

## **Appendix 1 Recommendations for pelvic floor services**

### 1. The pelvic floor multidisciplinary team

The management of pelvic floor disease is complex:

- The pelvic floor consists of multiple compartments traditionally managed by different specialties who may have different views about therapy, yet pathology often affects multiple pelvic compartments. Many staff work in isolation with surgeons, physicians, radiologists, specialist nurses and physiologists having little direct discussion.
- The evidence base for therapy is poor with a need for robust research and audit, which is not possible unless there is a unified method of streaming patients and central collection of data (c.f. NBOCAP).
- Patients may progress through several sequential therapies on a treatment pathway.
- Considering this complex management pathway there is a paramount need for uniform and clear communication with the patient as well as between primary, secondary and tertiary care.

The argument for a pelvic floor MDT appears strong. It would bring together staff with the necessary knowledge, skills and experience to ensure high quality diagnosis, treatment and care. This is supported by NICE guidance and is central to NHS England's commissioning of specialist pelvic floor services [complex colorectal and complex gynaecology]. (*NICE guidance CG49 on FI, Service Spec A08/S/d Adult FI, E10s Recurrent Prolapse & recurrent Urinary incontinence and is mandatory for the performance/funding purposes of SNS. MDT working is also supported by the British Society of Urogynaecology *Standards for Service Provision*.*). It is also supported by The Pelvic Floor Society membership and Executive.

In Scotland it is hoped that the Scottish Government Health and Social Care Directorate will accept that this is a disadvantaged patient group with little public voice and agree to incorporate Pelvic Floor Disease into strategic direction and resource allocation for NHS Scotland

An effective pelvic floor MDT should result in:

- Individualised treatment and care considered by professional healthcare workers with specialist knowledge and skills relevant to the pelvic floor
- Improved outcomes as a result of better understanding of the patient's issues and condition
- Patients being given information and tailored support needed to cope with their condition
- Continuity of care, even when this care involves different healthcare professionals
- Good communication between primary, secondary and tertiary care
- Good data collection, both for the benefit of the patient and for robust audit and research
- Adherence to local and national guidelines
- Promotion of good working relationships
- Optimisation of resources by more efficient working
- Opportunities for education and training
- Patients being offered the opportunity to be involved in clinical trials

*Team constitution:*

Core membership will include those considered to be core or essential to the running of a pelvic floor service. These will include:

- At least one colorectal surgeon who specialises in performing the spectrum of operations that may be needed to treat the conditions;
- A pelvic floor physiologist and/or a specialist nurse who undertake diagnostic evaluation of pelvic floor abnormalities and introduce and optimise conservative management at an early stage;
- A urogynaecologist;
- A radiologist (or trained equivalent) with an interest in pelvic floor disorders who is able to offer a high quality dynamic defaecography service and interpretation of endoanal ultrasound
- Administrative staff (MDT co-ordinator) to ensure that documentation is accurate and effectively recorded

Members that can be considered as valuable contributors but not essential (extended members) include:

- Further numbers of the above specialists: ideally a second colorectal surgeon and specialist nurse to cover absence
- A medical gastroenterologist with an interest in digestive motility
- A pain management specialist
- A psychiatrist or psychologist
- A functional urologist
- Trainees (colorectal or gynecological) with interest in pelvic floor disease
- Research staff e.g. CRN-funded NHS support staff to identify trial recruitment
- An MDT coordinator (see below)

*Attendance:*

MDT members (core and extended) should have dedicated time in their job plan to prepare for and attend MDT meetings. The frequency and amount of time dedicated to such meetings should be negotiated locally to reflect the local workload, but should be no less than monthly.

- Core members should be present for discussion of all cases where their input is required - it is for the chair to decide (in consultation with others) whether there is adequate representation at a single meeting to make safe recommendations about any/all patients.
- The chair is responsible for raising concerns about non-attendance and escalating these concerns if necessary. Frequent non-attendance should be addressed in the appraisal and job-planning review.
- Extended members and non-members may attend for the cases that are relevant to them.
- There should be a register maintained of those attending and minutes recorded.

*Chair:*

A Chair must be agreed who is responsible for the organisation and running of the MDT meetings (in conjunction with appropriate administrative staff). The responsibilities of the chair include:

- Preparing an agenda;
- Ensuring meeting is quorate taking action if not;
- Ensuring all relevant cases are discussed;
- Ensuring all relevant team members are included in discussion;
- Ensuring discussions are focused and relevant with clear communication;
- Ensuring that interventions are actioned and recorded;
- Ensuring all discussion points and treatment plans are complete before the next patient discussion starts and that all data is recorded and the recommendations summarised and fed back to the patient, GP and clinical team within a locally agreed time frame;
- Promoting evidence-based and patient-centred recommendations and to ensure that eligibility for relevant trial recruitment is considered;
- Promoting education and training.

