepsis Trust	Guideline	011	028	It is stated, "The evidence suggests that the recommendations may reduce rates of antibiotic prescribing for people with ARI,". The aim should never be to reduce rates of antibiotic prescribing in general. This statement should be qualified appropriately: the aim should be to reduce rates of inappropriate antibiotic prescribing. If 100% of all patients on a given day genuinely require antibiotics, they should all get them. But if only 50% require antibiotics and 75% are being prescribed them, this is what needs to be addressed. It should also be made clear which recommendations this statement is referring to and which evidence suggests the recommendations may reduce antibiotic prescribing. None of the review questions asked about interventions to reduce antibiotic prescribing (the reason for this omission should be included), so how can it be stated "the evidence suggestions that the recommendations may reduce rates of antibiotic prescribing…"?	Thank you. The committee have amended this.
The UK Sepsis Trust	Guideline	012	011	Please provide more specific details for context and so that clinicians can understand the possible impact and scale of such interventions e.g., how many hubs are there per integrated care board, how many	Thank you. The context section of the guideline is intended to provide a brief overview (normally less than half a page) of the broader context for the guideline. The information you are requesting is not within NICEs remit.

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				integrated care boards have access to virtual wards and what their capacity is.	
The UK Sepsis Trust	Guideline	012	013	It is stated, "NICE has been asked…". For transparency, please state who NICE was asked by.	Thank you. NICE was asked to produce this guideline by NHS England.
The UK Sepsis Trust	Guideline	012	014	It is stated, "This guideline will aid healthcare professionals in deciding where to refer people aged 16 and over with suspected ARIs including referrals to virtual wards and ARI hubs" but none of the recommendations provide specific advice about where to refer. There are two mentions of where to refer and those are only applicable to cases of suspected pneumonia, rather than "suspected ARIs" (two very distinct entities). Recommendations 1.1.12 uses CRB65 in a way that is not supported by the literature to suggest the next steps based on total score and recommendation 1.1.5 states where to refer should be based on certain symptoms but does not provide clear examples of who to refer where, essentially leaving it to "clinical judgement". Considering this, is it accurate to state "this guideline will aid… where to refer…"?	Thank you. The guideline is intended to inform the initial triage of people with suspected ARI and to help clinicians to get them onto the most appropriate care pathway for them. This may include admission to hospital, going from a remote to a face-to-face appointment, a referral to an ARI hub or emergency department, or self-care at home. Recommendation 1.1.12 is now recommendation 1.3.7. Recommendation 1.1.5 is now recommendation 1.2.3.
The UK Sepsis Trust	Guideline	012	020	"Committee member list" hyperlink does not direct to the intended page.	Thank you. This link has been fixed.
The UK Sepsis Trust	EIA	003		Point 3.1 There are equality issues relating to age. The guideline targets people aged 16 and over. This is a vastly heterogenous population. Despite this, the thresholds provided for certain physiological parameters and absolute, not relative, and not age specific. Even if age-specific thresholds are not known (the evidence reviews did not have questions to	Thank you for your comment. The committee discussed your comment and recognise the point raised regarding context and heterogeneity of the populations this guideline includes. 'Box 1' has now been deleted and recommendation 1.2.2 has been amended to outline that people with symptoms and signs of an ARI should be assessed with some examples outlined as to what some of the symptoms

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				investigate this), readers should be made aware that observations should be interpreted in context E.g., Box 1 mentions tachycardia, defined as pulse >100. Younger people and those with higher levels of fitness may be profoundly unwell even with a pulse of e.g. 95, if they have a baseline bradycardia (e.g. this is a >70% increase in heart rate for a patient with a baseline pulse of 55). To not include a caveat, as is present in NICE sepsis guideline NG51, to not state the heart rate should be interpreted in context and take certain things like fitness into account may discriminate against certain populations, including younger people, pregnant and post-partum patients, older people and those on betablockers. NG51 makes this clear, stating: "Interpret the heart rate of a person with suspected sepsis in context, taking into account that: • baseline heart rate may be lower in young people and adults who are fit • baseline heart rate in pregnancy is 10 to 15 beats per minute more than normal • older people with an infection may not develop an increased heart rate • older people may develop a new arrhythmia in response to infection rather than an increased heart	and signs could be. The corresponding rationale and impact section has been amended. In discussion the Committee noted that recommendation 1.2.1 specifies that remote consultations should be approached in a 'holistic and person-centred way' focusing any remote assessment on the individual context of the person being assessed.

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				rate • heart rate response may be affected by medicines such as beta-blockers." This guideline should do likewise. There may not be evidence for the above but evidence regarding this is not needed, as it is based on principles of physiology. The evidence required would be to do with age-specific values and the committee may wish to consider this as a question for further research.	
The UK Sepsis Trust	EIA	004	011	Recommendation 1.1.6 – The committee should consider clarifying the rationale for this recommendation. Two reasons are given later in the document as: "so a more thorough assessment can be carried out" and "should improve antimicrobial stewardship by reducing the number of antibiotics prescribed without a face-to-face assessment." None of the Evidence Reviews have highlighted evidence to show remote consultations are clearly and consistently associated with increased and inappropriate prescription of antibiotics in people with acute respiratory infection. Please may the committee explain the rationale for not including this as a review question in the evidence reviews? Without evidence, will the committee make clear, if they wish to keep this recommendation, it is based on opinion and not evidence? Some studies show higher antibiotic prescribing rates in remote consultations compared to face-to-face, others show lower antibiotic prescribing,	Thank you. Recommendation 1.1.6 is now recommendation 1.2.4. NICE guidelines are developed using the best available evidence, committee discussion of that evidence coupled with committee expertise and experience and insights from stakeholder consultations. The committee have considered your comment and have amended the guideline in line with your comment. Recommendation 1.2.4 now outlines that whilst antimicrobials should not be 'routinely' prescribed for ARI's based on a remote consultation alone if there is a 'sound clinical reason' to prescribe remotely for example if the person is unable to attend a face-to-face appointment and the prescriber is confident of the clear need for antibiotics they can be prescribed. The Committee have added recommendation 1.1.2 which outlines that self-care advice should be offered to people who can safely be managed remotely, based on the initial remote

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				others show no difference (see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7655728/, https://pubmed.ncbi.nlm.nih.gov/36168456/ and https://pubmed.ncbi.nlm.nih.gov/34497096/). The latter is a systematic review. In its conclusion it is clearly stated, "The impact of TH (telehealth) on prescribing appears to vary between conditions, with more increases than reductions. There is insufficient evidence to draw strong conclusions, however, and higher quality research is urgently needed." In our opinion, the deciding factor for clinicians making remote assessments of patients with acute respiratory infections to determine whether they should be seen face-to-face is not based on whether antibiotics are being considered but whether there are and signs/symptoms suggestive of serious illness and/or red/amber flags as listed in NG51 Sepsis guidelines. This recommendation should be re-worded accordingly. We believe this will help reduce cases of missed and delayed diagnosis of serious illness and this is a safer discriminating factor to decide on need for face-to-face review than whether an antibiotic prescription is being considered. Consider, "If there are red flags (e.g. signs of sepsis), symptoms or signs of serious illness (e.g. pneumonia), significant biopsychosocial concerns or the patient prefers, consider the need for urgent same day face-to-face assessment. Use the presence of abnormal vital signs (if accurate measurement is possible remotely), clinical judgement and consider illness severity and	assessment, which would include raising awareness of any red flags that would require a further discussion with a healthcare provider.

