Maidstone and Tunbridge Wells NHS
NHS Trust

Maidstone and Tunbridge Wells NHS
NHS Trust

Ref: FOI/CAD/ID 3115

Please reply to:
FOI Administrator
Trust Management
Service Centre
Maidstone Hospital
Hermitage Lane
Maidstone
Kent
ME16 9QQ
Email: mtw-tr.foiadmin@nhs.net

07 March 2018

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to Insulin pump and UFE NICE compliance.

1. Please enter the name of your Trust.
2. Does your Trust have a policy to ensure that all staff fully and objectively inform all patients of all their treatment options and offer them a choice of treatment? Please tick the appropriate box below
Yes
No
Don't know
3. How do your monitor your staff to ensure that all patients are properly and objectively informed? [Please tick all answers that apply]
Carry out patient surveys to ensure they have been given all the information about all their treatment options?
We have patient information leaflets available all treatments on our web site
We send patient information leaflets about all treatments options before their outpatient clinic so they can discuss them with their doctor
We include questions on patient information and treatment options in all patient surveys
We have a policy and expect all staff to comply
We do not have a policy and do not think this important
It is up to the individual clinician
Other (please specify)
4. How many complaints has your Trust received in the last 2 years about lack of patient information and choice of treatment?
5. NICE Clinical and Diagnostic Guidelines set minimum standards that patients would expect for the quality of their healthcare. Does your Trust have a policy to ensure that all your staff comply with all NICE Clinical and Diagnostic Guidelines? Please tick appropriate box
Please provide us with a copy of your Trust's policy on NICE Guideline compliance.
6. How do you monitor each of your clinical departments and clinicians to ensure their compliance with all NICE Guidelines? [Please tick all that apply]

Each department is required to update all care pathways to include the latest NICE Guidelines and this is reviewed by a Director
Every care pathway is reviewed by their clinical lead to ensure compliance with all NICE Guidelines
Audits are carried out in each clinical department to ensure NICE Guideline compliance and reported to the Board
Audit and patient surveys are carried out to ensure compliance
We trust our clinicians to comply with NICE Guidelines but do not monitor this
7. How many complaints has your Trust received in the past 2 years about lack of compliance with NICE Guidelines?
8. NICE Technology Appraisal Guidance 151 (TAG 151 Jul 08) states that continuous subcutaneous insulin infusion (CSII or insulin pump) therapy is a treatment option for adults and children with type 1 diabetes who meet certain criteria. How does your Trust ensure that all patients who meet the criteria are given the option of insulin pump therapy? [Please tick all that apply]
9. Which brands of insulin pump are offered at your Trust? [Please tick the appropriate box below]
10. What is the number of people with Type 1 diabetes registered with this Trust?
11. What is the number of patients using insulin pumps attending clinic at this Trust?
12. NICE Clinical Guidelines on Heavy Menstrual Bleeding (CG44 Jan '07), which includes uterine fibroids, states that all women with fibroids >3cm requiring hospital treatment must be offered hysterectomy, uterine artery embolisation and myomectomy. How does your Trust ensure that all women are given the choice of all 3 treatments and that there is no age discrimination in treatment choices given to women? [Please tick all that apply]
13. NICE Guidelines on Heavy Menstrual Bleeding state that "1.3.1 A woman with HMB referred to specialist care should be given information before her outpatient appointment." How does the Trust ensure compliance? [Please tick all that apply]
14. NICE Interventional Procedures Guidance on Uterine Artery Embolisation (IPG 367 Nov '10) states that - 1.3 Patient selection should be carried out by a multidisciplinary team, including a gynaecologist and an interventional radiologist. How does your Trust ensure multidisciplinary team working between gynaecologists and interventional radiologists to ensure women have access to all fibroid treatment recommended by NICE? [Please tick all that apply]
15. NICE Guidelines on Heavy Menstrual Bleeding (HMB) states that - 1.10.1 All those involved in undertaking surgical or radiological procedures to diagnose and treat HMB should demonstrate competence (including both technical and consultation skills) either during their training or in their subsequent practice. How does the Trust ensure all gynaecologists receive adequate training on UAE?
16. How is the training of gynaecologists about UAE monitored and recorded?
17. How many patients referred to your Trust in the last 2 years had a primary main diagnosis of heavy menstrual bleeding - Diagnostic Code N92?
18. How many patients referred to your Trust in the last 2 years in total (i.e. both primary and secondary main diagnosis) had a diagnosis of heavy menstrual bleeding Diagnostic Code N92?
19. How many patients had a primary main diagnosis of uterine leiomyoma/fibroids in the last two years Diagnostic Code D25.0 - 25.02 and D25.9?
20. How many patients in total (i.e. both primary and secondary main diagnosis) had a diagnosis of uterine leiomyoma/fibroids in the last two years Diagnostic Code D25.0 - 25.02 and 25.9?