*Team working and culture:*

It is essential that each MDT member has mutual respect and trust of each other and has an equal voice with different opinions valued. Best practice should be shared with an opportunity for learning from each other.

*Infrastructure:*

There should be:

- a dedicated room with a layout to allow all members to sit and hear each other and view all presented data
- equipment for projecting and viewing radiological images;
- access to PACS and other investigation results.

*Meeting organization and logistics*

Scheduling should ensure that:

- MDT meetings should take place regularly and at times so as not to clash with other fixed clinical commitments;
- Cases for discussion should be identified by each core member and included for submission to the agenda prior to the meeting;
- There is a locally agreed cut off time for inclusion of a case on the MDT. Flexibility for urgent cases should be allowed;
- The patient list is circulated to all members prior to the meeting which includes a locally agreed minimal dataset;
- Each case is discussed by the member relevant to the case;
- There is access to all relevant information at the meeting including patient notes, test results, images and appointment dates.

Post-MDT processes should be in place to:

- Communicate MDT recommendations to patients, GPs and clinical teams within locally agreed time frames;
- Ensure that agreed actions are implemented, or that the MDT is notified of significant changes made to their recommendations.

*Patient selection: Who to discuss?*

There should be local mechanisms in place to identify all patients where discussion at MDT is needed. The following patients mandate discussion:

- Any patient who is being considered for surgery with the primary intent of managing PFD
- Any patient with FI being considered for SNS [CQUIN requirement]
- Any patient with complications following surgery, or failed surgery to include recurrent POP or urinary incontinence [CQUIN requirement].
- Multi-compartment symptoms (e.g. faecal and urinary incontinence or multi-organ prolapse)
- Failed conservative treatments and in whom the next steps are unclear

*Clinical decision making process:*

- A locally agreed minimum dataset of information is provided at the meeting.
- All clinically appropriate treatment options should be considered even if they cannot be offered locally.
- There should be access to a list of all current and relevant clinical trials and suitability should be considered for each patient.
- Standard treatment protocols should be in place and used when appropriate.
- Patient views, preferences and needs inform the decision making process.
- MDT recommendations should always be:
  - Evidence-based and patient-centred (patients should be aware of the MDT purpose and structure. Their views should be represented by someone who has met the patient whenever possible.
  - In line with standard treatment protocols. Deviations should have good reason and the reason documented.
- If data is missing or incomplete it should be possible to bring the patient back for further discussion when the data becomes available.
- It should be clear who will communicate the MDT recommendation to the patient, GP and clinical team. This should be documented.

*Governance:*

Organisational support: There are costs associated with running an MDT. There is therefore the need for organisational (employer support) for MDT meetings demonstrated via recognition that MDTs are the accepted model to deliver safe and high quality care. The employer will need to fund the resources, required for MDT meetings to operate effectively.

Data collection, analysis and audit:

- Data collection resource should be available to the MDT
- Key information that directly affects treatment decisions should be collected
- National datasets should be developed and populated allowing refinement of treatment

- Data collected is analysed and fed back to the MDT for the purpose of learning
- There should be internal and external audits of process and outcome. This should include an annual general meeting for discussion of outcomes and an accreditation process for pelvic floor units.

Clinical governance:

The purpose of the MDT and its expected outputs are clearly defined locally. There should be agreed guidelines as to:

- How the MDT operates;
- Who the core and extended members are;
- The roles of the members;
- How the members should work together;
- How changes to clinical practice should be managed;
- Communications post meeting.

There should be mechanisms in place to:

- Record recommendations of the MDT versus the actual treatment given and reasons if there is variation;
- Record serious or adverse events;
- Monitor the proportion of patients discussed.

## 2. National structure of pelvic floor services

Hospitals that deliver pelvic floor services should only do this within an integrated MDT process. Where such MDT support is not available then patients with pelvic floor pathology should be referred to institutions that can provide suitable care. It is the responsibility of units referring patients to have previously excluded significant other pathology, especially with regard to having previously investigated any “red flag” symptoms thus excluding serious organic pathology (cancer, inflammatory bowel disease etc.) These hospitals may have basic specialist nursing for pelvic floor disorders who will meet with and co-ordinate with colleagues in centres offering pelvic floor services.

It is anticipated that patients with external rectal prolapse will still be treated in some local centres by perineal procedures and standard abdominal surgery, where suitable surgical experience exists. Surgery for incontinence, constipation and internal prolapse, or multi-compartment surgery should be performed in units where adequate MDT facilities are in place.

*Units offering pelvic floor services:*

It is expected that an accredited pelvic floor unit will have at least two colorectal surgeons with a pelvic floor interest and that these should represent a proportion of a sufficiently greater colorectal surgical department e.g. minimum of 6 consultants such that adequate subspecialty time can be devoted to pelvic floor disease management. Job plans should reflect between 0.75 and 1.0 whole time equivalents (for a referral population of between 250,000 and 500,000) and 1.0 and 1.5 whole time equivalents (for a referral population over 500,000).