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				rate of deterioration to determine the location of this assessment."	
The UK Sepsis Trust	EIA	General	Point 3.1	The guideline (Box 1) refers to confusion as an example of impaired consciousness. Younger people and those with higher levels of fitness compensate significantly before becoming confused i.e., confusion in a younger person may be a much more serious sign of significant illness than in an older adult with frailty and multimorbidity because it takes a greater physiological insult for them to become confused. Impaired consciousness in younger people may manifest, for example, as emotional lability and anxiety (which is a direct result of their illness and not due to mental health i.e., it is not due to generalised anxiety disorder). These considerations should appear in the guideline so that delays in prompt diagnosis and management in younger people can be minimised.	Thank you for your comment.The committee discussed your comment and recognise the point raised regarding context and heterogeneity of the populations this guideline includes. 'Box 1' has now been deleted and recommendation 1.2.2 has been amended to outline that people with symptoms and signs of an ARI and no alternative explanation should be assessed with some examples outlined as to what some of the symptoms and signs could be. The corresponding rationale and impact section has been amended. In discussion the Committee noted that recommendation 1.2.1 specifies that remote consultations should be approached in a 'holistic and person-centred way' focusing any remote assessment on the individual context of the person being assessed.
The UK Sepsis Trust	EIA	General	General	The evidence review documents highlight many of the studies are in older people, and basic demographic information e.g. comorbidities, biological sex, socioeconomic status, ethnicity are unclear. If it is discovered that most studies are in older, affluent, white Caucasian males then while this may be the only data the committee has identified, there must be some acknowledgement that the generalisability of this data to other groups (e.g. women, those from less affluent backgrounds, people from certain ethnicities, pregnant and postpartum patients) is unclear. It is correct that certain acute respiratory infections	Thank you for your comment. NICE guidelines are developed using the best available evidence, committee discussion of that evidence coupled with committee expertise and experience and insights from stakeholder consultations. The applicability of studies is one of the risk of bias consideration applied in the development of evidence reviews and is accounted for both within the development of the evidence reviews but also as part of guideline Committees' deliberations in developing the guideline.

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				become more prevalent with age, but younger people also experience morbidity and mortality from these conditions and if there is a gap in the literature in these cohorts, it needs to be addressed. One way to reduce these inequalities is to ensure there are clear research recommendations with these specific points in mind, which there are currently not. Did the committee consider this and will they update the research recommendations accordingly to ensure future studies are conducted in diverse populations?	The committee discussed your comment and recognise the limitations of the evidence base. The committee discussion section has been expanded to highlight this outlining the Committee's extrapolation from the evidence, the use of their expertise and experience in the guidelines development and that most of the evidence reviewed was from older people. The committee discussion section goes further to highlight that sub-group analysis for other groups, particularly those with protected characteristics was not possible. A research recommendation has been developed that specifies the need for sub-group analysis for people with protected characteristics, for pregnancy and post-partum populations.
The UK Sepsis Trust	Evidence Review A	019	016	The question includes "what are the signs, symptoms and early warning scores" that have been evaluated? Why does the answer (lines 19-25) make no mention of signs and symptoms and only addresses early warning scores? Even if the review did not find evidence to answer the question regarding signs and symptoms, this should be made clear, otherwise the reader is left to wonder why two of the three factors mentioned in the question have not been answered.	Thank you. The committee have passed your comment on to the external reviewers who undertook this evidence review.
The UK Sepsis Trust	Evidence Review A	093		Third row of table Second column states this article was excluded because "outcome is diagnosis of pneumonia" but the PICO does not list pneumonia as an exclusion criterion (only aspiration pneumonia) and pneumonia is specifically listed in the population criteria. Why was this excluded and what impact may it have had on the	Thank you. The protocol for the review specifies the outcomes of interest. See table 1 of the evidence review. The objective of the review was to assess the value and usefulness of different symptoms, signs and EWS for guiding management in patients with suspected ARI Diagnosis of pneumonia is not an outcome of interest.

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				overall guideline? If the focus of the guideline is pneumonia, would the committee have been able to gather more evidence if a review question specifically asked which signs and symptoms are predictive of a diagnosis of pneumonia?	
The UK Sepsis Trust	Evidence Review A	094		Second to last row Second column states this article was excluded because "outcome is diagnosis of CAP" but the PICO does not list pneumonia as an exclusion criterion (only aspiration pneumonia) and pneumonia is specifically listed in the population criteria. Why was this excluded and what impact may it have had on the overall guideline?	Thank you. The protocol for the review specifies the outcomes of interest. See table 1 of the evidence review. The objective of the review was to assess the value and usefulness of different symptoms, signs and EWS for guiding management in patients with suspected ARI Diagnosis of CAP is not an outcome of interest.
The UK Sepsis Trust	Evidence Review A	057 - 077	General	These comments refer to Appendix D. The comments exclude the Aalbers 2011 study, as this deals with sore throat and the ARI guideline directs readers to another guideline regarding that. Key features of the studies regarding patient characteristics are listed below: Akram, 2011. Mean age: range 46.8 - 77.3. Sex not reported. Total sample size 5444. Study location: USA, Canada, Netherlands, Germany, Spain, France, UK.Chalmers, 2011. Patient characteristics not reported. Total sample size 5092. Study location: USA, Canada, Spain and France Dosa, 2005. Patient characteristics not reported. Total sample size: 1942. Study location: USAEbell 2019: Age range 36.5 to 78.3. Sex: not reported. Total sample size: dependent on study setting. Study location: Not fully reported. All	Thank you. The committee noted that the studies were mostly in older adults, and that older adults were more likely to be at risk of serious illness, however in the absence of other evidence, they used their expertise and experience to apply the evidence across all adults.. No evidence was found on pregnancy and post-partum, but the committee agreed that these were very important and have made sure to add them to the sub-group analyses for the research recommendations in the hope that more evidence will be available in the future.

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				but 3 studies were set in Europe, including 10 in Germany and 6 in Spain; none were set in the USA or CanadaMcNally 2010. Age range 60.4 – 77.3. Sex: proportion male not reported. Sample size: 1817 community-based. 60.4 - 77.3. Study location: not reported.Metlay 2019. Patient characteristics: Not reported. Sample size: not reported. Study location: not reported. Nannan 2017. Age range: 70.5-74. Sample size: 3951 relevant to this review. Study location: 18 countries, UK included (unclear which we re relevant to this review). Smith 2021 Patient characteristics not reported. Sample size: not reported. Study location: multiple countries. Did the committee discuss that most of these studies are in older adults, there is a lack of information regarding patient demographics, sample sizes are generally small, details regarding country are also sparse and the impact this has on the generalisability of any findings to the intended population of the guideline (people aged 16 years and older, mostly presumably residing in the UK)? There is also no clear representation of pregnant/postpartum patients, but they seemed to be within the scope of the guideline. If evidence within specific groups was not found, does this need to be made clear as a caveat in the guideline, otherwise readers may take what is presented at face value and assume the guideline is equally applicable to pregnant/post-partum patients as it is to e.g. older adults even when the evidence is disproportionately representative of a specific group.	

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The UK Sepsis Trust	Evidence Review B	016	010	It is stated, "Acute respiratory infection mostly found in children and infants such as croup, bronchiolitis and whooping cough are therefore excluded". Whooping cough is not mostly found in children and infants. See https://www.bmj.com/content/365/bmj.l1623 "Most laboratory confirmed cases in the UK are now in teens and adults, but the symptoms are the same" and data from the UK Health Security agency: https://www.gov.uk/government/publications/pertussis-laboratory-confirmed-cases-reported-in-england-2022/laboratory-confirmed-cases-of-pertussis-in-england-july-to-september-2022 Did the committee discuss the impact of excluding this condition from the search and the guideline, particularly given a focus of the guideline appears to be appropriate antibiotic prescribing and morbidity and mortality is increased in older adults and in people with comorbidity who have whooping cough, and early antibiotics are integral to the management of whooping cough? The scope did not list this as an exclusion criterion.	Thank you. The committee did not discuss whooping cough since it was excluded from the review and therefore they did not see any evidence relating to it. Some text has been added to the committee discussion of the evidence section in the evidence summary to explain this.
The UK Sepsis Trust	Evidence Review B	031	020	It is stated, "The pooled result for all included studies showed that CRP POCT may increase the risk of needing a reconsultation compared to usual care". The point estimate for the relative risk was 1.61 i.e. 61% increased risk of reconsultation when CRP point of care testing was used. Did the committee factor this into their decision making when they specified in recommendation 1.1.9 that CRP testing should be	Thank you. Recommendation 1.1.9 is now recommendation 1.3.4. The committee did factor this into their discussions and it is one of the reasons that the CRP test recommendation is only for people where a judgment cannot be made clinically. See the committee discussion of the evidence section of the evidence summary.