21. How many patients with a diagnosis of heavy menstrual bleeding or fibroids (N92 and D25.0- 25.02 and 25.9) had a hysterectomy in the last 2 years Code Q07.1- Q08.9?
22. What were the ages of these women who had hysterectomy in the last 2 years Code Q07.1- Q08.9? (Please indicate the numbers for each age range below)
23. Does your Trust provide myomectomy - surgical removal of the fibroid(s) alone?
24. If 'Yes' how many myomectomies did your Trust perform in the last 2 years – open myomectomy code Q09.2, a endoscopic myomectomy in the last 2 years Code Q17.1?
25. What were the ages of the women who underwent myomectomy in the last 2 years (codes Q09.2 -9.3 + Q16.1 + Q17.1 and 17.4)? [Please indicate the numbers in each age range below]
26. Does your Trust provide uterine artery/fibroid embolisation? [Please tick the appropriate box below]
27. If 'No' where are patients wanting UAE referred?
28. If 'Yes' had uterine artery/fibroid embolisation in the last 2 years Code RC41Z?
29. Does your Trust provide beds for UAE patients on a regular basis - say once a week, as are provided for hysterectomy patients?
30. Do your interventional radiologists have admitting rights and named consultant status?
31. What were the age ranges of the women who had uterine artery/fibroid embolisation in the last 2 years Code RC41Z?

1. Maidstone and Tunbridge Wells NHS Trust

2. Yes

3.
Carry out patient surveys to ensure they have been given all the information about all their treatment options?
We send patient information leaflets about all treatments options before their outpatient clinic so they can discuss them with their doctor
We have a policy and expect all staff to comply

4. The complaints team do not have the specific code that will enable them to extract this data.

5. Yes

Maidstone and Tunbridge Wells NHS
NHS Trust

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Policy and Procedure for Management of NICE Guidance

Requested/ Required by:	Trust management and all clinical leads involved in the review and implementation of guidance produced by NICE
Main author:	Research and Clinical Audit Manager
Other contributors:	
Document lead:	Research and Clinical Audit Manager
	Contact Details: Research and Clinical Audit Department, Back of Medical Records, Maidstone Hospital, Maidstone Kent
Directorate:	Corporate – Clinical Governance
Specialty:	Research and Clinical Audit
Supersedes:	Policy and Procedure for Management of NICE Guidance (Version 6.0: September 2011)
	Policy and Procedure for Management of NICE Guidance (Version 6.1: February 2014)
Approved by:	Standards Committee, 16th April 2014
Ratified by:	Quality and Safety Committee, 7th May 2014
Review date:	April 2016