It is anticipated that a centre will have between 25 and 40 new referrals / month leading to a pelvic floor clinic at least weekly and a joint pelvic floor clinic (with urology / urogynaecology input) every 1 – 2 months. Larger units will have 35 and 100 new referrals / month leading to at least 2 pelvic floor clinics per week and a minimum of 2 joint pelvic floor clinics (with urology / urogynaecology input) per month. It is expected that a proportion of pelvic floor clinics in each institution will be “one stop” with some or all of the investigations indicated being carried out at the same visit.

All units offering a pelvic floor service should either have an MDT on site or be directly involved in an MDT which could be shared between two or three centres. Depending upon the number of centres sharing an MDT these should meet between weekly and monthly and discuss between 5 and 10 patients per meeting (no more than 20 cases). Each MDT (as detailed above) should be supported by a physiology service and imaging facilities to provide anal ultrasound, and defaecation proctography or MRI proctography (as per local preference). The physiology service should be run and supervised by a clinical scientist, physiologist or clinical nurse specialist with suitable training. A unit should expect to perform between 5 and 20 examinations per week per unit that it serves, depending upon the referral base. Equivalent numbers of anal ultrasound scans are expected with these being performed by a radiologist, surgeon, nurse, physiotherapist or scientist with suitable training.

Each centre should offer forms of adjunctive therapy in addition to specialist nurse-led bowel retraining for defaecation disorders (mainly incontinence and obstructed defaecation) Adjuncts may include visual biofeedback, pelvic floor muscle therapy, direct neuromuscular (vaginal or perineal) electrical stimulation and minimally invasive forms of neuromodulation e.g. percutaneous tibial nerve stimulation. Transanal rectal irrigation should be available offering both low and high volume therapy based on patient factors and preference.

Within each MDT group / centre there should be the facility to offer sacral neuromodulation and the full range of complex pelvic floor surgery in those cases where the MDT has decided that surgery is indicated. This surgery should be facilitated with a monthly combined operating list for those patients with multi-compartment pathology requiring input from colorectal surgeon and urologist / urogynaecologist. It is anticipated that details of these cases should be recorded in the future on a National Database for subsequent review and audit coordinated through The Pelvic Floor Society.

It is anticipated that several centres may have / develop the expertise to offer a service for the management of more complex problems and a shortlist of 'reference' centres will be developed nationally with the support of The Pelvic Floor Society (below) to facilitate appropriate referral. This list will include those offering:

- Revisional surgery for complex complications following primary mesh prolapse surgery
- Revisional surgery following sacral neuromodulation
- Anal and perineal reconstructive surgery incorporating tissue transposition
- Antegrade colonic enema (ACE) surgery
- Combined expertise (with gastroenterologists / neurologists) for the assessment of patients with complex primary and secondary neuro-gastroenterological disorders e.g. Hirschsprung's disease, autonomic neuropathies,
- Combined expertise for the management of severe learning or psycho-behavioral disorders
- Transitional care for older children and adolescents

### 3. Role of the pelvic floor society

The formation of TPFS, a subgroup of the Association of Coloproctology of Great Britain and Ireland, will provide a co-ordinated platform for the provision of training in the management of pelvic floor disorders as well as introducing initiatives in quality assurance and governance. The PFS has also taken the lead in developing a minimum dataset for all pelvic floor patients undergoing surgery and monitor the use and complication rates following surgery. This will include those specific to implanted material (synthetic and collagen mesh, stimulator units).

A number of accredited centres distributed throughout the country will be identified that can offer training for surgeons with a pelvic floor interest with free access to the MDT meetings and availability to attend operating lists to observe more complex operative procedures. Training should include local mentorship arrangements and the co-ordination of more structured courses. These courses will be co-ordinated through TPFS training and education committee.

A draft curriculum and PBAs has also been produced and will be posted on the societies website. These resources will be a welcomed tool for trainees to use over and above their CCT to demonstrate a special interest in pelvic floor surgery. It is not a requirement for CCT and will remain voluntary. With time TPFS will be developing modular courses (ultrasound and anorectal physiology), training fellowships and formalised research posts.

The purpose of peer review/accreditation is to define and monitor standards of care, organisation and quality within individual pelvic floor unit and MDTs. These standards will be measurable, comparable and identify those units, which deliver best practice. They will be designed to provide a robust mechanism for ensuring quality control in units managing patients with pelvic floor conditions, which will be of value to service users, commissioners and providers. The standards will also provide a framework that will help PF units/MDTs to improve patient care, encourage multidisciplinary working and enhance prospects for individuals units to grow and develop.