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				considered in certain cases, and the impact reconsultation may have on use of clinical time and availability of primary appointments which are already in high demand? Did they consider reconsultation in a real-world setting may not only include reconsultation in primary care but attending emergency departments also, due to staffing crisis and lack of available appointments in primary care and the associated time and economic costs of this?	
The UK Sepsis Trust	Evidence Review B	059	005	It is stated, "They found that allowing POC CRP to be used pragmatically in primary care led to it being borderline cost-effective, but by adhering to guidelines around usage, the model predicted a far lower incremental cost effectiveness ratio". Recommendation 1.1.9 adheres to the guidelines. Did the committee discuss this with respect to cost effectiveness when they made the recommendation?	Thank you. Recommendation 1.1.9 is now recommendation 1.3.4. The committee did factor this into their discussions and because the evidence was too limited to draw conclusions or did not indicate good value for money, they recommended that they not be used in primary care.
The UK Sepsis Trust	Evidence Review B	069	029	It is stated, "Many of the other studies lacked robust underpinning evidence on effectiveness." This is regarding CRP testing. If this is the case, please clarify the basis of recommendation 1.1.9 to use CRP? The rationale should be made clear in the guideline document and specifically address the lack of "robust underpinning evidence on effectiveness" because clinicians will query why they should follow a recommendation which is based on lack of "robust underpinning evidence on effectiveness".	Thank you. Recommendation 1.1.9 is now recommendation 1.3.4. This recommendation was originally published in the NICE pneumonia guideline in 2014 and was based on data from 3 European RCTs comparing CRP with usual care that covered LRTI and URTI, and an economic analysis. This guideline details how the threshold decisions were made by that guideline committee (table 16 in section 7.5 of the guideline). Although the evidence in the current review was of low or very low confidence, it supported the 2014 recommendation and was borne out by the committees expertise and experience. See

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					the committee discussion of the evidence section of the evidence summary for further detail. The NICE pneumonia guideline is in the process of being updated. If you would like to register as a stakeholder for this update please visit https://www.nice.org.uk/guidance/indevelopment/gid-ng10357
The UK Sepsis Trust	Evidence Review B	053		Table 8 The table provides the mean age of participants in studies. The vast majority are in older adults. It is not stated how many were in pregnant/post-partum patients (pregnancy/post-partum influences baseline CRP). Did the committee consider age differences in CRP when deciding to provide one threshold for CRP for all groups of patients in recommendation 1.1.9 and are there any concerns this will discriminate against younger adults, those who are pregnant and post-partum? Does there need to be a caveat to recommendation 1.1.9 that the thresholds stated may not be relevant to all groups of patients covered in the guideline, they are not absolute and clinical judgement is required?	Thank you. Recommendation 1.1.9 is now recommendation 1.3.4. The committee noted that the studies were mostly in older adults, and that older adults were more likely to be at risk of serious illness however in the absence of evidence in younger cohorts they used their expertise and experience to extrapolate from the evidence. No evidence was found on pregnancy and post-partum, but the committee agreed that these were very important and have made sure to add them to the sub-group analyses for the research recommendations in the hope that more evidence will be available in the future.
The UK Sepsis Trust	Evidence Summary	064	002	It is stated, "None of the included studies provided evidence about virtual wards or ARI hubs. This meant that the committee were unable to make recommendations about initial management of people in terms of a care pathway that might include virtual wards or referral through acute respiratory infection hubs. They noted that some of the severity scores	Thank you for pointing out this inconsistency. The committee have addressed it in the final version. Recommendation 1.1.12 is now recommendation 1.3.7. The guideline is intended to inform the initial triage of people with suspected ARI and to help clinicians to

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				might lend themselves to this, but they tended to be scores that were not validated or tested in undifferentiated populations in primary care." This contradicts recommendation 1.1.12 in the guideline which uses CRB65 score to suggest when referral to a virtual ward might take place. Please reconcile this inconsistency between what is stated in the Evidence Summary and what appears in the guideline itself. Likewise, in the context section of the guideline (page 12, line 14) it states, "This guideline will aid healthcare professionals in deciding where to refer people aged 16 and over with suspected ARIs including referrals to virtual wards and ARI hubs." If the paragraph in the Evidence Summary is correct and "the committee were unable to make recommendation …in terms of a care pathway that might include virtual hubs etc…" please clarify why the context of the guideline states the guideline will help in deciding where to refer people? The context section should be updated accordingly.	get them onto the most appropriate care pathway for them. This may include admission to hospital, going from a remote to a face-to-face appointment, a referral to an ARI hub or emergency department, or self-care at home.
The UK Sepsis Trust	Evidence Summary	065	038	It is stated, "This meant that the committee had to defer to clinical judgment in many recommendations, and to make a lower strength recommendation than they would have been able to make if the evidence had been more robust." The committee should make clear in the rationale section of the guideline which recommendations are based on the evidence, the quality of that evidence and which recommendations are based on expert opinion or committee consensus	Thank you. The committee discussion of the evidence section in the evidence summary makes that clear. NICE recommendations are worded in a specific way to convey the strength of the evidence as detailed in the box at the beginning of the recommendations. Please see Making decisions using NICE guidelines for further information about how the wording of NICE recommendations conveys their strength.

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				only. Clinicians do not have time to look through hundreds of pages of documents to gather this information themselves during a consultation. It should be clearly and succinctly presented, recommendation by recommendation, in the rationale section of the guideline. Currently the guideline gives no indication that many recommendations are based on "clinical judgement" only, and readers are left with the impression the decisions are evidence-based, despite the Evidence Summary showing this is not the case.	
The UK Sepsis Trust	Evidence Summary	066	006	It is stated, "The committee noted especially that the cough and sore throat management guidelines were useful for people who presented with those symptoms but might not have an acute lower respiratory infection" The acute cough guidelines also deal with those who have acute bronchitis (i.e., an acute lower respiratory infection). The current wording of the above implies those guidelines are not relevant in such cases, which is incorrect. This should be corrected.	Thank you. The committee have amended this.
The UK Sepsis Trust	Evidence Summary	066	036	We agree with the opening sentence. Red flags suggestive of serious illness like pneumonia or sepsis must be ruled out in all cases of acute respiratory infection but the guideline recommendation 1.1.1 indicates screening for sepsis only if a patient appears "seriously ill". A safer approach is any patient – not only those who appear "seriously ill" – presenting with an acute respiratory illness should be assessed for	Thank you. The committee have amended this as you suggest.

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				signs/symptoms of serious illness like sepsis and pneumonia.	
The UK Sepsis Trust	Evidence Summary	066	040	It is stated, "To support practitioners in deciding whether a person might have pneumonia, the committee included a list of symptoms that were found to have a specificity of more than 75% for bacterial pneumonia following the evidence in review." The committee has apparently misinterpreted specificity and therefore the associated evidence by conflating "specificity" and "positive predictive value". In the rationale section of the guideline (page 9, line 18) it is stated, "If a person with a suspected ARI has 1 or more of these symptoms, they are at least 75% likely to have bacterial pneumonia". This is an incorrect interpretation of specificity, and the committee cannot conclude this based on the specificity of a test. The specificity alone provides no information about the predictive value of a test. The specificity assesses the adequacy of a screening test. The average clinician and patient are not interested in this. They want to assess people, rather than screening tests, and want to know if a person's screening test is positive (in this case, if they have a certain symptom), what is the probability they have a certain condition (in this case, pneumonia). This is provided by positive predictive value, not specificity, but has not been calculated in any of the consultation documents. See here for further explanation: https://www.frontiersin.org/articles/10.3389/fpubh.201	Thank you. Box 1 has been removed following stakeholder consultation, and this section has been rewritten.