Document history

Requirement for document:	To ensure the Trust has a process for managing the implementation of NICE guidance in order to reduce the financial risk and risk to patient safety Care Quality Commission regulations Commissioner requirements
Cross references:	• Department of Health (2003). *Health Service Circular 2003/011. The interventional procedures programme: working with the National Institute for Clinical Excellence to promote safe clinical innovation*. Available at: www.dh.gov.uk • Department of Health. (2005). *Chief Medical Officer* Annual *Report: Learning how to Learn - Compliance with Patient Safety Alerts in the NHS*. London: Department of Health. Available at: www.dh.gov.uk • Department of Health (2006). *Standards for Better Health*. London: Department of Health. Available at: www.dh.gov.uk • Department of Health. (2008). Darzi, Professor the Lord. *High quality care for all: NHS Next Stage Review final report.* London: Department of Health. Available at: www.dh.gov.uk • Department of Health. (2010). *The NHS Constitution: The NHS belongs to us all.* London: Department of Health. Available at: www.dh.gov.uk • The Health Foundation. (2009). *Rising to the challenge: Using evidence about what works to improve quality and save money.* London: The Health Foundation. Available at: www.health.org.uk • National Institute for Health and Clinical Excellence (NICE). (2004). *Legal Context of NICE guidance*. London: NICE. Available at: www.nice.org.uk • National Institute for Health and Clinical Excellence (NICE). (2008). *How to put NICE guidance into practice: A guide to implementation for organisations.* London: NICE. Available at: www.nice.org.uk • National Institute for Health and Clinical Excellence (NICE). (2007). *How to change practice*. London: NICE. Available at: www.nice.org.uk • National Institute for Health and Clinical Excellence (NICE). (2008). *Our guidance sets the standard for good healthcare*. London: NICE. Available at: www.nice.org.uk • National Institute for Health and Clinical Excellence (NICE). (2008). *Vital Signs Mapping*. London: NICE. Available at: www.nice.org.uk • National Quality Board (2010). *NICE Quality Standards.* Available at: www.dh.gov.uk
Associated documents:	• Maidstone and Tunbridge Wells NHS Trust*. Clinical Audit and Effectiveness Strategy (2013-15)* [RWF-OPPPCS-C-CG3] • Maidstone and Tunbridge Wells NHS Trust. *Clinical Audit Policy and Procedure* [RWF-OPPPCS-NC-CG3]

Version control:		
Issue:	**Description of changes:**	**Date:**
4.0	Procedure for the Management of NICE Guidance	June 2007
5.0	Complete re-write of the original policy to reflect changes throughout the wider organisation, notably the Clinical Governance Management structure and changes to the NICE compliance process.	July 2009
6.0	Amendments made to the Policy and Procedure to reflect changes within the organisation and NHSLA requirements	September 2011
6.1	Standards Committee (14th February 2014) agreed to extend review date to 1st June 2014	February 2014

7.0	Complete re-write of the original policy to reflect changes throughout the wider organisation, notably the Clinical Governance Management structure and changes to the NICE compliance process.	March 2014

Maidstone and Tunbridge Wells NHS
NHS Trust

Policy Statement for

Management of NICE Guidance

Every NHS organisation is expected to have a process in place monitor the relevance, implementation and auditing of National Institute for Health and Clinical Excellence (NICE) guidance.

This document describes the process for the monitoring of all NICE documentation, including NICE Quality Standards, at Maidstone and Tunbridge Wells NHS Trust. It gives specific instructions on how to review, NICE guidance.

This policy is applicable to all NICE documentation including Clinical Guidelines, Interventional Procedures, Technology Appraisals and Public Health Interventions.

This policy is applicable to all staff involved in the gap analysis process in reviewing practice against NICE guidelines.

Procedure for Management of NICE Guidance

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Further appendices

No.	Title
4	NICE guidance and clinical audit process flowchart
5	NICE review forms
6	NICE guidance template letter
7	NICE quality standards review form

1.0 Introduction and scope

The National Institute for Health and Clinical Excellence (NICE) is an independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

The purpose of this policy and procedure is to detail the robust systems for dissemination, implementation, monitoring, audit and review of NICE guidance recommendations. This policy and procedure details -

- The arrangements in place to identify key staff responsible for disseminating reviewing and implementing guidance.
- The electronic system for dissemination and monitoring of compliance against NICE guidance
- The system to agree prioritisation of clinical audit of NICE guidance on the Trust clinical audit programme.