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				7.00307/full . Please note, under the 'uses and misuses of sensitivity and specificity' of this paper, it is stated, "Akobeng [(9), p. 340] has gone so far as to write that "both sensitivity and specificity … are of no practical use when it comes to helping the clinician estimate the probability of disease in individual patients."" None of the signs and symptoms in Box 1 trulyindicate, as claimed, that a patient is at least 75% likely to have pneumonia. We have calculated the actual predictive values of the signs and symptoms in Box 1, assuming a prevalence of pneumonia of 10% among those patients presenting to primary care with acute respiratory infection (likely an overestimate or prevalence), and they ranged from approximately 10% to 20% - far off the quoted 75%. It would be helpful if the committee clarified which of its members has experience/expertise of applying medical statistics, epidemiology or public health and which safeguards NICE has in place to ensure evidence has been correctly/appropriately interpreted prior to the approval of guidelines. There appears to have been a serious oversight, with respect to sensitivity, specificity and predictive values that significantly alters the contents and meaning of this guideline. Awareness of the safeguards NICE has in place to ensure such errors do not occur in the development of their guidelines may help restore confidence that similar mistakes	

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				have not occurred in the development of other guidelines already in use.	
The UK Sepsis Trust	Evidence Summary	066	027 - 031	These sentences raise a good point. How has this point (that not all home equipment is reliable and not all people know how to correctly use such equipment) manifested in the guideline? There is no mention of this in the guideline itself, but it seems a pertinent reminder for clinicians to be mindful of to ensure accuracy of measurements (it is often said 'no test is better than a bed test'). The committee should update the guideline accordingly.	Thank you. The committee have added this to the rationale and impact section of the guideline.
The UK Sepsis Trust	Evidence Summary	067	006	It is stated, "The confidence in this evidence ranged from very low to moderate, with most of the symptoms rating very low in GRADE (5 out of 9 symptoms), so the committee offered it as a guide to symptoms that might be useful in making a clinical diagnosis of pneumonia rather than as a definitive list." This needs to be reflected in the guideline itself. In its current format, the guideline seems to suggest the list is indeed definitive and based on strong evidence and not simply a rough guide, based on poor quality evidence.	Thank you. The committee have amended the guideline to indicate this uncertainty.
The UK Sepsis Trust	Evidence Summary	067	012 - 016	The guideline does not make this clear, though it is an important consideration. COPD is mentioned once in the guideline. This should be stated clearly in the guideline itself, "if you suspect a patient is at high risk of serious illness and has a respiratory infection that is exacerbating a co-existing condition (such as COPD or heart failure or x, y, z), offer (or consider?) a face-to-face appointment". Considering the urgency (same	Thank you. This was in recommendation 1.1.5 (which is now recommendation 1.2.3) in the guideline "if there is cause for concern (for example, co-morbidities that may be exacerbated by an ARI)". The committee have restructured the recommendation to make this more obvious.

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				day, next day etc) needs to be mentioned in such a recommendation, also.	
The UK Sepsis Trust	Evidence Summary	067	012 - 016	The committee appears to have focussed on suggesting face-to-face review if antibiotics are considered or pneumonia is suspected. We feel a safer approach would be to consider face-to-face review if there are any red flags or signs/symptoms of serious illness, regardless of if pneumonia or antibiotics are considered. Does the committee agree this would be a more appropriate consideration in helping decide need for face to face review than only whether antibiotics may be needed?	Thank you. The committee have made this clearer in recommendation 1.2.3 which now refers to "a serious illness such as pneumonia".
The UK Sepsis Trust	Evidence Summary	067	024 - 026	Regarding the first sentence beginning "the committee agreed that antibiotics…" Please may the committee clarify the data which allowed them to agree this or if it was based on opinion. None of the review questions asked whether remote consultations are associated with increased rates of and inappropriate antibiotic prescriptions for acute respiratory infections (the reason for this omission should be clarified, also). How does the committee respond to studies which show variable results: some studies show higher antibiotic prescribing rates in remote consultations compared to face-to-face, others show lower antibiotic prescribing in remote compared to face-to-face, others show no difference (see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7655728/, https://pubmed.ncbi.nlm.nih.gov/36168456/ and https://pubmed.ncbi.nlm.nih.gov/34497096/). The latter is a systematic review. In its conclusion it is	Thank you. NICE recommendations are based both on published evidence and on the expertise and experience of the committee members. In this case the committee considered their duty to antimicrobial stewardship and agreed that routine prescription of antimicrobials in remote consultations was likely to lead to more inappropriate prescribing. If a person was ill enough to require antibiotics then they should normally have a face to face assessment both for patient safety and for antimicrobial stewardship reasons. The wording of the recommendation has changed in the final version of the guideline and in the evidence summary to reflect situations where remote prescribing might be acceptable.

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				clearly stated there is insufficient evidence. Will the committee agree to a more complete search that includes this question and then decide on the recommendation or will it proceed with the original recommendation (if so, it must be made clear this is opinion based)?	
The UK Sepsis Trust	Evidence Summary	067	028 - 029	It is stated, "This position was supported by the lack of evidence for the usefulness of symptoms and signs to distinguish between bacterial and viral infections in evidence review". This lack of evidence does not support any of the preceding recommendations. Please can the committee clarify how a lack of evidence to distinguish between bacterial and viral infections is addressed by seeing a patient face-to-face, when the evidence review has not identified any measures than can accurately differentiate between bacterial and viral infections? The more pressing priority, in our opinion, is for clinicians to be able to rapidly and accurately identify patients remotely who cannot safely be managed remotely including those who may be at risk of serious illness and organise face-to-face review for these patients. This can be assessed based on red and amber flags listed in sepsis guideline NG51.	Thank you. The committee have removed this sentence.
The UK Sepsis Trust	Evidence Summary	067	033	It is stated, "They noted that all of the evidence was of very low quality and that they could not have much confidence in the effect estimates.". If the evidence is "very low quality" and "they could not have much confidence" the committee should explain why any recommendations have been made based on such	Thank you. The committee did not recommend any point of care tests other than considering CRP POCT if no decision could be made on clinical judgment alone. Instead, they made a research recommendation for more robust research on point of care tests (research recommendation 2). The

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				poor-quality data? It implies the decision is not evidence based.	committee made the recommendation for CRP testing because the new evidence, although poor was consistent with the committees expertise and experience, and with the existing recommendation in the 2014 NICE guideline on the assessment and management of pneumonia. On this basis they were content to keep the recommendation.
The UK Sepsis Trust	Evidence Summary	067	034 - 38	This is regarding the comment about consistency between guidelines. In this case, consistency is not the priority; accuracy and patient safety are. The pneumonia guidelines were published almost 10 years ago. If the most up to date evidence review has shown the evidence is "very low quality" and "they could not have much confidence" in the data, then either no recommendation should be made based on such poor-quality data or there must be very clear rationale for using such low-quality data. The potential risk of harm of inaccurate and unvalidated point of care CRP thresholds is too serious; the corresponding recommendation in the guideline indicates the sensitivity of CRP >100 is so poor that almost 50% of cases of pneumonia are missed. This level of risk to patients is unacceptable, even more so when based on "very low quality" data. It may increase morbidity/mortality associated with pneumonia by causing delayed treatment and increased rates of sepsis.	Thank you. CRP testing is not recommended for people with suspected pneumonia. The committee have rearranged the wording of the recommendation to make this clearer. The committee was aware that the evidence was not straightforward, not least because of quality issues, and for this reason they made the recommendation to 'consider' the use of CRP, and then only if a decision on prescribing could not be made based on clinical assessment alone. on clinical assessment alone. It is also important to note that the recommendation suggests a backup antibiotic prescription for people with CRP>20mg/l. At 20mg/l the Gentilotti review finds the CRP test 83% sensitive, which means more than 8 out of 10 'true positives' with pneumonia would receive an antibiotic. Antibiotics are not precluded at levels less than 20mg/l, the recommendation says that they should not 'routinely' be offered.
The UK Sepsis Trust	Evidence Summary	068	003	It is stated, "The evidence for POCT microbiological tests was of poor quality and there was low certainty	Thank you. The committee did not recommend any point of care tests other than considering CRP POCT

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				in the evidence". In some cases, when the evidence is poor quality, the committee has not made a recommendation (e.g., re POC microbiological tests), but in other cases, despite poor quality evidence, the committee has made a recommendation (e.g., POC CRP test). How has the committee decided between making and not making a recommendation when in each case the quality of evidence has been considered poor and how have they ensured their decision-making methods are consistent? It should be clarified why the committee considers it appropriate to make one recommendation over another when the evidence in each case is poor?	if no decision could be made on clinical judgment alone. Instead, they made a research recommendation for more robust research on point of care tests (research recommendation 2). The committee made the recommendation for CRP testing because the new evidence, although poor was consistent with the committees expertise and experience, and with the existing recommendation in the 2014 NICE guideline on the assessment and management of pneumonia. On this basis they were content to keep the recommendation.
The UK Sepsis Trust	Evidence Summary	068	017 - 036	The committee has misinterpreted sensitivity/specificity and in so doing applied the evidence incorrectly, in a way that may cause serious unintended harm to patients by withholding antibiotics from people for whom they are essential. It is claimed "the evidence showed that at a CRP of >100 mg/l a person is more than 90% likely to have a bacterial infection, and antibiotics should be prescribed". The evidence does not show this. The evidence is not just looking at "a bacterial infection" but pneumonia. The authors of the paper cited from which this threshold has been taken (Gentilotti 2022) themselves contradict the committee and state, "Clinical signs and symptoms, CRP and PCT are not sufficiently reliable as stand-alone tests to differentiate bacterial versus viral pneumonia. The main challenge	Thank you. The recommendation for CRP comes from NICE's 2014 pneumonia guideline and is not a new recommendation. It was based on data from 3 European RCTs comparing CRP with usual care that covered LRTI and URTI, and an economic analysis. This guideline details how the threshold decisions were made by that guideline committee (table 16 in section 7.5 of the guideline). The data presented in the Gentilotti (2022) review were consistent with the conclusions reached by the 2014 pneumonia guideline. The committee took this as further evidence that the thresholds were useful and useable and agreed to keep them. For the

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				to be addressed for biomarkers is consensus on a diagnostic threshold. With regards to CRP, one of the largest diagnostic European studies conducted in adults, identified a threshold of 30 mg/L as the best cut-off to be combined with signs and symptoms for ruling out severe bacterial infection and to avoid the misuse of antibiotics. Previous systematic reviews found that CRP >20 mg/L is of value in diagnosing bacterial pneumonia. In our meta-analysis CRP >10 mg/L described the best performance in terms of sensitivity (90%) in contrast with specificity (42%)." The committee should explain how they factored this into their decision-making and why their chosen threshold (>100) in the guideline takes priority over "one of the largest diagnostic European studies conducted in adults" thresholds of 30? Furthermore, the evidence regarding this is not only looking at any infection. It is specifically looking at pneumonia, a potentially life-threatening condition with significant morbidity and mortality. The evidence actually shows when a CRP threshold of >100 is used, the specificity of the test is 91%. This does not mean that a person is more than 90% likely to have pneumonia if their CRP is >100, as claimed (see: https://www.frontiersin.org/articles/10.3389/fpubh.2017.00307/full). It means the test correctly reports 91% of people without pneumonia as true negatives. Specificity gives no information about predictive value. This is provided by the positive and negative	evidence underpinning the 2014 recommendation, please see the pneumonia full guideline, section 7.1. Based your comment the committee considered the positive and negative likelihood ratios for the CRP thresholds and details of this are reported in the committee discussion section of the evidence summary. The committee was aware that the evidence was not straightforward, not least because of quality issues, and for this reason they made the recommendation to 'consider' the use of CRP, and then only if a decision on prescribing could not be made based on clinical assessment alone. It is also important to note that the recommendation suggests a backup antibiotic prescription for people with CRP>20mg/l. At 20mg/l the Gentilotti review finds the CRP test 83% sensitive, which means more than 8 out of 10 people with pneumonia would receive an antibiotic. Antibiotics are not precluded at levels less than 20mg/l, the recommendation says that they should not 'routinely' be offered but the recommendation makes clear that clinical judgment is more important than CRP level. This means that the NICE threshold could be interpreted as lower than that suggested by Gentilotti.

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				predictive values. The committee has chosen a CRP threshold of >100 based on low quality data with a sensitivity of 52% and specificity of 91%. If the prevalence (as an example only) of pneumonia is 10% then the predictive value of this CRP threshold is not 90% - it is actually 39%. In order words, the correct statement here is "the low quality evidence showed that at a CRP of >100 a person is only 39% likely (not "more than 90% likely", as claimed) to have pneumonia". This predictive value is extremely low and unacceptable to help decide whether a patient requires antibiotics, due to potential for serious harm, because it means many patients (more than 60%) who need antibiotics will not get them. These patients will likely deteriorate, and many will develop complications, including sepsis. All current recommendations based on what appear to be incorrectly interpreted statistics need to be corrected and revised. The committee caveats this paragraph by stating "it should only be used when clinical assessment has not provided an adequate diagnosis..." but this does not detract from the error with respect to sensitivity/specificity and predictive values and associated misinterpretation of the data. Will the committee, in the interests of candour, escalate this accordingly within NICE, because the error has occurred recurrently throughout this	The NICE pneumonia guideline is in the process of being updated. If you would like to register as a stakeholder for this update please visit https://www.nice.org.uk/guidance/indevelopment/gid-ng10357 We will pass your concerns about NICEs use of diagnostic accuracy data on to the NICE methods team for further consideration.

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				guideline, so that an investigation to understand how such serious errors have appeared in a publicly available draft guideline and how NICE has ensured this has not happened in other guidelines and will not happen again?	
The UK Sepsis Trust	Evidence Summary	070	009	It is stated, "The committee agreed that this was a useful supplement to clinical judgment, but that decisions about a person's care should not be based on the CRB 65 alone". This should be made clear in the guideline itself.	Thank you. Please see recommendation 1.3.7 "Use clinical judgment together with the CRB65 score…"
The UK Sepsis Trust	Evidence Summary	071	009	It is stated, "The main focus of this guideline was decided to be on the management of lower respiratory tract infections and pneumonia, which have greater consequences to the patient and to the healthcare system if not managed appropriately." The committee should explain the basis of this decision in detail, as it is inconsistent with the final scope document and review the draft guideline to ensure the focus of the guideline is clear throughout, including in the title, "who is it for" section and context section. Currently this (that the guideline focuses on lower respiratory tract infection and pneumonia) is not clearly stated anywhere in the guideline itself. The reason to deviate from protocol (the scope) should be made transparent.	Thank you. The committee decided that they would focus on pneumonia and LRTI as they felt that the triaging of many non-pneumonia conditions was sufficiently covered by other guidelines. This has been further explained in the evidence summary. NICE guidelines are based on a scope document, but have a separate review protocol which has more granular detail. The review protocol in normally in appendix A of any given evidence review and is normally available on PROSPERO.
The UK Sepsis Trust	Evidence Summary	071	039	It is stated, "but that using CRP POCT to inform an antibiotic reduction strategy was not detrimental to patient outcomes." There are ways in which this may be detrimental to patient outcomes, as follows. NB: The evidence this refers to looked at CRP thresholds	Thank you. The committee was aware that the evidence was not straightforward, not least because of quality issues, and for this reason they made the recommendation to 'consider' the use of CRP, and