2.0 Definitions

There are eight categories of NICE guidance:

- **Clinical guidelines**: guidance on the appropriate treatment and care of people with specific diseases and conditions
- **Interventional procedures**: are procedures used for diagnosis or treatment
- **Technology appraisals**: guidance on the use of new and existing medicines, treatments and procedures - Since January 2002 a new duty to identify funding for implementation of Technology Appraisals within *three months of publication* has been put in place
- **Public health guidance**: guidance on the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector.
- **Cancer service guidance**: guidance on the appropriate treatment and care of people with cancer
- **Quality standards:** NICE quality standards are a concise set of prioritised statements designed to drive measurable quality improvements within a particular area of health or care
- **Medical technologies guidance:** NICE medical technologies guidance helps the NHS to adopt medical technologies more rapidly and consistently by advising on efficacy and cost effectiveness.
- **Diagnostic guidance:** NICE diagnostics guidance makes recommendations to the NHS on the efficacy and cost effectiveness of new diagnostic technologies.

3.0 Duties

3.1 Duties of the Medical Director

The Medical Director is responsible for assuring the Trust Executive that all NICE Guidance is received, disseminated and reviewed for relevance. Assurance is in the form of regular reports to Trust Board. Non-compliance with this policy and process is escalated to the Medical Director via the Deputy Medical Director.

3.2 Duties of the Clinical Director

The Clinical Director will identify relevant leads within the directorate to review the NICE guidance on publication and support clinical leads in reviewing NICE guidance and developing implementation plans.

3.3 Duties of the Clinical Lead

This is the clinician identified by the Clinical Director as the person who should receive the guidance, lead on the review and complete NICE Compliance forms. The Clinical Lead is expected to:

- Discuss guidance and debate compliance status with clinical colleagues at a relevant specialty meeting (this could be a specialty governance meeting where both clinical and managerial staff is present).
- Ensure the compliance forms are completed following discussion with colleagues which will reflect current practice/service provided in relation to NICE guidance.
- In the event that the service does not fully comply with the NICE guidance liaise with the Clinical Director to complete the rationale for non-compliance section of the NICE Review Form.
- Ensure the NICE Review form is returned to the Clinical Audit Department.

3.4 Duties of the Research & Clinical Audit Manager

The Research and Clinical Audit Manager is responsible for implementing and overseeing the NICE compliance process within the Trust. This person is also responsible for ensuring policy, process and resources are in place to deliver the process.

3.5 Duties of Governance Database Officer

The Governance Database Officer receives new guidance published directly from NICE and ensures this is added to the NICE Monitoring Database. The post holder ensures that the relevant documents are collated and disseminated to Clinical Directors/ Directorate General Managers and/or Trust specialists. The post holder will ensure information on compliance is transferred to the NICE Monitoring Database and prepare monthly progress report for the Standards Committee.

3.6 MTW Staff

This policy and procedure is applicable to all staff involved in the gap analysis process in reviewing practice against NICE guidelines.

4.0 Training / competency requirements

Advice on all aspects of NICE guidance can be sought from the Governance Database Administrator within the Research and Clinical Audit Department.

When undertaking a new NICE review, the Trust Governance Database Administrator will support staff in understanding their responsibility for reviewing NICE guidance against current provision.

5.0 Procedure

Organisational Gap Analysis

The Clinical Audit Team conduct a monthly gap analysis by reviewing and disseminating published NICE guidance to either the Clinical Directors who identify a Trust lead to review the guidance, or directly to relevant lead where obvious.