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				to diagnose pneumonia so we have referred to 'pneumonia' here specifically. Using CRP point of care testing at the thresholds chosen by the committee will miss almost 50%|of cases of known pneumonia, or the disease/condition the threshold is meant to detect, (because the sensitivity is 52%) and cause delay in these people being given essential and time-sensitive antibiotics. People who have CRP >100, assuming pneumonia prevalence of 10%, will only be 39% likely to have pneumonia. This is a poor test which could seriously harm patients by failing to identify patients with pneumonia who genuinely require antibiotics asap. Did the committee consider the paper itself from which this threshold came? The authors clearly contradict the committee and the thresholds they refer to (which are evidence-based) are very different to those the thresholds the committee has chosen: "Clinical signs and symptoms, CRP and PCT are not sufficiently reliable as stand-alone tests to differentiate bacterial versus viral pneumonia. The main challenge to be addressed for biomarkers is consensus on a diagnostic threshold. With regards to CRP, one of the largest diagnostic European studies conducted in adults, identified a threshold of 30 mg/L as the best cut-off to be combined with signs and symptoms for ruling out severe bacterial infection and to avoid the misuse of antibiotics. Previous systematic reviews found that CRP >20 mg/L is of value in diagnosing bacterial	then only if a decision on prescribing could not be made based on clinical assessment alone. . It is also important to note that the recommendation suggests a backup antibiotic prescription for people with CRP>20mg/l. At 20mg/l the Gentilotti review finds the CRP test 83% sensitive, which means more than 8 out of 10 'true positives' with pneumonia would receive an antibiotic. Antibiotics are not precluded at levels less than 20mg/l, the recommendation says that they should not 'routinely' be offered.

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				pneumonia. In our meta-analysis CRP >10 mg/L described the best performance in terms of sensitivity (90%) in contrast with specificity (42%)."	
The UK Sepsis Trust	Evidence Summary	071	023 - 026	The second sentence beginning "recommending a face-to-face assessment for these people will save…" is presented as fact but appears to be the opinion of the committee. None of the evidence reviews were designed to answer the question whether in people aged 16 years and above presenting with signs of a respiratory tract infection, face-to-face consultations rather than remote consultations reduce the rate of inappropriate antibiotic prescriptions (and the reason(s) for not including this as a review question should be stated). The committee should also address/reconcile their view with the view in the literature which is presents a more balanced and uncertain view: some studies show higher antibiotic prescribing rates in remote consultations compared to face-to-face, others show lower antibiotic prescribing in remote compared to face-to-face, others show no difference (see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7655728/, https://pubmed.ncbi.nlm.nih.gov/36168456/ and https://pubmed.ncbi.nlm.nih.gov/34497096/). The latter states there "is insufficient evidence to draw strong conclusions, however, and higher quality research is urgently needed."	Thank you. NICE guidelines are based not only on the published evidence but also on the expertise and experience of the committee. This guideline did not compare face-to-face with remote consultations, but did search for evidence for its reviews in both remote and face to face settings. This statement has been edited to reflect the committee's view.
The UK Sepsis Trust	Evidence Summary	072	040	It is stated, "The committee considered that CRB-65 is an accurate measure for assessing the risk of pneumonia patients". The committee should consider	Thank you. The committee have reworded this.

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				elaborating on this, as it appears imprecise. Evidence review A assessed CRB65. It states further studies are needed in outpatient cohorts, CRB65 has not been validated sufficiently in primary care settings and the value of CRB65 as a prognostic indicator remains unclear. How does the committee explain these findings in Evidence Review A in relation to the comment made in this summary stating that CRB65 is "an accurate measure"? In some cohorts it may be accurate, but it is unknown if it is in primary care cohorts.	
The UK Sepsis Trust	Evidence Summary	064	024	It is stated, "whilst acknowledging the importance of test sensitivity, in the interests of good antimicrobial stewardship, the committee agreed that specificity was the most important outcome since more specific tests would mean that the people who received medication would be more likely to have an infection". Please can the committee provide examples of how they have interpreted the exact sensitivity values as applied to detecting known cases of pneumonia (what proportion will be detected and the impact/consequences of false negatives as well as the proportion of false negatives), other than "acknowledging the importance" of them? The evidence this section is based on has come from the Gentilotti 2022 paper. This paper is not only looking at "an infection" but thresholds of CRP to diagnose pneumonia. Pneumonia is a serious illness; mortality in some cases may exceed 30% (almost 1 in	Thank you. The committee was aware that the evidence was not straightforward, not least because of quality issues, and for this reason they made the recommendation to 'consider' the use of CRP, and then only if a decision on prescribing could not be made based on clinical assessment alone. It is also important to note that the recommendation suggests a backup antibiotic prescription for people with CRP>20mg/l TO 100mg/l. At 20mg/l the Gentilotti review finds the CRP test 83% sensitive, which means more than 8 out of 10 'true positives' with pneumonia would receive an antibiotic. Antibiotics are not precluded at levels less than 20mg/l, the recommendation says that they should not 'routinely' be offered.

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				3) and sepsis (itself a life-threatening medical emergency) is precipitated by pneumonia in approximately 50% of cases. The British Thoracic Society guidelines on pneumonia rightly refer to antibiotics as "essential" to its management. When dealing with a potentially life-threatening illness whose treatment is time-sensitive, public health principles dictate a test to screen for such a condition should have high sensitivity. This is to ensure as many people as possible with the condition are correctly identified because the cost of not identifying them (hospital admission, sepsis and septic shock, death) is unacceptable. Therefore, we strongly disagree with the above suggestion that specificity is "the most important outcome" in this case; it is not. The specificity the committee has chosen in this case for CRP >100 to identify pneumonia is calculated as 91% (CI 79 – 97) and this is based on low certainty of the body of evidence (see page 40 of the evidence summary). The corresponding sensitivity of this test is 52% (CI 31 to 72%). This means the test will fail to identify 48% of cases of pneumonia. The committee appears willing, therefore, to miss almost half of all cases of pneumonia. Is this correct/did the committee specifically discuss this and accept this as the trade-off for what they consider "good antimicrobial stewardship"? Did they consider if almost half of cases of pneumonia (or even other bacterial infection) are missed in the name of "good antimicrobial	

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				stewardship" that without antibiotics, an untold number of patients will progress to sepsis and septic shock, will eventually require even more broad-spectrum antibiotics due to increased disease severity than they initially would have, and longer hospital stays due to delays in diagnosis and treatment, therefore negating and even reversing any potential perceived benefit of "good antimicrobial stewardship"? In the context of diagnosing pneumonia or detecting bacterial illness requiring antibiotics, this is counter-intuitive and risks serious harm to patients. We advise the committee to re-think this approach as a matter of urgency. An appropriate CRP threshold has not been established based on high quality data. Therefore, in the interests of patient safety, particularly when the sensitivity of the test is almost equivalent to tossing a coin, no recommendation should be made in the guideline based on these CRP thresholds. Furthermore, the committee must reconcile how/why their conclusions and recommendations were based on a single paper (Gentilotti 2022) yet the authors' own conclusions contradict the committee. They write in their paper: "Clinical signs and symptoms, CRP and PCT are not sufficiently reliable as stand-alone tests to differentiate bacterial versus viral pneumonia. With regards to CRP, one of the largest diagnostic European studies conducted in adults, identified a threshold of 30 mg/L as the best cut-off to be combined with signs and	

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				symptoms for ruling out severe bacterial infection and to avoid the misuse of antibiotics. Previous systematic reviews found that CRP >20 mg/L is of value in diagnosing bacterial pneumonia. In our meta-analysis CRP >10 mg/L described the best performance in terms of sensitivity (90%) in contrast with specificity (42%)" The authors of the paper understand the importance of sensitivity in the context of pneumonia and the problems with failing to correctly identify people with pneumonia. On reflection, does the committee feel they may have misinterpreted the sensitivity and specificity and acknowledge their interpretation contradicts the authors' conclusions and may risk serious patient harm?	
The UK Sepsis Trust	Evidence Summary	065	013	It is stated, "The main reason for downgrading was for methodological limitations, with very serious methodological concerns being noted for all of the included studies. This was mostly due to uncertainties around selection bias and high risk of bias due to lack of blinding and incomplete outcome data reporting." The committee should make clear why any recommendations regarding point of care tests have been made when there are "very serious methodological concerns" and "high risk of bias", considering these features make the evidence of very low quality?	Thank you. The committee did not recommend any point of care tests other than considering CRP POCT if no decision could be made on clinical judgment alone. Instead, they made a research recommendation for more robust research on point of care tests (research recommendation 2). The committee made the recommendation for CRP testing because the recommendation was already in the 2014 NICE guideline on the assessment and management of pneumonia. The new evidence, although poor was consistent with the existing recommendation and the committees expertise and experience, so they were content to keep the recommendation.

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The UK Sepsis Trust	Evidence Summary	067	024 - 026	Regarding the first sentence beginning "the committee agreed that antibiotics…" Did the committee consider the lack of availability of primary care appointments, which become more stretched during winter months when acute respiratory infections are more prevalent and take into consideration that if this recommendation is not changed, some patients who would have rightly, correctly and appropriately received antibiotics remotely after telephone/video assessment may have to wait days (or weeks) for a face-to-face review and in this time there is a risk of significant complications, including sepsis? Did the committee analyse how many patients who would have received antibiotics appropriately/correctly after remote assessment may suffer from delays in treatment and complications as a result of this recommendation, while they wait for a face-to-face appointment?	Thank you. The committee discussed this and agreed to make the recommendation less definite. They noted that there were circumstances where a remote prescription might be appropriate. Please see the rationale and impact section of the guideline for more details
The UK Sepsis Trust	Evidence Summary	070	009	Did the committee consider at any stage that CRB65 underestimates severity in some cohorts, such as younger people, and the possible impact of not making this clear in any recommendation that encourages its use e.g., delayed treatment and diagnosis and increased risk of complications?	Thank you. The committee acknowledged that further research is needed to validate CRB-65 in primary care and community settings and have made a research recommendation to explore this further. They were clear that CRB65 should be used alongside clinical judgment and pointed out that various factors can influence the score. They have added this to the recommendation.
UK Sepsis Trust	Guideline	General	General	The committee membership is very bacteriological both in terms of microbiologists and antimicrobial pharmacists. It appears to be a major oversight that there is not a medical virologist or other source of	Thank you. The committee had two medical microbiologists whose expertise covers viral infection. The focus of the committee membership was on covering the broadest possible range of sites where a

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				specialist virological advice on a guideline about acute respiratory infections. Perhaps as a result, the guideline is very focused on the diagnosis and management of bacterial causes of ARI and neglects viral causes of ARI. COVID-19 is explicitly outside of the guidance but the management of undifferentiated ARI does not support management of other viral causes of ARI, such as influenza. There is a lack of holistic approach to ARI.	first presentation with a suspected ARI could take place. The recommendations have been updated since consultation and the committee believe they better reflect both bacterial and viral causes for ARI.
UK Health Security Agency	Guideline	General	General	There is a sense of this guidance being anti-testing for viruses such as influenza. POCT diagnosis supports appropriate patient management, infection prevention and control, and disease surveillance. NICE is out of step with current norms in the NHS and it would be a backwards step to discourage testing.	Thank you. The committee agreed that some influenza POCT (for example) are very accurate, however they did not think this was useful for prescribing antivirals because the decision for prescribing for ILI was primarily determined by clinical judgment and advice from UKHSA on 'flu season' and they did not see information on the clinical and cost-effectiveness of such current norms as described. The committee noted that for surveillance and infection control purposes flu POCT could be very useful. Please see the committee discussion of the evidence in the evidence summary for more detail.
UK Health Security Agency	Guideline	General	General	The guidance appears to downplay the role of testing; however, the evidence review points out that PCR tests (POC) for influenza are sensitive and specific. Given that there is widespread transmission of avian influenza in birds and increasing spillover into mammals, there is a significant concern that we may at some point have an outbreak of zoonotic influenza in people, it seems short sighted to not test for	Thank you. The committee agreed that some influenza POCT (for example) are very accurate, however they did not think this was useful for prescribing antivirals because the decision for prescribing for ILI was primarily determined by clinical judgment and advice from UKHSA on 'flu season'. NICE cannot give advice outside its remit as

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				influenza A, at least in those with higher CRPs/clinical assessment scores (e.g., NEWS and CRB65). Any positive POC tests for influenza should be referred for subtyping to exclude an emergent influenza. There is substantial concern that the increased incidence of avian influenza in the animal world, will spill over into humans and cause a pandemic with high morbidity and mortality. We therefore need to be detecting emergent influenzas at an early stage, before there is widespread transmission in the community. PCR point of care tests will support this.	described here with a potential emerging new zoonotic avian influenza pandemic. The committee noted that for surveillance and infection control purposes flu POCT could be very useful, but it was beyond the remit of this guideline. Please see the committee discussion of the evidence in the evidence summary for more detail.
UK Health Security Agency	Guideline	General	General	Recommendations for research Appreciating the guideline is bacterial-focused, but given the emerging evidence for effectiveness of ribavirin in observational studies of RSV treatment in adults, might the committee not consider a research recommendation for randomised trials of this as part of ARI management?	Thank you. NICE committees can only make research recommendations about evidence they searched for that was lacking. None of the evidence reviews looked at treatment for RSV, so the committee were unable to make a research recommendation about this.
UK Health Security Agency	Guideline	General	General	The absence of health protection advice on the committee is notable. Public health/health protection advice should be central to NICE guidance development where there are health protection implications.	Thank you. The committee membership was focussed on the range of settings where initial assessment of ARI might happen. Covering this broad range of settings meant there was not capacity on the committee for a health protection specialist, nor was health protection part of the remit of this guideline, which focused only on the initial assessment and management of ARI. Several members of the committee brought health protection expertise and antimicrobial management expertise.

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UK Health Security Agency	Guideline	General	General	Sampling should be encouraged to facilitate treatment refinement after having been established on empirical antibiotics and to support disease surveillance. Negative samples may enable early cessation of antibiotics and positive results may help refine treatment to be more appropriate and so should have an effect on outcomes and improve antibiotic stewardship. We need better data on mycoplasma incidence and resistance to macrolides. Other atypical infections should be considered – especially legionella – which is probably under diagnosed.	Thank you. Treatment of infections and disease surveillance are beyond the remit of this guideline, which is focussed on the assessment at first presentation either remotely or face-to-face.
UK Health Security Agency	Guideline	General	General	Very nice to see the antimicrobial resistance and diagnostic questions coming in as research areas, strongly support	Thank you for your support.
UK Health Security Agency	Guideline	General	General	Consider reference to National Infection Preventions and Control Manual re isolation and use of Respiratory Protective Equipment pertaining to identified clinical risk	Thank you. The sections of the manual relating to isolation and respiratory protective equipment are for secondary care. This guideline is focussed on primary care. All NHS staff should be adhering to this national guidance.
UK Health Security Agency	Guideline	003	008 - 010	Antimicrobials for sore throat and acute cough does not adequately cover management of undifferentiated ARI. If this is actually intended as a guidance on ARI, rather than the use of antibacterial antimicrobials in ARI, then it needs substantial revision. If it is intended a guidance on antimicrobials in ARI, then as a minimum it needs to signpost to NICE TA 168 on treatment of influenza like illness. This signposting should also be considered if the guideline is intended as a holistic ARI guideline.	Thank you. This guideline is not intended to cover the management of ARI. The purpose of this guideline is to provide a framework for the initial triage of people who present with symptoms of an ARI (at first presentation). The committee have clarified this in the title and narrative of the guideline and additional narrative has been added before the start of recommendations section.