An email is sent by the Governance Database Administrator (NICE Co-ordinator) containing the NICE guidance itself and a NICE Review form for completion **(Appendix Five).** The relevant Clinical Audit Facilitator is included in the email to ensure they are aware of the guidance, can support leads to complete the review if required and are aware of another possible addition to the clinical audit programme.

The Clinical Lead reviews the guidance and completes the NICE Review Form and/or sends the NICE Review Form to relevant leads for completion. The form is then emailed back to the Governance Database Administrator in the Clinical Audit Department.

Leads have up to six weeks to review the guidance with directorate colleagues and complete and return the NICE Review Form to the Clinical Audit department. If there is no response after six weeks from initial dissemination a reminder letter will be sent on behalf of the Deputy Medical Director. Should there be no response after a period of three months an “outstanding” entry will be made in the database and contact made with the Medical Director.

Once NICE documentation has been reviewed by the Trust lead, it is recorded on the NICE database as either relevant/non-relevant and if a NICE Clinical Guideline, added to the Annual Clinical Audit Programme.

Both the database and original review forms form part of the evidence provided to the Care Quality Commission that NICE guidance is regularly reviewed.

6.0 NICE Quality Standards

NICE quality standards are ‘a concise set of prioritised statements designed to drive measurable quality improvements within a particular area of health or care’. (www.nice.org.uk). Quality standards have been developed by NICE working collaboratively with a wide range of healthcare professionals from public health, social care and service users. NICE quality standards support the Government's vision for a health and social care system focussed on delivering the best possible outcomes for people as detailed in the 2012 Health and Social Care Act Health.

The Quality Standards published span a wide range of disease and service areas. Trust clinical leads are required to review Quality Standards for relevance and compliance in the same manner as NICE guidance. (Please see Appendix 4). Quality standards are designed to help health professionals make decisions about care based on the most up to date evidence and practice. Members of the public can review organisational data and compliance to better understand the quality of care they can expect. Commissioners require healthcare organisations to review and measure compliance against NICE Quality Standards to be confident that services they purchase are of high quality.

NICE compliance is becoming increasing important as it is reflected in commissioning requirements such as the Commissioning for Quality and Innovation (CQUIN) framework.

The process for reviewing new NICE Quality Standards is identical to the NICE Guidance review process.

7.0 Monitoring and audit

Information on all published NICE documentation is available for staff to view on the Trust Q-PULSE system.

7.1 Role of the Standards Committee

The Standards Committee receives monthly updates on NICE Guidance compliance from the Research and Clinical Audit Manager noting especially any non-responses, partial compliance and non-compliance. Directorate representatives at the Standards Committee report reasons for non compliance and any mitigating actions to be taken via the Directorate Reports.

7.2 Role of the Clinical Directors Meeting

To receive monthly updates on NICE compliance from the Clinical Audit Department and discuss issues relating to non compliance with staff. Decisions taken at these meetings will be fed back to the Standards Committee via the Directorate Reports to the Standards Committee.

7.3 Role of the Quality and Safety Committee

To receive summaries of compliance with NICE reviews, detailing risks, mitigating actions, achievements and outcomes following NICE reviews from the Standards Committee. Provide a summary of events to the Trust Board.

7.4 Monitoring of minimum requirements

The Medical Director as Chairman of the Standards Committee and the Clinical Audit Manager will be responsible for monitoring compliance with this policy / procedure on behalf of the Trust.

Regular reports will be produced by the Clinical Audit Department and submitted to the Standards Committee by the Research and Clinical Audit Manager. The report will include evidence of compliance with the following minimum requirements:

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Action Lead(s)	Change in practice and lessons to be shared
Duties (including leadership for all stages of the process)	Medical Director	Clinical Audit Management monthly Meeting updates	On going	Standards Committee (monthly) Quality and Safety Committee	Governance Database Administrator, Medical Director	Report on process given to members of the Standards Committee on a **bi-monthly** basis.
Process for identifying relevant documents	Medical Director/Governance Database Administrator	NICE Database and communication from NICE Report	monthly	Standards Committee (monthly) Quality and Safety Committee	Governance Database Administrator	Report on process given to members of the Standards Committee on a **monthly** basis.
Process for disseminating relevant documents	Governance Database Administrator	NICE Database and communication from NICE Report	monthly	Standards Committee (monthly) Quality and Safety Committee	Governance Database Administrator	Report on process given to members of the Standards Committee on a **monthly** basis.
Process for conducting an organisational gap analysis	Clinical Directors	Directorate CG sessions and minutes from these	monthly	Standards Committee (monthly) Quality and Safety Committee	Divisional teams lead by Clinical Director	Governance Minutes, discussion at Standards Committee and Audit Management meeting reports to divisions
Process for ensuring that recommendations are acted upon throughout the organisation	Medical Director	CD meeting minutes, Clinical Audit Report to Standards Committee	monthly	Standards Committee (monthly) Quality and Safety Committee	Clinical Directors and Medical Director	Governance Minutes, discussion at Standards Committee and Clinical Audit reports to directorates
Process for documenting decision not to implement NICE recommendations	Governance Database Administrator	NICE Database and NICE report for Standards Cttee	On going	Standards Committee (monthly) Quality and Safety Committee	Governance Database Administrator	Governance Minutes, discussion at Standards Committee and Clinical Audit reports to directorates

APPENDIX ONE

Process requirements

1.0 Implementation and awareness

- This policy will be bought to the attention of all key staff detailed in **Appendix Two** via the email system of dissemination. It will also be presented to members of the Audit Management Meeting for comment and to the Standards Committee.
- The policy will be held centrally on the Trust Q-PULSE system and be available from the Research and Clinical Audit Department.
- Once approved the document lead or author will submit this policy/procedural document to the Clinical Governance Assistant who will activate it on the Trust approved document management database on the intranet, under 'Trust polices, procedures and leaflets'.
- A monthly publications table is produced by the Clinical Governance Assistant which is published on the Trust intranet under "Policies"; notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.

2.0 Review

This policy will be reviewed in line with changes to wider Trust processes as appropriate. A full review will occur every two years.

3.0 Archiving

The Trust intranet retains all superseded files in an archive directory in order to maintain document history.

APPENDIX TWO

CONSULTATION ON: Policy and Procedure for Management of NICE Guidance

Please return comments to: Clinical Audit and Research Manager

By date: 6th April 2014

Name: *List key staff appropriate for the document under consultation. Select from the following:*	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Medical Director	24.03.14	16.04.14	N	N
Deputy Medical Director	24.03.14	16.04.14	N	N
Chief Nurse	24.03.14	16.04.14	N	N
Deputy Chief Nurse	24.03.14	16.04.14	N	N
Clinical Directors	24.03.14	16.04.14	N	N
Risk and Compliance Manager	24.03.14	16.04.14	N	N
Patient Safety and Risk Manager	24.03.14	16.04.14	N	N
Clinical Governance Assistant	24.03.14	30.03.14	Y	Y
Matrons	24.03.14	16.04.14	N	N
Clinical Audit Department	24.03.14	16.04.14	N	N
Governance Database Officer	24.03.14	16.04.14	N	N
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

APPENDIX THREE

Equality Impact Assessment

In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality. The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Human Rights Policy on the Trust intranet, for details on how to complete the grid. **Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.**