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UK Health Security Agency	Guideline	004	002	Box 1 Symptoms of one or more which include 'diarrhoea (type 5 or more on the Bristol stool chart), this would be best linked with at least one of the others, or a caveat put in about different presentations in immunosuppressed or at extremes of age	Thank you. Box 1 has been removed following stakeholder consultation.
UK Health Security Agency	Guideline	004	011 - 013	1.1.6 Useful from a stewardship perspective but is this realistic? A phone call where someone is unwell but complain so purulent green sputum and cough for >1 week would think was fine for prescribing antimicrobials	Thank you. The committee discussed this and agreed to make the recommendation less definite. They noted that there were circumstances where a remote prescription might be appropriate. Please see the rationale and impact section of the guideline for more details. Recommendation 1.1.6 is now recommendation 1.2.4.
UK Health Security Agency	Guideline	005	General	Noting that 1.1.7 only offers advice on antibiotics, the recommendations overall fail to recommend neuraminidase antivirals for influenza treatment, which are NICE recommended during periods of influenza circulation for treatment of acute presenters with influenza-like-illness (ILI) (a subset of ARI) in person at risk. Either this need to be substantially revised as a guideline for ARI, or it need to be explicit about having a narrow focus on antibiotics in ARI and rewritten accordingly.	Thank you. The committee discussed this and agreed that a recommendation to highlight UKHSA guidance on flu season would be useful. Please see recommendation 1.3.5 in the final guideline.
UK Health Security Agency	Guideline	005	004	'1.1.7 Do not offer microbiological tests or influenza tests to people with suspected ARI to determine whether to prescribe antibiotics.' That statement could imply rapid pathogen diagnostics are of no value. It is acceptable that	Thank you. Recommendation 1.1.7 is now recommendation 1.3.3. This recommendation focuses on the inability of tests to distinguish between bacterial and viral infection, and therefore their lack of usefulness in making decisions about whether to prescribe an antimicrobial agent. The committee have

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				clinical presentation is the primary driver for antibiotic choice, but testing still has a role. If there is concern that influenza diagnosis causes clinician to fail to consider bacterial causes of pneumonia, and sepsis, then be explicit.	clarified that this refers specifically to rapid, point-of-care tests for the purposes of prescribing, and not to slower diagnostic tests such as sputum cultures or the use of POCT for surveillance or disease control.
UK Health Security Agency	Guideline	005	004 - 005	Why would we not want to allow for bacterial sputum samples e.g. those with previous treatment, multiple hospital exposure, underlying conditions that may affect likely aetiology, and for viruses the evidence review discusses that for are available rapid diagnostics 'The committee also noted that normally, decisions about prescribing for flu are made by the UKHSA and communicated locally via communicable disease control units. Therefore, they did not recommend testing for flu.' That is for when community transmission is occurring, not for the role of a diagnostic test in pointing to a diagnosis.	Thank you. The committee have clarified that this refers specifically to rapid, point-of-care tests for the purposes of prescribing, and not to slower diagnostic tests such as sputum cultures or the use of POCT for surveillance or disease control.
UK Health Security Agency	Guideline	005	006 - 010	Suggest as it is a clinical and public audience to use 'crepitations/crackles' on auscultation	Thank you. This recommendation has been reworded following stakeholder consultation.
UK Health Security Agency	Guideline	005	011 - 019	Support CRP being allowed for in 1.1.9, would be good to add addendum in the rationale about the evidence for cut-offs for bacterial infection as discussed in the summary '90% if greater than 100, 50% at 20'	Thank you. Recommendation 1.1.9 is now recommendation 1.3.4. This detail is in the committee discussion of the evidence section of the evidence summary. The rationale and impact section only provides a concise justification for the recommendations and would not normally include the level of technical detail you describe.
UK Health Security Agency	Guideline	008	006 - 009	We recommend adding a research objective investigating the appropriate use of long-term antibiotics in the prevention of recurrent acute respiratory infections.	Thank you. This beyond the scope of this guideline, which was focused on triage at first presentation.

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UK Health Security Agency	Guideline	010	016 - 025	There appear to be either substantial gaps in the committee's awareness of molecular point of care test performance or some logical leaps: this suggests there may be "straw-man" arguments being used here to put point of care testing outside of the scope of the committee's considerations. For example, focusing on economic evaluation of single pathogen point of care testing (POCT) - outside of SARS-CoV-2 it is increasingly common to be considering multipathogen POCT. Simply calling for more research is not the way to address the committee's lack of awareness on POCT test accuracy. And clinicians are trained to interpret test with imperfect specificity and sensitivity. A positive flu test would support treatment with neuraminidase inhibitors even if a negative did not preclude it as a diagnosis.	Thank you. The committee were aware of these tests. Multi-pathogen POCT was included in the search however, no studies could be found therefore the committee felt it was appropriate to make a research recommendation asking for more evidence regarding their clinical and cost effectiveness over and above standard care. The committee have added a further statement to clarity this.
UK Health Security Agency	Guideline	011	019 - 020	"The committee considered people who had an ARI but did not have pneumonia, for example people with influenza." "Pneumonia" is used to refer to presumably bacterial pneumonia, as influenza can also cause a primary pneumonia. This is illustrative of the problematically bacteria-centric perspective of the guideline. Also, logically, patients can have both bacterial pneumonia and influenza (the bacterial pneumonia typically being considered a secondary infection of influenza) or RSV	Thank you. The use of influenza is an example of an ARI that a person could have if they didn't have pneumonia. It is not intended to imply that people with pneumonia cannot have flu. We have added a further example to avoid the perception of singling out flu.

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				etc so bacterial pneumonia does not exclude viral infection.	
UK Health Security Agency	Guideline	011	020 - 021	"They agreed that even though these infections are normally self-limiting, people who had co-morbidities, were frail, or were immunosuppressed could be at high risk and the thresholds for antimicrobial prescription or referral might need to be lowered." Again, this appears to be a bacterial-centric view of ARI. Committee appears to be unaware of NICE TA168 on influenza antivirals. Is antimicrobial being used in the broad sense to include antivirals – in which case this response is not about lowering thresholds but treating in primary care in line with the TA (technology appraisal) or appropriate Emergency Department / hospital treatment. As the latter often involves POCT, this NICE guidance seems behind the curve of NHS practice.	Thank you. The committee have added a recommendation to follow UKHSA advice on influenza management. NICE TA168 only evaluates 3 possible agents for treating influenza like illness.
UK Health Security Agency	Guideline	011	027 onwards	This makes explicit the antibacterial antimicrobial focus of the guideline. The other impacts of this recommendation on practice might include under treatment of patients with influenza.	Thank you. The committee have corrected antibiotic to antimicrobial.
UK Health Security Agency	Guideline	012	009 - 010	"Since the pandemic, the levels of ARI (particularly pneumonia caused by COVID-19 infection) have increased" Could the evidence that informed this statement please be explicitly stated?	Thank you. The committee have amended this to remove the reference to pneumonia caused by COVID-19 infection.

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				UKHSA syndromic data does not support the overall assessment on ARI rates. Though these were increased when influenza was highly prevalent in Dec 2022. Clearly since the emergence of COVID-19 as a pandemic caused by SARS-CoV-2 there is more (primary or secondary bacterial) pneumonia caused by SARS-CoV-2 compared to when it didn't exist, but SARS-CoV-2 is not particularly associated with secondary bacterial pneumonias.	

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**None of the stakeholders who comments on this clinical guideline have declared any links to the tobacco industry.*