Title of Policy or Practice	Policy and Procedure for Management of NICE Guidance
What are the aims of the policy or practice?	Ensure arrangements are in place to identify key staff responsible for disseminating reviewing and implementing guidance. Detail the electronic system for dissemination and monitoring of compliance against NICE guidance. Detail the system to agree prioritisation of clinical audit of NICE guidance on the Trust clinical audit programme
Identify the data and research used to assist the analysis and assessment	Equality and diversity policy and procedure (incorporating Single Equality Scheme (SES))
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no). If yes give details.**
Males or Females	NO
People of different ages	NO
People of different ethnic groups	NO
People of different religious beliefs	NO
People who do not speak english as a first language	Translations can be arranged on request
People who have a physical disability	NO
People who have a mental disability	NO
Women who are pregnant or on maternity leave	NO
Single parent families	NO
People with different sexual orientations	NO
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	Special arrangements for staff without access to the Trust – access via R&D Committee
People in deprived areas and people from different socio-economic groups	NO
Asylum seekers and refugees	NO
Prisoners and people confined to closed institutions, community offenders	NO
Carers	NO
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	YES
When will you monitor and review your EqIA?	With review of this policy/procedure
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this policy/procedure (Q-PULSE)

FURTHER APPENDICES

The following appendices are published as related links to the main policy /procedure on the Trust approved document management database on the intranet (Trust policies, procedures and leaflets):

No.	Title	Unique ID
4	NICE guidance and clinical audit process flowchart	RWF-OWP-APP69
5	NICE review forms	RWF-OWP-APP70
6	NICE guidance template letter	RWF-OWP-APP71
7	NICE quality standards review form	RWF-OPF-CS-NC-CG18

6. Audits are carried out in each clinical department to ensure NICE Guideline compliance and reported to the Board

7. The complaints team do not have the specific code that will enable them to extract this data.

8.
Patients are given the information that the diabetologist thinks appropriate at their outpatients appointment
We audit to ensure clinicians are using the criteria set by NICE without added restrictions

9.
Animas
Medtronic
OmniPod
Roche (Accu-Chek).

10.
We do not have accurate figures for the number of type 1 diabetic patients within our trust as we have no functioning diabetes database to extract this information

11.
234 – Adult patients

12. We do not provide patient information in advance but on the day of their appointment the doctor discusses the options.
We do audits of management intermittently to review our care

13. We do not provide patient information in advance but on the day of their appointment the doctor discusses the options.
We do audits of management intermittently to review our care

The gynaecologists work with the radiologists on embolization but the radiologists do not do outpatient clinics (so there is MDT discussion on all cases)

14. Gynaecologists are trained to understand the place of it in management and offer it to appropriate patients.

15. We do not monitor training on UAE but it forms part of the RCOG training programme for doctors in training

16. The Trust does not have a central data on UAE training.

17. 552

18. 933 (which includes the 552 primary diagnosis in qu 17)

19. 332

20. 691 (which includes the 332 primary diagnosis in qu 19)

21. Primary diagnosis only of N92 or D25 plus Procedure code Q07-Q08 = 233
Primary and secondary diagnosis of N92 or D25 plus Procedure code Q07-Q08 = 308 (including primary diagnosis only of 233)

22.

Age bands	Prim Diag only	Prim and secondary diag
<29	1	1
30-34	10	12
35-39	28	32
40-44	42	52
45-49	83	96
50-54	49	57
55+	20	58
Grand Total	**233**	**308**

23. Yes

24.

Procedure code	Total
Q092	39
Q093	6
Q161	4
Q171	536
Q174	135
Grand Total	**720**

25.

Procedure code	<29	30-34	35-39	40-44	45-49	50-54	55+	Grand Total
Q092	5	8	9	9	6		2	39
Q093	2		2				2	6
Q161						1	3	4
Q171	15	19	33	54	93	91	231	536
Q174	4	4	5	11	23	18	70	135
Grand Total	**26**	**31**	**49**	**74**	**122**	**110**	**308**	**720**

26. Yes

27. Not applicable

28. Zero HRG code RC41Z in financial year 2015/16 or 2016/17

29. Maidstone and Tunbridge Wells NHS Trust have very few UAE patients, and we liaise with radiology when a patient is identified and provide a bed accordingly

30. Our Interventional Radiologists do not have admitting rights, all patients who require admission for procedures must be booked through the referring consultant.

31. Zero HRG code RC41Z in financial year 2015/16 or 2016/17